Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS MEETING

Tuesday 7th November 2017 commencing at 1000

Venue: Large Meeting Room, Institute in the park

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action	Preparation
Board Business						
1.			**Apologies**	Chair	Michael Beresford	--
2.	**17/18/162**		**Declarations of Interest**	All	Board Members to declare an interest in particular agenda items, if appropriate	--
3.	**17/18/163**		**Minutes of the Previous Meeting**	Chair	To consider the minutes of the previous meeting to check for amendments and approve held on: **3rd October 2017**	Read Minutes
4.	**17/18/164**		**Matters Arising**	Chair	To discuss any matters arising from previous meetings and provide updates and review where appropriate	Verbal
5.	**17/18/165**		**Key Issues/Reflections**	All	The Board to reflect on key issues.	Verbal
Strategic Update						
6.	**17/18/166**	**1020**	**External Environment** **Progress against strategic themes:** - **Liverpool Community Services** - **Liverpool Women's Reconfiguration Options/Neonatal** - **Congenital Heart Disease**	 L Shepherd L Shepherd S Ryan	 To update the Board on progress.	 Verbal Verbal

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action	Preparation
7.	**17/18/167**		**Operational Plans** **Divisional Update** - **Surgery** - **Medicine** - **Community** - **Corporate Services** - **Research**	Adam Bateman Adrian Hughes Catherine McLaughlin Claire Liddy Charlie Orton	To provide an update on progress to date against the 2017/18 Trust Strategy and Operational Plan.	Presentations
Delivery of outstanding care						
8.	**17/18/168**	**1200**	**Serious Incidents Report**	H Gwilliams	To inform the Board of the recent serious incidents at the Trust in the last calendar month	Read Report
9.	**17/18/169**	**1205**	**Clinical Quality Assurance Committee: Chair's update**	A Marsland	To receive and review the approved minutes from the meeting held: 20th September 2017	Read report
10.	**17/18/170**	**1210**	**Alder Hey in the Park update**	D Powell	To receive an update on key outstanding issues / risks and plans for mitigation.	Read report
11.	**17/18/171**	**12:15**	**CQC Action Plan**	E Saunders/ H Gwilliams	To present the findings from the CQC inspection	Read report
The best people doing their best work						
12.	**17/18/172**	**1225**	**People Strategy Update** - **WRES Action Plan**	M Swindell	To provide an update on the strategy and staff survey For approval.	Read reports
1235-1300 Lunch						
13.	**17/18/173**	**1310**	**Well-led Governance Review – Terms of Reference**	Tim Crowley, MIAA/Cath Hill, Advancing Quality Alliances	To present the proposed terms of reference	Read report

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action	Preparation
Strong Foundations						
14.	**17/18/174**	**1320**	**Programme Assurance update** - **Deliver Outstanding Care** - **Growing External Partnerships** - **Global Digital Exemplar** - **Park Community Estates and Facilities** - **Strong Foundations**	J Gibson	To receive an update on programme assurance including the 2017/18 change programme	Read Report
15.	**17/18/175**	**1330**	**Corporate Report**	J Grinnell/ H Gwilliams/ M Swindell	To note delivery against financial , operational, HR metrics and quality metrics and mandatory targets within the Corporate Report for the month of August 2017	Read report
16.	**17/18/176**	**1345**	**Board Assurance Framework**	E Saunders	To receive the BAF report.	Read report
17.	**17/18/177**	**1350**	**Integrated Governance Committee**	S Igoe	To receive and review the approved minutes from the meeting held on: - 24th July 2017 - 27th September 2017	Read minutes
18.	**17/18/178**	**1352**	**Resources & Business Development Committee: Chair's update**	I Quinlan	To receive and review the approved minutes from the meeting held on: 28th September 2017.	Read minutes
Game Changing Research and Innovation						
19.	**17/18/179**	**1354**	**Global Digital Exemplar (GDE)**	P Young	To update the Board on the programme	Read report
Any Other Business						

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action	Preparation
20.	**17/18/180**	**1400**	**Any Other Business**	All	To discuss any further business before the close of the meeting	Verbal
Date and Time Of Next Meeting: Tuesday 5th December 2017 at **10:00am, Institute In The Park, Large Meeting Room**						

REGISTER OF TRUST SEAL
The Trust Seal was not used during the month of **October, 2017**

BOARD OF DIRECTORS

Minutes of the last meeting held on **Tuesday 3rd October 2017 at 11:00am,**
Large Meeting Room, Institute in the park

Present:	Sir D Henshaw	Chairman (Chair)	(SDH)
	Mrs C Dove	Non-Executive Director	(CD)
	Mrs J France-Hayhurst	Non-Executive Director	(JFH)
	Mr J Grinnell	Director of Finance	(JG)
	Mrs H Gwilliams	Chief Nurse	(HG)
	Mr S Igoe	Non-Executive Director	(SI)
	Dr S Ryan	Medical Director	(SR)
	Mrs L Shepherd	Chief Executive	(LS)
	Mrs M Swindell	Director of HR & OD	(MS)
	Mr I Quinlan	Non-Executive Director	(IQ)
	Dame J Williams	Non-Executive Director	(JW)
In Attendance:	Mr A Bateman	Acting Chief Operating Officer	(AB)
	Prof M Beresford	Assoc. Director of the Board	(PMB)
	Ms S Falder	Director of Clinical Effectiveness and Service Transformation	(SF)
	Dr A Hughes	Director of Medicine	(AH)
	Mr D Powell	Development Director	(DP)
	Ms E Saunders	Director of Corporate Affairs	(ES)
	Mrs J Tsao	Committee Administrator	(JT)
	Mr Andrew Williams	Director of CAMHS	(AW)
	Mr M Flannagan	Director of Communications	(MF)
Observing:	Ms Kathryn Foreman	Non-Executive Director, Urgent Care 24	
Agenda item: 142	Elaine Menarry	Emergency Preparedness and Business Continuity Manager	
144 & 145	Kerry Turner	Listening into Action Lead	
151	Prof Barry Pizer	Consultant Oncologist	
152	Peter Young	Chief Information officer	
Apologies:			
	Mr C Duncan	Director of Surgery	(ChrD)
	Mrs A Marsland	Non-Executive Director	(AM)
	Mrs C McLaughlin	Divisional Director of Community Services	(CMc)

Patient Story
Unfortunately, due to illness today's patient story was not available; it was therefore agreed this item would be deferred until the next meeting on 7th November 2017.

17/18/133 Declarations of Interest
None declared.

17/18/134 Minutes of the previous meetings held on 5th September 2017
Resolved:
The Board received and approved the minutes from the meeting held on 5th September 2017.

17/18/135 Matters Arising and Action Log

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

17/18/136 Key Issues/Reflections

Liverpool Community Health Services

Following the submission of a bid to NHS Improvement for Liverpool Community Health (LCH) Services, Mersey Care NHS Foundation Trust had been announced as the preferred acquirer. In the next few weeks information will be provided to Mersey Care to ensure a smooth handover by 31st October. The Chairman thanked the Board for its support over the last five months of the management contract and the work undertaken by the Executive Team to produce an excellent bid.

The Chairman suggested that the Board now takes the opportunity to review progress against the strategy set earlier in the year with the Divisions and receive an update at the November Board meeting.

17/18/137 External Environment

Liverpool Women's NHS Foundation Trust

The North West Clinical Senate's independent review had been completed and supported the Liverpool Women's preferred option to rebuild the hospital on the Royal Liverpool site. This was now the only option in the public consultation that had been announced.

Neonatal Network

Regular meetings are being held between Alder Hey and the Liverpool Women's to develop a single site Neonatal service.

Heart Congenital

The NHS England Board meeting has been deferred to 30th November 2017.

As these services are no longer available in Manchester patients are being transferred to London, Birmingham or Alder Hey. It has been agreed for patients to be seen at the Trust up to the age of 25 however no patients over the age of 18 have been transferred to date.

17/18/138 Serious Incidents Report

Hilda Gwilliams presented the report for August 2017. There had been no new SIRIs reported, eight ongoing and two closed. The eight ongoing incidents are all in progress within the timescales set.

Resolved:

The Board received the Serious Incident Report for August noting:

- No new SIRI, eight ongoing and two closed. There had been no new, ongoing or closed safeguarding incidents reported.

17/18/139 Clinical Quality Assurance Committee: Chair's Update

CQAC Minutes 19th July 2017

Resolved:

The Board received and noted the approved minutes from the CQAC meeting held on 19th July 2017. A detailed report on sepsis had been presented at the

meeting, which had provided an improved level of assurance that the processes for the early detection and monitoring of sepsis.

17/18/140 Learning from Deaths National Guidance and Trust policy

National Guidance on Learning from Deaths had been published earlier in the year requesting Trust policies are reviewed and published by 30th September 2017. This had been completed and the revised policy, which had been approved by CQAC was included with the Board papers.

The Board thanked Julie Grice and Sarah Stephenson for their work on the detailed policy. A query was raised regarding support for staff when a patient dies. Steve Ryan responded advising that support for staff is provided for in a separate policy and agreed that a reference to this policy would be included in the Learning from Deaths policy.

Resolved:
The Board received the Learning from Deaths National Guidance and Trust's revised policy.

17/18/141 Alder Hey in the Park

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

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

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

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

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

Park
A review is currently place to agree on the extension.

Community/CAMHS Estate Strategy
The team is currently exploring a financial analysis of proposed development and location options.

Car Park
Due to the current demand on the multi-storey car park David Powell and Hilda Gwilliams were asked to provide a report at the next Board meeting on further options.
Action: DP&HG

Resolved:

Board received an update on the current position.

17/18/142 NHS England Preparedness Resilience and Response

Resolved:

In line with the Emergency Preparedness Resilience and Response (EPRR) Core Standards, the Board received:

- The annual self-assessment of the core standards
- Work plan for the year ahead, based on any gaps in assurance
- A statement of compliance ratified by the Trust Board
- An update on the findings from the self-assessment/key lines of enquiry to NHS England during their visit to the Trust on Friday 27th October 2017.

17/18/143 People Strategy update

Melissa Swindell presented the August report.

In 2016/17, 60 BTEC Health and Social Care students from local schools have completed a two week placement programme at Alder Hey. Yesterday an induction was held for 65 students who will commence their placement in October. The programme is very successful, with a number of students securing a place at Edge Hill or John Moores universities to study for degrees in Children's Nursing/Learning Disabilities/Child Studies/Child Health and Wellbeing/Social Work. The universities guarantee the students an interview if they have completed a placement at Alder Hey as they see this as valuable experience.

PDR Compliance has increased to 84%.

Resolved:

The Board received the People Strategy report for August 2017.

17/18/144 Freedom to speak up survey 2017

The Board received the National Guardian Freedom to Speak up Survey. Kerry Turner went through the recommendations within the report and described the Trust's position against each to date. The Board received assurance that Alder Hey's approach had meant good progress in the majority of areas.

The recommendations covered:

- Appointment
- Potential conflicts of interest
- Local networks
- Diversity
- Communication and training
- Partnership
- Access to Senior Leadership
- Board Reporting
- Feedback
- Time for guardian/ambassador/champion to carry out their role.

Resolved:

The Board agreed to receive quarterly case updates. The process had been launched in March 2017, however it was agreed further communications would be circulated.
Action: KT

17/18/145 Listening into Action (LiA)

Kerry Turner updated the Board on progress to date, noting:

- The third team had now been established
- A big conversation to learn from previous teams had been arranged to take place this afternoon.
- Contact with the Children's Forum was to take place so they could also be involved.

Resolved:
The Board received an update on Listening into Action.

17/18/146 Winter Plan

Mags Barnaby reported on a national 'A&E preparations for winter' session hosted by the Secretary of State for Health.

The Board received the winter plans from 1st October 2017 – 31st April 2018. Seven weeks had been identified with occupancy predicated to exceed 93%. Plans for the three divisions Surgery, Medicine and Community on red and amber weeks had been included in the presentation. If the red action plans are sustainable it was agreed this would be implemented for the whole winter period.

Following a flu outbreak in Australasia it was predicted there would 170 further admissions relating to flu symptoms than last year. The Flu vaccination admission age has been lowered to the age of 8 to reduce the risk of infection.

Resolved:
The Board received the winter plans for 2017/18.

17/18/147 Programme Assurance Update

Resolved:
A formal half year review of progress against the change programme objectives is to take place and will be presented at the November Board meeting.

17//18/148Corporate Report

The Board received the report for August 2017.

Financial, Growth & Mandatory Framework

John Grinnell presented the financial risks for Month 5 and actions to be taken.
Performance Year to Date is "on plan", however:

- £4.5m deficit after 5 months, and
- Significant Risk in the second half of the year:
  a) CIP Back phased
  b) Divisional forecasts show £6.4m gap

Since these risks had been reported at the RABD meeting on 28th September progress had been against reducing the deficit. Risks will continue to monitored through weekly executive and monthly RABD meetings.

Performance
The Trust is compliant with all NHSI standards.

A discussion was held on reviewing the booking and scheduling processes to reduce the numbers of 'Did Not Attend' appointments. An update would be received at the November Board meeting.
Action: MB

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

Patient Experiences
There were five formal complaints in month, i.e. 27 year to date - very similar to last year's position. PALS contacts have reduced, with only 72 in August. The overall trend is lower than last year, reflecting an improvement in addressing concerns locally immediately and avoiding the need to refer to PALS.

'Patients knowing their Estimated Date of Discharge (EDD)' has reduced from 64% to 53.9%, as has 'patients involved in play and learning', down from 74% to 65.7% in month. All other inpatient survey results have also deteriorated, and Friends and Family responses from A&E and Community still need to be improved.

Clinical Effectiveness
There were five recorded hospital infections in August, resulting in 20 infections year to date compared with 41 at this time last year. MRSA and Clostridium difficile infections remain at zero year to date. There were 7 in month acute readmissions of patients with long term conditions within 48 hours of discharge, a slight increase on the previous month. For surgical patients with an (EDD), 3.9% were actually discharged later than the EDD. This is an improvement against 5.4% last year and equates to 66 patients.
Resolved:
The Board received the Corporate Report for Month 5.

17/18/149 Board Assurance Framework
Resolved:
The Board received the content of the BAF.

Steve Igoe and Erica Saunders reported on the Integrated Governance Committee held last week, noting the more detailed discussions on the higher risks following a review of risks led by the Associate Director of Nursing and Governance, Cathy Umbers.

17/18/150 Resource and Business Development Committee
Resolved:

The Board received the approved minutes from the meeting held on 1st August 2017.

17/18/151 International Child Health

Resolved:

Professor Barry Pizer and Sian Falder gave a presentation on the vision and case for a Department of International Child Health. The Board supported the vision and agreed for a strategy to be developed and presented at the January Board.

17/18/152 Global Digital Exemplar

The Alder Hey *Fast Follower* Trust, Clatterbridge Cancer Centre, had completed the first part of their 'due diligence'. Louise Shepherd asked Mark Flannagan to contact and support the communications team at Clatterbridge.

17/18/153 Any Other Business

No other business was reported.

Date and Time of next meeting: Tuesday 7th November 2017, at 1:30pm, Large Meeting Room, Institute in the park.

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Tuesday 7th November 2017

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

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1. Background:

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

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

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

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

2. SIRI performance data:

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

3. Recommendations:

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

New SIRI Incidents reported between the period 01/09/2017 to 30/09/2017:								
Reference Number	**Date investigation started**	**CBU**	**Incident Description**	**RCA Lead Investigator**	**72 hour review completed/ immediate actions taken and shared learning**	**Progress**	**60 working day compliance**	**Duty of Candour/ Being Open policy implemented**
2017/ 24137	29/09/2017	Medicine	Suboptimal care of deteriorating patient. Query sepsis pathway not followed. Complex patient with co-morbidities, known to Trust, attended for renal dialysis. Patient attended on 18/06/17, query septic during admission, staff recorded not concerned about the risk of sepsis and patient discharged as no clear cause of pyrexia. Patient returned 19/06/17 acutely unwell, patient transferred to PICU and sadly died on the 23/06/17.	Andrew Riordan, Consultant in Paediatric Infectious Diseases, Jeanette White, Matron, Amanda Turton, Head of Acute Care	Yes – Lessons learned include: 1. Sepsis pathway not identified, and therefore not followed. 2. Blood pressure not recorded at time of admission as per PEWS policy. 3. Blood pressure not repeated once found to be low. 4. Peripheral blood cultures could have been taken despite being unable to access haemo catheter, in line with sepsis policy. Immediate actions taken: 1. Appropriate	Information gathered, RCA panel meeting held 18/10/2017. RCA report being written.	Yes	Yes – patient's family informed of investigation by Associate Chief Nurse 04/10/2017. Formal Duty of Candour letter to follow.

					action has been put in place with the clinical member of staff involved in the specialist care of the patient to ensure patient safety and support for the staff member. 2. Senior nursing and medical staff have reiterated to all groups of staff the importance of adhering, rigorously, and consistently to the sepsis triggers and pathway/policy. 3. Staff involved in the incident to have repeated sepsis training. 4. Escalation and reporting processes followed as soon as incident known.			
StEIS 2017/ 23222	19/09/2017	Surgery	Suspension of PDA stent service following near miss but well managed decomposition of	Phil Raymond, Service Manager	Yes – Lessons learned include: 1. Lack of formalised, written pathway of BT shunt.	RCA Level 1 report completed	Yes	No harm is known to have been caused from the suspension

			a PDA stent and following previous incident in which a patient died (latter incident reported to StEIS previously, ref: StEIS 2017/9948).		2. Lack of clarity of training needs of staff over post-operative management of patients. 3. Lack of guidance on when senior cardiology review should be requested/ undertaken. 4. Inconsistent approach to post-operative nursing. 5. Need to limit number of elective PDA stent procedures undertaken on same day. Immediate actions taken: 1. Multi-professional meeting to be held to design and agree pathway. 2. Training to be delivered to relevant staff groups. 3. All patients to return to PICU post-operatively for a minimum of 24 hours. 4. Limit of 1			of the service, Duty of Candour not applicable.

					elective PDA stent to be undertaken per day.			

New Safeguarding investigations reported 01/09/2017 to 30/09/2017: For information							
Reference Number	**Date investigation started**	**CBU**	**Incident Description**	**RCA Lead Investigator**	**Progress**	**60 working day compliance**	**Being Open policy implemented**
Nil							

On-going SIRI incident investigations (including those above)							
Reference Number	**Date investigation started**	**Division**	**Incident Description**	**RCA Lead Investigator**	**Progress**	**60 working day compliance (or within agreed extension)**	**Duty of Candour/ Being Open policy implemented**
StEIS 2017/ 19060	31/07/2017	Surgery	Grade 3 Pressure Ulcer - A 7 year old patient with a head injury sustained in a road traffic accident has a right sided below knee plaster of paris (POP) insitu. The patient has numerous abrasions from the accident including behind the right knee. The patient has now been confirmed as having a Grade 3 pressure ulcer behind the right knee thought to have been caused by friction from the plaster cast.	Kelly Black, Surgical Matron	RCA panel meeting held, report in draft form. Further work required on report following quality check. Returned to author.	Yes	Yes
StEIS 2017/ 18783	26/07/2017	Business Support	Following a Medisec update to facilitate the switch to electronic letters, it was identified that a software bug was introduced that resulted in letters not being sent to two GP practices for a period of 3 months. Any letters associated to patients of these practices were also not sent.	Martin Levine, Head of Clinical Systems	72 hour review completed and updated action plan sent to CCG. Governance and Quality Assurance Team to liaise with CCG following further request for information.	Yes	N/A – No harm known.

			No patient harm identified.				
StEIS 2017/ 14196	02/06/2017	Surgery	An unwell, query septic child was referred to the General Paediatric team for review by the Orthopaedic team. He had undergone bilateral hip surgery 5 days prior. He was referred as he was febrile and tachycardic. He was referred to the paediatric team around 6.30pm on 24/5/2017. Delay in patient being reviewed.	Sarah Wood, Consultant Surgeon Sue Tickle, Clinical Nurse Manager ICU	Quality check completed 25/09/17 and draft RCA report returned to authors to review and revise, as further amendments required.	No	Yes
RCA 333 2016/17 **Internal**	28/03/2017	Medicine	The patient was brought to ED in November 2016 as an emergency with seizures and hypertension. Despite resuscitation and intensive care she died 2 days later. Subsequent post-mortem has revealed previously undiagnosed structural kidney disease which is the likely cause of the malignant hypertension. The child had presented to ED in June 2013 and October 2015 with a diagnosis of Bell's Palsy. Blood pressure	Amanda Turton, ED Manager	Draft report written, further amendments identified as required during quality check stage. Returned to report author to complete.	Internal	Being open completed, level of harm unknown.

			should have been recorded on each of these occasions but was not recorded.				
RCA 332 2016/17 **Internal**	28/03/2017	Medicine	During a complaint investigation it became apparent that some elements of the child's inpatient stay had not been managed as robustly as they should have been. During the 4 days of the child's stay there were a number of times where his clinical condition and monitoring of vital signs triggered his PEWS score and required a review by a doctor - all required reviews do not appear to have taken place.	Dianne Topping, Senior Nurse	Draft report written, further amendments identified as required during quality check stage. Returned to report author.	Internal	Being open completed, level of harm unknown.

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

SIRI incidents closed since last report						
Reference Number	Date investigation started	CBU	Incident Description	RCA Lead Investigator	Outcome	Duty of Candour/Being open policy Implemented
StEIS 2017/ 18792	26/07/2017	Medicine	Grade 3 Pressure Ulcer - Patient has nasopharyngeal airway (NPA) inserted into left nostril. Tissue Viability Nurse has reviewed and patient has a significant mucosal pressure ulcer to his left nostril.	Anne Hyson, Head of Quality	Final report sent to CCG and family.	Yes
StEIS 2017/ 17986	17/07/2017	Surgery	Unexpected death of cardiac patient.	Rachael Hanger, Theatre Matron	The baby's death was initially thought to be unexpected, and therefore reported to StEIS. Following review by clinical experts, it became apparent this was not an unexpected death. RCA Level 1 completed and report sent to CCG.	Following review, as patient's death was not unexpected, duty of candour not applicable.
StEIS 2017/9937	12/04/2017	Surgery	Sudden unexpected death – patient had adenotonsillectomy with subsequent deterioration, admitted to HDU, subsequent cardiac arrest and sadly died.	Christine Murray – HDU Sister	Final report sent to CCG. Family to be contacted to arrange meeting to discuss report findings.	Yes

Safeguarding investigations closed since last report
Nil

Clinical Quality Assurance Committee
Minutes of the last meeting held on Wednesday 20th September 2017
10.00 am, Large Meeting Room, Institute in the Park

Present:	Anita Marsland	(Chair) Non-Executive Director
	Jeannie France-Hayhurst	Non-Executive Director
	Mags Barnaby	Interim Chief Operating Officer
	Pauline Brown	Director of Nursing
	Erica Saunders	Director of Corporate Affairs
	Glenna Smith	General Manager – Medicine
	Adam Bateman	Acting Chief Operating Officer
	Catherine McLaughlin	Director of Community Services
	Tony Rigby	Deputy Director of Risk & Governance
	Cathy Umbers	Associate Director of Nursing & Governance
	Jo Williams	Non-Executive Director
	Christian Duncan	Director – Surgery
	Anne Hyson	Head of Quality - Medicine
	Sarah Stephenson	Head of Quality - Community

In Attendance

Joe Gibson	Programme Director
Julie Grice	Chair of HMRG
Martin Levine	Head of Clinical Systems IT
Julie Creevy	Executive Assistant (Minutes)

17/18/37 Apologies:

Hilda Gwilliams	Chief Nurse
Steve Ryan	Medical Director
Lachlan Stark	Head of Planning and Performance
Mark Peers	Public Governor
Melissa Swindell	Director of HR
John Grinnell	Director of Finance
Will Weston	Associate Chief of Operations
Julie Williams	Governor

17/18/38 Declaration of Interest
None declared

17/18/39 Minutes of the previous meeting held on 19th July 2017
Resolved:
P Brown apologies were omitted from the notes from 19th July 2017 meeting, with that exception the committee noted and approved the Minutes of the last meeting held on 19th July 2017.

17/18/40 Maters Arising and Action Log

Walkabout process

C Umbers confirmed that the Quality Assurance walkabouts had commenced, with 3 successful visits completed to date. Presentations were based on 5 CQC domains (key lines of enquiry). Teamwork was evident on all 3 visits, with limited areas of concern raised. Further visits are planned during October 2017.

Committee agreed that it would be beneficial to receive a high level quarterly summary report detailing key issues.

Action: ES & CU to meet and agree format of a quarterly report to be presented at CQAC mtgs.

17/18/45 16/17/133 & **16/17/175– Equality Analysis** – In the absence of MS, committee agreed to defer this item to the October meeting.

17/18/16 – Quality Impact Assessment – In the absence of MS, committee agreed to defer this item to the October meeting.

17/11/16 – **Bespoke quality metrics dashboard -** in the absence of LS the committee agreed to defer this item to the October meeting.

17/18/41 Complaints/PALS report

A Hyson presented the Complaints & Annual Report which had previously been discussed at CQSG in July 2017. Discussion took place regarding the grading of complaints, (medium/high etc), and whether consideration could be given to agreeing to describing the grading in a different way.

Resolved: CQAC NOTED, endorsed and supported the Complaints & Annual Report.

AM thanked AH for her update.

Complaints & Concerns Policy

A Hyson & S Stephenson presented the Complaints & Concerns policy which had been discussed at CQSG. CQAC NOTED that a complaint review by NEDS is scheduled for 18th October and any relevant comments following this review meeting would be incorporated into the policy if required.

CD stated that ownership is required at division level, and queried the benefit of early escalation to the Chief Nurse, CD stated that the Trust's responses are not always particularly helpful. Following discussion it was agreed that a meeting would be arranged to discuss this issue further.

Action: PB/MB/AH/CD/AB to meet to discuss this issue further.

AM would feedback current position to MIAA with regards to the NEDS review meeting on 18th October.

AM thanked SS and AH for the update.

17/18/42 Sepsis Update

D Porter & G Smith presented the Sepsis update.
DP provided update on background, progress and challenges.

Progress to date

- Nursing training – 99% of staff trained
- Sepsis Nurses
  - Delivering training (induction, ad-hoc)
  - Ward & ED liaison
  - Clinical Governance/case review
  - Pathway form completion 14 → 84%
- Medical training
  - Induction
  - ELearning
- Meditech
  - Updates (corrections, improvements)
- CQUIN submission
- GOSH visit

Group noted that the average time to antibiotics:-
ED - May 52.7 Minutes
- June 60 minutes
- July 59 minutes

Risks detailed as follows:-

- Increased assessment, AB initiations
- Workload
- Discrimination will always be imperfect – **reduction** not prevention of harm from sepsis.

Sepsis CQUIN Progress

- The rate of screening for sepsis increased from 52% in Quarter 1 2015/16 to 78% in Quarter 4 2015-16.
- Formal collection of time to first antibiotic began Q3 2015/16 and by end Q4 62% (3,466 of 5,550 patients identified as having met the criteria for 'red flag' sepsis) received antibiotics within one hour of arrival to an NHS trust this compares to a 58% rate reported in Quarter 3.

17/18/43 CQC Action plan

E Saunders presented the CQC Acute Services Action Plan.

CQAC NOTED that item 10 -'Improve staff compliance with mandatory training' is currently at 78%.

Item 21 – 'Overarching Transition Framework agreement across Healthy Liverpool' – The Trust continues to implement the 10 Steps Transition Pathway across the organisation.

Appropriate links with adult specialties are being identified or re-informed including the use of the 10 steps pathway.

CQAC noted contents of the Action plan.

AM thanked ES for her update.

17/18/44 Clinical Audit & Effectiveness Report

S Stephenson presented the Clinical Audit & Effectiveness Report.

Trust Clinical Audit Plan 2016/17

CQAC noted that one national audit was not completed by the deadline date (National Cardiac Arrest Audit), our Trust was given an extension in order to submit the data. The National Cardiac Arrest Audit Team had confirmed that records had been submitted.

Trust Clinical Audit Plan 2017/18

SS stated that slow progress had been made with regards to devolvement of the audit plan to divisions, with Steve Riley (Clinical Auditor) leading on Medical Division audit plan and Mary Biggan (Clinical Auditor) leading on the Surgery Division Audit Plan.

CU queried why no medical lead was included, SS confirmed that Adrian Hughes is involved in the process which required establishing in the first instance.

SS highlighted that additional resources are required, given the high volume of audits for the Trust. SS confirmed that she would liaise with HR to query whether there are any available clinical staff who are not currently undertaking any clinical duties who could assist with undertaking audits.

Action: MB, ES & SS to meet to progress this issue further.

Confidential Enquiries 2017/18

The Cancer in Children, Teens and Young Adults enquiry is still ongoing with continuing requests for data. Julie Marsden is working with the Oncology /Team to progress these requests.

- The 2016 MBRRACE-UK Perinatal Mortality Surveillance cases have all been submitted.

- No other enquires have been relevant to paediatrics in quarter 1 or 2 of 2017/18.

The week planned for the 'National 7 Day Service Survey' is Wednesday

4th October 2017- Tuesday 10th October 2017. This cycle of the survey is concentrating purely on Standard 2 – 'Time to first consultant review'. A meeting had taken place with clinical leads to discuss updating the Post Take Ward Round documentation to enable the survey to be completed effectively and encouraging other teams to adopt the use of the proforma.

AM thanked SS for her update.

17/18/45 Programme Assurance Progress update

JG presented the Programme Assurance Update.

CQAC noted that the latest forecast is savings of £0.40m, which is better than in previous update, but is still very low, and not sufficient to meet the financial objectives of the programme. The only projects currently forecasting savings are Best in Operative Care and Experience in Outpatients.

Action: The Executive sponsor is requested to review the saving potential as a matter of urgency, converting the opportunities into savings and increasing the value of the overall forecast.

Of the projects that have evidence logged on the SharePoint site and are rated:-

- 'Deteroriating Patient' – The Sepsis project documentation on SharePoint is not currently being updated and the milestone plan is over two months out of date. This is a significant issue given the importance of the project. **Resolution is required immediately.**
- 'Outpatients' – is providing a high level of documentary evidence giving a sound assurance rating.
- 'Best in Operative Care' – is also being regularly updated and has a good suite of evidence.

Projects that a red rated, as highlighted at Programme Board/ Trust Board are as follows:-

- Best in Operative Care – not updated since Programme Board/Trust Board and requiring benefits to be defined and a plan – have a draft PID but require evidence.
- 'GP Streaming' – has a PID, more work to do, no risk/no evidence

JG highlighted the importance of uploading supporting documentation promptly onto SharePoint. JG also stated that supporting reports could be emailed to him on 21st September to ensure that they could be promptly uploaded onto SharePoint.

AM expressed disappointment and stated that she would follow up with offline conversation with Exec sponsors.

Action: AM to have offline discussions with Exec sponsors.

JG indicated that J Grinnell & C Liddy would be managing Programme Assurance going forward and CQAC would be informed in due course regarding the framework for reporting.

17/18/45 Corporate Report – Quality Metrics

P Brown presented the Corporate Report – Quality Metrics, key issues as follows:-

Patient Safety

Clinical incident reporting remained high (352 year to date, compared to 188 last year), with an increase in the proportion of incidents resulting in harm (25% compared to 12% last year). There had also been a cumulative rise in incidents associated with moderate or higher harm from 3 last year to 8 this year, and there were 4 Serious Incidents requiring investigation in month, resulting in 10, year to date. Medication errors resulting in harm remain similar to last year, with 13 reported year to date. Pressure ulcers (grade 2 and above) had shown a rise with 8 reported in July (two of these were Grade 3), i.e. 20 year to date, compared to 9 at this point last year. The Trust have a comprehensive action plan, for Tissue Viability/Skin Integrity, a training needs analysis had been established with training being fundamental to provide increased flexibility.

A 'deep dive' review had been commissioned to ascertain whether the increase is due to a change of reporting structure in Ulysses. CU confirmed that her team are organising a meeting to address this issue.

Other increases related to Transfusion, with the majority - 70% relating to Liverpool Women's Hospital (sample issues).

Patient Experience

There were 4 formal complaints in July, this is the lowest in one month since January. PALS attendances were slightly lower than the previous month, but are maintaining an increasing trend since April. Family & Friends responses had improved, except in outpatients where there is a slight reduction in the percentage of families that would recommend Alder Hey. However there is a need to improve the number of responses in A&E and in Community. Inpatient survey metrics had all moved closer to their goal, with the exception of 'patients knowing their planned date of discharge' which had deteriorated slightly.

Clinical Effectiveness

The marked reduction in hospital acquired infections had been maintained this month, with a cumulative 15 HAIs compared with 33 HAIs at this point last year. MRSA and C. difficile remain at zero for the year. Year to date there had been 3.8% (235) of surgical patients discharged later then their plan, compared to 5.4% at this point last year. The number of deaths in

hospital had improved slightly at 23 cumulatively, compared to 27 last year.
Chair thanked PB for her update.

17/18/46 DIPC Report

Jo Keward presented the IPC Quarter 1 Report, key issues as follows:-

- At the end of Quarter 1 (53% 40/76) of the total deliverables of the actions had had been completed.
- 39% (30/76) of the total deliverables were in progress (amber).
- 8% (6/76) were classified as red.
- Progress had been made during Quarter 2 with 54% (41/76) of the total number of deliverables completed.
- 30% (23/76) of the total deliverables in progress (amber).
- 3% (2/76) classified as red which relate to the following:-
  - (IPC post advertised but not filled, PHE had expressed a significant level of concern that the Trust have no DIPC 'expert' in IPC subject matter, CD fully supported PHE views.
  - IPC PA/Admin support (admin hours had been sourced until end of October 2017 to assist with the flu campaign. Discussion ongoing with regards to permanent post.
  - Hand decontamination – (Introduction and dissemination of new hand hygiene posters for all clinical areas) – this had been rolled out to small group and will be rolled out further over the next 6-8 week and during Infection Control week during 16-20th October.
  - Review role and responsibilities of Link Nurses – Included in ADTT training facilitated by Sara Melville, training planned for October
  - Provide key trainer training – Key trainer programme had been developed. ICU key trainer sessions during August 2017, with further dates scheduled for October 2017.
  - Update IPC intranet page – Lead had been established, training had been completed and intranet currently being updated.

- There are 10 deliverables (13% which the Trust is unable to classify until the end of Quarter 2).

CD indicated that the Trust required a detailed plan for winter, MB confirmed that the Winter plan is due to be presented at Operational Delivery Board on 28th September.

CQAC acknowledged the significant decrease in Hospital Acquired infections, and the improved hand hygiene culture. MB confirmed that she would feedback the positive improvements to Operational Delivery Board at the next meeting.

Action: MB to feedback and share significant improvement at Operational Delivery Board on 28th September.

AM thanked JK for her update.

17/18/47 Board Assurance Framework

ES presented the Board Assurance Framework update. ES highlighted issue regarding senior nursing workforce issues which were currently being managed, which had previously resulted in temporary gaps due to long term sickness.

The senior nurse structure, together with the matron's structure had also been finalised.

Majority of targets had been met during August, with an increase of 333 electives during July, cancelled operations were slightly higher, and activity slightly lower, with August showing an improvement.

ES requested that if any information had not been captured to please let her know.

AM acknowledged the significant work with regards to the BAF and thanked ES for her update.

17/18/48 Self-Assessment against the Quality Governance Framework

ES presented the Self Assessment August position.

ES advised that the Board of Directors had commissioned a Well Led Review which would be undertaken by Mersey Internal Audit Agency. Terms of Reference had been drafted, however ES is currently awaiting feedback following the results of the preferred bidder for the acquisition of Liverpool Community Health. ES would progress. ToR would be shared once results of preferred bidder is known. ES would provide an update at October Trust Board.

AM thanked ES for her update.

17/18/49 Hospital Mortality Policy

Julie Grice, Chair of HMRG Lead & Sarah Stephenson, Head of Quality presented the Hospital Mortality Policy. CQAC noted progress to date. CQAC agreed that the tone and information within the policy was extremely clear, concise and easy to read.

Resolved: CQAC Ratified policy, prior to policy being published on 30th October 2017.

17/18/50 Clinical Quality Steering Group – Key Issues Report/Notes of CQSG meeting held on 8th August 2017

CU presented the Clinical Quality Steering Group key issues report:-
Quarterly Key Issues Report from Weekly meeting of harm:

Incident Severity
There had been 4 serious incidents reported in Quarter 1. Duty of Candour were completed for all 4 incidents, 7 incidents of moderate harm in Quarter 1. 1 incident was a never event (wrong site surgery). A level 2 RCA is ongoing.

Key achievements as follows:-

- Introduction of the weekly meeting of harm action log which is monitored to ensure actions from incidents; lessons are learned and minimise the risk of recurrence.
- The Trust had maintained its position as 3rd nationally in the recent NRLS data published in March 2017.
- The 72 hour review proforma was embedded into Ulysses in this quarter and is undertaken for all incidents of severe harm or death. Compliance with 72 hours reviews continues to be monitored via the governance and quality Assurance Team and any non-compliance escalated.

CQAC received and noted the CQSG summary report and notes from previous meeting held on 8th August 2017.

Chair thanked CU for her update.

17/18/51 Any Other Business
Recruitment – the Committee discussed the impact on nurse recruitment.

17/18/52 Date and Time of Next meeting
10.00 am – Wednesday 18th October 2017, Large meeting room, Institute in the Park

ALDER HEY IN THE PARK PROJECT

HIGHLIGHT REPORT **Site & Park Development**	**Date: 31/10/17**	**Period: October 2017**	**SRO: David Powell** **Author: Sue Brown**
	Report Number:	**11**	
Programme 2017/18	**Apr-17** | **May-17** | **Jun-17** | **Jul-17** | **Aug-17** | **Sep-17** | **Oct-17** | **Nov-17**		
Week Commencing	3 | 10 | 17 | 24 | 1 | 8 | 15 | 22 | 29 | 5 | 12 | 19 | 26 | 3 | 10 | 17 | 24 | 31 | 7 | 14 | 21 | 28 | 4 | 11 | 18 | 25 | 2 | 9 | 16 | 23 | 30 | 6 | 13 | 20 | 27		
Decommissioning & Demolition (Phase 1 & 2)			Programme progressing on track and advance to demolish to M/N block now agreed as part of phase one. No issues with dust have arisen, monitoring continues as per plan. The management plan is in place covering both : 1. demolition of retained estate; 2. R&E II construction, levels have remained safe to date. Removal of top ashphalt layer in main car park has been completed.
Residential			Community Engagment continues to progress in relation to the scale of the scheme. once resolved the appointment of the prefferred bidder (Elect) will follow. Bidder working with LCC planners to ensure all consultation material is acceptable within the rules of the planning process to ensure that the final scheme has a high level of acceptance to all parties.Preffered bidder (elect) has submitted a planning pre-application. The Trust placed the consultation process on hold until the Liverpool Community Health Bid process was concluded. Consultation still on hold awaiting further discussion with Mayor Anderson and LCC planners. Alternative development land options being considered and tested as an alternative if the scheme cannot progress as expected.
Research & Education Phase II			Research and Education phase II build remains on track, contract with Morgan Sindell still awaiting final agreement. University partners yet to sign sign off financial agreements. Although this was expected at the end of August or beginning of September, it still remains outstanding to date although all details are agreed in prinicipal.
Alder Centre			On Track. Dicussions and regular meetings in process and progressing with the Appointed Architect and users to refine the design.Initial planning meeting taken place between Architects and LCC to submit planning from towards end of November.
Park			Round 2 of Forest School underway. Nursery, primary and junior ages reached so far. Funding on rolling annual basis secured through partnership with Lancs Wildlife Trust. Proposals underway to run pilots with CAHMS to support treatment for young people with mental health issues.Springfield Park has been chosen as 1 of 10 sites across the UK for a 'Tree Charter Marker' sculpture. The sculptures will serve as a national monument to mark the launch of the Woodland Trust's Charter during National Tree Week end November. The 15ft sculpture, made of UK-sourced oak from the Crown Estate will bear commissioned words by poet Harriet Fraser representing the importance of trees and woods to health & wellbeing. It will highlight the work Alder Hey is doing to promote health and wellbeing through connection with the natural environment. To celebrate, we're launching a poetry competition inviting patients/ members of the public to submit poems.
International Design & Build Consultancy			Contract prepared and exchanged with XI'AN, contract documents and drawings being translated via china centre prior to commencment of the design review which is now likely to start in February 2018 due to delays in XI'AN. Jersey design review is ongoing with weekly visits to Jersey by team members gathering data from clinical design workshops. This design review and development work looks very likely to extend beyond November and additional income should be achieved. Sharepoint documentation still to be fully developed.
Community Cluster Building			RIBA design competition launched for Community Cluster Building including , Neurological Assessment, Community Paeds, Psychology, orthotics and Police station in phase one. There is also the option for phase two which could include the Dewi Jones re location from Alder Park and a new and separatley funded Sandfield Park School. There will be potential in the future for addition of a small rehabilitation unit if the Trust wishes to pursue the option.SQQ returned by November 2nd and final ITPN document required to be issued to successful bidders by 27th November. all potential changes to the contents of the buildling must therefore be decided by 20th November. Sharepoint documentation still to be fully developed.
Estates Strategy/Corporate Offices			Currently exploring and conducting a financial analysis of proposed developments and locations for Community services where current premisies have recieved notification of end of tenancy.Also financial analaysis of options for relocation to off site premises for CAMHS and Coroprate services. Sharepoint documentation still to be fully developed

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ALDER HEY CHILDREN'S NHS FOUNDATION TRUST CQC ACTION PLAN

Key	
B	Completed
G	In progress and on track to be completed by target date
A	Risk of non-completion by target date
R	Overdue

No.	Must / should do	Dept	CQC action	Alder Hey action	Director	Lead	Progress	BRAG	Target completion date	Monitoring Committee	Required outcome / output
1	Must	Trust	Must ensure that all serious incidents are reported in line with the trust policy and initial investigations are carried out in a timely way so that any immediate actions to mitigate risk are identified	1.1 Review and revision of Trust incident management framework including serious incidents	Hilda Gwilliams Chief Nurse	Cathy Umbers Associate Director of Nursing and Governance		In progress	20th December 2017	Clinical Quality Assurance Committee	Robust systems and processes in place for reporting and managing investigations. All serious incidents reported and investigated have clear action plans to address lessons learnt. Assurance evidence (Agendas, minutes, reports) via governance systems available for scrutiny. Learning from incidents with reduced number of serious incidents.
				1.2 Align the Trust mortality and morbidity review process with incident management process					20th December 2017		
				1.3 Relaunch of the Trust Incident management including serious incident framework via intranet, team brief, governance processes 'Board to Ward'					10th February 2018		
				1.4 Review and update of the Ulysses incident management module in the Trust Electronic Risk Managed system					20th December 2017		
				1.5 Develop and implement step by step guides to support staff understanding of mandatory requirements in terms of process including timeliness of actions					20th December 2017		
				1.6 Relaunch the incident reporting section of the Ulysses incident management module following completion of the review and update, and development of step by step guides					28th February 2018		
				1.7 Incident management including serious incidents will be standing item at all Governance meetings from Board to ward. Assurance reports will be provided including timeliness of reporting and process management of serious incident investigations, lessons learned and progress with actions					28th February 2018		

ALDER HEY CHILDREN'S NHS FOUNDATION TRUST CQC ACTION PLAN

				1.8 Development of regular lessons learned and actions taken newsletter to be published widely across Trust including Trust intranet					28th February 2018		
2	Must	Trust	Must take action to ensure all children and young people receive treatment in relation to sepsis within appropriate timeframes. Have a process to monitor adherence to policy for patient's treated for sepsis	2.1 Provide training to new clinical staff on induction in the NICE sepsis pathway and staff responsibilities for assessing, investigating and responding promptly to patients suspected of having sepsis	Steve Ryan Medical Director	David Porter Clinical Lead	**Update 24th October 2017:** Introduction of a Sepsis Team from July 2017. 99% training for front line nursing staff achieved. All doctor and nurse induction programmes include sepsis training. E-Learning package in development Trust committed to maintaining dedicated staff within the sepsis team to deliver education and training on sepsis management, monitor performance and drive improvement	In progress	**Complete:** 31st October 2017 and ongoing	Sepsis Steering Group Clinical Quality Assurance Committee	Children and young people will receive treatment in relation to sepsis within appropriate timeframes (60 mins for high risk / red flag sepsis; 180 mins for moderate risk) 90% compliance with staff training in line with Trust Sepsis policy
				2.2 Continuous monitoring and audit of sepsis management in Emergency Department and inpatient wards with associated monthly reports			**Update 24th October 2017:** Introduction of a case review process by the Sepsis Team.		31st November 2017		
				2.3 Review all cases of sepsis where antibiotics were given outside NICE recommended timeframes (60 mins for high risk / red flag sepsis, 180 mins for moderate risk) to identify factors leading to the delay			**Update 24th October 2017:** Introduction of a case review process by the Sepsis Team.		31st November 2017		

ALDER HEY CHILDREN'S NHS FOUNDATION TRUST CQC ACTION PLAN

				2.4 Report and disseminate all trends / themes / barriers surrounding delays in antibiotic administration to Sepsis Steering Group, CQAC and Best in Acute Care to maintain hospital oversight and inform changes in practice and policy.			**Update 24th October 2017:** Sepsis Steering Group commenced in February 2017 Regular reporting to CQAC began in April 2017 Best in Acute Care programme began in July 2017		**Complete:** 31st July 2017 and ongoing	
				2.5 Disseminate audit results to staff through Divisional leadership, risk and governance communication structure and by regular hospital Grand Round sessions						
				2.6 Submit progress and CQUIN update to CCG			**Update 24th October 2017:** Submission to CQC commenced in May 2017 First submission of CQUIN in August 2017 for Quarter 1.		**Complete:** 31st August 2017 and ongoing	
				2.7 Submit monthly report to CQC			**Update 24th October 2017:** Submissions to CQC started in May, and first submission of CQUIN in August 17 for Q1.		**Complete:** 31st August 2017 and ongoing	
3	Must	Trust	Must ensure that robust arrangements are in place to govern the fit and proper person's process	3.1 Incorporate the fit and proper persons process into the Trust Recruitment and Selection Policy	Melissa Swindell Director of Human Resources and OD	Sharon Owen Head of Human Resources	**Update 24th October 2017:** The Trust has fully incorporated the fit and proper persons process into the Trust Recruitment and Selection Policy, which was ratified on 21st June 2017	Complete	**Complete:** 21st June 2017	Workforce and Organisational Development Committee (WOD)	All relevant posts to be fully checked in accordance with the fit and proper persons requirements.
				3.2 Devise and implement a standard operating process (SOP) to provide full clarity of the process and responsibilities			**Update 24th October 2017:** SOP has been implemented		**Complete:** 21st June 2017	
4	Must	Trust	Must take action to ensure all staff who are involved with assessing, planning, and evaluating care for children and young people are trained to safeguarding level three in line with the safeguarding children and young people: roles and competencies for health care staff Intercollegiate	4.1 Cleanse ESR system to ensure all roles are aligned to correct safeguarding mandatory training competencies	Hilda Gwilliams Chief Nurse	Julie Knowles Assistant Director of Safeguarding	**Update 24th October 2017:** Cleanse of competencies against positions in ESR has already been completed and has seen a significant increase in the figures reported. The Trust has sourced systems expertise to ensure ESR is set up to accurately report against the Trust requirements	In progress	**Complete:** 31st August 2017	Workforce and Organisational Development Committee	90% compliance in Level 3 safeguarding training

ALDER HEY CHILDREN'S NHS FOUNDATION TRUST CQC ACTION PLAN

			Document (2014)	4.2 Monitor compliance with Level 3 safeguarding training across the Trust, within Divisions, and within specific departments			**Update 24th October 2017:** A full suite of detailed mandatory training reports have been compiled and disseminated to departmental and senior managers				
				4.3 Produce and share regular detailed mandatory training reports at divisional and departmental level, reported by staff group, which show compliance with Level 3 safeguarding training down to individual staff member level			**Update 24th October 2017:** A full suite of detailed mandatory training reports have been compiled		31st January 2018		
				4.4 Dedicate additional resource from within the Safeguarding Team to lead on training			**Update 24th October 2017:** Senior lead for safeguarding training appointed		**Complete:** 31st August 2017		
				4.5 Provide designated and targeted support to those areas of low compliance and work with managers to establish action plans to achieve a minimum of 90% compliance			**Update 24th October 2017:** Senior lead for safeguarding training appointed		31st March 2018		
				4.6 Report performance monthly at community and statutory services business meetings					**Complete:** 27th October 2017 and ongoing		
				4.7 Improve access to the ESR training database to improve accuracy and responsiveness to training			**Update 24th October 2017:** Senior lead for safeguarding to have access		31st March 2017		
5	Must	Trust	Must ensure that there is a member of staff trained in advanced paediatric life support available in every department at all times as outlined in the Royal College of Nursing guidelines	5.1 Perform Trust wide resuscitation Training Needs Analysis against national guidance	Hilda Gwilliams Chief Nurse	Rob Griffiths Theatre Manager / Phil O'Connor Deputy Director of Nursing	**Update 23rd October 2017:** Complete	In progress	**Complete:** 30th September 2017	Resuscitation Committee Clinical Quality Steering Group Clinical Quality Assurance Committee	80% compliance against Trusts Resuscitation Policy
				5.2 Recruit additional resuscitation training officers as required			**Update 23rd October 2017:** Recruitment complete, awaiting start dates		31st December 2017		
				5.3 Update Resuscitation policy			**Update 23rd October 2017:** Commenced		31st December 2017		

ALDER HEY CHILDREN'S NHS FOUNDATION TRUST CQC ACTION PLAN

				5.4 Develop phased roll out plan to maintain compliance against RCN standard based on service need			**Update 23rd October 2017:** Commenced		30th November 2017		
				5.5 Review compliance monthly at Resuscitation committee and Clinical Quality Steering Group			**Update 23rd October 2017:** From November 2017		30th November 2017		
				5.6 Deliver 80% compliance to ensure APLS trained member of staff on each identified area per shift in line with service need			**Update 23rd October 2017:** From January 2018		31st January 2018 – 31st March 2019		
				5.7 Audit quarterly compliance against Resuscitation policy and phased roll out			**Update 23rd October 2017:** From January 2018		31st January 2018		
6	Must	Trust	Must ensure that compliance with mandatory training is improved, particularly for medical staff.	6.1 Cleanse ESR system to ensure all roles are aligned to correct mandatory training competencies	Melissa Swindell Director of Human Resources and OD	Sharon Owen Head of Human Resources	**Update 24th October 2017:** Cleanse of competencies against positions in ESR has already been completed and has seen a significant increase in the figures reported. The Trust has sourced systems expertise to ensure ESR is set up to accurately report against the Trust requirements	In Progress	**Complete:** 31st August 2017	Workforce and Organisational Development Committee	90% compliance in mandatory training
				6.2 Produce and share regular detailed mandatory training reports at divisional and departmental level, reported by staff group which shows compliance down to individual staff member level			**Update 24th October 2017:** A full suite of detailed mandatory training reports have been compiled with targeted areas of low compliance being addressed		31st January 2018		
				6.3 Provide designated and targeted support to those areas of low compliance and work with managers to establish action plans to achieve a minimum of 90% compliance			**Update 24th October 2017:** L&D Officer has been meeting managers in areas where there is low compliance to establish a clear action plan that significantly increases compliance by end of January 2017		31st January 2018		
				6.4 Scope development of further e-learning packages and the roll out of the ESR portal to provide staff with further means of accessing training			**Update 24th October 2017:** E-learning packages have been made available for most of the core mandatory training subjects with a plan in place to roll out for all mandatory training subjects.		31st January 2018		

ALDER HEY CHILDREN'S NHS FOUNDATION TRUST CQC ACTION PLAN

				6.5 Provide monthly Trust wide communication on mandatory training compliance			**Update 24th October 2017:** Communications has commenced and been issued trust wide on the importance of ensuring compliance with mandatory training and this will continue on a monthly basis.	In progress	31st March 2018		
				6.6 Review and update training needs analysis in mandatory training policy					31st December 2017		
7	Must	Trust	Must ensure that formal risk assessments are undertaken in all departments and all identified risks are captured on the risk register where needed	7.1 Undertake formal risk assessment on all wards assessing the level of risk posed by resuscitation equipment being in different areas within the ward	Melissa Swindell Director of Human Resources and OD	Rob Griffiths Theatre Manager / Phil O'Connor Deputy Director of Nursing	**Update 30th October 2017:** Risk assessment complete as new standardised trolleys implemented Trust wide as per action 11.1	In progress	**Closed:** 29th October 2017	Integrated Governance Committee Health and Safety Committee	Formal risk assessments will be undertaken in all departments with all identified risks captured on the risk register Risk Assessments and Risk Registers will be up to date with appropriate review dates and evidence that actions identified to mitigate risk are in place in the Medical and Surgical Divisions
				7.2 Undertake formal risk assessment on all wards assessing the risk of children absconding or being abducted		Greg Murphy LSMS	**Update 23rd October 2017:** As per action 12.4		31st March 2018		
				7.3 Develop a Trust wide plan to support staff to undertake formal risk assessments in all departments in line with the Trust Risk Management Strategy and Risk Assessment policy for: • Environment • COSHH • Display Screen Equipment (DSE)		Amanda Kinsella Health and Safety Manager			31st January 2018		
				7.4 Health and Safety team to upload generic Risk Assessments onto the Risk Register to prevent duplication of risk assessments and associated risks		Amanda Kinsella Health and Safety Manager	**Update 27th October 2017:** Health and Safety team will also review any risks the Divisions cannot manage or control at local level		30th November 2017		

ALDER HEY CHILDREN'S NHS FOUNDATION TRUST CQC ACTION PLAN

				7.5 Provide Divisions with generic templates for environmental and DSE risk assessments with best practice examples of how to complete		Amanda Kinsella Health and Safety Manager	**Update 27th October 2017:** Templates and examples to be circulated to Divisions and uploaded onto the Health and Safety intranet page A newsletter communication will be circulated to inform staff of the above resources		31st March 2018 and ongoing		
				7.6 Identify staff who have had the required training and experience to undertake lead roles in Divisions for corporate Health and Safety functions and subject specific risk assessments		Amanda Kinsella Health and Safety Manager			30th November 2017		
				7.7 In collaboration with Health and Safety team, ensure appropriate staff are trained and supported to undertake / be involved in undertaking risk assessments for environmental and DSE in line with the Trust Risk Management strategy		Amanda Kinsella Health and Safety Manager	**Update 27th October 2017:** Health and Safety team to conduct workshops to assist Division in completing Risk Assessments		31st March 2018		
				7.8 In collaboration with Health and Safety team, ensure appropriate staff are trained and supported to undertake / be involved in undertaking stress risk assessments for staff as required		Amanda Kinsella Health and Safety Manager	**Update 27th October 2017:** Health and Safety team to conduct workshops to assist Division in completing Risk Assessments		31st March 2018		
				7.9 Widely disseminate Health and Safety training schedule		Amanda Kinsella Health and Safety Manager			30th November 2017		
8	Must	Community CAMHS	Must ensure that lone working practices are implemented, to ensure the safety of staff and others.	8.1 Each member of CAMHS staff to receive a copy of the Trust policy and CAMHS guideline and sign to they have read and understood the documents	Andrew Williams Director of CAMHS	Kate Brizell General Manager CAMHS	**Update 26th October 2017:** Completed for Liverpool Request sent out in Sefton. Possibility of some minor edits required to the CAMHS guideline. Task and Finish group being set up in Sefton CAMHS	In progress	**Complete:** 30th September 2017 31st November 2017	CAMHS Clinical Governance Integrated Governance Committee	Safe and robust lone working practices are implemented and sustained
				8.2 Disseminate process for use of Trust mobile phones to all CAMHS staff			**Update 26th October 2017:** Completed for Liverpool. Request sent out in Sefton.		**Complete:** 30th September 2017		

ALDER HEY CHILDREN'S NHS FOUNDATION TRUST CQC ACTION PLAN

							Possibility of some minor edits required to the CAMHS guideline. Task and Finish group being set up in Sefton CAMHS.	In progress	31st November 2017		
				8.3 Provide a briefing to all staff on the use of Personal Alarm Devices (PAD)			**Update 26th October 2017:** Completed for Liverpool. Clarion coming out to Sefton CAMHS regarding order for devices		**Complete:** 30th September 2017 31st November 2017		
				8.4 Test the PADs			**Update 26th October 2017:** Process established for weekly testing Process to be agreed when devices in place Devices on order, awaiting delivery		**Complete:** 30th September 2017 31st December 2017		
				8.5 Set up lone worker face to face training sessions with the Trust's LSMS to train on the policy and guidance			**Update 26th October 2017:** Dates set for 8th November 2017 (Sefton) and 14th November 2017 (Liverpool)		15th November 2017		
				8.6 Agree process for how lone working process is to be implemented for new starters on induction			**Update 26th October 2017:** To be integrated into the induction programme / induction checklist		30th November 2017		
				8.7 Audit of lone worker process			**Update 26th October 2017:** On audit plan. Data collection tool being developed		31st January 2018		
9	Must	Community CAMHS	Must ensure that the confidentiality of patient information is maintained, and that patient records are only accessible to authorised staff.	9.1 Provide keys to ensure and enable all offices can be locked if no one is in the office	Andrew Williams Director of CAMHS	Kate Brizell General Manager CAMHS	**Update 26th October 2017:** Keys issued	In progress	**Complete:** 30th September 2017	CAMHS Clinical Governance Information Governance Committee Integrated Governance Committee	Patient confidentiality will be maintained with records only accessible to authorised staff
				9.2 Implement the 'Clear Desk' policy			**Update 26th October 2017:** Communication sent to all CAMHS Sefton staff about the Clear Desk policy		**Complete:** 31st August 2017		
				9.3 Provide confidential waste bins on floor 4 and 5 to make it easier for staff to dispose of patient information safely, securely and promptly			**Update 26th October 2017:** Confidential waste bins in place		**Complete:** 31st August 2017		
				9.4 Undertake Information					31st December		

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				Governance spot check audits				2017			
				9.5 Disseminate guidance on clear desk principles / safe haven procedures and secure emails to all staff			**Update 26th October 2017:** Shared at away day (May 17) and via email / business meeting	**Complete:** 31st May 2017			
				9.6 Staff to use booking schedule system to ensure that clinic rooms are used for appointments only and not personal offices in order to support lone worker practices and information governance			**Update 26th October 2017:** Director and General Manager to write a reminder to all staff				

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Medicine and Surgery

No	Must / should do	Dept	CQC action	Alder Hey action	Director	Lead	Progress	BRAG	Target completion date	Monitoring Committee	Required outcome / output
10	Should	Medicine / Surgery	Review the systems in place to enable staff to be clear about their roles and responsibilities during an emergency resuscitation scenario	10.1 Deliver 90% compliance with Resuscitation Training policy	Hilda Gwilliams Chief Nurse	Rob Griffiths Theatre Manager Phil O'Connor Deputy Director of Nursing	**Update 23rd October 2017:** Commenced	In progress	31st March 2019	Resuscitation Committee Clinical Quality Steering Group Clinical Quality Assurance Committee	90% compliance with Trusts resuscitation policy. 90% staff aware of their roles and responsibilities
				10.2 Introduce in-situ emergency simulation training and ensure each ward / department receives this training twice a year			**Update 23rd October 2017:** Partial compliance		30th November 2018		
				10.3 Update Trusts Resuscitation policy and re-issue to all staff			**Update 23rd October 2017:** Commenced		31st December 2017		
				10.4 Audit staffs understanding of their roles and responsibilities during a resuscitation attempt			**Update 23rd October 2017:** From January 2018		28th February 2018		
11	Should	Medicine / Surgery	Ensure that all resuscitation equipment on inpatient wards is checked fully in line with the hospital resuscitation policy	11.1 Roll out of new resuscitation trolleys, defibrillators with associated checklists and trolley checking standard operating procedure	Hilda Gwilliams Chief Nurse	Rob Griffiths Theatre Manager	**Update 23rd October 2017:** Complete 29th October 2017	In progress	**Complete:** 31st October 2017	Resuscitation Committee Clinical Quality Steering Group Clinical Quality Assurance Committee	Resuscitation equipment checked in line with Trusts resuscitation policy
				11.2 Audit compliance against new trolley checking standard operating procedure		Cathy Wardell Associate Chief Nurse Medicine Denise Boyle Associate Chief Nurse Surgery	**Update 23rd October 2017:** Commence 1st November 2017		31st December 2017		
12	Should	Medicine / Surgery	Review the systems in place to mitigate the risk of children and young people absconding or being abducted from the ward areas	12.1 Review child absconsion policy	Hilda Gwilliams Chief Nurse	Pauline Brown Director of Nursing	**Update 23rd October 2017:** Review underway	In progress	31st January 2018	Integrated Governance Committee	Risk of absconsion or abduction mitigated
				12.2 Fit guards to all exit buttons on in-patient wards to make identification of the exit button less obvious		Greg Murphy LSMS	**Update 23rd October 2017:** Complete. Guards fitted to all exit buttons on in-patient wards August 2017. Spot check security audit conducted in September 2017 confirmed all in place		**Complete:** 30th September 2017		

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				12.3 Issue a Trust Risk Alert reminding staff that risk assessments to be undertaken for children and young people considered to be at risk of absconding		Pauline Brown Director of Nursing			30th November 2017		
				12.4 Annual risk assessment of abduction risk to be undertaken on all in-patient wards with Matrons / Ward Managers		Greg Murphy LSMS	**Update 23rd October 2017:** Child abduction policy reviewed and updated on occupying the new hospital building All ward entrance/exits are covered by CCTV		31st March 2017		
13	Should	Medicine / Surgery	Expedite plans and actions to enable all staff to improve compliance with mandatory training to the trust's target of at least 90%	13.1 Disseminate Divisional mandatory training reports and specific communication produced by Learning and Development				In progess			
				13.2 In collaboration with L&D team, devise specific and targeted actions in any areas with compliance less than 90%							
14	Should	Medicine	Have safe storage facilities in place for medical records on all wards to protect children and young people's confidentiality	14.1 Review system in place on Surgical Wards where CQC found that all paper based records were stored securely and were clearly identifiable at every nursing station	Hilda Gwilliams Chief Nurse	Catherine Wardell Associate Chief Nurse		In progress	31st December 2017	Information Governance Committee	Medical records will be safely stored to protect confidentiality
				14.2 Implement same system on Medical Wards to ensure a safe and consistent approach throughout the hospital					31st December 2017	Integrated Governance Committee	
15	Should	Medicine	Have disease specific pathways in place that are based on up to date evidenced based practice and a system for assurance during the period of transition from paper to	15.1 Review and disseminate diabetic pathways	Steve Ryan Medical Director	Adrian Hughes Associate Medical Director Medicine	**Update 27th October 2017:** Diabetic Ketoacidosis (DKA) pathway has been reviewed and changes disseminated All other diabetic pathways are under review and being overseen by the Head of Acute Services	In progress	31st January 2018	Divisional Risk and Governance Committee Clinical Quality Steering Group	Specific disease pathways will be in place Trust will be assured of patient safety during transition from

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			electronic pathways	15.2 Design and develop a website for and with our diabetic patients and their families in order to provide comprehensive and up to date accessible information and education			**Update 27th October 2017:** Website development underway with involvement from a patient and parent		31st December 2018	Clinical Quality Assurance Committee	paper to electronic pathways
				15.3 Implement the Alder Hey Acute Asthma pathway based on the British Thoracic Society guidance issued in September 2016			**Update 27th October 2017:** Alder Hey Asthma pathway in use from November 2016. Input into BTS guidance by Alder Hey consultant. The Alder Hey pathway is being adopted by other centres nationally as best practice		**Complete:** November 2016		
				15.4 Implement the Alder Hey Bronchiolitis pathway developed in conjunction with patients and families			**Update 27th October 2017:** Alder hey Bronchiolitis pathway in use from April 2017. The pathway has a focus on empowering parents to hold and feed babies. When compared with other pathways known to the team the parental empowerment is what makes this pathway unique		**Complete:** 30th April 2017		
16	Should	Medicine / Surgery	Improve staff appraisal rates to reach the at least the trust's target of 90%	16.1 Ensure the process for appraisals (PDR's) is communicated widely across the Trust so that all staff are aware of their role and responsibilities. This includes the process that there is a four month window annually (commencing April) in which to complete the PDR's across the Trust in order to manage the process effectively and ensure all staff have opportunity to reflect how Trust objectives align to their role	Melissa Swindell Director of Human Resources	Will Weston Associate Chief Operating Officer Medical Division Adam Bateman Associate Chief Operating Officer Surgical Division		In progress	30th November 2017	Workforce and Organisational Development Committee Divisional Board	90% compliance with staff appraisal rates
				16.2 Provide training to support managers with the process and to facilitate effective PDR's by reviewing performance for the year, reviewing achievements against agreed developments and planning of personal developments for the forthcoming year			**Update 30th October 2017:** Training in place		**Complete:** 31st October 2017 and ongoing		

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				16.3 Produce and share regular detailed PDR reports at divisional and departmental level					30th November 2017 and ongoing		
				16.4 Review local progress on ESR					30th November 2017 and ongoing		
				16.5 Provide designated and targeted support to those areas of low compliance and work with managers to establish action plans to achieve a minimum of 90% compliance			**Update 30th October 2017:** Local support is provided such as Human Resource Advisors having monthly meetings with Managers		30th November 2017 and ongoing		
				16.6 Annual review of PDR documentation and update as required					31st March 2017		
17	Should	Medicine	Consider training on the Mental Capacity Act for clinical staff being part of the mandatory training	17.1 Review the requirement / content for mandatory training on the Mental Capacity Act with Trust Learning and Development department	Melissa Swindell Director of Human Resources	Catherine Wardell Associate Chief Nurse Medical Division		In progress	31st January 2018	Clinical Quality Steering Group Clinical Quality Assurance Committee	All staff receive appropriate mandatory training
18	Should	Medicine	Ensure visual display screens on the wall behind the desk to the entrance of wards do not compromise patient confidentiality	18.1 Review practice at Information Governance Committee meeting	Hilda Gwilliams Chief Nurse	Catherine Wardell Associate Chief Nurse Medical Division		In progress	31st January 2018	Information Governance Committee Integrated Governance Committee	Relevant information to maintain patient safety and patient flow is available and patient confidentiality is not compromised
				18.2 Benchmark practice with other paediatric hospitals / wards							
				18.3 Scope the impact that turning off the visual display screens in some medical wards has had			**Update 30th October 2017:** The electronic screen information is felt to be integral to the effectiveness of ward Board Rounds including alerting that medication administration is due				
19	Should	Medicine / Surgery	Identify review dates on all risk registers and review monitor that actions identified to mitigate risk are in place in medical services and surgical services	19.1 Review Risk Register at Divisional Board / Risk and Governance meetings or bespoke Divisional Risk Register meeting	Hilda Gwilliams Chief Nurse	Adrian Hughes Associate Medical Director for Medicine Christian Duncan Associate Medical	**Update 30th October 2017:** Divisions to include Risk Register as a standing agenda item at either Divisional Board / Risk and Governance meetings Divisional Board / Risk and Governance Committee Division to monitor all risks, reviewing within the identified timescale and reviewing that actions identified to mitigate risk are in place	In progress	31st December 2018	Integrated Governance Committee	Risk Registers will be up to date with appropriate review dates and evidence that actions identified to mitigate risk are in place in the Medical and Surgical Divisions Focused assurance, that each and every

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				19.2 Risk Managers to be identified on each risk assessment, in addition to Risk Owners		Director for Surgery	**Update 30th October 2017:** All risks currently under review as per action 19.4 and all Risk Managers will be assigned		31st December 2018		risk is being managed effectively, i.e. risks clearly identified from assessment, risk rating reflects assessment of controls, gaps in controls, actions for improvement and progress with actions, review completed in line with timeframes identified on risk assessment, and escalation completed in a timely manner. Corporate risk registers to include all high risks only and linked to corporate objectives
				19.3 Ensure all staff responsible for inputting and managing risks on the Risk Register are trained and aware of their role and responsibilities			**Update 30th October 2017:** Training available within the Trust All staff identified within Division of Medicine have had training in risk management Train the trainer approach to be considered to develop risk management expertise across the Trust, and a systematic cascade of training in each Division		31st March 2018	
				19.4 Set up immediate Task and Finish group for each Division to validate risk registers attended by the senior team for each of the three Divisions			**Update 30th October 2017:** Monthly corporate meetings to support Divisions to review and progress Risk Registers have been commenced Chaired by the Associate Director of Risk and Governance. Meetings will take place for a minimum of six months to ensure significant assurance evident that risk is managed effectively and understood An additional meeting to be set up to support corporate services (for example medicines management, health and safety, infection control, information governance and records management, Governance and quality assurance, IM&T, Business Continuity) in the same way		**Complete:** 20th October 2017 and ongoing	
				19.5 Each Division to present their Risk Registers, focusing on high risks or others that may impact on the achievement of corporate objectives, at all Integrated Governance Committee meetings			**Update 30th October 2017:** Presentation of Divisional Risk Registers at Integrated Governance Committee has commenced Committee reports presented to focus on level of risk associated with the issues being presented, and actions to mitigate to achieve target risk rating. Risks elevated to 15 or above to transfer to executive responsible for associated corporate		31st December 2017	

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							objectives, until mitigated to at least a high moderate (meaning risk score = 12) and then transfer back to original risk owner. Management of the risk locally to remain with the identified risk manager / function where risk originated as identified on the Risk Register	In progress			
20	Should	Medicine / Surgery	Consider implementing a schedule for replacing curtains in the ward areas	20.1 Update the programme for planned curtain replacement, according to risk category	Hilda Gwilliams Chief Nurse	Lesley Cooper Domestic Operations Manager			30th November 2017	Infection Prevention and Control Committee	100% compliance with planned replacement programme
				20.2 Audit compliance with updated replacement programme on a quarterly basis					Quarterly commencing 31st March 2018		
				20.3 In addition to planned replacement, replace curtains as part of an environmental deep clean and on request if visibly not clean			Reminder notice to be sent to all wards and domestic staff		30th November 2017 and ongoing		
21	Should	Surgery	The management team should consider ways in which to improve monitoring of surgical site infections for patients who have undergone non-specialist surgery	21.1 Develop a Business Case to support the delivery of surgical site infection (SSI) data for all specialities within the Surgical Division	Steve Ryan Medical Director	Christian Duncan Associate Medical Director Surgical Division	**Update 26th October 2017:** Complete. Business case approved by Divisional Board and Investment Review Group 27th July 2017	In progress	**Complete:** 27th July 2017	Surgical Division Infection Control Board Infection Prevention and Control Committee	Improved monitoring of SSI in non-specialist surgery with associated opportunity to learn lessons, improve practice and reduce rates of infection
				21.2 Recruit to data analyst role			**Update 26th October 2017:** Recruitment underway		31st December 2017		
				21.3 Develop the required SSI			**Update 26th October 2017:** Pending recruitment of the data analyst		31st January 2018		
				21.4 Commence SSI data collection			**Update 26th October 2017:** Pending recruitment of the data analyst		31st January 2018		
				21.5 Review and disseminate reports of SSI data findings within the Surgical Division and to the Trust through Infection Prevention and Control Committee			**Update 26th October 2017:** Pending recruitment of the data analyst		31st March 2018		

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22	Should	Surgery	The management team should make sure that discarded controlled drugs across all departments are recorded appropriately	22.1 Pharmacy to undertake audit of all wards every 6 months as per Medicines Management Code Section 12	Steve Ryan Medical Director	Catrin Barker Chief Pharmacist	**Update 26th October 2017:** April audit demonstrates the following improvements since the last audit: 1. Recording of wastage at ward / departmental level 57% to 82% since previous audit 2. Documenting of administration/destruction from 72% to 94% since last audit	In progress	31st April 2018	Medicines Management Committee Clinical Quality Steering Group Clinical Quality Assurance Committee	All controlled drugs discarded will be recorded appropriately
				22.2 Share audit results with Ward Manager and Matron to establish local action plan for improvement Ward Manager or Matron to re-audit a month later to ensure actions implemented and compliance improved to acceptable standard					31st April 2018		
				22.3 Liaise with other hospitals to check and benchmark practice for discarding controlled drugs (CD)					31st December 2017		
				22.4 Investigate whether CD books are available that allow for discards to be recorded more clearly					31st December 2017		
				22.5 Provide training to ward staff to ensure they are aware of their role and responsibilities regarding recording discards as per Medicines Management Code Section 12					30th November 2017 and ongoing		
				22.6 Review Medicines Management Code and update as required					31st December 2017		
23	Should	Medicine / Surgery	The management team should consider ways in which to improve the meditech system so that it accurately reflects the time that medicines had been administered, reducing the potential risk of a medication overdose	23.1 Issue a Safety Alert advising users of the correct way to close a MEDITECH session to avoid the system closing before all data has saved	Steve Ryan Medical Director	Cathy Fox Head of Clinical Systems	**Update 25th October 2017:** Action complete. Two Safety Alerts have been sent to all users	In progress	**Complete:** October 2017	Global Digital Exemplar Programme Board Operational Delivery Board	Accurate recording of medication administration to reduce the risk of associated medication errors
				23.2 Complete testing and sign off of Multi User Desktop. Multi User Desktop is enhanced					**Complete:** 4th November		

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				functionality as part of Fast User Switching which allows up to four user accounts to run simultaneously on a computer. This will significantly reduce the risk of a MEDITECH session closing prematurely before data, such as medicines administration, has saved					2017		
				23.3 Commence pilot of Multi User Desktop in Emergency Department and Ward 3A to support use of the ELIS system with appropriate end user support					1st December 2017		
				23.4 Present pilot results and rollout plan to Global Digital Exemplar Programme Board on 12th December 2017. If agreed, commence rollout to all clinical areas with appropriate end user support from January 2018					31st May 2018		
24	Should	Medicine / Surgery	The hospital should find ways in which to make sure that there is always a supernumerary co-ordinator available in all areas, at all times to support staff	24.1 Undertake annual establishment of ward areas based on national standards (Royal College of Nursing / Paediatric Intensive Care Society / British Association of Perinatal Medicine), patient acuity and professional judgement	Hilda Gwilliams Chief Nurse	Pauline Brown Director of Nursing / Divisional Associate Chief Nurses		In progress	28th February 2018	Clinical Quality Assurance Committee	
				24.2 Undertake annual audit of nurse staffing against RCN core standards to identify gaps					28th February 2018		
				24.3 Review nursing model in wards where a supranumery co-ordinator is not currently being allocated					28th February 2018		
				24.4 If a gap in funded establishment is identified which is contributing to no supranumery co-ordinator, escalate to the attention of the Trust Board through bi annual nurse staffing paper					30th March 2018		

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25	Should	Medicine / Surgery	The management team should ensure that all staff receive a full annual appraisal in line with the trust supervision policy	25.1 Ensure the process for appraisals (PDR's) is communicated widely across the Trust so that all staff are aware of their role and responsibilities. This includes the process that there is a four month window annually (commencing April) in which to complete the PDR's across the Trust in order to manage the process effectively and ensure all staff have opportunity to reflect how Trust objectives align to their role	Melissa Swindell Director of Human Resources	Will Weston Associate Chief Operating Officer Medical Division Adam Bateman Associate Chief Operating Officer Surgical Division		In progress	30th November 2017	Workforce and Organisational Development Committee Divisional Board	90% compliance with staff appraisal rates
				25.2 Provide training to support managers with the process and to facilitate effective PDR's by reviewing performance for the year, reviewing achievements against agreed developments and planning of personal developments for the forthcoming year			**Update 30th October 2017:** Training in place		**Complete:** 31st October 2017 and ongoing		
				25.3 Produce and share regular detailed PDR reports at divisional and departmental level					30th November 2017 and ongoing		
				25.4 Review local progress on ESR					30th November 2017 and ongoing		
				25.5 Provide designated and targeted support to those areas of low compliance and work with managers to establish action plans to achieve a minimum of 90% compliance			**Update 30th October 2017:** Local support is provided such as Human Resource Advisors having monthly meetings with Managers		30th November 2017 and ongoing		
				25.6 Annual review of PDR documentation and update as required					31st March 2017		

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26	Should	Surgery	The hospital should consider ways in which to reduce the number of cancelled surgical procedures, and when this does happen to facilitate a further appointment within 28 days of the cancellation	26.1 Undertake capacity and demand modelling for the surgical wards	Mags Barnaby Chief Operating Officer	Adam Bateman Associate Chief Operating Officer Surgical Division	**Update 30th October 2017:** Modelling completed for the winter period. However the 'Best in Operative Care' steering group are progressing an annual plan based on annual bed occupancy This has meant that this winter operationally the Trust has implemented maximum in patient numbers per day, per ward This should see a real reduction in on the day cancellations and will be monitored daily	In progress	**Complete:** 27th October 2017	Operational Delivery Board Forward View meeting	The hospital should consider ways in which to reduce the number of cancelled surgical procedures, and when this does happen to facilitate a further appointment within 28 days of the cancellation
				26.2 Realign the Operating Theatre schedule to balance out the elective patients across the week					30th April 2018			
				26.3 Implement a daily huddle to review the day ahead based on winter pressures and to review any on the day cancellations that day and identify clear actions to ensure that the patient is re-dated within 28 days			**Update 30th October 2017:** Complete, daily huddle implemented from 30th October 2017		**Complete:** 27th October 2017		
				26.4 Introduce an escalation process whereby any patients not given an appropriate date are escalated to a senior manager to resolve with clinical teams			**Update 30th October 2017:** Complete, commenced 30th October in line with the daily huddle		**Complete:** 27th October 2017		
				26.5 Implement a more robust reminder service for patients			**Update 30th October 2017:** Currently this is a manual call however via the 'GDE Programme' we are progressing a two way text reminder service		31st May 2018		

				26.6 Review why discharges are delayed, resulting in lack of bed availability, within the Surgical Division utilising Clinical Utilisation Review (CUR)			**Update 30th October 2017:** Complete. Review undertaken and supporting actions identified following the review are: • Implement Nurse led discharge process • Increased nurse led prescribing- allowing those patients awaiting TTO's to be discharged by the nursing team • Estimated discharge dates given to all patients on admission with a clear plan to achieve this. This date will be visible for families and clinical staff		**Complete:** 27th October 2017		

Community CAMHS

No	Must/ should do	Dept	CQC action	Alder Hey action	Director	Lead	Progress	BRAG	Target completion date	Monitoring Committee	Required outcome / output
27	Should	Community CAMHS	Should ensure that all risk assessments are routinely reviewed, and the outcome of these reviews is clearly documented	27.1 GDE CAMHS work to include making the process of managing and viewing the risk assessments clearer	Andrew Williams Director of CAMHS	Kate Brizell General Manager CAMHS		In progress	31st January 2018	CAMHS Clinical Governance	Risk assessments are routinely reviewed, and the outcome of these reviews is clearly documented
				27.2 Development of a Super SOP to incorporate the processes for risk assessment			**Update 26th October 2017:** Agreement in CAMHS Governance to establish a working group to progress the Super SOP		28th February 2018		
				27.3 Monthly audit of record keeping			**Update 26th October 2017:** Audit tool set up to be rolled out at the end of November 2017		30th November 2017		

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28	Should	Community CAMHS	Should ensure that the environment, including furniture, is clean, well maintained, and in a good state of repair	28.1 Undertake environmental risk assessments	Andrew Williams Director of CAMHS	Kate Brizell General Manager CAMHS	**Update 26th October 2017:** Liverpool risk assessments completed Date set for 6th November for CAMHS Sefton risk assessments	In progress	**Complete:** 30th September 2017 10th November 2017	CAMHS Clinical Governance	All furniture will be clean, well maintained, and in a good state of repair
				28.2 Risk assess whether appropriate to move furniture from current locations to new sites					31st January 2018		
29	Should	Community CAMHS	Should ensure that the design and decoration of the environment is suitable for children and young people	29.1 Consider as part of the move from existing locations to new sites for Sefton and Liverpool. Involvement of the patient users groups to be set up	Andrew Williams Director of CAMHS	Kate Brizell General Manager CAMHS		In progress	31st December 2018	CAMHS Clinical Governance	The design and decoration of the environment will be suitable for children and young people evidenced by the involvement of patient user groups
30	Should	Community CAMHS	Should ensure that all rooms are adequately soundproofed	30.1 Obtain advice from the Estates department on monitoring sound proofing	Andrew Williams Director of CAMHS	Kate Brizell General Manager CAMHS	**Update 26th October 2017:** Request for advice made	In progress	10th November 2017	CAMHS Clinical Governance	All rooms will be assessed for soundproofing
				30.2 Clarify which clinic rooms currently have adequate sound proofing and those that lack sound proofing			**Update 26th October 2017:** Awaiting guidance from Estates		31st December 2017		
				30.3 Ensure rooms in new locations are assessed for sound proofing prior to moves			**Update 26th October 2017:** To be actioned as decisions on locations are finalised.		31st December 2018		
31	Should	Community CAMHS	Should ensure that people are provided with information in a language or format they understand	31.1 Undertake a review of Trust current position on the translation of clinic letters / reports / patient information	Andrew Williams Director of CAMHS	Sarah Stephenson Head of Quality	**Update 27th October 2017:** Position reviewed and advice being sought from Chief Nurse	In progress	30th November 2017	CAMHS Clinical Governance	Ensure that people are provided with information in a language or format they understand
				31.2 Undertake a review of how other organisations provide information in a language or format that families can understand			**Update 27th October 2017:** Some other organisations have an A4 sheet enclosed with all appointment and clinic letters that says 'this information can be made available in other languages and formats if requested' translated into a number of languages		31st December 2017		
				31.3 Implement actions based on feedback					31st December 2017		

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32	Should	Community CAMHS	Should ensure that effective strategies are in place to improve morale	32.1 Present update reports from the two working groups (Sefton / Liverpool) to the CAMHS Board	Andrew Williams Director of CAMHS	Kate Brizell General Manager CAMHS	**Update 26th October 2017:** CAMHS Liverpool have presented. Date for CAMHS Sefton update report to be presented to be agreed	In progress	31st January 2018	CAMHS Board	Should ensure that effective strategies are in place to improve morale
				32.2 Widely share the compliments and achievements in the monthly Quality Updates			**Update 26th October 2017:** Standing section for the Quality Updates from September 2017		**Complete:** 30th September 2017		
				32.3 Explore a Divisional 'Star of the Month'			**Update 26th October 2017:** To review options and/or promote Trust process for recognition awards		30th November 2018		
33	Should	Community CAMHS	Should ensure that staff feel confident in raising concerns about the service.	33.1 Monitor logging of Ulysses incidents to ensure incidents for all areas are increasing	Andrew Williams Director of CAMHS	Sarah Stephenson Head of Quality	**Update 26th October 2017:** Training for staff on incident reporting and regular monitoring of incident reporting by department	In progress	**Complete:** 30th September 2017 and ongoing	CAMHS Clinical Governance	Enable staff to feel confident in raising concerns about the service and ensure staff know how they can raise concerns
				33.2 Promote the use of existing Trust mechanisms for raising concerns including 'Raise It Change It' and 'Freedom to Speak Up' through wide communications to teams					30th November 2018		
				33.3 Investigate option for Community Head of Quality to become a Freedom to Speak Up Champion for the Division			**Update 26th October 2017:** Initial contact made with Kerry Turner (Freedom to Speak up Trust Lead) to enquire further		31st October 2018		

Version 1: Update as at 31st October 2017

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Alder Hey Children's NHS
NHS Foundation Trust

Board of Directors

7th November 2017

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

Section 1 - Engagement

Reward & Recognition

In response to the monthly Star Awards, a total of 18 nominations were received during September, (122 in Aug). The winner was voted for by the panel (comprising a range of staff and staff side) and arrangements are being made for presentation by an Executive Director slightly later this time due to leave for early November. Nominations for October will once again be reviewed later in November.

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

'Fab Change Week' is being held 13th-17th November, and will be celebrated through a number of different staff engagement initiatives, and is being led by the LiA 'Reward and Recognition' group.

Staff Survey

The 2017 Staff Survey campaign was launched on 22nd September. The staff survey strategy group have developed a Trust wide communication program aimed at managers to promote and engage staff to complete the survey. The program includes face to face meetings with managers to promote survey completion; a pocket guide for managers with reminders about previous actions "you said…we did.." plus weekly statistics on departmental response rates. The strategy group will meet weekly throughout the survey timeline, until 1st December to support the on-going campaign, and will review the results early 2018, to inform future Trust wide and local conversations and action plans.

The communications campaign is demonstrating a level of success; as at 1st November 2017 response rates are 39%, which is the same as the final response rate from 2016, and we still have 4 weeks until survey close to increase the response rate even further. we are aiming for a minimum of 50% this year.

Section 2 - Availability of key skills

Employee Consultations

Trust Nursery

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

Hotel Services

Domestics and Portering staff (Portering and Portering Supervisors) organisational change programmes were initiated on 9 June 2017 which consisted of proposed reductions of staff (Portering Supervisors) and review of shift patterns/rotas in the other groups. The three consultations were due to conclude on 24 July 2017. A number of issues were raised by staff and staffside during the consultation in each of the staffing groups and further investigation is being undertaken by management requiring an extension to each of the consultations until

25th August 2017. A review meeting was undertaken on 8th September 2017 with key management stakeholders and union representatives to agree deliverables. The consultation period was extended to 30th September 2017 with further management/union meetings to be scheduled in early October 2017. Dates for domestics' group meetings are currently in process of being arranged with staffside to review feedback from staff on updated draft rotas. A management/staffside meeting is to take place relating to porters on 1st November 2017 to review a recent independent audit on work activity.

Home Care Service – Community Division

The Organisational Change of the seven Band 3 HCA's is now nearing an end with six having secured alternative roles within the Trust and the final one with a potential role identified pending medical approval.

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

Education, Learning and Development

Apprenticeships

The first cohort of internally delivered apprenticeship qualifications for our existing staff will commence in October 2017 with Healthcare Support and Team Leading. We have over 30 staff currently enrolled. Work is still ongoing to develop this qualification portfolio further with Blackburne House as a support to ensure the apprenticeship strategy remains on track.

Mandatory Training

A significant amount of work has been undertaken in recent months to improve the recording and reporting of mandatory training via ESR, with the support of expertise from Liverpool Community Health colleagues. Detailed mandatory training reports by subject, department and team have been distributed across the Trust, with all managers expected to increase compliance with mandatory training in each of their teams, and hit the 90% compliance target by the 31st January 2018.

Section 3 - Structure & Systems

Employee Relations Activity

By the end of October the Trusts ER activity was at 20 cases, an increase of 2 since last month. These are 3 formal disciplinary cases (one fast track), 4 formal Bullying and Harassment cases (2 cases have moved to informal mediation stages), 6 formal grievances, and 4 Employment Tribunal (ET) cases. In addition there are 2 final absence dismissal cases and 1 formal capability cases.

Employment Tribunal Cases

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

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

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

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

Trade Union Elections

The Trade Union staffside group held their internal elections in October. Three new positions were appointed to; Tony Johnson, Unite, was appointed as the new Staffside Chair, Kerry Turner, RCN, was appointed as the Vice Chair and Claire Jones , British Society of Dietetics, was appointed as the secretary. These are one year tenures. The Director of HR & OD will be working with the new incumbents during November to agree new partnership arrangements.

Corporate Report

The HR KPIs in the September Corporate Report are:

- Sickness has remained static at 5%
- Corporate Induction reached 86% compliance
- PDR compliance has increased to 86.2%
- Mandatory training compliance has decreased slightly to 74.4%

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

Enhancements to ESR

The HR team have been continuing to work on developments in ESR and the roll out of the ESR portal is progressing well- with the exception of a small number of staff all paper payslips went electronic by end September.

The training on the ESR app has been well received and bespoke sessions have also been held across departments. Step by step guides have also been provided to managers and staff with many opting to follow the guides as opposed to full training, as they have found it very easy to access and use. To date the app and process has been well received amongst managers and staff. Further roll out of the portal and Manager Self Service will provide managers with a more user friendly platform for accessing their workforce data.

Section 4 - Health & Wellbeing

Staff Fab Change Week

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

Equality & Diversity

Implementing the Workforce Race Equality Standard (WRES) is a requirement for NHS healthcare providers through the NHS Standard contract, and is designed to ensure employees from black and minority ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace. This is important because studies shows that a motivated, included and valued workforce helps deliver high quality patient care, increased patient satisfaction and better patient safety.

Last year, we agreed a number of actions to improve the experience of BME staff working at Alder Hey, and also agreed a target of a 1% year on year increase over the next 5 years in the numbers of BME staff employed by Alder Hey to ensure the numbers reflect the local community population.

Appendix 1 is the WRES Action plan, which the Board is requested to approve. This action plan is the result of an analysis of the demographic data, staff survey results and feedback from the BME network.

Appendix 1 - WRES ACTION PLAN 2017/18

The action plan supports the Trust's 2017 WRES submission

WRES ACTION PLAN 2017/18		
ACTION	**RESPONSIBLE**	**BY**
Communicate the 2016/17 WRES position: • Trust Board • BME Network • WOD • Team Brief • Divisional Board / team meetings	Director of HR and OD and E&D Lead HRBP's	November 2017
Work in Partnership with the BME Network: • Agree data to be reported (no of applicants, starters, leavers, promotions, no of non-disclosures) • Send personal invitations to network • Devise Website page to include way of network communicating easier • Evidence of Network involvement in employment policy and process	ESR and Workforce Systems Lead Director of HR and OD and Head of HR ESR and Workforce Systems Lead Equality and Diversity Lead, Communications, BME network member Head of HR	November 2017 Ongoing from November 2017
Develop a report for WOD to closely monitor important recruitment and selection information: • reasons for leaving in exit interviews to be added to exit interview survey monkey questionnaire • Leavers to be broken down by protected characteristic • Spot check carried out for reasons why BME staff not appointed • Spot check carried out with line mangers	Recruitment Manager	Ongoing from November 2017

WRES ACTION PLAN 2017/18		
ACTION	**RESPONSIBLE**	**BY**
and candidates on quality of feedback given to unsuccessful BME candidates • No of panels where HRBP's HRA's or Equality Lead present • Reduce number of non-disclosure / non stated of ethnicity of new appointments		
Increase the number of BME applicants: • Advertise jobs in the community using existing networks and via Job Centre Plus • Attend / liaise with community advisory group (CAG) to talk about employment opportunities at Alder Hey • Work with our partners in Edge Hill, JMU and Chester Universities to understand their strategies for recruiting diversity in the nursing population • Visit hospital involved in refugee mentoring scheme http://www.bbc.co.uk/news/health-40442848 • Use images that are ethnically diverse	Recruitment Manager and E&D lead Recruitment Manager, Volunteer Manager Head of Nursing HR, BME Network Member Communications	January 2018
Review Equality and Diversity Training for Line Managers: • Unconscious Bias • Cultural Competence • Values and Behaviours • WRES awareness • Equality Analysis	Head of OD, E&D lead	January 2018
Monitor non-mandatory training and CPD: • Communicate to staff ESR portal / facility	ESR and Workforce Systems Lead	February 2018

WRES ACTION PLAN 2017/18		
ACTION	**RESPONSIBLE**	**BY**
• Target staff who have not stated / disclosed their ethnicity • Consider methodology of capturing this information centrally in ESR	Head of OD and E&D lead	
Develop and launch a B&H campaign: • Promote a harassment free workplace • Zero tolerance poster for public and staff • Signpost to Alder Centre counselling services • Review the policy • Involve communications • Review incidents for public and staff	HRBP/Head of HR/TU Colleagues/Security/ T&F group HRBP and Communications E&D Lead and Head of HR	March 2018

Mersey Internal Audit Agency

Well-led Governance Review

Terms of Reference

Alder Hey Children's NHS Foundation Trust

V.5

1. Introduction and Background

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

1.2. The guidance is issued on a 'comply or explain' basis. This means NHSI strongly encourage providers to carry out developmental reviews or equivalent activities approximately every three years to ensure they identify potential risks before these turn into issues. This involves selection of an external facilitator to provide tailored support and prioritise actions arising from reviews. There is also encouragement for providers to make more use of peer review, to utilise and enhance skills within the NHS, draw on learning from others and share learning back with the system.

1.3. The guidance retains a strong focus on integrated quality, operational and financial governance and includes a new framework of key lines of enquiry (KLOEs) and the characteristics of good organisations. It provides strengthened content on leadership, culture, system-working and quality improvement.

1.4. The structure of the framework (KLOEs and the characteristics) is wholly shared with the Care Quality Commission (CQC), and underpins CQC's regular regulatory assessments of the well-led question. This means that information prepared for regulation can also be used for development, and vice versa. However, while CQC's regulatory assessments are primarily for assurance, developmental reviews are primarily for providers themselves to facilitate continuous improvement.

1.5. The board of Alder Hey Children's NHS FT has agreed to commission a well-led review and this proposal provides more detail on how this can be taken forward.

1.6. This is an MIAA and AQuA partnership proposal. MIAA is a leading provider of audit, governance and assurance related services and AQuA is a highly regarded quality improvement agency. This brings together a partnership based multi-disciplinary team with the following features:

- Experience of evaluating board leadership and governance arrangements
- Knowledge of the healthcare sector; and
- Specialist expertise, specifically clinical and quality improvement; leadership experience (including culture and board development); and management information systems.

2. Scope

2.1 It is proposed that the scope of the review is structured around the eight key lines of enquiry (KLOEs set out below in Table 1). This will ensure that under the "comply and explain" principles the trust will not have to explain any departure from the guidance.

Table 1: the structure of the well-led framework

1 Is there the **leadership capacity and capability** to deliver high quality, sustainable care?	2 Is there a clear **vision** and credible **strategy** to deliver high quality, sustainable care to people, and robust plans to deliver?	3 Is there a **culture** of high quality, sustainable care?
4 Are there clear responsibilities, **roles** and systems of accountability to support good governance and management?	**Are services well led?**	5 Are there clear and effective processes for managing **risks**, issues and **performance**?
6 Is appropriate and accurate **information** being effectively processed, challenged and acted on?	7 Are the **people** who use services, the public, **staff** and **external partners engaged** and involved to support high quality sustainable services?	8 Are there robust systems and processes for **learning**, continuous **improvement** and **innovation**?

2.2 Further discussion has now taken place with the trust to determine whether additional areas are to be brought into scope or have an enhanced focus. The following areas have been highlighted:

- Learning from incidents as an organisation;
- Divisional leadership and devolved governance;
- Communication;
- Impact of CBU changes;
- Any governance issues raised by CQC.

2.3 The need to complete a self-review assessment is referenced in the next section and may well impact upon scope.

3. Approach

3.1 Self-review is an important first step in preparing for externally facilitated developmental reviews. Trusts should undertake this assessment to provide insight for themselves and the external facilitator into how they gauge their own leadership and governance performance and identify any particular areas of interest or concern either within or outside the eight questions.

3.2 A nominated trust lead or team may co-ordinate the self-review but it should be completed and signed-off by the full board. In practice, this could mean that a nominated board member works with the board secretary and their staff to gather the information and the evidence against each question and present their findings and initial conclusions to the board for discussion and challenge. The whole board is responsible for arriving at an overall conclusion. The output of the self-review will include the self-review questionnaire (or equivalent), ratings and rationale for the ratings.

3.3 During a developmental review, the self-review should be presented to the external facilitator for comments and further discussion. The reviewer will then agree areas for further scrutiny with the board.

3.4 **The trust has yet to complete a self-review so this is an important step to complete in order to proceed to the full external reviews.**

3.5 Once the self-review is completed the full review can commence and Table 2 sets out those steps:

Table 2: proposed review steps

Refining the Scope and Approach	*External review team meet with the Chair, Chief Executive and relevant directors to refine the approach, including:-* – *Agreement of additional areas to scope e.g. executive team capacity.* – *Reporting mechanism, timeframes, review ratings etc.* – *Establish senior point of contact and operational on site contact.*
Review Preparation	*External review team* – *Review the Trust's self-assessment and provide an evidence request template to the Trust, for completion (this will provide the evidence for the Trust's self-assessment).* – *Agree and set up the one to one interviews, workshops, board committee observation*
Detailed Review	*External review team will:-* – *Review the evidence base to form an independent view and to inform other dimensions of the approach.* – *Conduct interviews, surveys, workshops, observations and external engagement using triggers from the documentary evaluation and feedback.*
Board Reporting and Action Planning	*External review team will complete:-* – *A detailed report of the findings, comparative ratings and Trust developments identified from the review process drawing on best practice from elsewhere.* – *Agree with the Trust the draft report.* – *Present findings to the Board using a summary report (cause and effect diagram)*
Letter to NHSI	*Once the action-planning is completed, providers should send NHS Improvement a letter confirming they have completed the review, any material issues that have been found and/or any areas of good practice that could be shared with others, for example through a case study.*

4. Methodology

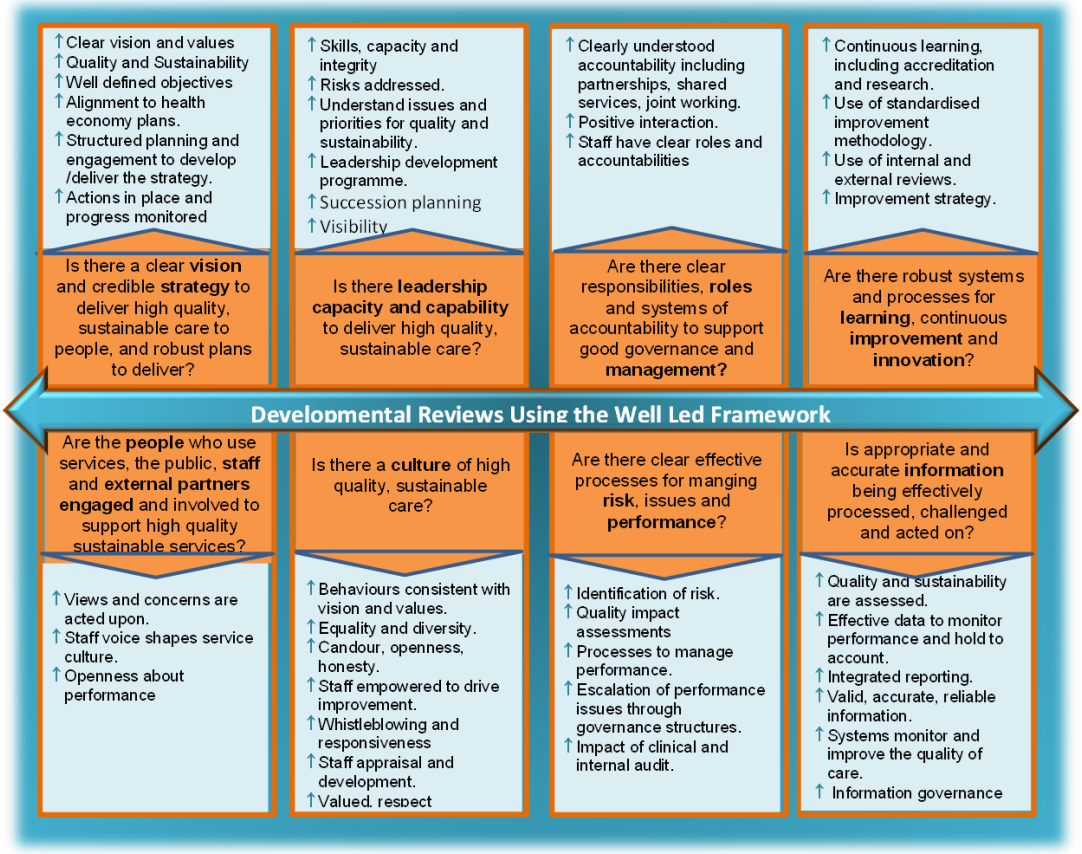
4.1 The diagnostic tools and methods for carrying out the review will be selected from those listed below:

Tool	Suggested components	Purpose	External review team focus
Desktop document review	Board minutes, papers, and agendas; board assurance framework; audit reports; strategic documents, eg the trust's strategy and business plan, quality strategy and people strategy; and internal/ external audit reports, annual governance and corporate governance statements, alongside any other relevant reviews	To provide a view of: • how ongoing issues and risks within the NHS foundation trust are communicated and managed • the quality of information being produced to support decision-making and • how the board prioritises issues at the trust and divides its attention.	Focus upon the communication and management of risks; the quality of information to support decision-making; and board prioritisation. The review team will validate those conclusions with particular focus upon areas that have been identified as strengths and weaknesses.
One-to-one interviews	All board members, the trust secretary, lead governor, clinical directors and leads, local stakeholders, including clinical commissioning groups and patient representatives	To gain individuals' views of the trust's governance and to provide a 'safe' environment in which to explore issues and discuss sensitive information, as appropriate.	External review team will undertake the full range of interviews. Those interviews will be informed in part by the self-assessment conclusions.
Board and sub-committee observations	Observations of at least 1 board meeting and relevant sub-committees, including audit and quality.	To identify the dynamics of the board, including agenda management, depth and breadth of the information used to make decisions and progress priorities, and the way they challenge and hold each other to account for the leadership of the trust.	External review team will undertake the full range of observations. Those observations will be informed in part by the self-assessment conclusions.
Peer practices	On areas of governance in the sector, in similar organisations or	To assess how the NHS foundation trust compares against any known examples	Drawing upon the extensive AQuA and MIAA client base practice from elsewhere will be an

Tool	Suggested components	Purpose	External review team focus
	NHS foundation trusts. This will include building a platform for clinical peer review.	of particularly effective and robust governance practices.	integral part of the external review approach.
Stakeholder surveys	Staff and patient groups, governors, commissioners and providers	To get internal and external parties' views of the trusts governance to cross-reference with the board's own views – to test the board's awareness.	Surveys will be undertaken in part informed by the self-assessment.
Interviews with internal and external stakeholders	Staff, patient groups, commissioners, contracted or outsourced suppliers		

5. Navigating the guidance

The review team have designed the following to help trusts interpret the well-led guidance:



6. The Proposed Team

The project leads will be Tim Crowley, Managing Director, MIAA, and Cath Hill Director, AQuA. Other members of the team will be drawn from within MIAA and AQuA and will be seconded in from other partners if appropriate. The selection of team members is driven by their wider expertise and experience in the conduct of similar governance reviews.

7. Trust Responsibility for Delivery

To ensure the effective delivery of the review, the Trust will be required to:-

- Nominate a lead officer to provide review information and to coordinate one to one meetings, attendance at committees and wider review meetings.
- Provide a validated self-assessment signed off by the Board by the commencement of the review.
- Provide access and facilities in order for the Review Team to conduct interviews, workshops, surveys and other engagement activity.

8. Fees and Delivery

- Single trust Well-Led review

  (AQuA/MIAA external review team: £25000)

Proposed Timescales

Element of the Review	Planned Completion Date
Refining the scope and approach	
Review preparation (including evidence gathering by the Trust)	
Detailed Review: Evidence evaluated Interviews/workshops/surveys/observations undertaken Independent rating produced	
Board reporting and action planning	
Monitor notified	

Key Contact

The key contacts for the review will be;

Name: Tim Crowley
Title: Managing Director, MIAA
Telephone: 0151 285 4500 / 07768131789
Email: tim.crowley@miaa.nhs.uk
Name: Cath Hill
Title: Director, AQuA
Telephone: 0161 206 8430 / 07860782386
Email: cath.hill@srft.nhs.uk

Alder Hey Children's NHS
NHS Foundation Trust

Programme Assurance Summary
Change Programme

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

1. The improvement ratings is to be welcomed and the Executive focus on delivery of our strategic commitments is now to the fore.
2. A recent Stock-Take of the programme by our External Programme Assurance, in close partnership with the leadership of each work stream and the Programme Board, has demonstrated the need to refine and adjust the change priorities to develop a more robust approach to the identification and measurement of benefits across the programme. As a result we are conducting a dynamic refresh of the projects - while all work streams proceed apace – and will be presenting the new change programme 'Blueprint' to the Trust Board in January 2018.
3. The financial benefits being delivered by our change portfolio are still not meeting targets and this will form a critical strand of the aforementioned refresh.

J Grinnell 27 Oct 17

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

1. This Board report contains assurance reports submitted to the following sub-Cttes: CQAC on 18 Oct and R&BD on 30 Oct 17.
2. The scope of the programme and the contribution to CIP benefits are shown in the following slides; the financial contributions are of particular concern, being significantly below target in many work streams, and are now subject to further project work being initiated together with a robust weekly review of delivery.
3. The overall assurance ratings have improved as the result of increased focus and attention by Executive Sponsors, Corporate Leads and their teams. The red rated projects in the 'Workforce' work stream remain a source of concern.

J Gibson 27 Oct 17

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

See CIP Slide 3 attached.

Change Programme
11 October 2017_v14

Trust Board

Alder Hey Children's NHS
NHS Foundation Trust

CQAC | R&BD | WOD | R&BD | R&BD

Internal Delivery Group (CiP) ⟷ **Programme Assurance Framework** ⟷ **Programme Delivery Board**

25/40 = £ indicated projects

Deliver Outstanding Care
Hilda / Steve

1. Experience in Outpatients £ SG
2. Best in Operative Care £ SG
3. Primary Care Streaming
4. Best in Acute Care £
5. Deteriorating Patient (Sepsis)
6. 7-day Services (incl. Out of Hours)

Growing Through External Partnerships
John / Steve SG

1. Single Service, 2 Site, Neonatal Service £
2. Strong Community Services Offer - Transition of New Community Services
3. Transforming Mental Health Services £
4. Strengthen the Stoke Partnership £
5. International Health & Non-NHS Patients £
6. Improving Pathways for Children with Complex Needs between Hospital and Home
7. CHD Liverpool Partnership £
8. Aseptics £

The Best People Doing Their Best Work
Melissa/Hilda SG

1. Staff Engagement & Development
   a) Apprenticeships £
   b) Engagement & Communication
2. Workforce Reviews
   a) Specialist Nurse Review £
   b) AHP Review £
   c) Improving Portering Services £
   d) Improving Domestic Services £
3. Agile Working
4. Temporary Staffing £
5. e-Rostering £

Global Digital Exemplar
John/Steve

1. Speciality Packages £ SG
2. Voice Recognition £

Strong Foundations
John

1. Inventory Management £
2. Collaborative Procurement £
3. Energy £

Park, Community Estate & Facilities
David

1. Decommission & Demolition SG
2. R&E 2
3. Alder Centre
4. Park
5. Residential Development
6. International Design & Build Consultancy £
7. Reprovision of Retained Estates
8. Neuro-Developmental Hub (TBC)

RE&I

Game Changing Research & Innovation
David

1. The Academy £
2. The Innovation Co £
3. Implement New Apps for Alder Hey
4. Expand Commercial Research £

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

Alder Hey Children's NHS
NHS Foundation Trust

CIP Status at Month 06

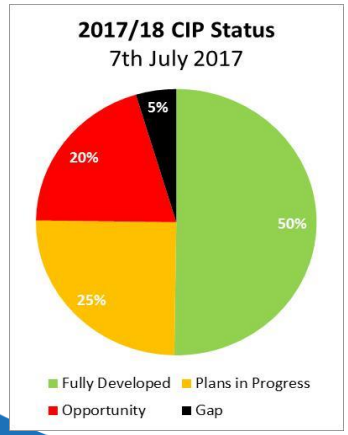
Trust Position

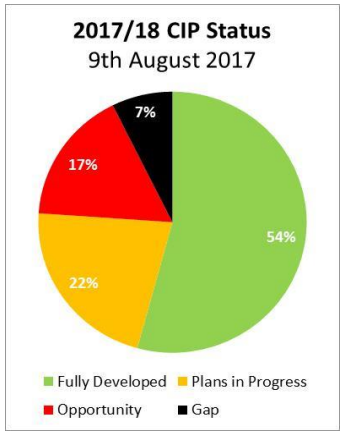
Risk Adjusted Forecast	at 6th Oct £000's
Implemented (Posted)	4,479
Fully Developed Plan	247
Plans in Progress	1,258
Subtotal: Forecast Delivery	5,984
Opportunity	709
Gap	1,307
Target	8,000

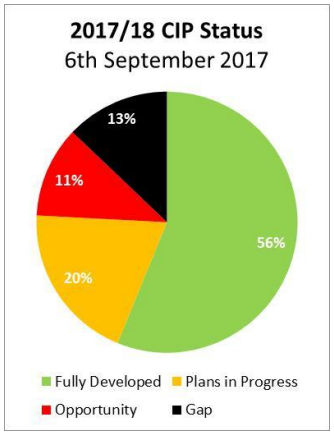
2017/18 CIP target is £8.0m:

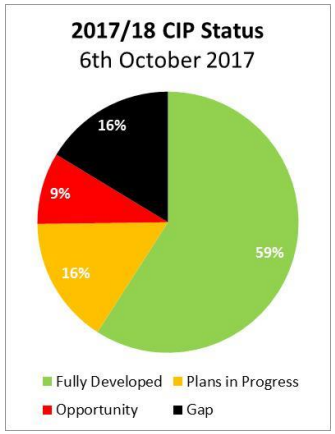
- In year forecast £6.0m (75%)
- **Current shortfall** **£2.0m** (25%)

There has been **no progress** over the last 4 months









Inspired by Children

Alder Hey Children's NHS
NHS Foundation Trust

CIP Status at Month 06 - Performance, by Theme

Project	In Month			Year to Date			In Year Forecast		
	Target £000's	Achieved (Posted) £000's	Gap £000's	Target £000's	Achieved (Posted) £000's	Gap £000's	Target £000's	Forecast £000's	Gap £000's
Deteriorating Patient	0	0	0	0	0	0	0	0	0
Reduce Variation by Developing Clinically Effective Pathwa	0	0	0	0	0	0	0	0	0
Experience in Outpatients	20	0	-20	60	0	-60	180	198	18
Best in Operative Care	34	13	-21	204	78	-126	407	157	-250
7 Day Services	0	0	0	0	0	0	0	0	0
Reduce Infections	0	0	0	0	0	0	0	0	0
Subtotal: Deliver Outstanding Care	**54**	**13**	**-41**	**264**	**78**	**-186**	**587**	**356**	**-231**
High Quality Acute & Emergency Care	0	0	0	0	0	0	0	0	0
Develop Clinical Support Services Offer	0	0	0	0	0	0	0	0	0
Strong Specialist Services Offer	0	0	0	0	0	0	0	0	0
Strong Community Services Offer	13	6	-8	80	35	-45	159	69	-90
Expand Mental Health Offering	0	0	0	0	0	0	0	0	0
Intermediary Care Unit	0	0	0	0	0	0	0	0	0
Strengthen Existing Partnerships	0	0	0	0	0	0	0	0	0
International Health & Non-NHS Patients	0	0	0	0	0	0	0	60	60
Subtotal: Growing Through External Partnerships	**13**	**6**	**-8**	**80**	**35**	**-45**	**159**	**129**	**-30**
Staff Engagement & Development	5	0	-5	33	0	-33	65	13	-52
Workforce Review - Specialist Nurses	0	0	0	0	0	0	30	0	-30
Workforce Review - AHP	0	0	0	0	0	0	30	0	-30
Workforce Review - Consultant Job Planning	0	0	0	0	0	0	30	0	-30
Workforce Review - GDE Workforce Change	0	0	0	0	0	0	0	0	0
Workforce Review - Portering	12	0	-12	74	0	-74	147	37	-110
Workforce Review - Domestics	11	0	-11	33	0	-33	100	65	-36
Agile Working	0	0	0	0	0	0	0	0	0
Implement Carter	0	0	0	0	0	0	0	0	0
Subtotal: The Best People Doing Their Best Work	**29**	**0**	**-29**	**139**	**0**	**-139**	**402**	**114**	**-288**
The Academy	0	0	0	0	0	0	0	0	0
The Innovation Co	8	0	-8	50	0	-50	100	0	-100
Expand Commercial Research	9	9	0	52	52	0	130	130	0
Subtotal: Game Changing Research and Innovation	**17**	**9**	**-8**	**102**	**52**	**-50**	**230**	**130**	**-100**
Implement New Apps for Alder Hey	0	0	0	0	0	0	0	0	0
GDE	0	0	0	0	0	0	0	0	0
Strategic Estate Review	0	0	0	0	0	0	0	0	0
STP Corporate Services	0	7	7	0	33	33	142	74	-69
Subtotal: Solid Foundations	**0**	**7**	**7**	**0**	**33**	**33**	**142**	**74**	**-69**
Business Development - Specialty Growth	136	64	-72	731	375	-356	1,692	1,070	-622
Business Development - Non-NHS Patient Income	0	10	10	0	43	43	0	67	67
Commercial / Non Clinical Income	0	1	1	0	5	5	0	13	13
Coding & Capture	166	159	-7	912	859	-54	1,919	2,228	310
CBU Pay Schemes	45	43	-3	199	420	221	528	676	147
Medicines Optimisation	60	65	5	260	65	-194	619	265	-354
Procurement	28	19	-9	165	111	-54	572	306	-266
Other Non Pay Savings	51	39	-12	266	198	-68	775	557	-218
Balance to NHSI Plan (23 Dec)	-186	0	186	-1,092	0	1,092	-0	0	0
Unidentified	16	0	-16	101	0	-101	376	0	-376
Subtotal: Business as Usual	**316**	**399**	**83**	**1,541**	**2,076**	**535**	**6,480**	**5,181**	**-1,298**
Grand Total	**429**	**434**	**5**	**2,125**	**2,273**	**147**	**8,000**	**5,984**	**-2,016**

Alder Hey Children's NHS
NHS Foundation Trust

Programme Assurance Summary
Delivering Outstanding Care

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

The latest forecast is savings of £0.4m, which has not changed since the previous update and is very low, and not sufficient to meet the financial objectives of the programme. The only projects currently forecasting savings are Best in Operative Care and Experience in Outpatients. The Executive sponsor is requested to review the saving potential as a matter of urgency, converting the opportunities into savings and increasing the value of the overall forecast.

Claire Liddy, Deputy Director of Finance – 11 Oct 17

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

Of the projects that have evidence lodged on the SharePoint site and are rated:

- 'Deteriorating Patient' – The 'Sepsis' project documentation on SharePoint has been updated and has some remaining issues to address but is in a much improved position relative to recent assurance assessments.
- 'Outpatients' – continues to provide a high level of documentary evidence giving a sound assurance rating.
- 'Best in Operative Care' – is also being regularly updated and has a good suite of evidence.

Projects that are red rated, as highlighted at Programme Board/Trust Board, are:

- 'Best in Acute Care' – still requires significant evidence of assurance as reflected in the dashboard ratings and comments.
- 'GP Streaming' – still awaiting any further evidence of assurance and absence of EA/QIA should now be considered a critical flaw in assurance and governance.
- 7 Day Services (includes Out of Hours) – no evidence on SharePoint therefore no assurance available

Joe Gibson, External Programme Assessment 11 Oct 17

Programme Assurance Framework
Delivering Outstanding Care (Completed by Assurance Team)

Alder Hey Children's NHS
NHS Foundation Trust

Sub-Committee	CQAC	Report Date	12 Sep 17
Workstream Name	Delivering Outstanding Care	Executive Sponsor	Hilda Gwilliams/Steve Ryan

Current Dashboard Rating:

See dashboard extract overleaf

Financial Reporting:

Project Title	RAG Rating	Budget £	Forecast £	Variance £	Comments
Deteriorating Patient	Black				No financial benefits identified to date
Reduce Variations by Developing Clinically Effective Pathways	Black				No financial benefits identified to date
Experience in Outpatients	Amber	180k	198k	-180k	Financial target based on 3% reduction in DNA rate in Medical specialities.
Best in Operative Care	Green	407k	157k	-250	Financial target based on indicative 2% growth in Elective and Daycase income in all Surgical specialties. Following detailed review and activity forecast, there is high confidence of increased income in Urology, Plastics and Pre-Op Assessment.
7 Day Services	Black				No financial benefits identified to date
Reduce Infections	Black				No financial benefits identified to date
Total		587k	356k	-231k	

Project Ref	Assurance Group	Project Title	Project Description	Executive Sponsor Assures the project	OVERALL PROJECT RAG	An effective project team is in place (Explored)	Scope and Approach is	Targets / benefits defined/on track	Milestone plan is defined/on track (Established)	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment (Designed)	Equality Analysis (Delivered / Sustained)	Comments for attention of the Project Team, Steering Group and sub-Committee
1.0 Deliver Outstanding Care 17/18 £TBC														
CQAC 1.2	**CQAC**	**Experience in Outpatients**	The project will improve patient & staff experience; understand demand and capacity; improve flow and environment	Hilda Gwilliams		🟢	🟢	🟡	🟢	🟢	🟢	🟢	🟢	SG meeting notes available to July. PID completed. Benefits defined - tracking/dashboard uploaded 29 Aug 17. Milestone Plans (Booking and Scheduling in particular) show some 'OM' tasks and requires populating with new actions. Comms/ engagement activities to be updated and evidence provided where possible. Risks available on Ulysses. **Last updated 4 October 2017**
CQAC 1.3	**CQAC**	**Best in Operative Care**	The "Best in Operative Care" strategy aims to deliver the best paediatric operative care in the world, as measured by low rates of mortality and harm, and high staff satisfaction rates	Steve Ryan		🟢	🟢	🟡	🟡	🟢	🟢	🟢	🟢	Steering Group notes available on SharePoint. PID available. Targets/benefits defined in PID, tracking/reporting to commence. All areas (tabs) of the Milestone Plan to be fully defined/populated and updated for September. Comms tracker available. Risks available on Ulysses. EA/QIA complete. **Last updated 9 October 2017**
CQAC 1.6	**CQAC**	**Primary Care Streaming**	Primary Care Streaming Description: Design, build and implement a dedicated Primary Care facility adjacent to ED in order to co-locate GP led primary care services with the aim of 1) supporting children with complex ongoing health needs and chronic illness in the community, 2) Improving patient flow and reducing breaches of the ED 4 hr standard.	Mags Barnaby		🟡	🟡	🔴	🟡	🔴	🔴	🔴	🔴	Draft PID now available on SharePoint with work left to ensure all sections are complete. Remaining projrect domains - Team Meetings, Benefits Definition, Milestones Plans, Stakleholders, Risks, EA/QIA - to have evidence that meets the standard lodged on SharePoint. **Last updated 26 September 2017**
CQAC 1.7	**CQAC**	**Best in Acute Care**	To deliver the best/safest paediatric acute care in the world, as measured by low rates of mortality and harm, and high staff satisfaction. We will achieve this through a strategy centered on patient safety, excellence and staffing wellbeing. There will be 6 key workstreams underpinning this strategy:1. Resuscitation; 2. Sepsis; 3. 7 Day Services incl. Out of Hours; 4. PEWS/ Deterioration; 5. Outreach; 6. Medical Management of Complex Surgical Patients.	Steve Ryan (Hilda Gwilliams)		🟡	🟡	🔴	🔴	🟡	🔴	🟢	🟢	Draft PID uploaded and incorporates the following projects/workstreams: Resuscitation; Deteriorating Patient/Sepsis; 7 Day Services - inclusive of Out of Hours; PEWs/Deterioration; Outreach; Medical Management of Complex Surgical Patients). The PID includes the scope with benefits yet to be defined. Minutes/notes of meetings are present, as is identification of high level stakeholders. **Last updated 2 October 2017.**
CQAC 1.7.1	**CQAC**	**Deteriorating Patient (Sepsis)**	This project will ensure prompt recognition and management of the deteriorating patient and implementation of the Sepsis Pathway	Hilda Gwilliams		🟢	🟢	🟡	🟢	🟡	🟡	🟢	🟢	Project implementation meeting notes available to August 2017. PID complete. Benefits defined, tracking/reporting of all benefits to commence. Milestone Plan is now being updated on SharePoint (old versions in separate folder to be deleted / archived). Comms/ Engagement Plan available, evidence has been provided for certain activities. Risks to be updated on Ulysses. EA/QIA complete. **Last updated 5 October 2017**
CQAC 1.7.2	**CQAC**	**7 Day Services (Includes Out of Hours)**	The Seven Day Services project is designed to ensure patients that are admitted as an emergency, receive high quality consistent care, whatever day they enter hospital. Ten clinical standards were developed; the purposes of the standards are to deliver safer patient care, to improve patient flow through the acute system, to enhance patients' experience of acute care, to reduce the variation in appropriate clinical supervision at weekends and, potentially, to mitigate the excess mortality that has been shown in large studies to be associated with weekend admission to hospital.	Steve Ryan (Hilda Gwilliams)										**No documentation available on SharePoint.**

Alder Hey Children's NHS
NHS Foundation Trust

Programme Assurance Summary
Growing Through External Partnerships

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

The improvements in this work stream are to be welcomed but still fall short of the Alder Hey programme management standards and should be remedied as soon as possible.

Further clarity is still required in 6 of the projects regarding the identification and measurement of clear benefits to the work in hand.

The clear priority then is for the rationale and goals for each project to be expressed in terms of measurable objectives.

Claire Liddy, Director of Operational Finance – 24 October 2017

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

The work stream continues to make progress to improve the assurance base since the previous sub-Committee review in September 2017. No projects are now red rated; however, the 7 amber rated projects should now expedite the necessary improvements to the standard of evidence on SharePoint to achieve a green rating. There do appear to be any overriding constraints that should prevent that being done quickly.

Of particular concern is the continuing £90k shortfall in the financial contribution to the CIP programme; the Executive Sponsor should improve this position.

The Executive Sponsor should work with all 'corporate leads 'of projects to attain green ratings as a matter of urgency.

Joe Gibson, External Programme Assessment – 24 October 2017

Programme Assurance Framework
Growing Through External Partnerships (Completed by Assurance Team)

Alder Hey Children's NHS
NHS Foundation Trust

Sub-Committee	R&BD	Report Date	24 October 2017
Workstream Name	Growing Through External Partnerships	Executive Sponsor	John Grinnell

Project Ref	Project Title	Project Description	Executive Sponsor Assures the project	OVERALL PROJECT RAG	An effective project team is in place	Scope and Approach is	Targets / benefits defined/on track	Milestone plan is defined/on track	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	Comments for attention of the Project Team, Steering Group and sub-Committee
					Explored			Established			Designed	Delivered / Sustained	
R&BD 2.1c	Single Service, 2 Site, Neonatal Service	Lead services to review options to collaborate and maximise joint working across the NM LDS and C&M Footprint including a single Neonatal Service with LWH	Steve Ryan										Now in implementation planning phase. Outline PID available. Milestone plan in last updated 27 Sep, some milestones past due date not reported. Definition of benefits in 'working draft' format with further work needed to establish SMART metrics. Comprehensive evidence of wide stakeholder engagement. Risk Register commenced with NHSE funding risk. QIA/EA now uploaded and signed off. **Last updated 17 October 2017.**
R&BD 2.1di	STP AH @ C&M Strong Community Services Offer - Transition of New Community Services	To ensure safe and efficient transfer of selection of Specialist Paediatric Community Services from LCH	John Grinnell										Team have requested closure of this project. Closure Report to be presented to July RABD meeting was not submitted, **Executive Sponsor is requested to ensure closure at 28 September R&BD meeting .** **Last updated 3 October 2017**
R&BD 2.1d	STP AH @ C&M Transforming Mental Health Services	Improvements to primary and specialist mental health services locally. Improve access to 24/7 crisis resolution and secure Alder Hey as a provider of Tier 4 childrens services.	John Grinnell										PID to be presented to Steering Group meeting in **September 2017.** **Last updated 3 October 2017**
R&BD 2.2	Strengthen the Stoke Partnership	Lead services to review options to collaborate and maximise joint working with Stoke partners	John Grinnell										**DRAFT Business Case on SharePoint - any eventual project subject to outcome of current discussions; meeting with NHSE 12 Sep 17.** **Last updated 31 August 2017**
R&BD 2.3	International Health & Non-NHS Patients	Establish International service offer including: International Health Partnerships and non-NHS patients	John Grinnell										Steering Group meeting notes available. PID complete. Milestone Plan is defined and on SharePoint shows slippage with Dubai workstream and PP privileges, Plan now being updated. Details/evidence of comms/engagement to be provided where possible. Risks now on Ulysses. EA/QIA complete. **Last updated 16 October 2017**
R&BD 2.4	Improving Pathways for Children with Complex Needs between Hospital and Home	To improve the experience of patients with complex needs between hopsital and home, reducing length of stay and delivering high quality, community based, services.	John Grinnell										Draft PID in evideince with more work required, particularly on benefits and measures. Some evidence of team working but attendees at meetings, as well as action logs, need to be documented. A detailed action plan is in place and would benefit from a 'red line' showing the date of the latest amnedments/changes. Evidence of stakeholder engagement, confirmation of risks registred and EA/QIA are all outstanding. **Last updated 3 October 2017.**
R&BD 2.5	CHD Liverpool Partnership	The aim of this project is to deliver the potential Level One centre status for adult congenital heart disease across the NW/North Wales and Isle of Man; bringing together a partnership of 4 Liverpool providers.	Steve Ryan										PID on SharePoint, awaiting outcome of NHSE decision (understood to be 30 Nov 17), hence limited domains rated. **Last updated 26 September 2017.**
RABD 2.6	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.	John Grinnell										DRAFT Business Case on SharePoint: Proposal for commissioning, validation and licensing of the Pharmacy Aseptic Services Unit. Targets and benefits are included in Buisness Case but further refinement required. Current issues include some late milestones and little evidence of wide stakeholder engagement. Audit of Aseptic Services has been uploaded to SharePoint. EA/QIA outstanding. Evidence of meetings to July 2017. **Last updated 17 October 2017**

Programme Assurance Framework
Growing Through External Partnerships (Completed by Assurance Team)

Alder Hey Children's NHS
NHS Foundation Trust

Sub-Committee	R&BD	Report Date	19 September 2017
Workstream Name	Growing Through External Partnerships	Executive Sponsor	John Grinnell

Financial Reporting: **Refer to CIP Update report**

Alder Hey Children's NHS
NHS Foundation Trust

Programme Assurance Summary
Global Digital Exemplar

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

The GDE programme continues to be well led and managed.

The key focus needs to be on the breath and depth of clinical engagement and maximising the discretionary effort that is brought to bear on the pathway analyses and re-design.

The responsibility for benefits realisation within the operational divisions needs to be fully owned with tangible, measurable benefits, identified and delivered.

Claire Liddy, Director of Operational Finance – 24 October 2017

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

The work stream continue s to set and maintain high standards of documentary evidence to support the programme management assurance process. The latest position shows all 3 strategic level projects (it having been decided that the more granular work streams will be assured at the project level) have comprehensive evidence on SharePoint and are all green rated. The team should be congratulated.

Of current concern is the lack of evidenced financial contribution to the CIP programme.

The national 'review and reflection' on the status of the GDE initiative is an issue that is being carefully monitored and managed by the CIO and programme team.

Joe Gibson, External Programme Assessment – 24 October 2017

Programme Assurance Framework
Global Digital Exemplar (Completed by Assurance Team)

Alder Hey Children's NHS
NHS Foundation Trust

Sub-Committee	R&BD	Report Date	24 October 2017
Workstream Name	Global Digital Exemplar	Executive Sponsors	John Grinnell / Steve Ryan

Current Dashboard Rating:

Project Ref	Project Title	Project Description	Executive Sponsor Assures the project	OVERALL PROJECT RAG	An effective project team is in place (Explored)	Scope and Approach is (Explored)	Targets / benefits defined/on track (Established)	Milestone plan is defined/on track (Established)	Stakeholders engaged (Established)	Risks are identified and being managed (Designed)	Quality Impact Assessment (Designed)	Equality Analysis (Designed)	Comments for attention of the Project Team, Steering Group and sub-Committee
4.0 Global Digital Exemplar 17/18 £TBC													
R&BD 4.1	GDE	Create exemplars that can inspire others by really showing how information technology can deliver both improved patient outcomes and enhanced business effectiveness	Steve Ryan/ John Grinnell		●	●	●	●	●	●	●	●	Overall benefits profile and schedule has now been finalised. Further stakeholder evidence to be uploaded and register maintained. Risk protocols vis-à-vis national and Trust sytsems have been harmonised. **Last updated 21 October 2017**
R&BD 4.1a	Speciality Packages	Delivery of electronic clinical documentation workflow designed to reflect best practice protocols and pathways	Steve Ryan/ John Grinnell		●	●	●	●	●	●			Overall benefits profile and schedule still to be finalised. Risk protocols vis-à-vis national and Trust sytsems to be harmonised and finalised. **Last updated 21 October 2017.** QIA/EA will be assured and assessed at project level.
R&BD 4.10	Voice Recognition	Deploy voice recognition solution in Medisec and Meditech	Steve Ryan/ John Grinnell		●	●	●	●	●	●	●	●	PID and detailed project workbook on SharePoint. Details of financial benefits on separate document. Detailed milestone plan available, shows actions on track. Comms/engagement activities detailed in PID, evidence required where possible. Risks detailed in workbook. EA/QIA has been signed and uploaded. **Last updated 20 October 2017.**

Financial Reporting: Refer to CIP update report

Alder Hey Children's NHS
NHS Foundation Trust

Programme Assurance Summary
Park, Community Estate and Facilities

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

The work stream, having initiated every project, needs to now bring the documentation to a standard that will attain green ratings for all projects

The current 'block' on the Residential Development' project, and resulting financial risk, should be noted by Programme Board and R&BD Committee.

The 'Neuro-Developmental Hub' project needs to be scoped in terms of rationale and objectives.

Claire Liddy, Director of Operational Finance – 24 October 2017

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

The work stream has continued to make significant efforts to improve the assurance base since the previous sub-Committee review in September 2017. The latest position shows 7 projects having commenced, with evidence on SharePoint and, of those: 2 green rated, 4 amber and 1 red. This positive trend should be continued with dates set by the Executive Sponsor by which all projects will be green rated.

The 1 red rated project 'Residential Development' is blocked due to circumstances beyond the control of the project team.

Of continuing concern is the overall lack of a financial contribution to the CIP programme; the Executive Sponsor should improve this position.

Joe Gibson, External Programme Assessment – 24 October 2017

Programme Assurance Framework
Park, Community Estate and Facilities (Completed by Assurance Team)

Alder Hey Children's NHS
NHS Foundation Trust

Sub-Committee	R&BD	Report Date	19 September 2017
Workstream Name	Park, Community Estate and Facilities.	Executive Sponsor	David Powell

Project Ref	Project Title	Project Description	Executive Sponsor Assures the project	OVERALL PROJECT RAG	An effective project team is in place	Scope and Approach is	Targets / benefits defined/on track	Milestone plan is defined/on track	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	Comments for attention of the Project Team, Steering Group and sub-Committee
					Explored			Established			Designed		Delivered / Sustained
R&BD 5.1	Decommission & Demolition	The aim of the project is to move out from and make safe the old hospital ready for demolition	David Powell										PID available, however details of benefits requires review in line with revised/ updated dates. Milestone plan shows slippage (car park demolition). Details of communication/engagement activities to be confirmed and evidence provided where possible. Risks now on Ulysses, some require review. **Last updated 20 October 2017**
R&BD 5.2	R&E 2	The aim of the project is to complete Phase 2 of the RI & E building to a world class standard	David Powell										Team action notes available to 13 September. PID available, benefits to be confirmed. Milestone Plan shows some delays (tenancy agreements and D&B contract signatures) now over 3 months from original milestone date. Details of comms/engagement activities to be confirmed and evidence provided where possible. Issues Log uploaded, risks to be entered on Ulysses. EA/QIA completed and signed off. **Last updated 20 October 2017**
R&BD 5.3	Alder Centre	To plan, develop and construct the new Alder Centre within the park setting	David Powell										Steering Group meeting notes available. Scope/approach defined in PID (revised recently). Benefits defined in PID. Milestone Plan has been revised recently - shows initial actions on track. Evidence of Comms/ Engagement activities. Risks to be confirmed on Ulysses. EA/QIA complete. **Last updated 20 October 2017**
R&BD 5.4	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										Updated PID on SharePoint - confirmation of updates required/approval at Steering Group. Benefits defined in PID, tracking/reporting of delivery required. Milestone plan shows actions on track, however clarification of those now missed. Risks on Ulysses - need confirmation these are up to date. EA/QIA complete. **Last updated 11 October 2017.**
R&BD 5.5	Residential Development	To create a high quality residential scheme that co-ordinates with the themes and activities within the wider park site	David Powell										Scope/approach and benefits defined in PID. Plan shows extended delays - planning permission and public consultation milestones missed and no revised milestones are currently showing on the plan. Evidence required of comms/engagement activities. Risks on Ulysses and require review (last review May 2017). EA/QIA complete. **Last updated 20 October 2017.**
R&BD 5.6	International Design & Build Consultancy	To develop business in advising other health organisations - both nationally and internationally - with organisational new builds	David Powell										Work stream reports need to be augmented with evidence of notes/minutes of project meetings. Draft/outline PID on SharePoint. All project documentation to be fully developed including risk register. **Last updated 20 October 2017**
R&BD 5.7	Reprovision of Retained Estates	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										Some statistics available on numbers for whom estate/space is needed. A high level critical path has been uploaded as well as an option for external provision of space. All project documentation to be fully developed. Important to have the 'people' aspects detailed on the plans for all departments (personal move plans, consultation, 'day in the life' etc as per hospital move). **Last updated 20 October 2017.**
R&BD 5.8	Neuro-Developmental Hub (TBC)	This project is currently at the exploratory and feasability stage and will be rated once fully launched	David Powell										SOA' available. All project documentation awaiting strategic decision on strategy. **Last updated 20 September 2017.**

Financial Reporting: Refer to CIP Update report

Alder Hey Children's NHS
NHS Foundation Trust

Programme Assurance Summary
Strong Foundations

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

All projects need to be brought to green ratings in a timescale set by the Executive Sponsor.

Inventory Management and Procurement Projects should now consider stretching their targets for FY17/18.

The Energy project aims should be considered with a view to achieving greater savings at the earliest possible date (stretching targets).

Claire Liddy, Director of Operational Finance – 24 October 2017

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

The work stream has recently been established to provide transparency and assurance of progress of 3 important initiatives which form a critical part of the CIP programme. The ratings are progressing towards green and the remaining actions to achieve that status should now be expedited.

At time of writing, the Assurance 'Team 'await the financial contribution figures towards the overall CIP which should be added to this report.

Joe Gibson, External Programme Assessment – 24 October 2017

Programme Assurance Framework
Strong Foundations (Completed by Assurance Team)

Alder Hey Children's NHS Foundation Trust

Sub-Committee	R&BD	Report Date	24 October 2017
Workstream Name	Strong Foundations	Executive Sponsor	John Grinnell/ David Powell

Current Dashboard Rating:

Project Ref	Project Title	Project Description	Executive Sponsor Assures the project	OVERALL PROJECT RAG	An effective project team is in place (Explored)	Scope and Approach is	Targets / benefits defined/on track	Milestone plan is defined/on track (Established)	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment (Designed)	Equality Analysis	Comments for attention of the Project Team, Steering Group and sub-Committee (Delivered / Sustained)
7.0 Strong Foundations 17/18 £TBC													
RABD 7.1	Inventory Management	The Procurement CIP scheme is an annual project aimed at ensuring that best value is obtained in respect of the supply of all goods and services purchased by the Trust.	John Grinnell										Documentation relevant to this specific type of project now on SharePoint. Plan to be updated, last upload 8Sep 17. Evidence of stakeholder engagement required and EA/QIA to be signed off. **Last updated 11 October 2017.**
RABD 7.2	Collaborative Procurement	The Procurement CIP scheme is an annual project aimed at ensuring that best value is obtained in respect of the supply of all goods and services purchased by the Trust.	John Grinnell										Documentation relevant to this specific type of project now on SharePoint. Evidence of stakeholder emgagement required and EA/QIA to be signed off. **Last updated 17 October 2017.**
RABD 7.3	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										Project documentation now available available on SharePoint. Precision required on benefits sought and delivered. More detail required in the project plan. Further evidence needed on risks, stakeholder engagement, meetings of the team. EA/QIA to be signed off and scanned copy uploaded. **Last updated 17 October 2017.**

Financial Reporting: Refer to CIP Update report

Corporate Report

Sep 2017

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Executive Summary

Sep 2017

Alder Hey Children's NHS Foundation Trust

Is there a Governance Issue?

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

Highlights

The Trust is compliant with all NHSI standards including the 4hr standard despite the higher than planned NEL admissions and ED attendance. We have also achieved Q2 performance against the 4 hour standard. Winter Plan to be come operational from October to support flow and to ensure we are Flu ready. Clinical Utilisation Review system is now operational to assist with the management of flow. 28 day breach management has meant zero breaches to report for September. No patients waiting >52 weeks

Challenges

High levels of Non Elective admissions for surgery and medicine in conjunction with higher than planned ED attendance have made September a challenging month. This has impacted upon flow which in conjunction with increased elective LOS has effectively reduced levels of productivity within the hospital. This has meant that cancelled operations have increased as capacity has not been available when required which directly and negatively impacts theatre utilisation. Despite this 28 day relist breaches have reduced. CUR data will now be used within bed meetings and support winter plan from October. ED 4 hour standard was achieved for the month and the quarter despite the high attendance.

Patient Centred Services

Deterioration noted in performance in metrics but core standards all achieved. High levels of NEL admission and ED attendance have tested the hospital and deterioration noted with theatre and OP utilisation. Theatre productivity hampered by cancelled operations on the day and when split surgical performance has improved but medical theatre utilisation has deteriorated. OP utilisation also requires further review as medical division utilisation has improved but community & surgery have worsened. Elective LOS has also increased by 0.6 days against same period last year notably within paediatric surgery so further review required although higher levels of acuity have been advised. DNA rates have improved but true performance maybe masked by cashing up challenges within clinics. This is being addressed through the OP improvement group.

Excellence in Quality

There were 3 medication errors associated with harm reported in September. This maintains the trend of lower medication incidents compared to last year. An increase in clinical incidents associated with harm is being explored further to identify any changes or trends. All inpatient survey measures improved in September, however 4 of the measures remain behind target. Friends and Family responses from A&E and Community still needs to be improved . The number of complaints remains similar to last year and PALS attendances remains lower year to date. There were 6 recorded hospital infections in September, i.e. 26 year to date compared with 51 at this time last year. There were 5 in month readmissions of patients with long term conditions within 48 hours. For surgical patients with an Estimated Date of Discharge (EDD), 4.1% (72 patients) were discharged later than planned.

Financial, Growth & Mandatory Framework

For the month of September the Trust is reporting a trading deficit of £0.6m which is slightly ahead of plan.

Income is ahead of plan by £0.1m mainly due to income relating non elective and critical care activity. Elective activity is behind plan by 10%, non elective is ahead by 11% and outpatient activity is behind by 8%.

Pay budgets are 0.1m overspent for the month relating to use of temporary staffing. The Trust is on plan with the CIP target to date. Cash in the Bank is £9.1m. Monitor Use of Resources rating of 3 in line with plan.

Great Talented Teams

The Trust position on sickness absence has not significantly altered in the last three months at 5%. However the trend is seeing an increase since the summer months where absence was only slightly above target at 4.6%. PDR's have continued to increase outside of the reporting window and are now at 86.2%. Mandatory training figures have decreased to 74.4% from previous month at 77.%. There is a strong focus to increase the mandatory training position to ensure that the Trust reaches a min of 90% compliance. HR&OD are working with the divisions to ensure that this target is achieved.

Leading Metrics

Sep 2017

Alder Hey Children's NHS
NHS Foundation Trust

Patient Centered Services

Metric Name	Goal	Aug 2017	Sep 2017	Trend	Last 12 Months
ED: 95% Treated within 4 Hours	95.0 %	98.3 %	95.0 %	▼	
RTT: 90% Admitted within 18 weeks		89.0 %	86.8 %	▼	
RTT: 95% Non-Admitted within 18 weeks		89.5 %	89.4 %	▼	
RTT: 92% Waiting within 18 weeks (open Pathways)	92.0 %	92.0 %	92.0 %	▼	
Diagnostics: Numbers waiting over 6 weeks		0	0	–	
Average LoS - Elective (Days)		2.9	3.1	▲	
Average LoS - Non-Elective (Days)		2.2	2.1	▼	
Daycase Rate	0.0 %	70.3 %	71.3 %	▲	
Theatre Utilisation - % of Session Utilised	90.0 %	87.5 %	86.5 %	▼	
28 Day Breaches	0.0	9	0	▼	
Clinic Session Utilisation	90.0 %	84.7 %	84.1 %	▼	
DNA Rate	12.0 %	11.4 %	10.6 %	▼	
Cancelled Operations - Non Clinical - On Same Day		15	47	▲	

Excellence in Quality

Metric Name	Goal	Aug 2017	Sep 2017	Trend	Last 12 Months
Never Events	0.0	0	0	–	
IP Survey: % Received information enabling choices about their care	90.0 %	92.1 %	96.5 %	▲	
IP Survey: % Treated with respect	100.0 %	99.3 %	99.5 %	▲	
IP Survey: % Know their planned date of discharge	80.0 %	53.9 %	65.0 %	▲	
IP Survey: % Know who is in charge of their care	95.0 %	91.2 %	92.8 %	▲	
IP Survey: % Patients involved in play and learning	80.0 %	65.7 %	73.0 %	▲	
Pressure Ulcers (Grade 2 and above) YTD		22	23	▼	
Total Infections (YTD)	42.0	20	26	▲	
Medication errors resulting in harm (YTD)	30.0	9	12	▲	
Clinical Incidents resulting in harm (YTD)	294.0	378	459	▲	

Great and Talented Teams

Metric Name	Goal	Aug 2017	Sep 2017	Trend	Last 12 Months
Corporate Induction	100.0 %	55.6 %	85.0 %	▲	
PDR	90.0 %	84.7 %	86.2 %	▲	
Medical Appraisal	100.0 %	81.0 %	8.0 %	▼	
Sickness	4.5 %	4.9 %	5.0 %	▲	
Mandatory Training	90.0 %	77.2 %	74.4 %	▼	
Staff Survey (Recommend Place to Work)		39.6 %	39.6 %	–	
Actual vs Planned Establishment (%)		92.9 %	93.2 %	▲	
Temporary Spend ('000s)		1166	999	▼	

Financial, Growth and Mandatory Framework

Metric Name	Aug 2017	Sep 2017	Last 12 Months
CIP In Month Variance ('000s)	37	5	
Monitor Risk Ratings (YTD)	3	3	
Trading Surplus/(Deficit)	-1691	-456	
Capital Expenditure YTD % Variance	-58.5 %	-3.5 %	
Cash in Bank (£M)	10.4	9.1	

Exceptions

Sep 2017

Alder Hey Children's NHS Foundation Trust

Positive (Top 5 based on % change)

Metric Name	Sep 2016	Oct 2016	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Last 12 Months
PDR	69.3%	73.3%	73.0%	70.5%	71.3%	71.1%	59.2%	2.1%	12.4%	48.3%	78.7%	84.7%	86.2%	
CIP In Month Variance ('000s)	42	157	-18	78	-373	-464	-183	-52	69	161	-72	37	5	
Temporary Spend ('000s)	969	894	800	550	1,442	813	1,037	948	917	883	1,092	1,166	999	
Trading Surplus/(Deficit)	2,293	500	1,104	-776	535	470	5,972	-1,905	-448	-127	-270	-1,691	-456	
Medication errors resulting in harm (YTD)	25	31	39	44	52	57	66	1	2	3	7	9	12	

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

Metric Name	Sep 2016	Oct 2016	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Last 12 Months
RTT: 90% Admitted within 18 weeks	88.9%	88.1%	89.2%	87.9%	87.5%	88.9%	87.9%	89.6%	90.3%	88.8%	89.1%	89.0%	86.8%	
RTT: 92% Waiting within 18 weeks (open Pathways)	92.0%	92.1%	92.1%	92.1%	92.4%	92.1%	92.1%	92.1%	92.1%	92.1%	92.0%	92.0%	92.0%	
Cancelled Operations - Non Clinical - On Same Day	16	22	28	12	17	29	31	7	57	19	31	15	47	
Actual vs Planned Establishment (%)	91.8%	87.0%	91.8%	87.7%	89.0%	92.3%	95.1%	94.8%	94.9%	94.8%	97.4%	92.9%	93.2%	
Total Infections (YTD)	51	60	69	75	84	93	104	6	9	13	15	20	26	

Challenge (Top 5 based on % change)

Metric Name	Sep 2016	Oct 2016	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Last 12 Months
Clinic Session Utilisation	83.0%	85.9%	86.9%	83.2%	84.4%	85.2%	88.0%	86.6%	85.9%	85.0%	85.7%	84.7%	84.1%	
Corporate Induction	85.5%	100.0%	74.1%	81.5%	77.8%	77.8%	82.4%	82.9%	85.7%	79.3%	100.0%	55.6%	85.0%	
Medical Appraisal	5.1%	11.0%	16.7%	48.4%	57.2%	64.8%	87.0%	77.7%	77.7%	33.3%	79.2%	81.0%	8.0%	
IP Survey: % Patients involved in play and learning	31.0%	55.9%	55.1%	56.1%	55.6%	77.1%	75.7%	81.4%	75.8%	71.3%	74.0%	65.7%	73.0%	
Mandatory Training	74.1%	75.4%	75.3%	76.1%	77.2%	78.8%	75.4%	76.1%	76.0%	76.2%	78.2%	77.2%	74.4%	

Patient Safety

Sep 2017

Alder Hey Children's NHS Foundation Trust

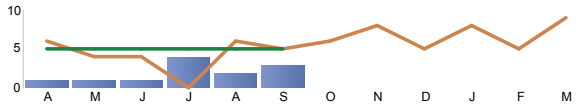
Summary

There were 3 medication errors resulting in harm reported in September which equates to 12 year to date compared with 25 last year. There was 1 pressure ulcer reported in month, increasing the year to date position to 23 (vs 16 last year). Never events remain at zero for the year. Clinical incidents with harm remains significantly higher at 464 compared to 295 last year. A deeper analysis is ongoing to explore if this is simply improved reporting or if there are any trends or areas causing a real increase in harm. There were 4 incidents resulting in moderate or higher harm in September, and 2 SIRIs declared in month taking the total to 12 for the year.

17/18 16/17 Threshold

Medication Errors

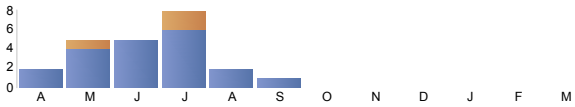
Medication errors resulting in harm (YTD) — 12 (goal: 30.0)



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

Pressure Ulcers

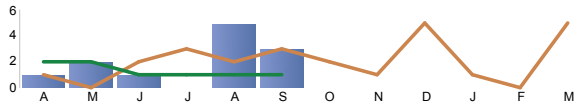
Pressure Ulcers (Grade 2 and above) YTD — 23 (Est. Baseline)



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

Readmissions to PICU within 48 hrs

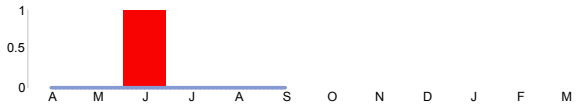
Readmissions to PICU within 48 hrs (YTD) — 12 (goal: 8.0)



YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	1	3	4	4	9	12						
16/17	1	1	3	6	8	11	13	14	19	20	20	25

Never Events

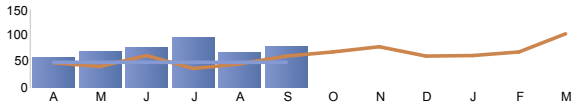
Never Events — 0 (goal: 0.0)



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

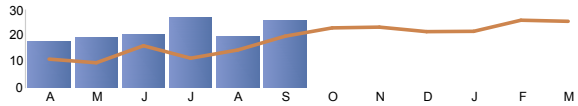
Incidents

Clinical Incidents resulting in harm (YTD) — 459 (goal: 294.0)



YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	60	131	210	309	378	459						
16/17	48	89	151	188	234	295	364	443	504	566	635	739

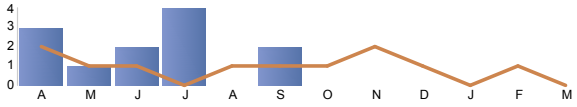
% of Total Clinical Incidents that resulted in Harm — 26.2 %



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

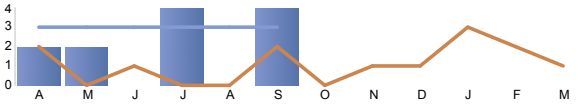
Serious incidents requiring investigation

Serious Incidents Requiring Investigation (Total) — 2



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

Clinical Incidents resulting in moderate, severe harm or death (YTD) — 12 (goal: 18.0)



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

Patient Experience

Sep 2017

Alder Hey Children's NHS Foundation Trust

Summary

There were 4 formal complaints in month, i.e. 31 year to date - very similar to last year's position. Cumulatively PALS attendances remain lower than last year, although 121 attendances in September is the highest of any month this year.
All in-patient survey measures have improved this month compared with last month. However 4 of these measures remain behind target. Friends and Family responses from A&E and Community remain low and still need to be improved.

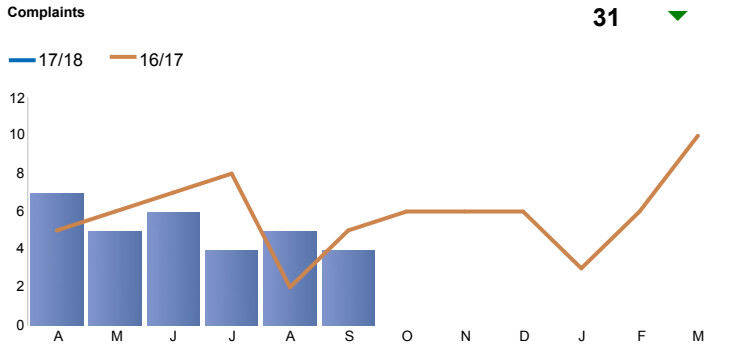
Inpatient Survey

Metric Name	Goal	Aug 2017	Sep 2017	Trend	Last 12 Months
% Know who is in charge of their care	95.0 %	91.2 %	92.8 %	▲	
% Patients involved in play and learning	80.0 %	65.7 %	73.0 %	▲	
% Know their planned date of discharge	80.0 %	53.9 %	65.0 %	▲	
% Received information enabling choices about their care	90.0 %	92.1 %	96.5 %	▲	
% Treated with respect	100.0 %	99.3 %	99.5 %	▲	

Friends and Family

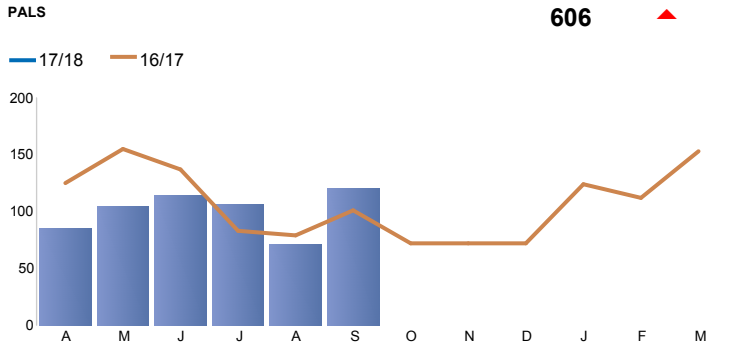
Metric Name	Required Responses	Number of Responses	Aug 2017	Sep 2017	Trend	Last 12 Months
A&E - % Recommend the Trust	250	59	92.3 %	93.2 %	▲	
Community - % Recommend the Trust	29	4	100.0 %	100.0 %	–	
Inpatients - % Recommend the Trust	300	452	94.2 %	98.5 %	▲	
Mental Health - % Recommend the Trust	27	27	96.7 %	96.3 %	▼	
Outpatients - % Recommend the Trust	400	440	92.0 %	91.4 %	▼	

Complaints



YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	7	12	18	22	27	31						
16/17	5	11	18	26	28	33	39	45	51	54	60	70

PALS



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

Clinical Effectiveness

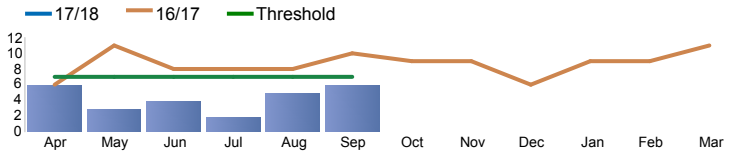
Sep 2017

Alder Hey Children's NHS Foundation Trust

Summary

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

Infections



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

Total Infections (YTD)

26 (goal: 42.0)

Hospital Acquired Organisms - MRSA (BSI) (YTD)

0 (goal: 0.0)

Hospital Acquired Organisms - C.difficile (YTD)

0 (goal: 0.0)

Outbreak Infections (YTD)

2

Cluster Infections (YTD)

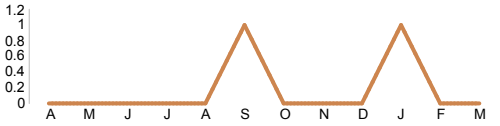
0

Legend

17/18
16/17
Threshold

Hospital Acquired Organisms - MRSA (BSI)

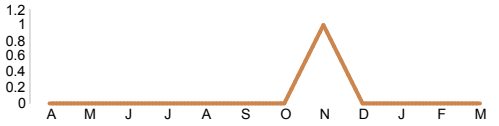
0 (goal: 0.0)



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

Hospital Acquired Organisms - C.difficile

0 (goal: 0.0)



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

Acute readmissions of patients with long term conditions within 28 days

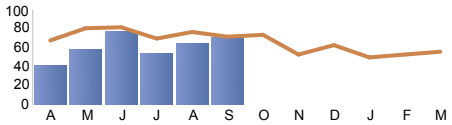
37 (Est. Baseline)

YTD	Apr	May	Jun	Jul	Aug	Sep
17/18	9	11	19	24	31	37

Admissions & Discharges

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

373 (Est. Baseline)

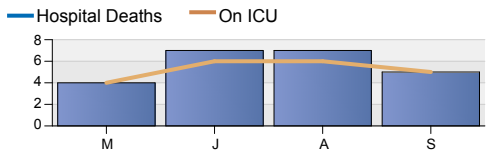


% of patients with an estimated discharge date discharge later than planned (only surgical)

4.1 % (Est. Baseline)

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

Mortality in Hospital



Deaths in Hospital

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

Access

Sep 2017

Alder Hey Children's NHS Foundation Trust

Summary

NHSI core standards achieved for September. Activity consistent with same period last year but hospital utilisation has increased. Very busy month for ED & NEL admissions with notable increases for surgery and medicine. Referrals consistent for Sep against same period last year with C&B capacity available to meet demand. No patients waiting greater than 52 weeks.

18 Weeks

RTT: 90% Admitted within 18 weeks 86.8 %

Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
87.6%	88.4%	88.0%	89.5%	88.3%

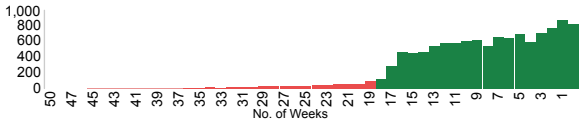
RTT: 95% Non-Admitted within 18 weeks 89.4 %

Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
87.9%	86.6%	88.9%	89.1%	89.2%

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

Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
92.1%	92.1%	92.2%	92.1%	92.0%

Open Pathways Weekly Profile Sep 2017



0-18 Wks	19-36 Wks	36-51 Wks
11,195	717	119

Cancer

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

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

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

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

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

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

Diagnostics

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

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

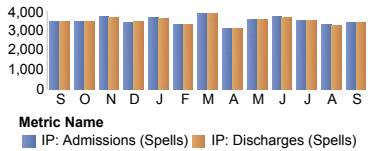
Waiting Times Failed 0

Waiting Times Passed 7

Number of Diagnostics

428

Admissions and Discharges



Bed Occupancy

Bed Occupancy (Funded Beds) 80.5 %

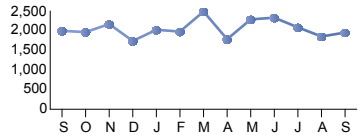
Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
76.6%	80.2%	83.9%	80.1%	79.3%

Provider

Convenience and Choice: Slot Availability 96.6 % *(goal: 96.0 %)*

Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
97.5%	99.2%	97.0%	98.0%	98.4%

Referrals Received (GP)



Emergency Department

Sep 2017

Alder Hey Children's NHS Foundation Trust

Summary

September achievement of the 4 hour waiting time standard secured the quarter result and associated STF funding. The longest waiting patient was due to clinical acuity and the time spent in ED was appropriate.We have also not reported any ambulance turn around time breaches. Focus has been on winter planning and supporting the introduction of the enhanced primary care streaming model.

ED

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

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

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

Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
705.0	838.8	714.0	717.0	753.0

ED: Longest Wait Time (Hrs) — 9.6 ▲ (goal: 0.0)

Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
27.6	36.0	30.6	61.3	28.5

ED: Number Treated Over 4 Hours

230

ED to Inpatient Conversion Rate

16.6 %

Sep 2017

ED

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

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

ED: 60 minute 'Time to Treat Decision' (Median) — 70.0 mins ▲ (goal: 60.0 mins)

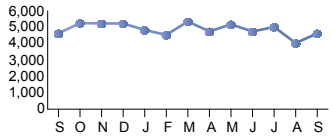
Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
184.0	239.0	227.0	247.5	206.0

ED: Percentage Left without being seen — 2.7 % ▲

Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
2.2%	3.1%	2.3%	3.0%	2.8%

ED: Number of Attendances

4624 Sep 2017



Ambulance Services

Ambulance: Acute Compliance — 79.3 % ▼ (goal: 85.0 %)

Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
86.5%	83.3%	90.1%	88.4%	84.2%

Ambulance: Average Notification to Handover Time (mins) — 4.3 mins ▲ (goal: 15.0 mins)

Ambulance: Patients Waiting between 30 and 45 minutes — 2 ▲

Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
16.0	5.0	11.0	9.0	4.0

Ambulance: Patients Waiting between 45 and 60 minutes — 0 ▼

Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
3.0	4.0	2.0	2.0	1.0

Productivity & Efficiency

Sep 2017

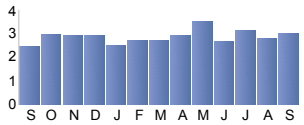
Alder Hey Children's NHS Foundation Trust

Summary

High levels of Non Elective admissions for surgery and medicine in conjunction with higher than planned ED attendance have made September a challenging month. This has impacted upon flow which in conjunction with increased elective LOS has effectively reduced levels of productivity within the hospital. This has meant that cancelled operations have increased as capacity has not been available when required which directly and negatively impacts theatre utilisation. Despite this 28 day relist breaches have reduced. CUR data will now be used within bed meetings and support winter plan from October

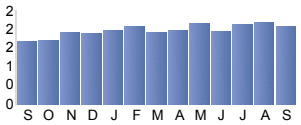
Length of Stay

Average LoS - Elective (Days) 3.1 ▲



Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
2.8	3.0	2.7	3.1	3.0

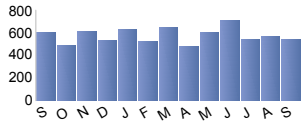
Average LoS - Non-Elective (Days) 2.1 ▼



Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
1.8	1.9	2.0	2.1	2.1

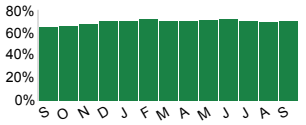
Day Case Rate

Daycases (K1/SDCPREOP) 550 ▼



Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
1,721	1,653	1,820	1,819	1,674

Daycase Rate 71.3 % ▲ *(goal: 0.0 %)*



Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
66.7%	68.6%	71.2%	71.9%	70.8%

Bed Refusals

Bed Refusals 0 – *(goal: 0.0)*

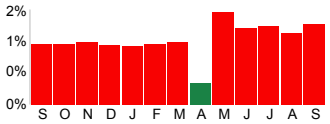
Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
0	0	1	0	0

Theatres / Surgery

Theatre Utilisation - % of Session Utilised * 86.5 % ▼ *(goal: 90.0 %)*

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

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



Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
0.8%	0.9%	1.1%	1.2%	1.4%

Cancelled Operations - Non Clinical - On Same Day 47 ▲

Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
50	62	77	83	93

28 Day Breaches 0 ▼ *(goal: 0.0)*

Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
12	11	8	11	10

Outpatients

Clinic Session Utilisation * 84.1 % ▼ *(goal: 90.0 %)*

Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
83.0%	85.4%	85.9%	85.8%	84.8%

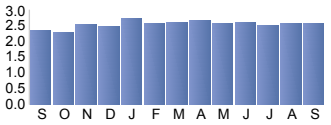
OP Appointments Cancelled by Hospital % 12.8 % ▼ *(goal: 5.0 %)*

Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
14.7%	14.6%	14.6%	13.3%	13.0%

DNA Rate 10.6 % ▼ *(goal: 12.0 %)*

Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
13.5%	12.6%	12.0%	12.6%	11.0%

OP: New/Follow Up 2.6 ▲



Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
2.4	2.5	2.7	2.6	2.6

Facilities

Sep 2017

Alder Hey Children's NHS Foundation Trust

Summary

Still have not been able to complete the full range of audits but planning this will be rectified during October. Figures submitted are for the small selection that have been completed during the month.

Facilities

Cleanliness Performance VH 97.7 % (goal: 98.0 %)

Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
97.5%	96.7%	97.7%	99.7%	96.9%

Cleanliness Performance H 96.0 % (goal: 95.0 %)

Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
94.4%	95.7%	94.0%	94.6%	96.0%

Cleanliness Performance S 85.2 % (goal: 85.0 %)

Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
93.0%	96.3%	96.5%	90.3%	84.6%

Cleanliness Performance L 75.7 % (goal: 75.0 %)

Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
98.2%	100.0%	100.0%	90.0%	75.1%

Facilities

Audit Compliance 25.0 % (goal: 85.0 %)

Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
100.0%	77.0%	40.0%	6.7%	21.7%

Facilities - Other

Routine Maintenance Resolution 92.4 % (goal: 85.0 %)

Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
97.4%	99.7%	96.6%	92.6%	95.7%

PPM% 96.9 % (goal: 85.0 %)

Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
97.8%	94.4%	96.1%	94.8%	97.9%

CAMHS

Sep 2017

Alder Hey Children's NHS
NHS Foundation Trust

Summary

The Average wait for the pathway continues to rise. Sefton this is a consequence of the removal of Local Authority Funding, which has resulted in the inability replace vacancy. Funding has now been identified and the team are now undertaking a remodelling exercise to identify gaps and where appropriate re-allocation of provision within the service. Liverpool waits are a consequence of sickness. A Deep Dive into DNAs is to be undertaken.

Waiting Times

CAMHS: Avg Wait to Partnership Appt (Weeks)- Liverpool Specialist 20.0

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

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

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

ED Pathways

Routine ED Pathway Average Wait in Weeks 2

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

Urgent ED Pathway Average Wait in Weeks 0

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

DNA Rates

CAMHS: DNA Rate - New 13.7 % (goal: 10.0 %)

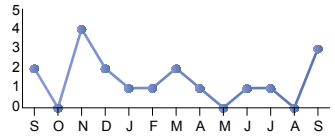
Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
15.2%	13.4%	13.4%	14.0%	17.3%

CAMHS: DNA Rate - Follow Up 15.8 % (goal: 14.0 %)

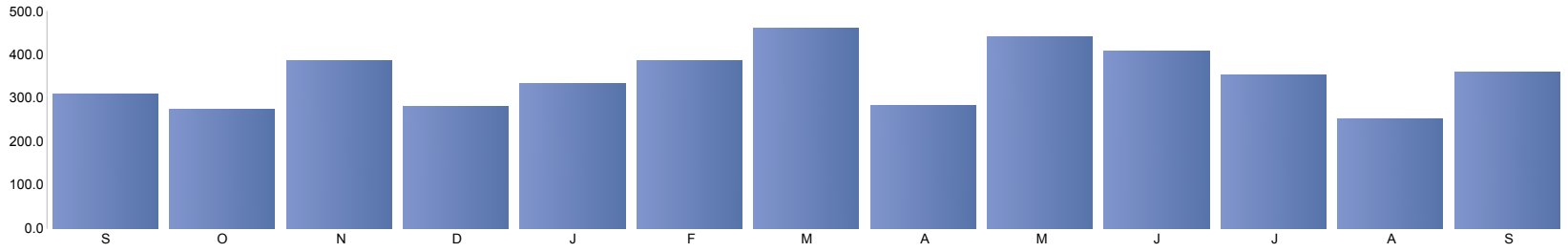
Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
15.5%	16.0%	17.5%	17.7%	15.9%

Tier 4 Admissions

CAMHS: Total Admissions to DJU 3



CAMHS: Referrals Received



External Regulation

Sep 2017

Alder Hey Children's NHS Foundation Trust

Summary

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

Monitor - Governance Concern

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

Monitor - Risk Rating

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

Monitor Sep 2017

Metric Name	Goal	Aug 17	Sep 17	Trend
ED: 95% Treated within 4 Hours	95.0 %	98.3 %	95.0 %	▼
RTT: 90% Admitted within 18 weeks		89.0 %	86.8 %	▼
RTT: 95% Non-Admitted within 18 weeks		89.5 %	89.4 %	▼
RTT: 92% Waiting within 18 weeks (open Pathways)	92.0 %	92.0 %	92.0 %	▼
Monitor Risk Ratings (YTD)	2.0	3	3	–
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals	100.0 %	100.0 %	100.0 %	–
All Cancers: 31 day wait referral to treament	100.0 %	100.0 %	100.0 %	–
All Cancers: 31 day wait until subsequent treatments	100.0 %	100.0 %	100.0 %	–
Hospital Acquired Organisms - C.difficile	0.0	0	0	–

Monitor - 18 Weeks RTT

RTT: 90% Admitted within 18 weeks

Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
87.6%	88.4%	88.0%	89.5%	88.3%

RTT: 95% Non-Admitted within 18 weeks

Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
87.9%	86.6%	88.9%	89.1%	89.2%

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

Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
92.1%	92.1%	92.2%	92.1%	92.0%

Monitor - All Cancers

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

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

All Cancers: 31 day wait referral to treament

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

All Cancers: 31 day wait until subsequent treatments

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

Monitor - A&E 4 Hour Target

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

Monitor - C difficile

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

Monitor - Data Completeness

No Data Available

Workforce

Sep 2017

Alder Hey Children's NHS Foundation Trust

Summary

The Trust position on sickness absence has not significantly altered in the last three months at 5%. However the trend is seeing an increase since the summer months where absence was only slightly above target at 4.6%. PDR's have continued to increase outside of the reporting window and are now at 86.2%. Mandatory training figures have decreased to 74.4% from previous month at 77.%. There is a strong focus to increase the mandatory training position to ensure that the Trust reaches a min of 90% compliance. HR&OD are working with the divisions to ensure that this target is achieved.

Staff Group Analysis

Sickness Absence (rolling 12 Months)

Staff Group	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Last 12 Months
Add Prof Scientific and Technic	5.0%	5.8%	5.2%	5.0%	5.9%	4.9%	3.6%	3.6%	3.9%	4.6%	4.3%	4.9%	
Additional Clinical Services	7.0%	6.9%	7.0%	6.6%	5.5%	5.7%	7.2%	7.4%	7.3%	7.7%	6.1%	5.7%	
Administrative and Clerical	5.2%	4.5%	4.7%	4.6%	5.0%	3.3%	2.9%	2.3%	2.4%	3.7%	4.2%	4.2%	
Allied Health Professionals	3.1%	3.3%	4.3%	2.3%	2.2%	3.5%	2.9%	3.2%	3.8%	3.2%	3.0%	3.2%	
Estates and Ancillary	8.4%	8.6%	10.9%	9.1%	7.4%	8.9%	10.7%	9.2%	9.1%	10.8%	14.6%	12.2%	
Healthcare Scientists	2.2%	1.9%	2.0%	1.7%	3.7%	2.3%	1.0%	3.3%	4.0%	4.6%	1.5%	3.1%	
Medical and Dental	2.7%	2.0%	1.6%	2.3%	2.4%	1.6%	1.1%	1.3%	1.3%	1.6%	1.6%	1.7%	
Nursing and Midwifery Registered	5.7%	6.2%	6.1%	6.4%	6.1%	5.5%	5.1%	5.4%	5.3%	5.1%	4.8%	5.2%	
Trust	5.4%	5.4%	5.6%	5.4%	5.2%	4.7%	4.5%	4.6%	4.6%	5.0%	4.9%	5.0%	

Staff in Post FTE (rolling 12 Months)

Staff Group	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Last 12 Months
Add Prof Scientific and Technic	200	199	198	198	197	201	197	199	201	200	197	199	
Additional Clinical Services	365	368	367	370	373	376	391	393	392	400	397	423	
Administrative and Clerical	568	574	573	586	589	586	611	621	618	624	626	623	
Allied Health Professionals	126	126	130	132	132	131	208	209	212	214	215	217	
Estates and Ancillary	192	190	190	189	189	189	187	185	184	184	183	182	
Healthcare Scientists	105	106	108	107	107	107	107	107	109	110	110	108	
Medical and Dental	245	246	245	245	246	243	243	242	246	241	248	250	
Nursing and Midwifery Registered	973	971	970	972	981	970	968	971	971	964	960	1,005	

Staff in Post Headcount (rolling 12 Months)

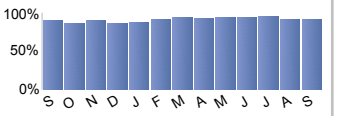
Staff Group	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Last 12 Months
Add Prof Scientific and Technic	221	220	218	218	217	221	218	220	223	223	219	220	
Additional Clinical Services	430	431	430	434	439	442	469	470	468	477	473	500	
Administrative and Clerical	666	671	670	677	679	673	700	709	708	714	715	711	
Allied Health Professionals	155	155	161	163	163	161	257	258	261	263	264	265	
Estates and Ancillary	241	238	238	236	236	236	234	231	231	230	229	228	
Healthcare Scientists	114	116	118	117	117	117	117	117	119	119	119	119	
Medical and Dental	283	285	284	284	287	284	285	285	288	284	290	294	
Nursing and Midwifery Registered	1,099	1,097	1,093	1,095	1,105	1,094	1,093	1,095	1,096	1,090	1,085	1,130	

Finance

Temporary Spend ('000s) 999

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

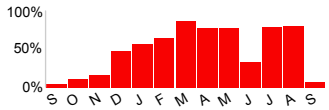
Actual vs Planned Establishment (%) 93.2 %



Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
90.9%	88.8%	92.2%	94.8%	94.3%

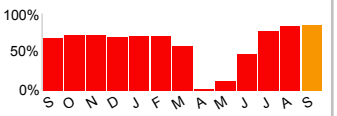
Appraisals

Medical Appraisal 8.0 % (goal: 100.0 %)



Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
5.2%	25.5%	68.5%	76.9%	57.8%

PDR 86.2 % (goal: 90.0 %)



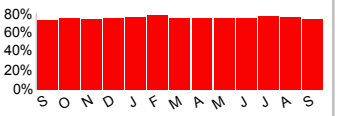
Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
62.7%	72.3%	67.2%	21.0%	83.1%

Training

Corporate Induction 85.0 % (goal: 100.0 %)

Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
81.5%	84.0%	79.5%	82.6%	81.0%

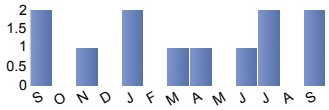
Mandatory Training 74.4 % (goal: 90.0 %)



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

Health and Safety

RIDDOR 2



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

Performance by CBU

Sep 2017

Alder Hey Children's NHS Foundation Trust

Operational

Metric name	COMMUNITY	MEDICINE	SURGERY
Clinic Session Utilisation	76.3%	87.4%	83.6%
Convenience and Choice: Slot Availability	100.0%	91.4%	100.0%
DNA Rate (Followup Appts)	13.6%	10.4%	9.7%
DNA Rate (New Appts)	13.1%	11.1%	9.6%
Referrals Received (GP)	332	634	985
Temporary Spend ('000s)	195	250	429
Theatre Utilisation - % of Session Utilised		82.0%	87.3%
Trading Surplus/(Deficit)	263	94	2,506

Patient

Metric name	COMMUNITY	MEDICINE	SURGERY
Average LoS - Elective (Days)	14.0	3.1	3.1
Average LoS - Non-Elective (Days)		1.6	2.7
Cancelled Operations - Non Clinical - On Same Day	0	2	45
Daycases (K1/SDCPREOP)	0	63	485
Diagnostics: % Completed Within 6 Weeks		100.0%	100.0%
Hospital Initiated Clinic Cancellations < 6 weeks notice	8	21	26
OP Appointments Cancelled by Hospital %	16.4%	13.6%	11.7%
RTT: 90% Admitted within 18 weeks		100.0%	85.0%
RTT: 92% Waiting within 18 weeks (open Pathways)	96.1%	94.2%	90.8%
RTT: 95% Non-Admitted within 18 weeks	87.3%	86.8%	90.7%

Quality

Metric name	COMMUNITY	MEDICINE	SURGERY
Cleanliness Scores			
Hospital Acquired Organisms - C.difficile	0	0	0
Hospital Acquired Organisms - MRSA (BSI)	0	0	0
Medication Errors (Incidents)	26	157	276

Workforce

Metric name	COMMUNITY	MEDICINE	SURGERY
Corporate Induction	100.0%	80.0%	71.4%
Mandatory Training	74.6%	75.7%	73.0%
PDR	87.4%	82.2%	90.1%
Sickness	6.6%	4.4%	4.7%

CBU Performance - Community

Sep 2017

Alder Hey Children's NHS
NHS Foundation Trust

Key Issues

Clinic session utilisation is below the required level despite increases in booking rates. This may be due to increase DNA rates which is being reviewed.

Support Required

Operational

Metric Name	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Last 12 Months
Theatre Utilisation - % of Session Utilised														
Clinic Session Utilisation	73.1%	78.4%	80.5%	74.1%	75.9%	80.3%	83.0%	79.0%	81.9%	79.9%	79.3%	76.7%	76.3%	
DNA Rate (New Appts)	12.9%	15.6%	12.8%	18.9%	15.4%	11.9%	11.8%	15.8%	16.5%	19.3%	16.2%	16.6%	13.1%	
DNA Rate (Followup Appts)	15.8%	13.8%	12.3%	17.7%	16.5%	15.7%	13.3%	15.2%	14.4%	16.0%	12.7%	16.1%	13.6%	
Convenience and Choice: Slot Availability	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%			100.0%	100.0%	
Referrals Received (GP)	313	307	393	298	268	336	385	229	387	323	320	232	332	
Temporary Spend ('000s)	144	37	60	47	77	72	150	67	103	116	146	169	195	
Trading Surplus/(Deficit)	244	355	341	415	410	256	442	343	414	299	224	145	263	

Patient

Metric Name	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Last 12 Months
RTT: 90% Admitted within 18 weeks														
RTT: 95% Non-Admitted within 18 weeks	87.5%	77.4%	78.0%	80.2%	75.3%	73.1%	88.4%	87.9%	85.4%	91.8%	91.4%	93.1%	87.3%	
RTT: 92% Waiting within 18 weeks (open Pathways)	88.5%	82.5%	85.9%	92.3%	92.8%	93.1%	94.4%	94.0%	97.4%	94.3%	94.6%	96.5%	96.1%	
Average LoS - Elective (Days)			22.00										14.00	
Average LoS - Non-Elective (Days)														
Hospital Initiated Clinic Cancellations < 6 weeks notice	29	23	29	1	9	19	8	15	3	12	5	13	8	
Daycases (K1/SDCPREOP)	0	0	0	3	0	0	0	0	2	0	1	0	0	
Cancelled Operations - Non Clinical - On Same Day	0	0	0	0	0	0	0	0	0	0	0	0	0	
OP Appointments Cancelled by Hospital %	22.9%	22.3%	17.0%	15.4%	14.2%	20.3%	20.8%	23.1%	14.7%	18.9%	13.6%	17.5%	16.4%	
Diagnostics: % Completed Within 6 Weeks														

Quality

Metric Name	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Last 12 Months
Medication Errors (Incidents)	20	24	26	27	29	30	31	3	5	8	10	17	26	
Cleanliness Scores														
Hospital Acquired Organisms - MRSA (BSI)	0	0	0	0	0	0	0	0	0	0	0	0	0	
Hospital Acquired Organisms - C.difficile	0	0	0	0	0	0	0	0	0	0	0	0	0	

Workforce

Metric Name	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Last 12 Months
Corporate Induction	86.7%	100.0%	72.7%	87.5%	87.5%	87.5%	100.0%	82.9%		88.9%	100.0%	57.1%	100.0%	
PDR	77.1%	82.1%	81.4%	75.4%	77.2%	76.4%	67.0%	0.0%	5.7%	26.5%	71.0%	82.8%	87.4%	
Sickness	6.2%	7.6%	8.8%	7.1%	7.1%	6.9%	5.9%	5.1%	5.6%	5.7%	6.4%	6.2%	6.6%	
Mandatory Training	73.2%	71.1%	70.9%	72.1%	75.8%	78.0%	57.1%	57.1%	56.1%	55.2%	74.5%	75.3%	74.6%	

CBU Performance - Medicine (Part 1)

Sep 2017

Alder Hey Children's NHS
NHS Foundation Trust

Key Issues

Division continues to review activity against last financial year and is identifying ways in which to address negative variance. Slot availability has dropped significantly and will be investigated. Temporary spend has fallen (a consequence of a greater complement of junior doctors and the internal financial delivery actions for the division). Improvement in PDR % also required. RTT: 95% Non-Admitted within 18 weeks also dropping and actions - validation discussions ongoing with Corp Information to find a resolution.

Support Required

N/A

Operational

Metric Name	Sep 2016	Oct 2016	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Last 12 Months
Theatre Utilisation - % of Session Utilised	85.0%	80.1%	79.1%	80.1%	82.9%	79.1%	85.4%	81.1%	83.6%	84.6%	76.9%	81.8%	82.0%	
Clinic Session Utilisation	84.0%	86.6%	86.9%	83.8%	85.4%	86.9%	89.6%	86.8%	86.7%	84.7%	86.7%	86.9%	87.4%	
DNA Rate (New Appts)	14.6%	14.8%	12.5%	14.6%	14.1%	12.4%	10.0%	15.0%	12.6%	12.6%	12.7%	12.1%	11.1%	
DNA Rate (Followup Appts)	15.4%	13.6%	16.1%	18.5%	16.3%	16.8%	13.0%	16.6%	15.8%	13.9%	11.1%	10.5%	10.4%	
Convenience and Choice: Slot Availability	99.4%	98.1%	100.0%	99.6%	96.1%	86.5%	99.4%	98.0%	96.3%	100.0%	100.0%	98.0%	91.4%	
Referrals Received (GP)	627	653	733	563	681	594	821	577	747	791	729	636	634	
Temporary Spend ('000s)	272	230	229	164	499	341	302	290	322	222	323	326	250	
Trading Surplus/(Deficit)	525	321	491	212	74	-113	1,012	-298	108	-152	-390	-302	94	

Patient

Metric Name	Sep 2016	Oct 2016	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Last 12 Months
RTT: 90% Admitted within 18 weeks	100.0%	89.6%	93.1%	87.6%	92.6%	100.0%	91.5%	96.4%		95.7%	90.5%	95.5%	100.0%	
RTT: 95% Non-Admitted within 18 weeks	85.4%	88.6%	83.2%	84.7%	92.4%	89.3%	90.9%	90.9%	86.2%	88.8%	89.1%	87.3%	86.8%	
RTT: 92% Waiting within 18 weeks (open Pathways)	93.2%	95.1%	96.0%	96.7%	96.9%	96.0%	94.8%	94.9%	94.5%	94.0%	93.6%	93.3%	94.2%	
Average LoS - Elective (Days)	2.72	3.27	3.25	3.66	3.64	3.22	3.20	3.50	3.40	2.94	3.05	2.90	3.06	
Average LoS - Non-Elective (Days)	1.34	1.29	1.54	1.53	1.44	1.69	1.57	1.62	1.60	1.51	1.65	1.49	1.63	
Hospital Initiated Clinic Cancellations < 6 weeks notice	27	22	41	29	41	37	27	20	18	23	17	16	21	
Daycases (K1/SDCPREOP)	86	52	46	65	68	63	70	58	70	103	70	71	63	
Cancelled Operations - Non Clinical - On Same Day	4	1	8	4	6	6	3	1	3	1	2	1	2	
OP Appointments Cancelled by Hospital %	13.4%	14.7%	13.6%	14.2%	14.6%	15.0%	14.1%	17.4%	11.2%	13.5%	14.6%	13.6%	13.6%	
Diagnostics: % Completed Within 6 Weeks	100.0%	76.9%	99.1%	99.5%	100.0%	99.7%	99.6%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	

Quality

Metric Name	Sep 2016	Oct 2016	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Last 12 Months
Medication Errors (Incidents)	146	168	198	228	251	270	305	25	58	84	109	139	157	
Cleanliness Scores	96.5%	95.8%	97.5%	97.0%	96.8%	96.8%	99.0%							
Hospital Acquired Organisms - MRSA (BSI)	1	0	0	0	1	0	0	0	0	0	0	0	0	
Hospital Acquired Organisms - C.difficile	0	0	0	0	0	0	0	0	0	0	0	0	0	

Workforce

Metric Name	Sep 2016	Oct 2016	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Last 12 Months
Corporate Induction	80.0%	100.0%	85.0%	83.3%	75.0%	75.0%	68.8%		81.8%	61.5%	100.0%	50.0%	80.0%	
PDR	81.6%	79.7%	79.4%	77.6%	76.7%	75.7%	69.7%	2.9%	15.4%	41.3%	73.8%	79.7%	82.2%	
Sickness	4.7%	4.9%	4.6%	4.8%	4.9%	5.3%	4.5%	4.0%	4.7%	4.2%	4.5%	3.8%	4.4%	
Mandatory Training	76.6%	76.9%	76.3%	76.4%	77.3%	79.2%	79.7%	80.1%	80.0%	80.5%	79.0%	78.3%	75.7%	

CBU Performance - Medicine (Part 2)

Sep 2017

Alder Hey Children's NHS
NHS Foundation Trust

Key Issues
MRI turnaround times continue to be a concern and are reliant on provision of an additional anaesthetist (due in February). Ultrasound waiting times also require investigation.

Support Required
N/A

Patient

Metric Name	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Last 12 Months
Imaging - % Report Turnaround times GP referrals < 24 hrs	89.0%	96.0%	95.0%	93.0%	96.0%	97.0%	87.0%	96.0%	91.0%	92.0%	90.0%	90.0%	86.0%	
Imaging - % Reporting Turnaround Times - ED	89.0%	88.0%	87.0%	88.0%	88.0%	93.0%	90.0%	80.0%	64.0%	76.0%	83.0%	82.0%	85.0%	
Imaging - % Reporting Turnaround Times - Inpatients	85.0%	87.0%	76.0%	80.0%	86.0%	89.0%	90.0%	78.0%	74.0%	79.0%	85.0%	85.0%	79.0%	
Imaging - % Reporting Turnaround Times - Outpatients	89.0%	93.0%	93.0%	94.0%	97.0%	98.0%	94.0%	92.0%	90.0%	92.0%	98.0%	98.0%	92.0%	
Imaging - Waiting Times - MRI % under 6 weeks	90.0%	88.0%	90.0%	92.0%	92.0%	86.0%	85.0%	71.0%	81.0%	67.0%	68.0%	77.0%	79.0%	
Imaging - Waiting Times - CT % under 1 week	90.0%	86.0%	84.0%	81.0%	81.0%	77.0%	87.0%	95.0%	89.0%	87.0%	87.0%	89.0%	87.0%	
Imaging - Waiting Times - Plain Film % under 24 hours	95.0%	95.0%	94.0%	94.0%	94.0%	92.0%	93.0%	93.0%	94.0%	93.0%	94.0%	92.0%	91.0%	
Imaging - Waiting Times - Ultrasound % under 2 weeks	88.0%	86.0%	85.0%	83.0%	83.0%	81.0%	87.0%	84.0%	88.0%	90.0%	91.0%	90.0%	87.0%	
Imaging - Waiting Times - Nuclear Medicine % under 2 weeks	91.0%	85.0%	100.0%	88.0%	88.0%	84.0%	93.0%	88.0%	95.0%	89.0%	100.0%	93.0%	72.0%	
BME - High Risk Equipment PPM Compliance	90.0%	90.4%	89.7%	93.0%	91.0%	91.1%	88.0%	80.2%	91.7%	91.6%	91.2%	90.1%	84.6%	
BME - Low Risk Equipment PPM Compliance	78.0%	77.0%	79.0%	80.0%	81.0%	80.8%	79.0%	100.0%	82.0%	81.9%	80.4%	75.5%	74.6%	
BME - Equipment Pool - Equipment Availability	100.0%	99.8%	100.0%	100.0%	99.8%	100.0%	100.0%	91.4%	99.8%	100.0%	100.0%	100.0%	100.0%	
Pharmacy - Dispensing for Out Patients - Routine	44.0%	45.0%	50.0%	51.0%	55.0%	50.0%	45.0%	57.0%	37.0%	60.0%	65.0%	63.0%	57.0%	
Pharmacy - Dispensing for Out Patients - Complex	100.0%	100.0%	97.7%	98.0%	100.0%	98.0%	98.0%	98.0%	100.0%	100.0%	96.0%	97.0%	100.0%	
Comm Therapy - % 1st Contact times following Pt opt in < 12 weeks	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	63.0%	63.0%	63.0%	54.3%	54.5%	80.0%	90.0%	

Quality

Metric Name	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Last 12 Months
Pathology - % Turnaround times for urgent requests < 1 hr	91.3%	90.2%	89.0%	87.9%	87.5%	88.7%	87.9%	89.7%	89.9%	91.0%	88.1%	88.1%	91.0%	
Pathology - % Turnaround times for non-urgent requests < 24hrs	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Reporting times for perinatal autopsies in 56 Calendar Days	100.0%	94.7%	100.0%	100.0%	80.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Blood Traceability Compliance	99.5%	100.0%	99.6%	99.8%	99.7%	98.8%	99.6%	99.4%	100.0%	100.0%	99.5%	99.8%	99.8%	

CBU Performance - Surgery

Sep 2017

Alder Hey Children's NHS
NHS Foundation Trust

Key Issues

Quality
Pressure ulcers- continued downwards trend, one for September.
Performance
Cancelled operations- remain high. Work underway to produce year round capped inpatient numbers for wards, currently only exist in winter plan period. Surgical flow working group set up: pro-active discharge management, nurse dispensing packs, EDD for all patients on admittance.
Improved number of discharges before 11AM, work will continue to decrease further.
Less OP appointments cancelled by trust, new booking system.

Support Required

Operational

Metric Name	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Last 12 Months
Theatre Utilisation - % of Session Utilised	88.3%	86.0%	86.1%	84.8%	87.2%	88.5%	87.1%	88.3%	87.9%	88.9%	87.7%	88.6%	87.3%	
Clinic Session Utilisation	84.0%	86.6%	87.9%	84.2%	85.5%	85.3%	88.0%	87.7%	86.1%	85.9%	86.3%	84.9%	83.6%	
DNA Rate (New Appts)	11.3%	10.1%	11.7%	13.2%	12.4%	11.9%	9.8%	10.3%	11.7%	12.4%	10.3%	10.7%	9.6%	
DNA Rate (Followup Appts)	10.6%	8.7%	9.0%	11.1%	8.7%	9.4%	8.3%	9.9%	10.1%	9.7%	9.7%	9.9%	9.7%	
Convenience and Choice: Slot Availability	99.1%	97.4%	100.0%	98.7%	100.0%	99.8%	95.3%	98.2%	99.5%	96.0%	99.0%	100.0%	100.0%	
Referrals Received (GP)	1,055	1,002	1,041	876	1,072	1,046	1,280	976	1,152	1,215	1,034	982	985	
Temporary Spend ('000s)	453	529	426	331	504	475	443	516	402	456	511	554	429	
Trading Surplus/(Deficit)	1,921	1,806	2,721	1,539	2,008	2,181	2,821	1,826	2,930	3,321	2,980	2,574	2,506	

Patient

Metric Name	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Last 12 Months
RTT: 90% Admitted within 18 weeks	87.7%	87.9%	88.9%	88.0%	86.8%	87.0%	87.2%	86.9%	90.3%	87.8%	88.8%	87.8%	85.0%	
RTT: 95% Non-Admitted within 18 weeks	88.7%	87.0%	88.6%	89.7%	92.8%	88.1%	89.1%	90.1%	89.8%	88.2%	88.1%	90.2%	90.7%	
RTT: 92% Waiting within 18 weeks (open Pathways)	92.0%	92.1%	91.3%	90.4%	90.6%	90.6%	90.9%	90.9%	90.8%	91.3%	91.2%	91.2%	90.8%	
Average LoS - Elective (Days)	2.43	2.87	2.88	2.73	2.17	2.39	2.62	2.58	3.57	2.57	3.10	2.90	3.06	
Average LoS - Non-Elective (Days)	2.27	2.65	2.64	2.55	3.02	2.78	2.64	2.84	3.06	2.57	2.86	2.96	2.74	
Hospital Initiated Clinic Cancellations < 6 weeks notice	56	34	72	20	30	54	22	19	23	28	35	32	26	
Daycases (K1/SDCPREOP)	515	442	570	471	562	461	582	426	540	609	472	499	485	
Cancelled Operations - Non Clinical - On Same Day	12	21	20	8	11	23	28	6	54	18	29	14	45	
OP Appointments Cancelled by Hospital %	13.8%	14.8%	14.6%	13.8%	14.0%	14.2%	13.7%	13.2%	11.2%	12.7%	12.0%	12.6%	11.7%	
Diagnostics: % Completed Within 6 Weeks	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	

Quality

Metric Name	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Last 12 Months
Medication Errors (Incidents)	264	295	336	367	396	430	477	40	97	146	188	243	276	
Cleanliness Scores	96.6%	95.1%	97.9%	96.0%	96.1%	96.2%	97.7%							
Hospital Acquired Organisms - MRSA (BSI)	0	0	0	0	0	0	0	0	0	0	0	0	0	
Hospital Acquired Organisms - C.difficile	0	0	1	0	0	0	0	0	0	0	0	0	0	

Workforce

Metric Name	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Last 12 Months
Corporate Induction	85.7%	100.0%	65.2%	71.4%	71.4%	71.4%	94.1%		90.0%	100.0%	100.0%	60.0%	71.4%	
PDR	64.2%	63.4%	63.3%	61.1%	63.4%	64.2%	45.1%	1.9%	11.2%	63.0%	87.6%	91.1%	90.1%	
Sickness	5.7%	5.7%	5.8%	5.5%	5.6%	4.9%	4.4%	4.5%	4.4%	4.7%	4.8%	4.6%	4.6%	
Mandatory Training	75.0%	75.3%	75.7%	77.0%	77.5%	78.7%	79.3%	80.6%	80.7%	81.5%	79.1%	77.0%	73.0%	

3. Financial Strength

3.1 Trust Income & Expenditure Report period ended September 2017

	In Month			Year to Date			Full Year		
	Budget £'000	Actual £'000	Variance £'000	Budget £'000	Actual £'000	Variance £'000	Budget £'000	Forecast £'000	Variance £'000
Clinical Income									
Elective	4,157	3,795	(362)	23,928	22,544	(1,385)	48,873	45,722	(3,151)
Non Elective	2,324	2,524	199	14,345	16,293	1,947	29,204	33,804	4,600
Outpatients	2,431	2,317	(114)	13,990	13,910	(80)	28,628	28,222	(406)
A&E	481	472	(9)	2,960	2,829	(131)	6,036	5,870	(167)
Critical Care	2,006	2,177	171	12,320	13,028	708	25,222	26,191	969
Non PbR Drugs & Devices	1,752	1,798	46	10,643	11,711	1,068	21,243	23,654	2,411
Excess Bed Days	388	332	(56)	2,329	2,183	(146)	4,658	4,063	(594)
CQUIN	261	262	1	1,567	1,570	3	3,134	3,337	203
Contract Sanctions	(10)	(7)	3	(63)	(43)	19	(125)	(87)	38
Private Patients	15	48	33	88	174	86	176	458	282
Other Clinical Income	3,012	3,127	116	17,873	18,405	532	37,476	40,117	2,640
Non Clinical Income									
Other Non Clinical Income	2,022	2,107	85	11,903	12,449	546	25,181	25,943	762
Total Income	18,838	18,952	114	111,884	115,052	3,167	229,707	237,295	7,588
Expenditure									
Pay Costs	(12,240)	(12,388)	(148)	(73,376)	(74,410)	(1,035)	(144,994)	(147,074)	(2,080)
Drugs	(1,528)	(1,691)	(163)	(9,640)	(11,203)	(1,563)	(19,228)	(22,244)	(3,016)
Clinical Supplies	(1,593)	(1,537)	56	(9,566)	(9,581)	(15)	(18,524)	(19,149)	(624)
Other Non Pay	(2,304)	(2,214)	89	(13,660)	(14,589)	(929)	(25,673)	(28,083)	(2,411)
PFI service costs	(329)	(307)	22	(1,974)	(1,847)	127	(3,948)	(3,721)	227
Total Expenditure	(17,994)	(18,137)	(143)	(108,215)	(111,630)	(3,415)	(212,367)	(220,272)	(7,905)
EBITDA	844	815	(29)	3,669	3,422	(248)	17,340	17,023	(317)
PDC Dividend	(114)	(114)	(1)	(683)	(683)	(1)	(1,365)	(1,365)	0
Depreciation	(548)	(495)	53	(3,225)	(2,970)	255	(6,409)	(6,154)	255
Finance Income	0	2	1	3	10	8	5	13	8
Interest Expense (non-PFI/LIFT)	(88)	(86)	2	(533)	(527)	6	(1,087)	(1,069)	18
Interest Expense (PFI/LIFT)	(675)	(675)	0	(4,049)	(4,049)	0	(8,098)	(8,098)	0
MASS/Restructuring	0	0	0	(247)	(284)	(37)	(247)	(284)	(37)
Gains/(Losses) on asset disposals	0	0	0	0	71	71	0	71	71
Control Total Surplus / (Deficit)	(580)	(553)	27	(5,066)	(5,009)	57	138	138	()
One-off normalising items									
STF Funding	0	0	0	0	93	93	0	93	93
Government Grants/Donated Income	614	1,633	1,019	5,715	3,603	(2,112)	12,750	7,695	(5,055)
Depreciation on Donated Assets	(176)	(172)	4	(1,046)	(1,025)	21	(2,089)	(2,068)	21
Fixed Asset Impairment	0	0	0	0	0	0	(1,536)	(1,536)	0
Reported Surplus/(Deficit)	(142)	908	1,050	(397)	(2,338)	(1,941)	9,263	4,322	(4,941)

Key Metrics	In Month			Year to Date			Full Year		
	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Forecast	Variance
Income £000	18,838	18,952	114	111,884	115,052	3,167	229,707	237,295	7,588
Expenditure £000	(19,418)	(19,505)	(87)	(116,950)	(120,061)	(3,111)	(229,569)	(237,157)	(7,588)
Control Total Surplus/(Deficit) £000	(580)	(553)	27	(5,066)	(5,009)	57	138	138	()
WTE	3,182	3,196	14	3,182	3,196	14			
CIP £000	429	434	5	2,125	2,273	147	8,000	5,984	(2,016)
Cash £000	1,400	9,116	7,716	1,400	9,116	7,716			
CAPEX FCT £000	2,002	1,932	70	11,114	5,947	5,167	28,972	23,844	5,128
Use of Resources Risk Rating	3	3	0	3	3	0	3	3	0

Activity Volumes	In Month			Year to Date			Full Year		
	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Forecast	Variance
Elective	2,490	2,243	(247)	14,394	13,462	(932)	29,307	27,112	(2,195)
Non Elective	1,061	1,182	121	6,661	7,202	541	13,769	14,708	939
Outpatients	17,567	16,157	(1,410)	101,538	103,200	1,662	206,735	204,398	(2,337)
A&E	4,493	4,619	126	27,690	28,264	574	56,463	58,646	2,183

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

	IN MONTH BUDGET	IN MONTH ACTUAL	IN MONTH VARIANCE	YEAR TO DATE BUDGET	YEAR TO DATE ACTUAL	YEAR TO DATE VARIANCE	FULL YEAR BUDGET	FULL YEAR FORECAST	FULL YEAR VAR TO REV BUDGET
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
ESTATES	**128**	**95**	**33**	**768**	**750**	**18**	**1,536**	**1,536**	**0**
RESEARCH & EDUCATION	**485**	**1,499**	**(1,014)**	**5,017**	**3,084**	**1,933**	**13,120**	**8,902**	**4,218**
ESTATES TOTAL CAPITAL	**613**	**1,594**	**(981)**	**5,785**	**3,834**	**1,951**	**14,656**	**10,438**	**4,218**
GDE, NETWORKING, INFRASTRUCTURE & OTHER IT	305	68	237	1,610	1,016	**594**	3,431	3,431	0
ELECTRONIC PATIENT RECORD	151	37	114	302	211	**91**	604	604	0
IM & T TOTAL CAPITAL	**456**	**105**	**351**	**1,912**	**1,227**	**685**	**4,035**	**4,035**	**0**
MEDICAL EQUIPMENT	104	185	(81)	925	527	**398**	1,529	1,529	0
NON-MEDICAL EQUIPMENT	0	()	0	220	108	**112**	220	220	0
CHILDRENS HEALTH PARK	142	18	124	885	102	**783**	5,347	5,347	0
ALDER HEY IN THE PARK TOTAL	**246**	**203**	**43**	**2,030**	**736**	**1,294**	**7,096**	**7,096**	**0**
OTHER	687	30	657	1,387	149	**1,238**	3,185	2,348	837
OTHER	**687**	**30**	**657**	**1,387**	**149**	**1,238**	**3,185**	**2,348**	**837**
CAPITAL PROGRAMME 17/18	***2,002***	***1,932***	***70***	***11,114***	***5,947***	***5,167***	***28,972***	***23,917***	***5,055***
FINANCE LEASES	***0***	***0***	***0***	***120***	***0***	***120***	***120***	***120***	***0***
CAPITAL PROGRAMME 17/18 INC FINANCE LEASES	***2,002***	***1,932***	***70***	***11,234***	***5,947***	***5,287***	***29,092***	***24,037***	***5,055***

Alder Hey Children's NHS
NHS Foundation Trust

Board of Directors
Tuesday, 7th November 2017

Report of	Director of Corporate Affairs
Paper prepared by	Executive Team, and Quality Assurance Officer
Subject/Title	2017/18 BAF Report
Background papers	Monthly BAF updates/reports
Purpose of Paper	To provide the Board with the BAF August report
Action/Decision required	The Board is asked to note the June position relating to the Board Assurance Framework
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	By 2020, we will: ➢ be internationally recognised for the quality of our care ***(Excellence in Quality)*** ➢ be recognised for the exceptional care we provide to our children, that is technologically enabled and matched by exceptional facilities ***(Patient Centred Services)*** ➢ have a fully engaged workforce that is actively driving quality improvement ***(Great Talented Teams)*** ➢ be a world class, child focussed centre of research & innovation expertise to improve the health and wellbeing outcomes for babies, children & young people ***(International Research, Innovation & Education)*** ➢ have secured sustainable long term financial and service growth supported by a strong international business ***(Growing our Services and Safeguarding Core Business)***
Resource Impact	Non achievement of the Trust's objectives could have a negative impact on the services provided by the Trust.

Alder Hey Children's NHS
NHS Foundation Trust

Board Assurance Framework 2017/18

1. Purpose

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

2. Review of the BAF

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

Alder Hey Children's NHS
NHS Foundation Trust

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

Changes since 30 May 2017 Board meeting

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

External risks

- ***Business development and growth (MB)***
  1) AH were awarded the Management Contract for Liverpool Community Health, (Liverpool Bundle) for May 2017. Future organisational structure being developed with NHSi, the 3 Acute Trusts, local authority, LCCG and local GP's. Opportunities for all to rationalise patient pathways.
  2) Partnership with Al Jalia now entering Phase 2. Specific deliverables identified and agreed. Work due to commence in Q2. Non NHS patient stretch target agreed and Q1 activity delivered.
  3) MOUs signed with two hospitals in China and work in progress to identifying workstreams and benefits.
  4) AH awarded contract for Design and Build Consultancy for Children's Hospital in Xian.

- ***Mandatory and compliance standards (ES)***
  Complaint with all national targets in month. Registration of community services with CQC is resolved.

- ***Developing the Paediatric Service Offer (MB)***
  Work commencing on the Implementation of the single service, two site model;
  1) Neonatal service model with NHS England and LWH on 6/7/17
  2) CHD Public Consultation closes in July. Results not expected to be released until January 2018. In the meantime AHCH and LCH are providing support to deliver services for patients due to the collapse of the Manchester service following the departure of their last remaining surgeon in June.
  3) Out of Hours group has been merged with the other workstreams to design a sustainable 24/7 paediatric service in light of further reductions and gaps in rotation. This workstream is named best in Acute Care and is led by the MD and Chief Nurse.

Internal risks:

- ***Maintain care quality in a cost constrained environment (HG)***
  All nursing staff now trained in Sepsis triggers; medical staff training to take place in August & September. Re-introduction of matron role across the Trust over next three months.

- ***Management Contract arrangement with Liverpool Community Health Trust (LS)***
  Stock take report compiled for NHS I. Plans in place to ensure services at both AH & LCH are managed safely and effectively. Senior Roles and associated back fill confirmed and communicated to all AH staff.

- ***New Hospital Environment (DP)***
  Probation period ended. Main outstanding issue – energy.

- ***Financial Environment (JG)***
  £0.3m behind control total at month 2. Residual Forecast financial risk of circa £5m identified by Divisions. Action Plan Produced and delivery tracked via Internal Recovery and RABD.

- ***Failure to fully realise the Trust's Vision for the Park (DP)***
  Consultation strategy presented at July board.

- ***IT Strategic Development (JG)***
  GDE funding confirmed and agreements signed / returned by DoF. Cash not received 27.06.17. Overall GDE programme milestones have slipped but on track to deliver objectives.

- ***Workforce Sustainability & Capability (MS)***
  Temporary Staffing Project initiated

- ***Staff Engagement (MS)***
  Launch of the Big Conversations with staff from across the Trust. Executive Visibility Programme commenced

- ***Workforce Diversity & Inclusion (MS)***
  First BME Network meeting. HRD as Exec sponsor.

- ***Research, Education & Innovation (DP)***
  Academy model agreed.

Erica Saunders
Director of Corporate Affairs
October 2017

Board Assurance Framework 2017-18

Alder Hey Children's NHS Foundation Trust

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

Risk Description

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

Existing Control Measures

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

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

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

Executive Lead's Assessment

APR 2017: no change in-month
MAY 2017: the Trust continues to maintain appropriate workforce levels ensuring care quality in a cost constrained environment. Achieving Monitor capped nursing agency targets
JUNE 2017: All nursing staff now trained in Sepsis triggers; medical staff training to take place in August & September. Re-introduction of matron role across the Trust over next three months.
JULY 2017: Staffing requirements for winter assessed as part of refresh of successful winter plan from 2016/17; also early consideration of flexing beds and surgical capacity. Trust has agreed support for development of an additional four ANPs as part of overall workforce plan.
August 2017: Measures being taken to address unexpected gaps in senior nursing leadership due to sickness and other personal issues. Preparatory work underway for new cohort of newly qualified nurses commencing September.
SEPTEMBER 2017: HEI new recruits commenced September 2017 aligned to staff vacancies and winter plan.
OCTOBER 2017: 70 new starters have completed their preceptorship (4 weeks) and the COHORT now form part of the clinical rotas.

Board Assurance Framework 2017-18

Alder Hey Children's NHS Foundation Trust

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

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

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

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

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

Executive Lead's Assessment
APR 2017: All access targets achieved at 31/3. Letter of congrats received from SoS for most improved ED 4 hour performance. MAY 2017: Need to maintain grip on activity plan and ensure community waiting times are a focus in the short term especially CAMHS and SALT JUNE 2017 Compliant with all national targets in month. Registration of community services with CQC is resolved. JULY 2017: A&E performance slipped to 93% for the month due to unseasonal levels of activity and gaps in medical cover; this has been recovered in August. All other national standards on track/on plan. AUGUST 2017: Month end position not known at time of writing but no significant issues reported in-month. SEPTEMBER 2017: ED performance back on track in August but dipping again in September; all other targets met. OCTOBER 2017: ED performance currently below target for the month and the quarter; Division has a recovery plan but requires particular focus in the context of winter. Being addressed through Exec Comm Cell - weekly scrutiny.

Board Assurance Framework 2017-18

Alder Hey Children's NHS Foundation Trust

BAF 1.3	**Strategic Objective:** Sustainability Through External Partnerships	Risk Title: Management Contract arrangement with Liverpool Community Health Trust		
Related CQC Themes: Well Led, Responsive, Safe				
Exec Lead: Louise Shepherd	**Type:** External, New	Current IxL: 4-3	Target IxL: 4-2	Trend: STATIC

Risk Description

- Risk to senior leadership team visibility & capacity
- Risk to operational delivery at Alder Hey (quality & performance standards)
- Financial risk to achieving the AH control total
- Risk to delivery of AH strategic plan and associated brand and reputation
- Impact on staff morale at AH

Existing Control Measures

• Backfill arrangements for some key members of Exec Team in place & gaps actively being backfilled	• MIAA due diligence process undertaken at LCH
• Cross agency Transition Board place at LCH to oversee safe transfer of remaining services	• Interim Provider Group in place to retain oversight of the Management Contract

Assurance Evidence	Gaps in Controls/Assurance
Interim governance arrangements in place including Exec Team meetings	Financial package not yet agreed with NHSI & Liverpool CCG Some senior and support posts not yet filled Potential for further quality risks to emerge Staff engagement & motivation across the two sites
Actions Required to Reduce Risk to Target Rating	**Latest Progress on Actions**
Develop plans to ensure services at both AH & LCH are managed safely and effectively	

Executive Lead's Assessment

MAY 2017: Plans continue to be developed to ensure services at both AH & LCH are managed safely and effectively
JUNE 2017: Stock take report compiled for NHS I. Plans in place to ensure services at both AH & LCH are managed safely and effectively. Senior Roles and associated back fill confirmed and communicated to all AH staff.
JULY 2017: Sustained levels of performance across majority of areas; assurance committees continue to have oversight of all key KPIs and plans including change programme
AUGUST 2017: A&E trajectory back on track following unseasonal levels of activity and concerted work by team. All corporate risks being validated through a structured process agreed by IGC at its meeting in July, led by Associate Director of Nursing and Governance. New Quality Ward round process to commence early September.
SEPTEMBER 2017: Performance against key metrics within both organisations receiving appropriate levels of scrutiny through Executive team and assurance processes; AH Quality Ward Rounds commenced and running effectively; risk revalidation exercise nearing completion; IGC receiving additional assurance from revised reporting.
OCTOBER 2017: Trust unsuccessful in bid for acquisition; management contract vacated at 31st October - risk therefore closed.

Board Assurance Framework 2017-18

Alder Hey Children's NHS Foundation Trust

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

Risk Description

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

Existing Control Measures

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

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

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

Executive Lead's Assessment

APR 2017: Shortlisted - first step as preferred bidder
MAY 2017: Compile draft Consultation Strategy. Consultation process held for purdah.
JUNE 2017: Consultation strategy presented at July board
JULY 2017: Pre planning process considered with LCC
AUGUST 2017: Evaluation of options with LCC Mayor
SEPTEMBER 2017: Public consultation delayed until outcome of LCH bid known.
OCTOBER 2017: Discussions continuing with LCC Mayor. Long list of options being produced

Board Assurance Framework 2017-18

Alder Hey Children's NHS Foundation Trust

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

Risk Description	
Failure to deliver an IM&T Strategy which will place Alder Hey at the forefront of technological advancement in paediatric healthcare	
Existing Control Measures	
• Key projects and progress tracked through the Clinical Systems Informatics Steering Group and RABD Committee	• Clinical Systems Informatics Project Group leading on stakeholder engagement - ad hoc groups on specific key topics as needed
• Forward Communications plan agreed and tracked at steering group.	• Board approval "Asset Owner" process in place to ensure organisational ownership of systems and system development
• Improvement scheduled training provision including refresher training and workshops to address data quality issues	• Formal change control processes now in place
• Executive level CIO in place	• Investment in IM&T Team (2016/17 budget)
Assurance Evidence	**Gaps in Controls/Assurance**
Regular progress reports presented to RABD and Operational Board MIAA providing assurance role Board agreed change process Participate in Digital Alder Hey programme Internal Audit Reviews	IM&T Strategy out of date - update work in progress Internal Programme Assurance Reports Resources required to deliver Strategy proposed and aspirations of Trust - review Oct 2016 - Strategy update deferred pending consultation with new restructure CBU leadership teams and outcome of Global Digital Excellence bid.
Actions Required to Reduce Risk to Target Rating	**Latest Progress on Actions**
Link to innovation partnerships in paediatric healthcare	
Conclude the review of IM&T Infrastructure	currently being reviewed in relation to GDE bid and business case
IM&T Strategy development & approval	Trust GDE bid submitted and approved by Board and NHSE Nov / Dec 2016. NHSE undertaking due diligence review pre sign off and approval of funding agreement. Full I&MT strategy to be updated Q4 2016/17
Continual improvement of MEDITECH and other clinical systems as prioritised by the Clinical Systems Informatics Steering Group	changes to software tracked by and reported to the Clinical Informatics Steering Group
Engage with iLinks programme to progress interoperability	

Executive Lead's Assessment
APR 2017: email confirmation from NHSE highlighting treasury approval - awaiting final confirmation MAY 2017: escalated NHSE funding for GDE by FD as impacting on programme delivery JUNE 2017: GDE funding confirmed and agreements signed / returned by DoF. Cash not received 27.06.17. Overall GDE programme milestones have slipped but on track to deliver objectives. JULY 2017: £2.5m capital funding received 10th July. AUGUST 2017: £0.8m revenue funding invoiced. Not yet paid as at 24th Aug. Overall GDE programme milestones have slipped but remain on track to deliver objectives. SEPTEMBER 2017: funding is now up to date, GDE project is green rated over all. The main risk that Board need to be aware of is the pace of realisation of benefits of the programme including specialty packages and VR. OCTOBER 2017: Programme remains green rated however challenges from NHSE regarding benefits realisation evidence and level of match funding

Board Assurance Framework 2017-18

Alder Hey Children's NHS Foundation Trust

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

Risk Description

Failure to deliver Trust control total and Risk rating Rating

Existing Control Measures

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

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

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

Executive Lead's Assessment

APR 2017: 16/17 control overachieved. 17/18 risks remain as CIP £4m, Activity run rate £3m, pay cost pressures (ward related) £3m
MAY 2017: key risks highlighted: pay, activity & CIP. Individual Exec Leads in place. Tracking of internal improvements through Internal Recovery Team
JUNE 2017: £0.3m behind control total at month 2. Residual Forecast financial risk of circa £5m identified by Divisions. Action Plan Produced and delivery tracked via Internal Recovery and RABD.
JULY 2017: Achieved Q1 control total of (£2.6m) deficit. Forecast financial risk of circa £6m identified by the Divisions.
AUGUST 2017: £0.1m behind year to date control total at month 4. Forecast financial risk now £6.3m. Delivery of the action plan continues to be tracked at the Internal Delivery Group and RABD.
SEPTEMBER 2017: year to date on track. Forecast risk remains at £6.3m, largely driven by variances in medicine, facilities, estates and surgery. Recovery process implemented.
OCTOBER 2017: year to date on track. Forecast risk reduced to c £4.5m. Pressures remain in Medicine and Facilities. Recovery Plan in place with key actions tracked through Exec Commcell

Board Assurance Framework 2017-18

Alder Hey Children's NHS Foundation Trust

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

Risk Description

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

Existing Control Measures

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

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

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

Executive Lead's Assessment

APR 2017: No change in-month.
MAY 2017: No change
JUNE 2017: 1) AH were awarded the Management Contract for Liverpool Community Health, (Liverpool Bundle) for May 2017. Future organisational structure being developed with NHSi, the 3 Acute Trusts, local authority, LCCG and local GP's. Opportunities for all to rationalise patient pathways.
2) Partnership with Al Jalia now entering Phase 2. Specific deliverables identified and agreed. Work due to commence in Q2. Non NHS patient stretch target agreed and Q1 activity delivered.
3) MOUs signed with two hospitals in China and work in progress to identifying workstreams and benefits.
4) AH awarded contract for Design and Build Consultancy for Children's Hospital in Xian.
JULY 2017: Indication to bid to acquire LCH services NHS Trust.
AUGUST 2017: Bid to go to Trust Board on 5th September 2017.
SEPTEMBER 2017: Decision on bid expected early October 2017. Awaiting to hear from Dubai regarding phase 2 extension.
OCTOBER 2017: LCH Bid unsuccessful

Board Assurance Framework 2017-18

Alder Hey Children's NHS Foundation Trust

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

Risk Description

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

Existing Control Measures

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

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

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Monitoring of action plans.	Now working with NHS England to secure a resolution for the North
Clear plan for delivery of strategic services (cardiac, neonatal, rehab, community care, primary care, Vanguard, CAMHS)	
Pro-active recruitment in identified areas.	Trust in discussion with Liverpool Women's re future service models for neonates and in discussion with Liverpool Heart and Chest re future model for cardiac service
Develop a strong Community Service offering for Children in Liverpool.	Alder Hey has been awarded a Management Contract for 6 months to deliver the LCH Community Services
Strengthening the paediatric workforce	Now part of Change Programme and 7 day service as Best in Acute Care led by Steve Ryan.

Executive Lead's Assessment

APR 2017: The ODN recommendation single service, single workforce, two site model has been accepted by NHS England and AH and LWH are now working on an implementation plan together with Alder Hey leading. There will be a need for some Capital funding to support the reconfiguration of the ICU and the number of cots required. This is a key work stream of the Trusts Change Programme for 2017/18.
Alder Hey has been awarded a Management Contract for 6 months to deliver the LCH Community Services.
MAY 2017:
JUNE 2017:
JULY 2017:
AUGUST 2017: Agreement that Liverpool Heart & Chest NHS Trust and Alder Hey provide Cardiac Services for Liverpool patients. This has not yet resulted in a change to the flow of cardiac patients to Liverpool.
SEPTEMBER 2017: No change since last update.
OCTOBER 2017: There are no further updates in terms of risk at this time (Neonates and Women's).

Board Assurance Framework 2017-18

Alder Hey Children's NHS Foundation Trust

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

Risk Description

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

Existing Control Measures

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

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

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

Executive Lead's Assessment

APRIL 2017: planning underway to support apprenticeship roll out. successful Recruitment Day for nursing, resulting in over 40 nurses being appointed.
MAY 2017: Task & Finish Group with staff side reviewing approach and sickness absence
June 2017: Temporary Staffing Project initiated
JULY 2017: Plans in place to increase support for development of ANP's
AUGUST 2017: Apprenticeship activity increased, with over 30 learners now registered for an apprenticeship.
SEPTEMBER 2017: New nurse pool cohorts commenced their induction period. Recruitment team engaged with national RCN jobs fair.
OCTOBER 2017: Mandatory training action plan launched, with a target to achieve 90% by end Jan 18.

Board Assurance Framework 2017-18

Alder Hey Children's NHS Foundation Trust

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

Risk Description

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

Existing Control Measures

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

Assurance Evidence	Gaps in Controls/Assurance
Outcomes from Annual Staff Survey reported to the Board. PDR completion rates Quarterly Engagement Temperature Check reported to the Board. Quarterly Engagement Temperature Check local data now sent to CBUs on a quarterly basis to enable them to analyse data locally. Ongoing consultation and information sharing with staff side and LNC Progress reports from LiA to Board	Reward & Recognition schemes embedded

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Revised governance arrangements that underpin effective assurance mechanisms utilising the discipline and systems provided by Programme Management methodology	Change programme monitors Listening into Action deliverables

Executive Lead's Assessment

APR 2017: Progress continues with LiA and development of C&E Project. Quarterly Temperature Check launched.
MAY 2017: Local staff survey conversations continue
JUNE 2017: Launch of the Big Conversations with staff from across the Trust. Executive Visibility Programme commenced
JULY 2017: Local staff survey conversations continue
AUGUST 2017: launch of the monthly 'Star Awards'. Preparation for the Staff Survey underway.
SEPTEMBER 2017: Medicine 100% compliance with local staff survey conversations, others on their way to full compliance. Staff Survey launched. 84% PDR compliance as at 25/09/16.
OCTOBER 2017: Staff Survey at 39% compliance 01/11/17 - same as the overall compliance for the whole of 2016. PDR compliance at 86%. Planning underway for Fab Staff Change week in November 2017.

Board Assurance Framework 2017-18

Alder Hey Children's NHS Foundation Trust

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

Risk Description

Failure to proactively develop a future workforce that reflects the diversity of the local population

Existing Control Measures

• Equality, Diversity & Human Rights Group	• Workforce Committee re-enforced and includes recruitment and education
• Workforce Plan established	• Staff Survey results
• Workforce Planning Poilcy signed off at WOD June 2015	• Equality Analysis Policy
• Equality, Diversity & Human Rights Policy	

Assurance Evidence	Gaps in Controls/Assurance
Monthly recruitment reports provided by HR/Payroll provider Quarterly reports to the Board via WOD on the Workforce Strategy and Workforce Plan Monthly Corporate Report (including workforce KPIs) to the Board Taking forward actions for LiA - enabling achievement of a more inclusive culture Equality Impact Assessments undertaken for every policy & project Workforce Race Equality Standards EDS Publication	Recruitment Strategy to focus on specific groups

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Workforce Planning Policy	Draft policy produced, however future work is to focus on identifying priority workforce needs in light of current financial position
Deliver on our new Recruitment and Retention Strategy to ensure an optimum workforce is in place and that the workforce reflects the diversity of the local community	Currently being drafted with action plan to support
Proactively utilise the EDS2 results to establish the composition of our workforce in order to target areas for improvement	Currently being refreshed with action plan to support

Executive Lead's Assessment

APR 2017: scoping apprenticeship opportunities for local communities as part of our strategy development.
MAY 2017: Recruitment Policy reviewed. EDS2 scoring agreed and equality objectives approved
JUNE 2017: First BME Network meeting. HRD as Exec sponsor.
JULY 2017: BME Network meetings continue with some success, bespoke work undertaken in ICU
AUGUST 2017: Disability network in development. Apprenticeship recruitment planning underway.
SEPTEMBER 2017: Job Centre Plus initiative to support long term unemployed on work placements underway. 65 BTEC students from a range of local schools commenced induction.
OCTOBER 2017: WRES action plan for Board approval. majority of actions are underway. BME network meetings ongoing.

Board Assurance Framework 2017-18

Alder Hey Children's NHS Foundation Trust

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

Risk Description

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

Existing Control Measures

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

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

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Educational Partnerships to be cemented	Academy proposals agreed at execs
Develop a robust Academy Business Model	Agreed
Establish pipeline structure for sensors including finances	Proposal agreed in principle
Appoint Academy Leadership Team	Appointment made
Launch Innovation Co. and secure funding	Funding plan agreed at Innovation Board
Execute plan to increase research portfolio	Outline plan develped
Execute contract for RIE with back to back arrangements with the Charity and HEIs	

Executive Lead's Assessment

APR 2017: Issue around charitable commitment now resolved - letter of intent to be re-issued.
MAY 2017: Institute Phase 2 building commenced
JUNE 2017: Academy model agreed
JULY 2017: Agreed funding plan for Innovation
AUGUST 2017: Approved Head of Academy
SEPTEMBER 2017: Head of Academy now in post.
OCTOBER 2017: Focus on developing business plan for Innovation co. plus activating research workstream

Alder Hey Children's NHS
NHS Foundation Trust

INTEGRATED GOVERNANCE COMMITTEE

Present:	Mr S Igoe	Non-Executive Director**(Chair)**	(SI)
	Mr J Grinnell	Director of Finance	(JG)
	Mrs P Brown	Director of Nursing *(deputising for Chief Nurse)*	(PB)
	Ms E Saunders	Director of Corporate Affairs	(ES)
	Mrs M Swindell	Director of HR & OD	(MS)
	Mr S Ryan	Medical Director	(SR)
In Attendance:	Mrs S Brown	Strategic Project Manager & Decontamination Lead	(SB)
	Mrs L Edwards	Head of Quality (Surgery)	(LE)
	Mrs A Hyson	Head of Quality (Medicine)	(AH)
	Mrs A Kinsella	Health & Safety Manager	(AK)
	Mrs E Menarry	EP and Business Continuity Manager	(EM)
	Miss L Calder	Quality Assurance Facilitator *(minutes)*	(LC)
	Mr T Rigby	Deputy Director of Risk & Governance	(TR)
	Mrs C Umbers	Assoc. Dir. Nursing & Governance	(CU)
	Mrs V Weston	Assoc. Chief of Operations (Medicine)	(VW)
	Miss J Wood	Risk Management Manager	(JW)
	Mr W Weston	Assoc Chief Operating Officer (Medicine)	(WW)
Item 17/18-21	Mr D Roberts	Interim Fire Safety Manager	(DR)
Apologies:	Mr D Powell	Development Director	(DP)
	Mr J Williams	Interim Assoc. Chief of Operations (Community)	(JW)
	Mrs B Doyle	Assoc. Chief Nurse(Community)	(BD)

Item No	Item	Key Discussion Points	Action	Owner	Time Scale
Housekeeping					
17/18-20	**Minutes of the Last Meeting& Action List**	The Committee considered the minutes of the previous meeting of the Integrated Governance Committee held on 24th May 2017. The Committee **APPROVED** the minutes as a correct record. The action list was updated accordingly.			
17/18-21	**Matters Arising**	**16/17-46 Fire Safety Training (Ulysses Ref: 1118)** The Committee received an update on the risk relating to fire safety arrangements in the CHP and retained estate.			

		DR drew the Committees attention to the main highlights within the report:- ○ Evacuation plan: Walk-through type drills were yet to be undertaken for clinical areas and to show staff exit 6/7 on AHP site. It was highlighted that a Quorum of people needed to help with current fire alarm system (main fire panel and Hercules) however funding is an issue. JG brought to the attention of Committee the recent fire drill - staff showed a lack of understanding as to the plan of action, unclear of their responsibilities on the wards. What is the plan for the Trust, who does what in the fire drill throughout the Trust. ○ DR has analysed Health & Safety report and has shown the fire team (porters & security) need additional training. ○ Ulysses report: smell of smoke, carbon has been used in smoke detectors to stop this showing as a risk. RCA report – toasters to be put only in certain areas. ○ Substantive Fire Safety Advisor being recruited shortly. ○ Inappropriate storage of cots in lift lobbies/stairwells – flagged as a risk. Head of Facilities would be asked to address this matter.	Update to September on fire drills	DR	13th Sept
17/18-22	**PFI contract risk – chillers for all MRI units**	16/17-102 PFI Contract Risk – chillers for all MRI Units (risk 962 – score 16) WW updated the Committee on progress made with regards to the chillers for all MRI units and reported that remedial work has been carried out. A maintenance contract was in place; one issue required resolution: 1. Electrical work needed for switches. There is a lack of understanding by the maintenance people and failed on work to be carried. Recommendation labelling to be redone. Need to double check relabelling when complete. May need independent engineer to carry out checks. A further update would be provided at the September meeting. Discussion ensued regarding further additional 'single point of failure' risks which would impact on a whole service. Heads of Quality have undertaken to work with estates to proactively identify potential risks within CBUs.	Single point of failure risks identified	W Weston Heads of Quality	Immediate Immediate

Governance Reports					
17/18-23	**BAF**	ES updated committee members – concerns are being managed on a monthly basis and are mostly static on the risk register with control measures in place. Risks in relation to internal balconies in new hospital there are 3 options under consideration. ES to speak to DP and report back to Committee.	ES to speak to DP	E Saunders D Powell	13th Sept
17/18-24	**Risk Management Review Report**	**CU advised the committee about the risk review she had undertaken** The purpose of the review was to provide the Trust with an update on the current risk management position in terms of compliance with the risk management strategy, in line with MIAA terms of reference for their risk management review. The review included discussions with The Chief Nurse, Director of Corporate Affairs, the Medical Director, Senior Managers, Senior Nurses, Medical staff, Heads of Quality and the Governance and Quality Assurance team – Corporate Services. In addition, the review included examination of the Trust Risk Strategy, the Board Assurance Framework to support understanding of the corporate objectives, the corporate risk register, divisional risk registers, corporate support services risk registers, ward department risk registers and a look back at the Integrated Governance Committee agendas and minutes. A detailed review was undertaken of the Trust Risk Register to determine the effectiveness of the management of risk across the Trust. The Trust risk register currently has 512 risk assessments with associated risks of which 385, (**74.7%)** are past the expected review date (review date is set by risk owners). There are 114 risk assessments with significant risks attached, i.e. scoring 15 or above, 29.82% linked to strategic objectives. There are 307 (59.61%) risk assessments with moderate risks attached, 33.55% linked to strategic objectives. Moreover, significantly 153 moderate risks are high moderate (scoring 12), 29.70% of all risks identified on the Trust risk register. There are 80 risk assessments scoring low risks, 15.53% of all risks, 38.75% are			Immediate

17/18-25		attached to strategic objectives, 13 risk assessments with very low risks of which 15.38% are linked to the strategic objectives. Review of the Trust register shows that 51% (263) of risk identified are within the three Divisions, the remaining 49% (251) are within corporate functions, i.e. information governance including health records and health informatics, health &safety, estates and facilities, emergency preparedness, finance, medicines management, emergency preparedness etc. The Divisions have a total of 65 high risks (57.4% of all high risks identified), 170 moderate risks (55.37% of all risks identified), 58 low risks (72.5% of all low risks identified), and 7 very low risks (53.84% of all risks identified).			
17/18-26		The corporate functions have a total of 49 high risks (42.98% of all risks identified), 137 moderate risks (44.62% of all risks identified), 22 low risks (27.5% of all risks identified), **CU outlined the findings from the review** 1. Responsibility for risk management has been clearly defined in the Trust Risk Management Strategy. 2. Processes have been defined to systematically identify, record, assess and analysis risks on a continuous basis. 3. The evidence from the review shows non-compliance with the Trust Risk Management Strategy and procedures. 4. The evidence from other sources shows that staff are safety conscious and act accordingly e.g. low level of serious harm incidents, low level of moderate harm incidents, low level of staff harms. 5. There is Inconsistent grading and treatment of risks identified on the risk register. 6. Risks are not effectively and robustly reviewed, managed and monitored. 7. Limited evidence that Trust Board is kept informed of significant			

		risks identified, (114 high risks/ 153 high moderate) 8. Risks not raised to an appropriate level within the organisation, i.e. poor escalation process from ward to board. 9. Over 75% of Trust risks not reviewed in line with expected review date, many have outstanding actions, or no actions attached. 10. Significant lack of connection between risks identified and Trust objectives i.e. limited evidence of link between corporate risk register and BAF (33% of identified risks linked to strategic objectives). Currently only 5 high risks identified on the corporate risk register 11. Many risks contain out of date information. 12. Limited evidence of understanding about the significance of managing risks on the register below board level, although there is evidence of understanding in some specific areas. 13. Ulysses risk register does not enable staff to add in gaps in controls onto the risk assessments, causing difficulties in identifying appropriate actions from the documentation, or if the actions are appropriate to mitigate the risks. 14. Ulysses does not currently provide numbers for different levels of risk or percentages. 15. Current Heliview (at a glance position) difficult to follow to determine issues at a glance. 16. Limited information in reports about progress with reducing risks. 17. The level of risks is more often not identified in reports, to enable committee determine priority of issues being raised. The committee were asked to consider the recommendations from the review. **Recommendations** 1. Task and finish groups to be set up to validate risk registers across the organisation. This should include the senior team for each of the three divisions and a fourth for corporate services including, medicines management, health and safety, infection control, information governance and records management, Governance and	13TH September	CU	

		quality assurance, IM&T, Business Continuity etc. 2. Increased focus at Integrated Governance Committee on risk to include: - Each division and corporate service to present their risk registers focusing on high risks or others that may impact on the achievement of corporate objectives at all IGC meetings from this point forward. The focus being on assurance, that each and every risk is being managed effectively, i.e. risks clearly identified from assessment, risk rating reflects assessment of controls, gaps in controls, actions for improvement and progress with actions, review completed in line with timeframes identified on risk assessment, and escalation completed in a timely manner. - All other committee reports presented to focus on level of risk associated with the issues being presented, and actions to mitigate to achieve target risk rating. - Corporate risk registers to include all high risks only and linked to corporate objectives. 3. Risks elevated to 15 or above to transfer to executive responsible for associated corporate objectives, until mitigated to at least a high moderate (meaning risk score = 12) and at that point transfer back to original risk owner. Management of the risk locally to remain with the identified risk manager/function where risk originated as identified on the register. 4. Training programme should be set up, using the train the trainer approach, to develop risk management expertise across the Trust, and a systematic cascade system of training in each division and across corporate functions. **Resolved** that**:** the Committee approved the risk review report and	Associate COO'S & Corporate leads 13th September October 2017	Risk owners CU	

	Trust and Corporate Risk Register	recommendations. **CU presented the Trust risk register and the corporate risk register to the Committee** • The total number of risks on the risk register is 512 • 22.23% (114) of the Trusts risks are rated as High/Extreme risks**.(CRR)** • 59.6% (307) of the Trusts risks are rated as moderate, with 29.70% (153) rated 12 i.e. High moderate. • 15.53% (80) of the Trust risks rated as Low risk • 2.52% of the Trust risks rated as very Low risk. • 74.7% (385) risk assessments have an overdue review date. • All 114 high/extreme risks that have been escalated to the CRR; ▪ 38 in the Medical Division, ▪ 22 in the Surgical Division, ▪ 5 in Community services ▪ 49 in Corporate Services **Resolved** that**:** the Committee approved the risk register report.			
	Risk Stratification Global Digital Excellence	Risk Stratification relating to the risks and issue is prescribed by NHSE and differs from the Organisational risk register used at Alder Hey. Paper outlines what risks belong to NHSE and what risks sit with Alder Hey. NHSE risk stratification is completed by the GDE programme. CU advised committee members that the Trust has a central risk register hub i.e. Ulysses and all risks are expected to be reported within that risk register, to ensure the Trust has a clear understanding of risks that potentially could threaten the strategic objectives. CU and SR agreed to meet with JW outside the meeting to review how GDE risks can be linked to the Ulysses risk register.		JW &CU&SR	

Committee / Sub Assurance Reports					
17/18-07 **17/18/08** **17/18-09**	**Emergency Preparedness Assurance Report**	EM presented the Emergency Preparedness assurance report and **provided a brief overview:-** ○ Pandemic Flu report – committee noted it will go to Infection Prevention and Control Meeting on 9th August ○ Large scale Major Burns Plan report is out of date. The National plan will be delivered in Sept and updates to the Alder Hey plan will be made after that. ○ NHSE Emergency Planning, Resilience and Response Assurance Process self-assessment audit will be presented to Trust Board in September for approval prior to being returned to NHSE by 22nd September 17. ○ Manchester Terrorist Attack Incident on 22nd May 17 – The Trust is to conduct a Mass Casualty (terrorism related) exercise on 21st August 17. EM will report back to the committee in Sept the learning from the exercise. ○ CBRNE/HAZMAT training – has not yet been established as new ED Clinical Lead not in post until 21st August. The training is required urgently as last training was over 12 months ago. It was agreed that IGC write to the Medical Division Associate Chief Officer to request this training is implemented and training dates provided. ○ Bomb threats and Suspicious Packages Plan – the committee approved the plan subject to any further comments received from the Emergency Preparedness Group and key responders. ○ Emergency Preparedness Annual Report and Work Plan – the committee approved the report/work plan and noted it will be submitted to the September Trust Board Meeting. **Resolved** that**:** the Committee approved the Emergency Preparedness report.		E Menarry	13th Sept
17/18-10	**Health and Safety Assurance Report**	AK presented the assurance report of the Health & Safety Committee. Main issues from the report were highlighted as follows:-			

		○ Entrapment – How to access trap door to lift. ○ If bed in lift roof opens into lift which makes it a patient safety risk. Correspondence from Schindler has been poor. ○ Electrical Isolation Incident RCA – need to review all switches as there is a lack of understanding by maintenance people which they failed on. Recommendation labelling to be redone. ○ Control of contractors remains a concern. Conflicting information around DBS's. Contractors' policy states they don't need it however they are being asked to have enhanced DBS before start. ○ Lack of access control to pantries / kitchens – risk of potential harm to patients as no swipe system in place. Wards are trying to manage. ○ Supply sockets – to be tested on all wards and EDU 1st week in August 17 AK was asked to add timescales for completion to this report. AK to ensure risk assessments and associated risks including level of risk i.e. risk scores to be included in future reports **Resolved** that: the Committee NOTED the contents of the report.	CEO to write to Schindler External overview of independent check	A Kinsella A Kinsella A Kinsella	Immediate Immediate
17/18-11	**Infection Control**	PB presented the assurance report of the Infection Prevention Control Committee Meeting and highlighted key issues and assurances:- ○ MSSA infections are increasing however MRSA is decreasing. Legionella is a closed risk. SR expressed to committee if corrosion in pipes could lead to more bugs in pipework. ○ Admin support is needed for pandemic flu. ○ Safety audit coming up will this report into IGC meeting? **Resolved** that the Committee: NOTED the contents of the report.	To be looked at on a monthly basis	V Weston	Immediate
17/18-12	**Information Governance Assurance Report**	The Committee received and considered the assurance report on behalf of the Information Governance (IG) Committee ES expressed that LB provided two very good papers. 2nd paper gave advice on training issues:	Work plan going forward	E Saunders	13th Sept

		If training is mandatory is it responsibility of individuals to update training on system. SI suggested putting system in place where you cannot access Alder Hey login if you are not compliant. Compliance rate for 12 month period is 58% and it was felt we move away from 12 month review as this rate is poor. Toolkit will always be there however we need to carry on with IG training. Work plan going forward ES to supply information. **Resolved** that the Committee: NOTED progress made to date.			
17/18-13	**Clinical Records**	The Committee received the Clinical Records assurance report from 20 March. A number of positive assurances were highlighted in the report including: ○ Scanning of documentation is behind due to staffing levels/staff turnover. New staff needed training which has slowed down the process, this was logged as a risk. ○ Data retrieval: PY to ask IT to look at as also a risk concern. Recently a staff member put forward a temporary solution to turn document into PDF as a priority to prepare patient records for a family. **Resolved** that: the Committee NOTED the contents of the report.	Data retrieval	P Young	13th Sept
17/18-14	**Data Quality**	SR presented the Data Quality Committee assurance report and highlighted the following key messages:- ○ Recording of Ethnic Group information – a system solution had been implemented with current position at 40% compliance with continual improvement being seen. ○ Demographics Audit – an action plan was in place to address inaccuracy issues of this data. A long term solution was being explored within Meditech. ○ Mismatch of Consultant data – a review of orders were being undertaken and an additional solution to improve was being sought. Resolved that: the Committee NOTED the progress to date		S Ryan	13th Sept
17/18-15	**Building Services Team**	The IGC received the list of issues currently being addressed by the Building Services Team (BST).			

		○ Pressure vessels – ongoing requests had been made to Interserve for sight of this list. Agreed to provide. ○ Water Safety Audit by MIAA there were issues raised with water temperature levels. Independent controller to come in and look at certain areas as they are no non-compliant due to temperature issues. Water engineer is reviewing. The issue is classed as defect and does not sit with INTERSERVE. Finding the correct contractual area responsible is an ongoing issue. AK has set up drop in sessions for staff on how to use COMPASS for flushing. Resolved that: the Committee NOTED progress to date.	Sight of list Update committee	D Powell G Dixon	13th Sept 13th Sept
Policies & Equality Analyses to be Ratified					
17/18-16 **17/18-17** **17/18-18**	**Confidentiality** **Anti-Fraud, Bribery and Corruption Policy** **Conflict of Interest Policy**	CU presented policy to the Committee. CU advised the committee about the changes to the policy ES highlighted key points in the policy ES highlighted key points in the policy **Resolved** that**:** the Committee Ratified the Confidentiality Policy The committee approved changes to the Anti-fraud, Bribery and Corruption policy and Conflict of Interest policy noting amends to be added		E Saunders	
Any other business, documentations for information					
17/18-19	**Any Other Business**	**No further business was discussed.**			
Date and Time of Next Meeting		The next meeting of the IGC will be held on Wednesday 27th September 2017, 2:00pm. Inst. Small Lecture Theatre.			

INTEGRATED GOVERNANCE COMMITTEE
ACTION LIST – July 2017

No	Item	Owner	When	Status
17/18-06	Resolution regarding five remaining high level risks on CHP Post Occ. Risk Register	D Powell	~~24 July~~ Update to Sept	Recommendations presented to May meeting; Execs to agree way forward – close-off report to July.
16/17-08	Full list of all pressure vessels to be requested.	D Powell	~~24 July~~ Update to Sept	Interserve to provide to David Powell
17/18-03	Schedule of warranties to be requested	B Laithwaite	~~24 July~~ Update to Sept	Further report to Sept
17/18-21	Fire Safety Plan • Evacuation drills – clearer process • Additional training for fire team	D Roberts / J Williams	Immediate	Further report to Sept
17/18-07	Emergency preparedness • Mass casualty terrorism related exercise on 21st Aug 17 • CBRNE/Hazmat training – It was agreed that IGC will write to the Medical Division Associate Chief Officer to request training be implemented and training dates provided	E Menarry	13th Sept Immediate	Learning from the exercise to be reported back to September committee
17/18-10	1. Electrical Isolation Incident RCA 2. Entrapment Trust correspondence to Schindler – from CEO 3. Schindler risk to go on Ulysses	A Kinsella	Update to Sept	Further report to Sept meeting
17/18-26	Risk Stratification Global Excellence – Risks to be added to Trust risk register.	J Wood	Immediate	Cathy Umbers to pick up with Jenny Wood
17/18-25	Ulysses to add percentage to system for risks	C Umbers	Immediate	Update Sept
17/18-17 17/18-18	Send out changes to policy Send out changes to policy	L Calder	Immediate Immediate	Emailed to committee 24 July
17/18-08	Timescales to be added to H&S Report	A Kinsella	Immediate	Update Sept

17/18-22	16/17-102 PFI Contract Risk – chillers for all MRI Units	W Weston	Update to Sept	Update Sept

Alder Hey Children's NHS
NHS Foundation Trust

INTEGRATED GOVERNANCE COMMITTEE

Present:	Mr S Igoe	Non-Executive Director**(Chair)**	(SI)
	Mr J Grinnell	Director of Finance	(JG)
	Ms E Saunders	Director of Corporate Affairs	(ES)
	Mrs M Swindell	Director of HR & OD	(MS)
	Mr S Ryan	Medical Director	(SR)
	Mrs M Barnaby	Interim Chief Operating Officer	(MB)
In Attendance:	Mrs S Brown	Strategic Project Manager & Decon Lead	(SB)
	S Stephenson	Head of Quality (Community)	(SS)
	Mrs A Hyson	Head of Quality (Medicine)	(AH)
	Mrs L Robinson	(Medicine)	(LR)
	Mrs A Kinsella	Health & Safety Manager	(AK)
	Mrs E Menarry	EP and Business Continuity Manager	(EM)
	Miss L Calder	Quality Assurance Facilitator *(minutes)*	(LC)
	Mr T Rigby	Deputy Director of Risk & Governance	(TR)
	Mrs C Umbers	Assoc. Dir. Nursing & Governance	(CU)
	Mrs V Weston	Assoc. Chief of Operations (Medicine)	(WW)
	Mrs R Greer	Assoc. Chief of Operations (Community)	(RG)
	Mr W Weston	Assoc. Chief Operating Officer (Medicine)	(WW)
	Ms C Lee	General Manager (Surgery)	(CL)
	Mrs C Wardell	Assoc. Chief Nurse (Medicine)	(CW)
	Mr C Gildea	Operational Lead (Building Services)	(CG)
	Mrs C Fox	Associate Director of Informatics	(CF)
	Ms L Baker	Information Governance Manager	(LB)
	Miss J Gwilliams	Clinical Risk Manager	(JG)
Item 17/18-23	Mr D Roberts	Interim Fire Safety Manager	(DR)
Apologies:	Mr D Powell	Development Director	(DP)
	Mr S Ryan	Medical Director	(SR)
	Mr A Bateman	Assoc. Chief of Operations (Surgery)	(AB)
	Mrs P Brown	Director of Nursing	(PB)
	Mrs D Walker	Head of Pharmacy	(DW
	Mrs C Barker	Chief Pharmacist	(CB)
	Mrs H Gwilliams	Chief Nurse	(HG)

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
Housekeeping						
	1.	**Apologies for absence**	Noted			
17/18-24	**2.**	**Minutes of previous Meeting**	The Committee considered the minutes of the previous meeting of the Integrated Governance Committee held on 24th July 2017. The Committee **APPROVED** the minutes as a correct record.			
	2.2	**Action list**	**Resolved** that: the Committee agreed all actions from 24th July have been addressed.			
	3.	**Risk Register Management Reviews**				
17/18/25	**3.1**	**Surgery Division**	CL presented the risk management report for Surgery. CL advised the committee that there is currently a vacancy for Head of Quality for surgery and the intention is this position will be recruited to on an interim basis. Advert going out next week for permanent position. Risks from the report were highlighted as follows: Total number of risks for surgery 93, new risks 15, closed risks 9, overdue risks 60, risks with no agreed action plan 48, high risks 4. CL focused on and presented all the current high risks to the committee. Actions: Risk 288 - mandatory training trust wide work ongoing, timescale to update risk assessment next week about progress. Work is ongoing at corporate & local divisions to address the deficits and ensure staffs are booked on to mandatory training in a timely manner. Risk 1306 - work underway including review of Trainee doctors' rotas to ensure gaps filled appropriately and in a timely manner. Risk 424 - vCJD Theatre department waiting on new instruments, once they arrive this can come off the risk register. The expectation	High risks to escalate to exec level Updates to be made to surgery risk register	AB/CL	Immediate

			is that this will be resolved imminently. Risk 964 - booking and scheduling are running a pilot of new ways of working from Feb 18, as current process not sufficient This may not eliminate the risk but is expected to reduce it considerably. It is currently showing as impact 5, but CL advised this can be reduced and will address this on the register. CL advised the committee as part of ongoing validation the Surgical Division will continue to focus on High risks but will also continue with work on all other risks on the register and any new risks. CL advised the committee that although there is ongoing work required, the division are satisfied with the progress at this point. **Resolved** that: the Committee NOTED the contents of the paper			
17/18/26	**3.2**	**Medical Division**	WW presented the risk management report for Medicine. Risks from the report were highlighted as follows: Total no of risks 141, new risks since last report 44, risk closed and removed 33, risks overdue 22, high risks need escalating to execs for their support 8 (high risks). WW presented the report and focused on the high risks from the Medical Division for this reporting period. Risk 1190 - delays in fully commissioning the Pharmacy Aseptic Unit. IGC meeting 11.01.17 agreed to merge risks to risk register as one risk. Risk 1418 – WW advised the committee that there are a considerable number of documents (boxes) awaiting scanning (200 existing boxes of loose documentation. Progress has been slow in addressing this issue leading to increased risk. No/limited resources were identified to support the management of these records. However LB added that the information is stored securely on the retained estate, and there is accessibility to this. This risk has been escalated to the Director of Finance. (ownership transfer?)		WW/CW	Immediate

			Risk 1344 – lack of secondary 'back up' refrigeration facilities on Pharmacy and Aseptic Services cold store, investment in a fridge now in progress and ongoing monitoring of safety issues and Division will continue to monitor progress. Risk 1210 – Failure to provide long-term 'look back' facility. Need to ensure migration of data is completed before Meditech5 is closed. Migration process needs to be included in the GDE project discussions so that a clear plan of action is agreed and implemented with an appropriate timeline in plan. CF is looking at transferring this over to Meditech6. Risk 581 - There is discrepancies in blood transfusion training figures between ESR information and managers, ward and departmental figures. However there is ongoing work to resolve this issue and this is reflected in the controls on the risk register.MD highlighted the ongoing work on the ESR system and advised there has been considerable improvements to the system in recent months, which will support accurate training information Risk 865 – Limitations of Meditech6 EPMA system implemented June 2015. It has no decision support system built in. Downtime MAR chart is less clear when compared to the electronic MAR chart. There has been limited maintenance and development resource included in the project. Work ongoing and controls in place but further work required to mitigate risks. Risk1429 - the Emergency Department (ED) have recently added this risk to the register due to nurse staffing skill mix issues identified. However the risks identified are consistently monitored daily, to ensure patient safety is not compromised and risks are not realised. Risk1430 - Full review of metabolic service underway currently. Controls under constant review to ensure patient safety is not compromised.	WW to speak to CF Migration of data before Mv5 closes		Immediate

			WW advised the committee that the Medical Division were not satisfied with the position of the risk register currently but with ongoing revalidation he expects by the next meeting the register will be where it needs to be in terms of effective management. **Resolved** that: the Committee NOTED the contents of the paper			
17/18/27	**3.3**	**Community Division**	RG presented the risk management report for Community. Risks from the report were highlighted as follows: There are currently 31 risks on the register. There are 5 high risks, 4 risks have been closed and removed during this reporting period. RG presented the risk management report and focused on the high risks identified on the community. The 5 high risks that have been escalated are community estates. Risk 902 – Inadequate connectivity in community sites and outreach venues for clinicians to view patient electronic records. Rolled out 4G in June 2017 to support access to Meditech6. This is now in a much better place than was. Scanning of community records are in progress**.** Risk 952 – NHS England procurement of Tier 4 in-patient mental health service. Dewi Jones currently provides 7x children's mental health beds off site at Alder Park. There are financial implications and CBU management team are to look at options with board to moving unit back on site. Risk 1157 – Community Division ability to achieve financial balance during 2017\18 and identify achievable cost improvement plan. Ability to increase income over and above plan is limited. Financial viability of Homecare service has increased financial risk during 2017/18. Risk 1275 – CAMHS Sefton provides the main site for CAMHS clinics and has been kept on register until they are relocated, as building in Waterloo is not fit for clinical use. RG is waiting on confirmed building lease accommodation costs. ES asked how this is linked into BAF. RG said it is aligned to delivery of care. CU advised the need for conversations around where this sits on BAF		RG/SS	

			going forward. Risk 803 – Lack of information to track CAMHS/ASD/ADHD waiting times though Meditech6. There has been an inability to measure performance effectively due to patient pathway information not being easily accessible. Data quality is poor and ability to report internal and externally on waiting times is limited. GDE specialties will deliver improvements in the way Meditech6 is used within the services leading to improvements in patient waiting list tracking. SI said being aware of all 31 risks that have all been reviewed is helpful. SS & RG agreed that the community risk register in terms of high and moderate are managed effectively. Work is ongoing to address low level risks effectively and ensure this is communicated across the division **Resolved** that: the Committee NOTED the contents of the paper			
17/18/28	**3.4**	**Infection Control Service**	JK presented the risk management report for Infection Prevention Control. Risks from the report were highlighted as follows: There are a total of 16 risks on the infection prevention and control risk register , 3 high risks and 3 overdue their expected review date was noted to be prior to Sept 2017 IGC meeting. Risk 1394 – DIPC post has been out to advert, but post not filled, therefore needs to go out again. Once filled risk will go down. However the Medical Director is acting in post and the previous DIPC remains in post one day per week. Risk 640 – Risk of hospital acquired Pseudomonas due to Pseudamonas in the water supply. This is being managed through Trust Water Safety Group in terms of controls and actions. Risk 1102 – Sepsis pathway rolled out and Sepsis reduced and showing current risk of 10**.** CU advised if the risk is moderate or below will come off the corporate register and revert back to local management. Risk 1225 HCAI due to unnecessary or inappropriate vascular device. Action to develop paediatric version of vessel health		VW/JK	

			preservation framework. Risk 1374 – Increase prevalence of HCAI MSSA bacteraemia with the Trust. MSSA reduction action plan being monitored through IPCC. Risk 1372 – This risk is be managed via the IPC work plan, which are monitored monthly via the IPC committee monthly meeting or more frequently by the IPC team as required. Risk 970 – Relates to rectal screening of patients on admission to hospital. Controls in place and actions to mitigate are monitored via the Infection control committee. Associate DIPC advise that some of the risks on the IPC risk register are not owned by IPC. E.g Legionella etc are risks that sit with a number of functions, involvement to minimise the risks. CU said this is owned by IPC in terms of their overall responsibilities overseeing the risks, however in terms of actions to ensure the risks are not realised, the IPC team need to hold staff to account to ensure the actions to mitigate the risks are implemented and monitored effectively. VW advised the committee that although there is ongoing work required, the Infection Control team are satisfied with the progress at this point. **Resolved** that: the Committee NOTED the contents of the paper			
17/18/29	**3.5**	**Facilities**	MD presented the risk management report for Facilities. Risks from the report were highlighted as follows: Risk 1456 Security Risk 1457 Domestics Risk 880 Catering Risk 1194 Switchboard/IT Facilities has low and moderate risks - switchboard, security, catering risk will be able to come off. Domestics & Catering 4 risks. JG thought 4 seem low for this area. 2 risks sit outside of facilities		MD	

			Risk 1194 IT failure of WIFI & 1366 HR Structure Academy. CU advise that other managers within the team for the different functions e.g. catering, portering, domestic services, car parking, security, linen can be given access to manage their own risks on the facilities risk register to add/update and advise MD on progress for the overall facilities risk register. JW to support. MD advised the committee that although there is ongoing work required, he satisfied with the progress at this point. **Resolved** that: the Committee NOTED the contents of the paper			
17/18/30	**3.6**	**IM&T**	CF presented the risk management report for IM&T. Risks from the report were highlighted as follows: There are a total of 17 risks identified on the IM&T risk register. Risks resolved and closed are: Risk 305 – no longer applicable as current EDMS system (ImageNow) has been tested for data extraction Risk 460 – document has been produced and forms part of BCP plan and action cards. Risk 630 – There was no delay to the move as the relevant telephone lines where installed into the CHP in advance, this had been operating at a stable level, no longer deemed a risk. CF advised GDE project need to be added. CF & SR met with GDE team following last IGC meeting and agreed with team that they would upload GDE risks onto register. SI asked committee where do clinical trials/research sit on the register? ES expressed to committee this is dislocated as should be showing on register but not showing right now. Further work required. ES to follow up. CF advised the committee that although there is ongoing work required, the IM&T are satisfied with the progress at this point.		PY/LF	

			Resolved that: the Committee NOTED the contents of the paper			
17/18/31	**3.7**	**HR**	MS presented the risk management report for HR. Risks from the report were highlighted as follows: There are currently 8 risks on the HR risk register – all either moderate or below. Risks 171/200 - Policy framework, robust management are being managed. CF advised the committee that she is satisfied of the current risk management position in terms of effectiveness of management. CF advised the committee that although there is ongoing work required, the IM&T are satisfied with the progress at this point. **Resolved** that: the Committee NOTED the contents of the paper		MS	
17/18/32	**3.8**	**Finance**	JG presented the risk management report for Finance. Risks from the report were highlighted as follows: There are 9 risks identified on the finance risk register. Risk 387 - Data Warehouse Resilience quality needs work on. Ensure regular plan to test resilience and explore other ways to backup database and reports. JG advised the committee that although there is ongoing work required, on the register the Finance department are satisfied with the progress at this point. **Resolved** that: the Committee NOTED the contents of the paper		JG	
17/18/33	**3.9**	**Estates/Building Services**	CG presented the risk management report for Building Services. Risks from the report were highlighted as follows:		DP/JW/SB	

			Risks on register for Building services. Risk 825 - Internal balconies & Risk 826 Central staircases the reviews on both expected to take 6 months. However interim controls are in place to minimise risk to patient safety. Risk 829 - Slips, trips & falls have been downgraded by DP. Pressure vessels – scheme by officer inspection some progress has been made. H&S are awaiting report to confirm details. Risk 1388 – There is potential for rapid corrosion of pipework to CHP. 36 sections of pipework are to be removed and taken for analysis across various areas of CHP for signs of perforation. The risk has been identified for some time and needs to be addressed. CG advised the committee that it is expected to take 6 months to complete work. However if a leak were to happen we have members of team on site to address. SI advised that the loop needs closing as there is currently no continuity. MS advised that we need to put additional mitigation plans together regards the pond outside Institute in the Park. CG said the designed plans are to be reviewed. SB to do separate report for all risks she oversees under Projects.as we don't have true account of all risks relating to this aspect of estates. To provide for next meeting CG advised the committee that although there is ongoing work required, the Estates department are satisfied with the progress at this point. **Resolved** that: the Committee NOTED the contents of the paper JW presented the risk management report for Estates. Risks from the report were highlighted as follows:	SB to provide report for Project risks she oversees		Submit Nov IGC

			There are 22 risk currently on the Estates risk register. 12 new risks. 4 closed risks and 2 risks with no agreed action plan. Damage being caused within Dewi Jones unit. SS expressed the patients' they have in Dewi unit at the moment one of them is strong and violent who damages property. The risk goes up and down, at the moment it's sitting at 12 moderate. Most of cases are behavioural issues right now not mental health. Needs specific skill set to deal with these patients and there is not enough skilled staff. High turnover of staff due to staffing levels. Long term plan for Dewi Unit is relocation. Short term we are dealing with disruptive patients. JW informed committee Estates risks are being managed effectively. **Resolved** that: the Committee NOTED the contents of the paper			
17/18/34	**3.10**	**Health & Safety**	AK presented the risk management report for Health & Safety. Risks from the report were highlighted as follows: H&S risks need to be linked in with other depts to look at risks and take action. Risk 1386 - Lift entrapment actions to mitigate ongoing. Risk 1440 - unsecured access to service yard needs to be reviewed – plan in place Concerns with IFM regarding other risks not picked up on. AK to pick this up with IFM and ensure actioned as appropriate. **Resolved** that: the Committee NOTED the contents of the paper	AK to link with other dept to action risks AK to speak to IFM to ensure actioned		Immediate Update Nov IGC
17/18/35	**3.11**	**Business Preparedness & Associated reports**	EM presented the risk management report for Business Preparedness & Associated reports. Risks from the report were highlighted as follows: The Business Preparedness and Emergency Planning risk register has currently 13 open risk assessments with associated risks Risk 1435 - EAD are using paper records at the moment. Working		ES	

			group to look at in Oct 17. CF & PY to look at this with Elaine. Risk 1443 - there has been a rise in terrorist level – NHSE wanted to know risk levels. EM is satisfied with management of risks on register in this area. **Resolved** that: the Committee NOTED the contents of the paper			
17/18/36	**3.12**	**Information Governance**	CL presented the risk management report for Information Governance. Risks from the report were highlighted as follows: Number of risks 9 – risks are either moderate or below, currently no high risks. All risks have controls in place. SI expressed a concern that PCI-DSS, payment and protection governance may be an issue for the trust. LB is happy with risks in place and where they sit. **Resolved** that: the Committee NOTED the contents of the paper		ES	
17/18/37	**4.**	**Corporate Risk Register Review**	CL presented the Corporate Risk Register Review. CU informed the committee that there are 537 risks on the Trust risk register, and the detail is reflected in the Division and corporate functions risk registers. The total number of risks on the risk register is 545 compared to 515 for the previous reporting period. 67 (12.29%) of the Trusts risks are rated as' High/Extreme' risks compared to 114 (42% reduction) for the previous reporting period. 350 (64.22%) of the Trusts risks are rated as 'Moderate', 177 (32.47%) rated 12 (High moderate). 100 (18.34%) of the Trust risks rated as 'Low risk' 20 (3.66%) of the Trust risks rated as 'Very Low risk'. 167 (30.66%) risk assessments have an overdue review date.		CU	

			All 67 high/extreme risks that have been escalated to the CRR; 9 (13.43%) in the Medical Division, 4 (5.97%) in the Surgical Division. 5 (7.46%) in Community services. 49 (73.13%) in Corporate Services. CU advised the committee that 90% + of Risk Register revalidations exercises recommended in risk management review paper (July 2017) with divisions and corporate functions have been completed. This work is reflected in the improved position in the Trust and corporate risk register and by association the Divisions and Corporate functions risk registers. However there remains work to do to provide the necessary assurance that risk in being managed effectively in the divisions and corporate functions, and is it expected with the revised processes and there will be month by month visible improvements for the management on risk via the risk registers including dissemination via local governance processes. **Resolved** that: the Committee NOTED the contents of the paper			
17/18/38	**5.**	**Board Assurance Framework (BAF)**	ES presented the Board Assurance Framework. ES updated committee regarding control measures in place for BAF. Advising that links are made through strategic objectives **Resolved** that: the Committee NOTED the contents of the paper		ES	
17/18/39	**6.**	**Integrated Governance Committee – Terms of Reference**	SI presented the Integrated Governance Committee Terms of Reference and highlighted as follows: SI highlighted to committee of the changes to be made on the TOR including membership, job titles, CBU to division, amend Head of building services. Subject to amendments the TOR approved. **Resolved** that**:** the Committee approved the IGC TOR subject to amendments.	LC to update IGC TOR	SI	Immediate

	7.	**Policies**				
		None	Suspicious persons policy not been ratified at last IGC meeting 24th July 17. SI asked the committee if they were satisfied to approve this policy. The policy approved.			
	8.	**Ad Hoc Reports**				
17/18/40		**Research IG Toolkit** We need clarity of who info Go leads are	ES presented the Research IG Toolkit paper and highlighted as follows: LB presented the research paper. There are 2 key studies that have not progressed, as could not evidence. Ist study We need to have a greater level of embeddedness as required in the IGC toolkit. LB has put an information governance data flow mapping together. Risk assessment will need completing on this. (LB to action) 2nd study M Beresford – CAG didn't approve subject to conditions. This paper had Ethic sign off but needs business sign off to progress. Action plan to complete by December 17. Mechanisms are there but need the support from IGC. If we get systems right we can get validation going forward. SI expressed this is a risk that needs managing and asked committed members are they happy to support - all agreed. **Resolved** that: the Committee NOTED the contents of the paper	LB to provide update at next meeting LB risk assessment to be completed	ES/LB	
	9.	**Meeting effectiveness**	SI concluded that he believed the new processes has led to a meeting that is much more fluid in terms of means that the Meeting are much more fluid. Need assurance measures in place to capture risks. Seek assurances from divisions which will help resolutions. Information was sent out earlier by WW? Committee members agreed that the revised way of reporting was more effective and enabled an understanding of risk management		SI	

			across the trust including 'hot spots' and assurance measures in place including areas where additional support required from committee and/or executives.			
	10.	**Any other business**	Suspicious persons policy not been ratified at last IGC meeting 24th July 17. SI asked the committee if they were satisfied to approve this policy. The policy approved. Resolved: that: the Committee NOTED the contents of the policy and approved.			
Date and Time of Next Meeting			The next meeting of the IGC will be held on Wednesday 1st November 2017, 10:00am. Room 8, Mezzanine.			

INTEGRATED GOVERNANCE COMMITTEE
ACTION LIST – September 2017

No	Item	Owner	When	Status
17/18/25	Surgery Risk Management Report	A Bateman/C Lee	Immediate	Updates to be made to surgery risk register. High risks escalating to exec level.
17/18/26	Medicine Risk Management Report	W Weston	Immediate	High risks escalating to exec level. WW to speak to CF Migration of data before Mv5 closes.
17/18/27	Community Risk Management Report	R Greer/S Stephenson	Immediate	Risk 1275 discuss where sits on BAF register with C Umbers.
17/18/34	Health & Safety Risk Management Report	A Kinsella	Immediate	Link in with other depts to action risks.

				Concerns with IFM regarding other risks not picked up on. AK to pick this up with IFM and ensure actioned as appropriate.
17/18/35	Business Preparedness & Associated Risk Management Report	E Menarry	Immediate	To contact P Young & C Fox to look at risk 1435
17/18/39	Integrated Governance Committee Terms of Reference	S Igoe	Immediate	L Calder to amend TOR
17/18/33	Estates/Building Services	S Brown	Report submitted to Nov IGC	SB to do separate report for all risks she oversees under Projects, as we don't have true account of all risks relating to this aspect of estates. To provide for IGC next meeting.
17/18/40	Ad hoc reports - Research IGC Toolkit	L Baker	Immediate	LB risk assessment to be completed

Resource and Business Development Committee
Minutes of the meeting held on: **Thursday 28th September 2017**, **at 1330**
Large Meeting Room, Institute in the park

Present:	Ian Quinlan (Chair)	Non-Executive Director	IQ
	Mags Barnaby	Interim Chief Operating Officer	MB
	John Grinnell	Director of Finance	JGr
	Claire Liddy	Deputy Director of Finance	CLi
	Jo Williams	Non- Executive Director	JW
In Attendance:	Sue Brown	Project Manager and Decontamination Lead	SB
	Melissa Swindell	Director of HR	MS
	Julie Tsao	Executive PA	JT
Agenda item: 66	Cathy Fox	Associate Director Informatics Officer	CF
70	Joe Gibson	External Programme	JGi
75	Phil Morgan	Trust Engineer Advisor	PM
Apologies:	Claire Dove	Non-Executive Director	CD
	Mark Flannagan	Director of Communication	MF
	Rob Griffiths	Service Manager Theatres	RG
	David Powell	Development Director	DP
	Steve Ryan	Medical Director	SR
	Lachlan Stark	Head of Planning and Performance	LS
	Erica Saunders	Director of Corporate Affairs	ES

17/18/64 Minutes of the previous meeting held on 1ST August 2017
Resolved:
RABD received and approved the minutes of the previous meeting.

17/18/65 Matters Arising and Action log
All items for discussion had been included on the agenda.

17/18/66 Global Digital Excellence Programme
Cathy Fox reported the Alder Hey *Fast Follower* Trust, Clatterbridge, had completed their 'due diligence'.

NHS Digital visited Alder Hey last week to complete their first assurance inspection. NHS Digital had responded to advise they are pleased with progress made against the milestones set earlier in the year.

Recruitment to all approved posts has commenced. It is anticipated the full team will be in place by the end of September.

The Voice Recognition project has completed an initial pilot with the Orthopaedic team. General Paediatrics and Nephrology are due to go live on the 30th August. The August rotation of Junior Doctors have been trained alongside thirty three champions

Resolved:
RABD received and noted the content of the GDE report.

17/18/67 Performance
Service Level Agreement Monitoring (SLAM) summary identifies improved levels of activity within Medicine where they were 4% ahead of plan; Daycase, A&E and Outpatients performed well. Improved position for Nephrology where previously identified coding

issues have been rectified with better performance both in month and with improved nephrology coding, which has been backdated as far as possible within the flex and freeze dates. As part of the Internal Turnaround process the Division is reviewing activity compared with 2016/17 and identifying in more detail where the challenged specialties have case mix opportunities to improve. Ongoing medical vacancies continue to impact upon performance. Winter plan being finalised to support ED attendance, elective and non-elective flow throughout the NHS winter period (October 17 to April 18).

Resolved:
RABD received and noted the content of the performance report for month 5.

17/18/68 Finance report

For the month of August the Trust is reporting a trading deficit of £1.6m which is ahead of plan by £0.1m. Income is ahead of plan by £0.9m but expenditure is higher than budgeted by £0.8m. The year to date position is a deficit of £4.5m which is ahead of plan by £0.03m. The Use of Resources risk rating is 3 which is in line with plan and cash in the bank of £10.4.

John Grinnell presented the financial risks for Month 5 and actions to be taken.
Performance Year to Date is "on plan", however:

- £4.5m deficit after 5 months, and
- Significant Risk in the second half of the year:
  a) CIP Back phased
  b) Divisional forecasts show £6.4m gap

Already "brought forward" some reserves to support YTD performance.

Divisions had been asked to respond by tomorrow lunchtime with proposals to reduce the deficit. Proposals would be discussed at the Executive Committee on 5th October 2017.

It was agreed facilities would be asked to report on proposals to reduce the deficit at the next RABD meeting on 30th October 2017.
Action: HG

John Grinnell agreed to brief the Board at the meeting on Tuesday with risks to a continuing deficit.
Action: JG

Resolved RABD:
Received and noted the content of the Finance report for month 5.

Corporate report
Performance
Mags Barnaby reported on the Trust's performance for month 5 noting the winter plan has been accepted by NHS Improvement.

Workforce
The Trust position on sickness absence saw a small increase in August to 5.10%. Medical Appraisals continue to increase in line with the window to 81%.

Resolved RABD:
Received and noted the contents of the CR report for month 5.

17/18/69 Programme Assurance

RABD received the programme assurance report for: External Partnerships, Global Digital

Excellence, Park Community Estates and Facilities and STP AH @ C&M- Strong Community Services Offer - Transition of New Community Services.

Rachel Greer presented the closure report following the transfer of 130 staff in April 2017 from Liverpool Community Health Services to Alder Hey. Next steps include a bid to transform community services for complex patients receiving care at home.

Resolved:
RABD noted the report and the work being undertaken to increase pace and benefit opportunities.

17/18/70 Weekly waiting times update

All core access standards have been achieved for August; ED performance failed in July due to medical staffing challenges and higher than planned attendance (n+333). CAMHS waits have increased due to staffing shortages in key areas and impact of reduced funding to 3rd sector.

Resolved:
RABD noted the report.

17/18/71 Marketing and Communication Activity report

Resolved:
RABD received the report for July 2017.

17/18/72 Monthly Debt Write Off

Resolved:
RABD approved September's write offs for £7,172.42.

17/18/73 Service Reviews

Resolved:
RABD received the progress report on service reviews indicating the benefits of clinical engagement; the improvements made to the Nephrology SLR position, the rolling programme of coding education and a summary of proposed next steps.

17/18/76 PFI Contract Monitoring report

RABD noted the settlement deal with PFI had now been resolved however this had not been included in the report. As Graeme Dixon or Christopher Gildea had been unable to attend this meeting the item was deferred until the October meeting.

Energy report

Phil Morgan presented the energy report noting a new facility provided by Project Co, was consuming circa 30% more energy than the contract provides and circa 50% more than the initial design. Consequently the facility produced more carbon dioxide than the contractual limits. Reliability issues with the plant have resulted in the renewable energy target set in the contract to be exceeded. The Trust is entitled to compensation for the excesses and has set reduction targets for Project Co to align the consumption with the design. The Trust is also experiencing poor environmental conditions in some parts of the facility.

There was little evidence or reassurances from Project Co during the first year of operation of the facility that much interrogation and investigation was ongoing to understand the issues related to the over consumption of energy and develop a credible and deliverable plan of rectification.

Following the first year of operation the Trust requested that Project Co set up workshops to engage all stakeholders including the Trust in order to develop a plan of rectification which was initially resisted by Project Co but eventually acceded to and the workshop process was set in motion in March 2017. The paper outlined progress to date following the energy workshops and further actions to be taken.

Resolved:
RABD received the PFI report and a presentation on energy services.

17/18/64 Any Other Business
No further business was reported.

Date and Time of the next meeting: Monday 30th October at 3:30pm Room 11, Level 1 Mezzanine.

Alder Hey Children's NHS
NHS Foundation Trust

Trust Board
7th November 2017

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

Summary of progress in last month

Project Delivery within October

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

- SOPB - The Statement of planned benefits completed and submitted for NHS Digital to review.
- Specialty Packages - System development completed for three Speciality Packages, Gynaecology, Emergency Department and Rheumatology
- Specialty Packages - Development underway on eight Specialty Packages
- Voice Recognition - The Voice Recognition project now live within ten specialities (Gen Paeds, Ortho, Ophthalmology, Amb, Neph, Allergy, Dietetics, Endo, Plastics, Immunology)
- Voice Recognition - The average turnaround time has reduced from 16 days to 7.5 days.
- Paediatric Portal - Scoping of the Paediatric Portal completed and development is underway with linking key systems into the portal environment.
- IMO - IMO Clinical Terminology software purchased and testing underway.
- Data Migration – Task and Finish Group established in order to determine scope, first meeting held.

Upcoming Deliverables

- SOPB - On-going development of the Statement of Planned Benefits to support all projects
- PACs other O'logies project – Commence roll-out in both Gait Lab and Speech and Language Therapy.
- Speciality Packages - Development to be completed on six packages by December 2017.
- Speciality Packages - Rheumatology to go live on the 4th December 2017.
- Voice Recognition - Due to go live in EEG and Urology, A&E, Respiratory by end of November 2017
- Paediatric Portal - Development of the Paediatric Portal with view to full a pilot in February 2018. Awareness Sessions will be held in November.
- TCI – Theatre Pathway - Pathway re-design is underway and due to be piloted within General Surgery in February 2018
- GDE Prescribing Projects (Dose Range Checking and Continuous Infusions Pilot) - Task and finish group to be established with a view to delivery in February 2018.

Summary of Key Benefits

Project	Aim	Measurement	Baseline Position	Improvement Target	Actual Progress to Target (current)
Voice Recognition	Safer handover of care between Trust & Primary Care	Average turnaround time for letters (working days)	16 working days	3 working days (Jun-18)	65% 7.5 days

		Longest waiting letter (working days)	19 working days	5 working days (Jun-18)	64% 10 days
Fast User Switching	Improve efficiency when logging into systems in clinical areas – releasing time to care	Time taken to log into system (minutes) 4950 transactions per day	1:45 minutes	<0:10 minutes	100%
Bi-directional interface with kiosks (Intouch & Meditech)	Improve efficiency in booking in for outpatient appointments, releasing time to cash up outpatient clinics	Average time taken to add an appointment to the InTouch system (minutes) 650 transactions per month	1:00 minutes	0:00 minutes (Sep-17)	100%

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

Programme Assurance

NHS Digital attended Alder Hey and completed their assurance testing for the second milestone. Presentations and a number of demonstrations were given in relation to the individual GDE Projects.

Feedback has been received and we are working to provide additional information required subsequent to the inspection.

Fast Follower

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

Next Steps

- Continue working towards the delivery of Milestone three (February 2018).
- Continue to work with Specialties to identify target benefits and support the monitoring of these benefits throughout the project lifecycle.

- Continue to closely monitor the GDE Programme Risks and raise high level risks through the appropriate governance structure.

- Review of assurance testing results which are due to be returned by NHS Digital for Milestone two.

Recommendations

The Trust Board is asked to:-

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

2. Note the on-going risks associated with the GDE Programme, specifically the actions required by the Board.

Peter Young

Chief Information Officer 30 October 2017

GDE Programme Dashb(31 May 2018 - Stage 2

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						PROJECT TEAM	PROJECT RAG	
Project Ref	GDE?	Project Title	Project Description	Delivery Date	Executive Sponsor	IM&T Project Manager	OVERALL PROJECT RAG status	% Progress
Workstream 1 - HIMSS level 7 EPR - System wide projects								
1B(a)	GDE	Voice recognition deployment	Deploy voice recognition solution in MEDITECH	November 2019 - Stage 2		HT		25%
1B(b)	GDE	Voice recognition deployment	Deploy voice recognition solution in Medisec	November 2019 - Stage 2		HT		25%
1C(a)	IM&T	Prescribing and Medicines Administration Enhancements	Warfarin	Wednesday, February 28, 2018		JS		75%
1C(b)	IM&T	Prescribing and Medicines Administration Enhancements	Antimicrobial	Wednesday, February 28, 2018		GSR		35%
1C(c)	IM&T	Prescribing and Medicines Administration Enhancements	Bedside medication verification	Wednesday, February 28, 2018		JS		
1C(d)	GDE	Prescribing and Medicines Administration Enhancements	Continuous infusions	Wednesday, February 28, 2018		JS		
1C(e)	GDE	Prescribing and Medicines Administration Enhancements	Dose range checking	28 Febraury 2018		JS		
1E	GDE	MEDISEC enhancements	Tertiary letter improvements	Wednesday, February 28, 2018		DR		
1E(b)	GDE	MEDISEC enhancements	Inclusion of letters into ImageNOW	Saturday, September 30, 2017		TD		100%
1F	GDE	POCT device integration	Integration of POCT devices into the MEDITECH system	Wednesday, February 28, 2018		DR		5%
1G	GDE	GS1 Barcodes	Enable technical solution for use of GS1 barcodes where appropriate	Wednesday, October 31, 2018		DR		5%
1H	GDE	Vital Sign device integration	Integration of Welch Alyn vital signs monitors into MEDITECH	31 May 2018 - Roll out		DR		80%
1J(a)	GDE	Theatre improvements - Emergency List.	Emergency list solution	Saturday, September 30, 2017		ZH	Completed	Stage 1 100%
1J(b)	GDE	Theatre improvements - TCI to Theatre	TCI to Theatre improvements	28th February 2017 - Stage 2 - Pilot		ZH		25%
1K(a)	GDE	Internal interfaces Haemonetics	Haemonetics	28th February 2017 - Stage 2 - Implementation		DR		10%
1K(b)	GDE	Internal interfaces ECM	ECM file import	Saturday, September 30, 2017		DR		90%
1L	GDE	IMO implementation	Implementation of Clinical interface terminology software	28 Febraury 2018		DR/FM		40%
1M	GDE	Day Forward Scanning	Automate the production and scanning of records	Saturday, September 30, 2017		DR		100%
1N	GDE	Historic data migration	Complete migration of historical data from MEDITECH 5 including Blood bank, bulliten and pathology	Thursday, May 31, 2018		FM/DR		22%
1O(a)	GDE	PACS Other Ologies	EEG - Consolidation of all clinical images into the PACS system	Thursday, May 31, 2018		BS		
1O(b)	GDE	PACS Other Ologies	ECG - Consolidation of all clinical images into the PACS system	Sunday, December 31, 2017		BS		75%
1O(c)	GDE	PACS Other Ologies	Gait Lab - Consolidation of all clinical images into the PACS system	Sunday, December 31, 2017		BS		10%
1O(d)	IM&T	PACS Other Ologies	SLT - Consolidation of all clinical images into the PACS system	Sunday, December 31, 2017		BS		10%
1P	GDE	Encoder implementation	Implement integrated encoding software for the Clinical Coding team	Stage 1 - depoly coding solution 30 September 2017		DR		95%
1R	GDE	Mobile Phlebotomy solution	Adaptation of COWs to allow sample labels to be printed at the point of care	Saturday, March 31, 2018		CP		

GDE Programme Dashb 31 May 2018 - Stage 2

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Project Ref	GDE?	Project Title	Project Description	Delivery Date	Executive Sponsor	PROJECT TEAM: IM&T Project Manager	PROJECT RAG: OVERALL PROJECT RAG status	% Progress
1S	GDE	Infrastructure	Provision of additional hardware (subject to approval) to suppport clinical processes including fast user switching	Saturday, September 30, 2017		LF		
1T	IM&T	Booking and Scheduling Enhancements	Develop an enhanced solution to support improvements to booking and scheduling processes	Saturday, September 1, 2018		BS		10%
Workstream 2 - Speciality Packages								
2A	GDE	Emergency Department	Delivery of electronic clinical documentation workflow designed to reflect best practice protocols and pathways	Friday, September 1, 2017		CP/MD&JS	Completed	100%
2B	GDE	Gynaecology	Delivery of electronic clinical documentation workflow designed to reflect best practice protocols and pathways	Friday, September 1, 2017		CP/MD	Completed	100%
2C	GDE	Rheumatology	Delivery of electronic clinical documentation workflow designed to reflect best practice protocols and pathways	Saturday, September 30, 2017		CP/MD		60%
2D	GDE	Gastroenterology	Delivery of electronic clinical documentation workflow designed to reflect best practice protocols and pathways	Thursday, November 30, 2017		CP/MD		25%
2E	GDE	Neurosurgery	Delivery of electronic clinical documentation workflow designed to reflect best practice protocols and pathways	Friday, November 3, 2017		CP		25%
2F	GDE	Respiratory	Delivery of electronic clinical documentation workflow designed to reflect best practice protocols and pathways	Friday, November 3, 2017		CP		10%
2G	GDE	CAMHS	Delivery of electronic clinical documentation workflow designed to reflect best practice protocols and pathways	Thursday, October 19, 2017		JS/CP		40%
2H	GDE	Community Paeds	Delivery of electronic clinical documentation workflow designed to reflect best practice protocols and pathways	Tuesday, October 24, 2017		CP/ZH		40%
2I	GDE	Dietetics	Delivery of electronic clinical documentation workflow designed to reflect best practice protocols and pathways	Tuesday, October 24, 2017		CP		70%
2J	GDE	Junior Doctors	Delivery of electronic clinical documentation workflow designed to reflect best practice protocols and pathways	Friday, December 1, 2017		NB		25%
2K	GDE	LTV	Delivery of electronic clinical documentation workflow designed to reflect best practice protocols and pathways	Friday, February 2, 2018				TBC
2L	GDE	Pre-Op	Delivery of electronic clinical documentation workflow designed to reflect best practice protocols and pathways	Friday, February 2, 2018		ZH		25%
2M	GDE	Chronic Pain	Delivery of electronic clinical documentation workflow designed to reflect best practice protocols and pathways	Friday, February 2, 2018				20%
2N	GDE	Immunology & Infectious Diseases	Delivery of electronic clinical documentation workflow designed to reflect best practice protocols and pathways	Friday, February 2, 2018				10%
2O	GDE	Transitional Care	Delivery of electronic clinical documentation workflow designed to reflect best practice protocols and pathways	Friday, February 2, 2018		DE		25%
2P	GDE	LCH	Delivery of electronic clinical documentation workflow designed to reflect best practice protocols and pathways	Friday, February 2, 2018		ZH/CP		5%
2Q	GDE	Physiotherapy and Occupational Therapy	Delivery of electronic clinical documentation workflow designed to reflect best practice protocols and pathways	Wednesday, February 28, 2018				TBC
2R	GDE	Haematology	Delivery of electronic clinical documentation workflow designed to reflect best practice protocols and pathways	28 Febraury 2018				TBC
2S	GDE	Tissue Viability	Delivery of electronic clinical documentation workflow designed to reflect best practice protocols and pathways	Wednesday, February 28, 2018				TBC
2T	GDE	Safeguarding /Rainbow	Delivery of electronic clinical documentation workflow designed to reflect best practice protocols and pathways	Wednesday, February 28, 2018				TBC
2U	GDE	Anaesthetics	Delivery of electronic clinical documentation workflow designed to reflect best practice protocols and pathways	Wednesday, February 28, 2018				TBC
2V	GDE	Consent - Trust Wide	Delivery of electronic clinical documentation workflow designed to reflect best practice protocols and pathways	Wednesday, February 28, 2018				TBC
2W	GDE	Vascular Access & OPAT	Delivery of electronic clinical documentation workflow designed to reflect best practice protocols and pathways	Wednesday, February 28, 2018				TBC

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						PROJECT TEAM	PROJECT RAG	
Project Ref	GDE?	Project Title	Project Description	Delivery Date	Executive Sponsor	IM&T Project Manager	OVERALL PROJECT RAG status	% Progress
3A	GDE	Paediatric Clinical Portal	Provide secure access to multiple aspects of a pateint record in one place	Stage 1 Scope and commence procurement 28 February 2017		BS		30%
Workstream 4 - Patient Portal								
4A	GDE	Patient Portal	To allow patients/families/carers secure access to patient records	Wednesday, February 28, 2018		BS		
Workstream 5: Interoperability & APIs								
5A	GDE	MESH	Implementation of MESH standard for message exchange	31 Ocotober 2017		DR		85%
5B	GDE	EMIS to MEDITECH interface	Electronic access to primary care records	Tuesday, October 31, 2017		DR		10%
5C	GDE	GP Ordering for Diagnostics	To provide the ability for GPs to order Pathology investigations direct	Saturday, March 31, 2018		DR		50%
5D	GDE	GP Ordering for Diagnostics	To provide the ability for GPs to order Radiology investigations direct	Saturday, March 31, 2018		FM/DR		50%
Workstream 6: Improving Patient Experience								
6A	GDE	PET App	Development of an App to improve patient experience	30 September 2017 - Stage 1, complete engagement phase for PET App 28th February 2018 - Stage 2 , build pilot for PET App		TR		Stage 1 100%
Workstream 7: National Requirements								
7A	IM&T	e-Referrals	e-Referral paper switch off programme	Monday, October 1, 2018		ML		50%
7B	IM&T	Emergency Care Data Set	Emergency Care data set to be added as part of IMO	Sunday, October 1, 2017		ML		100%
Workstream 8: Other								
8A	IM&T	Chemocare HL7 Interface	HL7 ADT Interface for Chemocare	Thursday, March 1, 2018		DR		95%
8B	IM&T	R&E 2	The aim of the project is to complete Phase 2 of the RI & E building to a world class standard	Friday, June 1, 2018	David Powell	David Houghton		
8C	IM&T	Outpatient Coding	Outpatient Coding	Friday, September 1, 2017		CP/JS		
8D	IM&T	Sepsis Management	Review of Sepsis Pathway	Friday, September 1, 2017		CP/MD		85%
8D	IM&T	Data Centre back on site	Move of the Data Centre back onto site	Monday, January 1, 2018				
8E	IM&T	A&E Capacity and Demand App	Deployment of an A&E waiting time app across the STP footprint	01 January 2018?		CF		

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