Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS MEETING

Tuesday 6th February 2018 commencing at 10:30am

Venue: Small Meeting Room, Institute in the Park

AGENDA

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action	Preparation
Board Business						
1.	**17/18/239**	**10:30**	**Apologies.**	Chair		--
2.	**17/18/240**	**10:31**	**Declarations of Interest.**	All	Board Members to declare an interest in particular agenda items, if appropriate.	--
3.	**17/18/241**	**10:32**	**Minutes of the Previous Meeting.**	Chair	To consider the minutes of the previous meeting to check for amendments and approve held on the 9th of January 2017.	Read Minutes
4.	**17/18/242**	**10:35**	**Matters Arising:** • **Action Log from the previous meeting held on the 9th of January 2018.** • **Booking and Scheduling Review update.** • **Sepsis/Meditech update.**	Chair Chair A. Bateman J. Grinnell	To discuss any matters arising from previous meetings and provide updates and review where appropriate. To provide an update on the Booking and Scheduling Review. To provide an update on the actions taken to improve the Trust's Sepsis improvement journey.	Verbal Presentation Read correspondence
Strategic Update						
Delivery of outstanding care						
5.	**17/18/243**	**10:40**	**Serious Incidents Report.**	H. Gwilliams	To inform the Board of the recent serious incidents at the Trust in the last calendar month.	Read Report
6.	**17/18/244**	**10:45**	**Clinical Quality Assurance Committee: Chair's update.** - **Chair's update from the**	A. Marsland	To receive and review the approved minutes from the meeting held on the 12th of December 2017.	Read minutes

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action	Preparation
			meeting that took place on the 17.1.18. - **Approved Minutes from the Meeting that took place on the 15.12.17**			
7.	**17/18/245**	**10:48**	**Integrated Governance Committee:** • **Approved minutes from the meeting that took place on the 1st of November 2017.**	S. Ryan	To receive and review the approved minutes from the meeting held on the 1st of November 2017.	Read minutes
Strong Foundations						
8.	**17/18/246**	**10:50**	**Corporate Report.**	J. Grinnell/ A. Bateman/ H. Gwilliams/ M. Swindell	To note delivery against financial, operational, HR metrics and quality metrics and mandatory targets within the Corporate Report for the month of December 2017.	Read minutes
9.	**17/18/247**	**--**	**2017/18 Board Assurance Framework Report.**	E. Saunders	For noting.	Read report
10.	**17/18/248**	**10:55**	**Board Assurance Policy**	E. Saunders	For ratification.	Read report
11.	**17/18/249**	**11:00**	**Resources & Business Development Committee:** - **Chair's verbal update from the meeting that took place on the 29.1.18.** - **Approved Minutes from the Meeting that took place on the 13.12.17.**	I. Quinlan	To receive and review the approved minutes from the meeting held on the 13th of December 2017	Read minutes
Game Changing Research and Innovation						
12.	**17/18/250**	**11:02**	**Liaison Committee:**	D. Powell	To receive and review the approved minutes from the	Read minutes

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action	Preparation
			• **Approved minutes from the meeting that took place on 18th December 2018.**		meeting held on the 18th of December 2018.	
Any Other Business						
13.	**17/18/251**	**11:04**	**Any Other Business.**	All	To discuss any further business before the close of the meeting.	Verbal
Date And Time Of Next Meeting (Part 1): Tuesday 6th March 2018 At **10:00am, Institute In The Park, Small Lecture Theatre**						

REGISTER OF TRUST SEAL

Confirmed **BOARD OF DIRECTORS**

Minutes of the last meeting held on **Tuesday 9th January 2108 at 10:00am,**
Small Lecture Theatre, Institute in the park

Present:	Sir D Henshaw	Chairman (Chair)	(SDH)
	Mrs J France-Hayhurst	Non-Executive Director	(JFH)
	Mr S Igoe	Non-Executive Director	(SI)
	Mr J Grinnell	Director of Finance	(JG)
	Mrs H Gwilliams	Chief Nurse	(HG)
	Mrs A Marsland	Non-Executive Director	(AM)
	Mr. I. Quinlan	Non-Executive Director	(IQ)
	Mrs L Shepherd	Chief Executive	(LS)
	Mrs M Swindell	Director of HR & OD	(MS)
	Dame J Williams	Non-Executive Director	(JW)
In Attendance:	Prof M Beresford	Assoc. Director of the Board	(PMB)
	Mr. Adam Bateman	Chief Operating Officer	(AB)
	Ms. Pauline Brown	Director of Nursing	(PB)
	Mr C Duncan	Director of Surgery	(ChrD)
	Ms S Falder	Director of Clinical Effectiveness and Service Transformation	(SF)
	Dr A Hughes	Director of Medicine	(AH)
	Mrs D Jones	Director of Strategy	(DJ)
	Mrs C McLaughlin	Director of Community Services	(CMc)
	Mr D Powell	Development Director	(DP)
	Ms E Saunders	Director of Corporate Affairs	(ES)
	Ms Jo Minford	Director of Clinical Effectiveness and Service Transformation	(JM)
	Mrs K McKeown	Committee Administrator (minutes)	(KMc)
	Mr M Flannagan	Director of Communications	(MF)
Observing:	Dr. Sarah Parker	Paediatric Registrar	
Agenda item: **226**	Joe Gibson	External Programme Assurance	
231	Peter Young	Chief Information Officer	
Apologies:	Mrs C Dove	Non-Executive Director	(CD)
	Dr S Ryan	Medical Director	(SR)

17/18/216 Declarations of Interest
There were none declared.

17/18/217 Minutes of the previous meetings held on 5th December 2017
Resolved:
The Board received and approved the minutes from the meeting held on 5th December 2017.

17/18/218 Matters Arising and Action Log

Action 17/18191: *Liverpool Health Partners/KPMG Update* - It was agreed at December's LHP Board to move forward with the recommendations made following work that has taken place in association with KPMG. It will be a challenge to ensure that research teams comply with the clinical review process, but it has been formally noted in

the KPMG report that the LHP Board wishes to move forward with an integrated approach to address population health by putting children at the centre of it. Professor Michael Beresford confirmed that a more detailed update will be available for February's Trust Board.

17/18/218.1 Action: MB

17/18/219 Key Issues/Reflections

There were no issues identified that would not be covered by the agenda.

17/18/220 Strategy Discussion/Stocktake and Priorities for 2018/19

The Chairman opened the session by providing the Board with a summary of the external mechanisms and plans that are in place which are driving the NHS at the present time. The Chairman discussed the forthcoming change to national drivers and approaches within the NHS, highlighting the core plan for the merging of two large trusts in Liverpool. It was pointed out that Liverpool City Council is involved in an integrated piece of work and Mersey Care NHSFT is positioned as the principal provider of Community Services in the city. Alder Hey is a specialist provider and is in a strong position due to having its own market. It is imperative that the Trust builds its own success; it has a long-standing core vision and mission that is solid but needs to look at delivering a strategy that will benefit the Trust as it moves forward into 2018/19.

Dani Jones presented a number of slides to the Board that highlighted the Trust's strategic challenges and the shifting landscapes of the NHS in order to stimulate discussion around the long term sustainability of the organisation. Dani Jones described where the Trust is at the moment and the steps that need to be taken to drive growth, address sustainability and refocus on commercial opportunities.

The Board was informed that the purpose of the strategy session is to reflect and take stock, think about sustainability and to agree priorities for 2018/19. The Board discussed the market in respect to private patient growth and the steps that could be implemented to increase capacity and deliver efficiently whilst safeguarding NHS services. Adam Bateman informed the Board of the high level approach that will be taken to address priorities which will support the maximising of benefits and opportunities to enable the organisation to move forward.

Louise Shepherd reported on the work that is taking place across the Trust to link outcomes with quality improvement and highlighted the issues around governance along with CQC's approach, which are both in the process of being addressed. Louise Shepherd informed the Board that the objective is to have a whole hospital approach for quality improvement by the end of the 2017/18 financial year.

Michael Beresford highlighted the opportunity for capturing change as a result of intervention/impact and felt that this evidence would assist the Trust to define quality. Michael Beresford highlighted the importance of looking at how the organisation can share this information internally/externally and have it benchmarked. Creating a step change would allow the Trust to bring in new income streams.

A discussion ensued following a query raised by the Chairman in respect to the Board being sighted, from an assurance perspective, on the progress that is being made in relation to the quality agenda. It was reported that that progress is fed into the Board via the Clinical Quality Assurance Committee (CQAC). The Chair of CQAC, Anita Marsland provided her analysis of the development of quality within the organisation in the last two years or so and what the Committee needs in order to strengthen assurance in this area, with a particular emphasis upon clinical engagement from the Divisions.

Sian Falder advised the Board that work is taking place to establish a group that will look towards developing the next phase of the Quality Strategy, address issues raised via the Board/Executive Directors and ensure a joined up approach across the Trust.

Christian Duncan highlighted the importance of having a clinical leadership approach for quality across the Trust and felt that Clinician attendance at CQAC is a necessity in order to drive the conversation. Mr Duncan suggested that CQAC should be run via the Heads of Divisions with representation at meetings from departments so that those responsible can be held to account. Anita Marsland agreed with Mr Duncan's suggestion and highlighted the importance of addressing this matter to enable the Committee to provide the assurance that is required.

Dame Jo Williams reminded the Board of the importance of focusing upon the safety domain from an assurance perspective and highlighted the need for safety metrics to be clear and prominent within the organisation's reporting systems.

The Chairman reiterated his previous comments on the importance of ensuring that the Board is kept abreast of progress on a regular basis, via the provision of appropriate information to enable legitimate challenge. A discussion took place around the responsibilities of NEDs and peers from an assurance perspective and it was felt that a Clinical/Divisional approach for CQAC would be beneficial and also support the assurance process. Adrian Hughes pointed out that the Divisions are at different levels of maturity at the present time and felt that a corporate position is still required to hold the Divisions to account.

Following the conclusion of discussions it was agreed that a further session will take place during February's Board meeting to address research and reflect on the Trust's priorities for 2018/19. Louise Shepherd advised that the organisation should be aware of the Liverpool Community model and what it looks like when agreeing priorities, as well as being clear on the Trust's proposals and what they entail.

17/18/220.1 Action: DJ

The Chairman requested that further work take place in relation to the forthcoming strategy/priorities for 2018/19 to ensure that the information provided to the Board is focussed and measurable.

17/18/220.2 Action: Exec Team

Resolved

The Board received the presentation from Dani Jones and agreed that a positive conversation had taken place as a result of this.

17/18/221 External Environment

Liverpool Women's NHS Foundation Trust/ Neonatal Network

The business case for the implementation of a single neonatal service at two sites, Alder Hey Children's NHS Foundation Trust and the Liverpool Women's NHS Foundation Trust, was submitted to the Trust Board for approval.

It was reported that the business case has been developed to set out the need to invest in the neonatal services that are based in Liverpool and provide care to families in the City and the North West. This investment will lead to the delivery of outstanding outcomes for babies and families. The proposal is centred on investment in the neonatal surgical service at Alder Hey Children's Hospital (AHCH), and investment in neonatal

services at Liverpool Women's Hospital (LWH). The model of care will be underpinned by a new partnership for delivering neonatal services as a single service across two sites. The enhanced service would deliver full-compliance with national standards for neonatal care and improve outcomes for babies.

Adam Bateman provided a short presentation to the Board to give an overview of the following areas of the business case:

- The purpose of conducting this piece of work.
- The case for change.
- The options for implementation.
- Governance arrangements.
  - *Feedback has been received confirming that the Liverpool Women's NHS FT is not ready to put their services in scope with this model at the present time.*
- High-level financials.
  – *Discussions are taking place around the case for investment.*
- Capital.
  – *Further financial analysis is required.*
- Next steps

It was reported that the Liverpool Women's Trust Board will receive the same paper in January for approval.

Following discussion the general consensus of the Non-Executive Directors was that the implementation of a single neonatal surgical service at two sites will deliver a better outcome and a good return on the project.

Louise Shepherd highlighted the importance of ensuring that the Trust Board is clear about what it is agreeing to. Commissioners have provided funding of £15m to the Liverpool Women's Hospital without factoring in time in which to address this piece of work. Louise Shepherd felt that a discussion should take place to emphasise Alder Hey's commitment to the joint partnership and advised against the Trust going out to consultation until all aspects of neonatal care have been addressed. There needs to be a clear message in respect of the support the Alder Hey Board has shown for this area of work.

Resolved
The Board approved the Business Case for the implementation of a single Neonatal service at two sites, Alder Hey Children's NHS Foundation Trust and the Liverpool Women's NHS Foundation Trust,

Acting as One – Proposed Memorandum of Understanding for Corporate Services

The proposed Memorandum of Understanding for Corporate Services was submitted to the Trust Board for ratification.

It was reported that there are no legal requirements associated with this document and a further version may be submitted for approval in the event of any changes. Approval of this document will enable the Trust to work collaboratively in line with the agreed aims of the LDS Corporate Services Transformation Design Group.

Resolved
The Board ratified the Proposed Memorandum of Understanding for Corporate Services

17/18/222 Serious Incidents Report

Pauline Brown provided an update to the Trust Board on the Serious Incidents highlighted in November's report.

Pauline Brown reported that there was one serious incident that required investigation. This related to a patient who collapsed on the ward due to poor blood gasses and resulted in a cardiac arrest. It was confirmed that a 72 hour review was conducted and key learnings were established in relation to human factors and responding to abnormal gas results when the patient looks well. It was confirmed that the escalation plan has been amended for blood gas results in relation to cardiac patients and an RCA is currently underway.

An RCA relating to an on-going SIRI investigation, reference number 2017/24137, is in the final check quality stage and will be available on the 12th of January 2018.

Two SIRI incidents have been closed since the submission of October's report, StEIS 2017/23222 and RCA 333 2016/17. It was reported that serious incidents are decreasing and investigations are being completed on time.

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

17/18/223 Clinical Quality Assurance Committee: Chair's Update
CQAC Minutes 18th October 2017
The approved minutes from November's Clinical Quality Assurance Committee meeting were submitted to the Trust Board for noting purposes.

Anita Marsland drew attention to the work that has taken place by Dr. David Porter and his colleagues in order to address the challenges experienced in the implementation of the sepsis pathway.

The Board was informed of the Meditech issues being experienced in relation to the collating of sepsis data. It was reported that staff members are having to manually count figures which is a critical issue for the team due to the time consuming nature of this task. Anita Marsland reported that all avenues have been exhausted trying to find a solution to this matter and therefore felt it was necessary to escalate it to the Trust Board.

A discussion took place around the clinical risk element of the Meditech issue and it was agreed that John Grinnell will liaise with Meditech to try and resolve the current problems. An update will be provided to the Trust Board in February.

17/18/223.1 Action: JG

Resolved:
The Board received and noted the approved minutes from the CQAC meeting held on November 2017.

17/18/224 Alder Hey in the Park

The Board was provided with an update on the development of the Alder Hey in the Park site. The following points were highlighted and discussed:

- *Car Parking Facilities* – A low level car park is to be built which will accommodate 200 vehicles with plans to build upwards economically.
- *Residential:* The consultation process has been put on hold by the Trust whilst on-going discussions with Mayor Anderson and LCC planners continue. Alternative development

land options are being considered and tested to provide a contingency plan in the event that the scheme is unable to progress as expected

- *Springfield Park*: The 15ft sculpture, made of UK-sourced oak from the Crown Estate has now been erected in the park. The poetry competition inviting patients/ members of the public to submit poems was extremely successful receiving 500 entries from across the world, the winning entries will be permanently displayed in the park. Charity funding from Veolia has been secured to create a new permanent and accessible path through the forest walk.
- *Retained Estate Plan*: Work is on-going to acquire accommodation within the Police station.

Resolved:
The Board received the update on the current position.

17/18/225 People Strategy update
Mandatory training

The Board was advised of the work has taken place to increase training compliance levels and it was reported that all areas are showing an increase month on month. The core mandatory training position as of mid-December is 86% and the team are continuing to work with managers, staff and subject matter experts to continually increase this and achieve the Trust's compliance target of 90%

The Board was updated on the three on-going employment tribunals and it was confirmed that one tribunal concluded on the 7th of December with a ruling in favour of the Trust.

Steve Igoe reported on the reduction of applications to universities for nursing courses as result of the change to student finance. This is a concern for universities from a core business perspective and will impact the NHS when trying to refresh the workforce.

Staff Survey

The 2017 Staff Survey closed on the 1st December and the target this year was to reach a 50% response rate (*last year's response rate was 39%*). The Trust exceeded this by achieving a response rate of 54%. The overall response rate for Acute Specialist Trusts was 47.4%. Early analyses of results indicate improvements across a significant number of questions within the survey. The Trust will have access to the reporting portal, SOLAR, in late January, to enable a detailed analysis of responses. The Staff Survey Strategy Group are currently working up the plans for how we best use the results to improve staff experience.

Melissa Swindell reported that the Trust has approached the regulators to see if they will share their comparison figures. Ian Quinlan queried the process for disseminating the Staff Survey information across the Trust. It was reported that a discussion is due to take place between Melissa Swindell and Mark Flannagan to address communications for this area of work.

On behalf of the Board, the Chairman congratulated all those involved who brought about a positive outcome in relation to the Staff Survey. It was confirmed that a further update will be provided during February Trust Board meeting.

17/18/225.1 Action: MS

Health Education England Workforce Strategy

The draft Health Education England Workforce Strategy was submitted to the Trust Board for information purposes. It was reported that discussions are taking place with Executive Directors in relation to feedback on this document.

Workforce and Organisational Development Committee
The approved minutes from September's and October's Workforce and Organisational Development Committee meeting were noted.

Resolved:
The Board:

- Received and noted the People Strategy report for November 2017.
- Received and noted the draft Health Education England Workforce Strategy.
- Received and noted the approved minutes from September's and November's Workforce and Organisational Development Committee meeting.

17/18/226 Programme Assurance Update

The Board was provided with an update on the assurance framework for the current change programme.

Joe Gibson informed the Board that work is continuing to take place on the assurance ratings and confirmed the appointment of a programme and project manager to assist the Medical Division's project work and address the compliance issues across the portfolio. This additional capacity is expected to increase assurance levels.

The High Level Plan shared at the December Board continues to be refined and will be submitted, in its completed state, to the Programme Board on 25th of January 2018 and, thereafter, to the Trust Board on the 6th of February 2018. The Plan will evidence the renewed focus on benefits and the application of programme 'gates' to describe which phase each project is in.

The financial benefits being delivered by the change portfolio are still not meeting targets and this has formed a critical strand of the programme review to ensure that the forecasts of efficiencies derived from the programme are accurate for the financial year 2018/19. A mini PMO has been established with a primary focus to support the programme and the project teams.

The Board discussed the pre-committed projects and were advised that designated Executive sponsors have been appointed to address assurance issues for their respective projects with point of accountability sitting with the appropriate sub-committees

The Chairman raised concerns around the proportion of projects currently rated red in the report. Joe Gibson reported that some project leads aren't updating the progress plan on a sufficiently regular basis which is having an effect on the RAG rating.

Steve Igoe queried the means and capacity to achieve the set targets in the last quarter of the financial year, and highlighted the importance of ensuring that the trajectories for 2018/19 are realistic. The Board discussed the forthcoming refresh, the focus on the five operational areas that are doing well and the organisation's plans to operate on a larger scale in 2018/19.

The Chairman pointed out that a similar conversation had taken place twelve months prior and reiterated Steve Igoe's query as to whether there is enough time and capacity to achieve the set targets by the end of the 2017/18 financial year. Louise Shepherd highlighted the issues that had been experienced at the beginning of the year in the

Medical Division along with an issue that related to coding which is being addressed and once concluded should have a positive effect on revenue. It was confirmed that there is clear plan in place and that the Programme Board has a pivotal role in overseeing the overall progress of the programme.

Following further discussion on this agenda item it was agreed to invite the Executive Sponsors to provide an update in February on their respective areas of responsibility in relation to the Change Programme.

17/18/226.1 Action: Executive Sponsors/JG

Resolved
The Board received the Change Programme Assurance update.

17//18/227 Corporate Report

The Corporate report for month 8, 2017/18 was submitted to the Board for information purposes. The following areas were discussed:

Operational

- The Trust winter plan has now formally commenced. Continuing higher than planned levels of Non Elective admissions for surgery and medicine in conjunction with high levels of ED attendance have made November a challenging month. Analysis identifies increased acuity in ED attendance. Compounding the challenge were two infection control challenges with measles and norovirus. The norovirus outbreak temporarily closed 24 beds on Ward 4A. This closure affected flow which resulted in increased levels of elective cancellation and ED breaches along with reduced activity against forecast. Productivity was adversely affected and theatre productivity dropped, however OP utilisation has increased and DNA rates reduced
- There were no Never Events reported in November 2017. There has been an increase in the reporting of medication errors but a reduction in the harm as a result of these errors.
- The level of sickness absence for November was 5.1%. There have been some spikes due to diahorrea and vomiting.
- The reported position for PDR's remains static at 87%. The core mandatory training position continues to show a month on month increase, reporting 86% as of the end of November.

Financial, Growth & Mandatory Framework

- For the month of November the Trust is reporting a trading surplus of £1.2m which is £0.4m ahead of plan.
- Income is ahead of plan mainly due to technical adjustments which are offset by expenditure. Shortfalls in elective income (£0.6m) is offset by over performance in non-elective activity (£0.8m) and outpatients (£0.1m). Elective activity is behind plan by 9%, non-elective is ahead by 21% and outpatient activity is ahead by 1%.
- Pay budgets are £0.7m overspent for the month relating to use of temporary staffing and the impact of unachieved savings targets. The Trust is behind plan with the CIP target by £0.7m to date. Cash in the Bank is £6.8m. NHSI Use of Resources rating of 3 in line with plan.

Resolved:
The Board received the Corporate Report for Month 8.

17/18/228 Board Assurance Framework

The Board was provided with an update on the Board Assurance Framework (BAF) for November 2017. The following points were highlighted:

- Forward plan for management of ED performance was agreed by the Executives.
- The Exec Comm Cell will continue to be a focus for weekly planning. This process is improving and has enabled the organisation to focus on issues.
- The revised Single Oversight Framework was submitted to the RABD Committee and the corporate report is to be reviewed in light of updated NHSI metrics.
- The Executives confirmed priorities for 2018/19 are inclusive of clinical network developments; a strategic discussion has been scheduled to take place during January's Trust Board.
- Steve Igoe advised the Board that the Audit Committee is testing the BAF along with key issues during each committee meeting and where possible the committee is seeking external validation. Steve Igoe reported that MIAA have indicated that the organisation is addressing the right items.

Resolved:
The Board received and noted the content of November's BAF.

17/18/229 CQC Action Plan

The Board was advised that the CQC Action Plan is being monitored on a monthly basis via CQAC.

Work is taking place to prepare for the next CQC visit. It was reported that narrative has been included in the Board Assurance Framework highlighting that a plan is in the process of being compiled to ensure that the organisation is 'regulatory ready'.

Correspondence from CQC – 18.12.17.

The Board noted the letter from CQC in response to the Trust's request for a review of some of the ratings from April's unannounced inspection.

Resolved

- **The Board noted the contents of the CQC Action Plan.**
- **The Board noted the correspondence from CQC dated the 18.12.17.**

17/17/230 RABD

The approved minutes from October's RABD Committee meeting were submitted to the Trust Board for noting. Ian Quinlan advised the Board that the Terms of Reference have been updated to reflect the following changes:

- It was agreed that attendance by Non-Executive Directors would be reduced from three to two.
- It was agreed that the Chief Executive would be removed from the membership.

Resolved
The Board received and noted the approved minutes from the RABD meeting held on 30.10.17.

17/18/231 Global Digital Exemplar (GDE)

Peter Young advised the Board that the GDE programme is on track and work is continuing to ensure the delivery of the third milestone in February 2018. The next NHS Digital assurance testing is planned and will take place on the 16th of January 2018.

Peter Young highlighted the risk in relation to receiving the funds for the Trust's spend profile prior to the end of March 2017. It was reported that shadowing of clinicians is

also taking place to see if time can be released during a clinicians working day to increase productivity.

Peter Young provided an update on Proof of Concept, the roll out of standard documents, the Alder Hey Fast Follower and GDE prescribing projects

The Board was advised that the Trust has asked Meditech to conduct a piece of work on prescribing of which they have declined. The Chairman informed Peter Young of the conversation that had taken place earlier around Meditech in relation to the implementation of the sepsis pathway. Peter Young advised that Meditech have proposed a solution for this area of work but it won't address the whole of the problem. The Chairman raised his concerns regarding this matter. Louise Shepherd undertook to raise this issue with the company's senior executives when they visit the Trust in February.

17/18/232 Any Other Business

There were no other items of business.

Date and Time of next meeting: Tuesday 6th February 2018, at 10:00am, Small Lecture Theatre, Institute in the park.

Alder Hey Children's NHS Foundation Trust
Trust Board - Part 1
Action Log following the meeting on the 9.1.18

Alder Hey Children's NHS Foundation Trust

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
5.12.17.	17/18/190.1	Key Issues Reflected	***Booking Schedule Review:*** Submit a progress report to the Trust Board in January 2018.	Adam Bateman	30.1.18		30.1.18 - This item has been included on February's Trust Board agenda. **ACTION COMPLETE**
9.1.18.	17/18/220.1	Strategy Discussion/Stocktake and Priorities for 2018/19	A further strategy session is to take place on the 6.2.18.	Dani Jones	30.1.18		30.1.18 - A further session has been scheduled and will take place following February's Trust Board meeting. **ACTION COMPLETE**
9.1.18.	17/18/220.2	Strategy Discussion/Stocktake and Priorities for 2018/19	Provide focussed and measurable information in relation to the forthcoming strategy/priorities for 2018/19.	Exec Team			30.1.18 - This action will be discussed during February's strategy session. **ACTION COMPLETE**
Actions for March 2018							
9.1.18.	17/18/218.1	Matters Arising and Action Log	***Liverpool Health Partners/KPMG Update*** - A detailed update to be provided during March's Trust Board meeting.	Professor Michael Beresford	26.2.18		
9.1.18.	17/18/223.1	Clinical Quality Assurance Committee	Liaise with Meditech to try and resolve the issues relating to the collating of sepsis data.	John Grinnell	26.2.18		
9.1.18.	17/18/225.1	Staff Survey	Provide a further update on the 2017 Staff Survey during March's Trust Board meeting.	Melissa Swindell	26.2.18		
9.1.18.	17/18/226.1	Programme Assurance Update	Executive Sponsors to provoide an update on their respective areas of responsibility for the Change Programme.	Executive Sponsors	26.2.18		
Closed Actions							
5.12.17.	17/18/191.1	Liverpool Health Partners/KPMG update	***Integrated approach to addressing the health of the population, by putting children at the centre:*** Discuss an approach prior to aligning the Divisions with the forthcoming partnership work.	Dr. Duncan/ Michael Berseford	05.01.18		**21.12.17:** An update will be provided during January's Trust Board meeting. **ACTION COMPLETE**

Alder Hey Children's NHS Foundation Trust
Trust Board - Part 1
Action Log following the meeting on the 9.1.18

Alder Hey Children's NHS
NHS Foundation Trust

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
5.12.17.	17/18/196.1	Mortality Report Q2	Discuss the possibility of using narrative to support performance figures in the Mortality Report and look at linking in with other Children's Trusts to discuss the streamlining of weighting tools for performance data.	Dr. Ryan/ Louise Shepherd	05.01.18		**21.12.17:** SR spoke with Julie Grice who has recently spoken with the national Lead who regards AH's approach as leading and has asked for the Trust's documentation. AQUA are engaged and meeting with SR to plan a Board session. **ACTION COMPLETE**
5.12.17.	17/18/196.2	Mortality Report Q2	Liaise with the Coroner's office via letter to confirm the Coroner's expectations of the Trust.	Dr. Ryan	05.01.18		**21.12.17:** A meeting took place on the 4.12.17 and the Trust has followed up with a letter. **ACTION COMPLETE**
5.12.17.	17/18/197.1	Infection Prevention and Control Q2	*Launch of the Sure Washing Machine:* Discuss staff accountability and responsibility, following education.	Mags Barnaby/ Valya Weston	05.01.18		**21.12.17:** The Sure Wash machine is owned by the Hand hygiene company Gojo. Dates have been arranged for the company to come in and take the machine around the Trust. First date is the 18/01/2018. **ACTION COMPLETE**
5.12.17.	17/18/201.1	Listening into Action	Compile a list to reflect the changes that have been made as a result of Listening into Action.	Kerry Turner	02.01.18		**21.12.17:** An update was circulated to Board members on the 4.1.18. **ACTION COMPLETE**
5.12.17.	17/18/202.1	Programme Assurance Update	***Change Programme Delivery:*** Provide an update during January's Trust Board on the outcome of the Exec Sponsor review meeting/Quality session.	Joe Gibson	02.01.18		**21.12.17:** This action has been included on January's Trust Board agenda. **ACTION COMPLETE**

Alder Hey Children's NHS Foundation Trust
Trust Board - Part 1
Action Log following the meeting on the 9.1.18

Alder Hey Children's NHS Foundation Trust

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
5.12.17.	17/18/203.1	Patient Safety Report	***Recorded Levels of Harm:*** Include narrative or an alternative definition for severe harm, in the Patient Safety report.	Dr. Ryan/ Hilda Gwilliams	02.01.18		**21.12.17:**The incident detail has been enhanced with clear succinct narrative defining the impact and immediate action taken. **ACTION COMPLETE**

Status	
Overdue	
On Track	
Closed	

Alder Hey Children's NHS
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Brilliant booking system

Trust Board 6 February 2018

Inspired by Children

Alder Hey Children's NHS
NHS Foundation Trust

Diagnostic

Data

- < 85% clinic utilisation
- > 12% rate of DNA
- ⇧ postage spend until 2017 improvements

Booking & scheduling team

- Extremely committed
- Implementation of capacity-based booking stalling
- Insufficient staff to re-fill cancelled appointments

Patient experience

- Multiple letters sent to confirm and/or change appointment
- Families invited to book for appointments despite no capacity available = frustration
- Appointments made for date and times that are not guaranteed (i.e. more than 6 weeks ahead)

Good practice

- Capacity-based booking system in place in cardiology & ophthalmology
- Text reminders and bi-directional appointment confirmation

Inspired by Children

Alder Hey Children's NHS
NHS Foundation Trust

What will be different

What	How
Families of children with multiple appointments receive personal support	•My buddy service
Cancellation of clinic appointments by the Trust halved	• Capacity-led booking system (patients booked into guaranteed appointment dates)
Booking or changing an appointment is as easy as booking a hotel room	•Partner with organisation with proven booking system. Contacts with supplier to hotel, travel and Google • E-booking and m-booking system
Clinic utilisation at 90%	•Capacity-led booking system (patient choice) •Bi-directional appointment system •Appointments cancelled at short-notice backfilled

Our operational plan 2018-20

5 improvement priorities

Project overview document

Delivery of **Outstanding care**

Project title (improvement priority): Brilliant patient booking systems

Brilliant Patient Booking Systems

What

To provide a booking system that puts children and families first and meets the needs of clinicians that use it.

Why

- Improve patient experience
- Reduce appointment cancellations
- Reduce the time from referral to first outpatient appointment
- Improve clinicians' experience of our systems

How

- E- booking and M-booking systems
- Capacity-based booking system
- All patients checked out
- 'My buddy' for patients with multiple appointments

Alder Hey Children's NHS
NHS Foundation Trust

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Our Ref: JG/KMC 01

2nd February, 2018

To: Trust Board Members

Dear colleague,

At the last meeting the Board had a discussion regarding the next steps in the organisation's Sepsis improvement journey, and more importantly how the Trust ensures that its Meditech system supports this. Since the last Board meeting a number of discussions have taken place, including:

- Meetings with the Sepsis project team to establish how the system could further support the process of managing patients on a sepsis pathway.
- A detailed update was provided during the CQAC meeting.
- An initial meeting has taken place between the CEO and FD from Alder Hey and Meditech UK in order to outline the Trust's concerns with the current system.

We have a more formal meeting planned with members of Meditech's Senior Team on the 6th of February which includes the CEO, MD, FD and CIO from Alder Hey. During the meeting we will detail our requirements and highlight how more generally we want to see an improved set of relationships and associated service from Meditech.

As a different approach to recent developments we will be requiring Meditech to send within one month a team to work onsite with our Sepsis team to develop a workable solution. We will be requiring that this team from Meditech have both the technical skills and ability to make decisions to ensure that we have something that can be rolled out quickly following that visit. We will ensure that there is Director oversight of this programme of work and that Meditech and the Sepsis team will report back at the end of, what we envisage to be about a week on site, to the Executive Team to confirm the agreed outcomes.

I trust this provides the Board with the assurance that we are taking forward concerns raised at the last meeting. In addition to this system based work we continue to track the improvement programme through CQAC, and our sepsis performance is also tracked through our weekly Exec Comm Cell meetings.

Kind Regards

John Grinnell
Director of Finance

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Tuesday 6th February 2018

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

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1. Background:

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

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

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

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

2. SIRI performance data:

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

3. Recommendations:

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

New SIRI Incidents reported between the period 01/12/2017 to 31/12/2017:								
Reference Number	**Date investigation started**	**Division**	**Incident Description**	**RCA Lead Investigator**	**72 hour review completed/ immediate actions taken and shared learning**	**Progress**	**60 working day compliance**	**Duty of Candour/ Being Open policy implemented**
StEIS 2017/31185	21/12/2017	Surgery	Pressure ulcer to left heel. Referral to plastics team following review by senior nurse with expert knowledge in relation to tissue viability. Confirmation received that this is a grade 3 pressure ulcer 21/12/2017.	Kelly Black, Surgical Matron	Yes – immediate actions taken: 1.Ensure that staff know to follow up meditech referrals with a phone request and ensure that patients are seen as requested. 2. Explore with Badger team, the possibility of having Braden Q score in the patient safety check on badger. Lessons learned: 1. Good documentation in Badger of skin checks done on every shift. All necessary precautions taken to prevent pressure ulcers from admission. 2. Follow up of incident was delayed due to transfer of patient to another ward. 3. Staff not aware that referrals on Meditech had to be followed up with a phone call. 4. Braden Q is currently	Statement gathering commenced, timeline being produced, RCA panel meeting to be arranged.	Yes	Yes

					recorded on paper version of skin bundle and not always documented in Badger as done.			
StEIS 2017/30500	13/12/2017	Surgery	Unexpected death of neurosurgical patient.	Rachael Hanger, Theatre Matron and Simon Kenny, Consultant Surgeon	Yes – immediate actions taken: 1. Medical staff placed on restricted duties and removed from on call rota for service. 2. Senior staff undertaking immediate review of process for escalation of concerns, in addition to review of process for attendance of on call Consultants out of hours. 3. Staff and family offered full support. Lessons learned: 1. Clinical review of the patient by a Consultant Surgeon should have taken place.	Statements being gathered, timeline commenced. RCA panel meeting to be arranged.	Yes	Being open policy implemented, letter delayed on compassionate grounds.

New Safeguarding investigations reported 01/12/2017 to 31/12/2017: For information							
Reference Number	**Date investigation started**	**CBU**	**Incident Description**	**RCA Lead Investigator**	**Progress**	**60 working day compliance**	**Being Open policy implemented**
Nil							

On-going SIRI incident investigations (including those above)							
Reference Number	**Date investigation started**	**Division**	**Incident Description**	**RCA Lead Investigator**	**Progress**	**60 working day compliance (or within agreed extension)**	**Duty of Candour/ Being Open policy implemented**
StEIS 2017/27996	10/11/2017	Surgery	Patient transferred to the Trust on 11/07/17, at the time of the incident the patient was on the sepsis pathway. Patient had a blood gas taken on the 08/11/17 at 02:58, patient had a repeat blood gas was taken and temperature spiked at 04:15. Patient's saturations and heart rate subsequently dropped and arrest team called at 04:35. Concern raised that blood results not acted on in a timely manner.	James Ashton, Sepsis Nurse Specialist	RCA panel meeting held 18/12/17, further panel meeting held 02/01/18. RCA report being written.	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
2017/ 24137	29/09/2017	Medicine	Suboptimal care of deteriorating patient. Query sepsis pathway not followed. Complex patient with co-morbidities, known to Trust, attended for renal dialysis. Patient attended on 18/06/17, query septic during admission, staff recorded not concerned about the risk of sepsis and patient discharged as no clear cause of pyrexia. Patient returned 19/06/17 acutely unwell, patient transferred to PICU and sadly died on the 23/06/17.	Andrew Riordan, Consultant in Paediatric Infectious Diseases, Jeanette White, Matron, Amanda Turton, Head of Acute Care	Final report sent to CCG.	Yes

Safeguarding investigations closed since last report
Nil

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Tuesday 6th February 2018

Report of:	Clinical Quality Assurance Committee
Paper Prepared by:	Anita Marsland
Subject/Title:	CQAC Key issues report
Background Papers:	None
Purpose of Paper:	To update Board of Directors.
Action/Decision Required:	To note the contents.
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	
Resource Impact:	

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

6th February 2018

Clinical Quality Assurance Committee (CQAC) – Chairs Note

1. Purpose of the Report

The purpose of this report is to update the Board on the key issues raised at the CQAC held on 17th January 2018.

2. Key Issues

The following issues were raised and discussed at the Clinical Quality Assurance Committee on 17th January 2018; the minutes of the meeting will be submitted to the March 2018 Board for noting.

- Committee to receive Annual Inpatient Survey at 21st February 2018 CQAC meeting.
- Committee to receive Transition update at Feb/March CQAC meeting.
- Committee to receive Complaints increase update at 21st February 2018 meeting.
- The Committee **received** a Sepsis update, and **received** a presentation on the new technology app for Sepsis, CQAC to receive a Sepsis update at the next CQAC meeting on 21st February 2018
- The Committee **received** the CQC action plan and **noted** that further amendments/refining are necessary, CQC action plan to be discussed at next CQAC meeting on 21st February 2018.
- The Committee agreed that Committee Chairs would receive a detailed CQC action plan position statement to ensure Committee ownership.
- The Committee **received** and noted progress updates regarding Programme Assurance
- The Committee **received** Quality Metrics Corporate report update including Patient Experience, Clinical Effectiveness and Patient Safety.
- The Committee **received** the Board Assurance Framework and would continue to receive monthly updates at CQAC.
- The Committee **received** the Clinical Quality Steering Group key issues report and would continue to receive monthly updates from CQSG.

3. Recommendations

It is recommended that the Board **note** the contents of the Chairs Update relating to the key issues from the Clinical Quality Assurance Committee Committee held on 17th January 2018.

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Alder Hey Children's NHS
NHS Foundation Trust

Clinical Quality Assurance Committee
Minutes of the last meeting held on Friday 15th December 2017
10.00 am, Room 20, Institute in the Park

Present:	Anita Marsland	(Chair) Non-Executive Director
	Louise Shepherd	Chief Executive
	Mags Barnaby	Interim Chief Operating Officer
	Jeannie France-Hayhurst	Non-Executive Director
	Pauline Brown	Director of Nursing
	Hilda Gwilliams	Chief Nurse
	Lachlan Stark	Head of Planning and Performance
	Steve Ryan	Interim Medical Director
	Erica Saunders	Director of Corporate Affairs
	Tony Rigby	Deputy Director of Risk & Governance
	Melissa Swindell	Director of HR
	Jo Williams	Non-Executive Director
	Anne Hyson	Head of Quality - Medicine
	Sarah Stephenson	Head of Quality – Community
	Cathy Umbers	Associate Director of Nursing & Governance
	Julie Williams	Governor
	Julie Knowles	Director of Safeguarding
	Denise Boyle	Associate Chief Nurse
	Matthew Peak	Director of Research
	Christian Duncan	Director, Surgical Division
	Adrian Hughes	Director, Medicine Division

In Attendance

David Porter	
Glenna Smith	General Manager - Medicine
Cath Hill	Director, Aqua (observing as part of the Well Led Review)
Julie Creevy	Executive Assistant (Minutes)

17/18/86 Apologies:

Adam Bateman	Acting Chief Operating Officer
John Grinnell	Director of Finance
Steve Igoe	Non-Executive Director
Mark Peers	Public Governor
Cathy Wardell	Associate Chief Nurse
David Walker	Interim Head of Quality – Surgery
Will Weston	Associate Chief of Operations
Rachel Greer	Associate COO - Community

17/18/87 Declaration of Interest

None declared

17/18/88 Minutes of the previous meeting held on 15th November 2017

Resolved:

CQAC approved the minutes of the previous meeting held on 15th November 2017.

17/18/89 Maters Arising and Action Log

16/17/131 – SIRI – CQAC confirmed that this item had been discussed at CQSG, and revisions had been made, with a simplified methodology, this item would now be closed and removed from the action log.

Water Tracker – MB presented the Water tracker, MB confirmed that there had been a level of maturity reached at the water safety committee meetings. The water tracker is reviewed at every water safety meeting, and a technical water safety group had been establishment which fully addresses issues regarding flushing, estate water issues, PFI issues. MB stated that the technical team agree relevant actions and report into the water safety committee. Water safety committee meet bi monthly and any relevant actions which are raised are appropriately managed.

HG queried those items that still required confirmation within the tracker. MB confirmed that the tracker is 'work in progress' and any outstanding actions are flagged and addressed at the water safety group meetings.

JFH queried whether the building issue had been resolved, MB stated that there were 3 elements water/PFI builders/Trust estate team, with the technical sub group required to resolve issues prior to discussion at water safety group. MB stated that she is reluctant to state that the PFI issue had been completely resolved, filter issue had been resolved 9 months ago, with no issues reported since that time.

AM thanked MB for the update.

Quality Metrics – LS confirmed that work is ongoing to improve quality metric information. A small group had been established, with group fully reviewing 6 different corporate reports from 6 other organisations. Leads had been identified within the working group to review style and content, with further work ongoing.

TR confirmed that he is hoping to have a strategy away day involving a children exercise, ensuring it is fully patient orientated, with a larger group to review the quality plan going forward, which will link in with CQC domains. High level plan had been devised, with a need for a long term projection/vision with initial work to conclude regarding corporate report.

CQAC noted that further work is required, and noted the challenge regarding business intelligence team, to incorporate into the corporate reports, given the small number of skilled individuals available within the team to support. AM stated that the Trust should aim to provide as much resource as possible to aid progression regarding this issue.

CQAC noted work in progress.

LS highlighted the importance of ensuring best practice learning is captured to ensure continuous improvement.

AM thanked LS & TR for the update, and looked forward to receiving a substantive report for the next CQAC meeting In January 2018.

Action: Detailed update to be received at next meeting.

Update regarding review of clinical investigations – NB confirmed that he had recently met with Steve Ryan on 5th December 2017 to plan next steps. NB confirmed that there is a requirement for 'standard operation procedures' to be agreed which would be governed through GDE, with a roll out programme to be confirmed. SR highlighted the importance of clinical engagement and ensuring clinicians 'own' this issue going forward. CQAC noted the continuing issues regarding meditech, however a safe work around to address these issues had been found. Timeframe for completion is 1st April. CQAC to receive a further update in March 2018.

AM thanked NB for his update.

Action: Further update at March 2018 meeting.

Devolved Governance framework – HG confirmed that a meeting had been diarised on 8th January to fully review the devolved model.

17/18/09 **Confidential Enquiries 2016/17,** CQAC noted that appropriate meetings had taken place to discuss process with further meeting with HG/HoQ/CU diarised for early January 2018.

17/18/90 **Quality Ward Round Update**

CU confirmed that following the Trust Board initiative in January, there had now been a total of 49 Quality Assurance visits scheduled, this is a rolling programme over a 12 month period to ensure ward to board reporting. CU stated that excellent engagement within the clinical team had been evident throughout all of the visits completed to date.

JW echoed CU comments, and confirmed that the quality assurance visits that she had attended had been extremely informative, with visits extremely professional and the visits provided opportunity to interrogate, review processes and effectiveness; JW stated that this provided her with a considerable degree of assurance, JFH also echoed JW comments. AM confirmed that the quality assurance visit process would be kept under review at CQAC.

CU confirmed that L Calder had worked extremely well in co-ordinating the logistics of the visits. CU confirmed that there will still some gaps in the quality assurance dates that had been sent – and that there were some dates that still required filling, those outstanding dates to be recirculated.

Action: L Calder to circulate dates that required filling

CQAC agreed it helpful to use the quality assurance visits evidence to articulate regarding services provided when required.

AM thanked CU for her update.

17/18/91 Self Assessment against the Quality Governance Framework

ES stated that quarterly reviews had been undertaken.

- Significant assurance by Mersey Internal Audit Agency noted by Audit Committee. Well Led review currently in process which had been commissioned by Board to provide focus on consideration of skills going forward.

- NED succession plan to be developed given tenure of longer standing Board members coming to an end in the next 12 months.

Staff survey – work continues to ensure more advocates are signed up to attend training, K Turner, is more visible throughout the Trust in her capacity as Freedom to Speak Up. There had been a delay in the website going live, however this is scheduled for January 2018, continuing to review.

AM thanked ES for her update.

17/18/92 Sepsis Update

June – November 2017 – ED had received 600 admissions

DP confirmed that from June 2017 – October/November, Emergency Department had received over 1000 patients within the ED.

55-60 minutes for time of antibiotics had seen an increase to 65-70 minutes, which was expected given the influx of patients within ED. Work will continue to ensure patients are rapidly managed.

- DP confirmed that the issue regarding electronic documentation continued, resulting in process being difficult for doctors on the ward completing the correct forms. DP stated that continued difficulty is encountered regarding retrieving accurate and comprehensive data from the system, with a significant amount of sepsis data information being completed manually, which is extremely time consuming.
- Training – linking junior doctors mandatory training, - MS agreed that this would be followed up offline to ensure sufficient package is available to assist.

Action: MS to address training/linking junior doctor training issue

- Aim for 1st February - doctors would use standard documentation, which should be a prompt for clinicians, this would take time for documentation to be used appropriately, however this would aid clinicians going forward.

- DP confirmed that an 'Aid' would be beneficial for supporting clinicians which would link with meditech, as there is currently no specific guidance document.

  Discussion took place regarding the lack of response from meditech, CQAC confirmed that this issue needed to be followed up to ensure that the meditech team had exhausted all options in addressing and responding to issues raised, and highlighted the need to suggest a 'work round' to address issues.

Action: **Ensure offline discussion is diarised with Chief Information Officer and relevant personnel to ensure progress is made regarding lack of meditech response**.

AM agreed that a continued monthly update to CQAC would be beneficial.

AM thanked DP for his update.

17/18/93 CQC Action Plan

ES confirmed that evidence continued to be collected, with some areas making improvements, all staff had been extremely supportive in providing timely/prompt evidence. Evidence column had now been included within the action plan.

ES stated that a quarterly strategic engagement meeting had taken place on 11th December 2017, with the Trust receiving compliment regarding how robust the plan was, with CQC reviewing, once it had been through the internal assurance process.

AM confirmed that CQAC should continue to receive monthly updates.

L Shepherd required clarity whether the Trust had in place quality assurance regarding set of reports, CQAC noted that the outstanding issue related to improving the way the Trust collects/extracts data in terms of Sepsis.

Action: **CQAC to received CQC Action plan on a monthly updates.**

AM thanked ES for her update.

17/18/94 Programme Assurance Update

JG presented the Programme Assurance update.
The latest forecast - savings of £157k which has deteriorated since the previous update and still insufficient to meet the financial objectives of the programme.
-'Experience in Outpatients' – is reflected as amber, project is well run, - benefits related work to do.

- 'Best in Operative Care' – is not projected to achieve the project benefits in the planned timescale and is currently off track.
-'Best in Community Care' – has commenced the upload of initial documentation to SharePoint – further work to continue with 1st tranche - due for discussion at January 2018 Programme Board meeting.
-Deteriorating Patient' - The 'Sepsis' project documentation is missing the 90% prescribing target by some 10% (as at October 2017).
-'Best in Acute Care'- still required to provide further evidence of assurance as reflected in the dashboard ratings and comments, JG envisaged that he expects to see improvements imminently now sufficient programme support had been provided.
-7 Day services (includes Out of Hours) – still required to provide further evidence of assurance as reflected on the dashboard ratings and comments.
-'Primary Care streaming' – evidence required to ensure SG & SR are content with arrangement, - currently have 5 days of streaming, however bid for support for £185,000 had not been supported.

Action: MB to progress outstanding issue.

AM confirmed that she had received assurance that the finance implications are being followed up during weekly financial recovery meetings.

AM thanked JG for his update.

17/18/97 Corporate Report – Quality Metrics

Patient Experience
There were 10 formal complaints in October, the highest number in any month so far this year. The cumulative number of PALS attendance had reduced from 752 last year to 699 this year, a focussed piece of work will commence in January to review this further. Continued effort is required to continue to improve the metrics 'patients are aware of their planned date of discharge', (currently at 57.4% versus 65% last month), this is included within GDE work stream/redevelopment of clinical pathways which will inform length of stay. Work is progressing regarding patients involved in play and learning which equated to 73%. Discussions are underway to improve family and friends feedback from A&E and Community areas.

Clinical Effectiveness

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

on ICU, with each case following due process with a complete HMRG review.

Patient Safety
Targeted area regarding medication errors had seen an improved position. There was 1x medication errors associated with harm recorded in October, compared to 3 in September. This is 13 in year, compared to 31 last year. There were 3 grade 2 or higher pressure ulcers reported in October i.e. 26 year to date compared to 18 last year. Clinical incidents associated with harm fell slightly from 81 last month to 77 in October. This was previously flagged as a significant increase and a review of the recorded harm levels had shown this to be in minor harm incidents. The Trust continued to be in top percentile of reporting of incidents, with robust systems in place for addressing areas of concern during discussion at weekly meeting of harm, with feedback to Executive Team thereafter.

AM thanked HG for her update.

17/18/98 Board Assurance Framework

ES presented the Board Assurance Framework, with main focus regarding the following items:

- Failure to maintain appropriate levels of care quality in a cost contained environment.
- Sepsis/meditech issues would continue to be tracked, with suppliers response to be escalated by Chief Information Officer, with monthly updates to CQAC to provide assurance.
- CQC Annual inpatient survey, CQAC will receive an update at January 2018 meeting.
- D&V outbreak on 4A had occurred since last CQAC meeting, good collaboration had been achieved with Public Health England, with positive feeback received from Public Health England, outbreak was managed extremely robustly, as was the Norovirus.
- Measles issue had been robustly and well managed with the Trust working together with local Romanian family to educate family regarding vaccination programme.

CQAC received and noted the BAF update.

AM thanked ES for her update.

17/18/99 PLACE Assessment Update

This item was deferred as the PLACE assessment had not yet been presented at Clinical Quality Steering Group meeting.

17/18/100 Clinical Quality Steering Group key issues report

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

- Signficiant improvements relating to some of the quality aims including a 50% reduction in HAIs compared to 16/17. The Trust

had seen 8 consecutive months without an MRSA Bacteramia and 10 months without a HAI. Estimated length of stay had also improved with a figure of 3.8% compared to 5.3% last year. 50% reduction in medication errors resulting in harm had been maintained.

- Patients staying in hospital longer than expected is 3.8% compared to 5.3 last year.
- All patient experience measured had improved.
- Maintained an almost 50% reduction in medication errors associated with harm since last year.
- Pressure ulcers remained high, but hope to see these start to reduce as training continued to be rolled out. In the future Tissue viability will report to Divisional Risk and Governance meetings, Clinical incidents associated with harm remain high compared to last year, with a deep dive to ascertain if this is due to changes in reporting or whether there is some underlying issue.
- Work is ongoing to bring back on line those few CQUINS that are not currently on track, with support being sought from divisions to help deliver the work within the agreed quarterly timeframes.
- Medicine Devices report was submitted which highlighted some concerns, relating to the funding for capital replacement programme. The Trust is prioritising key equipment, but some devices lifespan is being extended longer than was previously expected. Training is an issue with limited opportunity for key transfers to train staff, and team unable to add the many pieces of kit onto ESR. The MDSO is developing a ward based training database and is also supporting key trainers with study sessions using the E Learning library as a resource. Clinical Educators at ward level are able to address this by supporting the link nurse and key trainers.
- MS stated that it would be benefical to have HR representation in attendance at future CQSG meetings

Action: MS to provide PB/P O'Connor with details of HR rep who would attend CQSG going forward.

CQAC received and noted the CQSG key issues report.

AM thanked Pauline on behalf of CQAC for continued invaluable support provided by CQSG to date.

17/18/101 Any Other Business

None

17/18/102 Date and Time of Next meeting

10.00 am – Wednesday 17th January, Large meeting room, Institute in the Park

Alder Hey Children's NHS
NHS Foundation Trust

Integrated Governance Committee
Minutes of the last meeting held on Wednesday 1st November 2017
10.00 am, Large Meeting Room, Institute in the Park

Present:	Mr S Igoe	Non-Executive Director**(Chair)**	(SI)
	Mr J Grinnell	Director of Finance	(JG)
	Ms E Saunders	Director of Corporate Affairs	(ES)
	Mrs M Swindell	Director of HR & OD	(MS)
In Attendance:	Mr R Griffiths	Service Manager (Surgery)	(RG)
	S Stephenson	Head of Quality (Community)	(SS)
	Mrs A Hyson	Head of Quality (Medicine)	(AH)
	Mrs A Kinsella	Health & Safety Manager	(AK)
	Mrs E Menarry	EP and Business Continuity Manager	(EM)
	Miss L Calder	Quality Assurance Facilitator *(minutes)*	(LC)
	Mr T Rigby	Deputy Director of Risk & Governance	(TR)
	Mrs C Umbers	Assoc. Dir. Nursing & Governance	(CU)
	Mrs R Greer	Assoc. Chief of Operations (Community)	(RG)
	Mrs V Weston	General Manager (Surgery)	(CL)
	Mrs C Wardell	Assoc. Chief Nurse (Medicine)	(CW)
	Mr G Dixon	Operational Lead (Building Services)	(CG)
	Mrs C Fox	Associate Director of Informatics	(CF)
	Ms L Baker	Information Governance Manager	(LB)
	Ms J Gwilliams	Clinical Risk Manager	(JG)
	Mr M Devereaux	Head of Facilities and Soft Service	(MD)
	Mr J Gibson	E-Portfolio Director	(JG)
	Ms K Morgan	Deputy Head of Information	(KM)
	Mrs R Douglas	Safeguarding Nurse	(RD
Apologies:	Mr D Powell	Development Director	(DP)
	Mr S Ryan	Medical Director	(SR)
	Mr W Weston	Assoc. Chief of Operations (Medicine)	(AB)
	Mrs P Brown	Director of Nursing	(PB)
	Mrs D Walker	Head of Pharmacy	(DW
	Mrs C Barker	Chief Pharmacist	(CB)

Mrs H Gwilliams Chief Nurse (HG)

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
Housekeeping						
	1.	**Apologies for absence**	Noted			
17/18/42	**2.**	**Minutes of previous Meeting**	The Committee considered the minutes of the previous meeting of the Integrated Governance Committee held on 27th September 2017. The Committee **APPROVED** the minutes as a correct record.			
	2.2	**Action list**	**Resolved** that: the Committee agreed all actions from 27th September have been addressed. The committee agreed the revised terms of reference will be presented at the January Meeting.		SI/CU	
	3.	**Risk Register Management Reviews**				
17/18/43	**3.1**	**Surgery Division**	Rob Griffiths (RG) presented the risk management report for Surgery. RG advised the committee about the challenges in the surgical division in terms of not having permanent Head of Quality in post and currently ACN on extended leave. The committee discussed accountabilities and responsibilities for the management of risk, and the risk register. It was clarified and agreed that the division's senior management team are accountable and responsible with support from Heads of Quality to manage risks via the divisions risk register. In the corporate functions it will be the senior lead for that function who will retain accountability and responsibility. The accountability for risk management and the associated risk register will not be devolved to junior staff. However responsibility for managing individual risks on the register will be delegated as appropriate via the named risk owners. Risks from the Surgical Divisions report were highlighted as follows: Total number of risks for surgery 97, new risks 3, closed risks 2,		AB/CL	

			overdue risks 79, risks with no agreed action plan 30, high risks 5. RG advised that all outstanding risks have been validated. Risk 424 – risk of transmission of vCJD is an 18 month on-going project. The go live date for new instruments is December 2017 and it is expected this risk will be eliminated at that time Risk 964 - booking and scheduling. JG felt a risk of 25 is high for a scheduling and elective risk? RG advised the risk is at the clinical end and Clinical systems manager is visiting the dep't on 30th Oct 2017 to review recent incidents and whether changes can be made to the system earlier for assurance. CU advised that section 6 on the assurance statement needs to be revisited. RG advised the committee that although there is ongoing work required, the division are comfortable with the progress and expect further work to be completed prior to the next reporting period. Issues are expected to be resolved by the next IGC meeting. **Resolved** that: the Committee NOTED the contents of the paper	AB to review section 6 in report		Update IGC Jan 18
17/18/44	**3.2**	**Medical Division**	CW presented the risk management report for Medicine. Risks from the report were highlighted as follows: • Total number of risks = 143 • Number of new risks identified since the last reporting period = 14 • Number of risks closed and removed from the risk register = 7 • Number of risks with an overdue review date = 23 • Number of risks with no agreed action plan = 5		WW/CW	Immediate

			• Number of high/extreme risks escalated to the Executive Team = 8 CW focused on the high risks from the Medical Division for this reporting period. Risk 1190 - delays in fully commissioning the Pharmacy Aseptic Unit. JG advised that this risk is showing as having a financial link .The current risk rating is 12 ,and is being managed Risk 581 – score 15 – The current systems and processes need further work, to align ESR with local blood transfusion training figures. There continue to be discrepancies with training figures on ESR, and managers, ward and departmental figures, although both show non-compliance with expected target. Moreover staff who are not employed by the Trust i.e. locums, medical students, trainees training stats are not recorded on the Trust ESR system as they are not employed by the Trust. MS confirmed she is working with Tracy Shackleton to complete a piece of work outside of the IGC meeting to reduce the current risk level of risk. JG questioned the financial risk in terms of rating currently scoring 12. CW advised that further work is being undertaken and a further update will be provided in due course. CW advised the committee that the Medical Division are satisfied with progress, while recognising that ongoing work is required to enable assurance of effective management of risk across the division. **Resolved** that: the Committee NOTED the contents of the paper	MS/TS to complete work outside IGC meeting.	MS	Immediate
17/18/45	**3.3**	**Community Division**	RG presented the risk management report for Community. Risks from the report were highlighted as follows: Total no of risks 35, new risks since last report 5, risk closed and removed 1, risks overdue 0, no of risks with no agreed action plan 0, high risks need escalating to execs for their support 4 (high risks).		RG/SS	

			RG presented the risk management report and focused on the high risks identified for community. Risk 1275 – CAMHS Sefton provides the main site for CAMHS clinics and has been kept on risk register until they are relocated scheduled for May 2018, as building in Waterloo is not fit for clinical use. RG advised the committee that the division are confident they are keeping on top of all risks in terms of effective management. **Resolved** that: the Committee NOTED the contents of the paper			
17/18/46	**3.4**	**Infection Control Service**	VW presented the risk management report for Infection Prevention Control. Risks from the report were highlighted as follows: Total no of risks 15, new risks since last report 0, risk closed and removed 1, risks overdue 3, no of risks with no agreed action plan 0, high risks need escalating to execs for their support 8 (high risks). Risk 1394 – DIPC post has been out to advert, however post not filled, therefore needs to be re-advertised. Once post is filled risk should go down. However the Medical Director is acting in post and the previous DIPC remains in post one day per week for 6 months from Sept 17, which is mitigating the risk. Risk 1374 – Increase prevalence of HAI MSSA bacteraemia within the Trust. MSSA reduction action plan being monitored through IPCC. RCA executive review system commenced and monthly review dates scheduled up to and including March 2018. Risk 1372 – This risk is being managed via the IPC work plan, which is monitored monthly via the IPC committee monthly meeting or more frequently by the IPC team as required. Audit programme and TOR now devised and regular audits to take place commencing 1st		VW/JK	

			Nov 17. VW advised the committee that although there is ongoing work required, the Infection Control team are satisfied with the progress at this point. **Resolved** that: the Committee NOTED the contents of the paper			
17/18/47	**3.5**	**Facilities**	MD presented the risk management report for Facilities. Risks from the report were highlighted as follows: Total no of risks 6, new risks since last report 2, risk closed and removed 1, risks overdue 1, no of risks with no agreed action plan 1, high risks need escalating to execs for their support 0 (high risks). Risk 1103 – Beds not in use. Staff are pushing to one side on the wards and is causing risk in terms of patient safety and other health and safety issues. The porters know where the surplus beds are stored and would call and collect from wards if they were informed. MD confirmed they did look at storing beds off site but this wasn't feasible. The turnover with AED can create a risk with the beds. It was suggested to put a Task & Finish Group together to look at this issue and put some actions in place to rectify. SI has asked Margaret Barnaby to organise the Task & Finish Group to look into this issue. MD advised the committee that although there is ongoing work required, he is satisfied with the progress at this point. **Resolved** that: the Committee NOTED the contents of the paper	MD to ask MB to form a Task & Finish Group	MD	Immediate
17/18/48	**3.6**	**IM&T**	CF presented the risk management report for IM&T. Risks from the report were highlighted as follows: Total no of risks 20, new risks since last report 4, risk closed and removed 0, risks overdue 0, no of risks with no agreed action plan 12, high risks need escalating to execs for their support 0 (high		PY/LF	

			risks). Since the last IGC, IM&T have had a Cyber security review which has highlighted the following risks based on initial feedback. Risk 1488 – N3 hosted application with vulnerabilities based on the use of older versions of software. Risk 1489 – Significant volumes of patient data held on the file shares. Risk 1490 – Meditec application vulnerabilities. There is an action plan to review in Dec 17. CF advised the committee that although there is ongoing work required, the IM&T are satisfied with the progress at this point. **Resolved** that: the Committee NOTED the contents of the paper			CF to provide update at Jan IGC
17/18/49	**3.7**	**HR**	MS presented the risk management report for HR. Risks from the report were highlighted as follows: There are currently 8 risks on the HR risk register – all either moderate or below. MS advised the committee that there hasn't been a great deal of change since the last meeting. Risk 172 – Mandatory Training Compliance. MS advised the risk is due to staff not being compliant. Processes have been devised to ensure new starters are 100% compliant on day one of start to the Trust. MS advised the committee that she is satisfied in relation to the current risk management position in terms of effectiveness of management. MS advised that 50% of the risks need reviewing however we are only one week out of this time period and at the last IGC HR was up to date with risks. MS advised the committee that although there is ongoing work		MS	

			required, Human Resources are satisfied with the progress at this point. **Resolved** that: the Committee NOTED the contents of the paper			
17/18/50	**3.8**	**Finance**	JG presented the risk management report for Finance. Risks from the report were highlighted as follows: There are 7 risks identified on the finance risk register. new risks since last report 0, risk closed and removed 2, risks overdue 0, no of risks with no agreed action plan 0, high risks need escalating to execs for their support 0 (high risks). JG advised the committee that the Finance department are satisfied with the progress at this point. **Resolved** that: the Committee NOTED the contents of the paper		JG	
17/18/51	**3.9**	**Estates/Building Services**	GD presented the risk management report for Building Services. Risks from the report were highlighted as follows: Risks on register for Building services. There are 3 risks identified - new risks since last report 0, risk closed and removed 0, risks overdue 0, no of risks with no agreed action plan 0, high risks need escalating to execs for their support 0 (high risks). Risk 1388 – There is potential for rapid corrosion of pipework to CHP. GD advised committee there have been 40 burst pipes within CHP. DP & GD to meet and look at all risks and decided who they need to be assigned to, to make sure they are all showing on Ulysses. GD advised the committee that although there is ongoing work required, the Estates department are satisfied with the progress at this point.		DP/JW/SB	

			Resolved that: the Committee NOTED the contents of the paper GD present the risk management report for Estates. Risks from the report are highlighted as follows: Total no of risks 22, new risks since last report 1, risk closed and removed 1, risks overdue 0, no of risks with no agreed action plan 0, high risks need escalating to execs for their support 0 (high risks). **Resolved** that: the Committee NOTED the contents of the paper	SB to provide report for Project risks she oversees		Submit to Dec 17 Estates Revalidation meeting
17/18/52	**3.10**	**Health & Safety**	AK presented the risk management report for Health & Safety. Risks from the report were highlighted as follows: Total no of risks 11, new risks since last report 0, risk closed and removed 0, risks overdue 0, no of risks with no agreed action plan 0, high risks need escalating to execs for their support 2 (high risks). Risk 809 – Security provision on the retained estate has been reduced since occupation of the new hospital CHP. Vulnerability of staff and risk of personal injury/harm to staff on the retained estate has been raised. Risk 799 – Failure to control contractors on site. There is a risk of dangerous occurrence, contractors going into areas of Trust and leaving ladders & tools unsupervised. There is risk of personal injury/harm to staff, patients and visitors, which could cause damage to reputation of Trust and adverse media and external enforcement notices. AK advised the committee there is a meeting on 13th Nov with SPV/IFM/LOR regarding control of contractors on site. AK advised the committee that there is a financial risk in relation to PFI. Any claims are now the responsibility of the Trust to settle and we have a 10k access. AK & JG to meet up and discuss the	13th Nov meeting to review policy AK/JG to meet to	MS	Update Jan IGC Update Jan IGC

			financial implications to this risk and update the next risk management report. **Resolved** that: the Committee NOTED the contents of the paper	discuss financial implications		
17/18/53	**3.11**	**Business Preparedness & Associated reports**	Preparedness & Associated reports. Risks from the report were highlighted as follows: Total no of risks 15, new risks since last report 2, risk closed and removed 0, risks overdue 0, no of risks with no agreed action plan 0, high risks need escalating to execs for their support 0 (high risks). Risk 1469 – Emergency Preparedness mandatory training compliance demonstrates a compliance score figure of 39%. EM informed committee that a formal presentation will be provided for the emergency preparedness training from 7th Nov 17 rather than using a workbook which will improve compliance going forward. Risk 1470 – Major incident cascade taking over 30 minutes to complete which is too long. This is an objective for the EP/BC manager/administrator to investigate costings for an automated cascade system. EM will update committee when she knows more. RG has suggested in the interim the nursing teams to help with the training. EM to look at best way to deliver this training. MS & EM to meet and discuss. EM is satisfied with management of risks on register in this area. **Resolved** that: the Committee NOTED the contents of the paper	MS/EM to meet to discuss cascade training	MS	Update Jan IGC
17/18/54	**3.12**	**Information Governance**	LB presented the risk management report for Information Governance. Risks from the report were highlighted as follows: Total no of risks 9, new risks since last report 2, risk closed and removed 2, risks overdue 0, no of risks with no agreed action plan 0, high risks need escalating to execs for their support 0 (high risks).		ES	

			LB advised all risks have actions except for one. Risk 1491 – IG Toolkit compliance needed to provide evidence to CAG for approval of research studies. Action plan is required to be completed by Dec 17. LB sent out actions to everyone concerned and still waiting on responses from divisions. Risk 1286 - ES Storage of records in the retained site archive room. ES advised that we need to look at storage off site; this has been delayed due to having access to the archive/storage room on the retained estate. SI asked would it be possible to destroy some of records after a certain period of time. LB advised that due to the Goddard Report we are unable to destroy related records as they may be required for the review. LB is confident that all risks have controls in place and is happy where they sit. **Resolved** that: the Committee NOTED the contents of the paper	Divisions to action and sent to LB		Immediate
17/18/55		**Global Digital Excellence Programme**	KM presented the risk management report for Global Digital Excellence Programme reports. Risks from the report were highlighted as follows: Total no of risks 16, new risks since last report 16, risk closed and removed 0, risks overdue 0, no of risks with no agreed action plan 16 (mitigations in place), high risks need escalating to execs for their support 0 (high risks). Contract compliance and reporting driving the GDE. KM is happy with management of risks on register in this area. **Resolved** that: the Committee NOTED the contents of the paper		KM	
17/18/56	**4.**	**Corporate Risk**	CU presented the Corporate Risk Register Review.		CU	

		Register Review	CU informed the committee that there are 570 risks on the Trust risk register, and the detail is reflected in the Division and corporate functions risk registers. The total number of risks on the risk register is 570 compared to 545 for the previous reporting period. 63 (11.1%) of the Trusts risks are rated as' High/Extreme' risks compared to 67 (12.29%) for the previous reporting period. 375 (65.8%) of the Trusts risks are rated as 'Moderate', 177 (32.47%) rated 12 (High moderate). 104 (18.2%) of the Trust risks rated as 'Low risk' 24 (4.2%) of the Trust risks rated as 'Very Low risk'. 268 (47%) risk assessments have an overdue review date. All 63 high/extreme risks that have been escalated to the CRR; 8 (12.69%) in the Medical Division, 4 (6.34%) in the Surgical Division. 4 (6.34%) in Community services. 44 (74.60%) in Corporate Services. CU advised the committee that we need to show on the risk assessments on the risk registers that all elements of the identified risks are being managed effectively, including controls, actions to address gaps, progress and effectiveness of actions to mitigate the risks etc. In summary we need to be working towards a shift in the risk profile to demonstrate managed risks that show evidence of consistent movement towards the target level, mostly low level as far as possible, unless agreed otherwise for specific risks. CU advised that the monthly risk validation meetings are going to continue for a further 12 months, or until such time as there is assurance that risks are being managed effectively. The risks need to be overseen and driven by Senior Management in the 3 divisions and heads of department in corporate functions. CU informed the committee that there are concerns that not all risks are showing on Ulysses system i.e. project risks. However all GDE risks have now been inputted onto Ulysses. CU met with JG and agreed that rather than create numerous additional risk reports, the			

			project risks would be attached as a part 2 to the reports relevant to the portfolio of individual executives. The committee agreed with this approach. JG informed the committee that the projects risks were put on a separate system and assurance was in place via the project board, we need assurance that if a high risk is identified it comes through the part 2 of the risk reports to the IGC. Risks may have shown as high on Projects system but could come down when sits with the business owner. SI advised the committee that there has been a positive turnaround following the initial risk validation meetings and it's good that we are continuing with the validation over the coming months. SI expressed his concerns regarding overdue risk reviews and outstanding actions. SI further advised that the MIAA audit will take place quarter/4 and this time should enable Divisions and corporate functions time to rectify the deficits in their risk registers and show consistent effective management. SI strongly advised the Division leads and corporate functions leads to address the deficits identified on their registers and provide the necessary assurance of effective management of their risks **Resolved** that: the Committee NOTED the contents of the paper			
17/18/57	**5.**	**Board Assurance Framework (BAF)**	ES presented the Board Assurance Framework. ES updated the committee that the BAF report included on 1st November IGC is the September report as the October report has to be approved at board on 7th November. ES advised there is nothing in particular to report. There is a gap in the senior team and a gap in community at the moment. Mandatory compliance is showing as AED being fragile at the moment and there is a 4 hour AED target. Last year they were managing their target and we hope to have this back on track as soon as possible. The risk needs managing as the last update on this report was August 2017 and will be updated to reflect this. Community health to be updated and taken off. AED to September is showing as a 6. Mandatory training compliance needs further review.		ES	

			Resolved that: the Committee NOTED the contents of the paper			
	7.	**Policies**				
17/18/59		**Alder Hey Social Media Guidelines**	ES explained to the committee that Alder Hey Social Media Guidelines should have been presented to Information Governance Steering Group and not IGC meeting. The guidelines were not presented to the committee.			
	8.	**Ad Hoc Reports**				
17/18/58	**9.**	**WSG Tracker Update Report**	AK presented the WSG Tracker Update report to the committee and highlighted as follows. AK advised the committee that SPV have confirmed there is little they can do. Flushing is up to 95%. Installation of pipework. There are recommendations to audit all (PPMS) Planned Preventative Maintenance and this is a substantial amount of work. GD advised the committee that the Trust is using a 3rd less water than expected and in turn this is creating hotter water. Temperatures are being monitored and managed effectively. There are resolutions in place to resolve this as showing as a high risk to the Trust. The temperature is not as it should be and the risk is low/moderate and there are mitigations in place. There are 100 samples taking place each month however we are taking more samples right now. The issue is the water coming in to the system is 18. The risk controls are in place and being managed. **Resolved** that: the Committee NOTED the contents of the paper		MB	
	10.	**Any other business**	none			
Date and Time of Next Meeting			The next meeting of the IGC will be held on Wednesday 10th January 2018, 1:00pm. Large Meeting Room.			

INTEGRATED GOVERNANCE COMMITTEE

ACTION LIST – November 2017

No	Item	Owner	When	Status
17/18/39	Integrated Governance Committee Terms of Reference	S Igoe	Immediate	Cathy Umber to amend TOR to be presented to IGC Jan 18. Subject to amendments the TOR approved.
17/18/56	Risk Movement Report	G Gwilliams	Immediate	Risk movement report is not accurate and Jo Gwilliams advised not to use to submit reports. Jo Gwilliams to send out communications to divisions and corporate services.
	IGC Committee Timetable	L Calder	Immediate	LC to send out to the committee members.
17/18/40	Research IGC Toolkit	L Baker	Immediate	This action is for the divisions - IG Action Plan to be completed.
17/18/51	Projects – Estates Services	S Brown	Immediate	SB to provide the projects report CU for the next Estates Risk Revalidation meeting 8th Dec 17
17/18/44	Align ESR with Local Blood Transfusion Training Figures	M Swindell	Immediate	MS & TS to complete piece of work outside of IGC.

Corporate Report

Dec 2017

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Executive Summary

Dec 2017

Alder Hey Children's NHS Foundation Trust

Is there a Governance Issue?

Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
N	N	N	N	N	N	N	N	N

Highlights

Despite high levels of ED attendance with more complex and sicker children attending we have continued to deliver robust ED performance (best in Merseyside). Winter plan continues within which we have managed to deliver an elective plan with only 15 cancelled ops noted which was a reduction from 42 in Nov. We have achieved diagnostic and incomplete pathway standards and 2/3 of the cancer standards. We failed the 2WW standard as 1 patient DNA'd despite confirming. Overall we have seen strong operational performance despite the winter & festive challenges.

Challenges

The Trust winter plan has now formally commenced. Challenge maintaining optimal elective throughput heading into festive season with continuing trend of both higher than planned levels of ED attendance and acuity. Analysis identifies this has continued across all areas of triage. UC24 are unable to fill all GP/ED/Primary Care Streaming shifts which impacts upon flow and 4hr performance. Productivity was adversely affected with reductions in theatre and Out Patient Utilisation couples with increased DNA rates.

Patient Centred Services

Overall improvement noted in performance in metrics for December despite challenging operational conditions. Continuing high levels of ED attendance have challenged the department however we have seen improved performance against the 4hr standard and achievement of the NHSI core standards. EI LOS has increased which is a result of improved discharges of long stay patients. Winter plan still operational within which EI plan has been maintained and canx ops has significantly reduced.

Excellence in Quality

The key issues in Decembers report relate to the continued reduction in medication errors resulting in harm; the reduction in infections and the continued improved performance in patients actually being discharged on or before their estimated date. Despite winter pressures and capacity and demand challenges, complaints and PALS remained roughly the same as last year at this time. Although we did not have any never events or MRSA bacteraemia we did have 2 serious incidents requiring investigation relating to pressure ulcers. There is currently a plan in place to cover the gap in terms of tissue viability and a business case is going through IRG for an increase in resources to help address the challenges around pressure ulcer management

Financial, Growth & Mandatory Framework

For the month of December the Trust is reporting a trading surplus of £0.08m which is £0.2m ahead of plan.

Income is ahead of plan by £0.4m. Elective income is in line with plan whereas non elective income is behind plan by £0.2m and outpatients income is behind by £0.1m. Elective activity is ahead of plan by 3%, non elective is behind by 8% and outpatient activity is in line with plan.

Pay budgets are 0.4m overspent for the month relating to use of temporary staffing and the impact of unachieved savings targets. The Trust is behind plan with the CIP target by £0.9m to date. Cash in the Bank is £8.2m. Monitor Use of Resources rating of 3 in line with plan.

Great Talented Teams

December has seen a reported increase in absence from 5.2 to 5.9%, however there have been national technical ESR issues which have impacted on input, which includes not being able to close open ended absence -, therefore this is possibly not a truly reflective position. The PDR position will remain the same until the compliance window opens again (April to July). Mandatory training continues to see an increase, now reporting as 86.28%, which is just below our target of 90%. HR&OD are continuing to work with managers to ensure this target is achieved by 31st Jan 18.

Leading Metrics

Dec 2017

Alder Hey Children's NHS Foundation Trust

Patient Centered Services

Metric Name	Goal	Nov 2017	Dec 2017	Trend	Last 12 Months
ED: 95% Treated within 4 Hours	95.0 %	92.8 %	94.1 %	▲	
RTT: 90% Admitted within 18 weeks		90.4 %	89.6 %	▼	
RTT: 95% Non-Admitted within 18 weeks		90.3 %	89.7 %	▼	
RTT: 92% Waiting within 18 weeks (open Pathways)	92.0 %	92.0 %	92.0 %	▲	
Diagnostics: Numbers waiting over 6 weeks		0	1	▲	
Average LoS - Elective (Days)		3.0	3.6	▲	
Average LoS - Non-Elective (Days)		2.0	2.0	▼	
Daycase Rate	0.0 %	72.4 %	74.2 %	▲	
Theatre Utilisation - % of Session Utilised	90.0 %	84.4 %	85.8 %	▲	
28 Day Breaches	0.0	5	4	▼	
Clinic Session Utilisation	90.0 %	88.4 %	84.4 %	▼	
DNA Rate	12.0 %	9.7 %	10.5 %	▲	
Cancelled Operations - Non Clinical - On Same Day		40	15	▼	

Excellence in Quality

Metric Name	Goal	Nov 2017	Dec 2017	Trend	Last 12 Months
Never Events	0.0	0	0	–	
IP Survey: % Received information enabling choices about their care	90.0 %	94.9 %	94.7 %	▼	
IP Survey: % Treated with respect	100.0 %	99.8 %	99.4 %	▼	
IP Survey: % Know their planned date of discharge	80.0 %	61.9 %	62.5 %	▲	
IP Survey: % Know who is in charge of their care	95.0 %	94.9 %	90.6 %	▼	
IP Survey: % Patients involved in play and learning	80.0 %	76.7 %	76.4 %	▼	
Pressure Ulcers (Grade 2 and above) YTD		30	31	▼	
Total Infections (YTD)	61.0	49	58	▼	
Medication errors resulting in harm (YTD)	46.0	16	20	–	
Clinical Incidents resulting in harm (YTD)	441.0	612	664	▼	

Great and Talented Teams

Metric Name	Goal	Nov 2017	Dec 2017	Trend	Last 12 Months
Corporate Induction	100.0 %	96.9 %	77.3 %	▼	
PDR	90.0 %	86.9 %	87.3 %	▲	
Medical Appraisal	100.0 %	11.6 %	13.6 %	▲	
Sickness	4.5 %	5.2 %	5.9 %	▲	
Mandatory Training	90.0 %	81.4 %	86.3 %	▲	
Staff Survey (Recommend Place to Work)		64.0 %	64.0 %	–	
Actual vs Planned Establishment (%)		93.2 %	92.8 %	▼	
Temporary Spend ('000s)		938	761	▼	

Financial, Growth and Mandatory Framework

Metric Name	Nov 2017	Dec 2017	Last 12 Months
CIP In Month Variance ('000s)	-433	-149	
Monitor Risk Ratings (YTD)	3	3	
Trading Surplus/(Deficit)	1296	88	
Capital Expenditure YTD % Variance	6.6 %	-63.7 %	
Cash in Bank (£M)	6.8	8.2	

Exceptions

Dec 2017

Alder Hey Children's NHS Foundation Trust

Positive (Top 5 based on % change)

Metric Name	Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Last 12 Months
Cancelled Operations - Non Clinical - On Same Day	12	17	29	31	7	57	19	31	15	48	26	40	15	
Mandatory Training	76.1%	77.2%	78.8%	75.4%	76.1%	76.0%	76.2%	78.2%	77.2%	74.4%	75.5%	81.4%	86.3%	
Staff Survey (Recommend Place to Work)	73.2%						39.6%	39.6%	39.6%	39.6%	39.6%	64.0%	64.0%	
Temporary Spend ('000s)	550	1,442	813	1,037	948	917	883	1,092	1,166	999	918	938	761	
Total Infections (YTD)	75	84	93	104	6	9	13	15	20	26	36	49	58	

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

Metric Name	Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Last 12 Months
RTT: 95% Non-Admitted within 18 weeks	87.2%	90.5%	86.7%	89.5%	90.2%	88.3%	88.7%	88.6%	89.5%	89.4%	90.3%	90.3%	89.7%	
RTT: 92% Waiting within 18 weeks (open Pathways)	92.1%	92.4%	92.1%	92.1%	92.1%	92.1%	92.1%	92.0%	92.0%	92.1%	92.2%	92.0%	92.0%	
Theatre Utilisation - % of Session Utilised	84.1%	86.6%	87.0%	86.8%	87.2%	87.3%	88.3%	86.1%	87.5%	86.5%	86.4%	84.4%	85.8%	
IP Survey: % Received information enabling choices about their care	96.3%	98.7%	96.0%	96.0%	94.1%	94.9%	94.7%	95.7%	92.1%	96.5%	96.1%	94.9%	94.7%	
Actual vs Planned Establishment (%)	87.7%	89.0%	92.3%	95.1%	94.8%	94.9%	94.8%	97.4%	92.9%	93.2%	94.4%	93.2%	92.8%	

Challenge (Top 5 based on % change)

Metric Name	Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Last 12 Months
Clinic Session Utilisation	83.1%	84.3%	85.1%	87.9%	86.7%	85.9%	85.0%	85.7%	84.8%	84.9%	86.7%	88.4%	84.4%	
Sickness	5.5%	5.4%	5.3%	4.7%	4.5%	4.6%	4.6%	5.0%	4.9%	4.8%	5.3%	5.2%	5.9%	
IP Survey: % Treated with respect	100.0%	98.7%	100.0%	100.0%	98.5%	100.0%	98.8%	99.4%	99.3%	99.5%	99.3%	99.8%	99.4%	
IP Survey: % Know who is in charge of their care	93.2%	93.0%	90.9%	91.9%	91.2%	96.1%	90.9%	92.9%	91.2%	92.8%	93.8%	94.9%	90.6%	
IP Survey: % Patients involved in play and learning	56.1%	55.6%	77.1%	75.7%	81.4%	75.8%	71.3%	74.0%	65.7%	73.0%	72.6%	76.7%	76.4%	

Patient Safety

Dec 2017

Alder Hey Children's NHS Foundation Trust

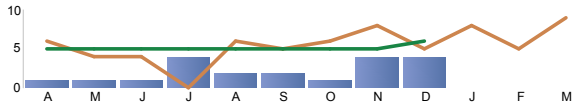
Summary

Medication errors were an identical amount from November performance with 4. Still overall significantly down from 16/17 figure of 44 to 21 in 17/18. There was 1 pressure ulcer grade 2 and above in December compared to 4 in November up by 5 in comparison to same stage last year. There were no never events in December and clinical incidents resulting in harm were down from 92 reported in November to 53 in December. However the total reported is 665 compared to 501 at same stage last year. There were 2 reported serious incidents requiring investigation in December both pressure ulcer related.

17/18 16/17 Threshold

Medication Errors

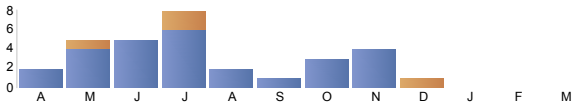
Medication errors resulting in harm (YTD) 20 (goal: 46.0)



YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	1	2	3	7	9	11	12	16	20			
16/17	6	10	14	14	20	25	31	39	44	52	57	66

Pressure Ulcers

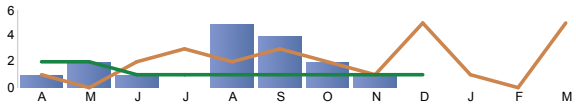
Pressure Ulcers (Grade 2 and above) YTD 31 (Est. Baseline)



YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	2	7	12	20	22	23	26	30	31			
16/17	3	6	8	9	11	16	18	22	26	28	29	32

Readmissions to PICU within 48 hrs

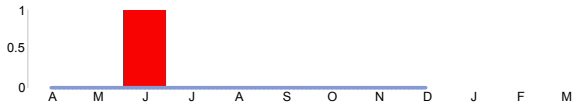
Readmissions to PICU within 48 hrs (YTD) 16 (goal: 11.0)



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

Never Events

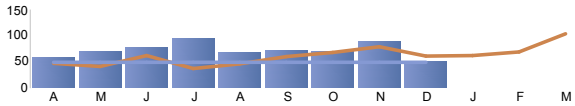
Never Events 0 (goal: 0.0)



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

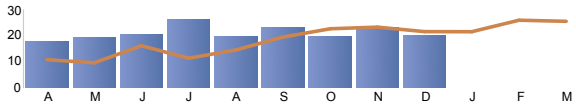
Incidents

Clinical Incidents resulting in harm (YTD) 664 (goal: 441.0)



YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	60	131	210	307	376	449	520	612	664			
16/17	47	88	150	187	233	293	361	440	501	563	632	736

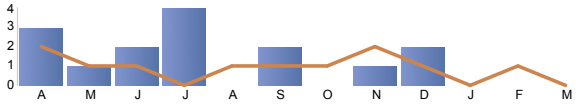
% of Total Clinical Incidents that resulted in Harm 20.7 %



YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	18	19	20	22	21	22	21	22	22			
16/17	11	10	12	12	12	13	14	16	16	17	17	18

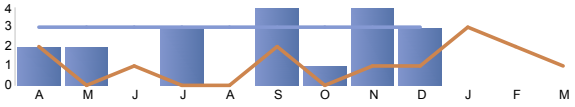
Serious incidents requiring investigation

Serious Incidents Requiring Investigation (Total) 2



YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	3	4	6	10	10	12	12	13	15			
16/17	2	3	4	4	5	6	7	9	10	10	11	11

Clinical Incidents resulting in moderate, severe harm or death (YTD) 19 (goal: 27.0)



YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	2	4	4	7	7	11	12	16	19			
16/17	2	2	3	3	3	5	5	6	7	10	12	13

Patient Experience

Dec 2017

Alder Hey Children's NHS Foundation Trust

Summary

In patient survey results in December are very similar to Novembers with the exception being the percentage of patients who know who is in charge of their care falling to 90.6% from 94.9% last month. There were 5 complaints in month down from 12 in November and PALS attendances were also down to 98 compared to 117 in November. Total numbers of both complaints and PALS are similar to last year

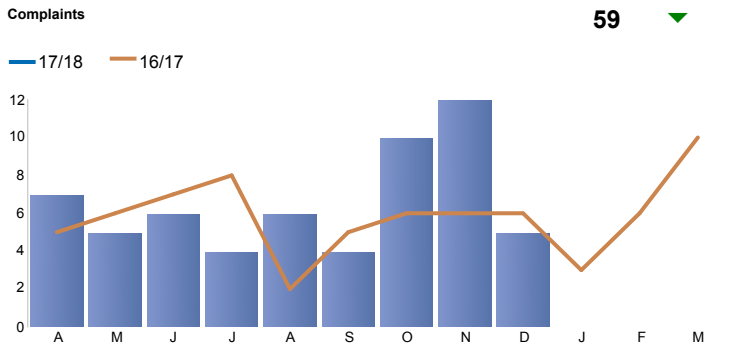
Inpatient Survey

Metric Name	Goal	Nov 2017	Dec 2017	Trend	Last 12 Months
% Know who is in charge of their care	95.0 %	94.9 %	90.6 %	▼	
% Patients involved in play and learning	80.0 %	76.7 %	76.4 %	▼	
% Know their planned date of discharge	80.0 %	61.9 %	62.5 %	▲	
% Received information enabling choices about their care	90.0 %	94.9 %	94.7 %	▼	
% Treated with respect	100.0 %	99.8 %	99.4 %	▼	

Friends and Family

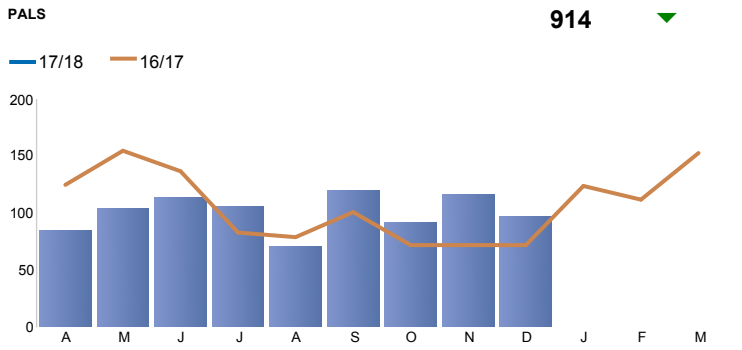
Metric Name	Required Responses	Number of Responses	Nov 2017	Dec 2017	Trend	Last 12 Months
A&E - % Recommend the Trust	250	33	89.1 %	90.9 %	▲	
Community - % Recommend the Trust	29	15	100.0 %	100.0 %	–	
Inpatients - % Recommend the Trust	300	409	97.5 %	97.3 %	▼	
Mental Health - % Recommend the Trust	27	12	96.0 %	100.0 %	▲	
Outpatients - % Recommend the Trust	400	347	92.0 %	97.7 %	▲	

Complaints



YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	7	12	18	22	28	32	42	54	59			
16/17	5	11	18	26	28	33	39	45	51	54	60	70

PALS



YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	86	191	306	413	485	606	699	816	914			
16/17	125	280	417	500	579	680	752	824	896	1,020	1,132	1,285

Clinical Effectiveness

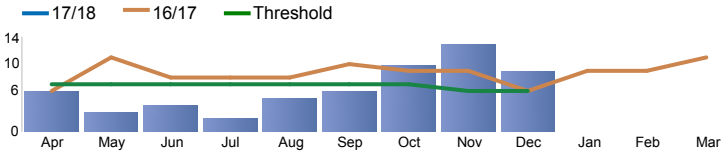
Dec 2017

Alder Hey Children's NHS Foundation Trust

Summary

Infections are down in month from 13 in November to just 8 in December. The downward trend continues with the yearly total 57 compared to 75 in 16/17. There were no hospital acquired MRSA or C Diff infections in December. We continue to perform well compared to 16/17 in relation to the percentage of patients with an estimated date of discharge later than planned. The number of hospital mortalities is also down compared to last year.

Infections



YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	6	9	13	15	20	26	36	49	58			
16/17	6	17	25	33	41	51	60	69	75	84	93	104

Total Infections (YTD)

58 ▼ (goal: 61.0)

Hospital Acquired Organisms - MRSA (BSI) (YTD)

2 ▼ (goal: 0.0)

Hospital Acquired Organisms - C.difficile (YTD)

0 – (goal: 0.0)

Outbreak Infections (YTD)

34 ▼

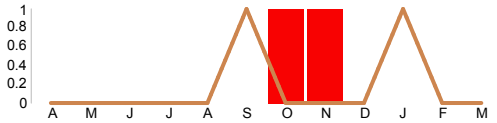
Cluster Infections (YTD)

0 –

Legend

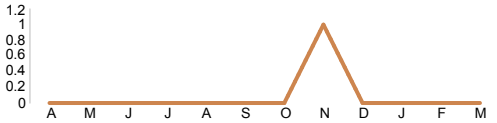
17/18
16/17
Threshold

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



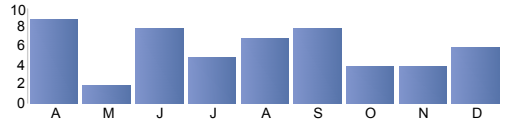
YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	0	0	0	0	0	0	1	2	2			
16/17	0	0	0	0	0	1	1	1	1	2	2	2

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



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

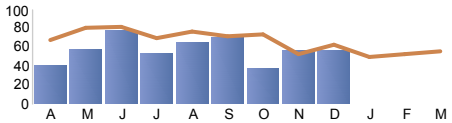
Acute readmissions of patients with long term conditions within 28 days 53 (Est. Baseline)



YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
17/18	9	11	19	24	31	39	43	47	53

Admissions & Discharges

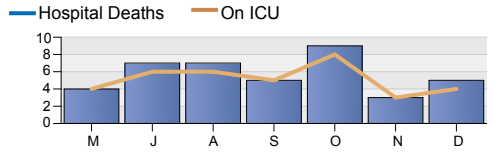
Patients with an estimated discharge date discharge later than planned (only surgical) 528 (Est. Baseline)



% of patients with an estimated discharge date discharge later than planned (only surgical) 3.9 % (Est. Baseline)

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

Mortality in Hospital



Deaths in Hospital

Actual	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	7	4	7	5	6	5	9	3	5			
16/17	7	8	6	6	8	2	7	6	8	4	5	9

Access

Dec 2017

Alder Hey Children's NHS Foundation Trust

Summary

Incomplete pathway & diagnostic standards achieved for December. Cancer 2 week rule standard failed for December due to 1 patient DNA (despite confirming) ED attendance higher than planned however acuity of patients attending is increasing. Analysis to be shared with ED Board / CCG. Hospital occupancy reduced as per plan; referrals reduced as per seasonal variation with Choose & Book available to meet demand. No patients waiting greater than 52 weeks.

18 Weeks

RTT: 90% Admitted within 18 weeks 89.6 %

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
88.4%	88.0%	89.5%	88.3%	89.7%

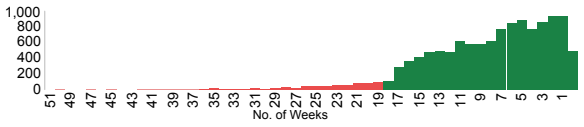
RTT: 95% Non-Admitted within 18 weeks 89.7 %

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
86.6%	88.9%	89.1%	89.2%	90.1%

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

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

Open Pathways Weekly Profile Dec 2017



Cancer

Cancer: 2 week wait from referral to date 1st seen - all urgent referrals 93.3 % (goal: 100.0 %)

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
94.4%	100.0%	100.0%	100.0%	97.5%

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

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
100.0%	100.0%	96.4%	100.0%	96.3%

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

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

Diagnostics

Diagnostics: % Completed Within 6 Weeks 99.8 % (goal: 99.0 %)

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

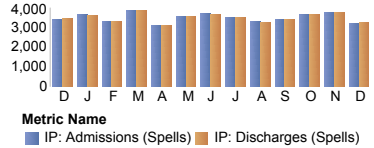
Waiting Times Failed 1

Waiting Times Passed 6

Number of Diagnostics

428

Admissions and Discharges



Bed Occupancy

Bed Occupancy (Funded Beds) 77.2 %

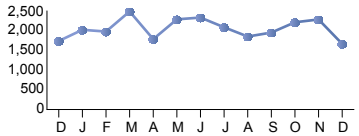
Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
80.2%	83.9%	79.8%	78.9%	81.4%

Provider

Convenience and Choice: Slot Availability 99.1 % (goal: 96.0 %)

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
99.2%	97.0%	98.0%	98.4%	98.8%

Referrals Received (GP)



Emergency Department

Dec 2017

Alder Hey Children's NHS Foundation Trust

Summary

Attendances in Dec 17 were equal to Dec 16. However, acuity was greater with a 30% increase in patients who needed to be seen very urgently. Performance for patients seen in under 4 hours and the decision to treat time improved on the previous month and the STF target to improve on Q3 performance in 2016 was met.

ED

ED: 95% Treated within 4 Hours — 94.1 % (goal: 95.0 %)

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
93.1%	96.7%	96.0%	95.3%	93.8%

ED: Total Time in ED (95th Percentile) — 264.0 mins (goal: 240.0 mins)

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
838.8	714.0	717.0	753.0	824.4

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

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
36.0	30.6	61.3	28.5	33.6

ED: Number Treated Over 4 Hours

306

ED to Inpatient Conversion Rate

16.1 %

Dec 2017

ED

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

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

ED: 60 minute 'Time to Treat Decision' (Median) — 80.0 mins (goal: 60.0 mins)

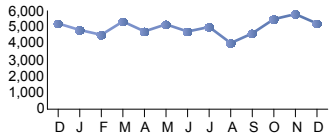
Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
239.0	227.0	247.5	206.0	266.5

ED: Percentage Left without being seen — 3.9 %

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
3.1%	2.3%	3.0%	2.8%	4.1%

ED: Number of Attendances

5226 Dec 2017

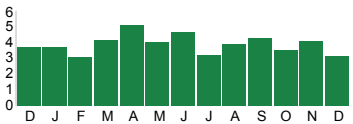


Ambulance Services

Ambulance: Acute Compliance — 78.6 % (goal: 85.0 %)

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
83.3%	90.1%	88.4%	84.2%	79.3%

Ambulance: Average Notification to Handover Time (mins) — 3.2 mins (goal: 15.0 mins)



Ambulance: Patients Waiting between 30 and 45 minutes — 3

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
5.0	11.0	9.0	4.0	10.2

Ambulance: Patients Waiting between 45 and 60 minutes — 0

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

Productivity & Efficiency

Dec 2017

Alder Hey Children's NHS Foundation Trust

Summary

December traditionally sees a fluctuation in productivity. Winter plan commenced which has supported flow with reduced cancellations and 28 day breaches noted. Elective LOS has increased for 3rd consecutive month; currently being reviewed by BI. ED attendance consistent with same period last year but acuity increased. Theatre utilisation has improved slightly with focus on daycase activity noted. OP cancellations and increased DNA's in line with seasonal variation.

Length of Stay

Average LoS - Elective (Days) 3.6 ▲

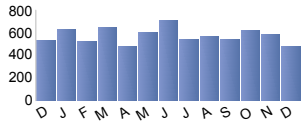
Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
3.0	2.9	3.1	3.0	3.0

Average LoS - Non-Elective (Days) 2.0 ▼

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

Day Case Rate

Daycases (K1/SDCPREOP) 492 ▼



Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
1,653	1,820	1,819	1,674	1,724

Daycase Rate 74.2 % (goal: 0.0 %) ▲

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
68.6%	71.2%	71.9%	70.9%	72.5%

Bed Refusals

Bed Refusals 0 (goal: 0.0) –

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

Theatres / Surgery

Theatre Utilisation - % of Session Utilised * 85.8 % (goal: 90.0 %) ▲

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
84.8%	86.8%	87.6%	86.7%	85.5%

Cancelled Operations - Non Clinical - On Same Day (%) (YTD) 1.2 % (goal: 0.8 %) ▼

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

Cancelled Operations - Non Clinical - On Same Day 15 ▼

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
62	77	83	94	81

28 Day Breaches 4 (goal: 0.0) ▼

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

Outpatients

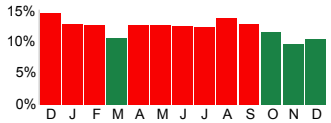
Clinic Session Utilisation * 84.4 % (goal: 90.0 %) ▼

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
85.4%	85.8%	85.8%	85.1%	86.7%

OP Appointments Cancelled by Hospital % 14.3 % (goal: 5.0 %) ▲

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
14.6%	14.6%	13.3%	13.0%	13.6%

DNA Rate 10.5 % (goal: 12.0 %) ▲



Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
12.6%	12.0%	12.6%	13.1%	10.6%

OP: New/Follow Up 2.7 ▼

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

Facilities

Dec 2017

Alder Hey Children's NHS Foundation Trust

Summary

During December the number of audits increased but we still need to improve our compliance rates and we are working towards being fully compliant

Facilities

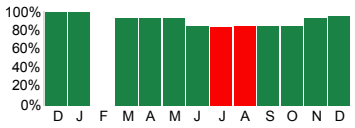
Cleanliness Performance VH 98.9 % ▲ (goal: 98.0 %)

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
96.7%	97.7%	99.7%	96.9%	98.2%

Cleanliness Performance H 96.7 % ▲ (goal: 95.0 %)

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
95.7%	94.0%	94.6%	96.0%	96.3%

Cleanliness Performance S 96.0 % ▲ (goal: 85.0 %)



Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
96.3%	96.5%	90.3%	84.6%	91.8%

Cleanliness Performance L 75.0 % – (goal: 75.0 %)

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

Facilities

Audit Compliance 65.0 % ▲ (goal: 85.0 %)

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
77.0%	40.0%	6.7%	21.7%	66.7%

Facilities - Other

Routine Maintenance Resolution 96.9 % ▲ (goal: 85.0 %)

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
99.7%	96.6%	92.6%	95.7%	94.2%

PPM% 96.9 % ▼ (goal: 85.0 %)

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
94.4%	96.1%	94.8%	97.9%	97.5%

CAMHS

Dec 2017

Alder Hey Children's NHS Foundation Trust

Summary

RTT for Liverpool is at 73% and Sefton 63% - average wait for Liverpool is currently at 13 weeks and 15 weeks for Sefton. A task and finish group has commented to create a PTL for CAMHS outpatient clinics.

Waiting Times

CAMHS: Avg Wait to Partnership Appt (Weeks)- Liverpool Specialist 13.0

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
0.0	0.0	43.0	51.0	47.0

CAMHS: Avg Wait to Partnership Appt (Weeks)- Sefton Specialist 27.0

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
0.0	0.0	43.0	51.0	47.0

Eating Disorder Pathway

Routine EDYS Pathway Average Wait in Weeks 2

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
0.0	0.0	6.0	5.0	6.1

Urgent EDYS Pathway Average Wait in Weeks 1

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
0.0	0.0	1.0	0.1	2.2

DNA Rates

CAMHS: DNA Rate - New 8.5 % ▲ *(goal: 10.0 %)*

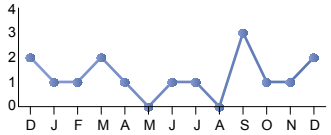
Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
13.5%	13.4%	14.0%	18.3%	9.6%

CAMHS: DNA Rate - Follow Up 12.4 % ▼ *(goal: 14.0 %)*

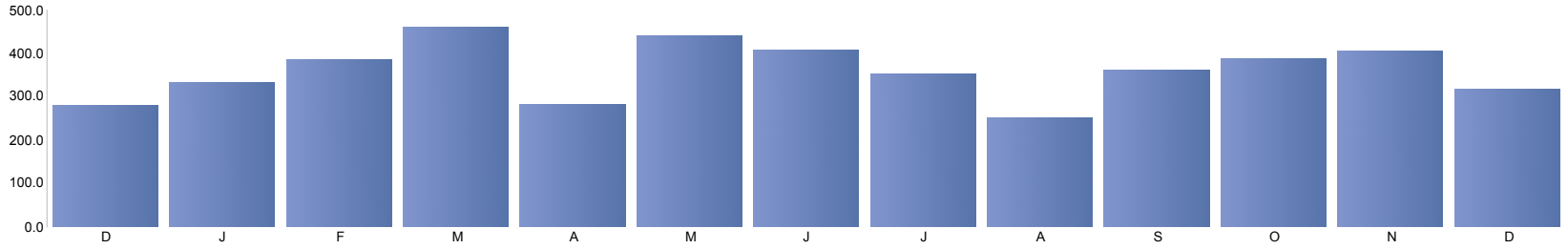
Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
16.0%	17.7%	17.7%	20.8%	13.5%

Tier 4 Admissions

CAMHS: Total Admissions to DJU 2 ▲



CAMHS: Referrals Received



External Regulation

Dec 2017

Alder Hey Children's NHS Foundation Trust

Summary

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

Monitor - Governance Concern

Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17
N	N	N	N	N	N	N	N	N

Monitor - Risk Rating

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

Monitor Dec 2017

Metric Name	Goal	Nov 17	Dec 17	Trend
ED: 95% Treated within 4 Hours	95.0 %	92.8 %	94.1 %	▲
RTT: 90% Admitted within 18 weeks		90.4 %	89.6 %	▼
RTT: 95% Non-Admitted within 18 weeks		90.3 %	89.7 %	▼
RTT: 92% Waiting within 18 weeks (open Pathways)	92.0 %	92.0 %	92.0 %	▲
Monitor Risk Ratings (YTD)	2.0	3	3	–
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals	100.0 %	100.0 %	93.3 %	▼
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

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
88.4%	88.0%	89.5%	88.3%	89.7%

RTT: 95% Non-Admitted within 18 weeks

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
86.6%	88.9%	89.1%	89.2%	90.1%

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

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

Monitor - All Cancers

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

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
94.4%	100.0%	100.0%	100.0%	97.5%

All Cancers: 31 day wait referral to treament

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
100.0%	100.0%	96.4%	100.0%	96.3%

All Cancers: 31 day wait until subsequent treatments

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

Monitor - A&E 4 Hour Target

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
93.1%	96.7%	96.0%	95.3%	93.8%

Monitor - C difficile

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

Monitor - Data Completeness

No Data Available

Workforce

Dec 2017

Alder Hey Children's NHS Foundation Trust

Summary

December has seen a reported increase in absence from 5.2 to 5.9%, however there have been national technical ESR issues which have impacted on input, which includes not being able to close open ended absence -, therefore this is possibly not a truly reflective position. The PDR position will remain the same until the compliance window opens again (April to July). Mandatory training continues to see an increase, now reporting as 86.28%, which is just below our target of 90%. HR&OD are continuing to work with managers to ensure this target is achieved by 31st Jan 18.

Staff Group Analysis

Sickness Absence (rolling 12 Months)

Staff Group	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Last 12 Months
Add Prof Scientific and Technic	5.0%	5.9%	4.9%	3.6%	3.6%	3.9%	4.6%	4.2%	4.9%	2.8%	3.6%	4.8%	
Additional Clinical Services	6.6%	5.5%	5.6%	7.1%	7.4%	7.3%	7.7%	6.1%	5.8%	7.4%	8.1%	8.7%	
Administrative and Clerical	4.6%	5.0%	3.3%	2.8%	2.3%	2.4%	3.8%	4.4%	4.1%	4.2%	4.1%	4.7%	
Allied Health Professionals	2.3%	2.2%	3.5%	2.9%	3.2%	3.8%	3.2%	2.8%	2.7%	3.0%	2.4%	2.1%	
Estates and Ancillary	9.1%	7.4%	8.9%	10.7%	9.2%	9.2%	10.8%	14.7%	12.3%	13.2%	11.4%	10.1%	
Healthcare Scientists	1.7%	3.7%	2.3%	1.0%	3.3%	4.0%	4.6%	1.5%	2.9%	2.0%	3.2%	2.7%	
Medical and Dental	2.3%	2.4%	1.6%	1.1%	1.3%	1.3%	1.6%	1.6%	1.7%	2.2%	2.0%	2.4%	
Nursing and Midwifery Registered	6.4%	6.1%	5.5%	5.1%	5.4%	5.3%	5.1%	4.8%	5.0%	5.9%	5.6%	6.7%	
Trust	5.4%	5.2%	4.7%	4.5%	4.6%	4.6%	5.0%	4.9%	4.8%	5.3%	5.2%	5.8%	

Staff in Post FTE (rolling 12 Months)

Staff Group	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Last 12 Months
Add Prof Scientific and Technic	198	197	201	197	199	201	200	197	199	199	196	197	
Additional Clinical Services	370	373	376	391	393	392	400	397	408	409	406	404	
Administrative and Clerical	586	589	586	611	621	618	624	626	624	622	625	627	
Allied Health Professionals	132	132	131	209	210	213	215	216	219	223	224	223	
Estates and Ancillary	189	189	189	187	185	184	184	183	182	182	180	180	
Healthcare Scientists	107	107	107	107	107	109	110	110	108	107	107	106	
Medical and Dental	245	246	243	244	243	247	242	248	249	251	248	248	
Nursing and Midwifery Registered	972	981	970	968	970	971	964	959	1,019	1,024	1,017	1,006	

Staff in Post Headcount (rolling 12 Months)

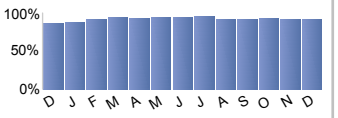
Staff Group	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Last 12 Months
Add Prof Scientific and Technic	218	217	221	218	220	223	223	219	220	219	216	218	
Additional Clinical Services	434	439	442	469	470	468	477	473	485	487	484	481	
Administrative and Clerical	677	679	673	700	709	708	713	714	711	709	711	712	
Allied Health Professionals	163	163	161	258	259	262	264	265	267	271	272	271	
Estates and Ancillary	236	236	236	234	231	231	230	229	228	228	226	226	
Healthcare Scientists	117	117	117	117	117	119	119	119	119	116	116	115	
Medical and Dental	284	287	284	286	286	289	284	290	293	294	293	293	
Nursing and Midwifery Registered	1,095	1,105	1,094	1,093	1,095	1,096	1,090	1,085	1,145	1,151	1,144	1,132	

Finance

Temporary Spend ('000s) 761

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

Actual vs Planned Establishment (%) 92.8 %



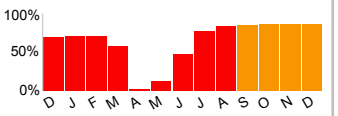
Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
88.8%	92.2%	94.8%	94.3%	93.5%

Appraisals

Medical Appraisal 13.6 % (goal: 100.0 %)

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
25.5%	68.5%	76.9%	57.8%	11.1%

PDR 87.3 % (goal: 90.0 %)



Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
72.3%	67.2%	21.0%	83.1%	87.2%

Training

Corporate Induction 77.3 % (goal: 100.0 %)

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
84.0%	79.5%	82.6%	81.0%	80.6%

Mandatory Training 86.3 % (goal: 90.0 %)

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
75.6%	77.1%	76.1%	76.6%	80.9%

Health and Safety

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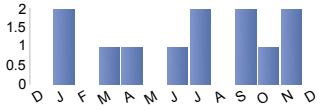


Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
1	3	2	4	3

Performance by CBU

Dec 2017

Alder Hey Children's NHS Foundation Trust

Operational

Metric name	COMMUNITY	MEDICINE	SURGERY
Clinic Session Utilisation	73.7%	90.1%	83.6%
Convenience and Choice: Slot Availability	100.0%	100.0%	98.7%
DNA Rate (Followup Appts)	12.1%	8.8%	9.7%
DNA Rate (New Appts)	13.0%	13.4%	11.4%
Referrals Received (GP)	271	562	831
Temporary Spend ('000s)	131	207	331
Theatre Utilisation - % of Session Utilised		82.5%	86.4%
Trading Surplus/(Deficit)	247	346	1,819

Patient

Metric name	COMMUNITY	MEDICINE	SURGERY
Average LoS - Elective (Days)		3.9	3.3
Average LoS - Non-Elective (Days)		1.5	3.1
Cancelled Operations - Non Clinical - On Same Day	0	2	13
Daycases (K1/SDCPREOP)	0	49	435
Diagnostics: % Completed Within 6 Weeks		100.0%	95.0%
Hospital Initiated Clinic Cancellations < 6 weeks notice	19	41	37
OP Appointments Cancelled by Hospital %	17.2%	15.3%	13.3%
RTT: 90% Admitted within 18 weeks		85.3%	90.4%
RTT: 92% Waiting within 18 weeks (open Pathways)	97.3%	92.6%	91.3%
RTT: 95% Non-Admitted within 18 weeks	90.0%	85.2%	91.6%

Quality

Metric name	COMMUNITY	MEDICINE	SURGERY
Cleanliness Scores			
Hospital Acquired Organisms - C.difficile	0	0	0
Hospital Acquired Organisms - MRSA (BSI)	0	0	0
Medication Errors (Incidents)	46	239	375

Workforce

Metric name	COMMUNITY	MEDICINE	SURGERY
Corporate Induction	100.0%	70.0%	77.8%
Mandatory Training	86.7%	86.6%	85.8%
PDR	90.4%	84.0%	89.5%
Sickness	6.4%	5.3%	6.0%

CBU Performance - Community

Dec 2017

Alder Hey Children's NHS Foundation Trust

Key Issues

DNAs and short notice cancellations remain an issue for the Division. Robust monitoring being put in place to minimise loss of capacity. Referrals in December were above predictions

Support Required

NA

Operational

Metric Name	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Last 12 Months
Theatre Utilisation - % of Session Utilised														
Clinic Session Utilisation	74.0%	75.9%	80.3%	83.0%	79.1%	81.9%	79.9%	79.2%	76.9%	86.4%	86.2%	85.8%	73.7%	
DNA Rate (New Appts)	19.0%	15.5%	12.0%	11.8%	15.8%	16.1%	19.3%	17.6%	18.0%	13.1%	15.4%	12.3%	13.0%	
DNA Rate (Followup Appts)	17.7%	16.7%	15.8%	13.3%	15.2%	14.5%	15.9%	15.2%	20.0%	17.5%	12.1%	11.0%	12.1%	
Convenience and Choice: Slot Availability	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%			100.0%	100.0%	100.0%	100.0%	100.0%	
Referrals Received (GP)	298	268	336	385	230	387	324	321	232	331	405	394	271	
Temporary Spend ('000s)	47	77	72	150	67	103	116	146	169	195	141	167	131	
Trading Surplus/(Deficit)	415	410	256	442	343	414	299	224	145	263	284	271	247	

Patient

Metric Name	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Last 12 Months
RTT: 90% Admitted within 18 weeks														
RTT: 95% Non-Admitted within 18 weeks	80.2%	75.3%	73.1%	88.4%	87.9%	85.4%	91.8%	91.4%	93.1%	87.3%	87.9%	83.2%	90.0%	
RTT: 92% Waiting within 18 weeks (open Pathways)	92.3%	92.8%	93.1%	94.4%	94.0%	97.4%	94.3%	94.6%	96.5%	96.1%	96.3%	96.8%	97.3%	
Average LoS - Elective (Days)										14.00				
Average LoS - Non-Elective (Days)														
Hospital Initiated Clinic Cancellations < 6 weeks notice	1	9	19	8	15	3	12	5	13	8	19	17	19	
Daycases (K1/SDCPREOP)	3	0	0	0	0	2	0	1	0	0	1	3	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 %	15.4%	14.2%	20.3%	20.8%	23.1%	14.8%	18.9%	13.5%	17.3%	16.1%	15.2%	17.0%	17.2%	
Diagnostics: % Completed Within 6 Weeks														

Quality

Metric Name	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Last 12 Months
Medication Errors (Incidents)	27	29	30	31	3	5	8	10	17	26	37	44	46	
Cleanliness Scores														
Hospital Acquired Organisms - MRSA (BSI)	0	0	0	0	0	0	0	0	0	0	0	0	0	
Hospital Acquired Organisms - C.difficile	0	0	0	0	0	0	0	0	0	0	0	0	0	

Workforce

Metric Name	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Last 12 Months
Corporate Induction	87.5%	87.5%	87.5%	100.0%	82.9%		88.9%	100.0%	57.1%	100.0%	33.3%	100.0%	100.0%	
PDR	75.4%	77.2%	76.4%	67.0%	0.0%	5.7%	26.5%	71.0%	82.8%	87.4%	90.4%	88.8%	90.4%	
Sickness	7.1%	7.1%	6.9%	5.9%	5.1%	5.6%	5.7%	6.4%	6.2%	6.5%	5.4%	5.2%	6.4%	
Mandatory Training	72.1%	75.8%	78.0%	57.1%	57.1%	56.1%	55.2%	74.5%	75.3%	74.6%	75.1%	80.3%	86.7%	

CBU Performance - Medicine (Part 1)

Dec 2017

Alder Hey Children's NHS Foundation Trust

Key Issues

Whilst there was a significant improvement for Theatre utilisation in December, outpatient metrics have deteriorated, largely due to the Christmas period. Outpatient run rate analysis will be used to improve bookings and utilisation over the last quarter. Bidirectional texting should also improve DNA rates. Pleased to see downward trend for temporary spend. Daycase activity down as predicted, but will increase again for the final three months of the financial year.

Support Required

Operational

Metric Name	Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Last 12 Months
Theatre Utilisation - % of Session Utilised	80.1%	82.9%	79.1%	85.4%	81.1%	83.6%	84.6%	76.9%	81.8%	82.0%	81.5%	79.6%	82.5%	
Clinic Session Utilisation	83.7%	85.1%	86.6%	89.3%	86.6%	87.0%	84.9%	87.1%	87.0%	87.6%	88.1%	91.5%	90.1%	
DNA Rate (New Appts)	14.6%	14.1%	12.4%	10.0%	15.0%	12.6%	12.6%	12.9%	12.3%	10.5%	13.1%	10.0%	13.4%	
DNA Rate (Followup Appts)	18.5%	16.3%	16.8%	13.0%	16.6%	15.8%	13.9%	13.6%	15.0%	14.2%	12.7%	8.4%	8.8%	
Convenience and Choice: Slot Availability	99.6%	96.1%	86.5%	99.4%	98.0%	96.3%	100.0%	100.0%	98.0%	91.4%	99.4%	97.8%	100.0%	
Referrals Received (GP)	563	681	594	821	577	747	792	729	636	635	723	758	562	
Temporary Spend ('000s)	164	499	341	302	290	322	222	323	326	250	186	242	207	
Trading Surplus/(Deficit)	212	74	-113	1,012	-298	108	-152	-390	-302	94	131	1,222	346	

Patient

Metric Name	Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Last 12 Months
RTT: 90% Admitted within 18 weeks	87.6%	92.6%	100.0%	91.5%	96.4%		95.7%	90.5%	95.5%	100.0%	94.2%	92.7%	85.3%	
RTT: 95% Non-Admitted within 18 weeks	84.7%	92.4%	89.3%	90.9%	90.9%	86.2%	88.8%	89.1%	87.3%	86.8%	89.0%	90.1%	85.2%	
RTT: 92% Waiting within 18 weeks (open Pathways)	96.7%	96.9%	96.0%	94.8%	94.9%	94.5%	94.0%	93.6%	93.3%	94.2%	92.7%	91.2%	92.6%	
Average LoS - Elective (Days)	3.66	3.64	3.22	3.20	3.50	3.40	2.94	3.05	2.90	3.06	2.89	3.33	3.93	
Average LoS - Non-Elective (Days)	1.53	1.44	1.69	1.57	1.62	1.60	1.51	1.65	1.49	1.63	1.39	1.41	1.52	
Hospital Initiated Clinic Cancellations < 6 weeks notice	29	41	37	27	20	18	23	17	16	21	32	30	41	
Daycases (K1/SDCPREOP)	65	68	63	70	58	70	103	70	71	63	76	74	49	
Cancelled Operations - Non Clinical - On Same Day	4	6	6	3	1	3	1	2	1	2	2	5	2	
OP Appointments Cancelled by Hospital %	14.2%	14.6%	15.0%	14.1%	17.4%	11.2%	13.4%	14.5%	13.4%	13.3%	14.0%	13.3%	15.3%	
Diagnostics: % Completed Within 6 Weeks	99.5%	100.0%	99.7%	99.6%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	

Quality

Metric Name	Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Last 12 Months
Medication Errors (Incidents)	231	254	273	308	25	59	85	110	141	160	190	212	239	
Cleanliness Scores	97.0%	96.8%	96.8%	99.0%										
Hospital Acquired Organisms - MRSA (BSI)	0	1	0	0	0	0	0	0	0	0	0	1	0	
Hospital Acquired Organisms - C.difficile	0	0	0	0	0	0	0	0	0	0	0	0	0	

Workforce

Metric Name	Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Last 12 Months
Corporate Induction	83.3%	75.0%	75.0%	68.8%		81.8%	61.5%	100.0%	50.0%	80.0%	70.0%	100.0%	70.0%	
PDR	77.6%	76.7%	75.7%	69.7%	2.9%	15.4%	41.3%	73.8%	79.7%	82.2%	84.0%	85.0%	84.0%	
Sickness	4.8%	4.9%	5.3%	4.5%	4.0%	4.7%	4.2%	4.6%	3.8%	4.1%	4.9%	5.3%	5.3%	
Mandatory Training	76.4%	77.3%	79.2%	79.7%	80.1%	80.0%	80.5%	79.0%	78.3%	75.7%	77.3%	82.2%	86.6%	

CBU Performance - Medicine (Part 2)

Dec 2017

Alder Hey Children's NHS Foundation Trust

Key Issues

Imaging metrics not available to comment upon. All other trends have improved or maintained good performance.

Support Required

Patient

Metric Name	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Last 12 Months
Imaging - % Report Turnaround times GP referrals < 24 hrs	93.0%	96.0%	97.0%	87.0%	96.0%	91.0%	92.0%	90.0%	90.0%	86.0%	97.9%	88.4%	97.0%	
Imaging - % Reporting Turnaround Times - ED	88.0%	88.0%	93.0%	90.0%	80.0%	64.0%	76.0%	83.0%	82.0%	85.0%	96.7%	96.7%	78.0%	
Imaging - % Reporting Turnaround Times - Inpatients	80.0%	86.0%	89.0%	90.0%	78.0%	74.0%	79.0%	85.0%	85.0%	79.0%	97.8%	94.4%	78.0%	
Imaging - % Reporting Turnaround Times - Outpatients	94.0%	97.0%	98.0%	94.0%	92.0%	90.0%	92.0%	98.0%	98.0%	92.0%	89.5%	90.0%	95.0%	
Imaging - Waiting Times - MRI % under 6 weeks	92.0%	92.0%	86.0%	85.0%	71.0%	81.0%	67.0%	68.0%	77.0%	79.0%	93.7%	96.8%	96.0%	
Imaging - Waiting Times - CT % under 1 week	81.0%	81.0%	77.0%	87.0%	95.0%	89.0%	87.0%	87.0%	89.0%	87.0%	93.3%	94.4%	84.0%	
Imaging - Waiting Times - Plain Film % under 24 hours	94.0%	94.0%	92.0%	93.0%	93.0%	94.0%	93.0%	94.0%	92.0%	91.0%	98.9%	100.0%	91.0%	
Imaging - Waiting Times - Ultrasound % under 2 weeks	83.0%	83.0%	81.0%	87.0%	84.0%	88.0%	90.0%	91.0%	90.0%	87.0%	95.6%	93.3%	85.0%	
Imaging - Waiting Times - Nuclear Medicine % under 2 weeks	88.0%	88.0%	84.0%	93.0%	88.0%	95.0%	89.0%	100.0%	93.0%	72.0%	100.0%	96.8%	83.0%	
BME - High Risk Equipment PPM Compliance	93.0%	91.0%	91.1%	88.0%	80.2%	91.7%	91.6%	91.2%	90.1%	84.6%	90.2%	90.1%	89.2%	
BME - Low Risk Equipment PPM Compliance	80.0%	81.0%	80.8%	79.0%	100.0%	82.0%	81.9%	80.4%	75.5%	74.6%	70.9%	76.0%	77.7%	
BME - Equipment Pool - Equipment Availability	100.0%	99.8%	100.0%	100.0%	91.4%	99.8%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Pharmacy - Dispensing for Out Patients - Routine	51.0%	55.0%	50.0%	45.0%	57.0%	37.0%	60.0%	65.0%	63.0%	57.0%	61.0%	60.0%	61.0%	
Pharmacy - Dispensing for Out Patients - Complex	98.0%	100.0%	98.0%	98.0%	98.0%	100.0%	100.0%	96.0%	97.0%	100.0%	100.0%	100.0%	100.0%	
Comm Therapy - % 1st Contact times following Pt opt in < 12 weeks	100.0%	100.0%	100.0%	63.0%	63.0%	63.0%	54.3%	54.5%	80.0%	90.0%	100.0%	100.0%	100.0%	

Quality

Metric Name	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Last 12 Months
Pathology - % Turnaround times for urgent requests < 1 hr	87.9%	87.5%	88.7%	87.9%	89.7%	89.9%	91.0%	88.1%	88.1%	91.0%	89.1%	87.4%	87.6%	
Pathology - % Turnaround times for non-urgent requests < 24hrs	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.9%	100.0%	100.0%	
Reporting times for perinatal autopsies in 56 Calendar Days	100.0%	80.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.3%	100.0%	
Blood Traceability Compliance	99.8%	99.7%	98.8%	99.6%	99.4%	100.0%	100.0%	99.5%	99.8%	99.8%	99.2%	99.5%	100.0%	

CBU Performance - Surgery

Dec 2017

Alder Hey Children's NHS Foundation Trust

Key Issues

Cancelled ops reduced December- caps in place to minimise, daily huddle to maximise activity but within safe levels.
Clinic utilisation- reduced in December but planned remains over 100%, same issues around high DNA rates and less than 24 hr cancellations. Actions being taken internally- DNA audits, increased templates, data capture issues.
RTT- Spinal and ENT. Spinal undergoing a number of high volume clinic days to reduce wait times, ENT out to recruitment as consultant vacancy.
Theatre utilisation has increased in December and those at lowest end taking key actions to improve.

Support Required

We still require further support with outpatients in terms of improving our actual utilisation. Backfilling of short notice cancellations and the resource to validate waiting lists.
We are in discussion with the medicine division via recovery to understand how we can potentially increase bed capacity for medical patients in order to increase our elective caps between now and year end.

Operational

Metric Name	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Last 12 Months
Theatre Utilisation - % of Session Utilised	84.8%	87.2%	88.5%	87.1%	88.3%	87.9%	88.9%	87.7%	88.6%	87.3%	87.3%	85.2%	86.4%	
Clinic Session Utilisation	84.2%	85.4%	85.3%	88.0%	87.9%	86.0%	85.8%	86.2%	84.9%	83.3%	86.1%	87.3%	83.6%	
DNA Rate (New Appts)	13.2%	12.4%	11.9%	9.8%	10.3%	11.7%	12.4%	11.6%	12.6%	11.8%	11.5%	11.8%	11.4%	
DNA Rate (Followup Appts)	11.1%	8.8%	9.4%	8.3%	9.9%	10.1%	9.8%	10.6%	11.4%	11.3%	10.1%	8.6%	9.7%	
Convenience and Choice: Slot Availability	98.7%	100.0%	99.8%	95.3%	98.2%	99.5%	96.0%	99.0%	100.0%	100.0%	99.8%	97.4%	98.7%	
Referrals Received (GP)	876	1,072	1,046	1,280	977	1,152	1,215	1,035	982	985	1,084	1,131	831	
Temporary Spend ('000s)	331	504	475	443	516	402	456	511	554	429	479	383	331	
Trading Surplus/(Deficit)	1,539	2,008	2,181	2,821	1,826	2,930	3,321	2,980	2,574	2,506	2,634	2,379	1,819	

Patient

Metric Name	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Last 12 Months
RTT: 90% Admitted within 18 weeks	88.0%	86.8%	87.0%	87.2%	86.9%	90.3%	87.8%	88.8%	87.8%	85.0%	88.0%	90.0%	90.4%	
RTT: 95% Non-Admitted within 18 weeks	89.7%	92.8%	88.1%	89.1%	90.1%	89.8%	88.2%	88.1%	90.2%	90.7%	91.2%	91.2%	91.6%	
RTT: 92% Waiting within 18 weeks (open Pathways)	90.4%	90.6%	90.6%	90.9%	90.9%	90.8%	91.3%	91.2%	91.2%	90.9%	91.6%	92.0%	91.3%	
Average LoS - Elective (Days)	2.73	2.17	3.26	2.62	2.58	3.57	2.57	3.10	2.90	3.03	2.36	2.76	3.34	
Average LoS - Non-Elective (Days)	2.55	3.02	2.78	2.64	2.84	3.06	2.57	2.86	2.96	2.74	2.90	3.16	3.14	
Hospital Initiated Clinic Cancellations < 6 weeks notice	20	30	54	22	19	23	28	35	32	26	27	26	37	
Daycases (K1/SDCPREOP)	471	562	461	582	426	540	609	472	499	485	552	521	435	
Cancelled Operations - Non Clinical - On Same Day	8	11	23	28	6	54	18	29	14	46	24	35	13	
OP Appointments Cancelled by Hospital %	13.8%	14.0%	14.2%	13.7%	13.2%	11.2%	12.7%	12.0%	12.8%	11.8%	12.3%	13.1%	13.3%	
Diagnostics: % Completed Within 6 Weeks	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	95.0%	

Quality

Metric Name	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Last 12 Months
Medication Errors (Incidents)	365	394	428	475	40	96	145	187	242	274	304	350	375	
Cleanliness Scores	96.0%	96.1%	96.2%	97.7%										
Hospital Acquired Organisms - MRSA (BSI)	0	0	0	0	0	0	0	0	0	0	1	0	0	
Hospital Acquired Organisms - C.difficile	0	0	0	0	0	0	0	0	0	0	0	0	0	

Workforce

Metric Name	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Last 12 Months
Corporate Induction	71.4%	71.4%	71.4%	94.1%		90.0%	100.0%	100.0%	60.0%	71.4%	85.0%	88.9%	77.8%	
PDR	61.1%	63.4%	64.2%	45.1%	1.9%	11.2%	63.0%	87.6%	91.1%	90.1%	89.5%	88.1%	89.5%	
Sickness	5.5%	5.6%	4.9%	4.4%	4.5%	4.4%	4.7%	4.8%	4.6%	4.5%	5.0%	4.8%	6.0%	
Mandatory Training	77.0%	77.5%	78.7%	79.3%	80.6%	80.7%	81.5%	79.1%	77.0%	73.0%	73.8%	80.9%	85.8%	

Alder Hey Children's NHS
NHS Foundation Trust

Board of Directors
Tuesday, 6th February 2018

Report of	Director of Corporate Affairs
Paper prepared by	Executive Team, Governance Manager
Subject/Title	Board Assurance Framework Update (Jan 2018)
Background papers	Monthly BAF updates/reports
Purpose of Paper	To provide the Board with the BAF update report
Action/Decision required	The Board is asked to discuss and note the changes to the Board Assurance Framework – January position.
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	By 2020, we will: ➢ be internationally recognised for the quality of our care ***(Excellence in Quality)*** ➢ be recognised for the exceptional care we provide to our children, that is technologically enabled and matched by exceptional facilities ***(Patient Centred Services)*** ➢ have a fully engaged workforce that is actively driving quality improvement ***(Great Talented Teams)*** ➢ be a world class, child focussed centre of research & innovation expertise to improve the health and wellbeing outcomes for babies, children & young people ***(International Research, Innovation & Education)*** ➢ have secured sustainable long term financial and service growth supported by a strong international business ***(Growing our Services and Safeguarding Core Business)***
Resource Impact	Non achievement of the Trust's objectives could have a negative impact on the services provided by the Trust.

Alder Hey Children's NHS
NHS Foundation Trust

Board Assurance Framework 2017/18

1. Purpose

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

2. Review of the BAF

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

Alder Hey Children's NHS
NHS Foundation Trust

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

Changes since January 2018 Board meeting

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

External risks

- ***Business development and growth (DJ)***
  Strategic refresh underway. Growth plan target for NHS planned growth and commercial ambition by 2020 under agreement at Board level; individual schemes under development through Business Planning cycle 18/19

- ***Mandatory and compliance standards (ES)***
  ED performance on recovery trajectory to year-end.

- ***Developing the Paediatric Service Offer (DJ)***
  Key partnerships scheduled for Board away day 6 Feb 2018.

Internal risks:

- ***Maintain care quality in a cost constrained environment (HG)***
  Nurse recruitment day successful, additional 31 WTE recruited. Advanced nurse practitioners, in training, funded by the Trust.

- ***Financial Environment (JG)***
  Financial recovery now showing £2M gap to control although mitigating actions to close gap progressing. Key risk is concluding commissioner year-end discussions

- ***Failure to fully realise the Trust's Vision for the Park (DP)***
  Residential development is on hold whilst approach to housing is discussed with LCC. Plans are now in discussion to increase Park footprint and enhance existing areas.

- ***IT Strategic Development (JG)***
  Programme continues to be green. NHSE cash flow now in agreement.

- ***Workforce Sustainability & Capability (MS)***
  Nurse recruitment event successful. Core Mandatory training increased to 88%. Appointment of Apprenticeship Delivery Manager.

- ***Staff Engagement (MS)***
  Plans are in place to communicate and share staff survey results with wider workforce, and a plan is developed for taking action on results. Annual Staff Awards held on the 19th January, recognising many staff for the excellent contribution.

- ***Workforce Diversity & Inclusion (MS)***
  Staff Survey published, analysis of data underway

- ***Research, Education & Innovation (DP)***
  Academy and Innovation portfolios now moving forward. More focus now on increasing research portfolio.

Erica Saunders
Director of Corporate Affairs
February 2018

Board Assurance Framework 2017-18

Alder Hey Children's NHS Foundation Trust

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

Risk Description

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

Existing Control Measures

• Quality impact assessment completed for all planned changes	• Risk assessment and utilisation of risk registers in responding to risks.
• Quality section of Corporate Report performance managed at Clinical Quality Assurance Committee and Trust Board.	• Division and Corporate Dashboards in place and monitored consistently via performance framework
• Weekly Meeting of Harm monitors incidents, including lessons learned, immediate actions . Escalation process in place	• Programme of quality assurance rounds, developed and implemented across all services, aligned to Care Quality Commission, Key lines of enquiry (KLOE).
• Annual nursing workforce assurance report presented to Board, aligned to Nursing and Midwifery Council Standards.	• Continuous monitoring of professional re validation compliance for the workforce via Electronic Staff Record (ESR)
• Quality Improvement Change Programme established - associated workstreams subject to sub-committee assurance reporting.	• Governance including risk processes from Ward to Board, linked to NHSI Single Oversight Framework
• Quality Strategy 2016-2020 implemented to deliver safe and effective services, with measurable Quality Aims.	• Acute Provider Infection Prevention and Control framework implemented and monitored internally and externally via the Clinical Commissioning Group External review on Infection Prevention and Controlresulted in action plan to address issues identified and track improvements.
• Internal Nursing pool established and funded	• Nursing leadership in alignment with Royal College of Nursing and Midwifery Standards.
• Annual inpatient Patient Survey reports	

Assurance Evidence	Gaps in Controls/Assurance
Impact assessments monitored via the Performance Board Risk assessments etc. monitored via the Integrated Governance Committee Clinical Quality Assurance Committee and Trust Board Quality monitor the quality section of Corporate Report. Performance framework monitored via Performance Board Weekly meeting of Harm outcomes including lessons learned reviewed by Executive team and by exception the Trust Board. Quality Assurance Rounds available on Trust Governance and Assurance web page for viewing accessible for all staff and shared across divisions. Annual Nursing workforce report to Board, including fill rate compliance. Nursing re validation report via Clinical Quality Assurance Committee. Governance and Risk monitored via the Integrated Governance Committee Infection Prevention and Control 'Acute Providers Framework' reports are monitored via the Trust Board. Quality performance monitored via the Clinical Quality Performance Group (external monitoring via Clinical Commissioning Group) NRLS national reports (incidents) Annual CQC patient survey results - performance monitored via Trust Board.	National reduction in post graduate education training Budget. Reduced investment opportunity to respond to clinical development as a result of this reduction. Nursing maternity leave continues to rise - currently 10 WTE above the expected rise. Reduced student nurse higher education applications due to funding changes nationally.

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
please work with the divisions HR Business Partners to reduce the sickness rate to the expected trust standard.	
Please ensure nursing educational budget is sufficient to meet post graduate nurse education and development requirements. Please advise of plan	
Please ensure the opportunity for development of non-registered staff to commence registered nurse training programme is implemented and funded.	

Executive Lead's Assessment

OCTOBER 2017: 70 new starters have completed their preceptor ship (4 weeks) and the COHORT now form part of the clinical rotas.
NOVEMBER 2017: October audit results for sepsis show month on month reducing time to treatment for suspected sepsis (mean time to antibiotics now 42 minutes); D&V outbreak on 4A well managed to prevent spread; measles outbreak on 4C also contained and managed in accordance with PHE requirements.
DECEMBER 2017: Exec comma cell now focusing on leading quality metrics as well as activity and performance.
JANUARY 2018: Nurse recruitment day successful, additional 31 WTE recruited. Advanced nurse practitioners, in training, funded by the Trust.

Board Assurance Framework 2017-18

Alder Hey Children's NHS Foundation Trust

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

Risk Description

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

Existing Control Measures

• New Operational Delivery Group (July 2016) to take action to resolve non-compliance relating to performance. Reporting to RBD	• Emergency Planning & Resilience meetings in pace
• Divisional Executive Review Meetings taking place monthly with 'three at the top'	• Regulatory status with: NHSI, CQC,NHSLA, ICO, HSE, CPA, HTA,MHRA etc.
• Compliance tracked through the corporate report and Divisional Dashboards.	• Risks to delivery addressed through Operational Board, RBD, CQAC, WOD & CQSG and then through to Board
• Early Warning indicators now in place	• Weekly performance meetings in place to track progress
• 6 weekly meetings with commissioners (CQPG)	• Divisional leadership structure to implement and embed clinically led services
• Weekly Exec Comm Cell overseeing key operational issues and blockages.	

Assurance Evidence	Gaps in Controls/Assurance
Regular reporting of delivery against compliance targets through CQSG, CQAC & Board. Monthly reporting to the Board via the Corporate Report. Monitor / NHSI governance risk rating Operational effectiveness measures (key risks with early warning measures) to RABD Compliance assessment against NHSI Provider Licence to go to Board Divisional/Executive performance reviews Exceptions discussed / resolved at Ops Board Quarterly Report to NHSI	Critical Care bed capacity Some areas remain fragile e.g. ED 4 hour target. Assurance required to underpin Divisional reporting on CQC standards Work with CCG to manage demand & develop / fully utilise existing capacity across PC

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Plans to ensure performance sustained across the year need to be embedded and maintained	Operational teams sighted on ensuring and maintaining flow across the hospital via weekly performance, bed meetings etc.
Review bed capacity and staffing model for seasonal variation	Winter Plan revised and widely shared, highlighting 'red weeks' and including seasonal capacity projections.
Ensure divisional governance embedded and working effectively to reflect ward to board reporting	All matron roles now filled; new Head of Quality for Surgery appointed.

Executive Lead's Assessment

NOVEMBER 2017: COO has gained agreement for Children's WIC activity to be counted in ED figures; performance now disaggregated by stream to enable closer management of 'greens'; discussions happening with UC24 re GP slots. Weekly Comm Cell has become routine practice with full team participation.
DECEMBER 2017: Forward plan for management of ED performance agreed by Exec Comm cell to end of calendar year, then review. Revised Single Oversight Framework taken through RBD; corporate report to be reviewed in light of updated NHSI metrics.
JANUARY 2018: ED performance on recovery trajectory to year end.

Board Assurance Framework 2017-18

Alder Hey Children's NHS Foundation Trust

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

Risk Description	
Failure to fully realise the Trust's vision for the Park and campus, in partnership with the local community and other key stakeholders as a legacy for future generations	
Existing Control Measures	
• Business Cases developed for various elements of the Park & Campus	• Alignment with the 'Alder Hey in the Park' vision and the 'Alder Hey Campus' visions
• Heads of Terms agreed with LCC for joint venture approved	• Redeveloped Steering Group
• Monthly reports to Board & RABD	
Assurance Evidence	**Gaps in Controls/Assurance**
Establishment of a Community Interest Charity to operate the park for AHCH and the local community Approved Business Cases for various elements of the Park & Campus approved Every Project has a dedicated Project Manager assigned to it End user consultation events held Highlight reports to relevant assurance committees and through to Board Representation at Springfield Park Shadow Board Stakeholder events held Representation at Friends of Springfield Park Group	Fully reconciled budget with Plan. Risk quantification around the development projects. Joint business case approval with LCC
Actions Required to Reduce Risk to Target Rating	**Latest Progress on Actions**
Approval of Business Case at LCC / Discuss park Heads of Terms with LCC	On hold-Dependent upon residential scheme (revised target date no April 2018)
Income generation opportunities to be thoroughly explored (grant applications) and reconcile requirement for funding versus available	Draft Business Case prepared. First grant application successful.
Develop a Planning Process Communication Strategy	Strategy presented. Action complete
Executive Lead's Assessment	
NOVEMBER 2017: Options paper sent to LCC DECEMBER 2017: Options discussed with LCC JANUARY 2018: Residential development is on hold whilst approach to housing is discussed with LCC. Plans are now in discussion to increase Park footprint and enhance existing areas.	

Board Assurance Framework 2017-18

Alder Hey Children's NHS Foundation Trust

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

Risk Description	
Failure to deliver an IM&T Strategy which will place Alder Hey at the forefront of technological advancement in paediatric healthcare	
Existing Control Measures	
• Key projects and progress tracked through the Clinical Systems Informatics Steering Group and RABD Committee	• Clinical Systems Informatics Project Group leading on stakeholder engagement - ad hoc groups on specific key topics as needed
• Forward Communications plan agreed and tracked at steering group.	• Board approval "Asset Owner" process in place to ensure organisational ownership of systems and system development
• Improvement scheduled training provision including refresher training and workshops to address data quality issues	• Formal change control processes now in place
• Executive level CIO in place	• Investment in IM&T Team (2016/17 budget)
• GDE Programme Board in place & fully resourced - Chaired by Medical Director	• Clinical Engagement in IT Roadmap
Assurance Evidence	**Gaps in Controls/Assurance**
Regular progress reports presented to RABD and Operational Board & Trust Board MIAA providing assurance role Board agreed change process Participate in Digital Alder Hey programme Internal Audit Reviews NHSE tracking of GDE Programme	IM&T Strategy out of date - update work in progress to produce Roadmap Internal Programme Assurance Reports
Actions Required to Reduce Risk to Target Rating	**Latest Progress on Actions**
Conclude the review of IM&T Infrastructure	NHSE signed off latest milestones. Meditech joint meeting 6th Feb to prioritise improvements
IT Roundup to be concluded	Meditech joint meeting 6th Feb to prioritise improvements
Continual improvement of MEDITECH and other clinical systems as prioritised by the Clinical Systems Informatics Steering Group	changes to software tracked by and reported to the Clinical Informatics Steering Group
Engage with STP programme to progress interoperability	
Executive Lead's Assessment	
NOVEMBER 2017: programme remains green rated. Benefits workshop with NHSE undertaken. NHSE challenging cashflow forecast however near an acceptable solution. DECEMBER 2017: Programme remains green rated with focus on ensuring clinical and operational benefits. NHSE cashflow now in agreement. JANUARY 2018: Programme continues to be green. NHSE cashflow now in agreement	

Board Assurance Framework 2017-18

Alder Hey Children's NHS Foundation Trust

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

Risk Description	
Failure to deliver Trust control total and Risk rating Rating	
Existing Control Measures	
• Organisation-wide financial plan.	• Monitor financial regime and financial risk ratings.
• Financial systems, budgetary control and financial reporting processes.	• Capital Planning Review Group
• Monthly performance review meetings with Divisional Clinical/Management Team and the Executive	• Financial Position (subject to regular monitoring).
• Weekly meeting with divisions to review forward look bookings for elective and day case procedures to ensure activity booked meets contract and recovery plans. Also review of status of outpatient slot utilisation	• Financial Recovery Board in place
• CIP subject to programme assessment and sub-committee performance management	
Assurance Evidence	**Gaps in Controls/Assurance**
Monthly Corporate Performance Report presented to both Board and the RABD. Specific Reports (i.e. NHSI Plan Review by RABD) Monthly Performance Management Reporting with General Managers. Internal and External Audit reporting through Audit Committee. Daily activity tracker to support divisional performance management of activity delivery Pay cost control 10 point plan introduced aimed at forecasting and tracking actions to reduce pay cost overspend run rate - updates to Execs, R&BD. Full electronic access to budgets & specialty performance results	Divisions improved financial control and effective recovery required in identified where slippage against agreed recovery trajectories occurring Ongoing cost of temporary staff Divisional recovery plans to hit yearend financial control targets to ensure delivery of overall Trust financial plan. 'Grip' on CIP Recovery Plan still demonstrating £2M gap although mitigating close gap consolidated Conclude commissioner year-end discussions
Actions Required to Reduce Risk to Target Rating	**Latest Progress on Actions**
implement divisional recovery plan	
Focus on activity delivery	Recovery plans under development and review
Tracking actions from Financial Recovery Board	Activity tracking in place
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
Conclude commissioner year end positions	

Executive Lead's Assessment
NOVEMBER 2017: Forecast risk remains at £4.6m deficit (unmitigated) however recovery action plan demonstrating a mitigated position of £2.2m deficit (currently likely forecast). Further opportunities equate to further £2.2m which if realised will allow achievement of control. Financial Recovery Board in place beginning to show early signs of improved performance. DECEMBER 2017: Continued tracking of recovery through Financial Recovery Board with required improvement in Activity run rate, pay control and facilities spend during Q4 to ensure Trust meets control total. Current forecast as per Nov update. JANUARY 2018: Financial recovery now showing £2M gap to control although mitigating actions to close gap progressing. Key risk is concluding commissioner year-end discussions

Board Assurance Framework 2017-18

Alder Hey Children's NHS Foundation Trust

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

Risk Description	
Risk to business development/growth due to NHS financial environment and constraints on internal infrastructure to deliver business as usual as well as maximise growth opportunities	
Existing Control Measures	
• Divisional Performance Management Framework.	• Clear trajectories for challenged specialities to deliver.
• Business Development Plan	• 2016 Change Programme Projects (Strategic Partnerships & International Clinical Business and non NHS Patient Services)
• Five year plan agreed by Board and Governors in 2014	• Capacity Plan identifies beds and theatres required to deliver BD Plan.
• Service development strategy including Private / International patient proposal approved by Council of Governors as part of strategic plan sign off.	• Capacity Plan identifies beds and theatres required to deliver BD plan
• Jan 2016 :- Weekly meeting with divisions established to review forward look re elective and day case patient bookings to ensure activity scheduled meets contract requirements	
Assurance Evidence	**Gaps in Controls/Assurance**
Business growth and market analysis reports considered fully by Marketing & Business Development Committee and reported regularly to RBDC. Business Development Committee and reported regularly to Board via RBDC. Business Development Plan reviewed monthly by RBDC via Contract Monitoring Report. Daily activity tracker and forecast monitoring performance for all activity. CIPs in new Change Programme subject to assurance and sub-committee performance management	Ability to respond swiftly to potential problems. Workforce constraints in specialised services. Early warning indicators for leading indicators. Potential delay to cardiac growth - current gap c. £0.8m forecast against 16/17 CIP target
Actions Required to Reduce Risk to Target Rating	**Latest Progress on Actions**
Development of the international agenda	
Operational Business Planning underway - to contain forecasts regarding growth opportunities	
Executive Lead's Assessment	
NOVEMBER 2017: Strategy refresh scheduled for December 17. Acting director of strategy newly in post. Risk to be reviewed during December 17. DECEMBER 2017: Refresh workshop completed November; initial suite of 18/19 priorities agreed at Exec level; focus on sustainability and growth potential. Board discussion scheduled January 2018. JANUARY 2018: Strategic refresh underway. Growth plan target for NHS planned growth and commercial ambition by 2020 under agreement at Board level; individual schemes under development through Business Planning cycle 18/19	

Board Assurance Framework 2017-18

Alder Hey Children's NHS Foundation Trust

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

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

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

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

Actions Required to Reduce Risk to Target Rating	**Latest Progress on Actions**
Strengthening the paediatric workforce	Now part of Change Programme and 7 day service as Best in Acute Care led by Steve Ryan.
Monitoring of action plans.	Now working with NHS England to secure a resolution for the North
Clear plan for delivery of strategic services (cardiac, neonatal, rehab, community care, primary care, Vanguard, CAMHS)	Action closed. Individual actions added for key strategic services
Pro-active recruitment in identified areas.	Trust in discussion with Liverpool Women's re future service models for neonates and in discussion with Liverpool Heart and Chest re future model for cardiac service
Agreement of key partnerships for sustainability 2018/19 +	
Delivery of a refreshed clinical and sustainability strategy	
Development of a single neonatal service business case across Alder Hey & LWH	Next stage business case to be finalised March 2018
CHD Liverpool partnership - development of Level 1 status for adult congenital heart disease across North West / NW / Wales and Isle of Man, bringing together a partnership across 4 Liverpool providers	

Executive Lead's Assessment
NOVEMBER 2017: Strategy refresh during December 17 to include paediatric service offer priorities. Acting director of strategy newly in post. Risk to be reviewed during December 17. DECEMBER 2017: Exec confirmed priorities for 18/19 are inclusive of clinical network developments; discussion and ratification planned with Board January 2018. JANUARY 2018: key partnerships scheduled for Board away day 6 Feb 2018.

Board Assurance Framework 2017-18

Alder Hey Children's NHS Foundation Trust

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

Risk Description

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

Existing Control Measures

• Compliance tracked through the corporate report and divisional dashboards	• Divisional Performance Meetings.
• Mandatory Training fully reviewed in 2017, and aligned competencies on ESR.	• Mandatory training records available online and mapped to Core Skills Framework
• Permanent nurse staffing pool	• 'Best People Doing our Best Work' Steering Group implemented
• Attendance management process to reduce short & long term absence	• Positive Attendance Policy
• Large-scale nurse recruitment event 4 times per year	• Training Needs Analysis linked to CPD requirements

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

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Positive Attendance Policy refreshed.	Training ongoing. Actions agreed with Occupational Health to further support complex long-term sickness cases Trade Unions engaged with discussions on managing sickness absence
Recruitment & Retention Strategy developed	Implementation of the Strategy on-going. Promotional materials developed for the website in order to promote careers at Alder Hey. Recruitment Team engaged with local careers fairs, are supporting the large-scale nursing recruitment events working with Job Centre Plus on the Pre-employment programmes.
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	Appointment of Apprenticeship Delivery Manager Jan 18. taking part on the pilot of the Nurse Associates
Project to increase mandatory training compliance to 90%. This included fully aligning all mandatory training to ESR.	All training fully aligned to ESR. Regular reports provided to wards/teams to monitor training. Reminders and communications regularly sent to staff. Training delivered in a variety of ways -online/classroom etc to allow for flexibility of delivery when there are challenges with releasing staff.

Executive Lead's Assessment

NOVEMBER 2017: Attendance at local recruitment fair. Nurse pool staff now embedded into wards. focus on sickness absence at divisional level. continued focus on increasing mandatory training.
DECEMBER 2017: New Nurse recruitment fair scheduled for January 18. Core Mandatory Training increased to 86%.
JANUARY 2018: Nurse recruitment event successful. Core Mandatory training increased to 88%. Appointment of Apprenticeship Delivery Manager.

Board Assurance Framework 2017-18

Alder Hey Children's NHS Foundation Trust

BAF 4.2	**Strategic Objective:** The Best People Doing Their Best Work		Risk Title: Staff Engagement		
Related CQC Themes: Safe, Effective, Responsive, Well Led					
Exec Lead: Melissa Swindell	**Type:** Internal, Known		Current IxL: 3-3	Target IxL: 3-1	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 in development by new incumbent into Director of Communications role	• Roll out of Leadership Development and Leadership Framework
• Action Plans for Engagement, Values and Communications.	• Medical Leadership development programme
• Staff Temperature Check Reports to Board (quarterly)	• Values based PDR process
• People Strategy Reports to Board (monthly)	• Listening into Action methodology
• Staff surveys analysed and followed up (shows improvement)	• Reward and recognition schemes in place: Annual Awards, Star of the Month and quarterly Long Service Recognition Event, Annual Fab Staff Change Week.

Assurance Evidence	Gaps in Controls/Assurance
Outcomes from Annual Staff Survey reported to the Board. PDR completion rates Quarterly Engagement Temperature Check reported to the Board. Quarterly Engagement Temperature Check local data now sent to Divisions on a quarterly basis to enable them to analyse data locally. Ongoing consultation and information sharing with staff side and LNC Progress reports from LiA to Board	None recorded.
Actions Required to Reduce Risk to Target Rating	**Latest Progress on Actions**
Revised governance arrangements that underpin effective assurance mechanisms utilising the discipline and systems provided by Programme Management methodology.	Engagement Project progress monitored via Change Programme.

Executive Lead's Assessment

NOVEMBER 2017: Staff Survey 51% compliance (28/11/17). Fab Staff Change week completed, with very positive feedback from staff. PDR remains at 86%, with community over 90%.
DECEMBER 2017: Staff Survey closed 01/12/17 with 54% response rate. Initial results showing improvements across a number of areas.
JANUARY 2018: Plans are in place to communicate and share staff survey results with wider workforce, and a plan is developed for taking action on results. Annual Staff Awards held on the 19th January, recognising many staff for the excellent contribution.

Board Assurance Framework 2017-18

Alder Hey Children's NHS Foundation Trust

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

Risk Description

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

Existing Control Measures

• Equality, Diversity & Human Rights Group	• WOD Committee ToR includes duties around diversity and inclusion, and requirements for regular reporting.
• Workforce Plan established	• Staff Survey results analysed by protected characteristics, where possible and actions taken by E&D Lead.
• Workforce Planning Policy signed off at WOD June 2015	• Equality Analysis Policy
• Equality, Diversity & Human Rights Policy	• BME Network established, sponsored by Director of HR & OD
• Disability Network established, sponsored by Director of HR & OD	• Actions taken in response to the WRES
• Action plan specifically in response to increasing the diversity of the workforce.	

Assurance Evidence	Gaps in Controls/Assurance
Monthly recruitment reports provided by HR to divisions Quarterly reports to the Board via WOD on diversity and inclusion issues Monthly Corporate Report (including workforce KPIs) to the Board Taking forward actions for LiA - enabling achievement of a more inclusive culture Equality Impact Assessments undertaken for every policy & project Workforce Race Equality Standards EDS Publication	LGBTQ Network not yet in place Comprehensive TNA needs further development

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Workforce Planning Policy	Draft policy produced, however future work is to focus on identifying priority workforce needs in light of current financial position
Deliver on our new Recruitment and Retention Strategy to ensure an optimum workforce is in place and that the workforce reflects the diversity of the local community	Strategy implemented; work ongoing with local job centres eg the pre-employment programme. Appointment of Apprenticeship Delivery Manager
Proactively utilise the EDS2 results to establish the composition of our workforce in order to target areas for improvement	Ongoing
Establish LGBTQ network	
Newly appointed L&D Manager to work with E&D Manager to develop TNA	

Executive Lead's Assessment

NOVEMBER 2017: Disability Network launched, with first meeting in November. Trust attendance at local jobs fairs.
DECEMBER 2017: A number of tactical actions have been agreed at a meeting with NED lead and BME Network reps to help progress the agenda.
JANUARY 2017: Staff Survey published, analysis of data underway

Board Assurance Framework 2017-18

Alder Hey Children's NHS Foundation Trust

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

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

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

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

Actions Required to Reduce Risk to Target Rating	**Latest Progress on Actions**
Execute plan to increase research portfolio	Commercial research plan in implementation
Educational Partnerships to be cemented	Academy Head appointed
Develop a robust Academy Business Model	Model in implementation
Establish pipeline structure for workstreams including finances (sensors, virtual reality, AI)	Proposal agreed. First 2 prototypes developed
Execute contract for RIE with back to back arrangements with the Charity and HEIs	LJMU and Edge Hill close to completion.

Executive Lead's Assessment
NOVEMBER 2017: Innovation Co papers taken through Board DECEMBER 2017: Papers being finalised for agreement with Edge Hill and LJMU JANUARY 2018: Academy and Innovation portfolios now moving forward. More focus now on increasing research portfolio.

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Tuesday 6th February 2018

Report of:	Director of Corporate Affairs
Paper Prepared by:	Director of Corporate Affairs
Subject/Title:	Board Assurance Framework Policy
Background Papers:	Board Assurance Framework Policy/Equality Analysis
Purpose of Paper:	The purpose of the policy is to provide an assurance framework to effectively manage risk. It is an overarching policy and having considered the equality implications, they are of low relevance.
Action/Decision Required:	For ratification.
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	By 2020, we will: ➢ be internationally recognised for the quality of our care ***(Excellence in Quality)*** ➢ be recognised for the exceptional care we provide to our children, that is technologically enabled and matched by exceptional facilities ***(Patient Centred Services)*** ➢ have a fully engaged workforce that is actively driving quality improvement ***(Great Talented Teams)*** ➢ be a world class, child focussed centre of research & innovation expertise to improve the health and wellbeing outcomes for babies, children & young people ***(International Research, Innovation & Education)*** have secured sustainable long term financial and service growth supported by a strong international business ***(Growing our Services and Safeguarding Core Business)***
Resource Impact:	Non achievement of the Trust's objectives could have a negative impact on the services provided by the Trust.

Equality Analysis (EA) for Policies		
Please refer to guidance when completing this form		
Policy Name	Board Assurance Framework Policy	
Policy Overview	Sets out the key structures, systems and processes by which the Board of Directors is assured, via the Board Assurance Framework and the underpinning risk registers that the Trust's strategic and operational objectives are being achieved through the effective management of the strategic and operational risks.	
Equality Relevance Select LOW, MEDIUM or HIGH	LOW	
If the policy is LOW relevance, you **MUST** state the reasons here.	The purpose of the policy is to provide an assurance framework to effectively manage risk. It is an overarching policy and having considered the equality implications, they are of low relevance.	
Form completed on:	Date: 21/12/2017	
Form completed by:	Name: Erica Saunders	Job Title: Director of Corporate Affairs

If LOW relevance, proceed to Approval and Ratification Section. No further information required

If MEDIUM or HIGH Equality Relevance, complete all sections	
Equality Indicators Identify the equality indicators which will or could potentially be impacted by the policy. (use hyperlink to assess the impact on each protected characteristic)	Age ☐ Details: Click here to enter text. Disability ☐ Details: Click here to enter text. Gender reassignment ☐ Details: Click here to enter text. Marriage & Civil Partnership ☐ Details: Click here to enter text. Pregnancy or Maternity ☐ Details: Click here to enter text. Race ☐ Details: Click here to enter text. Religion or Belief ☐ Details: Click here to enter text. Sex ☐ Details: Click here to enter text. Sexual Orientation ☐ Details: Click here to enter text. Human Rights (FREDA principles) ☐ Details: Click here to enter text.
Equality Information & Gaps What equality information is available for protected groups affected by the policy? If none available, include steps to be taken to fill gaps.	Click here to enter text.
Stakeholder Engagement What stakeholders are engaged to help understand the potential effects on protected groups?	Click here to enter text.
Interdependency How will this affect other policies, projects, schemes from an equality perspective?	Click here to enter text.
Summary of Equality Analysis Findings & Mitigation Include details of all actions to mitigate negative equality impact on protected groups.	Click here to enter text.
Monitoring Include details of how the equality impact will be	Click here to enter text.

monitored.	

If MEDIUM or HIGH relevance, the EA should be reviewed annually. Complete Approval and Ratification Section.

Approval & Ratification of Equality Analysis		
Policy Author:	Name: Erica Saunders	Job title: Director of Corportae Affairs
Approval Committee:	Integrated Governance Committee	Date approved: XX/XX/2018
Ratification Committee:	Board of Directors	Date ratified: 09/01/2018
Person to Review Equality Analysis:	Name: Director of Corporate Affairs	Review Date: XX/XX/2019
Comments:	Click here to enter text.	

Alder Hey Children's NHS
NHS Foundation Trust

RM58 – BOARD ASSURANCE FRAMEWORK POLICY

Version:	4
Name of ratifying committee:	Board of Directors
Date ratified:	06/02/2018
Name of originator/author:	Director of Corporate Affairs
Name of approval committee:	Integrated Governance Committee
Date approved:	10/01/2018
Executive Sponsor:	Director of Corporate Affairs
Key search words:	Assurance, Risk, BAF, RM58
Date issued:	January 2018
Review date:	January 2019

Version Control, Review and Amendment Logs

Version Control Table				
Version	**Date**	**Author**	**Status**	**Comment**
4	January 2018	Director of Corporate Affairs	Current	
3	September 2016	Director of Corporate Affairs	Archived	
2	July 2015	Director of Corporate Affairs	Archived	
1	July 2014	Director of Corporate Affairs	Archived	

Record of changes made to Board Assurance Framework Policy – Version 4			
Section Number	**Page Number**	**Change/s made**	**Reason for change**
		• Clinical Business Units changed to reference Divisions • Removed reference to Health Act • Removed reference to General Managers	

Contents

1 Introduction

A Board Assurance Framework (hereafter referred to as the BAF) must be driven by the objectives of the organisation. Therefore it follows that clear strategic and operational objectives need to be identified before an effective system of internal control can be established. Without clear objectives, the Trust would be unable to identify and evaluate the risks that threaten the achievement of its goals and design and operate a system of internal control to manage those risks. The corporate objectives for the Trust are determined by the Board of Directors, based on organisational, local and national priorities, stated in the Trust's operational plan and other related documents. The BAF enables the Board to demonstrate that it has been properly informed about the totality of its risks and is able to sign the Annual Governance Statement required annually by NHS Improvement.

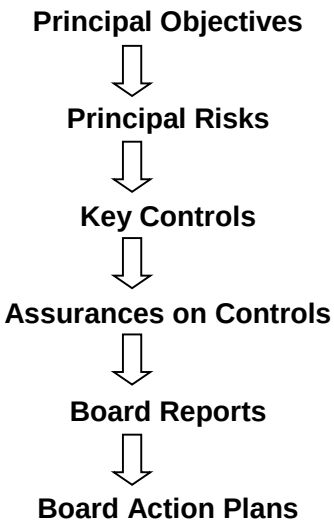
The BAF must be a dynamic tool to enable the Board to assure itself that all significant strategic risks are being managed effectively. The elements involved in this assurance process are:

- The BAF must be reviewed and updated with progress towards closing the identified risks and associated gaps in control and/or assurance at least quarterly.
- Independent scrutiny must take place to ensure that these updates are valid.
- Both of these processes must also consider whether new risks have arisen with the potential to jeopardise the achievement of the Trust's principal strategic objectives.

2 Purpose of Policy

The purpose of this policy is to set out the key structures, systems and processes by which the Board of Directors is assured, via the BAF and the underpinning risk registers that the Trust's strategic and operational objectives are being achieved through the effective management of the strategic and operational risks. See Fig.1 below.

The Board Assurance Framework



3 Duties and Responsibilities

3.1 Board of Directors

- It is the duty of Board members to ensure that they monitor the Trust's significant risks as detailed in the corporate risk register and that those corporate risks link into the high level risks on the BAF, that relate to specific strategic objectives and the associated controls and assurances in line with the work plan. In particular, the Board should focus upon progress by exception of action plans to address gaps in control and assurance.
- The Board should ensure that all systems, processes and procedures required for the BAF function effectively, including where elements have been delegated to Committees.

3.2 Board Committees

- The overall role of the Board's committees is to carry out the detailed work of assurance on behalf of the Board. They report recommendations to the Board. The Board Committee's core role and responsibilities is to:
  - Scrutinise reports on the relevant risks to that Committee's remit from the BAF and the corporate risk register; the delivery of the Annual Plan and compliance with CQC Standards.
  - Contribute to the development of the Annual Planning cycle and ensure that this plan reflects stakeholder requirements.
  - Give the Board confidence that the systems, policies and people they have put in place to deliver the Annual Plan are operating in compliance with CQC Standards, are effective, are focused on key risks and are driving the delivery of the Trust's objectives.
  - Recommend to the Board the level of assurance required, the source of assurance required and how the reporting of assurances will be managed and coordinated.
  - Provide the Board with the evidence required of the effectiveness of controls in order to be able to sign the Annual Governance Statement and maintain unconditional registration with the CQC.
  - Scrutinise reports and evidence of assurances provided by clinicians, managers, Trust committees and independent assurers on the status of the Trust's internal controls.
  - Ensure that unacceptable levels of assurance and risks are reported to the Trust Board for their consideration.

3.3 Integrated Governance Committee

- The Integrated Governance Committee oversees the design and effective operation of the risk management process across the Trust including the management of the production of the BAF.
- The Committee provides the Board with assurance that a comprehensive corporate risk register is in place derived from the Executives' view of the major risks to the Trust and the risks being escalated from Divisions and business support functions.

- The Committee oversees the integration of clinical, organisational and financial risk management systems across the Trust with that of corporate business planning.
- It is authorised to take remedial action to resolve weaknesses and incorporate best practice.

3.4 Divisions and Business Unit Functions

- All Divisions and Business Unit Functions should complete and report to the Integrated Governance Committee on their specific accountabilities and responsibilities as defined in the work plans.

3.5 Director of Corporate Affairs

- The Director of Corporate Affairs will facilitate the process for updating the BAF.
- The Director of Corporate Affairs will ensure the Board of Directors is provided with an updated BAF every month.
- The Director of Corporate Affairs will ensure that timely risk modelling is undertaken for all new identified or emerging risks.

3.6 Executive Directors

- Each risk identified on the BAF will have an Executive Director owner who holds accountability for updating entries in the Assurance Framework against that risk i.e. associated controls, actual assurances (reports etc), action plans and impact/likelihood score.
- Once all updates from risk owners have been received, the Executive Lead will sign off the refreshed BAF.
- The Executive Directors with responsibility for staff groups in each will be accountable for the proactive timely and accurate review and update of all risks owned by their Divisions / corporate service. This will include continuously supporting risk owners, control owners and action owners to scrutinise their existing risks and progress made to reduce them. It is also an opportunity to identify any emerging new risks for assessment and inclusion in the corporate risk register.

3.7 Non-executive Directors

- It is the role of all Non Executive Directors to contribute to Board and Committee discussions and make constructive challenges.
- They should identify issues, either through Committee activities or at the Board itself, of which the Audit Committee will undertake a more detailed review.

3.8 Associate Chief Operating Officers/Heads of Business Unit Functions, Project and Programme Managers

- Associate Chief Operating Officers, business support function Heads of Departments, Project and Programme Managers are accountable for the complete and accurate review and update of all risks owned by their Divisions/ service/ programme. This will include continuously supporting risk owners, control owners and action owners to scrutinise their existing risks and progress made to reduce them.
- They are also accountable for identifying any emerging new risks for assessment and escalation to the corporate risk register.

3.9 All Staff

- Contributing to the identification of risk through active participation in the risk assessment and incident reporting processes by ensuring they comply with their responsibilities identified in the risk assessment and incident reporting policies.
- Following all relevant safety precautions in line with the policy.
- Keeping mandatory training up to date through attendance and updating identified in the training needs analysis.

4 Process for maintaining the Board Assurance Framework

4.1 The BAF is utilised by the Board of Directors as a planned and systematic approach to the identification, assessment and mitigation of the risks that could hinder the Trust in achieving its strategic goals.

4.2 The BAF contains information regarding internal and external assurances that organisational goals are being met. Where risks are identified, mitigations and subsequent action plans are mapped against them.

4.3 Risks are scored using a 5x5 matrix of impact and likelihood. This 5x5 matrix, in which scores for impact or consequence of the risk is multiplied by the score for likelihood of occurrence. The total score generated is known as the risk rating.

4.4 The BAF is maintained by the Director of Corporate Affairs. The information recorded on the Framework includes:

- Description of the risk
- Current risk score
- Control measures in place
- Evidence of current assurances
- Gaps in controls/ assurances
- Target risk rating
- Actions required to achieve the target risk rating – the appetite for the specific risk.

4.5 The Board of Directors has delegated responsibility of monitoring risks and assurances to the Integrated Governance Committee (IGC), which will review and update the BAF at each of its bi-monthly meetings. It will provide an updated BAF and summary of the corporate risk register to the subsequent Board meeting and also an extract of the relevant risks to the other Board

Committees: Clinical Quality Assurance Committee, the Resources and Business Development Committee and Workforce and Organisational Development Committee.

4.6 The Audit Committee has delegated responsibility from the Board to oversee this process, ensuring that there is adequate external review and assurance and that this is used to inform the Annual Governance Statement.

5 Process for the local management of risk (which reflects the organisation wide Risk Management Strategy)

- Each Clinical Division and Corporate Function will refresh their risk register on an annual basis as per the Trust's Risk Management Strategy.
- The locally identified risks, derived from completing the risk assessment tool, will be utilised to inform the departmental risk registers. Divisional Associate COOs/Heads of Corporate Functions are responsible for ensuring that actions are put in place to mitigate identified risks.
- The ways in which risk can be escalated from Ward and department level to Divisions and corporate levels is outlined in the Risk Management Strategy.
- Divisions/Corporate Functions will provide exception reports to the Integrated Governance Committee in line with that's Committee's work plan.

6 Monitoring Compliance with the Processes

As stipulated within this policy, the Trust will keep the BAF under review via the Integrated Governance Committee and monthly reports to Board of Directors and its Committees.

- The reports will be presented by the Director of Corporate Affairs to the Board of Directors and its assurance committees.
- An annual audit of the corporate risk register/ Assurance Framework will form part of the internal audit programme, to support the Annual Governance Statement.
- The purpose of this annual audit is to monitor the systems and processes of the approved organisation- wide risk register.
- The Trust's BAF will be monitored to assess compliance with the key performance indicators.
- The audit process will assess whether responsibilities are clearly agreed and recorded and there is evidence to support objectives which are clearly linked to the Trust's operational plan or other strategic documentation.
- Risks are clearly linked to objectives, their priority (impact/likelihood) has been determined and they have been attributed to a lead.
- Risks are assessed and new/amended risks are considered and included where appropriate.
- Controls effectively manage the risk, there is evidence that the controls are in place and that there is adequate management of controls.
- Controls relied upon are sufficient to manage the risk i.e. expected assurances have been received and provide sufficient information to efficiently manage the risk.

- Positive assurance evidence is collated and uploaded onto performance accelerator and signed off by the accountable Executive Director.
- Where gaps in control/assurance have been identified, appropriate actions plans have been agreed to address these and are monitored consistently in line with policy standards.
- Board reports, Integrated Governance Committee minutes, Resources and Business Development Committee minutes, Clinical Quality Assurance Committee minutes, Workforce and Organisational Development Committee minutes and Audit Committee minutes provide evidence that the Assurance Framework has been effectively discussed and considered and progress/ action has been taken to address areas raised following the audit.
- The Integrated Governance Committee and Audit Committee monitor reports ensuring that recommendations/actions are implemented where monitoring has identified deficiencies. This is to ensure that lessons have been learned and agreed changes in practice made.

7. Further Information

Equality Analysis (hyperlink)

References

- *The Healthy NHS Board*
- *Taking it on Trust*
- *Board Assurance Frameworks – A Simple Rules Guide for the NHS*
- CQC Standards
- NHSI Single Oversight Framework updated November 2017
- NHSI Annual Reporting Manual 2017/18

Associated Documentation

This policy should be read in accordance with the Trust Risk Management Strategy.

Appendix A

1. Definitions

1.1 Assurance

Confidence based on sufficient evidence, that internal controls including policies, procedures, practices and organisational structures are in place and operating effectively ensuring the strategic objectives are being achieved.

1.2 Key Elements Assurance Framework

- An Assurance Framework (BAF) is a simple but comprehensive method for:
- The management of the principal risks to meeting the organisation's objectives.
- Providing evidence for the Annual Governance Statement. Guidance on what should be included within the Statement is provided within Monitor's Annual Reporting Manual each year.

1.3 Principal Objectives

- Principal Objectives are statements of the crucial measurable results which the organisation must achieve in order to achieve its overall goals in line with its strategic aims.
- Clinical Divisions and Corporate functions must align their objectives with the principal objectives in order to ensure that their activities contribute to the achievement of the Trust's principal objectives.
- The BAF must specify the Director who is accountable to the Board for delivering the Principal Objectives of the corporate plan.
- The Principal Objectives must be stated in terms which are:

Specific
Measurable
Achievable
Realistic
Time-based

1.4 Risk Registers

- Risk registers are held at Divisional level, Departmental level, business support function level, and at Trust Wide level, (Assurance Framework and Corporate Risk Register). The principal risks associated with each strategic objective must be identified on the BAF.
- The risk rating tool (5x5 matrix) enables staff to consider the potential harm that would be caused if a hazard or threat was realised and how likely this is to happen. The two factors of likelihood and impact/consequence are used to establish the level of risk; this will assist staff in deciding which risks take priority and highlight areas which need rapid attention.
- The Divisional/Department/Business Support Function level risk register must reflect the proactive annual risk assessments undertaken and

reactive risks identified through incident reporting etc. including demonstrating action taken against these risks at least monthly.

- Each Division/Department/Business Support function has responsibility to review their own risks and to inform the Integrated Governance Committee of actions completed to reduce or eliminate the identified risk.
- The Division /Department/Business Support Function risk assessments will contribute to the formulation of the high level Trust Corporate Risk Register along with other forms of risk identification. This will ensure that the risk registers are consistent and that meaningful decisions on the prioritisation and treatment of risks can be made.
- Risk Registers will be kept at Business Support Functions, Divisional and Department/Ward levels within the Trust.
- At Board level the corporate risk register will include risks to the achievement of Principal Objectives together with risks escalated from business support functions, Divisions and Department/Ward levels.

1.5 Principal Risks

- Factors which potentially threaten the achievement of the principal objectives are called principal risks and need to be identified. They should be stated as "If x happens then y will be the consequence".
- Using risk profiling the principal risks to achieving the principal objective are identified and summarised on the BAF together with a score of their likelihood and potential impact.

1.6 Risk Profiling

Risk Profiling is a process that involves the identification and assessment of all risks encountered by an organisation, enabling the identification of high risk issues, facilitating the management and prioritisation of such risks.

- Risk profiling gives a risk a 'Likelihood score' of:

  1 = rare - do not expect this to happen.
  2 = unlikely - most probably will not happen.
  3 = occasionally - 50:50 chance of occurring.
  4 = likely - most probably will happen.
  5 = almost certain - confident that this will happen.

- Risk profiling gives an impact/consequence score of

  1 = almost non - no obvious harm.
  2 = minor - no permanent harm (recovery within month).
  3 = moderate - semi-permanent harm (recovery takes longer than 1 month but no more than 1 year) and/or adverse publicity for the Trust.
  4 = major - permanent harm not resulting in death or severe disability to a person or persons and/or start of a national investigation into the Trust and/or disruption of key Trust services which significantly hinder the Trust in meeting its responsibilities.
  5 = catastrophic - death or permanent severe disability to a person or persons and/or significant loss of reputation for the Trust and/or

loss of key Trust services which prevent the Trust meeting its responsibilities.

Note: Harm in all the above includes damage to the organisation, its finances, its reputation, its business, its patients, staff or visitors.

1.7 Identification of Risks

Potential principal risks to the achievement of the Trust's objectives are identified in two ways: the 'top down' proactive (risk assessment) identification of risks that directly affect the Trust's achievement of its principal objectives, combined with the 'bottom up' assessment of the most significant risks within the business support, programme and Clinical Risk Registers, which in turn originated in Clinical Business Units, programme and Business Support Function Risk Registers.

1.8 Controls and Assurance

- Controls are the many different things that are in place to mitigate risk and assist in securing the delivery of objectives; they should make a risk less likely to happen, or reduce its effect if it does happen.
- The Assurance Framework requires the Trust to consider the effectiveness of each control through the process of obtaining assurances that the control is in place and is operating effectively.
- The Assurance Framework summarises how the Board knows that the controls it has in place are effectively managing the principal risks together with references to documentary evidence that the assurances are working effectively.
- There are two groups of assurances on controls:
  - Internal Assurance
  - Independent Assurance
- Internal assurance is provided by the following Committees:
  - Audit Committee
  - Clinical Quality Assurance Committee
  - Integrated Governance Committee
  - Workforce and Organisational Development Committee
  - Health and Safety Committee
  - Clinical Systems Informatics Project Group
  - Information Governance Committee
- The purpose of the committees is to carry out an analysis of assurances received, identify any key gaps in the assurance mechanisms and provide an evaluation of the effectiveness of these mechanisms to inform the relevant strategic objectives on the Assurance Framework.
- The Board of Directors then receive summary reports from these committees together with Audit Committee reports and makes a final judgement on the level of assurances received and any actions required to ensure delivery of the Trust's objectives and obligations.

- Independent assurance is provided by:
  - Audit Committee
  - Internal Audit and External Auditors
  - Care Quality Commission
  - Health and Safety Executive
  - Monitor/NHS Improvement

1.9 Key Controls

- Key controls are the means by which the risk's impact or likelihood may be reduced together with references to documentary evidence of the existence and effectiveness of that control mechanism. Risk control is achieved by reducing the likelihood of the risk, reducing the impact of the risk and/or transferring the risk. The risk controls are also identified through a risk profiling process and summarised on the Assurance Framework as are any gaps in risk control.

- The Board of Directors and all other Trust staff grade risks must use the same tool.

1.10 Gap in control and assurance

- A gap in control is deemed to exist where adequate controls are not in place, or where collectively they are not effective. A failure to put in place sufficient effective policies, procedures, practices of organisational structures to manage risks and achieve objectives.
- A gap in assurance is deemed to exist where there is a failure to gain evidence that the controls are effective. In other words a failure to gain sufficient evidence that policies, procedures, practices or organisational structures on which reliance is placed is operating effectively.
- Wherever gaps in control or assurance are identified, action plans must be clearly defined, monitored consistently for improvement and allocated to appropriate lead Directors.

1.11 Controls Performance Reports and Associated Action Plans

- Performance reports e.g. audit reports provide strong evidence of the effectiveness of control activities and should identify necessary improvements where controls are lacking. It therefore follows that performance reports generate valuable information for the Assurance Framework and that there is a clear need for performance reporting and the Assurance Framework to be strongly linked.
- Where there is deficits identified in performance action plans must be formulated and consistently monitored to ensure compliance with performance standards (strategic objectives).

Alder Hey Children's NHS
NHS Foundation Trust

Resource and Business Development Committee
Confirmed Minutes of the meeting held on: Wednesday 13th December 2017, at 9:30am
Large Meeting Room, Institute in the park

Present:	Claire Dove (Chair)	Non-Executive Director	CD
	Mags Barnaby	Interim Chief Operating Officer	MB
	John Grinnell	Director of Finance	JG
	Claire Liddy	Deputy Director of Finance	CL
	Sue Brown	Project Manager and Decontamination Lead	SB
	David Powell	Development Director	DP
	Steve Ryan	Medical Director	SR
	Melissa Swindell	Director of HR	MS
In Attendance:	Mark Flannagan	Director of Communication	MF
	Phil O'Connor	Deputy Director of Nursing	POC
	Erica Saunders	Director of Corporate Affairs	ES
	Karen McKeown	Minute Taker	KMc
Agenda item: 95	Cathy Fox	Associate Director Informatics Officer	CF
98	Joe Gibson	Interim Programme Director	JG
105	Alan Burgess	Procurement Team Manager	AB
107	Graeme Dixon	Building Services Manager	GD
Apologies:	Ian Quinlan (Chair)	Non-Executive Director	IQ

17/18/93 Minutes of the previous meeting held on 30th October 2017
Resolved: Agreed
Resources and Business Development Committee received and approved the minutes of the meeting held on the 30th of October 2017.

17/18/94 Matters Arising and Action log
All items for discussion were included on the agenda.

17/18/95 Global Digital Excellence Programme

Cathy Fox provided an update on the progress of the GDE Programme and the Committee discussed the recent delivery of projects. Work is continuing towards the delivery of the third milestone which is due at the end of February 2018 and it was reported that the organisation is expecting funding as a result of delivering the first milestone. A discussion took place around the release of funding on work that has been completed to date, and it was agreed that a budgetary position will be submitted to the Committee on the 24.1.18.

John Grinnell informed the Committee of the need to improve the efficiency of IT systems to enable frontline staff to carry out their daily duties. A suggestion was made to collect the issues raised by staff and submit them to the GDE Board for debate and to ensure that the work taking place makes sense as a whole.

17/18/95.1 Action: CF

Resolved:
The Resources and Business Development Committee received and noted the content of the GDE report.

17/18/96 Performance/Run Rate

The Committee was provided with an overview for month 7 of the activity summary for the Medical and Surgery Division. The following points were highlighted and discussed:

- A&E attendance is 22% above plan and it was reported that there is a potential for higher admissions and cancellations.
- Improvements have been noted in the day case position and work is on-going within the Medical Day Case unit to improve capture and the depth of coding. The Division is continuing to refine and improve its forecast position.
- The Committee was informed of the underperformance in General Paediatrics, Outpatients and Accident and Emergency. It was reported that this is an activity position and not a financial position. Following discussion it was agreed to refine the template to define the activity of finance.
- Concerns were raised around the high level of red indicators and the pronounced variance between month 6 and 7 data. The Committee was informed that this could be a capture issue. Mags Barnaby reported that work is on-going to improve the capture of activity which will assist the Trust to pinpoint low benchmarking. Following discussion it was felt that the figures reported are not a true reflection of the Trust's actual activity and it was agreed that a conversation should take place with the Chair of the Weekly Activity meeting and Associate COO's to escalate the situation to the divisions. Claire Liddy highlighted the importance of understanding the financial consequences of this issue.

17/18/96.1 Action: AB
17/18/96.2 Action: AB

Resolved:
The Resources and Business Development Committee received and noted the content of the performance report for month 7.

17/18/97 Finance Report

For the month of October the Trust is reporting a trading surplus of £0.3m which is behind plan by £0.7m. Income is in line with plan but this is offset by expenditure which is higher than budgeted by £0.7m. The year to date position is a deficit of £4.7m which is behind plan by £0.6m. The Use of Resources risk rating is 3 which is in line with plan and cash in the bank of £10.9m.

Claire Liddy delivered a presentation to support the finance report for month 7 and provide an overview of key messages for month 8. The Committee was advised that the provision figures for month 8 reported a reduction to the year to date variance against control total to a £20.2m adverse variance.

Corporate report

The Committee received the Corporate Report for month 7.

Resolved RABD:
The Resources and Business Development Committee received and noted the contents of the Finance Report for month 7 and the Corporate Report for month 7.

17/18/98 Programme Assurance

The Resources and Business Development Committee received the Programme Assurance summary for the following workstreams:

Growing Through External Partnerships

- *STP, Alder Hey and C&M Strong Community Services* – A closure report is to be submitted to the Programme Board following a request by the team to close this project.
- *International Health and None NHS Patients* - This project has been rag rated as amber due to the lack of updates.
- *Aesptics* – A meeting is due to take place to drill down and find out what steps need to be taken to enable the project to be rag rated as green.
- *Single Service, 2 site, Neonatal Service* – An update on the joint business case for neonates is imminent and a report is to be submitted to the Trust Board in January 2018.
- CHD Liverpool Partnership – CHD Liverpool Partnership Board announced that NHS England have ratified their decision regarding this area of work and it will be completed by the third week in December 2017.

Global Digital Excellence

- The Committee was advised of the need for close management of benefits realisation within the operational divisions. Since the last report the 'Voice Recognition' project has been rated to 'amber'; this is related to the issue surrounding the realisation of benefits. Further work on organisational development change may need to be conducted to achieve benefits.

  Mags Barnaby informed the Committee of the agreement to establish an operational sub-group to look at the technical timetable and changes. This sub-group will be fully formed by the end of January and will feed into the Programme Board.

Park, Community, Estates and Facilities

- It was confirmed that known delays against the master plan have been addressed and the workstreams are now back on track.
- *R&E 2* - Claire Liddy advised that the funding agreements are in delay by four months and have been rag rated as red on the dashboard. It was reported that work is taking place to address the collection of £3m from external funders. An escalation process will be in place by January 2018 if the Trust hasn't received a response in relation to this matter.

Resolved:
Resources and Business Development Committee noted the report and the work being undertaken to increase pace, benefit and opportunities.

17/18/99 Weekly Performance Update

This item was discussed under agenda item 5.

17/18/100 Board Assurance Framework

The Board Assurance Framework (BAF) was submitted to the Committee for assurance purposes. Erica Saunders provided an update and highlighted the importance of including key risks such as funding for Research, Education and Innovation in the BAF.

17/18/100.1 Action: DP

Resolved:
The Resources and Business Development Committee noted the Board Assurance Framework for month 7.

17/18/101 Single Oversight Framework

The Single Oversight Framework was submitted to the Committee in order to note the changes to NHS Improvement metrics. The Committee was advised that Well Led interviews are taking place and a report on the outcome will be compiled as soon as possible by Tim Crowley. A date will be agreed with MIAA in order to receive feedback.

A query was raised around the necessity for updating the organisation's reports to reflect the language in the Single Oversight Framework. Erica Saunders felt that it should be given some consideration and pointed out that the Information Team need to be sighted on any changes.

17/18/102 Marketing and Communication Activity report

Mark Flannagan provided an update on activity for Marketing and Communications during October 2017. A discussion took place around the on-going situation in respect to AE and Mark Flannagan advised of his intention to introduce a Communications Plan for the Trust which will be submitted to the Committee in January.

17/18/102.1 Action: MF

Resolved:
The Resources and Business Development Committee noted the update provided.

17/18/103 Revised use of the normal course of business loan for residual services and corporate accommodation.

A report was submitted to the Committee to acquire approval to broaden the use of a £15m loan that was previously agreed. Initially the Trust approved a case in 2015 to invest £15m for the site development of Corporate Offices. This case did not provide a solution for all staff currently located within the retained estate as it excluded Community Paediatrics and CAMHS.

The Trust has looked at a combination of on site and off site accommodation during 2016/17 to fully accommodate both clinical and non-clinical services. The team were challenged to review the options being considered testing value for money and estate principles. This has resulted in a revised Estates Strategy that has now been approved.

Resolved
The RABD approved the change to the £15m loan and authorised the Director of Finance to liaise with NHS Improvement and sign any necessary documentation to enable the change.

17/18/104 Monthly Debt Write Off
Resolved:
The Resources and Business Development Committee approved November's write off of £8054.23

17/18/105 Procurement Update

The Committee received a presentation from Alan Burgess which provided an update on progress since the last report that was submitted in August 2017. A discussion took place

on the forecast of £1.1m, the three top suppliers and the tender for Occupational health that is taking place in order to try and reduce costs.

The Committee focussed on the procurement plans for 2018/19. A discussion took place around the next generation of procurement, the influence the STP work stream will have in Cheshire and Merseyside in the next six months and the clinical procurement plan for the Trust.

Alan Burgess raised a query in respect to how much emphasis should be placed on environmental/social elements when going out to tender. Claire Dove suggested referring to the Crown Department guidance in relation to this matter and advised that Johnson and Johnson are conducting a large piece of work on this. Joe Gibson informed the Committee that there is £1b being allocated for the social element of procurement. Suppliers are selling incentives in order to continue a one to one relationship with customers. Following the conclusion of discussions, a recommendation was made for members of the Trust's Procurement department to visit Salford Trust in order learn and share best practice.

17/18/105.1 Action: AB

Resolved
The Resources and Business Development Committee noted the update provided.

17/18/106 Relocation of CAMHS, Physiotherapy and Occupational Therapy Services in Sefton

A report was submitted to the Committee to escalate the urgent need to re-locate Sefton CAMHS and Therapy services. The Committee discussed the current premises that house the services along with the reasons for change. The Committee was advised that a recommendation has been made to rehouse the three services in Burlington House, following refurbishment of the premises.

A query was raised around the poor parking facilities for staff and patients at Burlington House. The Committee was informed of the land that has become available behind Burlington House due to the demolition of buildings. It was reported that this land will be used for staff parking whilst spaces have been allocated in the plan for patients and families. The Committee was also advised of the excellent bus routes available.

John Grinnell advised that this area of work forms part of the larger Estates Strategy that was submitted to the Trust Board on the 5.12.17.

Resolved:
RABD ratified the report that was submitted in respect to the relocation of CAMHS, Physiotherapy and Occupational Therapy in Sefton.

17/18/107 PFI Contract Monitoring Report

The Building Services monthly report for October was submitted to the committee for information purposes. Graeme Dixon informed the committee that the energy consumption for October was 15% below the contractual target and 1% over the design target. The figure has increased slightly for November.

It was reported that the organisation is working with the independent consultant who has been appointed by key stakeholders and a meeting is taking place on the 18.12.17 to discuss early outcomes.

A discussion took place around the steps that need to be taken to achieve the agreed contractual targets by the end of the financial year for 2017/18. The Committee was informed of the plans to work closely with Comms and the Trust's Energy Lead, address the savings in theatres and upload screen savers onto PCs to remind staff to switch lights off, etc. Claire Liddy highlighted the benefits of having an Environmental policy.

Resolved:
The Resources and Business Development Committee noted the update provided.

17/18/108 Terms of Reference

The amended Terms of Reference were submitted to the Committee for approval. The amendments to the Terms of Reference incorporated the following changes:

- It was agreed that attendance by Non-Executive Directors would be reduced from three to two.
- It was agreed that the Chief Executive would be removed from the membership.

Resolved:
RABD approved the amended Terms of Reference.

17/18/109 Any Other Business

There was no further business to discuss.

Date and Time of the next meeting: Wednesday 24th January at 9:30am Large Room, Institute in the Park.

ALDER HEY CHILDREN'S HEALTH PARK LIAISON COMMITTEE

Title	**Liaison Committee Meeting Minutes**	
Date / time	Monday 18th December 2017, 14:00	
Location	Seminar Room 1, Ground Floor CHP offices, Alder Hey Children's NHS Foundation Trust, Eaton Road, Liverpool L12 2AP	
Present	**Trust Senior Management:**	Rachel Lea (Associate Director of Development) **RL** David Powell (Development Director) **DP** Graeme Dixon (Head of Building Services) **GD**
	Project Co Directors:	James Heath (John Laing Investments Ltd) **JH** Alan Travis (Explore Investments Ltd) **AT**
	Other Attendees	Stuart Wilkinson – (Project Co Representative) **SW** Laura Joseph-Chamberlain– (Interserve FM) **LJC**
Apologies	Louise Shepherd (CEO) **LS** Margaret Barnaby (Chief Operating Officer) **MB** Tristan Meredith (Interserve Dev Co No 1 Ltd) **TM** Jing Hao – (Project Co) **Jha**	

Item	Discussion	Action
1.0	**Quorum** – the meeting was quorate as defined within clause 12.1 of the PA.	Note
2.0	**Previous Minutes dated 8th November 2017** – The previous minutes were accepted as an accurate record of the meeting.	
2.1	(2.2) SFP Uplift. Project Co had previously agreed to review DP's paper regarding SFPs and that this would be discussed further at the next Liaison Committee meeting. It was agreed for the SFP uplift to be discussed separately, directly after the December Liaison Committee meeting.	
2.2	(2.3) Endoscope Washer Disinfectors – Trust Withholding of Non-Agreed Sum: RL confirmed that the Trust responded by letter on 9th November to Project Co's letter. JH advised that Project Co were considering their position.	

2.3	(2.5) Trust H&S Review: A H&S review meeting took place with the Trust on 21st November, with a number of actions agreed, mainly for the Trust to review existing design related information.	
2.4	(3.2) Generator Testing (Black Start): It was noted that the black start was scheduled to take place on the morning of 19th December.	
3.0	**Other Key Issues / Hot Topics**	
3.1	Pipework Corrosion: SW advised that the scope and appointment amendments requested by two of the three specialist consultants had led to a delay, with the final confirmations now expected by 22nd December. The revised target date for issue of the final report is 27th March 2018. In the meantime, Project Co has requested from the supply chain that the hot spots be highlighted and mitigations considered, to enable a plan to be communicated at the next liaison committee meeting.	**LJC / SW**
3.2	Green Roof: SW advised that vegetation replacement work had been completed in a number of areas by LORC. Quality concerns have been raised by the Trust in relation to Zone 1, which is in the process of being addressed with LORC. Project Co has issued a copy of their expert's investigation report to the Trust. The key recommendation relates to the irrigation system. Project Co has discussed the recommendations with LORC with a view to establishing an agreed action plan. The target is to advise an agreed action plan at the next liaison committee meeting.	**SW**
3.3	Energy: It was agreed that energy performance had improved based on November's data. SW advised that Concept, the independent energy adviser, had issued an outline plan and are targeting the issue of a draft report during w/c 22nd January 2018. SW summarised the activities carried out to date and planned for the next period. The next joint energy committee meeting and workshop is scheduled for 19th December. RL queried the energy implications associated with variations. It was agreed to address this at the next energy meeting on 19th December.	**RL**

	DP asked about the apportionment of retrospective over-spend. JH advised that Project Co would be better placed to respond once Concept had provided their report.	
3.4	Subcontractors: LJC advised that IFM were unlikely to continue their lifts subcontract with Schindlers. LJC advised that problems remain with Atlas' performance which are being proactively managed through working closely with the Trust's Aseptic Suite Manager. LJC confirmed that Rigbys have been removed by IFM and replaced with another catering equipment subcontractor. DP thanked IFM for their proactive approach.	
4.0	**SFP Uplift**	
4.1	See item 2.1 above.	
5.0	**Any Other Business**	
5.1	GD welcomed SW as the new Project Co Representative.	
6.0	**Next Meeting**	
6.1	Next meeting date (and all 2018 meeting dates) are to be arranged.	**Trust**

ALDER HEY CHILDREN'S HEALTH PARK LIAISON COMMITTEE

AGENDA

1. Quorum
2. Previous Meeting Minutes
   - 2.1 Accuracy & Approval
   - 2.2 Actions
3. Key Issues / Hot Topics
   - 3.1 Endoscope Washer Trust Withheld Sum Disagreement
   - 3.2 Pipework Corrosion
   - 3.3 Green Roof
   - 3.4 Energy
   - 3.5 Subcontractors
4. SFP Uplift
5. Any Other Business
6. Next Meeting

Alder Hey Children's NHS
NHS Foundation Trust

Corporate Report 17/18 Change Control - Refresh Update to Board

05th February 2018

This document is intended to provide detail of changes to some of the metrics within current Performance Corporate Report.

The content of the current performance report has been under review by the CQAC committee and an action to refresh the quality content to ensure alignment with strategic and national objectives was agreed during 2017. Subsequent to this action, there was a detailed discussion at Trust Board in January 2018 that prompted a more detailed review and resulted in this change control process.

The change control process will allow for correction of anomalies with some current thresholds and RAG ratings with the current 2017/18 report to be corrected as well as to add in some priority national quality metrics not currently reported (Sepsis indicators).

The approach taken to this review utilises a robust change control and full transparency with the process. The change control document attached provides details of all of the changes to be made.

The work to change the metrics within the automated Corporate report are currently in production and a new version of Month 9 (December 2017) report will be issued when this work has been completed. The changes will flow through from Month 10 as per normal timetable for production of the Corporate report

The Trust Board have also commissioned a full refresh of content and style of the Corporate report from 2018/19 onward.

Change control document: M9 Corporate Report

Alder Hey Children's NHS
NHS Foundation Trust

Metrics in corporate report to be impacted by change

Page	Metric	Remove metric?	If metric is removed provide rationale	Change metric?	If metric is changed provide rationale	Adjust Threshold	Threshold Change	Threshold Rationale	Change authorised by which Exec?	Date of authorisation
Patient Safety	Pressure Ulcers (Grade 2 and above) YTD	No		Yes	Align to Grade 3 + above only as peers report	Yes	To be Zero	Correct target for G3 & above	H Gwilliams	02/02/2018
Patient Safety	Never Events	No		No		Yes	Visually green when no never events	Missing from current view	H Gwilliams	02/02/2018
Patient Safety	Clinical Incidents resulting in harm	No		Yes	Rename metric to indicate excludes 'Near Miss & No Harm'. Adjust graph to be stacked chart to illustrate volume of each reported impacts	Yes	Improved levels of reporting to be green	Ensure compliance reporting of harms was maximised	H Gwilliams	05/02/2018
Patient Safety	Readmissions to PICU	No		Yes	Review if can be patients readmitted due to same condition only	TBC	TBC	TBC	H Gwilliams	02/02/2018
Patient Experience	FFT (Friends & Family)	No		No		Yes	Apply FFT Targets	Use latest (Nov-17) national scores as baseline	H Gwilliams	02/02/2018
Patient Experience	Complaints	No		No		Yes	Year End Target <70 Green, 70-90 Amber, 90+ Red	Was no RAG. To be based on 1617 baseline	H Gwilliams	02/02/2018
Clinical Effectiveness	MRSA	No		No		Yes	Visually green when no MRSA	Missing from current view	H Gwilliams	02/02/2018
Clinical Effectiveness	Patients with an estimated discharge date discharge later than planned (only surgical)	Yes	Prioritise addition of Sepsis detail / current metric divison focused only						H Gwilliams	02/02/2018
Clinical Effectiveness	% of patients with an estimated discharge date discharge later than planned (only surgical)	Yes	Prioritise addition of Sepsis detail / current metric divison focused only						H Gwilliams	02/02/2018
ED	ED: 15 minute 'Time to Initial Assessment' (95th Percentile)	Yes	Void metric to portray						A Bateman	05/02/2018
ED	ED: Percentage Left without being seen	No		No		Yes	Apply <5% Green	CCG Target we meet however no RAG in CR	A Bateman	05/02/2018
Productivity	Clinic Session Utilisation	No		No		Yes	Apply Amber Tolerance 85%-90%	Currently only Pass/Fail (Green/Red)	A Bateman	31/01/2018
Productivity	Daycase Rate	No		No		Yes	Remove threshold	Currently incorrect as 0% target	A Bateman	05/02/2018
Productivity	DNA Rate	No		Yes	Account for 'cashing up' challenges - to include un-actioned DNAs that are likely to be a DNA	Yes	Apply Amber Tolerance 12-14%	Currently only Pass/Fail (Green/Red)	A Bateman	05/02/2018

Change control document: M9 Corporate Report

Alder Hey Children's NHS
NHS Foundation Trust

Metrics in corporate report to be impacted by change

Page	Metric	Remove metric?	If metric is removed provide rationale	Change metric?	If metric is changed provide rationale	Adjust Threshold	Threshold Change	Threshold Rationale	Change authorised by which Exec?	Date of authorisation
CAMHS	DNA Rate New	No		No		Yes	Apply Amber Tolerance 10-12%	Currently only Pass/Fail (Green/Red)	A Bateman	05/02/2018
CAMHS	DNA Rate FU	No		No		Yes	Apply Amber Tolerance 14-16%	Currently only Pass/Fail (Green/Red)	A Bateman	05/02/2018
External Regulation	NA - Page Change	NA		Yes	Remove wording of 'Monitor' & replace with NHSI				J. Grinnell	05/02/2018
Workforce	Medical Appraisal	No		No		Yes	Remove threshold as only reported on at end of cycle	Gives wrong impression as in month RAG	M.Swindell	02/02/2017
Workforce	PDR	No		No		Yes	Remove Threshold for April - July	Not applicable to RAG as PDR window ongoing	M.Swindell	02/02/2017
Workforce	Sickness	No		No		Yes	Apply amber tolerance from 4.6%-5%	Currently only Pass/Fail (Green/Red)	M.Swindell	02/02/2017
Workforce	RIDDOR	Yes	Not required						M.Swindell	02/02/2017

Measures where the performance target has been lowered and threshold for achieving green status is lowered

Division	In IPF however not in Performance Template Metrics	Remove metric	If metric change = yes provide detail	Change metric	If threshold is changed provide rationale	Adjust Threshold	Threshold Change	Threshold Rationale	Change authorised by which Exec?	Date of authorisation
Workforce	Corporate Induction	No		No		Yes	Green >90%, Amber 80-90%, Red <80%	Currently set at 100%	M.Swindell	02/02/2017

Additions to go in

Division	In IPF however not in Performance Template Metrics	Add Metric	If metric change = yes provide detail	Change metric	If threshold is changed provide rationale	Adjust Threshold	Threshold Change	Threshold Rationale	Change authorised by which Exec?	Date of authorisation
Patient Safety	% Patients receiving antibiotic within 60 mins for ED	Yes	Key national quality indicator			Yes	TBC	TBC	H Gwilliams	02/02/2017
Patient Safety	% Patients receiving antibiotic within 60 mins for Inpatients	Yes	Key national quality indicator			Yes	TBC	TBC	H Gwilliams	02/02/2017