Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS MEETING

Tuesday 5th July 2016 commencing at 1000

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

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action	Preparation
		1000	**PATIENT STORY**			
Board Business						
1.	**16/17/66**	**1015**	**Apologies**	Chair		--
2.	**16/17/67**	**1016**	**Declarations of Interest**	All	Board Members to declare an interest in particular agenda items, if appropriate	--
3.	**16/17/68**	**1017**	**Minutes of the Previous Meeting**	Chair	To consider the minutes of the previous meeting held on **23 May 2016** and check for amendments and approve	Read Minutes
4.	**16/17/69**	**1018**	**Matters Arising and Board Action List**	Chair	To discuss any matters arising from previous meetings and provide updates and review where appropriate	Verbal
5.	**16/17/70**	**1020**	**Key Issues/Reflections**	All	The Board to reflect on key issues.	Verbal
Strategic Update						
6.	**16/17/71**	**1030**	**External Environment/STP** **Progress against strategic pillars** - **Community Services** - **Liverpool Women's Reconfiguration Options** - **Global Health**	L Shepherd T Patten T Patten T Patten	To update the Board with regard to ongoing processes with the local health economy	Presentation Presentation
7.	**16/17/72**	**1100**	**Proposed revised CBU Structure**	L Shepherd/ M Barnaby	To brief the Board in relation to proposed timescale for the move to three CBUs.	Presentation

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action	Preparation
Inspiring Quality						
8.	**16/17/73**	**1120**	**Infection Prevention and Control** - **Quarter 4 report** - **Strategy and Delivery plan for 2016-17**	R Cooke	To provide an overview of the Quarter 4 IPC report The DIPC delivery plan outlines the objectives to be achieved in 2016-17	Read report Read report
9.	**16/17/74**	**1130**	**Serious Incidents Report**	H Gwilliams	To inform the Board of the recent serious incidents at the Trust in the last calendar month	Read Report
10.	**16/17/75**	**1135**	**Revalidation Annual Report**	H Blackburn	To receive the annual revalidation report for the Trust.	Read report
11.	**16/17/76**	**1145**	**Mortality Board report Quarter 4**	R Turnock	To receive the Quarter 3 mortality report	Read report
12.	**16/17/77**	**1150**	**Clinical Quality Assurance Committee: Chair's update**	A Marsland	To receive and review the minutes from the meeting held on; 18th May 2016	Read minutes
Great Talented Teams						
13.	**16/17/78**	**1155**	**People Strategy Update** - **Health and Wellbeing update** - **LiA update** - **Workforce Diversity task and finish group** - **WOD Annual report 2015/16 2015/16 and minutes held on 8th June 2016**	M Swindell M Swindell M Swindell C Dove	To provide an update on the strategy To provide an update on progress To provide an update on progress since the last meeting To receive the latest set of minutes for information and approve the annual report	Read report Read report Verbal Read report
Patient Centred Services						
14.	**16/17/79**	**1205**	**Alder Hey in the Park update**	D Powell	• To receive an update on key outstanding issues / risks and plan for mitigation .	Read report
Financial Growth and Safeguarding Core Business						

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action	Preparation
15.		**1215**	**Working Capital Loan Agreement**	J Stephens	For discussion and approval.	Read report
16.	**16/17/80**	**1230**	**Corporate Report**	J Stephens/ M Barnaby/ H Gwilliams/ M Swindell/ E Saunders/	To note delivery against financial , operational, HR metrics and mandatory targets within the Corporate Report for the month of March 2016	Read report
17.	**16/17/81**	**1240**	**Programme Assurance update** • **Workforce and Organisational Development** • **Clinical Quality Assurance Committee** • **Resource Assurance and Business Development**	J Gibson	To receive an update on programme assurance.	Read report
18.	**16/17/82**	**1245**	**Integrated Assurance Report** - **Board Assurance Framework June 2016**	E Saunders	To receive monthly BAF update.	Read report
19.	**16/17/83**	**1250**	**Car parking**	M Swindell/ H Gwilliams	To provide an update on the latest developments	Verbal
20.	**16/17/84**	**1255**	**Resources & Business Development Committee: Chair's update**	I Quinlan	To receive and review the minutes from the meeting held on; 25th May 2016	Read report
Any Other Business						
21.	**16/17/85**	**1300**	**Any Other Business**	All	To discuss any further business before the close of the meeting	Verbal
NB: Extraordinary Board: Monday 18th July 2016 at 1400, Institute in the Park, Large Meeting Room						

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action	Preparation
Date and Time of Next Meeting: Tuesday 6th September 2016 at **10:00am, Institute in the Park, Large Meeting Room**						
Lunch						

REGISTER OF TRUST SEAL
The Trust Seal was used during the month of **July 2016** for; • Deed of Novation (Transfer of Contract) with Calderstones Partnership regarding ELFS shared services

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Minutes of the last meeting held on **Monday 23rd May 2016, at 10am,**
Institute in the Park Large Meeting Room at Alder Hey

Present:	Mr S Igoe (Chair)	Non-Executive Director	(SI)
	Mrs M Barnaby	Interim Chief Operating Officer	(MB)
	Mrs J France-Hayhurst	Non-Executive Director	(JFH)
	Mrs H Gwilliams	Chief Nurse	(HG)
	Mrs A Marsland	Non-Executive Director	(AM)
	Mr J Stephens	Director of Finance	(JS)
	Mrs L Shepherd	Chief Executive	(LS)
	Mrs M Swindell	Interim Director of HR & OD	(MS)
In Attendance:	Prof M Beresford	Assoc. Director of the Board	(MB)
	Ms L Dunn	Director of Marketing and Communications	(LD)
	Ms T Patten	Associate Director of Strategic Development	(TP)
	Mr D Powell	Development Director	(DP)
	Dr M Ryan	Clinical Director (for Mr Turnock)	(MR)
	Ms E Saunders	Director of Corporate Affairs	(ES)
Apologies:	Mrs C Dove	Non-Executive Director	(CD)
	Sir David Henshaw	Chairman	(DH)
	Mr R Turnock	Medical Director	(RT)
	Mr I Quinlan	Non-Executive Director	(IQ)

Agenda item:

Patient Story
The Board welcomed Wendy Dixon, mum of Max, to the meeting.

Max had been rushed into the Intensive Care Unit in a critical condition after falling 12ft from a cliff face.

Overall Wendy commended the Trust for the outstanding care Max had received.

The family had however experienced a few areas for improvement. Max was unconscious for the first few weeks when he arrived. Communication may not have always been considerate of Max's state and unaware he may have been able to hear conversations taking place around him. Wendy placed notes on Max's of door to tell those caring for him about his interests and likes to encourage staff to discuss them with Max.

When Max moved from IDU to HDU Max's notes had not been transferred, Max's dad had gone back to ICU to collect the notes.

Wendy had met with mums going through similar situations as herself and they were looking into providing a supportive pack for other parents.

The family had also been using Reiki therapies to support Max's recovery.

The Chair thanked Wendy for attending the meeting today and sharing her experiences with the Board.

16/17/39 Declarations of Interest
None declared.

16/17/40 Minutes of the previous meeting held on 3rd May 2016
Resolved:
The Board reviewed and approved the minutes of the last meeting.

16/17/41 Matters Arising and Board Action list
All matters for discussion were listed on the agenda.

16/17/42 Key Issues/Reflections
All key issues were on the agenda as an item.

16/17/43 Quality Summit
Hilda Gwilliams provided an update from the internal Quality Summit held on 18th May 2016 following the three never events. An audit and associated action plan from the never events had been presented by the CBU to ensure any identified gaps had been closed.

The feedback from the quality summit had been positive, but it was acknowledged that it was the first one of its kind and lessons could be learned with regard to streamlining the process and the preparation in particular.

Resolved:
Board noted the update on the recent Quality Summit.

16/17/44 CQC Engagement meeting
The most recent engagement meeting had been held on Monday 16th May to discuss the Trust's response to the recent never events in particular, as well as progress against the overall CQC inspection action plan. Ann Ford had noted good progress with the actions in place to date.

The community CAMHS re-inspection was to take place when the Trust had addressed the key actions and supplied relevant evidence. The Board asked for an update on the process to ensure standards are maintained or improved.

Resolved:
The Board received an update on the recent CQC Engagement meeting and asked for an update on the process in place for the next CQC Inspection once this had been finalised.

16/17/45 Serious Incident Report
Hilda Gwilliams presented the Serious Incident report for April 2016 noting that there had been two new serious incidents, seven ongoing and two closed. There are no new or ongoing safeguarding cases.

Following the two new serious incidents within SCACC an action plan was to be developed and presented to the next CQAC.

Resolved:
The Board received the Serious Incident report for April 2016 noting the two new serious incidents and the action plans to be developed and presented to CQAC.

16/17/46 Clinical Quality Assurance Committee: Chair's update and Annual report
The Board received the CQAC minutes from the last meeting held on 20th April 2016.

The Board reviewed the CQAC Annual Report noting that a key focus for 2016/17 would be the revised governance arrangements to support the change programme and the projects. The Change Programme would continue to be a weekly item on the Executive agenda to ensure any concerns were resolved quickly.

Resolved:
The Board received the CQAC minutes held on 20th April 2016 and APPROVED the CQAC Annual report.

16/17/47 People Strategy update
Melissa Swindell provided the People Strategy progress update report.

The first Listening into Action 'Big Conversation' event had taken place on 18th May 2016. The event was well attended with representation from departments including Radiology and Outpatients.

A Task and Finish Group had been established in relation to the current under-representation of BME staff within the workforce. The first meeting was due to be held on 15th June followed by fortnightly meetings. Progress would be reported in to the bi-monthly Workforce and Organisational Development Committee.

The long term target will be to achieve a 1% increase per annum in improvements in numbers of BME staff employed by the Trust over the next five years and a workforce aligned more closely to the local working population.

Resolved:
The Board received and noted the content of the People Strategy update.

16/17/48 Alder Hey in the Park
Sue Brown provided an overview of the 11 programmes within the Alder Hey in the park project.

The Decommissioning and Demolition project was behind plan by two months. This was primarily due to a lack of funding for phase three to meet demolition tender pressures. Due to this, a revised plan would be presented to RABD for approval.

Sue Brown provided an update on the Temporary Move project noting all departments based on the old site had moved into their temporary

accommodation apart from IT who were due to move themselves in a couple of weeks. The project team were working with CAMHS as there were a few concerns with regard to their temporary accommodation including the private discussion room was not sound proof and noise from the building site.

Resolved:
The Board received an update of Alder Hey in the park project.

16/17/49 2015/16 Annual Report and Accounts

The Board received the 2015/16 Annual report and Accounts for approval, that had previously been presented to the Audit Committee on 19th May 2016.

Audit Committee had ratified the two Board representation letters confirming the financial statements within the Annual report and accounts;

a) The financial statements disclose all of the key risk factors, assumptions made and uncertainties surrounding the Trust's ability to continue as a going concern as required to provide a true and fair view.

b) Any uncertainties disclosed are not considered to be material and therefore do not cast significant doubt on the ability of the Trust to continue as a going concern.

The representation letter for the Quality Report confirms the report was prepared in accordance with the NHS Foundation Trust Annual reporting manual 2015/16 and supporting guidance.

The Trust's external auditor's opinion on the financial statements is unmodified. One new risk was identified for 2015/16: recognition of the new hospital Development, Alder Hey Children's Health Park £162.4 million and related net Private Finance Initiative (PFI) liability £111m.

Monitor's guidance had been modified with further requirements on the 2015/16 Annual Report and Accounts audit. The Board noted the additional pressures to complete the reports and thanked all those involved.

Resolved:
The Board APPROVED;
a) The Annual Report and Accounts 2015/16.
b) The Annual Report and Accounts 2015/16 Board representation letter
c) The Quality Report Board representation letter.

16/17/50 Corporate Governance Statement

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

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

16/17/51 Board Self – Certification of compliance with the Provider Licence

NHS Foundation Trusts are required to submit declarations to NHS Improvement signed by the Chair and Chief Executive. The declarations include; Compliance

withLlicense conditions, Corporate Governance Statement and certification on training of Governors.

Resolved:
The Board APPROVED the Board Self – Certification of compliance with the Provider License to be submitted to NHS Improvement.

16/17/52 Corporate Report

At the end of April the Trust is reporting a deficit position of £2.5m which is £0.4m behind plan. £0.1m overspend was relating to agency overspends mainly on wards and facilities. The Board received assurance agency overspends were reducing and there was a consistent message for departments to stay within the planned budgets.

To resolve the challenges in achieving the run rate a weekly task and finish group had been arranged to take place for six weeks. Three main concerns had been identified as: cancelling patients on day of surgery, lack of forward look at theatre cases planned for lists and Non Elective patients occupying beds whilst waiting for surgery. The Board received assurance on each of the concerns being able to be resolved within the six weeks. Achieving Run Rate would continue to report to RABD until resolved.

The four hour access target was achieved for the month of April; this was a combination of attendances returning to predicted levels, the introduction of slots for GP patients and the ongoing development to streamline the triage process.

All clinical improvement targets for April are being met or exceeded, with the exception of acute readmission of patients with long term conditions within 28 days, which has exceed the monthly target by one day.

PDR rates were currently down due to the rates being reset at the beginning of the financial year. A suggestion was made to have a rolling rate.

Since approval and circulation of the revised Sickness Absence policy, sickness rates had reduced.

Feedback from Monitor was awaited on the submission of the Monitor plan.

Resolved:
The Board received and noted the content of the April 2016 Corporate report.

16/17/53 Programme Assurance Update

An overview of programme assurance arrangements was presented following approval of the workstreams to report to the committees of the Trust Board.

Joe Gibson provided a breakdown of each of the workstreams and a summary position.

Steve Igoe noted that the internal audit plan for 2016/17 included a review of the Change Programme to take place half way through the year.

Resolved:
The Board noted the importance for the programme to meet the targets set.

16/17/54 Integrated Assurance Report and supporting documents
The Board received the Board Assurance Framework for 2016-17.

A number of suggestions have been made on the current principal risks to reflect progress in the achievement of the strategic objectives (2011-16) and to account for emerging external factors that are likely to present a risk to delivery of the Trust's refreshed strategic objectives to 2020.

An exercise has been undertaken looking at weaknesses, opportunities and threats that had then been cross referenced with high level context of the existing BAF.

The Board went through the risks for 2015/16 noting the non-compliant estate. A suggestion had been put forward from the BAF team to rename this risk; Failure to fully realise the Trust's vision for the park. This was to be decided on at the weekly Executive Team.

The Board noted the lost opportunity of the Public Health Strategy signalled in 2011 and discussed the ongoing work to develop community services; it was agreed to link these two issues in relation to the strategic risk.

BAF report for May 2016 highlighted a number risks returning to the CBU to be resolved noting good practice.

Resolved:
a) The Board noted the closure of the 2015/16 Board Assurance Report.
b) Approved the risk ratings and the proposed changes to 2016/17 BAF subject to further changes at Executive Team.
c) Received May 2016 Board Assurance report.

16/17/56 Integrated Governance Committee Annual report 2015/16
Resolved:
The Board received and approved Integrated Governance Committee Annual report 2015/16.

16/17/57 Resource and Business Development Committee: Chair's Update
Resolved:
The Board received and approved Resource and Business Development Committee Annual report 2015/16.

16/17/58 Audit Committee Chairs update and Annual report 2015/16
Resolved:
a) The Board received and approved the Integrated Governance Committee Annual report 2015/16.

16/17/59 Any Other Business

Board Governor Away day – Tuesday 7th June 2016

Due to the meeting today there would be no Board meeting required in June. The date would be used for a Board Governor Away day. Agenda items and timings to be confirmed.

Date and Time of next meeting: - Tuesday 5th July 2016, at 10:00am, Large Meeting Room, Institute in the park.

Alder Hey Children's NHS Foundation Trust
Board
Action Log April 2016 - March 2017

Alder Hey Children's NHS Foundation Trust

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
03.05.16	16/17/27	People Strategy update	To review reducing the number of meetings to be visible and provide support for staff	Executive team	May-16	Ongoing	
23.05.16	16/17/44	CQC Engagement meeting	To provide a proposal on plans in place for the next CQC CAMHS Inspection to be arranged.	Chief Nurse	Oct-16	Ongoing	
23.05.16	16/17/45	Serious Incident Report	Action plans following the 2 Serious Incidents within SCACC to be presented to the June CQAC	SCACC	Jun-16	Completed	

Alder Hey Children's NHS
NHS Foundation Trust

DIPC REPORT QUARTER 4 (Jan- March) 2015-16

KEY MESSAGES

- The IPCT have worked to their capability in delivering the DIPC delivery plan but have been limited by the degree of engagement / capacity of colleagues

DIPC DELIVERY PLAN 2015 review QTR 4.d

- An external review of the IPC service was undertaken by Julie Hughes Interim DIPC during QTR 4. An action plan has been developed to progress the actions required.

AHH IPC External Review 2016.doc

External IPC review Action plan June 201(

Key actions included a review of Hand hygiene products through the Trust, review of cleaning methods and products and working with the CHP team to progress the outstanding issues related to the New Hospital.

INCIDENTS QTR 4

Date	Incident
16.02.2016	HEPA filter incident on 3B
23.3.2016	ARJO bath *Pseudomonas* contamination

Minutes available on request

SUPPORTING INFORMATION

Minutes from January 26th 2016 IPCC

IPCC Minutes 26012016 draft appr(

Alder Hey Children's NHS
NHS Foundation Trust

DIPC DELIVERY PLAN 2015-16 (QTR 4 Review Jan-Mar 2016)

Rag rating GREEN –Complete, ORANGE-In progress, RED –incomplete requires additional input. Blue – Not commenced

Aim: No child will acquire a preventable infection due to care delivered at Alder Hey.

Objective	Action Required	Lead / Rating	Comments	Additional actions required
No increase in HAI as a consequence of the move into the CHP	• **IPCT to meet with all ward teams to assist them in the development of IPC protocols to reduce the risk of HAI in the CHP**	**RC**	No increase in numbers of alert organisms using	
Review of MSSA bacteraemia at Alder Hey to identify risk factors and areas for development	• **Trust to learn from all cases of HAI MSSA**	**IPCT**	All cases of HAI MSSA bacteraemia investigated by the IPCT	
Sub aim:	**No Child will acquire a viral illness**		**due to care delivered at Alder**	**Hey**
Objective	**Action Required**	**Lead**	Comments	Additional actions required
Policies available for the management of respiratory viruses and viral gastrointestinal diseases	**Produce policies**	**JK/RC**	Insufficient capacity during 2015-16. Management of respiratory viruses and patients with diarrhoea and vomiting outlined in C17 Isolation policy Policies must be concise and easy for staff to access	Policies to be developed in 2016-17

Sub aim:	No Child will acquire a	Multi drug	Resistant organism due to care at	Alder hey
Objective	Action Required	Lead	Comments	
Policy available for the multi-antibiotic resistant organisms	Update policy on CRE to include CPE, ESBL, VRE MR-Acinetobacter	JK/RC/JC	Inadequate capacity during 2015-16 Plan to develop more concise policy for management of patients with CPE and include management of other MRO in to appendix of C17 isolation policy	Update CRE policy in 2016-17
Sub aim:	**No child will acquire an**	**infection**	**From the environment**	
Objective	**Action Required**	Lead		
Centralisation of all environmental microbiology results	Reporting Review	CQ	Out of IPCT control. Resource issue	
Standard operating procedures available for all environmental microbiology (P)	Review and production of SOP	FH	SOP available for all environmental microbiology	
Sub aim:	**No child will acquire an**	**infection**	**Following surgery due to care**	**Given at Alder Hey**
Objective	**Action Required**	**Lead**	**Comments**	**Additional Actions**
Development of Infection Prevention policy for Theatres (P)	THEATRE SAFETY BOARD set up Development of Policy	Rob Griffiths	Not completed during 2015-16 Staff member allocated in QTR 1	Work commenced in QTR 1 2016-17
Introduction of SSIS for PEG (P)	Setting up of project group to carry SSI surveillance for PEG	RC	Unable to complete due to capacity issue	Review in 2017-18
Introduction of surveillance for Ventilator Associated pneumonia (P)	Develop and implement care bundle for VAP	Andy Derbyshire Sam Ellis ANP	Baseline retrospective data collected. Care bundle not complete. No prospective audit yet undertaken.	Monthly meeting commenced in QTR 1 2016-17 with IPC

Development of SSIS for K wire (P)	**Develop surgical care bundle 2015 Development of electronic data collection proforma**	**Dave Wright**	No progress due to capacity issues within IPCT	**Commence work on methodology for K wire surveillance in 2016-17**
Trust wide Surgical Site Infection (SSI) risk assessment to identify gaps, improve performance, measure compliance, impact of interventions and provide feedback (P)	**Setting up surgical multi-disciplinary group**	**RC**	**1st Meeting being arranged for QTR1 2016-17 lead by Bernadetta Pettorini**	
Sub aim:	**No child will develop a**	**CLABSI**	**Due to care delivered at Alder hey**	
Reduction in number of Hospital acquired CLABSI	**Implementation and monitoring of Skin bundle for IV care Relaunch of ANTT education programme**	**SM**	**Skin bundle implemented ANTT education programme relaunched ANTT Quality control audits commenced by IVT**	
Sub aim:	**Compliance with the assurance**	**Health and**	**Social care Act 2015, mandatory**	**Reporting and Trust**
Audit	**Action Required**	**LEAD**	**Comments**	**Additional Actions**
Audit compliance with Infection Prevention & control practices	**Develop and undertake audit program for inpatient/outpatient departments. Audit all Clinical areas at CHP by September 2016 Audit compliance with 2 key IPC policies** • **Isolation** • **Standard precautions**	**JK**	**Ongoing. Audit programme developed. Currently IPCN are working completion of Ward IPC audits**	

Comply with MRSA screening and surveillance for resistant gram negative organisms	**Monthly compliance audit**	**CQ**	**Data being collected and feedback to clinical areas. Compliance with screening for CPE needs improvement**	
Education	**Action Required**	**Quarter 1**	**Comments**	**Additional Actions**
Develop educational strategy for IPC	**Development of educational strategy for IPC**	RC	Medical leadership programme commenced Review of IPC training for mandatory training and induction completed	
Infection Prevention to go into medical Re- accreditation and appraisal	**RC to discuss with medical Director and Deputy**	**RC**	DIPC has advised Consultants to use IPC ward round as quality initiative (section 8) of appraisal document	Medical director and new appraisal lead to progress
Development of IPC Link Nurse Program (P)	**IPCT to organise educational updates and work with Link nurses**	**JK**	Ongoing	
Feedback on effectiveness of IPC service	**360 degree feedback on IPC service**	**DP/RC**	Completed May 2015 and feedback at IPCC Plan to repeat in 2016.	
Hand Hygiene	**Action Required**	**Quarter 1**	**Comments**	**Additional actions**
Multimodal Hand hygiene campaign to be initiated and implemented before December 2015 (P)	**Development of PID**	**JK**	Capacity issue during 2015-16 IPC awareness day on Patient safety week in June 2016	**Plan for IPC week in October 2016**
Hand Hygiene technique compliance to be assessed for all clinical staff yearly	**Link Nurses/SGL to assess colleagues on an annual basis certificates to be issued**	**JK**	Light boxes still not available in all ward areas. Limited progress. Plan to include Hand hygiene in staff induction market place in addition to Link nurses.	

Improved Medical staff compliance with hand hygiene	**Medical staff to observe colleagues practice and feedback compliance**	**RC**	DIPC has been attending Consultant ward rounds and feeding back on IPC compliance	
Introduction of electronic methods of measuring hand hygiene compliance i.e. Sure wash	**Develop Business case**	**JK**	Decision made not to progress.	
Decontamination	**Action Required**		**Comments**	**Measure**
Decontamination register established for all reusable patient equipment (P)	**All clinical areas to produce a list of all patient equipment and how they are decontaminated**	**Sue Brown**	**Decontamination audit programme developed. Audits completed in ward areas On going**	
Parent/Family Engagement	**Action Required**	**Lead**	**Comments**	**Additional action**
Introduce digital technology to engage parents/families in IPC (P)	**Explore use of texting, twitter, podcasts, website**	**SL**	Difficulty engaging with communications	**Plan for 2016-17**
Patient histories to drive service improvement (P)	**IPCN to work with parents to record patient Histories**	**SL**	Families identified. Awaiting communications	**Plan for 2016-17**
Research	**Action Required**	**Lead**	**Comments**	**Additional action**
Project Epidemiology microbiology of CHP	**Research project** **Research priorities established**	**RC**	Research project ongoing	

Author: Lead Nurse IPC J. Keward / Dr Richard Cooke DIPC
June 2016

Alderhey Children's Hospital NHS Foundation Trust

Infection Prevention and Control Service External Review

Jan - March 2016

Undertaken by:
Dr. Julie Hughes RSCN/RGN, MSc, D Prof
Independent Nurse Consultant Infection Control

Report commissioned by:
Gill Core - Chief Nurse
Hilda Gwilliams – Director of Nursing and Quality

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Infection Prevention and Control Services – External Review Jan-Mar 2016

1. Introduction

All NHS Trusts as registered providers of health care have to adhere to the standards set out by *The Health and Social Care Act 2008: Code of Practice for health and adult social care on the prevention and control of infections (updated 2012)* and related guidance in order to prevent healthcare associated infections (HCAI) and their impact on patients and services. This entails having robust appropriate management and monitoring arrangements with a clear governance structure and accountability in place. The code was revised in 2015 to formally include cleanliness as an integral part of infection prevention

In 2015 Alderhey Children's Foundation Trust reported 3 cases of Meticilln Resistant *Staphylococcus aureus* bacteraemia infection acquired post 48 hours admission. This resulted in the Trust not achieving its objectives and trajectory of 0 in 2015-16. However, to date there does not appear to be an associated link or evidence of transmission. There have also been other reported serious incidents of healthcare associated infections such as a neonate who acquired a bacteraemia due to *Klebsiella pneumonia* and a cardiac patient who acquired influenza Type A. In addition, the Trust moved site to the current Children's Hospital Park with potential challenges for infection prevention and control. Therefore an external review was commissioned by Gill Core Chief Nurse. The review took place in Jan - Mar 2016 by Dr Julie Hughes an experienced Nurse Consultant Infection Prevention and Control with over 25 years' experience in the field, including paediatrics, adult, mental health and community services and has undertaken other external reviews. During this time she was also employed by the Trust as the Interim Director Infection Prevention and Control whilst Dr Cooke was on long term leave. The review included a cross section of ward visits/audits, interviews with several key Trust personnel and stakeholders attendance at

several key Trust operational and strategic meetings, accompanying ward rounds/huddles and working with the IPCT.

2. Aims and objectives of the review

- To review compliance with practices and procedures in relation to infection prevention and control (IPC)
- To undertake a spot-check of wards/departments to gauge:
    - Standards
    - Staff engagement
    - Skills and knowledge
    - General environmental cleanliness
- To advise the organisation on service gaps as evidenced through policies and procedures and interviews with staff
- To advise on skill mix to achieve compliance and develop the service to meet any needs identified

This report presents the findings of the review undertaken and is considered under the following:

- IPC Team structure
- Reporting arrangements/assurance frameworks and deliverance on the HCAI agenda
- Key documents review
- Audit processes and compliance with IPC practices
- HCAI monitoring and incident surveillance and reporting
- Training and education

3. Findings

3.1. Infection Prevention and Control Team (IPCT) Structure

The IPCT currently consists of 7 team members:

- Lead Nurse Infection Prevention and Control – Band 8 B - 1WTE

- Infection Prevention and Control Nurse Specialist – Band 7 – 0.4 WTE (currently on maternity leave)
- Infection Prevention and Control Nurse Specialist – Band 6 – 2 WTE
- Data Analyst – Band 5 – 0.6 WTE
- Administrative/Clerical Support –Band 4 0.5 WTE
- Support Worker – Band 3 – 1 WTE

Specialist microbiological advice and support is provided by:

- Consultant Microbiologist – 1 WTE – (who is also the DIPC and the designated Infection Control Doctor)
- Consultant Microbiologist – 1 WTE

There is also an Infectious Diseases Service Provision led by 3 Consultant ID Physicians who liaise closely with the Microbiologists although not fully integrated.

Overall discussion, interviews and working closely with the IPCT identified a proactive, dedicated team, keen and enthusiastic to provide a quality infection prevention and control service. However, although the IPCT appear relatively well resourced in terms of staffing, with a wide range of skills and expertise within the team, the Lead Nurse is the only practitioner with a qualification in infection prevention and control. The IPCT are also a relatively new team and although experienced practitioners in other fields require further specialised training and development in infection prevention which is in progress. The Consultant Microbiologist/DIPC is also retiring at the end of ?? March 2017.

The IPCT do not currently provide an on call service as this is undertaken by the Consultant Microbiologists and Infectious Disease consultants. Therefore, although the IPCT team and arrangements are in place there is work in progress to develop the current team which will aid the Lead Nurse to develop a more strategic focus and help further support the Director of Infection Prevention and Control.

3.2. Reporting Arrangements/Assurance Frameworks

There is a robust reporting structure and audit programme in place to help assure the Trust Board that it meets the requirements of the revised code of practice for HCAI through the following reporting arrangements and processes:

- Bi -monthly DIPC reporting dashboard to the Clinical Quality Assurance Committee (CQAC) and via the IPC Assurance Framework to the commissioners
- Bi-monthly report to the Infection Prevention and Control Committee (IPPC)
- Monthly reporting of HCAI surveillance and incidents of infection dashboard to the Integrated Governance and Risk Committee and Trust Board
- Serious Incidents RCA and any MRSA Post Incident Review reports to the Clinical Commissioning Groups
- Ad hoc/update/progress report on the Trust Infection Prevention and Control Action Delivery Plan/Work Programme as required or any untoward incidents.
- IPC Delivery Plan/Work Programme is driven and monitored by the bi-monthly IPPC
- Annual Report and Delivery Plan/Work Programme is presented to and agreed by the IPPC
- Presentation of Annual Report and Delivery Plan/Work Programme to the Trust Board

3.3. Key Documents Reviewed

These consisted of:

- Infection Prevention and Control Policies
- IPC and Surveillance Assurance Framework Supporting Information
- Ward IPC specific Programme/Objectives
- IPC Strategic Delivery Plan/ Work Programme 2015- 16

- IPCC minutes and agenda
- Proposed Key Performance Indicators

A review of all the above were in the main satisfactory. The IPC Policy clearly sets out the roles and responsibilities of the Trust and employees in key arrangements and management of the HCAI agenda. Similarly the succinct information included in the Annual Report appeared to comply with the requirements of the Health Act and should provide assurance to the Trust Board. The strategic IPC Delivery Plan/Work Programme identified a comprehensive programme with measurable timescales for delivery which complies with the requirements set out in *The Health and Social Care Act 2008.* However, some key policies such as Decontamination and Disinfection policy require updating particularly in line with the update to the Health Act 2015 (in progress).

The reviewer also chaired the Trust Infection Prevention and Control Committee as Interim DIPC which was well attended. The agenda and minutes included all the relevant information required to assure compliance with the Health and Social Care Act. In addition the membership of the IPPC appeared inclusive although there was no Non-Executive Lead present or Service User representative. However, although all business streams were represented there was limited medical representation apart from Paediatric Intensive Care Unit and Surgical Specialities. Therefore, in accordance with the IPCC Terms of Reference the meeting was deemed not to be quorate. This was highlighted as an ongoing problem and has been raised with the Medical Director. For those who did attend opportunity was provided to challenge any issues discussed and engagement in the IPC agenda was apparent. However, most of the information presented was but the Lead Nurse who delivered the quarterly IPC report and there was no formal exception reporting from Clinical Business Unit leads. Key areas highlighted as areas for concern were poor compliance with:

- patient admission screening for Carbapenamase producing *Enterobacteraeciae* (CPE)

- hand hygiene particularly amongst medical personnel
- water outlet flushing regimes recordings

3.4. IPC Audit Programme

An ongoing audit programme is a key feature of performance management and the Trust has a robust audit programme in place across all services to monitor compliance with IPC policies. This is based on the National Infection Prevention Society National Audit Standards and the Department of Health High Impact Intervention /Saving Lives Tools. Most of the auditing is currently undertaken by the IPCT although the Link Practitioners are responsible for the monthly hand hygiene audits reporting their findings to the IPCT. The Lead Nurse is also working with the Trust Decontamination Lead undertaking additional audits in decontamination processes. Findings are reported to ward/department managers and discussed at the IPCC and individual business Governance Meetings.

Concerns were expressed by the IPCT that not all areas feedback their hand hygiene results promptly feeling that some wards expect the IPCT service to undertake all the audits. This may result in healthcare workers not seeing IPC as 'core business' and is essential that staff do undertake their own audits in order to take on ownership and responsibly for the HCAI and IPC agenda. This was reported as mainly due to lack of dedicated time given to Link Practitioners to perform and again leads to a lack of ownership in relation to actioning results etc. In addition wards should audit each other which would help with potential bias as hand hygiene results are higher when self audit has been undertaken as compared to those done by the IPCT.

Feedback by Ward Managers/Lead Nurses during staff interviews and observations on wards/departments identified that in the main they understood the need to undertake their own audits. Managers and Lead Nurses in particular acknowledged that this was crucial in helping them identify issues in their own area. They stated that they understood the

importance of the IPC agenda although commenting that the challenge they faced was due to time/capacity to undertake audits not only just in relation to IPC but other aspects of Trust business. This they felt was exacerbated by the move to the new Children's Health Park and layouts of the new wards which they felt contributed to difficulties in releasing staff to undertake the audits. The IPCT have considered providing the wards with palm pilots or iPads to enable simplifying of audit processes and enhance use of resources. However Wi-Fi reception is currently suboptimal resulting in this not being an alternative option.

As part of the overall review spot-checks a cross selection of different areas across the Trust was undertaken by the reviewer (see Table 1 for results) to assess compliance with IPC policies and practices. The audit tool used was based on the National Infection Prevention Society Quality Improvement Tools incorporating aspects of the Trust own IPC Checklist Tool in order to gauge as many areas as possible within the short time frame of the review. All the audits were unannounced. Patients with known infections were also identified on the wards visited during the time period of the inspection. Therefore the reviewer was able to observe compliance with practice in this area. This identified some issues with adherence to the use of personal protective equipment (PPE) in some areas. However, all staff questioned were able to verbally demonstrate understanding and knowledge in relation to caring for patients with infections (see table 1 for results).

The reviewer was made to feel very welcome on all wards/departments visited and staff knowledge and compliance with IPC policies and practices overall was satisfactory. Main issues identified included:

- lack of decontamination checklists and documentation of cleaning processes
- poor compliance with COMPASS water flushing recording
- general lack of posters demonstrating correct hand hygiene decontamination technique at ward/department entrances
- several hand hygiene dispensers handles were broken

- several staff reported issues with sore hands/skin conditions allegedly as a result of using the TECcare soap particularly in PICU and Oncology
- lack of admission screening for CPE
- some observations of poor compliance with PPE

A scoping exercise was in process of being undertaken as part of the review to address the above issues in relation to hand hygiene, including meeting with the TECcare Director to rectify the problems identified. In addition an alternative company product has been introduced as a trial to provide a suitable alternative.

Difficulty in maintaining adequate levels of cleanliness in most clinical areas and the main atrium was also highlighted Several issues were identified in relation to cleanliness of the Trust allegedly since the introduction of Villeda Microfibre system. Many domestics acknowledged that they did not feel the system adequately cleaned properly and as not used with detergent did not deodorise areas. There have also been reports of parents in some areas complaining about cleanliness on some wards. Meetings held with the Facilities and Domestic Manager identified there was also not enough cleaning machinery available to support the system including a lack of adequate decontamination facilities as the new laundry was not functioning at the time of the report. However, these issues were in the process of being addressed at the time of the report.

Table 1: Results of individual audits

Ward /Unit	**RAG rating (Pass > 85%)**	**Particular Issues identified/observed**
PICU		Decontamination checklists unavailable. ATP swabs- high counts around suction units and IV trolley. General clutter in dirty utility rooms. No lock on Milk Kitchen. Feeds left on kitchen

		surfaces incorrect date/time.
3C		Decontamination checklists unavailable. Several TECcare containers uncovered. Store room cluttered.
1 C		Decontamination checklists unavailable
Neonatal		Decontamination checklists unavailable
OPD		Decontamination checklists unavailable. General clutter.
Radiology		Lack of hand sanitisers in most areas.
AED		Decontamination checklists unavailable.
Dewi Jones Unit		

3.5. HCAI Surveillance and Incident Monitoring Programme

The Trust has an alert organism and conditions incidence surveillance programme. This includes mandatory reporting on all HCAI. Data is presented to the bi-monthly IPPC and to individual wards/Clinical Business Units. Overall incidence of infections such as MRSA, *Clostridium Difficile* and Carbapenem producing *Enterobacteraceae* (CPE) are low. However, the Trust experienced 3 cases of MRSA bacteraemia in 2015 and although no links were identified as a result the Trust commissioned an external review to ensure they were compliant with policy and with the potential challenge of moving to the CHP. There has also been serious incident reporting of other HCAI resulting in morbidity and mortality such as a bacteraemia due to *Klebsiella pneumoniae* and Influenza Type A. Despite the latter there is no Trust Lead Immunisation Coordinator which could help coordinate immunisations for long term patients who may have missed their opportunity for being immunised and are at risk of acquiring preventable illnesses and a risk to others.

Admission screening of MRSA and CPE is also in place as outlined by the Department of Health MRSA Screening Operational Guidance and CPE Toolkit. The Trust also undertakes some surgical site surveillance although this is currently limited to neurology and cardiology. There is no current

structured programme in general surgery although there is no national mandatory programme for paediatrics.

Laboratory results are available electronically to the IPCT and wards via the Trust laboratory Foundation Trust. In general results are deemed timely although a business case is in progress to purchase laboratory equipment that could further enhance prompt, timely feedback.

3.6. Training and education

The IPCT are actively involved in training and education. Induction and mandatory training figures are monitored and provided for the IPPC via the Learning and Development Department. Staff can attend face to face mandatory training although there is also online training available. This is part of the Core Skills Reader developed in conjunction with the Core Skills Framework for the North West Health Sector. Currently the requirements to undertake mandatory training are every three years. However, training is poorly attended and training figures in general are currently particularly amongst medical staff. Reasons given for poor attendance by non-medical staff this were related to difficulty in releasing staff due to the layout of the new wards requiring additional staff therefore challenging releasing staff to training. There is also an active Link Worker Programme with regular updates although issues were identified again with areas releasing staff to attend. Most staff interviewed stated they were up to date with mandatory training which was reflected in knowledge of IPC practices in areas inspected. This included several student nurses who were also audited as part of the review although practices in relation to use of PPE particularly in the use of gloves were observed at times to be suboptimal.

There was however an apparent lack of formalised training in relation to the care of indwelling devices. Although the Central IV Access Team deliver all vascular device related training and Aseptic Non Touch Technique Training there is limited formalised additional training such as urinary catheters and gastrostomy care.

3.7. Staff engagement and involvement

Several staff interviews were undertaken including Lead Nurses, Business Leads, General Managers, nursing, medical, Allied Health Professionals, non qualified healthcare assistants, Pharmacy, ancillary staff, Head of Facilities, Head of Procurement, PALS, Interserve Managers and CHP Team. All staff appeared knowledgeable in relation to the IPC agenda and engaged being aware of recent issues. All praised the approachability and support of the IPCT although commented that they did not appear as 'visible' in the new build and at times difficult to contact although this was deemed to be partly due to issues with bleeps or telephone reception. There also appeared to some extent an over reliance on the IPCT particularly in relation to 'information giving' with little exception reporting back to the team. This was apparent in the fact that staff said they would often contact the IPCT for advice which is often available via Trust policies. However, staff questioned were in the main aware of what to do but expressed the need to confirm this with the IPCT and acknowledged that this was possibly a result of the increased profile on HCAI and the anxiety of not 'doing the right thing'. Staff felt actively involved in the RCA process taking ownership with increasing involvement and engagement but felt that medical staff were not always as committed and that IPC was seen by some to be more a nursing responsibility. Medical engagement was also lacking in relation to support at the IPCC. However, several examples of good practice in this area were acknowledged particularly in relation to medical engagement at the IPCC from PICU and Surgical Specialities.

Antimicrobial stewardship and IPC ward rounds and huddles were highlighted as good practice and all staff interviewed thought that this should be expanded to all areas identifying this as increasing communication and awareness. There was some feedback that there could be overlap between clinical rounds undertaken by Infectious Disease Consultants and Consultant Microbiologists and perceived lack of integration/interface with some areas unclear who to contact in the first instance. However, there are daily morning meetings between both teams to ensure that there is handover in regards to

patients and the clinical rounds/attending ward huddles are excellent examples of good practice as observed when the reviewer accompanied several of the rounds.

3.8. Key issues identified with moving to new CHP

Several members of staff expressed concerns with the amount of problems encountered as a result of the move to the new hospital. Some of the key issues are outlined below:

- moving into the new build before allegedly some contract specifications agreed/finalised or completely signed off leading to risks and further costs for the Trust e.g.
    - commissioning of new theatres and validation/verification of air sampling – difficulty in obtaining evidence of this being undertaken post commissioning and lack of independent validation – now completed
    - air sampling of BMT in Oncology – filters not inserted in air space and ? not fit for purpose
- initial ongoing issues with water end of line temperatures constantly being $>20^0$ – lack of clarity/clear agreement for who was responsible for resolving the issue leading to a risk of legionella – now in process of being resolved long term with Lang O'Rouke
- ongoing issues with hydrotherapy pool filter breakdown, poor water quality,
- lack of clarity perceived by staff in relation to roles and responsibilities of Trust personnel and Interserve e.g. undertaking water sampling and costing- this has resulted in unacceptable delays in programme
- issues highlighted in equipment being ordered with perceived lack of staff involvement
- bedwasher area or machine not fit for purpose - no separation for clean and dirty beds/incubators and no clean transfer lift resulting in FM lift having to be utilised to transfer clean beds, decontamination manual only available in German

- no bed storage area in new build
- lack of laundry facilities for microfibre system in new build
- lack of ward/department hand hygiene signage
- incomplete finishing of some floor areas leading to difficulty with cleaning of areas

4. Summary and recommendations

The review was undertaken over a period of several weeks whilst the reviewer was working as part of the IPCT. Therefore some of the areas highlighted initially were or are in the process of being resolved with the reviewer working closely with the CHP Team attending weekly post commissioning meetings. However, this has been a challenging process and at times difficult to gain resolution. In relation to water sampling there was initial ongoing disagreement with responsibility and accountability for funding the process resulting in a lack of legionella sampling from November until March despite high end of line water temperatures with the potential risk to the Trust. This is now resolved with Interserve undertaking responsibility and no issues have been identified with the results. Lang O'Rouke has agreed responsibility for investigating and resolving the end of line temperatures. There was no record of water sampling in augmented care areas and although now resolved pseudomonas has been cultured in some of the Arjo baths and water outlets in several areas. This has resulted in isolation of the areas identified whilst being investigated, an incident meeting held and being actioned.

A representative cross section/sample of several key in-patient areas were audited and observations of clinical practice undertaken. Several IPC documents and processes were examined. Therefore, for the purpose of the review this is comparable with some of the principles used during a CQC visit. In addition issues identified by previous external reviews and a CQC visit in the old build were also reviewed e.g. compliance with infection prevention in Radiology, OPD and medical engagement. Some of the actions had already been addressed or were in progress. From the information requested and the

areas audited the Trust has a comprehensive infection prevention and control delivery plan, incorporating assurance processes and HCAI surveillance system which captures this information with good laboratory reporting systems. The service is led by a proactive DIPC and IPCT although relatively junior and inexperienced with the Lead Nurse currently being the only practitioner qualified in infection prevention and control. This has been challenging in particular with a move to a new build and the ongoing challenges. However the current practitioners are enthusiastic and experienced general practitioners and plans are in place for further development and support.

An area of further concern is that considering the CHP is a new build there is evidence of some areas already appearing to look worn with overall cleanliness sub optimal. As outlined this is identified as possibly being due to introduction of the new Villeda Microfibre Cleaning System which has not been well received. This is currently under review and the Trust is working closely with the company to resolve as may be partly due to how the system is being managed and implemented by the Trust.

Therefore, the following recommendations are made which could help support the Trust to resolve the key issues identified and to continue to deliver its IPC programme. This has been discussed with the IPCT and where possible already shared with areas responsible for auctioning and agreed timescales being proposed.

- Support development and support of the IPCT to enable delivery of the service plan- this could include developing the Support worker role and review Surveillance Coordinator role
- Increase the ‘visibility’ of the IPCT by reviewing ways of working to also include more representation at specific ward rounds/huddles and integration with ID rounds, working with various specialities
- Consider succession planning in relation to the potential retirement of the current DIPC and Consultant Microbiologist in 2017

- Consider DIPC representation at Board level
- Review Medical Engagement particularly around antimicrobial prescribing and attendance/representation at IPCC
- Progress the trial of alternative hand hygiene products to alleviate current issues with TECcare
- Review and reintroduce the Ward Decontamination Checklists of which the utilisation is varied across the Trust
- Relook at training in relation to decontamination working with the decontamination Lead and Medical Equipment Lead
- Review water flushing recording regime to ensure this is undertaken and documented as currently time consuming for staff
- Enable and empower Infection Prevention and Control Link Practitioners to participate in own audits in addition to hand hygiene for areas to take more ownership of issues in their areas e.g environment and decontamination
- Review audit programme to include colleagues reviewing each other's areas to increase objectivity
- Expand hand hygiene audits to other Trust Departments/community teams
- Improve/develop IPCT audit feedback and lessons learnt including CBU Lead Nurses providing action plans/feedback report to IPCC
- Work with Villeda to ensure the issues with microfibre are resolved as a matter of urgency including evaluation of the system
- Progress opening of new laundry
- Review current cleaning schedules working with Ward/Department Managers
- Review Bedwasher area and storage to enable room to be utilised as currently not fit for purpose
- Review training in relation to invasive devices
- Consider the introduction of a Immunisation Coordinator to enable vaccination of long term patients
- Review the introduction of the Paediatric Sepsis Six and PEWS

- Work with Ward Managers to review process and feedback for admission screening for CPE as poor compliance which could lead to risk for Trust particularly as incidence of patients being admitted with CPE has recently increased
- Continue to work closely with the CHP Team and Interserve to ensure completion and resolution of any outstanding issues
- Review membership of the Water Safety Group to ensure appropriate representation and managerial support

Report prepared by:

Dr. Julie Hughes – Associate Director Infection Prevention and Control
March 2016

5. References

Care Quality Commission. (2008) *Registering with the Care Quality Commission in relation to healthcare associated infection. Guidance for trust 2009/10.* London: Care Quality Commission.

Department of Health. (2009) *Health & Social Care Act 2008: Code of Practice on the prevention and control of healthcare associated infections and related guidance.* Department of Health: London.

Loveday, H.P. J.A. Wilson, J.A, Pratt, R.J. et al (2014) epic3: National Evidence-Based Guidelines for Preventing Healthcare-Associated Infections in NHS Hospitals in England. *Journal of Hospital Infection* 86S1 (2014) S1–S70.

Public Health England (2014) Patient Safety Alert Stage 2 Resources: *Addressing rising trends and outbreaks in Carbapenamase producing Enterobacteriaceae* March 6th 2014. NHS England.

Alderhey Hospital NHS Foundation Trust Infection prevention and Control Policies and Procedures.

ACTION PLANS

External service review

NO.	Recommendation	Timescale	Responsibility	Progress
8	Relook at training in relation to decontamination working with decontamination lead and medical equipment lead	Sept 2016	Lead Nurse IPC	Met with DL and MEL. Reviewing policy which includes training. Including ME and decontamination awareness into MT
9	Review water flushing recording regime to ensure this is undertaken and documented as time consuming to staff	April 2016	Lead Nurses Howard Davies	HD has met with WM. Increasing the number of staff that can input on to COMPASS system.
10	Enable and empower IPC link nurses to participate in own audits in addition to Hand hygiene for areas to take more ownership of issues in their areas	Mar 2017	Lead Nurse IPC	IPC Data analyst will input audits onto SNAP so links can be sent to Link nurses and ward managers on a monthly basis. Reports can then be run off by the IPCT team and feedback to Ward areas
11	Review audit programme to include colleagues reviewing each other's areas to increase objectivity	Mar 2017	Lead Nurse IPC	Identified hand hygiene audit will be first area. Link nurses to audit within their CBU
12	Expand Hand hygiene audits to other Trust departments / community teams	Mar 2017	Lead Nurse IPC Department leads	Parent / child tool developed being trialled in radiology and clinics
13	Improve/develop IPCT audit feedback and lessons learnt including CBU Lead nurses providing action plans / feedback report to IPCC.	April 2016	CBU lead nurses IPC to feed back audit at R&G	CBU lead nurses have agreed in principle. Template to be developed by IPC lead nurse / DIPC
14	Work with Villeda to ensure the issues with microfiber are resolved as a matter of urgency including evaluation of the system	July 2016	Soft FM manager	Visit undertaken. Villeda training for staff organised. Use of chemicals for Microfibre.

NO.	Recommendation	Timescale	Responsibility	Progress
14b	Progress opening of new laundry	Sept 2016	Soft FM manager	IPCT working with Hotel services and building services team to progress
15	Review cleaning schedules	Sept 2016	Soft FM manager	Cleaning schedule only produced for pantry
16	Review bed wash area and storage to enable room to be utilised as currently not fit for purpose	Mar 2017	Decontamination lead	Audit undertaken by IPCT. Plan for area to be cleared to allow bed to be processed
17	Review training in relation to invasive devices	Mar 2017	Training lead	Review of clinical skills education
18	Consider the role of immunisation co-ordinator to enable vaccination of long term patients	Mar 2017	DIPC	Audit in progress looking at gaps and opportunities in provision.
19	Review the introduction of the Sepsis Six and PEWS	April 2016	Medical Director DIPC	Medical Director has agreed that it must be implemented
20	Work with ward managers to review process and feedback for admission screening for CPE as poor compliance could lead to risk for Trust	July 2016	Data analyst Lead Nurse IPC	Meetings planned
21	Continue to work with CHP team and Interserve to ensure completion and resolution of any outstanding issues	On going	Lead Nurse IPC DIPC	Weekly meeting with Building services team and regular communications.
22	Review membership of water safety group to ensure appropriate representation and managerial support	May 2016	DIPC Operational Director	Decision pending on who should attend.

Alder Hey Children's NHS
NHS Foundation Trust

Infection Control Committee Meeting

Tuesday 26th January 2016

Level 1, Room 11

9.30am -11.30am

Present:	Julie Hughes (Chair)	Interim DIPC	JH	**Apologies:**	Francine Verhoeff	Consultant General Paediatrician	FV
	Jo Keward	Lead Nurse Infection Prevention & Control	JK		Joyce Russell	Consultant Orthodontist	JR
	Carly Quirk	Infection Control Data Analyst	CQ		Howard	Health & Safety Advisor	HD
	Denise Boyle	Lead Nurse SCACC	DB		Davies	Medical Director	RT
	Carol Zanin	Deputy Hotel Services Manager	CZ		Rick Turnock	Consultant Paediatric Surgeon	JM
	Pauline Brown	Acting Deputy Director Nursing	PB		Jo Minford	Lead Nurse ICS	PO
	Ann Butler	Quality & Safety Lead	AB		Phil O'Connor	Consultant	JB
	Linda Newsham	HCAI Programme Manager Liverpool CCG	LN		James Bunn	CCG Liverpool	DR
	Jean Hutfield	Compliance, Risk & Contracts Manager	JHT		Denise	Clinical Risk Advisor	JG
	Steve Kerr	Service Group Lead PICU	SK		Roberts	Ward Manager 3A	TK
	Mandy Connolly	Trust Advisor for serious incidents and risks	MC		Joanne	Consultant in Paediatric Infectious Diseases	AR
	Karen Kay	Head of Risk	KK		Gwilliams	Consultant	AS
	Jeanette White	Unit Manager 3B	JW		Teresa Kelly	Consultant Paediatric Pathology Consultant	JM
	Janet Smith	Ward Manager 3B	JS		Andrew Riordan	A&E Consultant	BM
	Tracey Wileman	Team Leader ED	TW		Andrew Selby	Consultant Psychiatrist	SE
	Sue Brown	Decontamination Lead	SB		Jo McPartland		
	Kelly Black	Ward Manager DMU	KB		Bimal Metha		
	Tracy Wilson	Ward Manager 1C	TW		Steve Earnshaw		
	Elvina White	Care Pathways, policies & Guidance Manager	EW				
	Colin Baillie	Consultant Surgeon	CB				
	Claire Oliver	Infection Control Nurse	CO				
	Sara Melville	IV nurse Specialist	SM				
	David Sharpe	Antimicrobial Pharmacist	DS				
	Brigid Doyle	Lead Nurse NMSS	BD				
	Chris Bedson	Ward Manager 4B	CB				

Agenda item	Discussion points	Owner	Action	Time frame
Welcome & Apologies	• JH welcomed the committee and commented that although the group was represented with members from each of the CBUs there was no medical representative from Medical CBU therefore the committee was non quorate.	JH/RC/ RT	Discuss membership	ASAP
Previous Minutes	• Group agreed previous minutes			

Actions from previous minutes	• CZ commented that the ***fogging issue*** is still ongoing. She explained that the union had queried domestics carrying out fogging. MD had picked this up with JA and it had been put on hold. BD commented that this is now causing operational problems the Trust have breached on several occasions due to cubicles not being available as not being fogged. JH agreed to pick this up outside of the meeting. • CZ commented that the ***scrubber dryers*** are still an issue, they are still being taken from ward areas to clean the rest of the hospital. This is a finance issue. JH agreed to pick this up with JA/MD outside. • CZ commented that ***cleaning in theatres*** is working well currently the Trust have now filled the total number of hours required. • JK commented that the ***point prevalence*** had been started in December but had not been completed due to winter pressures therefore IPC would commence a point prevalence study in February. • JH commented that ***immunisation co-ordinator*** will hopefully be taken forward following the IPC review that she is currently carrying out. She commented that this would need a lead clinician. The group suggested Andrew Riordan. RC is also meeting with David Seddon to discuss. • BD commented that a SOP should be drawn up with who is responsible for ***cleaning the kitchen, pantry*** etc. as this is an ongoing confusion on the wards. JH agreed to pick this up in her meeting with MD.	JH JH JK JH	Meet with MD to discuss fogging. Meet with JA/MD re scrubber dryers. Point prevalence study Discuss responsibilities for cleaning kitchen areas with MD.	ASAP ASAP Feb 2016 ASAP
PHE Update	• No update had been provided from PHE. • JH commented that influenza A is on the rise although the expectation is that it will not be a bad year due to childhood immunisations. JK commented that with the problems in pathology with the autoclave samples are being sent off to the Royal so there is a delay with results, therefore patients maybe being placed in bays when they should be in cubicles. • JH also mentioned that ZIKA Virus is also on the rise, mainly a tropical virus but staff should be aware of symptoms. Currently awaiting further guidance from PHE which will be circulated.			
DIPC & IPC Nurse	• JH shared the DIPC/Lead Nurse reported with group.			

Report	• The group was asked to share their thoughts on how effective the ***winter plan*** had been. BD commented that last year it had made a huge impact and had helped with the flow in EDU this year which is key. SK commented that it was a great source for ensuring the patients are appropriately nursed. CB commented that the cohorting of patients had a detrimental effect on our surgical patients. He added that due to the loss of number of surgical beds in the move they were promised that surgical beds would be ring fenced and that this is not happening. BD commented that the flow chart shared by RC for winter shows which areas are to be used to cohort and surgical wards were on the very bottom of the chart but these beds had only been used due to the high number of admissions over this winter season. CB suggested that perhaps we should be sending children to their local hospital when they arrive at A&E rather than being open to admission to everybody. The group agreed that this was an issue for the Chief Operating Officer. PB agreed to speak to Lachlan Stark, Head of Performance and Planning about lessons learned from the season and how this point is possible to move forward. • JH noted the ***poor compliance rates for screening*** our admissions. SK commented that Nick Barnes had mentioned a reminder that can be set in Meditech which could be used in this instance to remind staff to complete screening for appropriate patients. CB commented that there is confusion over MRSA and some further education may be appropriate. The question was raised as to whether being an MRSA carrier is a problem. The group discussed that if hand hygiene amongst staff is poor a child who is carrying MRSA may then pass MRSA onto a sick child via a member of staff who could potentially become very sick with MRSA therefore identifying which patients have MRSA is key to minimising risk of infection to other patients. JH also commented that CPE is now becoming more apparent in our local hospitals therefore low compliance of screening is very concerning. JH mentioned a business case that she is involved with to purchase a new machine for pathology	PB	Speak with LS re not admitting patients from outside the local area.	ASAP

	which will carry out film array for numerous different organisms including MRSA and CPE within 2 hours. This business case needs clinical support and she would be very grateful if clinicians could get in touch with her as to why this machine would benefit them and their patients. • The group discussed how we improve completion of action plans from audits and PIRs. KK commented that following a discussion with herself and JK a new process will take place for action plans from audit and PIRs that will mirror the process used for level 2 RCA investigations.			
ANTT Policy	• SM shared the ANTT policy with the group. She stated that the policy had been updated with new references. • JK pointed out a mistake on page 9 of the policy SM agreed to change. • JK questioned the education of ANTT and how this was rolled out across the trust. SM stated that vascular access is incorporated into mandatory training, there is an online training update and there are also ANTT link nurses across the Trust supported by Anna Hulse to deal with the line side of ANTT. JK commented that she had met with Urology nurse last week and they have produced a urine catheter policy which needs to be reviewed in terms of antibiotics but will hopefully be ready for approval at the next committee meeting. She also commented that there was a lack of clinical skills training across the Trust. DB commented that at a meeting last week this issue had been identified, this is now being looked at by a working group who will scope the gaps and produce a plan to implement this over the next two years. JH commented that she has arranged to meet with Paula Davies Learning and Development to discuss and action. • SM commented that the CLABSI rate was remaining stable with 2 reported in November and 7 in December. Although an increase in December figures remain fairly stable. She commented that not all CLABSI are preventable. JH commented that there had been discussion with the IPS Forum co-ordinator who has shown an interest in working with us. This would help to improve comparisons for the future. JH has	SM	Update page 9	ASAP

	invited SM to attend a meeting that she has arranged regarding this. • The group approved this policy.			
Uniform and Dress Code Policy	• EW presented the policy in POs absence. She explained that following the discussion at the last IPCC meeting a scope of changing facilities had been carried out. There are only 50% of areas in the Trust with changing facilities. Therefore the committee agreed that staff should be allowed to wear uniform to and from work whilst facilities are inadequate. JK commented that the high risk areas are the areas of most concern staff need to ensure that uniform are fresh each day. JH commented that Mike Travis had also added his concerns via email. CB commented that the changing facilities in theatre are inadequate. • The committee discussed the wearing of lanyards and concluded that lanyards can be worn in non-clinical areas. The group asked EW to add a bullet point to the policy to indicate this. • The committee agreed to approve the policy. • JH suggested adding the lack of changing facilities to the risk register with the actions that we are taking to minimise risk.	JK	Add to the risk register	ASAP
Opening and Closing of Wards Policy	• EW presented this policy. She explained that this would be an interim policy as it would need to be updated once the hospital water safety plan was in place. JHT commented that there were alterations needed in it from estates perspective before it could be approved. The committee asked for JHT to make any alterations and bring back to the committee for approval. • CB queried how policies were disseminated. EW advised that policy authors are responsible for ensuring policies are disseminated. • CB queried filters on taps JK advised that there is only one unit in theatre that has a filter. The committee discussed water testing JK confirmed that in house water testing has not commenced, PB expressed great concern that this was not being carried out particularly in augmented care areas. JK agreed to speak to JC and PB agreed to pick this up outside of meeting. JH agreed to also discuss with HD & AK later today.	JHT JK PB JH	Amend opening and closing of wards policy Speak to James C re water testing. Follow up flushing with HD Speak to HD & AK	Before next IPCC meeting ASAP ASAP Today

	• CB asked who was in charge of flushing in different areas. Committee agreed that it was the ward managers responsibility to complete the online flushing log but housekeepers had been allowed to completed the flushing as it can take up to 20 hours per week to complete. BD commented that wards should be working together with domestic staff as they are also flushing outlets whilst cleaning. It was confirmed that HD is looking at how the system can be improved to be more efficient. • EW commented that temperature issues are still ongoing throughout the hospital. JH agreed that this is major concern. JHT commented that temperature testing will form part of the report from the regular audits that will take place by the outside contractor who is contracted to complete the audits. JH asked to meet with JHT to discuss outside of this meeting. • LN commented that now the CCG were aware of the situation they would be duty bound to monitor this she also added that she would help/advise as needed. JH agreed to meet regularly with LN.	JH	Meet with JHT re water testing	ASAP
Toy Policy	• JK shared the policy with the group. She stated that the policy listed toys and how they should each be decontaminated. She also said that Christmas decorations were now also included. • KK asked if the cars etc. being used for children to play on in the main atrium were being decontaminated JK agreed to speak to concierge staff. • The committee approved the policy.	JK	Speak to concierge staff re decontaminating toys in main atrium.	ASAP
Animal & Pet Policy	• JK confirmed that this is a new policy. The policy will only allow dogs into the Trust but they must be assessed beforehand. Policy includes new guidance. • Committee approved the policy.			
Patient Safety Alert	• DS shared the patient safety alert: Addressing antimicrobial resistance through implementation of an antimicrobial stewardship programme for information. He stated there are now antimicrobial ward rounds 3 times per week whereby the antimicrobial pharmacist will offer advice and recommendations for those patients receiving antimicrobials.			

	• DS confirmed that NICE guidance has now been produced for antimicrobial stewardship and he was currently working on a gap analysis so show where the gaps where within the Trust. He agreed to bring this back to the next committee. • DS commented that Meditech 6 could be used so much better for antimicrobials. As earlier SK mentioned the flagging system that could be used. A request must be logged but they are then prioritised. JH suggested she meet with NB to follow up.	DS JH	Present gap analysis Meet with Nick Barnes	Next IPCC Meeting ASAP
RCA Report H1N1 Influenza	• MC confirmed this case was referred from hospital mortality review group as they had agreed that this patient death could have been avoided with the use of antivirals. MC confirmed that the patient had received excellent care and had been reviewed by many teams but it had never occurred to any of the reviewing teams to prescribe Tamiflu to this patient. • CB suggested as it is Micro reporting the result they should ensure the lead clinician is informed. MC commented that that usually happens with the use of the bug board but didn't in this instance and one action from this RCA is to comment on the bug board once the micro/clinician conversation has happened. • JH commented that the ID/Micro daily consults are working well and would prompt this conversation. • MC confirmed that antimicrobial guidelines have also been updated to include the use of Tamiflu. She stated that RC had done a lot of work on this and it now needs to be communicated. • MC suggested a debrief with RC upon his return to ensure actions are in place. • CB commented that the email from the weekly meeting of harm is an excellent communication method, using bullet points to quickly alert people for those who do not have time to read reports.	MC	Meet with RC	After 22/02/2016
Winter viral season	• JH confirmed this was covered earlier in the meeting but confirmed she would appreciate clinical support for her business case for the replacement of old machine in pathology.			

Learning from MRSA on 1B	• Not discussed		Defer to next meeting	March 2016
AOB	• SM confirmed that the Trust is now working towards using an Octenisan wash on all surgical patients before surgery. CB commented that it was currently very confusing as to who is responsible and which patients should have it. It was confirmed that currently high risk patients have a wash the night before and the morning of surgery by the ward staff but this would hopefully be rolled out across all patients. CB commented that the Trust is moving toward daycase surgery so will clinicians have to prescribe the wash in these circumstances? SM confirmed this will be considered in the roll out plan. JH suggested the plan came back to this committee. • EW commented that Sepsis is topical at the moment. The national patient safety alert for Sepsis had been issued over 12 months ago with little paediatric guidance. In September/October 2015 the paediatric guidance was issued. EW had worked with A&E developing pathways for those patients diagnosed with sepsis in A&E but there has been no progress. We need to look at patients who are diagnosed with sepsis as inpatients. MC commented that as part of the RCA involving the septic patient many of these issues will be actioned. MC suggested that EW be part of the panel for the RCA. The group suggested that this may need a lead clinician to carry forward suggestions were James Bunn, Eileen Burn, Jo Minford. JH suggested a task and finish to bring in all together. EW agreed to take this forward. The group suggested Enitan Carroll be part of the working group as she is doing lots of research into sepsis.	SM MC EW	Bring roll out plan to committee. Invite EW onto RCA panel Organise task and finish for sepsis pathway/guideline.	When available ASAP ASAP
Next Meeting: Tuesday 29th March 9.30am – 11.30am Institute, Large Meeting room				

Infection Prevention & Control strategy & Delivery plan 2016-17

Alder Hey Children's NHS
NHS Foundation Trust

The DIPC delivery plan outlines the objectives to be achieved in 2016-17 by designated individuals on behalf of the DIPC to ensure that the Trust is compliant with the Health & Social care Act (2008 –revision 2015.)

The plan Links into Trust Strategy 'Developing our 2020 vision – Alder hey in the Park and beyond' – excellence in quality – Safe effective caring

The Health & Social care Act 2008 (Revision 2015). This was revised to reflect the structural changes of the NHS which came into force after April 2013 and the role of Infection Prevention (including cleanliness) in optimising antimicrobial use and reducing antimicrobial resistance.

The delivery plan also outlines actions required to ensure complaint with the below documents.

- NICE quality standard QS113 Healthcare associated infection published 11 February 2016
- NICE quality standard QS121 Antibiotic stewardship published 21 April 2016
- NICE quality standard QS49 Surgical site infection published 31 October 2013
- NICE quality standard QS61 Infection prevention & control published 17 April 2014
- Infection Prevention & Control Service External Review Jan-Mar 2016
- Quality Contract: Infection Prevention & Control measures

Priority	Objective	Relates to document / strategy	Action required	Action lead	Relates to Risk on IPC risk register
1	**Responsive Cleanliness service compliant with H&S Care Act 2008 revision 2015**	Health & Social care Act 2008 External Service review	1. Revision of Hospital cleaning policy to ensure responsibilities clearly outlined and how staff can request additional cleaning. 2. Development of cleaning schedules for all areas of the hospital 3. Provision of SOP for all cleaning procedures 4. Production of Cleaning Webpage on internet to ensure easy access to SOP policies and audit results available 5. Regular meetings with Ward managers, IPC and Hotel services & CBU lead nurses to discuss service planning and delivery at ward level. 6. Review of education and implementation of competency based programme for Hotel services staff 7. Revision of Cleanliness monitoring process to incorporate IPC/ ward managers / supervisors and Domestics 8. Introduction of quarterly cleanliness audit by IPC, Hotel services, patient forum, CBU lead nurses. 9. Establishment of robust process for cleaning / disinfection of cubicles lead by clinical demand 10. Development of Laundry policy 11. Review Micro fibre – organise additional competency based training and review use of cleaning product to use with micro fibre. 12. Principles and practice of prevention of infection & cleanliness included in induction and training programmes for new staff	Mark Devereaux Head of Soft FM IPCT	**638** Cubicle cleaning & fogging process

Priority	Objective	Relates to document / strategy	Action required	Action lead	Relates to Risk on IPC risk register
	Improve Antibiotic stewardship and compliance with NICE QS121 & NICE QS62 statement 1 NICE QS49 statement 2	NICE QS121 Health & social care act 2008 CQUIN	**1.** Gap analysis and action plan for compliance with NICE QS121. **2.** Antibiotic review 48 hours – to be built into Meditech Clinical indication for antibiotic use , dose **and** duration included in prescription – To be built into Meditech **3**. Individuals and teams responsible for AB stewardship monitor data and feedback at prescriber level, team and organisation and commissioner level	Catrin Barker David Sharpe Martin Levine Meditech OPAT team	**658** incomplete antibiotic stewardship
	Sepsis – Implementation of the SEPSIS 6	NICE QS XXXX July 2016 CQUIN	• Task and finish group to implement Paediatric Sepsis 6 Trust wide. • Audit compliance with Sepsis management -50 patients per month.	Chair of sepsis task and finish group	To be entered on Risk register
	IPC service development	External service review NICE QS62	**Statement 3 Hand hygiene** • Signage for atrium • Revise Hand hygiene posters • Review of hand hygiene products • Staff trained at Induction & on annual basis in hand hygiene • Hand hygiene tool developed and trial. • Hand hygiene awareness campaign • Development of Link nurse so able to undertake monthly IPC audits using snap tool	Josephine Keward	**637** Hospital acquired infection NEW RISK Inadequate education on indwelling invasive devices

Priority	Objective	Relates to document / strategy	Action required	Action lead	Relates to Risk on IPC risk register
			Statement 4 urinary catheters • Policy available on urinary catheter maintenance • Regular updates for all staff on care of urinary catheters • Audit of practice NICE CG 139 clinical tool (baseline review of urinary catheter care) • CAUTI surveillance 1 quarter of each year **Statement 5 Vascular access** • Review innovations to reduce CLABSI rates on Critical care • Production of line data per 1000 line days • Regular (min quarterly) QC audit of ANTT and feedback to IPCC and clinical teams **Statement 6 – Education** • Review of IPC education programme to include annual stand up session, work book and bespoke training • Development of IPC link programme to enable IPC links to support quality initiatives • Regular update training in care of all invasive devices. **Team development** • Development of IPC support worker to support SSIS, audit and fit testing • Development of IPC surveillance co coordinator role **Improve visibility of IPC** • Ward rounds • Safety huddles **Audit programme for 2016-17** • Ward and departments • Policies – include urinary catheter, ANTT, MRSA, Isolation	Sarah Doyle IPCT Sara Melville Jo Keward Paula Davies Jo Keward	

			• IPC practice – bedpan audit, sharp audit, Isolation practice • EBM, Hand hygiene	Richard Cooke Jo Keward	
Priority	**Objective**	**Relates to document / strategy**	**Action required**	**Action lead**	**Relates to Risk on IPC risk register**
	Reduction in Health Care associated infection	NICE QS113 Quality Contract NICE QS62 Statement 2	**Statement 1 Surveillance** • Quarterly Prevalence survey to identify HAI and help inform practice • Utilise Meditech & Epiquest to produce surveillance reports • Data analyst to gain access to SNAP system in IPC office **Statement 2 Collaborative action** • Develop networks with external agencies (PHE, CCG & other specialised paediatric trusts) • Regular collaboration with CCG / PHE • IPCT develop internal networks **Statement 3 Responsibilities of staff** • Trust staff to have clear objectives in relation prevention & control that are linked to trust board objectives i.e.in PDR and in JD **Statement 4 Planning maintenance of hospital facilities** • Regular meetings with IPC and building services and involve of IPC **Statement 5 Admission discharge and transfer** • Information of IPC given for patient transfer and admissions	IPCT IPCT Human Resources Building services team Ward managers	**637** Hospital acquired infection **640** Risk of HAI due to pseudomonas in the water supply **969** incomplete surveillance screening for CPE **659** New Hospital build

			• Improve CPE surveillance screening • Compliance audit by IPCT		
Priority	**Objective**	**Relates to document / strategy**	**Action required**	**Action lead**	**Relates to Risk on IPC risk register**
	Compliance with Health & Social care act 2008	Health & Social care act 2008 External review	**Criteria 1 Systems** ○ CBU lead nurses to provide report bimonthly to the IPCC **Criteria 4 Information** • Information available for carers on appropriate use of antimicrobials **Criteria 7 isolation facilities** • additional KWIK screens on 4C, EDU & SDU **Criteria 9 policies** • Policies to be developed ; Chickenpox management, Respiratory viruses, gastrointestinal viruses, • Revision of CRE policy and additional of appendices on MRO in C17 Isolation policy **Criteria 10 OCH & IPC training for staff** • OCH policy on pregnant staff • Monthly compliance audit for IPC training records	CBU lead nurses Dave Sharpe Lead nurses ICS & SCACC IPCT OCH Jo Downes	**601** inadequate cubicle provision in critical care, EDU & Medical assessment **639** inadequate information on IPC MT compliance

Priority	Objective	Relates to document / strategy	Action required	Action lead	Relates to Risk on IPC risk register
	Reducing the risk of Infection due to surgery	NICE QS 49 Quality Contract	1. Audit of compliance with NICE QS 49 and development of action plan 2. **Development of IPC policy and regular audit of compliance with policy** 3. **Development of surgical care bundles for all surgery and the development of monthly monitoring of compliance with feedback to clinicians** 4. Set up SSI reduction group 5. Develop methodology for K wire SSIS and pilot by end of QTR 4 2016-17 6. SSI surveillance report annual basis	Lisa Moore Rob Griffiths Rob Griffiths Bernadetta pettorini Lisa Moore & Dave Wright Lisa moore	**970** Risk of HAI due to surgical site infection
	Decontamination	Health & Social Care Act 2008 External review	1. Ward decontamination checklists 2. Central Records kept for all training in decontamination of medical devices 3. Decontamination audits on annual basis for all wards and clinical departments 4. Revision of decontamination policies – medical devices / disinfection	Sue Brown Jill Barber Sue Brown, Sue Brown	**641** Incubator cleaning **656** Decontamination of reusable patient equipment

Priority	**Objective**	**Relates to document / strategy**	**Action required**	**Action lead**	**Relates to Risk on IPC risk register**
	Staff engagement in IPC	External review CCG quality contract	Ensure there is adequate signage available to highlight the importance of Infection prevention & control To include the following; • Stand up signage for atrium • New hand hygiene posters • New isolation posters • Hot boards displaying IPC and cleanliness information for children/ families	IPCT Ward managers	**634** CBU staff engagement
	Reducing the risk of HAI due to infectious disease		• Audit with PHE on missed opportunities for vaccination • Review of immunisation coordinator role • Lead on Flu Campaign in conjunction with OCH and pharmacy • Respirator fit testing	IPCT Stephanie Longmuir IPCT	**635** pandemic flu **654** Fit testing for respirators **657** Vaccination of HCW against influenza **636** Under reporting of NSI **630** failure to wear appropriate PPE

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Tuesday 5th July 2016

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

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1. Background:

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

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

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

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

2. SIRI performance data:

SIRI (General)														
2014/15							2015/16							
Month	**Apr**	**May**	**June**	**July**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**
New	1	0	5	0	3	2	2	2	1	1	3	1	2	1
Open	5	6	5	7	5	2	3	3	3	5	6	7	6	3
Closed	1	0	1	3	2	4	1	0	2	1	0	2	2	5
Safeguarding														
Month	**Apr**	**May**	**June**	**July**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**
New	2	0	0	0	1	0	0	0	0	1	2	0	0	0
Open	1	3	0	0	0	0	0	0	0	0	0	0	0	0
Closed	0	0	3	0	0	0	0	0	0	0	0	0	0	0
Total closed	**0**	**0**	**0**	**3**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

3. Recommendations:

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

New SIRI Incidents reported between the period 01/05/2016 to 31/05/2016:							
Reference Number	**Date investigation started**	**CBU**	**Incident Description**	**RCA Lead Investigator**	**Progress**	**60 working day compliance**	**Duty of Candour/ Being Open policy implemented**
RCA 190 2016/17 StEIS 2016/14784	31/05/2016	ICS	Delayed transition of a 17.5 year old CAMHS patient.	Lindsey Marlton, Service Manager, CAMHS	Initial fact finding underway.	Yes	Yes

New Safeguarding investigations reported 01/05/2016 to 31/05/2016:							
Reference Number	**Date investigation started**	**CBU**	**Incident Description**	**RCA Lead Investigator**	**Progress**	**60 working day compliance**	**Being Open policy implemented**
Nil							

On-going SIRI incident investigations (including those above)							
Reference Number	**Date investigation started**	**CBU**	**Incident Description**	**RCA Lead Investigator**	**Progress**	**60 working day compliance (or within agreed extension)**	**Duty of Candour/ Being Open policy implemented**
RCA 183 2016/17 StEIS 2016/9552	11/04/2016	SCACC	Never Event – Wrong side chest drain inserted into patient.	Paul Baines, Consultant, Paediatric Intensive Care Unit	RCA panel meeting held 08/06/16, further questions raised following the panel, 2nd panel to be held on 30/06/16.	Yes	Yes
RCA 180 2015/16 StEIS 2016/8081	21/03/2016	NMSS	Delay in referral to Paediatric Ophthalmic Unit. Patient underwent cataract surgery, attended Accident & Emergency Department 6 weeks later with red eye, subsequent clinic appointment 5 days later revealed retinal detachment, surgical repair not possible due to delay from onset of symptoms, resulting in permanent loss of vision.	Brigid Doyle, Lead Nurse	RCA panel meeting held 04/05/16, report written, quality check raised further questions and clarity required on some points. Questions to be answered and final report to be written.	Yes	Yes
RCA 172 2015/16 StEIS 2016/3088	01/02/2016	SCACC	Never Event. Wrong site surgery. Patient listed and marked for umbilical hernia repair. Surgical incision made at site of marking and not below the umbilicus as planned. Incision closed and new incision made approximately 1 inch lower.	Harriet Corbett, Consultant Surgeon and Maureen Arrowsmith, Ward Manager	Draft report sent to CCG.	Yes	Yes

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

SIRI incidents closed since last report						
Reference Number	**Date investigation started**	**CBU**	**Incident Description**	**RCA Lead Investigator**	**Outcome**	**Duty of Candour/Being open policy Implemented**
RCA 136 L2 2015/16 StEIS 2015/29703	11/09/2015	CS	Delay in diagnosis of CF in patient.	Paul Newland, Clinical Director	Final multi agency report sent to CCG and family.	Yes
RCA 155 L2 2015/16 **Internal**	26/11/2015	MS	Patient suffered 10x medication (teicoplanin) error repeated on 3 occasions.	Dave Walker, Medication Safety Officer	Final internal report completed.	Awaiting parents' decision
RCA 162 2015/16 StEIS 2016/1409	14/01/2016	SCACC	Never Event. Wrong site anaesthetic block to patient. During anaesthesia for a right femoral fixation, left side block performed.	Kerry Turner, Theatre Risk and Governance Lead and Paul Dunn, Clinical Lead	Final report sent to CCG, family did not wish to receive a copy of the report.	Yes
RCA 173 2015/16 StEIS 2016/4710	15/02/2016	NMSS	Grade 4 pressure sore to patient's heel from plaster cast, identified at OPD.	Keith Rafferty, Quality and Safety Improvement Lead	Final report sent to CCG and family.	Yes

RCA 184 2016/17 StEIS 2016/10039	12/04/2016	SCACC	Grade 3 Pressure Sore to back of patient's head.	Sue Tickle, Sister, Paediatric Intensive Care Unit	Letter sent to family, pressure sore deemed unavoidable.	Yes

Safeguarding investigations closed since last report
Nil

Alder Hey Children's NHS
NHS Foundation Trust

Trust Board
June 2016

Medical Revalidation & Appraisal

1. Purpose Of The Paper

1.1. To update Trust Board on medical revalidation and appraisal for the year 2015/16.

1.2. To set out the key priorities that the Trust needs to take forward into 2016/17.

2. Recommendations

2.1. The Trust Board is asked to review the contents of this paper.

3. Strategic Context

3.1. The purpose of revalidation is to ensure that doctors remain up to date and continue to be fit to practise. It aims to support doctors in their professional development, to contribute to improving patient safety and quality of care and to sustain and improve public confidence in the medical profession.

4. Performance Data for Appraisal and Revalidation in 2015/16

4.1. The table below shows appraisal and revalidation performance data for each of the CBU's

GMC Rating	**1A**	**1B**	**2**	**3**	Not done yet	Total
Consultants						
ICS	37	7	3	1	1	48
Medical Specialties	23	15	2	1		41
Clinical Support	9	8	2			19
SCAAC	45	6	5	3		59
NMS	42*	3	1			46
Total consultant numbers	**156**	**39**	**13**	**5**		**213**
Other (hon contracts or reciprocal RO)	2			2		4
Staff grade, Associate Specialists, Specialty Drs	11	9	1			21
Clinical Fellows	9	1	12	5		27
Total	**178**	**49**	**26**	**12**		**265**
	ICS	**MS**	**CS**	**SCACC**	**NMS**	**Total**
Positive Revalidation 2015/16	30	21	10	34	13	108
Number of revalidation deferrals	0	0	0	1		1

	DSCC	MS	CS	SCACC	NMS	Total
	CS	ICC	MS	SCACC	NMS	
Number of trained appraisers	19	6	4	17	12	58

*Included Dental Consultants- not included in GMC figures

4.2 Number of appraisals completed 86.9% - a further 9.5% were approved delayed appraisals due to sick leave or new starters who had not had sufficient time to complete an appraisal – giving an overall appraisal rate of 96.4% with 3% missed appraisals

4.3 Survey monkey used for appraisee, appraiser feedback

4.4 Appraisee feedback 71 roughly same proportion as previous years (27%) and 53 appraisers (almost all providing some feedback)

5. Doctors in Difficulty

Updated information from the last ELS meeting (May 16) is not yet available for this report. Therefore the following information is based on notes from September 2015.

5.1 At the time of the report 1 Doctor had an on-going review by GMC, two Doctors had cases closed
5.2 Two Doctors had on-going concerns , one of whom is being managed through an MHPS process

6. Quality monitoring for year ending April 2015.

In the last year, with the support of the audit department two survey monkey questionnaires for appraisee and appraiser feedback were implemented.

6.1 There was still concerns about the supporting information provided by the Trust. This was rated lower than last year: 6% poor, 7% borderline, 28% average, 38% good and 20% as very good. Comments about improving the data supporting appraisal by including mandatory training record, critical incidents, complaints, PALS in integrated way.

6.2 An audit of 50 electronic appraisal forms indicated that the summary form was well documented, covered all roles and commented on incidents as well as reviewing PDP and planning future PDP. It identified the need to help appraisees increase their reflective practise and ensure that the requirement of a yearly audit was clearly documented and met.

Appraisee feedback

Key findings:

6.3 **97%** of appraisers were rated as very good or good at their preparation for appraisal, and **100% `were good or very good** at conducting the appraisal and also challenging to help review practice **97%** - higher than last year.
6.4 79% found the appraisal useful in preparing for revalidation.
6.5 Annonymised comments for appraisers provided this year are all very positive and will be fed back to the appraisers for reflection (along with the audit of their appraisal summaries score out of 20)

The appraiser feedback

Key findings:

1. Organisation training equipped well for appraisal 83**%**.
2. Most appraisers thought the appraisees were well prepared for the appraisal.

3. Appraisers also thought that supporting information could be improved: access to mandatory training record, complaints, RCA and SUI, audits and other information 24.5% average, 35.8% good and 37.7% very good.
4. Appraisers weren't given adequate notice of the date of the appraisal (96% good or very good).

7. Key Priorities for 2015/16

7.1. The Trust has renewed the contract with Allocate Software to provide a fully electronic system for appraisal, multi-source feedback and revalidation, as well as modules for job planning and leave management. It is expected that the system will be ready for implementation by the end of July, and available for the forthcoming round of appraisals. The system will provide significant benefits in terms of electronic appraisal sign off, comprehensive appraisal reporting and automatic link with GMC for revalidation.

7.2 The quality programme that was implemented in 2015 will continue to be developed to support appraisers/appraisees as part of the Quality strategy.

8. Conclusion

8.1. Medical revalidation commenced in December 2012 and Trusts should ensure that there are adequate systems in place that meet the needs of doctors, patients and the public.

8.2. NHS organisations and their boards should recognise the benefits of revalidation as a major driver towards improving patient safety.

8.3. Significant progress has been made to ensure that the Trust is well prepared for revalidation and that the first year of revalidation has progressed well.

8.4. The Trust has identified some keys areas of development for improving the quality of data to support appraisal and this will be a priority in the coming months.

Appendices

Appendix1. Revalidation - Assessment of appraisal summary
Appendix2. Qualityreport.auditsummaries2015

Paper prepared on behalf of Rick Turnock by:

Dr Omnia Marzouk, Associate Medical Director
Helen Blackburn, Education & Revalidation Services Manager

Q5 **Encompass all? Does the summary comment on context, including stage of revalidation cycle, and reflection on the whole of the scope of work?**

0=No (absent from summary)..... 0 (0.0%)
1=Partially (room for improvement) 148 (80.4%)
2=Yes (well done)..... 36 (19.6%)
Comments (if answer 0 or 1): 136 (73.9%)

Q6 **EXclude bias and prejudice? Are all statements objective, free from bias and prejudice and based on evidence? Is it a typed, professional document?**

0=No (absent from summary)..... 0 (0.0%)
1=Partially (room for improvement) 40 (21.7%)
2=Yes (well done)..... 144 (78.3%)
Comments (if answer 0 or 1): 118 (64.1%)

Q7 **Challenge, support and encourage? Does the summary demonstrate that the appraisal was challenging, supportive and focussed on the needs of the doctor?**

0=No (absent from summary)..... 0 (0.0%)
1=Partially (room for improvement) 33 (17.9%)
2=Yes (well done)..... 151 (82.1%)
Comments (if answer 0 or 1): 26 (14.1%)

Q8 **Explain why any statements (including health and probity) have not been agreed? Does appropriate commentary explain any 'no' or 'disagree' answers? (Score 2 if N/A)**

0=No (absent from summary)..... 0 (0.0%)
1=Partially (room for improvement) 0 (0.0%)
2=Yes (well done)..... 184 (100.0%)
Comments (if answer 0 or 1): 1 (0.5%)

Reviewing:

Q9 **Look at supporting information, lessons learned and changes made? Does the summary drive quality improvements by reflecting what has been learned and what needs to be changed as a result?**

0=No (absent from summary)..... 1 (0.5%)
1=Partially (room for improvement) 43 (23.4%)
2=Yes (well done)..... 140 (76.1%)
Comments (if answer 0 or 1): 35 (19.0%)

Q10 **Look at last year's PDP and reflect on each objective? If any objectives have not been achieved, have the reasons been discussed and documented?**

0=No (absent from summary)..... 1 (0.5%)
1=Partially (room for improvement) 11 (6.0%)
2=Yes (well done)..... 172 (93.5%)
Comments (if answer 0 or 1): 11 (6.0%)

Q11 **Encourage excellence, celebrate accomplishments and record aspirations? Does the summary capture examples of good practice and record aspirations (some of which may have a timescale over one year)?**

0=No (absent from summary)..... 1 (0.5%)
1=Partially (room for improvement) 25 (13.6%)
2=Yes (well done)..... 158 (85.9%)
Comments (if answer 0 or 1): 10 (5.4%)

Planning Ahead:

Q12 **Note any gaps/no gaps in the requirements for revalidation and how they will be addressed? What supporting information is outstanding for each role?**

0=No (absent from summary)..... 1 (0.5%)

1=Partially (room for improvement) 158 (85.9%)

2=Yes (well done)..... 25 (13.6%)

Comments (if answer 0 or 1): 156 (84.8%)

Q13 **Contain SMART PDP Objectives? Are they Specific, Measurable, Achievable, Relevant and Timely? Do they challenge the doctor to make quality improvements?**

0=No (absent from summary)..... 0 (0.0%)

1=Partially (room for improvement) 8 (4.3%)

2=Yes (well done)..... 176 (95.7%)

Comments (if answer 0 or 1): 4 (2.2%)

Q14 **Explain the new PDP items? Does the summary show how the PDP objectives are relevant and derive from the supporting information and appraisal discussion?**

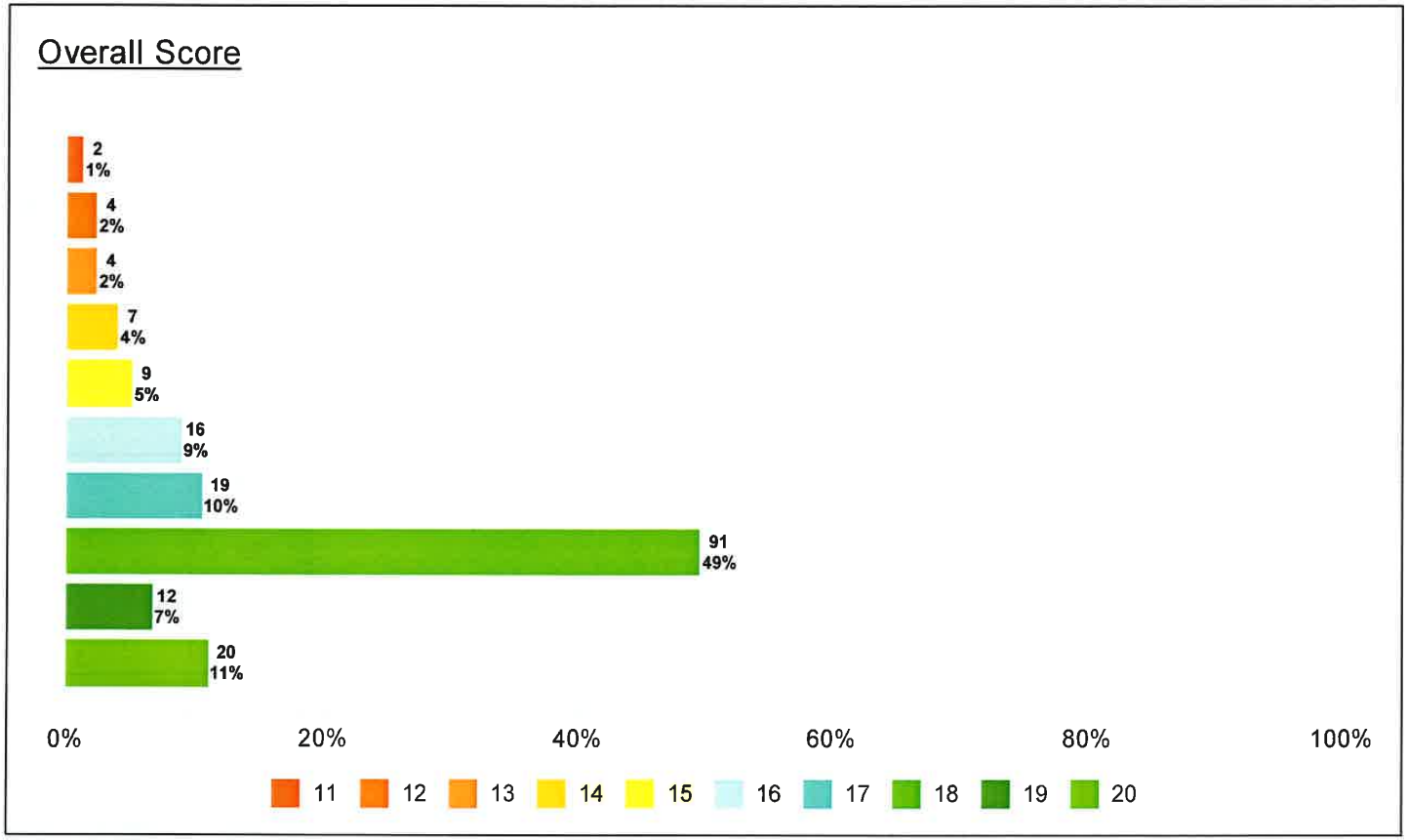
0=No (absent from summary)..... 0 (0.0%)

1=Partially (room for improvement) 6 (3.3%)

2=Yes (well done)..... 178 (96.7%)

Comments (if answer 0 or 1): 1 (0.5%)

2015-16 Revalidation Summary Total Scores n=184



- Median = 18
- Mode =18
- Average = 17.39

Table of Total Scores: n=184

Overall Score	184 100%
11	2 1%
12	4 2%
13	4 2%
14	7 4%
15	9 5%
16	16 9%
17	19 10%
18	91 49%
19	12 7%
20	20 11%

Q5 **Encompass all? Does the summary comment on context, including stage of revalidation cycle, and reflection on the whole of the scope of work?**

0=No (absent from summary)..... 0 (0.0%)
1=Partially (room for improvement) 148 (80.4%)
2=Yes (well done)..... 36 (19.6%)
Comments (if answer 0 or 1): 136 (73.9%)

Q6 **eXclude bias and prejudice? Are all statements objective, free from bias and prejudice and based on evidence? Is it a typed, professional document?**

0=No (absent from summary)..... 0 (0.0%)
1=Partially (room for improvement) 40 (21.7%)
2=Yes (well done)..... 144 (78.3%)
Comments (if answer 0 or 1): 118 (64.1%)

Q7 **Challenge, support and encourage? Does the summary demonstrate that the appraisal was challenging, supportive and focussed on the needs of the doctor?**

0=No (absent from summary)..... 0 (0.0%)
1=Partially (room for improvement) 33 (17.9%)
2=Yes (well done)..... 151 (82.1%)
Comments (if answer 0 or 1): 26 (14.1%)

Q8 **Explain why any statements (including health and probity) have not been agreed? Does appropriate commentary explain any 'no' or 'disagree' answers? (Score 2 if N/A)**

0=No (absent from summary)..... 0 (0.0%)
1=Partially (room for improvement) 0 (0.0%)
2=Yes (well done)..... 184 (100.0%)
Comments (if answer 0 or 1): 1 (0.5%)

Reviewing:

Q9 **Look at supporting information, lessons learned and changes made? Does the summary drive quality improvements by reflecting what has been learned and what needs to be changed as a result?**

0=No (absent from summary)..... 1 (0.5%)
1=Partially (room for improvement) 43 (23.4%)
2=Yes (well done)..... 140 (76.1%)
Comments (if answer 0 or 1): 35 (19.0%)

Q10 **Look at last year's PDP and reflect on each objective? If any objectives have not been achieved, have the reasons been discussed and documented?**

0=No (absent from summary)..... 1 (0.5%)
1=Partially (room for improvement) 11 (6.0%)
2=Yes (well done)..... 172 (93.5%)
Comments (if answer 0 or 1): 11 (6.0%)

Q11 **Encourage excellence, celebrate accomplishments and record aspirations? Does the summary capture examples of good practice and record aspirations (some of which may have a timescale over one year)?**

0=No (absent from summary)..... 1 (0.5%)
1=Partially (room for improvement) 25 (13.6%)
2=Yes (well done)..... 158 (85.9%)
Comments (if answer 0 or 1): 10 (5.4%)

Planning Ahead:

Q12 **Note any gaps/no gaps in the requirements for revalidation and how they will be addressed? What supporting information is outstanding for each role?**

0=No (absent from summary)..... 1 (0.5%)

1=Partially (room for improvement) 158 (85.9%)

2=Yes (well done)..... 25 (13.6%)

Comments (if answer 0 or 1): 156 (84.8%)

Q13 **Contain SMART PDP Objectives? Are they Specific, Measurable, Achievable, Relevant and Timely? Do they challenge the doctor to make quality improvements?**

0=No (absent from summary)..... 0 (0.0%)

1=Partially (room for improvement) 8 (4.3%)

2=Yes (well done)..... 176 (95.7%)

Comments (if answer 0 or 1): 4 (2.2%)

Q14 **Explain the new PDP items? Does the summary show how the PDP objectives are relevant and derive from the supporting information and appraisal discussion?**

0=No (absent from summary)..... 0 (0.0%)

1=Partially (room for improvement) 6 (3.3%)

2=Yes (well done)..... 178 (96.7%)

Comments (if answer 0 or 1): 1 (0.5%)

Alder Hey Children's NHS
NHS Foundation Trust

TRUST BOARD REPORT

MORTALITY ASSESSMENT AT ALDER HEY
Medical Director's Mortality Report

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

Section two is the Quarter 4 Mortality report which includes a review of statistical analysis in PICU and Cardiac Surgery, followed by more detailed analysis of the place of death, teams involved and specifics about expected v observed deaths.

Section 1: Report from the Hospital Mortality Review Group (HMRG) Jan-Dec 2015

Summary table 2015:

Number of in-hospital deaths (Jan. 2015 – Dec. 2015)	66
Number of in-hospital deaths reviewed	53
Departmental/Service Group mortality reviews within 2 months (standard) – i.e. up to Oct. 2015	86% (57/66)
HMRG Primary Reviews within 4 months (standard)	41% (27/66)
HMRG Primary Reviews currently within 4 months status	69% (38/55)
Number of deaths within 30 days of discharge (Jan. 2015 – Dec. 2015)	18*
Number of 'within 30 days' deaths reviewed	11

*3 of the 18 will be picked up by the LWH review process.

Summary table 2016:

Number of deaths (Jan. 2016 – Apr. 2016)	30
Number of deaths reviewed	0
Departmental/Service Group mortality reviews within 2 months (standard)	22/23 (96%)
HMRG Primary Reviews within 4 months (standard)	-
Number of deaths within 30 days of discharge (Jan. 2016 – Apr. 2016)	10
Number of 'within 30 days' deaths reviewed	0

The HMRG has completed 53 mortality reviews of in-hospital deaths thus far for the year 2015. In 2016 there have been 30 deaths till the end of April which are not yet reviewed by the HMRG. Most in-hospital deaths had completed at least one full Mortality Review within 2 months of their death – i.e. reviewed by a Service Group within the 2-month limit.

The HMRG has performed less well than previously in attaining its 4-month targets. There are a number of reasons this has occurred:

1) The number of HMRG members undertaking reviews has steadily decreased over recent years due to a number of factors e.g. retirement, other commitments, time/workload pressures. It has always been a voluntary process with no allocation of time in job plans.
2) Difficulties undertaking case reviews as a result of ImageNow, presenting considerable issues reviewing the notes. People are finding reviews take much longer and some information is not accessible.
3) High numbers of deaths over winter and spring. The numbers are not in themselves concerning, but it has resulted in an increasing backlog in reviews with the current issues the HMRG is facing.

These issues have been addressed within limitations:

There has been a recruitment drive for new members for the HMRG currently at least 5 new consultants have expressed an interest. Discussion is on–going with Medical Records to enable access to the hard copy of the notes for the HMRG-reviewer. Clearly a considerable amount of "Catch-up" will be required, but usually the deaths plateau and average out over the year, enabling this to occur.

Additionally, all the CD's have been contacted to identify the mortality lead in each CBU and service group, if appropriate. The aim is to enable clearer communication and consistency across the Trust related to mortality matters.

Reviewing deaths within 30 days of hospital discharge (i.e. deaths outside of Alder Hey) is ongoing – with one of the main challenge being the time taken to identify the cases. In addition, it is difficult to obtain information because Alder Hey has patients from such a wide area. For 2015 the HMRG are aware of 18 such 'within-30-days' deaths and has managed to review 11 'within-30-days' deaths thus far. In 2016 there are 10 such deaths.

Outputs of the new mortality review process for 2015:

Month	Number of Inpatient Deaths	HMRG Review Completed	Dept. Reviews within 2 month timescale	HMRG Reviews within 4 month timescale	Discrepancies HMRG – Dept.	HMRG Review – Death Potentially Avoidable
Jan	9	9	9	5	3	1
Feb	2	2	2	2	0	0
March	3	3	2	1	1	1
April	7	7	7	4	1	1
May	3	3	3	3	0	1
June	6	6	6	5	1	1
July	5	5	5	3	2	0
August	5	5	4	0	0	2
Sept	4	4	3	1	0	0
Oct	8	8	7	2	2	0
Nov	3	0	1	0		
Dec	11	1	8	1		

Outputs of the new mortality review process for 2016:

Month	Number of Inpatient Deaths	HMRG Review Completed	Dept. Reviews within 2 month timescale	HMRG Reviews within 4 month timescale	Discrepancies HMRG – Dept.	HMRG Review – Death Potentially Avoidable
Jan	6		6			
Feb	7		6			
March	10		10			
April	7		6			

Discordant conclusions of the HMRG vs. Departmental/Service Group reviews:

Since the previous Trust Mortality Report there has been 1 case where the HMRG mortality review conclusion was discordant with the Service Group/Departmental Reviews' conclusions:
The Service Group review found that aspects of organisational care could have been better however the HMRG review found that it was 'adequate/standard practice'.

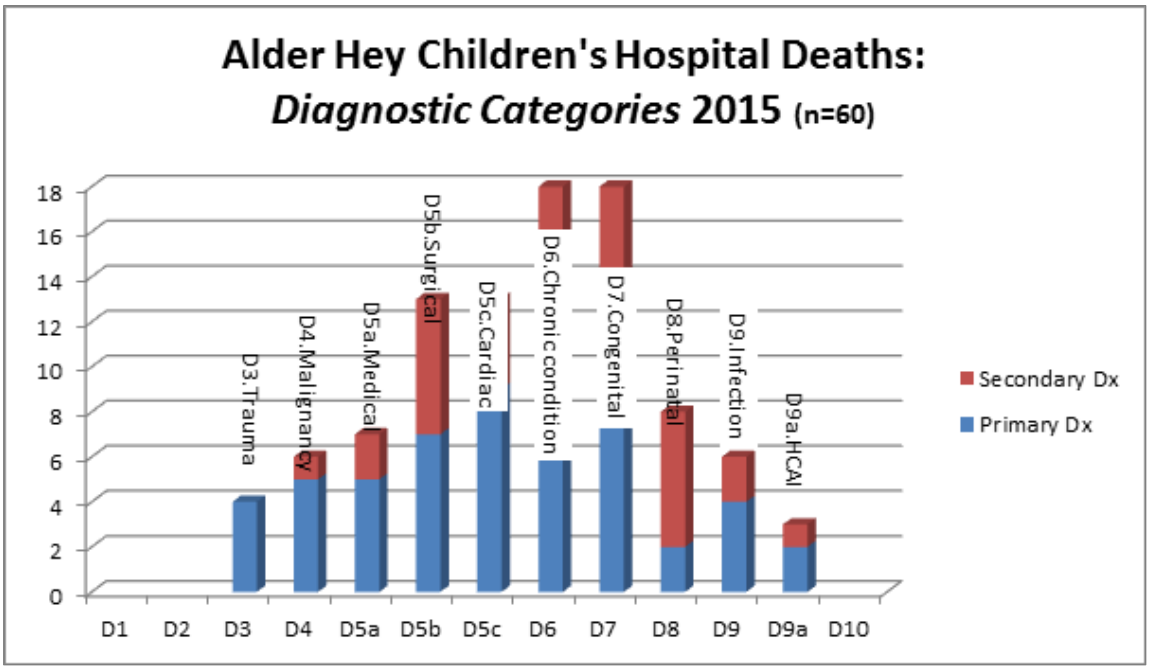
Potentially avoidable factors and actions:

Since the previous Trust Mortality Report, there has been 1 in-hospital death where potentially avoidable factors may have played a role in the patient's death.

1. A 3-year old girl who suffered catastrophic brain injury when a stone fire surround fell on her at home. Her pupils were unequal + unresponsive and GCS 3/15 on arrival of the paramedics at home. She still had a GCS 3 with dilated unresponsive pupils on arrival at the DGH Emergency Department.

Following discussion with the AH Trauma Team she was a helicopter transfer to AH by the DGH Team. She was unstable during transfer with hypotension + bradycardia + bleeding from nose and mouth.
She had fixed + dilated pupils on arrival at AH and was hypotensive + bradycardia → further resus. CT scans at AH showed a catastrophic brain injury with likely widespread diffuse axonal injury + the patient had coned; a constellation of changes on the abdominal CT related to hypoperfusion secondary to neurogenic shock; hypoperfusion had affected the kidneys, spleen, liver and pancreas. Neurosurgery + PICU Team had discussions parents regarding her severe brain injury = inoperable + unsurvivable.
The avoidable factor was the hazard of the fire surround at home there was certainly no concerns with the care provided by all the teams involved.

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

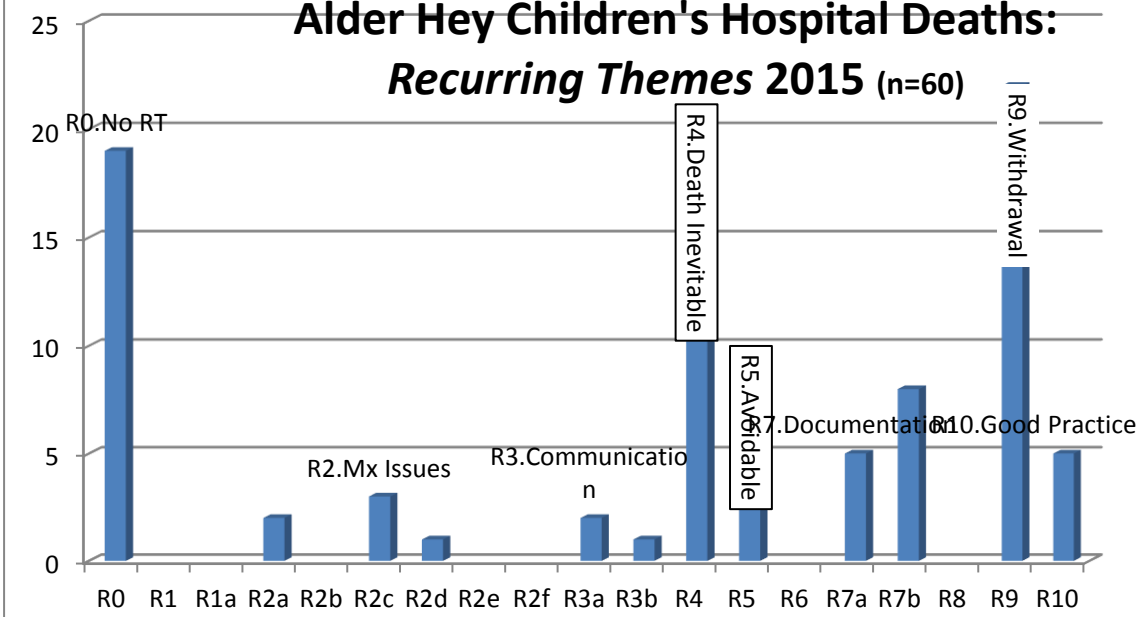


Diagnostic/Disease Categories (based on CEMACH categories - ref. *Arch Dis Child* 2011;96:922-6 + 927-31)

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

The chart shows that the highest proportion of deaths thus far in 2015 fell under the diagnostic categories: congenital; chronic medical conditions; cardiac; surgical; perinatal and medical.

The chart below shows the Recurring Themes identified in HMRG Reviews.



Recurring Themes

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

The chart demonstrates that thus far in 2015: withdrawal of care occurred in 37% of deaths; and death was inevitable on admission in 35%. There was no recurrent theme in 32%.

The number of deaths in the tables for diagnostic and recurring themes is 60 although 64 cases have been reviewed by HMRG. The discrepancy is because further information was requested by the group prior to them being coded.

Section 2: Quarter 4 Mortality Report: April 2015 – March 2016

1) Statistical analysis of mortality:

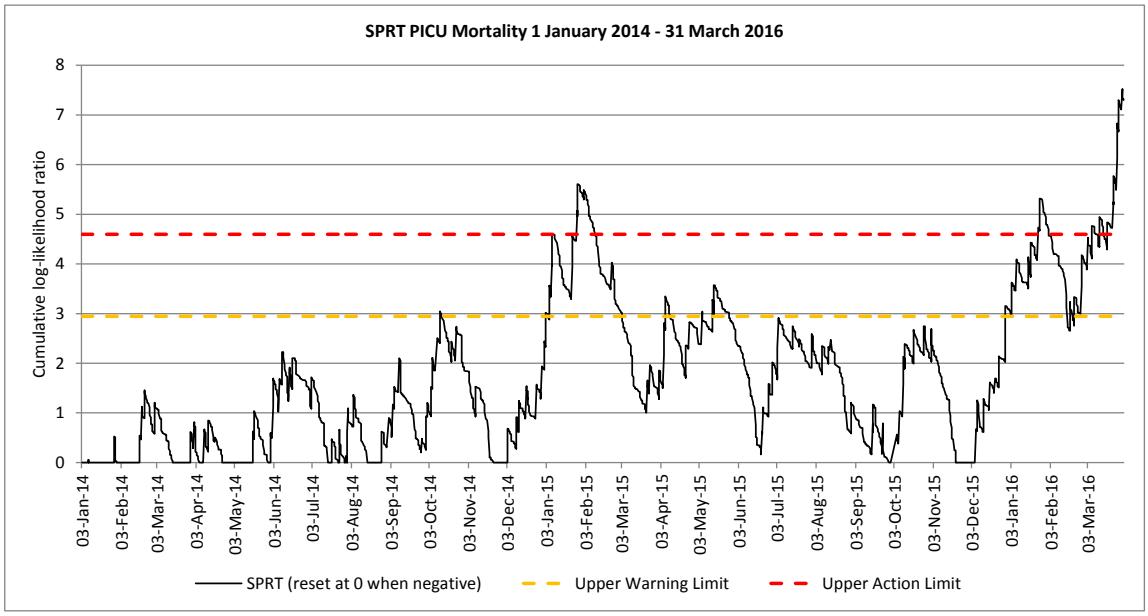
a) Close to real time statistical analysis of mortality in PICU: CUSUM and SPRT

We use two methodologies for monitoring mortality in PICU – Cumulative Sum Chart (CUSUM) and Sequential Probability Ratio Test (SPRT) Charts. This report will show the SPRT charts as this shows an upper warning limit and an upper action limit to help identify whether mortality is occurring at a higher level than expected.

Sequential Probability Ratio Test (SPRT)

SPRT tests the hypothesis that the odds of death in PICU has doubled against the alternate hypothesis that the odds of death has not doubled. The predicted mortality for PICU is given by the risk adjustment model the Paediatric Index of Mortality 3 (PIM3). Control limits are set to determine whether the hypothesis should be accepted or rejected.

Below is the SPRT chart for PICU for the period 1 January 2014 – 31 March 2016:



The SPRT chart is designed to test the two alternate hypotheses that the odds of death as doubled, and the odds of death as halved.
The x-axis plots each patient in sequence of discharge/death date; the y-axis plots the cumulative log likelihood ratio for a doubling odds of death.

The line moves up for a death, and down for a survival, the extent of the shift up or down depends on the extent to which the outcome was unexpected. E.g. the death of a patient with a low probability of death has a larger shift upward than a death of a patient with a high probability of death. The graph resets at zero, ensuring that a period of good performance will not delay the recognition of a period of higher mortality. A warning limit and an action limit are added to the chart to help the user determine whether the mortality is deemed 'in control' or 'out of control'. Mortality is deemed 'out of control' if the odds of death have exceeded twice the odds of dying.

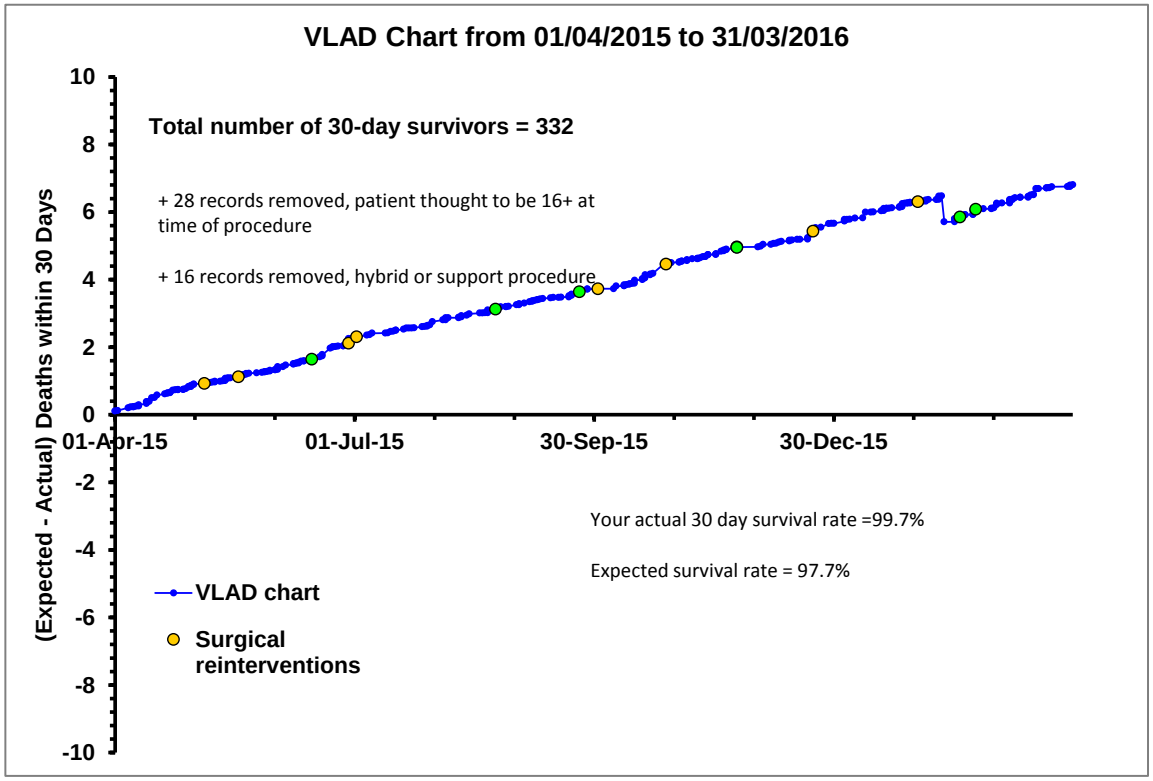
The upper action limit was exceeded in January 2015; a review of the cluster of deaths was undertaken and no unifying remediable or modifiable factors were identified (discussed in an earlier mortality report). The lower warning limit was exceeded in May, July and August 2015, suggesting that mortality is occurring higher than expected. The more recent conversion to utilising the updated PIM3 in place of the outdated PIM2r had resulted in the SPRT trends being elevated overall. Additionally, deaths in patients with low (admission) PIM3 scores (e.g. chronic multiple comorbidity patients + numerous stable yet ultimately hopeless cases) had impacted on the SPRT trend.
The upper action limit peak was again exceeded in January 2016 and in March onwards. This has been carefully monitored by the PICU team and the deaths have all been reviewed to confirm there is no underlying factor. These cases will all be reviewed by HMRG at a later date but currently there are no identifiable issues.

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

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

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

survivals than it will decrease for a run of deaths. Re-interventions are displayed as circles on the plotted line. Monitoring of VLAD charts provides additional quality assurance.



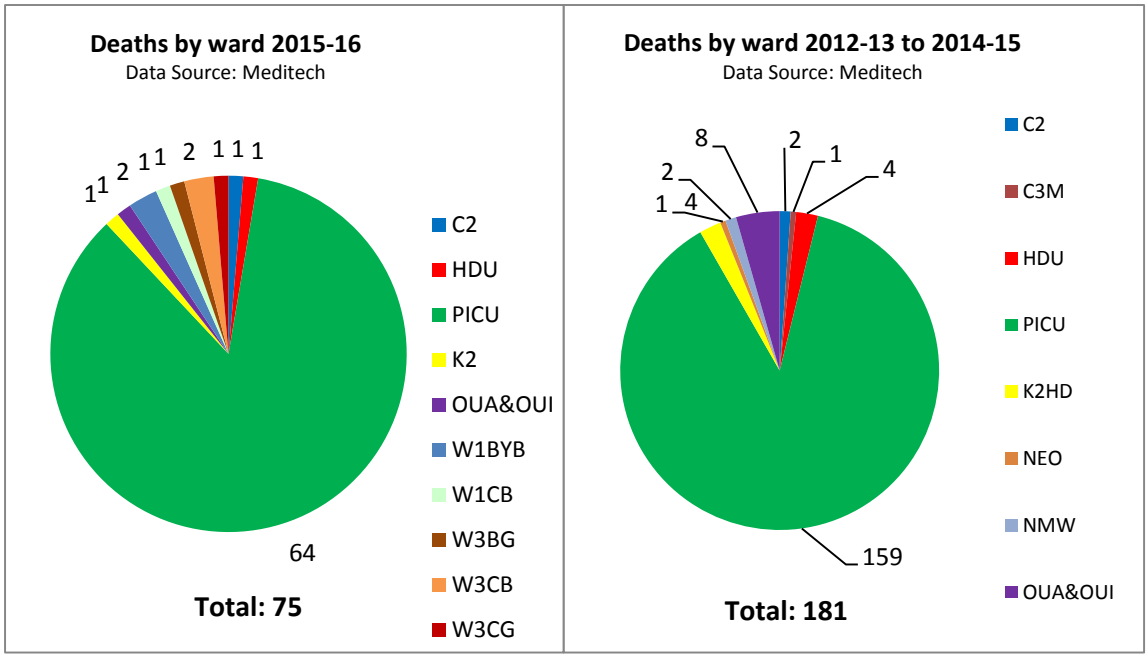
The VLAD chart above shows mortality is occurring lower than expected for the twelve months from 1 April 2015 to 31 March 2016. The survival rate at 30 days was 99.7% against an expected rate of 97.7%.

It is important to note that the risk factors included within the PRAiS model do not fully account for extreme prematurity and the model underestimates the risk for the highest risk patients. This is identified as patients with an estimated risk of above 10%.

2) Real time monitoring of mortality

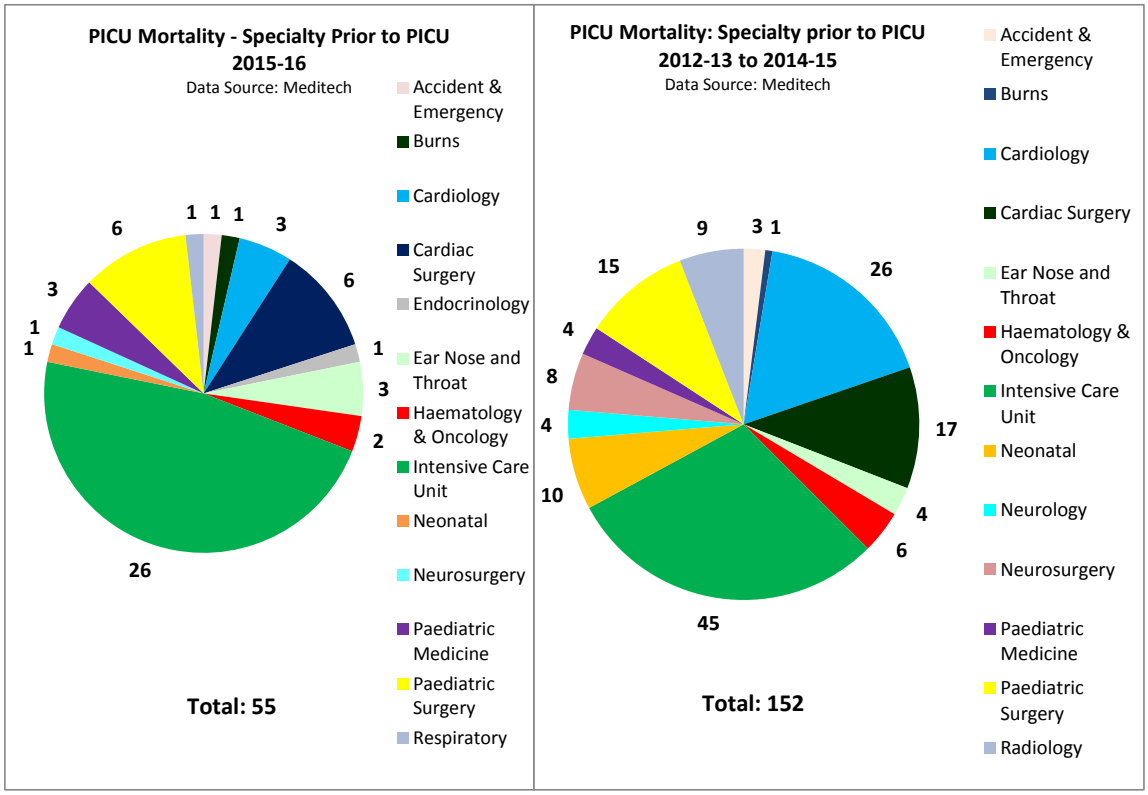
Mortality is now being monitored in real time and analysed by year, ward, specialty, deaths within 30 days from admission and over 30 days from admission.

i) Below are the charts showing mortality by ward for 2015-16, and the previous three years 2012-13 to 2014-15.



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

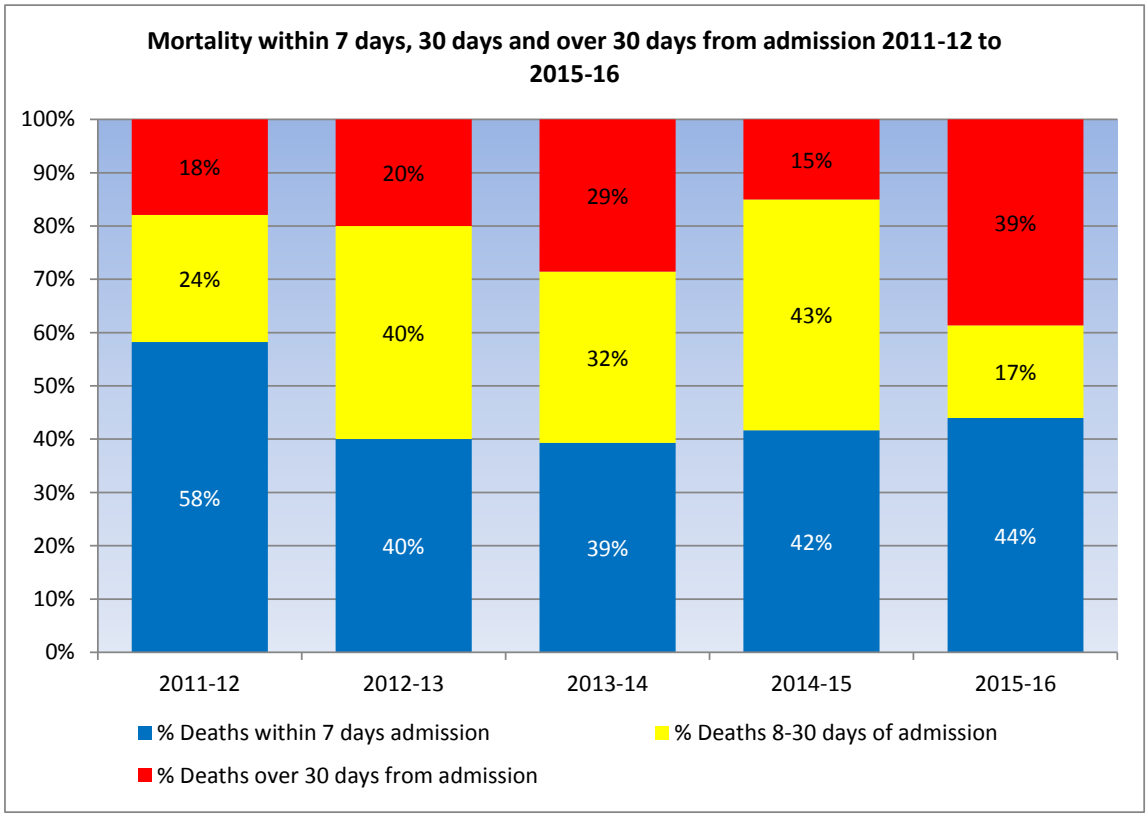
ii) Below are the charts showing mortality by specialty prior to PICU for 2015-16, and the previous three years 2012-13 to 2014-15.



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

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

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



The chart shows that usually the highest percentage of deaths occurs within 7 days of admission, around 40-60% of deaths occur within this time frame. In the current year 44% occurred within 7 days of admission, 17% occurred within 8-30 days from admission, and 39% deaths occurred over 30 days from admission.

3. External Benchmarking

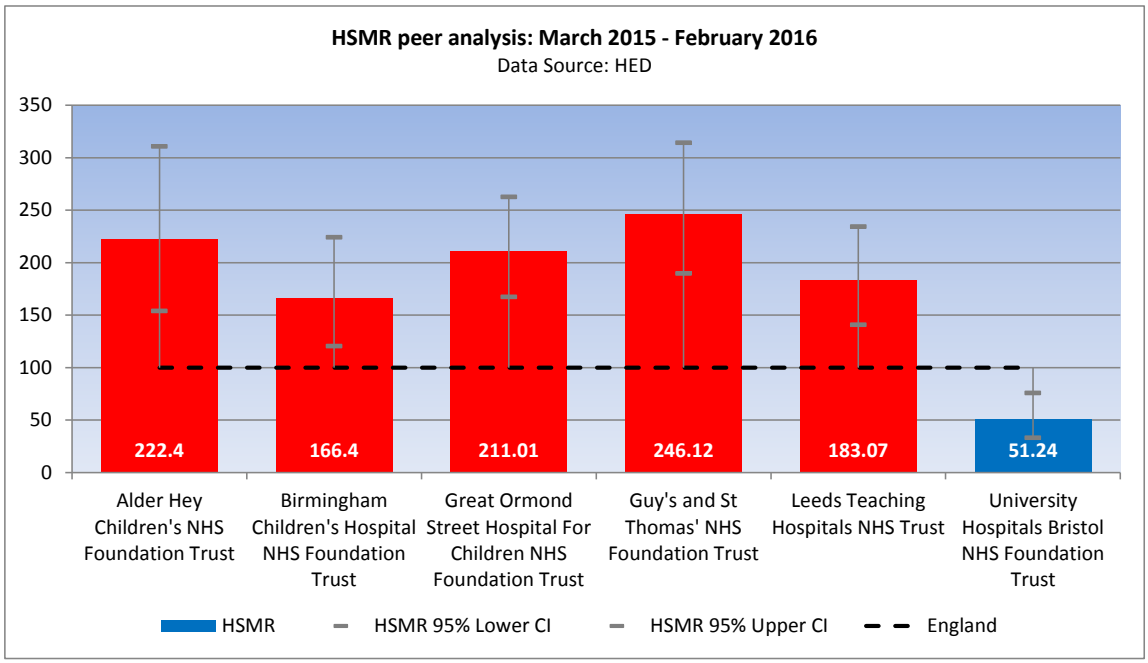
a) Hospital Standardised Mortality Ratio (HSMR) – HED

The Trust has purchased a new benchmarking system Healthcare Evaluation Data (HED), this allows the Trust to monitor and benchmark a number of

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

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

The chart below compares HSMR for Alder Hey against its peers for the period March 2015 to February 2016.



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

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

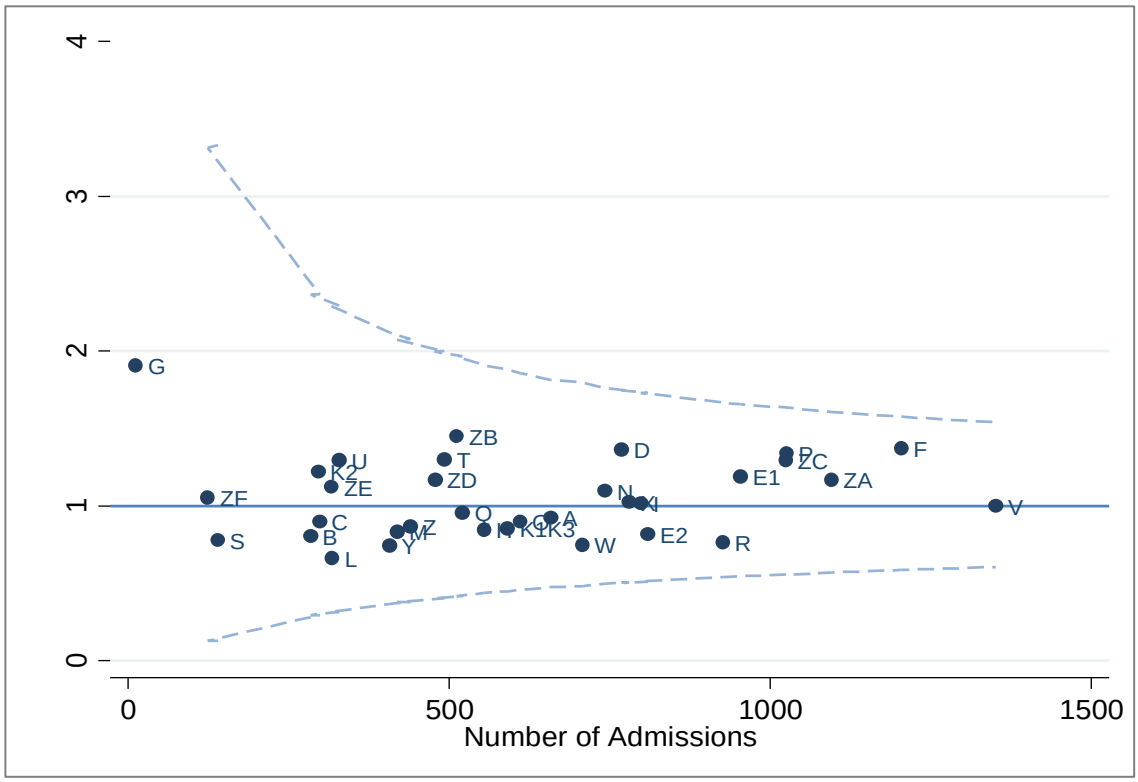
b) External benchmarking against comparator organisations for specific patient groups in addition to Dr Foster.

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

PICU

It is important to recognise that 85-90% of our deaths occur in PICU as in other children's trusts. In the most recent PICANet report (2015 Annual Report of the Paediatric Intensive Care Audit Network January 2012-December 2014), mortality is displayed in funnel plots. The Standardised Mortality Ratios (SMRs) for each organisation are plotted against the number of admissions. The risk adjusted SMR is the ratio of the observed number of deaths in the population against the expected number of deaths predicted by a recalibrated version of PIM2. Control limits are displayed on the funnel plots; variation within these limits is termed common-cause variation; variation outside of these limits is special-cause variation. Points above the upper control limit indicate higher than normal mortality; highlighting the need for further investigation into the mortality rate.

The chart below is taken from PICANet's most recent report, and shows the PICU SMRs by organisation with 99.9% control limits, 2014: PIM2r adjusted.



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

Conclusions

The HMRG has reviewed 53 deaths in 2015. There were 10 cases where the HMRG mortality review conclusions were disconcordant with the Service Group/Department Review's conclusions.

Statistical analysis of mortality using CUSUM and SPRT continue to be monitored, the action limit was exceeded in January and continues to be in March 2016 suggesting mortality is higher than expected. This has been carefully monitored by the PICU team and the deaths have all been reviewed to confirm there is no underlying factor.

Alder Hey uses VLAD charts to monitor the trend in mortality in cardiac surgery; the latest chart shows observed mortality is lower than expected mortality. All cardiac surgery patient deaths will be reviewed in the Cardiac M&M meetings and also the HMRG.

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

Rick Turnock
Julie Grice
Kerry Morgan
1st June 2016

Alder Hey Children's NHS
NHS Foundation Trust

Clinical Quality Assurance Committee
Minutes of the last meeting held on Wednesday 18th May 2016,
10:00am, Large Meeting Room

Present:	Anita Marsland, (Chair)	Non- Executive Director	AM
	Mags Barnaby	Interim Chief Operating Officer	MB
	Gill Core	Chief Nurse	GC
	Hilda Gwilliams	Director of Chief Nurse	HG
	Jeannie France Hayhurst	Non- Executive Director	JFH
	Erica Saunders	Director of Corporate Affairs	ES
	Jonathan Stephens	Director of Finance	JS
	Melissa Swindell	Interim Director of HR	MS
	Rick Turnock	Medical Director	RT
In Attendance:	Adam Bateman	General Manager Surgery	AB
	Pauline Brown	Lead Nurse, SCACC	PB
	Sue Brown	Strategic Project Manager	SB
	Richard Cooke	DIPC	RC
	Christian Duncan	Clinical Director for NMSS	CD
	Dan Grimes	General Manager, Medical Spec	DG
	Jacqui Flynn	Integrated Community Services	JF
	Joe Gibson	External Programme	JG
	Rachel Greer	General Manager NMSS	RG
	Gail Hewitt	Deputy Director of Quality	GH
	Janette Richardson	Programme Manager	JR
	Tony Rigby	General Manager, Quality Strategy	TR
	Mary Ryan	Clinical Director ICS	MR
	Lachlan Stark	Head of Planning and Performance	LS
	Julie Tsao	Committee Administrator	JT
Agenda item: 21	Peter Arrowsmith	Resuscitation Lead	PA
22	Anne Hyson	Complaints Manager	AH

16/17/16 Apologies:

Mark Caswell	Consultant Paediatrics	MC
Simon Kenny	Clinical Director SCACC	SK
Paul Newland	Clinical Director for Clinical Support CBU/Consultant Biochemis	PN
Louise Shepherd	Chief Executive	LS

16/17/17 Declarations of Interest
None Declared.

16/17/18 Minutes of the previous meeting held on 20th April 2016
The Committee approved the minutes of the last Clinical Quality Assurance Committee held on 20th April 2016.

16/17/19 Matters Arising and Action list
The action log was updated.

16/17/20 Programme Assurance 'Our Patients at the Centre'
Improving outpatients Project Initiation Document (PID)
CQAC went through the Project Initiation Document (PID) for Improving Outpatients and agreed the PID would be further developed prior to being approved by CQAC.

The service was still underdevelopment due to this CQAC were asked to defer the PID until further work had been completed to develop the service.

The Finance team were working on Appendix 1 Financial Information, it was agreed this would be completed prior to approval of the PID.

The CQC had asked for a re-visit of Outpatients and had asked for the Trust to confirm when a date would be suitable over the next 6-12 months.

Resolved:
CQAC agreed for the 'Improving Outpatients' services project to be further developed prior to the PID being presented for approval at the CQAC meeting on 15 June 2016; papers due by 6 June.

Improving Patient Flow Project Initiation Document (PID)
The steering group for Improving Patient Flow had now been established. 42 workstreams had been agreed and were making progress.

Under Benefits and Measures a number of benefit start dates had been delayed and the correct start dates were included in the final PID.

CQAC noted the workstream assurance templates would provide information on when actions have been completed or if there are any delays and asked for further assurance that the committee was kept updated.

Resolved:
a) CQAC APPROVED the Improving Patient Flow Project Initiation Document.

Cost Improvement Programme Standard Operating Procedure
The Standard Operating Procedure (SOP) is to be used as a reference document to guide successful delivery of the 16/17 Alder Hey Cost Improvement Programme and would be presented to the sub committees of the Board to ensure a standardised approach.

Lachlan Stark reported on the Red, Amber, Green (RAG) rating system and the financial tracker that would highlight if any of projects were likely to slip from the set financial target. Action would then be taken to identity any gaps and resolve.

CQAC noted the development of the projects was to provide quality and efficiency as well as the delivery of financial targets.

Resolved:
CQAC APPROVED the CIP SOP.

Programme Assurance progress update
There is a critical minimum CIP savings dependent upon the projects in this work stream amounting to circa £1m. Of this total, £0.8m has been identified in PIDs. £271k relates to Complex Care Made Simple and had been awaiting the outcome of the Vanguard bid that did not receive the funding requested. Mags Barnaby advised other options for funding were being looked into.

Dan Grimes reported on the improved co-ordination of care and the progress made with social workers to reduce the length of stay with complex patients. It was noted the reduction had not seen an increase in the number of available beds, a task and finish group was in the diary for next week to review this.

Part of the project was to increase the engagement with teams. Listening into Action was being launched this afternoon and would be the beginning of a number of steps to improve engagement.

A Project Initiation Document was to be established with the aim of £600k from productivity from areas including Outpatients and Rehab. Mags Barnaby agreed to update CQAC further once plans had been agreed.

The development of a PID for the Clinical Support Services project was raised and it was stated that the PID for this project would be submitted for the CQAC meeting to be held in July.

Resolved:
a) CQAC received an update on programme assurance
b) To update CQAC on plans of productivity to reach £600k.
c) CQAC agreed for the 'Clinical Support Services' project to be further developed prior to the PID being presented for approval at the CQAC meeting on 20 July 2016; papers due by 11 July.

16/17/21 Resuscitation Services Action Plan

Peter Arrowsmith, Resuscitation Lead went through the action plan following the external Resuscitation services review.

A number of the actions had been completed and progress would continue to be monitored through the Resuscitation committee.

Peter highlighted the resuscitation department was understaffed and a business case was developed to request funding.

Resolved:
The Chair thanked Peter Arrowsmith for the update on the resuscitation services action plan.

16/17/22 Complaints Quarter 4 report

The Trust received 16 formal complaints during this period of which 2 were withdrawn by the complainant therefore 14 registered. Two complaints were also then identified to be dealt with as a serious incident and registered on StEIS. Therefore 12 formal complaints where processed - 1 in January, 5 in February and 6 March.

The Trust received 34 complaints in quarter four in 2015 –this is a significant reduction of 68%.

Trust wide difficulties with appointments continues to be a theme this quarter with specific issues regarding not receiving cancellation letters for the appointments. Parents are taking their child out of school, taking time off work and then upon arrival the appointment has been cancelled. Also last minute cancellations (24 hours notice) but parents are not receiving a call to update them about this.

Another theme in complaints was around breakdown of communication and parents advising they were unclear on the care their child was receiving.

Previously one of the main themes for complaints had been around staff attitude. Anne Hyson was pleased to report the reduction in complaints regarding staff attitude.

The Trust endeavours to respond to complaints within 25 working days. Only one Complaint for this quarter was responded to within the 25 days. Timescales can be extended if a team are aware the response will take longer than 25 days to respond to and the complainant is made aware of this at the beginning of the lodged complaint. Anne asked members of CQAC to feed this back to their teams.

Patient and Liaison (PALS) team received 366 enquiries for this quarter, 25% increase compared to 2015 Quarter 4. A summary of some the enquiries were given. Lachlan Stark advised that there was a correlation between waiting time issues identified through the weekly waiting times meetings and the PALS data. Provision of the waiting times challenges may provide the PALS teams with information in advance. Lachlan agreed to forward these details to the PALs team.

Issues with patients calling the PALs team for clinical appointments continued. Anne advised the PALs team were directing the patients to the clinics directly.

Integrated Community Services had received the highest number of complaints in the quarter. Work was being done with the team to reduce the number of complaints.

Jeannie France Hayhurst asked if smoking close to the Hospital grounds was still a main concern. Louise Dunn reported on the ongoing work to make the Hospital a smoke free site and agreed to circulate the update from the marketing and communications April report.

Resolved:
CQAC received an update and content of the Quarter 4 complaints report.

16/17/23 CQSG Key Issues report
Resolved:
Gail Hewitt provided an update from the latest Clinical Quality Steering Group.

16/17/24 Best in Operative Care Walkabout
The Walkabout was held in the following areas;
- Inpatient Theatres led by Simon Kenny, Clinical Director
- Day Case Surgery led by Adam Bateman, General Manager

Due to the two areas being clinical CQAC was split into two small groups. It was agreed feedback from the areas would be presented at the next meeting.

Date and Time of next meeting: - Wednesday 15th June at 10am, Large Meeting Room, Institute in the Park.

Alder Hey Children's NHS
NHS Foundation Trust

Board of Directors
July 5th 2016

Report of:	Director of Human Resources & Organisational Development
Paper Prepared by:	Interim Director of Human Resources & Organisational Development
Subject/Title:	People Strategy Progress Update May 2016
Background Papers:	Employee Temperature Check for May
Purpose of Paper:	To present to the Board monthly update of activity for noting and/or discussion.
Action/Decision Required:	The Committee is asked to note the contents of the report.
Link to: **Trust's Strategic Direction Strategic Objectives**	Great Talented Teams
Resource Impact:	None

Section 1 - Engagement

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

People Support and Engagement

The Trust signed up to Listening into Action (LiA) in April, a methodology which will, over the next 12 months, support improved staff engagement and patient care. Since the previous report we have completed the Pulse Check and the Leadership Scorecard, two staff surveys taken at the start of the 12 month journey which provide baseline data from which to compare progress in 12 months' time; have held 5 very successful 'Big Conversations' with over 220 staff have attended, and held the launch event for the first ten clinical teams who are going to work the 'LIA way' on the 18th May 2016.

The feedback has been very positive so far, and we have been able to share some 'quick wins' with staff already to demonstrate progress.

To supplement this engagement work, the OD team will continue to issue the Temperature Check, the results of which will supplement understanding with LiA processes and it will also serve as an indicator of our progress with our developing Leadership and Management Strategy.

Development of Leaders

The Leadership and Management Development Strategy was ratified in April 2016; this supports the implementation of interventions to support management and leadership development across the Trust. The team will be supporting the implementation of these programmes with a coaching approach. The Leadership Values programme has commenced with it's first action learning set cohort for a group of existing managers (it will be open to new managers from October), and a Management Induction programme is being finalised that will link in with the review of Corporate Induction content and processes.

Improving communication and hearing the employee voice

In the May Temperature Check the Staff Friends and Family scores for place to work and place for treatment were 43% and 87% respectively. CBUs are provided with their own data each month to enable them to identify specific locally raised issues. Both scores are improvements on the scores from the previous month and the local data is used to identify areas of concern.

Section 2 - Availability of key skills

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

Effective workforce planning

Human resources Business Partners continue to engage closely with Finance colleagues and senior CBU and Corporate Managers to support strategic development and delivery of CIP requirements.

The workforce CIP project continues to focus on reducing the variable pay costs arising from control of agency, bank, overtime, sickness and vacancies. Close engagement with NHSP colleagues is ongoing, who are in the process of increasing both internal and external banks across staff groups in the Trust (excluding medics) and seeking alternative agency routes where there are barriers to meeting Monitor Agency cap requirements. Weekly Monitor submissions are being completed in line with reporting requirements to detail totals of weekly agency shifts undertaken in various staff groups.

Meetings are also taking place to review ongoing use of medical locums and to consider alternative use of STAFFflow to reduce cost of VAT and to enable a more streamlined approach to recruitment of medical locums within Monitor requirements. Recent information indicates an increasing usage of STAFFflow at 42% of locum engagement. A review meeting has been arrange for 28th July 2016 with key stakeholders and to review progress to date and to consider any further improvements

The HR team, in support of the Trust's CIP challenge for 2016/17, continue to focus on all options in relation to reducing workforce costs within CBUs/Depts and discussions are ongoing with managers to review all cost saving opportunities.

Hotel Services – Following the conclusion of the consultation process in relation to staffing structures and working practises/ patterns in the CHP, only one appeal remains outstanding. The appeal hearing chaired by a General Manager took place on 9th May 2016 with the decision made not to uphold the appeal. Confirmation has been communicated to the individual and notified as to the change to working hours from 29th May 2016.

A&E reception – An organisational change document is being finalised to commence consultation on adjustments to shift patterns. The consultation documents are in the process of being circulated for commencement on 23rd May 2016 until 28th June 2016 with staffing structures to be in place on 1st August 2016

Pathology - Discussions are ongoing with senior pathology management as a result of a re-tendering of a contract for pathology services with a local Trust – it is understood that the Department will be submitting an application to continue providing the service. Should the application not be successful this could result in TUPE transfer of 3 staff to the successful bidder – informal discussions taking place with staff.

Learning and Development

The PDR window for 2016/17 reopened again in April 2016. The emphasis is on supporting new managers with review skills, recording, as well as mandatory training and nurse revalidation. Individual and group coaching sessions have been accessed by staff and

further groups learning sessions have been planned with the leadership development facilitator for the remainder of the window. HRBPs, with the support of L&D, are providing CBU's with highlight reports to enable the identification of low compliance and to inform local action plans for an improved position.

The Practice Education KPI's were published in May 2016 by Health Education Northwest. Alder Hey received a silver rating with a score of 96% across all outcomes required. This is the highest rating the Trust has had since the development of these outcome measures.

The vocational service has also been subject to a quality inspection across assessment and quality of learning for NVQ's. Once again the centre retained it's A class status which puts us in a great position to facilitate the delivery of a quality apprenticeship service in the coming months.

Section 3 - Structure & Systems

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

Effective Policies

Progress continues with the implementation plan for the revised "Absence and Attendance Policy" and the "Management of Stress at Work Policy" with go live dates of 1st July 2016. The plan includes CBU targeted training sessions across July to managers who have responsibility for managing the policy which includes transition arrangements between the old and new absence policy triggers; managers guides; and drop in Q & A sessions for staff.

Employee Relations Activity

There are currently 9 formal cases ongoing with 1 staff member suspended. The HR Advisors are working well with Investigating Officers to ensure that investigations are concluded in a timely manner. In addition to formal cases, HR continues to advise managers on managing behaviours within their teams on an informal basis.

Corporate Report

The May Corporate Report shows all five HR areas under target, three of which are 'red', including PDR compliance, medical appraisal and sickness absence. These areas remain a key area of focus for the HR Team, and form elements of the priority projects plans going forward for Workforce Capability and Leadership & Management Development.

Section 4 - Health & Wellbeing

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

Creating a healthy workforce

A Health and Wellbeing subgroup has been formed as part of the Quality Strategy Steering Group, and is exploring ideas and priorities to support employee health and wellbeing.

A separate paper is attached detailing progress to date in working with our Employee Health and Wellbeing partner, Team Prevent.

Promoting positive attendance

The Trust's absence rate is 4.9 % for end of May 2016, which is a 0.7% improvement on the previous month.

We continue to focus on highlighting the importance of effectively managing sickness in line with the existing policy and putting in place a framework of additional management information and improving the current policy with updated training.

The HR team continue to meet weekly and monthly with General Managers, operational service leads and CBU management teams to review absence statistics/trends/hotspots and trigger information; to review and report on outstanding actions to support improved absence rates, to deliver focussed masterclass absence training and to provide one-to-one coaching in difficult and complex absence case work.

Leading in Equality & Diversity

The Task and Finish Group has now been set up for June 16, which will agree approach we are taking to address the issues we have identified regarding workforce diversity. Further updates will be provided in future meetings.

Alder Hey Children's NHS
NHS Foundation Trust

Update on Employee Health and Wellbeing Service Contract: Trust Board – July 2016

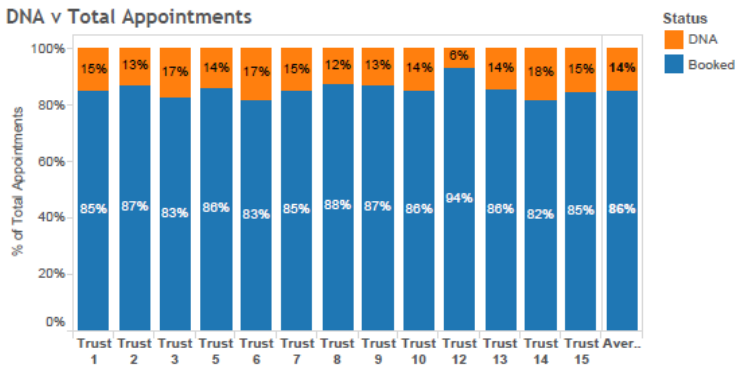
1. Background:

Alder Hey has contracted with Team Prevent for the provision of Occupational Health Services since June 2011, and this relationship has recently been extended until June 2017. Team Prevent are the fastest growing provider of health and wellbeing services in the UK; SEQOHS accredited since 2012, they have been working closely with the Trust not only to manage attendance but also to develop their role in delivering our Trust Health and Wellbeing strategy and work plan. Upwards of £350,000 funding is available annually through CQUINS for Health and Wellbeing initiatives, and this alongside our agreed focus on wellbeing as part of our Quality Strategy and an acknowledgement of its importance in increasing workforce engagement, is driving our focus in this important area.

2. Current Position:

We have been working collaboratively with Team Prevent over a number of years and they have reported some significant improvements in service provision in the last 12 months; some of these include:

- A more robust and positive approach to the management of absence by ensuring a timely referral and early access for employee support and intervention. The timeline measuring employee absence to management referral to the Team Prevent service has **substantially reduced by 38%** (from May 2014 - June 2015 the average timeline was 33 days, and from May 2015 - June 2016 the average was 20.3 days).
- In Feb 2015 the Early Intervention Centre (EIC) was rolled out, in the last month this has become a Central Support Service (CSS). This increase in resource has assisted the Trust in taking a positive approach to managing absence; with initial employee contact through the service **increasing by 52%** from May 2015 to May 2016.
- With the Trust's aim to offer proactive, preventative and excellent services that are in line with best practice and our values; 48.3% of staff seen by Employee Health and Wellbeing services are in work, as opposed to the previous year where only 32% were in work; **an increase of 16%.**
- Health surveillance activity (e.g. skin and respiratory surveillance; COSHH, 2002) meeting the Trust's legislative requirements in the management of health and safety at work, has **increased by 104%** from May 2015-May 2016.
- An improved drive to get employees to attend their booked OH appointments, has **reduced the DNA rate to 6%** (Alder Hey is identified as Trust 12 in the benchmarking sample below).



3. Moving Forwards:

Team Prevent will partner with Alder Hey to adopt a holistic approach to Employee Health and Wellbeing, in line with the Trust's values, focussed on Prevention and Early Intervention, which encourages employees to take responsibility for their own health. We will jointly develop an integrative Health and Wellbeing Strategy, enhancing the existing Health and wellbeing work plan which is output focussed and targeted towards the health needs of the organisation. We will work together to undertake an Occupational Health Needs Assessment, the process of which will raise issues, highlight problem areas and engage employees and management; the needs assessment can be carried out confidentially on line and the outcome will help to shape Health Improvement Strategies for the key occupational health issues of Stress, Musculoskeletal Disorders and the Ageing Workforce: our Health and Wellbeing plan is a genuine target-driven approach to creating a healthy workplace culture, helping to improve resilience, wellbeing and life satisfaction.

This integrative approach to health, safety & wellbeing reflects contemporary Occupational Health & Public Health practice (Hanlon et al, 2012), and includes the three main areas related to health improvement in the workplace:

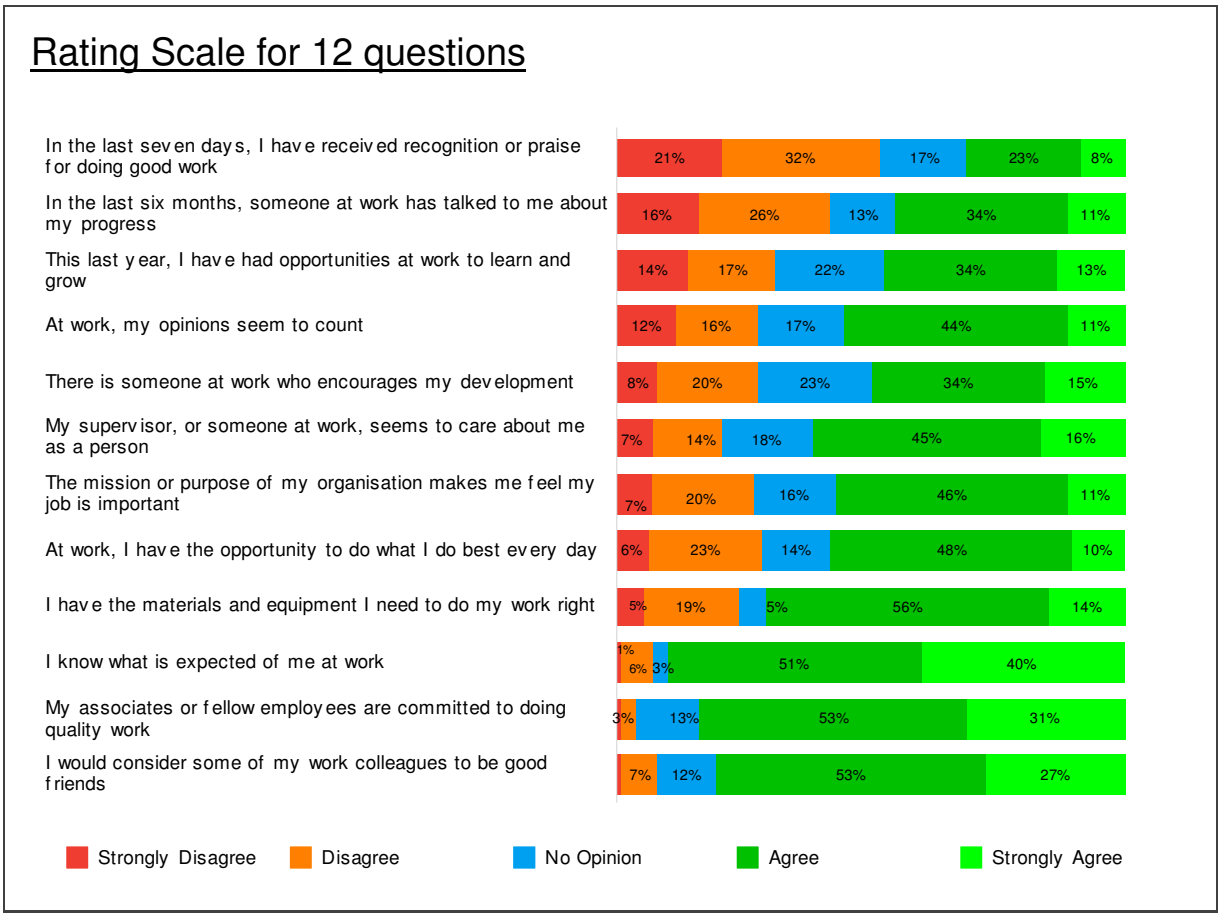
- Health and safety management: to control work related risks
- Attendance management: to assist employees to remain or return to work following ill health and injury.
- Health promotion: Activity based on the health needs of the workforce (Young and Bhaumik, 2011).

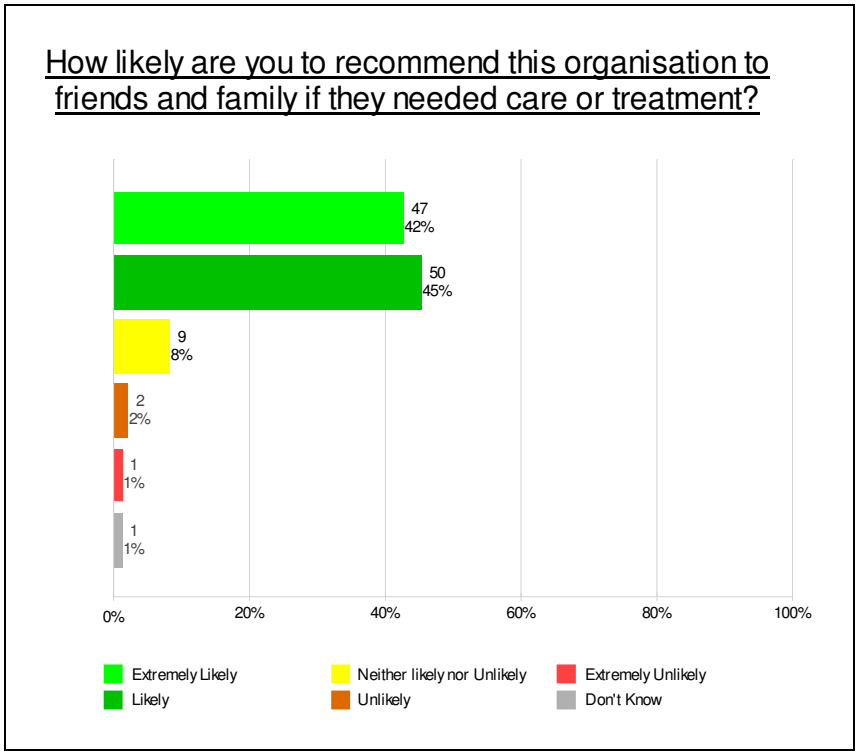
Fleur Flanagan, Human Resources & OD
Helen Bishop, Team Prevent

Summary of monthly Employee Temperature Check for: May

The percentage of staff who were in Overall agreement with the 12 questions for **May** was **61%**.

The area most in need of improvement was **In the last seven days, I have received recognition or praise for doing good work.** This question recorded an overall Disagreement score of **52%**.



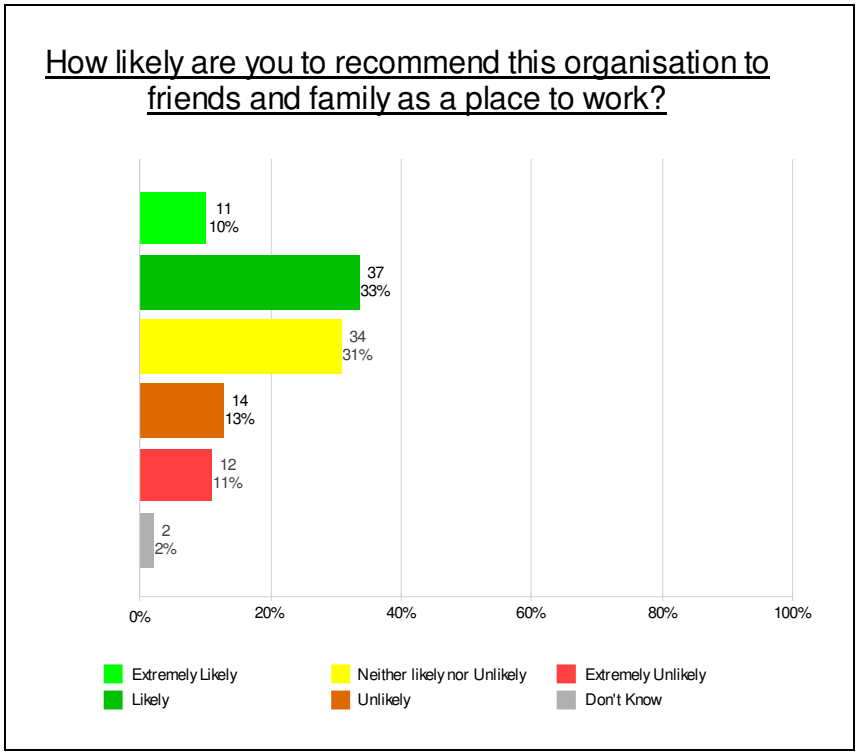


What is the main reason for the answers you have chosen?

The Consultants and staff here at Alder Hey provide excellent service
Logical choice for a paediatric hospital in the area
My children have never really had to use the hospital for care or treatment and I work in a non-clinical environment, so it would be hard to recommend from a personal perspective.
depends on the problem
staff are committed to delivering the best care, but the environment, politics and lack of staff make it difficult for us to deliver the best care possible.
the feedback that I have received back from patients under the care of our CBU
Other paediatric hospitals in the region are worse - main reason but not excuse for the logistic failures of the Trust. Patients are lost in the system. There is no clinical priority, but instead priority of breaking waiting time targets.
this is an excellent hospital with excellent professionals and could not recommend it highly enough
Because I believe here at Alder Hey we strive to give the best service.
excellent care patients receive
feel we do have some staff who care and have a genuine desire to give their best , but am concerned that staff are so demoralised that before long a major incident will occur
the skills the staff have and the caring nature of staff

What is the main reason for the answers you have chosen?
Having insight into the myriad of internal problems and the structure which should provide necessary facilities and stability for the continuous service provision, I have serious doubts about the sustainability of the service provision (despite massive individual effort from staff to provide it). Most of the staff is unhappy/disillusioned (in my working environment)
I value tht eopinions of most of my hospital colleagues. the environment for patients is pleasant on the whole. I woujld be concerned at the barriers to communications between professionals within the trust
I am a parent of two children with complex health needs, so have been under review at various departments, and would recommend the organisation to friends and family.
I think the care and service that patients receive here, on the whole, is good.
I FEEL WE ARE NOW WORKING IN AN UNSAFE ENVIROMENT FOR CERTAIN PATIENT GROUPS
The building was not ready for the move, not enough experienced staff. Staff extremely stressed and families are picking up on this.
staff work extremely hard and are very conscientious caring people.
The work the doctors and nurses provide is excellent
We deliver quality direct patient care
The Hospital is of A high standard in the treatment of children
this is a specialised trust so the need for recommendation is outweighed by the choice there is in the region. i.e. very little choice
Despite the unavailability of workforce and workoverload we stretch ourselves to meet the needs of child and family.
the staff on this ward are very committed individuals who make great efforts to produce a good working team .
I think the care provided in our clinical area ,is good.
having worked in different nhs trusts, I feel nursing and medical care provided at alder hey is excellent most of the time.
staff always try and do the best for their patients regardless of the work environment, poor staffing etc
It depends what is wrong with them.
It's a centre of excellence. I have experience of Alderhey and other hospitals with my child and would choose Alderhey every time
not settled yet in new work place.
Both my children have been treated at the hospital and I was very pleased with the level of care they received.
If I had to advice accessing other services probably likely but Developmental Paediatrics service in Sefton (despite best effort of the few clinicians remaining) not a service I would recommend anyone to access at present
Staff strive to provide excellent care to patients and their families
local hospital
Personal experience of lack of care for my child's health issues - failure to diagnose a serious problem although for emergency care I would highly recommend

What is the main reason for the answers you have chosen?
Very confident of the medical care provided by Alder-Hey.
quality of the work
I have become aware of a en mass approach to nurse recruitment here which I feel is an unsafe way to recruit nurses. We should have nurses competing to come to our hospital with a standard of proficiency to meet and not automatically offering contracts to them. It does not do our reputation any good at all.
Most care areas are providing excellent care even though they are running on low staff numbers due to staff shortages and long term sickness
The medical, nursing and clerical staff are second to none and work tirelessly to ensure that the patients get the best care possible. Never underestimate the value of "good will" - staff going the extra mile for the sake of the patient is how Alder Hey and the NHS as a whole has survived despite the extreme financial pressures.
Staff here are very knowledgeable and experienced.
myself and my colleagues give good care.
It is better than the local general hospitals as it is specialised for children.
I believe the individual front line clinicians are hugely commited to their patients and providing a good service. In most cases by going the extra mile, they are able to achieve this in the face of difficulties with a clunky IT system and bureaucratic processes.
I believe the patients have very good service but not the staff
there is a large amount of resources and trained clinical specialist and staff who give excellent care.
I BELIEVE WE DELIVERY GOOD SAFE CARE,I ALSO HAVE A CHILD WHO RECIEVES CARE FROM ANOTHER SPECIALTY AND CAN SAY I HAVE ALSO RECEIVED EXCELLENT CARE AS A FAMILY REQUIRING TREATMENT HERE.
I think that it stills functions reasonably well despite challenges, particularly on communication front.
world class care.
good and safe service
staff at AHH are committed to providing the best possible clinical care. Systems and the environment may be difficult but clinical care is good.
I have worked at Alder Hey for 25 years and I know that the staff care about providing the best quality of care to patients.
Excellent medical staff and nursing staff
only in the unit where I work
The innate attitude of all staff is that of a very high standard of care. We all work in the paediatric field of health to provide the very best outcome for all our patients & their families.



What is the main reason for the answers you have chosen?

Don't feel the staff are valued by management, we make money for them and as long as we do that then their happy. Shame it's only our Consultants who value us.
Good sense of purpose and good working conditions
I enjoy working with my current team. However there is little scope for progression for A&C staff.
There are good bits but certainly also bad bits.
I get job satisfaction from looking after children and their families in spite of the obstacles put in our way.
I enjoy the role most of the time but have found it extremely difficult this pass year when people from other areas make decisions about your role who do not know what you do in the day to day job. The training we received for meditech 6 was not good enough.
As I have the hope that people with common sense will make a different to this burocracy mayhem.
I can only answer for where I work and I like my job so would recommend to anyone
Because you are not valued at all.
PAY SCALE GRADING VERY POOR AS OPPOSED TO MY PARTICULAR JOB IN ANOTHER TRUST. I WOULD BE A HIGHER BAND IN ANOTHER TRUST
depending on which department job is

What is the main reason for the answers you have chosen?
Since moving to the new hospital, I feel isolated and lonely even when sitting in a room full of people I've known for many years. The new hospital has changed team dynamics and morale and not for the better. I am full time and based in one location and haven't been provided with a proper desk to work at and have been told I have to make do and manage. I have expressed my concerns over the last few years about how unhappy I've become but nothing has been done, in fact I feel worse now because my concerns have gone unheard. I feel I can offer more and have proven my abilities and demonstrated my skills during my time here but don't feel I am being allowed to put these to use any more. I actually feel as though my role is regressing. I feel invisible, undervalued and insignificant. I heard a comment made by a snr manager recently whose opinion of secretaries is that we are just secretaries and not important in the grand scheme of things. Comments like these just undermine confidence, self-esteem and trust. We are also hearing rumours about further changes with A & C staff but managers are not telling us what's going on. The last restructure was very difficult to go through and took far too long. The thought of having to go through another is making me seriously consider leaving an organisation I believe in and used to be proud to work at but don't feel I belong to any more. I haven't enjoyed coming to work for quite a while now and that really upsets me as I believe in what we do here as we do amazing work but feel staff are never listened to and are not valued. For an organisation whose purpose is caring for people, we are appallingly bad at caring for the carers.
Feel if staff raise an issue that lip service is paid , time is given to discuss, then the door is closed then you pay the price for raising an issue by not being included and any chance of learning new skills is limited and in many cases being forced out of your job or suffering stress and taking time off then leads to sickness warning. Think this is why most staff are frightened of speaking out.
it is very stressful
Having insight into the myriad of internal problems and the structure which should provide necessary facilities and stability for the continuous service provision, I have serious doubts about the sustainability of the service provision (despite massive individual effort from staff to provide it). Most of the staff is unhappy/disillusioned (in my working environment). Some professions and staff working in those areas are NOT treated appropriately and not valued enough, mainly though turning blind eye on problems they are faced
until resources and systems are changed to be fit for purpose
As I think it is a good organisation to work for.
There are too many reasons to list but the main one for me is feeling undervalued.
WE ARE UNDERVALUED
Unless the stress starts to ease off, more and more experienced, valuable staff will continue to leave and the ones left behind will have to carry the burden.
staffing levels means staff are put under unnecessary stress at the moment. i would have no hesitation in telling people that job satisfaction is fantastic but currently its hard. things are improving in the logistics like IT and working practices but there is still not enough people on the floor such as nurses at ward level to deliver the care.
the Staff moral is very low
There are not enough worker on the 'shop floor' to enable you to do your job properly. More and more is expected of us and there is no time to do it

What is the main reason for the answers you have chosen?
Staff are not listening to. The people making decisions aren't the people having to deal with those decisions. Quality of care is compromised regularly. The change in staff morale is noticable and is much worse than it was six years plus ago. Too few staff working too long, with too much pressure with failing systems and no light at the end of the tunnel. I used to love my job and gradually over the past 5 years pressure is getting worse and worse and now there ia hardly any day when I don't come to work and wish I was working anywhere else. This organisation works only because some of the staff working on it work hard way beyond their duty to keep things going, but a system based on good will like that is not sustainable and is bound to collapse eventually and I feel we are close to that point
management structure at all levels is not very effective as seeing what the future could hold
No progression.
I feel very overworked and undervalued as do most of my colleagues..
no progression in the career, no support for junior staff. at times completely demoralising, takes advantage of people who work hard.
poor staff levels with increasing works loads. lack of effective communication from senior management.
you are not always valued and supported
The arrogance and bullying style of the management
Because of care and empathy.
Although I feel valued by my line manager and my colleagues, I don't feel valued by the organisation. Staff have not been prioritised in the new building and morale is low. Many staff are supporting the success of the 'new hospital' by 'going the extra mile' to ensure patients continue to receive excellent quality care but the needs of the staff are not being met.
It is hard work to maintain a positive attitude at present - more should be done at a quicker pace to resolve serious staffing issues as well as absence of Pathways for assessment in Sefton. There is a big discrepancy between what patients in Liverpool are offered to the little available to Sefton patients. This is not acceptable.
Great team to work with
Staffing has become very difficult since the move and the job seems to have become more stressful especially since introduction of meditech 6
the only children's hospital locally
Lovely building, good teams and friendly atmosphere. General feeling that staff care and put the patient first.
There is no progression, visible succession or talent management.
I have fantastic colleagues and I work with a great team.
interesting place to work. Very supportive line managers.
I enjoy my role but don not get any praise for my hard work.
Treatment of staff and morale is not always good.
I believe most individuals working here come to work with the intention of doing a good job, and are commited to the well being of children.
I believe the patients have very good service but not the staff
The resources are to be tapped.

What is the main reason for the answers you have chosen?
I WORK IN A VERY SUPPORTIVE LARGE TEAM WHO COMMUNICATE WELL AND GIVE HIGH QUALITY CARE ACROSS 3 SPECIALITIES. I AM VERY PROUD TO WORK IN MEDICAL SPECIALITES AS THE CARE WE PROVIDE IS FIRST CLASS AND FEEDBACK IS EXCELLENT FORM THOSE WE TREAT.
I think there must be a problem coming if long-serving members of the nursing staff are still leaving.
I feel that it often takes time for things to get done, and as staff we are not always listened to for example the room tempretures in the unit are not as they should be it can be either too hot or too cold because everything is computerised you can not change the air tempreture, lighting by turning a button on and off
The staff here are fantastic,dynamic,friendly.....but there is a gap between senior management and floor level. Management do not seem to appreciate the pressures of working on a ward ,delivering friendly,top class care. We cannot deliver the level of care we want to when we have to have agency staff working with us. Management need to work with NHSP to offer staff better more competitive rates of pay comparable to Agency rates.
good place to work
AHH is a nice place to work but something has been lost in the move, clinicians are reporting feelings of isolation which leads to unhappiness. Working here at the moment can be difficult because systems and processes get in the way.
It's a great environment to work in!
Staff are very poorly valued by higher managers
sometimes lack of communication, support and professionalism
The cultural ethos of the management & senior clinical staff really doesn't set the tone of caring leadership for its workforce on the wards, units & departments who are at the coal face of care delivery. Just get on with it, put up & shut up doesn't cut it. We're highly trained & educated professionals, NOT trained monkeys that you are waiting to screw up. A happy workforce is an above productive workforce. Leadership lesson 101

Alder Hey Children's NHS
NHS Foundation Trust

Workforce and Organisational Development Committee Annual Report 2015-16

The Workforce and Organisational Development Committee

The Workforce and Organisational Development Committee (WOD) was established by the Board of Directors to be responsible for overseeing the implementation of the Trust's People Strategy and Equality Agenda and ensuring the organisational development culture of the organisation is maintained. During 2015-16, the committee interfaced with RABDC by providing assurance of management of key workforce risks to that committee.

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

- Oversee the development of the Trust's Workforce Strategy to assure the Trust Board that the Strategy is implemented effectively by receiving progress reports against the Plan and Workforce Key Performance Indicators.
- Ratify/approve workforce policies as necessary.
- Monitor workforce risks contained in the Trust's Corporate Risk Register and Board Assurance Framework, and risks arising from transformation projects and report these to the Trust Board as required.
- Monitor the overall resilience of the organisation and staff through appropriate measurement of engagement and health and wellbeing, and provide reports to the Trust Board as required.
- Oversee the development of the workforce elements of the Equality Delivery Scheme (EDS2) action plan and ensure the effective implementation of the EDS2 by receiving regular reports against the action plans. In addition, oversee the development and reporting requirements for the Workforce Race Equality Standards (WRES).
- Obtain assurance that the organisational values and behaviour framework continues to be embedded and championed across the Trust.
- Obtain assurance that partnership arrangements with the Trust's Trade Unions are effective to support organisational change. More specifically, the Committee will oversee the development of the Partnership Agreement.

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

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

Constitution

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

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

- Head of HR Operations and Transformation
- Deputy Director of Human Resources
- Equality and Diversity Manager
- Representative of Staff Side
- CBU General Manager

Minutes of the Committee are presented to the Board and are supported by a summary report from the Committee Chair. Terms of reference are revised annually and were last approved in November 2015.

Achievements

During 15/16, there were changes to the leadership of the Committee; in October 2015, Melissa Swindell took up the role of Interim Director of HR & OD. Claire Dove, Chair, has worked well with Melissa to support the development of the Committee in terms of taking a more focused, strategic approach, which has been reflected in the new Terms of Reference which were approved in November 2015.

The following areas were the main focus of the Committee's attention in 15/16:

- The Equality agenda, especially in relation to workforce diversity and under-representation of BME staff. Approval was given to the Workforce Equality and Diversity Objectives and review of progress against those objectives
- Support was given to a task and finish group specifically focusing on under-representation in the workplace.
- Supporting the Transition – approval was given to the plans for how the Trust were planning to support the staff through the challenging transition to their new environment in the new hospital.

- Scrutiny of progress against the targets and measures contained within the People Strategy

- Approval of the plans being deployed for supporting the ongoing leadership and management development needs of staff
- Ratification of all relevant workforce policies
- Monitoring of key workforce risks and assurance that strategic plans and operational policies exist to mitigate all significant risks
- Approval of the Trust Recruitment Strategy and review of progress
- Approval of the Trust Health and Wellbeing Strategy and review of progress

Self Assessment

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

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

Assurance Statement

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

Committee Developments

Whilst the Committee has performed its duties as delegated by the Board it has identified a number of areas to focus on during 2016/17.

- In line with the revised governance arrangements of holding Board sub-committees accountable for the assurance and monitoring of the 'Change programme' across the organisation, WOD will have devolved responsibility for all projects relating to workforce issues. This will therefore mean a split in committee meeting time into Strategic and Operational issues to ensure focus on both priorities.
- Agree the key areas which would receive increased focus from the Committee in 206/17 which would enable the Trust to deliver its people related targets, especially:
    - Management and leadership development
    - The Equality agenda
    - Key workforce risks
    - Health & wellbeing
    - Workforce sustainability and capability

  - Staff training and development, with a particular focus on the apprenticeship agenda
  - Attracting, recruiting and retaining talent
  - Culture and engagement

- Ensure that particular attention is given to maintenance of engagement of people in the change programme and to ensuring appropriate support is given throughout the change.
- Enhance the monitoring and reporting of follow-up actions taken in respect of its areas of responsibility.

Claire Dove
Committee Chair April 2016

WORKFORCE & ORGANISATIONAL DEVELOPMENT COMMITTEE
2015-16 AGENDA TIMETABLE

Agenda Item	17th Mar	23rd Jun	10th Sept	03rd Dec	11th Mar 15
Review and Approve People Strategy				✓	
Monitor progress against People Strategy	✓	✓	✓	✓	✓
Ratify employment policies	✓	✓	✓	✓	✓
Review workforce risks for inclusion in Board Assurance Framework	✓	✓	✓	✓	✓
Sign-off Annual Report to the Trust Board					✓

WORKFORCE & ORGANISATIONAL DEVELOPMENT COMMITTEE MEMBERSHIP ATTENDANCE 2014/15

	23rd June	10th September	3rd December (rescheduled to 19th January)	11th March
Mrs C Dove (Non-Executive Director)	X	✓	✓	✓
Mr I Quinlan (Non-Executive Director)			✓	✓
Mrs J France-Hayhurst (Non-Executive Director)	✓	✓	X	X
Mr D Alexander (Director of Human Resources & Organisational Development) – Deputy Chair	✓	✓	✓	✓
Mrs Jude Adams (Chief Operating Officer)	✓	✓	✓	X
Mrs H Gwilliams or Deputy Director of Nursing	X	X	X	X
Mr R Turnock or Deputy Medical Director		X	X	X

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Tuesday 5th July 2016

Workforce & Organisational Development Committee (WOD) – Chairs Note

1. Purpose of the Report

The purpose of this report is to update the Board on the key issues raised at the WOD Committee held in June 2016.

2. Key Issues

The following issues were raised and discussed at the Workforce & Organisational Development Committee on the 8th June 2016; the minutes of the meeting will be submitted to the September 2016 Board for noting.

- The Committee received the Programme Assurance Summary for May 2016 and **agreed** the content for progression.
- The Committee received an update on the following Project Initiation Documents and **agreed** the content for progression.
    - Capability & Sustainability
    - Management & Leadership Development
    - Starters & Leaders
- The Committee received the CIP Standard Operating Procedures and **noted** the content.
- The Committee received the Annual Report for 2015-16 and **approved** the content.
- The Committee received the Work Plan for 2016-17 and **approved** the content.
- The Committee received an update on latest developments of Listening into Action relating to the 'Big Conversations' with staff and **noted** progress.
- The Committee received an EDS2 Summary Report outlining the equality objectives and **approved** the content.
- The Committee received a revised WRES report for publication in July 2016 and **approved** the content.
- The Committee received an update of the Workforce Leading Indicators for April and **noted** the content.

3. Recommendations

It is recommended that the Board note the contents of the Chairs Update relating to the key issues from the Workforce and Organisational Development Committee held on 8th June 2016.

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Alder Hey Children's NHS
NHS Foundation Trust

ANNEX A

WORKFORCE & OD COMMITTEE
MINUTES FROM MEETING
8th June 2016

Present:	Ms C Dove	Non-Executive Director (Part Attendance)	(CD)
	Mrs J France-Hayhurst	Non-Executive Director	(JFH)
	Mrs M Swindell	Director of HR & OD (Interim) (Chair)	(MKS)
In Attendance:	Mrs F Flanagan	Head of OD	(FF)
	Mr M Travis	Chair of Staff Side	(MT)
	Mrs C Liddy	Deputy Director of Finance	(CL)
	Mrs M Barnaby	Chief Operating Officer	(MB)
	Mrs H Ainsworth	Equality & Diversity Manager (Part Attendance)	(HA)
	Mr R Turnock	Medical Director (Part Attendance)	(RT)
	Ms J Richardson	Programme Manager	(JR)
	Mr J Gibson	External Programme Assurance	(JG)
	Mrs S Brown	Strategic Project Manager & Decontamination Lead	(SB)
	Ms S Stephenson	Quality & Governance Manager	(SS)
	Mrs S Owen	HR Business Partner	(SO)
	Ms D Brannigan	Patient Governor (Parent and Carer)	(DB)
Apologies:	Mr I Quinlan	Non-Executive Director	(IQ)
	Ms T Kelly	HR Manager	(TK)
	Mr N Davies	HR Business Partner	(ND)

Agenda Item	Key Discussion Points	Action	Owner	Timescale
16/14 Minutes of the Previous Meeting & Introduction	The Committee considered the minutes of the last meeting held on 13th April 2016 and **approved** minutes as an accurate record. Dot Brannigan, Patient Governor was in attendance, introductions were made and it was noted that Dot will attend future Committee's.			
16/15 Matters Arising /Actions	The Committee considered the following under matters arising: **15/26 Creating A Healthy Workforce** MKS advised that an update on Occupational Health will be brought to the next meeting (Melissa as per actions, is this the overall strategy on health and wellbeing coming to next WOD or just Occupational Health analysis??) Remove 15/31 as complete (Melissa confirm which one as there are two actions under 15/31 in the actions??).			

Agenda Item	Key Discussion Points	Action	Owner	Timescale
	Improving Communications – update to be received. (Melissa is this update to be received at next WOD??)			
16/16 Programme Assurance 'Developing our Workforce'	**Developing Our Workforce – Programme Assurance Framework** The Committee received an updated programme assurance summary for May 2016 completed by Executive Sponsors of the assurance framework/External programme assessor and Assurance Team. The purpose of the assurance framework is to ensure the monitoring of robust processes for progression of three key projects. MKS advised that both non-financial projects – 'Developing High Quality Leadership & Management' and 'Starters & Leavers Process' are on track with milestone plans, with targets and benefits defined and on track. EIA/QIA's have been completed. **Workforce Capability & Sustainability** JG/MKS made reference to the concern raised in the programme assurance summary relating to the pace of identification of CIP opportunities in this project. There is a requirement for CIP opportunities to be increased as a matter of urgency. An initial opportunity assessment completed by CBU's identified £1,033k of CIP 'ideas' leaving a gap of £101k and many of the 'ideas' do not have a developed plan and will therefore will be captured in a "hopper" in future. Action to address these gaps should be given priority at Developing our Workforce Steering Group. JG made reference to the lack of progress made relating to incorporating the planning of tasks and reporting of benefits across the different levels of activity (Business Units and Cross-cutting); separate plans need to be posted onto SharePoint to provide transparency. Following letters (copies received at WOD) issued by CEO and addressed to the 6 corporate areas and 5 clinical businesses; outlining the 3 stepped approach to deliver workforce efficiencies, JG noted the lack of progress. Just 6 of 14 areas have generated plans onto SharePoint, as Q1 of financial year draws to a close this lack of progress should be addressed. All areas (excluding ward based nurses, junior doctors and R&D have been set a target of 3.75% reduction in workforce budgets for 16/17. It was noted that a vast majority of savings are non recurrent and that the recurrent strategy is important. MT suggested that revised MAS scheme salary cap of £80K may be difficult to impose as not in contracts. MKS confirmed that anyone applying to the MAS Scheme do so voluntarily so the MAS Scheme does not have any implications contractually.			

Agenda Item	Key Discussion Points	Action	Owner	Timescale
	The Committee **noted** the content of the report. **CIP 16-17 Standard Operating Procedures** The Committee received a report from the Deputy Director of Finance & Business Development concerning CIP standard operating procedures for Alder Hey. The purpose of the report is for use as reference document to guide successful delivery of the 16/17 Alder Hey Cost Improvement Programme. This will ensure the monitoring of best practice and open and transparent cost improvements programmes. **Workforce and Organisational Development Committee Annual Board Report 2015-16** The Committee received from the Interim Director of HR & OD the Annual Report for 2015-16 for approval, prior to being presented to the Audit Committee followed by Trust Board. WOD was established by the Board of Directors and the purpose is to oversee the implementation of the Trust's People Strategy and Equality Agenda and ensuring the organisational development culture of the organisation is maintained. MKS outlined the content of the report and a couple of updates were made to the Constitution; update 'Representative of Staff Side' to read 'Chair of Staff Side'; include 'Deputy Director of Finance'. The Committee **approved** the Annual Board Report 2015-16 **Workforce & Organisation Development Committee Work Plan 2016-2017** The Committee received from the Interim Director of HR & OD the Work Plan for 2016-17 for approval. The purpose of the work plan is to organise a programme of duties for the year ahead. Minor changes were agreed, a further date has been added for 'discuss and identify key workforce themes'. The Committee **approved** the Work Plan for 2016-17.			
16/17 Progress Against the People Strategy	**Listening into Action** The Committee received a verbal summary from the Interim Director of HR & OD outlining the activity that has commenced with the LiA scheme, with particular attention brought to the 'Big Conversations'. The first 'Big Conversations' with staff, hosted by the CEO and the Trust LiA Lead took place prior to WOD and will be followed by a further 4 to be hosted in June. MKS shared the processes in place for the 'Big Conversations', with staff responding to 2 key questions; 'what day to day frustrations get in the way of us delivering the very best care for our patients' and			

Agenda Item	Key Discussion Points	Action	Owner	Timescale
	'what changes that we can make between us would make the biggest difference to patient care and the way we work'. Separate meetings to include frontline clinical/ward staff are to be arranged on department/wards. MKS to update on developments at future WOD Committees. **Equality Update** EDS2 - The Committee received the Equality Delivery Summary Report prepared by the Equality & Diversity Manager. The report outlines the Trusts 7 equality objectives for April 2016-April 2017. HA advised that a template has been produced and will be presented to future WOD/CQAC Committees to update on progress on how the Trust is measured on performance relating to equality objectives. WRES – The Committee received a Workforce Race Equality Standard reporting template, revised in 2016 and prepared by the Equality & Diversity Manager. HA gave a brief update of both reports with particular attention paid to the commitment of 7 objectives with the focus on quality and advised on milestones and monitoring processes. A number of suggestions were raised to support the equality objectives: • Objective No. 7 – 'broaden opportunities for equality training' – CD suggested training could be incorporated into the Trust Mandatory Training Programme. • Objective No. 1 – 'to increase the representation of black and minority ethnic (BME) staff – CD suggested that Edge Hill only take in the highest achievers and it would be beneficial if the Trust had more control of processes. HA advised that a Task and Finish Group is looking at the whole practice and there is a vast amount of work taking place including reviewing adverts/cultural event to take place. CD said it would be great to see the analysis of who applies. MKS added that now that recruitment has been brought back in-house, this will enable us to review/unpick internal and NHS job methods. The Committee **approved** both EDS2 and WRES reports. JFH recognised the hard work that HA has prepared to date and noted that it does take time for plans to become established.			
16/18 Key Workforce Risks – Review of top Workforce Risks action planning against most significant risks	**Workforce Performance Monitoring** The Committee considered a regular report prepared by the Interim Director of HR & OD concerning the key risks relating to workforce monitoring for April 2016. The purpose of the report is to update on key targets/measures and advise of actions to			

Agenda Item	Key Discussion Points	Action	Owner	Timescale
	support improvement. Particular attention was brought to: • **Sickness Absence** Sickness reported a slight increase at 5.38%, with target of 4.5%, still a lot of work to do. MT suggesting that as an organisation we need to delve more into the reasoning behind staff sickness components, particularly affecting woman. CD acknowledged that a lot has been achieved via the health and wellbeing and sickness is firmly on the agenda. MKS advised that Team Prevent are looking to revise the Trusts sickness policy and an action plan will be brought back to August WOD. • **Completeness of Training** **PDR** – MKS reported that the 4 month window for PDR's has commenced as of April with this month coming in at 10%. PDR completion should always be recorded on ESR to enable a true record to be received. Medical PDR's have a different recording process. **Trust Induction** – there is a downward trend of 69.23%. Held once a month for all new starters, presently all department managers receive a letter advising of staff who are due attend. Processes are being reviewed, currently looking at a structure to be rolled out via the Payroll Dept. **Mandatory Training** – SB highlighted that there is a requirement for further stress risk assessment training to be implemented. **Agency/Bank Costs** – It was acknowledged that agency costs are still high with concerted efforts to monitor caps being made. Medical Agencies – looking at alternatives. It was noted that Locum Costs are down, performance should read green. SS highlighted that turnover in consultants is high and suggested we need to review the reasons behind this. MKS to have a conversation with the Medical Director. The Committee noted MT's comments relating to career development for nurses. CD reiterated that LiA is important for Trust and will bring to light lots ideas for progression to support the Trust. CD recognised that as Staff Side Chair MT is in a great position to encourage staff to attend the LiA Big Conversations to be held in June. MT acknowledged that LiA is a positive step in supporting staff members. DB asked if HR had thought about the re-instatement of 'exit interviews'. MKS confirmed that a HR Business Partner is currently reviewing the exit interview process. The Committee **noted** the content of the report.	Action plan re sickness policy to be presented?? Discuss consultant turnover with Medical Director	Team Prevent & MKS MKS	10th August ASAP

Agenda Item	Key Discussion Points	Action	Owner	Timescale
16/19 Legislation, terms & conditions, employment policies – review & ratification/approval	No policies were received by the Committee for approval.			
AOB				
Review of Meeting	CD thanked everyone for their contribution to the Committee.			
Date of Next Meeting	**Wednesday 10th August 2016 2016, 2pm-4pm, Room 6, Mezzanine, CHP**			

Action List

Minute Reference	Action	Who	When	Status
Meeting Protocol				
Matters Arising /Actions				
People Strategy Overview & Progress Against Strategic Aims				
	Engagement			
15/08 16/02	• Develop Values in Procurement, values based recruitment – develop opportunities to incorporate into the Procurement processes/standards for contractors. Liaise with Deputy Director of Finance to progress to review employment opportunities.	MKS/CL	TBC	Ongoing
	Creating A Healthy Workforce			
15/26	• Review current suitability of Junior Doctors mess – progressed by the Development Director	MKS/DP	Ongoing	Update at Future Meetings
15/26	• Discuss with Occupational Health analysis on outcomes of OH referrals, supporting people back to work process and review of stress levels and report back (Health & Wellbeing Strategy)	MKS	August 2016 (Invite OH??)	Update of Future Meetings
	Equality & Diversity			
15/03	• Present data on applied/shortlisted recruitment – currently being reviewed.	HA	When available	
15/03	• Align E&D deliverables with people strategy	DA/HA	Ongoing	Update at future meetings

15/31	• Equality agenda – produce a dashboard to track progress	HA	February 2016	Complete?
16/03	• Arrange Task & Finish Group to progress diversity agenda issues in conjunction with HR lead	HA/MKS	ASAP	Progressing
	Availability of Key Skills			
15/15, 15/30	• Pilot supported by Manchester & Warwick University – non medical pharmacists – update on developments – MKS to make enquiries re affected workforce and feedback to MT	SB/MT/MKS	Ongoing	Periodic update on progress
	Improving Communications			
15/20	• Arrange a meeting to discuss how to reach small hard to reach groups. Initial meeting took place with Director of Marketing & Communications – feedback on progress	LD/MKS		Update to be received
	Leadership & Management Development Strategy			
15/31 16/03	• Update on progress of Leadership & Management Development Strategy	FF	Ongoing	
	Implementing The Apprenticeship Model			
16/11	• Update on progression of work at Blackburn House & apprenticeship levy.	PD/MKS	August 2016	
Key Workforce Risks – Review of Top Workforce Risks				
16/12	CBU PDR completion - explore outside of WOD recording processes linked to name to highlight completion/none completion/yet to be arranged.	MKS/CBU's	ASAP	
Legislation Terms & Conditions & Employment Policies				
15/09 16/06	• Review the agendas and work plan for subsequent WOD meetings and present draft for discussion • Present TOR to include governance of Change Programme	DA MKS		Annual update Required Complete for 2016

ALDER HEY IN THE PARK PROJECT

HIGHLIGHT REPORT Site & Park Development	Date: 27/06/16 Report Number:	Period: June 2016 2	SRO: David Powell Author: Chris McCall

Programme 2016/17	Apr-16				May-16					Jun-16				Jul-16				Aug-16					Sep-16				
Week Commencing	**4**	**11**	**18**	**25**	**2**	**9**	**16**	**23**	**30**	**6**	**13**	**20**	**27**	**4**	**11**	**18**	**25**	**1**	**8**	**15**	**22**	**29**	**5**	**12**	**19**	**26**	
Temporary Moves																											All moves completed - project closed
Decommissioning & Demolition (Phase 1 & 2)																											3 months behind programme primarily due to lack of funding to fully meet demolition tender pressures, over budget. Exploring options to bring back into budget. Phase 1 demolition due to commence in July. Preferred bidder selected, Trust Board to approve recommendation.
Residential																											Programme continues to be on track. Dialogue sessions have commenced with the 6 selected bidders. Project team meeting with bidders on a weekly basis for an 8 week period. Initial bids to be submitted 5th August.
Park																											Major design event/workshop on 10th June identified early wins within the next 12 months within the existing Springfield Park including events calendar, shrubbery clearance, review of access routes and potential pop up cafe. List of key items to be drawn up and trialled for inclusion in long term development model.
Corporate Offices/Clinical on-site																											Scheme developed on reduced area which provides 288 desks. Desks allocated to each department to be accommodated within the new building and revised designs shared with users. Hopkins to provide revised design to RIBA stage C mid July. Trust considering moving to a steel frame to further improve affordability, this will be decided over the next 2 weeks.
Community																											Project due to commence end June 2016. PID completed 30th June.
Reseach & Education Phase II																											Trust has instructed design to be developed up to a stage for pricing and construction ready. Continue to have a funding shortfall. Clarity required around space to be provided for Edge Hill, UoL, UCLan and other partners
Agile Working																											Project due to commence end June 2016. PID partially completed, will be complete in July following first 2 project meetings.
On-site Residual																											Project anticipated to commence September 2016 (to be confirmed)
Alder Centre																											Project due to commence July 2016 - Project Lead and Centre Manager currently visiting other recently built centres. Initial information update and discussion with Alder Centre Senior Team took place in June. Project team members from Alder Centre identified and confirmed.
Commercial																											Discussions continue with Police regarding occupying space in corporate offices with a view to a deal on acquiring the Eaton Road police station site. Veterinary surgery proposed land swap with Trust, decision to be made by Trust within the next 3 months.

Issues for Escalation	
Decommissioning & Demolition	
Cost of decommissioning and demolition works exceeds current available budget by c£1m	
Timing of transfer of IT/phone/data links to new hospital from old site will delay electrical isolations and possibly demolition works	
Research & Education Phase II	
Project is only progressing the design to RIBA stage E due to the funding shortfall. Project team not progressing any other works until funding is secured. Fundraising is part of a separate work-stream managed by a steering group involving Trust, University of Liverpool and others	

BOARD OF DIRECTORS

Tuesday 4th July 2016

Report of:	Director of Finance
Paper Prepared by:	Director of Finance
Subject/Title:	Normal Course of Business Working Capital Facility (WCF) / Distressed finance revolving working capital facility (WCF).
Purpose of Paper:	To provide the Board with details of new loan and obtain Board authorisation of the actions detailed
Action/Decision Required:	The Board is asked to: • Approve the terms of, and the transactions contemplated by, the Finance Documents to which it is a party and resolving that it execute the Finance Documents to which it is a party; • Authorise the Director of Finance or Chief Executive to execute the Finance documents on behalf of the Trust • Authorise the Director of Finance to sign and despatch any documents. • Confirm the Trusts undertaking to comply with the additional terms and conditions. •
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	**Financial Strength**
Resource Impact:	Interest repayments at rate to be advised

BOARD OF DIRECTORS

Tuesday 4th July 2016

2016/17 Requirement for Normal Course of Business Loan / Distress Financial Support

1. **Purpose of the Report**
   The purpose of this paper is to obtain Board approval to apply for the new loan / support funding.

2. **Background**
   The Board is aware of the need to access cash support as part of the 2016/17 budget approved by the Board. The Trust, dependent on the decision of NHS Improvement may apply for either a 'Normal Course of Business (NCB) Working Capital Facility (WCF)' or 'Distressed finance revolving working capital facility (WCF). The trust has been advised a NCB loan would be approved only if the Trust accepts financial control.

   This decision is currently under review by NHS I.

3. **Distressed finance revolving working capital facility (WCF).**

   The Trust has requested £8.5m WCF.

   Distressed finance revolving working capital facility (WCF) has an interest rate of 3.5% per annum.

4. **Schedule 8: Additional terms and conditions**
   (i) The Trust understand s and accepts the surplus/deficit limits and will not put forward a utilization request that exceeds these limits without explicit agreement.
   (ii) The Trust will comply with nursing agency spending rules (set out 1st Sept 2015)
   (iii) The Trust will implement the NHS Five High Impact Actions
   (iv) The Trust will not enter into professional fees or consultancy in excess of £50k without approval.
   (v) The Trust will comply with VSM pay cost approvals.
   (vi) The Trust will benchmark estate costs within 3 months of approval

(vii) The Trust will ensure it has an up to date estates strategy for 3 years from the date of the agreement, shared with DH within 6 weeks of the date of agreement. Surplus land is released by 31 March 2020

(viii) Trust must use P21+ procurement framework for capital

(ix) Trust must undertake SBS financial services baselining within 6 months

(x) Trust must review of outsourced staff Bank provider within 6 months

(xi) Trust must comply with non-pay / procurement submissions and asset registers within 6 months

(xii) Trust review savings under Crown Commercial services (CCS) within 6 months

(xiii) Trust must comply with EEA/non-EEA charging and reporting.

5. Recommendation

The Board is asked to:

(i) Approve the terms of, and the transactions contemplated by, the Finance Documents to which it is a party and resolving that it execute the Finance Documents to which it is a party;

(ii) Authorise the Director of Finance or Chief Executive to execute the Finance Documents to which it is a party on its behalf; and

(iii) Authorise the Director of Finance, on its behalf, to sign and/or dispatch all documents and notices (including if relevant, any Utilisation Request and) to be signed and/or despatched by it under or in connection with the Finance Documents to which it is a party.

(iv) Confirm the Trusts undertaking to comply with the additional terms and conditions.

Jonathan Stephens
Director of Finance & Information
July 2016

Corporate Report

May 2016

Corporate Report

Alder Hey Children's NHS
NHS Foundation Trust

Table of Contents

Executive Summary

May 2016

Alder Hey Children's NHS Foundation Trust

Is there a Governance Issue?

Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16
N	N	N	N	N	N	N	N	N	N	N	N

Highlights

The Trust met the Monitor ED Improvement Trajectory at 93.6%. ED attendances continued to be high over the month, and the introduction of observation beds in EDU part month resulted in fewer General Paediatric Specialty ED breaches. It is anticipated this improved performance will continue and delivery of 95% for June is anticipated. Continued achievement of Cancer Standards and RTT standards is highlighted. Continued improvement of Theatre Utilisation has also been seen.

Challenges

Clinic Utilisation, delivery of activity plan and maintenance of performance against RTT standards requires attention. Performance in May indicates that the Trust is not yet resilient in meeting RTT performance standards nor productivity standards . Focus in June has been on actions to assure delivery of the Run Rate 2016-2017 and this focus will continue on a weekly basis. This strengthens delivery of RTT performance. A slight deterioration in productivity and performance across a number of areas is due in part to having two bank holiday periods and half term holiday period in month.

Patient Centred Services

Although good performance overall, there is evidence through Aril and May Performance that delivery of RTT is more challenged, and this is linked with a lower level of productivity against plan. This is of concern, root causes of these challenges will be identified and action taken to mitigate and resolve these during June and July 2016.

Excellence in Quality

All leading metrics are within target for May except 'Pressure Ulcers – Grade 2 and above', which has resulted in 6 against a target of 5, plus 1 Never Event that was reported in April. This includes improvements in trend for total Infections, medication errors and clinical incidents (resulting in harm). Patient Safety performance has improved in May with zero readmissions to PICU within 48 hours, zero incidents in month that resulted in moderate harm or above, and no 'Serious Incidents Requiring Investigations (SIRIs)' reported in month. Clinical effectiveness has maintained excellent performance for the first two months of the year with zero Clostridium difficile and MRSA infections, plus no reported outbreak or cluster infections. Acute readmission of long term conditions within 28 days remains off target and patients discharged later than their EDD remains ahead of target at 5.5%.

Financial, Growth & Mandatory Framework

At the end of May the Trust is reporting a trading deficit position of £3.9m which is £0.2m behind plan. Income is behind plan by £0.3 largely relating to elective activity which is behind plan by 13% and outpatient activity which is behind by 6%.
Pay budgets are £0.4m overspent relating to use of agency staffing. The Trust is £0.3m behind the CIP target. Cash in the Bank is £7.9m. Monitor risk rating of 2

Great Talented Teams

Sickness absence shows a reduction from last month and - at 4.9% - is now only 0.4% above target. Mandatory training compliance as at 81.8%, although Corporate Induction attendance has increased to 94%. Medical appraisal compliance is at 0% as the new monitoring window has opened. Work continues on improving all KPIs.

Leading Metrics

May 2016

Alder Hey Children's NHS Foundation Trust

Patient Centered Services

Metric Name	Goal	Apr 2016	May 2016	Trend	Last 12 Months
ED: 95% Treated within 4 Hours	95.0 %	95.7 %	93.6 %	▼	
RTT: 90% Admitted within 18 weeks		88.3 %	87.4 %	▼	
RTT: 95% Non-Admitted within 18 weeks		89.6 %	87.8 %	▼	
RTT: 92% Waiting within 18 weeks (open Pathways)	92.0 %	92.2 %	92.1 %	▼	
Diagnostics: Numbers waiting over 6 weeks		0	0	–	
Average LoS - Elective (Days)		2.8	3.1	▲	
Average LoS - Non-Elective (Days)		2.0	2.0	▼	
Daycase Rate	0.0 %	70.0 %	66.5 %	▼	
Theatre Utilisation - % of Session Utilised	85.0 %	80.1 %	81.3 %	▲	
28 Day Breaches	0.0	7	11	▲	
Clinic Session Utilisation	90.0 %	79.5 %	79.8 %	▲	
DNA Rate	12.0 %	9.6 %	9.0 %	▼	
Cancelled Operations - Non Clinical - On Same Day		35	35	–	

Excellence in Quality

Metric Name	Goal	Apr 2016	May 2016	Trend	Last 12 Months
Never Events	0.0	1	0	▼	
IP Survey: % Received information enabling choices about their care	90.0 %	95.2 %	94.2 %	▼	
IP Survey: % Treated with respect	90.0 %	99.3 %	98.7 %	▼	
IP Survey: % Know their planned date of discharge		62.0 %	59.3 %	▼	
IP Survey: % Know who is in charge of their care		85.5 %	82.7 %	▼	
IP Survey: % Patients involved in play and learning		60.4 %	54.1 %	▼	
Pressure Ulcers (Grade 2 and above)	5.0	3	6	–	
Total Infections (YTD)	20.0	6	17	▲	
Medication errors resulting in harm (YTD)	14.0	7	11	▼	
Clinical Incidents resulting in harm (YTD)	114.0	50	91	▼	

Great and Talented Teams

Metric Name	Goal	Apr 2016	May 2016	Trend	Last 12 Months
Corporate Induction	100.0 %	64.3 %	94.1 %	▲	
PDR	90.0 %	2.8 %	11.5 %	▲	
Medical Appraisal	100.0 %	96.9 %	TBC		
Sickness	4.5 %	5.2 %	4.9 %	▼	
Mandatory Training	90.0 %	81.2 %	81.8 %	▲	
Staff Survey (Recommend Place to Work)		27.8 %	43.6 %	▲	
Actual vs Planned Establishment (%)		88.4 %	87.1 %	▼	
Temporary Spend ('000s)		971	1105	▲	

Financial, Growth and Mandatory Framework

Metric Name	Apr 2016	May 2016	Last 12 Months
CIP In Month Variance ('000s)	-179	-107	
Monitor Risk Ratings (YTD)	1	2	
Normalised I & E surplus/(deficit) In Month ('000s)	-2459	-1486	
Capital Expenditure YTD % Variance	0.3 %	-11.8 %	
Cash in Bank (£M)	7	8	

Exceptions

May 2016

Alder Hey Children's NHS Foundation Trust

Less than 4Hour EDU Hospital Stays now included as part of inpatient data from April 2016 which reduced Trust NEL LOS

Positive (Top 5 based on % change)

Metric Name	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Last 12 Months
Average LoS - Non-Elective (Days)	2.8	2.6	2.8	2.6	2.4	2.3	2.5	2.6	2.2	2.4	2.6	2.0	2.0	
DNA Rate	12.1%	14.0%	15.5%	14.6%	13.4%	13.4%	11.8%	12.9%	12.0%	12.8%	12.5%	9.6%	9.0%	
Cancelled Operations - Non Clinical - On Same Day	25	24	27	21	16	18	41	11	21	27	48	35	35	
Medication errors resulting in harm (YTD)	20	29	33	41	53	59	65	67	71	76	85	7	11	
Clinical Incidents resulting in harm (YTD)	130	212	268	319	372	418	473	507	563	607	670	50	91	

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

Metric Name	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Last 12 Months
RTT: 90% Admitted within 18 weeks	90.1%	90.7%	90.0%	90.1%	87.8%	87.3%	100.0%	85.5%	85.2%	84.7%	88.3%	88.3%	87.4%	
RTT: 92% Waiting within 18 weeks (open Pathways)	92.1%	92.0%	92.1%	92.1%	92.1%	92.1%	92.2%	92.2%	92.2%	92.5%	92.3%	92.2%	92.1%	
Mandatory Training	62.0%	71.7%	72.0%	76.4%	78.9%	77.2%	84.0%	83.7%	83.4%	82.7%	82.3%	81.2%	81.8%	
Staff Survey (Recommend Place to Work)		55.8%	55.8%	55.8%	59.1%	54.1%	54.1%	38.3%	52.7%	46.9%	44.2%	27.8%	43.6%	
Normalised I & E surplus/(deficit) In Month ('000s)	-392	505	160	-1,276	-101	-1,570	-907	-439	-608	-276	687	-2,459	-1,486	

Challenge (Top 5 based on % change)

Metric Name	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Last 12 Months
28 Day Breaches	2	1	12	5	4	2	3	10	4	5	7	7	11	
Clinic Session Utilisation	90.3%	80.8%	84.2%	79.2%	80.0%	75.2%	81.9%	80.3%	83.6%	81.3%	82.7%	79.5%	79.8%	
PDR	30.3%	89.3%	89.3%	90.1%	90.1%	90.1%	90.1%	90.1%	90.1%	90.1%	90.1%	2.8%	11.5%	
Sickness	4.6%	4.6%	4.4%	3.9%	4.5%	4.6%	5.6%	5.5%	5.7%	5.8%	5.3%	5.2%	4.9%	
Pressure Ulcers (Grade 2 and above)	3	5	7	8	8	11	13	13	15	22	24	3	6	

Patient Safety

May 2016

Alder Hey Children's NHS Foundation Trust

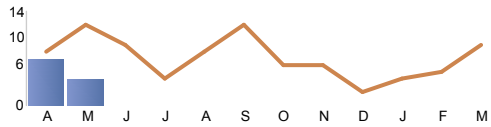
Summary

Patient Safety performance has also shown improvement in May with zero readmissions to PICU within 48 hours in month, no incidents in month that resulted in moderate harm or above, and no 'Serious Incidents Requiring Investigations (SIRIs) reported in month.

16/17 15/16 Threshold

Medication Errors

Medication errors resulting in harm (YTD) 11 (goal: 14.0)



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

Pressure Ulcers

Pressure Ulcers (Grade 2 and above) 6 (goal: 5.0)

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

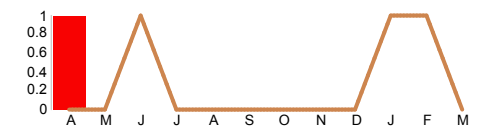
Readmissions to PICU within 48 hrs

Readmissions to PICU within 48 hrs (YTD) 1 (goal: 4.0)

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

Never Events

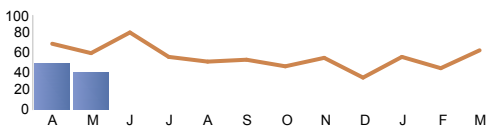
Never Events 0 (goal: 0.0)



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

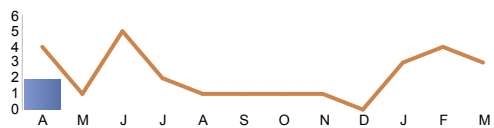
Incidents

Clinical Incidents resulting in harm (YTD) 91 (goal: 114.0)



YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
16/17	50	91										
15/16	70	130	212	268	319	372	418	473	507	563	607	670

Clinical Incidents resulting in moderate, severe harm or death (YTD) 2 (goal: 10.0)



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

Serious incidents requiring investigation

Serious Incidents Requiring Investigation (Total) 1

YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
16/17	2	3										
15/16	1	1	5	5	6	8	9	9	11	12	14	16

Patient Experience

May 2016

Alder Hey Children's NHS Foundation Trust

Summary

Complaints and PALs are undergoing revalidation and may not reflect accurately what is declared.
Complaints figures continue to be at a very reduced level – however PALS contacts have risen by 29% so far this year.

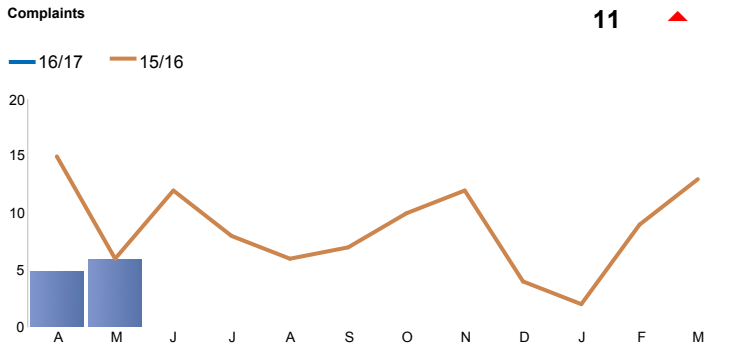
Inpatient Survey

Metric Name	Goal	Apr 2016	May 2016	Trend	Last 12 Months
% Know who is in charge of their care		85.5 %	82.7 %	▼	
% Patients involved in play and learning		60.4 %	54.1 %	▼	
% Know their planned date of discharge		62.0 %	59.3 %	▼	
% Received information enabling choices about their care	90.0 %	95.2 %	94.2 %	▼	
% Treated with respect	90.0 %	99.3 %	98.7 %	▼	

Friends and Family

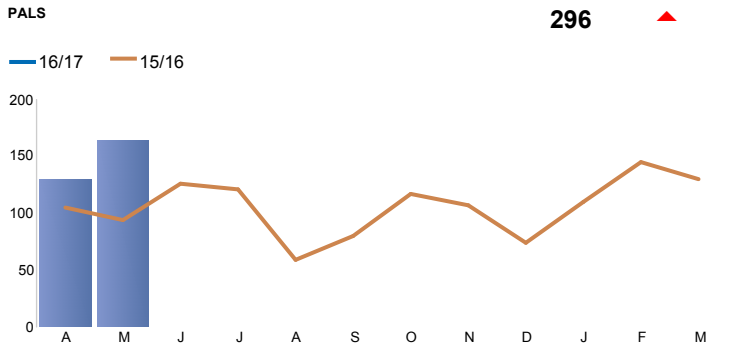
Metric Name	Number of Responses	Apr 2016	May 2016	Trend	Last 12 Months
A&E - % Recommend the Trust	34	84.0 %	58.8 %	▼	
Community - % Recommend the Trust	4	TBC	25.0 %		
Inpatients - % Recommend the Trust	117	86.3 %	75.2 %	▼	
Mental Health - % Recommend the Trust	4	100.0 %	25.0 %	▼	
Outpatients - % Recommend the Trust	217	80.3 %	59.4 %	▼	

Complaints



YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
16/17	5	11										
15/16	15	21	33	41	47	54	64	76	80	82	91	104

PALS



YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
16/17	131	296										
15/16	105	199	325	446	505	585	702	809	883	993	1,138	1,268

Clinical Effectiveness

May 2016

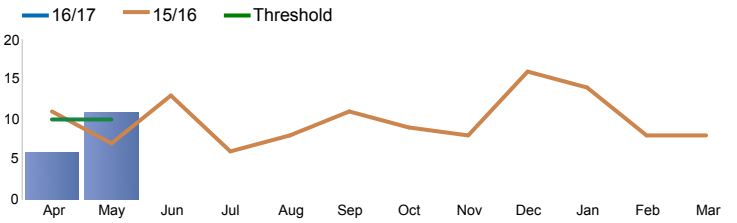
Alder Hey Children's NHS Foundation Trust

Summary

Clinical effectiveness has maintained excellent performance for the first two months of the year with zero Clostridium difficile and MRSA infections, plus no reported outbreak or cluster infections.
Acute readmission of long term conditions within 28 days remains off target and patients discharged later than their EDD remains ahead of target at 5.5%

Infections

Total Infections (YTD) — 17 (goal: 20.0)



YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
16/17	6	17										
15/16	11	18	31	37	45	56	65	73	89	103	111	119

Total Infections (YTD) 17 (goal: 20.0)

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

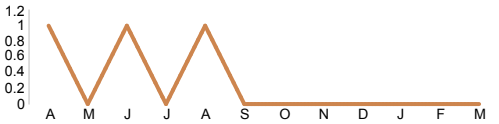
Hospital Acquired Organisms - C.difficile (YTD) 0 (goal: 0.0)

Outbreak Infections (YTD) 0

Cluster Infections (YTD) 0

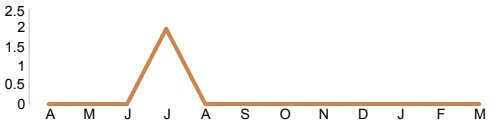
Legend
16/17
15/16
Threshold

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



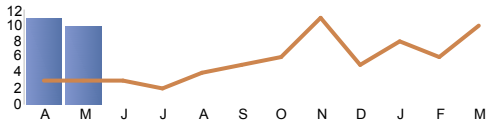
YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
16/17	0	0										
15/16	1	1	2	2	3	3	3	3	3	3	3	3

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



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

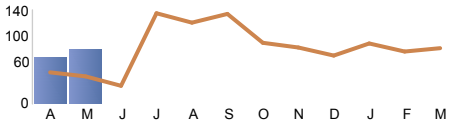
Acute readmissions of patients with long term conditions within 28 days — 21 (goal: 11.0)



YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
16/17	11	21										
15/16	3	6	9	11	15	20	26	37	42	50	56	66

Admissions & Discharges

Patients with an estimated discharge date discharge later than planned (only surgical) — 153 (goal: 166.0)



% of patients with an estimated discharge date discharge later than planned (only surgical) — 5.5 %

YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
16/17	71	153										
15/16	47	88	115	250	371	505	596	680	752	842	920	1,003

YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
16/17	5.2%	5.5%										
15/16	3.4%	3.3%	2.8%	4.6%	5.5%	6.2%	6.5%	6.5%	6.4%	6.4%	6.4%	6.3%

Access

May 2016

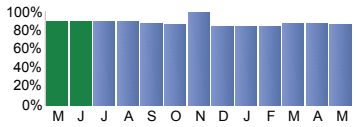
Alder Hey Children's NHS Foundation Trust

Summary

Incomplete pathway, cancer and diagnostic standards achieved; admitted and non admitted standards failed in line with planning assumptions. Increased levels of admissions/discharges and activity noted against the same period last year with continued increase in bed occupancy to 84.1% . Referrals received continues to increase showing strong demand however this needs to be offset with capacity to manage. Choose & Book availability has improved with challenges noted in a small number of specialties; currently being reviewed to ensure balanced going forward.

18 Weeks

RTT: 90% Admitted within 18 weeks 87.4 %



Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
90.3%	89.3%	91.5%	86.0%	87.9%

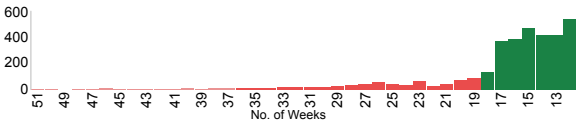
RTT: 95% Non-Admitted within 18 weeks 87.8 %

Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
95.2%	93.7%	88.3%	85.7%	88.7%

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

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

Open Pathways Weekly Profile May 2016



0-18 Wks	19-36 Wks	36-51 Wks
2,775	691	141

Cancer

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

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

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

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

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

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

Diagnostics

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

Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
98.6%	100.0%	99.7%	99.9%	100.0%

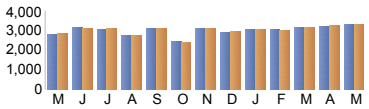
Waiting Times Failed 0

Waiting Times Passed 4

Number of Diagnostics

200

Admissions and Discharges



Bed Occupancy

Bed Occupancy (Funded Beds) 84.2 %

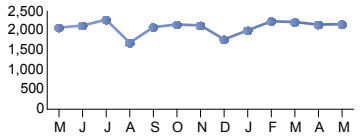
Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
		79.0%	79.8%	82.4%

Provider

Convenience and Choice: Slot Availability 96.5 % *(goal: 96.0 %)*

Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
99.9%		99.6%	93.7%	96.0%

Referrals Received (GP)



Emergency Department

May 2016

Alder Hey Children's NHS Foundation Trust

Summary

Trust achieved the monitor trajectory for 93.6%. Attendances during May, were in line with trust predications.

Utilisation of UC24 GP has improved from under 50% to 85% per week. The Team continues to meet on a monthly basis with colleagues from UC24 to continue to improve the process

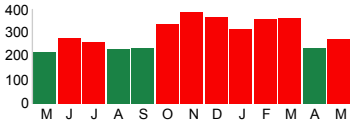
To support the improvement of flow Assessment beds have been created on EDU (23/5/2016).

ED

ED: 95% Treated within 4 Hours — 93.6 % (goal: 95.0 %)

Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
95.5%	95.3%	82.8%	84.5%	94.6%

ED: Total Time in ED (95th Percentile) — 276.0 mins (goal: 240.0 mins)



Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
730.0	736.0	1,101.4	1,046.0	515.0

ED: Longest Wait Time (Hrs) — 10.8 (goal: 0.0)

Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
31.4	27.8	44.6	35.7	20.6

ED: Number Treated Over 4 Hours

332

ED to Inpatient Conversion Rate

17.8 %

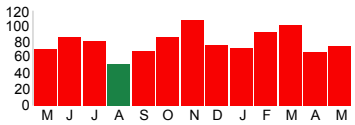
May 2016

ED

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

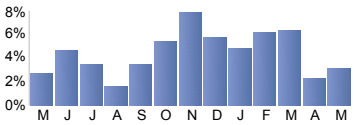
Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
0.0	0.0	0.0	0.0	0.0

ED: 60 minute 'Time to Treat Decision' (Median) — 76.0 mins (goal: 60.0 mins)



Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
231.0	205.0	273.0	270.0	144.0

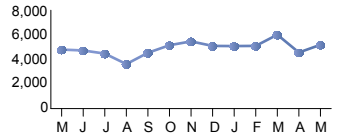
ED: Percentage Left without being seen — 3.2 %



Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
3.6%	3.0%	6.5%	5.9%	2.8%

ED: Number of Attendances

5189 May 2016

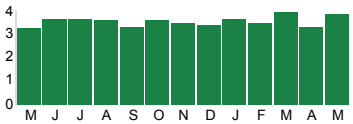


Ambulance Services

Ambulance: Acute Compliance — 88.9 % (goal: 85.0 %)

Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
75.9%	81.9%	82.8%	85.9%	89.8%

Ambulance: Average Notification to Handover Time (mins) — 3.9 mins (goal: 15.0 mins)



Ambulance: Patients Waiting between 30 and 45 minutes — 3

Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
16.0	10.0	7.0	16.0	6.0

Ambulance: Patients Waiting between 45 and 60 minutes — 2

Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
3.0	3.6	0.0	0.0	3.0

Productivity & Efficiency

May 2016

Alder Hey Children's NHS Foundation Trust

Summary

OP utilisation has improved, DNA rates reduced for the 4th consecutive month and continues to be subject to weekly review and intervention. Theatre utilisation has improved for the 4th consecutive month but remains the focus of dedicated intervention as D/C activity has reduced for the 3rd month. Overall activity against the same period last year has increased but noted fluctuations in EL/NEL admissions reflective of a change in case mix. Cancellations on the day have plateaued however within this reductions noted due to no bed availability but offset by list overruns and staff availability.

Length of Stay

Average LoS - Elective (Days) 3.1 ▲

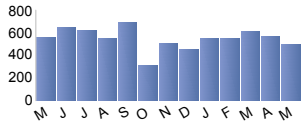
Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
2.7	2.8	3.0	2.9	3.0

Average LoS - Non-Elective (Days) 2.0 ▼

Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
2.7	2.6	2.5	2.4	2.0

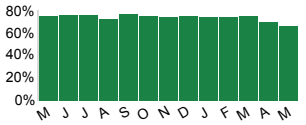
Day Case Rate

Daycases (K1/SDCPREOP) 503 ▼



Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
1,856	1,892	1,300	1,738	1,080

Daycase Rate 66.5 % ▼ *(goal: 0.0 %)*



Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
75.8%	75.6%	75.0%	74.6%	68.3%

Bed Refusals

Bed Refusals 1 ▲ *(goal: 0.0)*

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

Theatres / Surgery

Theatre Utilisation - % of Session Utilised * 81.3 % ▲ *(goal: 85.0 %)*

Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
84.9%		72.7%	77.2%	80.7%

Cancelled Operations - Non Clinical - On Same Day (%) (YTD) 1.7 % ▲ *(goal: 0.8 %)*

Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
0.9%	1.0%	1.3%	1.5%	1.7%

Cancelled Operations - Non Clinical - On Same Day 35 ▬

Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
60	64	70	96	70

28 Day Breaches 11 ▲ *(goal: 0.0)*

Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
8	21	15	16	18

Outpatients

Clinic Session Utilisation * 79.8 % ▲ *(goal: 90.0 %)*

Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
85.0%	81.1%	79.5%	82.5%	79.6%

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

Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
16.4%	14.2%	15.7%	14.9%	14.5%

DNA Rate 9.0 % ▼ *(goal: 12.0 %)*

Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
12.6%	14.5%	12.6%	12.5%	9.3%

OP: New/Follow Up 2.3 ▼

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

Facilities

May 2016

Alder Hey Children's NHS Foundation Trust

Summary

Audit Compliance (85%) April 2016 42/93 45.17% VHR Critical Care (98%) - 97.35% Lower than national standard High Risk General Wards (95%) - 94.83 Lower than national standard Significant Risk - Clinics (85%) none complete Low - Non Cllinical Areas - non scheduled Of 42 audits undertaken 21 areas reached nursing scores of between 100% exceeding the national standard - excellent results. PICU Domestic remain disappointing and requires further monitoring Patient Food Wastage - Ward 0% due to making meals on request.

Facilities

Cleanliness Performance VH

97.4 % (goal: 98.0 %) ▲

Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
94.5%	97.0%	96.3%	96.5%	97.2%

Cleanliness Performance H

94.8 % (goal: 95.0 %) ▼

Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
94.0%	95.0%	97.0%	94.8%	95.6%

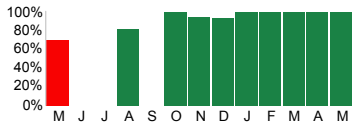
Cleanliness Performance S

100.0 % (goal: 85.0 %) ▲

Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
86.4%	93.4%	95.0%	94.6%	99.2%

Cleanliness Performance L

100.0 % (goal: 75.0 %) –



Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
70.0%	82.0%	96.0%	100.0%	100.0%

Facilities

Patient Food Wastage

0.0 % –

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

Audit Compliance

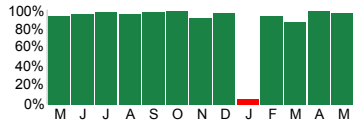
45.2 % (goal: 85.0 %) ▼

Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
100.0%	85.1%	98.8%	98.4%	62.2%

Facilities - Other

Routine Maintenance Resolution

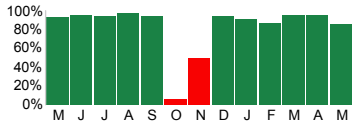
97.3 % (goal: 85.0 %) ▼



Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
96.8%	97.7%	95.6%	67.3%	98.1%

PPM%

86.5 % (goal: 85.0 %) ▼



Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
95.5%	96.3%	30.8%	92.6%	91.9%

Summary

Waiting times from referral to assessment increased slightly during April due to reduced capacity. Action plan and capacity mapping in place to address.

Waiting Times

CAMHS: Avg Wait to Choice Appt (Weeks) 0.0

Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
0.0	0.0	14.2	18.8	0.0

CAMHS: Avg Wait to Partnership Appt (Weeks) 11.3

Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
0.0	0.0	17.4	26.9	25.9

DNA Rates

CAMHS: DNA Rate - New 16.8 % ▲ *(goal: 10.0 %)*

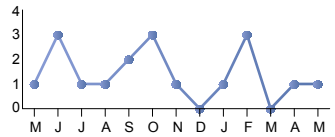
Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
19.3%	23.0%	18.6%	19.9%	15.5%

CAMHS: DNA Rate - Follow Up 15.6 % ▲ *(goal: 14.0 %)*

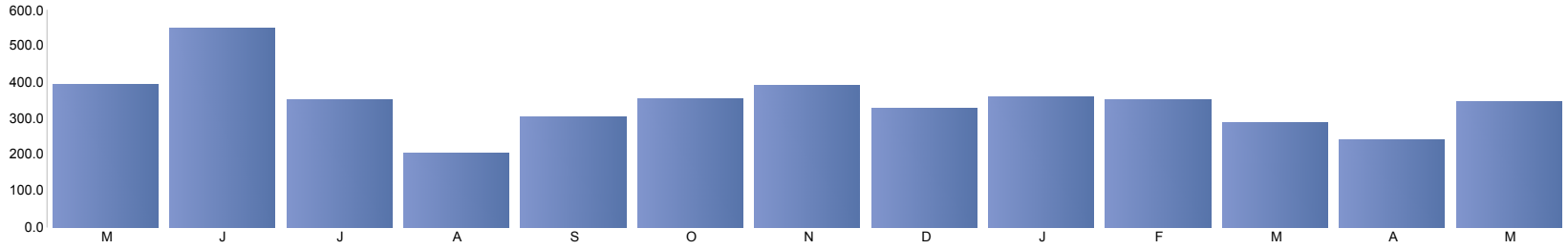
Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
16.9%	17.0%	15.2%	13.9%	14.4%

Tier 4 Admissions

CAMHS: Total Admissions to DJU 1 –



CAMHS: Referrals Received



External Regulation

May 2016

Alder Hey Children's NHS Foundation Trust

Summary

The Trust is currently rated as Good by CQC and remains registered without conditions. We are compliant with our Provider Licence and have recently submitted a Corporate Governance Statement to Monitor/NHSI to confirm this. We currently have a CoSR of 1 althougth this was planned and relates largely to the PFI.

Monitor - Governance Concern

Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16
N	N	N	N	N	N	N	N	N	N	N	N

Monitor - Risk Rating

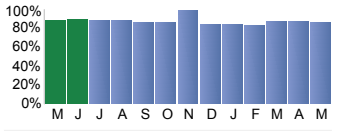
Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16
4	4	2	2	2	2	2	2	2	2	1	2

Monitor May 2016

Metric Name	Goal	Apr 16	May 16	Trend
ED: 95% Treated within 4 Hours	95.0 %	95.7 %	93.6 %	▼
RTT: 90% Admitted within 18 weeks		88.3 %	87.4 %	▼
RTT: 95% Non-Admitted within 18 weeks		89.6 %	87.8 %	▼
RTT: 92% Waiting within 18 weeks (open Pathways)	92.0 %	92.2 %	92.1 %	▼
Monitor Risk Ratings (YTD)	3.0	1	2	▲
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals	100.0 %	100.0 %	100.0 %	–
All Cancers: 31 day wait referral to treament	100.0 %	100.0 %	100.0 %	–
All Cancers: 31 day wait until subsequent treatments	100.0 %	100.0 %	100.0 %	–
Hospital Acquired Organisms - C.difficile	0.0	0	0	–

Monitor - 18 Weeks RTT

RTT: 90% Admitted within 18 weeks



Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
90.3%	89.3%	91.5%	86.0%	87.9%

RTT: 95% Non-Admitted within 18 weeks

Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
95.2%	93.7%	88.3%	85.7%	88.7%

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

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

Monitor - All Cancers

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

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

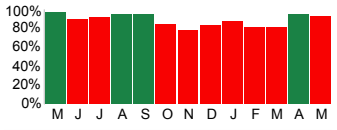
All Cancers: 31 day wait referral to treament

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

All Cancers: 31 day wait until subsequent treatments

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

Monitor - A&E 4 Hour Target



Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
95.5%	95.3%	82.8%	84.5%	94.6%

Monitor - C difficile

Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
0	2	0	0	0

Monitor - Data Completeness

No Data Available

Workforce

May 2016

Alder Hey Children's NHS Foundation Trust

Summary

Sickness absence shows a reduction from last month and - at 4.9% - is now only 0.4% above target. Mandatory training compliance as at 81.8%, although Corporate Induction attendance has increased to 94%. Medical appraisal compliance is at 0% as the new monitoring window has opened. Work continues on improving all KPIs.

Staff Group Analysis

Sickness Absence (rolling 12 Months)

Staff Group	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Last 12 Months
Add Prof Scientific and Technic	3.0%	3.6%	4.0%	3.2%	1.3%	2.7%	2.8%	4.3%	4.1%	4.5%	4.2%	2.0%	2.4%	3.5%	
Additional Clinical Services	8.9%	7.0%	5.3%	5.7%	6.5%	7.0%	7.5%	8.6%	7.6%	6.8%	6.7%	7.4%	6.6%	5.9%	
Administrative and Clerical	3.8%	4.0%	3.6%	3.3%	3.2%	3.3%	3.8%	4.6%	4.7%	4.2%	4.7%	3.9%	4.2%	4.2%	
Allied Health Professionals	1.8%	2.4%	1.6%	1.4%	1.4%	1.4%	1.4%	2.3%	2.4%	3.6%	2.4%	2.7%	2.6%	2.5%	
Estates and Ancillary	5.5%	6.5%	6.8%	5.7%	4.8%	5.6%	5.5%	7.6%	9.8%	9.2%	9.6%	8.1%	8.2%	10.4%	
Healthcare Scientists	5.0%	5.5%	4.4%	2.8%	1.0%	0.9%	1.5%	1.3%	2.0%	2.2%	2.2%	1.6%	2.4%	4.0%	
Medical and Dental	2.4%	2.2%	2.5%	2.1%	1.2%	1.3%	0.8%	1.7%	1.5%	1.8%	1.9%	2.1%	1.5%	1.4%	
Nursing and Midwifery Registered	5.0%	4.8%	5.5%	5.8%	5.2%	6.1%	5.8%	6.8%	6.5%	7.4%	7.6%	7.1%	6.7%	5.4%	
Trust	4.8%	4.6%	4.6%	4.4%	3.9%	4.5%	4.6%	5.6%	5.5%	5.7%	5.8%	5.3%	5.2%	4.9%	

Staff in Post FTE (rolling 12 Months)

Staff Group	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Last 12 Months
Add Prof Scientific and Technic	185	186	187	184	187	193	171	174	174	177	179	180	185	190	
Additional Clinical Services	360	353	354	352	351	359	352	346	348	359	360	360	358	361	
Administrative and Clerical	528	530	533	542	538	534	532	534	531	529	532	525	537	538	
Allied Health Professionals	120	121	124	126	125	126	126	127	127	126	126	127	126	126	
Estates and Ancillary	145	147	148	148	147	153	169	172	173	172	173	172	188	190	
Healthcare Scientists	99	100	98	100	102	102	102	102	100	100	99	100	101	101	
Medical and Dental	232	228	228	229	229	229	229	231	235	237	230	234	236	238	
Nursing and Midwifery Registered	900	907	907	903	898	914	948	947	945	948	952	946	937	939	

Staff in Post Headcount (rolling 12 Months)

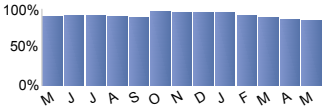
Staff Group	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Last 12 Months
Add Prof Scientific and Technic	209	211	212	207	210	218	192	195	196	197	198	200	205	210	
Additional Clinical Services	416	411	414	411	411	420	414	410	411	422	423	425	423	426	
Administrative and Clerical	616	618	621	633	630	624	622	624	621	618	622	613	626	627	
Allied Health Professionals	148	148	153	155	153	154	155	156	156	155	155	156	155	156	
Estates and Ancillary	185	190	192	194	193	198	212	214	213	211	211	210	237	239	
Healthcare Scientists	109	110	108	110	113	113	113	113	111	111	110	111	111	111	
Medical and Dental	270	267	265	268	268	267	266	268	271	274	269	273	275	277	
Nursing and Midwifery Registered	1,024	1,032	1,032	1,025	1,020	1,039	1,076	1,073	1,070	1,073	1,077	1,070	1,060	1,061	

Finance

Temporary Spend ('000s) 1105 ▲

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

Actual vs Planned Establishment (%) 87.1 % ▼



Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
92.0%	92.0%	97.7%	93.4%	87.7%

Appraisals

Medical Appraisal TBC (goal: 100.0 %)

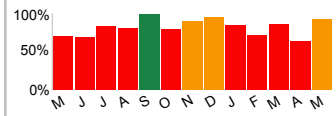
Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
97.1%	97.1%	97.1%	90.5%	96.9%

PDR 11.5 % ▲ (goal: 90.0 %)

Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
45.4%	89.9%	90.1%	90.1%	6.8%

Training

Corporate Induction 94.1 % ▲ (goal: 100.0 %)



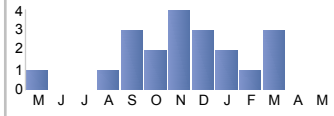
Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
63.8%	87.1%	88.2%	83.5%	83.5%

Mandatory Training 81.8 % ▲ (goal: 90.0 %)

Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
65.5%	75.8%	81.7%	82.8%	81.5%

Health and Safety

RIDDOR 0 –



Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
1	4	9	6	0

Performance by CBU

May 2016

Alder Hey Children's NHS
NHS Foundation Trust

Operational

Metric name	ICS	MED SPECS	NMSS	SCACC
Clinic Session Utilisation	67.2%	80.9%	87.4%	85.3%
Convenience and Choice: Slot Availability	95.7%	96.3%	95.7%	98.9%
DNA Rate (Followup Appts)	13.9%	8.6%	6.3%	6.5%
DNA Rate (New Appts)	12.1%	11.2%	7.1%	9.3%
Normalised I & E surplus/(deficit) In Month ('000s)	321	1,021	1,907	90
Referrals Received (GP)	633	417	813	301
Temporary Spend ('000s)	348	103	171	271
Theatre Utilisation - % of Session Utilised		72.4%	81.4%	83.1%

Patient

Metric name	ICS	MED SPECS	NMSS	SCACC
Average LoS - Elective (Days)	5.5	3.4	2.9	3.2
Average LoS - Non-Elective (Days)	1.8	3.2	2.1	3.6
Cancelled Operations - Non Clinical - On Same Day	0	0	23	12
Daycases (K1/SDCPREOP)	0	50	327	118
Diagnostics: % Completed Within 6 Weeks			100.0%	
Hospital Initiated Clinic Cancellations < 6 weeks notice	1	2	11	0
OP Appointments Cancelled by Hospital %	11.1%	12.6%	14.5%	14.7%
RTT: 90% Admitted within 18 weeks		98.2%	83.8%	89.1%
RTT: 92% Waiting within 18 weeks (open Pathways)	91.5%	96.6%	89.9%	96.1%
RTT: 95% Non-Admitted within 18 weeks	75.1%	91.6%	89.8%	92.9%

Quality

Metric name	ICS	MED SPECS	NMSS	SCACC
Cleanliness Scores	98.0%	99.0%	94.7%	96.6%
Hospital Acquired Organisms - C.difficile	0	0	0	0
Hospital Acquired Organisms - MRSA (BSI)	0	0	0	0
Medication Errors (Incidents)	11	6	2	22

Workforce

Metric name	ICS	MED SPECS	NMSS	SCACC
Corporate Induction	88.9%	66.7%		100.0%
Mandatory Training	75.8%	87.1%	88.6%	87.0%
PDR	7.0%	20.7%	21.1%	13.9%
Sickness	4.6%	5.2%	5.0%	4.9%

CBU Performance - Clinical Support

May 2016

Alder Hey Children's NHS
NHS Foundation Trust

Key Issues

Support Required

Operational

Metric Name	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Last 12 Months
Theatre Utilisation - % of Session Utilised	88.8%	85.1%				57.4%	70.6%	69.1%	62.8%	62.9%	69.1%	70.9%	79.5%	
Temporary Spend ('000s)	66	64	80	-5	66	67	63	48	64	58	52	89	51	
Normalised I & E surplus/(deficit) In Month ('000s)	-1,134	-1,228	-1,176	-1,262	-1,333	-1,068	-1,179	-1,155	-1,253	-1,346	-1,300	-1,273	-1,303	
Expenditure vs Budget ('000s)	0	0	0	0	0	0	0	0	0	0	0	0	0	

Patient

Metric Name	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Last 12 Months
Imaging - % Report Turnaround times GP referrals < 24 hrs	92.0%	95.0%	96.0%	97.0%	86.0%	93.0%	96.0%	97.9%	91.6%	98.0%	95.0%	85.0%	93.0%	
Imaging - % Reporting Turnaround Times - ED	80.0%	60.0%	78.0%	70.0%	76.0%	76.0%	72.0%	100.0%	91.0%	92.0%	91.0%	83.0%	65.0%	
Imaging - % Reporting Turnaround Times - Inpatients	86.0%	79.0%	90.0%	79.0%	86.0%	93.0%	81.0%	83.0%	93.0%	89.0%	83.0%	83.0%	75.0%	
Imaging - % Reporting Turnaround Times - Outpatients	97.0%	96.0%	97.0%	97.0%	96.0%	96.0%	97.0%	98.0%	98.0%	96.0%	97.0%	93.0%	89.0%	
Imaging - Waiting Times - MRI % under 6 weeks	99.0%	96.6%	97.7%	92.5%	100.0%	100.0%	95.0%	96.0%	85.0%	91.0%	90.0%	90.0%	92.0%	
Imaging - Waiting Times - CT % under 1 week	86.6%	85.0%	89.9%	85.6%	87.9%	87.9%	88.0%	96.0%	88.0%	88.0%	86.0%	94.0%	88.0%	
Imaging - Waiting Times - Plain Film % under 24 hours	94.2%	95.0%	91.7%	91.8%	95.4%	96.1%	95.0%	94.0%	95.0%	95.0%	95.0%	95.0%	95.0%	
Imaging - Waiting Times - Ultrasound % under 2 weeks	98.8%	97.8%	99.2%	99.0%	99.6%	99.6%	92.0%	85.0%	85.0%	85.0%	91.0%	92.0%	89.0%	
Imaging - Waiting Times - Nuclear Medicine % under 2 weeks	100.0%	100.0%	88.9%	81.2%	100.0%	100.0%	88.0%	91.0%	86.0%	95.0%	76.0%	96.0%	100.0%	
BME - High Risk Equipment PPM Compliance	89.0%	89.5%	88.0%	90.5%	88.0%	87.0%	89.0%	87.0%	89.0%	90.0%	88.0%	89.0%	90.0%	
BME - Low Risk Equipment PPM Compliance	75.0%	76.0%	74.0%	79.0%	87.0%	75.0%	76.0%	78.0%	78.0%	78.0%	78.0%	80.0%	80.0%	
BME - Equipment Pool - Equipment Availability	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%	
Pharmacy - Dispensing for Out Patients - Routine	55.0%	49.0%	34.0%	50.0%	57.0%	63.0%	59.0%	87.0%	84.0%	85.0%	76.0%	74.0%	64.0%	
Pharmacy - Dispensing for Out Patients - Complex	79.0%	73.0%	67.0%	57.0%	65.0%		100.0%	100.0%	100.0%	100.0%	97.0%	100.0%	100.0%	
Comm Therapy - % 1st Contact times following Pt opt in < 12 weeks	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	

Quality

Metric Name	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Last 12 Months
Medication Errors (Incidents)	0	0	0	0	0	0	0	0	0	0	0	0	0	
Hospital Acquired Organisms - MRSA (BSI)	0	0	0	0	0	0	0	0	0	0	0	0	0	
Hospital Acquired Organisms - C.difficile	0	0	0	0	0	0	0	0	0	0	0	0	0	
Pathology - % Turnaround times for urgent requests < 1 hr	88.9%	82.3%	76.4%	82.0%	78.2%	71.9%	75.1%	79.6%	79.2%	82.9%	87.0%	84.3%	86.6%	
Pathology - % Turnaround times for non-urgent requests < 24hrs	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.8%	98.5%	95.1%	98.0%	99.0%	98.7%	99.3%	
Reporting times for perinatal autopsies in 56 Calendar Days	98.8%	73.0%	92.9%	98.6%	98.7%	90.9%	100.0%	81.0%	68.8%	81.0%	88.9%	84.6%	90.0%	

Workforce

Metric Name	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Last 12 Months
Corporate Induction	90.0%	75.0%	100.0%	40.0%	100.0%	77.8%	100.0%	87.5%	71.4%	0.0%	75.0%	50.0%	100.0%	
PDR	44.9%	91.4%	91.4%	91.4%	91.4%	91.4%	91.4%	91.4%	91.4%	91.4%	91.4%	0.8%	12.7%	
Sickness	4.0%	2.9%	1.7%	1.8%	2.4%	3.2%	3.7%	4.4%	5.1%	5.1%	4.2%	4.8%	4.8%	
Mandatory Training	66.1%	77.4%	79.1%	80.5%	84.2%	80.3%	87.2%	87.2%	86.8%	86.2%	86.5%	85.6%	85.9%	

CBU Performance - ICS

May 2016

Alder Hey Children's NHS
NHS Foundation Trust

Key Issues

DNA rates above predications remain an issue, all patients are being called 72 hours before their appointment to confirm attendances.

ICS NEL Avg LOS currently still excludes less than 4 hour hospital stays in EDU, work is underway to remove this exclusion at CBU level with this activity now included in inpatient data. This will reflect a significant decrease in LOS once applied from April 2016.

Support Required

N/A

Operational

Metric Name	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Last 12 Months
Theatre Utilisation - % of Session Utilised														
Clinic Session Utilisation	75.9%	74.6%	81.5%	74.2%	73.3%	70.9%	75.4%	73.6%	75.4%	69.2%	75.7%	62.7%	67.2%	
DNA Rate (New Appts)	17.7%	24.2%	21.2%	20.4%	17.6%	19.6%	14.8%	17.5%	16.2%	18.7%	16.7%	14.0%	12.1%	
DNA Rate (Followup Appts)	14.3%	19.7%	16.7%	14.6%	14.9%	14.2%	13.2%	14.8%	13.7%	14.9%	14.5%	12.6%	13.9%	
Convenience and Choice: Slot Availability	100.0%						100.0%	100.0%	100.0%	98.8%	87.2%	85.3%	95.7%	
Referrals Received (GP)	621	717	639	470	648	649	658	555	618	670	643	592	633	
Temporary Spend ('000s)	197	269	186	178	203	260	232	247	204	272	297	185	348	
Normalised I & E surplus/(deficit) In Month ('000s)	608	686	334	454	534	530	692	446	651	728	401	402	321	

Patient

Metric Name	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Last 12 Months
RTT: 90% Admitted within 18 weeks										100.0%				
RTT: 95% Non-Admitted within 18 weeks	90.4%	95.4%	97.2%	98.5%	90.6%	92.3%	87.8%	86.7%	84.4%	86.3%	84.6%	84.7%	75.1%	
RTT: 92% Waiting within 18 weeks (open Pathways)	90.9%	92.0%	92.2%	94.0%	93.3%	93.8%	91.1%	92.3%	91.8%	91.4%	92.4%	91.9%	91.4%	
Average LoS - Elective (Days)	2.40	3.00	4.00	3.75	3.50	8.00	3.80	4.50	6.00	1.00	1.00	1.33	5.50	
Average LoS - Non-Elective (Days)	2.26	2.20	2.21	1.97	1.90	2.00	2.05	2.19	1.97	1.77	1.85	1.65	1.82	
Hospital Initiated Clinic Cancellations < 6 weeks notice	5	12	4	2	18	46	33	1	3	0	6	1	1	
Daycases (K1/SDCPREOP)	0	0	0	0	1	0	0	0	0	0	1	1	0	
Cancelled Operations - Non Clinical - On Same Day	0	0	0	0	0	0	0	0	0	0	0	0	0	
OP Appointments Cancelled by Hospital %	11.0%	18.0%	13.9%	13.5%	11.4%	14.6%	13.7%	14.8%	11.9%	12.1%	13.2%	14.8%	11.1%	
Diagnostics: % Completed Within 6 Weeks		100.0%							100.0%	100.0%	100.0%	100.0%		

Quality

Metric Name	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Last 12 Months
Medication Errors (Incidents)	4	5	5	8	12	15	23	25	26	30	34	7	11	
Cleanliness Scores		97.3%		98.5%			99.0%	99.0%	95.0%	98.0%	95.0%	98.0%	98.0%	
Hospital Acquired Organisms - MRSA (BSI)	0	0	0	0	0	0	0	0	0	0	0	0	0	
Hospital Acquired Organisms - C.difficile	0	0	0	0	0	0	0	0	0	0	0	0	0	

Workforce

Metric Name	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Last 12 Months
Corporate Induction	85.7%	100.0%	66.7%	100.0%	100.0%	81.8%	100.0%	100.0%	93.8%	75.0%	50.0%	60.0%	88.9%	
PDR	19.8%	92.2%	92.2%	92.2%	92.2%	92.2%	92.2%	92.2%	92.2%	92.2%	92.2%	0.9%	7.0%	
Sickness	4.3%	4.2%	4.1%	3.2%	4.7%	5.3%	6.4%	4.8%	4.4%	5.1%	5.0%	4.6%	4.6%	
Mandatory Training	62.9%	71.9%	59.4%	74.4%	75.8%	76.2%	79.1%	76.6%	77.3%	76.8%	75.0%	75.0%	75.8%	

CBU Performance - Medical Specialties

May 2016

Alder Hey Children's NHS
NHS Foundation Trust

Key Issues

Support Required

Operational

Metric Name	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Last 12 Months
Theatre Utilisation - % of Session Utilised	83.9%	82.0%				59.3%	75.3%	72.3%	72.0%	75.6%	75.5%	76.3%	72.4%	
Clinic Session Utilisation	90.9%	75.5%	78.1%	76.0%	78.5%	76.9%	79.9%	77.1%	81.1%	79.8%	83.1%	81.0%	80.9%	
DNA Rate (New Appts)	11.7%	13.5%	15.7%	16.0%	12.3%	11.5%	13.1%	13.0%	11.9%	11.7%	11.9%	9.6%	11.2%	
DNA Rate (Followup Appts)	10.8%	10.8%	17.2%	16.4%	14.3%	16.6%	12.8%	15.5%	13.6%	14.5%	11.9%	7.8%	8.6%	
Convenience and Choice: Slot Availability	100.0%						100.0%	100.0%	93.7%	89.2%	86.2%	95.5%	96.3%	
Referrals Received (GP)	358	366	397	261	348	329	321	308	350	388	382	368	417	
Temporary Spend ('000s)	86	66	77	66	100	74	82	63	58	60	55	80	103	
Normalised I & E surplus/(deficit) In Month ('000s)	716	894	1,237	915	572	722	1,180	1,117	1,080	982	1,157	719	1,021	

Patient

Metric Name	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Last 12 Months
RTT: 90% Admitted within 18 weeks	100.0%	100.0%	100.0%	100.0%	100.0%	98.4%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.2%	
RTT: 95% Non-Admitted within 18 weeks	96.8%	94.3%	92.3%	88.6%	93.6%	90.5%	90.1%	83.9%	85.0%	89.2%	86.2%	91.7%	91.6%	
RTT: 92% Waiting within 18 weeks (open Pathways)	94.2%	94.9%	96.9%	95.4%	95.6%	94.0%	95.9%	95.7%	96.4%	96.8%	97.7%	97.0%	96.6%	
Average LoS - Elective (Days)	2.41	3.70	3.64	3.38	3.00	3.20	3.85	3.53	4.78	2.95	3.51	3.30	3.41	
Average LoS - Non-Elective (Days)	3.74	3.00	4.22	2.85	2.71	3.16	2.22	2.44	2.01	2.35	4.03	2.99	3.17	
Hospital Initiated Clinic Cancellations < 6 weeks notice	2	2	13	13	16	22	8	3	0	3	6	4	2	
Daycases (K1/SDCPREOP)	69	78	60	54	74	31	71	73	74	76	71	76	50	
Cancelled Operations - Non Clinical - On Same Day	1	0	0	0	1	2	2	1	2	2	3	1	0	
OP Appointments Cancelled by Hospital %	13.7%	18.2%	13.0%	12.3%	12.3%	16.1%	12.0%	12.7%	10.5%	12.6%	12.8%	14.7%	12.6%	
Diagnostics: % Completed Within 6 Weeks	100.0%	66.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		

Quality

Metric Name	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Last 12 Months
Medication Errors (Incidents)	4	7	8	9	11	13	17	20	22	25	27	1	6	
Cleanliness Scores	94.8%	93.2%	96.4%	96.0%	97.0%		95.5%	96.5%	94.5%	98.0%	98.0%	99.0%	99.0%	
Hospital Acquired Organisms - MRSA (BSI)	0	0	0	0	0	0	0	0	0	0	0	0	0	
Hospital Acquired Organisms - C.difficile	0	0	1	0	0	0	0	0	0	0	0	0	0	

Workforce

Metric Name	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Last 12 Months
Corporate Induction	100.0%	0.0%		50.0%		100.0%	66.7%	100.0%	66.7%	100.0%	100.0%	100.0%	66.7%	
PDR	62.2%	92.2%	92.2%	92.2%	92.2%	92.2%	92.2%	92.2%	92.2%	92.2%	92.2%	3.6%	20.7%	
Sickness	4.4%	5.2%	6.2%	5.6%	5.4%	3.5%	5.1%	5.0%	6.9%	7.5%	6.7%	6.6%	5.2%	
Mandatory Training	66.0%	76.2%	81.1%	80.4%	85.8%	81.3%	86.9%	87.2%	87.3%	85.5%	84.8%	85.4%	87.1%	

CBU Performance - NMSS

May 2016

Alder Hey Children's NHS
NHS Foundation Trust

Key Issues

Achievement of income remains a significant challenge to the CBU. Work is ongoing to improve both clinic and theatre utilisation to support increases in activity. In addition, there are specific actions in place for ENT and plastic surgery. Improvements have been seen in PDR compliance and mandatory training rates within the CBU. Sickness absence rates also continue to fall although remain above the Trust target level. Cancelled operations on the day were 23 in May.

Support Required

In order to improve levels of activity across the CBU, collaborative work with theatres is required to ensure effective utilisation of all available theatre lists and reductions in cancellations. Clinical engagement across the CBU is required to ensure that teams bot own and understand the requirements and help to develop innovative ideas to address the challenge. Improvements are required in the process which underpin outpatients.

Operational

Metric Name	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Last 12 Months
Theatre Utilisation - % of Session Utilised	83.4%	86.3%				72.6%	75.5%	68.7%	74.7%	78.0%	79.9%	81.0%	81.4%	
Clinic Session Utilisation	89.7%	80.2%	87.9%	80.5%	82.6%	74.6%	82.7%	81.4%	86.3%	83.7%	85.5%	88.0%	87.4%	
DNA Rate (New Appts)	11.1%	12.6%	15.6%	14.9%	12.2%	10.8%	12.5%	12.5%	11.4%	10.4%	10.3%	9.1%	7.1%	
DNA Rate (Followup Appts)	10.4%	11.2%	13.2%	12.8%	12.4%	10.4%	9.4%	10.5%	9.8%	11.4%	11.9%	9.0%	6.3%	
Convenience and Choice: Slot Availability	100.0%						99.3%	99.6%	96.1%	97.5%	98.5%	97.0%	95.7%	
Referrals Received (GP)	815	767	873	708	798	826	816	652	738	841	867	862	813	
Temporary Spend ('000s)	114	200	187	154	147	134	121	132	123	134	224	156	171	
Normalised I & E surplus/(deficit) In Month ('000s)	1,777	1,496	1,779	1,295	1,736	1,498	1,283	1,330	1,803	1,646	1,474	1,707	1,907	

Patient

Metric Name	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Last 12 Months
RTT: 90% Admitted within 18 weeks	88.4%	87.9%	87.0%	86.0%	81.5%	83.0%	100.0%	80.4%	79.7%	75.9%	86.5%	86.7%	83.8%	
RTT: 95% Non-Admitted within 18 weeks	95.9%	94.9%	95.5%	94.3%	92.6%	92.8%	84.7%	86.0%	87.3%	80.2%	84.2%	89.1%	89.8%	
RTT: 92% Waiting within 18 weeks (open Pathways)	90.3%	89.8%	89.8%	89.6%	89.6%	89.9%	90.0%	90.0%	89.8%	90.5%	89.8%	89.5%	89.9%	
Average LoS - Elective (Days)	1.71	2.33	2.16	1.71	2.55	2.09	2.20	2.56	2.03	2.40	2.72	2.54	2.91	
Average LoS - Non-Elective (Days)	2.51	1.89	2.10	2.05	1.87	1.78	2.45	2.88	1.73	2.11	2.96	2.64	2.05	
Hospital Initiated Clinic Cancellations < 6 weeks notice	20	36	19	3	51	9	49	39	39	64	24	29	11	
Daycases (K1/SDCPREOP)	358	372	351	381	416	234	317	284	357	371	360	330	327	
Cancelled Operations - Non Clinical - On Same Day	17	13	22	8	11	7	29	3	11	9	10	15	23	
OP Appointments Cancelled by Hospital %	13.7%	21.1%	16.4%	14.7%	14.6%	18.8%	14.8%	18.2%	19.4%	18.3%	18.4%	17.7%	14.5%	
Diagnostics: % Completed Within 6 Weeks	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	

Quality

Metric Name	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Last 12 Months
Medication Errors (Incidents)	6	6	6	9	11	12	14	15	19	22	30	0	2	
Cleanliness Scores	98.0%	94.2%	94.0%	94.5%	98.3%		98.7%	98.0%	96.3%	91.0%	95.0%	96.3%	94.7%	
Hospital Acquired Organisms - MRSA (BSI)	0	0	0	0	0	0	0	0	0	0	0	0	0	
Hospital Acquired Organisms - C.difficile	0	0	0	0	0	0	0	0	0	0	0	0	0	

Workforce

Metric Name	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Last 12 Months
Corporate Induction	77.8%	0.0%	0.0%	75.0%		88.9%	100.0%	100.0%	100.0%	100.0%	100.0%	66.7%		
PDR	49.3%	79.7%	79.7%	80.7%	80.7%	80.7%	80.7%	80.7%	80.7%	80.7%	80.7%	10.1%	21.1%	
Sickness	4.2%	5.7%	5.3%	4.4%	3.6%	4.4%	4.6%	5.6%	5.4%	4.1%	5.2%	5.0%	5.0%	
Mandatory Training	68.4%	76.1%	78.4%	80.7%	82.2%	79.7%	86.8%	86.9%	87.8%	84.1%	84.3%	85.3%	88.6%	

CBU Performance - SCACC

May 2016

Alder Hey Children's NHS Foundation Trust

Key Issues

Theatre session utilisation: theatre dashboard now finalised. Circulated to all SGLs and service managers. Each specialty requested to make two productivity improvements in June and July. Clinic session utilisation: audit has found DNC and DNA lists not provided to clinicians. New process to provide this information will be actioned in June. Financial performance: recovery plan developed . Controls for HCA expenditure on wards introduced. Individual funding request for burns patient submitted in response to £150k non-pay cost pressure.

Support Required

Operational

Metric Name	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Last 12 Months
Theatre Utilisation - % of Session Utilised	86.6%	86.8%				76.0%	78.5%	75.8%	79.4%	80.4%	84.0%	82.8%	83.1%	
Clinic Session Utilisation	111.4%	105.8%	86.4%	84.5%	81.5%	81.8%	88.5%	88.4%	88.5%	90.1%	82.2%	84.3%	85.3%	
DNA Rate (New Appts)	12.9%	12.1%	12.6%	9.6%	10.3%	13.9%	9.7%	10.3%	9.7%	10.4%	12.7%	7.2%	9.3%	
DNA Rate (Followup Appts)	12.5%	12.5%	12.4%	12.4%	11.9%	11.6%	9.6%	7.2%	9.8%	10.1%	12.1%	8.0%	6.5%	
Convenience and Choice: Slot Availability	100.0%						100.0%	97.9%	98.4%	84.8%	88.8%	98.1%	98.9%	
Referrals Received (GP)	282	280	369	251	292	352	336	262	300	340	325	331	301	
Temporary Spend ('000s)	361	322	345	227	250	268	218	222	237	221	319	274	271	
Normalised I & E surplus/(deficit) In Month ('000s)	-70	-211	-133	-449	457	-267	-119	253	-179	-156	1,351	-391	90	

Patient

Metric Name	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Last 12 Months
RTT: 90% Admitted within 18 weeks	94.1%	96.4%	94.8%	91.6%	95.9%	91.5%	100.0%	86.1%	94.5%	96.6%	89.0%	88.8%	89.1%	
RTT: 95% Non-Admitted within 18 weeks	97.2%	97.0%	95.1%	87.7%	95.5%	83.8%	94.7%	88.4%	90.1%	92.2%	91.1%	93.1%	92.9%	
RTT: 92% Waiting within 18 weeks (open Pathways)	98.0%	97.2%	96.0%	96.1%	96.8%	97.3%	97.3%	96.6%	96.1%	96.0%	95.7%	96.6%	96.1%	
Average LoS - Elective (Days)	4.43	2.93	3.73	2.55	4.30	3.38	3.22	2.94	3.38	3.27	3.23	3.03	3.18	
Average LoS - Non-Elective (Days)	4.01	3.88	3.88	4.03	4.55	2.97	3.78	3.60	3.21	4.86	3.29	3.31	3.64	
Hospital Initiated Clinic Cancellations < 6 weeks notice	0	3	0	5	4	1	3	1	0	1	1	1	0	
Daycases (K1/SDCPREOP)	110	169	190	105	183	56	118	104	118	112	174	165	118	
Cancelled Operations - Non Clinical - On Same Day	7	10	4	13	4	9	9	7	8	15	11	16	12	
OP Appointments Cancelled by Hospital %	19.3%	25.5%	15.6%	17.7%	15.8%	22.3%	16.8%	19.1%	15.0%	12.5%	13.6%	13.6%	14.7%	
Diagnostics: % Completed Within 6 Weeks	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		

Quality

Metric Name	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Last 12 Months
Medication Errors (Incidents)	11	20	28	32	41	48	57	70	77	89	100	16	22	
Cleanliness Scores	93.5%	96.0%	95.2%	95.9%	96.5%		97.4%	92.2%	95.0%	94.6%	97.0%	96.4%	96.6%	
Hospital Acquired Organisms - MRSA (BSI)	0	1	0	1	0	0	0	0	0	0	0	0	0	
Hospital Acquired Organisms - C.difficile	0	0	1	0	0	0	0	0	0	0	0	0	0	

Workforce

Metric Name	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Last 12 Months
Corporate Induction	44.4%	70.0%	80.0%	100.0%	100.0%	88.9%	75.0%	100.0%	92.3%	25.0%	100.0%	50.0%	100.0%	
PDR	17.6%	89.1%	89.1%	91.2%	91.2%	91.2%	91.2%	91.2%	91.2%	91.2%	91.2%	3.5%	13.9%	
Sickness	6.3%	6.2%	6.5%	5.7%	6.9%	6.5%	7.5%	6.9%	7.0%	7.0%	6.6%	5.7%	4.9%	
Mandatory Training	61.9%	73.6%	77.3%	83.1%	85.2%	81.3%	89.1%	88.3%	85.8%	87.5%	87.1%	86.9%	87.0%	

3. Financial Strength

3.1 Trust Income & Expenditure Report period ended May 2016

	In Month			Year to Date			Full Year		
	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Forecast	Variance
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Clinical Income									
Elective	3,691	3,380	(311)	7,166	6,540	(626)	42,982	42,982	0
Non Elective	2,279	2,556	276	4,541	4,467	(74)	26,512	26,512	0
Outpatients	2,396	2,312	(84)	4,668	4,372	(296)	28,190	28,190	0
A&E	451	427	(24)	887	804	(83)	5,310	5,310	0
Critical Care	1,965	2,002	36	3,868	4,014	146	23,739	23,739	0
Non PbR Drugs & Devices	1,558	1,508	(50)	3,112	3,092	(19)	18,665	18,665	0
Excess Bed Days	405	311	(94)	796	639	(157)	4,765	4,765	0
CQUIN	245	245	(0)	490	490	(0)	2,942	2,942	0
Contract Sanctions	0	(20)	(20)	0	(20)	(20)	0	0	0
Private Patients	15	21	7	29	22	(8)	176	176	0
Other Clinical Income	2,265	2,884	619	4,531	5,776	1,245	24,262	24,262	0
Non Clinical Income									
Other Non Clinical Income	1,652	1,403	(249)	3,282	2,867	(415)	31,222	31,222	0
Total Income	**16,923**	**17,028**	**105**	**33,371**	**33,063**	**(308)**	**208,765**	**208,765**	**0**
Expenditure									
Pay Costs	(11,473)	(11,732)	(258)	(22,972)	(23,342)	(370)	(135,887)	(135,887)	0
Drugs	(1,407)	(1,481)	(74)	(2,768)	(3,116)	(348)	(16,570)	(16,570)	0
Clinical Supplies	(1,412)	(1,456)	(44)	(2,787)	(2,887)	(100)	(16,722)	(16,722)	0
Other Non Pay	(2,467)	(2,237)	229	(4,921)	(4,028)	893	(25,874)	(25,874)	0
PFI service costs	(299)	(81)	218	(589)	(574)	15	(3,526)	(3,526)	0
Total Expenditure	**(17,058)**	**(16,987)**	**71**	**(34,038)**	**(33,947)**	**90**	**(198,578)**	**(198,578)**	**0**
EBITDA	**(136)**	**41**	**177**	**(667)**	**(885)**	**(218)**	**10,186**	**10,186**	**0**
PDC Dividend	(97)	(97)	0	(194)	(194)	0	(1,161)	(1,161)	0
Depreciation	(683)	(668)	15	(1,366)	(1,337)	29	(8,323)	(8,323)	0
Finance Income	1	4	2	3	8	5	15	15	0
Interest Expense (non-PFI/LIFT)	(83)	(82)	0	(162)	(162)	0	(1,042)	(1,042)	0
Interest Expense (PFI/LIFT)	(666)	(687)	(21)	(1,333)	(1,375)	(42)	(7,995)	(7,995)	0
Trading Surplus / (Deficit)	**(1,663)**	**(1,490)**	**173**	**(3,719)**	**(3,945)**	**(226)**	**(8,320)**	**(8,320)**	**0**
One-off normalising items									
Government Grants/Donated Income	14	12	(2)	28	18	(10)	2,352	2,352	0
Normalised Surplus/(Deficit)	**(1,649)**	**(1,478)**	**171**	**(3,691)**	**(3,927)**	**(235)**	**(5,968)**	**(5,968)**	**0**
MASS/Restructuring	0	0	0	0	0	0	0	0	0
Fixed Asset Impairment	0	0	0	0	0	0	(1,920)	(2,618)	(698)
Gains/(Losses) on asset disposals	0	418	418	0	418	418	0	418	418
Reported Surplus/(Deficit)	**(1,649)**	**(1,060)**	**589**	**(3,691)**	**(3,509)**	**183**	**(7,888)**	**(8,168)**	**(280)**

Key Metrics	In Month			Year to date			Full Year		
	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Forecast	Variance
Income £000	16,923	17,028	105	33,371	33,063	(308)	208,765	208,765	0
Expenditure £000	(18,586)	(18,518)	68	(37,090)	(37,007)	82	(217,085)	(217,085)	0
Trading Surplus/(Deficit) £000	(1,663)	(1,490)	173	(3,719)	(3,945)	(226)	(8,320)	(8,320)	0
WTE	2,970	2,930	40	2,970	2,930	40			
CIP £000	281	174	(107)	555	248	(307)	7,200	4,739	(2,461)
Cash £000	7,249	7,908	659	7,249	7,908	659			
CAPEX FCT £000	262	193	70	574	506	69	10,167	10,968	(801)
Risk Rating	2	2	0	2	2	0	2	2	0

Activity Volumes	In Month			Year to date			Full Year		
	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Forecast	Variance
Elective	2,305	1,888	(417)	4,474	3,890	(584)	26,950	26,950	0
Non Elective	1,366	1,332	(34)	2,693	2,496	(197)	16,071	16,071	0
Outpatients	17,014	16,032	(982)	33,091	31,066	(2,025)	199,463	199,463	0
A&E	4,746	5,186	440	9,341	9,744	403	55,899	55,899	0

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

	Prior Year Expenditure	IN MONTH BUDGET	IN MONTH ACTUAL	IN MONTH VARIANCE	YEAR TO DATE BUDGET	YEAR TO DATE ACTUAL	YEAR TO DATE VARIANCE	FULL YEAR BUDGET	FULL YEAR FORECAST	FULL YEAR VARIANCE
	£000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
ESTATES	*1,506*	8	35	(27)	17	241	(224)	2,270	2,968	(698)
RESEARCH & EDUCATION	*4,697*	0	74	(74)	0	74	(74)	0	75	(75)
ESTATES TOTAL CAPITAL	*6,203*	8	109	(101)	17	314	(298)	2,270	3,043	(698)
NETWORKING, INFRASTRUCTURE & OTHER IT	*3,072*	31	2	29	63	16	46	440	440	0
ELECTRONIC PATIENT RECORD	*6,172*	58	20	38	117	58	59	700	720	(20)
IM & T TOTAL CAPITAL	*9,244*	90	22	68	179	74	105	1,140	1,160	(20)
MEDICAL EQUIPMENT		24	()	24	48	6	42	2,761	2,769	(8)
CHILDRENS HEALTH PARK		100	52	48	250	64	186	3,514	3,514	0
ALDER HEY IN THE PARK TOTAL	*17,320*	124	54	71	298	72	226	6,275	6,283	(8)
OTHER		40	8	32	80	45	35	482	482	(0)
OTHER	*802*	40	8	32	80	45	35	482	482	(0)
CAPITAL PROGRAMME 16/17	*33,569*	*262*	*193*	*70*	*574*	*506*	*69*	*10,167*	*10,968*	*(801)*

In-Month

CBU	Specialty	POD	Activity Plan	Activity Actual	Activity Variance	Price Plan	Price Actual	Price Variance	Price Variance (Casemix)	Price Variance (Volume)
ICS CBU	Accident & Emergency	Daycases	0	0	0	£151	£0	-£151	£0	-£151
		Elective	0	0	0	£166	£0	-£166	£0	-£166
		Non-elective	493	427	-66	£226,461	£280,396	£53,935	-£84,318	£138,253
		Excess Bed Days	7	0	-7	£2,394	£0	-£2,394	£0	-£2,394
		Outpatient New	216	174	-42	£72,885	£58,749	-£14,136	-£108	-£14,028
		Outpatient Follow-up	23	12	-11	£7,686	£4,052	-£3,634	£0	-£3,634
		Ward Attender	1	0	-1	£173	£0	-£173	£0	-£173
		A&E Attendance	4,746	5,186	440	£450,845	£425,298	-£25,547	£67,363	-£92,910
	Accident & Emergency Total		**5,486**	**5,799**	**313**	**£760,761**	**£768,495**	**£7,734**	**-£17,063**	**£24,797**
	CAMHS	Elective	0	0	0	£249	£0	-£249	£0	-£249
		Outpatient New	201	246	45	£0	£0	£0	£0	£0
		Outpatient Follow-up	1,002	1,363	361	£13,991	£5,872	-£8,119	£13,153	-£21,272
	CAMHS Total		**1,204**	**1,609**	**405**	**£14,240**	**£5,872**	**-£8,368**	**£13,153**	**-£21,521**
	Community Medicine	Outpatient New	381	264	-117	£30,802	£12,811	-£17,991	£8,507	-£26,498
		Outpatient Follow-up	750	503	-247	£4,581	£3,157	-£1,424	-£86	-£1,338
		OP Procedure	0	0	0	£15	£0	-£15	£0	-£15
		Ward Based Outpatient	1	0	-1	£0	£0	£0	£0	£0
	Community Medicine Total		**1,133**	**767**	**-366**	**£35,397**	**£15,968**	**-£19,430**	**£8,421**	**-£27,850**
	Diabetes	Outpatient New	31	7	-24	£6,585	£1,478	-£5,107	£10	-£5,117
		Outpatient Follow-up	3	22	19	£297	£2,173	£1,876	£224	£1,652
		Ward Based Outpatient	0	0	0	£42	£0	-£42	£0	-£42
	Diabetes Total		**34**	**29**	**-5**	**£6,924**	**£3,651**	**-£3,273**	**£234**	**-£3,506**
	Paediatrics	Daycases	33	4	-29	£27,263	£3,888	-£23,376	-£544	-£22,832
		Elective	14	4	-10	£15,325	£9,257	-£6,068	-£4,774	-£1,295
		Non-elective	282	310	28	£320,226	£406,005	£85,779	-£54,501	£140,280
		Excess Bed Days	68	152	84	£25,131	£52,505	£27,374	£3,969	£23,406
		Outpatient New	321	315	-6	£74,010	£72,718	-£1,292	-£181	-£1,112
		Outpatient Follow-up	440	467	27	£62,151	£65,558	£3,408	£343	£3,064
		OP Procedure	0	0	0	£32	£0	-£32	£0	-£32
		Ward Based Outpatient	169	70	-99	£23,877	£9,827	-£14,049	£51	-£14,100
		Ward Attender	19	7	-12	£2,617	£983	-£1,634	£5	-£1,639
	Paediatrics Total		**1,346**	**1,329**	**-17**	**£550,632**	**£620,741**	**£70,109**	**-£55,631**	**£125,740**
ICS CBU Total			**9,202**	**9,533**	**331**	**£1,367,953**	**£1,414,727**	**£46,773**	**-£50,886**	**£97,659**
Medical Specialties CBU	Allergy	Daycases	0	21	21	£0	£9,412	£9,412	£0	£9,412
		Elective	0	1	1	£0	£695	£695	£0	£695
		Outpatient New	65	68	3	£14,990	£15,698	£709	-£40	£749
		Outpatient Follow-up	73	87	14	£10,292	£12,258	£1,965	£20	£1,946
		OP Procedure	0	0	0	£49	£0	-£49	£0	-£49
		Ward Based Outpatient	0	0	0	£31	£0	-£31	£0	-£31
		Ward Attender	0	0	0	£47	£0	-£47	£0	-£47
	Allergy Total		**139**	**177**	**38**	**£25,408**	**£38,062**	**£12,654**	**-£20**	**£12,674**
	Dermatology	Daycases	2	0	-2	£1,243	£0	-£1,243	£0	-£1,243
		Outpatient New	174	175	1	£23,515	£23,657	£142	£26	£116
		Outpatient Follow-up	570	581	11	£56,154	£56,791	£637	£460	£177
		OP Procedure	93	87	-6	£10,644	£10,015	-£630	-£13	-£616
		Ward Based Outpatient	8	8	0	£819	£782	-£37	£6	-£43
		Ward Attender	1	0	-1	£63	£0	-£63	£0	-£63
	Dermatology Total		**847**	**851**	**4**	**£92,438**	**£91,245**	**-£1,193**	**£480**	**-£1,673**
	Endocrinology	Daycases	96	91	-5	£100,184	£100,851	£667	-£5,897	£6,564
		Elective	8	4	-4	£11,116	£6,150	-£4,966	-£425	-£4,540
		Non-elective	3	4	1	£4,010	£22,059	£18,050	-£15,741	£33,791
		Excess Bed Days	14	32	18	£5,166	£13,680	£8,514	-£1,886	£10,400
		Outpatient New	68	64	-4	£27,207	£25,622	-£1,585	£67	-£1,652
		Outpatient Follow-up	378	290	-88	£73,152	£57,473	-£15,679	-£1,389	-£14,289
		Ward Based Outpatient	34	118	84	£6,628	£22,824	£16,195	-£3	£16,198
		Ward Attender	17	20	3	£3,289	£3,868	£579	-£1	£580
	Endocrinology Total		**618**	**623**	**5**	**£230,752**	**£252,528**	**£21,776**	**-£25,275**	**£47,051**
	Gastroenterology	Daycases	135	111	-24	£148,157	£124,898	-£23,259	-£3,038	-£20,221
		Elective	43	22	-21	£81,626	£41,647	-£39,979	£504	-£40,483
		Non-elective	11	8	-3	£29,593	£24,121	-£5,471	-£3,004	-£2,467
		Excess Bed Days	187	148	-39	£73,993	£63,825	-£10,168	-£5,347	-£4,821
		Outpatient New	106	73	-33	£28,202	£19,509	-£8,693	-£146	-£8,547
		Outpatient Follow-up	285	194	-91	£45,331	£30,260	-£15,071	£559	-£15,630
		Ward Based Outpatient	217	71	-146	£34,386	£11,075	-£23,311	£168	-£23,479
		Ward Attender	6	16	10	£992	£2,496	£1,504	£38	£1,466
	Gastroenterology Total		**991**	**643**	**-348**	**£442,281**	**£317,832**	**-£124,449**	**-£10,267**	**-£114,183**
	Haematology	Daycases	25	13	-12	£29,772	£18,173	-£11,599	-£2,514	-£9,085
		Elective	3	2	-1	£21,661	£4,022	-£17,639	£9,934	-£27,573
		Non-elective	17	9	-8	£51,829	£12,761	-£39,068	£14,265	-£53,333
		Excess Bed Days	4	0	-4	£1,799	£0	-£1,799	£0	-£1,799
		Outpatient New	23	13	-10	£10,408	£6,178	-£4,230	-£223	-£4,007
		Outpatient Follow-up	158	50	-108	£34,441	£11,075	-£23,367	-£162	-£23,205
		OP Procedure	0	0	0	£16	£0	-£16	£0	-£16
		Ward Based Outpatient	0	1	1	£28	£214	£186	£4	£182
		Ward Attender	82	116	34	£18,004	£24,850	£6,846	£469	£6,377
	Haematology Total		**313**	**204**	**-109**	**£167,957**	**£77,272**	**-£90,685**	**£21,773**	**-£112,458**
	Immunology	Daycases	0	2	2	£0	£1,422	£1,422	£0	£1,422
		Outpatient New	13	15	2	£3,063	£3,490	£427	-£36	£463
		Outpatient Follow-up	10	22	12	£1,372	£3,089	£1,716	£16	£1,700
		Ward Based Outpatient	17	23	6	£2,422	£3,229	£807	£17	£790
		Ward Attender	4	12	8	£616	£1,685	£1,068	£9	£1,059
	Immunology Total		**45**	**74**	**29**	**£7,473**	**£12,914**	**£5,441**	**£6**	**£5,435**
	Metabolic Disease	Outpatient New	5	7	2	£1,997	£2,688	£691	-£0	£691
		Outpatient Follow-up	31	27	-4	£12,048	£10,368	-£1,680	-£0	-£1,679
	Metabolic Disease Total		**37**	**34**	**-3**	**£14,045**	**£13,056**	**-£989**	**-£0**	**-£988**
	Nephrology	Daycases	99	6	-93	£63,699	£6,074	-£57,625	-£2,204	-£55,421
		Elective	33	14	-19	£20,700	£39,622	£18,922	-£30,709	£49,631
		Non-elective	4	7	3	£7,629	£20,783	£13,154	-£7,632	£20,786
		Excess Bed Days	18	0	-18	£6,676	£0	-£6,676	£0	-£6,676
		Outpatient New	16	19	3	£1,937	£2,243	£305	-£0	£305
		Outpatient Follow-up	131	217	86	£15,433	£25,615	£10,181	£0	£10,181
		Ward Based Outpatient	59	69	10	£6,959	£8,145	£1,186	-£0	£1,186
		Ward Attender	83	60	-23	£9,782	£7,082	-£2,700	£0	-£2,700
	Nephrology Total		**442**	**392**	**-50**	**£132,817**	**£109,564**	**-£23,253**	**-£40,545**	**£17,293**
	Oncology	Daycases	329	266	-63	£188,869	£123,667	-£65,202	£29,150	-£94,351
		Elective	27	44	17	£167,274	£253,325	£86,050	£14,498	£71,552
		Non-elective	37	70	33	£94,274	£196,034	£101,759	-£19,159	£120,919
		Excess Bed Days	31	19	-12	£14,097	£5,150	-£8,948	£3,482	-£12,430
		Outpatient New	11	7	-4	£2,726	£1,813	-£914	£0	-£914
		Outpatient Follow-up	261	305	44	£67,380	£78,718	£11,338	£54	£11,284
		Ward Based Outpatient	19	24	5	£4,888	£6,215	£1,326	-£16	£1,342
		Ward Attender	14	91	77	£3,732	£23,564	£19,831	-£61	£19,892
	Oncology Total		**729**	**826**	**97**	**£543,242**	**£688,484**	**£145,242**	**£27,947**	**£117,294**
	Respiratory Medicine	Daycases	10	15	5	£10,181	£13,799	£3,618	£1,043	£2,575
		Elective	5	4	-1	£12,226	£7,552	-£4,674	£1,957	-£6,631
		Non-elective	67	47	-20	£62,580	£47,742	-£14,838	-£3,566	-£11,273
		Excess Bed Days	52	8	-44	£16,353	£2,396	-£13,958	£141	-£14,099
		Outpatient New	78	103	25	£23,331	£30,572	£7,241	£81	£7,160
		Outpatient Follow-up	264	301	37	£39,723	£47,717	£7,994	-£2,511	£10,505
		OP Procedure	144	0	-144	£20,830	£0	-£20,830	£0	-£20,830
		Ward Based Outpatient	142	89	-53	£21,324	£13,975	-£7,350	-£629	-£6,721
		Ward Attender	1	4	3	£134	£628	£494	-£28	£522
	Respiratory Medicine Total		**764**	**571**	**-193**	**£206,683**	**£164,381**	**-£42,302**	**-£3,511**	**-£38,791**
	Rheumatology	Daycases	179	175	-4	£149,615	£139,065	-£10,550	£7,589	-£18,138
		Elective	21	7	-14	£21,129	£52,165	£31,036	-£45,051	£76,087
		Non-elective	2	1	-1	£1,530	£674	-£856	£331	-£1,187
		Excess Bed Days	11	8	-3	£4,323	£2,598	-£1,725	£473	-£2,197
		Outpatient New	58	38	-20	£8,665	£5,715	-£2,950	£6	-£2,956
		Outpatient Follow-up	174	169	-5	£26,245	£25,416	-£829	£28	-£857
		OP Procedure	0	0	0	£15	£0	-£15	£0	-£15
		Ward Based Outpatient	13	1	-12	£1,923	£150	-£1,773	-£0	-£1,773
		Ward Attender	26	23	-3	£3,943	£3,459	-£484	£0	-£484
	Rheumatology Total		**483**	**422**	**-61**	**£217,387**	**£229,242**	**£11,855**	**-£36,625**	**£48,480**
Medical Specialties CBU Total			**5,407**	**4,817**	**-590**	**£2,080,483**	**£1,994,580**	**-£85,903**	**-£66,037**	**-£19,866**
NMSS CBU	Audiology	Outpatient New	725	515	-210	£68,799	£48,855	-£19,944	£2	-£19,946
		Outpatient Follow-up	248	282	34	£23,468	£26,652	£3,184	£0	£3,184
		OP Procedure	1	1	0	£147	£113	-£34	£2	-£36
		Ward Based Outpatient	0	0	0	£0	£0	£0	£0	£0

NMSS CBU	**Audiology Total**		**975**	**798**	**-177**	**£92,414**	**£75,620**	**-£16,794**	**£4**	**-£16,798**
	Burns Care	Daycases	0	9	9	£146	£17,951	£17,805	-£2,543	£20,348
		Elective	7	1	-6	£17,228	£2,203	-£15,025	£335	-£15,360
		Non-elective	28	26	-2	£71,518	£55,989	-£15,530	£9,929	-£25,459
		Outpatient New	32	14	-18	£6,340	£2,690	-£3,650	£78	-£3,728
		Outpatient Follow-up	89	61	-28	£10,130	£6,973	-£3,157	-£11	-£3,146
		OP Procedure	0	0	0	£16	£0	-£16	£0	-£16
		Ward Based Outpatient	12	7	-5	£1,345	£800	-£545	£0	-£545
		Ward Attender	4	33	29	£482	£3,772	£3,290	£0	£3,290
	Burns Care Total		**172**	**151**	**-21**	**£107,205**	**£90,378**	**-£16,827**	**£7,789**	**-£24,616**
	Dentistry	Daycases	102	89	-13	£59,203	£50,922	-£8,281	£644	-£8,925
		Elective	12	1	-11	£7,185	£563	-£6,622	£60	-£6,682
		Non-elective	1	1	0	£1,239	£980	-£260	£106	-£365
		Excess Bed Days	1	0	-1	£334	£0	-£334	£0	-£334
		Outpatient New	119	92	-27	£4,277	£3,272	-£1,005	£23	-£1,028
		Outpatient Follow-up	153	102	-51	£5,438	£3,628	-£1,810	£5	-£1,815
		OP Procedure	32	23	-9	£5,156	£3,682	-£1,474	£27	-£1,501
	Dentistry Total		**420**	**308**	**-112**	**£82,833**	**£63,047**	**-£19,786**	**£865**	**-£20,651**
	ENT	Daycases	115	95	-20	£130,488	£104,107	-£26,381	£3,781	-£30,162
		Elective	97	73	-24	£137,067	£101,240	-£35,827	£1,952	-£37,779
		Non-elective	24	26	2	£36,705	£34,885	-£1,820	£5,688	-£7,508
		Excess Bed Days	29	11	-18	£11,551	£3,640	-£7,911	£762	-£8,672
		Outpatient New	362	283	-79	£40,077	£31,552	-£8,525	-£219	-£8,306
		Outpatient Follow-up	522	342	-180	£35,604	£23,553	-£12,051	-£204	-£11,847
		OP Procedure	179	255	76	£23,464	£32,877	£9,413	£517	£8,896
		Ward Based Outpatient	5	0	-5	£341	£0	-£341	£0	-£341
		Ward Attender	0	0	0	£17	£0	-£17	£0	-£17
	ENT Total		**1,332**	**1,085**	**-247**	**£415,314**	**£331,854**	**-£83,460**	**£12,277**	**-£95,736**
	Epilepsy	Outpatient New	12	10	-2	£2,622	£2,215	-£407	£5	-£412
		Outpatient Follow-up	27	38	11	£5,012	£6,718	£1,705	£231	£1,474
	Epilepsy Total		**39**	**48**	**9**	**£7,634**	**£8,932**	**£1,299**	**£236**	**£1,062**
	Maxillo-Facial	Outpatient New	75	46	-29	£10,740	£6,123	-£4,618	£477	-£5,095
		Outpatient Follow-up	148	31	-117	£21,436	£4,313	-£17,122	£179	-£17,301
		OP Procedure	0	2	2	£44	£324	£280	£21	£260
		Ward Attender	0	0	0	£19	£0	-£19	£0	-£19
	Maxillo-Facial Total		**223**	**79**	**-144**	**£32,239**	**£10,761**	**-£21,478**	**£677**	**-£22,155**
	Neurology	Daycases	9	12	3	£10,096	£14,267	£4,171	-£472	£4,643
		Elective	6	6	0	£13,393	£9,102	-£4,292	£3,564	-£7,856
		Non-elective	9	9	0	£17,123	£27,561	£10,438	-£9,702	£20,141
		Excess Bed Days	56	135	79	£22,676	£58,219	£35,543	-£3,504	£39,047
		Outpatient New	94	91	-3	£26,056	£25,226	-£830	£90	-£919
		Outpatient Follow-up	272	172	-100	£74,269	£47,680	-£26,589	-£662	-£25,927
		Ward Based Outpatient	25	26	1	£6,878	£7,207	£330	£0	£330
		Ward Attender	2	15	13	£638	£4,158	£3,520	-£0	£3,520
	Neurology Total		**472**	**466**	**-6**	**£171,129**	**£193,421**	**£22,292**	**-£10,686**	**£32,978**
	Neurosurgery	Daycases	1	1	0	£741	£3,868	£3,127	-£3,186	£6,314
		Elective	18	20	2	£110,348	£125,531	£15,183	-£2,380	£17,563
		Non-elective	31	24	-7	£196,402	£175,861	-£20,541	-£24,263	£3,722
		Excess Bed Days	74	43	-31	£24,675	£15,729	-£8,946	-£1,322	-£7,624
		Outpatient New	68	61	-7	£6,104	£5,428	-£676	£55	-£731
		Outpatient Follow-up	187	156	-31	£16,370	£13,882	-£2,488	-£249	-£2,239
		OP Procedure	0	0	0	£29	£0	-£29	£0	-£29
		Ward Based Outpatient	0	4	4	£11	£356	£345	-£0	£345
		Ward Attender	41	42	1	£3,619	£3,738	£119	£0	£119
	Neurosurgery Total		**420**	**351**	**-69**	**£358,300**	**£344,395**	**-£13,906**	**-£31,345**	**£17,439**
	Ophthalmology	Daycases	43	19	-24	£38,084	£14,053	-£24,030	£2,817	-£26,848
		Elective	9	3	-6	£13,065	£2,278	-£10,787	£1,913	-£12,700
		Non-elective	2	2	0	£2,357	£2,124	-£232	£733	-£966
		Excess Bed Days	7	0	-7	£2,405	£0	-£2,405	£0	-£2,405
		Outpatient New	314	262	-52	£47,655	£41,794	-£5,861	-£1,994	-£3,867
		Outpatient Follow-up	1,169	889	-280	£116,589	£95,700	-£20,889	-£7,021	-£13,868
		OP Procedure	0	0	0	£66	£0	-£66	£0	-£66
		Ward Based Outpatient	2	0	-2	£229	£0	-£229	£0	-£229
	Ophthalmology Total		**1,546**	**1,175**	**-371**	**£220,451**	**£155,949**	**-£64,501**	**-£3,552**	**-£60,949**
	Oral Surgery	Daycases	35	17	-18	£29,935	£14,023	-£15,912	£520	-£16,432
		Elective	16	11	-5	£34,058	£33,671	-£387	-£9,700	£9,314
		Non-elective	13	7	-6	£13,912	£5,996	-£7,916	£1,602	-£9,518
		Excess Bed Days	2	0	-2	£1,167	£0	-£1,167	£0	-£1,167
	Oral Surgery Total		**66**	**35**	**-31**	**£79,071**	**£53,690**	**-£25,381**	**-£7,578**	**-£17,803**
	Orthodontics	Daycases	0	0	0	£92	£0	-£92	£0	-£92
		Outpatient New	5	3	-2	£882	£538	-£344	-£53	-£291
		Outpatient Follow-up	17	17	0	£1,433	£1,499	£66	-£85	£151
		OP Procedure	14	16	2	£1,762	£2,023	£261	£19	£242
	Orthodontics Total		**37**	**36**	**-1**	**£4,169**	**£4,060**	**-£109**	**-£119**	**£10**
	Plastic Surgery	Daycases	67	71	4	£68,999	£69,727	£728	£3,279	-£2,551
		Elective	25	4	-21	£38,555	£4,154	-£34,401	£1,913	-£36,314
		Non-elective	105	86	-19	£129,354	£114,611	-£14,743	-£8,572	-£6,171
		Excess Bed Days	4	1	-3	£862	£271	-£591	-£44	-£547
		Outpatient New	241	240	-1	£34,274	£34,428	£154	-£270	£424
		Outpatient Follow-up	454	433	-21	£50,271	£47,277	-£2,994	£650	-£3,644
		OP Procedure	67	63	-4	£8,043	£7,492	-£550	£40	-£590
		Ward Based Outpatient	10	1	-9	£1,152	£109	-£1,043	£2	-£1,045
		Ward Attender	3	14	11	£284	£1,529	£1,244	£29	£1,216
	Plastic Surgery Total		**976**	**913**	**-63**	**£331,795**	**£279,598**	**-£52,197**	**-£2,974**	**-£49,223**
	Sleep Studies	Elective	26	13	-13	£46,711	£22,562	-£24,149	£1,168	-£25,317
		Non-elective	0	2	2	£0	£5,985	£5,985	£0	£5,985
		Excess Bed Days	0	0	0	£0	£0	£0	£0	£0
	Sleep Studies Total		**26**	**15**	**-11**	**£46,711**	**£28,547**	**-£18,164**	**£1,168**	**-£19,332**
	Spinal Surgery	Daycases	0	1	1	£623	£1,508	£884	£150	£735
		Elective	14	12	-2	£359,196	£336,528	-£22,668	-£19,596	-£3,072
		Non-elective	0	1	1	£0	£1,240	£1,240	£0	£1,240
		Outpatient New	22	48	26	£3,744	£8,086	£4,342	£20	£4,322
		Outpatient Follow-up	77	102	25	£8,144	£10,501	£2,356	£343	£2,013
	Spinal Surgery Total		**113**	**164**	**51**	**£371,707**	**£357,862**	**-£13,845**	**-£19,083**	**£5,238**
	Trauma And Orthopaedics	Daycases	44	51	7	£64,823	£75,674	£10,852	-£871	£11,723
		Elective	65	45	-20	£243,239	£220,125	-£23,114	-£51,417	£28,303
		Non-elective	66	81	15	£165,205	£200,892	£35,687	£2,001	£33,686
		Excess Bed Days	37	10	-27	£12,705	£4,136	-£8,569	-£739	-£7,830
		Outpatient New	778	800	22	£140,060	£139,006	-£1,054	£4,931	-£5,986
		Outpatient Follow-up	1,142	1,529	387	£134,685	£173,576	£38,892	£6,683	£32,208
		OP Procedure	43	57	14	£7,632	£10,372	£2,739	-£366	£3,106
		Ward Based Outpatient	0	0	0	£0	£0	£0	£0	£0
		Ward Attender	0	0	0	£26	£0	-£26	£0	-£26
	Trauma And Orthopaedics Total		**2,177**	**2,573**	**396**	**£768,374**	**£823,781**	**£55,407**	**-£39,778**	**£95,184**
NMSS CBU Total			**8,993**	**8,197**	**-796**	**£3,089,347**	**£2,821,895**	**-£267,451**	**-£92,098**	**-£175,353**
SCACC CBU	Cardiac Surgery	Elective	28	24	-4	£365,655	£259,012	-£106,643	£48,920	-£155,563
		Non-elective	12	11	-1	£231,636	£203,290	-£28,347	£9,709	-£38,055
		Excess Bed Days	67	69	2	£29,950	£29,756	-£194	£1,079	-£1,273
		Outpatient New	9	17	8	£6,568	£12,240	£5,672	£0	£5,672
		Outpatient Follow-up	29	22	-7	£20,840	£15,840	-£5,000	£0	-£5,000
		Ward Attender	0	1	1	£0	£720	£720	£0	£720
	Cardiac Surgery Total		**146**	**144**	**-2**	**£654,649**	**£520,857**	**-£133,792**	**£59,708**	**-£193,500**
	Cardiology	Daycases	23	22	-1	£62,308	£78,494	£16,186	-£18,417	£34,602
		Elective	24	22	-2	£94,617	£89,379	-£5,238	-£2,692	-£2,546
		Non-elective	12	11	-1	£55,204	£34,103	-£21,101	£17,459	-£38,560
		Excess Bed Days	18	12	-6	£7,131	£5,415	-£1,716	-£557	-£1,160
		Outpatient New	170	149	-21	£40,536	£35,481	-£5,054	£40	-£5,095
		Outpatient Follow-up	417	443	26	£55,151	£57,582	£2,431	£942	£1,489
		Ward Based Outpatient	30	2	-28	£3,953	£260	-£3,693	£4	-£3,697
		Ward Attender	11	14	3	£1,470	£1,820	£350	£29	£321
	Cardiology Total		**705**	**675**	**-30**	**£320,369**	**£302,534**	**-£17,835**	**-£3,191**	**-£14,644**
	Gynaecology	Daycases	1	0	-1	£1,060	£0	-£1,060	£0	-£1,060
		Elective	1	1	0	£665	£1,621	£956	-£425	£1,381
		Outpatient New	24	28	4	£3,503	£4,018	£515	£4	£511
		Outpatient Follow-up	40	45	5	£3,779	£4,165	£386	£65	£321
		OP Procedure	0	0	0	£15	£0	-£15	£0	-£15
		Ward Attender	0	0	0	£12	£0	-£12	£0	-£12
	Gynaecology Total		**67**	**74**	**7**	**£9,034**	**£9,804**	**£770**	**-£356**	**£1,126**
	Intensive Care	Elective	0	0	0	£849	£0	-£849	£0	-£849
		Non-elective	16	13	-3	£37,159	£128,092	£90,932	-£98,737	£189,669
		Excess Bed Days	31	11	-20	£11,641	£4,744	-£6,897	-£570	-£6,327
		Outpatient New	9	18	9	£6,708	£12,533	£5,824	£752	£5,072

SCACC CBU	Intensive Care	Outpatient Follow-up	35	102	67	£24,730	£75,196	£50,466	-£3,531	£53,997
		OP Procedure	1	3	2	£57	£324	£267	£12	£255
		Ward Based Outpatient	5	0	-5	£3,193	£0	-£3,193	£0	-£3,193
	Intensive Care Total		**97**	**147**	**50**	**£84,338**	**£220,889**	**£136,551**	**-£102,073**	**£238,625**
	Paediatric Surgery	Daycases	120	88	-32	£141,499	£112,733	-£28,766	-£9,389	-£19,376
		Elective	49	42	-7	£206,499	£125,531	-£80,968	£52,826	-£133,794
		Non-elective	126	137	11	£492,142	£417,749	-£74,393	£116,540	-£190,933
		Excess Bed Days	256	70	-186	£101,059	£24,927	-£76,132	£2,721	-£78,852
		Outpatient New	194	178	-16	£34,387	£31,466	-£2,920	£42	-£2,963
		Outpatient Follow-up	306	303	-3	£35,363	£34,687	-£676	£370	-£1,046
		OP Procedure	0	0	0	£15	£0	-£15	£0	-£15
		Ward Based Outpatient	32	0	-32	£3,758	£0	-£3,758	£0	-£3,758
		Ward Attender	75	125	50	£8,626	£14,299	£5,672	£164	£5,509
	Paediatric Surgery Total		**1,158**	**943**	**-215**	**£1,023,347**	**£761,392**	**-£261,955**	**£163,274**	**-£425,228**
	Urology	Daycases	147	214	67	£137,652	£193,750	£56,098	£6,548	£49,550
		Elective	13	17	4	£49,991	£42,422	-£7,569	£23,998	-£31,566
		Non-elective	3	8	5	£11,153	£22,333	£11,180	£5,789	£5,392
		Excess Bed Days	6	0	-6	£2,403	£0	-£2,403	£0	-£2,403
		Outpatient New	108	87	-21	£19,370	£15,651	-£3,719	£18	-£3,737
		Outpatient Follow-up	224	207	-17	£34,157	£30,996	-£3,161	£536	-£3,697
		OP Procedure	0	0	0	£22	£0	-£22	£0	-£22
		Ward Based Outpatient	0	0	0	£58	£0	-£58	£0	-£58
		Ward Attender	3	2	-1	£526	£300	-£227	£5	-£232
	Urology Total		**505**	**535**	**30**	**£255,332**	**£305,452**	**£50,119**	**£36,894**	**£13,225**
SCACC CBU Total			**2,677**	**2,518**	**-159**	**£2,347,069**	**£2,120,928**	**-£226,141**	**£154,256**	**-£380,397**
Clinical Support CBU	Radiology	Daycases	113	94	-19	£114,206	£107,810	-£6,396	-£12,398	£6,002
		Elective	15	4	-11	£24,386	£7,735	-£16,651	-£1,079	-£15,572
		Non-elective	3	4	1	£19,421	£49,665	£30,244	-£23,050	£53,294
		Excess Bed Days	64	24	-40	£26,237	£10,350	-£15,887	-£569	-£15,318
	Radiology Total		**194**	**126**	**-68**	**£184,251**	**£175,561**	**-£8,690**	**-£37,097**	**£28,406**
Clinical Support CBU Total			**194**	**126**	**-68**	**£184,251**	**£175,561**	**-£8,690**	**-£37,097**	**£28,406**
Grand Total			**26,473**	**25,191**	**-1,282**	**£9,069,103**	**£8,527,690**	**-£541,412**	**-£91,861**	**-£449,551**

Year-to-Date

CBU	Specialty	POD	Activity Plan	Activity Actual	Activity Variance	Price Plan	Price Actual	Price Variance	Price Variance (Casemix)	Price Variance (Volume)
ICS CBU	Accident & Emergency	Daycases	0	0	0	£293	£0	-£293	£0	-£293
		Elective	0	0	0	£323	£0	-£323	£0	-£323
		Non-elective	971	802	-169	£445,721	£541,519	£95,798	£173,241	-£77,443
		Excess Bed Days	13	3	-10	£4,713	£1,204	-£3,509	£115	-£3,624
		Outpatient New	421	323	-98	£141,755	£109,058	-£32,697	£200	-£32,897
		Outpatient Follow-up	44	15	-29	£14,948	£5,065	-£9,884	-£0	-£9,884
		Ward Attender	1	0	-1	£336	£0	-£336	£0	-£336
		A&E Attendance	9,341	9,744	403	£887,352	£802,263	-£85,089	-£123,400	£38,312
	Accident & Emergency Total		**10,791**	**10,887**	**96**	**£1,495,440**	**£1,459,108**	**-£36,331**	**£50,156**	**-£86,488**
	CAMHS	Elective	0	0	0	£484	£0	-£484	£0	-£484
		Outpatient New	391	469	78	£0	£0	£0	£0	£0
		Outpatient Follow-up	1,949	2,668	719	£27,211	£14,313	-£12,898	-£22,928	£10,030
	CAMHS Total		**2,341**	**3,137**	**796**	**£27,695**	**£14,313**	**-£13,382**	**-£22,928**	**£9,546**
	Community Medicine	Outpatient New	742	507	-235	£59,906	£26,902	-£33,004	-£14,037	-£18,966
		Outpatient Follow-up	1,460	979	-481	£8,910	£7,462	-£1,448	£1,486	-£2,933
		OP Procedure	0	0	0	£28	£0	-£28	£0	-£28
		Ward Based Outpatient	2	0	-2	£0	£0	£0	£0	£0
	Community Medicine Total		**2,203**	**1,486**	**-717**	**£68,844**	**£34,364**	**-£34,480**	**-£12,552**	**-£21,928**
	Diabetes	Outpatient New	60	27	-33	£12,807	£5,699	-£7,107	-£38	-£7,069
		Outpatient Follow-up	5	32	27	£578	£3,161	£2,583	-£325	£2,908
		Ward Based Outpatient	1	0	-1	£81	£0	-£81	£0	-£81
	Diabetes Total		**66**	**59**	**-7**	**£13,466**	**£8,861**	**-£4,606**	**-£363**	**-£4,242**
	Paediatrics	Daycases	63	14	-49	£53,025	£14,037	-£38,988	£2,332	-£41,319
		Elective	27	7	-20	£29,806	£39,153	£9,347	£31,306	-£21,960
		Non-elective	556	609	53	£630,267	£748,230	£117,962	£57,694	£60,268
		Excess Bed Days	132	529	397	£48,877	£191,264	£142,388	-£5,278	£147,666
		Outpatient New	625	556	-69	£143,942	£128,352	-£15,590	£319	-£15,909
		Outpatient Follow-up	857	824	-33	£120,877	£115,674	-£5,202	-£605	-£4,597
		OP Procedure	0	0	0	£63	£0	-£63	£0	-£63
		Ward Based Outpatient	329	104	-225	£46,438	£14,601	-£31,837	-£76	-£31,761
		Ward Attender	36	16	-20	£5,090	£2,246	-£2,843	-£12	-£2,832
	Paediatrics Total		**2,625**	**2,659**	**34**	**£1,078,384**	**£1,253,557**	**£175,173**	**£85,680**	**£89,493**
ICS CBU Total			**18,027**	**18,228**	**201**	**£2,683,829**	**£2,770,204**	**£86,375**	**£99,993**	**-£13,618**
Medical Specialties CBU	Allergy	Daycases	0	35	35	£0	£15,587	£15,587	£0	£15,587
		Elective	0	2	2	£0	£1,934	£1,934	£0	£1,934
		Outpatient New	127	117	-10	£29,153	£27,065	-£2,089	£122	-£2,211
		Outpatient Follow-up	142	143	1	£20,017	£20,185	£168	£5	£163
		OP Procedure	1	2	1	£95	£216	£122	-£37	£159
		Ward Based Outpatient	0	1	1	£61	£140	£80	-£1	£81
		Ward Attender	1	0	-1	£91	£0	-£91	£0	-£91
	Allergy Total		**270**	**300**	**30**	**£49,416**	**£65,128**	**£15,712**	**£89**	**£15,622**
	Dermatology	Daycases	4	0	-4	£2,418	£0	-£2,418	£0	-£2,418
		Outpatient New	338	319	-19	£45,733	£43,123	-£2,610	-£47	-£2,563
		Outpatient Follow-up	1,108	1,192	84	£109,214	£116,515	£7,300	-£945	£8,245
		OP Procedure	180	188	8	£20,702	£21,637	£935	£24	£911
		Ward Based Outpatient	16	17	1	£1,593	£1,662	£69	-£13	£82
		Ward Attender	1	0	-1	£123	£0	-£123	£0	-£123
	Dermatology Total		**1,648**	**1,716**	**68**	**£179,783**	**£182,937**	**£3,154**	**-£981**	**£4,135**
	Endocrinology	Daycases	187	166	-21	£194,849	£177,859	-£16,989	£4,647	-£21,636
		Elective	15	7	-8	£21,619	£10,245	-£11,374	£227	-£11,601
		Non-elective	5	4	-1	£7,892	£22,059	£14,168	£15,741	-£1,574
		Excess Bed Days	28	32	4	£10,167	£13,680	£3,513	£1,886	£1,627
		Outpatient New	132	102	-30	£52,915	£40,835	-£12,079	-£107	-£11,972
		Outpatient Follow-up	736	513	-223	£142,273	£101,347	-£40,926	£2,137	-£43,063
		Ward Based Outpatient	67	198	131	£12,891	£38,297	£25,406	£5	£25,401
		Ward Attender	33	42	9	£6,398	£8,124	£1,726	£1	£1,725
	Endocrinology Total		**1,202**	**1,064**	**-138**	**£449,004**	**£412,447**	**-£36,556**	**£24,536**	**-£61,092**
	Gastroenterology	Daycases	262	227	-35	£288,151	£248,577	-£39,574	-£631	-£38,942
		Elective	83	71	-12	£158,755	£128,965	-£29,789	-£7,068	-£22,721
		Non-elective	22	15	-7	£58,244	£35,472	-£22,772	-£4,122	-£18,650
		Excess Bed Days	369	159	-210	£145,633	£67,120	-£78,514	£4,295	-£82,809
		Outpatient New	207	155	-52	£54,851	£41,423	-£13,428	£310	-£13,737
		Outpatient Follow-up	555	383	-172	£88,164	£59,740	-£28,424	-£1,104	-£27,320
		Ward Based Outpatient	422	222	-200	£66,878	£34,630	-£32,248	-£524	-£31,724
		Ward Attender	12	36	24	£1,930	£5,616	£3,686	-£85	£3,771
	Gastroenterology Total		**1,932**	**1,268**	**-664**	**£862,606**	**£621,543**	**-£241,063**	**-£8,930**	**-£232,132**
	Haematology	Daycases	48	23	-25	£57,904	£28,468	-£29,435	£765	-£30,200
		Elective	6	4	-2	£42,128	£5,560	-£36,569	-£22,353	-£14,215
		Non-elective	34	12	-22	£102,009	£19,283	-£82,726	-£16,752	-£65,974
		Excess Bed Days	8	0	-8	£3,541	£0	-£3,541	£0	-£3,541
		Outpatient New	44	33	-11	£20,242	£15,564	-£4,678	£448	-£5,126
		Outpatient Follow-up	307	91	-216	£66,985	£20,221	-£46,764	£361	-£47,125
		OP Procedure	0	0	0	£31	£0	-£31	£0	-£31
		Ward Based Outpatient	0	1	1	£54	£214	£160	-£4	£164
		Ward Attender	160	233	73	£35,015	£49,913	£14,898	-£941	£15,840
	Haematology Total		**608**	**397**	**-211**	**£327,909**	**£139,223**	**-£188,686**	**-£38,478**	**-£150,208**
	Immunology	Daycases	0	5	5	£0	£3,605	£3,605	£0	£3,605
		Outpatient New	26	25	-1	£5,957	£5,799	-£158	£42	-£200
		Outpatient Follow-up	19	47	28	£2,669	£6,707	£4,039	£75	£3,964
		Ward Based Outpatient	33	61	28	£4,710	£8,564	£3,853	-£45	£3,898
		Ward Attender	8	31	23	£1,199	£4,352	£3,153	-£23	£3,176
	Immunology Total		**87**	**169**	**82**	**£14,535**	**£29,027**	**£14,492**	**£49**	**£14,442**
	Metabolic Disease	Outpatient New	10	9	-1	£3,884	£3,456	-£428	£0	-£428
		Outpatient Follow-up	61	46	-15	£23,432	£17,664	-£5,768	£0	-£5,768
	Metabolic Disease Total		**71**	**55**	**-16**	**£27,316**	**£21,120**	**-£6,196**	**£1**	**-£6,196**
	Nephrology	Daycases	192	11	-181	£123,889	£10,894	-£112,995	£3,799	-£116,794
		Elective	63	31	-32	£40,260	£68,481	£28,220	£48,745	-£20,525
		Non-elective	8	8	0	£15,016	£24,684	£9,668	£9,654	£14
		Excess Bed Days	35	15	-20	£13,140	£6,469	-£6,671	£836	-£7,508
		Outpatient New	32	41	9	£3,768	£4,840	£1,072	£0	£1,072
		Outpatient Follow-up	254	433	179	£30,016	£51,111	£21,095	-£1	£21,096
		Ward Based Outpatient	115	106	-9	£13,535	£12,512	-£1,023	£0	-£1,023
		Ward Attender	161	163	2	£19,025	£19,241	£216	-£0	£216
	Nephrology Total		**860**	**808**	**-52**	**£258,648**	**£198,231**	**-£60,417**	**£63,034**	**-£123,451**
	Oncology	Daycases	639	575	-64	£367,331	£312,525	-£54,807	-£17,813	-£36,994
		Elective	53	78	25	£325,332	£472,527	£147,195	-£2,250	£149,445
		Non-elective	73	120	47	£185,551	£336,667	£151,116	£33,453	£117,663
		Excess Bed Days	61	63	2	£27,747	£22,026	-£5,721	-£6,595	£874
		Outpatient New	20	16	-4	£5,303	£4,143	-£1,160	-£0	-£1,160
		Outpatient Follow-up	507	609	102	£131,047	£157,436	£26,389	£150	£26,239
		Ward Based Outpatient	37	29	-8	£9,507	£7,509	-£1,998	£19	-£2,017
		Ward Attender	28	184	156	£7,259	£47,645	£40,386	£124	£40,262
	Oncology Total		**1,420**	**1,674**	**254**	**£1,059,076**	**£1,360,477**	**£301,401**	**£7,089**	**£294,312**
	Respiratory Medicine	Daycases	20	26	6	£19,801	£24,138	£4,338	-£1,588	£5,926
		Elective	10	5	-5	£23,778	£8,694	-£15,084	-£3,193	-£11,891
		Non-elective	131	106	-25	£123,171	£120,404	-£2,767	£20,772	-£23,539
		Excess Bed Days	101	88	-13	£32,187	£34,656	£2,469	£6,747	-£4,278
		Outpatient New	152	180	28	£45,376	£53,401	£8,025	-£168	£8,192
		Outpatient Follow-up	514	546	32	£77,258	£86,402	£9,144	£4,400	£4,744
		OP Procedure	280	0	-280	£40,511	£0	-£40,511	£0	-£40,511
		Ward Based Outpatient	277	146	-131	£41,474	£22,925	-£18,549	£1,032	-£19,581
		Ward Attender	2	6	4	£261	£942	£681	£42	£639
	Respiratory Medicine Total		**1,488**	**1,103**	**-385**	**£403,816**	**£351,562**	**-£52,254**	**£28,045**	**-£80,299**
	Rheumatology	Daycases	347	364	17	£290,985	£285,695	-£5,291	-£19,344	£14,053
		Elective	40	12	-28	£41,094	£56,562	£15,468	£44,366	-£28,898
		Non-elective	3	2	-1	£3,011	£1,985	-£1,026	-£24	-£1,002
		Excess Bed Days	22	65	43	£8,508	£25,598	£17,091	£650	£16,440
		Outpatient New	112	84	-28	£16,852	£12,633	-£4,219	-£14	-£4,206
		Outpatient Follow-up	339	284	-55	£51,044	£42,711	-£8,333	-£47	-£8,287
		OP Procedure	0	0	0	£30	£0	-£30	£0	-£30

Medical Specialties CBU	Rheumatology	Ward Based Outpatient	25	1	-24	£3,741	£150	-£3,590	£0	-£3,590
		Ward Attender	51	41	-10	£7,668	£6,166	-£1,502	£0	-£1,502
	Rheumatology Total		**940**	**853**	**-87**	**£422,933**	**£431,500**	**£8,567**	**£25,588**	**-£17,021**
Medical Specialties CBU Total			**10,526**	**9,407**	**-1,119**	**£4,055,042**	**£3,813,196**	**-£241,846**	**£100,042**	**-£341,888**
NMSS CBU	Audiology	Outpatient New	1,410	992	-418	£133,807	£94,141	-£39,666	£31	-£39,697
		Outpatient Follow-up	483	583	100	£45,643	£55,099	£9,456	-£0	£9,456
		OP Procedure	2	2	0	£286	£227	-£60	-£3	-£56
		Ward Based Outpatient	0	1	1	£0	£95	£95	£0	£95
	Audiology Total		**1,896**	**1,578**	**-318**	**£179,736**	**£149,562**	**-£30,175**	**£28**	**-£30,202**
	Burns Care	Daycases	0	14	14	£284	£25,785	£25,501	£1,817	£23,684
		Elective	13	1	-12	£33,507	£2,203	-£31,304	-£335	-£30,969
		Non-elective	56	49	-7	£140,763	£99,715	-£41,047	-£24,515	-£16,532
		Outpatient New	62	28	-34	£12,330	£5,381	-£6,950	-£157	-£6,793
		Outpatient Follow-up	173	126	-47	£19,701	£14,403	-£5,298	£23	-£5,321
		OP Procedure	0	1	1	£31	£112	£81	-£13	£94
		Ward Based Outpatient	23	8	-15	£2,616	£914	-£1,701	£0	-£1,701
		Ward Attender	8	56	48	£938	£6,401	£5,463	£0	£5,463
	Burns Care Total		**335**	**283**	**-52**	**£210,170**	**£154,915**	**-£55,255**	**-£23,180**	**-£32,075**
	Dentistry	Daycases	199	196	-3	£115,143	£111,973	-£3,170	-£1,589	-£1,582
		Elective	22	4	-18	£13,974	£2,446	-£11,528	-£43	-£11,485
		Non-elective	2	1	-1	£2,439	£980	-£1,459	-£106	-£1,354
		Excess Bed Days	2	0	-2	£658	£0	-£658	£0	-£658
		Outpatient New	232	207	-25	£8,319	£7,363	-£956	-£52	-£904
		Outpatient Follow-up	297	171	-126	£10,576	£6,082	-£4,494	-£9	-£4,485
		OP Procedure	62	49	-13	£10,029	£7,900	-£2,129	-£3	-£2,126
	Dentistry Total		**817**	**628**	**-189**	**£161,138**	**£136,743**	**-£24,394**	**-£1,801**	**-£22,594**
	ENT	Daycases	223	179	-44	£253,787	£191,301	-£62,486	-£11,982	-£50,504
		Elective	189	133	-56	£266,582	£197,858	-£68,724	£9,851	-£78,575
		Non-elective	46	47	1	£72,243	£70,286	-£1,958	-£3,058	£1,100
		Excess Bed Days	57	15	-42	£22,734	£5,013	-£17,721	-£990	-£16,732
		Outpatient New	704	497	-207	£77,945	£55,362	-£22,583	£337	-£22,920
		Outpatient Follow-up	1,014	674	-340	£69,246	£46,338	-£22,908	£323	-£23,231
		OP Procedure	348	497	149	£45,635	£63,235	£17,600	-£1,852	£19,452
		Ward Based Outpatient	10	0	-10	£662	£0	-£662	£0	-£662
		Ward Attender	0	0	0	£34	£0	-£34	£0	-£34
	ENT Total		**2,592**	**2,042**	**-550**	**£808,869**	**£629,394**	**-£179,476**	**-£7,371**	**-£172,105**
	Epilepsy	Outpatient New	23	19	-4	£5,099	£4,208	-£891	-£10	-£880
		Outpatient Follow-up	53	63	10	£9,748	£11,137	£1,389	-£383	£1,772
	Epilepsy Total		**76**	**82**	**6**	**£14,847**	**£15,345**	**£498**	**-£393**	**£891**
	Maxillo-Facial	Outpatient New	146	85	-61	£20,889	£11,314	-£9,575	-£882	-£8,694
		Outpatient Follow-up	288	92	-196	£41,690	£12,682	-£29,008	-£649	-£28,359
		OP Procedure	0	2	2	£86	£324	£239	-£21	£259
		Ward Attender	0	0	0	£36	£0	-£36	£0	-£36
	Maxillo-Facial Total		**434**	**179**	**-255**	**£62,701**	**£24,320**	**-£38,381**	**-£1,552**	**-£36,829**
	Neurology	Daycases	17	18	1	£19,636	£20,949	£1,312	£256	£1,056
		Elective	12	17	5	£26,048	£28,041	£1,992	-£7,845	£9,838
		Non-elective	17	18	1	£33,702	£53,562	£19,860	£17,844	£2,016
		Excess Bed Days	110	246	136	£44,631	£93,434	£48,803	-£6,269	£55,071
		Outpatient New	182	195	13	£50,676	£54,056	£3,380	-£192	£3,573
		Outpatient Follow-up	528	370	-158	£144,445	£102,568	-£41,877	£1,423	-£43,300
		Ward Based Outpatient	48	35	-13	£13,376	£9,702	-£3,674	£0	-£3,674
		Ward Attender	4	22	18	£1,241	£6,099	£4,858	£0	£4,858
	Neurology Total		**920**	**921**	**1**	**£333,756**	**£368,410**	**£34,654**	**£5,217**	**£29,438**
	Neurosurgery	Daycases	2	3	1	£1,441	£4,736	£3,295	£2,690	£604
		Elective	35	33	-2	£214,616	£213,425	-£1,191	£10,224	-£11,416
		Non-elective	61	40	-21	£386,558	£286,072	-£100,486	£33,408	-£133,893
		Excess Bed Days	145	62	-83	£48,565	£22,006	-£26,560	£1,232	-£27,792
		Outpatient New	132	124	-8	£11,873	£11,035	-£838	-£112	-£726
		Outpatient Follow-up	364	305	-59	£31,839	£27,142	-£4,697	£487	-£5,183
		OP Procedure	0	0	0	£57	£0	-£57	£0	-£57
		Ward Based Outpatient	0	4	4	£22	£356	£334	£0	£334
		Ward Attender	79	91	12	£7,039	£8,098	£1,059	-£0	£1,059
	Neurosurgery Total		**819**	**662**	**-157**	**£702,009**	**£572,869**	**-£129,140**	**£47,930**	**-£177,069**
	Ophthalmology	Daycases	83	43	-40	£74,069	£37,966	-£36,102	-£214	-£35,889
		Elective	18	9	-9	£25,410	£13,905	-£11,505	£1,332	-£12,837
		Non-elective	3	3	0	£4,639	£3,096	-£1,543	-£1,191	-£353
		Excess Bed Days	13	0	-13	£4,734	£0	-£4,734	£0	-£4,734
		Outpatient New	610	587	-23	£92,685	£92,342	-£343	£3,172	-£3,516
		Outpatient Follow-up	2,273	1,840	-433	£226,753	£194,647	-£32,106	£11,105	-£43,211
		OP Procedure	1	0	-1	£129	£0	-£129	£0	-£129
		Ward Based Outpatient	4	3	-1	£446	£256	-£190	-£43	-£147
	Ophthalmology Total		**3,006**	**2,485**	**-521**	**£428,865**	**£342,212**	**-£86,654**	**£14,162**	**-£100,815**
	Oral Surgery	Daycases	68	33	-35	£58,220	£25,958	-£32,262	-£2,273	-£29,988
		Elective	30	26	-4	£66,239	£78,093	£11,853	£21,433	-£9,580
		Non-elective	25	15	-10	£27,382	£16,694	-£10,688	£413	-£11,101
		Excess Bed Days	4	1	-3	£2,296	£563	-£1,733	£13	-£1,747
	Oral Surgery Total		**128**	**75**	**-53**	**£154,137**	**£121,307**	**-£32,829**	**£19,586**	**-£52,416**
	Orthodontics	Daycases	0	0	0	£179	£0	-£179	£0	-£179
		Outpatient New	11	6	-5	£1,715	£1,021	-£694	£51	-£745
		Outpatient Follow-up	33	21	-12	£2,787	£1,824	-£963	£76	-£1,040
		OP Procedure	27	35	8	£3,427	£4,504	£1,077	£39	£1,038
	Orthodontics Total		**71**	**62**	**-9**	**£8,108**	**£7,349**	**-£759**	**£167**	**-£926**
	Plastic Surgery	Daycases	131	138	7	£134,197	£134,501	£305	-£7,399	£7,703
		Elective	49	7	-42	£74,986	£6,797	-£68,189	-£3,819	-£64,370
		Non-elective	206	170	-36	£254,594	£217,298	-£37,295	£7,687	-£44,983
		Excess Bed Days	7	2	-5	£1,697	£570	-£1,127	£117	-£1,244
		Outpatient New	468	451	-17	£66,659	£64,546	-£2,113	£359	-£2,471
		Outpatient Follow-up	883	733	-150	£97,773	£80,033	-£17,740	-£1,100	-£16,640
		OP Procedure	131	140	9	£15,642	£16,727	£1,085	-£11	£1,096
		Ward Based Outpatient	20	2	-18	£2,241	£218	-£2,023	-£4	-£2,018
		Ward Attender	5	22	17	£553	£2,402	£1,849	-£45	£1,894
	Plastic Surgery Total		**1,902**	**1,665**	**-237**	**£648,342**	**£523,094**	**-£125,248**	**-£4,215**	**-£121,033**
	Sleep Studies	Elective	50	36	-14	£90,848	£58,127	-£32,721	-£7,586	-£25,135
		Non-elective	0	2	2	£0	£5,985	£5,985	£0	£5,985
		Excess Bed Days	0	28	28	£0	£8,560	£8,560	£0	£8,560
	Sleep Studies Total		**50**	**66**	**16**	**£90,848**	**£72,672**	**-£18,176**	**-£7,586**	**-£10,590**
	Spinal Surgery	Daycases	1	2	1	£1,213	£5,481	£4,269	£2,167	£2,102
		Elective	26	24	-2	£698,600	£734,986	£36,385	£101,121	-£64,736
		Non-elective	0	1	1	£0	£1,240	£1,240	£0	£1,240
		Outpatient New	43	67	24	£7,281	£11,287	£4,006	-£29	£4,034
		Outpatient Follow-up	149	188	39	£15,839	£19,354	£3,514	-£633	£4,147
	Spinal Surgery Total		**219**	**282**	**63**	**£722,933**	**£772,347**	**£49,414**	**£102,626**	**-£53,213**
	Trauma And Orthopaedics	Daycases	86	91	5	£126,073	£135,625	£9,551	£2,153	£7,398
		Elective	126	108	-18	£473,075	£478,507	£5,432	£73,609	-£68,177
		Non-elective	130	129	-1	£325,156	£324,176	-£980	£1,049	-£2,029
		Excess Bed Days	74	43	-31	£25,006	£13,998	-£11,008	-£610	-£10,397
		Outpatient New	1,514	1,496	-18	£272,404	£266,416	-£5,988	-£2,747	-£3,241
		Outpatient Follow-up	2,222	2,997	775	£261,948	£337,531	£75,582	-£15,797	£91,380
		OP Procedure	85	132	47	£14,844	£22,625	£7,781	-£545	£8,326
		Ward Based Outpatient	0	1	1	£0	£98	£98	£0	£98
		Ward Attender	0	3	3	£50	£293	£243	-£10	£253
	Trauma And Orthopaedics Total		**4,237**	**5,000**	**763**	**£1,498,557**	**£1,579,269**	**£80,713**	**£57,103**	**£23,609**
NMSS CBU Total			**17,502**	**16,010**	**-1,492**	**£6,025,017**	**£5,469,810**	**-£555,207**	**£200,721**	**-£755,927**
SCACC CBU	Cardiac Surgery	Elective	56	51	-5	£718,044	£585,978	-£132,065	-£68,377	-£63,688
		Non-elective	26	19	-7	£505,543	£356,942	-£148,601	-£10,964	-£137,637
		Excess Bed Days	132	123	-9	£58,947	£54,068	-£4,879	-£900	-£3,979
		Outpatient New	18	33	15	£12,774	£23,760	£10,985	-£0	£10,985
		Outpatient Follow-up	56	38	-18	£40,532	£27,360	-£13,172	-£0	-£13,172
		Ward Attender	0	1	1	£0	£720	£720	£0	£720
	Cardiac Surgery Total		**288**	**265**	**-23**	**£1,335,841**	**£1,048,828**	**-£287,013**	**-£80,241**	**-£206,772**
	Cardiology	Daycases	40	37	-3	£109,749	£122,589	£12,840	£21,550	-£8,710
		Elective	42	37	-5	£166,497	£153,136	-£13,361	£7,344	-£20,705
		Non-elective	24	23	-1	£114,355	£72,624	-£41,731	-£35,187	-£6,544
		Excess Bed Days	35	41	6	£14,035	£15,262	£1,226	-£1,336	£2,563

SCACC CBU	Cardiology	Outpatient New	331	301	-30	£78,838	£71,677	-£7,161	-£81	-£7,080
		Outpatient Follow-up	812	918	106	£107,263	£119,324	£12,061	-£1,952	£14,013
		Ward Based Outpatient	58	2	-56	£7,687	£260	-£7,427	-£4	-£7,423
		Ward Attender	22	20	-2	£2,858	£2,600	-£258	-£42	-£216
	Cardiology Total		**1,364**	**1,379**	**15**	**£601,282**	**£557,471**	**-£43,811**	**-£9,709**	**-£34,102**
	Gynaecology	Daycases	2	3	1	£2,061	£3,132	£1,071	£513	£558
		Elective	1	2	1	£1,294	£2,236	£942	-£157	£1,099
		Outpatient New	47	49	2	£6,812	£7,032	£219	-£7	£226
		Outpatient Follow-up	78	74	-4	£7,349	£6,849	-£500	-£107	-£393
		OP Procedure	0	0	0	£30	£0	-£30	£0	-£30
		Ward Attender	0	0	0	£23	£0	-£23	£0	-£23
	Gynaecology Total		**130**	**128**	**-2**	**£17,569**	**£19,248**	**£1,679**	**£242**	**£1,437**
	Intensive Care	Elective	1	0	-1	£1,652	£0	-£1,652	£0	-£1,652
		Non-elective	32	26	-6	£73,136	£227,840	£154,704	£169,131	-£14,427
		Excess Bed Days	60	35	-25	£22,640	£11,931	-£10,709	-£1,350	-£9,359
		Outpatient New	18	28	10	£13,047	£19,905	£6,858	-£760	£7,618
		Outpatient Follow-up	68	169	101	£48,098	£124,590	£76,492	£5,850	£70,642
		OP Procedure	1	3	2	£112	£324	£213	-£12	£225
		Ward Based Outpatient	9	0	-9	£6,209	£0	-£6,209	£0	-£6,209
	Intensive Care Total		**189**	**261**	**72**	**£164,894**	**£384,591**	**£219,697**	**£172,859**	**£46,838**
	Paediatric Surgery	Daycases	234	212	-22	£275,201	£251,693	-£23,508	£2,728	-£26,236
		Elective	95	74	-21	£401,619	£216,595	-£185,024	-£97,652	-£87,372
		Non-elective	248	259	11	£968,632	£758,592	-£210,040	-£251,488	£41,447
		Excess Bed Days	504	111	-393	£198,904	£38,655	-£160,249	-£5,187	-£155,062
		Outpatient New	378	359	-19	£66,879	£63,463	-£3,416	-£85	-£3,331
		Outpatient Follow-up	594	583	-11	£68,777	£66,755	-£2,022	-£698	-£1,324
		OP Procedure	0	0	0	£28	£0	-£28	£0	-£28
		Ward Based Outpatient	63	18	-45	£7,309	£2,059	-£5,250	-£24	-£5,227
		Ward Attender	145	207	62	£16,777	£23,679	£6,901	-£271	£7,173
	Paediatric Surgery Total		**2,262**	**1,823**	**-439**	**£2,004,127**	**£1,421,491**	**-£582,636**	**-£352,676**	**-£229,960**
	Urology	Daycases	286	435	149	£267,719	£408,395	£140,676	£1,247	£139,429
		Elective	25	32	7	£97,227	£84,466	-£12,761	-£40,560	£27,799
		Non-elective	6	9	3	£21,951	£23,612	£1,661	-£8,025	£9,686
		Excess Bed Days	11	3	-8	£4,730	£1,294	-£3,437	£48	-£3,484
		Outpatient New	209	205	-4	£37,673	£36,879	-£794	-£41	-£753
		Outpatient Follow-up	436	433	-3	£66,432	£64,838	-£1,595	-£1,122	-£473
		OP Procedure	0	0	0	£43	£0	-£43	£0	-£43
		Ward Based Outpatient	1	0	-1	£114	£0	-£114	£0	-£114
		Ward Attender	7	6	-1	£1,023	£899	-£125	-£16	-£109
	Urology Total		**982**	**1,123**	**141**	**£496,912**	**£620,381**	**£123,469**	**-£48,469**	**£171,938**
SCACC CBU Total			**5,214**	**4,979**	**-235**	**£4,620,626**	**£4,052,010**	**-£568,616**	**-£317,995**	**-£250,621**
Clinical Support CBU	Radiology	Daycases	219	222	3	£222,120	£270,778	£48,658	£45,442	£3,216
		Elective	29	7	-22	£47,429	£18,602	-£28,827	£6,953	-£35,781
		Non-elective	6	7	1	£38,225	£97,698	£59,474	£51,123	£8,351
		Excess Bed Days	127	31	-96	£51,640	£11,879	-£39,762	-£755	-£39,007
	Radiology Total		**380**	**267**	**-113**	**£359,414**	**£398,957**	**£39,543**	**£102,763**	**-£63,220**
Clinical Support CBU Total			**380**	**267**	**-113**	**£359,414**	**£398,957**	**£39,543**	**£102,763**	**-£63,220**
Grand Total			**51,648**	**48,891**	**-2,757**	**£17,743,928**	**£16,504,177**	**-£1,239,751**	**£185,525**	**-£1,425,276**

Alder Hey Children's NHS
NHS Foundation Trust

Programme Assurance Summary

Change Programme – 8 Work streams (work stream reports attached for reference)

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

1. Despite improvements made on PiD completeness, there has been insufficient progress in resolving the financial GAP on CIP across a number of the work-streams : 55% behind after 2 months. It is Essential Exec Sponsors and relevant sub committees focus on resolving this as a matter of priority.
2. The committees must complete a full and rigorous quarter 1 stocktake and agree a robust action plan that both ensures effective performance management against financial targets/milestones and delivers a credible plan to close the gap. This is imperative to ensure the financial stability of the trust. This must be delivered by end of July. **Jonathan Stephens 28.06.16**

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

1. This Board reports integrates the assurance reporting received (from the work streams) by WOD on 8 Jun 16, CQAC on 15 Jun 16 and R&BD on 29 Jun 16. The assurance report to the RE&I Sub-committee of 12 May was received by the Trust Board at its meeting of 23 May.
2. The Sub-Committees discharging the responsibility for 'assurance, performance management and direction' of the work streams comprising the programme of change is taking time to evolve into a mature system; however, the Executive Team continues to devote considerable time and energy to action tracking/issue resolution on a weekly basis.
3. It has been agreed by the Audit Committee that the External Programme Assurance should conduct a 6-month review on the performance and results of the new assurance framework; this review will be carried out at the end of FY 16/17 Q2.
4. A number of the 'developmental' CIP projects have either stalled or are estimated to fall short of target; therefore, there is an urgent need to extend/stretch other projects or seek new 'quick-wins' in order to close a growing CIP Gap.

J Gibson

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

Trust target is £7.2m, at month 2, forecast is £4.8m, a gap of £2.3m. (a £0.3m deterioration since last month).To achieve Monitor targets the trust needs to deliver £5.2m, however given slippage against operational financial targets the trust needs to be planning for at least £2m headroom. Since last Trust Board the following actions have been taken;

a) Business development - Workshop results to be reported back via RABD in July.
b) Workforce – Stop/go milestones agreed (end July full comfort around in year, end Aug full comfort around recurrent).
c) Our patients - Re-submission of Outpatient, Complex Care & Clinical Support PiDs in July to CQAC to include accurate financials.
d) Supporting – Decision required on Car parking pricing strategy in order to improve financial forecast

Jonathan Stephens 28.06.16

Alder Hey Children's NHS
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Programme Assurance Summary
Developing Our Workforce

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

1. The pace of identification of CIP opportunities in project 1.1 'Workforce Capability and Sustainability' needs to be increased as a matter of urgency. The initial opportunity assessment completed by CBU's identified £1,033k of CiP 'ideas' leaving a gap of £101k. However, many of these ideas do not have a developed plan and will therefore be captured in a "hopper" in future. These opportunities require full project documentation and opportunity quantification to convert to schemes for delivery and be transferred to the CIP tracker for inclusion in the figures.

2. It is concerning to note that despite a final deadline of 13 May being communicated, only 6 plans have been submitted (CSS, Finance & Information, ICS, Medical Specialities, NMSS and SCACC). Teams should urgently complete and upload plans to SharePoint, or link with their Finance Lead if any support is required. The first Steering Group meeting for this Workstream, which includes three projects (Capability & Sustainability, Developing High Quality Leadership & Management and Starters & Leavers Process) was held on 17 May and action to address the gaps in the Capability and Sustainability project should be given the highest priority.

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

1. The assessment provided to the WOD Sub-Committee on 13 Apr 16 - *"The 'Workforce Capability and Sustainability', project 1.1, structures need to be refined to incorporate the planning of tasks and reporting of benefits across the different levels of activity – Business Unit (BU) and Cross-cutting;* ***separate plans need to be posted onto SharePoint to provide transparency****"* - has not seen the substantial movement required or expected.
2. The letters issued by the CEO on 14 March 2016 call for 6 corporate services and 5 clinical business to deliver workforce efficiencies as stipulated in those letters; moreover, there are 3 cross-cutting strands of the project that need to create plans. To date, as noted by the Executive Sponsor of the assurance framework, just 6 (including the 5 CBUs)of these 14 areas have generated plans onto SharePoint. The sub-Committee should address this lack of progress, and the reasons for it, as a high priority as Q1 of the financial year draws to a close.

J Gibson

Alder Hey Children's NHS
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Programme Assurance Framework

Developing Our Workforce Update (to be completed by Executive Sponsor)

Work Stream Summary:

For the three projects identified in this workstream, the Project Initiation Documents (PIDs) have been finalised, the High Quality Leadership & Management project documentation (QIA/EA) has been submitted for Exec sign off. At the second meeting of the Starters and Leavers project group, gaps in stakeholder representation (IT) will be addressed. For the Capability and Sustainability project only 7/15 plans have been submitted and the remainder need to be developed and presented on 8 June 2016. First Workforce steering group has been held (17 May 2016) and the second meeting is scheduled for 8 June 2016, updates on all plans are expected at this meeting.

Project	Key tasks delivered in month	Milestones on Track (Y/N)
Capability & Sustainability	7/15 plans have been developed in this period.	N
Developing High Quality Leadership & Mgt	PID finalised and draft delivery plan prepared and submitted to Steering Group.	Y
Starters & Leavers Process	PID completed. First project meeting took place 9 May 2016, second meeting taking place 8 June 2016	Y

Milestones for Next Month:

Project	Key tasks to be delivered in month
Capability & Sustainability	7/15 plans have been submitted and the remainder need to be developed and presented on 8 June 2016
Developing High Quality Leadership & Mgt	First Leadership & Management interventions to commence
Starters & Leavers Process	Full communications plan to be developed; key process maps developed
Work Stream	Project Groups to continue to meet as required

Issues for Escalation to Sub-Committee:

The sub-Committee is requested to:

- Note concerns regarding gap in number of plans received.

Alder Hey Children's NHS
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Programme Assurance Framework
Developing Our Workforce Update (completed by Assurance Team)

Sub-Committee	W&OD	Report Date	24 May 2016
Workstream Name	Developing Our Workforce	Executive Sponsor	Melissa Swindell

Current Dashboard Rating:

Project Ref	Project Title	Project Description	Executive Sponsor Assures the project	OVERALL PROJECT RAG status	An effective project team is in place	Scope and Approach is defined	Targets / benefits defined/on track	Milestone plan is defined/on track	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	Comments for attention of the Project Team, Steering Group and sub-Committee
1.0 Developing Our Workforce 16/17 £3.5m and 17/18 £1m													
WOD 1.1	Workforce Capability & Sustainability	To support the development of a capable, sustainable workforce; sufficiently flexible to meet the changing needs of our services in the hospital & the community	Melissa Swindell										Steering Group meeting arranged for 17/5. Overarching PID is complete, however detailed plans and financial information to be fully developed (only 6 available on Sharepoint). Risk Log is available to be fully completed. EA/QIA to be completed and signed off for each individual plan. **Last updated 4 May 2016**
WOD 1.2	Developing High Quality Leadership & Management	To implement a Trust wide Leadership and Management Strategy which supports leaders at all levels to develop a positive, high performance culture	Melissa Swindell										SG meeting held 17/5. PID contains details of benefits - tracking to be comm-enced. Milestone Plan shows actions broadly on track (some slippage/push back to Y2) - evidence to be uploaded to Sharepoint where available. Comms activities being tracked, clarification required re some actions. Risk Log complete. EA/QIA sign off process to commence. **Last updated 19 May 2016**
WOD 1.3	Improving Employee Communication & Engagement	To implement a Trust wide employee communication and engagement plan which supports the development of a positive, high performance culture	Melissa Swindell/ Louise Dunn										Executive Sponsors advise that this project is now superceded by the Trust LIA roll-out; Trust Board of 5 Apr 16 decided to receive assurance/feedback directly from the first 10 LIA teams in 3 months (July 2016).
WOD 1.4	Starters & Leavers Process	To establish the internal processes with regards to sharing and maintaining information on staff starters, leavers and changes, also to establish an agreed process for those non-employees	Melissa Swindell										First Project Team meeting held. PID complete which contains details of benefits. Milestone Plan on Sharepoint shows actions up-to-date. Comms Plan to be developed. Gaps in stakeholder attendance at first meeting, however commitment already obtained to attend future meetings. Risk Log available. EA/QIA complete. **Last updated 9 May 2016**

Financial Reporting:

Project Title	RAG Rating	Budget (£)	Forecast (£)	Variance (£)	Comments
Workforce Capability & Sustainability	R	1,135,121	1,033,249	(101,872)	Gap IYE of £101k but GAP FYE of £2,223k. Schemes under review and ideas to be collected in a "hopper"
Developing High Quality Leadership & Management	Not Applicable				Non financial project
Starters & Leavers Process	Not Applicable				Non Financial project

Alder Hey Children's NHS
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Programme Assurance Summary
Developing Our Business

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

There is a significant financial gap for business development (£800k) which requires a robust action plan before end of July. An horizon scanning workshop has been held which requires financial evaluation and conclusion.

It is pleasing to note the international patient project is progressing well with more patients than original planned at this stage, the team are requested to consider stretching the forecast in order to mitigate some of the work stream gap. An update is required in July,

Jonathan Stephens
21.06.16

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

1. At the time of writing, both the 'Strategic Partnerships' and 'Other Business Development' project lines are red rated. The Executive Team, on 9 Jun 16, agreed a number of steps to accelerate progress.
2. The Clinical Leadership of the implementation phase of certain business development opportunities will be critical to success; the sub-Committee should ensure that this aspect of governance is robust.

J Gibson
9 Jun 16

Programme Assurance Framework
Developing Our Business Workstream Update

Alder Hey Children's NHS
NHS Foundation Trust

Work Stream Summary:

The above workstream accommodates the following projects:
- Strategic Partnerships – Andy McColl
- International Clinical Business and Non NHS Patients – Angie May

Work Stream Progress:

Project	Key tasks delivered in month	Milestones on Track (Y/N)
Strategic Partnerships	UNHM: Developed proposal for expansion of Paediatric Surgery Service in Stoke	Yes
	UNHM: Developed/agreed implementation plan for changing the Cardiac Surgery pathway	Yes
	UNHM: Children's Hospital - Business Development Group took place 13.06.2016	Yes
	WHH: Draft MOU formalised	Yes
International/Non NHS	Further dissemination of communications plan for Non NHS work took place	Yes
	Commercial terms to be agreed with Al Jalila	Yes
	3 visiting fellows agreed to attend placement at Alder Hey during August	Yes
	Patient activity/financial activity on track.	Yes

Milestones for Next Month:

Project	Key tasks to be delivered in month
Strategic Partnerships	UNHM: Exec to Exec meeting
	LWH: ODN options appraisal planned for early July
	CMFT: NorCHI: Formalise and document Network Agreement
	CMFT: NorCHI: Agree financial arrangements for 2016/17
International/Non NHS	Agree financial value of Al Jalila Partnership

Issues for Escalation to Sub-Committee:

No issues to raise.

Programme Assurance Framework
Developing Our Business

Alder Hey Children's NHS
NHS Foundation Trust

Sub-Committee	RABD	Report Date	17 June 2016
Workstream Name	Developing Our Business	Executive Sponsor	Jonathan Stephens

Current Dashboard Rating:

Project Ref	Project Title	Project Description	Executive Sponsor Assures the project	OVERALL PROJECT RAG status	An effective project team is in place	Scope and Approach is defined	Targets / benefits defined/on track	Milestone plan is defined/on track	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	Comments for attention of the Project Team, Steering Group and sub-Committee
R&BD 2.1	Strategic Partnerships	To grow and strengthen existing partnerships, as well as to look for new opportunities as a means to improve the quality of care across the region	Jonathan Stephens										June SG actions available (M&BD Group). Benefits to be confirmed (WHH) and tracking established for non-financial benefits. Milestone Plan shows some delays, some milestones requiring revised dates and some outstanding actions. Evidence required of stakeholder engagement. QIA/EA complete. **Last updated 15 June 2016**
R&BD 2.2	International Clinical Business and Non-NHS Patient Services	The aim of the project is to grow existing operations and brand name beyond the domestic region by increasing our international footprint	Jonathan Stephens										June Steering Group notes available (M&BD Group). Benefits defined, tracking process being developed. Milestone Plan broadly on track (delay with bed man/operational aspects). Comms Plan available. Risk Log up-to-date. EA/QIA complete. **Last updated 16June 2016**
R&BD 2.3	Other Business Development	CBU Business Development Plans	Jonathan Stephens										Financial tracking information now available. Programme Assurance information/details to be reviewed end of June 2016.

Project Title	RAG Rating	Budget £	Forecast £	Variance £	Comments
Strategic Partnerships	R	1,273,400	527,768	(745,632)	
International Patients	G/A	112,000	112,000	0	
CBU Business Development	R	114,600	48,039	(66,561)	
Total		1,500,000	687,807	(812,193)	

Alder Hey Children's NHS
NHS Foundation Trust

Programme Assurance Summary
Our Patients at the Centre

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

There is a critical minimum CIP savings dependency upon the projects in this work stream amounting to circa £1m. Of this total, £0.8m has been identified in PIDs, however £271k of this figure relates to Complex Care Made Simple and is under review. A meeting to re-scope the work stream and identify other ways of implementing step-down rehab without significant additional resource is scheduled for key stakeholders on 17/06/16. The PID for Outpatients is being reviewed and is due to be presented to this group in June. The PID for Clinical Support Services is due to be presented to CQAC in July.
Regarding Complex Care Made Simple, there is a risk that the £292k CIP identified is at risk. Therefore, the potential CIP gap overall for "Our Patients at the Centre" ranges from £300k best case or £600k worst case. This gap needs to be mitigated and resolved as a matter of urgency by the Executive Sponsors for the work stream. With regard to Complex Care Made Simple, Trust Colleagues met with representatives from Specialised Commissioning and Liverpool CCG in order to progress the Rehab development. The Rehab development is the key success factor for the Complex Care Made Simple project. It is anticipated positive agreement and timescales for implementing the proposed rehab model will be secured over June / July.

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

1. Nearing the end of FY Q1 there is an absence of an agreed PID for the Outpatients Improvement Project. While the leadership focus now coalescing around the issue is strong, and the Listening Into Action approach in evidence, this needs to be accompanied by a tempo and precision about the work in hand; since the launch of Phase 1 of the change programme in 2013, there has never been consensus around an agreed PID through the programme governance structures. Therefore, a detailed and compelling PID needs to be issued **by an agreed date** to instil the conviction and confidence the Outpatients service merits.

2. The principle that Executive Sponsor(s) should ensure that the work stream targets for CIP are met – by adjusting existing projects or introducing new initiatives - should be robustly applied by the CQAC Sub-Committee.

J Gibson

Alder Hey Children's NHS
NHS Foundation Trust

Programme Assurance Framework

Our Patients at the Centre Update (to be completed by Executive Sponsor)

Work Stream Summary:

There is a critical minimum CIP savings dependency upon the projects in this work stream amounting to circa £1m. Of this total, £0.8m has been identified in PIDs, however £271k of this figure relates to Complex Care Made Simple, which was based on expectation of the Vanguard, which has not materialised. A positive meeting was held with key stakeholders, where principles of the Care Pathway were reaffirmed, and actions focused on securing commissioner commitment/resource. The PID for Outpatients is being reviewed, and the staff engagement listening exercise has been completed. Workstreams and deliverables have been re-focussed and improved resources and governance of this improvement project have been identified. A paper confirming this is on the agenda for CQUAC in June 2016. The PID for Clinical Support Services is due to be presented to CQAC in July, this follows a revised staff engagement approach using LiA in Radiology in particular. At this stage of performance improvement both the outpatient CIP and the Complex Care CIP remain at risk. . Therefore, the potential CIP gap overall for "Our Patients at the Centre" ranges from £300k best case or £600k worst case. This gap needs to be

Project	Key tasks delivered in month	Milestones on Track (Y/N)
CSSD	Radiology a LiA service	Y
Outpatients	Listening events, revised priorities identified, milestones to be revised in updated PID	N

Milestones for Next Month:

Project	Key tasks to be delivered in month
CSSD	Revised PID Completed informed by staff engagement
Outpatients	Strengthened leadership and focus on delivery in place with agreed milestones
	Updated PID to go CQUAC July

Issues for Escalation to Sub-Committee:

At this stage CIP at risk , work still to be done to identify source of savings for CSSD and Outpatients

Programme Assurance Framework
Our Patients at the Centre (Completed by Assurance Team)

Alder Hey Children's NHS Foundation Trust

Sub-Committee	CQAC	Report Date	6 June 2016
Workstream Name	Our Patients at the Centre	Executive Sponsor	Hilda Gwilliams/COO

Current Dashboard Rating:

Project Ref	Project Title	Project Description	Executive Sponsor Assures the project	OVERALL PROJECT RAG status	An effective project team is in place	Scope and Approach is defined	Targets / benefits defined/on track	Milestone plan is defined/on track	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	Comments for attention of the Project Team, Steering Group and sub-Committee
3.0 Our Patients at the Centre 16/17 £1m and 17/18 £2m													
CQA 3.1	Implementing New Quality Strategy	To implement a Quality Strategy characterised by a strong Clinical Cabinet with strong clinical leadership to deliver improvements in patient safety, patient experience and clinical effectiveness	Hilda Gwilliams		G	G	G	G	G	G	G	G	Steering Group information on Sharepoint. Benefits defined in PID. Milestone Plan shows actions on track., Comms/Engagement tracker available and information available on Sharepoint. Risk Log up has been reviewed, but date needs amending on form. QIA/EA complete. **Last updated 26 May 2016**
CQA 3.2	Best Operative Care	The "Best in Operative Care" strategy aims to deliver the best paediatric operative care in the world, as measured by low rates of mortality and harm, and high staff satisfaction	Mags Barnaby		G	G	G	A	G	A	G	G	Steering Group notes available. Detailed tracking commenced for benefits starting 04/16. Milestone Plan shows some delays - more detail required for Wellbeing workstream. Comms/Engagement information available for most workstreams. Evidence required of risk management. **Last updated 3 June 2016**
CQA 3.3	Improving Outpatients	The project will improve patient & staff experience; understand demand and capacity; review processes & communication; & improve the flow & environment	COO/ Hilda Gwilliams		A	A	A	A	A	G	G	G	SG notes available - some gaps with attendance inc Workstream Leads. Scope to be clarified - revised PID to be presented at June CQAC meeting, following which project documentation will be reviewed. EA/QIA complete. **Last updated 19 May 2016**
CQA 3.4	Complex Care Made Simple	The aim of this project is to improve the quality of care at Alder Hey to Children and Young People with complex health needs	Mags Barnaby		G	A	A	A	G	G	G	G	Steering Group notes available on Sharepoint. Benefits tracker has been created. Detailed plan is available, however Rehab position key milestone missed - scope/approach to be clarified. Comms tracker available and parent rep on SG. Risk Log is up-to-date. EA/QIA has been completed and signed off. **Last updated 3 June 2016**
CQA 3.5	Improving Flow	The aim of the project is to provide the most efficient and effective means of supporting patient flow across the organization	Hilda Gwilliams		G	G	G	A	A	A	G	G	Project Team meeting papers available. PID complete with full details of benefits - tracking process commenced. Milestone Plan shows some delays and some outstanding actions - evidence to be uploaded to Sharepoint where possible. Evidence of stakeholder engagement/comms required. Risk Log to be updated. EA/QIA complete **Last updated 3 June 2016**
CQA 3.6	Clinical Support Services	Resolve the potentially conflicting priorities of making efficiencies whilst continuing to provide a flexible approach to supporting clinical services, maintaining a focus on delivering high quality services to patients	Mags Barnaby										21/4/16 Advised project is to be re-framed and re-phased to allow clinical/professional engagement and ownership. PID to be presented at July CQAC.

Project Title	RAG Rating	Budget £	Forecast £	Variance £	Comments
Implementing New Quality Strategy	N/A				Non-Financial
Improving Flow	N/A				Non-Financial
Best Operative Care	G/A	505,304	**454,386**	**(50,918)**	No Postings in Ledger M1 so reduction in forecast
Improving Outpatients	B	156,250	**0**	**(156,250)**	No Schemes submitted for financial tracker
Complex Care Made Simple	A	291,571	**291,571**	**0**	
Clinical Support Services	B	93,750	**0**	**(93,750)**	No Schemes submitted for financial tracker
Total		1,046,875	**745,957**	**300,918**	

Alder Hey Children's NHS
NHS Foundation Trust

Programme Assurance Summary
Services in Communities

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

The project ratings for both of these projects have improved considerably, thanks to the teams providing appropriate updates and evidence to SharePoint.

The Financial detail around the Existing Community Services project should be clarified at the earliest opportunity, before July update.

Jon Stephens
17 June 2016

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

1. The project management ratings for the 'Existing Community Services – Quality Improvement' project should be given high priority – it was confirmed at the Executive Team of 9 Jun 16 that the appointment of a project manager, previously agreed in principle, was within the gift of the CBU concerned.

J Gibson
9 Jun 16

Alder Hey Children's NHS
NHS Foundation Trust

Programme Assurance Framework
Services in Communities Workstream Update

Work Stream Summary:

The above workstream accommodates the following projects:

- **Developing a Partnerships Model for Community Services – Clare Mahoney**
- **Quality Improvement of Existing Community Services – Jacqui Flynn**

Work Stream Progress:

Project	Key tasks delivered in month	Milestones on Track (Y/N)
Community Model	Workshops delivered with the local authority to further develop community model	Yes
	LCH transaction: explicit terms of arrangement confirmed by Bridgewater & AHFT, MOU drawn up	Yes
	LCH transaction: data room opened 16.05.2016	Yes
	Bid team brought together to work on LCH/Sefton 0-19 Services Bids	
Quality Improvement	The Eating Disorder Steering Group has been established and will meet weekly- providing monthly reports to CBU Board.	Yes
	Economies of scale in relation to staffing costs have been introduced at the Dewi Jones Unit- with utilisation of senior staff across the Dewi and eating Disorder Service.	

Milestones for Next Month:

Project	Key tasks to be delivered in month
Community Model	Submit first draft of LCH RFP 20.07.2016
	Sefton 0-19 Tender information release date mid June 2016
Quality Improvement	

Issues for Escalation to Sub-Committee:

No issues to raise.

Programme Assurance Framework
New Services in Communities

Alder Hey Children's NHS
NHS Foundation Trust

Sub-Committee	RABD	Report Date	17 June 2016
Workstream Name	New Services in Communities	Executive Sponsor	Therese Patten & Mags Barnaby

Current Dashboard Rating:

Project Ref	Project Title	Project Description	Executive Sponsor Assures the project	OVERALL PROJECT RAG status	An effective project team is in place	Scope and Approach is defined	Targets / benefits defined/on track	Milestone plan is defined/on track	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	Comments for attention of the Project Team, Steering Group and sub-Committee
4.0 New Services in Communities 16/17 £200k and 17/18 £2m													
R&BD 4.1	Developing a Partnership Model for Community Services	The aim of the project is to work with partners to work out what an integrated model for childrens services in Liverpool will look like	Therese Patten										May Project Team notes available, SG minutes for June on Sharepoint. PID shows some gaps in team and current services detail. Deliverables and benefits detailed within PID. Plan available on Sharepoint, shows some delays and some tasks outstanding (to be marked as complete or missed. Risk Log reviewed in May. EA/QIA complete. **Last updated 6 June 2016**
R&BD 4.2	Existing Community Services - Quality Improvement	To deliver quality improvement of existing services within the ICS CBU, specifically in the following services: Child & Adolescent Mental Health Services (CAMHS), Neurodisability and General Paediatrics'	Mags Barnaby										No named PM, however some team meeting notes now available. PID complete and contains details of benefits, tracking to be clarified for those with April start date. Milestone Plan shows actions broadly on track. Comms/ Engagement Plan available, evidence to be provided where possible. Some minor details O/S with Risk Log. EA/QIA complete. **Last updated 16 June 2016**

Project Title	RAG Rating	Budget £	Forecast £	Variance £	Comments
Developing a Partnership Model for Community Services					Non financial
Existing Community Services – Quality Improvement	B	200,000	0	(200,000)	
Total		200,000		(200,000)	

Alder Hey Children's NHS
NHS Foundation Trust

Programme Assurance Summary
Developing IM&CT and EPR

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

The PIDs for the projects in this workstream have recently been completed and the team should now focus on developing all other project documentation to meet the assurance standards. EA/QIAs are outstanding for all projects and priority should be given to developing the milestone plans so visibility of progress across all projects is available.
There are no CIP target applicable or financial budget concerns to note.
Assurance requirements are currently being confirmed with regard to the Other Clinical Systems project – discussion between the Executive Sponsor of the Workstream and the Chief Information Officer.

Jon Stephens
17 June 2016

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

1. The PIDs for this work stream should be aiming to meet the standard set by the EPR Project, this document is of a particularly high quality.
2. At the time of writing, the only PID still in a developmental stage is 'Other Clinical Systems' and there needs to be particular focus on this multifaceted project to ensure the definition is completed in a timely fashion.
3. The External Programme Assessment has agreed in principle with the CIO to track some of the early 'change control process' initiatives to see how the benefits realisation is 'owned' and tracked by the operational users and asset owners.

J Gibson
9 Jun 16

Alder Hey Children's NHS
NHS Foundation Trust

Programme Assurance Framework
Developing IM&CT and EPR Update

Work Stream Summary:

PIDS have been written and detailed implementation plans are now in development.
The final testing is underway for the MEDITECH 6 system upgrade which goes live on July 21st 2016. (Training is scheduled to start on 27th June 2016). Uptake of training is being monitored and reported to the Executive team on a weekly basis.

Work Stream Progress:

Project	Key tasks delivered in month	Milestones on Track (Y/N)
EPR	Testing of software enhancements and development of training materials.	Y
Other Clinical Systems	Initial discussions about scope and priorities completed.	Y
Connectivity	Baseline assessment complete.	Y
Imaging	ECG and Medical Photography workflows built and tested. Ready to go live (subject to PACS upgrade)	Y

Milestones for Next Month:

Project	Key tasks to be delivered in month
EPR	System upgrade 21/07/16
Other Clinical Systems	iGrow live 21/07/16. Specification for MEDISEC Tertiary referrals development to be finalised.
Connectivity	Initial requirement scoping complete.
Imaging	PACS upgrade timescales confirmed.

Issues for Escalation to Sub-Committee:

None

Programme Assurance Framework
Developing IM&CT and EPR

Alder Hey Children's NHS
NHS Foundation Trust

Sub-Committee	RABD	Report Date	17 June 2016
Workstream Name	Developing IM&CT and EPR	Executive Sponsor	Jonathan Stephens

Current Dashboard Rating:

Project Ref	Project Title	Project Description	Executive Sponsor Assures the project	OVERALL PROJECT RAG status	An effective project team is in place	Scope and Approach is defined	Targets / benefits defined/on track	Milestone plan is defined/on track	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	Comments for attention of the Project Team, Steering Group and sub-Committee
R&BD 6.2	EPR Development	O/S issues from P1& 2 (technical & process related) as well as deferred work from P1 & the list of potential projects for P3: need prioritisation & wider discussion to ensure org ownership	Jonathan Stephens										PID presented at May Steering Group meeting and now uploaded to Sharepoint. Project documentation to be fully developed, including Milestone Plan, Risk Log (target scores) and EA/QIA. **Last updated 31 May 2016**
R&BD 6.1	Imaging	Project aims to digitise all existing paper records, implement a full electronic patient record solution and provide a repository for all clinical images	Jonathan Stephens										PID presented at May Steering Group meeting and now uploaded to Sharepoint together with some project documentation. Detail of benefits to be confirmed, including baseline data. Some information on Milestone Plan requires clarification and position re Workstream risks to be confirmed. **Last updated 31 May 2016**
R&BD 6.3	Other Clinical Systems	To implement full electronic patient record in PICU, allowing recording, maintenance & reporting, in addition to interface with relevant systems including PAS, pathology & key medical devices	Jonathan Stephens										PID available on Sharepoint, however there are gaps with information required. Assurance requirements to be confirmed with Exec Sponsor. **Last updated 31 May 2016**
R&BD 6.4	Community Infrastructure	This workstream will cover IT connectivity at off site locations and interoperability and projects that it is hoped to implement as part of the iLinks programme	Jonathan Stephens										PID presented at May Steering Group meeting and now uploaded to Sharepoint. Project documentation to be fully developed, including Milestone Plan, Risk Log (target scores) and EA/QIA. **Last updated 31 May 2016**

Project Title	RAG Rating	Budget £	Forecast £	Variance £	Comments
Total	Not applicable				Non financial projects

Alder Hey Children's NHS
NHS Foundation Trust

Programme Assurance Summary
Supporting Front Line Staff

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

Since preparation of the External Programme Assessment update, it is pleasing to note that the issue regarding completion of the EA/QIA for Coding & Capture has been addressed.

The projects are progressing well within this workstream, however the Facilities project documentation should be updated at the earliest opportunity (last update 1 June).

There are financial gaps in the facilities and medicines optimisation areas which require addressing and mitigating urgently. The decision making for car parking which holds Signiant financial value should be escalated as now behind milestone plan

Jon Stephens
17 June 2016

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

1. The Executive Sponsor, through the established Steering Groups, should ensure that the Trust policy for both Equality Assessment and Quality Impact Assessment (EA/QIA) is applied without further delay for the 'Coding and data Capture' project and that the EA/QIA forms are completed and signed off.

J Gibson
9 Jun 16

Programme Assurance Framework
Supporting Front Line Staff

Alder Hey Children's NHS Foundation Trust

Sub-Committee	RABD	Report Date	17 June 2016
Workstream Name	Supporting Front Line Staff	Executive Sponsor	Jonathan Stephens, Rick Turnock, Hilda Gwilliams

Current Dashboard Rating:

Project Ref	Project Title	Project Description	Executive Sponsor Assures the project	OVERALL PROJECT RAG status	An effective project team is in place	Scope and Approach is defined	Targets / benefits defined/on track	Milestone plan is defined/on track	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	Comments for attention of the Project Team, Steering Group and sub-Committee
R&BD 7.1	Procurement	Deliver best in class purchasing. Action the team 10 point plan to ensure service delivered to CBUs is high standard, with great customer service and releases £1m	Jonathan Stephens										Steeering Group meeting notes available. Benefits tracked via Financial Tracker. Detailed workplan is available on Sharepoint - updated recently. Stakeholder Engagement information is available showing activities for May. Risk log up-to-date. QIA/EA signed off by Execs. **Last updated 17 June 2016**
R&BD 7.2	Coding & Data Capture	To deliver best in class coding service that improves the depth of doing. To ensure the trust is getting paid for activity it delivers; to educate and train end users and clinicians to capture all activity	Jonathan Stephens										Project Team notes available for February. Targets & benefits detailed in PID, tracking/visibility required of non-financial benefits. Detailed Milestone Plan available which is up-to-date. Evidence required of Comms/Stakeholder engagement. Risk Log needs to be reviewed. EA/QIA complete. **Last updated 17 June 2016**
R&BD 7.3	Medicines Optimisation	Medicines optimisation is a patient-focused approach to getting the best from investment in and use of medicines. It requires a holistic approach, an enhanced level of patient centred professionalism	Rick Turnock										Steering Group meeting notes available. PID complete. Workplan available - tracking process has been confirmed with team. Evidence of Comms/engagement available on Sharepoint - plan to be confirmed. Evidence required of review of risk log. QIA/EA signed off by Execs. **Last updated: 7 June 2016**
R&BD 7.4	Facilities	The project aims to review all Facilities Services to ensure that all services are maximising quality at the lowest cost resulting in a CIP contribution of £500k	Hilda Gwilliams										Evidence of Project Team meetings available. Tracking for non-financial benefits has commenced but current position unclear. Milestone plan updated but shows some slippage with dates. AGV workstream tasks to be confirmed Risk Log to be fully completed and reviewed regularly QIA/EA signed off by Execs. **Last updated: 1 June 2016**
R&BD 7.5	Pathfinders	To embed SLR costing information and introduce Pathfinders to improve Trust financial health and clinical engagement	Jonathan Stephens										Evidence of meetings available on Sharepoint for May. PID complete and contains details of benefits. Plan up-to-date and shows actions broadly on track. Comms/engagement activities detailed in PID, evidence to be made available on delivery. Risk Log is up-to-date. EA/QIA complete. **Last updated 14 June 2016**

Project Title	RAG Rating	Budget £	Forecast £	Variance £	Comments
Procurement	G/A	1,018,000	1,008,409	(9,591)	
Coding & Data Capture	G/A	900,000	875.000	(25,000)	
Medicines Optimisation	A	500,004	313,248	(186,756)	
Facilities	A	500,000	289,762	(210,238)	This relates largely to delays in decision making for carpark price strategy.
Pathfinders					Non Financial
Total		2,918,004	2,486,419	(431,585)	

Alder Hey Children's NHS
NHS Foundation Trust

Programme Assurance Summary
Park, Community Estate & Facilities

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

The team have worked hard to make available on Sharepoint the range and standard of project documentation to improve the project ratings across the workstream. This work should continue to improve the ratings further.

The Project team to work with finance to ensure all projects are delivered within approved budget and per the business case.

Assurance for a further three projects within this workstream is due to commence early in July, so arrangements should be made to ensure the documentation is available to meet the agreed timescales.

Jon Stephens
17 June 2016

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

1. At the time of writing, the ratings for the projects in this work stream have improved since the previous report and that effort is welcome. However, with 3 projects still amber rated, and one at red, the teams should continue to work to ensure the right evidence (see the guide to assurance ratings) to meet the assurance standard needs to be posted onto SharePoint to provide transparency.
2. The Executive Sponsor and Strategic Project Manager have worked hard to improve the Steering Group function for this work stream which is now much improved and operating to a good standard with clear reporting.
3. Equality Assessments and Quality Impact Assessments (EA/QIA) still need to be completed and signed off for the 'Park' project and the 'Residential Development' project.

J Gibson
9 Jun 16

Alder Hey Children's NHS
NHS Foundation Trust

Programme Assurance Framework 29th June 2016

Site Development Update - Park, Community Estate and facilities

Work Stream Summary:

This work stream consists of a number of projects which focus on development of the park, land, additional campus buildings and relocation of existing services including the community services . Demolition , decommissioning, temporary departmental moves, residential and the corporate /clinical block have all commenced and are at varied stages of their specific project programme.

Projects yet to fully commence but planned are;

- Agile working – June- PID in Draft and project group identified
- Community Estate – Initial Project discussions and documentation development commenced this month
- Alder Centre and Residual services - July
- REII- TBC initial designs and outstanding funding requirement currently being confirmed.

Project	Key tasks delivered in month	Milestones on Track (Y/N)
Temporary moves	All completed along with all retained estate telephone migrations	Y COMPLETE
Residential/land project	Six bidders selected for invitation and attended initial Introduction/visionary meetings and weekly dialogue discussions planned over the next 8 weeks.	Y
Decommission/demolition	Site clearance commenced in Theatres and Mulberry House Tender submissions evaluated and anticipating awarding the contract this month.	y N- 3 months behind plan
Corporate/clinical block	Floor space was reduced by 300M^2 and revised plans presented to end users. Desk numbers have now been finalised and shared with end users	N- one month behind plan
Park development	Stakeholder meeting held with local community and LCC partnership. Following business case approval	Y

Project	Key tasks to be delivered in month
Corporate/clinical block	Architects requested to further develop design to RIBA stage C at which point we will undertake a full pricing exercise. Full benchmarking exercise underway to dictate strategic design approach.
Residential/land project	Continue dialogue sessions with bidders (8 weeks)
R&E Phase II	Develop design to next stage and secure residual funds

Issues for Escalation to Sub-Committee:

- **Budget to fund Demolition all three phases currently has a shortfall £1.23M**
- **Currently No budget identified for residual estate**
- **Programme slippage due to demolition pricing review and clearance of IM&T links**

Programme Assurance Framework
Developing The Park, Our Community Estate and Facilities

Alder Hey Children's NHS
NHS Foundation Trust

Sub-Committee	RABD	Report Date	17 June 2016
Workstream Name	Developing The Park, Our Community Estate & Facilities	Executive Sponsor	David Powell & Melissa Swindell

Current Dashboard Rating:

Project Ref	Project Title	Project Description	Executive Sponsor Assures the project	OVERALL PROJECT RAG status	An effective project team is in place	Scope and Approach is defined	Targets / benefits defined/on track	Milestone plan is defined/on track	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	Comments for attention of the Project Team, Steering Group and sub-Committee
R&BD 8.1	Decommission & Demolition	The aim of the project is to move out from and make safe the old hospital ready for demolition	David Powell										Steering Group notes available. The PID is complete and contains details of expected benefits, tracking to be confirmed. Plan on Sharepoint requires fully populating with actions, currently shows delays of 2 months (isolation of services & contract award). Workstream Risk Register available, shows financial risk which is being monitored closely. **Last updated 6 June 2016**
R&BD 8.2	Park	To set up a JV with LCC & the local community to create a world class Springfield Park that complements & adds value to the New Alder Hey in the Park & the local area	David Powell										Steering Group notes available. PID complete, some financial details to be confirmed. Plan has been updated but shows some outstanding tasks and missed milestones (3 months +). Evidence of recent comms/stakeholder engagement to be provided. Risk Log available. **Last updated 23 May 2016**
R&BD 8.3	Temporary Moves	Project aims to survey and establish departments to be retained on-site, not already incorporated in new build, and provide the office estate to achieve this	David Powell										Steering Group notes available. Evidence of benefits to be provided where possible. Milestone Plan updated, only a few actions remain. Workstream Risk Log available. EA/QIA complete. **Last updated 16 June 2016**
R&BD 8.4	Agile Working	The aim of the project is to deliver an agile working solution for the Trust that complements the on site and off-site developments	Melissa Swindell										PID is to be completed by 30 June 2016, when capacity is released to complete the work
R&BD 8.5	Research & Education	The aim of the project is to complete Phase 2 of the RI & E building to a world class standard	David Powell										Design work may continue - subject to approval - in advance of funding being secured
R&BD 8.6	Community Services	The aim of the project is to create a suitable home for our network of community services	David Powell										Project work is to commence in June 2016 (irrespective of the bid outcome) to ensure that viable solution (s) are in place
R&BD 8.7	Corporate Offices and On-site clinical Services	The aim of the project is to create a suitable home for the corporate clinical and associated staff/services on the Alder Hey campus	David Powell										Steering Group notes available. PID complete. Milestone Plan is available on Sharepoint, showing missed milestone re design/cost alignment. Remaining project documentation to be fully developed. EA/QIA complete. **Last updated 6 June 2016**
R&BD 8.8	On Site Residual Services	The aim of the project is to create a suitable home for the residual services on the Alder Hey campus	David Powell										PID will be available in July
R&BD 8.9	Residential Development	TBC	David Powell										Steering Group notes available. PID complete, some financial details to be confirmed. Milestone plan available which shows some actions outstanding - to be marked as complete or missed. Comms/Engagement Plan to be developed. Risks to be captured on template and managed in accordance with Trust process. EA/QIA to be completed. **Last updated 27 May 2016**
R&BD 8.10	Alder Centre	TBC	David Powell										PID will be available at the end of July
R&BD 8.11	Commercial	TBC	David Powell										PID will be available at the end of June

Project Title	RAG Rating	Budget £	Forecast £	Variance £	Comments
Total	Not applicable				Non financial projects

Alder Hey Children's NHS
NHS Foundation Trust

Board of Directors
Tuesday, 5 July 2016

Report of	Director of Corporate Affairs
Paper prepared by	Exec Team & Quality Assurance Officer
Subject/Title	Board Assurance Framework 2016/17
Background papers	• Monthly BAF updates/reports • Quarterly Corporate Risk Register Reports • Developing our '2020 Vision' – Alder Hey in the Park and beyond *(presentation to April Board)*
Purpose of Paper	The purpose of this report is to obtain Board approval on the BAF Risks for 2016/17
Action/Decision required	The Board is asked to approve the proposed 2016/17 BAF
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	By 2020, we will: ➢ be recognised for the **exceptional quality of care** we provide to our children, that is technologically enabled and matched by exceptional facilities ➢ be a **world class,** child-focussed **Centre of Research**, innovation and education expertise to improve the health and wellbeing outcomes for children and young people ➢ have a fully **engaged workforce** that is actively driving quality improvement ➢ have secured sustainable long term **financial and service growth** supported by a **strong international business**
Resource Impact	Non achievement of the Trust's objectives could have a negative impact on the services provided by the Trust.

Board Assurance Framework 2016/17

1. Introduction

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

The BAF directly underpins the Annual Governance Statement (AGS) and is the subject of annual review by Internal and External Audit, with the former providing a formal opinion on the fitness for purpose of the process and approach.

2. Key issues

Following the presentation at the April Trust Board '*Achieving our Ambition; Our Strategic Pillars by 2020'* and associated SWOT analysis 2016, an exercise was undertaken looking at strengths, weaknesses, opportunities and threats and cross-referencing these with high level content of the existing BAF.

A number of suggestions have been made on the current principal risks to reflect progress in the achievement of the strategic objectives (2011-16) and to account for emerging external factors that are likely to present a risk to delivery of the Trust's refreshed strategic objectives to 2020.

The Board is asked to consider changes to the risk ratings in this regard taking into account the following questions:

- Have all strategic risks been identified and accurately captured?
- Are there any changes required to the causes and effects?
- Are controls and assurances in place?
- Are the controls in place sufficiently robust to manage risks?
- Is there sufficient assurance regarding the operation of controls to manage the risks?
- Are there any concerns in respect of the assurance given?
- Is the progress on actions sufficient to address gaps in controls and assurance?
- Are there any out of date assurances or overdue actions?

3. Recommendation

The Board is asked to discuss and approve the proposed changes to the 2016/17 BAF.

BOARD ASSURANCE FRAMEWORK 2016/17

BAF 1.1	**Strategic Pillar: Excellence in Quality**	***Risk Title: Maintain care quality in a cost constrained environment***		
Related CQC Themes: Safe, Caring, Responsive, Well-led				
Exec Lead: Hilda Gwilliams	**Type:** Internal, known	***Current IxL: 4-2***	**Target IxL: 4-2**	**Trend: STATIC**

Risk Description	
Failure to maintain appropriate levels of care quality in a cost constrained environment	
Existing Control Measures	
Quality impact assessment of all planned changes	Risk assessment and utilisation of risk registers in responding to incidents and other drivers.
Quality Report performance against quality aims scrutinised at CQAC and Board.	CBU and Corporate Dashboards in place and are part of updated Performance Framework.
Weekly Meeting of Harm	Programme of quality reviews (deep dives) planned across all departments. Implemented and being reported via the quality report.
Ward dashboards	Refresh of CQAC to provide a more performance focussed approach
Changes to ESR to underpin workforce information	New Change programme established – associated workstreams subject to sub-committee assurance reporting
Robust risk and governance processes from ward to board, linked to Monitor's Quality Governance Framework	Quality Strategy 2016-2020 implemented to deliver safe and effective services demonstrated via measurable Quality Aims and Sign up to Safety campaign
External Review on IPCC issues to eradicate reportable HCAIs	Our Patients at the Centre Projects subject to sub-committee monitoring (CQAC)
Assurance Evidence	
Monthly reporting to CQSG	CQAC focus on performance.
Analysis of incident reports	Monthly reporting of the Corporate Report to Board.
Improved reporting – in the top 20% of NRLS nationally	Monthly Quality Report.
Outputs from Quality Review Programme	New CQC style ward accreditation (Journey to the Stars) rolled out
Gaps in Controls/ Assurances	
Full electronic access to specialty performance results	Reduced investment opportunity to respond to clinical development as a result of financial situation
Sign up to Safety 'resource' ending July 2016	

Actions required	**Progress**
~~1.~~ Quality reporting redesigned in line with Quality Strategy and corporate aims. New report scheduled to be received at Board	Chief Nurse & Deputy Head of Information continuing to refine data
2. Successfully implement all change programme workstreams to improve efficiency and flow	Alder Hey Board assurance committees operating to revised Terms of Reference
3. Roll out PFCC model for all appropriate services	Links to patient experience domain – further work awaited
4. Continue to maintain nurse staffing pool	Ongoing
5.	
Exec Lead's assessment	

BOARD ASSURANCE FRAMEWORK 2016/17

BAF 1.2	Strategic Pillar: Growing our Services & Safeguarding Core Business	*Risk Title: Mandatory & compliance standards*		
Related CQC Themes: Safe, Caring, Effective, Responsive, Well-led				
Exec Lead: Margaret Barnaby	**Type:** Internal, known	***Current IxL: 4-5***	**Target IxL: 4-2**	**Trend: STATIC**

Risk Description	
Failure to deliver on all mandatory and compliance standards due to lack of engagement with internal throughput plans and targets	
Existing Control Measures	
Performance Review Group.	CBU Performance Meetings – now strengthened as of May 2016
Risks to delivery addressed through RBD, CQAC, WOD & CQSG and then through to Board	Regulatory status with: Monitor, CQC,NHSLA, ICO, HSE, CPA, HTA,MHRA etc.
Compliance tracked through the corporate report and CBU Dashboards.	New Operational Delivery Group (July 2016) to take action to resolve non-compliance relating to performance. Reporting to RABD
Run rate task & finish group established & ongoing	Early warning indicators now in place
Assurance Evidence	
Regular reporting of delivery against compliance targets through CQSG, CQAC & Board.	Monthly reporting to the Board via the Corporate Report.
Monitor / NHSI governance risk rating	Operational effectiveness measures (key risks with early warning measures) identified and reported monthly to RABD
CQC Action plan reviewed at CQAC and Operational Delivery Group	Compliance assessment against Monitor Provider Licence to Board
	A&E Target Recovery Plan
Gaps in Controls/ Assurances	
Failure of CCG and local health economy to successfully deliver on agreed plans to meet reduction in ED attendances – discussions ongoing with commissioners	Theatre and bed capacity
Some areas remain fragile e.g. IG toolkit, 4 hour waits, MSE, evidence of compliance relating to learning disabilities declaration.	Assurance required to underpin CBU reporting on CQC standards.
'Horizon scanning' to anticipate risks and issues now implemented through performance review meeting	Work with CCG to manage demand & develop/fully utilise existing capacity across PC
Actions required	**Progress**
1. Theatre improvement and cancelled operations improvement plan required	Winter plan 16/17 in development
2. Review bed capacity and staffing and plans for seasonal variation	Complete; refreshed annually in December
3. Implement devolved governance structure (quality governance teams within CBUs)	
Exec Lead's assessment	

BOARD ASSURANCE FRAMEWORK 2016/17

BAF 2.1	**Strategic Pillar: Patient Centred Services**	***Risk Title: New Hospital Environment***		
Related CQC Themes: Safe, Caring, Responsive, Well-led				
Exec Lead: David Powell	**Type:** Internal, known	***Current IxL: 4-3***	**Target IxL: 4-1**	**Trend: NEW**

Risk Description	
Failure to deliver world class healthcare due to constraints of new environment	
Existing Control Measures	
Regular Fix-It Team reports to Execs, CQAC & IGC	Interserve Reports & representation at Health & Safety Committee
Monitoring & Fix-It Team in place responsible for day to day management of PFI Contractor ensuring Services are delivered to the required standards	Fit-It Team governed by a Steering Group (meets monthly)
Assurance Evidence	
Tracker in place	Reporting compliance of PFI Services against contract to the Trust Board
Confirmation that invoices and sums charged are correct (Finance Lead to approve all invoices and expenditure)	
Gaps in Controls/ Assurances	
Interface management between Alder Hey Staff and the PFI Contractor and in-house services teams	
Actions required	**Progress**
Increase profile of hospital Fix-It Team and correct procedure for resolution of issues	Action being taken forward following BIG conversations
Exec Lead's assessment	

BOARD ASSURANCE FRAMEWORK 2016/17

BAF 2.2	**Strategic Pillar: Patient Centred Services**	***Risk Title: Failure to fully realise the Trust's Vision for the Park***		
Related CQC Themes: Safe, Effective				
Exec Lead: David Powell	**Type:** Internal, known	**Current IxL: 4-3**	**Target IxL: 4-1**	**Trend: NEW**

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

Existing Control Measures	
Business Cases developed for various elements of the Park & Campus	Alignment with the 'Alder Hey in the Park' vision and the Alder Hey Campus vision
Heads of Terms agreed with LCC for joint venture approved	Redeveloped Steering Group
Monthly reports to Board / RABD	
Assurance Evidence	
Establishment of a Community Interest Charity to operate the park for AHCH and the local community.	Approved Business Cases for various elements of the Park & Campus approved
Highlight Report to relevant assurance Committees and through to Board	Representation at Springfield Park Shadow Board
Representation at Friends of Springfield Park Group	
Gaps in Controls/ Assurances	
Continued engagement of key stakeholders	Stakeholder events held
Reputational impact due to inexperience in management of such a venture.	Reputational impact due to inexperience in management of such a venture.
Responsibility of providing resource to manage the park	Every Project had a dedicated Project Manager assigned to it
Capital / revenue cash flow pressure	Fully reconciled budget with Plan
End user consultation events held	Ongoing legal and financial liability
Funding yet to be identified for community / residual project	

Actions required	**Progress**
1. Income generation opportunities to be thoroughly explored (grant applications)	
2. Reconcile requirement for funding versus available	
3. Broaden Stakeholder engagement	
4. Completion of all appointments to the Team	
5. Approval of Business Case at LCC	
6. Bid for Biomedical Research Unit	

Exec Lead's assessment

BOARD ASSURANCE FRAMEWORK 2016/17

2.3	**Strategic Pillar: Patient Centred Services**	***Risk Title: IT Strategic Development***		
Related CQC Themes: Safe, Caring, Effective, Responsive, Well-led				
Exec Lead: Jonathan Stephens	**Type:** Internal, known	***Current IxL: 3-4***	***Target IxL*: 3-2**	**Trend: NEW**

Risk Description	
Failure to deliver an IM&T Strategy which will place Alder Hey at the forefront of technological advancement in paediatric healthcare	
Existing Control Measures	
Key projects and progress tracked through the Clinical Systems Informatics Steering group and R&BD Committee.	Clinical Systems Informatics Project group leading on stakeholder engagement – ad hoc groups on specific key topics as needed
Forward Communications plan agreed and tracked at steering group.	Board approval "Asset Owner" process in place to ensure organisational ownership of systems and system development
Improved scheduled Training provision including refresher training and workshops to address data quality issues	Formal change control process now in place
Executive level CIO in place	Investment in IM&T Team (2016/17 budget)
Assurance Evidence	
Regular progress reports presented to R&BD and Operational Board.	MIAA providing assurance role.
Board agreed change control process	Participate in Digital Alder Hey programme
Internal audit reviews	
Gaps in Controls/ Assurances	
IM&T Strategy out of date – update work in progress	Internal programme assurance reports
Resources required to deliver strategy proposed and aspirations of Trust – review Oct 2016	
Actions required	**Progress**
1. Conclude the review of IM&T Infrastructure	
2. IM&T Strategy development & approval	Draft for October 2016
3. Continual improvement of MEDITECH and Other clinical systems as prioritised by the Clinical Systems Informatics Steering group.	
4. Engage with iLinks programme to progress interoperability	
5. Link to innovation partnerships in paediatric healthcare	
6. Meditech6 update planned July 2016 to resolve a number of current operational user issues	
Exec Lead's assessment	

BOARD ASSURANCE FRAMEWORK 2016/17

3.1	**Strategic Pillar: Growing our Services & Safeguarding Core Business**	***Risk Title: Financial Environment***		
Related CQC Themes: Safe, Effective, Responsive, Well-led				
Exec Lead: Jonathan Stephens	**Type:** Internal, known	***Current IxL: 4-4***	**Target IxL: 4-2**	**Trend: STATIC**

Risk Description

Failure to deliver 2016/17 I&E plan and planned Continuity of Service Risk Rating

Existing Control Measures	
Organisation-wide financial plan.	Monitor financial regime and financial risk ratings.
Financial systems, budgetary control and financial reporting processes.	Capital Planning Review Group
Monthly performance review meetings with CBU Clinical/Management Team and the Executive	Financial Position (subject to regular monitoring).
Weekly meeting with CBUs to review forward look bookings for elective and day case procedures to ensure activity booked meets contract and recovery plans. Also review of status of outpatient slot utilisation	COO task & finish group targeted at increasing activity in line with planned levels
CIP subject to programme assessment and sub-committee performance management	
Assurance Evidence	
Monthly Corporate Performance Report presented to both Board and the RBDC.	Specific Reports (i.e. Monitor Plan Review by RBDC)
Monthly Performance Management Reporting with General Managers	Internal and External Audit reporting through Audit Committee.
Daily activity tracker to support CBU performance management of activity delivery	Pay cost control 10 point plan introduced aimed at forecasting and tracking actions to reduce pay cost overspend run rate - updates to Execs, R&BD.
Full electronic access to budgets & specialty performance results	
Gaps in Controls/ Assurances	
Improved financial control and effective recovery required in identified CBU's where slippage against agreed recovery trajectories occurring.	Ongoing cost of temporary staff
CBU recovery plans to hit financial control targets to ensure delivery of overall Trust financial plan.	'Grip' on CIP
Actions required	**Progress**
Plans to address CIP shortfall - scheme PIDs to be complete by end of May Progressing against milestones agreed	Trust in discussions with NHSI re. formal approval of required £8m interim cash support
Improve delivery of clinical business developments to meet local CCG outcome needs, e.g. as part of *Healthy Liverpool*, to achieve and exceed financial targets	COO task & finish group established; targeted at increasing activity in line with planned levels
Focus on activity delivery	Recovery plans under development & review

Exec Lead's assessment

BOARD ASSURANCE FRAMEWORK 2016/17

3.2	**Strategic Pillar: Growing our Services & Safeguarding Core Business**	***Risk Title: Business Development and Growth***		
Related CQC Themes: Safe, Caring, Effective, Responsive, Well-led				
Exec Lead: Jonathan Stephens	**Type:** External, known	***Current IxL: 4-3***	**Target IxL: 4-2**	**Trend: STATIC**

Risk Description	
Risk to business development / growth due to NHS financial environment and constraints on internal infrastructure to deliver business as usual as well as maximise growth opportunities	
Existing Control Measures	
CBU Performance Management Framework.	Clear trajectories for challenged specialities to deliver.
Business Development Plan	2016 Change Programme Projects (Strategic Partnerships & International Clinical Business and non NHS patient services)
Five year plan agreed by Board and Governors in 2014	Capacity Plan identifies beds and theatres required to deliver BD plan
Service development strategy including private / international patient proposal approved by Council of Governors as part of strategic plan sign off	
Assurance Evidence	
Business growth and market analysis reports considered fully by Marketing & Business Development Committee and reported regularly to RBDC.	Business Development Committee and reported regularly to Board via RBDC.
Daily activity tracker and forecast monitoring performance for all activity.	Business Development Plan reviewed monthly by RBDC via Contract Monitoring Report.
CIPs in new Change Programme subject to programme assurance and sub-committee performance management	
Gaps in Controls/ Assurances	
Early warning indicators for leading indicators.	Ability to respond swiftly to potential problems. Workforce constraints in specialised services.
New change programmes reporting monthly to RABD (Strategic Partnerships & International Clinical Business and non NHS patient services)	Potential delay to cardiac growth – current gap c.£0.8m forecast against 16/17 CIP target
Actions required	**Progress**
Identify models & services to provide to non NHS patients / commercial offers	Trust currently progressing tender application for LCH paediatric community services. Timeframe: June-end Aug 2016. Financial assessment will be part of due diligence. Report to RABD and through to Board. Discussions with surgical teams and Stoke to accelerate increase in cardiac cases.
Workshop held in June to identify options for bridging business development gap.	Alternative schemes being developed. Report to RABD
Exec Lead's assessment	

BOARD ASSURANCE FRAMEWORK 2016/17

3.3	Strategic Pillar: Growing our Services & Safeguarding Core Business	*Risk Title: Developing the Paediatric Service Offer*		
Related CQC Themes: Safe, Caring, Effective, Responsive, Well-led				
Exec Lead: Rick Turnock	**Type:** External, known	***Current IxL: 4-3***	**Target IxL: 4-2**	**Trend: NEW**

Risk Description	
Failure to maximise opportunities with regard to service reconfiguration	
Existing Control Measures	
Internal review of service specifications as part of Specialist Commissioning review.	Analysis of compliance and actions agreed where not fully met.
Gap/risk analysis against all national/regional service specification undertaken and action plans developed.	Accreditations confirmed through national review processes.
Compliance with Neonatal Standards	Compliance with All Age ACHD Standard
Post implementation review of Trauma Business Case.	Derogations secured in relation to specialist service specs.
Assurance Evidence	
Key developments monitored through CBU Boards. Risks highlighted to CRC.	Monitored at Performance Management Group.
Monthly to Board via RBDC & Board	Compliance with final national specifications
Gaps in Controls/ Assurances	
Inability to recruit to highly specialist roles due to skill shortages nationally.	Trust has sought derogation in a number of service areas where it does not meet certain standards and is progressing actions to ensure compliance by due date.
Potential elective underperformance due to cancelled sessions	Awaiting final result re CHD service at national level

Actions required	**Progress**
1. Monitoring of action plans.	1. CF service derogation issue requires resolution – now working with NHS England to secure a resolution for the North
2. Pro-active recruitment in identified areas.	2. Trust in discussion with Liverpool Women's re future service models for neonates and in discussion with Liverpool Heart and Chest re future model for cardiac service.
3. Clear plan for delivery of strategic service developments *(cardiac, neonatal, rehab, community care, primary care, Vanguard, CAMHS)*	
4. Pursue the community tender incorporating the public health offer	

Exec Lead's assessment

BOARD ASSURANCE FRAMEWORK 2016/17

BAF 4.1	**Strategic Pillar: Great Talented Teams**	***Risk Title: Workforce sustainability & capability***		
Related CQC Themes: Safe, Effective, Caring, Responsive, Well-led				
Exec Lead: Melissa Swindell	**Type:** Internal, known	***Current IxL: 4-3***	**Target IxL: 4-1**	**Trend: STATIC**

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

Existing Control Measures	
Compliance tracked through the corporate report and CBU Dashboards.	Workforce Group
Performance Review Group.	CBU Performance Meetings.
Mandatory training reviewed and updated in summer 2014	OLM restructured to include key competencies
All training records available online and mapped to competency framework	E-learning updated in January 2015 with one click access
'Developing our Workforce' workstream implemented.	Attendance management process to reduce short & long term absence
Positive attendance Policy	Permanent nurse staffing pool
Assurance Evidence	
Regular reporting of delivery against compliance targets via corporate and CBU reports	Monthly reporting to the Board via the Corporate Report.
Reporting at ward and SG level which supports Ward to Board	
Gaps in Controls/ Assurances	
Poor compliance in critical training e.g. safeguarding, transfusion, manual handling.	Inability to train staff due to clinical workload and acuity preventing them leaving the clinical area.
No proactive assessment of impact on clinical practice	Previous actions have failed to address the problem and poor compliance is increasing.
Education Strategy	Small number of issues remain re the interface with ESR which has slowed the progress of the action plan and reducing assurance

Actions required	**Progress**
1. Task and finish group to review prior action failures and identify solution.	Action plan signed off at WOD
2. Review mandatory training programme – July 2016	
3. Develop our Education Strategy	
4. Recruitment and Retention Strategy to focus on specific groups	
5. Develop and support talent identified within the organisation and via local supply routes e.g. apprenticeships by leveraging networks via HEE and HENW to address future workforce supply challenges	
6. Build and sustain leadership capacity and capability	Workforce Capability and Sustainability project commenced
7. Sickness Policy refreshed	Implement 1 July 2016

Exec Lead's assessment

BOARD ASSURANCE FRAMEWORK 2016/17

BAF 4.2	Strategic Pillar: Great Talented Teams	*Risk Title: Staff Engagement*		
Related CQC Themes: Safe, Effective, Responsive, Well-led				
Exec Lead: Melissa Swindell	**Type:** Internal, known	***Current IxL: 3-3***	**Target IxL: 3-2**	**Trend: STATIC**

Risk Description	
Failure to improve workforce engagement which impacts upon operational performance and achievement of strategic aims	
Existing Control Measures	
Internal Communications Strategy.	Refine Trust Values.
Roll out of Leadership Development and Leadership Framework	Action Plans for Engagement, Values and Communications.
Medical Leadership development programme	Staff Temperature Check Reports to Board
Values based PDR process	People Strategy Reports to Board
Listening into Action methodology	Staff surveys analysed and followed up (shows improvement)
Assurance Evidence	
Outcomes from Annual Staff Survey reported to the Board.	
PDR completion rates	Monthly Engagement Temperature Check reported to the Board.
Monthly Engagement Temperature Check local data now sent to CBUs on a monthly basis to enable them to analyse data locally.	Ongoing consultation and information sharing with staff side and LNC
Progress reports from LiA to Board	
Gaps in Controls/ Assurances	
Overarching Engagement Strategy	Reward and recognition
Actions required	**Progress**
1. Analysis of Staff Survey	
2. Communications Strategy published	
3. Listening into Action Methodology to provide the framework for organisational engagement	3. Roll out commenced May 2016
4. Revised governance arrangements that underpin effective assurance mechanisms utilising the discipline and systems provided by Programme Management methodology.	4.
Exec Lead's assessment	

BOARD ASSURANCE FRAMEWORK 2016/17

BAF 4.3	Strategic Pillar: Great Talented Teams	*Risk Title: Workforce diversity & inclusion*		
Related CQC Themes: Safe, Effective, Responsive, Well-led				
Exec Lead: Melissa Swindell	**Type:** Internal, known	***Current IxL: 3-3***	**Target IxL: 3-1**	**Trend: NEW**

Risk Description	
Failure to proactively develop a future workforce that reflects the diversity of the local population	
Existing Control Measures	
Equality, Diversity & Human Rights Group	Workforce committee re-enforced and includes recruitment and education
Workforce plan established	Staff Survey results
Workforce Planning Policy signed off at WOD June 2015	Equality Analysis Policy
Equality, Diversity & Human Rights Policy	
Assurance Evidence	
Monthly recruitment reports provided by HR/Payroll provider.	Quarterly reports to the Board Via WOD on the Workforce Strategy and Workforce plan
Monthly Corporate Report (including workforce KPI's) to the Board.	Taking forward actions for LiA – enabling achievement of a more inclusive culture
Equality Impact Assessments undertaken for every Policy & Project	Workforce Race Equality Standards
Gaps in Controls/ Assurances	
Proactive working with partners to promote our commitment to diversity and inclusion	Recruitment Strategy to focus on specific groups

Actions required	**Progress**
1. Workforce planning policy published	2. Draft Workforce Planning policy to April RABD
3. Deliver on our new Recruitment and Retention Strategy to ensure an optimum workforce is in place and that the workforce reflects the diversity of the local community	3.
4. Work with partner organisations to develop effective BME recruitment strategy	4.
5. Proactively utilise the EDS2 results to establish the composition of our workforce in order to target areas for improvement	5.
6. Increase declaration rates with Equality Act 2010	6.
Exec Leads assessments	

BOARD ASSURANCE FRAMEWORK 2016/17

BAF 5.1	Strategic Pillar: Research Education & Innovation	*Risk Title: Research, Education & Innovation*		
Related CQC Themes: Responsive, Well-led				
Exec Lead: David Powell	**Type:** Internal, known	***TBC***	***TBC***	***NEW***

Risk Description	
Failure to develop a cohesive approach to research, innovation & education	
Existing Control Measures	
Work closely with LHP and other strategic partners in formulating new Research Strategy	Digital Hospital, Innovation Machine, Innovation Income Generation, Commercial Research & Commercial Education Projects established and reporting into relevant assurance Committees & Board
Steering Groups established for all Projects	
Assurance Evidence	
Research Strategy Committee set up as a new Board Assurance Committee.	
Research, Education and Innovation Committee established	
Gaps in Controls/ Assurances	
Lack of integration with other academic partners	Lack of funding for Alder Hey App.
Appointment of commissioned industry partner for AH App.	Innovation Strategy not yet translated into tactical plan
Commercial research offer	Education Strategy needs to be refreshed
Actions required	**Progress**
1. Develop a single integrated approach across research, education & innovation	1.
2. Develop a robust commercial Education Business model	2.
2. Progress towards making Alder Hey the 'world's first living hospital'	3.
3. Work with our Charity colleagues to raise the profile of our research and innovation capability	4.
4. Creation of a robust commercial machine	5.
5. Educational partnerships to be cemented	6.
Exec Lead's assessment	

Ref, Owner	Risk Title		Risk Rating: I x L	
(15-16 references given in brackets where different)			Current	Target
STRATEGIC PILLAR: Excellence in Quality				
	2015/16	**2016/17**		
1.1 HG	**Maintain care quality in a cost constrained environment** (Deliver clinical excellence in all our services)	**Maintain care quality in a cost constrained environment**	4-2	4-2
1.2 MB	**Mandatory & compliance standards** (Deliver clinical excellence in all our services)	**Mandatory & compliance standards**	4-5	4-2
STRATEGIC PILLAR: Patient Centred Services				
	2015/16	**2016/17**		
2.1 (1.3) DP	**Non-compliant estate** (Deliver clinical excellence in all our services)	**New hospital environment**		
2.2 (2.1) DP	**Finance for Phase 2 of the Research facility** (Be a world class centre for children's research and development)	**Failure to fully realise the Trust's Vision for the Park**	4-3	4-1
2.3 (6.2) JS	**EPR Implementation** (Be the provider of first choice for children, young people and their families)	**IT Strategic Development**	3-4	3-2
STRATEGIC PILLAR: Growing our Services & Safeguarding Core Business				
	2015/16	**2016/17**		
3.1 (5.1) JS	**Income & expenditure plan** (Further improve our financial strength in order to continuously invest in our services)	**Financial Environment**	4-4	4-2
3.2 (6.1) JS	**Business Development & Growth** (Be the provider of first choice for children, young people and their families)	**Business Development & Growth**	4-3	4-2
3.3 (6.3) RT	**Sustaining national designations for specialist services** (Be the provider of first choice for children, young people and their families)	**Developing the Paediatric Service Offer**	4-3	4-2
STRATEGIC PILLAR: Great Talented Teams				
	2015/16	**2016/17**		
4.1 MS	**Sustain workforce capability** (Ensure all our staff have the right skills, competence, motivation and leadership to deliver our vision)	**Workforce Sustainability & Capability**	4-3	4-1
4.2 MS	**Workforce engagement and support** (Ensure all our staff have the right skills, competence, motivation and leadership to deliver our vision)	**Staff Engagement**	3-3	3-2
4.3 MS	-	**Workforce Diversity & Inclusion**	3-3	3-1
STRATEGIC PILLAR: International Innovation, Research & Education				
	2015/16	**2016/17**		
5.1 DP	-	**Research, Education & Innovation**		

Alder Hey Children's NHS
NHS Foundation Trust

Resource and Business Development Committee

Minutes of the meeting held on **Wednesday 26th May 2016**, **at 2:00pm, Room 5, Level 1, Mezzanine**

Present:	Ian Quinlan (Chair)	Non-Executive Director	IQ
	Mags Barnaby	Interim Chief Operating Officer	MB
	Jeannine F Hayhurst	Non-Executive Director	JFH
	Jon Stephens	Director of Finance	JS
In Attendance:	Alison Chew	Head of Operational Finance	AC
	Louise Dunn	Director of Marketing and Comms	LD
	Laurence Murphy	Head of contracting	LM
	Janette Richardson	Programme Manager	JR
	Erica Saunders	Director of Corporate Affairs	ES
	Melissa Swindell	Interim Director of HR	MS
	Therese Patten	Associate Director of Strategic Dev	TP
	Peter Young	External IM&T Consultant	PY
Agenda item: 29	Sue Brown	Project Manager and Decontamination Lead	SB
40	David Houghton	Estates Manager	DH
39	Matt Templeton	Commercial & Developments Advisor	MT
Apologies:	Claire Dove	Non-Executive Director	CD
	Joe Gibson	External Programme	JG
	Claire Liddy	Deputy Director of Finance	CL
	Andy McColl	Business Development	AMc
	Louise Shepherd	Chief Executive	LS
	Lachlan Stark	Head of Planning and Performance	LS
	Rick Turnock	Medical Director	RT

16/17/27 Minutes of the previous meeting held on 27th April 2016

Resolved:
RABD approved the minutes of the previous meeting.

16/17/28 Matters Arising and Action list

The Chair thanked Jeannie France Hayhurst for attending RABD today to ensure the meeting was quorate.

Jonathan Stephens advised the 2015/16 Annual report and Accounts had been approved by the Board and had been submitted to Monitor.

As all actions were completed or on the agenda there was no action log for this meeting.

16/17/29 Project Initiation Document/Standing Order Procedure/Reports

Medicines Optimisation Project Initiation Document (Supporting Frontline Staff)

The Medicines optimisation project is a patient-focused approach to getting the best from investment in and use of medicines. It requires a holistic approach, an enhanced level of patient centred professionalism, and partnership between clinical professionals and the patient.

Resolved:
RABD APPROVED the Medicines optimisation project.

Pathfinders Project Initiation Document (PID) (Supporting Frontline Staff)
The Pathfinders project involves a series of workstreams dedicated to facilitating the use of costing data to help improve financial performance and quality in the trust. Pathfinders themselves are a series of projects in clinical or functional areas.

Therese Patten noted the Pathfinders (PID) would be beneficial to use for external partnerships, in particular with Warrington NHS Trust to drive out any variation between the Trusts. Mags Barnaby agreed to include this as an agenda item at the weekly CBU meeting and feedback to TP.

Resolved:
RABD approved the Pathfinders project.

Decommission and Demolition Initiation Document (PID) (Park Community Estate)
The primary purpose of the project is a requirement of the land swap agreement with the local City Council to demolish and remediate substantial area of the previous hospital site back to parkland to replace land used to construct the new hospital.

One of the risks on the register was due to the lack of funding for the project. Sue Brown said three options were being looked into and agreed to keep RABD updated with any further developments.

A further risk was the £200K shortfall against the expected income from sale of goods/assets as the cost to sell the items left a small or minus profit margin. Sue Brown went through the process before selling any items had been to keep any of the good quality furniture currently being stored within Theatres.

Queries from staff Governors had recently been received on the furniture from the old estate and the plans for it. Sue Brown agreed to action communications to staff.

Resolved
a) RABD approved the Decommission and Demolition project.
b) Sue Brown agreed to provide communication to staff on the furniture from the old estate.

Corporate Office and Community Services Project Initiation Document (PID) (Park Community Estate)
At the December 2015 RABD a revised and combined business case for the corporate office was approved on the basis of a floor area sized 4,548M2 costing £15.635M for construction. A loan from the department of Health for £15M had now been approved. Sessions were being held with staff to ensure the site would be fit for purpose.

Resolved:
RABD approved the Corporate Office and Community Services project.

Future estate requirements and plans
Currently the Trust has a plan to relocate the majority of departments and services into either the planned R&E phase II building, a move into the CHP and/ or the new Corporate/Clinical building for completion in April 2018. There is however a number of departments/services that currently have no future planned long term location or identified funding for estate.

A table with a breakdown of the corporate services and desks per area was discussed. Staff equating to 152 had not been included on the corporate site premises for 2018. This

was in line with proposals to introduce agile working by 30-34%. Sue Brown said since reviewing these proposals it was more likely agile working would equate to around 20%.

A bid for community services and whether staff would require desk space on site was also awaited. Further information would be known in the next couple of months, a separate project would be established in July 2016 to review this then.

Jeannie France Hayhurst noted the importance of keeping staff informed. Sue Brown responded advising there had been regular meetings with the teams and this would continue.

Resolved:
An update on future estate requirements and plans was received.

Cost Improvement Plan (CIP) Standard Operating Procedure
The Standard Operating Procedure (SOP) is to be used as a reference document to guide successful delivery of the 16/17 Alder Hey Cost Improvement Programme and would be presented to the sub committees of the Board to ensure a standardised approach.

Mags Barnaby was holding weekly CBU meetings to ensure each of the CBUs were staying on track, support would be provided if there were signs of slippage from the CIP 16/17 agreed plans. RABD would be informed of any changes from the agreed plan.

Resolved:
RABD received and APPROVED the Cost Improvement Plan (CIP) Standard Operating Procedure.

16/17/30 Programme Assurance 'developing our business'

RABD noted the approval at Board for the committee to receive updates on five workstreams from April 2016 and went through the programme assurance summary for each workstream;

Developing our business Workstream
Following the update at the last meeting RABD noted the £0.7m gap, RABD went through the dashboard noting the projects in place to bridge the gap;

Strategic Partnerships – Possibilities for the Trust to manage a clinical previously managed by a Trust in Birmingham was being looked into.

International Clinical Business and Non-NHS Patient Services – Proposals included increasing spinal surgery. RABD asked for planned milestone details for the year ahead to be presented at the next meeting.

Resolved:
a) An update on the developing our business workstream was received.
b) Therese Patten AGREED to present the years plans for; International Clinical Business and Non-NHS Patient Services at the next RABD meeting on the 29th June 2016.

Services in Communities Workstream
The CIP target for the projects in this work stream equates to £0.2m in 16/17 and £2m in 17/18. The 16/17 forecast amounts to £0 and is not yet underpinned clear plans. RABD went through the dashboard noting the projects in place to bridge the gap;

Developing a partnership model for Community Services – An update on the joint bids for the Liverpool and Sefton Children's Community services was given. The Liverpool Community Health tender had now been shortlisted to three Trusts;

- Bridgewater Community Healthcare NHS Foundation Trust in partnership with Alder Hey
- Merseycare NHS Trust in partnership with Alder Hey
- 5 Boroughs Partnership NHS Foundation Trust

The outcome of the bid was awaited, Therese Patten agreed to keep RABD informed.

Resolved:
An update on Services in Communities Workstream was received.

Developing IM&CT and EPR Workstream
These projects are planned to have PIDs completed by the 31 May 16 and therefore are not subject to assurance commentary at this time. There is no financial CiP target attributed to this work stream.

The Clinical Systems Informatics Steering Group previously known as the EPR steering group had gone through the Project Initiation Documents and would be presented at the next RABD.

Resolved:
An update on Developing IM&CT and EPR Workstream was received.

Supporting Frontline Staff Workstream
The CIP target for the projects in this work stream equates to £2.9m in 16/17 and £3m in 17/18. The 16/17 forecast amounts to £2.7m and underpinned by plans to date. The gap is in the Facilities project and relates to a delay in implementation of the car parking initiatives and a need to expedite the decision making process. Therefore, it is imperative the gap is mitigated by the end of Apr 16 with additional schemes.

As Executive Leads Rick Turnock and Hilda Gwilliams may not be available to attend RABD meetings Mags Barnaby agreed to feedback for them both at future meetings.

Resolved
Mags Barnaby to feedback on the supporting Frontline Staff Workstream if Rick and Hilda are unavailable to attend.

Park, Community Estate and Facilities Workstream
The following projects in this workstream had commenced and were ongoing;
- 8.1 Decommission and Demolition
- 8.2 Park
- 8.7 Corporate Offices on-site clinical services
- 8.9 Residential Development

Waiting for funding to be identified;
- 8.4 Agile Working
- 8.5 Research and Education

Projects to start on;
- 8.6 Community Services was due to commence in June 2015.
- 8.8 On site Residual Services was due to commence in July 2016.

Resolved:
An update on Park, Community Estate and Facilities Workstream was received.

16/17/3116/17 Cost Improvement Plan

To date the 16/17 programme had identified £7.2 million worth of Cost Improvement Plan (CIP) opportunities, £5.2 million of schemes have been described leaving a gap of £1.9 million.

RABD discussed the CIP ideas hopper that had been arranged to develop and progress ideas to identify £5.2million. Concerns had been raised as a number of the ideas had not been progressed. A review was to take place to ensure ideas agreed were deliverable. Monitoring would continue through the fortnightly meetings. RABD asked for a further update on this at the next meeting.

A conversation on the £100K CIP allocation for Research and Development was discussed. A Research, Education and Innovation Committee had recently been established and was due to have their 3rd meeting in July 2016. RABD asked for an agenda item on the CIP being achieved to be discussed at this meeting and for an update to be presented at the July RABD.

Resolved:
a) RABD received the content of the CIP update.
b) To provide an update on progress from the CIP ideas hopper.
c) An item on achieving CIP plans to be discussed at the next REIC.

16/17/32 Agency Compliance report

Melissa Swindell provided an update on progress since the last meeting noting the success of not using Pulse, nursing agency since they had refused to comply with Monitors agency cap.

The Sickness policy had been revised and approved. Training dates to provide support to managers and staff was to be circulated.

The use of staff-flow the new process to book Locums had increased by 42% since the last meeting.

Resolved:
a) RABD received the content of the agency compliance report.
b) Melissa Swindell agreed to provide a further update at the next RABD with details of financial savings at the beginning of the report.

16/17/33 Achieving run rate 16/17 plan

Mags Barnaby provided a further update to RABD since the previous meeting. There are challenges in delivering RTT at specialty level, and planned run rate in each of the CBUs. The Task and Finish Run Rate Team meeting had been established and three main challenges for not delivering RTT had been identified.

1. Cancelling Patients on Day of Surgery subject to clinical priority but not RTT/Theatre. Scheduling and Booking is undertaken without regard for bed availability/Mismatch between admissions and discharges every morning/No overview of bed availability/bed occupancy to inform decisions before cancellations take place.

2. No forward look at theatre cases planned for lists – diary records not on Meditech/Number of lists available and utilised by specialties (42-52 weeks/process for reallocating lists to hard pressed specialties).

3. Non Elective Patients often occupy beds waiting for surgery. reduce this delay and optimise Demand/Capacity.

The Task and Finish Run Rate Team meetings would continue to take place for a total of 6 weeks with the aim to remodel delivery of run rate services.

Resolved:
a) RABD received an update on the Achieving run rate.
b) A further update would be presented at the next meeting.

16/17/34 Five Priority Areas

RABD went through the five priority areas to be reported on for 2016/17.

1. Run Rate – Mags Barnaby
2. Pay Cost, under control – Claire Liddy
3. Workforce CIP close gap – Melissa Swindell
4. Business Development - Therese Patten
5. Cash – Claire Liddy

Resolved:
An update on the five priority areas for RABD was received.

16/17/35 Monthly Debt Write Off

Six proposed write offs for the total of £8,469.11 was presented. The write offs were mainly for overpayments made by the Trust's previous HR/Payroll providers Capita and dated back to October 2014. Numerous efforts had been made for the payments to be reimbursed however as there was no strong evidence to continue to pursue or it would be uneconomical to continue RABD was asked to approve the proposed write offs for May 2016.

Resolved:
RABD APPROVED the total of £8,469.11 write offs for May 2016.

16/17/36 Finance report

Alison Chew presented month 1 Finance report. The report had been revised to include the summary from the corporate report. The Trust is reporting a deficit of £2.5m, £0.4m behind plan. This mainly relates to income under achievement and continued agency overspend.

A number of risks have emerged in month 1 that may deteriorate the overall Trust position including pay run rate for ward nursing and facilities, underachievement on income and the cost of the move to the interim estate. This is currently being reviewed by CBUs and Executive review processes. A further update would be presented at the next RABD.

CIP target is £0.2m behind however this is consistent with the in year CIP slippage anticipated in the original plan. £6.9m is in the bank, £0.3m less from the target. Monitor risk rating is 1 which is in line with planned Monitor ratings.

RABD went through the detailed focus for the 10 point plan meetings.

A number of debts to the Trust had exceeded the 90 day deadline to a total of £708K. The finance team were working with the debtors for the outstanding payments to be made.

Resolved:
RABD received and noted the content of the Finance report for Month 1.

16/17/37 Contract Income Monitoring

Laurence Murphy presented the Contract report for April 2016 highlighting the contract with NHS England had now been approved. As part of the contract a CQUIN to review the Clinical Utilisation would take place. A detailed presentation on this had been presented at the last Operational Board.

Negotiations on the terms and conditions of the Welsh contract continued.

Resolved:
RABD received and noted the content of the Contract Income Monitoring report.

16/17/38 2015/16 Reference Costs

Following the recently published guidance from the Department of Health on 2015/16 Reference Costs Submissions a report setting out the requirement of the Trust Board and sub Committees to approve the reference cost process prior to submission was presented.

The reference costs return will be submitted by 22nd July and signed off by the Director of Finance by 28th July 2016. RABD will receive an update with comparison to previous years against other NHS Children's Trusts in England.

The Trust was complaint with the recent reference cost audits.

A recommendation to not complete the Medical Cost Review was presented. This was due to the review being timely and would not affect the approval of the 2015/16 reference costs.

Resolved:

a) RABD APPROVED the 2015/16 Reference coasts process.
b) To receive comparison to previous year's reference costs following the return submission at the end of July 2016.

16/17/39 PFI Contract Monitoring report

Matt Templeton presented month 7 of the Building Services report April 2016 in a new template. Graham Dixion, Building Services team lead had now commenced in post.

A summary of unavailability and performance positions relative to construction defects was received. A performance report to be included for each service would commence in June 2016.

A review of the draining system was currently taking place.

Lifts continued to breakdown, while the responses to fixing the lifts had improved it could still take a maximum of the contracted 4 hours for a lift to be fixed. Jeannie France Hayhurst reported on the long wait time for lifts once they had been called. Matt Templton agreed to look into this.

The most significant variation going through Project Co (PCo) is the Hybrid Theatre installation. PCo are currently seeking funder approval to progress. Timetable for completion is October 2016.

The ongoing dispute for a settlement deal with PCo regarding the non performance mainly attributable to construction defects continues.

Fortnightly meetings with IM&T continue to resolve outstanding issues.

Regular meetings were also in place to ensure external contractors were complying with the Trusts Health and Safety regulations. Concerns were raised regarding ambulance staff using the front entrance of the Hospital rather than the ambulance entrance area. Therese Patten noted the increase of patients outside of Merseyside and agreed to communicate the processes to other ambulance service providers.

Resolved:

a) RABD received an update on the PFI monitoring report.
b) To provide an update at the next RABD on waiting times for lifts once they have been called.
c) Therese Patten agreed to inform ambulance providers outside of Merseyside on Hospital entries for ambulance staff.

16/17/40The Springfield Park Business Case

The Development Team are seeking approval to enter into a Joint Venture Company (JVC) with Liverpool City Council (LCC) with the understanding that it will take on either a long term lease or free hold of Springfield Park and set up a Community Interest Charity (CIC) to operate the park for Trust and the local community.

David Houghton went through the 3 options. The preferred way forward is option 2 to enter into a joint venture which will take on a 200 year lease from Liverpool City Council and take over ownership and management. This option will give the Trust enough control to enable the 'Alder Hey in the Park' vision to be achieved, whilst splitting legal liability with LCC. The Trust would receive a contribution of £50,000/year towards maintenance costs and having access to LCC's park management expertise.

Resolved:

RABD agreed;

- Heads of terms proposed need to be presented to RABD in June
- Need formal agreement from LCC of the £50k per annumn funding for park maintenance
- Due diligence required to be undertaken which will pick up potential risks articulated by investment review group. Due diligence required to support final approval of the case and commercial vehicles.
- Team need to consider public liability, insurance and cost of security.

16/17/41 Corporate Performance update

Resolved:

The corporate report for the end of April 2016 Month 1 was received and discussed under the Finance report.

16/17/42 Weekly waiting times update

Resolved:

Mags Barnaby presented the weekly waiting times report for information.

16/17/43 Marketing and Communication Activity report

The Official Hospital opening was taking place on 22nd June 2016. Invitations would be limited to ensure health and safety regulations around the maximum numbers of people were met. Louise Dunn agreed to seek confirmation of maximum numbers from Lang O'Rouke.

Resolved:

RABD received and noted the contents of the report for April 2016.

16/17/44 Any Other Business

Staff Car Parking Charges

Melissa Swindell provided an update on the previous staff side meeting and agreement to increase staff car parking charges. Sessions to agree on the increases would be held over the next 4 weeks.

16/17/45 Date and Time of the next meeting: Wednesday 29th June 2016 at 9:30am, Level 1 Room 5.