Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS PUBLIC MEETING

Tuesday 7th May 2019 commencing at 09:45

Venue: Tony Bell Board Room, Institute in the Park

AGENDA

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action	Preparation
Trust Board Annual Photo – To be taken by Katy Simic (09:45 – 10:00)						
STAFF STORY – Dr. Richard Cooke (10:00 – 10:15)						
1.	**19/20/37**	**10:15**	**Apologies.**	Chair	To note apologies.	For noting
2.	**19/20/38**	**10:16**	**Declarations of Interest.**	All	Board Members to declare an interest in particular agenda items, if appropriate.	For noting
3.	**19/20/39**	**10:17**	**Minutes of the Previous Meeting.**	Chair	To consider the minutes of the previous meeting to check for amendments and approve held on: **Tuesday 2nd April 2019**	Read Minutes (page 5–13)
4.	**19/20/40**	**10:20**	**Matters Arising and Action Log.**	Chair	To discuss any matters arising from previous meetings and provide updates and review where appropriate.	Verbal (page 14)
5.	**19/20/41**	**10:30**	**Key Issues/Reflections.**	All	Board to reflect on key issues.	Verbal
Strategy						
6.	**19/20/42**	**10:50**	**Liverpool Integrated Care Partnership.**	D Jones	To update the Board on progress.	Verbal
7.	**19/20/43**	**11:00**	**Review of 2018/19.**	Execs	To update the Board of the progress at the end of the year.	Read report (page 15-25)
Delivery of Outstanding Care						
8.	**19/20/44**	**12:00**	**Infection, Prevention and Control Quarter 4 report.**	V Weston	To receive the quarter 4 report.	Read report (page 26-51)
9.	**19/20/45**	**12:10**	**Serious Incidents Report.**	H Gwilliams	To inform the Board of the recent serious incidents at the Trust in the last calendar month.	Read report (page 52-59)

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action	Preparation
10.	**19/20/46**	**12:20**	**Digital update.**	K Warriner	To update the Board on the programme.	Read report (page 60-67)
Lunch (12:30pm–13:00pm)						
11.	**19/20/47**	**13:00**	**Alder Hey in the Park Site Development update:** - **Pipework.** - **Liaison Committee Minutes 15.03.19.**	D Powell	To receive an update on key outstanding issues / risks and plans for mitigation. To update the Board on progress to date. To receive the approved minutes from the last meeting.	Read report (page 68-81)
12.	**19/20/48**	**13:10**	**Clinical Quality Assurance Committee Report:** - **Chair's verbal update from the meeting on 17.03.19.** - **Minutes from the meeting held on 20.03.19.**	A Marsland	To receive a verbal report of key issues from the April meeting and the approved minutes from the 20th of March 2019.	Read minutes (page 82-93)
The Best People Doing Their Best Work						
13.	**19/20/49**	**13:15**	**People Strategy:** - **Junior Doctors Strategy.** - **WOD - Chair's verbal update from the meeting on 03.05.19.**	M Swindell N Murdock C Dove	To provide an update. To present the current position to the Board To receive a verbal report of key issues from May's meeting.	Read report Read report Verbal (page 94-104)
Sustainability Through External Partnerships						
14.	**19/20/50**	**13:30**	**Joint Neonatal Partnership – Alder Hey and Liverpool Women's Hospital.**	A Bateman	To update the Board on progress towards the single service model.	Verbal
Strong Foundations						
15.	**19/20/51**	**13:40**	**Brexit Plan.**	J Grinnell/ L Stark	To update the Board as to preparations for a 'no deal' exit from the EU.	Presentation
16.	**19/20/52**	**13:50**	**Programme Assurance update:** - **Deliver Outstanding Care.**	N Deakin	To receive an update on programme assurance.	Read Report (page 105-120)

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action	Preparation
			- **Growing External Partnerships.** - **Solid Foundations.** - **Park Community Estates and Facilities.**			
17.	**19/20/53**	**14:05**	**Committee Annual Reports:** - **Audit Committee.** - **Resource and Business Development Committee.** - **Workforce and Organisational Development.**	K Byrne I Quinlan C Dove	To receive the annual report of the sub-committees that report into the Trust Board.	Read report (page 121-136)
18.	**19/20/54**	**14:15**	**Resources & Business Development Committee Report:** - **Chair's verbal update from the meeting held on 29.04.19.** - **Minutes from the meeting held on 01.4.19.**	I Quinlan	To receive a verbal report of key issues from the last meeting and the approved minutes from 1st of April 2019.	Read report (page 137-141)
19.	**19/20/55**	**14:20**	**Audit Committee Report:** - **Verbal update from the last meeting held on 18th April 2019.** - **Minutes from the meeting held on 24th January 2019.**	K Byrne	To receive a verbal report of key issues from the April meeting and the approved minutes from January 2019.	Read minutes (142-148)
20.	**19/20/56**	**14:25**	**Corporate Report** - **Monthly update by Executive Leads.**	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.	Read report (page 149-202)
21.	**19/20/57**	**14:40**	**Board Assurance Framework.**	Executive leads	To receive an update.	Read report (page 203-224)

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action	Preparation
22.	**19/20/58**	**14:50**	**Register of Interest.**	E Saunders	To receive an update.	Read report (page 225-230)
23.	**19/20/59**	**14:55**	**Any Other Business.**	All	To discuss any further business before the close of the meeting.	Verbal
Date And Time Of Next Meeting: 28th May 2019 at 10:00am, Tony Bell Board Room, Institute in the Park.						

REGISTER OF TRUST SEAL
The Trust Seal was used in March/April 2019:
Land Sale: Option Agreement, Legal Change, Construction Lease, Research Unit Lease and Transfer Contract.
Alder Centre Building Contract x 2
PFI Deed of Amendment Settlement Agreement x 4 copies
PFI Deed of Amendment Settlement Agreement x 4 copies

Alder Hey Children's NHS
NHS Foundation Trust

PUBLIC MEETING OF THE BOARD OF DIRECTORS

Minutes of the meeting held on **Tuesday 2nd April 2019 at 10:00am,**
Toni Bell Board Room, Institute in the Park

Present:	Dame Jo Williams	Chair	(DJW)
	Mr. A. Bateman	Chief Operating Officer	(AB)
	Mrs K Byrne	Non-Executive Director	(KB)
	Mrs J France-Hayhurst	Non-Executive Director	(JFH)
	Mr J Grinnell	Director of Finance	(JG)
	Mrs H Gwilliams	Chief Nurse	(HG)
	Mrs A Marsland	Non-Executive Director	(AM)
	Dr N Murdock	Medical Director	(NM)
	Mr D Powell	Development Director	(DP)
	Mr I Quinlan	Vice Chair	(IQ)
	Mrs L Shepherd	Chief Executive	(LS)
	Mrs M Swindell	Director of HR & OD	(MS)
In Attendance:	Prof M Beresford	Assoc. Director of the Board	(PMB)
	Mrs Kate Burnell	Parent and Carer Governor	(KB)
	Mr C Duncan	Director of Surgery	(ChrD)
	Ms L Cooper	Director of Community Services	(LC)
	Ms S Falder	Director of Clinical Effectiveness and Service Transformation	(SF)
	Mr M Flannagan	Director of Communications	(MF)
	Dr A Hughes	Director of Medicine	(AH)
	Mrs D Jones	Director of Strategy	(DJ)
	Ms E Saunders	Director of Corporate Affairs	(ES)
	Mrs K Warriner	Chief Information Officer	(KW)
	Mrs J Tsao	Committee Administrator (minutes)	(JT)
Apologies:	Mrs C Dove	Non-Executive Director	(CD)
	Prof L Kenny	Executive Pro Vice Chancellor	(PLK)
	Ms J Minford	Director of Clinical Effectiveness and Service Transformation	(JM)
Agenda item:			
Item 7	Prof Barry Pizer	Consultant Oncologist	
Item 7	Joe Gibson	Interim Commercial Advisor	
Item 10	Julie Knowles	Assistant Director of Safeguarding	
Item 12	Cathy Fox	Associate Director of Informatics	
Item 13	Vicky Charnock	Arts Co-ordinator	
Item 13	Dr Jane Ratcliffe	Consultant	
	Lachlan Stark	Head of Performance and Planning	
	Natalie Deakin	Programme Assurance Manager	

Patient Story
The Chair welcomed patient Freddy, Mum Katie and Juliet Weston, Physiotherapist to the Trust Board meeting.

Freddy was born nine weeks early in 2014. His care transferred later that year from Liverpool Women's Hospital to the Physiotherapy team at Alder Hey. Freddy was discharged in 2015 however was referred back to the Specialist Physio Occupational Therapy team three months later as his progress had plateaued.

Following an MRI Scan at two years of age Freddy was diagnosed with spastic diplegia cerebral palsy. Freddy's physio treatment has continued since that time. In 2017 Juliet suggested that

Freddy might benefit from Botox injections. To date Freddy has received four rounds of Botox injections. Katie noted the improvement seen from this treatment. Following this it was suggested Freddy might also benefit from SDR surgery, carried out by Miss Pettorini. Freddy is due to have this surgery in five weeks' time.

Katie spoke highly of the team supporting Freddy, particularly Juliet Weston and Christine Sneade. Katie said that the positive experience they had had meant that she could provide support to newly diagnosed families.

The Chair wished Katie and Freddie well for the future and for the upcoming surgery; she asked that they come back to update the Board on Freddie's progress.

19/20/02 Declarations of Interest

There were none to declare.

19/20/03 Minutes of the previous meetings held on 5th March 2019

Subject to an amendment under agenda item:

18/19/333 People Strategy Update
Sickness absence rates had reduced by 6.08% – sentence to be removed.

The Board APPROVED the minutes from the meeting held on 5th March 2019.

19/20/04 Matters Arising and Action Log

Infection Prevention and Control Mandatory Training

Board members received the above mandatory training. In line with new guidance all staff are required to complete a practical as part of the MT. It was agreed that this would be actioned outside of the meeting.

Action: VW

First meeting with Manchester Children's Hospital Partnership Board

Dani Jones updated the Trust Board following the meeting, noting agreement to develop a strategy to address current issues both trusts are facing. The next meeting will be held on 4th June 2019. It was agreed a further update would be received at the Trust Board meeting on 2nd July 2019.

19/20/05 Key Issues/Reflections

The Chair welcomed Kate Warriner, Chief Information Officer to her first Trust Board meeting.

Dani Jones thanked all those who had responded to her email circulated last month on the draft of a population health framework for Liverpool from Public Health. The Trust Board discussed the much stronger emphasis on children and young people.

Chair noted there are future workshops planned and asked for any further suggestions to be sent to Dani Jones

19/20/06 International Child Health

Barry Pizer gave a presentation on progress to date and future goals since the agreement of International Child Health (ICH) 12 months ago.

A slide on the structure of ICH Department was shared, with the decision to include leads for Research, Innovation and Education.

The ICH Department was officially launched on 9th November 2018 with over 160 people attending and coverage through social media supported by Colin Beaver, Head of Communications.

A discussion was held on linking with universities. Nicki Murdock highlighted the activities of NCD Child, a global multi-stakeholder coalition focused on the prevention, treatment, and management of non-communicable diseases (NCDs) in children, adolescents, and young people. The organisation is based in the US and welcomes contact from related institutions.

Barry Pizer went through a number of challenges the department are currently facing. One of the main concerns was supporting staff with special leave to allow them to undertake philanthropic visits. It was noted that a business case for this would be developed.

On behalf of the Board John Grinnell thanked Barry Pizer and the team for developing the department whilst continuing with their main roles.

Resolved:
The Board noted progress to date and future ambitions.

19/20/07 Integrated Care Partnership

Louise Shepherd reported that Liverpool Integrated Partnership - a collaboration of healthcare organisations with Liverpool City Council - has been established to address health priorities across the city. Following two workshops held in March both attend by herself and the Chair, all organisations had been asked for their top priorities to be included in a five year strategy. The Board noted the wider health care agenda around poverty and poor housing needed to be a focus for LIP.
Action: ALL

19/20/08 Draft Strategic Plan 2018-21

Dani Jones gave a presentation on Alder Hey's ambitions by 2024 and each area of focus to achieve this. The Board was asked to work together in groups on how this would be achieved. The Board was asked to send their findings to Dani Jones for further discussion and development of the strategic plan.
Action: ALL

19/20/09 Mortality Report Quarter 3

Nicki Murdock presented the above report noting 41of the 55 deaths from January to December 2018 had been reviewed by the HMRG.

The Board discussed sharing learning from deaths and how this could be improved by further developing Grand Rounds internally, as well as sharing information with other trusts.

Resolved:
The Board received the quarter 3 Mortality report.

19/20/10 Safeguarding Annual Report

Julie Knowles presented the Safeguarding Annual Report Summary noting key achievements for the year.

In addition, Julie Knowles outlined the priorities for the team going forward:

- Training was to be developed in particular for cases that come under the Mental Capacity Act.
- Support on advice for staff was to be developed.

- Further training to staff on how to identify patients who are being abused.

The Board thanked Julie Knowles and team for dealing with difficult cases and noted the huge amount of work undertaken to support staff as well as ensure the Trust was performing well against the KPI's set by commissioners.

Resolved:
The Board noted the progress set out in the Safeguarding Annual Report summary for 2017-18. (NB the full Safeguarding Annual Report had been circulated separately).

19/20/11 Serious Incident Report

The Board received and noted the contents of the Serious Incidents report for February 2019. Hilda Gwilliams reported that during this reporting period there were two new Serious Incidents in relation to two unexpected deaths.

Serious Incident 1
A patient sadly passed away through septic shock. Early findings have shown no lapse in care.

Serious Incident 2
Following a gastro tube change procedure it was found that the patient had a perforated bowel. Laparotomy and repair of bowel perforation were performed. Following readmission and introtropic support provided the patient sadly went into multi organ failure. An RCA level 2 has been commissioned.

Never Event and Serious Incident reported at the March Board
Hilda Gwilliams noted the investigations for both the wrong site surgery never event and unexpected death of 24 week gestation baby are ongoing.

Resolved:
The Board received the Serious Incident report for February 2019.

19/20/12 Global Digital Exemplar

Cathy Fox presented the update reported and noted this is the final financial year of the agreed three years for the GDE Programme.

There has been excellent engagement from the specialties involved in tranche one of the programme, as well as testing taking place for Cardiac Surgery and Cardiology. Engagement is underway for tranches two and three, with several specialties already working on their requirements in advance of their commencement date.

The Trust will be undertaking accreditation with Healthcare Information and Management System (HIMSS) over the next 12 months with aim of achieving level 7.

John Grinnell noted that the Trust was the host organisation for a range of system-wide digital initiatives including the Share2Care programme. John Grinnell reported that a review was underway with regard to the organisation's digital roadmap moving forward.

Resolved:
The Board noted the monthly GDE report and programme benefits.

19/20/13 Arts Update

Vicky Charnock presented a paper relating to the Arts Programme; it was noted that the programme is currently resourced through charitable funds. To deliver a more

ambitious agenda going forward the department want to secure funding for two additional posts and a yearly budget of £150,000.

The paper outlined benefits to patients and provided details on what similar trusts' Art Programmes offer.

Resolved:
The Board supported the proposed funding in principal, noting the request would need to go through the budget setting process.

19/20/14 Alder Hey in the Park Site Development Update

David Powell provided this month's update to the Board with regard to the key components of the site as they currently stand.

Park and Land
Planning work remains on track for all phases of the Park.

David Powell reported the transaction of the land sale at the Alder Road end of the site had been completed with the preferred bidder Step. Engagement and consultation with the community will take place over the coming months.

Temporary Car Park
Access to the interim site car park is now available. Communication on accessing the interim car park will be circulated to staff, patients and visitors.

Community Cluster
The construction contract for the community cluster is currently out to tender. David Powell commented on the rising cost of construction which would need to be closely monitored.

Alder Centre
The Board requested that the Charity be kept updated on timescales on the build of the Alder Centre.

Resolved:
The Board received:
- Park Site Development update.
- Liaison Committee Minutes, 26th February 2019

19/20/15 Clinical Quality Assurance Committee

Anita Marsland briefed the Board on the key issues from the most recent CQAC meeting, noting updates had been received on Inspiring Quality and the Brilliant Booking project.

The next CQAC meeting was to be a joint meeting with the Clinical Quality Steering Group.

Resolved:
The Board received and noted:
- The minutes from the Clinical Quality Assurance Committee meeting held on 20th February 2019.

19/20/16 People Strategy Update

The Board received and noted the contents of the People Strategy report for March 2019. The following points were highlighted and discussed:

- Consultations are in place for staff transitioning from Band 1 to Band 2 as part of the Agenda for Change new pay deal. Any members of staff deciding not to transition to a band 2 will stay on a spot salary.
- Sickness rates have remained static at 5.6%.
- Two pension briefing sessions are being held for long serving consultants.

The Board received the staff survey action plan noting update on progress would be reported to Operational Board.

Junior Doctors
It was agreed this item would be deferred until the next Board on 7th May 2019 when an update on an education strategy for Junior Doctors would be presented.

Resolved:
The Board received and noted:
- People Strategy report for March 2019.
- Staff Survey Trust Action Plan

19/20/17 Staff Influenza Vaccination Programme
The Board received the completed checklist for healthcare worker vaccinations for 2018.The Trust had met the 75% target. For 2019 the target has increased to 80%. The Board noted actions in place to reach 100%.

Resolved:
The Board received the completed healthcare worker vaccinations for 2018 noting actions to improve uptake in 2019. A return relating to this information had been submitted to NHS England.

19/20/18 Joint Neonatal Partnership – Alder Hey and Liverpool Women's Hospital
The Estates team are currently reviewing three options for the Neonatal Unit however as all three options exceeded the agreed funding; further work was to be undertaken to bring the project back in budget.

A joint recruitment campaign was also to be undertaken.

Resolved:
The Board received an update on the Joint Neonatal Partnership.

19/20/19 Operational Plan 2019/20
The Board received the Draft Operational Plan; the final version would be submitted to NHS Improvement on Thursday 4th April 2019.

Following negotiations with NHS Improvement regarding a calculation error with the Control Total this has now been re-set to £1.6m. Negotiations with NHSI regarding the £3m reduction to the children's tariff are ongoing.

The Board noted the Trust's NHSI risk rating 1(lowest) to 4(highest) for 2019/20 would be reduced from 2 to 1.

All contracts for 2019/20 have been approved with exception of the Wales contract.

Three key risks that will continue to be monitored are:
- Divisional Run Rate – to contain spend within allocated resource.
- CIP - £60m schemes have been identified, 60% are recognised as high risk of delivery.

- Capital Affordability – the Trust's capital programme is dependent on cash availability to support.

Resolved:
The Trust Board APPROVED 2019/20 Operational Plan for submission to NHS Improvement on Thursday 4th April 2019.

19/20/20 Alder Hey Ventures

KMPG have been commissioned to review the governance structure for ACORN, a workshop is due to be held on 10th April 2019.

In March, the Trust was required to file the company accounts for Alder Hey Ventures Ltd (as a wholly owned subsidiary) for the period 1st July 2017 to 30th June 2018. The Trust asked Weightmans to act as company secretary and to prepare the statutory accounts as required. The company had no trading activity during the period and the account was filed as a Micro Entity.

Resolved:
The Board:
- Agreed to receive an update from the KPMG Workshop to be held on 10th April 2019.
- Received and APPROVED the Alder Hey Ventures Accounts.

19/20/21 Register of Shareholder Interests

The Trust entered into 3 shareholder agreements in March for companies that had already been established by ACORN on companies House:

- Hand Hygiene Solutions
- Cofoundary Enterprpise 36
- Digital Audiology Technologies Ltd.

Resolved:
The Board noted and received the Register of Shareholder Interests.

19/20/22 Business Continuity Plan for European Union Exit

Following the Government's decision not to exit the EU on 29th March 2019 the latest guidance from NHS England is to plan for EU Exit on 12th April 2019 with no deal.

An On Call Managers meeting was held on 22nd March to brief 1st and 2nd on call managers with regard to the EU exit arrangements including command and control arrangements. The meeting was well attended with good engagement from Divisional and corporate leads.

From Monday 8th April 2019 a command team will be in place based in room 8, Mezzanine. Operational walkabouts have been organised to take place across the divisions.

Staff who have paid for EU Cards are able to reclaim this.

Communication will continue to be circulated to staff, patients and visitors.

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

19/20/23 Programme Assurance Update

Natalie Deakin presented the Programme Assurance report for March 2019.

The Board noted the evolving change programme for 2019/20.

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

19/20/24 Resource and Business Development Committee

Resolved:
The Board received and noted the approved minutes from the Resources and Business Development Committee held on 1st April 2019.

19/20/25 Integrated Governance Committee

Going forward it was noted a deep dive would be actioned on red rated risks that had been on the risk register for some-time to agree if the risk had been superseded or if further actions are required.

As there was a large amount of information presented at IGC a sub-group was to be arranged to support the Committee with review and ratification of policies.

Resolved:
The Board received and noted the minutes from the meeting held on 15th January 2019.

18/19/343 Corporate Report

Performance
February 2019 position - waiting times for treatment in ED increased as we had the most challenging month to date of Winter 2019/20.

Adam Bateman updated the Board on the March 2019 position noting ED had achieved the 95% target for the national standard for access to emergency care. The Board noted this achievement and agreed to a lunch for the department as a thank you.

Finance
The Trust delivered a £3.4m surplus in February (including PSF incentive) which was £0.4m behind plan. Cumulatively we have now delivered a surplus of £20.9m which is £0.36m behind plan.

Safe
The Board noted the ratings for Sepsis had been red rated for over 12 months. Due this it was agreed the target would be reviewed and an update would be presented at the May Board.
Action: HG

Resolved:
The Board received and noted the contents of the Corporate Report for month 10.

19/20/27 Board Assurance Framework (BAF)

The Board noted the key strategic risks would be reviewed for 2019/20.

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

19/20/28 Trust Board Work-plan

Resolved:
The Board received the revised work-plan.

19/20/29 **Any Other Business**
No further business was discussed.

Date and Time of next meeting: Tuesday 7th May 2019 at 10.00 in the Tony Bell Board Room, Institute in the park.

Alder Hey Children's NHS Foundation Trust
Trust Board - Part 1
Action Log

Alder Hey Children's NHS Foundation Trust

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
Actions for May 2019							
23.01.19	18/19/143.3	PFI	To update the Board on progress against pipes	Graeme Dixon/David Powell	02.04.19		As this item was being presented to the March IGC this item was deferred until April 2019- Item was deferred to April ICG to be presented at May Board
05.02.19	18/19/302	People Strategy Update	To develop a strategy on education including research for Junior Doctors	Nicki Murdock	7.5.19		
05.03.19	18/19/327	Department of Infection, Prevention and Control	To provide an update on the response from NHSI in relation to reported themes from the RCAs undertaken for E Coli bacteraemia and to discuss how the Trust's findings can be benchmarked with other paediatric Trusts.	Valya Weston	7.5.19		To update the Board under the Quarter 4 report
05.03.19	18/19/327	Department of Infection, Prevention and Control	To request a peer review of the IPC action plan at the next Lead Nurse Network at the next meeting on Monday 25th March 2019	Valya Weston	7.5.19		To update the Board under the Quarter 4 report
05.03.19	18/19/328	Complaints Quarter 3 Report	Going forward Anne Hyson agreed to carry out a deep dive on one of the high categories of concern.	Anne Hyson	7.5.19		To update the Board under the Quarter 4 report
02.04.19	19/20/04	Matters Arising and Action Log	In line with new guidance all staff are required to complete a practical as part of the Infection Control MT. It was agreed that this would be actioned outside of the meeting.	Valya Weston	May-18		In progress- VW is meeting with Execs and Non Execs to complete.
02.04.19	19/20/26	Corporate Report	To review the red rated target for Sepsis	Hilda Gwilliams	7.5.19		To provide an update under Corporate report
Actions for July 2019							
05.03.19	18/19/328	Complaints Quarter 3 Report	To provide an update on the review of ADHD/ASD services	Lisa Cooper	02.07.19		

Status	
Overdue	
On Track	
Closed	

Alder Hey Children's NHS Foundation Trust
Trust Board - Part 1
Action Log

Alder Hey Children's NHS Foundation Trust

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

Alder Hey Children's NHS
NHS Foundation Trust

A Review of 2018/19 – Achievements at Year End

	Strategic Objective	Progress at the end of 2018/19
Delivering Outstanding Care	Alder Hey will be inspired by Quality which is led from the front line.	Inspiring Quality Delivery phase 1 implementation plan approved by the Executive Team in April 2019. Inspiring Quality leadership programme designed. £0.8 million of investment secured for 2019-20. **Clinical Cabinet** Clinician Engagement is an issue that over the past decade has been crystallised as key to delivering great outcomes for any health service and its patients. Clinician engagement is about how clinicians are involved in the design, planning, decision making and evaluation of activities. Involving clinicians in the decision making of the organisation is crucial as they have the major influence over patient care, from triage at the front doors of the hospital, determination of entry to the Trust, through diagnosis, management and care to discharge, or end of life planning. It is also important that clinicians engage with other clinicians and across disciplines to ensure optimal care is provided for patients. Creation of a Clinical Cabinet would provide a single point of contact for clinicians to discuss and explore opportunities and issues relating to health service development, innovation, integration, planning and monitoring, with each other across the broader service. These discussions can then be condensed and presented to the board by representatives. The position of the cabinet in the governance structure would be advisory to the board. The Senate would meet monthly and the Executive would be invited to the first half hour to update the Senate of contemporary issues and provide answers to questions posed to them. The Senate would send three representatives to the board meeting, to present issues of importance for half an hour before lunch to allow networking at lunch with the NED's.
	Introduce digital pathways to improve patient care across all specialities	33 out of 52 speciality packages implemented to date; next milestone of 52 to be achieved by November (on track).
	Further improve patient services focused on 5 key priorities; Brilliant patient booking systems; Comprehensive Mental Health; Best In Outpatient Care; Patient Flow; Best	Brilliant Booking & Scheduling - Clinical utilisation improved throughout Q4 and reached 88% in March 2019. - The number of Was Not Brought patients reduced to less than 10% through the introduction of the mobile appointment reminder service

	in Acute Care	SAFER - The SAFER care bundle has been implemented on six wards; the percentage of children discharged by 12.00 pm increase by 4.7% over each ward. - In quarter 4 there has been a year-on-year reduction of 68% reduction in cancelled operations due to non-clinical reason Best in Acute Care; - In March 2019 we were rated the seventh best Emergency Department in the NHS in relation to the delivery of care within 4 hours - Agreed a pilot to extended senior cover for general paediatrics until 21.00 hrs and to delivery 7 day medical cover on HDU Comprehensive Mental Health; - Investment secured to build a new a new Tier 4 specialist mental health unit in the Children's Health Park - Earned nations trailblazer status for the delivery of enhanced mental health support in schools in Liverpool - Successful delivery of mental health liaison pilot during winter to support children and young people in mental health crisis in A&E Best in Outpatient Care; - Improving children, families and young people's experience of outpatient care, as measured by a satisfaction rate of 89% in February 2019.
	Achieve outstanding performance in all CQC domains at every level	Current CQC action plan nearing full completion; small number of maintenance and ongoing actions remain, with Divisions fully sighted on timescales. Performance against Quality Aims and CQC KLOE's has continued to be tracked via corporate report with key achievements described in Quality Account: **Safe** • Eradication of grade 4 pressure ulcers for last three years and significant reduction in grade 3, from 6 in 2017/18 to 1 in 2018/19. • Zero MRSA bacteraemias in the year; 25% reduction in hospital acquired MSSA; 10% decrease in hospital acquired CLABSI's (PICU).

		• Top performing children's hospital for incident reporting and second highest reporter nationally. • Medication incidents associated with harm were 2.6% of all incidents reported, representing a 18.6% reduction since 2014/15. • No cancelled operations for 'staffing unavailable' in the year and no beds closed due to nurse staffing. • Nursing agency spend eradicated in 2018/19. **Experience/Caring** • *Healthwatch* listening exercise results showed: ➢ 95% of respondents thought that staff were kind and caring; ➢ 93% would give Alder Hey 4 or 5 stars out of 5. • 89% of patients reported that their confidence had significantly improved through participation in the Music as Medicine project. • Rated outstanding for caring by CQC in report published June 2018. **Effective** • Clinical Educator roles funded and fully established in all inpatient areas. • On the diabetes pathway, increased compliance with 7 key health checks (against the national average of 50%) from 17% to 59% in 2 years. • Asthma 'SCORE' project – ED attendances decreased; quality of life increased.
	Deliver the new Alder Centre	Project delayed due to cost creep, however construction due to commence on site first week in May.
	Develop our Health Park vision	A re-set paper proposing a revised approach to the campus development has been agreed by the Resources and Business Development Committee; this re-focuses on delivery of the remaining elements of the campus vision.

	Strategic Objective	Progress at the end of 2018/19
Supporting the Best people to do their best work	Our workforce must reflect the diversity of the communities we serve, and we will improve the experience of our staff from Diverse backgrounds	-LGBTQI+ Network now established -Staff Survey results demonstrate improvements in staff reporting discrimination due to their ethnic background – 15.9 % in 2017 to 10% in 2018 -launched the Reciprocal Mentoring Programme for BAME and disabled staff
	We will have identified supply pipelines for all key staffing groups, working in partnership with our local HEI's	-Nurse associate roles have been supported -Agreement reached with UCLAN to support a new cohort of medical students -Over 115 nurses recruited during the year, significant numbers of these were students
	Deliver at least 50 apprenticeship starts through the Academy each year	-63 learners enrolled on an apprenticeship -Alder Hey chosen as Employer/ Apprentice Ambassadors for the Liverpool City Region -The Trust won the Employer Award from Southport College due to successful partnership working -Successful business case to increase the Apprenticeship Team
	Implement the Wellbeing Strategy, supporting staff to improve all aspects of their health and wellbeing – with a focus on a reduction in sickness absence	-Implementation of the Wellbeing Strategy: -Successful engagement with NHSI's national sickness absence programme -'Time to Change' mental health awareness programme agreed -March 2019 sickness rate <5.5%, down from 6% in December 2018 -Successful bid for central funds to support staff weight loss initiative -Secured the 'Smoke Free Bus' to attend Alder Hey over Spring 2019 -Ran the second 'Fab Staff Week' in October 2018 -Successfully hosted the annual Star Awards -Reward and Recognition group established; multi-disciplinary involved in a range of incentives and initiatives
	Build line, clinical and system leadership capability; focused on supporting quality improvement	-2 cohorts of the Mary Seacole Leadership Programme launched – a third is in development -Leadership apprenticeships very successful – 20 staff enrolled to date -Leadership Strategy ratified and rolling out; Strong Foundations Programme developed and ready to launch in May 2018
	Additional achievements:	**Staff Survey 2018:** -Highest ever response rate at 60% (2000 staff) -Very exciting results; highest ever scores across the survey, significant improvement in 4 of the ten themes, and improvements in all questions especially for recommend for care (87%) and work (72%). Action planning has started at local and Trust level. **Vocational Learning:** -Implementation of Vocational Placement Adviser role

		-Successfully ran the Pre-employment Programme - At the end of each Programme the majority of learners have secured employment with the Trust or NHS Professionals. -Worked in partnership with local schools offering clinical placements to Health and Social care students -Successful work experience placement of 98 students across the organisation -Hosted the Trust inaugural career fair which showcased career opportunities across 10 specialties within the Trust to students from 6 local schools and community organisations -Hosted career events for over 50 students from local Higher Education Institutes. The Trust careers events have been promoted widely using social media platforms and have received positive feedback **Recruitment:** -Hosted 4 successful Nursing Recruitment Events recruiting 115 nurses in total -Re-design of Alder Hey website recruitment content, and implementation of careers brochure and video, use of social media platforms for recruitment -Supported the recruitment of 19 new consultants with a streamlined recruitment process **Learning & Development:** -significant increase in the use of e-learning for mandatory training and maintained 90% compliance -Achieved 90% compliance for PDR's -Comprehensive Training Needs Analysis undertaken **Library and Medical Education:** -Library Quality Assurance Framework 96% compliance -Funding secured and development of a bespoke APP for junior doctors induction -Introduction of a Junior Doctors Forum **Workforce:** -Implemented Agenda for Change pay reforms, including the successful transition of over 110 staff from Band 1 to Band 2 -Developed stronger partnerships with staff side in order to facilitate better partnership working -Corporate division sickness reduced by 50% since November 2018. Facilities down to 7% - last 2 years' previously at 14%. Significant reduction in long term sickness cases across Corporate areas.

	Strategic Objective	Progress at the end of 2018/19
Sustainability through external partnerships	Deliver single neonatal service in partnership with Liverpool Women's Hospital	2018/19 has seen significant developments in the delivery of the 7 day service for the Neonatal Unit, which is now established and running. A business Case to specialist commissioners has been approved in principle for 22 cots; this commitment to the establishment of a surgical Neonatal Intensive Care Unit (NICU) is a superb outcome for the region. Plans for this new NICU on the Alder Hey site are currently being developed across the partnership. The intention is for the same 'look and feel' across both the LWH and AH units, to facilitate a seamless sense for parents and families.
	Deliver all-age Coronary Heart Disease Services in partnership with Liverpool Heart and Chest, Royal Liverpool University and Liverpool Women's Hospital	Level 1 Adult Congenital Heart Disease (CHD) is now fully underway in Liverpool. This partnership is enabling delivery of seamless, local, and lifelong care for children, young people and adults with CHD in the North West. For example, to date there have been 25 cases paediatric surgeons from Alder Hey performing CHD surgeries on adults in LHCH. A partnership bid for a broadened all-age CHD network has been approved by NHSE this year. Work to implement the new network has begun; expected to be established by July 19.
	Deliver Liverpool Children's Integrated Transformation Plan	2018/19 has seen significant positive progress through the Children's Transformation Plan. Two successful bids have brought in funding from C&M HCP Women & Children's Partnership. These bids are accelerating - a) Development of 2 pilot 'community hubs' for Children and Young People (Speke and Aintree). The aim of these hubs is to bring together multidisciplinary services for C&YP in a coordinated way to better support C&YP. Implementation is being led via an Innovation Manager, who is hosted on behalf of the partnership at Liverpool City Council. b) A multi-agency Workforce Development programme, to facilitate integrated working for those involved in the community hub development.

		This year, the Children's Transformation Board has also developed; • A partnership model for Paediatric Urgent Care (in line with the Liverpool system's plans for the Urgent Treatment Centre all-age model); • A systematic approach to the first 1001 days of a child's life, for example, focusing on early identification of needs in terms of infant development and parenting interventions; • Improved support for C&YP with mental health conditions, for example through a focus on ACE's and trauma informed practice; • A model for measuring the impact of MDT working on families with children & young people with disabilities. - Next steps for 2019/20 are to focus on: 0-5 early years (specifically preparedness to learn, and therefore earn), infant mortality, development of further LTC protocols across tertiary/secondary and primary care, and next steps for Urgent Treatment Centres following completion of the ongoing public consultation.
	Increase specialist child health services regionally, nationally and internationally	Significant work has taken place during 2018/19 to establish formal partnership working with Royal Manchester Children's Hospital. The objectives of this partnership are to; • Work together to effectively support our jointly-hosted Operational Delivery Networks • Develop our joint approach to neurosciences; move towards joint multi-disciplinary teams, joint bids to support growth of specialist treatments, and collaboration across research, innovation and education to deliver national leading outcomes; • Improving collaboration across the Cardiology/CHD network, standardising pathways and meeting national CHD standards to improve quality, safety and patient experience • Continue collaboration across the Northern Burns Network footprint • Support further joint work between NWTS, neonatal transport services and NHS England Partnership work with Southport and Ormskirk has progressed during 2018/19; Alder Hey are supporting the development of a potential networked model of care for Women and Children. Confirmed funding in place from NHS England for new build of current Dewi Jones Unit which will increase capacity to 12 beds and support the delivery of new models of care relating to

		children and young people's mental health
	Lead the co-creation of new models of care for paediatric mental health with Mental Health and LD Programme as part of the Cheshire and Merseyside Sustainability and Transformation Partnership	Alder Hey successful lead in trailblazer pilot in primary schools within Liverpool. Work also commenced across STP focusing on new models of care for Tier 4.
	Develop regional paediatric / neonatal services as part of Women's and Children's Partnership (STP)	During 2018/19, the C&M W&C Partnership has contributed significantly to progress in Children's Transformation (as referenced above), funding and driving the implementation of the community C&YP's hubs as well as the integrated Workforce Development programme. During 2018/19 the programme has continued to supporting, along with the Neonatal ODN, the development of the single neonatal service between Alder Hey and LWH. CEO's of Alder Hey and LWH take up as joint SRO's of the C&M W&C programme and the cross-cutting theme from April 19; planning is underway for the next stage of the programme via the HCP-required plan on a page.

	Strategic Objective	Progress at the end of 2018/19
Game changing research and innovation	Establish a core team from Alder Hey and UoL to co-create a Strategic Plan to ensure clinical and non-clinical services are best organised to offer children, young people and families every opportunity to take part in clinical research opportunities	Some elements of October Trust Board activated/implemented, notably: - Agreement of Associate Divisional Research Directors (Clinical) [ADRD} - Support for UoL honorary chairs - Senior Research Nurse post submitted to IRG - Workshop on integrated plan for research facilitated by Director of Research and COO - Research Management Board ToR approved by Trust Board - Winner at UoL Staff Awards (Partnership Award) - Revised business model for research, including mechanisms for professional involvement incentivisation, agreed in principle
	Strengthen our position to attract and appoint internationally renowned leaders and new talent in paediatric research	Update on chairs offered by UoL: - Epilepsy - Job description developed and UK candidate visited Liverpool to meet senior personnel - Cardiac – discussions ongoing with Prof Lip (UoL) and cardiac surgeons (not cardiologists) - Infection – needs to be linked to BRC plans - Public Health – Execs discussed overall package with Prof Taylor-Robinson (DTR). DTR will check nationally who might be possible to encourage re Chair position - Other – Prof Iain Buchan has affiliated his NHS honorary contract and NIHR Senior Investigator award with Alder Hey - Meeting between representatives of Alder Hey Charity and Trust held in Jan 2019. Director of Research and Brough Chair have proposed an investment plan for research based on £600k p.a. from Charity.
	Contribute to specialist paediatric education through Alder Hey Academy	Award winners in the Great China awards North West 2019, held by the Department for International Trade for the Observership programme. Academy visit undertaken in China in April 2019.
	Co-create with staff a new set of innovation products whilst Alder Play is rolled out	Innovation reset completed in Oct 18 with new strategy launched focused on a portfolio approach: AI, sensors and immersive/Visualisation supplemented by a funding strategy. Digital Innovation included and integrated with the 'Inspiring Quality' programme. AI competition completed with 1st phase funding part of GDE. Partnership with Hollow lens and Microsoft Speakman Family agreed to support an Innovation seed fund Alder Play live, training being rolled out and App store/Android downloads 800 per month.

		Tesla cars received for wards distraction as part of project MOVE. Worlds first 3D printed Hypospandia trainer joint with Al Jalila and Sony. First simulation week and VR teaching UoL and Medical Students ERDF Health exchange Project milestone's achieved
	Integrate front line and research activity through an increasing number of clinicians involved in research	3 x Honorary Profs and 1 x Honorary Associate Prof appointed. Meeting of these four + Research Director and Brough Chair held in Feb 2019 – agreeing roles and responsibilities and development of leadership capabilities. Each to check within host division options for protected research time. No new mechanisms yet for increasing institutional capacity for healthcare professionals to contribute to research compared to current status. Will be key role for ADRDs. Research Scholarship applications (NIHR Clinical Research Network) internally prioritised and three put forward.
	Contribute to Liverpool Health Partner themes relevant to 'Starting Well'	Prof Beresford appointed as LHP Starting Well Programme Lead with Carrie Hunt as Programme Manager. Series of meetings underway between Starting Well Lead/Manager and key Trust personnel, other LHP Theme Leads etc. Key year one objective for Starting Well Theme being finalised (with input from Director of Research).

	Strategic Objective	**Progress at the end of 2018/19**
Strong Foundations	Deliver business plans and achieve financial targets Spend wisely and reduce waste	***Financial*** 2018/19 draft financial results are a £49.9m control total surplus, £17.7m ahead of plan. The reported control includes £35.8m Provider Sustainability Funding (PSF) of which £29.6m is incentive funding. This represents a £(1.4)m underlying deficit after exclusion of one-off transactions and PSF. Trust achieved a Risk rating of 1, the best achievable and ended the year with £33m cash in bank and £6.9m (99%) CIP delivery. ***Campus*** Successful bid to STP Capital for £7m new CAHMS Tier 4 unit relocation. Opening of the Institute in the Park Phase 2 building, a £14m development which will co-locate four HEE partners to promote Research, Education and Innovation advancement. Next phases of campus development progressed with enabling land disposal completed and next phase park planning approved. Significant upgrade and relocation of significant parts of our community estate.

		Alder Hey agreed as host for three major STP Digital Transformation programmes including the LACRE Programme ***Digital*** Positive progress with Global Digital Exemplar (GDE) programme with external milestones delivered.

Alder Hey Children's NHS
NHS Foundation Trust

IPC REPORT
Q4 2018-19
(1st April 2018 -31st March 2019)

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

The work plan for 2018-19 consists of 14 objectives and a total of 118 deliverables. At the end of Q4 2018-19; ***78%*** (93/118) of the total of deliverables have been completed. ***17%*** (21/118) of the total deliverables are in progress (amber). ***0%*** are classified as red. 5% (6/118) are classified as grey as these are objectives that have not yet been progressed. Please see table 1 below for RAG rating.

Reporting Period	No of objectives	No. of deliverables	Red	Amber	Green	Grey
Q1	14	118	0% (0)	25% (30)	59% (70)	16% (18)
Q2	14	118	0% (0)	21% (25)	72% (85)	7% (8)
Q3	14	118	0% (0)	19% (23)	75% (88)	6% (7)
Q4	14	118	0% (0)	17% (21)	78% (93)	5% (6)

Table 1: Deliverables RAG rating

Table 2 below shows the total number of hospital acquired bacteraemia each quarter for 2018-19 compared to 2017-18. Table 4 shows the total 2018-19 compared to 2017-18.

Bacteraemia	Q1 17-18	Q1 18-19	Q2 17-18	Q2 18-19	Q3 17-18	Q3 18-19	Q4 17-18	Q4 18-19
MRSA	0	⟷ 0	0	⟷ 0	2	↓ 0	2	↓ 0
MSSA	3	↓ 1	4	↓ 1	4	↓ 3	3	↑ 5
E.coli	1	⟷ 1	1	↑ 2	2	↑ 4	2	↓ 0
Klebsiella	1	⟷ 1	0	↑ 1	4	↓ 2	1	↑ 4
Pseudomonas	0	↑ 1	1	↓ 0	1	↓ 0	2	↓ 0
Infections								
Cdiff	0	⟷ 0	0	⟷ 0	0	⟷ 0	1	⟷ 1
Outbreaks	0	⟷ 0	0	⟷ 0	3	↓ 0	0	↓ 1

Table 2: Hospital acquired bacteraemia 2017-18 and 2018-19

Bacteraemia	Total 17-18	Total 18-19
MRSA	4	↓ 0
MSSA	14	↓ 10
E.coli	6	↑ 7
Klebsiella	6	↑ 8
Pseudomonas	4	↓ 1
Infections		
Cdiff	1	↔ 1
Outbreaks	3	↓ 1

Table 3: Total hospital acquired bacteraemia 17-18 compared to 2018-19

For 2018-19 we have agreed target for each of the metrics set out below in table 4 for hospital acquired cases.

Metric	Target 2018-19	Target Figure	Actual Figure	Current Status
HA - MRSA (BSI)	*Zero Tolerance*	***0***	***0***	✓
C.difficile	*Zero Tolerance*	***0***	***1***	✗
MSSA	*25% Reduction from 17-18*	***10***	***10***	✓
CLABSI (ICU Only)	*10% Reduction from 17-18*	***18***	***18***	✓
Gram-Negative BSI	*10% Reduction from 17-18*	***14***	***16***	✗

Table 4: 2018-19 Targets

Table below shows 2017-18 total against the target for 2018-19 and actual for 2018-19.

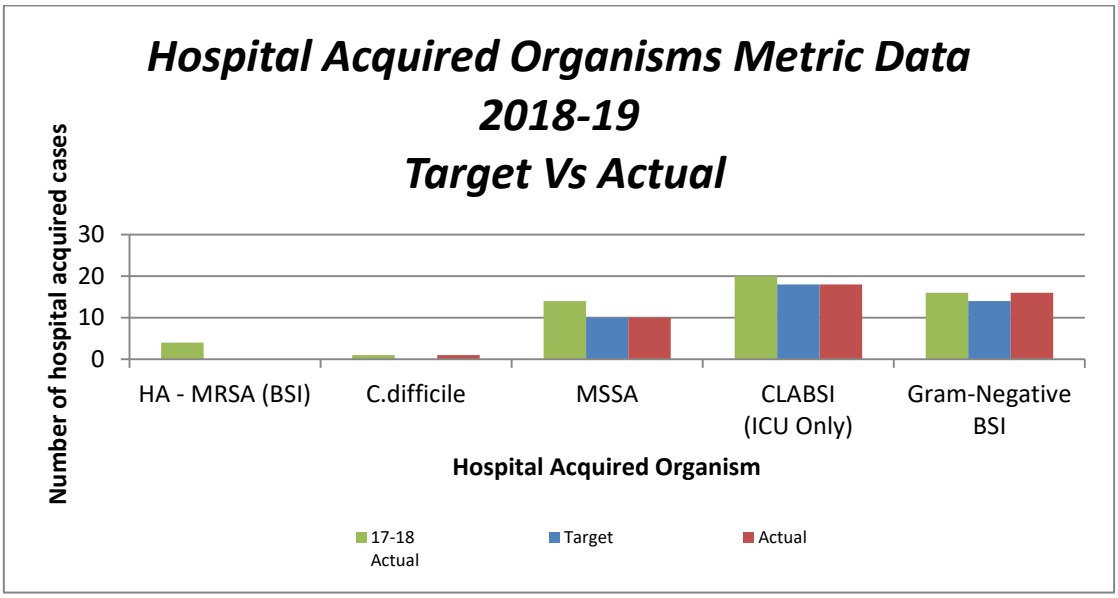

Table 5: Metric Data Actual VS Target.

Infection Prevention & Control Annual Work Plan 2018-2019

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

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

Alder Hey Children's NHS
NHS Foundation Trust

Infection Prevention & Control Annual Work Plan 2018/19

IPC Code & Trust Values	Plan & Priority Activities 2018-19	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
1. IPC Staffing								
IPC Code: 1,3,4,8,9 **Trust Values:** Excellence Togetherness	Director of Infection Prevention and Control – Medical Director	Nicki Murdoch (NM)						***Q4*** *– New Medical Director has commenced and will take over the role of DIPC.*
	IPC Doctor Role: Consultant Microbiologist Consultant Infectious Diseases	Dr Chris Parry (CP) Dr Beatrix Larru (BL)						***Q1*** *- IPC Doctor/Consultant Microbiologist to take up post 3rd September 2018.* ***Q2*** *– IPC Dr now in post*
	Associate DIPC	Val Weston (VW)						
	Lead Nurse IPC	Jo Keward (JK)						
	IPC Specialist Nurse (Band 7)	Claire Oliver (CO)						
	0.4 Surgical site Specialist nurse(Band 7)	Lisa Moore (LM)						
	0.2 Seconded IPC Associate Nurse (Band 6) – initially for 1 year	Alan Bridge (AB)						
	0.6 IPC Data Analyst (Band 5)	Carly Quirk (CQ)						
	Clinical assistant (Band 3)	Vickie Lam (VL)						
	PA/Admin assistant -	Lucy Whitfield						

IPC Code & Trust Values	Plan & Priority Activities 2018-19	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
	shared with the Sepsis Team (Band 4)	(LW)						
	Infection Prevention & Control Committee (IPCC) The IPC reports to the Board via the IPCC. The IPCC meets 6 times per year and is chaired by the DIPC. The Terms of Reference were reviewed and amended in February 2018.	DIPC and Associate DIPC						
2. *Surveillance*								
IPC Code: 1,4,5,6,7,8 & 9 **Trust Values:** Excellence Openness Respect Together	**Alert organisms** To maintain and alert staff to any potential risks from pathogenic organisms	Microbiology and IPC Team	To provide IPC advice and support in order to minimise the risks to patients, staff and visitors.					
	Mandatory Reporting It is mandatory requirement for the Trust to report a variety of pathogenic organisms/ infections to PHE for monitoring							

IPC Code & Trust Values	Plan & Priority Activities 2018-19	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
	purposes							
	MRSA/ MSSA/VRE/E.coli Bacteraemia	DIPC/ Associate DIPC/ IPC Doctor(BL), IPC Team and a review panel	To identify, communicate and instigate investigations by the clinical teams for all Trust apportioned cases. All cases to be reviewed under the Post Infection Review (PIR) and Root Cause Analysis (RCA) processes, through a Review Panel and to disseminate lessons learned from the process and actions required and monitored.					
	Clostridium difficile/PTP	Microbiology/ IPC Team and Antimicrobial Pharmacist (AT)	To identify, communicate and instigate investigations by the clinical teams for all cases. All cases to be reviewed under the Post Infect Review (PIR) and Root Cause Analysis (RCA) processes, through a Review Panel and to disseminate lessons learned for the process and actions required and monitored.					
			To instigate an incident meeting with clinical team for all hospital acquired cases. Disseminate lessons learned for the process and actions required and monitored.					
	CPE	Microbiology and	To instigate an incident meeting with					

IPC Code & Trust Values	Plan & Priority Activities 2018-19	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
		IPC Team	clinical team for all hospital acquired cases. Disseminate lessons learned for the process and actions required and monitored.					
			To develop and submit a business plan for rapid PCR testing to ensure timely screening and isolation of identified at risk and previous positive patients.					***Q1*** *- Business case submitted. Further data required for review July meeting.* ***Q2*** *– Business case successful August 2018.*
	Surgical Site Infection (SSI) for Orthopaedics (spinal, elective implants and k wires), Cardiac Surgery, Neurosurgery and plastics.	Microbiology, LM, Theatre safety board & clinical Review Panel	To assist in the collection and submitting of data for SSIs. To disseminate reports to the relevant clinical staff. To include data and reporting in the DIPC IPC report on a quarterly basis.					
			To support the clinical teams to take more ownership of their SSI data – through attendance at the SSI teaching sessions at Colindale London. To support the investigation and presentation of incidences of SSI through the RCA process at the Review Panel meetings and to support the dissemination of lessons learned to the relevant staff and actions required and monitored.					***Q1****-Review panels to be progressed once IPC Doctor is in post. New SSI reporting template (Shared by Royal Wolverhampton Hospital) – work to be progressed so that reporting can be available across the surgical division.* ***Q2*** *– To progress with introduction of review panels with significant infections. IPC Lead Theatres and ADIPC to attend December SSI training. Two places booked for 6th Dec.* ***Q3*** *– SSI MDT validation meetings to commence Jan 2019. ADIPC and IPC Lead in Theatre attended SSI teaching in Collindale 6th Dec 18.*
	Viruses	Microbiology &	To provide data on HAI Influenza &					

IPC Code & Trust Values	Plan & Priority Activities 2018-19	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
		IPC Team	RSV rates per 1000 bed days.					
			To support investigations into HAI Influenza and RSV cases and investigations into outbreaks with other respiratory viruses.					
			To provide predictions and provide commentary during the winter season on Respiratory viruses (in collaboration with the PHE) to assist in planning elective activity and patient flow.					
	Expert Virology provision and expertise	Medicine General Manager Glenna Smith (GS) and Microbiology.	To secure expert Virology provision and expertise.					***Q1***- *Talks ongoing with Virology department at The Royal Liverpool Hospital.* ***Q2*** *– Awaiting progress* ***Q3*** *– Contract now signed and awaiting appointment at the Royal.* ***Q4*** *–Awaiting substantive appointment. To be taken forward to 2019-20.*
3. Hand Decontamination								
IPC Code: 1,2,4,5,6,7,8 & 9 **Trust Values:** Excellence Openness Respect Together Innovation	Children's Hand Hygiene Initiative – in conjunction with PDI	IPC Team and PDI	Complete an initial evaluation of hand hygiene behaviour of children across the areas identified for the pilot.					
			Introduce the pilot scheme into the identified areas. Pilot study to run over 2 months.					***Q1 –*** *Meetings continue with industry partner. Delay due to long term sickness (industry partner). Progress meeting scheduled for 2nd August 2018.* ***Q2*** *– Industry partner to present work so far to IPC link nurses on 24th September 2018. Plans to then trial process on identified wards and roll out across the Trust in Infection Control Week (15th*

IPC Code & Trust Values	Plan & Priority Activities 2018-19	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
								October 2018). *Update: Due to Industry partner reorganisation plans have halted associate DIPC to seek alternative Industry Partner.* ***Q3** – Initial company has now pulled out of this initiative. IPC team are currently exploring other parties to progress this work.* ***Q4** - Meeting has taken place with new Industry Partner, awaiting feedback. Due to this we will be taking this activity forward to 2019-20.*
			Present finding of the pilot study to the Trust, and at the Infection Prevention Society Conference – October 2018.					***Q1** – Awaiting commencement of pilot study.* ***Q2** – As above to be progressed once alternative industry partner has been found.* ***Q3** – To be progressed once alternative industry partner has been found.*
			Write up study for publication.					***Q1** – Awaiting commencement of pilot study.* ***Q2** – As above to be progressed once alternative industry partner has been found.* ***Q3** – To be progressed once alternative industry partner has been found.*
			If pilot successful – to introduce scheme across the Trust.					***Q1** – Awaiting commencement of pilot study.* ***Q2** – As above to be progressed once alternative industry partner has been found.* ***Q3** – To be progressed once alternative industry partner has been found.*
	To scope and implement new and innovative hand hygiene signage across the Trust.	IPC Team	To explore the feasibility of introducing new and innovative hand hygiene signage across the Trust.					***Q1** – ADIPC to approach hand hygiene industry partner to scope feasibility of developing new signage.* *Q2 – Roll out of new hand hygiene products across the Trust now completed, including increased signage in public areas.* ***Q3** – Plans to look at this with Communications team. New and*

IPC Code & Trust Values	Plan & Priority Activities 2018-19	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
								innovative ways to promote hand hygiene for staff, patients and visitors. ***Q4*** *– Meeting have taken place with communication team and various strategies have been discussed. This piece of work will be taken forward into the work plan 2019/20.*
	To explore new hand hygiene audits tools and technology incorporating the use of Protective Personal Equipment (PPE)	Hand Hygiene audit tools – IPC Team	IPC team to source, trial and decide on new hand hygiene tool.					***Q1*** *– IPC to discuss new hand hygiene alternatives. IPC hand hygiene summit to be organised.* ***Q2*** *– Industry partner in process of setting up system to fit Trust requirements. Training sessions organised for users in Sept and Oct 2018 with launch to follow.*
		New Technology – IPC Team and data analyst (CQ)	IPC team and CQ – to investigate how new tool can be recorded and results disseminated across the Trust.					***Q1*** *– IPC to discuss new hand hygiene alternatives. IPC hand hygiene summit to be organised.* *Q2 – Summit has taken place. Industry partner in process of setting up system to fit Trust requirements. Training sessions organised for users in Sept and Oct 2018 with launch to follow.* ***Q3*** *– New hand hygiene app rolled out across the Trust.*
	To ensure that the non-compliance with hand hygiene proforma is utilised throughout the Trust.	DIPC, Associate DIPC and IPC Team	IPC team to scope how non-compliance can be reported across the Trust.					***Q1*** *– IPC to discuss new hand hygiene alternatives. IPC hand hygiene summit to be organised.* ***Q2*** *– Discussions have taken place to scope out new non-compliance proforma. To be trialled on a medical ward.* ***Q3*** *– Proforma to be introduced on medical ward and evaluated.* ***Q4*** *– Proforma being trialled on 4A and 4B. Feedback to be communicated in Q1.*
			IPC team to communicate the process via the Link Nurse/Representatives and the governance structures					***Q1*** *– IPC to discuss new hand hygiene alternatives. IPC hand hygiene summit to be organised.* ***Q2*** *– To be progressed following proforma. Lead IPC Nurse to liaise with identified link nurses in the medical division.* ***Q3*** *– Proforma to be introduced on medical*

IPC Code & Trust Values	Plan & Priority Activities 2018-19	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
								ward and evaluated. ***Q4*** *– Proforma being trialled on 4A and 4B. Feedback to be communicated in Q1*
	Introduction of new hand hygiene audit technology as part of monthly audit indicators	Lead Infection Prevention & Control Nurse, IPC Team& link nurses	Dissemination of new hand hygiene audit technology to link personnel through meetings and training					***Q1*** *– To be scheduled into Link Nurse Programme.* ***Q2*** *– Summit has taken place. Industry partner in process of setting up system to fit Trust requirements. Training sessions organised for users in Sept and Oct 2018 with launch to follow.* *Update: Now completed.*
	To ensure that hand hygiene technique assessments are recorded as a mandatory field on an annual basis for all clinical staff and reflected in ESR.	Associate DIPC and Learning and Development.	To explore the feasibility of putting hand hygiene compliance on the ESR system for all clinical staff on an annual basis.					***Q1*** *– Meeting arranged with Head of Learning and Development 5th July 2018.* ***Q2*** *– Awaiting feedback from L&D. Reminder sent to L&D awaiting reply.* ***Q3*** *– Further discussions have taken place with L&D. Awaiting decision.* ***Q4****- Completed – now incorporated into IPC mandatory training.*
			Once hand hygiene assessments are recorded on ESR. To develop a monitoring system across the Trust.					***Q1*** *– Awaiting meeting with L&D.* ***Q2*** *– Awaiting feedback from L&D. Reminder sent to L&D awaiting reply.* ***Q3*** *– Awaiting feedback from L&D.* ***Q4*** *– This will be monitored through the IPC mandatory training figures.*
			Include compliance in IPC Dashboards to provide assurance.					***Q1*** *– Awaiting meeting with L&D.* ***Q2*** *– Awaiting feedback from L&D. Reminder sent to L&D awaiting reply.* ***Q3*** *– Awaiting feedback from L&D.* ***Q4****- Now incorporated into Mandatory training, these figures are shown on the dashboard.*
4. Policies								
IPC code 1,2,3,4,5,6,7,8,9 & 10 **Trust Values**	Review and update IPC policies as required.	IPC Team	Monitored reviewed and updated as part of the IPCT meetings on a bi-weekly basis.					
	To provide advice and support on IPC policies.	IPC Team						

IPC Code & Trust Values	Plan & Priority Activities 2018-19	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
Respect Excellence Innovation Togetherness Openness	Participation in updating where IPC is an integral component of relevant policies.	EW	Provide an update of policy review dates					
5. ANTT								
IPC Code: 1,2,3,4,5,6 & 9 **Trust Values:** Excellence Openness Respect Together Innovation	Monitor Trust wide compliance and increase compliance.	ANTT Specialist Nurse	Provide updated compliance figures to the relevant care groups and for IPCC.					
			ANTT compliance scores to be communicated in IV Newsletter and IPCC Report.					
			ANTT compliance scores communicated in ward and department dashboards.					
	To ensure that ANTT assessments are recorded as a mandatory field on an annual basis for all clinical staff and reflected in ESR.	Associate DIPC, ANTT Specialist and Learning and Development	To explore the feasibility of putting ANTT annual assessments on the ESR system as a mandatory field for all clinical staff.					***Q1*** *– ADIPC to meet with L&D Lead. Meeting scheduled for 5th July 2018.* ***Q2*** *– Meeting has taken place. Awaiting discussion from L&D. Reminder sent to L&D awaiting reply.* ***Q3*** *– Further discussions have taken place with L&D. Awaiting decisions.* ***Q4*** *– Now agreed, awaiting implementation by L&D.* ***Update:*** *L&D contacted 27.03.2019. Awaiting reply.*
	Ensure guidelines and ANTT policy remain up to date with latest evidence based practice.	IV Lead Nurse (SM) and ANTT Specialist Nurse	Review all latest evidence based practice and review guidelines and update policy where necessary and appropriate.					
	Provide and update Key	ANTT Specialist	Key trainer training days are provided					

IPC Code & Trust Values	Plan & Priority Activities 2018-19	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
	Trainer training on an annual basis.	Nurse assisted by BBraun.	6 times per year.					
	Liaise with St Helens and Knowsley Trust regarding standardising ANTT rotational staff assessments	Associate DIPC/SM	To develop a SOP to standardise ANTT assessments for rotational staff recognising from other Trusts within the last 12 months.					***Q1*** *– SOP discussions have taken place to be progressed.* ***Q2*** *– Meetings have taken place across the North West with regard to standardising ANTT training. Permission has been granted by National ANTT authors to progress standardisation across the whole of the North West.* ***Q3*** *– Work continues with IV Forum Group. ADIPC to attend meeting at Whiston February 2019.* ***Q4*** *– ADIPC to attend IV Therapy Meeting at St Helens & Knowsley April 2019. This will be moved over to 2019-20 due to scheduled meetings.*
	Plan to expand this process to cover other Trusts in the North West	Associate DIPC/SM	To progress the work started with Whiston to other Trusts in the region through the North West IV Forum.					***Q1*** *– ADIPC progressing this work through NW IV Forum group.* ***Q2*** *– Meetings have taken place across the North West with regard to standardising ANTT training. Permission has been granted by National ANTT authors to progress standardisation across the whole of the North West.* ***Q3*** *– Work continues with IV Forum Group* ***Q4*** *– North West IV Forum meeting scheduled for 25th March 2019.* ***Update:*** *Progress being made, to be carried forward to 2019/20 work plan.*
	Liaise with ANTT experts to review and refine existing processes.	Associate DIPC/SM	Attend annual ANTT conference and to attend North West IV Forum meetings.					***Q1*** *– ANTT Lead to attend conference in November 2018.* ***Q2*** *– ANTT place booked on Conference. New ANTT lead Nurse to attend conference on 2nd Nov 2018.* ***Q3*** *– Conference attended.*
6. Vascular Access								

IPC Code & Trust Values	Plan & Priority Activities 2018-19	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
IPC Code: **Trust Values:**	Improving patient flow for vascular access.	Lead Nurse IV	Initiation of GDE project – the use of digital technology to implement evidence based practice to improve patient care delivery.					***Q1*** *– GDE work complete and will be launched at the beginning of September 2018.* ***Q2*** *– GDE work now live.*
			Implementation of IV access team assessment from receipt of Meditech referral					***Q1*** *– GDE work complete and will be launched at the beginning of September 2018.* ***Q2*** *– GDE work now live.*
	Implementation of vessel health and preservation.	Lead Nurse IV	Initiation of GDE project incorporating VHP decision tool.					***Q1*** *– GDE work complete and will be launched at the beginning of September 2018.* ***Q2*** *– GDE work now live.*
	Improve workload awareness in vascular access team.	Lead Nurse IV ANS IV	Introduction of daily workload planner.					
	Widen accessibility of teaching and training for MDT	IV Team and Learning and Development	Introduction of ward based workshop/training updates to keep staff educated in the best evidence based vascular access practice.					***Q1*** *– Dates to be scheduled workshop content completed.* ***Q2****- Completed*
			Training drop in sessions in clinical skills room accessible to MDT.					***Q1*** *– To be reviewed following workshop implementation.* ***Q2*** *– Drop in sessions commenced but did not work. Therefore piloting targeted training sessions organised through PDNs.* ***Q3*** *– Meeting with L&D in January 2019.* *Q4 – Drop in sessions completed – however up take was sporadic.*
			Records to be kept by IV team and sent to L&D for recording on ESR.					***Q1*** *– Attendance records kept by IV Team for all training. Meeting to be scheduled with ESR Lead to discuss process.* ***Q2*** *– Awaiting meeting with L&D.* ***Q3*** *– Meeting with L&D in January 2019.* *Q4 – Awaiting feedback from L&D with regards to how records of training will be kept. ANTT Assessments are now*

IPC Code & Trust Values	Plan & Priority Activities 2018-19	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
								centralised and wards are responsible for entering their own data to enable the most up to date information. ***Update:*** *L&D contacted 27.03.2019 awaiting reply.*
	Review of Sharps safety and vascular access	IV Team ADIPC	Review of butterfly needles and clinical trials.					***Q1*** *– This will be reviewed following the cannula review. IV Team have started to obtain butterfly needles for review.* ***Q2*** *– Reviewed. Awaiting decision and feedback from IV Forum for trial. Table top review session organised for safety products in December 2018.* ***Q3*** *– Review completed. Trial of safety butterfly needles to commence January 2019.* *Q4 - Safety butterfly trials to commence in Q1-2019 due to the introduction of prefilled saline syringes which will need to be completed prior to the introduction to the butterfly needles. Therefore to continue into 2019-20.*
			Review of cannula and clinical trials.					***Q1*** *– Review underway. Workshop taking place July 2018 to discuss. Plan to take to table top exercise open to the Trust for evaluation.* ***Q2*** *– Reviewed. Awaiting decision and feedback from IV Forum for trial. Table top review session organised for safety products in December 2018.* ***Q3*** *– Review completed. Trial of safety cannula to commence early 2019.* *Q4 - Safety butterfly trials to commence in Q1 2019 due to the introduction of prefilled saline syringes which will need to be completed prior to the introduction to the butterfly needles. Therefore to continue into 2019-20.*
			Revisit innovative sharps disposal					***Q1*** *– Delay due to workload of IV Team and IPC Team. Meeting to be scheduled with company.* ***Q2*** *– Discussed at Sharps Safety Group.*

IPC Code & Trust Values	Plan & Priority Activities 2018-19	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
								Product not suitable for entire Trust. A targeted trial introduction to be progressed. ***Q3*** *– Trial to be discussed with Lead nurse IPC.* ***Q4*** *– Further discussion with sharp group needed. This action will be closed and will form part of the Environmental Cleanliness Action Plan.*
			Exploration of possible introduction of pre filled saline syringes.					***Q1*** *– These are being trialled July 2018 in A&E, Radiology and Community.*
	Review of vascular access dressings.	IV Team	Explore dressing options					***Q1*** *– New 3M peripheral vascular access dressings being implemented across the Trust July 2018 with exception of Theatres.*
			Undertake clinical trial					
			Implementation of new dressing for peripheral vascular access.					***Q1*** *– New 3M peripheral vascular access dressings being implemented across the Trust July 2018 with exception of Theatres.* ***Q2*** *– Completed except for Theatres.*
7. Training								
IPC Code: 1,2,3,4,5,6,7,8,9 & 10 **Trust Values:** Excellence Openness Respect Together Innovation	To ensure that IPC staff are kept updated with IPC evidence based practice.	Lead IPC Nurse	To ensure that a member IPC Team attends the North West Infection Prevention Society (IPS) meetings at least once per year.					***Q1*** *– Dates to be arranged.* ***Q2*** *– Unable to attend September meeting due to Geography (Cumbria). ADIPC and Specialist IPC Nurse attended IPS Conference October 2018.* ***Q3*** *– Unable to attend meeting in December due to winter pressures and increased RSV rates.* ***Q4*** *– CO and VL attended 12th March 2019.*
		Associate DIPC	To regularly attend local HCAI whole health economy meetings.					
		Associate DIPC/Lead IPC Nurse	To attend local and national IPC/relevant conferences as the service will allow					
		Lead IPC Nurse	To attend Vaccinator training or					***Q1*** *– Lead IPC booked onto training.*

IPC Code & Trust Values	Plan & Priority Activities 2018-19	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
			undertake on line update					
	To ensure that Trust staff are kept updated with IPC evidence based practice: Please see plan below.							
	Induction	Lead Nurse IPC/CO	At least once per month					
	Mandatory	IPC Team	For all clinical staff yearly (monthly sessions) & work book.					
			To develop a new E-Learning package to replace monthly sessions and workbook for clinical staff.					***Q1*** *– IPC Team to be training in setting up e-learning packages.* ***Q2*** *– Team meetings have commenced to progress.* *Update: New innovative E-Learning package has been developed by an Industry partner. Alder Hey have been asked to be one of the first to trial specific e-learning packages for staff.* ***Q3*** *– Awaiting company experts to visit the Trust.* ***Q4*** *– Awaiting company experts to visit the Trust. To be carried forward to 2019/20 work plan.*
			Non-clinical 3 yearly – work book					
			To develop a new E- Learning package to replace the work book. Following the same principles developed from the Clinical E-Learning package.					***Q1*** *– To be progressed once clinical staff package is developed.* ***Q2*** *– Team meetings have commenced to progress.* *Update: New innovative E-Learning package has been developed by an Industry partner. Alder Hey have been asked to be one of the first to trial specific e-learning packages for staff.* ***Q3*** *– Awaiting company experts to visit the Trust.*

IPC Code & Trust Values	Plan & Priority Activities 2018-19	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
								***Q4** – Awaiting company experts to visit the Trust. To be carried forward to 2019/20 work plan.*
	ANTT Key Trainers	SM	Bimonthly					
	Volunteer IPC Training	CO/VL	Quarterly					
	Hotels Services IPC training	VL	At least once per quarter					
	Link Personnel	IPCT	Monthly					
	Fit Testing Key Trainers	CO	Updated Annually – records of staff training reported through IPC Dashboards					***Q1** – Training sessions continue. However update from wards and departments remains sporadic.* ***Q2** – Fit testing compliance now forms part of the monthly dashboard.*
	Flu vaccinator Training	Lead Nurse IPC	Annual (4 sessions per year)					***Q1** – Training sessions arranged prior to flu season.* ***Q2** – Completed*
	Ad hoc training	IPCT	As required					
8. Audit								
IPC Code: 1,2,3,4,5,6,7,8 & 9 **Trust Values:** Excellence Openness Respect Together Innovation	To provide assurance to the board and relevant committees of adherence to high quality IPC practices.	Lead IPC Nurse/ IPC Specialist Nurse/IPC clinical assistant follow the audit plan The Audit programme is revised on a yearly basis. Further audits are undertaken by the IPC Team as	All findings are communicated to the relevant clinical staff and reported via the IPC dashboards and discussed at divisional governance meetings and the IPCC. All lessons learnt are disseminated to the relevant staff and other agencies as Appropriate in a timely manner.					

IPC Code & Trust Values	Plan & Priority Activities 2018-19	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
		set out in the work plan and as the service requires.						
9. Antimicrobial Prescribing								
	Antimicrobial Stewardship (AMS) ward rounds	Antimicrobial Pharmacist	AMS ward rounds (x3/week)					
	AMS Committee meetings		AMS Committee (meet at least quarterly)					
	Introduction of AMS training to all clinical staff in the Trust.	Antimicrobial Pharmacist (AT) Sepsis Nurse Specialist – James Ashton (JA) OPAT Nurse Specialist – Ruth Cantwell (RC).	AMS training to be introduced across the Trust – currently delivered to junior doctors on induction but not to nurses. To introduce AMS training into induction training.					***Q1*** *– Initial discussions have taken place with Learning and Development.* ***Q2*** *– Induction programme agenda discussed and to be progressed.* *Q3 – Work continues to progress. Plan in place to deliver sessions by the end of financial year.* *Q4 – Training to rolled out at next induction day at the end of March 2019*
			To introduce AMS training into mandatory training					***Q1*** *– Initial discussions have taken place with Learning and Development.* ***Q2*** *– Awaiting feedback from L&D* ***Q3*** *– Further meetings have taken place awaiting decisions from L&D.* *Q4 – To be implemented after discussion with L&D –implementation end of March 2019.*
10.Communication								
IPC Code: 1,2,3,4,5,6,7,8,9 & 10 **Trust Values:**	IPC bi-monthly report	Lead Nurse IPC	IPC bi-monthly report reported through the IPCC.					
	IPC Dashboard	IPC Data Analyst	Monthly dashboard distributed Trust wide reported through Divisional Governance meetings and IPCC.					

IPC Code & Trust Values	Plan & Priority Activities 2018-19	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
Excellence Openness Respect Together Innovation	Communication with the Whole Health Economy	ADIPC	To attend HCAI/IPC meetings across the local area.					
	Communication with other Trusts and agencies such as Public Health England (PHE) and NHS England	IPCT	To attend local meetings. Communication and information gathering with other Trusts and agencies to assist in IPC investigations.					
	To keep Infection Prevention and Control Intranet page up to date with relevant information	IPC Administrator	Ensure that the IPC intranet pages are kept up to date on a monthly basis or as necessary.					
	To ensure that Paediatric Infection Prevention and Control remains high on the agenda at a national level.	Associate DIPC	Associate DIPC to communicate specific paediatric needs to Infection Prevention Society (IPS) through representation on the IPS Board.					
	Communication with other Paediatric Trusts and other hospitals/healthcare facilities caring for paediatric patients.	Associate DIPC/CO	Commencement of the national IPS Paediatric Forum to share best evidence based practice, benchmarking and innovative projects. To include meetings face to face and virtual and a national annual					

IPC Code & Trust Values	Plan & Priority Activities 2018-19	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
	Scoping Paper for the Paediatric Special		conference.					
11. Information Technology								
IPC Code: 1,2,3,4,5,6,7,8,9 & 10 **Trust Values:** Excellence Openness Innovation Together	To continue to enhance the use of Meditech to assist the IPC team in monitoring HCAI	IPC Team, IT team and Pathology IT Manager.	Set up regular meetings to explore how the Meditech system can assist IPC.					***Q1*** *– Ad hoc meetings have taken place. Diary of regular meetings to be developed.* ***Q2*** *– Meetings convened and ongoing.*
	To develop opportunities to enhance epidemiological surveillance systems and monitoring opportunities within the Trust	Consultant Infectious Diseases/ADIPC/ Data Analyst	To instigate a working group to explore possibilities to enhance the surveillance systems and reporting across the Trust.					***Q1*** *– ADIPC to organise initial meeting.* ***Q2*** *– Awaiting arrival of IPC Doctor. Update: Meeting organised for 29th Oct to progress.* ***Q3*** *– Meeting has taken place with ADIPC, IPC Dr and ID Dr ongoing meetings arranged for New Year.* ***Q4*** *– Ongoing meetings arranged. To be taken forward to 2019-20.*
			To develop a business case to develop the enhanced surveillance system agreed.					***Q1*** *– To be progressed through working group.* ***Q2*** *– To be progressed through working group.* ***Q3*** *– To be progressed through working group.*
12. Interface with relevant groups								
IPC Code: 1,2,3,4,5,6,7,8,9 & 10 **Trust Values:** Excellence Openness	IPC to attend and provide expert opinion for topics related to IPC.							
	Escalate issues to DIPC as necessary.	Associate DIPC	Regular meetings with DIPC					***Q1*** *– IPC review equipment as requested. However IPC not always involved in the process.* ***Q2*** *– ADIPC to highlight process through Divisional meetings.*
	To review new	IPCT	Ad hoc meetings as required.					

IPC Code & Trust Values	Plan & Priority Activities 2018-19	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
Respect Together Innovation	equipment /environmental utilisation							
	Decontamination	Lead Nurse IPC Associate DIPC to attend as required.	To attend scheduled meetings. To provide expert advice and support as required.					
	Water Safety	Associate DIPC	To attend scheduled meetings. To provide expert advice and support as required.					
	Health & Safety/IPC/Interserve & Building services	Associate DIPC/Lead Nurse IPC	To attend scheduled meetings. To provide expert advice and support as required.					
	Hotel services	Lead Nurse IPC Associate DIPC to attend when required.	To attend scheduled meetings. To provide expert advice and support as required.					
	Ward managers/matrons	Lead Nurse IPC Associate DIPC or IPCT to attend when required.	To attend scheduled meetings. To provide expert advice and support as required.					
	Health and Safety	Lead Nurse IPC	To attend scheduled meetings. To provide expert advice and support as required.					
	Integrated Governance Committee	DIPC/Associate DIPC/ Lead Nurse	To attend scheduled meetings. To provide expert advice and support					

IPC Code & Trust Values	Plan & Priority Activities 2018-19	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
		IPC	as required.					
	Medical Devices Committee	DIPC/ CO	To attend scheduled meetings. To provide expert advice and support as required.					
	Trust Quality meetings • ***CQAC*** • ***CQSG*** • ***CQPG***	Associate DIPC Lead Nurse IPC to deputise. IPCT to attend ad hoc for training purposes.	To attend scheduled meetings. To provide expert advice and support as required.					
	Theatre Safety Board	LM/CO	To attend scheduled meetings. To provide expert advice and support as required.					
		Associate DIPC/ LM/CO	To assist in the introduction of the OneTogether programme.					***Q1*** *– OneTogether programme instigated and progressing.* ***Q2*** *– IPC Lead for Theatre to progress and feedback to Surgical Division Board.* ***Q3*** *– IPC Lead for Theatre to progress and feedback to Surgical Division Board.* ***Q4*** *– Theatre baseline observations completed.*
	Trust Board	DIPC/ Associate DIPC	To attend scheduled meetings. To provide expert advice and support as required.					
13. Gram Negative Bacteraemia								
IPC Code: 1,3,4,5,6,7,8 & 9	Adherence with regards to Gram Negative Blood Stream Infections	DIPC/ Associate DIPC	To attend whole health economy meetings to develop robust action plans to tackle gram negative					

IPC Code & Trust Values	Plan & Priority Activities 2018-19	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
Trust Values: Excellence Innovation Respect Together Openness	(GNBSIs) targets		bacteraemia reduction targets.					
		IPC Data Analyst	Ecoli, Klebsella spp, Pseudomonas aeruginosa bacteraemia data to be recorded on the MESS system.					
		DIPC/ Associate DIPC	PIR reviews to be commenced for all named gram negative bacteraemia.					
		Associate DIPC/IPC Data Analyst	Trust wide situation reports to be developed to share lessons learnt.					***Q1**-Situation reports for 2017-18 completed and to be disseminated. Monthly sit reps to be shared going forward.* ***Q2** - Completed*
		Associate DIPC	PIR reviews to be shared across the whole health economy and NHSI.					***Q1**-Situation reports for 2017-18 completed and to be disseminated. Monthly sit reps to be shared going forward.* ***Q2** - Completed*
14. Community								
IPC Code 1, 2, 3, 4, 5, 6, 8, 9. 10 **Trust Values** Respect Excellence Innovation Together Openness	To ensure that a high quality Infection Prevention Service (IPC, Tissue Viability and IV services) is delivered to Community Services	Sarah Stephenson (SS) – Quality Lead for Community, Associate DIPC, Lisa Cooper (LC) Director of Children & Young People Community & Mental Health Division	To scope out the provision and requirements for Infection Prevention Services for Community Services. To include an audit programme, specific training – mandatory and ad hoc, advisory services and Link personnel updates and requirements. To include what is achievable able with the existing team resources.					***Q1**-Work has begun to scope out requirements for community.* ***Q2** – Meetings have commenced. Areas for immediate consideration addressed. Training to commence once personnel is organised.* ***Q3** – Meetings continue to scope out provision needed.* ***Q4** – Business plan developed to address additional provision for IPC in the Community.*
			Impact assessment on the existing Infection Prevention Services in delivering the required service to the Community.					***Q1** - To be progressed once scoping exercise is completed.* ***Q2** – Process commenced.* ***Q3** – Progress continues.* ***Q4** – Completed.*

IPC Code & Trust Values	Plan & Priority Activities 2018-19	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
			Development of a Business case to deliver the appropriate identified service across Community services.					***Q1*** *- To be progressed once scoping exercise is completed.* ***Q2*** *– Awaiting results of impact assessment.* ***Q3*** *– Awaiting results of impact assessment.* ***Q4*** *– Business case completed.*

Alder Hey Children's NHS
NHS Foundation Trust

Trust Wide Infection Prevention and Control Action Plans

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

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

These Actions Plans will be reviewed and monitored via the IPCC and the governance structures in each relevant division and progress communicated to the Trust Board.

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Tuesday 7th May 2019

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

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1. Background:

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

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

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

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

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

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

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

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

Current position

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

During this reporting period, there were no serious incidents reported. There were no safeguarding incidents reported and no never events. There were no SIRI's closed during this reporting period.

Table 2 shows the cumulative position; there are five open serious incident investigations.

Table 3 shows the Trust had no moderate harm incidents during this reporting period.

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

	SIRI (General)												
	2017/18	2018/19											
Month	**Mar**	**Apr**	**May**	**Jun**	**July**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
New	0	0	1	1	1	1	0	0	0	1	2	2	0
Open	3	3	2	3	2	2	4	3	0	0	3	5	5
Closed	0	0	0	0	2	1	1	1	3	0	0	0	0
	Safeguarding												
Month	**Mar**	**Apr**	**May**	**Jun**	**July**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
New	0	0	0	0	0	0	0	0	0	0	0	0	0
Open	0	0	0	0	0	0	0	0	0	0	0	0	0
Closed	0	0	0	0	0	0	0	0	0	0	0	0	0
	Never Events												
Month	**Mar**	**Apr**	**May**	**Jun**	**July**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
New	0	0	0	0	0	2	0	0	0	0	1	0	0
Open	0	0	0	0	0	0	0	0	0	0	0	1	0
Closed	0	0	0	0	0	0	0	0	0	0	0	0	0
	Cumulative Position												
	5												

Table 2 Ongoing serious incidents requiring investigation (cumulative):

On-going SIRI incident investigations							
Reference Number	**Date investigation started**	**Division**	**Incident Description**	**RCA Lead Investigator**	**Progress**	**60 working day compliance (or within agreed extension)**	**Duty of Candour applied**
StEIS 2019/3312	08/02/2019	Medicine	**Unexpected death:** The patient was admitted from ED suffering from septic shock. Multiple inotropic support was provided and the massive haemorrhage protocol was	**Investigation lead:** Amanda Turton, Head of Acute Care	ED and PICU M&M meetings have been held; report is being written.	Yes - Report due for submission to CCG and CQC 08/05/2019.	Completed.

			activated. The patient deteriorated and went into multi organ failure. Full intensive care support was supported until the afternoon of the 6.02.19; patient sadly passed away.				
StEIS 2019/3163	07/02/2019	Surgery	**Unexpected death:** The patient was admitted from the Emergency Department (ED) on the 03.02.19 after collapse at home. Gastro-jej tube changed on the 01.02.19. Perforated bowel secondary to migration of Gastro-jej tube following the procedure on the 01.02.19. Laparotomy and repair of bowel perforation performed on the 04.02.19 (01.30), patient returned to PICU (03.00). Multiple inotropic support was provided; patient sadly went into multi organ failure. Extensive discussion with teams involved in the care. Decision to withdraw treatment; patient sadly died at 16:38.	Kelly Black, Surgical Matron	Panel meeting held; report is being written.	Yes - Report due for submission to CCG and CQC 07/05/2019.	Completed.

StEIS 2019/1967	24/01/2019	Surgery	**Never Event Wrong Site Surgery - Wrong site anaesthetic block:** A wrong site block was performed on a patient. Full checks were completed and the 'stop before you block' undertaken, however this was before the local anaesthetic was drawn up. Markings were noted as part of the check; however the operator position changed for ergonomics with the ultrasound scan. The error was identified and immediate action was taken, including the declaration of the incident as a 'never event' and a discussion held with the family.	Paula Clements, Theatre Matron	RCA report completed; final report sent to CCG 11/04/2019.	Yes - Report was due for submission to CCG and CQC 18/04/2019.	Completed.
StEIS 2019/1718	22/01/2019	Medicine	**Unexpected death:** Four month old baby was admitted to Alder Hey via ED on 15.01.19 with a bronchiolitis type illness, admitted to Ward 4C. The patient was managed with Airvo and nasal cannula oxygen plus a mixture of bottle and NGT feeds. Respiratory PCR positive for coronavirus, human metapneumovirus and rhino/enterovirus. The	**Nursing lead:** Amanda Turton, Head of Acute Care **Medical lead:** Theo Anbu, Consultant	RCA report went through first quality check; further work required before sign off.	Yes - Report due for submission to CCG and CQC 28/06/2019.	Completed.

			baby previously had multiple attendances to the Trust. Just over 12 hours pre acute collapse, the baby became tachycardic and had episodes of fever for which she was given paracetamol and ibuprofen on the ward. At 12:00 on 19.01.19, a cardiac arrest call was issued because the baby had been found moribund and peri-arrest on the ward by her mother. The cardiac arrest team resuscitated her with assisted ventilation, dextrose and fluid boluses, IM and IV antibiotics. The baby was intubated on the ward, a high dose adrenaline infusion started and quickly transferred to PICU. Shortly after arriving in PICU, she went into PEA and CPR was commenced at 12:55hrs. Sadly, the baby did not respond to resuscitation and this was discontinued at 13:20 hours				
StEIS 2018/30070	19/12/2018	Surgery	**Unexpected death:** 24 week gestation baby, transferred from Liverpool Women's Hospital for central line insertion. The	Stefan Verstraelen, Head of Quality, Surgery	RCA report completed and sent to CCG 18/04/2019.	Yes – Report was due for submission to CCG and CQC 18/04/2019.	Completed.

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

Table 3 Moderate harm incidents:

	Duty of Candour (excluding SIRIs)							
Reference Number	**Date investigation started**	**Type of investigation**	**Division**	**Incident Description**	**Lead Investigator**	**Progress**	**60 working day compliance (or within agreed extension)**	**Duty of Candour applied**
Nil								

END

Alder Hey Children's NHS
NHS Foundation Trust

Trust Board
7th May 2019

Subject/Title	Digital and Information Technology Update
Paper prepared by	Kate Warriner, Chief Digital and Information Officer
Action/Decision required	The Trust Board is asked to note the update on Digital and Information Technology current position and planned next steps
Background papers	GDE Programme updates
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	IM&CT Strategy Significant contribution to the strategic objectives for:- - Clinical Excellent - Positive patient experience - Improving financial strength - World class facility

Digital and Information Technology Update

1.0 Purpose of Paper

The purpose of this paper is to provide an update on Alder Hey Digital and Information Technology current position and future developments.

2.0 Context

Alder Hey NHS Children's Foundation Trust has a good track record of delivery of major digital programmes. The Trust implemented an integrated Electronic Patient Record in 2015. As part of the new building, a range of core Information Technology infrastructure is in place for inpatient and outpatient services and a number of community services. Recognising the excellent foundations in place, Alder Hey was identified by NHS England as a Global Digital Exemplar Trust in 2017.

3.0 Current Position

3.1 Global Digital Exemplar Programme

Alder Hey has performed very well with regards to the Global Digital Exemplar Programme. The programme has had both an internal and external focus. All milestones as agreed with NHS England and NHS Digital have been achieved to date. 19/20 sees the final year of the GDE programme for Alder Hey, as the programme is set to close in March 2020.

Internally, focus has largely been on removing paper from care processes, and streamlining pathways through the implementation of 'specialty packages'. Speciality packages have been implemented with services and should be considered a core tenant of the Trust's Inspiring Quality priorities with regards to improving care through digital technologies. Internally, much of this work has been around embedding core processes and developing the Trust's EPR system.

Externally, focus has been with regards to the leadership and early stages of delivery of the regional shared care record through the Share2Care programme. This programme is part of the national Local Health and Care Record Exemplar Wave 2 programme with NHS England. The aim of the programme is to deliver a shared care record to health and social care professionals across the North West Coast region.

A more detailed GDE programme update is included as an appendix to this report.

3.2 Operational Information Technology Delivery

With regards to operational Information Technology delivery, there are a range of services delivered to staff with a blended approach of in house, NHS shared service and external supplier partnerships.

On average, there are between 2000 and 2500 operational IT incidents managed on a monthly basis. These can range from individual user issues through to wider IT operational issues.

In addition, there are a range of technical delivery programmes in development. Some of these are national 'must dos' including upgrading the hardware estate to Windows 10 and achieving Cyber Essential accreditation.

There are a number of known operational pressures requiring quick attention including a review of the requirements and service model for Community services, some departmental hot spots, and improvements made to the operation of Multi Disciplinary Team meetings with external partners.

4.0 Key Developments

Since implementation of the EPR, new build and GDE, progress has been good, however it is timely to consider the next phase of developments for Alder Hey. These developments include:

- Development of revised Alder Hey Digital Strategy
- Review of Information Technology Operating Model
- Delivery of current priorities

4.1 Alder Hey Digital Strategy

As a digitally mature Trust, Alder Hey has major ambitions in terms of progressing with digital advancements. This is highlighted through the identification of delivering digitally enabled care as part of the strong foundations of the organisational strategy, Inspiring Quality and the emerging 5 year plan.

In addition, there are ambitions of ensuring a brilliant digital basics for staff, whilst progressing with key digital innovations such as artificial intelligence and sensor technologies.

Given the opportunity of the role technology can play in improving care for children, young people and their families, aligned to Alder Heys organisational developments and priorities, it is prudent to consider the various digital developments, excellence and ambitions that exist across the Trust and coalesce them into a single, clear digital strategy. This should be led by the priorities of the 5 year plan and Inspiring Quality strategy and respond to internal, local, regional and national service and digital priorities.

4.2 Information Technology Operating Model

The current Information Technology Operating Model has developed organically over a long period of time. Parts of the model are fairly complex with many partners involved in delivery. There are often competing demands between operational issues and technical project developments.

A clear operating model with divisional integration where required would strengthen delivery and staff experience. In addition, a clear and resourced technology and infrastructure strategy to underpin the digital strategy will be required.

4.3 Current Priorities

Against the backdrop of developing a new digital strategy and operating model, it is pertinent to continue a significant focus to ensure success of current priorities.

These include:

- Delivery of the final year of GDE: this includes HIMSS Level 7 international digital maturity accreditation which will further consolidate Alder Hey as a world leading digital healthcare organisation
- Upgrade of Electronic Patient Record: this will add additional functionality and a new user interface in parts of the EPR. Consideration of timing against operational pressures and digital strategy developments is key
- Immediate operational pressures service improvement plans: to include community IT, integration with divisions, and other operational and clinical priorities

5.0 Summary and Next Steps

In summary, Alder Hey is in a strong position with regards to digital and information technology. Benchmarked against other Trusts, the levels of digital maturity are excellent, as recognised through the GDE programme.

Given the priority of technology across health and care services, and internal quality and safety developments through inspiring quality, plus the exciting ‘art of the possible for the future’ opportunities, it is a good time to develop a new digital strategy and operating model for Alder Hey.

The potential to deliver outstanding ‘digital first’ excellence for staff, children, young people and their families is incredibly exciting.

The Trust Board is asked to note the content of this report and planned next steps:-

- Digital strategy development – to be presented to Trust Board in July 2019
- Information Technology Operating Model – baseline assessment underway
- GDE/HIMSS – gap analysis undertaken, plans developing for deliver in 19/20
- Operational pressure areas – improvement plans developing
- EPR upgrade – work ongoing regarding timescales, to be confirmed May 2019

Alder Hey Children's NHS
NHS Foundation Trust

Trust Board
7th May 2019

Subject/Title	Global Digital Excellence (GDE) Programme Update
Paper prepared by	Kate Warriner, Chief and Digital Information Officer Cathy Fox, Programme Director for Digital Kerry Morgan, GDE Programme Manager
Action/Decision required	The Committee is asked to note the updated progress of the Trusts GDE Programme the achievement of Milestone 5 and the commencement of Milestone 6
Background papers	N/A
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	IM&CT Strategy Significant contribution to the strategic objectives for:- - Clinical Excellence - Positive patient experience - Improving financial strength - World class facility

1.0 Executive Summary

The purpose of this paper is to provide the Committee with an update on the progress of the Trusts Global Digital Exemplar (GDE) Programme; the achievement of Milestone 5 and the commencement of Milestone 6.

2.0 Update of Progress

Since the previous update to the Committee on 1 April 2019 the Trust continues to ensure phase six milestones are achieved; primary areas of work include:

HIMSS

It is a requirement of GDE sites that Healthcare Information and Management Systems Society (HIMSS) Level 7 is achieved by the end of the Programme. A full gap analysis has been undertaken to ensure that the Trust is able to accomplish this. GDE plans have been modified for 2019 to address identified gaps within the planned assessment and accreditation timescales. In order to achieve HIMSS Level 7 Accreditation there are a number of processes required as follows:

- HIMSS Level 6 online assessment and gap analysis – completed December 2018
- HIMSS Level 6 onsite assessment – planned September 2019
- HIMSS Level 7 onsite gap analysis – planned in conjunction with the Level 6 onsite assessment September 2019
- HIMSS Level 7 onsite assessment – planned February 2020
- HIMSS Level 7 accreditation – planned March 2020

Progress with HIMSS will be monitored via the monthly GDE Programme Board.

Specialty Packages

There are now 33 specialty packages live. Five specialties in Tranche One are in varying stages of test and build, (Plastics, Gastroenterology, Transfusion, Allergy, Diabetes) with a plan to go live in May/early June, the delays for go live dates have been caused by annual leave and clinical demands. We potentially have three specialties that will be ready for development at the end of May from Tranche 2, with a further four specialties working on their requirements gathering.

We are in the process of documenting all "live" specialties that have further requirements as part of their post implementation review.

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

E-Consent

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

The e-Consent pilot review meeting took place in early April. This was an opportunity for the clinicians who have been using e-Consent to give their feedback to the suppliers. Overall, the response from users was positive, and a number of suggestions were made about how the system

could be changed and further developed to help clinicians. The developers are currently making changes in response to this to improve the system. New users within surgery have now begun using e-Consent along with the initial pilot group and a staggered deployment plan is in progress.

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

Voice Recognition

The VR project has now closed as a result of VR being successfully integrated into both Medisec and Meditech as per the key deliverables the project set out to do. Completion of the project has also resulted in VR being used in other applications outside of Medisec and Meditech. It has been deployed to all specialities and so is available for all clinicians to use, if they prefer to use it to complete their clinical documentation instead of using a keyboard and mouse.

The number of users has remained steady at around 130 and average usage is around 60 minutes per month. Users have become more proficient in setting up voice commands which automatically inserts pieces of text, reducing the dictation time. The usage stats for the system will continue to be monitored in line with the post project 3-monthly review. This will be completed by way of M*Modal, supplier of the system, providing monthly user adoption reports which will be reviewed on a monthly call by both M*Modal's Adoption Specialist and the Trust's GDE IM&T Project Manager. This will help to identify users that need additional support.

Future releases of the system with regards to system updates will be managed by the Asset Owner of the system in line with normal system update procedures. This will be completed by way of the Asset Owner receiving a copy of the release notes for the system upgrade and taking this to IM&T Change Board for review and sign off.

An outstanding item that needs to be completed to allow more clinicians who are keen to use VR to be able to use it is the replacement of under spec PCs. This is being addressed by the IM&T PC replacement programme.
Although all benefits deliverables have not been met, the reasons behind this are justified in the VR Closure Report.

The clinicians who are using the VR system well find it an invaluable tool in their daily clinical practice. See feedback from some of the clinicians below:

- "VR, I couldn't work without it. Couldn't go back. Love it" – Nurse Specialist - Orthopaedics / Baby Hip clinic
- "For me, voice recognition is a game changer…it's frankly magic" – Consultant Community Paediatrician
- "Community Speciality Package forms with the use of VR has allowed me to finish my clinics on-time" – Community Consultant

3.0 Summary of Key Benefits

Project	Aim	Measurement	Baseline Position	Improvement Target	Actual Progress to Target (current)
Booking & Scheduling Project	Increased income from backfilling cancelled outpatient appointments -	Income received minus costs of resource to call and backfill appointment slots	£0	£71,811 Mar-2019	£368,996 Oct-Mar 2019

	bi-directional texting				
Voice Recognition	Safer handover of care between the Trust and Primary Care	Average turnaround time for letters in working days	16 working days	3 working days Mar-2019	2 working days Mar-2019
Voice Recognition	Improve clinician experience with VR	Percentage of positive responses to 'VR is useful and helps with my daily clinical practice	4.35% Jan-2018	50% Mar-2019	53.3% Mar-2019

4.0 Milestone Assurance

The assurance for milestone 5 has been completed; work on milestone 6 has commenced.

5.0 Next deliverables

Work on milestone 6 has commenced, by November 2019 we will deliver:

- **HIMSS level 6 -** The Trust underwent a formal gap analysis assessment for HIMSS Stage 6 EMRAM assessment in December 2018. Feedback has now been received and an action plan developed to ensure achievement of level 6 is completed by September 2019. In terms of HIMSS level 7, a parallel piece of work is being carried out to identify the gaps to be addressed for HIMSS level 7 along with an action plan to address these with a view to a full assessment taking place in February 2020.
- **Bedside medication verification:** A pilot was undertaken in January 2019; an action plan has been developed to ensure this can be rolled out across the Trust. Updates are provided at GDE Programme Board.
- **Complete a total of 52 Speciality Package deployments:** 33 specialties are live, and a further 19 by November 2019.
- **Patient Portal –** Develop a secure online web portal that gives patients and their responsible guardian view-only access to patients own health records.
- **Share2Care –** Integration of the E-Xchange platform with EMIS.
- **Nordinet (Endocrinology) PC Pal –** live
- **API/FHIR interfacing –** included within Share2Care

6.0 Recommendations

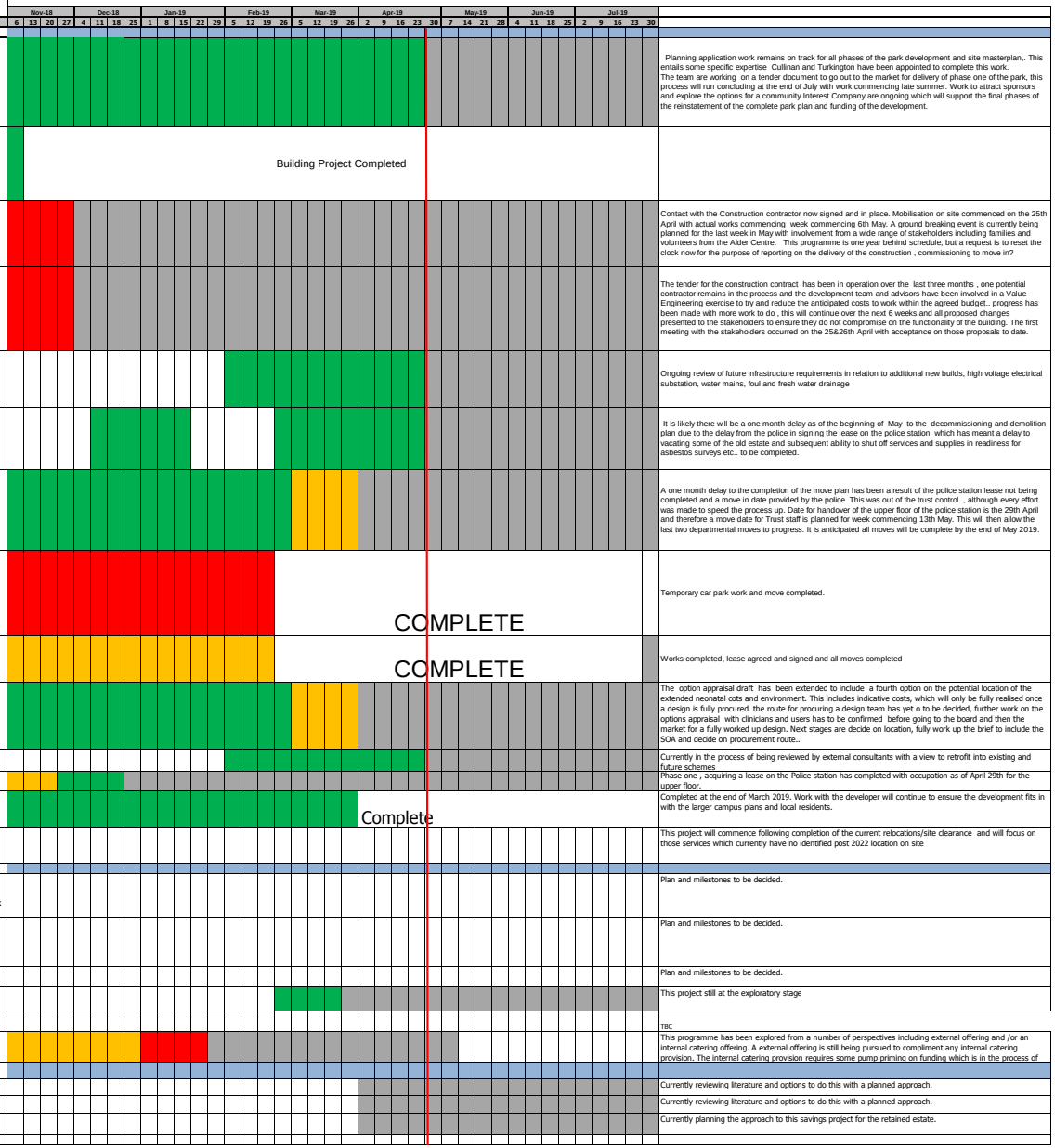
The Committee are asked note the progress of the Trusts GDE Programme; the achievement of milestone 5 and the on-going progress towards Milestone 6.

Kate Warriner
Chief Digital and Information Officer

HIGHLIGHT REPORT Site & Park Development April 2019

SRO: David Powell
Author: Sue Brown

Key
Planned project timeline
On track
up to 3 months delay
Over 3 months delay



The Park	Planning application work remains on track for all phases of the park development and site masterplan,. This entails some specific expertise Cullinan and Turkington have been appointed to complete this work. The team are working on a tender document to go out to the market for delivery of phase one of the park, this process will run concluding at the end of July with work commencing late summer. Work to attract sponsors and explore the options for a community Interest Company are ongoing which will support the final phases of the reinstatement of the complete park plan and funding of the development.
New Schemes: Institute Phase II	
New Schemes: The Alder Centre	Contact with the Construction contractor now signed and in place. Mobilisation on site commenced on the 25th April with actual works commencing week commencing 6th May. A ground breaking event is currently being planned for the last week in May with involvement from a wide range of stakeholders including families and volunteers from the Alder Centre. This programme is one year behind schedule, but a request is to reset the clock now for the purpose of reporting on the delivery of the construction , commissioning to move in?
New Schemes: Community Cluster	The tender for the construction contract has been in operation over the last three months , one potential contractor remains in the process and the development team and advisors have been involved in a Value Engineering exercise to try and reduce the anticipated costs to work within the agreed budget.. progress has been made with more work to do , this will continue over the next 6 weeks and all proposed changes presented to the stakeholders to ensure they do not compromise on the functionality of the building. The first meeting with the stakeholders occurred on the 25&26th April with acceptance on those proposals to date.
Supporting scheme. Infrastructure	Ongoing review of future infrastructure requirements in relation to additional new builds, high voltage electrical substation, water mains, foul and fresh water drainage
Site Clearance-Demolition and decommission Phase 2	It is likely there will be a one month delay as of the beginning of May to the decommissioning and demolition plan due to the delay from the police in signing the lease on the police station which has meant a delay to vacating some of the old estate and subsequent ability to shut off services and supplies in readiness for asbestos surveys etc.. to be completed.
Site Clearance-relocation of on-site services/corporate teams	A one month delay to the completion of the move plan has been a result of the police station lease not being completed and a move in date provided by the police. This was out of the trust control. , although every effort was made to speed the process up. Date for handover of the upper floor of the police station is the 29th April and therefore a move date for Trust staff is planned for week commencing 13th May. This will then allow the last two departmental moves to progress. It is anticipated all moves will be complete by the end of May 2019.
Site Clearance: Temporary car park	Temporary car park work and move completed.
Community services in Kilby house	Works completed, lease agreed and signed and all moves completed
Neonatal	The option appraisal draft has been extended to include a fourth option on the potential location of the extended neonatal cots and environment. This includes indicative costs, which will only be fully realised once a design is fully procured. the route for procuring a design team has yet o to be decided, further work on the options appraisal with clinicians and users has to be confirmed before going to the board and then the market for a fully worked up design. Next stages are decide on location, fully work up the brief to include the SOA and decide on procurement route..
District Heating Scheme	Currently in the process of being reviewed by external consultants with a view to retrofit into existing and future schemes
Securing Neighbourhood sites (police etc...)	Phase one , acquiring a lease on the Police station has completed with occupation as of April 29th for the upper floor.
North East Plot/Land sale	Completed at the end of March 2019. Work with the developer will continue to ensure the development fits in with the larger campus plans and local residents.
Housing corporate teams long term	This project will commence following completion of the current relocations/site clearance and will focus on those services which currently have no identified post 2022 location on site
Exploration of the Campus	
Activating and building the community alliance around the park including a local ownership model	Plan and milestones to be decided.
Linking the park and the Campus to the UNICEF Initiative/starting well/health and wellbeing agenda/social care agenda at LCC	Plan and milestones to be decided.
The Science quarter opportunity linked to innovation	Plan and milestones to be decided.
Exploring linkages with Broadgreen site.	This project still at the exploratory stage
Creating a growth /expansion strategy for Alder hey	TBC
Arranging Catering offer for site/park/estate	This programme has been explored from a number of perspectives including external offering and /or an internal catering offering. A external offering is still being pursued to compliment any internal catering provision. The internal catering provision requires some pump priming on funding which is in the process of
Other	
Space Utilisation review	Currently reviewing literature and options to do this with a planned approach.
Post occupancy evaluation (CHP)	Currently reviewing literature and options to do this with a planned approach.
Energy review and Optimisation	Currently planning the approach to this savings project for the retained estate.

Alder Hey Children's NHS
NHS Foundation Trust

CORRODED PIPEWORK REPORT

APRIL 2019

Background

In May 2016 a Central Alerting System notice was issued to all NHS organisations in relation to an increase in the use of thin-wall low carbon steel press-fit pipe work for new installations of water heating systems. It had been discovered that this type of pipework may be susceptible to rapid corrosion as a result of the introduction of air (via pin holes, inadequate joints or as a result of poor installation / commissioning practices). Corrosion could progress to an advanced stage much quicker than expected leading to unexpected failures in the pipework and this may require more frequent routine inspection to detect the problem.

Since the report was issued, a number of closed water systems within the new hospital have been identified as having such pipes fitted, which have led to 44 recorded pipework bursts and an estimated 20 non recorded incidents. This has led to disruption in several areas of the new build although the majority have been isolated to plant rooms. Nevertheless, the disruption has caused heating issues and the latest incident caused an area of the neuro department to be closed for a period of time whilst remedial works took place.

In October 2017 the SPV appointed a specialist consultant to undertake a survey of the pipework and components including water quality. The survey completed in February 2019 and the results were published and presented to the Trust, although there was no single cause identified, rather a build up of multiple issues including water quality within the pipework, the pipework itself, the storage of the pipework prior to installation and the dosing of chemicals to the system not being adequate.

Progress

Early progress reports issued on a monthly basis since February 2018, focused on the replacement of the pipework. However, since August 2018 the reports have indicated that a monitoring process was the preferred solution. Meetings have taken place with the SPV and Trust representatives on a regular basis although it is evident that since February 2019 progress has been limited and has led to increased discussions with the SPV. A letter was also issued to the SPV on the 11th March outlining the perceived lack of progress to date.

Since June 2018 the Building Services team have been in touch with Newcastle Royal Victoria hospital who has experienced similar disruption in regards to corroded pipework. Similarities' with Alder Hey include the same builder, Laing O'Rourke, Hard FM services provided by Interserve and the building managed by HCP.

The issues experienced at Royal Victoria have mainly been confined to non clinical areas and thus a programme of partial replacement was agreed with one metre of pipework replaced for every two meters of existing. It is unclear to date what affect this will have as the replacement has no yet fully concluded.

According to the independent consultant appointed by HCP, several schools across the UK have also been affected with corroded pipework with the solution being to replace the affected pipework with plastic instead of steel. It has been reported that since these replacements issues have been discovered with the connection of the pipework and thus caused further disruptions. Further information on this replacement has been requested.

The current proposal from the independent consultant for Alder Hey is to introduce a new technology known as thermal imaging. This is a fairly new concept and research has proved little evidence to suggest its success. This is a new proposal and further discussions are required in order to ascertain it suitability. An automated chemical dosing system is also to be introduced although the installation of this system has again slipped. Full or partial replacement of the affected pipework has been ruled out by the independent consultant representing the SPV in recent progress reports and

the reasons behind this should be discussed with the SPV. It would also be prudent for the Trust to undertake an exercise to understand the affect this would have on the hospital if a full or partial replacement was to be undertaken.

Notices received to date:

- Sections of pipework samples taken from 40 areas (completed)
- Results varied from satisfactory to immediate replacement (completed).

Corrosion rating 1 ok - 4 replace. See table below for further information.

Sample Ref	Service	Zone	Level	Pipe Dia. (mm)	Corrosion rating	Date	Category	Area Description	Serves
1	CWS	1	5	54	3	140201			
1	CHW	1	5	76	1	140423	High point	Plantroom	AHUs
2	CHW	7	-1	18	2	150402	Low point	Imaging	FCU
3	CHW	7	3	76	2	140726	AHU supply	Plantroom	AHUs
4	CHW	3	2	18	1	150402	Terminal supply	Offices	FCU
5	CHW	2	3	28	0	-	Ward	Ward	FCU
7	CHW	5	0	18	2	-	General	Meeting Room	FCU
8	CHW	2	5	54	2	140422	Riser	?	FCUs/AHUs
10	LPHW (CT)	7	-1	18	1	-	Low point	Imaging	FCU
12	LPHW (CT)	3	2	18	2	150402	Terminal supply	Offices	FCU
15	LPHW (CT)	5	0	18	3	140130	General	Meeting Room	FCU
16	LPHW (CT)	2	5	42	2	-	Riser	?	
18	LPHW (VT)	7	-1	18	2	150215	Low point	Imaging	Radiant Panel
22	LPHW (VT)	1	4	18	3	140315	Ward	Ward	Radiant Panel
24	LPHW (VT)	1	4	42	2	-	Riser	?	
25	GSHP (CT)	3	3	18	1	-	Ward (ACB)	Ward	ACB
26	GSHP (CHW)	3	3	18	1	150416	Ward (ACB)	Ward	ACB
27	GSHP (CT)	2	4	54	4	140510	General		
28	GSHP (CHW)	2	4	24	2	141009	Ward (ACB)	Ward	ACB
29	GSHP (CT)	1	2	35	4	-	AHU supply	Plantroom	AHU
30	CHW	5	2	24	1	141103	General	?	FCU
31	LPHW (CT)	5	2	18	1	150402	General	?	FCU
33	CHW	3	0	42	0	150909	AHU Supply	Plantroom	AHUs
34	LPHW (CT)	3	0	28	0	151006	AHU Supply	Plantroom	AHUs
35	GSHP (CT)	2	2	76	4	140204	AHU supply	Plantroom	AHU/2/10
36	GSHP (CT)	3	3	18	1	141115	Ward (ACBs)	Lift Lobby	ACBs
37	GSHP	2	2	76	4	140204			
38	GSHP	2	4	54	1	150623			
39	GSHP	1	2	35	4				
40	CT	5	0	18	3	140130			

- Example of ratings:

Rating 1 - good

External surfaces bright and clear of any oxidation.

Internal surfaces generally dull grey with some speckling of orange corrosion products on one side.

One side of tube dull grey.

Rating 4 - replace

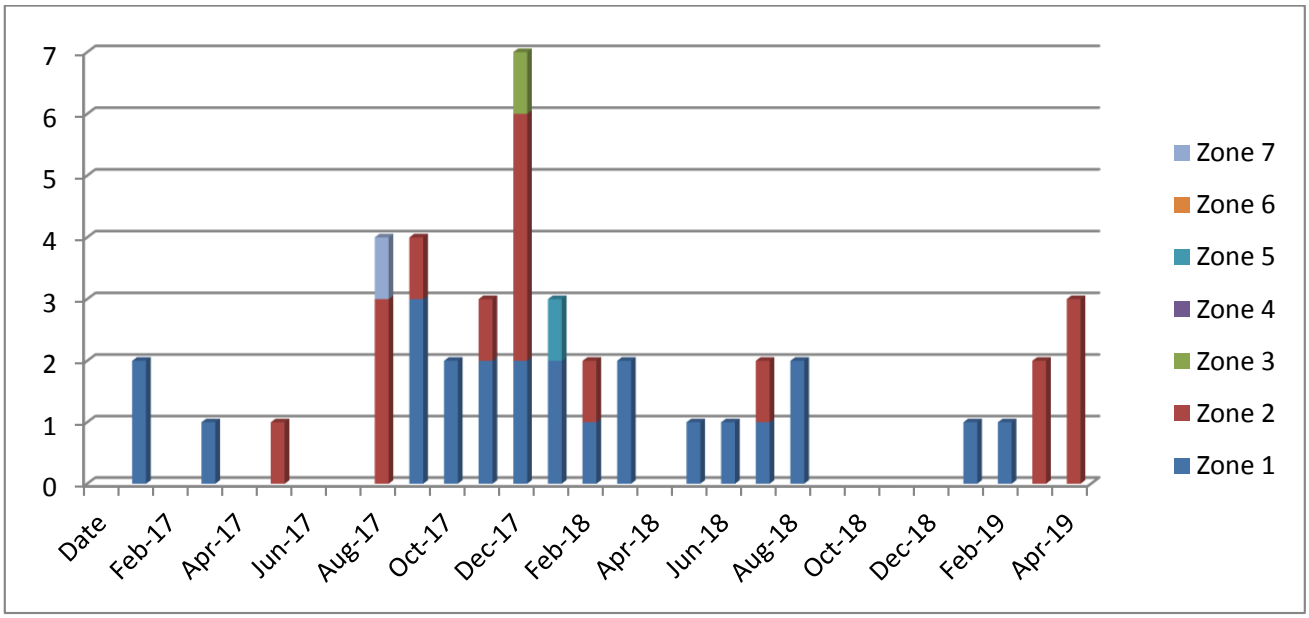
External surface bright and clear of any oxidation.

Internal surface heavily corroded with thick layers of oxides.

Small tubercles of corrosion products.

- Approximately 64 failures over the past three years (44 officially recorded). SOP in place to deal with failures and replacement of pipework when a failure occurs (ongoing).

Pattern of failures:



The commissioning records indicate that the correct treatment was set in place during commissioning. However, there is no indication as to what happened prior to commissioning and therefore there is a possibility that there was corrosion established during installation.

The Ground Source Heat Pump (GSHP) system has the highest levels of contamination. The key issue currently is the levels of dissolved oxygen in the system; this is likely due to the system make-up water following remedial works following leaks, the levels of make-up are not currently tracked. High levels of dissolved oxygen will promote corrosion. A key remedial measure is the removal of the oxygen within the system with an oxygen scour. Allied to the scouring on re-filling the system would benefit from an auto-dosing system to ensure that any make-up water introduced into the system is correctly dosed to avoid compromising the system.

Combining each of the experts' reviews it is not possible to determine a definite root cause of failure; this is also true of probable cause. The largest contributory factor is the levels of oxygen in the system. However, this cause is a symptom of the remedial works, particularly re-filling of the system following leaks; this is also a possibility which could have occurred had the pipework been filled multiple times during installation.

Possible causes include:

- Poor storage of pipework pre-install – unlikely due to the requirement for high humidity to initiate corrosion
- Poor commissioning of the system – commissioning records indicate that the commissioning was performed correctly
- Pipework being left full following commissioning
- Poor operational water treatment
- Insufficient filtration
- Seasonality resulting in low consistent flow rates
- Poor control resulting in motorised valves not effectively controlling flow through all areas (e.g. actuators not installed onto valves)
- Poor system balance
- Commissioning of a system and then extending the system
- Corrosion becoming established prior to the system being fully operational
- Inhibitors not penetrating the corrosion products to the metal surfaces below
- Inconsistent treatment
- Poor maintenance practice (e.g. balancing valves used as isolation valves and not returned to the correct setting).

Actions to rectify date:

- The systems affected by corrosion have had a manual dosing system introduced in order to stabilize the water within the pipework. This has the effect of removing any additives known to promote corrosion. However, it depends on strict monitoring and testing of the water to prove effective (ongoing monitoring and dosing).

- An automated dosing system alongside a side stream filtration has also been recommended and a date to install is currently being sought. This will address the quality of the water and remove any unwanted particles and will also reduce the risk compared to manual dosing (ongoing).
- All pipework that had been previously identified as having the most serious corrosion (level 4) has been replaced (completed). However, it is not clear on the levels of corrosion on areas that were not sampled, nor if the pipework installed as a result of the original corrosion is holding up.
- Testing of adjacent pipes and replacement where appropriate. This is to be addressed using thermal imaging although its success rate is currently unknown due to it being a new technology.

Proposed next steps:

- Continuous monitoring on impact of water treatment/dosing with results analysed of contaminants and necessary actions taken to reduce/remove. It's possible that an automated system can be introduced in order to provide constant monitoring on the condition of the water.
- A full and detailed tracking system should be introduced that contains information such as area, cause, water quality, replacement etc.
- Introduction of a non destructive monitoring device such as, but not limited to, thermal imaging. This will potentially identify corroded pipework that is not visible and thus result in a more pro active replacement before the pipe bursts which will result in less disruption. Surveys would need to be conducted on a regular basis for it to be successful as it is not automated.
- Introduction of a side filtering system to remove contaminants from water within affected pipework. This would again reduce the risk of the water quality deteriorating and thus creating corrosion within the pipes.
- Monthly meeting with Exec/Non-Execs representatives and senior management form HCP/LO'R in order to review progress.
- HCP report on other sites (including hospitals) on the cause/effect and rectification process and if successful. A lessons learnt would also prove helpful and may well benefit other organisations with the same issue.

Mitigations to date:

- Shielding of electricals that are in the same area as any pipework to prevent further disruption (completed).
- Ensuring LO'R maintains a rapid response team on site until rectification of all pipework is complete. To date the reaction times and performance from the onsite team has prevented any major incidents.
- An SOP is in place which address's the issue of dealing with leaks in all areas (completed). This is a process that includes contacting various departments within the Trust to ensure the area is safe for reopening.
- It is recommended that a further review of mitigations is undertaken by HCP in order to ensure sufficient and adequate controls are in place.

Questions raised at liaison committee and awaiting a response:

- Are there any legacy pipework issues? How can this be addressed to ensure no further bursts or leaks?
- Is there further degradation? Have the areas that have been replaced holding up? Are there any signs of corrosion in these areas?
- How effective is the current manual dosing/testing and to what extent will the automated dosing be successful? Are there any examples of this from other sites?
- Are any systems in place that can detect bursts before they occur? How successful have they been?

Future Options

As a result of a recent meeting with senior Trust representatives it was agreed to provide a list of options available to the Trust in order to ensure the SPV progresses the issue in a timelier manner. Further to this the SPV are to be called to a monthly meeting with Execs and Non Execs in order to monitor progress.

Increased monitoring – it has already been decided that the SPV should be placed under increased scrutiny in regards to corroded pipework. This should be implemented as soon as possible with Exec and Non Exec members of both the SPV and the Trust in attendance ensuring any actions identified are carried out within an agreed timescale. The meetings should be held monthly until such a time is deemed that sufficient progress has been made. This should be the first course of action and an initial internal meeting has been set up for May 7th.

Step in – Step in is usually seen as a last resort and whilst it may address the issue, it comes with several complications. It consists of taking full control of the works required and then reclaiming any costs incurred back from the SPV (HCP). Whilst this option may well speed up the process the downsides are that the SPV may not accept the works undertaken are to a standard they would expect, or may not even grant access to the areas where the pipework is located (plant rooms). Full legal advice should be sought before attempting to undertake step in and every other alternative should be explored before progressing. Step in should be seen as a last resort.

Legal advice – in line with the increased monitoring, further legal advice should be sought on step in and any further options available.

David Powell
Graeme Dixon

ALDER HEY CHILDREN'S HEALTH PARK LIAISON COMMITTEE

Title	**Liaison Committee Meeting Minutes**	
Date / time	Tuesday 19 March 2019, 1230hrs	
Location	Executive Meeting Room, Alder Hey Children's NHS Foundation Trust, Eaton Road, Liverpool L12 2AP	
Present	**Trust:**	David Powell (Development Director) **DP** Claire Liddy (Trust Representative) **CL** Graeme Dixon (Head of Building Services) **GD**
	Project Co Directors:	Alan Travis (Laing O'Rourke, Explore Investments) **AT**
	Other Project Co Attendees:	Andrew Saunders (Project Co Representative) **AJS** Carl Roberts (Interserve FM) **CR**
Apologies	Louise Shepherd (Trust CEO) **LS** John Grinnell (Trust Deputy CEO and Finance Director) **JG** Rachel Lea (Trust Associate Director of Development) **RL** Bob Marsden (Interserve Investments) **BM** Andy Pearson (John Laing Investments Ltd) **AP** Tristan Meredith (Interserve Developments) **TM**	

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 26 February 2019** – The previous minutes were accepted as an accurate record of the meeting.	**Note**
3.0	**Key Issues / Hot Topics**	

3.1	Pipework corrosion AJS referred Committee Members to Mark Cades Progress Update, dated 11 April 2019. AJS summarised the highlights from the report which included a proposal for non-destructive testing, the installation of side stream filtration, an auto-dosing system, and the ongoing analysis of water quality following the implementation of an improved dosing regime. CR advised that IFM were also reviewing ways in which the pipework system could be monitored more proactively. DP acknowledged these points and advised that several the stated actions detailed within the Progress Update were long standing and questioned whether any meaningful progress had been made been made in the reporting period. Considering the reported position, the Trust sought further assurance around the mitigations that are currently in place. AJS advised that a programme setting out when the next steps would be implemented would be available during week commencing 25 March 2019, and that a call would be arranged to discuss the associated key dates and activities.	**Note** **Note** **AJS**
3.2	Interserves corporate position CR confirmed that following Interserve's EGM on 15 March 2019 an alternative restructuring proposal was being implemented as the shareholders of Interserve Plc did not approve the Deleveraging Plan. The restructuring proposal will involve Interserve Plc going into Administration and the sale then taking place of Interserve Plc's business and assets to a newly incorporated entity (Interserve Group Limited) which will be wholly owned by their lenders. CR advised that the delivery of Services had continued uninterrupted and that IFM's supply chain partners were engaged and being provided with appropriate assurance. AT informed Committee Members that because of the Administration further Defaults had occurred under the Service Contract and Common Terms Agreement, and that details of the same would be relayed to the Trust in due course. CL queried what the Administration meant for Interserve as a Shareholder in the Project Co, AT advised attendees that the Project Co Board of Directors were awaiting written advice from Interserve.	**Note** **Note** **Note** **AJS** **Note**
4.0	**Any Other Business**	
4.1	Nothing to report.	**Note**

5.0	**Next Meeting**	
5.1	Tuesday 15 April 2019; 1230hrs – Executive Meeting Room	**Note**

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
4. Any Other Business
5. Next Meeting

Clinical Quality Assurance Committee
Minutes of the last meeting held on Wednesday 20th March 2019
10.00 am, Large Lecture Theatre, Institute in the Park

Present:	Anita Marsland	(Chair) Non-Executive Director
	Adam Bateman	Chief Operating Officer
	Denise Boyle	Associate Chief Nurse - Surgical Division
	Lisa Cooper	Director of Children & Young People Community & Mental Health
	Christian Duncan	Divisional Director, Surgical Division
	Hilda Gwilliams	Chief Nurse
	Rachel Greer	Chief Operating Officer, Community Division
	Anne Hyson	Head of Quality – Corporate Services
	Erica Saunders	Director of Corporate Affairs
	Jeannie France-Hayhurst	Non-Executive Director
	Adrian Hughes	Acting Joint Medical Director & Director, Medicine Division
	Pauline Brown	Director of Nursing
	Mark Flannagan	Director of Communications and Marketing
	Melissa Swindell	Director of HR & OD
	Cathy Umbers	Associate Director of Nursing & Governance
	Stefan Verstraelen	Head of Quality – Surgery
	Tony Rigby	Deputy Director of Risk & Governance

In Attendance:
Agenda Item:

	Lesley Taylor	Matron, Outpatients
	Lachlan Stark	Head of Performance & Planning
	Angie May	Head of Clinical Partnerships
	Julie Creevy	Executive Assistant (Minutes)

18/19/164 Apologies:

	John Grinnell	Deputy Chief Executive/Director of Finance
	Dani Jones	Director of Strategy
	Jo McPartland	Clinical Director for Cancer Services & Laboratory Medicine
	Matthew Peak	Director of Research
	Sarah Stephenson	Head of Quality – Community
	Cath Wardell	Associate Chief Nurse – Medicine Division
	Julie Williams	Appointed Governor

18/19/165 Declaration of Interest
None declared

18/19/166 Minutes of the previous meeting held on 20th February 2019
Resolved:
CQAC approved the minutes of the previous meeting held on 20th February 2019.

18/19/167 Matters Arising and Action Log
Action Log

18/19/01 – DETECT update - HG reported that a meeting had taken place with Nik Barnes, Geri Sefton, & Enitan Carroll, on 12th March 2019. Agreement had been reached that DETECT would be governed through GDE with 6 monthly updates at CQAC. CQAC agreed that this item would be closed and removed from action log.

18/19/122 – Programme Assurance Update – re evidence uploading regarding Sepsis – HG reported that she had met with Sepsis team on 19th March 2019 and had discussed key performance indicators, performance and challenges, and discussion had taken place with regards to refresh of blueprint. ND was now assured regarding the correct level of detail and amendments.

18/19/123 – Safer Bundles & Play responses – this item is included on agenda, item to be removed from the action log.

18/19/134 – BAF Inspiring Quality – this item is included on the agenda, item to be removed from the action log.

18/19/137 - Transition update – Jacqui Rogers to attend Triumvirate meeting on 26th February 2019, item to remain on action log to review at April 2019 meeting.

18/19/141 – CQC Action Plan – Training figures - MS stated that she had spoken with Darren Shaw, Learning & Development Manager and had received assurance that the sepsis training figures had been resolved. MS confirmed that she would share the mandatory training report at the joint CQAC/ CQSG meeting in April 2019.

Action: CQAC to receive report regarding training figures, detailing any gaps, indicating specifcs against the CQC action plan.

18/19/142 – Corporate Report – Quality Metrics – Friends & Family action plan – this is on track for review at April CQAC/CQSG meeting.

18/19/152 & 168 - Sepsis Update – Junior Doctor mandatory training figures on ESR – MS agreed to provide CQAC with a detailed update report at April joint CQAC/CQSG meeting.

Action: MS to provide Junior Doctor training figures report to CQAC at April 2019 meeting.

18/19/153 – Comprehensive Mental Health Update – regarding app benefits for support for CAMHS patients and families - JFH had forwarded app details to Andrew Williams, who is currently in the process of following this up.

18/19/160 – Quarter 3 DIPC report – offline discussion to be held with LC & VW regarding future requirements – Lisa Cooper had met with Valya Weston to progress the IPC Support to Community & Mental Health Division, and a Business Case in progress. Discussion also took place with LC & VW with regards to involvement of the young people's forum in any trust wide development regarding IPC.

18/19/169 Best in Outpatient Care and Brilliant Booking update

AB presented the Best in Outpatient Care Update, key issues as follows:-

Achievement of Outpatient CIP opportunities identified for 2018/19

- Increase room bookings to 90% - room booking scheduling work plan underway. Rapid improvement cycle started to deliver the standard of 90% use of clinic time. Achieved 85% as at January 2019, enabled through data packs.
- Increase clinic template by 1 slot – work plan to undertake full clinic template review underway – improvement target was set at 3.5% by the end of March 2019, against November 2018 baseline. There had been a slight increase in utilisation to date.
- Increase OPD Procedure coding – Activity up by 780 procedures against plan. CIP badged to GDE
- Improve recording of Ward Based OPD – Based on Month 11 income for ward based OPD only (+1,703 attendances). Ward attender variance being investigated – may be due to timing of data capture. CIP badged to GDE.

Root cause for under utilisation of clinics

- Issues under-managed over a period of years
- Session times not formally defined
- Clinical template not aligned
- Planned utilisation/number of patients booked less than 100%
- Patients invited to attend appointments, but have not contacted to indicate that they will attend (DNC's)
- Protected clinic appointment slots that often go unused
- Patient not brought/DNA rate
- Clinic pathway forms not completed on the day

Response

- All departments had been given data packs
- Each service manager presented data at departmental meeting and agreed improvement plan
- Improvement plan presented to Operational Performance Delivery group in February 2019.
- Standard set out from Chief Operating Officer is to achieve 90% by March 2019.
- CQAC noted the divisional approach to increase utilisation to 90%.

Outpatients – latest improvements

Lachlan Stark introduced Lesley Taylor and Ellie Johnson who presented the latest Outpatient improvements update, key issues and examples of actions are outlined below:-

- Additional signage is due to be installed week commencing 18th March 2019, to improve the patient experience and navigation around outpatients department.
- Ultrasonic height and weight scale currently being trialled, with the aim to improve waiting times and flows
- Waiting area seating under review, enlisted help of the Trust Disability Network and invited families to vote on seating they want to improve the patient experience

AM thanked LS, LT and EJ for update and asked for thanks to be extended to outpatient team for continued improvements to date.

Brilliant Booking Update

AB presented the Brilliant Booking update, key issues as follows:-

- AB updated CQAC on the 5 improvement priorities for 2018-20 regarding Brilliant Booking system.
- 8 out of the 30 specialities were now live with hybrid booking and plan is on track.
- CQAC noted the hybrid high level roll out plan, together with the hybrid booking process and Bi-Directional text flow chart information.

Issues with current processes:-

- Some follow-up patients not booked in order or clinical importance
- Poor experience as invited to book an appointment, but no slot available and multiple cancellations
- High number of hospital cancellations as appointments booked not aligned with clinicians' leave.
- Inefficient process, with duplication and high postage costs
- Too many queues – a large 'did not contact' (DNC) list requires consistent admin and clinical review.
- 27 out of 30 specialities now live with Bi-Directional texting, with remaining specialities to go live by April 2019.

Benefits realisation:-

- All patients with a safeguarding flag on a DNC waiting list have had a safety review – (709).
- 16% reduction in the number of patients from 12,590 in September 2018, as compared to current number of 10,575.
- Hybrid booking and bi-directional texting hade reduced patient cancellations within 24 hours.

Next Steps:-

- Digital booking service – ability to book appointments via email and mobile.
- Introduction of 'was not brought' awareness campaign
- Process for patient demographic checks on the NHS Spine to improve communication reliability.
- Deliver 90% clinic utilisation

AM thanked AB for the update.

18/19/170 Safer Bundle – this item to be deferred for CQAC to receive an update at April 2019 meeting.

Play Responses

Pauline Brown provided a verbal update regarding play responses, key issues as follows:

PB stated that the play and learning metric within the corporate report had been consistently red. PB confirmed that progress had been made via initiatives led by Helen Pinder including an 18 month strategic plan which had identified areas for action; this has already resulted in improvements. PB reported that the metrics will be split in April 2019 and it is envisaged that scores would improve. The play scheme had commenced week commencing 18th March 2019 with bespoke training. PB confirmed that distraction and play is recorded on Meditech 6. Referrals for play specialist support for both in and out patients are now being recorded. The play specialist clinic activity is now be captured by GDE. The

increased financial benefit is in the process of being investigated by the finance team.

The first cohort of Liverpool Pediatric Society Bedside Play scheme volunteers is due to commence by end of March 2019. Bespoke training had been delivered by the play specialist team. Additional activities have been identified in ED and outpatient areas in order to improve performance.

The installation of games consoles and tablets for inpatient recreational use on the wards and departments has been established and the play team are working alongside the Alder Play team to facilitate and encourage use of the app by patients and families.

The team hade now developed links with the Vocational Placement Adviser & have commenced student placements . On the 15th February the play team engaged in the first careers event for year ten students from the local community.

AM asked PB to extend thanks on behalf of CQAC to the volunteering team for continuing to support patients and families.

18/19/171 Inspiring Quality update

AB provided an Inspiring Quality update, which detailed aims, priority outcomes and process metrics. AB provided detailed information regarding Phase 1of the implementation plan, as follows:-

1. Build a culture of Inspiring Quality and raising awareness
2. Create capacity and capability
3. Signs and symbols and early wins

Specific actions are as follows:

- Establishing an Inspiring Quality Clinical Cabinet to include children, young people and families
- Inspiring Quality Leadership Faculty providing learning and development on communicating safely, leadership and improving quality with children and families
- Have a digital platform, including mobile application, to communicate and exchange Inspiring Quality
- Create a social movement and invite every member of staff to be involved; ask each Department to share their plan for Inspiring Quality.
- Signs and symbols to signal the start of the implementation phase of the Inspiring Quality Programme

Build a culture of Inspiring Quality, and raise awareness

- Division's annual plans aligned to Inspiring Quality
- Circulation of video
- Departmental visits
- Strong Foundations Leadership proposal

Delivering Capacity & capability

- Programme Management Support (N Deakin)
- Establish Inspiring Quality Clinical Cabinet
- Process to secure partnership(s)
- Appoint 4 leads (with 1 day allocation) for changes to how we will work

NM requested further discussion in relation to patient safety data and response. It was agreed that it would be beneficial for an offline discussion with AM/HG/NM with regard to quality metrics and would be fed back through CQAC, it was noted that it would be beneficial for a further update on Quality and Safety at CQAC, and that this could potentially be included on the agenda at the Joint CQAC and CQSG joint meeting in April. NM sought clarification on the purpose of the joint CQAC/CQSG group meeting. AM confirmed that it was to acknowledge that CQAC could not operate efficiently and effectively without the work of CQSG, the joint meeting would also aid joint planning and collaborative working, and also for both committees to reflect on what works well and what could be improved.

Next Steps

- Inspring Quality implementation paper to be tabled at Executive Directors meeting on 4th April 2019.
- Work streams to be established
- Big conversation with each department
- Resource plan through budget setting

AM stated that she would be keen to be involved in any future discussions regarding quality and safety.

AM thanked all for updates received.

18/19/172 Programme Assurance Update

Natalie Deakin, Delivery Management Office Lead presented the Programme Assurance Update. Key issues as follows:-

- Overall for the 'Delivery of Outstanding Care' programme, project governance is satisfactory with all projects rated amber or green.
- The 'Sepsis' project had seen a deterioration in overall governance rating this month and agreement of the new target thresholds and a detailed plan for 'year 2' is required imminently - targets require agreement.
- The 'Comprehensive Mental Health' project had also seen a deterioration in some areas this month and the lack of any positive trends on metrics should be reviewed.
- The 'Models of Care' project had seen an improvement in some areas this month, but still require clarification on metrics for success.

HG highlighted the importance of review and updates for 2019/20 plan.

ND stated that she is content with the governance process, however further improvements are required in order to improve project ratings to 'green'. AM asked whether there is anything specifically CQAC could do to assist programme delivery office with regards to current ratings. ND stated the importance of spending focussed time regarding metrics.

AM thanked ND for update.

18/19/173 CQC Action plan update

ES presented the CQC action plan, key issues as follows:-

ES updated the committee with regards to item 2 "Ensure that all services have up to date strategies or improvement plans in place" and asked the Committee to note that Dani Jones would be leading on the development of a new

five year strategic plan which would provide the vehicle to complete this action in the early summer.

ES confirmed that with regard to item 4 regarding 'Consider the recording of discussion and challenge at meetings' that staff training had taken place with 27 administrative support staff attending NHS Providers minute taking course on 31st January 2019.

'Radiology Systems' with regards to information recording. AH stated that Action 6 is currently on track to be completed by end of April 2019, as there had been IT development issues experienced.

Action 9 – "Ensure that they are fully compliant with the appropriate Lampard recommendations" – Staff side discussions are to be concluded to agree a rolling programme of DBS checks to take place for all eligible staff. This is currently on track.

ES stated that all completed actions would be removed from the action plans and the remaining actions reported by exception until completion or movement to an assurance committee for ongoing monitoring. CU stated that excellent progress had been made, however reminded committee members regarding the importance of adhering to agreed timeframes and setting realistic achievable target dates at the outset.

Concern was expressed regarding Community Division in relation to IM&T issues, this issue was also included on the Risk Register – which is an ongoing concern.

End of life care – 6 out of the 8 items had still not been completed. A number of the actions are not due yet, however committee agreed the importance of not extending the timeframe dates any further.

AH stated that within the Radiology Action plan – Action 7 with regards to "Developing a vision and strategy specific for the service" – AH stated that this item would not be signed off until April 2019.

Action: Divisions to present CQC action plan update at April 2019 meeting.

ES stated that the local Inspection engagement meeting with CQC scheduled for March had been cancelled by the inspector, with the next meeting to take place on 11th June 2019. ES asked colleagues to aim to have as many actions completed with relevant evidence provided ahead of this meeting.

AM thanked ES for her update.

18/19/174. **Corporate Report – Quality Metrics**

HG presented the Corporate Report – Quality Metrics, keys issues as follows:-

- HG reported that there had been two moderate harm incidents reported, however both relate to the same incident for the same patient – a second moderate harm incident form was submitted to consolidate the initial moderate and two additional minor harm reports. This related to a child in A&E with a wound infection who was a cardiac patient. A Level 1 RCA investigation is currently underway. Duty of Candour had been completed, in line with

regulation 20. The 72 hour review report had been completed in line with National Standards and Trust policy. Incident submitted to NRLS.

- HG stated that there had been one catastrophic incident which is currently under investigation. Duty of Candour had been completed in line with regulation 20. The 72 hour review report had been completed in line with National Standards and the Trust policy and submitted to the CQC and CCG. The incident had been reported to StEIS and NRLS and SUDIc notification. Level 2 comprehensive investigation is currently underway led by R Mullholland with a panel meeting on the afternoon of 20th March 2019. K Black is leading on the immediate learning which will be shared as appropriate. NM queried whether there should be external representation at panel meetings and whether it should be standard protocol to include external representation. DB stated that colleague from the CCG are invited along to attend. CD stated the importance of the terminology used within the corporate report with regards to catastrophic incidents, and that terminology should state 'unexpected death'.
- Never Event – relating to wrong site block used in Day surgery; following the 72 hour review it has been established that the 'stop before you block' moment did occur, however this was followed by an interruption, with no re check following the interruption. NM questioned whether the patient had site markings evident, HG confirmed that the patient did have appropriate site markings in situ. The individual realised very quickly, escalated and the procedure stopped. The NHS Serious Incident Framework and Never Event framework were followed to assure standards of investigations and lessons learned are implemented. Duty of Candour had been completed in line with regulation 20. The 72 hour review report had been completed in line with National Standards and Trust policy and submitted to the CQC and CCG. Incident reported to STEIS and NRLS Level 2 comprehensive investigation is underway and reflection is taking place.

HG reported that following the 3 Never events approximately 18 months ago that the national template was reviewed, with regard to the WHO moments/checklist. The national tool was felt to be fit for purpose.

Friends & Family

- HG stated that there had been a decrease in feedback with regard to mental health services; Community Division is currently reviewing this.
- A&E - HG reported that she had recently met with A&E Team, on 19th March 2019, together with Patient Experience Team regarding challenges, and with regard to issues raised by Council of Governors on 12th March 2019 about cleanliness and availability of paly/toys in the waiting room. An action plan is currently being completed, and will be shared with CQAC at April 2019 meeting, HG stated that she envisaged that within 6-12 month period that the Trust should see real improvements.

Action: Receive Action plan at April 2019 meeting.

AM thanked HG for her update.

18/19/175 Board Assurance Framework

ES presented the Board Assurance Framework, key issues as follows:-

- ES stated that weekly Quality Performance Planning meetings (QIPP) meetings had commenced, Chaired by Chief Nurse, and attended by Associate Chief Nurses to monitor progress with regulatory requirements (Duty of Candour,

complaint responses, RCA timeframes), with devised clear schedule for ward based annual risk assessments.

- BAF 1.2 'Failure to meet targets and internal performance metrics due to poor flow and lack of capacity to fulfil activity plans and respond to increasing demand – ED performance had again been challenged by high volume of patients with high acuity, although bed availability had been good. The change programme project on patient flow had impacted positively on capacity in the last month, with only one cancelled operation at time of reporting. A plan to rectify the ED position in March had been developed by the team. CQAC acknowledged the significant effort of ED teams with regards to service delivery, ensuring patients are seen timely.

  AB stated that access to Cardiac programme is good and the team is on track to hit the target 400 CCAD cases for the year. CD stated that the division are currently reviewing how many patients unexpectedly go onto ECMO.

  BAF 2.1 Failure to deliver consistent high quality patient centred services due to not having the right people, with the right skills and knowledge, in the right place at the right time. Apprenticeships continue to progress, 61 learners enrolled to date. Successful school careers event hosted in February, with over 30 Year 10 students in attendance.

  Workforce KPIs tracked through the corporate report and Divisional dashboards.

  ES stated that Kerry Byrne, had commenced a cycle of deep dives within Integrated Governance Committee to fully test assurance.

  AM thanked ES for her update.

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18/19/176 Quarter 3 Complaints Report

AH presented Quarter 3 Complaints report (October 2018 – December 2018, key issues as follows:-

- The Trust received 26 formal complaints during this period.
- One complaint from this quarter was subsequently withdrawn from the process as mum requested that it wasn't the right time for her to proceed with the complaint process.
- In 2017/18 Q3 The Trust received 27 formal complaints, this is therefore a very slight reduction of 1 formal complaint, it is however the first time this year there had been a reduction of complaints compared to last year's timeframe.
- In Quarter 3, 25 out of 26 complaints were acknowledged within 3 days – 61% on the same day. One complaint was not acknowledged for 38 days. This was an oversight by the Division and sincere apologies were given directly to mum, who accepted the explanation and apology.
- Withdrawn complaints – one complaint was withdrawn this quarter. As mums personal circumstances had changed very soon after she had raised complaint, she had suffered a very close personal bereavement and her daughter had been readmitted, mum therefore felt it was not the most appropriate time for her to raise concerns, and commit to liaising with staff to get issues resolved. Mum was advised that her complaint is recorded on the system and mum had been provided with contact details, for when she feels able to get in touch with PALS to reopen her complaint.

- 17 complaints were upheld within this quarter and 7 were not upheld. 2 complaints are ongoing.
- Once case from Quarter 2 is still being assessed by the PHSO as to whether they plan to investigate or not.

PALS summary

- In Quarter 3 2018-2019 PALS contact had been received, totalling 324, in comparison to the same quarter in 2017/18 this is a very slight increase of 13.
- Face to face contact equated to 66%, whilst written concerns accounted for 33%.
- CQAC noted a slight downward trend of contacts into PALS team during the last 2 quarters.
- Highest area of concern related to waiting time for appointments, with communication failure (medical) being the second high and third highest area of concern related to cancellation of appointment. This category had not been seen in this volume for a number of months. Looking at this more closely the three specialities this these categories relate to in Q3 are Community paediatrics, ENT and Gastroenterology.

Key actions & lessons learnt from PALS during Quarter 3

- The main issues identified within Q3 relate to appointments management – waiting times. The specialities that have issues relating to these categories are:-
  Waiting time for appointments – Community Paediatrics, Ophthalmology, Audiology, CAMHS – Liverpool.

  This is the first quarter since Q1 that the complaints team had seen this volume of concerns regarding appointment cancellation.

- PALS and complaints are communicated and fed back to senior staff at three Divisional Integrated Governance meetings, to ensure appreciation of current trends are fully disseminated and actions could be taken to review specific areas of concern. Updates are shared by Divisions at Clinical Quality Steering Group (CQSG) at each meeting.
- Compliments are recorded on Ulysses system and shared with relevant teams – with seven compliments recorded this quarter on Ulysses.
- Staff support – within Quarter 3 the PALS team had valued the continued support provided by the LIA team. These sessions had taken place away from the office and had provided a safe environment to discuss any issues relating to cases that the staff find difficult, challenging or emotional and how they had dealt with them, the opportunity to reflect had been invaluable.

NM stated that it would be extremely helpful to review all trends, and that it would be informative to remove medication prescription incidents in order to review supporting detail.

AM thanked AH for update.

18/19/187 Private Patient Policy

Angie May presented the Private Patient Policy which had been previously reviewed at CQSG. The Policy reflected regulatory requirements to ensure clear guidance to staff in the management of private patients. This would ensure that income generated from this source is done so within the terms of the Trust's authorisation and in accordance with national guidance, that there are processes

to ensure that NHS patients are not disadvantaged and controls are in place to ensure the private income is collected and no losses are incurred. The policy sets out the Trusts current position on private practice and describes the arrangements and control mechanism for fee paying work at the Trust.

MS queried whether issues relating to arrangements for staff charges/contractual issues/pay covers part of NHS time/remuneration.

Angie May stated that remuneration principles are under discussion, with a meeting scheduled on 1st April 2019.

CQAC agreed that at present they are not content to sign off the policy, with regards to the above issues/remuneration issues which required further clarity – i.e. who in the team would be remunerated for the activity.

A May questioned whether there was an alternative mechanism to adhere to, in order to not prevent patients being assessed and treated, until such time when the remuneration issues are addressed and resolved.

A May queried whether a Standard Operating Procedure could be used in the interim, minus the policy until the policy is approved.

CQAC agreed that the remuneration/financial issues regarding activity should be discussed further at RABD. HG confirmed that she is content with regards to the clinical and operational detail and that it would be acceptable to use Standard Operating Procedure until such time that there was clarity/agreement regarding remuneration and contractual issues.

AM thanked Angie May for update.

18/19/188 **Clinical Quality Steering Group key issues report**

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

- Quarterly Patient Safety meeting report – There were 1288 clinical incidents reported between October to December 2018, with the main themes accounting for 67% of all incidents. The main themes related to medications, documentation, access/admissions, transfer, discharge, treatment/procedure, samples and medical devices. Key issues learning and quality improvements were identified within the report.
- Performance management of Incidents – Duty of Candour, STEIS, 72 hour reviews and 60 working day completion of SIRI reports are fully compliant with local and national reporting requirements. Reporting to NRLS within 30 days remains at 90% at reporting near misses to NRLS within 30 days had improved to 93% Incidents reported within 24 hours remain at 80% with non-compliance relating to time constraints and workload. A rationale is to be added to Ulysses in future for incidents not reported within the standard timeframe.
- Transfusion Report – Annual wastage had increased to £65,751 in 2018. The annual report had been submitted to MHRA and accepted with no actions required. There had been 2 incidents reported on SHOT 0 incidents reported to SABRE. O NEQAS failures. A new BMS had been appointed to help address pressured created by ECMO activity. Successful launch of the zero tolerance on sample labelling and 2 sample rule. Some challenges relating to attendance and engagement with Hospital Transfusion Committee particularly medical

attendance and chairmanship. Massive haemorrhage simulated required further testing to include blood transfusion lab and these would take place over the next 12 months. Work continued on the 3 risk associated with transfusion i.e. use of TAR, Training and access rights with progress being made regarding TAR, but little progress regarding training records or access rights. CQSG envisage that these 2 risks would be addressed over the next 6 months.

- Policy Compliance report – currently 87% of policies are in date, with the majority that are non-compliant relating to HR and staff side engagement. Work is ongoing to address these issues. There is an ongoing risk regarding the control of contractor's policy with some ownership and monitoring issues (on risk register). TPN policy is out of date and there had been some CIVAS issues delaying the update on this. The Nutrition policy is significantly out of date and is being re written and the steering group had been re-energised. There are a number of Health and Safety policies out of date, MS reviewing this.
- Infection Prevention and Control Quarterly update - There had been a significant reduction in all bacteraemia apart from E.Coli which had increased from 4 to 7. The PIR meetings are providing a challenge regarding medical staff attendance and availability. Staff flu vaccination stands at 75.1% with some challenges regarding community staff and accessibility.
- Ward Accreditation report – By February 2019 all wards will have been reviewed twice. There are 3 areas scoring gold. 12 silver and 2 bronze. CRF assessment scheduled for February 2019. Action plans from all assessments are reviewed and monitored at Divisional Governance meetings, with reports being shared at CQSG via the monthly reporting framework. Awaiting MIAA report following review in November 2018 of ward accreditation process.
- Divisional Quality Dashboard information received.

AM thanked POC for update.

18/19/189 **Any Other Business**

ES informed the Committee that the Council of Governors had selected mortality as an indicator for the external audit limited assurance work on the Quality Account this year.

18/19/190 **Date and Time of Next meeting**

10.00 am – Wednesday 17th April 2019, Large meeting room, Institute in the Park (Joint CQAC & CQSG meeting).

Alder Hey Children's NHS
NHS Foundation Trust

Board of Directors

7th May 2019

Report of:	Director of Human Resources & Organisational Development
Paper Prepared by:	Director of Human Resources & Organisational Development
Subject/Title:	People Strategy Update for March 2019
Background Papers:	
Purpose of Paper:	To present to the Board monthly update of activity for noting and/or discussion.
Action/Decision Required:	none
Link to: **Trust's Strategic Direction Strategic Objectives**	The Best People Doing their Best Work
Resource Impact:	None

1. Staff Engagement

Reward & Recognition

The current focus of the Reward and Recognition group is on arranging a large scale/high profile summer event, bringing together staff and the local community on the Alder Hey and Springfield Park site. It is anticipated that this will be a music event.

Staff Survey

Following the excellent response rates to the staff survey (60%) and results which highlight clear improvements across the majority of the survey themes the HR & OD team has been working hard to break down the Trust data into meaningful reports for divisions, departments and relevant networks.

The divisional and departmental breakdowns of the staff survey results are currently being distributed to the relevant heads to support them with facilitating 'Big Conversations' with their staff.

The key principle of these conversations is to discuss their own responses and identify their key strengths and areas of focus for the year ahead, ultimately agreeing 3 priorities for 2019/20.

These conversations will be supported by HR & OD if required.

Presentations are also being delivered to the various networks including LGBTIQ+, BAME, Disability network and the Health and Well-being group to identify key trends relevant to their network and support action plans for the year ahead.

Improving Staff Wellbeing

The Trust is commitment to changing and challenging attitudes towards mental Health and continuing work on a complete Action to sign up to the Employer Time to Change Pledge, which is run by mental health charity, Mind. The HR team are working collaboratively with communications on the launch of the Health and Wellbeing Strategy and the Time to Change Pledge.

Brexit- EU Settlement Scheme

For the right to work in the UK after 31/12/2020, EU citizens must apply for UK immigration status under the EU Settlement Scheme. On 29/11/18 the Home Office launched a pilot of the scheme for individuals working in the health and social care sectors.

To date **17** individuals (27%) have confirmed either UK Citizenship or Settled/ Pre-settled status.

The HR department continue to be contact with individuals through specific communications on-going with on a 1:1 basis with EU colleagues. The HRBP's are supporting the divisions in offering wrap round support to staff including signposting and guidance.

2. Workforce Sustainability and Capability

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

Staff side and management met in February 2019, to discuss the National Changes to Terms and conditions that affect those staff in band 1 posts transitioning to Band 2, following the removal of the band 1 payscale. Those staff affected by the transition from band 1 to band 2;

- Domestic Assistants
- Catering Assistants
- Linen Assistants

To date 114 staff, from the above staffing groups have confirmed that they wish to transition across to a band 2. These have now been actioned by the HR team and will be reflected in April's pay. Band 1 staff will also receive a one of non-consolidated lump sum payment of £194 (pro-rata) in April's pay, in accordance with the National Terms and Conditions of Service.

Education, Learning and Development

Apprenticeships-

The Apprenticeship Team has successfully recruited two additional Tutors/Assessors to deliver internal Apprenticeships, as an Employer Provider. Both Tutors have vast experience delivering Apprenticeships in further education (FE). It is expected that they will commence delivery of internal Apprenticeships from June 2019 onwards.

The team recently attended an awareness event held at Liverpool University relating to the delivery of Advanced Clinical Practitioner Apprenticeship Level 7. The information has been circulated across the Trust to gather interest. The lack of paediatric modules has caused low numbers of interest; and feedback has been provided to Liverpool University, who are happy to visit the Trust to discuss content of this Apprenticeship.

Mandatory Training- Mandatory training figures have increased slightly to 89.67% for Core Mandatory Training (from 88.77% in Feb). Overall Mandatory training has increased from 87.45% in Feb to 88.3% in March.

The key outlier in terms of low compliance continues to be Information Governance, the Learning and Development team are working with the IG lead to identify ways to improve compliance for this topic over the coming months.

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

3. Employee Relations

Employee Consultations

Organisational Change

Portering

Following a meeting with trade unions, arrangements were made to meet with key affected individuals during early March 2019 with a view to progressing along the basis of the alternative proposals. Further discussions are now taking place between Facilities Management and the Chief Nurse to agree the basis of progression, further discussions are now being arranged with the portering team during April and May 2019

Emergency Department Reception team

An organisational change consultation to review the shift rotas within the reception team, has now concluded, following good engagement from the reception team with a number of suggestions for alternative arrangements having been considered by management, some of which was included within the final rota. Discussions are now taking place with individual staff to implement the new shift patterns expected to be in place by the beginning of June 2019.

Day Case Theatres

The Surgical Day Case (SDC) Surgical Admissions Lounge unit currently have separate staffing models and a format of working which have previously enabled the departments to provide continuity of care to patients and families whilst also meeting the flexible working requirements of the staff. As part of service development from November 2018 the department will be introducing a process of staggered admissions. Batched admissions will help the service to manage activity times and

staffing requirements and also enable the service to provide a safe and high quality admission route for patients.

In order to support these changes the SDC and SAL services will need to review the current shift patterns across both teams. The current arrangements are not currently conducive to supporting a batched admission process and a dynamic nursing model is required that enables the service to provide safe, effective quality care and enhance patient experience.

Catering Department

A number of staff briefing sessions were conducting on 14th March 2019 to launch the proposed organisational change within the dept. The proposed changes affect the rotas of the Catering Assistants, Chefs and Supervisors. This is following recommendations made from an external catering review.

The 30 day formal consultation process has now commenced. Group consultation meetings have now taken place and 1:1 meetings with staff commenced commencing 22nd April 2019.

Employee Relations Activity

The Trust's ER activity is currently is detailed below:

Row Labels	Number of cases
Community	**3**
Disciplinary	2
Capability	1
Corporate	**3**
Disciplinary	1
Harassment	2
Medicine	**2**
Disciplinary	2
Surgery	**10**
Disciplinary	4
Grievance	4
Harassment	2
Grand Total	**18**

Employment Tribunal Cases

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

The Trust has received a notification of an ET case relating to a member of staff who feels they have suffered detrimental treatment, following their request for set days,

through a flexible working request. The Trust is currently working with our Solicitors to progress.

4. Corporate Report

The HR KPIs in the March Corporate Report are:

- Sickness rates have seen a slight decrease in month from 5.6% to **5.47 %**
- The Rolling 12 month sickness figure has reduced slightly to **5.43%**
- Core Mandatory training compliance decreased to **90%**
- PDR compliance is at **90%**

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Tuesday 7 May 2019

Report of:	Executive
Paper Prepared by:	Dr Nicki Murdock
Subject/Title:	
Background Papers:	Junior Doctor Strategy
Purpose of Paper:	To describe the strategy to improve moral, recruitment and retention of Junior Doctors. To satisfy external accreditation of posts by HEE
Action/Decision Required:	Noting
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	**Best People doing their Best Work** **Delivering Outstanding Care**
Resource Impact:	Initial impact minimal Medium term funds to be sourced

Junior Doctor Strategy at Alder Hey Children's NHS Foundation Trust

Dr Nicki Murdock Medical Director

The Alder Hey Children's Hospital NHS Foundation Trust (the Trust) recognises that the education, training and pastoral support offered to the trainees in paediatrics and paediatric surgery at Alder Hey is not meeting the needs of the junior doctors. The working environment and employee expectations of work have changed markedly in the last 15 years but the Trust has not necessarily changed to meet those expectations. Over the past ten years attention has been primarily focused on building the new hospital, the move into the hospital and improvements for children and their families. However the long-term patient outcomes depend on training and recruiting the right workforce and that includes the pipeline of junior doctors leading into qualified Specialists.

Herzberg's two factor theory of motivation says that there are two types of motivators which are important to those in employment, Hygiene Factors and Motivator Factors. Since the junior doctors are employed by another trust and subject to national pay awards there are some factors that the Alder Hey Trust is unable to influence. This makes the other factors within our sphere of influence even more important since the satisfaction of our employees with working here in Alder Hey are dependent on even fewer factors.

Within the two sets of factors below those which are influenced directly by Alder Hey are highlighted in bold:

Hygiene Factors

1. Wages, salaries and other financial remuneration
2. **Company policy and administration**
3. **Quality of interpersonal relations**
4. **Working conditions**
5. Feelings of job security
6. **Quality of supervision**

Motivator Factors

Motivator factors emerge from the need of an individual to achieve personal growth. Job satisfaction results from the presence of motivator factors. Moreover, effective motivator factors do not only lead to job satisfaction, but also to better performance at work. The motivator factors are:

7. **Challenging or stimulating work**
8. **Status**
9. **Opportunity for advancement**

10. Responsibility

11. Sense of personal growth/job achievement

12. Acquiring recognition

To improve the morale of the junior doctors and therefore the recruitment and retention Alder Hey needs to address the factors over which we have influence.

2. Company policy and administration	Policies to be reviewed by Medical Executive which includes junior doctor representation	September 2019
3. Quality of interpersonal relations	• Senior junior doctor will sit on the Medical Executive Committee to ensure the views of junior doctors are represented • Medical Director to attend Junior Doctors Forum	✓
4. Working conditions	• New doctor's mess created in Treehouse. • Future plans for larger mess in New Build • New process to ensure taking of mandatory breaks • Review of rosters being undertaken • Introduction of ACT being progressed to support OOH • HDU model of care being progressed to provide increased support OOH	✓ September 2019 ✓ June 2019 April 2020 December 2019
6. Quality of supervision	The RCPCH provides training for supervisors, AH can also supplement this with Sessions on different types of instruction as per "Teaching on the Run"	September 2019
7. Challenging or stimulating work	• The work is both of these. However support to reduce non-medical work is being pursued, such as employing scribes and role differentiation • Grand Rounds reinvigoration • Establishment of Health Ethics and Law Liverpool (HEALL)	December 19 ✓ August 2019

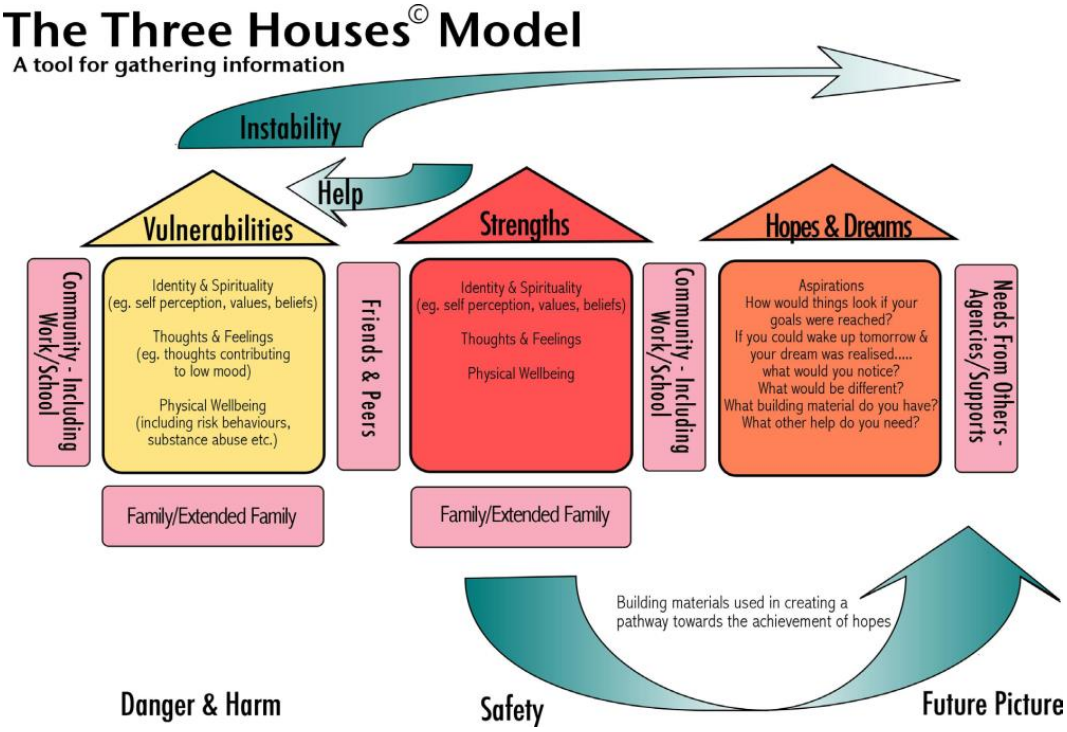
8. Status	Creation of Alder Hey tutor post to recognise the teaching that junior doctors undertake. This would be dependent on attending bespoke train the trainer sessions.	June 2019
9. Opportunity for Advancement	Creation of additional opportunities within Alder Hey to broaden experience and qualifications. For example access to Health Informatics Certification, Management Certification.	June 2020
10. Responsibility	There is graded responsibility accorded the junior doctors as they progress. However the ability to control their own environment is not high. Adapting the Three Houses Model for gathering views on what is working and what is not, giving back responsibility for the design of their own position.	July 2019
11. Sense of Personal Growth/Job Achievement	• Establishing a robust learning needs development process at the beginning of each period of time spent in Alder Hey and sourcing training or opportunities for this. • Work with Deanery to improve attendance at training days and also input to training days • Appointment of Data Analysts, Qualitative Research expert and Biostatistics support through the Inspiring Quality program	August 2019 August 2019 July 2019
12. Acquiring recognition	• Recognition of Tutor status. • Introducing recognition and reward for a number of achievements throughout the course of their time here, these to be developed by Medical Executive. • Discount at meetings held at Alder Hey for “graduates” of our training programs. Alder Hey VIP program.	June 2019 August2019 August 2019

- New Doctors Mess will be in the top level of the Treehouse. This will consist of fully equipped kitchen, seating area, bathroom and office area. TV with Sky subscription, newspapers, milk/bread/butter/tea and coffee, Weekend handover breakfast. There will be a monthly charge for doctors and this will be designed and administered by a Junior Doctor Committee.

- Acute Care Team Project (ACT), a team which will be available initially out of hours but ultimately 24/7 to identify and provide acute care to the deteriorating child. Currently the on-call staff are responsible for assessing and managing the acute presentations, to the hospital as well as caring for children who are already in patients. Trainees will no longer be faced with the impossible task of prioritising unwell patients who both need urgent care.

- Out of Hours Project. This project is looking at the data to determine the hours that on-site consultant cover is necessary to assist trainees to care for the children who are often the sickest, being admitted in what is traditionally seen as after hours. The change to working hours will facilitate one to one training at the bedside, with increased supervision and support. This will also contribute to better care for the children and their families.

- Skills evaluation of different tasks to identify an appropriate workforce to support junior doctors and facilitate them concentrating on medical work and not on clerical or other non-medical tasks.



Alder Hey Children's NHS
NHS Foundation Trust

Programme Assurance Summary
Change Programme

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

1. This Board report comprises of extracts from the assurance dashboard covering 4 of the 7 themes of the change programme as reporting to the Board sub-Committees: CQAC 17 April, R&BD 29 April and WOD 3 May .
2. Slide 2 of this programme assurance report contains the current scope for the19/20 change programme.
3. Of the 20 projects rated in this report with regards to the **overall delivery** assessment: none of the projects are green rated with 55% amber and 45% red. These percentage summary assessments show improvement from the previous month. Executive Sponsors should support their project teams to attain greater confidence in delivery.
4. The **overall governance** position is satisfactory with 45% of the projects green rated, 40% amber and 15% red. Although the governance position is satisfactory, there is room for improvement in some areas.

N Deakin, Head of Programme Management and Independent Programme Assurance 26 April 19

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

CIP Position as at 11th April by work stream

Workstream	Target 18/19 £000's	Actual 18/19 £000's	Gap £000's
Deliver Outstanding Care	2,500	1,055	-1,445
Growing Through External Partnerships	800	0	-800
The Best People Doing Their Best Work	1,000	1,037	37
Game Changing Research and Innovation	500	0	-500
Strong Foundations	2,200	1,935	-265
Park, Community Estate & Facilities	0	18	18
Global Digital Exemplar (GDE)	1,000	255	-745
Subtotal: Strategic Workstreams	8,000	4,299	-3,701
Divisional Business	-1,043	2,571	3,615
Grand Total	6,957	6,871	-86

Change Programme 19/20

£ = High Impact Scheme

Trust Board

Programme Assurance Framework, DMO & Delivery Board

Alder Hey Children's NHS
NHS Foundation Trust

Inspiring Quality

CQAC

Nicki Murdock

Do Everything with Children . Communicate Safely . Transform patient care through Digital Technology .Build a culture of Inspiring Quality

CQAC — *Delivering Outstanding Care*

Safety
Hilda Gwilliams
Sepsis
DETECT study

Brilliant Basics
Adam Bateman
Best in outpatient care
SAFER
Best in mental health care
Best in acute care

Teams inspiring quality systematically
Theatre scheduling (£)

WOD — *Best People doing their Best Work*

Melissa Swindell
Hilda Gwilliams

Portering
Catering
E-Rostering (£)

AHPs 2023 & Beyond
Health and well being(£)
Temporary staffing (£)
Culture / place to work
Workforce for the future

R&BD — *Sustainability through Partnerships*

Dani Jones

Aseptics

Collaboration at scale (£)
Single neonatal service
NW Pediatric Partnerships(AH/Manc)
All age CHD network
Corporate Transformation (Collaboration at Scale) (£)

RE&I — *Game Changing Research and Innovation*

John Grinnell

Export Catalyst

Research Strategy (£)
Innovation growth (£)
Academy growth (£)
Private patients (£)

TO BE INITIATED

R&BD — *Digital* *Kate Warriner*

Speciality Packages
Voice Recognition

Paperless (£) A.I and Robotics (£) E-Inventory (£)

TO BE INITIATED

R&BD — *Park, Community Estate & Facilities* *David Powell*

Hospital Moves. Alder Centre.
Community Cluster. Park. Energy

Healthcare campus Tier 4 Community

Alder Hey Children's NHS
NHS Foundation Trust

Programme Assurance Summary
Delivering Outstanding Care

Work Stream Summary (completed by Independent Programme Assurance)

Overall, for the 'Delivery of Outstanding Care' programme, project governance is satisfactory with all projects rated amber or green. However, delivery ratings still require improvement and have in fact deteriorated further this month.

The 'Sepsis' project has seen a deterioration in overall governance rating this month and agreement of the new target thresholds and a detailed plan for 'year 2' has been outstanding for a number of months.

The 'Comprehensive Mental Health' project has seen further deterioration this month and the lack of any positive trends on metrics should be addressed by the Exec Sponsor.

Clarification on metrics for success are still required for the 'Models of Care' project.

Natalie Deakin, Head of Programme Management and Independent Programme Assurance – 11 April 19

Programme Assurance Framework

Alder Hey Children's NHS
NHS Foundation Trust

Delivering Outstanding Care (completed by independent Programme Assurance)

Sub-Committee	CQAC	Report Date	11 Apr 19
Workstream Name	Delivering Outstanding Care	Executive Sponsor	Gwilliams/Bateman/Cooper

Current Dashboard Rating (sheet 1 of 2):

Project Title	Project Description	Executive Sponsor Assures the project	OVERALL PROJECT GOVERNANCE	An effective project team is in place	Scope and Approach is defined	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	OVERALL PROJECT DELIVERY	Targets / benefits defined/on track	Milestone plan is defined/on track	Comments for attention of the Project Team, Steering Group and sub-Committee
1.0 Delivering Outstanding Care													
Best in Outpatient Care	The Best in Outpatients Project aims to deliver an outstanding experience of outpatient services for children, families and professionals as well as safely increase the number of patients we see in clinic	Hilda Gwilliams											Evidence of Steering Group meetings available to 6 Mar 2019. PID is detailed and clear. Benefits are being tracked and positive trends are seen in 3 out of the 5 metrics however none have yet reached their targets. There is a comprehensive milestone plan being tracked however most milestones have now been met and milestone reflecting the 'refresh' of the project for 19/20 is required. Risks are managed via Ulysses and are all within review date. There is a planned approach to stakeholder engagement with some tracking of completion of engagement activities required. Monthly highlight reports which have been presented to Programme Board are available. The March edition the outpatients newsletter is available. EA/QIA signed and uploaded. **Last updated 10 Apr 19.**
Brilliant Booking and Scheduling	To provide a booking system that puts patients and families first and meet the needs of clinicians that use it.	Adam Bateman											Project team meetings are scheduled and documented up to 19 Mar 19. A comprehensive PID is available. New data indicates positive trends in planned and actual utilisation when comparing pre and post bi-directional texting switch on. Specialty plans for 10 specialities are available and are being closely tracked, but with several milestones delayed. There is a comprehensive suite of stakeholder engagement updated to 20 March 19 with presentations available to all specialities in preparation for Hybrid Booking Go Live. Risks are detailed and are within their review period. EA/QIA signed off and uploaded. **Last updated 11 Apr 19.**
Comprehensive Mental Health	Deliver improvements in mental health services to better meet the needs of children and young people. Be recognised as leading the way for CAMHS services nationally	Lisa Cooper											Evidence of CAHMS Board meetings (where Comprehensive Mental Health in a standing agenda item) evidenced to 6 Dec 18 however it is indicated that the Board met on 7 Mar 19. Project team meetings are scheduled fortnightly and evidenced to 17 Dec 18. There is a comprehensive PID available. 3 out of the 5 benefits are able to be measured with none of the three showing positive trends. A good milestone plan is in place but some milestones have now slipped with no revised dates for completion. A stakeholder analysis has been completed but further evidence required of wider stakeholder engagement. Risks are on Ulysses and are within their review period. A signed EA/QIA has been uploaded. **Last updated 9 Apr 19.**

Programme Assurance Framework

Alder Hey Children's NHS
NHS Foundation Trust

Delivering Outstanding Care (completed by independent Programme Assurance)

Sub-Committee	CQAC	Report Date	11 Apr 19
Workstream Name	Delivering Outstanding Care	Executive Sponsor	Bateman/Hughes/Gwilliams

Current Dashboard Rating (sheet 2 of 2):

Project Title	Project Description	Executive Sponsor Assures the project	OVERALL PROJECT GOVERNANCE	An effective project team is in place	Scope and Approach is defined	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	OVERALL PROJECT DELIVERY	Targets / benefits defined/on track	Milestone plan is defined/on track	Comments for attention of the Project Team, Steering Group and sub-Committee
1.0 Delivering Outstanding Care													
SAFER	Improve our processes to enable timely implementation of clinical decisions, and support patients through their pathway efficiently: minimising delays and reducing time spent in hospital. This project consists of 3 workstreams; Expanding Day Surgery, Expanding Pre-Op Assessment and SAFER Bundle.	Adam Bateman											Evidence of SAFER Task Force evidence, for 3A, 4C, 3C & Burns up to 28 Mar 19. A comprehensive PID is available but there appears to be a disconnect between the original PID and how the project is being managed. There are benefits slides for most of the wards with the majority showing positive trends. A high level milestones is now available but needs tracking more closely. Evidence of wider stakeholder engagement is now required. All risks on Ulysses and within review date. An EA/QIA has been signed. **Last updated 11 Mar 19.**
Best in Acute Care	**What:** Consultant led delivery of patient pathways is currently suboptimal for some patients. Care is not always organised around needs of the following patient cohorts: 1) Complex patients (Surgery & Medicine) 2) HDU 3) Specialities 4) General Paediatrics 5) Medical Management of Non-Complex Surgery Patients **Why:** To improve consistency of the management of deteriorating and high dependency patients (in terms of consultant lead, patient pathway and time of day / day of week)	Adrian Hughes											Evidence of Models of Care workshops available up to 18 Mar 19. Pathway threshold documents are available for nine specialities. A draft PID has been started but now requires completion. Various data packs are in evidence but the project still requires clear metrics for success. A high level milestone plan is available for the Models of Care work stream and a detailed plan available for the implementation of the ACT Team. There is evidence of stakeholder. Risks now available on Ulysees. No signed EA/QIA. **Last updated 1 Apr 19.**
Sepsis	To improve working within and across clinical teams.	Hilda Gwilliams											Sepsis Steering Group minutes to 6 Mar 19 with agendas and minutes. 'Year 2 PID' now uploaded but still in draft form. New benefits / targets now need to be signed off at Programme Board. Milestone Plan for 'year 2' PID now needs to be developed as current milestone plan on Sharepoint is not being tracked and requires further meaningful milestones beyond March 2019. The communications plan 2018-20 gives a high level list of activities but there is no tracked (for completion) milestone plan. All risks are within review date on Ulysses system. EA/QIA complete. **Last updated 28 Mar 19.**
DETECT Study	Using smart technology to reduce critical deterioration	Hilda Gwilliams											Evidence of project team meetings has been uploaded to SharePoint up to 2 Apr 19. A high level description of the scope is available in a 7 slide pack and a detailed PID has now been completed. Benefit metrics are outlined however not being tracked. A detailed Gantt Chart is available (uploaded 3 Dec 18) but is not being tracked. There is no recent evidence of stakeholder engagement. Risk register is in place and risks were last reviewed on 6 Dec 18. Risks now need to be uploaded to Ulysees. EA/QIA signed and uploaded. **Last updated 11 Apr 19.**

Programme Assurance Summary

The Best People doing their Best Work

Alder Hey Children's NHS
NHS Foundation Trust

Work Stream Summary (completed by Independent Programme Assurance)

Closure of the 'Apprenticeships' project was agreed at Programme Board. All benefits have been met and milestones delivered.

The 'Improving Portering Services' project still requires a thorough review which should include charting the course of the project through this year and to its eventual closure.

The 'Catering' project displays a very good standard of governance and initial trends for benefits/metrics appear positive.

A considerable number of projects are now to be initiated in *The Best People doing their Best Work* programme. It is crucial that these projects are initiated as soon as possible to allow any projects with a contribution to CIP to have the greatest financial impact.

Natalie Deakin, Head of Programme Management and Independent Programme Assurance – 26 Apr 19

Programme Assurance Framework

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

Alder Hey Children's NHS
NHS Foundation Trust

Sub-Committee	WOD	Report Date	26 Apr 19
Workstream Name	The Best People doing their Best Work	Executive Sponsor	Swindell/Gwilliams

Current Dashboard Rating (sheet 1 of 1):

Project Title	Project Description	Executive Sponsor Assures the project	OVERALL PROJECT GOVERNANCE	An effective project team is in place	Scope and Approach is defined	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	OVERALL PROJECT DELIVERY	Targets / benefits defined/on track	Milestone plan is defined/on track	Comments for attention of the Project Team, Steering Group and sub-Committee
2.0 The Best People Doing Their Best Work													
Improving Portering Services Project	The aim of this project is to deliver an effective portering service which meets all KPIs agreed by the Trust relating to all portering tasks and to ensure that the department has the right resource at the right times throughout the working day and week .	Hilda Gwilliams		🔴	🟢	🔴	🟢	🟢	🟢		🔴	🔴	Project team meeting notes available but no evidence of recent meetings. PID available which contains benefits and metrics. The Milestone Plan show significant slippage of all remaining milestones. No recent evidence of stakeholder engagement. All risks are within review date on Ulysses. EA/QIA complete. **Last updated 15 Jan 19.**
Catering	To implement the recommendations from the Independent Catering review to improve the overall food service delivery at Alder Hey whilst reducing the financial loss current operating within the Catering Department.	Hilda Gwilliams		🟢	🟢	🟢	🟢	🟢	🟢		🟡	🟡	Evidence is available for the project 'Steering Group' meetings up to 4 Jan 19.The extensive and detailed 'Review of Catering Services – Final Version' dated January 2018 is serving as a detailed PID. There is a detailed 'Catering Project Benefit Tracker 2019/20' with all benefits tracked and 4 out of 5 of the benefits showing positive trends albeit too early to ascertain whether trends will continue. May be useful to compare metrics with last year to allow for variation. A comprehensive Gantt chart plan has been prepared arising from the review which is tracked up to 15 Apr 19 but now shows numerous delays to milestones. Evidence of stakeholder engagement is available on SharePoint. All risks are within review date on Ulysses. **Last updated 17 Apr 19.**

Alder Hey Children's NHS
NHS Foundation Trust

Programme Assurance Summary

Growing Through External Partnerships

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

The governance of the 'Aseptics' project is maintained to a good standard however the overall delivery rating of the project has deteriorated significantly in recent months. This is due to a lack of measurable benefits and significant delays on a number of key milestones.

Numerous projects are now featured in the pipeline for the *Sustainability through External Partnerships* programme. It is crucial that these projects are initiated as soon as possible to allow any projects with a contribution to CIP to have the greatest financial impact.

Natalie Deakin, Head of Programme Management and Independent Programme Assurance – 23 Apr 19

Alder Hey Children's NHS
NHS Foundation Trust

Programme Assurance Framework
Growing Through External Partnerships

Sub-Committee	R&BD	Report Date	23 Apr 2019
Workstream Name	Growing Through External Partnerships	Executive Sponsor	Dani Jones

Current Dashboard Rating:

Project Title	Project Description	Executive Sponsor Assures the project	OVERALL PROJECT GOVERNANCE	An effective project team is in place	Scope and Approach is defined	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	OVERALL PROJECT DELIVERY	Targets / benefits defined/on track	Milestone plan is defined/on track	Comments for attention of the Project Team, Steering Group and sub-Committee
3.0 Sustainability Through Partnerships													
Aseptics	Validate and commission aseptic unit. To provide internal service which reduces outsourcing to minimal levels. Take unit to licence to offer income generating opportunities.	Dani Jones											Minutes of the Quality Management Meeting of the Aseptics Services Department are available up to 7 Feb 19. Scope is described by the 'Proposal for commissioning, validation and licensing of the Pharmacy Aseptic Services Unit' dated 16 March 2018' together with a 'Project Overview Document' dated 14 Jun 2018. A final business case dated 9th April 2019 is also evidenced. Some of the targets and benefits are being closely tracked, others need to identify a sustainable way of measuring improvement. Benefits tracker last updated on 23 April 19, with none of the measures yet reaching aspired thresholds. A 'Project Milestone Plan' is in place and being tracked up to 23 April 2019 however a considerable number of milestones have been revised numerous times. Project risks are within review date on Ulysees. EA/QIA signed off. **Last updated 23 Apr 19.**

Alder Hey Children's NHS
NHS Foundation Trust

Programme Assurance Summary
Global Digital Exemplar

Work Stream Summary (completed by Independent Programme Assurance)

The 'Statement of Projected Benefits' now requires updating for 19/20.

The focus for the Speciality Packages project should remain on the completion of tranche 1 for delivery in April 2019.

The 'Voice Recognition' project is 'red' rated for delivery, due to the difficulty in realising the planned benefits. A closure report is due to Programme Board at the end of May 19.

Natalie Deakin, Head of Programme Management and Independent Programme Assurance – 23 Apr 19

Alder Hey Children's NHS
NHS Foundation Trust

Programme Assurance Framework

Global Digital Exemplar (Completed by Assurance Team)

Sub-Committee	R&BD	Report Date	23 Apr 2019
Workstream Name	Global Digital Exemplar	Executive Sponsors	John Grinnell

Current Dashboard Rating:

Project Title	Project Description	Executive Sponsor Assures the project	OVERALL PROJECT GOVERNANCE	An effective project team is in place	Scope and Approach is defined	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	OVERALL PROJECT DELIVERY	Targets / benefits defined/on track	Milestone plan is defined/on track	Comments for attention of the Project Team, Steering Group and sub-Committee
5.0 Digital													
GDE	Create exemplars that can inspire others by really showing how information technology can deliver both improved patient outcomes and enhanced business effectiveness	John Grinnell											GDE Delivery Group action log in evidence to 26 Mar 19 with Programme Board Minutes and Agenda in evidence up to 16 Apr 2019. There is no SoPB document for 19/20 and this has not been updated since 16 Oct 18. There is a 'GDE Programme Dashboard' which RAG rates progress and looks largely on track. There is evidence of some stakeholder engagement. Some risks are now overdue their review date on Ulysses. **Last updated 16 Apr 19.**
Speciality Packages	Delivery of electronic clinical documentation workflow designed to reflect best practice protocols and pathways	Kate Warriner						N/A	N/A				Limited evidence of meetings taking place. PID is available. Overall benefits profile and schedule is shown on the SoPB tracker; however a more updated version is now required as the version on SharePoint was last updated in March 18. Project Plan was last updated on 15 Apr 2019 and indicates progress per speciality however this plan would benefit from specific dates rather than overall progress percentages. A high level roll out plan is available. Evidence of stakeholder engagement last uploaded on 16 Oct 18. Comprehensive risk log last updated on 3 Jan 19 however this now needs reviewing. QIA/EA will be assured and assessed at project level. **Last updated 15 Apr 19.**
Voice Recognition	Deploy voice recognition solution in Medisec and Meditech	Kate Warriner											Limited evidence of effective project team meetings. PID and detailed project workbook on SharePoint. Details of financial benefits on separate document however these have not been realised as planned. Project Plan has no outstanding actions. Comms/engagement activities are detailed in workbook. Risks register is held and all risks are within review date in workbook as of 31 Mar 19. EA/QIA has been signed and uploaded. **Last updated 17 Apr 19.**

Alder Hey Children's NHS
NHS Foundation Trust

Programme Assurance Summary
Global Digital Exemplar

Work Stream Summary (completed by Independent Programme Assurance)

The 'Statement of Projected Benefits' now requires updating for 19/20.

The focus for the Speciality Packages project should remain on the completion of tranche 1 for delivery in April 2019.

The 'Voice Recognition' project is 'red' rated for delivery, due to the difficulty in realising the planned benefits. A closure report is due to Programme Board at the end of May 19.

Natalie Deakin, Head of Programme Management and Independent Programme Assurance – 23 Apr 19

Alder Hey Children's NHS
NHS Foundation Trust

Programme Assurance Framework

Global Digital Exemplar (Completed by Assurance Team)

Sub-Committee	R&BD	Report Date	23 Apr 2019
Workstream Name	Global Digital Exemplar	Executive Sponsors	John Grinnell

Current Dashboard Rating:

Project Title	Project Description	Executive Sponsor Assures the project	OVERALL PROJECT GOVERNANCE	An effective project team is in place	Scope and Approach is defined	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	OVERALL PROJECT DELIVERY	Targets / benefits defined/on track	Milestone plan is defined/on track	Comments for attention of the Project Team, Steering Group and sub-Committee
5.0 Digital													
GDE	Create exemplars that can inspire others by really showing how information technology can deliver both improved patient outcomes and enhanced business effectiveness	John Grinnell											GDE Delivery Group action log in evidence to 26 Mar 19 with Programme Board Minutes and Agenda in evidence up to 16 Apr 2019. There is no SoPB document for 19/20 and this has not been updated since 16 Oct 18. There is a 'GDE Programme Dashboard' which RAG rates progress and looks largely on track. There is evidence of some stakeholder engagement. Some risks are now overdue their review date on Ulysses. **Last updated 16 Apr 19.**
Speciality Packages	Delivery of electronic clinical documentation workflow designed to reflect best practice protocols and pathways	Kate Warriner						N/A	N/A				Limited evidence of meetings taking place. PID is available. Overall benefits profile and schedule is shown on the SoPB tracker; however a more updated version is now required as the version on SharePoint was last updated in March 18. Project Plan was last updated on 15 Apr 2019 and indicates progress per speciality however this plan would benefit from specific dates rather than overall progress percentages. A high level roll out plan is available. Evidence of stakeholder engagement last uploaded on 16 Oct 18. Comprehensive risk log last updated on 3 Jan 19 however this now needs reviewing. QIA/EA will be assured and assessed at project level. **Last updated 15 Apr 19.**
Voice Recognition	Deploy voice recognition solution in Medisec and Meditech	Kate Warriner											Limited evidence of effective project team meetings. PID and detailed project workbook on SharePoint. Details of financial benefits on separate document however these have not been realised as planned. Project Plan has no outstanding actions. Comms/engagement activities are detailed in workbook. Risks register is held and all risks are within review date in workbook as of 31 Mar 19. EA/QIA has been signed and uploaded. **Last updated 17 Apr 19.**

Alder Hey Children's NHS
NHS Foundation Trust

Programme Assurance Summary
Park, Community Estate and Facilities

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

Once again this month, the governance and delivery ratings for the individual project management standards have improved but not enough to alter overall governance or delivery ratings.

Focus should remain on maintaining project management documentation to a good standard and some consideration should be given on whether some of the projects benefit from featuring on the Change Programme.

The Energy project now needs to be addressed immediately as its position has not altered since December 2018.

Natalie Deakin, Head of Programme Management and Independent Programme Assurance – 23 Apr 19

Alder Hey Children's NHS
NHS Foundation Trust

Programme Assurance Framework
Park, Community Estate and Facilities

Sub-Committee	R&BD	Report Date	23 Apr 2019
Workstream Name	Park, Community Estate and Facilities.	Executive Sponsor	David Powell

Current Dashboard Rating:

Project Title	Project Description	Executive Sponsor Assures the project	OVERALL PROJECT GOVERNANCE	An effective project team is in place	Scope and Approach is defined	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	OVERALL PROJECT DELIVERY	Targets / benefits defined/on track	Milestone plan is defined/on track	Comments for attention of the Project Team, Steering Group and sub-Committee
6.0 Park, Community and Estate Facilities													
Hospital Moves	To re-provide a high standard of working accommodation for those teams and services currently lodged in interim facilities on the retained estate	David Powell		🔴	🟢	🔴	🟡	🟢	🟢		🔴	🟢	Minutes of the 'Hospital Moves Steering Group' are available to 14 Aug 2018 and there is an agenda for the meeting planned for 16 Oct 2018; there are notes of the 'Records and Transcriptions meeting' up to 17 Sep 18. The PID dated 9 Jan 18 is available on SharePoint and provides a comprehensive summary of scope and approach. There is a lack of any recent information regarding communications and engagement. There is a comprehensive plan for hospital moves within the wider programme plan which is broadly on track apart from moves to the police station. Risks are now out of review date on Ulysees. EA/QIA signed, important to review during the project as different accommodation options are decided upon. **Last updated 10 Apr 19.**
Alder Centre	To plan, develop and construct the new Alder Centre within the park setting	David Powell		🔴	🟢	🟡	🟢	🟢	🟢		🔴	🟡	Steering Group agenda for 21 Nov 18 but no minutes on SharePoint. Scope/approach defined in PID. Benefits defined in PID but no evidence of the tracking of benefits. Milestone Plan has been revised recently and is being closely tracked however shows the commencement of building work has slipped significantly from original planned date. No recent evidence of Comms/ Engagement activities. Risks are on Ulysses and are within date. EA/QIA complete. **Last updated 10 Apr 2019.**
Community Cluster	This project is currently at the exploratory and feasability stage and will be rated once fully launched	David Powell		🟡	🟡	🟢	🔴	🔴	🔴		🔴	🟡	Draft PID uploaded 1 Feb 2018 with 'Initiation' Slides uploaded 27 Mar 2018. The 'Community Cluster board report April 19' details the winning design of the building. Plan for this scheme is available in the wider programme plan 'Development site 2018-2021' however this shows slippage on a number of key milestones. A highlight report for March to be presented at Programme Board is available. Evidence of stakeholder engagement. Risks are not within review date on Ulysees. EA/ QIA complete but not signed by Exec Sponsor. **Last updated 10 Apr 2019.**

Alder Hey Children's NHS
NHS Foundation Trust

Programme Assurance Framework

Park, Community Estate and Facilities

Sub-Committee	R&BD	Report Date	23 Apr 2019
Workstream Name	Park, Community Estate and Facilities.	Executive Sponsor	David Powell

Current Dashboard Rating:

Project Title	Project Description	Executive Sponsor Assures the project	OVERALL PROJECT GOVERNANCE	An effective project team is in place	Scope and Approach is defined	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	OVERALL PROJECT DELIVERY	Targets / benefits defined/on track	Milestone plan is defined/on track	Comments for attention of the Project Team, Steering Group and sub-Committee
6.0 Park, Community and Estate Facilities													
Park	To set up a JV with LCC & the local community to create a world class Springfield Park that complements & adds value to the New Alder Hey in the Park & the local area	David Powell											Steering Group reports available to 21 November 2018.Evidence of reports suggest a planned steering group for January but no evidence whether or not this took place. Updated PID on SharePoint showing comprehensive suite of benefits and high level milestones through to end of project life cycle. A comprehensive benefits tracker has now been uploaded which indicates whether benefits are on/off track. There is a comprehensive and detailed Milestone Plan which is being tracked with a handful of missed milestones. There is a suite of evidence of stakeholder engagement. Risks are on Ulysees with some risks now out of review date. EA/QIA complete. **Last updated 10 Apr 2019.**
Energy	To bring down energy cost and ensure budget forecast matches contractual target. Forecast budget for next 12 months for all fuels in line with contractual usage.Once the contractual target of 46.7 G has been achieved look at ways of reducing further by means of energy awareness for staff.	David Powell	**N/A**										Monthly energy committee minutes available until 13 Nov 18. The POD available on SharePoint gives no details of financial benefits expected for 2018/19. The project plan for 18/19 contains only 6 actions and was last updated July 2018 (2 of these relate to usage monitoring and 2 relate to a compensation claim; more detail is required if this is to be considered a project). QIA signed off for the 18/19 programme. **Last updated 17 Dec 18.**

Alder Hey Children's NHS
NHS Foundation Trust

Audit Committee Annual Report 2018/19

The Audit Committee

The aim of the Audit Committee is to provide one of the key means by which the Board of Directors ensures effective internal control arrangements are in place. In addition, the Committee provides a form of independent check upon the executive arm of the Board.

As defined within the NHS *Audit Committee Handbook* (2014), the Committee has responsibilities for the review of governance, risk management and internal control covering both clinical and non-clinical areas. In discharging these duties the Committee is required to review:

- Internal financial control matters, such as safeguarding of assets, the maintenance of proper accounting records and the reliability of financial information.
- Risks regarding disclosure statements (for example the Annual Governance Statement) which are supported by the Head of Audit Opinion and other opinions provided.
- The underlying assurances as detailed in the Board Assurance Framework.
- The adequacy of relevant policies, legality issues and Codes of Conduct.
- The policies and procedures related to fraud and corruption.

The conduct of this remit is achieved firstly, through the Committee being appropriately constituted, and secondly by the Committee being effective in ensuring internal accountability and the delivery of audit and assurance services.

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

Constitution

In accordance with the terms of reference which are reviewed on an annual basis to take into account governance developments and the remit of other assurance committees, the membership of the Committee comprises three Non-Executive Directors. Its chair has 'recent relevant financial experience' which is best practice. The Director of Finance and Director of Corporate Affairs together with the Operational Director of Finance are invited to attend, and the Committee may request the attendance of the Chief Executive and any other officer of the Trust to answer any points which may arise. In addition, the Internal and External auditors are invited to each meeting, together with regular attendance from the Local Counter Fraud Specialist. A schedule of attendance at the meetings is provided in Appendix A which demonstrates full compliance with the quorum requirements and regular attendance by those invited by the Committee. The Audit Committee members have also had the opportunity through the year to meet in private with internal audit and external audit.

Five meetings were held during the financial year 2018/19 of which one, in May was devoted to consideration of the auditors report on the Annual Accounts and ISA 260. The Committee has an annual work plan with meetings timed to consider and act on specific issues within that plan.

Minutes of the Audit Committee are presented to the Board and are supported by a verbal report from the Committee Chair.

Achievements in 2018/19

In discharging its duties, the Committee meets its responsibilities through self assessment and review, requesting assurances from Trust officers and directing and receiving reports from the auditors and fraud specialists.

Self-Assessment

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

- Agreement and monitoring of an annual work programme aimed at testing the adequacy of the control environment
- Prepared an Annual Report of its activities
- Reviewed and updated its terms of reference

Work undertaken

At each meeting the Audit Committee has considered:

- The Board Assurance Framework report
- Internal Audit Reports in accordance with the approved 2018/19 work plan
- External Audit Reports in accordance with the approved 2018/19 work plan

In addition throughout the year the Audit Committee has reviewed and dealt with the following matters:

- Annual Governance Statement
- Consideration of the 2017/18 Annual Accounts
- NHS Improvement quarterly narrative reports
- External Assurance Report on the quality account
- External Audit report on the financial statements to 31st March 2018 and ISA 260
- Losses and special payments
- Gifts & Hospitality Register
- Waiver Activity Report
- Counter Fraud reports by the MIAA specialist in accordance with the approved 2018/19 work plan
- Progress against the Risk Management Improvement Plan
- Progress against the Trust's Policy Review schedule
- Approval of the Treasury Management Policy
- Internal Audit work plan for 2018/19
- External Audit strategy relating to the Audit of the Trust's 2017/18 Accounts
- Financial Statement audit risks for 2018/19
- Accounting policies for the 2018/19 Financial Statements
- Audit Committee work plan 2018/19
- Review and approval of the terms of reference for the Audit Committee
- Annual Reports of the Trust's assurance committees, including the Clinical Quality Assurance Committee.

Key Conclusions

The key role of the Committee is to establish the following:

- Assurance Framework is fit for purpose
- Systems for risk management identify and allow for the management of risk
- Organisation has robust governance arrangements
- Organisation has self-assessed against the CQC Standards
- Organisation has robust systems of financial control
- Organisation operates a robust control environment

Based on the information provided, the Committee members can confirm that they agree to the declaration reported to the Board of Directors in respect of the Annual Governance Statement.

This opinion is based upon the Committee's processes for gaining assurance as summarised below.

Internal Processes

In accordance with the Committee's authority, in addition to the Director of Finance, other officers of the Trust were called to attend the Committee to provide updates.

Following receipt of audit reports the Committee has directed audit resources to complete follow-up reviews into specific issues and high risk areas. The Committee will review outstanding actions until completion. A database is maintained of all audit recommendations which is reviewed by exception. Additionally, to support the Committee's control of implementation of key actions, internal audit include within their plan provision for follow-up of the implementation of audit recommendations. During the year the Committee chair was focussed on gaining assurance around follow up actions in order to ensure the closure of any potential gaps in the control environment.

The Annual Report and Accounts and the Quality Account were reviewed by External Audit and the reports arising from their review presented to the Committee.

The Committee reviewed the findings of other significant assurance functions of the Trust including the Clinical Quality Assurance Committee and Resources and Business Development Committee by receiving and scrutinising the Annual Reports in support of approving the Annual Governance Statement.

Independent Assurances / Audit

External Audit

The provision of External Audit services was delivered by Ernst and Young in 2018/19.

The work of External Audit can be divided into two broad headings:-

- To audit the financial statements and provide an opinion thereon,
- To form an assessment of our use of resources.

The Committee has approved an External Audit Plan and receives regular updates on the progress of work including audit work undertaken on the quality account. An unqualified opinion on the accounts for 2018/19 was provided to the Board on the 28th May 2019.

Internal Audit

The Internal Audit service is provided by Mersey Internal Audit Agency (MIAA), an independent NHS organisation. The Director of Audit Opinion and Annual Report for 2018/19 reports that MIAA have demonstrated their compliance with NHS mandatory Internal Audit Standards. Internal Audit provides an independent and objective appraisal service embracing two key areas:-

1. The provision of an independent and objective opinion to the Accountable Officer, the Board and the Audit Committee on the degree to which risk management, control and governance support the achievement of the agreed objectives of the organisation.

2. The provision of an independent and objective consultancy service specifically to help line management improve the organisation's risk management, control and governance arrangements.

The Audit Committee contributed to the risk assessment and subsequently approved the content of the Internal Audit Plan. This plan was structured to provide the Director of Audit Opinion which gives an assessment of the:

- design and operation of the underpinning Assurance Framework and supporting processes;
- range of individual opinions arising from risk-based audit assignments contained within internal audit risk-based plans that have been reported throughout the year, this assessment has taken account of the relative materiality of these areas and management's progress in respect of addressing control weaknesses; and
- process by which the organisation has taken steps to implement and embed the systems and processes to ensure regulatory compliance with the CQC fundamental standards.

The key conclusion from their work for 2018/19 as provided in the Director of Audit Opinion and Annual Report was that 'Substantial Assurance' was given that there were generally sound systems of internal control to meet the organisation's objectives and that controls are generally being applied consistently.

During the course of the year the Committee ensured that regular progress reports were received from MIAA on the delivery of the Internal Audit Plan. As part of this process the Committee have influenced changes to the plan to direct work to risk areas identified during the course of the year.

Fraud

As with the Internal Audit Service, Counter Fraud is provided by Mersey Internal Audit Agency.

As requested by the Committee to meet mandated requirements, an annual report was provided outlining the delivery of the fraud plan for 2018/19. The Committee also received the results of the annual Self-Review Tool (SRT) assessment against the NHS Counter Fraud Authority Standards for Providers for 2018/19 which assessed the Trust as an overall GREEN rating'. The Counter Fraud service provided regular updates to the Committee on work undertaken to prevent and detect fraud including any investigations.

Assurance Statement

Through the various mechanisms set out above, the Audit Committee has gained assurance that the Trust's control environment is operating at a satisfactory level. It has clearly expressed its expectations in relation to areas where controls need to be strengthened and these will be addressed in the coming year.

Committee Developments/Priorities for 2019/20

Whilst the Committee has performed its duties as delegated by the Board and mandated through governance requirements, in the forthcoming year focus will be given to developing and responding to the system reforms and risks as detailed below:-

- To maintain a review of our Terms of Reference and activities to fully support the governance arrangements within the Trust and to ensure the Board continues to be appropriately briefed on our activities.
- To develop our work plan based on the Assurance Framework and focus audit resources into risk areas and the provision of assurances from the organisation.
- To enhance assurance through the attendance of key officers to account for actions taken in respect of internal and external reviews.
- To embed the monitoring and reporting of follow-up actions taken in respect of internal audit reports and especially those reported as "Limited Assurance".
- To receive formal reports from the Trust's key assurance committees to provide effective oversight of the systems and processes of assurance
- To ensure the Annual Governance Statement is presented and reviewed by the Audit Committee prior to Board approval.

Kerry Byrne, Audit Committee Chair
18th April 2019

APPENDIX A

AUDIT COMMITTEE - RECORD OF ATTENDANCE 2018/19

Quorum: Two Non-Executive Directors

Member/Date of Meeting	2018				2019	TOTAL
	19 April	18 May	20 Sept	22 Nov	24 Jan	
Members						
Mr Steve Igoe (Non-Executive Director)	✓ **(Chair)**	✓ **(Chair)**	✓ **(Chair**	**N/A**	**N/A**	**3/3**
Mrs Kerry Byrne (Non-Executive Director)	**N/A**	**N/A**	✓	✓ **(Chair**	✓ **(Chair**	**3/3**
Mrs Anita Marsland (Non-Executive Director)	✓	✓	✓	✓	✓	**5/5**
Mrs Jeannie France-Hayhurst (Non-Executive Director)	✘	✘	✘	✘	✘	**0/5**
In attendance						
Mr John Grinnell (Director of Finance/Deputy CEO)	✓	✓	✘	✓	✓	**4/5**
Mrs C Liddy (Deputy Director of Finance)	✓	✓	✓	✓	✓	**5/5**
Ms Erica Saunders (Director of Corporate Affairs)	✓	✓	✓	✓	✓	**5/5**
Ernst & Young (External Audit)	✓	✓	✓	✓	✓	**5/5**
MIAA (Internal Audit)	✓	✓	✓	✓	✓	**5/5**
Local Counter Fraud Service	✓	✘	✓	✘	✓	**3/5**

Ernst & Young Representatives:
Mrs C Davies (CD); Mr H Rohimun (HR)

Mersey Internal Audit Agency Representatives:
Mrs M McMahon (MMc); Ms L Cobain (LC)

Local Counter Fraud Service –
Representatives attend for presentation of fraud related reports
Ms V Martin (VM)

Alder Hey Children's NHS
NHS Foundation Trust

Resources and Business Development Committee Annual Report 2018/19

The Resources and Business Development Committee

The Resources and Business Development Committee was established by the Board of Directors to be responsible for overseeing financial, operational and contractual performance, workforce metrics, business development and strategic IM&T issues and the approval of business cases to limits delegated by the Board.

The principal devolution of the Board's responsibilities are as follows:

- Review and recommend business, operational and financial plans to the Board
- Monitor performance, assuring the Board that performance is in line with plans
- Ensure value for money is obtained by the Trust
- Identify related areas of strategic and business risk and report these to the Board
- Oversee the development of the Trust's long term financial strategy, its Business Development Strategy and its Investment Strategy
- Scrutinise, challenge and sign off the Trust's quarterly submission to NHS Improvement, including requisite Board statements.

The conduct of this remit was achieved firstly through the Committee being appropriately constituted and secondly by the Committee being effective in ensuring internal accountability and the delivery of assurance on specific issues.
This report outlines how the Committee has complied with the duties delegated by the Board through its terms of reference and identifies key actions to address developments in the Committee's role.

Constitution

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

- Non-Executive Directors x 2 [one of whom is the Chair]
- Director of Finance
- Deputy Director of Finance
- Chief Operating Officer
- Director of Human Resources

The Committee may request the attendance of any Non-Executive Directors, any Executive Directors and any other persons by invitation. A schedule of attendance at the meetings is provided in Appendix A. Three meetings in-year were not quorate. The Committee has an annual work plan with meetings timed to consider and act on specific issues within that plan.

Minutes of the Committee were presented to the Board and are supported by a verbal report from the Committee Chair.

Achievements in 2018/19

In discharging its duties the Committee met its responsibilities through self assessment and review, requesting assurances from Trust officers and directing and receiving reports from relevant individuals.

The following areas were the main focus of the Committee's attention:

- Review of progress against the organisations top 5 risks/priority areas for 2018/19.
- Scrutinised the Trust's 10 Year Capital Plan prior to submission to the Board of Directors.
- Oversight of the Trust's overall financial position and where relevant internal recovery plans including scrutiny of financial data in particular leading/lagging KPIs, income/expenditure and the CIP.
- Monthly monitoring of the PFI Contract.
- Review and challenge of divisional operational/run rate and financial recovery plans.
- Oversight of the Trusts Service Line Reporting position.
- Scrutiny and approval on behalf of the Board of the NHSI Quarterly narrative report
- The financial outcome for the year end with a risk rating of 1.
- Regular review of the Board Assurance Framework and adjustments to this as required.
- Oversight of the Global Digital Excellence programme.
- As part of the devolved governance structure, a significant amount of time remains dedicated to the programme assurance function and specifically the following elements of the Framework:
    - Growing through external partnerships;
    - Park, Community Estate and Facilities;
    - Solid foundations; and
    - Global Digital Exemplar

Self-Assessment

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

- Agreement and monitoring of an annual work programme.
- Prepared an Annual Report of its activities incorporating a review of the key elements of the Terms of Reference, as follows:
    - Review of the annual financial plan for revenue and capital for recommendation to the Board.
    - Advising the Board on all proposals for major Capital expenditure over £500,000 and to approve proposals under £500,000.
    - Review of progress against key financial and external targets, including performance ratings (e.g. NHSI metrics).
    - Consideration of any regulatory developments e.g. Single Oversight Framework.
    - Ensure appropriate contracting arrangements are in place and review overall performance against contract.
    - Examine specific areas of financial risk and highlight these to the Board as appropriate.
    - Review of key workforce/HR performance indicators.
    - Maintain an oversight on all major investments and business developments.
    - Scan the environment and identify strategic business risks and report to the Board on the nature of those risks and their effective management.
    - Oversee delivery of the marketing strategy, including brand management, market positioning, marketing activity, market research and competitor analysis.
    - Advise and provide insight to the board on changing dynamics in the market and stakeholders.

Assurance Statement

Through the various mechanisms set out above, the Committee has gained assurance that the Trust's financial, operational and contractual systems and processes were operating at a satisfactory level, with year-end performance ending positively.

Committee Priorities for 2019/20

Whilst the Committee has performed its duties as delegated by the Board it has identified a number of areas to focus on during 2019/20:

- Once agreed, the Committee will continue to focus and seek assurances regarding the top five risks/key priority areas in 2019/20 which would enable the Trust to deliver its clinical, operational and financial targets.
- Ensure the activities and areas of the focus by the Committee continue to take proper recognition of the effects on the organisation of moving into the new hospital.
- Enhance the monitoring and reporting of follow-up actions taken in respect of its areas of responsibility.
- The governance arrangements that underpin the Change Programme and its specific projects will again be a key focus for the Committee in the coming year.
- The Committee will continue to hold the Divisions to account for their performance and will seek to drive measurable improvements in efficiency and productivity.
- Ensure that particular attention is given to the CIP and Business Development initiatives in 2019/20 and beyond, in the context of the national financial environment.

Ian Quinlan
Committee Chair
29 April 2019

RESOURCES AND BUSINESS DEVELOPMENT COMMITTEE - RECORD OF ATTENDANCE 2018/19

Quorum: Chair or nominated deputy, one other NED, one Executive Director

Member/Date of Meeting		2018								2019			TOTAL
	25th April	25th May	27th June	25th July	Aug	26th Sept	24th Oct	28th Nov	18th Dec	23rd Jan	27th Feb	1st April	
Mr Ian Quinlan (Non-Executive Director)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	NO MEETING HELD	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	11/11
Mrs Claire Dove (Non-Executive Director)	x	x	✓	x		x	✓	x	x	✓	x	x	3/11
Mrs Anita Marsland (Sub NED)	N/A	N/A	N/A	N/A		✓	N/A	N/A	N/A	N/A	N/A	✓	-
Kerry Byrne (Sub NED)	N/A	N/A	N/A	N/A		N/A	N/A	✓	N/A	N/A	N/A	N/A	-
Dame Jo Williams (Sub NED)	N/A	N/A	N/A	N/A		✓	N/A	N/A	✓	N/A	✓	N/A	-
Mr John Grinnell (Director of Finance)	✓	✓	✓	✓		✓	✓	✓	✓	✓	x	✓	10/11
Mrs Claire Liddy (Director of Operational Finance)	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	x	10/11
Mr Adam Bateman (Chief Operating Officer)	✓	✓	✓	✓		✓	✓	✓	✓	✓	x	✓	10/11
Mrs M Swindell (Director of HR & OD)	✓	✓	✓	✓		✓	x	x	✓	✓	✓	✓	9/11

ATTENDEES

Member/Date of Meeting		2018								2019		
	25th April	25th May	27th June	25th July	Aug	26th Sept	24th Oct	28th Nov	18th Dec	23rd Jan	27th Feb	1st April
Ms E Saunders (Director of Corporate Affairs)	✓	✓	✓	✓	NO MEETING HELD	✓	✓	✓	✓	✓	✓	✓
Andy McColl (Head of Business Development)	For 1 item	x	x	x		x	x	x	x	For 1 item	x	
Mr M Flannagan (Director of Marketing and Coms)	✓	✓	✓	✓		x	x	✓	✓	✓	✓	
David Powell (Development Director)	x	x	For 1 item	For 2 items		For 1 item	x	x	x	x	x	

Alder Hey Children's NHS
NHS Foundation Trust

Workforce and Organisational Development Committee

Annual Report 2018-2019

The Workforce and Organisational Development Committee

The Workforce and Organisational Development Committee (WOD) was established by the Board of Directors to be responsible for providing strategic direction and board assurance in relation to all workforce matters, and making recommendations, as appropriate, on workforce matters to the Board of Directors, in support of the delivery of high quality patient and family centred care. In addition, to support the organisation in delivering a positive patient centred culture, embedding the values and behaviours that the trust aspires to demonstrate.

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

- Oversee the development and implementation of the Trust's People & OD Strategy to assure the Trust Board that the strategy is implemented effectively and supports the Trust's vision and values, by receiving progress reports against the annual plan and Key Performance Indicators.

- Monitor workforce risks contained in the Trust's Corporate Risk Register and Board Assurance Framework, and risks arising from transformation and Quality Improvement programmes, and report these to the Trust Board as required.

- Ensure mechanisms are in place to support the development of leadership capacity and capability within the Trust, including talent management.

- Ensure the optimum design and development of the workforce to ensure that the Trust has productive, engaged staff with the right skills, competencies and information to meet the required contractual obligations. Receive reports relating to workforce planning.

- Monitor the overall resilience of the organisation and staff, and support the development of a positive and healthy culture through appropriate measurement of engagement and wellbeing.

- Ensure that the Trust is meeting its legal obligations in relation to equality and diversity. This will include overseeing the development of the workforce elements of the Equality Delivery Scheme (EDS), Workforce Race Equality Standards (WRES) and Workforce Disability Equality Standards (WDES) action plans and ensure the effective implementation of the EDS by receiving regular reports against the action plans.

- Ensure robust and proactive plans are in place for supporting innovative approaches to diversity and inclusion, ensuring we support all staff from all backgrounds to have a positive experience working at Alder Hey.

- Obtain assurance that arrangements are effective to support effective partnership working with Trade Unions. More specifically the Committee will oversee the development of the Partnership Agreement.

- Obtain assurance that the Trust has an appropriate pay and reward system that is linked to the delivery of the Trust's strategic objectives and desired behaviours.

- Provide assurance to the Board that there are mechanisms in place to allow staff to raise concerns and that are dealt with in line with policy and national guidance.

- Monitor education, training and learning activities to ensure it complies with required regulations i.e. Learning and Development Agreement, Education Outcomes Framework Deanery, GMC Standards, CQC, Health Education England. Receive regular reports from Education Governance Group.

- Ensure that processes are in place to support the mental and physical health and wellbeing of Trust staff. Monitor and review the Trust's Occupational Health Service, receiving reports where required.

  Ensure delivery of an improved strategy for internal communications, and monitor progress against this strategy. To advise of any significant issues identified through internal communications.

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

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

Constitution

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

MEMBERSHIP: 1 Non-Executive Director [Chair]
2 Non-Executive Directors
Director of Human Resources & Organisational Development – [Deputy Chair]
Chief Operating Officer
Chief Nurse (or Deputy)
Medical Director (or Deputy)
Director of Marketing & Communications
1 x Representative from each Division

Minutes of the Committee are presented to the Board and are supported by a summary report from the Committee Chair. Terms of Reference are revised annually and were last approved in December 2017

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Achievements

In discharging its duties the Committee met its responsibilities through self assessment and review, requesting assurances from Trust officers and directing and receiving reports from relevant individuals.

The following areas were the main focus of the Committee's attention:

- Governance and Programme Assurance for all workforce projects relating to the 'Change Programme'
- Monitoring of the Listening into Action journey
- Monitoring of Mandatory Training progress against targets
- Approval of the Staff Survey action planning process
- Scrutiny of progress against the targets and measures contained within the People Strategy
- Ratification of all relevant workforce policies
- Monitoring of key workforce risks and assurance that strategic plans and operational policies exist to mitigate all significant risks
- Approval of the Trust Apprenticeship Strategy and review of progress
- Approval of the Library and Knowledge Management Strategy
- Approval of the Workforce Equality and Diversity Objectives and review of progress against those objectives
- Monitoring of the Management and Leadership Development Strategy
- Approval of Health & Wellbeing Priorities, including focus on Sickness Absence
- Approval of HEE Self -Assessment Report
- Monitoring of progress against relevant workforce indicators in CQC Action Plan.
-

<u>Self Assessment</u>

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

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

Assurance Statement

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

Committee Developments

Whilst the Committee has performed its duties as delegated by the Board it has identified a number of areas to focus on during 2019/20:

- Focus on monitoring the implementation of the refreshed People Strategy.
- Focus on monitoring the implementation of the Change Programme
- Focus on the key areas which would enable the Trust to deliver its people related targets, namely:
    - Health & Wellbeing
    - Leadership & Succession
    - Equality, Diversity and Inclusion
    - Culture and Engagement
    - Future Workforce Needs

- Enhance the monitoring and reporting of follow-up actions taken in respect of its areas of responsibility.

Claire Dove
Committee Chair April 19

WORKFORCE & ORGANISATIONAL DEVELOPMENT COMMITTEE
2019-20 AGENDA TIMETABLE

Agenda Item	APRIL	JUNE	AUG/SEPT	OCT	DEC	FEB
Review and agree WOD TOR & WORKPLAN						✓
Discuss and identify key workforce themes/risks			✓			✓
Review/amend and approve People Strategy	✓					
Monitor progress against People Strategy	✓	✓	✓	✓	✓	✓
Ratify employment policies	✓	✓	✓	✓	✓	✓
Review workforce risks for inclusion in Board Assurance Framework	✓	✓	✓	✓	✓	✓
Sign-off Annual Report to the Trust Board						✓
Change Programme Assurance	✓	✓	✓	✓	✓	✓
Equality & Diversity Monitoring Process	✓	✓	✓	✓	✓	✓
Staff Survey Results (dependent upon date of publication)	✓					✓
Nurse Workforce Report	✓					
Sickness Absence		✓	✓	✓	✓	✓
Marketing & Communications update (Activity Report)	✓	✓	✓	✓	✓	✓

WORKFORCE & ORGANISATIONAL DEVELOPMENT COMMITTEE MEMBERSHIP ATTENDANCE 2018/19

	21st May	26th June	3rd September	23 October	23rd January	1st March	Attendance
Mrs C Dove - Chair (Non-Executive Director)	✓	✓	✓	✓	✓	✓	6/6
Mr I Quinlan (Non-Executive Director)	✓	✓	X	X	X	✓	3/6
Mrs J France-Hayhurst (Non-Executive Director)	✓	X	X	✓	✓	✓	4/6
Mrs M Swindell (Director of HR&OD	✓	✓	✓	✓	✓	✓	6
Mr A Bateman	X	✓	✓	X	✓	X	3/6
Mrs H Gwilliams or Deputy (Chief Nurse)	✓	X	✓	✓	✓	✓	5/6
Mr S Ryan or Deputy (Medical Director) Nicky Murdock Joined February 2019	✓	✓	X	X	X	✓	3/6
Mr M Flannagan Director of Marketing & Communications	✓	✓	✓	✓	✓	✓	6/6

Alder Hey Children's NHS
NHS Foundation Trust

Resources and Business Development Committee
Approved Minutes of the meeting held on: Monday 1st April 2019 at 3:00pm in Tony Bell Board Room, Institute in the Park

Present	Ian Quinlan (Chair)	Non-Executive Director	(IQ)
	John Grinnell	Director of Finance	(JG)
	Anita Marsland	Non- Executive Director	(AM)
In attendance	Adam Bateman	Chief Operating Officer	(AB)
	Sue Brown	Associate Director for Development	(SB)
	Alison Chew	Head of Operational Finance	(AC)
	Mark Flannagan	Director of Communications	(MF)
	Dani Jones	Director of Strategy	(DJ)
	Rachel Lea	Associate Director of Finance	(RL)
	Sara Naylor	Associate Director – Financial Planning	(SN)
	Erica Saunders	Director of Corporate Affairs	(ES)
	Melissa Swindell	Director of HR &OD	(MS)
	Julie Tsao	Committee Administrator (*minutes*)	(JT)
Apologies	Claire Liddy	Director of Operational Finance	(CL)
	Claire Dove	Non-Executive Director	(CD)
Agenda Item: **5&6**	Graeme Dixon	Head of Building Services	(GD)
9	Natalie Deakin	Change Programme Manager	(ND)
14	Jason Dean	Costing Accountant	(JD)
15	Cathy Fox	Programme Director for Digital	(CF)

19/20/02 **Apologies**
The Chair noted the apologies above.

19/20/03 **Minutes from the meeting held on 27th February 2019**
Subject to the wording under 18/19/170 Corporate Report Performance being updated as below RABD approved the minutes from 27th February 2019:

Lachlan Stark noted there had been 11 cancelled operations for the month of January. 2 of the cancellations were due to no beds being available.

Resolved:
RABD approved the minutes from the last meeting held on 27th February 2019.

19/20/04 **Matters Arising and Action log**
The chair thanked Anita Marsland for attending on behalf of Claire Dove.

All actions on the log had been included on the agenda.

19/20/05 **Top 5 Risks/Key Priority Areas for 2018/19.**
RABD received the latest slides on the three areas below:
CIPs
The forecast outturn as at March 2019 is over 90% delivered. RABD noted the year end position.

PFI
Graeme Dixon updated RABD against the 6 risks noting:

Work had commenced to replace corroded pipes and was due to be completed by November 2019.

Elective Programme
For Month 11 there had been 123 less elective cases than planned. Adam Bateman referred to the improvement plan that was in place and it was hoped to see improvements in month 12.

Areas of concern included issues with the number of Anaesthetist employed at the Trust and the negative impact this was having on spinal cases. The current position was three spinal cases behind plan. It was noted this was a national issues and the action plans in place to address this previously reported at RABD.

Looking forward cardiac cases will over perform in month 12. RABD noted the recruitment plans in place.

Pennine dental activity is significantly less than proposed levels, this is under review.

19/20/05 **Top Risks/Key Priority Areas for 2018/19.**
As risks would be assessed throughout the meeting this item would be deferred until the next RABD in April 2019.
Action: JT

19/20/06 **PFI Monitoring Contract**
Energy forecast for the next few months are due to be within the contractual target.

Resolved:
The Committee noted the Building Services report for month 11.

19/20/07 **Finance Report**
The Trust is reporting a trading surplus for the month of £3.4m which is behind plan by (£0.4m). Income is ahead of plan by £0.3m but this is offset by overspends of (£0.7m) in the month. The Use of Resources risk rating is 1 in line with plan and cash in the bank of £22m.

Contracts with all Commissioners for 2019/20 have now been agreed.

John Grinnell highlighted temp spend is £1m over budget noting this should be considered as a 2019/20 top risk.

RABD discussed overspend in relation to temporary staffing. RABD noted a lot of the spend was in relation to middle grade staff.

Areas to focus on going forward are surgical challenges. The Trust has received £1.8m from the Trust Charity and the land sale has now been completed.

John Grinnell went through a number of concerns in relation to agreeing the PFI deal. It was hoped the deal would be agreed and signed off no later than Friday 5th April 2019. It was noted Alder Hey are not the only this Trust with this issue. RABD noted this was an item at the Trust Board meeting tomorrow.

Resolved:
The Committee noted the contents of the Finance report for month 11.

19/20/08 **Budget Setting 2019/20**
The final budget setting would be emailed to NHSI on Thursday 4th April 2019 after approval from Trust Board tomorrow.

Following negotiations with NHSI regarding a calculation error with the Control Total this has now been re-set to £1.6m. Negotiations with NHSI regarding the £3m reduction to the Children's tariff are ongoing.

RABD noted the Neonatal Single Site Service being developed on the Trust site. Development of the site is over budget and is under review.

A discussion was held on the estates projects. Sue Brown agreed to update RABD at the next meeting in April.
Action: SB

The divisions' target CIP for 2019/20 is £6m. £1m Finalised plans are to be agreed by the end of April 2019.

RABD discussed medical staff vacancies and the impact this was having on the temporary staffing budget. Melissa Swindell agreed to look into this and feedback.
Action: MS

Resolved:
RABD noted the current position of the 2019/20 budget setting.
To be presented tomorrow at Trust Board for approval.

19/20/09 **Programme Assurance**
Natalie Deakin presented the Programme Assurance 2018/19 closing report with the 2019/20 report.

It was noted that Aseptics project was behind timescales. It was agreed an update on progress would be received at the May RABD.

Resolved:
RABD received the latest programme assurance report.

19/20/10 **Marketing and Communications Activity Report**
Resolved:
RABD received and noted the contents of the Marketing and Communications Activity report.

19/20/11 **Board Assurance Framework (BAF)**
Resolved:
RABD received and noted the BAF cover report for month 11.

19/20/12 **Debt Write Off report**
RABD noted the briefing in the report referring to the private patient issue raised at the last RABD. RABD noted the write off no longer required sign off

RABD received the proposed debt write off report for £96.40 in relation to medical records.

Resolved:
RABD approved the March 2019 Debt write off for a total of £96.40.

19/20/13 **Corporate Report**

Performance
Waiting times for treatment in ED increased as February was the most challenging month to date of Winter 19-20.

Workforce
Appraisals for 2019/20 are to be organised from today.

Resolved:
The Committee received and noted the Corporate Report for month 11.

19/20/14 **Reference Costs**

Jason Dean went through requirements set by the Department of Health requesting RABD to confirm the section in relation to 2018/19 national costs collection return.

The Chair noted the positive position and thanked Jason Dean and the team.

Resolved:
RABD APPROVED the reference costs process.

19/20/15 **Global Digital Exemplar**

Work is ongoing in Tranche one with requirements gathering and build. There has been excellent engagement from the specialties involved in the Tranche one, as well as testing taking place for Cardiac Surgery and Cardiology. Engagement is underway for Tranche two and three, with several specialties already requirements gathering in advance of their commencement date. Positive conversations are also taking place with services outside of the original 18 identified for 2019 to understand their requirements.

As previously reported Alder Hey is hosting the Share2Care programme. All 7 sites are now connected to the platform; four sites are operational and three other sites are to go operational mid-April. Three sites are publishing clinic letters to the live platform and the remaining sites are working toward publishing clinic letter by the end of April.

Voice recognition system had now been upgraded, support was being provided to all departments.

Resolved:
RABD noted the progress of the Trusts GDE Programme and the on-going progress towards Milestone 5.

19/20/16 **RABD Work-Plan 2019/20**
Resolved:
RABD was asked to review the work plan and forward any changes to Julie Tsao.

19/20/17 **RABD Terms of Reference**
Resolved:
As the latest version had not been circulated it was agreed this item would be deferred until the next RABD in April.

19/20/18 **Any Other Business**
No other business was reported.

Date and Time of Next Meeting: Monday 29th April 2019, 9:30am – 12:30pm, Tony Bell Board Room, Institute in the park.

Audit Committee

Approved Minutes of the meeting held on **Thursday 24th January 2019**

Room 7, Mezzanine

Present:	Mrs K Byrne (Chair)	Non-Executive Director	(KB)
	Mrs. A. Marsland	Non-Executive Director	(AM)
In Attendance:	Mrs L Cobain	Assistant Director, MIAA	(LC)
	Mr J Grinnell	Director of Finance	(JG)
	Mrs C Liddy	Deputy Director of Finance	(CL)
	Mrs V Martin	Counter Fraud Specialist, MIAA	(VM)
	Ms M McMahon-Joseph	Senior Audit Manager, MIAA	(MMc)
	Mr H Rohimun	Executive Director, Ernst and Young	(HR)
	Ms E Saunders	Director of Corporate Affairs	(ES)
	Mrs M Swindell	Director of HR & OD (item 18/19/66)	(MS)
	Mrs J Tsao	Committee Administrator *(minutes)*	(SS)
Apologies:	Mrs. J. France-Hayhurst	Non-Executive Director	(JFH)

18/19/64 Minutes of the previous meetings held on 20th September and 22nd November 2018

Resolved:
Audit Committee received minutes from the previous meeting held on 20th September and 22nd November 2018. The Chair noted a number of abbreviations not including an explanation and typos from the minutes held in November. Subject to abbreviations and typos being corrected the Audit Committee approved both set of minutes.

18/19/64.1 Action: KB/JT

18/19/65 Matters Arising and Action List

All actions had either been closed or had been included on the agenda.

18/19/66 Progress Report, MIAA

Maria McMahon-Joseph presented the Internal Audit Progress Report noting completion of four reports and progress to date:

Theatres Stock Management and Logistics – Limited Assurance (July 2018)

The review highlighted 3 key areas for enhancement. Maria McMahon-Joseph went through progress to date since a follow up audit had taken place in January 2019:

- Stock PAR Levels, actions had now been implemented.
- Receipt of Stock Ordered, action partially implemented. The residual risk in relation to receipting of stock ordered by Theatres is accepted by the Trust due to the current manual system in operation. Claire Liddy said an electronic system was being looked into, if it was to go ahead it would take around 12 months to be implemented. The Chair asked both Internal and External Audit if they considered the residual risk remaining was unacceptable to the Trust. Both parties confirmed this was not the case. As such, it has been agreed that this element of the action will not be carried forward.
- Inventory Management Records / Systems – action partially implemented. Actions to be taken forward relate to increasing awareness of the requirement for robust clinical governance processes, specifically ensuring audit trails are in place for all patient implants.

The Chair commented that it is not expected to be usual for an internal audit report to take this amount of time to be reported to Audit Committee. Having spoken to both Internal Audit and Management it is understood that, whilst the findings were agreed, there is disagreement over the risk rating of the findings. The Chair was pleased to note that actions to address the findings had been taken promptly, and this has been confirmed by a follow up audit, but restated that reports should not normally be delayed for presentation to Audit Committee. The Chair asked that the date of completion of audit fieldwork be added to audit reports.

18/19/66.1Action: MMc

ESR (HR / Payroll) – Moderate Assurance

One of the high risks identified was building in the regular review access for ELF's into the Trust's User Responsibility Profile audit process. Melissa Swindell said an ESR Manager is now in place and the action would be completed by the end of January 2019.

The Chair noted that 8 Internal Audit Reports are due to the next Audit Committee, which would make for a heavy agenda and reiterated the need for internal audit reports to be presented evenly throughout the year.

18/19/66.2 Action: MMc

Audit Committee was asked to approve the following amendment to the Internal Audit Plan:

Control of Contractors: Following concerns raised by the Trust, MIAA have been requested to undertake a review. An initial scoping meeting has taken place and Terms of Reference are in the process of being drafted. It is proposed that the contingency line within the Plan will be utilised for the review.

Resolved:

Audit Committee received the Internal Audit Progress Report and APPROVED the above change to the Internal Audit Plan.

18/19/67 Follow Up Audits

Audit Committee received the Follow Up Audit Report and the completed follow up reports:

- Theatre Inventory Management
- ESR final report

The Chair noted the amount of information outstanding preventing MIAA from concluding on the extent of implementation of the actions. The Chair requested that MIAA and Management meet to agree a process for following up agreed actions to ensure that sufficient time is available for the provision of evidence by Trust Leads and chasing up by Management when not provided, prior to the Follow Up Report being presented to Audit Committee.

18/19/67.1 Action: Management/MIAA

The Chair requested that, in reporting on the implementation of actions, it is made clear which specific parts of an agreed action are outstanding, as there are often multiple actions for a finding. Also, for MIAA to consider different implementation dates for actions within a single finding when the requirements for some actions will take longer than others.

18/19/67.2 Action: MIAA

Resolved:

Audit Committee received the Follow up Report.

18/19/68 Anti-Fraud Progress Report

Virginia Martin presented the report noting closure of three cases:

- False claims were made at Trust Cash Office by a patient's parent under the Healthcare Travel Costs Scheme (HTCS). The subject agreed a repayment plan with the Trust. Repayments have stopped and the balance is with healthcare debt recovery specialist 'CCI'. Investigation management responses have been agreed to strengthen procedures and increase applicable staff and general public awareness. Final report issued, and closed in December 2018.

- Trust reported a patient's parent had allegedly made a false claim at Trust Cash Office. Anti-Fraud Team confirmed one false claim made by the subject totalling £8.08, and advised Trust to discuss with subject indicating Trust's non-tolerance of abuse of the system, and to seek recovery. No further anti-fraud specialist action is appropriate. Incident Report closed in September 2018.

- An anonymous allegation alleged that a full time Trust employee was working elsewhere whilst off sick. Anti-Fraud team confirmed that the subject worked elsewhere in an NHS setting on two occasions. Trust HR made the decision not to pursue, owing to subject's personal mitigating circumstances. HR confirmed to Anti-Fraud that the subject will be reminded of the Trust policy in relation to working elsewhere whilst off sick. Information report closed in September 2018.

Two cases of fraud had been reported at a local Trust. Both relating to bank mandate fraud, requesting Trust Finance systems be checked against details of specified bank accounts relating to fraudulent bank mandate activities. Steve Begley, Head of Procurement had notified local suppliers to be aware of the scam.

The Chair queried why no action had been taken against a staff member who was found to be performing other NHS work whilst off sick from the Trust. Melissa Swindell undertook to investigate and report back to the Committee.

18/19/68.1 Action: MS

Resolved:
Audit Committee received the MIAA Anti-Fraud Report.

18/19/69 Ernst and Young Update

The new Audit Manager was due to start in February 2018, Hassan Rohimun would be supporting the Trust until the new person started their post.

The Audit Committee noted progress against the Integrated Care Systems and this was due to go live in 2020. Kerry Byrne and Anita Marsland agreed to discuss this further after the meeting.

IFRS 16 will replace IAS 17 Leases with expected implementation in 2019/20. This new Standard will eliminate the distinction between operating leases and finance leases. Claire Liddy agreed to provide an update on progress at the September meeting.

18/19/69 Action: CL

The Chair reiterated the need for a detailed handover to the new Audit Manager, particularly given the prior EY Audit Lead (Senior Manager) has now left EY.

Resolved:
Audit Committee received the Quarter 4 Health Audit Briefing.

18/19/70 Losses and Special Payment Report

Claire Liddy presented the report for the period September – December 2018. The Audit Committee noted the reduction in overpayment of salaries compared to the previous quarter.

Bad debts uneconomical to pursue came to a total of £431. Bad debts are presented to Resource and Business Development Committee on a monthly basis for approval.

The Chair queried the £20k stock loss in the quarter, noting that there was a loss for the same amount in the same quarter last year. Claire Liddy advised that she would look into this and provide an update.

18/19/70.1 Action: CL

Resolved:
Audit Committee received the Losses and Special Payment report for September – December 2018.

18/19/71 Potential Impact of IFRS9 Financial Instruments and IFRS 15 Revenue Recognition

IFRS 15 introduces a new five stage model for the recognition of revenue from contracts with customers. The core principle is that the Trust should recognise revenue when it transfers goods/services to customers and the amount recognised should reflect the amount to which the Trust expects to be entitled in exchange for those goods/services.

Claire Liddy noted particular issues with contracts over 2 years, advising contracts here are 12 months or less.

IFRS 15 is not expected to have a material effect on the financial reporting of the Trust. Material contracts have been reviewed and fall within the financial reporting period. The Trust will continue to account for partially completed spells.

IFRS 9 was published in July 2014 with the intention of replacing the existing Standard, IAS39 Financial Instruments: Recognition and Measurement. It introduced a new approach to the classification and measurement of financial instruments, a new "expected losses" model of impairment, and a less restrictive approach to hedge accounting. Additionally, it made extensive amendments to IFRS 7 Financial Instruments: Disclosures.

The financial instruments standards are complex and not all relevant to the Trust. HM Treasury has interpreted and adapted IFRS 9 in the Group Accounting Manual.

IFRS9 is not expected to have a material effect on the financial reporting of the Trust. Revenue will be reviewed at the time of recognition for expected credit losses and impairments recognised. Impairment of receivables with DHSC bodies is not normally allowed. This is not a change from previous years.

Loans payable will be measured at amortised cost using the effective interest method. Interest payable will now be reported within borrowings, rather than accruals.

The Chair thanked Claire Liddy for reporting the changes and noted the well written paper. Claire said the paper had been written by Angela McMahon and she would feed these comments back.

Resolved:
The Audit Committee noted the new accounting standards and their potential impact.

18/19/72 Shareholders

As previously reported Alder Hey is a shareholder in Acorn Ltd. The purpose of the company is to work through business ideas ending with financial earnings. 17 companies are currently in collaboration with the number growing.

As this is a new approach for Alder Hey and the NHS as a whole a number of governance concerns have been raised. Due to this, KPMG have been appointed to develop a governance structure.

KPMG are due to submit their findings in 2 weeks. As the KPMG report would need to be actioned quickly a workshop would be held on developing the new guidance.

18/19/72.1Action: JG/CL

Resolved:
An update was received on the current shareholdings of the Trust.

18/19/73 Accounting Policies

Claire Liddy presented the paper outlining changes to the Accounting Policies. Audit Committee was asked to support the changes in preparation of submission of the statutory Annual Accounts.

The accounting policies are reflective of the Department of Health Group Accounting Manual standard accounting policies. Therefore the wording on the policies has been amended or added to slightly throughout.

The 5 main changes are:

- The provision for Injury Costs Recovery debt is 10%, reflecting Alder Hey current levels of withdrawals of cases without payment. This is consistent with 2017/18.
- There is a change in the discount rate for general provisions. Discount rates are used to calculate the present value of future cash flows.
- HM Treasury have also changed the discount rate for post-employment benefits from 0.10% to 0.29%.
- There is an amended policy on revenue recognition to reflect adoption of IFRS 15 and financial instruments to reflect IFRS 9.
- A policy has been added to reflect lessor accounting relating to Research & Education Institute phase 2 lease with Edge Hill University.

The Chair questioned the current annual leave process and asked if there are any plans to move from a paper version to an electronic. Claire Liddy noted this was a HR process and agreed to forward to Melissa Swindell to consider.

18/19/73.1Action: CL/MS

Resolved:
Audit Committee APPROVED the changes to the Accounting Policies in preparation for the statutory Annual Accounts.

18/19/74 Draft Capital Accounting Manual 2018 – 19

Audit Committee received the above manual for approval.

Audit Committee questioned the value of the Manual being approved by the Committee. Claire Liddy advised going forward any changes would be reported as an update.

The Chair noted the number of very large documents included within this Audit Committee pack (such as this one, and the Corporate Governance Manual) and asked that, in future, big documents are circulated a month in advance to provide Audit Committee members with sufficient time to read them properly.

Resolved:
Audit Committee APPROVED the draft Capital Accounting Manual 2018-19.

18/19/75 External Audit Strategy and Accounting Issues

Audit Committee was asked to note accounting issues and accounting transactions which may arise during the preparation of the Trust's Annual Accounts.

Accounting issues included:

- The Trust has entered into an agreement with Edge Hill University to lease part of the new Research & Education Institute to the University for a period of 60 years. The consideration to be received from the University is a lease premium.
- The Trust has entered into agreements with LJMU and UCLAN to lease part of the new Research & Education Institute for 12 years and 10 years respectively. The consideration to be received is being treated as donated income.
- Demolition of the old estate was necessary to facilitate the building of the new hospital. Consequently, all demolition costs have been capitalised and impaired each year. It is proposed to continue with this treatment in 2018/19.
- The Trust will not consolidate the Alder Hey Living Hospital Joint Venture in 2018/19 due to immateriality. The Trust will continue to disclose as per 2017/18 accounts.
- The Trust have a number of minority interests in innovation companies through the ACORN partnership. The Trust will include narrative disclosures in the accounts and will provide the names of the entities and the relevant shareholdings.
- The Trust will provide a narrative disclosure in the accounts for the Trust wholly owned subsidiary. There has been no financial activity through this company in 2018/19 and therefore consolidation is not required due to immateriality.
- Discussions are ongoing between the Trust and Project Co regarding compensation for over-consumption of energy.
- As the Trust had a full valuation of estate as at 31 March 2018, values will be adjusted by BCIS indices at 31 March 2019.

Accounting Transactions included: PFI deal, Charity Swap, Land Sale and Grants.

Resolved:
Audit Committee AGREED the proposed accounting treatments and noted the accounting transactions.

18/19/76 Corporate Governance Manual

Audit Committee received the Governance Manual for approval.

The Chair noted the useful document and agreed to highlight some typos outside of the meeting.

Resolved:

Audit Committee APPROVED the Corporate Governance Manual.

18/19/77 Board Assurance Framework (BAF)

The Chair provided an update from the Integrated Governance Committee on 15th January 2019 where is was agreed that a "deep dive" will be undertaken each meeting on a sample of the BAF risks such that they are all reviewed in detail across the year. The Chair also noted that the BAF is presented to each Board and relevant risks are presented regularly to the other Board Sub Committees.

Anita Marsland, Chair of Clinical Quality Assurance Committee agreed to replicate this at their meetings also. On this basis, no detailed review of the BAF risks was undertaken in this meeting.

Resolved:

Audit Committee received and noted the contents of the Board Assurance Framework for including the ongoing scrutiny of all strategic risks by the relevant assurance committee.

18/19/78 Audit Committee Work-plan

Audit Committee received the Work-Plan for approval.

MIAA and EY were asked to confirm, to the Committee minute taker, the specific reports that they will present to each Committee throughout the year so that the Work Plan can be updated.

18/19/78.1: Action MIAA and EY

Resolved:

Subject to the above amendments Audit Committee APPROVED the work-plan.

18/19/79 Any Other Business

There was none to discuss.

18/19/80 Meeting Review

John Grinnell noted Shareholders would be an item on the February Board.

Date and Time of next meeting: Thursday 18th April 2019, at 14:00, Large Meeting Room, Institute in the park.

NHS
Alder Hey Children's
NHS Foundation Trust

Corporate Report March 2019

How Did We Do?

Executive Summary **Month: March** **Year: 2019**

Alder Hey Children's NHS
NHS Foundation Trust

Delivery of Outstanding Care

Safe

- Review of incident thresholds and associated RAG ratings underway
- Consistently high rates of incident reporting reflected in improved NRLS position to highest reporting Children's Hospital

Highlight

- No pressure ulcer of Category 3 and above since May 2018, only one occurrence in 2018/19.

Challenges

- Patients with suspected Sepsis not receiving antibiotics with 60 minutes, new escalation process introduced by Medical Director and Chief Nurse with clinical teams

The Best People Doing their Best Work

Caring

- 2018/19 year end position shows an increase in formal complaints based on previous year however complaints are viewed as a valuable source of feedback
- Overall theme of reduced PALS concerns in the second half of the year following effective local resolution of concerns

Highlight

- Consistently above 95% of inpatients would recommend being cared for at Alder Hey.

Challenges

- The overarching theme in 2018/19 relates to CYP feedback regarding play and learning opportunities, however full action plan to address issues developed and action underway.

Delivery of Outstanding Care

Effective

- We had a strong end to the year with regard to operational delivery of effective services. We were ranked seventh in the NHS for the proportion of patients treated in the Emergency Department in less than 4 hours. In congenital cardiac surgery the national standard for volume of surgery was achieved with 410 waiting operations undertaken.

Highlight

- The Emergency Department 4 hour waiting time standard was achieved at 95.65%.
- Fourth consecutive month of improving clinic utilisation with March at 88.7%.
- For Quarter 4, short notice cancellation for non- clinical reasons reduced by 69% relative to the same quarter in the previous year
- The Was Not Brought rate (previously known as DNA) has reduced to below 10% following the introduction of the mobile reminder service

Challenges

Delivery of Outstanding Care

Responsive

- Our performance in relation to access standards for planned care remains strong, as indicated by RTT performance and waiting list size.
- Whilst the number of patients waiting over 21 days is 33 against a target of 32, only a very small proportion (n=3) are medically fit for discharge. The complex care project team and the MDT are now focused on earlier intervention to undertake preparations for discharge sooner.
- There is significant disruption to the radiopharmacy service due to production challenges at the Royal Liverpool Hospital. This is affecting appointment schedules for patients. We are exploring alternative service delivery options to increase resilience and mitigate the number of changes to and cancellations of appointments.

Highlight

- Delivery of all open pathway waiting time and cancer standards

Challenges

- Diagnostic waiting times are meeting the national threshold, however there are challenges with reporting turnaround times and in radiopharmacy services.
- Increasing the number of patients who know their planned date of discharge
- Number of patients waiting over 21 days

The Best People Doing their Best Work

Well Led

- March sees the year-end position finalised for the Trust with the figures at this stage being at the pre-audit stage so subject to potential change.
- Year-end saw the Trust deliver a £49.9m surplus which was £17.7m ahead of plan. This significant improvement in performance was driven by our one off transactions (land sale and commercial agreements) being higher than the plan, improved divisional run rates in March, securing contract over performance and addition PSF funding (incentive and year-end bonus allocation).
- Underlying Trust position excluding one off transactions and PSF allocations is a £1.4m deficit which was £0.4m better than planned however reinforces that whilst the in-year performance is exceptional our focus must remain on improving our underlying sustainability.
- CIP delivery was £6.8m for the year which is marginally short of the plan however shows improved performance in the last quarter.
- Whilst overall divisional performance improved during March we were met with some one-off pay costs which was disappointing as a number were back dated issues. Temporary staffing costs remain high and are a focus of next years programme.
- Year-end cash balances was £33m which was £4m ahead of plan. Additional PSF funding is due June/July.
- Use of resource rating was a 1 which is the lowest risk.
- Capital spending for the year was £16.3m against a £24m plan. Slippage was incurred on the Estate largely driven by delays in the Alder Centre and the Community Cluster build. These are built into our 2019/20 plan.

Highlight

- Activity Run Rates
- Year-end surplus
- CIP delivery
- Cash balances
- PDR Rates

Challenges

- Sickness levels
- Temporary staffing requirements

Game Changing Research and Innovation

Research and Development

- The research portfolio of open studies across academic and commercial sectors continues to show a small decrease over the year to date. This is in part due to saturation within the research delivery workforce and lack of capacity to deliver more studies. It may also be due to the lack of new studies nationally which are feasible for the Alder Hey patient population.

Highlight

- Revised business model for research, including mechanisms for professional involvement incentivisation, agreed in principle.
- Plans to improve front line and research activity through an increasing number of clinicians involved in research are progressing.

	Challenges
	• Currently around 15 commercial studies in the contracting stage which can't be progressed because of lack of financial capacity within the Clinical Research Division. • Staffing within the Division has been significantly reduced due to a number of leavers.

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Delivery of Outstanding Care

SAFE

Alder Hey Children's NHS
NHS Foundation Trust

	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Last 12 Months	RAG			Comments Available
Total no of incidents reported Near Miss & Above	513	412	446	489	432	447	452	478	460	347	424	422	460		>=515	>=463	<463	✔
Clinical Incidents resulting in minor harm & above	93	83	76	90	84	80	91	94	96	70	85	90	106		<=84	<=94	>94	✔
Clinical Incidents resulting in moderate, semi permanent harm	1	0	1	2	1	1	2	0	1	1	2	1	0		<=1	N/A	>1	✔
Clinical Incidents resulting in severe, permanent harm	0	0	0	0	0	0	0	0	0	0	0	0	0		0	N/A	>0	✔
Clinical Incidents resulting in catastrophic, death	0	0	0	0	0	0	0	0	0	0	1	2	0		0	N/A	>0	✔
Pressure Ulcers (Category 3)	0	0	1	0	0	0	0	0	0	0	0	0	0		0	N/A	>0	✔
Pressure Ulcers (Category 4)	0	0	0	0	0	0	0	0	0	0	0	0	0		0	N/A	>0	✔
Medication errors resulting in harm	6	4	3	4	3	4	4	2	6	2	2	4	2		<=2	N/A	>2	✔
Never Events	0	0	0	0	0	2	0	0	0	0	1	0	0		0	N/A	>0	✔

The Best People doing their best Work

CARING

Alder Hey Children's NHS
NHS Foundation Trust

	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Last 12 Months	RAG	Comments Available
Friends & Family A&E - % Recommend the Trust	86.4%	85.4%	82.6%	83.9%	86.3%	88.2%	85.5%	80.0%	80.6%	90.1%	90.5%	80.3%	89.5%		>=95 % >=90 % <90 %	✔
Friends & Family Community - % Recommend the Trust	97.7%	100.0%	96.8%	96.4%	92.2%	100.0%	100.0%	93.2%	100.0%	100.0%	98.5%	100.0%	98.6%		>=95 % >=90 % <90 %	✔
Friends & Family Inpatients - % Recommend the Trust	96.8%	93.7%	95.5%	94.9%	97.0%	97.0%	98.3%	98.2%	97.9%	98.2%	97.0%	96.2%	97.8%		>=95 % >=90 % <90 %	✔
Friends & Family Mental Health - % Recommend the Trust	100.0%	87.5%	82.6%	88.9%	100.0%	89.9%	89.4%	84.7%	97.5%	100.0%	88.9%	76.9%	82.9%		>=95 % >=90 % <90 %	✔
Friends & Family Outpatients - % Recommend the Trust	89.3%	90.3%	88.6%	86.9%	85.5%	89.7%	90.0%	90.3%	91.4%	91.7%	87.4%	89.1%	91.1%		>=95 % >=90 % <90 %	✔
Complaints	5	8	11	11	14	14	12	13	5	7	6	8	16		<=4 <=5 >5	✔
PALS	129	151	126	99	100	100	125	132	115	71	137	98	93		<=116 <=129 >129	✔

Delivery of Outstanding Care

EFFECTIVE

Alder Hey Children's NHS
NHS Foundation Trust

	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Last 12 Months	RAG			Comments Available
Sepsis: Patients treated for Sepsis - A&E	60.9%	66.7%	55.6%	57.1%	65.5%	68.2%	54.5%	65.4%	57.6%	51.9%	77.4%	71.1%	79.4%		>=90 %	N/A	<90 %	✔
Sepsis: Patients treated for Sepsis within 60 mins - Inpatients	79.2%	76.0%	72.7%	78.9%	71.4%	72.5%	78.2%	70.2%	76.2%	73.3%	70.2%	82.1%	73.3%		>=90 %	N/A	<90 %	✔
No of children that have suffered avoidable death - Internal	0	0	0	0	0	0	0	0	0	0	0	0	0		0	N/A	>0	✔
% Readmissions to PICU within 48 hrs	4.1%	3.6%	2.5%	2.7%	6.5%	0.0%	2.7%	1.0%	1.1%	2.4%	1.4%	1.8%	2.5%		<=3 %	N/A	>3 %	✔
Hospital Acquired Organisms - MRSA (BSI)	0	0	0	0	0	0	0	0	0	0	0	0	0		0	N/A	>0	✔
Hospital Acquired Organisms - C.difficile	1	0	0	0	0	0	0	0	0	0	0	0	1		0	N/A	>0	✔
Hospital Acquired Organisms - MSSA	0	0	1	0	0	0	1	2	0	1	1	0	4		<=1	N/A	>1	✔
Hospital Acquired Organisms - CLABSI - ICU Only	2	2	2	2	0	1	0	2	1	3	0	1	3		<=1	N/A	>1	✔
Hospital Acquired Organisms - Gram Negative BSI	3	2	0	1	0	1	2	2	2	2	1	3	0		<=1	N/A	>1	✔
Bed Occupancy (Accessible Funded Beds)	89.6%	90.3%	84.9%	88.5%	83.9%	76.2%	79.9%	85.8%	85.3%	73.7%	72.9%	80.8%	79.1%		<=89 %	<=93 %	>93 %	✔
ED: 95% Treated within 4 Hours	97.2%	95.3%	95.0%	95.6%	96.5%	98.4%	93.7%	90.9%	93.8%	95.3%	92.1%	90.6%	95.6%		>=95 %	N/A	<95 %	✔
Average LoS - Elective (Days)	3.21	2.79	2.87	2.89	3.13	2.80	2.79	3.05	2.90	3.58	2.35	3.04	3.14		<=3.2	N/A	>3.2	✔
Average LoS - Non-Elective (Days)	2.10	1.96	2.01	2.01	1.85	2.03	1.73	2.05	1.98	1.92	1.81	1.90	1.70		<=2.1	N/A	>2.1	✔
Theatre Utilisation - % of Session Utilised	86.2%	88.2%	88.6%	87.9%	89.3%	87.0%	86.6%	86.5%	87.2%	85.8%	88.7%	88.7%	89.2%		>=90 %	>=80 %	<80 %	✔
On the day Elective Cancelled Operations for Non Clinical Reasons	37	26	30	43	35	18	12	28	38	21	11	10	11		<=22	N/A	>22	✔
28 Day Breaches	8	10	5	6	6	7	1	0	6	6	4	1	1		0	N/A	>0	✔
Clinic Session Utilisation	84.0%	83.7%	84.0%	84.9%	82.4%	83.1%	84.3%	83.1%	84.6%	82.2%	83.0%	86.3%	88.8%		>=90 %	>=85 %	<85 %	✔
Was Not Brought Rate	11.3%	10.7%	11.5%	12.1%	12.4%	13.5%	11.4%	11.8%	11.5%	13.3%	12.2%	11.1%	9.7%		<=12 %	<=14 %	>14 %	✔
Transcription Turnaround (days)	28.50	15.00	6.00	4.50	4.00	1.00	4.00	1.50	2.00	2.50	1.25	1.50	2.75		<=3	<=5	>5	✔

Delivery of Outstanding Care

RESPONSIVE

Alder Hey Children's NHS
NHS Foundation Trust

	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Last 12 Months	RAG	Comments Available
IP Survey: % Received information enabling choices about their care	93.1%	94.8%	91.6%	96.2%	94.7%	94.7%	96.3%	96.4%	95.1%	96.7%	96.0%	94.9%	95.7%		>=95 % >=90 % <90 %	✔
IP Survey: % Treated with respect	99.8%	97.7%	98.8%	99.7%	99.7%	99.6%	99.5%	99.6%	100.0%	99.6%	100.0%	99.3%	99.5%		100 % >=95 % <95 %	✔
IP Survey: % Know their planned date of discharge	60.1%	60.5%	76.1%	63.7%	65.7%	60.6%	55.3%	60.2%	69.0%	59.4%	76.5%	82.8%	80.6%		>=90 % >=85 % <85 %	✔
IP Survey: % Know who is in charge of their care	91.6%	91.3%	90.9%	92.7%	94.7%	91.6%	94.9%	92.2%	92.2%	92.5%	96.3%	94.3%	93.4%		>=95 % >=90 % <90 %	✔
IP Survey: % Patients involved in play and learning	75.0%	74.9%	77.8%	74.4%	73.1%	74.8%	73.7%	74.3%	72.5%	68.2%	78.5%	78.8%	77.9%		>=90 % >=85 % <85 %	✔
RTT: Open Pathway: % Waiting within 18 Weeks	92.1%	92.1%	92.0%	92.1%	92.0%	92.0%	92.1%	92.1%	92.1%	92.0%	92.0%	92.0%	92.0%		>=92 % >=90 % <90 %	✔
Waiting List Size		13,235	13,238	12,879	12,962	12,925	12,884	12,961	12,934	12,859	12,872	12,888	12,746		<=12905 N/A >12905	✔
Waiting Greater than 52 weeks	1	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0	✔
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.7%	100.0%	100.0%	100.0%	95.5%	100.0%		100 % N/A <100 %	✔
All Cancers: 31 day diagnosis to treament	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	87.5%	100.0%		100 % N/A <100 %	✔
All Cancers: 31 day wait until subsequent treatments	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100 % N/A <100 %	✔
Diagnostics: % Completed Within 6 Weeks	99.8%	99.8%	99.8%	99.2%	99.3%	99.0%	99.8%	99.8%	99.3%	100.0%	99.7%	99.6%	99.5%		>=99 % N/A <99 %	✔
Number of Super Stranded Patients (21+ Days)	32	34	27	32	29	32	29	32	28	24	35	38	33		<=32 N/A >32	✔
PFI: PPM%	98.0%	98.6%	99.0%	99.0%	96.0%	98.0%	100.0%	98.0%	99.0%	100.0%	100.0%	100.0%	98.0%		>=98 % N/A <98 %	✔

The Best People doing their best Work

WELL LED

Alder Hey Children's NHS
NHS Foundation Trust

	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Last 12 Months	RAG	Comments Available
CIP In Month Variance (£'000s)	864	-248	104	153	-238	-137	175	-174	-285	151	-199	-74	-75		>=0% >=-20% <-20%	✔
Control Total In Month Variance (£'000s)		-426	154	285	29	-396	359	-463	-48	564	-21	-433	18,105		>=0% >=-20% <-20%	✔
Capital Expenditure In Month Variance (£'000s)	-887	1,090	-333	1,701	-462	-129	2,907	-751	1,041	1,032	1,032	259	1,610		>=-5% >=-10% <-10%	✔
Cash in Bank (£'000s)	12,244	12,406	10,455	9,455	23,910	21,519	20,023	20,315	17,580	23,136	19,983	22,068	33,699		>=0% >=-20% <-20%	✔
Income In Month Variance (£'000s)	19,658	218	591	425	998	741	263	624	684	142	456	355	19,495		>=0% >=-20% <-20%	✔
Pay In Month Variance (£'000s)	546	-17	-7	-38	-111	-311	51	-372	-74	-267	-510	-850	-495		>=-1% >=-20% <-20%	✔
Non Pay In Month Variance (£'000s)	1,368	-627	-431	-102	-858	-825	95	-715	-659	689	41	63	-865		>=0% >=-20% <-20%	✔
NHSI Use of Resources	1	3	3	3	3	3	2	2	1	1	1	1	1		<=1 N/A >1	✔
AvP: IP - Non-Elective		1,342	1,338	1,247	1,318	1,134	1,344	1,438	1,508	1,432	1,310	1,215	1,385		>=0 N/A <0	✔
AvP: IP Elective vs Forecast		379	435	397	422	399	388	441	419	328	412	401	457		>=0 N/A <0	✔
AvP: Daycase Activity vs Forecast		1,809	1,905	1,917	1,894	1,873	1,722	2,007	1,954	1,621	2,011	1,764	1,850		>=0 N/A <0	✔
AvP: Outpatient Activity vs Forecast		18,189	19,295	18,591	19,414	17,542	17,813	21,140	21,215	15,984	20,644	18,830	20,739		>=0 N/A <0	✔
PDR	76.4%	1.3%	11.3%	31.1%	64.7%	82.3%	88.8%	90.1%	90.1%	90.1%	90.1%	92.2%	92.2%		>=90 % >=85 % <85 %	✔
Medical Appraisal	67.6%	69.0%	69.0%	2.0%	4.0%	6.3%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		>=95 % >=90 % <90 %	✔
Mandatory Training	92.9%	92.1%	92.0%	92.1%	91.6%	88.6%	88.1%	89.7%	89.7%	89.0%	89.4%	88.8%	89.6%		>=90 % >=80 % <80 %	✔
Sickness	4.7%	4.4%	4.6%	4.9%	5.3%	5.2%	5.4%	5.6%	5.6%	6.0%	5.7%	5.7%	5.5%		<=4.5 % <=5 % >5 %	✔
Short Term Sickness	1.5%	1.3%	1.2%	1.4%	1.5%	1.3%	1.4%	1.5%	1.6%	1.6%	1.8%	1.7%	1.6%		<=1.5 % N/A >1.5 %	✔
Long Term Sickness	3.2%	3.1%	3.4%	3.5%	3.8%	4.0%	4.0%	4.0%	3.9%	4.4%	3.9%	4.0%	3.9%		<=3 % N/A >3 %	✔
Temporary Spend ('000s)	1,067	977	973	947	901	1,082	820	998	971	883	937	1,057	1,357		<=800 <=960 >960	✔
% of Correct Pay Achieved	98.9%	99.8%	99.4%	99.5%	99.5%	99.5%	99.4%	99.4%	99.5%	99.5%	99.5%	99.5%	99.5%		>=99.5 % >=99 % <99 %	✔
Staff Turnover	10.9%	10.6%	10.9%	10.6%	11.5%	10.4%	10.9%	11.2%	10.6%	9.5%	9.8%	9.6%	10.4%		<=10 % <=11 % >11 %	✔
Safer Staffing (Shift Fill Rate)	95.0%	96.4%	96.5%	94.8%	95.0%	93.9%	93.1%	93.2%	95.3%	94.2%	94.5%	92.8%	95.4%		>=90 % N/A <90 %	✔
Domestic Cleaning Audit Compliance	90.0%	90.0%	85.0%	65.5%	97.5%	85.0%	93.8%	60.0%	90.0%	90.0%	92.0%	95.0%	86.0%		>=85 % N/A <85 %	✔
Performance Against Single Oversight Framework Themes	0	0	0	0	0	0	0	0	0	0	0	0	0		0 <=1 >1	✔

Game Changing Research & Innovation

R&D

Alder Hey Children's NHS
NHS Foundation Trust

GROW THE FUTURE

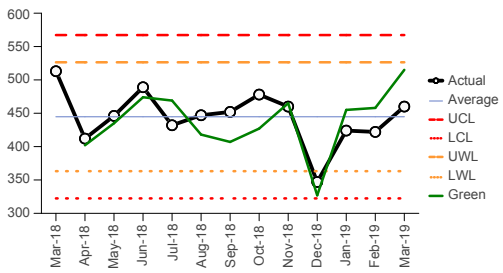
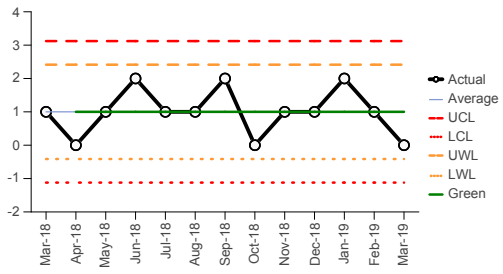
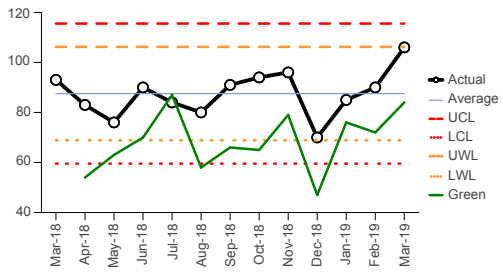
	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Last 12 Months	RAG	Comments Available
Number of Open Studies - Academic	0	148	153	159	159	156	115	143	136	123	121	121	153		>=50 N/A <50	✔
Number of Open Studies - Commercial	0	34	33	34	34	37	27	31	28	27	29	26	60		>=5 N/A <5	✔
Number of New Studies Opened - Academic	0	5	2	5	7	2	3	6	8	2	6	5	3		>=4 N/A <4	
Number of New Studies Opened - Commercial	0	3	0	0	1	2	3	2	0	0	1	1	4		No Threshold	
Number of patients recruited	0	272	308	245	288	249	238	195	296	158	238	211	314		>=417 N/A <417	✔

Delivery of Outstanding Care

7.1 - QUALITY - SAFE

Alder Hey Children's NHS Foundation Trust

BRILLIANT BASICS

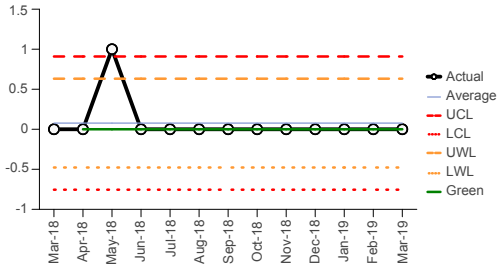
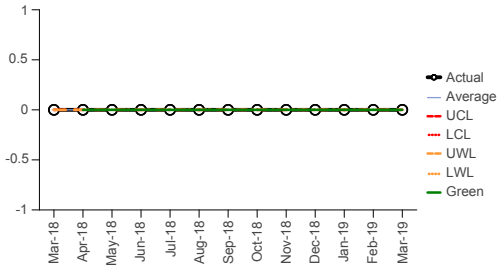
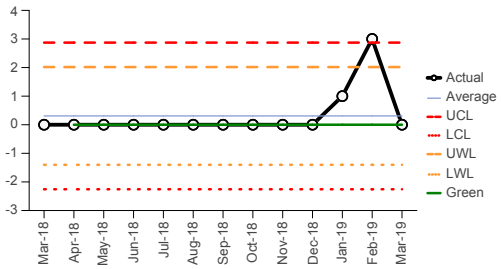
	Description	Performance	Threshold	Trend	Management Action (SMART)
Incidents: Increasing Reporting	**Total no of incidents reported Near Miss & Above** Total number of Incidents reported. The threshold is based on increasing on last year for the period Apr 17 - Mar 18 (4,241) 18/19 aim is more than last year for the same month to demonstrate a learning culture. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	460	R <463 A >=463 G >=515		Weekly 'Patient Safety Meeting' review and highlight importance of reporting , also monitor actions for improvement. Divisional Governance monthly assurance reports including lessons learned presented to Divisional Governance Assurance Committee and Clinical Quality Steering group.
Incidents: Reducing Harm	**Clinical Incidents resulting in moderate, semi permanent harm** Incidents reported resulting in moderate harm. The threshold is based on achieving a 10% reduction on the period Apr 17 - Mar 18 (16). 18/19 aim is 12 or less, annually. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	0	R >1 A N/A G <=1		No Action Required
Incidents: Reducing Harm	**Clinical Incidents resulting in minor harm & above** Incidents reported resulting in minor, moderate, major or catastrpohic (death) harm. The threshold is based on achieving a 10% reduction on the period Apr 17 - Mar 18 (913). 18/19 aim is 10% less than last year for the same month. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	106	R >94 A <=94 G <=84		Weekly 'Patient Safety Meeting' review and highlight importance of reporting , also monitor actions for improvement. Divisional Governance monthly assurance reports including lessons learned presented to Divisional Governance Assurance Committee and Clinical Quality Steering group.

Delivery of Outstanding Care

7.2 - QUALITY - SAFE

BRILLIANT BASICS

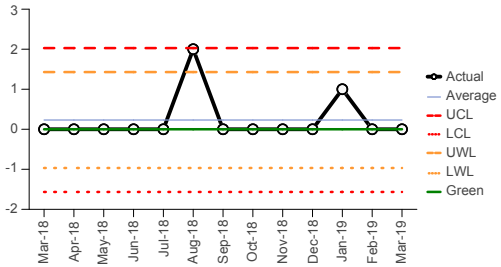
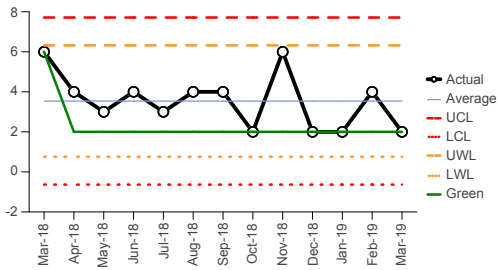
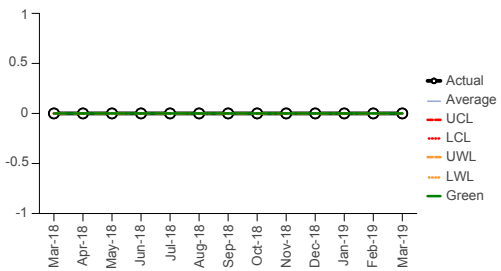
Alder Hey Children's NHS
NHS Foundation Trust

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

Delivery of Outstanding Care

7.3 - QUALITY - SAFE

Alder Hey Children's NHS Foundation Trust

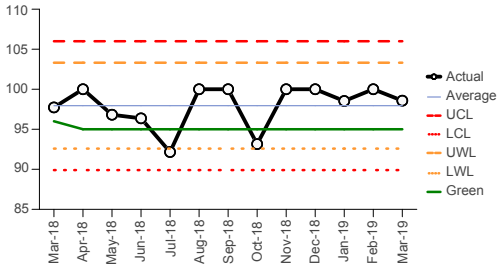
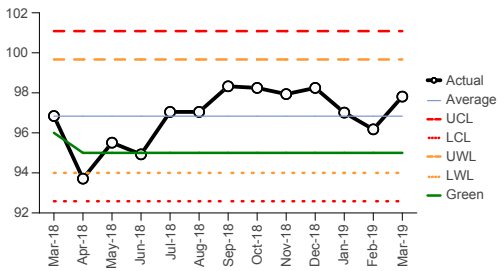
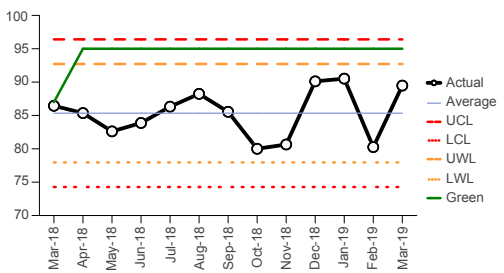
	Description	Performance	Threshold	Trend	Management Action (SMART)
Never Events	**Never Events** Never Events. The threshold is based on this event never occuring. 18/19 aim is zero annually. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	0	R >0 A N/A G 0		No Action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

The Best People doing their best Work

8.1 - QUALITY - CARING

Alder Hey Children's NHS Foundation Trust

BRILLIANT BASICS

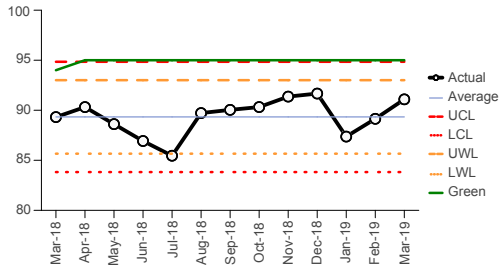
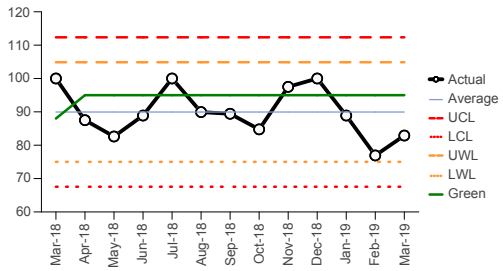
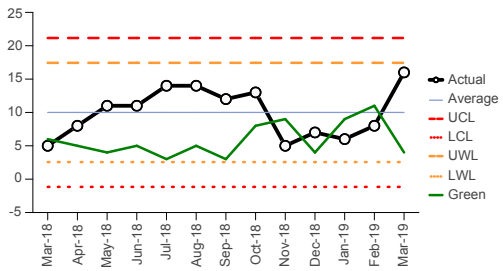
	Description	Performance	Threshold	Trend	Management Action (SMART)
Friends & Family	**Friends & Family Community - % Recommend the Trust** Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	98.57 %	R <90 % A >=90 % G >=95 %		No Action Required
Friends & Family	**Friends & Family Inpatients - % Recommend the Trust** Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	97.81 %	R <90 % A >=90 % G >=95 %		No Action Required
Friends & Family	**Friends & Family A&E - % Recommend the Trust** Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on exceeding the National average in Nov 17. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	89.47 %	R <90 % A >=90 % G >=95 %		This is a great improvement. We will continue to provide volunteers in the waiting room assisting children and families and also the team with cleaning of toys and updating the board so that families are aware of the waiting times. We will then move the volunteers into the clinical areas to support staff with other non-clinical duties.

The Best People doing their best Work

8.2 - QUALITY - CARING

Alder Hey Children's NHS Foundation Trust

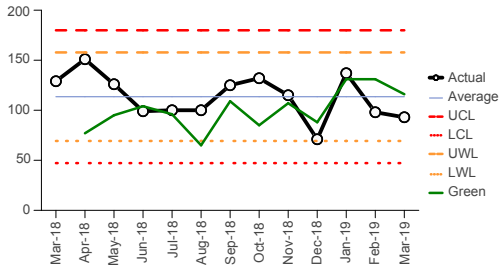
BRILLIANT BASICS

	Description	Performance	Threshold	Trend	Management Action (SMART)
Friends & Family	**Friends & Family Outpatients - % Recommend the Trust** Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	91.09 %	R <90 % A >=90 % G >=95 %		The Best in Outpatient Care Project' continues to find ways to improve the experience in Outpatients. Areas of focus are play and distraction for phlebotomy, volunteers are being utilised in calling patients and taking blood samples to the labs which has improved patients flow. The booking process, communication, access to check in machines, signage have all been identified as needing improvements. Signs are due to arrive April. Feedback around staff attitude has been addressed. Overcrowding in the waiting areas is being reviewed again through the care project.
Friends & Family	**Friends & Family Mental Health - % Recommend the Trust** Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	82.89 %	R <90 % A >=90 % G >=95 %		A key issue is the ability to get FFT cards from community sites to the PE team for input in time for reporting in that month; Community admin staff will input their own feedback digitally, through SMS messaging as well as online, we will look for funding for community to use tablets as an alternative to completing cards. Staff are to be reminded via the Division's Quality Update report to submit cards for inclusion as soon as possible. Head of Quality will monitor all feedback.
Complaints	**Complaints** Total complaints received. The threshold is based on achieving a 25% reduction on the period Apr 17 - Mar 18 (90). 18/19 aim is to reduce by 25% or more for the same month last year. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	16	R >5 A <=5 G <=4		This is the highest number of formal complaints received in one month since March 2015. There do not appear to be any identifiable themes of areas although between the three Divisions it appears a general complaint of waiting time, for apt, for admission, for test results

The Best People doing their best Work

8.3 - QUALITY - CARING

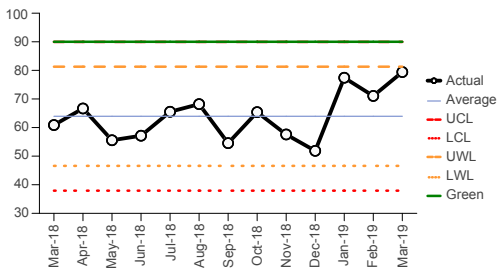
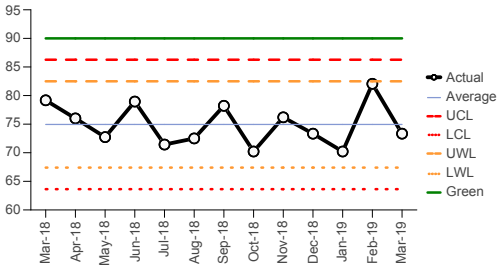
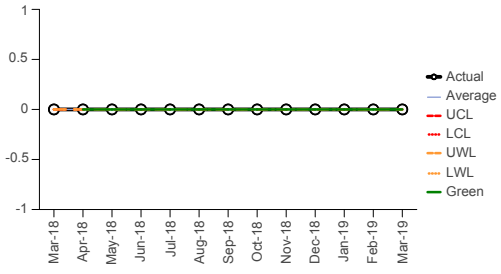
Alder Hey Children's NHS
NHS Foundation Trust

	Description	Performance	Threshold	Trend	Management Action (SMART)
PALS	**PALS** Total number of PALS contacts. Threshold is based on a 10% Reduction on 17/18 (1336). 18/19 aim is to reduce by 10% or more for the same month last year. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	93	R >129 A <=129 G <=116		No Action Required

Delivery of Outstanding Care

9.1 - QUALITY - EFFECTIVE

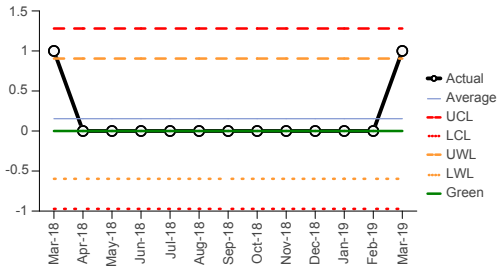
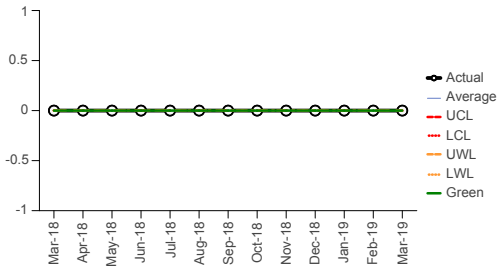
Alder Hey Children's NHS Foundation Trust

	Description	Performance	Threshold	Trend	Management Action (SMART)
Sepsis	**Sepsis: Patients treated for Sepsis - A&E** Percentage of Sepis Patients receiving antibiotic within 60 mins for ED. 18/19 aim is 90%. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	79.41 %	R <90 % A N/A G >=90 %		A slight reduction in the number of high risk treated patients compared to February, many of which required initial assessment and treatment in high dependency / resuscitation. A further decrease in mean time to antibiotics (48 minutes to 45 minutes). Difficulties still remain regarding extraction of accurate data from the electronic system.
Sepsis	**Sepsis: Patients treated for Sepsis within 60 mins - Inpatients** Percentage of Sepis Patients receiving antibiotic within 60 mins for Inpatients. 18/19 aim is 90%. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	73.33 %	R <90 % A N/A G >=90 %		Sepsis status now live across the trust making it much easier view documentation as now all electronic. Although decrease from last month, 2 patients who were over 60 minutes received iv bolus first, 1 had LP before administration of ivab. Tailoring care to individual patient needs is paramount in provideing effective treatment for sepsis. IVAB are only one aspect. Using new sepsis status % would increase to 87%.
Mortality	**No of children that have suffered avoidable death - Internal** Total number of children that have suffered avoidable death with issues relating to care provided in Alderhey. Figures provided by HMRG group. The threshold for 18/19 is zero. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	0	R >0 A N/A G 0		No Action Required

Delivery of Outstanding Care

9.2 - QUALITY - EFFECTIVE

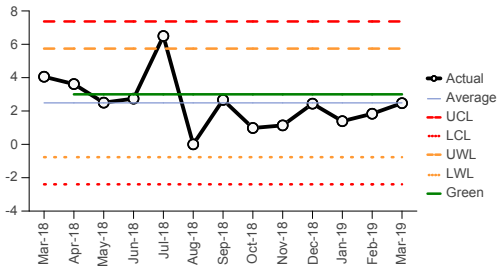
Alder Hey Children's NHS Foundation Trust

	Description	Performance	Threshold	Trend	Management Action (SMART)
Reducing Infections	**Hospital Acquired Organisms - C.difficile** The threshold is based on this event never occuring. 18/19 Aim is zero annually. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	1	R >0 A N/A G 0		Initial RCA undertaken. Awaiting further information from Clinical Team. May be able to appeal the case with CCG if we find there was no lapse in care.
Reducing Infections	**Hospital Acquired Organisms - MRSA (BSI)** The threshold is based on this event never occuring. 18/19 Aim is zero annually. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	0	R >0 A N/A G 0		No Action Required

Delivery of Outstanding Care

9.2 - QUALITY - EFFECTIVE

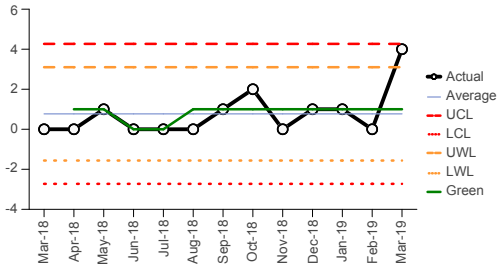
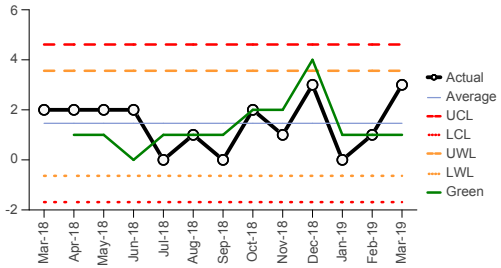
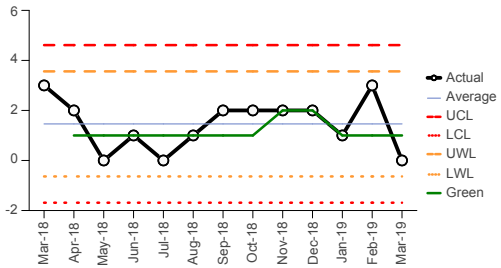
Alder Hey Children's NHS Foundation Trust

	Description	Performance	Threshold	Trend	Management Action (SMART)
PICU Re-admissions	**% Readmissions to PICU within 48 hrs** % of discharges readmitted to PICU within 48hrs sourced from PICANet [Paediatric Intensive Care Audit Network]. Threshold agreed with PICU is based on the reported range nationally from all UK PICUs, most recent published range (16/17) was 0-3% averaged over a calendar year. Data is presented as monthly incidence for the purpose of this report. Annual average for this site was 2.4% **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	2.47 %	R >3 % A N/A G <=3 %		No Action Required

Delivery of Outstanding Care

9.3 - QUALITY - EFFECTIVE

Alder Hey Children's NHS Foundation Trust

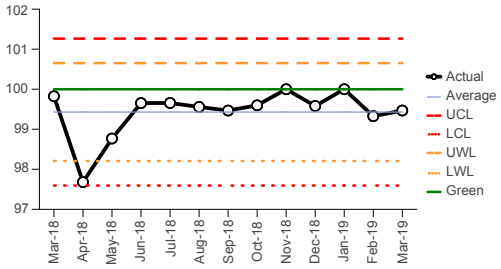
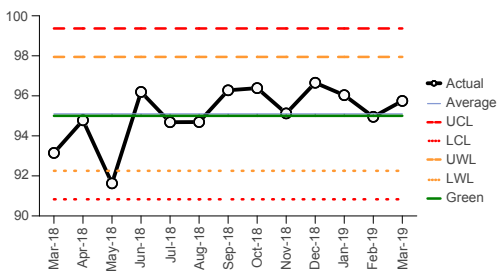
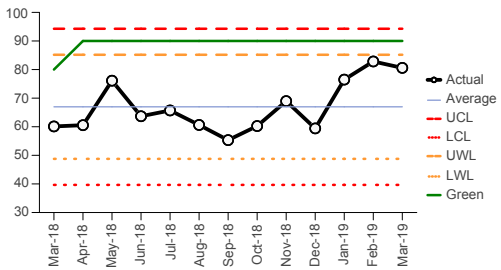
	Description	Performance	Threshold	Trend	Management Action (SMART)
Reducing Infections	**Hospital Acquired Organisms - MSSA** Hospital Acquired Organisms - MSSA . 18/19 aim is to reduce by 25% or more. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	4	R >1 A N/A G <=1		Although we have exceeded the March target figure we have achieved our annual 25% reduction target for 2018-19.
Reducing Infections	**Hospital Acquired Organisms - CLABSI - ICU Only** Hospital Acquired Organisms - CLABSI on ICU Ward Only. 18/19 aim is to reduce by 10% or more. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	3	R >1 A N/A G <=1		Although we have exceeded the target set for the month of March. We have met our 10% annual reduction target for 2018-19 of 18 CLABSI on PICU. We aim to further this next year by again meeting another 10% reduction.
Reducing Infections	**Hospital Acquired Organisms - Gram Negative BSI** Gram - Negative BSI to include E Coli, Klebsiella and Pseudomonas . 18/19 aim is to reduce by 10% or more. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	0	R >1 A N/A G <=1		No Action Required

Delivery of Outstanding Care

10.1 - QUALITY - RESPONSIVE

Alder Hey Children's NHS Foundation Trust

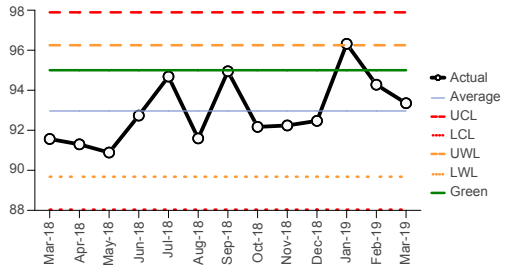
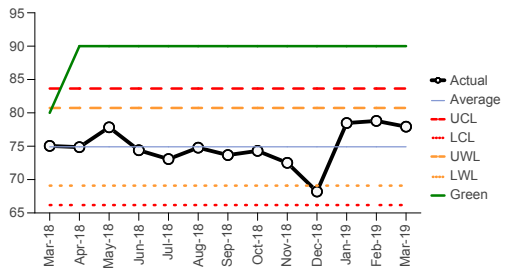
BRILLIANT BASICS

	Description	Performance	Threshold	Trend	Management Action (SMART)
Inpatient Survey: Respect	**IP Survey: % Treated with respect** Percentage of children / families that report being treated with respect. Thresholds are based on previously defined local targets. The 18/19 is 100%. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	99.47 %	R <95 % A >=95 % G 100 %		This is a great improvement at 99%. Staff are aware of the Trust values and how this should be demonstrated, the Trust values are visible to clinical and non-clinical staff, C&YP and families. Staffs that are identified as not treating C&YP and their families with respect will be supported and managed appropriately. Any PALS, complaints or family friends test survey feedback both positive and negative is shared at ward level. Any themes/trends will be added to the high level patient experience survey action plan by the patient experience/quality lead and shared at CQSG.
Inpatient Survey: Choices	**IP Survey: % Received information enabling choices about their care** Percentage of patients / families that report receiving information to enable them to make choices. Thresholds are based on previously defined local targets. The 18/19 aim is 95% or above. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	95.74 %	R <90 % A >=90 % G >=95 %		No Action Required
Inpatient Survey: Date of Discharge	**IP Survey: % Know their planned date of discharge** Percentage of children / families that report knowing their planned date of discharge. Thresholds are based on previously defined local targets. The 18/19 aim is 90% or above. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	80.59 %	R <85 % A >=85 % G >=90 %		Continued roll out of the SAFER project focusing on improving efficiencies and flow, ensure all C&YP have a review before midday encouraging nurse or criteria led discharge. The GDE programmes will support more accurate and well communicated discharge dates. Close working with the pre-op service looking at information given to families pre-admission; will advise C&YP how long they are likely to be in hospital. 'MY PAD', is a visual aid in each cubicle for C&YP/ families to document progress and be fully informed of what is outstanding in their care pathway and when they are likely to go home.

Delivery of Outstanding Care

10.2 - QUALITY - RESPONSIVE

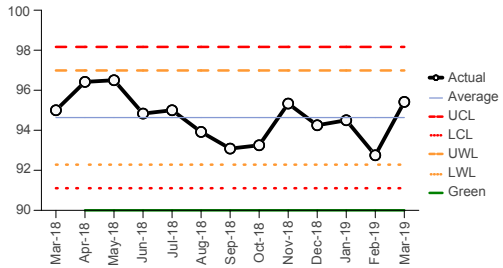
Alder Hey Children's NHS Foundation Trust

	Description	Performance	Threshold	Trend	Management Action (SMART)
Inpatient Survey: In Charge of Care	**IP Survey: % Know who is in charge of their care** % of children / families that report knowing who is in charge of their care. Thresholds are based on previously defined local targets. The 18/19 aim is 95% or above. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	93.35 %	R <90 % A >=90 % G >=95 %		Ward staff continue to introduce themselves on each shift to all families and children, FFT will continue to be monitored by patient experience quality lead and disseminated to the Heads of quality
Inpatient Survey: Play and Learning	**IP Survey: % Patients involved in play and learning** % of children / families that report engaging in play / learning. Thresholds are based on previously defined local targets. The 18/19 aim is 90% or above. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	77.93 %	R <85 % A >=85 % G >=90 %		It has been agreed to separate play and learning and to be more specific when asking the question. An action plan has been created to identify areas of concern which focus on actual play. The involvement of play staff, volunteers, and junior doctors (who will be volunteering starting May) are working together for continuous improvement. A calendar of activities/entertainment and involvement is distributed weekly across the inpatient and outpatient departments. Further communication tools are required to deliver the service we provide. We strive to offer play/education to any C&YP that wants t

The Best People doing their best Work

11.1 - QUALITY - WELL LED

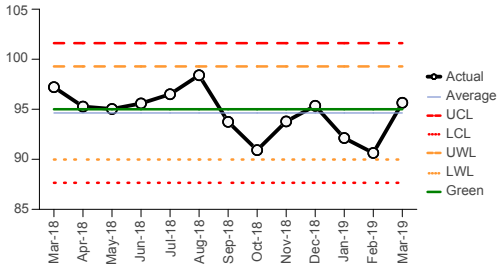
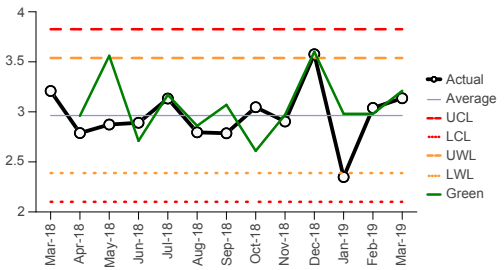
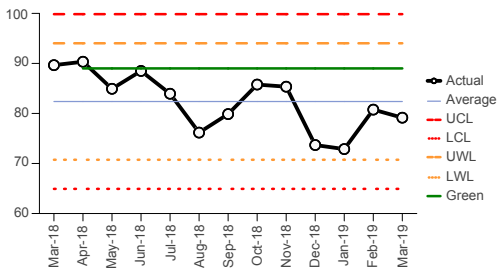
Alder Hey Children's NHS Foundation Trust

	Description	Performance	Threshold	Trend	Management Action (SMART)
Staffing	**Safer Staffing (Shift Fill Rate)** Safer Staffing. Threshold is based on National Target of 90% or above. **Exec Lead:** Pauline Brown **Committee:** CQAC	95.42 %	R <90 % A N/A G >=90 %		No Action Required

Delivery of Outstanding Care

12.1 - PERFORMANCE - EFFECTIVE

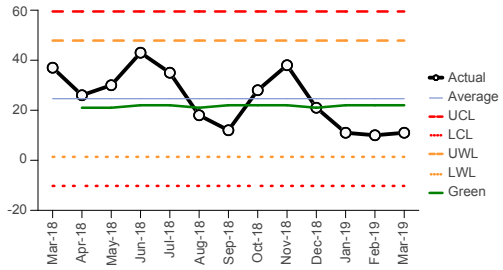
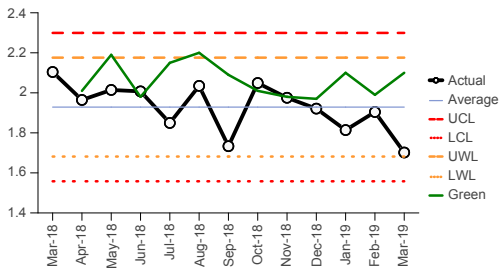
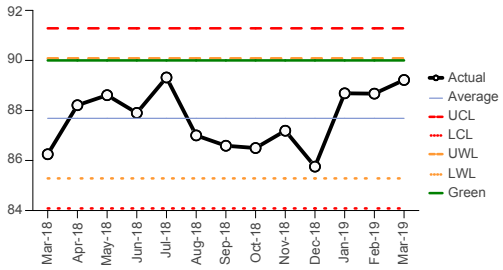
Alder Hey Children's NHS Foundation Trust

	Description	Performance	Threshold	Trend	Management Action (SMART)
ED 4 Hour Standard	**ED: 95% Treated within 4 Hours** Threshold is based on National Guidance set by NHS England at 95%. **Exec Lead:** Adam Bateman **Committee:** RABD	95.65 %	R <95 % A N/A G >=95 %		No Action Required
LoS: Elective	**Average LoS - Elective (Days)** Average Elective Length of Stay (days). 18/19 aim is to not increase Length of Stay for the same month last year. **Exec Lead:** Adam Bateman **Committee:** RABD	3.14	R >3.2 A N/A G <=3.2		No Action Required
Bed Occupancy	**Bed Occupancy (Accessible Funded Beds)** Percentage of funded beds that are occupied in accessible wards 3A, 4A, 3C and 4C, this is based on 3 occupnacy readings measured throughout the day. Threshold is based on National NHS Guidance on safe staffing and occupancy levels. **Exec Lead:** Adam Bateman **Committee:** RABD	79.15 %	R >93 % A <=93 % G <=89 %		No Action Required

Delivery of Outstanding Care

12.2 - PERFORMANCE - EFFECTIVE

Alder Hey Children's NHS Foundation Trust

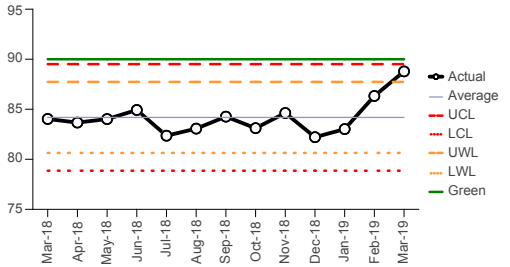
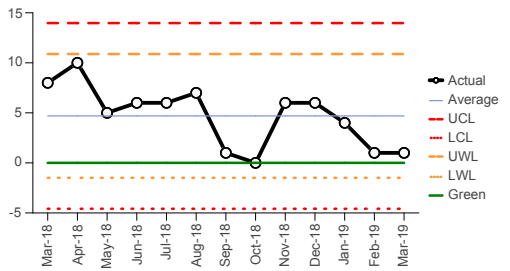
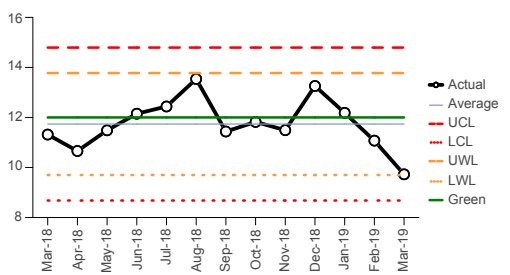
	Description	Performance	Threshold	Trend	Management Action (SMART)
Cancelled Operations	**On the day Elective Cancelled Operations for Non Clinical Reasons** Performance is measured for on the day cancelled elective operations for non clinical reasons. This based on National Guidance. Threshold aims to reduce cancellations by 25% based on 17/18 overall performance. **Exec Lead:** Adam Bateman **Committee:** RABD	11	R >22 A N/A G <=22		No Action Required
LoS: Non-Elective	**Average LoS - Non-Elective (Days)** Average Non Elective Length of Stay (days). 18/19 aim is to not increase Length of Stay for the same month last year. **Exec Lead:** Adam Bateman **Committee:** RABD	1.70	R >2.1 A N/A G <=2.1		No Action Required
Theatre Utilisation	**Theatre Utilisation - % of Session Utilised** Threshold is based on the productive theatre improvement measures at greater than or equal to 90% utilisation of theatres. **Exec Lead:** Adam Bateman **Committee:** RABD	89.22 %	R <80 % A >=80 % G >=90 %		Improvement compared to previous month and highest utilisation in 8 months. Weekly review of utilisation is ongoing

Delivery of Outstanding Care

12.3 - PERFORMANCE - EFFECTIVE

BRILLIANT BASICS

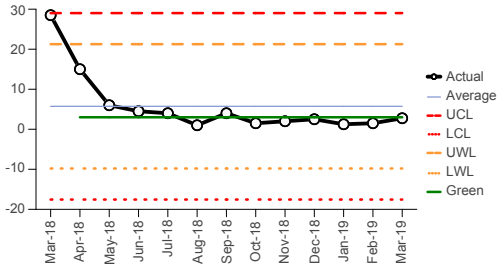
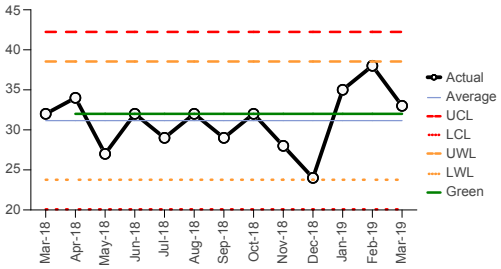
Alder Hey Children's NHS
NHS Foundation Trust

	Description	Performance	Threshold	Trend	Management Action (SMART)
Clinic Utilisation	**Clinic Session Utilisation** Threshold is based on a resonable expectation utilising clinics at 90% or greater to take into account short notice cancellations and DNAs. **Exec Lead:** Adam Bateman **Committee:** RABD	88.78 %	R <85 % A >=85 % G >=90 %		Continued improvement in line with booking programme. Whilst not quite achieving 90% we have seen a 6.4% improvement since Dec 2018. We also have had two simultaneous months over 85% the first time we have had over 85% in 2018/19.
Operation Breaches	**28 Day Breaches** Standard is when a patients operation is cancelled by the hospital last minute for non-clinical reasons, the hospital will have to offer another binding date with 28 days. This is based on national guidance. **Exec Lead:** Adam Bateman **Committee:** RABD	1	R >0 A N/A G 0		1 breach in March due to patient cancelled for no HDU bed. Patient received operation at 39 days. No breaches expected in April.
Was Not Brought	**Was Not Brought Rate** The target of 12% is a local target aligned to outpatient improvement workstreams (Hybrid Booking, Patient Demogrpahic Checking and bidirectional automate text reminders). **Exec Lead:** Adam Bateman **Committee:** RABD	9.73 %	R >14 % A <=14 % G <=12 %		No Action Required

Delivery of Outstanding Care

12.4 - PERFORMANCE - EFFECTIVE

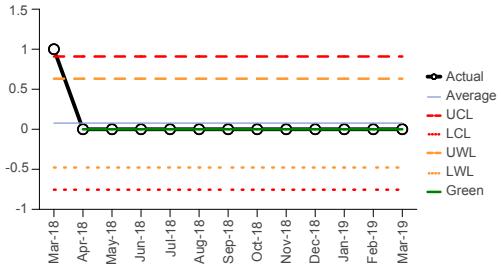
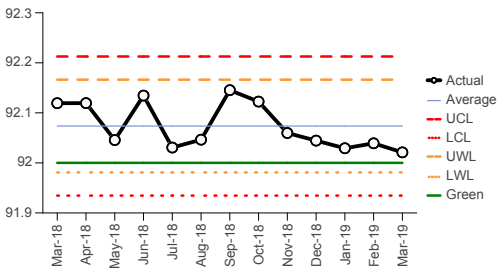
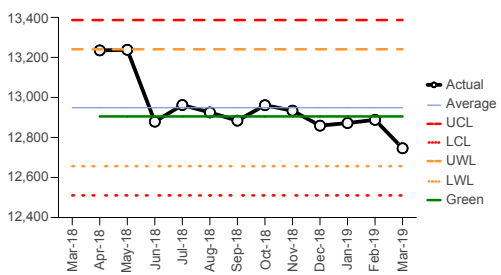
Alder Hey Children's NHS
NHS Foundation Trust

	Description	Performance	Threshold	Trend	Management Action (SMART)
Transcriptions	**Transcription Turnaround (days)** Days from dictation to typing clinic letters for services transcribed by Transcription service. Based on working day average. This is also monitored externally by our local commissioners. **Exec Lead:** Adam Bateman **Committee:** RABD	2.75	R >5 A <=5 G <=3		No Action Required
Stranded Patients	**Number of Super Stranded Patients (21+ Days)** National measure as part of the 18/19 NHSI plan. The target is to reduce the number of stranded patients 21 or more days from March 2018. This excludes patients on ICU/HDU/NEO and Cardiac HDU. **Exec Lead:** Adam Bateman **Committee:** RABD	33	R >32 A N/A G <=32		From the current cohort of 51 Children whose LOS is 7+ days, only 3 are medically fit for discharge. 2 of those have discharge dates within the next 5 days. All have plans in place. Delays are attributable to Housing issues, carers being employed for packages of care (outside agencies).

Delivery of Outstanding Care

13.1 - PERFORMANCE - RESPONSIVE

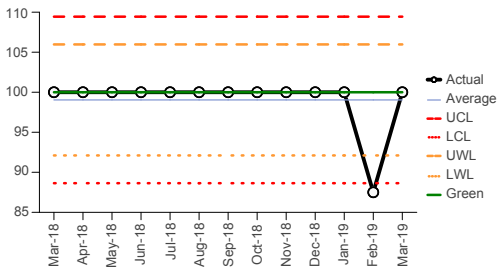
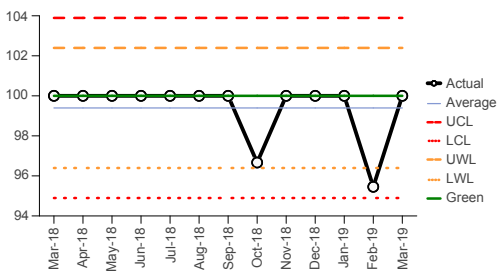
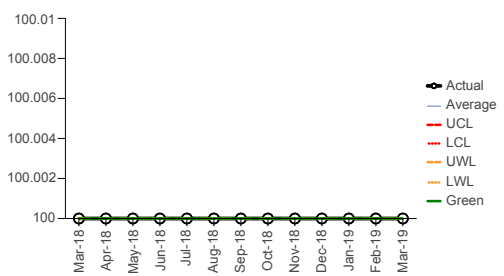
Alder Hey Children's NHS Foundation Trust

	Description	Performance	Threshold	Trend	Management Action (SMART)
Waiting Times	**Waiting Greater than 52 weeks** Total number of more than 52 weeks for first treatment. The threshold is based on this event never occuring. 18/19 aim is zero annually. There is a financial and contractual penalties in the failure to achieve this. **Exec Lead:** Adam Bateman **Committee:** RABD	0	R >0 A N/A G 0		No Action Required
RTT	**RTT: Open Pathway: % Waiting within 18 Weeks** Percentage of patients waiting within 18 weeks. Threshold is based on previous national target of 92%, this is applied in order to maintain monitoring of measure. **Exec Lead:** Adam Bateman **Committee:** RABD	92.02 %	R <90 % A >=90 % G >=92 %		No Action Required
Waiting Times	**Waiting List Size** National threshold as part of the 18/19 NHSI plan. The target is to reduced the total waitlist size from March 2018. **Exec Lead:** Adam Bateman **Committee:** RABD	12746	R >12905 A N/A G <=12905		No Action Required

Delivery of Outstanding Care

13.2 - PERFORMANCE - RESPONSIVE

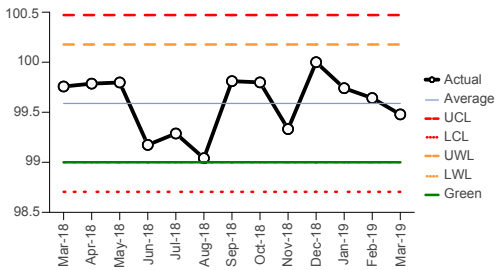
Alder Hey Children's NHS Foundation Trust

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

Delivery of Outstanding Care

13.3 - PERFORMANCE - RESPONSIVE

Alder Hey Children's NHS Foundation Trust

	Description	Performance	Threshold	Trend	Management Action (SMART)
Diagnostics	**Diagnostics: % Completed Within 6 Weeks** Threshold is based on National Guidance set by NHS England at 99%. **Exec Lead:** Adam Bateman **Committee:** RABD	99.48 %	R <99 % A N/A G >=99 %		No Action Required

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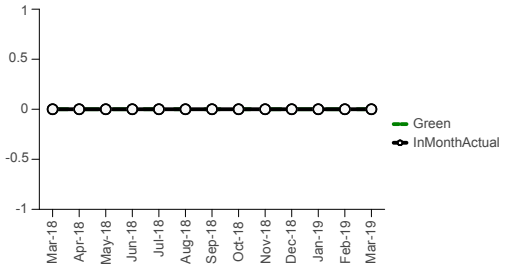
14.1 - PERFORMANCE - WELL LED

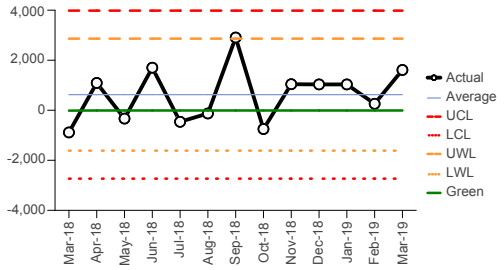
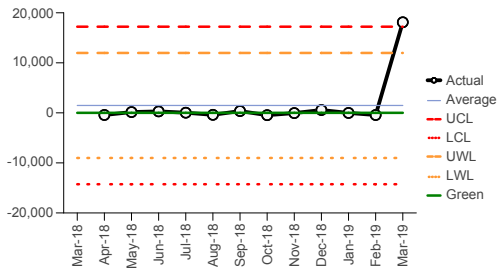
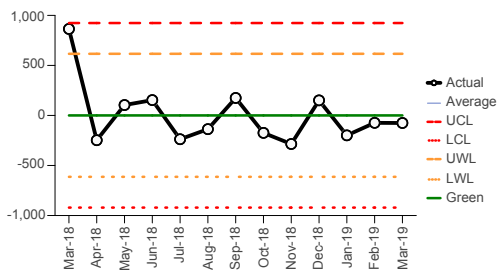
Alder Hey Children's NHS Foundation Trust

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

The Best People doing their best Work

15.1 - FINANCE - WELL LED

Alder Hey Children's NHS Foundation Trust

	Description	Performance	Threshold	Trend	Management Action (SMART)
Finance	**Capital Expenditure In Month Variance (£'000s)** Variance from capital plan. Variation between months is usual and the threshold of + or - 5% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	1,610	R <-10% A >=-10% G >=-5%		No Action Required
Finance	**Control Total In Month Variance (£'000s)** Variance from Control Total plan. Variation between months is usual and the threshold of + or - 20% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	18,105	R <-20% A >=-20% G >=0%		No Action Required
Finance	**CIP In Month Variance (£'000s)** Variance from Sustainability plan (CIP). Variation between months is usual and the threshold of + or - 20% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	-75	R <-20% A >=-20% G >=0%		The Trust achieved CIP for 2018/19 of £6.9m which represents 99% of the CIP target.

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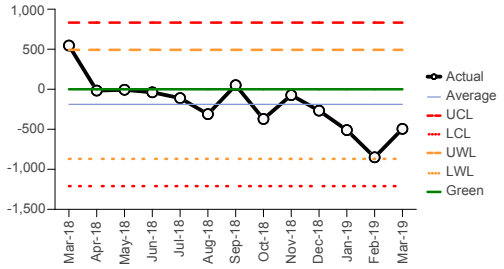
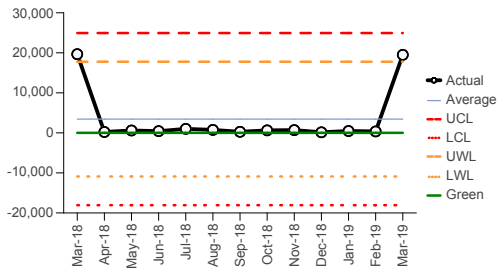
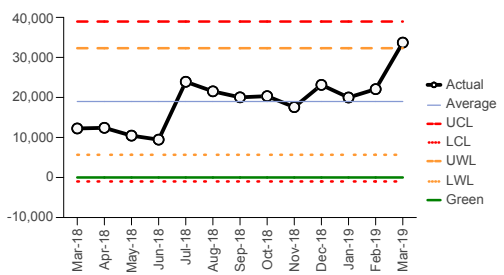
15.2 - FINANCE - WELL LED

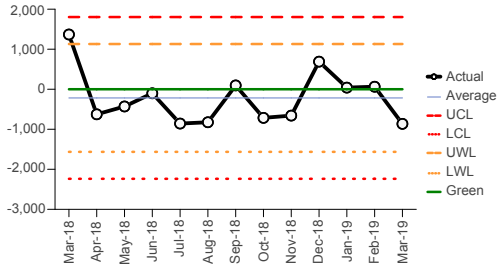
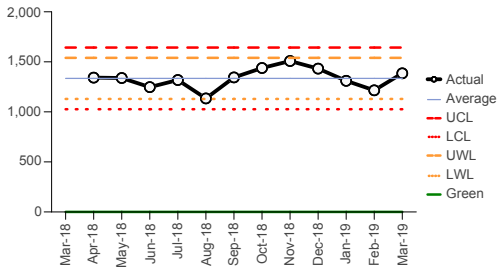
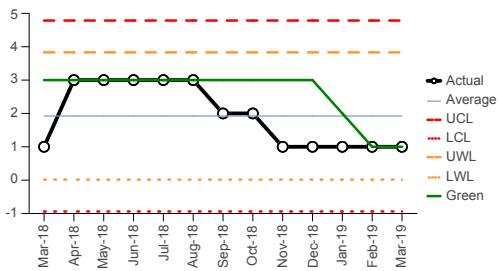
Alder Hey Children's NHS Foundation Trust

	Description	Performance	Threshold	Trend	Management Action (SMART)
Finance	**Pay In Month Variance (£'000s)** Variance from pay plan. Variation between months is usual and the threshold of + or - 20% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	-495	R <-20% A >=-20% G >=-1%		For the month of March pay costs were higher than budget by £0.5m In addition to the costs of temporary spend a number of unexpected backdated payments were made in March. The Trust is improving processes to ensure this does not happen again.
Finance	**Income In Month Variance (£'000s)** Variance from income plan. Variation between months is usual and the threshold of + or - 20% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	19,495	R <-20% A >=-20% G >=0%		No Action Required
Finance	**Cash in Bank (£'000s)** Variance from Cash plan. Variation between months is usual and the threshold of + or - 20% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	33,699	R <-20% A >=-20% G >=0%		No Action Required

The Best People doing their best Work

15.3 - FINANCE - WELL LED

Alder Hey Children's NHS
NHS Foundation Trust

	Description	Performance	Threshold	Trend	Management Action (SMART)
Finance	**Non Pay In Month Variance (£'000s)** Variance from non pay plan. Variation between months is usual and the threshold of + or - 20% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	-865	R <-20% A >=-20% G >=0%		For the month of March non pay was overspent by £0.9m. Approximately half of this was offset by income and the remainder relate to onngoing overspends which have been partly resolved in the 2019/20 budget.
Finance	**AvP: IP - Non-Elective** Actvity vs Forecast for Inpatient Non-Elective Activity. The threshold is based on achieving forecast or higher. **Exec Lead:** John Grinnell **Committee:** RABD	1385	R <0 A N/A G >=0		No Action Required
Finance	**NHSI Use of Resources** NHSI Use of Resources Metric indicates financial sustainability of the Trust. This varies from 1 to 4 with 1 being the highest score possible and 4 being the lowest **Exec Lead:** John Grinnell **Committee:** RABD	1	R >1 A N/A G <=1		No Action Required

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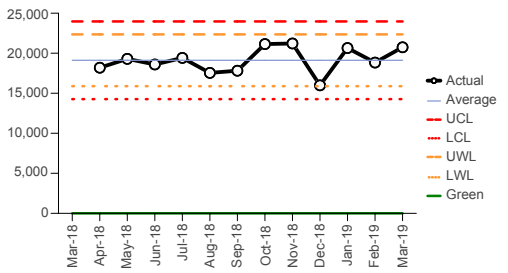
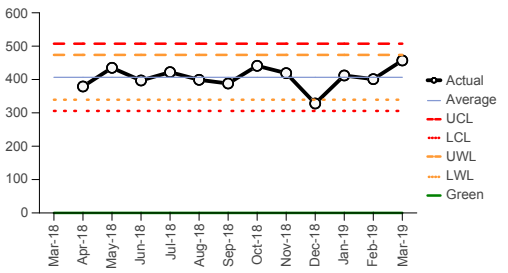
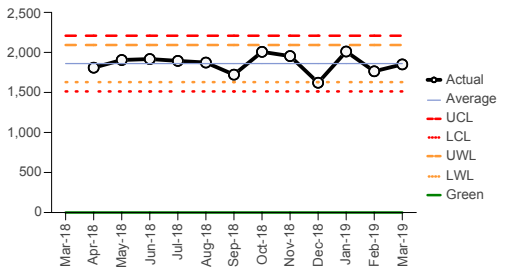
15.4 - FINANCE - WELL LED

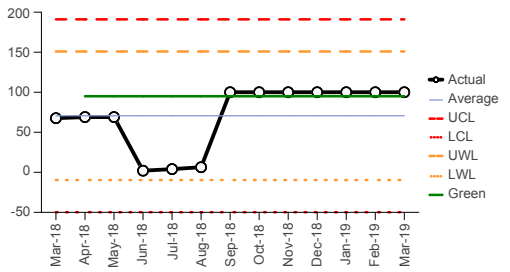
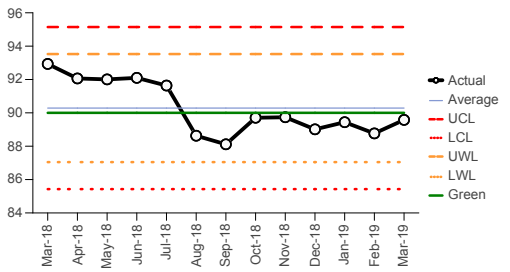
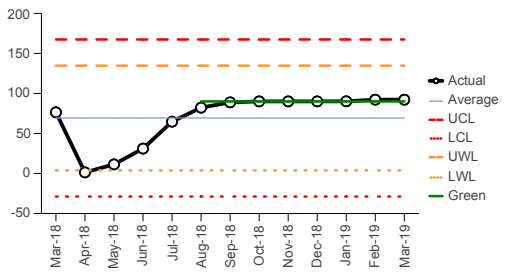
Alder Hey Children's NHS Foundation Trust

	Description	Performance	Threshold	Trend	Management Action (SMART)
Finance	**AvP: Outpatient Activity vs Forecast** Actvity vs Forecast for Outpatient activity. The threshold is based on achieving forecast or higher. **Exec Lead:** John Grinnell **Committee:** RABD	20739	R <0 A N/A G >=0		No Action Required
Finance	**AvP: IP Elective vs Forecast** Actvity vs Forecast for Inpatient Elective activity. The threshold is based on achieving forecast or higher. **Exec Lead:** John Grinnell **Committee:** RABD	457	R <0 A N/A G >=0		No Action Required
Finance	**AvP: Daycase Activity vs Forecast** Actvity vs Forecast for Daycase activity. The threshold is based on achieving forecast or higher. **Exec Lead:** John Grinnell **Committee:** RABD	1850	R <0 A N/A G >=0		No Action Required

The Best People doing their best Work

16.1 - HR - WELL LED

Alder Hey Children's NHS Foundation Trust

	Description	Performance	Threshold	Trend	Management Action (SMART)
Appraisal	**Medical Appraisal** Trust Target for compliance for medical staff, which is on a rolling 12mth period. **Exec Lead:** Melissa Swindell **Committee:** WOD	100 %	R <90 % A >=90 % G >=95 %		No Action Required
Training	**Mandatory Training** This is a Trust target that measures the 6 core mandatory training modules that are required of all staff (Safeguarding L1, Moving and Handling, Information Governance, Equality and Diversity, Fire Safety and Health and Safety) **Exec Lead:** Melissa Swindell **Committee:** WOD	89.58 %	R <80 % A >=80 % G >=90 %		Core Training continued to increase in March. Overall training has also increased but there continue to be challenges with Information Governance and Safeguarding Level 3 compliance. The IG lead is continuing to offer additional face to face sessions and provide regular reminders to staff and managers to complete their training. Learning and Development are continuing to support this with regular reports to divisional and departmental managers as well as direct emails to staff who are outstanding any mandatory training, highlighting what is outstanding & how to complete.
Personal Development	**PDR** Trust target, measuring compliance of staff Personal Development Reviews (Non medical). The Trust compliance period is set to be achieved in the first 4 months of each year (April -July). **Exec Lead:** Melissa Swindell **Committee:** WOD	92.19 %	R <85 % A >=85 % G >=90 %		No Action Required

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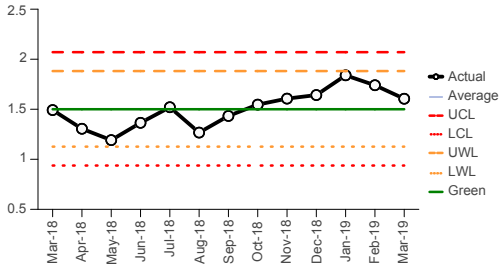
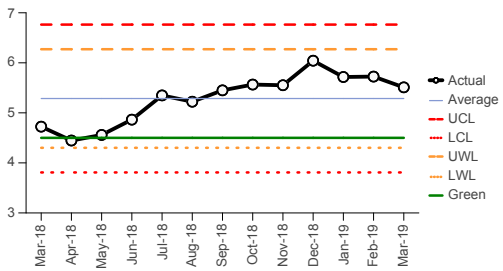
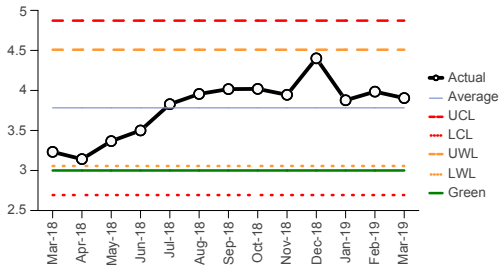
16.2 - HR - WELL LED

Alder Hey Children's NHS Foundation Trust

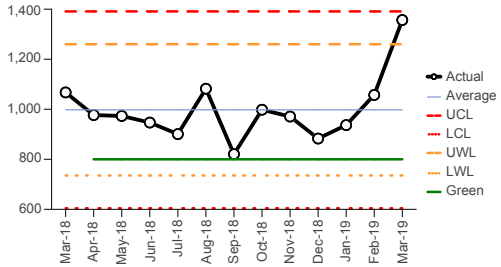
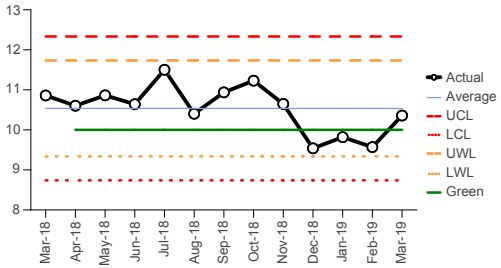
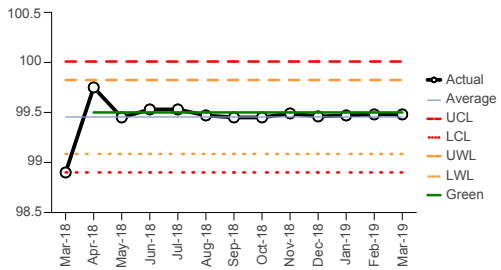
	Description	Performance	Threshold	Trend	Management Action (SMART)
Sickness	**Short Term Sickness** % of Trust staff who have been absent from work due to sickness lasting less than 28 days **Exec Lead:** Melissa Swindell **Committee:** WOD	1.61 %	R >1.5 % A N/A G <=1.5 %		see above comment
Sickness	**Sickness** % of staff who have been absent from work due to sickness, this is broken down into LTS & STS in further metrics **Exec Lead:** Melissa Swindell **Committee:** WOD	5.51 %	R >5 % A <=5 % G <=4.5 %		The absence rate has started to reduce but still remains significantly above the Trust target. Absences relating to Anxiety, Stress & Depression have come down slightly to 33% of all absences in March, this is followed by Other Musculoskeletal Problems (10%) and Gatrointestinal problems (8.7%), Action plans are in place for areas with significant absence. In addition a full review of all absences has been undertaken with individual action plans in place.
Sickness	**Long Term Sickness** % of Trust staff who have been absent from work due to sickness lasting 28 days or more **Exec Lead:** Melissa Swindell **Committee:** WOD	3.90 %	R >3 % A N/A G <=3 %		see above comment

The Best People doing their best Work

16.3 - HR - WELL LED

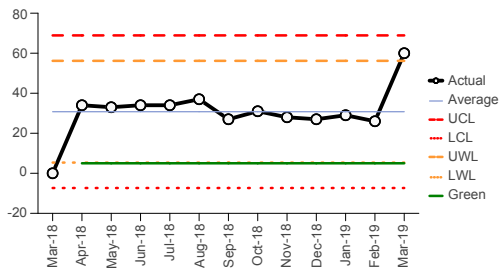
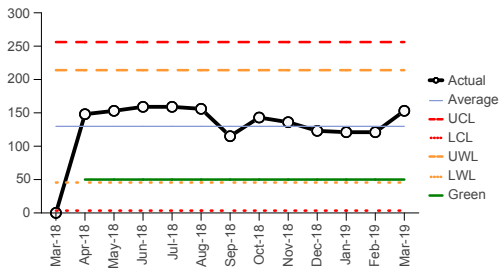
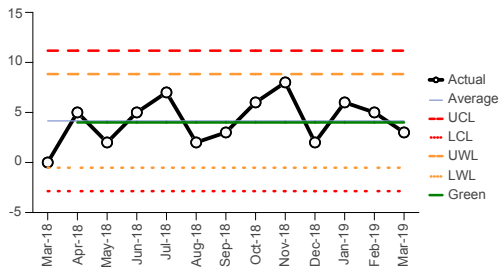
Alder Hey Children's NHS
NHS Foundation Trust

BRILLIANT BASICS

	Description	Performance	Threshold	Trend	Management Action (SMART)
Temporary Spend	**Temporary Spend ('000s)** Indicates the expenditure on premium temporary pay spend and monitors the reduction. **Exec Lead:** Melissa Swindell **Committee:** WOD	1356.59	R >960 A <=960 G <=800		Business Partners together with Finance Accountants and Ass COOs regularly review status in Divisions and advise on actions as appropriate. Monthly temporary staffing reviews also take place with the Director & Deputy Directors of HR & Finance
Staff Turnover	**Staff Turnover** Trust Target which is based on a rolling 12mth period **Exec Lead:** Melissa Swindell **Committee:** WOD	10.36 %	R >11 % A <=11 % G <=10 %		31.5% of leavers came from the Division of Medicine this month, with a more than half being Nursing Staff.
Payroll	**% of Correct Pay Achieved** An agreed service Level target with the Trust payroll provider. **Exec Lead:** Melissa Swindell **Committee:** WOD	99.48 %	R <99 % A >=99 % G >=99.5 %		Bi-Monthly meetings between ELFS, HR & Finance are ongoing to pick up any issues

Game Changing Research & Innovation

17.1 - RESEARCH & DEVELOPMENT - WELL LED

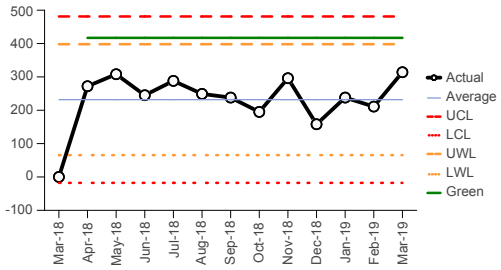
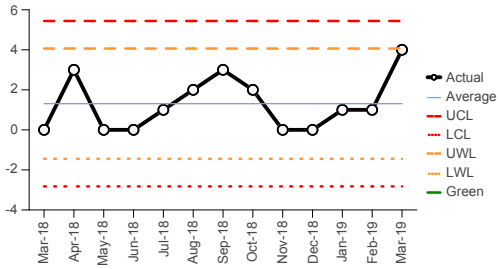
	Description	Performance	Threshold	Trend	Management Action (SMART)
Clinical Research	**Number of Open Studies - Commercial** Number of commercial studies currently open. **Exec Lead:** Matthew Peak **Committee:** REIC	60	R <5 A N/A G >=5		No Action Required
Clinical Research	**Number of Open Studies - Academic** Number of academic studies currently open. **Exec Lead:** Matthew Peak **Committee:** REIC	153	R <50 A N/A G >=50		No Action Required
Clinical Research	**Number of New Studies Opened - Academic** Number of new academic studies opened in month. **Exec Lead:** Matthew Peak **Committee:** REIC	3	R <4 A N/A G >=4		

Game Changing Research & Innovation

17.2 - RESEARCH & DEVELOPMENT - WELL LED

Alder Hey Children's NHS Foundation Trust

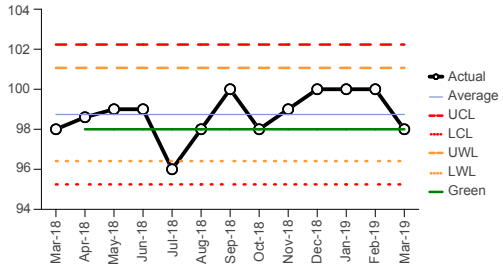
GROW THE FUTURE

	Description	Performance	Threshold	Trend	Management Action (SMART)
Clinical Research	**Number of patients recruited** Number of patients recruited in month. **Exec Lead:** Matthew Peak **Committee:** REIC	314	R <417 A N/A G >=417		Overall participant recruitment to studies is achieving the internal plan annual target as estimated in April 2018. The figure included in the corporate report is the external, unnegotiated target imposed by the NIHR Clinical Research Network which is based on performance in the 2017/18 year and which is not reflective of the portfolio in 2018/19. The target for 2019/20 has been reset internally and based on the knowledge of the portfolio of studies at April 2019 due to be open in the coming 12 months.
Clinical Research	**Number of New Studies Opened - Commercial** Number of new commercial studies opened in month. **Exec Lead:** Matthew Peak **Committee:** REIC	4	No Threshold		

Delivery of Outstanding Care

18.1 - FACILITIES - RESPONSIVE

Alder Hey Children's NHS Foundation Trust

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

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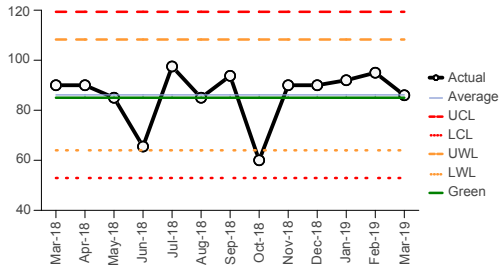
19.1 - FACILITIES - WELL LED

Alder Hey Children's NHS Foundation Trust

	Description	Performance	Threshold	Trend	Management Action (SMART)
Facilities	**Domestic Cleaning Audit Compliance** Auditing for Domestic Services, esnure is to National Cleaning Standards. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** RABD	86 %	R <85 % A N/A G >=85 %		No Action Required

All Divisions

SAFE

	COMMUNITY	MEDICINE	SURGERY	RAG
Total no of incidents reported Near Miss & Above	41	140	236	No Threshold
Clinical Incidents resulting in minor harm & above	3	31	60	No Threshold
Clinical Incidents resulting in moderate, semi permanent harm	0	0	0	No Threshold
Clinical Incidents resulting in severe, permanent harm	0	0	0	0 N/A >0
Clinical Incidents resulting in catastrophic, death	0	0	0	0 N/A >0
Pressure Ulcers (Category 3)	0	0	0	0 N/A >0
Pressure Ulcers (Category 4)	0	0	0	0 N/A >0
Medication errors resulting in harm	0	1	1	No Threshold
Medication errors resulting in moderate, sever harm or death	0	0	0	0 N/A >0
Never Events	0	0	0	0 N/A >0
Acute readmissions of patients with long term conditions within 28 days	0	2	0	No Threshold

CARING

	COMMUNITY	MEDICINE	SURGERY	RAG
Complaints	5	3	3	No Threshold
PALS	30	20	16	No Threshold

EFFECTIVE

	COMMUNITY	MEDICINE	SURGERY	RAG
Sepsis: Patients treated for Sepsis within 60 mins - Inpatients		60.0%	90.9%	>=90 % >=85 % <90 %
Readmissions to PICU within 48 hrs	0	0	0	No Threshold
% of acute readmissions within 48 hrs of discharge (exc Oncology)	0.0%	1.3%	1.1%	<=1.5 % N/A >1.5 %
Readmissions within 48 hrs	0	27	18	No Threshold
Outbreak Acquired Organisms - Other	0	0	0	0 N/A >0
Hospital Acquired Organisms - MRSA (BSI)	0	0	0	0 N/A >0
Hospital Acquired Organisms - C.difficile	0	0	1	0 N/A >0

All Divisions

	COMMUNITY	MEDICINE	SURGERY	RAG
Hospital Acquired Organisms - MSSA	0	1	3	No Threshold
Hospital Acquired Organisms - RSV	0	1	0	No Threshold
Hospital Acquired Organisms - CLABSI - ICU Only			3	No Threshold
Outbreak Infections	0	0	0	No Threshold
Referrals Received (Total)	1,061	2,127	3,960	No Threshold
ED: 95% Treated within 4 Hours		95.6%		>=95 % N/A <95 %
Average LoS - Elective (Days)		2.87	3.16	No Threshold
Average LoS - Non-Elective (Days)		1.21	2.59	No Threshold
Theatre Utilisation - % of Session Utilised		82.4%	90.1%	>=90 % >=85 % <80 %
Cancelled Operations - Non Clinical - On Same Day (%)	0.0%	0.0%	0.9%	<=0.8 % N/A >0.8 %
On the day Elective Cancelled Operations for Non Clinical Reasons	0	0	11	No Threshold
28 Day Breaches	0	0	1	0 N/A >0
Clinic Session Utilisation	87.1%	88.2%	89.5%	>=90 % >=85 % <85 %
OP Appointments Cancelled by Hospital %	22.8%	14.1%	14.4%	<=5 % <=10 % >10 %
Was Not Brought Rate	10.4%	9.6%	9.6%	<=12 % <=14 % >14 %
Incomplete Pathway Forms in Outpatients	920	5,617	9,401	No Threshold
Referral Turnaround (days to log)	6.58	3.54	5.17	No Threshold
Referral Turnaround (Consultant to Action)	8.05	4.97	4.04	No Threshold
Coding average comorbidities	6.00	3.90	3.90	No Threshold
CAMHS: Was Not Brought Rate - New	8.8%			<=6 % <=8 % >8 %
CAMHS: Was Not Brought Rate - Follow Up	13.0%			<=10 % <=16 % >16 %

RESPONSIVE

	COMMUNITY	MEDICINE	SURGERY	RAG
IP Survey: % Received information enabling choices about their care		94.2%	96.8%	>=95 % >=90 % <90 %
IP Survey: % Treated with respect		99.4%	99.5%	100 % >=95 % <95 %
IP Survey: % Know their planned date of discharge		76.0%	83.8%	>=90 % >=85 % <85 %

All Divisions

	COMMUNITY	MEDICINE	SURGERY	RAG
IP Survey: % Know who is in charge of their care		92.9%	93.7%	>=95 % >=90 % <90 %
IP Survey: % Patients involved in play and learning		76.6%	78.8%	>=90 % >=85 % <85 %
RTT: Open Pathway: % Waiting within 18 Weeks	74.2%	93.9%	94.0%	>=92 % >=90 % <90 %
Waiting List Size	1,262	3,355	8,129	No Threshold
Waiting Greater than 52 weeks	0	0	0	0 N/A >0
Diagnostics: % Completed Within 6 Weeks		99.6%	92.3%	>=99 % N/A <99 %
Number of Stranded Patients (7+ Days)		35	17	No Threshold
Number of Super Stranded Patients (21+ Days)		23	10	No Threshold
CAMHS: 2 Appointments within 6 weeks	0			No Threshold
Urgent EDYS Pathway Average Wait in Weeks	0	0	0	No Threshold
Routine EDYS Pathway Average Wait in Weeks	0	0	0	No Threshold
Routine Eating Disorders (EDYS) Pathway Average Wait in Days	23.00			No Threshold
Urgent Eating Disorders (EDYS) Pathway Average Wait in Days	0.00			No Threshold
CAMHS: Avg Wait from referral to Partnership Appt (Weeks)- Liverpool Specialist	14.00	0.00	0.00	No Threshold
CAMHS: Avg Wait from referral to Partnership Appt (Weeks)- Sefton Specialist	24.00	0.00	0.00	No Threshold

WELL LED

	COMMUNITY	MEDICINE	SURGERY	RAG
Control Total In Month Variance (£'000s)	-151	-421	67	>=0% >=-20% <-20%
Income In Month Variance (£'000s)	336	416	581	>=0% >=-20% <-20%
Pay In Month Variance (£'000s)	-299	-252	-393	No Threshold
Non Pay In Month Variance (£'000s)	-188	-585	-85	>=0% >=-20% <-20%
AvP: IP - Non-Elective		917	468	>=0 N/A <0
AvP: IP Elective vs Forecast		121	335	>=0 N/A <0
AvP: OP New	413.00	2,599.00	4,239.00	>=0 N/A <0
AvP: OP FollowUp	2,698.00	3,501.00	6,281.00	>=0 N/A <0
AvP: Daycase Activity vs Forecast		965	883	>=0 N/A <0

All Divisions

	COMMUNITY	MEDICINE	SURGERY	RAG
AvP: Outpatient Activity vs Forecast	3,111	6,100	10,520	>=0 / N/A / <0
PDR	93.7%	89.2%	96.6%	>=90 % / >=80 % / <85 %
Mandatory Training	90.3%	90.7%	89.4%	>=90 % / >=80 % / <80 %
Actual vs Planned Establishment (%)	92.5%	95.7%	101.4%	No Threshold
Sickness	5.0%	5.9%	5.6%	<=4.5 % / <=5 % / >5 %
Attendance (HR)	95.0%	94.1%	94.4%	>=95.5 % / >=90 % / <90 %
Short Term Sickness	1.3%	2.0%	1.5%	<=1.5 % / N/A / >1.5 %
Long Term Sickness	3.7%	3.9%	4.1%	<=3 % / N/A / >3 %
Temporary Spend ('000s)	339	354	591	No Threshold
Staff Turnover	14.1%	9.2%	10.7%	<=10 % / <=11 % / >11 %
Safer Staffing (Shift Fill Rate)	106.0%	103.2%	89.4%	>=90 % / >=80 % / <90 %

Medicine

SAFE

	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Last 12 Months	RAG
Acute readmissions of patients with long term conditions within 28 days	0	1	1	4	0	3	2	4	6	3	3	3	2	No Data Available	No Threshold

CARING

	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Last 12 Months	RAG
Complaints	3	1	7	4	4	3	6	6	1	4	3	1	3		No Threshold
PALS	39	51	31	27	28	23	21	34	19	21	41	33	20		No Threshold

EFFECTIVE

	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Last 12 Months	RAG
Hospital Acquired Organisms - MRSA (BSI)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Hospital Acquired Organisms - C.difficile	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Referrals Received (Total)	1,961	1,843	1,948	2,011	1,904	1,569	1,678	2,081	1,983	1,743	2,019	1,915	2,127	No Data Available	No Threshold
ED: 95% Treated within 4 Hours	97.2%	95.3%	95.0%	95.6%	96.5%	98.4%	93.7%	90.9%	93.8%	95.3%	92.1%	90.6%	95.6%		>=95 % N/A <95 %
Average LoS - Elective (Days)	3.17	3.23	2.66	4.01	3.84	2.85	3.18	2.89	3.08	3.54	2.88	3.10	2.87		No Threshold
Average LoS - Non-Elective (Days)	1.50	1.52	1.55	1.59	1.28	1.45	1.35	1.54	1.64	1.45	1.39	1.53	1.21		No Threshold
Theatre Utilisation - % of Session Utilised	83.5%	75.4%	75.6%	78.6%	83.0%	77.8%	84.8%	80.4%	80.9%	86.7%	84.5%	83.8%	82.4%		>=90 % >=80 % <80 %
Clinic Session Utilisation	85.8%	85.2%	83.7%	84.9%	82.2%	82.0%	85.0%	83.9%	85.9%	82.2%	82.2%	88.1%	88.2%		>=90 % >=80 % <85 %
OP Appointments Cancelled by Hospital %	17.5%	13.5%	14.1%	12.8%	16.3%	15.6%	13.9%	14.4%	14.2%	15.6%	15.3%	15.5%	14.1%	No Data Available	<=5 % <=10 % >10 %
Was Not Brought Rate	11.1%	10.1%	11.0%	12.6%	12.3%	13.6%	12.3%	12.4%	11.0%	13.3%	11.7%	11.8%	9.6%		<=12 % <=14 % >14 %
Coding average comorbidities	3.34	3.52	3.35	3.54	3.40	3.52	3.54	3.57	3.57	3.84	3.73	4.10	3.90	No Data Available	No Threshold

RESPONSIVE

	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Last 12 Months	RAG
RTT: Open Pathway: % Waiting within 18 Weeks	89.8%	90.0%	90.2%	89.5%	89.7%	90.2%	91.1%	89.9%	91.5%	92.7%	92.9%	92.5%	93.9%		>=92 % >=90 % <90 %
Diagnostics: % Completed Within 6 Weeks	100.0%	99.8%	99.8%	99.1%	99.3%	99.0%	99.8%	99.8%	99.3%	100.0%	99.7%	100.0%	99.6%		>=99 % N/A <99 %

WELL LED

	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Last 12 Months	RAG
Control Total In Month Variance (£'000s)		127	122	408	223	75	178	-115	15	69	-444	-254	-421		>=0% >=-20% <-20%
AvP: IP - Non-Elective		911	858	772	823	672	931	1,016	1,103	1,026	926	849	917		>=0 N/A <0
AvP: IP Elective vs Forecast		106	122	101	118	105	84	111	100	82	107	93	121		>=0 N/A <0
AvP: OP New		2,321.00	2,446.00	2,501.00	2,452.00	2,055.00	2,164.00	2,475.00	2,455.00	2,082.00	2,459.00	2,279.00	2,599.00	No Data Available	>=0 N/A <0
AvP: OP FollowUp		3,068.00	3,282.00	3,260.00	3,095.00	3,022.00	3,148.00	3,678.00	3,646.00	2,772.00	3,685.00	3,208.00	3,501.00	No Data Available	>=0 N/A <0
AvP: Daycase Activity vs Forecast		1,040	1,088	1,055	1,068	1,091	984	1,113	1,043	940	1,145	1,007	965		>=0 N/A <0
AvP: Outpatient Activity vs Forecast		5,389	5,728	5,761	5,547	5,077	5,312	6,153	6,101	4,854	6,144	5,487	6,100		>=0 N/A <0
PDR	81.5%	2.2%	13.4%	35.5%	67.2%	85.5%	88.6%	89.2%	89.2%	89.2%	89.2%	89.2%	89.2%		>=90 % >=85 % <85 %
Mandatory Training	93.8%	92.7%	92.8%	92.4%	91.3%	87.9%	87.6%	89.4%	90.4%	90.0%	91.0%	90.1%	90.7%		>=90 % >=85 % <80 %
Sickness	4.3%	3.8%	4.0%	4.4%	5.8%	5.1%	5.3%	5.2%	5.3%	6.1%	5.8%	5.6%	5.9%		<=4.5 % <=5 % >5 %
Temporary Spend ('000s)	316	246	276	196	227	261	212	217	261	197	247	324	354		No Threshold

Surgery

SAFE

	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Last 12 Months	RAG
Acute readmissions of patients with long term conditions within 28 days	0	0	0	0	0	0	0	0	0	0	0	0	0	No Data Available	No Threshold

CARING

	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Last 12 Months	RAG
Complaints	2	1	2	1	5	3	1	1	1	0	1	1	3		No Threshold
PALS	20	25	36	28	20	22	27	27	27	16	27	18	16		No Threshold

EFFECTIVE

	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Last 12 Months	RAG
Hospital Acquired Organisms - MRSA (BSI)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Hospital Acquired Organisms - C.difficile	1	0	0	0	0	0	0	0	0	0	0	0	1		0 N/A >0
Referrals Received (Total)	3,682	3,769	4,092	3,834	4,250	3,378	3,237	3,660	3,771	2,817	3,633	3,749	3,960	No Data Available	No Threshold
Average LoS - Elective (Days)	3.14	2.40	2.94	2.55	2.68	2.72	2.66	2.97	2.72	3.38	2.10	2.85	3.16		No Threshold
Average LoS - Non-Elective (Days)	3.31	2.63	2.78	2.63	2.61	2.72	2.49	3.15	2.69	2.91	2.65	2.45	2.59		No Threshold
Theatre Utilisation - % of Session Utilised	86.8%	90.5%	90.6%	89.5%	90.4%	88.7%	86.9%	87.4%	88.2%	85.6%	89.4%	89.5%	90.1%		>=90 % >=80 % <80 %
Clinic Session Utilisation	85.0%	84.2%	84.9%	85.8%	82.8%	83.8%	84.3%	82.8%	84.5%	83.0%	84.2%	86.3%	89.5%		>=90 % >=80 % <85 %
OP Appointments Cancelled by Hospital %	12.7%	11.2%	12.2%	12.2%	12.3%	12.6%	14.3%	13.5%	12.7%	13.3%	14.1%	14.5%	14.4%	No Data Available	<=5 % <=10 % >10 %
Was Not Brought Rate	10.3%	9.6%	10.6%	11.1%	12.0%	12.9%	10.6%	11.7%	11.2%	13.1%	12.1%	10.8%	9.6%		<=12 % <=14 % >14 %
Coding average comorbidities	3.24	3.11	3.31	3.50	3.63	3.65	3.66	3.60	3.58	3.92	3.87	3.88	3.90	No Data Available	No Threshold

RESPONSIVE

	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Last 12 Months	RAG
RTT: Open Pathway: % Waiting within 18 Weeks	92.6%	92.3%	92.5%	93.1%	92.9%	92.7%	93.1%	93.6%	94.1%	93.7%	93.1%	94.0%	94.0%		>=92 % >=90 % <90 %
Diagnostics: % Completed Within 6 Weeks	94.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	89.5%	92.3%		>=99 % N/A <99 %

WELL LED

	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Last 12 Months	RAG
Control Total In Month Variance (£'000s)		-167	32	-23	81	-63	-308	0	-211	-255	-228	-478	67		>=0% >=-20% <-20%
AvP: IP - Non-Elective		431	479	474	495	462	413	422	405	406	384	366	468		>=0 N/A <0
AvP: IP Elective vs Forecast		273	311	294	302	293	304	328	319	245	305	308	335		>=0 N/A <0
AvP: OP New		4,131.00	4,624.00	4,413.00	4,479.00	3,958.00	3,823.00	4,440.00	4,375.00	3,336.00	4,230.00	3,763.00	4,239.00	No Data Available	>=0 N/A <0
AvP: OP FollowUp		5,828.00	5,844.00	5,396.00	6,060.00	5,809.00	5,713.00	6,959.00	7,147.00	5,316.00	6,804.00	6,170.00	6,281.00	No Data Available	>=0 N/A <0
AvP: Daycase Activity vs Forecast		767	815	858	825	782	736	894	909	680	861	756	883		>=0 N/A <0
AvP: Outpatient Activity vs Forecast		9,959	10,468	9,809	10,539	9,767	9,536	11,399	11,522	8,652	11,034	9,933	10,520		>=0 N/A <0
PDR	83.3%	1.1%	10.0%	33.5%	64.4%	83.6%	90.7%	90.0%	90.0%	90.0%	90.0%	96.6%	96.6%		>=90 % >=85 % <85 %
Mandatory Training	91.5%	90.2%	89.9%	90.9%	90.3%	87.2%	87.8%	88.6%	87.8%	88.0%	90.0%	88.4%	89.4%		>=90 % >=85 % <80 %
Sickness	4.0%	4.3%	4.7%	5.5%	5.4%	5.6%	6.0%	6.5%	5.9%	6.5%	6.3%	6.6%	5.6%		<=4.5 % <=5 % >5 %
Temporary Spend ('000s)	514	468	420	480	445	509	373	529	485	484	474	564	591		No Threshold

Community

SAFE

	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Last 12 Months	RAG
Acute readmissions of patients with long term conditions within 28 days	0	0	0	0	0	0	0	0	0	0	0	0	0	No Data Available	No Threshold

CARING

	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Last 12 Months	RAG
Complaints	0	2	2	3	5	5	3	2	2	1	1	4	5		No Threshold
PALS	33	32	28	20	21	26	43	36	40	11	35	27	30		No Threshold

EFFECTIVE

	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Last 12 Months	RAG
Hospital Acquired Organisms - MRSA (BSI)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Hospital Acquired Organisms - C.difficile	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Referrals Received (Total)	1,004	862	1,094	849	1,079	663	691	974	1,059	764	902	967	1,061	No Data Available	No Threshold
Average LoS - Elective (Days)									1.00	3.00					No Threshold
Clinic Session Utilisation	72.7%	75.3%	79.2%	78.7%	79.9%	80.7%	80.5%	82.7%	81.6%	77.7%	79.1%	81.0%	87.1%		>=90 % >=85 % <85 %
OP Appointments Cancelled by Hospital %	17.2%	16.1%	10.8%	16.8%	16.2%	23.3%	22.3%	17.7%	22.1%	23.6%	18.4%	21.8%	22.8%	No Data Available	<=5 % <=10 % >10 %
Was Not Brought Rate	14.6%	14.6%	14.6%	14.2%	13.8%	15.6%	12.6%	11.1%	13.1%	13.5%	13.3%	10.7%	10.4%		<=12 % <=14 % >14 %
Coding average comorbidities	3.33	5.00	2.33		2.33	8.00	4.00	2.00	2.67		2.00	1.50	6.00	No Data Available	No Threshold

RESPONSIVE

	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Last 12 Months	RAG
RTT: Open Pathway: % Waiting within 18 Weeks	96.7%	97.1%	96.1%	95.3%	92.2%	92.7%	87.3%	87.1%	78.8%	78.3%	82.7%	78.3%	74.2%		>=92 % >=90 % <90 %

WELL LED

	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Last 12 Months	RAG
Control Total In Month Variance (£'000s)		-108	-70	30	62	-144	87	54	-61	118	-23	26	-151		>=0% >=-20% <-20%
AvP: OP New		406.00	446.00	421.00	408.00	311.00	355.00	532.00	531.00	337.00	407.00	390.00	413.00	No Data Available	>=0 N/A <0
AvP: OP FollowUp		2,379.00	2,614.00	2,496.00	2,502.00	1,938.00	2,141.00	2,631.00	2,629.00	1,812.00	2,604.00	2,421.00	2,698.00	No Data Available	>=0 N/A <0
AvP: Outpatient Activity vs Forecast		2,785	3,060	2,917	2,910	2,249	2,496	3,163	3,160	2,149	3,011	2,811	3,111		>=0 N/A <0
PDR	83.9%	0.4%	9.3%	31.9%	58.8%	78.7%	87.9%	93.0%	93.0%	93.0%	93.7%	93.7%	93.7%		>=90 % >=85 % <85 %
Mandatory Training	95.7%	95.4%	95.0%	94.1%	94.2%	92.7%	91.2%	92.5%	91.4%	90.9%	88.3%	89.2%	90.3%		>=90 % >=85 % <80 %
Sickness	6.0%	4.8%	5.2%	3.9%	3.5%	3.4%	4.1%	4.0%	5.2%	5.3%	5.3%	5.3%	5.0%		<=4.5 % <=5 % >5 %
Temporary Spend ('000s)	202	166	180	142	131	154	125	131	150	121	151	91	339		No Threshold

Alder Hey Children's NHS
NHS Foundation Trust

Board of Directors
7th May 2019

Report of	Director of Corporate Affairs
Paper prepared by	Executive Team Governance Manager
Subject/Title	2018/19 Year-end Board Assurance Framework Review
Background papers	Monthly BAF Reports
Purpose of Paper	The purpose of this annual report is to brief the Board on the progress made with risk management and the board assurance framework over the last twelve months.
Action/Decision required	The Board is asked to discuss and note the Board Assurance Framework
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	➢ Delivery of outstanding care ➢ The best people doing their best work ➢ Sustainability through external partnerships ➢ Game-changing research & innovation
Resource Impact	Non achievement of the Trust's objectives could have a negative impact on the services provided by the Trust.

Board Assurance Framework 2018-19

Year End Review

1. Introduction

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

The BAF directly underpins the Annual Governance Statement (AGS) and is the subject of annual review by Internal and External Audit, with the former providing a formal opinion on the fitness for purpose of the process and approach. This assessment comprises a view on the BAF's structure, the Board's engagement with it and the quality of the content.

The Framework aims to allow the Board to monitor progress against the Trust's four strategic aims:

1. Delivery of outstanding care
2. The best people doing their best work
3. Sustainability through external partnerships
4. Game-changing research & innovation

2. Key issues

The Board must satisfy itself that appropriate and timely action is being taken to sufficiently mitigate the risks to the achievement of the Trust's objectives.

The BAF continues to be utilised interactively and is used by the Trust Executive Team, the Board and its sub-committees to better drive the management and mitigation of our key risks.

This report provides a comparison of the BAF at the start and end of 2018/19; an analysis of progress thorough the year, potential changes for next year and finally a table that shows links between the BAF and associated corporate risks.

3. BAF at start of financial year 2018-19 (April 2018)

BAF Risk Register - Overview at 5 April 2018
3.4: Financial Environment (S)
3.2: Business Development and Growth. (S) 3.3: Developing the Paediatric Service Offer (S)
2.2: Failure to fully realise the Trust's Vision for the Park (S) 2.3: IT Strategic Development (S)
4.1: Workforce Sustainability & Capability (S) 4.2: Staff Engagement (S) 4.3: Workforce Diversity & Inclusion (S)
2.1: Research, Education & Innovation (S)
1.1: Failure to maintain appropriate levels of care quality in a cost constrained environment. (S)
1.2: Mandatory & compliance standards (S)

4. BAF at end of financial year 2018-19 (30 April 2019)

BAF Risk Register - Overview at 30 April 2019
3.4: Financial Environment (S) 1.3: New Hospital Environment (S)
2.3: Workforce Equality, Diversity & Inclusion (S) 3.2: Service sustainability and Growth. (S)
1.1: Achievement of Outstanding Quality for Children and Young People as defined by the Care Quality Commission (CQC) regula (S)
3.1: Failure to fully realise the Trust's Vision for the Park (S) 4.1: Research, Education & Innovation (S)
1.4: Sustaining operational delivery in the event of a 'No Deal' exit from the European Union (B)
2.1: Workforce Sustainability (S) 2.2: Staff Engagement (S) 4.2: IT Strategic Development. (S)
1.2: Achievement of national and local mandatory & compliance standards (B)

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

5. Comparison of ratings: start and end of financial year (April 2018 and March 2019)

Ref	Risk Title	Risk Rating: I x L	
		Current: Apr 18 **: Mar 19**	Target: Apr 18: **Mar 19**
STRATEGIC PILLAR: Delivery of Outstanding Care			
1.1 (HG)	**Achievement of Outstanding Quality for Children and Young People as defined by the CQC Regulations**	4-2 < 3-3	4-2 > 2-2
1.2 (ES)	**Achievement of national and local mandatory standards**	5-1 < 3-3	3-1 < 2-2
1.3 (DP)	**New Hospital Environment**	n/a : 4-4	n/a : 4-2
1.4 (JG)	**Sustainable operational delivery in the event of a 'No Deal' exit from EU**	n/a : 4-4	n/a : 3-3
STRATEGIC PILLAR: The Best People doing their Best Work			
2.1 (MS)	**Workforce Sustainability & Capability**	4-3 > 3-3	4-2 > 3-2
2.2 (MS)	**Staff Engagement**	3-3 = 3-3	3-1 = 3-1
2.3 (MS)	**Workforce Equality, Diversity & Inclusion**	3-3 = 3-4	3-1 = 3-1
STRATEGIC PILLAR: Sustainability through External Partnerships			
3.1 (DP)	**Failure to fully realise the Trusts Vision for the Park**	4-3 > 3-3	4-2 > 3-2
3.2 (DJ)	**Service Sustainability & Growth**	4-3 = 4-3	4-2 = 4-2
3.3 (DJ)	**Developing the Paediatric Service Offer** ***(closed April 2019)***	4-3 = 4-3	4-2 = 4-2
3.4 (JG)	**Financial Environment**	4-4 = 4-4	3-4 = 4-3
STRATEGIC PILLAR: Game-Changing Research & Innovation			
4.1 (DP)	**Research, Education & Innovation**	4-2 > 3-3	4-1 < 3-2
4.2 (JG)	**I.T. Strategic Development**	3-4 > 3-3	3-3 = 3-3

6. Analysis of the risk ratings

It can be difficult to effectively score and update the ratings of BAF risks, because of their very nature they are often a composite of a number of lower level risks: the risk rating score is therefore largely indicative at any point in time and any consideration of progress at the end of a year represents a direction of travel rather than an absolute score. However, the following observations can be made:

Two NEW risks were added during 2018/19 both sitting under the strategic pillar “Delivery of Outstanding Care” and both rated 16. These risks were:

1.3 New Hospital Environment (re-opened from Oct 2017)

1.4 Sustainable operational delivery in the event of a ‘No Deal’ exit from EU

Financial Environment remains one of the biggest risks to the Trust maintaining a score of 16 in-year.

Of the thirteen risks on the BAF 5 didn’t change their current rating during the course of the year. The two risks sitting under the strategic pillar ‘Game Changing Research & Innovation’ both decreased their current ratings.

The risk entitled ‘Developing the Paediatric Service Offer’ was closed in April 2019 as it was more appropriate to amalgamate with risk 3.2 ‘Service Sustainability and Growth’.

The full Board Assurance Framework for the month of April can be found at Appendix A.

7. Summary of BAF - at 30 April 2019

The diagram above shows that two risks improved at year-end; all other risks remained static.

Ref, Owner	Risk Title	Risk Rating: I x L		Monthly Trend	
		Current	Target	Last	Now
STRATEGIC PILLAR: Delivery of Outstanding Care					
1.1 HG	**Achievement of outstanding quality for children and young people**	3-3	2-2	STATIC	STATIC
1.2 ES	**Achievement of national and local mandatory standards**	3-2	3-2	STATIC	**BETTER**
1.3 DP	**New Hospital Environment**	4-4	4-2	WORSE	STATIC
1.4 JG	**Sustainable operational delivery in the event of a 'No Deal' exit from EU**	3-3	3-3	STATIC	**BETTER**
STRATEGIC PILLAR: The Best People Doing Their Best Work					
2.1 MS	**Workforce Sustainability & Capability**	3-3	3-2	STATIC	STATIC
2.2 MS	**Staff Engagement**	3-3	3-1	STATIC	STATIC
2.3 MS	**Workforce Equality, Diversity & Inclusion**	3-4	3-1	STATIC	STATIC
STRATEGIC PILLAR: Sustainability Through External Partnerships					
3.1 DP	**Failure to fully realise the Trust's Vision for the Park**	3-3	3-2	STATIC	STATIC
3.2 DJ	**Service Sustainability & Growth**	4-3	4-2	STATIC	STATIC
3.3 DJ	**Developing the Paediatric Service Offer**	4-3	4-2	STATIC	**CLOSED**
3.4 JG	**Financial Environment**	4-4	4-3	STATIC	STATIC
STRATEGIC PILLAR: Game-Changing Research And Innovation					
4.1 DP	**Research, Education & Innovation**	3-3	3-2	STATIC	STATIC
4.2 KW	**IT Strategic Development**	3-3	3-2	STATIC	STATIC

8. Changes since April 2019 Board meeting

External risks

- ***Service Sustainability and Growth (DJ)***
  Agreement reached for Alder Hey to host the expanded all-age ACHD network; plans underway with Level 1 partners to shape.
  Alder Hey maintain senior presence at every stage of Liverpool's System Capability Programme; final session scheduled for 15th May, expectation that agreed 'One Liverpool' programme of work retains existing links with Children's Transformation Plan

- ***Achievement of National and Local Mandatory & Compliance Standards (ES)***
  All access targets met for March including ED 4 hour wait placing Alder Hey as one of only ten trusts nationally to achieve against this standard. Target number of CCAD cases exceeded (410 for the year - highest level of performance for Trust).

- ***Developing the Paediatric Service Offer (DJ)***
  Risk amalgamated into risk 3.2 (Service Sustainability and Growth)

- ***Sustaining operational delivery in the event of a 'No Deal' exit from the European Union (JG)***
  All actions previously identified continue.

Internal risks:

- ***Achievement of Outstanding Quality for Children and Young People as defined by the Care Quality Commission (CQC) regulations (HG)***
  CCG event in relation to CIP QIAs complete; positive outcome. Annual workforce report complete and due to be presented at WOD in May followed by Trust Board in June.

- ***Financial Environment (JG)***
  Year-end surplus target achieved which included strong end of year performance from divisions, end of year contract agreements and two material transactions relating to the agreed land sale and PFO contractual reset. Alongside PSF incentive and bonus culminated in £49.9m surplus (pre audited accounts). Focus now on underlying position for 19/20 that without PSF see us remain in underlying deficit. Work to be done to bridge CIP gap (currently £2+m.)

- ***Failure to fully realise the Trust's Vision for the Park (DP)***
  Planning application is with Council and consultations being held with the public.

- ***IT Strategic Development (KW)***
  New CIO in post, Digital Strategy & operating model in development. Strategy due for July Trust Board.

- ***Workforce Sustainability & Capability (MS)***
  All actions on track.

- ***Staff Engagement (MS)***
  All actions on track. Staff Survey roll out continues.

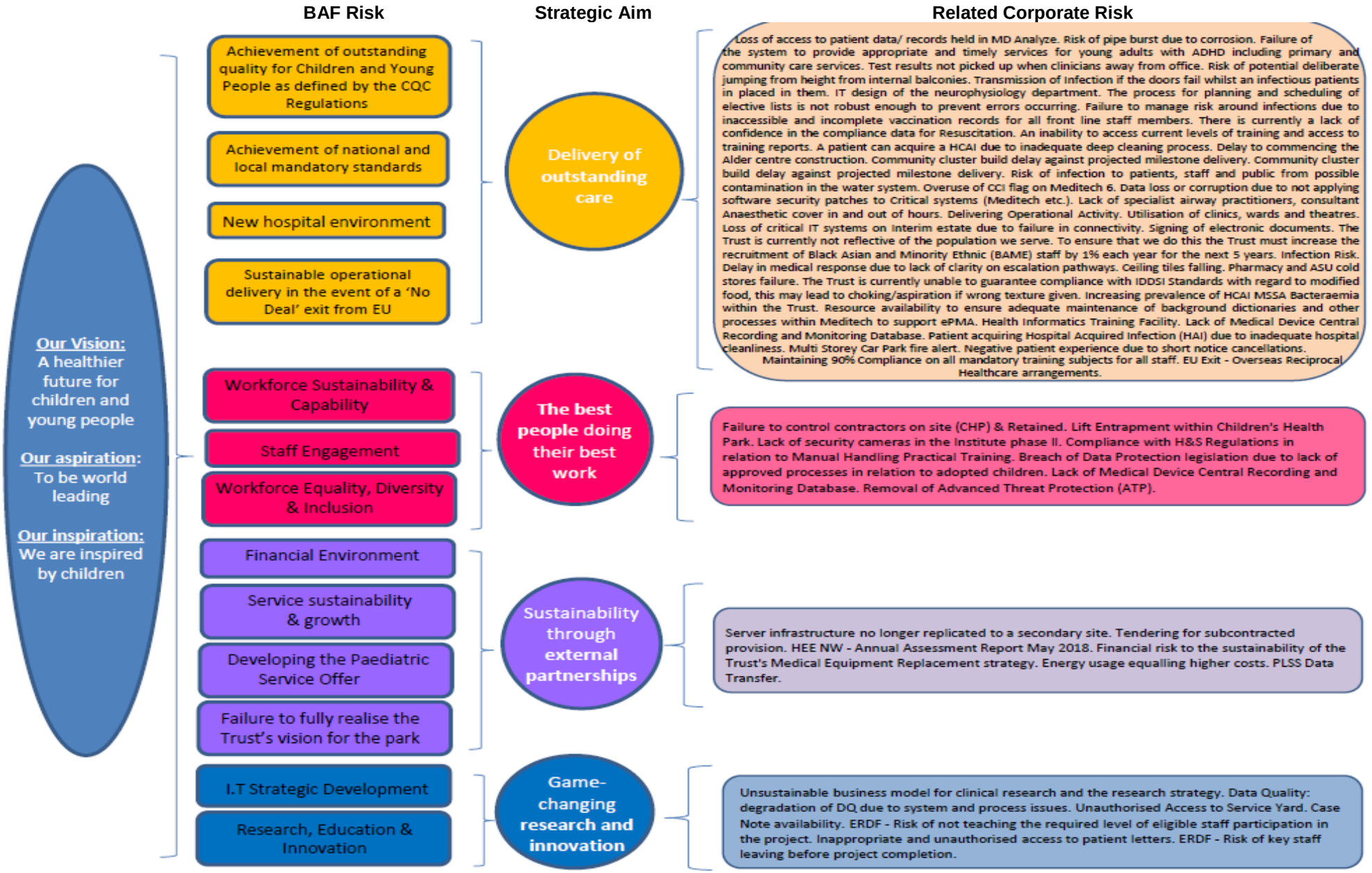
- ***Workforce Equality, Diversity & Inclusion (MS)***
  All actions on track.

- ***New Hospital Environment (DP)***
  Pipework discussed at Liaison Committee - planned series of meetings with Project Co

- ***Research, Education & Innovation (DP)***
  Occupation of building almost complete

Erica Saunders
Director of Corporate Affairs
7 May 2019

9. Links between BAF and corporate risks – as at April 2019



Board Assurance Framework 2019-20

Alder Hey Children's NHS Foundation Trust

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

Risk Description

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

Existing Control Measures

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

Assurance Evidence	Gaps in Controls/Assurance
1. Annual QIA assurance report and change programme assurance report 2. Risk assessments etc and associated risks monitored via the Integrated Governance Committee. Trust Board informed via Integrated Governance Committee minutes. Divisional Integrated Governance Committee minutes. 3. Clinical Quality Assurance Committee, Trust Board and Divisional Governance minutes 4. Corporate report/quality section, Trust Board and Divisional Quality Board minutes. 5. Minutes from Trust Board, Clinical Quality Assurance Committee, Executive Committee, Weekly patient safety group, Clinical Quality Steering Group, Divisional Integrated Governance Committees. Also MIAA audit report. 6. Reports and minutes from Clinical Quality Assurance Committee and Divisional Integrated Governance Committees. 7. Annual Medical Appraisal Report and Nurse staffing report to Trust Board biannually and associated minutes. 8. Board and sub-board committees minutes and associated reports. 9. Minutes from NHSI Quarterly engagement meetings, CQC engagement meetings, Trust Board, Clinical Quality Assurance Committee, Executive Committee, Weekly patient safety group, Clinical Quality Steering Group, Divisional Integrated Governance Committees. Patient survey reports and associated action plans, 10. IPC action plan and Trust Board, Clinical Quality Assurance Committee, Integrated Governance Committee, Divisional Quality Board minutes. 11. Nursing Workforce report and associated Board minutes. 12. Nursing Workforce report and associated Board minutes. 13. Patient survey reports and associated action plans, Trust Board, Clinical Quality Steering Group, Workforce and Organisational Development Committee, Divisional Quality Board minutes. 14. Audit committee reports and minutes. 15. CQC action plan monitoring via Board and sub board committees	15. CQC regulation ratings.

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Robust action plan to be developed, implemented and monitored via the Trust Board, Board subcommittees and individual services.	Continued monthly monitoring via CQAC; commitment to remove completed actions to focus on the outstanding elements in closer detail at the next meeting.

Executive Lead's Assessment
MAR 2019: Preparations underway in relation to the Trust's CIP plans and Quality Impact Assessment mandated processes to be presented by the Chief Nurse and Medical Director at the CCG first week in April. APR 2019: CCG event in relation to CIP QIAs complete, positive outcome. Annual workforce report complete and due to be presented at WOD in May followed by Trust Board in June.

Board Assurance Framework 2019-20

Alder Hey Children's NHS Foundation Trust

BAF 1.2	**Strategic Objective:** Delivery Of Outstanding Care		Risk Title: Achievement of national and local mandatory & compliance standards		
Related CQC Themes: Safe, Caring, Responsive, Well Led, Effective					
Exec Lead: Erica Saunders		**Type:** Internal, Known	Current IxL: 3-2	Target IxL: 3-2	Trend: BETTER

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

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

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

Actions Required to Reduce Risk to Target Rating	**Latest Progress on Actions**
Monitor flow, length of stay and utilisation rates to ensure full activity plan delivered as per profile by Division; review activity profile through winter months.	Significant improvements in management of flow achieved in 2018/19 via bed meetings chaired by Hospital Manager of the Week, weekly performance meetings and specific task and finish work eg clinic utilisation
Plans to ensure performance sustained across the year need to be embedded and maintained	New Models of Care review findings presented and agree at Ops Board September; action plan agreed.

Executive Lead's Assessment
JANUARY 2019: ED performance remains fragile, slipping below the 95% threshold at the end of the month, having sustained well in the post Christmas period. All Winter Plan measures remain in place and other access targets were achieved in month. The POCU model now fully operational for suitable cases. FEBRUARY 2019: ED performance has again been challenged by high volumes of patients with high acuity although bed availability has been good. The change programme project on patient flow has impacted positively on capacity in the last month with only one cancelled operation at time of reporting. A plan to rectify the ED position in March has been developed by the team. MARCH 2019: ED 4 hour target on track to be met for the month of March; all other access targets achieved; cancelled operation performance sustaining at lowest ever levels; clinic utilisation on improvement trajectory. APRIL 2019: All access targets met for March including ED 4 hour wait placing Alder Hey as one of only ten trusts nationally to achieve against this standard. Target number of CCAD cases exceeded (410 for the year - highest level of performance for Trust).

Board Assurance Framework 2019-20

Alder Hey Children's NHS Foundation Trust

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

Risk Description	
Sale of PFI Project co. whilst a number of commissioning risks are still present could lead to lack of focus and problems in maintaining safe environment	
Existing Control Measures	
• Monthly issue meetings	• Monthly liaison meetings
• Regular reports to IGC	• Liaison minutes reported to Trust Board monthly
• Building Management Services Risk Register	
Assurance Evidence	**Gaps in Controls/Assurance**
Maintenance of Issues List Issues Review Meeting Escalation to Liaison meeting Red Button escalation mechanism Help Desk monitoring reports	Some repeat/overlap reporting Some lack of clarity over risk ownership/H&S role
Actions Required to Reduce Risk to Target Rating	**Latest Progress on Actions**
Replacement programme for pipe work to be agreed with builder	Paper top be presented 7 May 2019 Board
Interserve developing water safety action plan	Completed
Prepare recommendation to Board on proposed pipework replacement strategy	Project Co have been asked to meet with Board representatives to establish plan
Executive Lead's Assessment	
February 2019: Liaison meeting with Project Co. to review outstanding risk items APR 2019: Pipework discussed at Liaison Committee - planned series of meetings with Project Co	

Board Assurance Framework 2019-20

Alder Hey Children's NHS Foundation Trust

BAF 1.4	**Strategic Objective:** Delivery Of Outstanding Care		Risk Title: Sustaining operational delivery in the event of a 'No Deal' exit from the European Union		
Related CQC Themes: Safe, Effective, Responsive					
Exec Lead: John Grinnell	**Type:** External,		Current IxL: 3-3	Target IxL: 3-3	Trend: BETTER

Risk Description

Failure of measures put in place nationally and locally in the event of a 'no deal' exit from the EU to safeguard the organisation's ability to deliver services safely and maintain business continuity.

Existing Control Measures

• National NHS EU coordination centre established to oversee planning and provide support to local teams to resolve escalating issues. Internal team in place to implement operational guidance.	• Internal command team structure focusing on eight key areas each week to assess level of risk and update plans based on national information. Group responds to national guidance as it is published.
Assurance Evidence	**Gaps in Controls/Assurance**
Information provided by the centre with regard to provision being made for vital clinical supplies to continue to flow to the UK post 29th March. National coordination centre overseeing three functions: central control, logistics and EPRR. Trust command team planning for operational readiness: SRO identified, risks kept under review, EPRR plans tested, communications plan implemented, Brexit mailbox in place, walkabouts commenced, divisional leads in place, NHSE assessment of hospital is green.	There may be supply issues in the event of a No deal Brexit. Our assurance is that we are in a position to respond to this and have alternatives in place for the identified high ridsk areas which we do.
Actions Required to Reduce Risk to Target Rating	**Latest Progress on Actions**
Continuing to refine oversight arrangements and associated resources ahead of 30 June 2019 deadline	
Continue to engage and lobby NHSE colleagues to ensure centrally managed mitigations are understood and adequate	

Executive Lead's Assessment

Progress made since last Board in strengthening business continuity plans including further assessment of high risk areas, staff brieifings, on call arrangements, command room in place. Operational Divisional Leads identified to supplement subject matter experts. Next stage to test on the ground business continuity risks e.g. supply failure. Patient information on the subject to reviewed.
APR 2019: All actions previously identified continue.

Board Assurance Framework 2019-20

Alder Hey Children's NHS Foundation Trust

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

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

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

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

Actions Required to Reduce Risk to Target Rating	**Latest Progress on Actions**
Continue with regular reporting of data target hotspot areas and staff groups review methodology of accessing training	
Action plan developed in conjunction with NHSI to support the reduction of sickness absence across the organisation. Target is 4% absence rates across the organisation.	
Development of a methodology to roll-out across the organisation. Plan for a workforce summit in June/July 2019	

Executive Lead's Assessment
APR 2019: all actions on track.

Board Assurance Framework 2019-20

Alder Hey Children's NHS Foundation Trust

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

Risk Description

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

Existing Control Measures

• People Strategy	• Wellbeing Strategy implementation
• Action Plans for Staff Survey	• Values and Behaviours Framework
• Staff Temperature Check Reports to Board (quarterly)	• Values based PDR process
• People Strategy Reports to Board (monthly)	• Listening into Action Guidance and Programme of work
• Staff surveys analysed and followed up (shows improvement)	• Reward and recognition schemes in place: Annual Awards, Star of the Month and quarterly Long Service Recognition Event, Annual Fab Staff Change Week.
•	• BME and Disability Staff Networks
• LGBTQI+ Network launched December 2019	

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

Actions Required to Reduce Risk to Target Rating	**Latest Progress on Actions**
Brand paper taken to March Ops Board and detailed implementation now under way	
High level leadership strategy has been approved; the plan will be rolled out during 19/20	

Executive Lead's Assessment

APR 2019: All actions on track. Staff Survey roll out continues.

Board Assurance Framework 2019-20

Alder Hey Children's NHS Foundation Trust

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

Risk Description

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

Existing Control Measures

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

Assurance Evidence	**Gaps in Controls/Assurance**
Monthly recruitment reports provided by HR to divisions Diversity and Inclusion Action Plan reported to Board Bi-monthly reporting to Board via WOD on diversity and inclusion issues Monthly Corporate Report (including workforce KPIs) to the Board Taking forward actions for LiA - enabling achievement of a more inclusive culture Equality Impact Assessments undertaken for every policy & project Workforce Race Equality Standards EDS Publication Equality Objectives	Workforce not representative of the local community BME and disabled staff reporting lower levels of satisfaction in the Staff Survey than non-BME other staff

Actions Required to Reduce Risk to Target Rating	**Latest Progress on Actions**
Work with the BME and Disability Networks to develop specific action plans to improve experience.	
Work with Community Engagement expert to develop actions to work with local community	

Executive Lead's Assessment

APR 2019: all actions on track

Board Assurance Framework 2019-20

Alder Hey Children's NHS Foundation Trust

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

Risk Description	
Failure to fully realise the Trust's vision for the Park and campus, in partnership with the local community and other key stakeholders as a legacy for future generations	
Existing Control Measures	
• Business Cases developed for various elements of the Park & Campus	• Monitoring reports on progress
• Heads of Terms agreed with LCC for joint venture approved	• Redevelopment Steering Group
• Monthly reports to Board & RABD	
Assurance Evidence	**Gaps in Controls/Assurance**
Approved Business Cases for various elements of the Park & Campus approved Every Project has a dedicated Project Manager assigned to it End user consultation events held Highlight reports to relevant assurance committees and through to Board Stakeholder events held/reported back to Trust Board Representation at Friends of Springfield Park Group Monthly Board report	Fully reconciled budget with Plan. Risk quantification around the development projects.
Actions Required to Reduce Risk to Target Rating	**Latest Progress on Actions**
Secure approval for plans to increase Park footprint	Planning for Park extension submitted 31/07/2018
Approval of Business Case at LCC / Discuss park Heads of Terms with LCC	On hold-Dependent upon residential scheme (revised target date no April 2018)
Prepare and submit planning application	Application submitted
Executive Lead's Assessment	
March 2019- interaction events with the public continue and engagement with local residents. More positive feedback on revised plans shared with them APR 2019: Planning application is with Council and consultations being held with the public.	

Board Assurance Framework 2019-20

Alder Hey Children's NHS Foundation Trust

BAF 3.2	**Strategic Objective:** Sustainability Through External Partnerships	Risk Title: Service sustainability 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 service sustainability development/growth; due to NHS financial environment and constraints on internal infrastructure to deliver business as usual as well as maximise growth opportunities. External opportunities for partnership, and/or to reduce variation in Children & Young People's services (across the city and beyond) may not be fully optimised.

Existing Control Measures

• Divisional Performance Management Framework.	• Clear trajectories for challenged specialities to deliver.
• Business Development Plan	• Change Programme Projects (Strategic Partnerships & International Clinical Business and non NHS Patient Services)
• Five year plan agreed by Board and Governors in 2014	• Capacity Plan identifies beds and theatres required to deliver BD Plan.
• Service development strategy including Private / International patient proposal approved by Council of Governors as part of strategic plan sign off (March 18, September 18)	• Capacity Plan identifies beds and theatres required to deliver BD plan
• Weekly meeting with divisions established to review forward look re elective and day case patient bookings to ensure activity scheduled meets contract requirements	• Growth and sustainability through external partnerships is a key theme in the Change Programme.
• Internal review of service specifications as part of Specialist Commissioning review	• Gap / risk analysis against all draft national service specification undertaken and action plans developed
• Compliance with Neonatal Standards	• Post Implementation review of Trauma Business Case
• Growing Through External Partnerships - Change Programme Workstream (all projects)	• Alder Hey leading the partnership development of the future model of Paediatric Urgent Care in Liverpool
• Change Programme - 7 Day Working Project	• Current derogations secured in relation to specialist service specs.
• Compliance with All Age ACHD Standard	• Accreditations confirmed through national review processes

Assurance Evidence	Gaps in Controls/Assurance
Marketing and Business Development Committee has been refreshed as a Growth Through Sustainable Partnerships Group. First meeting planned July 2018. Business Development Plan reviewed monthly by RBDC via Contract Monitoring Report. Daily activity tracker and forecast monitoring performance for all activity. CIPs in new Change Programme subject to assurance and sub-committee performance management. Clinical Network Partnership development with Manchester Children's Hospital. Key developments monitored through Divisions Monitored at refreshed 'Sustainability Through External Partnerships Steering Group' (proposal to develop this during Q1 2019 into Strategy & Ops Delivery Board - to maximise alignment to the strategy and delivery agendas). Monthly to Board via RABD and Board. Compliance with final national specifications. Single Neonatal Services Business Case approved by NHS England. Growth through Partnerships included in Strategic Business planning - both annual operational plan and developing long term plan. ACHD Level 1 service now up and running; developing wider all-age network to support - agreement reached to host at Alder Hey.	Ability to respond swiftly to potential problems. Workforce constraints in specialised services. Early warning indicators for leading indicators. 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.

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Development of the international agenda	Series of 'Export Catalyst' workshops scheduled; beginning May 19.
Strengthening the paediatric workforce	6 monthly audit of 7-day standards is subject to external scrutiny. Global Digital Excellence has improved measurement capability. Adrian Hughes is now leading as one of the top 5 Operational Priorities known as 'New Models of Care'. In addition, junior doctor numbers were bolstered during the winter which improved cover and consultant arrangements.

Executive Lead's Assessment

APR 2019: Agreement reached for Alder Hey to host the expanded all-age ACHD network; plans underway with Level 1 partners to shape.
Alder Hey maintain senior presence at every stage of Liverpool's System Capability Programme; final session scheduled for 15th May, expectation that agreed 'One Liverpool' programme of work retains existing links with Children's Transformation Plan.

Board Assurance Framework 2019-20

Alder Hey Children's NHS Foundation Trust

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

Risk Description

Failure to deliver Trust control total and financial risk rating

Existing Control Measures

• Organisation-wide financial plan.	• NHSi financial regime and Use of Resources risk rating.
• 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	• Weekly Sustainability Delivery Group overseeing efficiency programme
• CIP subject to programme assessment and sub-committee performance management	• RABD deep dive into key financial risk areas at every meeting

Assurance Evidence	Gaps in Controls/Assurance
Monthly Corporate Performance Report presented to both Board and the RABD. Specific Reports (i.e. NHSI Plan Review by RABD) Monthly Performance Management Reporting with General Managers. Internal and External Audit reporting through Audit Committee. Daily activity tracker to support divisional performance management of activity delivery Pay cost control 10 point plan introduced aimed at forecasting and tracking actions to reduce pay cost overspend run rate - updates to Execs, R&BD. Full electronic access to budgets & specialty performance results Weekly Financial Sustainability delivery meeting papers Board 2 Board with Spec comm High Impact changes amalgamated into Programme Delivery Board	Divisions improved financial control and effective recovery required in identified where slippage against agreed recovery trajectories occurring Ongoing cost of temporary staff Divisional recovery plans to hit yearend financial control targets to ensure delivery of overall Trust financial plan. 'Grip' on CIP CIP Position improved however Divisional forecasts still showing a potential £1.6m gap

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Tracking actions from Sustainability Delivery Group	on target
Develop fully worked up CIP programme - only 50% fully identified and a number of red RAG schemes	Reviewed at financial sustainability group 2.7.18 Further work to take place as part of Q1 review and in July. Review again at expected completion date

Executive Lead's Assessment

APRIL 19 - year end surplus target achieved which included strong end of year performance from divisions, end of year contract agreements and two material transactions relating to the agreed land sale and PFO contractual reset. Alongside PSF incentive and bonus culminated in 49.9m surplus (pre audited accounts). Focus now on underlying position for 19/20 that without PSF see us remain in underlying deficit. Work to be done to bridge CIP gap (currently £2+m.)

Board Assurance Framework 2019-20

Alder Hey Children's NHS Foundation Trust

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

Risk Description	
Failure to exploit new opportunities in research, innovation & education due to incomplete management systems.	
Existing Control Measures	
• Establishment of RIE Board Sub-committee	• Steering Board reporting through to Trust Board
• RABD review of contractual arrangements	• Programme assurance via regular Programme Board scrutiny
• Digital Exemplar budget completed and reconciled	• Innovation Co budget in place
Assurance Evidence	**Gaps in Controls/Assurance**
Research Strategy Committee set up as a new Board Assurance Committee Research, Education and Innovation Committee established Secured ERDF funding for Innovation Team Innovation Board established	Sporadic meetings of RIE committee Governance structure for Innovation Board to be agreed Re-energise Research governance processes Reporting frameworks and standards for all services to be agreed/harmonised
Actions Required to Reduce Risk to Target Rating	**Latest Progress on Actions**
Develop a robust Academy Business Model	Framework refresh
Execute contract for RIE with back to back arrangements with the Charity and HEIs	Final Documentation with solicitors prior to completion before move in to Institute Phase 2
Agree incentivisation framework for staff and teams	
Agree Funding Strategy for Innovation	Draft completed
	Draft contract shared with University
Executive Lead's Assessment	
Feb 2019: Funding strategy review APR 2019: Occupation of building almost complete	

Board Assurance Framework 2019-20

Alder Hey Children's NHS Foundation Trust

BAF 4.2	**Strategic Objective:** Game-Changing Research And Innovation		Risk Title: IT Strategic Development.		
Related CQC Themes: Safe, Caring, Effective, Responsive, Well Led					
Exec Lead: Kate Warriner		**Type:** Internal, Known	Current IxL: 3-3	Target IxL: 3-2	Trend: STATIC

Risk Description	
Failure to deliver a Digital Strategy which will place Alder Hey at the forefront of technological advancement in paediatric healthcare	
Existing Control Measures	
• Key projects and progress tracked through the Clinical Systems Informatics Steering Group and RABD Committee	• Clinical Systems Informatics Project Group leading on stakeholder engagement - ad hoc groups on specific key topics as needed
• Forward Communications plan agreed and tracked at steering group.	• Board approval "Asset Owner" process in place to ensure organisational ownership of systems and system development
• Improvement scheduled training provision including refresher training and workshops to address data quality issues	• Formal change control processes now in place
• Executive level CIO in place	• Monthly update to Trust Board on digital developments
• GDE Programme Board in place & fully resourced - Chaired by Medical Director	• Clinical Engagement in Digital Strategy
• NHSE & NHS Digital external oversight of GDE programme	• Resilience of underlying infrastructure
• A plan is now in place to develop new strategy and roadmap to present to Board in Summer 2019	• Integration with divisions needs strengthening
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 NHSD tracking of GDE Programme GDE Programme Board tracking delivery - Chaired by MD Implementation of weekly Oversight group	IM&T Strategy out of date - update work in progress to produce Roadmap for Summer 2019 Resilience of underlying infrastructure - replacement being installed I.T operating model assessment underway
Actions Required to Reduce Risk to Target Rating	**Latest Progress on Actions**
Replacement equipment procured - equipment is now installed however delay in ensuring appropriate electrical back up in place which is being rectified. Awaiting final solution on electrical supply.	Engagement with clinical & divisional teams in place, Strategy scheduled for July 2019 Trust Board
Digital Strategy & operating model work to be concluded	Meeting held with Meditech to agree how we work more effectively going forward and have more onsite presence
Executive Lead's Assessment	
MAR 19: Progress is being maintained. Clinical leads interviews have taken place and offers being formalised APR 19: New CIO in post, Digital Strategy & operating model in development. Strategy due for July Trust Board.	

Alder Hey Children's NHS
NHS Foundation Trust

Board of Directors
Tuesday 7 May 2019

Report of	Director of Corporate Affairs
Paper prepared by	Governance Manager
Subject/Title	Register of Interest 2018/19
Background papers	N/A
Purpose of Paper	The purpose of this paper is to provide the Board with the Register of Interests 2018/19
Action/Decision required	The Board is requested to receive and note the Register of Interests 2018/19
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Robust corporate governance arrangements support the achievement of all Trust Strategic Objectives: ➢ Delivery of outstanding care ➢ The best people doing their best work ➢ Sustainability through external partnerships ➢ Game-changing research & innovation
Resource Impact	N/A

1. Executive Summary

In June 2017, new guidance was issued by NHS England designed to increase public confidence by providing a transparent view of how decisions are made and taxpayers' money spent, meaning that not only will Board Members' and Directors' be required to declare an interest, but this would now include all decision makers employed by the Trust.

A new reporting software (MES Declare) has now been implemented to ensure that the Trust is fully compliant with the guidance.

This paper provides the current Register of Interests for the Trust. Updates to the register are provided to the Board at annual intervals, and in line with the Trust's Declaring Conflicts of Interest and Gifts and Hospitality Policy.

Please note however that due to the technicalities of the new system set up and the use of non-Alder Hey emails, this report does not include the Non-Executive Directors' declaration; this will be provided at the next Board meeting.

2. Current position

The Codes of Conduct and Accountability for NHS Boards, require the declaration of Board Members' and Directors' interests and the maintenance of a register of interests. This is reinforced through the Trust's Standing Orders.

The Board has a clear view that it aspires to the highest standards of probity and governance. Setting out publicly its Declarations of Interests makes it clear to key stakeholders, commissioners and the public that the Board aims to meet these standards and ensure good conduct in public business.

3. Recommendation

The Board is requested to note the Register of Interests attached at appendix A.

ID	Role	InterestType	DateInterestDeclared	DateInterestMade	Interest Description
1	Senior Specialist Physiotherapist - Neurodisability	Clinical Private Practice	05/11/2018	01/04/2018	Respiratory physiotherapy assessment and training/intervention for children and young adults.
2	Senior Specialist Physiotherapist - Neurodisability	Shareholdings and other ownership interests	05/11/2018	01/09/2018	Part of the acorn process through innovation department. 33% Shares. Currently in explore phase
3	Physiotherapy Manager	Outside Employment	19/02/2019	01/04/2018	Provide Physio services for the everton fc youth academy
4	Consultant	Nil Declaration	28/03/2019	28/03/2019	
5	Finance Director	Outside Employment	28/03/2019	01/04/2018	Voluntary third sector housing organisation
6	Senior Manager	Nil Declaration	29/03/2019	29/03/2019	
7		End of Year Nil Declaration	01/04/2019	31/03/2019	
8	Consultant	End of Year Nil Declaration	01/04/2019	31/03/2019	
9	Consultant	End of Year Nil Declaration	01/04/2019	31/03/2019	
10	Nurse Manager	End of Year Nil Declaration	01/04/2019	31/03/2019	
11	Consultant	End of Year Nil Declaration	01/04/2019	31/03/2019	
12	Senior Manager	End of Year Nil Declaration	01/04/2019	31/03/2019	
13	Senior Manager	End of Year Nil Declaration	01/04/2019	31/03/2019	
14	Consultant	Outside Employment	01/04/2019	01/04/2019	Consultant work (ad hoc) for Proton Partners International (Rutherford Cancer Centres) - a commercial firm providing private cancer care
15	Manager	End of Year Nil Declaration	01/04/2019	31/03/2019	
16	Manager	End of Year Nil Declaration	01/04/2019	31/03/2019	
17	Senior Manager	Hospitality	01/04/2019	06/09/2018	Overnight hotel accommodation (bed and breakfast) linked to speaking at Resilience Forum meeting on 7th September.
18		End of Year Nil Declaration	01/04/2019	31/03/2019	
19	Manager	End of Year Nil Declaration	01/04/2019	31/03/2019	
20	Senior Manager	End of Year Nil Declaration	01/04/2019	31/03/2019	
21	Consultant	End of Year Nil Declaration	01/04/2019	31/03/2019	
22	Manager	End of Year Nil Declaration	01/04/2019	31/03/2019	
23	Consultant	Hospitality	01/04/2019	17/07/2018	Travel, accommodation and registration for ISTH Conference, Dublin
24	Consultant	End of Year Nil Declaration	01/04/2019	31/03/2019	
25	Manager	End of Year Nil Declaration	01/04/2019	31/03/2019	
26	Senior Manager	End of Year Nil Declaration	01/04/2019	31/03/2019	
27	Consultant	Clinical Private Practice	01/04/2019	01/04/2018	Audiovestibular Medicine and Nuerotology in adults only; no procedure undertaken, clinic based practice at Claremont Private Hospitals in Sheffield and Hallamshire Physiotherapy in Sheffield
28		End of Year Nil Declaration	01/04/2019	31/03/2019	
29		End of Year Nil Declaration	01/04/2019	31/03/2019	
30	Manager	End of Year Nil Declaration	01/04/2019	31/03/2019	
31	Consultant	Shareholdings and other ownership interests	01/04/2019	01/04/2018	1 Share
32	Consultant	Donations	01/04/2019	01/12/2018	Donation of 4 Tesla mini cars to the hospital for children to play with. From The Tesla Owners group. I was approached by email to receive these to the Innovation hub. I engaged with charity to provide receipts and publicize.
33	Senior Manager	End of Year Nil Declaration	01/04/2019	31/03/2019	
34	Consultant	Gifts	01/04/2019	21/03/2019	David Speakman is a major donor to the hospital who is working with us to develop a charitable innovation funding pipeline. He has invited myself and a guest to join him at a music concert in June. This is a key opportunity for us to develop a continued partnership with David Speakman and may lead to further future donations.
35	Consultant	End of Year Nil Declaration	01/04/2019	31/03/2019	

36	Consultant	Loyalty Interests	01/04/2019	01/04/2018	I act as a clinical advisor and have in the past been paid to provide anatomy tutorials for their staff. I have helped develop this company from it's inception at Alder Hey Innovation Hub to the thriving company that it is today. I therefore have an interest in them succeeding.
37	Consultant	Outside Employment	01/04/2019	28/12/2018	In March 2018 I provided a single 1 week Anatomy course for 3D life prints during annual leave. I obtained approval for this from David Powell (Dev Director) and Claire Liddy (Deputy Director of Finance). £3000
38		End of Year Nil Declaration	01/04/2019	31/03/2019	
39	Ward Manager	End of Year Nil Declaration	01/04/2019	31/03/2019	
40	Consultant	End of Year Nil Declaration	01/04/2019	31/03/2019	
41	Consultant	Outside Employment	01/04/2019	01/03/2019	Trustee and Lead Cardiac Surgeon for the Healing Little Hearts charity - All work done out of hours in my spare time and the 3 missions/camps are done during my annual leave. The charity work complements my work at AH and helps improving Alder Hey and NHS reputation.
42	Consultant	Outside Employment	01/04/2019	01/04/2019	Trustee and Lead Cardiac Surgeon for the Healing Little Hearts charity - All work done out of hours in my spare time and the 3 missions/camps per year are done during my annual leave. The charity work complements my work at AH and helps improving Alder Hey and NHS reputation.
43	Manager	End of Year Nil Declaration	01/04/2019	31/03/2019	
44	Consultant	Loyalty Interests	01/04/2019	01/04/2018	I have acted as a clinical advisor for the Thinking of Oscar Charity. It is a charity set up by 2 parents that lost a child to a viral illness that would like to use AI to improve childrens healthcare. I have helped introduce them to our charity and communications team.
45	Chief Operating Office	End of Year Nil Declaration	01/04/2019	31/03/2019	
46	Consultant	Outside Employment	01/04/2019	01/04/2018	I have been appointed as the theme lead for healthcare technology and design at the Medical school. This has involved working closely with the universities engineering and design department. I am being paid 2PA which is administered through the hospital.
47	Senior Manager	Hospitality	01/04/2019	22/11/2018	Overnight bed and breakfast provided as I was keynote speaker at the PMEA (Pharmaceutical Marketing Excellence Awards). Return rail and other transport reimbursement. Overnight accommodation paid for by award £66 Travel costs paid by me and then claimed back from PMEA Train: 67.95 Uber: £18.62 London Transport Underground tickets: £2.40 £3.90
48	Consultant		01/04/2019	01/04/2018	Unpaid membership of LEP Innovation Board. Involved in identifying and promoting innovation in the Liverpool area across all sectors.
49	Senior Manager		01/04/2019	13/11/2018	Gift(s) One boxed set of silk tie and silk scarf, Chinese origin and design
50	Consultant		01/04/2019	01/03/2019	Unpaid post. Member of the Innovation agency board. Role is to provide insight into how NHS innovation is promoted in the North West region. Since 2017.
51	Consultant		01/04/2019	02/04/2018	I am employed 0.5PA by the NIHR to lead on the development of Paediatric surgical technologies. This is a national role.
52	Nurse Manager		01/04/2019	31/03/2019	
53			01/04/2019	31/03/2019	
54			01/04/2019	31/03/2019	
55	Manager	0	01/04/2019	31/03/2019	
56	Manager	Outside Employment	01/04/2019	31/03/2019	
57	Senior Manager	Gifts	01/04/2019	31/03/2019	
58	Consultant	Outside Employment	01/04/2019	01/04/2018	Paediatric neurology. No procedures undertaken. Advice only.
59	Consultant	Outside Employment	01/04/2019	01/04/2019	Drug trial of Epidiolex

60	Consultant	End of Year Nil Declaration		01/04/2019	01/04/2018	I will see patients, advise parents and prepare reports. I do not see patients who have any connection to Alder Hey and my private practice is based in Hale, Cheshire.
61	Consultant	End of Year Nil Declaration		01/04/2019	01/04/2018	50%
62	Consultant	End of Year Nil Declaration		01/04/2019	01/04/2018	I am a director of KLES Professional Services Ltd, which is how I do my medico-legal practice (majority of the work) and some private medical consultations.
63		End of Year Nil Declaration		01/04/2019	31/03/2019	
64	Consultant	End of Year Nil Declaration		01/04/2019	01/04/2018	I undertake the majority of my private medical consultations for which I am approached via two companies: PSP Neuro & Physiotherapy Ltd and also NPP Paediatrics Ltd (they act as a combination of marketing agent, fee collection, secretarial duties).
65		End of Year Nil Declaration				
66		0 Clinical Private Practice		00/01/1900	0	
67	Nurse Manager	Sponsored Research		01/04/2019	31/03/2019	
68	Consultant	Clinical Private Practice		01/04/2019	22/02/2019	Paid for attendance course costs at the European Continuing Medical Training meeting King's London on deep brain stimulation. I was on annual leave and was in London so I attended since this is a significant area of my involvement.
69	Consultant		0	01/04/2019	08/09/2018	Meeting with dinner at restaurant. Discussion of deep brain stimulation service development.
70		Shareholdings and other ownership interests		01/04/2019	31/03/2019	
71	Nurse Manager	NULL		01/04/2019	31/03/2019	
72	Manager	Outside Employment		01/04/2019	31/03/2019	
73		End of Year Nil Declaration		01/04/2019	31/03/2019	
74	Consultant	Loyalty Interests		01/04/2019	31/03/2019	
75	Manager			01/04/2019	31/03/2019	
76			0	01/04/2019	01/04/2018	My cousin works within the IM&T team. She is not directly managed by me and reports via the Associate Director of Operational IT
77	Consultant	End of Year Nil Declaration		01/04/2019	01/04/2018	Paediatric radiology imaging - Xray, Ultrasound, MRI and CT
78		Hospitality		01/04/2019	31/03/2019	
79	Consultant	Hospitality		01/04/2019	31/03/2019	
80	Consultant	End of Year Nil Declaration		01/04/2019	01/04/2018	Research involving MRI scans in children with brain tumours. This is a matched funded project between the university of Liverpool and Alderhey Children's charity for a PhD student to undertake this research over 3 years.
81	Consultant	End of Year Nil Declaration		01/04/2019	02/08/2018	Philps contributes to educational funds to the radiology department as a godwill gesture for our cooperation when medical teams visit our hospital to examine our MRI service. As part of the Educational funding for the department as agreed by Philips, my accomodation at a scientific meeting (Posterior Fossa society consensus meeting -2018) at Reykjavik, Iceland was funded by the company.
82		0 End of Year Nil Declaration		00/01/1900	0	
83	Consultant	End of Year Nil Declaration		01/04/2019	20/03/2019	I was invited to a lecture by Professor David Olusoga at St Georges Hall on the history of St Georges Hall in Liverpool. I was invited as a guest of the Rutherford Diagnostics team.
84		End of Year Nil Declaration				
85		0 End of Year Nil Declaration		00/01/1900	0	
86	Senior Manager	Loyalty Interests		01/04/2019	31/03/2019	
87	Other Executive Director	Clinical Private Practice		01/04/2019	31/03/2019	
88		End of Year Nil Declaration		02/04/2019	31/03/2019	
89	Consultant	End of Year Nil Declaration		02/04/2019	01/04/2018	This is fro medico legal work only. It is in paediatric neurology
90	Consultant	Sponsored Research		02/04/2019	01/04/2018	Paediatric Orthopaedics - OPD assessments
91		0 Hospitality		00/01/1900	0	
92	Nurse Manager		0	02/04/2019	31/03/2019	
93	Manager	Hospitality		02/04/2019	31/03/2019	
94	Nurse Manager			02/04/2019	31/03/2019	
95	Nurse Manager		0	02/04/2019	31/03/2019	
96		End of Year Nil Declaration		02/04/2019	31/03/2019	
97	Manager	End of Year Nil Declaration		02/04/2019	31/03/2019	

98	Consultant	End of Year Nil Declaration		02/04/2019	31/03/2019	
99	Manager	Clinical Private Practice		02/04/2019	31/03/2019	
100	Consultant Clinical Psychologist	Clinical Private Practice		02/04/2019	31/03/2019	
101	Consultant		0	02/04/2019	01/04/2018	I was involved in the original design of the EoSurgical simulator and it's validation. I am personal friends with the co founder Roland Partridge. Interest since 2011.
102	Consultant	End of Year Nil Declaration		02/04/2019	01/04/2018	I am an Author for the Elsevier Publishing House. I receive book royalties for Macleod's Clinical Diagnosis, Macleod's Clinical Examination, Introduction to clinical examination and Arterial Blood Gases Made Easy
103	Manager	End of Year Nil Declaration		02/04/2019	31/03/2019	
104	Manager	End of Year Nil Declaration		02/04/2019	01/04/2019	Nursing duties for NHS Professionals on an ad hoc basis for MFT neonatal unit.
105	Manager	End of Year Nil Declaration		02/04/2019	01/04/2019	Clinical teaching on neonatal/CPD programmes of study paid on an hourly basis as required. Maximum 4 half days of teaching annually. Always undertaken outside of my normal working hours.
106	Consultant	End of Year Nil Declaration		03/04/2019	31/03/2019	
107		End of Year Nil Declaration		03/04/2019	31/03/2019	
108	Consultant	End of Year Nil Declaration		03/04/2019	31/03/2019	
109		End of Year Nil Declaration		03/04/2019	23/03/2019	I am CEO (Chief Executive Officer) of IHRIM. This is an elected post for a 3 year term. The term was renewed on 23/03/2019. This is an unpaid position.
110		0 End of Year Nil Declaration		00/01/1900	0	
111	Consultant	Loyalty Interests		03/04/2019	01/04/2018	General Ophthalmology Cataract surgery
112		Outside Employment		03/04/2019	31/03/2019	
113	Senior Manager	End of Year Nil Declaration		03/04/2019	31/03/2019	
114		Outside Employment		03/04/2019	31/03/2019	
115	Consultant	Outside Employment		04/04/2019	31/03/2019	
116	Consultant	End of Year Nil Declaration		04/04/2019	04/04/2019	
117		End of Year Nil Declaration		05/04/2019	31/03/2019	
118	Consultant	End of Year Nil Declaration		05/04/2019	01/04/2018	Respite Foster Carer
119	Consultant	Loyalty Interests		07/04/2019	01/04/2018	I work for Wiley publishers. I am a section editor for Clinical Otolaryngology. I receive an honorarium of £1,500 per annum. This is an honorarium and not a paid employment. I do declare it on HMRC tax forms. This work originally started in 2014.
120	Consultant		0	08/04/2019	31/03/2019	
121	Consultant	Clinical Private Practice		08/04/2019	31/03/2019	
122	Consultant	End of Year Nil Declaration		08/04/2019	31/03/2019	
123	Manager	End of Year Nil Declaration		09/04/2019	31/03/2019	
124	Manager	End of Year Nil Declaration		09/04/2019	31/03/2019	
125	Speech and Language Therapist Manager	End of Year Nil Declaration		11/04/2019	01/04/2018	Team Leader & Expert Practitioner Adult Community Speech & Language Therapy Department
126	Speech and Language Therapist Manager	Nil Declaration		11/04/2019	01/04/2018	Consultancy & Training in Complex Needs & Ethical Practice since 01/09/2008
127		0 End of Year Nil Declaration		00/01/1900	0	
128		Outside Employment		11/04/2019	31/03/2019	
129	Consultant	Outside Employment		14/04/2019	13/09/2018	Invited speaker for quality improvement in children with inflammatory bowel disease
130	Consultant	End of Year Nil Declaration		14/04/2019	08/05/2018	Hospitality to attend ESPGHAN working group and annual meeting/conference in Geneva
131	Consultant	End of Year Nil Declaration		15/04/2019	01/04/2018	I am a trustee of the ADHD Foundation, a charity supporting children, families and adults with ADHD.
132	Consultant	End of Year Nil Declaration		15/04/2019	22/03/2019	Return flights to Berlin and transfers, two nights in hotel, conference and conference dinner (all delegates attended).
133	Manager	End of Year Nil Declaration		16/04/2019	31/03/2019	
134	Nurse Manager	End of Year Nil Declaration		18/04/2019	31/03/2019	
135	Consultant	Outside Employment		27/04/2019	31/03/2019	
		Clinical Private Practice				