Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS MEETING

Tuesday 10th April 2018 commencing at 10:00am

Venue: Small Lecture Theatre, Institute in the Park

AGENDA

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action	Preparation
STAFF STORY – (10:00am-10:15am)						
Board Business						
1.	**18/19/01**	**10:15**	**Apologies.**	Chair	To note.	Verbal
2.	**18/19/02**	**10:16**	**Declarations of Interest.**	All	Board Members to declare an interest in particular agenda items, if appropriate	Verbal
3.	**18/19/03**	**10:17**	**Minutes of the Previous Meeting.**	Chair	To consider the minutes of the previous meeting to check for amendments and approve held on: **6th March 2018**	Read Minutes
4.	**18/19/04**	**10:20**	**Matters Arising:** • **Action Log.**	Chair	To discuss any matters arising from previous meetings and provide updates and review where appropriate	Verbal
5.	**18/19/05**	**10:25**	**Key Issues/Reflections.**	All	To reflect on key issues.	Verbal
Strategic Update						
6.	**18/19/06**	**10:35**	**Draft Clinical and Sustainability Strategy**	M. Barnaby	For approval	Presentation
7.	**18/19/07**	**10:50**	**Liverpool Women's Reconfiguration Options/Neonatal.**	L. Shepherd / A. Bateman	To receive an update.	Presentation
8.	**18/19/08**	**11:00**	**International & Private Patients**	J. Gibson	To update the Board	Read Report
9.	**18/19/09**	**11:10**	**International Child Health Strategy**	J. Gibson / M. Gladstone	For approval	Read Report

Delivery of outstanding care						
10	**18/19/10**	**11:20**	**Pipe Corrosion**	A. Bateman / D. Powell	To update on the actions taken to mitigate the risk from pipe corrosion.	Read Reports
11	**18/19/11**	**11:30**	**Mortality report, Quarter 3, 2017/18.**	S. Ryan	To receive the quarterly report	Read report
12	**18/19/12**	**11:40**	**Quality Strategy Update: Clinical Quality Assurance Committee:** - **Key Issue report from the meeting that took place on the 21.3.18.** - **Approved minutes from the meeting that took place on the 21.2.18.**	A. Marsland	To receive and review the approved minutes from the meeting held on the 17.1.18.	Read minutes
13	**18/19/13**	**11:45**	**Integrated Governance Committee:** • **Approved minutes from the meeting that took place on 16.02.18**	S. Igoe	To receive and review the approved minutes from the meeting held on the 16.2.18.	Read reports
14	**18/19/14**	**11:50**	***'Getting it Right First Time'* National Report.**	Simon Kenny	For information and discussion.	This item was deferred until the 22.5.18.
15	**18/19/15**	**12:00**	**Listening into Action.** - **BME Network Group** - **Disability Network Group**	Fatima Ashif Margaret Eccleston Hannah Ainsworth	For information and discussion.	This item was deferred until the 1.5.18.
16	**18/19/16**	**12:10**	**Serious Incidents Report.**	H. Gwilliams	To inform the Board of the recent serious incidents at the Trust in the last calendar month.	Read Report
17	**18/19/17**	**12:20**	**Cardiac Review**	A. Bateman	To update the Board	Presentation
LUNCH (12:30)						
18	**18/19/18**	**13:00**	**Alder Hey in the Park Site Development update.**	D. Powell	To receive an update on key outstanding issues / risks and plans for mitigation.	Read Report

19	**18/19/19**	**13:10**	**People Strategy Update**	M. Swindell	To update the Board	Read report
20	**18/19/20**	**13:20**	**Equality Act**	M. Swindell	For information	This item was removed
21	**18/19/21**	**14:30**	**Gender Pay Gap**	M. Swindell	To update the Board	Read report
22	**18/19/22**	**14:40**	**New Pay Deal**	M. Swindell	To update the Board on the NHS Pay Deal proposals in England	Presentation
Strong Foundations						
23	**18/19/23**	**14:50**	**Resources & Business Development Committee:** - **Chair's verbal update from the meeting that took place on the 4.4.18.** - **Approved minutes from the meeting that took place on the 5.3.18.**	I. Quinlan	To provide the key points from the meeting that took place on the 4.4.18. To receive and review the approved minutes from the meeting held on the 5.3.18.	Verbal Read minutes
24	**18/19/24**	**15:05**	**Programme Assurance update.**	J. Gibson	To receive an update.	Read Report
25	**18/19/25**	**15:15**	**Corporate Report.**	J. Grinnell/ A. Bateman/ H. Gwilliams/ M. Swindell	To note delivery against financial, operational, HR metrics and quality metrics and mandatory targets within the Corporate Report for the month of February 2018.	Read report
26	**18/19/26**	**15:30**	**Board Assurance Framework**	E. Saunders	To receive the 2017/18 year-end position relating to the Board Assurance Framework	Read reports
27	**18/19/27**	**15:40**	**Governor Election Results**	E. Saunders	To inform the Board of the outcome of the Governor Bi-Election	Read report
28	**18/19/28**	**15:45**	**Freedom to Speak-up**	Kerry Turner	To provide an update to the Board.	Read Report

29	**18/19/29**	**15:55**	**CQC Action Plan**	E. Saunders	To provide the Board with progress to date (position to end of February)	Read Report
Game Changing Research and Innovation						
30	**18/19/30**	**16:05**	**Research Update:** • **Progressive muscle strengthening and fitness training for children with neuro-disabilities in a universal services setting.**	Stuart Clarke / Lee Evans	To receive a presentation on recent research work that has taken place.	Presentation
31	**18/19/31**	**16:20**	**Global Digital Exemplar (GDE).**	P. Young	To update the Board on the programme.	Read report
32	**18/19/32**	**16:30**	**Liaison Committee:** • **Approved minutes from the meeting that took place on the 14.2.18.**	D. Powell	To receive and review the approved minutes from the meeting held on the 14 February 2018.	Read minutes
Any Other Business						
33	**18/19/33**		**Any Other Business.**	All	To discuss any further business before the close of the meeting.	Verbal
Date And Time Of Next Meeting (Part 1): Tuesday 1st May At **10:00am, Institute In The Park, Large Meeting Room**						

REGISTER OF TRUST SEAL
Deed of amendment to PFI (SFP deed)

PUBLIC MEETING OF THE BOARD OF DIRECTORS

Confirmed Minutes of the meeting held on **Tuesday 6th March 2018 at 10:30am,**
Small Lecture Theatre, 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)
	Mrs A Marsland	Non-Executive Director	(AM)
	Mr I Quinlan	Non-Executive Director	(IQ)
	Dr S Ryan	Medical Director	(SR)
	Mrs L Shepherd	Chief Executive	(LS)
	Mrs M Swindell	Director of HR & OD	(MS)
	Dame J Williams	Non-Executive Director	(JW)
In Attendance:	Mrs M Barnaby	Interim Director of Strategy	(MB)
	Mr. A. Bateman	Acting Chief Operating Officer	(AB)
	Prof M Beresford	Assoc. Director of the Board	(PMB)
	Mr C Duncan	Director of Surgery	(ChrD)
	Ms S Falder	Director of Clinical Effectiveness and Service Transformation	(SF)
	Mr M Flannagan	Director of Communications	(MF)
	Dr A Hughes	Director of Medicine	(AH)
	Mrs K McKeown	Committee Administrator (minutes)	(KMc)
	Mr D Powell	Development Director	(DP)
	Ms E Saunders	Director of Corporate Affairs	(ES)
	Mr A Williams	Director of CAMHS	(AW)
Agenda item: 262	Prof M Peak	Director of Research	(MP)
264	Mr J Gibson	External Programme Assurance	(JG)
279	Mr J Gibson	External Programme Assurance	(JG)
271	Ms V Weston	Operational DIPC	(VW)
287	Mr P Young	Chief Information Officer	(PY)
Apologies:	Mr S Igoe	Non-Executive Director	(SI)
	Mrs. C. McLaughlin	Director of Community Services	(CMc)
	Ms J Minford	Director of Clinical Effectiveness and Service Transformation	(JM)

Patient story

The parents of a baby who required open heart surgery shortly after birth were invited to the Trust Board meeting to share their son's journey. Sam's mum informed the Board that Sam had arrested twice while being transported to Alder Hey and had remained a patient for quite some time following surgery. Both parents stayed on site and used the facilities of Ronald McDonald House as they lived in Macclesfield. It was reported that Sam has had to have several other surgeries and procedures since but is now at home and doing well. Sam is still being monitored via the Outpatients Department. Sam's parents informed the Board that the staff from Alder Hey who cared for their son saved his life as well as becoming an extended part of their family during their stay, offering support, information and advice. Both parents agreed that if it wasn't for the staff at Alder Hey they would not be holding their son in their arms today.

The Chairman felt that Sam's story was positive from a whole system perspective and also emphasised the long haul some patients and families have before being able to return home. The

Chairman thanked the family for sharing their story with the Board and wished them well for the future.

17/18/257 Apologies

The Chairman noted the apologies received from Steve Igoe, Cath McLaughlin and Jo Minford.

17/18/258 Declarations of Interest

There were none to declare.

17/18/259 Minutes of the previous meetings held on 6th March 2018
Resolved:
The Board received and approved the minutes from the meeting held on the 6th February 2018.

17/18/260 Matters Arising and Action Log

All outstanding actions were addressed during the meeting.

17/18/261 Key Issues/Reflections

Unannounced CQC Visit.

On behalf of the Trust Board, Louise Shepherd thanked all of those involved in ensuring the unannounced CQC visit went smoothly.

Louise Shepherd briefed Board members on the outcome of the visit and explained the next steps and the process CQC will follow post inspection. It was reported that there were a small number of low level issues but it was felt that the Head of Hospital Inspection understood the culture at Alder Hey and was very positive in what she saw, for example, the relationships between people, the Executive Team and the Trust Board. There was also an opportunity for Steve Ryan to discuss End of Life Care provision with CQC and provide a balanced overview.

Following the high level feedback after the visit the Trust is going to follow up on some areas to ensure CQC are able to give an accurate picture across all domains and services inspected. A refresh of the Board committees is going to take place as part of the Well Led work, it is also imperative that the organisation is able to demonstrate to CQC the work that is taking place around the Quality Strategy.

17/18/262 Development of the Strategic Plan

The Board noted the presentation that was provided to give an overview for the delivery of an Integrated Research Strategy along with the NHR Alder Hey CRF Strategy. The Board discussed the umbrella partnership with Liverpool University that will focus on the child and the wellbeing of children. A graph detailed how risk reduction and health promotion strategies influence health development. The Liverpool Health Partners/KPMG work will encompass maternal, young people and transition through to adulthood.

The Board discussed the initiatives and key areas of research, innovation, education and the academy along with children's health and wellbeing which will be supported by Liverpool City Council's Child Friendly City bid. Michael Beresford highlighted how critical integration becomes as relationships mature and felt that achieving depth of

integration is the next step. Following discussion it was agreed that an invitation should be extended to Professor Louise Kenny to attend a future Board meeting in order to discuss integration and the next steps for driving this area of work forward, plus the re-establishing of the honorary contract.

Louise Shepherd reported that a review of the Research, Innovation and Education Committee is taking place and further work is required to progress this. The review will be addressed via the Executive Team and the outcome will be fed back to the Board accordingly. It was pointed out that additional support will be required to enable Michael Beresford and Matthew Peak to drive the agendas forward.

17/18/262.1 Action: LS/MB

Resolved
The Board received and noted the Research, Education and Innovation presentation.

17/18/263 Draft Financial Plan 2018/19

John Grinnell submitted the 2018/19 draft budget to the Trust Board for approval. The Board discussed the 2018/19 control total of £4.4m and the receipt of the £6.6m of STF whilst noting the targets and risks associated with it.

John Grinnell reported on the Trust's income and expenditure, the contract position, Capital Programme and the inclusive process of prioritisation for Divisions which is to be discussed at the Executive Team meeting on the 8.3.18. Following discussion it was agreed to submit the draft 2018/19 budget to NHS Improvement on the 8th of March and present the final version of the plan to Resource and Business Development Committee at the end of April and the Trust Board in May.

17/18/263.1 Action: JG
17/18/263.2 Action: JG

Resolved
The Board received the 2018/19 draft budget and it was agreed to:

- Submit the 2018/19 draft budget to NHS Improvement on the 8th March.
- Present the final version of the 2018/19 Financial Plan to the Resources and Business Development Committee on the 25.4.18.
- Present the final version of the 2018/19 Financial Plan to the Trust Board on the 1.5.18.

17/18/264 Alder Hey Promotional Pack

The Board was provided with the new promotional pack in support of Alder Hey's international business development effort. A request was made for feedback on the layout/contents of the pack by the close of play on the 9th of March. Joe Gibson reported that there are a number of Consulates and Embassies who are keen for copies of these packs as they wish to promote Alder Hey when meeting people. The Board thanked the team for the work that has taken place to compile the promotional literature and Jo Williams asked that each Trustee of the Charity be furnished with a pack.

17/18/264.1 Action: All
17/18/264.2 Action: JG

Resolved:

The Trust Board approved the new promotional pack subject to any feedback.

17/18/265 Change Programme (*Growing Through External Partnerships*)

John Grinnell informed the Board that a meeting is due to take place between Liverpool CCG, Alder Hey and Liverpool Women's Hospital in order to discuss the joint Neonatal business case. Partnership working will be launched next week following approval of the business case.

It was reported that the CHD network group have approved an implementation plan/risk sharing agreement with LHCH. The ECMO designation expansion has been implemented and the Aseptic unit has been partially utilised.

The Trust has new contracts in the Chinese markets coming through on the Academy front and a strategic partnership project is being prepared for 2018/19. The Trust is also exploring business opportunities in India and the Middle East due to receiving a number of enquiries.

Resolved:

The Trust Board noted the Change Programme update.

17/18/266 Liverpool Women's Reconfiguration Options/Neonatal

It was reported that a meeting has taken place between Arrowe Park, Alder Hey and Liverpool Women's to discuss partnership working across the three trusts. Discussions are also taking place with the Medical Director of the Women's to look at the possibility of a specialist centre for women's and children's services going forward.

The Board was advised that the consultation on the future of Liverpool Women's is due to go ahead during the summer of 2018. Liverpool CCG is in the middle of refreshing its strategy which will be published in April 2018. Alder Hey has been asked to provide feedback on the draft strategy during the initial consultation on its content.

17/18/267 Quality Strategy update
CQAC
It was reported that work is on-going in respect to quality metrics.

Resolved:

- The Trust Board noted the contents of the Chair's key issues update from the Clinical Quality Assurance Committee meeting that took place on the 21.2.18.
- The Trust Board received and noted the approved minutes from the meeting that took place on the 17.1.18

17/18/268 Listening into Action

Cardiac Surgical Pathway

Members of the Cardiac team presented a number of slides to the Board highlighting the planned process for patients who require cardiac surgery, the process for accessing the hospital and the obstacles that the Cardiac department have experienced during the winter period due to the blockage of PICU beds.

The Board was made aware of the impact upon staff, patients and families as a result of having to cancel operations at the last minute, along with the loss of reputation that follows due to an increased lack of patient trust/confidence.

Adam Bateman informed the Board that following discussions, clinicians from the ECMO service, PICU service and the Cardiac service have been challenged to find a solution to the bed blockage situation and to that end have agreed to a structured review process to address the current system over a three month period and report back on a new solution for addressing issues with cardiac patients.

17/18/268.1 Action: AB

Resolved:
The Board received and noted the presentation from the Cardiac department.

Outpatients Department

The Board was apprised on the outcome of the 2017/18 Outpatient project. The presentation covered the key achievements of the Outpatient department, Phlebotomy service, Fracture Clinic/Plaster Room and the key themes for booking and scheduling.

The Board discussed the next steps that need to be taken to progress forthcoming aspirations and the lack of funding currently for the Haven Room was raised. Jo Williams agreed to liaise with the Trust Charity with regard to the potential for funding for the Haven Room.

17/18/268.2 Action: JW

Resolved:
The Board received and noted the presentation from the Outpatients department.

17/18/269 Nursing Workforce Report

The nursing workforce report was submitted to the Trust Board in order provide assurance that safe nurse staffing levels are being maintained across all in-patient and day case wards and appropriate systems are in place to manage the demand for nursing staff. The following points were highlighted and discussed:

- The Trust's mandated monthly submission of staffing levels to NHS Choices presented an overall fill rate of 97% registered staff and 100% unregistered staff for planned inpatient staffing levels against actual staffing levels for the month of January 2018, in the context of the nationally accepted level of 90%.
- Hilda Gwilliams informed the Board of the issue relating to 24/7 senior nursing cover which has a red RAG rating. It was reported that cover was in place for the daytime but not during the night. It was confirmed that this matter is in the process of being addressed. Louise Shepherd pointed out the Trust is running a large high dependency unit and all of the inpatient wards are specialist wards that require dedicated ICU nurses. HG highlighted the importance of demonstrating the level of acuity to link into funding.
- It was reported that CQC have identified that most hospitals with children's service are failing with staffing.
- Claire Dove informed the Board of the discussions that have taken place at WOD around the diversity of the organisation and confirmed that Edge Hill have agreed for a member of the Trust to sit on recruitment panels to assist with the targeting of appropriate students.

- Long-term sickness (LTS) has reduced again in January 2018, with 9.73 WTE currently off on LTS and it was reported that short-term sickness has reduced significantly during 2017/18.
- The current maternity leave rate at January 2018 is 38 WTE. In 2016/17 the Trust Board agreed to establish a nursing pool of 20 WTE in order to improve resilience and optimise bed occupancy. This will give the Trust a pool of nurses to cover maternity and sick leave.
- There has been a notable increase in leavers in Q3 of 2017/18; this is due to retirement and staff wanting to go to other countries. The senior nursing team is continuing to work with the HR department to ensure that there are no underlying issues as to why staff are leaving.
- The Board discussed the age profiling of nursing staff and it was reported that there are 57 WTE achieving retirement age in the next five years. It was pointed out that this is a significant number and could be a risk for the Trust. In order to impact assess and mitigate the risk of future gaps in the nursing workforce, work will continue to seek staff intentions over the coming years.
- Use of agency nursing staff has continued to be low in 2017 with virtually no agency used in summer months with 0.2 WTE used in August 2017. This is the lowest ever rate.
- The Board discussed the workforce development that took place in 2017 and it was reported that the Trust has joined a group across Cheshire and Merseyside to mobilise and maximise nursing leadership.

The Chairman commended Hilda Gwilliams and her team for the work undertaken to ensure that the Trust continues to be in a strong position in terms of its nursing workforce.

Resolved:
The Board noted the Nursing Workforce Report

17/18/270 Serious Incidents Report

The Board received and noted the contents of the Serious Incidents report for January 2018. The following points were highlighted and discussed:

- The Board discussed the circumstances surrounding the death of a patient with congenital hyperinsulinism Beckwith Weidemann Syndrome and Gastroesophageal Reflux Disease. Prior to death concerns were raised by the patient's mother in respect to feeding and an urgent referral was made to the SALT team. The appointment never occurred and the patient's consultant was informed via Ormskirk Hospital of the child's death on the 22.1.18. It was confirmed that the family have contacted Alder Hey requesting an explanation into the delay of the referral/ appointment. Following a review of the baby's care a decision was made to investigate this case further. An RCA is underway and the Trust is awaiting confirmation of the cause of death from the Coroner.
- The Board discussed the case relating to a patient who was transferred from Whiston Hospital on the 23.10.17 due to a secondary scalding episode and a laceration that required surgery. It was reported that an RCA is being conducted that will address the wider elements of this case.
- Grade 3 pressure ulcer to patient's scalp - It was confirmed that a significant piece of work is taking place around pressure ulcers in terms of learning and sharing best practice.

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

17/18/271 Infection Prevention and Control, Q3 2017/18

Valya Weston provided the Board with an update on the challenges for delivery of the Infection Prevention and Control work plan for 2017/18. The following points were highlighted and discussed:

- *Measles Outbreak (November 2017)* – Sixteen cases were identified and were all admitted from the community along with one hospital case. It was reported that there is no national provision for staff to have boosters.
- *Norovirus Outbreak (December 2017)* – There was a Norovirus outbreak on Ward 4B with thirteen patients and 14 staff members affected. The ward was closed from the 13th to the 18th of December 2017, this action contained the virus.
- A discussion took place around the current red rated objectives which are presently at 1% of the total. It was confirmed that interviews for the IPC doctor's post are planned for the end of March 2018 and therefore this risk should change to amber/green in Q4. Steve Ryan informed the Board of the additional posts that have been filled/in the process of being filled; a doctor is due to commence in post in the Infectious Diseases team and interviews are planned for the end of March for a Microbiologist.
- The new contract for hand hygiene products commences on the 7th of March. Work is taking place with the new contractors to look at training for staff as well as a process for auditing.
- A piece of work is taking place in order to change the cleaning products being used in the hospital. One of the issues that will be addressed as part of this project is the amount of personal belongings that parents/families bring into the hospital which hinders cleaning. The Trust is working together to keep the hospital clean and small bags are in the process of being produced for children which will incorporate a book on the front to provide information on how to wash your hands.

  It was reported that a paediatric interest group has been set up and is being funded by the IPS. The first meeting will take place in June and a conference is being planned for September 2018 in Sheffield.

Resolved:
The Board received and noted the Infection Prevention Control update for Q3, 2017/18.

17/18/272 Complaints Report Q3, 2017/18

The Trust Board received the current Complaints report and update regarding previous issues. The following points were highlighted and discussed:

- The main category of complaints received in Q3 were jointly shared between treatment and care (41%) and communications/consent (41%). It was confirmed that work is taking place to address this matter.
- *Report against three day acknowledgement* – In Q3 there was one complaint that wasn't acknowledged until day 10, this was a repeat complaint which was very complex. The delay was due to awaiting a decision as to whether this could be included in the on-going complaint or whether it would have to be treated as a

new issue. The additional complaint with a fourteen day delay was sent directly to the clinical area by the mother of the patient and there was a delay in sending this to the Complaints team to be logged and acknowledged.

- It was reported that there is one on-going Ombudsman case at the present time.
- Discussions have taken place with the PALs team and those who offer assistance in dealing with concerns, re the high numbers of PALs contacts that are not being logged. Training has since been delivered to all relevant staff and concerns are now going to be logged directly onto Ulysses enabling a wider appreciation of all of the issues the Trust should be aware of.
- Hilda Gwilliams referred to the poem recently shared with the Oncology/ Haematology team that was compiled by a nine year old patient, to highlight the impact staff and services make to children and their families.
- Jo Williams queried as to whether complaints being received by the Trust from a treatment/care perspective were influenced by parental expectation. Hilda Gwilliams reported that a drill down had taken place and it had been difficult to identify a theme. It was agreed that the outcome of the drill down would be submitted to CQAC.

17/18/272.1 Action: HG

Resolved:
The Trust Board received the Complaints Performance Report for Q3, 2017/18.

17/18/273 Alder Hey in the Park

David Powell provided an update to the Trust Board on the Alder Hey in the Park site development. The following points were highlighted and discussed:

- It was reported that demolition of the site is on schedule and the new Alder Centre is going out to tender and plans to commence building are imminent.
- *Retained Estates and Community Cluster* – The design competition is now complete and the four bidders will reveal their bids on the 7th March. There will be two phases for this area of work; 1. Neuro-developmental assessment, CAMHS and Single Point of Assessment 2. Agree the design for the Dewi Jones unit so that it can commence at the same time as the rest of the building work.
- It was reported that funding is still required from Liverpool City Council for the building of a school on site. Louise Shepherd confirmed that the Director of Children's Services has approved the funding for the new Sandfield Park School which is to be built on the Alder Hey site.
- David Powell confirmed that a report is to be compiled to highlight all of the work that is taking place and how it interlinks.

Resolved:
The Trust Board received and noted the update on the current position on the site development.

17/18/274 Change Programme – Park, Community, Estates and Facilities

An update was provided under item 17/18/273.

17/18/275 Change Programme (Delivery Outstanding Care)

Hilda Gwilliams presented a number of slides to the Trust Board on the Delivery of Outstanding Care and highlighted the key benefits of the programme. It was pointed

out that the majority of patients are now being screened for Sepsis and receiving antibiotics within an hour. It was reported that there have been a number of challenges on the system in respect to the collection of Sepsis data but it was confirmed that this is being addressed via discussions with Meditech.

Following a piece of work that took place around the shadowing of clinicians it came to light that there are a number of systems that need to be simplified to give clinicians more time to focus on patients during clinics.

A discussion took place around the viability of the 98% target set for ensuring children and families are very happy with their experience of Outpatient services and it was agreed to re-look at this target. Christian Duncan reported that work is taking place to look at what it would take for both patients and clinicians to have a good experience. Adam Bateman felt that clinicians based in the Outpatient Department would benefit from additional support. Hilda Gwilliams agreed to look into this matter.

17/18/275.1 Action: HG
17/18/275.2 Action: HG

Resolved:
The Trust Board noted that Change Programme update.

17/18/276 People Strategy update

The Trust received the National Staff Survey results for 2017 and an accompanying presentation which highlighted where we have significantly improved and areas for further improvement, and discussed the next steps. The following points were highlighted and discussed:

- Melissa Swindell reported that the Trust's results have significantly improved since 2016 and confirmed that there has been an improvement in 18 of 32 Key Findings.

- Louise Shepherd queried the results in comparison to the results of the comparator group (acute specialist trusts). Melissa Swindell confirmed that our results show a mixed picture when compared to this group, but when compared to acute trusts in general, our results are higher in a range of key questions. LS asked what needs to be done to improve the results for next year. The Chairman enquired as to whether there is anything that we need to be focusing on which may undermine continued progress.

  Melissa Swindell informed the Board that the survey results are moving in the right direction, and reflect the efforts made over the last 12-18 months to improve the working lives of our staff; all measures around job satisfaction/managers have improved and less staff members are reporting discrimination. 11% more staff than last year (64%) are reporting that they would recommend alder hey as a place to work. We have one of the highest scores amongst our comparators for staff reporting they discussed the Trust values within their appraisal. Further work will be required in a number of areas, including improving access to training, lowering the levels of reported work related stress and improving equality of opportunity for careers. A detailed analysis is underway to identify hotspots, including areas with very low scores and work is taking place to get teams to identify the areas that they feel require improvement.

- Jo Williams highlighted the low level of response to the staff questionnaire, despite an 11% increase since 2016, and she queried as to whether the final results are a true reflection of the organisation.

- The Chairman requested assurance from the Exec Team that the plan that is going to underpin the next steps for the Trust is correct.

Resolved:

The Trust Board noted the following:

- Key issue report from February's Workforce and Organisational Committee meeting.
- National Staff Survey results for 2017 and the next steps.
- People Strategy update for December 2017/January 2018.
- Approved minutes from the Workforce and Organisational Committee meeting that took place on the 12.12.17.

17/18/277 Change Programme (The Best People Doing Their Best Work)

Hilda Gwilliams informed the Board of the key benefits for 2017/18. The following points were highlighted and discussed:

- The Domestic Services/Portering Services projects were delivered with positive outcomes.
- The apprenticeships project was launched and a successful ESFA inspection was conducted. It was reported that 50 starts is the aim for the Apprenticeship strategy implementation in 2018/19.
- An AHP Review team was established and the project launched.
- Phase 1 of the Specialist Nurse Review has been completed.

Resolved:
The Board noted the Change Programme update.

17/18/278 Resource and Business Development Committee
Resolved:
The Board noted the Chair's verbal update from the Resources and Business Development Committee meeting that took place on the 5.3.18.

17/18/279 Programme Assurance Update
The Trust Board was informed of the assurance status of the Change Programme and the actions that have been requested of the Executive Sponsors. The following points were highlighted and discussed:

- The assurance ratings continue to be addressed and the current positive trend now needs to be accelerated to underpin the Trust's plans for 2018/19; the deployment of a programme and a project manager as a supporting PMO has proved extremely successful and may need to be expanded to ensure delivery across the portfolio.
- The Programme Board is gaining further traction in driving the programme and has invoked a disciplined approach to only initiating those projects that can demonstrate clear metrics so that measurable benefits can be assured.
- The scope of the change programme for 2018/19 is now being finalised with a focus on prioritisation of major programmes and phasing of project launch dates. A key focus will be on benefits and realisation and how they are tracked through the committees/Trust Board.

Resolved:
The Board noted the Change Programme update.

17/18/280 Change Programme (Global Digital Exemplar)

Peter Young provided an overview of the key benefits for 2017/18 along with the Trust's
ambitions for 2018/19. A discussion took place around the portal that is being sponsored by Alder Hey for the whole of Cheshire and Merseyside which will be accessible to families and clinicians. Sian Falder and Jo Minford pointed out that the speciality packages are fit for purpose and access will be available in respect to the portal, audit, clinical intelligence, etc. It was confirmed that NHS Digital are pleased with the Trust's progress.

Resolved:
The Board noted the Change Programme update.

17//18/281 Corporate Report

The Corporate report for month 10, 2017/18 was submitted to the Board for information and assurance purposes. The following points were highlighted and discussed:

- The issues relating to known planned date of discharge have been addressed via project work and GDE.
- It was reported that there has been a significant increase in the Friends and Family Test responses.
- Performance is strong and the Trust has achieved all of the NHSI core standards.
- For the month of January the Trust is reporting a tracking surplus of £1.7m which is £0.2m ahead of plan.
- The Trust is in the process of finalising the Welsh contract along with a year-end deal via Specialist Commissioners.
- Sickness absence has increased to 6.2% and it was reported that the Trust achieved a target of 94% for core mandatory training.

Resolved:
The Board received the Corporate Report for Month 10.

17/18/282 GDPR Status Report

Erica Saunders provided the Board with an update on the actions taken to date to prepare the organisation for the introduction of the General Data Protection Regulation that is due to commence in May 2018.

Resolved:

- The Board noted the change to legislation and agreed to support the steps required by the Trust to comply with the changes by the 25.5.18.
- The Board noted the progress that has been made to date along with the residual actions to be taken.

17/18/283 Board Assurance Framework

Erica Saunders presented the Board Assurance Framework (BAF) for February 2018.

Adam Bateman advised of the issues relating to pipe corrosion across the hospital. It was reported that there have been 41 leaks to date due to the use of low grading steel, therefore, what had commenced as erosion has become corrosion. Teams are presently working on this matter with Health and Safety, and a letter has been drafted to SPV with a seven day response timeline requesting a plan of action to address the issues that have been raised. The Board was advised of the risks to patient and staff

safety along with the greater issue in the event that a total refit is required. It was agreed that a further update on this matter should be provided during April's Board.

17/18/283.1 Action: AB

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

17/17/284 Research Update
This item was deferred until April 2018.

17/18/285 Change Programme – Game Changing Research and Innovation
Resolved
An update was provided under item 17/18/262.

17/18/286 Liverpool Health Partners/KPMG Update
There were no items to report.

17/18/287 Global Digital Exemplar (GDE)
Resolved:
The Board noted the updated progress towards participation in NHS England's GDE Programme and subsequent initiation of the Programme.

17/18/288 Research, Education and Innovation Committee (REIC)
Resolved:
The Board noted the approved minutes from the REIC meeting that took place on the 13.7.17.

17/18/289 Liaison Committee
Resolved:
The Board noted the minutes from the Liaison Committee meeting that took place on the 16.1.18.

17/18/232 Any Other Business

The Board was informed of the sudden passing of the previous Chief Executive of Alder Hey, Tony Bell. A suggestion was made to have an area of the hospital named after Tony in memory of the great work that he conducted for the Trust and re-establishing links with Liverpool University. Michael Beresford agreed to look into this matter.

17/18/232.1 Action: MB

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

Alder Hey Children's NHS Foundation Trust
Trust Board - Part 1
Action Log following the meeting on the 6.3.18

Alder Hey Children's NHS Foundation Trust

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
Actions for March 2018							
6.2.18.	17/18/242.2	Matters Arising and Action Log.	***Meditech Update*** - Provide a further update to the Trust Board in March 2018.	John Grinnell.	6.3.18		**6.3.18** - A verbal update will be provided during April's Trust Board meeting.
6.3.18.	17/18/262.1	Development of the Strategic Plan.	Invite Professor Louise Kenny to a future Trust Board meeting.	Louise Shepherd/ Michael Beresford.	16.3.18.		**5.4.18.** Professor Louise Kenny has confirmed that she will be attending May's Trust Board meeting. **ACTION CLOSED**
6.3.18.	17/18/263.2	Draft Financial Plan 2018/19.	Present the final version of the 2018/19 Financial Plan to the Resources and Business Committee on the 25.4.18.	John Grinnell.	18.4.18.		**5.4.18 -** This item has been included on April's agenda for the Resources and Business Development Committee. **ACTION CLOSED**
6.3.18.	17/18/264.1	Alder Hey Promotional Pack.	Feedback required on the layout/contents of the Alder Hey promotional pack.	All.	9.3.18.		**5.4.18** - A verbal update will be provided on the 10.4.18.
6.3.18.	17/18/264.2	Alder Hey Promotional Pack.	Provide Charity Trustees with a copy of the Alder Hey promotional pack.	Joe Gibson.	12.3.18.		**5.4.18** - A verbal update will be provided on the 10.4.18.
6.3.18.	17/18/268.1	Listening into Action.	***Cardiac Surgical Pathway*** - Provide an update on the new system that is being devised for addressing bed blockage issues for cardiac patients.	Adam Bateman.	10.4.18.		**5.4.18** - A verbal update will be provided on the 10.4.18.
6.3.18.	17/18/268.2	Listening into Action.	***Outpatients Department*** - Liaise with the Trust Charity re potential funding for the Haven Room.	Jo Williams.	10.4.18.		**5.4.18** - A verbal update will be provided on the 10.4.18.

Alder Hey Children's NHS Foundation Trust
Trust Board - Part 1
Action Log following the meeting on the 6.3.18

Alder Hey Children's NHS Foundation Trust

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
6.3.18.	17/18/272.1	Complaints Report Q3, 2017/18.	Submit the outcome of the complaints drill down to CQAC on the 18.4.18.	Hilda Gwilliams.	11.4.18.		**5.4.18** - This item has been included on April's CQAC agenda. **ACTION CLOSED**
6.3.18.	17/18/275.1	Change Programme.	***Delivering Outstanding Care*** - Review the 98% target set for 'ensuring children and families are very happy with their experience of Outpatients services'.	Hilda Gwilliams.	10.4.18.		**5.4.18** - A verbal update will be provided on the 10.4.18.
6.3.18.	17/18/275.2	Change Programme.	***Delivering Outstanding Care*** - Review the support being received by clinicians in the Outpatients department.	Hilda Gwilliams.	10.4.18.		**5.4.18** - A verbal update will be provided on the 10.4.18.
6.3.18.	17/18/283.1	Board Assurance Framework.	Provide an update following the submission of a letter to SPV requesting a plan of action to address the issue of the corroded pipes across the hospital.	Adam Bateman.	10.4.18.		**5.4.18** - A verbal update will be provided on the 10.4.18.
6.3.18.	17/18/282.1	Any Other Business.	Enquire as to whether it would be possible to have an area of the hospital named after the previous Chief Executive, Tony Bell.	Michael Beresford.	10.4.18.		**5.4.18** - A verbal update will be provided on the 10.4.18.
6.3.18.	17/18/242.1	Matters Arising and Action Log	***Booking and Scheduling Review Update*** - Provide a further update to the Trust Board on the 1.5.18.	Adam Bateman	1.5.18.		
6.3.18.	17/18/263.1	Draft Financial Plan 2018/19	Present the final version of the 2018/19 Financial Plan to the Trust Board on the 1.5.18.	John Grinnell	1.5.18.		
Closed Actions							
5.12.17.	17/18/190.1	Key Issues Reflected	***Booking Schedule Review:*** Submit a progress report to the Trust Board in January 2018.	Adam Bateman	30.1.18		30.1.18 - This item has been included on February's Trust Board agenda. **ACTION COMPLETE**

Alder Hey Children's NHS Foundation Trust
Trust Board - Part 1
Action Log following the meeting on the 6.3.18

Alder Hey Children's NHS
NHS Foundation Trust

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
5.12.17.	17/18/191.1	Liverpool Health Partners/KPMG update	***Integrated approach to addressing the health of the population, by putting children at the centre:*** Discuss an approach prior to aligning the Divisions with the forthcoming partnership work.	Dr. Duncan/ Michael Beresford	05.01.18		**21.12.17:** An update will be provided during January's Trust Board meeting. **ACTION COMPLETE**
5.12.17.	17/18/196.1	Mortality Report Q2	Discuss the possibility of using narrative to support performance figures in the Mortality Report and look at linking in with other Children's Trusts to discuss the streamlining of weighting tools for performance data.	Dr. Ryan/ Louise Shepherd	05.01.18		**21.12.17:** SR spoke with Julie Grice who has recently spoken with the national Lead who regards AH's approach as leading and has asked for the Trust's documentation. AQUA are engaged and meeting with SR to plan a Board session. **ACTION COMPLETE**
5.12.17.	17/18/196.2	Mortality Report Q2	Liaise with the Coroner's office via letter to confirm the Coroner's expectations of the Trust.	Dr. Ryan	05.01.18		**21.12.17:** A meeting took place on the 4.12.17 and the Trust has followed up with a letter. **ACTION COMPLETE**
5.12.17.	17/18/197.1	Infection Prevention and Control Q2	*Launch of the Sure Washing Machine:* Discuss staff accountability and responsibility, following education.	Mags Barnaby/ Valya Weston	05.01.18		**21.12.17:** The Sure Wash machine is owned by the Hand hygiene company Gojo. Dates have been arranged for the company to come in and take the machine around the Trust. First date is the 18/01/2018. **ACTION COMPLETE**
5.12.17.	17/18/201.1	Listening into Action	Compile a list to reflect the changes that have been made as a result of Listening into Action.	Kerry Turner	02.01.18		**21.12.17:** An update was circulated to Board members on the 4.1.18. **ACTION COMPLETE**

Alder Hey Children's NHS Foundation Trust
Trust Board - Part 1
Action Log following the meeting on the 6.3.18

Alder Hey Children's NHS Foundation Trust

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
5.12.17.	17/18/202.1	Programme Assurance Update	***Change Programme Delivery:*** Provide an update during January's Trust Board on the outcome of the Exec Sponsor review meeting/Quality session.	Joe Gibson	02.01.18		**21.12.17:** This action has been included on January's Trust Board agenda. **ACTION COMPLETE**
5.12.17.	17/18/203.1	Patient Safety Report	***Recorded Levels of Harm:*** Include narrative or an alternative definition for severe harm, in the Patient Safety report.	Dr. Ryan/ Hilda Gwilliams	02.01.18		**21.12.17:**The incident detail has been enhanced with clear succinct narrative defining the impact and immediate action taken.
9.1.18.	17/18/218.1	Matters Arising and Action Log	***Liverpool Health Partners/KPMG Update*** - A detailed update to be provided during March's Trust Board meeting.	Professor Michael Beresford	6.3.18		**1.3.18 -** This item has been included on March's Trust Board agenda. **ACTION COMPLETE**
9.1.18.	17/18/220.1	Strategy Discussion/Stocktake and Priorities for 2018/19	A further strategy session is to take place on the 6.2.18.	Dani Jones	30.1.18		30.1.18 - A further session has been scheduled and will take place following February's Trust Board meeting. **ACTION COMPLETE**
9.1.18.	17/18/220.2	Strategy Discussion/Stocktake and Priorities for 2018/19	Provide focussed and measurable information in relation to the forthcoming strategy/priorities for 2018/19.	Exec Team	6.2.18		30.1.18 - This action will be discussed during February's strategy session. **ACTION COMPLETE**

Alder Hey Children's NHS Foundation Trust
Trust Board - Part 1
Action Log following the meeting on the 6.3.18

Alder Hey Children's NHS Foundation Trust

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
9.1.18.	17/18/223.1	Clinical Quality Assurance Committee	Liaise with Meditech to try and resolve the issues relating to the collating of sepsis data.	John Grinnell	6.2.18		**6.2.18** - The Board was advised that a number of meetings have taken place with AH Sepsis Team to discuss the issues being experienced, and a scheduled on-site meeting is to take place on the 6.2.18 with Meditech. **ACTION CLOSED**
9.1.18.	17/18/225.1	Staff Survey	Provide a further update on the 2017 Staff Survey during March's Trust Board meeting.	Melissa Swindell	6.3.18		**1.3.18 -** This item has been included on March's Trust Board agenda. **ACTION COMPLETE**
6.2.18.	17/18/251.1	Any Other Business	***Corporate Report*** - Circulate the refreshed Corporate Report for month 9 to the Trust Board. Board members to feedback any comments they may have to John Grinnell.	John Grinnell/ Trust Board	26.2.18		**6.3.18** - The refreshed Corporate Report was circulated as requested. **ACTION COMPLETE**
9.1.18.	17/18/226.1	Programme Assurance Update	Executive Sponsors to provide an update on their respective areas of responsibility for the Change Programme.	Executive Sponsors	6.3.18		**1.3.18 -** This item has been included on March's Trust Board agenda. **ACTION COMPLETE**

Status	
Overdue	
On Track	
Closed	

Alder Hey Children's NHS
NHS Foundation Trust

Board of Directors
Tuesday 10 April 2018

Report of	Director of Finance
Paper prepared by	External Programme Assessment
Subject/Title	Non-NHS and International Patient Partnership – Procurement Proposal
Background papers	Presentation to Council of Governors, 13 March 2018
Purpose of Paper	The purpose of this paper is to provide a summary update on 'Non-NHS and International Patient' activity and proposes exploring a partnership with a Non-NHS and International healthcare organisation to facilitate an expansion of services at scale.
Action/Decision required	The Board is asked to discuss and note the contents of the paper and to approve the proposal.
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	➢ Delivery of outstanding care ➢ The best people doing their best work ➢ Sustainability through external partnerships ➢ Game-changing research & innovation
Resource Impact	Non achievement of the Trust's objectives could have a negative impact on the services provided by the Trust.

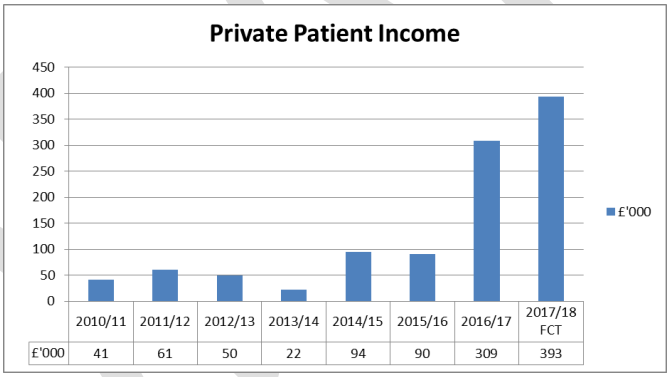
Non-NHS and International Patient Partnership – Procurement Proposal: R&BD January 2018

Introduction

This paper provides a summary update on 'Non-NHS and International Patient' activity and proposes exploring a partnership with a Non-NHS and International healthcare organisation to facilitate an expansion of services at scale. The Committee is asked to note the contents of the paper and to approve the proposal.

Status

Offering highly specialised services to the Non-NHS and International market is a key theme of delivering Alder Hey Children's NHS Foundation Trust Strategic Plan 2014-19 and the Trust vision to 'Grow the Future'. Systems and processes have been developed to manage patients and ensure compliance with regulatory requirements. The current operational model incorporates both international and UK patients; non-commissioned activity and independent Non-NHS and International practice. The table below outlines the growth in income. This demonstrates a significant achievement for the Trust – something in the region of a sevenfold increase against the previous trend - particularly in the last two years.



	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18 FCT
£'000	41	61	50	22	94	90	309	393

Opportunity and Constraints

Further growth in Non-NHS and International patient activity for 2018/19 will benefit the Trust through an enhanced international reputation and increase of income to support financial sustainability. However this is likely to remain a constrained, incremental, increase if we carry on working within the current paradigm. The learnt experience of the Trust is that Alder Hey possesses neither the capabilities nor capacity to achieve a further step change in the contribution from Non-NHS and International patient activity. Moreover, to pursue a course to develop that capability would be lengthy, expensive and risk laden.

Challenge

The corporate position of the Trust is that there is a critical need to achieve sustainability and that includes the ongoing ability to invest in NHS services. Therefore, latest strategic thinking of the Trust is to secure an additional £5 million

contribution from commercial activity in its widest sense, the constraints mentioned here are material to that ambition; especially as an expanded Non-NHS and International patient service is seen to be by far the most significant potential route to secure this goal. Many of the most prestigious and successful NHS Trusts have adopted such a model and there is every reason for Alder hey to at least explore the potential of such a partnership initiative.

Such an expanded Non-NHS and International patient service will require sustainable capacity to be made available for outpatient, theatre and inpatient services. There is a need to manage the risk of releasing sufficient capacity to grow Non-NHS and International patient activity without compromise to, and meeting the demands of, NHS patient services.

Operating an increased Non-NHS and International patient service will require enhanced organisational capability to understand the market demand for specialty paediatric Non-NHS and International patient services, marketing and establishing relationships with Non-NHS and International healthcare purchasers.

Support from an external 'Subject Matter Expert' to gain market insight has been explored but requires further financial investment and will not provide a solution to operational capability and capacity. Conversely, a carefully designed procurement exercise should result in sufficient transfer of knowledge from interested bidders to allow the Trust to become an 'intelligent customer' in such partnership negotiations.

Proposal

It is proposed that Alder Hey designs and implements a strategic procurement project that explores a strategic partnership with a Non-NHS and International healthcare organisation as a solution to the Trust's gap in terms of market insight, additional capacity and operational capability. It is envisaged that an appropriately designed procurement process will enable the trust to leverage market knowledge to ensure that it is an intelligent customer of such a partnership.

If the proposal is supported a partner selection process will take place by means of a strategic procurement project.

Governance

If supported by the sub-Committee, the proposal is planned to be submitted to the Trust Board on 6 February 2018 and to the Council of Governors on 6 March 2018. Given the fundamental change that such a partnership would represent not least due to the political sensitivity and risk management issues involved, the executives wish to seek and gain approval to commence planning at this earliest possible stage. Thereafter, at every phase of the process, the R&BD sub-Committee of the Board will oversee the process (with updates to other key stakeholder groups) with decisions and issues escalated to the Board as required.

With specific regard to the Council of Governors, the constitution on the Trust states that: 'A trust which proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of the health service in England may implement the proposals only if more than half of the members of the council of governors of the trust voting approve its implementation'.

Leadership

The leadership of strategic procurement project that explores a strategic partnership with a Non-NHS and International healthcare organisation is clearly an important facet.

In terms of the core team, it will include, but not be limited to the following:

- Executive Sponsorship: John Grinnell
- Executive Clinical Sponsor: Christian Duncan
- Project Director: Joe Gibson
- Internal SME: Angie May
- Procurement Project Manager: Steve Begley

The full project team will be described in the associated Project Initiation Document (PID). There will need to be a formally established 'Medical Advisory Committee' to guide and inform the clinical voice and this will be created as part of the early design work. There will also need to be close links with, and transparent reporting to, the JNCC.

Partnership Procurement Process

A number of options for procuring a partnership have been reviewed and the Head of Procurement recommends that the Concession Contracts Regulations 2016 (CCR16) would be the most appropriate course of action.

This process requires a number of stages as follows:

- Project assessment
- Planning
- Procurement
- Management and monitoring

It is estimated this process would be complete within 6 months. Throughout the process there will be regular reports to both the RABD committee and the Trust Board. Moreover, due to the sensitivity of such a potential partnership the primacy of clinical engagement and leadership will be central to the process. Furthermore, the project team will be actively seeking the guidance and involvement of Non-Executive Directors.

Recommendation

It is recommended that the committee support the proposal to initiate a procurement process to explore the potential for a strategic partnership with a Non-NHS and International healthcare organisation.

Additional Information

Ernst & Young Review

Delivering Alder Heys International Strateg

Proposed procurement process

Procurement Partner Briefing Note (2).doc

Alder Hey Children's NHS
NHS Foundation Trust

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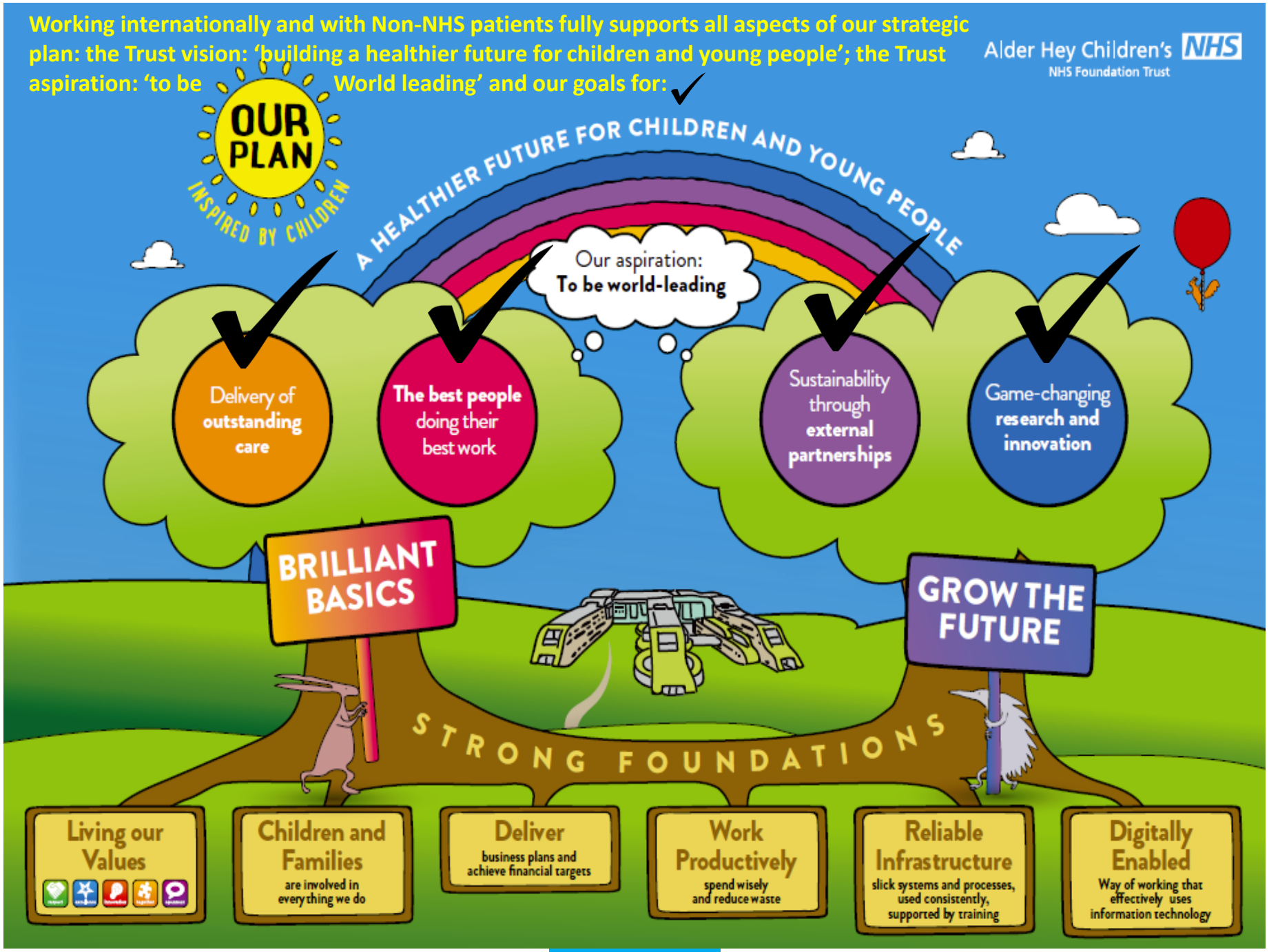
Alder Hey

International & Non-NHS Service Choices and Provision

Inspired by Children

Working internationally and with Non-NHS patients fully supports all aspects of our strategic plan: the Trust vision: 'building a healthier future for children and young people'; the Trust aspiration: 'to be World leading' and our goals for: ✓



International

"Our vision is that Alder Hey will be contributing to improving the health of the world's children, have an established, international paediatric brand with a reputation for excellence, be a proven partner with a track record of international delivery and have a balanced portfolio of income-generating and mutually BENEFICIAL activities in all areas of paediatric health delivery".

- Creation of the Department of International Child Health led by Prof. Barry Pizer
- Better recognising and communicating ALL the great work our clinicians do across the globe
- Benefitting the Trust in terms of: recruitment and retention; research and education; reputation and, in some cases, revenue

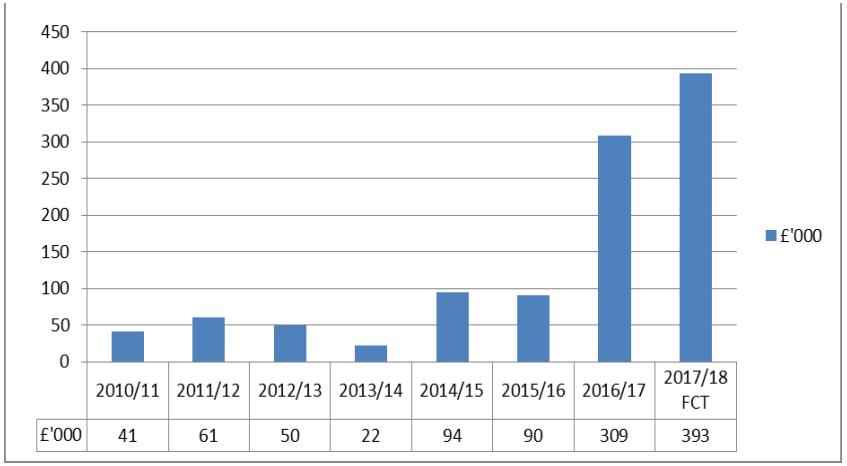
Alder Hey Children's NHS
NHS Foundation Trust

Non-NHS

"The current operational model incorporates both international and UK patients; non-commissioned activity and independent practice. The table below outlines the growth in income. This demonstrates a significant achievement for the Trust – something in the region of a sevenfold increase against the previous trend - particularly in the last two years. The majority of this increase is in provision of services no longer commissioned by the NHS".

- Continuing to offer choice to children and families for those services no longer provided by the NHS
- Non-NHS activity is clinically led, across the divisions, by a senior nurse as Head of Clinical Partnerships
- Benefits to the Trust include: recruitment and retention; reputation; and revenue to support NHS provision

International and Non-NHS Revenues 2011-2018



	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18 FCT
£'000	41	61	50	22	94	90	309	393

Inspired by Children

Alder Hey Children's NHS
NHS Foundation Trust

Sustainability and Partnership

"Further growth in international and Non-NHS patient activity for 2018/19 will benefit the Trust through an enhanced international reputation and increase of income to support financial sustainability. However, we recognise that we do not currently have the resources to make this happen. Therefore, we are proposing to run a project to explore a strategic partnership with a healthcare organisation as a possible solution".

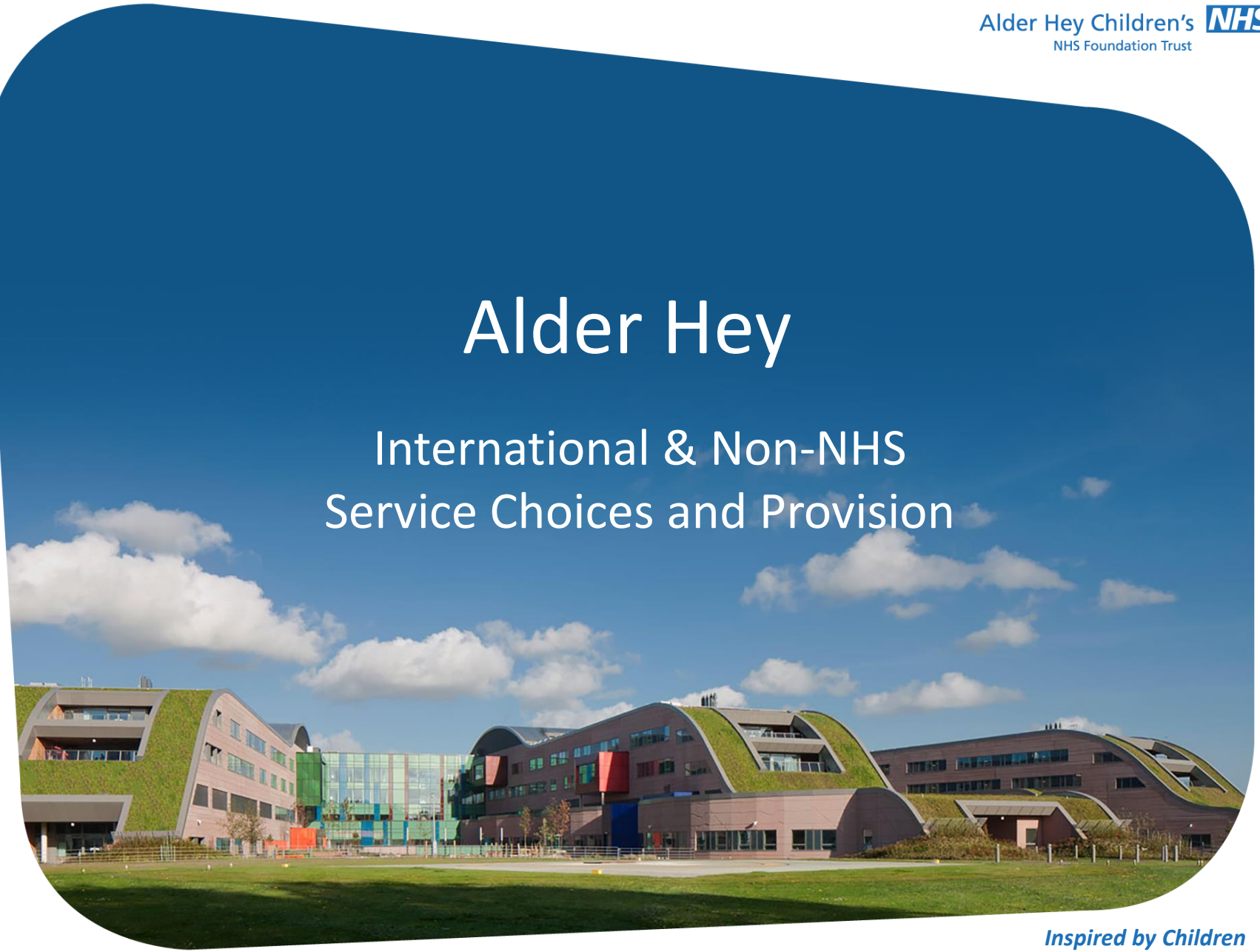
- The project is exploratory in nature, the Trust is not wedded to any particular solution
- Any partnership will have to be rooted in the values, principles and culture lived at Alder Hey
- The Council of Governors and Trust Board will be kept fully and transparently informed of project progress

Inspired by Children

Alder Hey Children's NHS
NHS Foundation Trust

Alder Hey

International & Non-NHS Service Choices and Provision



Inspired by Children

Alder Hey Children's NHS
NHS Foundation Trust

Board of Directors
Tuesday 10 April 2018

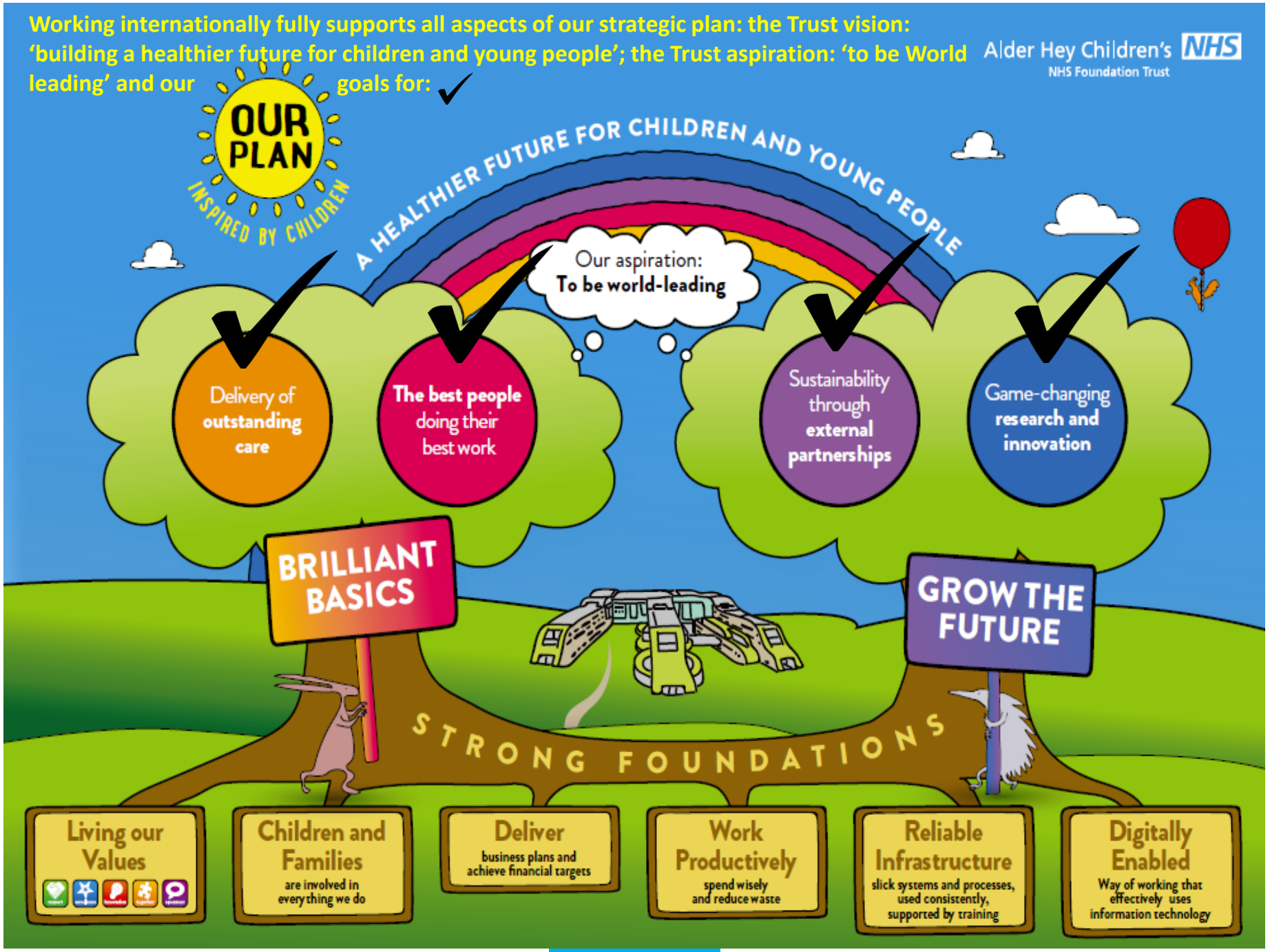
Report of	Director of International Child Health (designate)
Paper prepared by	External Programme Assessor
Subject/Title	Alder Hey Department of International Child Health Strategy and Plans 2018-2020
Background papers	Papers comprise: Presentation, Executive Summary and Sections 1-8
Purpose of Paper	The purpose of this paper is to summarise the current position at Alder Hey with respect to involvement in health activities abroad and describes the functions, form and modus operandi of the Department for International Child Health.
Action/Decision required	This paper seeks Board ratification for the establishment of the Department for International Child Health (ICH) at Alder Hey
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	➢ Delivery of outstanding care ➢ The best people doing their best work ➢ Sustainability through external partnerships ➢ Game-changing research & innovation
Resource Impact	Non achievement of the Trust's objectives could have a negative impact on the services provided by the Trust.

Alder Hey
Department of International Child Health
Strategy and Plans 2018-2020

Executive Summary

Inspired by Children

Working internationally fully supports all aspects of our strategic plan: the Trust vision: 'building a healthier future for children and young people'; the Trust aspiration: 'to be World leading' and our goals for: ✓



Executive Summary

"OUR VISION IS THAT ALDER HEY WILL BE CONTRIBUTING TO IMPROVING THE HEALTH OF THE WORLD'S CHILDREN, HAVE AN ESTABLISHED, INTERNATIONAL PAEDIATRIC BRAND WITH A REPUTATION FOR EXCELLENCE, BE A PROVEN PARTNER WITH A TRACK RECORD OF INTERNATIONAL DELIVERY AND HAVE A BALANCED PORTFOLIO OF INCOME-GENERATING AND MUTUALLY BENEFICIAL ACTIVITIES IN ALL AREAS OF PAEDIATRIC HEALTH DELIVERY".

This paper seeks Board ratification for the establishment of the Department for International Child Health (ICH) at Alder Hey and how this can be brought about. The paper summarises the current position in Alder Hey with respect to involvement in health activities abroad and describes the functions, form and modus operandi of the Department for International Child Health. Once endorsed, we will work collaboratively on implementation and associated governance arrangements. This umbrella unit would be responsible for implementing a comprehensive strategy for ICH, coordinating all aspects of international work within a cohesive framework, and contribute to Alder Hey becoming recognised as one of the best children's hospitals in the World.

The BOARD OF DIRECTORS Minutes of the meeting held on Tuesday 3rd October 2017 at 11:00am, 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.**

Rationale

The rationale for a Department for International Child Health includes (but is not limited to) the following:

- Alder Hey has a long history of engagement with International Child Health, encompassing a wide range of activities by both individuals and departments
- Ernst Young in 2014 recognised the benefits of pursuing ICH activities including reputational, recruitment and retention, research and educational and bringing in revenue
- There has been progress with some business development opportunities particularly with Al Jalila Hospital, Dubai but it is believed that there is great scope for significant expansion
- there is great scope for significant expansion with the resultant benefits of a major income stream and enhanced standing of our organisation. A clear business plan for commercial activities is required.
- A directorate of ICH will provide the recognition and the key functions required to realise the vision of ICH being both truly valued and a key strategic aim.

Themes

This comprehensive ICH strategy will incorporate six key themes:

- international health partnerships (particularly with low-income countries);
- humanitarian 'mission' operations;
- commercial/business development;
- education and training;
- Research
- innovation.

Alder Hey has many strengths in each of these areas with potential to fulfil its vision of being a world-leading children's hospital by developing all aspects of ICH.

Inspired by Children

Executive Summary (cont.)

Benefits

The benefits arising from the work of the Department for International Child Health fall into 4 categories as follows:

- **Reputation:** One of Alder Hey's five key strategic aims, expressed in the Strategic Plan 2014-2019, was to "to grow existing operations and brand name beyond the domestic region by growing our international footprint." We provide excellent secondary and tertiary level services for our patients. However we do not hold the status as an internationally recognised children's hospital of excellence. Examples of such institutions include Great Ormond Street Hospital, the Hospital for Sick Kids, Toronto and Boston Children's Hospital. Enhanced participation in international activities will greatly enhance our ambition to be recognised as a world leading children's hospital.
- **Recruitment and Retention:** 'We look to attract world-leading medical professionals and researchers and we recruit from a limited global pool of such individuals. We also want to retain our current world-leading professionals. Working internationally will improve our retention rate and improve satisfaction levels.
- **Research and Education:** Our clinical academics and other staff have a very strong portfolio of research in ICH. Our research activities and our reputation as a leading centre for research will be enhanced by increasing engagement with research activities overseas. Increased international networks will support us to maintain our role as a leading education centre and enhance the development of the Alder Hey Academy.
- **Revenue:** Our international work will lead to additional revenue for us, forecasts are currently being adjusted as part of the annual planning round. This will be achieved through enhanced delivery of care provision to international patients both at our hospital and at the overseas partner institutions. It is envisaged that educational activities may also attract significant income-generation.

Governance

Given the now impressive portfolio of International Child Health (ICH) initiatives, this 'function' needs to be given a concrete 'form' within the organisation. The key tenets of governance in this strategy are:

- The primacy of clinical leadership and engagement will be enshrined in the appointment of the first Clinical Director of ICH
- Following the 'three at the top' logic of the Alder Hey divisional structure the Department of ICH
- These leaders will have project management and administrative resources at their disposal as well as dedicated support from the Communications and Marketing Team
- The Department of ICH will hold monthly meetings to include, predominantly, senior clinical colleagues to direct and drive the various initiatives with sufficient corporate linkages to underpin support to the Department of ICH
- Governance will define how the departmental leads hold each other to account, make decision and comply with any relevant statutory duties.
- Given that the department is a new entity, it is considered a pragmatic approach to have it report directly to the Trust Board – every 3 months – until it is has matured its systems and processes
- The Department has a strong 'Steering Group' function currently chaired by the vice-Chair of the Trust Board

Strategy

The detailed description of strategy development for the Department of ICH, the strategic intent of the six themes together with the delivery model - with high level implementation plans - are laid out in the detailed strategy document Sections 1-8.

This strategy will evolve according to the requirements of the organisation and the Department of International Child Health. As outlined at the start, strategy development is a continuous process and evolution will involve:

- **recommitting** to an existing strategy
- **refreshing** it if the environment has changed
- **recreating** it if the environment has significantly changed

Evolution will be easier if there is strong leadership and a departmental culture where staff:

- are involved in defining and committed to a clear vision for their local area
- have clear priorities and objectives that are linked to organisational performance
- are treated consistently, inclusively and with compassion
- are continually learning, improving quality and innovating together
- feel connected within and between teams across the organisation.

Strategy development: Top tips

Having a good understanding of your technical data is important – but analysis can lead to paralysis and is sometimes used to block progress.

It's worth agreeing how much analysis is enough for your purpose, and to cross-check findings with non-technical data sources.

Don't pick too many things to work on – choosing what not to do is as important as choosing what to do.

Improvement science methodologies can be really helpful for thinking about how to review and design services.

There is no one right way – what matters is that you pick one and own it.

This strategy document seeks Board ratification for the establishment of the Department for International Child Health (ICH) at Alder Hey

Inspired by Children

Issue 1.0 28 Mar 18

Alder Hey
Department of International Child Health
Strategy and Plans 2018-2020

Presentation

Inspired by Children

01] Strategy

"INTERNATIONAL CHILD HEALTH WILL BE INTEGRATED INTO STRATEGIC PLANNING, LEADING TO ALDER HEY ESTABLISHING A REPUTATION AS A TRULY GLOBAL ORGANISATION, RATHER THAN JUST A VERY GOOD CHILDREN'S HOSPITAL"

- **Clear progress made towards developing commercial activities overseas, including relationships with Al Jalila and China.**
- **World-leading research is a corporate aim; much of Alder Hey's research has been carried out on a global basis.**
- **The Academy has tremendous potential to benefit Alder Hey e.g. global reputation, staff benefits, income generation.**
- **Established, formal and equitable two-way health partnerships between institutions in high income and those in low income settings.**
- **Humanitarian work: Individuals and teams, largely gone unrecognised.**

01] Strategy

McKinseys (2013) and NHSI (2017)

We…

- have a shared understanding of the key questions we need to answer together. We have agreed which are the most important.
- will develop an agreed and common view of activity, finance, workforce and performance across our department.
- are developing shared planning assumptions. We will agree what scenarios we need to plan for.
- will engage across the organisation, and with our international partners, to develop options, including with patients and clinicians.
- will need to agree common criteria to assess and prioritise these options.
- have a clear plan, with milestones, assigned owners and appropriate resources.
- have a culture and approach will allow us to adapt our plans to the changing environment.

Inspired by Children

01] Mutual Benefits

- **Reputation:** Strategic Plan 2014-2019 sought to grow existing operations and brand name beyond the domestic region by growing our international footprint.
- **Recruitment and Retention:** We look to attract world-leading medical professionals and researchers and we recruit from a limited global pool of such individuals. We also want to retain our current world-leading professionals.
- **Research and Education:** Our research activities and our reputation as a leading centre for research will be enhanced by increasing engagement with research activities overseas. Increased international networks will support us to maintain our role as a leading education centre and enhance the development of the Alder Hey Academy.
- **Revenue:** Our international work will lead to additional revenue for us, forecasts are currently being adjusted as part of the annual planning round.

02] Health Partnerships

"WORKING INTERNATIONALLY FULLY SUPPORTS ALL ASPECTS OF OUR STRATEGIC PLAN: THE TRUST VISION: 'BUILDING A HEALTHIER FUTURE FOR CHILDREN AND YOUNG PEOPLE'; THE TRUST ASPIRATION: 'TO BE WORLD LEADING' AND OUR GOALS FOR: DELIVERY OF OUTSTANDING CARE"

- **Enhanced leadership and professional skills for NHS clinicians and managers.**
- **Enhanced reputation of the organisation amongst the public, staff and the media.**
- **Greater staff satisfaction and improved retention and productivity. Staff return refreshed.**
- **Greater understanding and sensitivities of the needs of individual patients.**

Inspired by Children

03] Humanitarian

"MANY STAFF THROUGHOUT THE TRUST INVEST THEIR OWN TIME AND RESOURCES IN OVERSEAS WORKING, EMPHASISING THE VALUE THAT IS PLACED ON THIS WORK BY INDIVIDUALS THROUGHOUT THE ORGANISATION. THIS WORK MUST BE CELEBRATED SO THAT WE REALISE OPPORTUNITIES TO PROMOTE OUR REPUTATION"

- **Staff return from visits abroad with a wide range of skills and a better ability to work in a challenging environment, and in teams, for minimal cost to the organisation.**
- **Enhanced leadership and professional skills for NHS clinicians and managers.**
- **Enhanced reputation of the organisation amongst the public, staff and the media.**

Inspired by Children

04] Commercial Activities

"EXPLORING INTERNATIONAL CLINICAL BUSINESS OPPORTUNITIES: TO GROW EXISTING OPERATIONS AND BRAND NAME BEYOND THE DOMESTIC REGION BY GROWING OUR INTERNATIONAL FOOTPRINT"

- **Delivery of recurrent income targets for Non NHS patients and international partnerships.**
- **Establishing capability to deliver commercial offers in an international market.**
- **Establishing capability to expand non NHS patient activity within Alder Hey.**
- **Developing corporate infrastructure to operate commercially in an international market.**

05] Research

"THE TRUST IS FOCUSED ON THE DELIVERY OF EXCELLENT AND HIGH QUALITY CARE AND THIS IS EMBODIED BY ITS STRATEGIC OBJECTIVE TO BE ONE OF THE RECOGNISED WORLD LEADERS IN CHILDREN'S RESEARCH AND HEALTHCARE"

- **To have a major beneficial impact on the lives of children and young people.**
- **Strengthen and develop robust strategic partnerships with key partners directed at producing translational research that is world leading / internationally excellent in terms of originality, significance and rigour conducted in an environment of excellence in healthcare research.**
- **Target robust recruitment of high achieving, internationally competitive leaders of paediatric research.**
- **Establish Alder Hey as a competitive, major recruitment centre for national and international paediatric clinical trials.**

06] Education

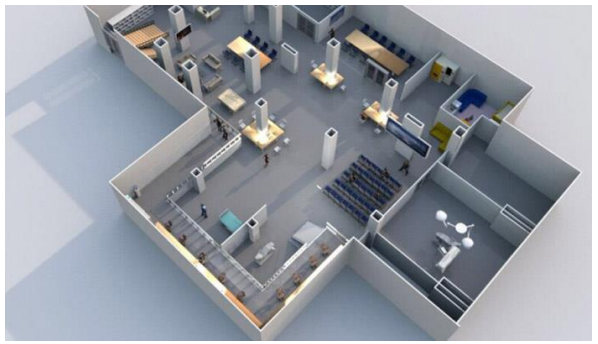
"ALDER HEY NHS FOUNDATION TRUST HAS A VISION IN LINE WITH ITS 5 YEAR STRATEGIC PLAN TO DEVELOP A WORLD RENOWNED INTERNATIONAL EDUCATION ACADEMY THAT DELIVERS HIGH QUALITY ACCESSIBLE EDUCATION"

- **To establish Alder Hey within the Educational Environment.**
- **To be a first class provider of Education.**
- **To develop International Education Partnerships.**
- **To increase the education offering at Alder Hey in terms of range and quantity of education.**
- **To provide a financial return on investment to the trust.**

07] Innovation

"ALDER HEY IS PROUD OF ITS LONG HISTORY OF PROVIDING PIONEERING AND INNOVATIVE HEALTHCARE TO CHILDREN AND YOUNG PEOPLE. AT A TIME WHEN TECHNOLOGY IS CHANGING THE WAY WE LIVE, ALDER HEY IS AT THE FOREFRONT OF DRIVING INNOVATION IN HEALTH SERVICES"

- **We are putting children first and accelerating the creation of new medicines, devices and therapies for them.**
- **The hospital has been recognised as one of the world's top 100 infrastructure projects and creates an environment where the latest devices can be developed and tested ahead of international roll-out.**
- **From cognitive computing to nanotechnology we are open to ideas, wherever they come from.**



Inspired by Children

08] Delivery

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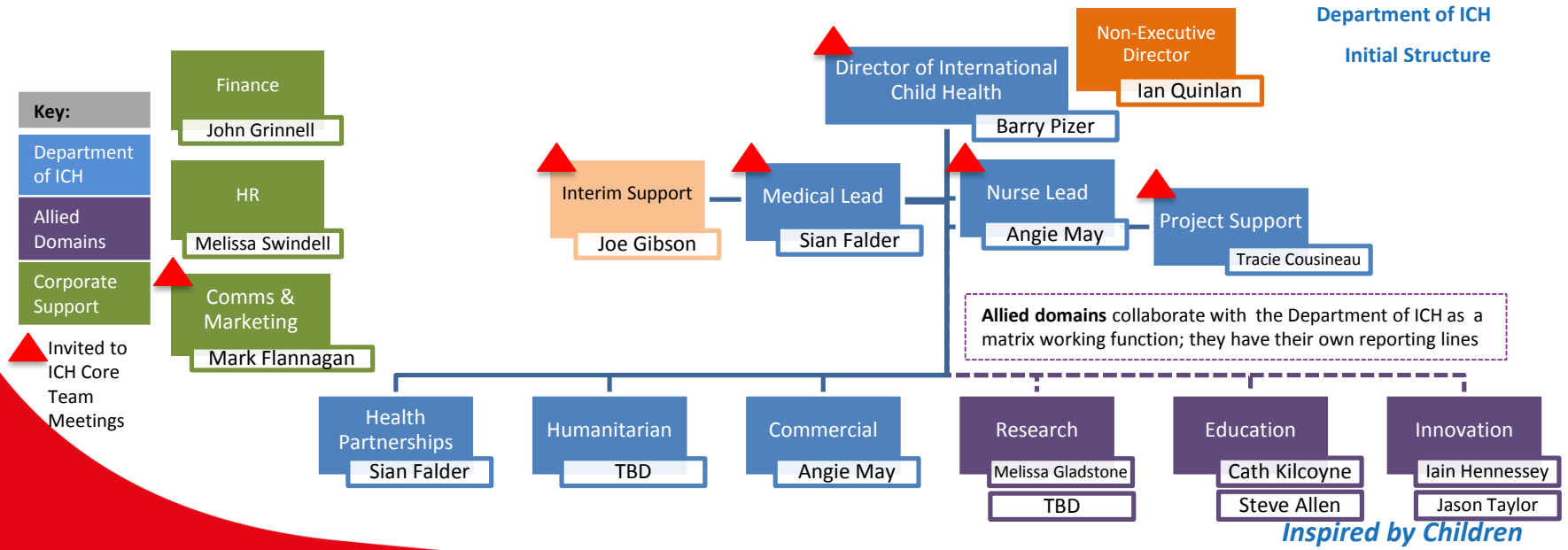
Resources → Capability → Delivery

Organisation and Leadership

Given the now impressive portfolio of International Child Health (ICH) initiatives, this 'function' needs to be given a concrete 'form' within the organisation. The creation of a Department of International Child Health (Department of ICH) will address this need in a compelling yet pragmatic way. The primacy of clinical leadership and engagement will be foremost.



Inspired by Children

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This strategy document seeks Board ratification for the establishment of the Department for International Child Health (ICH) at Alder Hey

Alder Hey
Department of International Child Health
Strategy and Plans 2018-2020

Sections 1-8

Inspired by Children

01] Strategy

"INTERNATIONAL CHILD HEALTH WILL BE INTEGRATED INTO STRATEGIC PLANNING, LEADING TO ALDER HEY ESTABLISHING A REPUTATION AS A TRULY GLOBAL ORGANISATION, RATHER THAN JUST A VERY GOOD CHILDREN'S HOSPITAL"

- **Clear progress made towards developing commercial activities overseas, including relationships with Al Jalila and China;**
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- **The Academy has tremendous potential to benefit AH e.g. global reputation, staff benefits, income generation. Multiple opportunities;**
- **Established, formal and equitable two-way health partnerships between institutions in high income and those in low income settings;**
- **Humanitarian work: Individuals and teams, Largely gone unrecognised**

History and Context

Alder Hey has a long history of engagement with International Child Health, encompassing a wide range of activities by both individuals and departments. There are historical and strong links to the Liverpool School of Tropical Medicine (one of only two institutions in the country and the oldest in the country). Liverpool, being a port city, had a large number of tropical diseases that needed to be managed and treated therefore bringing expertise in this area to Liverpool. Many still come to train and work in Liverpool due to these strong and well-known connections in tropical medicine.

More recently, the Trust supported an initial vision statement (2011) and a proposed strategy (2012) regarding global child health and commissioned an independent review of ICH activities by Ernst Young in 2014. EY recognised benefits of pursuing ICH activities including reputational, recruitment and retention, research and educational and bringing in revenue.

There has been progress with some business development opportunities particularly with Al Jalila Hospital, Dubai but it is believed that there is great scope for significant expansion with the resultant benefits of a major income stream and enhanced standing of our organisation. A clear business plan for commercial activities is required.

Many activities overseas (including humanitarian, research and education) have taken place and are ongoing, driven by committed individuals. There is, however, only one formal partnership existing between Alder Hey and a developing country partner.

A comprehensive ICH strategy would incorporate six key themes: international health partnerships (particularly with low-income countries); humanitarian 'mission' operations; commercial/business development; education and training; research and innovation.

Alder Hey has many strengths in each of these areas with potential to fulfil its vision of being a world-leading children's hospital by developing all aspects of ICH.

A directorate of ICH will provide the recognition and the key functions required to realise the vision of ICH being both truly valued and a key strategic aim.

ICH is an area where Alder Hey can stand out from its competitors and move towards the status of an internationally-recognised children's hospital of excellence.

In 2011, Barry Pizer was asked by Ian Lewis, on behalf of the Trust Board, to develop a vision statement for international child health (ICH). An ICH group was established and developed a strategy which was shared with the Board. This encompassed broad areas of work including commercial consultancy, treating overseas private patients, research and education, as well as international humanitarian and partnership work in resource-poor countries.

An exercise was conducted (2013) to map out the areas of activity by Alder Hey staff around the World, that highlighted the scope and value of international collaboration and training (Appendix 1).

EY (formerly Ernst Young), a London-based multinational professional services firm, were commissioned in 2014, to conduct a free-of-cost scoping exercise in ICH activity, which identified benefits as the 'four R's': **Reputation; Recruitment and Retention; Research and Education and Revenue.**

01] Strategy

"INTERNATIONAL CHILD HEALTH WILL BE INTEGRATED INTO STRATEGIC PLANNING, LEADING TO ALDER HEY ESTABLISHING A REPUTATION AS A TRULY GLOBAL ORGANISATION, RATHER THAN JUST A VERY GOOD CHILDREN'S HOSPITAL"

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Strategy

There are many different definitions of strategy: all of which have virtues/ advantages. We define strategy here as: a set of principles and choices designed to help the Department of International Child Health achieve our long term goals in terms of an 'International' reach and positive impact.

Strategy development is not a simple, linear process. In practice, organisations will stall on, revisit, and adapt different stages of the strategy. The strategy will evolve as you understand more about the organisation and situations develop around you. Strategy development is complex and many factors will be uncertain. The agreed vision, clear goals and consistent leadership already in place will help keep us on track.

In sum, strategy development is a continuous process. The seven process elements followed in this section are derived from work by McKinsey's (2013) and more recently adopted and adapted by NHSI (2016).

The Strategic Rationale for the Department of International Child Health

Our vision is that Alder Hey will be contributing to improving the health of the world's children, have an established, international paediatric brand with a reputation for excellence, be a proven partner with a track record of international delivery and have a balanced portfolio of income-generating and philanthropic activities in all areas of paediatric health delivery.

International Child Health will be fully integrated into strategic planning and Trust development, leading to Alder Hey establishing a reputation as a truly global organisation, rather than just a very good children's hospital.

We have a shared understanding of the key questions we need to answer together. We have agreed which are the most important. The international child health portfolio will encompass:

1. **Health Partnerships:** Established, mutually beneficial, partnerships including our longstanding relationships in Malawi and our 21 year association with Kanti Children's Hospital, Kathmandu (with MoU).
2. **Humanitarian work: A**n incredible amount of work being undertaken including: Ram Dhannapuneni's cardiac surgery health camps in India, Caron Moores' work with charities in Nepal and Andrew Curran's links with India.
3. **Commercial activities:** Some progress has been made towards developing commercial activities overseas, including our relationship with Al Jalila. Exploratory discussions and proposals with potential partners in China.
4. **Research: H**istorically, much of Alder Hey's research has been carried out on a global basis: internationally-based clinical trials in oncology and other areas; world-leading research being conducted by: Prof Atif Rahman (child and maternal mental health), Prof Nigel Cunliffe (infectious disease), Dr Melissa Gladstone (child development and disability), Dr Mike Griffiths (encephalitis), Prof Enitan Carrol (infectious diseases), Prof Stephen Allen (nutrition) and Dr Calum Semple (Ebola).
5. **Education:** This area offers tremendous potential to benefit Alder Hey with respect to global reputation, staff benefits and income generation.
6. **Innovation:** Is a more recently development that we believe has a strong clinical and corporate fit with ICH.

01] Strategy (cont.)

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We are clear about what drives our performance in the field of international child health today and in the future. We will develop an agreed and common view of activity, finance, workforce and performance across our department.

The six key themes of ICH have a degree of overlap between them. For example, international health partnerships may contain educational and/or research elements. Business development opportunities may well include a strong health partnership component and have education and training and research opportunities. There is potential for cross-subsidization principles between international private patient activity and other activities, including work in low income nations, as well as the core business.

However, currently, we have further work to do as a Department to arrive at a clear understanding of Alder Hey's 'offer' in each of these areas including why and how we are in the best position to deliver it and what are our comparative advantages over our competitors. Without this, we cannot maximise opportunity and are unable to describe and therefore realise expected commitments and benefits.

A department of ICH will provide a central point of information and contact, coordinating overseas work and links with other organisations to deliver a cohesive strategy. The establishment of a department recognises the importance of defined roles and responsibilities in key areas for the effective delivery of the above vision. This includes strong clinical leadership and experience in this field, which may mean recruiting external individual(s) with a proven track record. Additional core functions such as administration / financial / communications / legal / HR / IM&T support are required.

The department's responsibilities will be devising and delivering Alder Hey's offer, taking into account a resourcing plan and due diligence. There must also be a formal review process for all international working with robust governance and commercial systems.

We are developing shared planning assumptions. We will agree what scenarios we need to plan for. We will agree the gaps we need to address. To do this we will create an appropriate (PEST is just one benchmark) analytical tool.

PEST analysis (political, economic, socio-cultural and technological) describes a framework of macro-environmental factors used in the environmental scanning component of strategic management. It is a strategic tool for understanding potential and direction for operations.

Political factors are basically how the government intervenes in the economy. Political factors may also include services which the (UK) government aims to provide or be provided (merit goods). Furthermore, governments have a high impact on the health, education, and infrastructure of a nation.

Economic factors include interest rates, exchange rates, and the tax regime. These factors greatly affect how businesses operate and make decisions. For example, exchange rates can affect the costs of exporting goods and the supply and price of imported goods in an economy.

Social factors include the cultural aspects and health consciousness, population growth rate, age distribution, and emphasis on safety. High trends in social factors affect the demand for a enterprises services and how that business operates.

Technological factors include technological aspects like R&D activity, automation, technology incentives and the rate of technological change. These can determine barriers to entry, the degree to which positive impact can be made and influence the partnership arrangements.

Other dimensions often used in addition to the basic PEST analysis include: legal and environmental factors, ethical and demographic factors, as well as ecological concerns. The Department will develop a bespoke forecasting / planning tool, along the lines of a PEST framework, to help with future forecasting.

01] Strategy (cont.)

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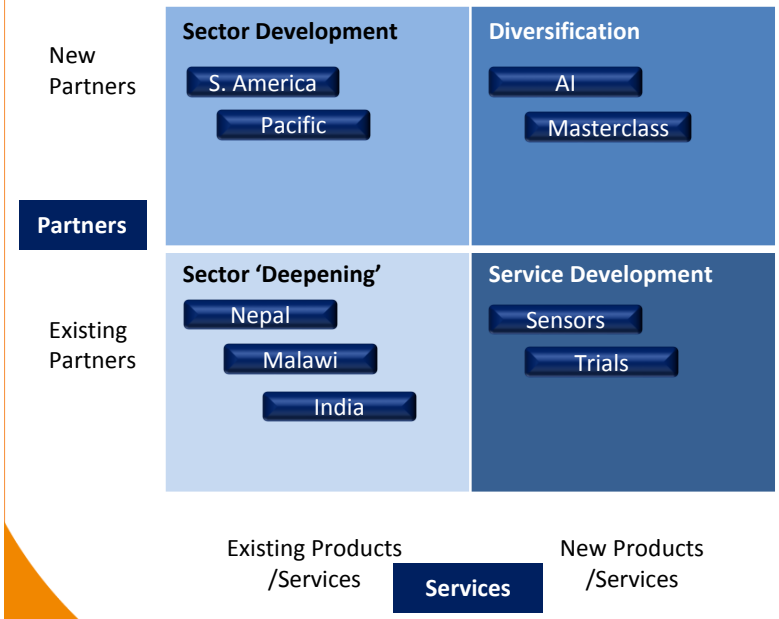
Options

We have agreed how we are going to approach the departmental goals (e.g. geographical segments, specific pathways). We will engage across the organisation, and with our international partners, to develop options, including with patients and clinicians.

Ansoff provided a definition for product-market strategy as 'a joint statement of a product line and the corresponding set of missions which the products are designed to fulfil'. He describes four growth alternatives:



The Department will adapt the Ansoff framework to show the aspiration for future partnerships across the globe; this will then be mapped against the services and products that we aspire to grow in each country for mutual or commercial benefit.

Prioritise

We will need to agree common criteria to assess and prioritise these options. We have also decided what we are not going to do. We can articulate simply our combined strategy.

The Department of ICH is developing a set of criteria to enable us to prioritise the options we generate. These criteria will build upon, and be extensions of, the dimensions we use in our forecasting. The criteria will be clinically led and cross-referenced to any metrics agreed with other departments – Research, Academy, Innovation – for commercial or related returns on investment. As such the criteria will have a strong ethical and humanitarian basis particularly in the areas of our partnership working.

These priorities will then form the backbone of our delivery plans with appropriate milestones and benefits thresholds clearly identified. The plans will remain sufficiently agile to exploit emergent opportunities while at all times remaining grounded in the vision and goals that drive the work of the Department of ICH. These decisions, whether to proceed with a project or not, will be taken in the context of a set of 'out of scope' criteria for countries / specialities / products that, fro whatever reason, the Trust is currently unwilling or unable to countenance.

The criteria used will be the subject of regular review under the auspices of the Department of ICH and relevant Trust committees will be kept informed of any substantive changes.

It follows that these criteria will need to form part of the comprehensive communications plan that the Department of ICH needs to roll out; thereby ensuring that the efforts we are making to pursue our aims are being deployed on a fair and equitable basis in line with any associated Equality & Quality Impact Assessment that forms part of the day-to-day work of the department.

01] Strategy (cont.)

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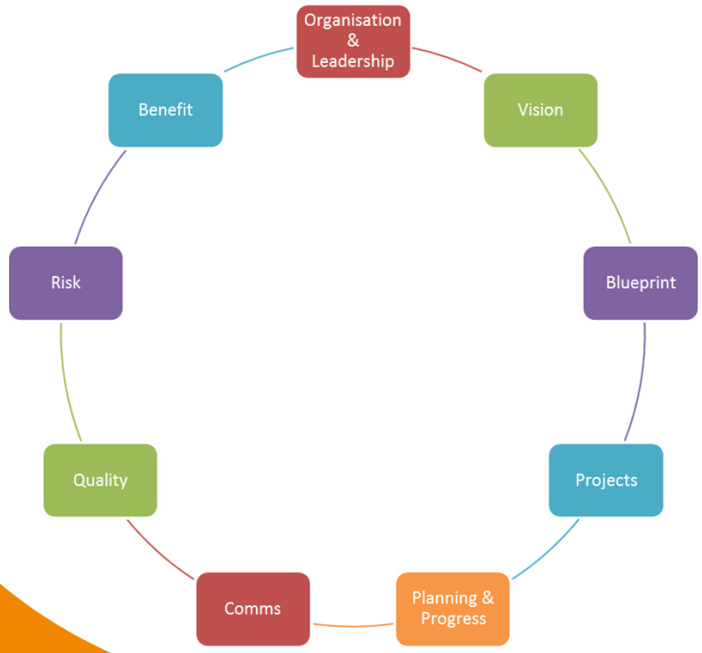
Deliver

We have a clear plan, with milestones, assigned owners and appropriate resources. We are clear what changes we need to make to current working practices to ensure success.

Evolve

We have a clear approach to measuring the impact of our plans (clear KPIs and escalation and resolution procedures). We will have a culture and approach will allow us to adapt our plans to the changing environment.

The delivery framework for the Department of International Child Health will, initially, follow the internationally recognised best practice standard 'Managing Successful Programmes' (of work). Section 8 of this document sets out how the Department will adopt the MSP disciplines to bring focus and tempo to the portfolio of clinical initiatives.



Key Performance Indicators will be measured under four domains, the 4 R's:

Reputation: One of Alder Hey's five key strategic aims, expressed in the Strategic Plan 2014-2019, was to 'to grow existing operations and brand name beyond the domestic region by growing our international footprint'. We provide excellent secondary and tertiary level services for our patients. However we do not hold the status as an internationally recognised children's hospital of excellence. Examples of such institutions include Great Ormond Street Hospital, the Hospital for Sick Kids, Toronto, and Boston Children's Hospital. Enhanced participation in international activities will greatly enhance our ambition to be recognised as a world leading children's hospital.

Recruitment and Retention: We look to attract world-leading medical professionals and researchers and we recruit from a limited global pool of such individuals. We want to retain our current world-leading professionals. Working internationally will improve our retention rate and improve satisfaction levels.

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Escalating and Resolving Issues

The escalation of issues and blocks will be expedited as described in the governance section of the delivery plans at Section 8 of this document.

Culture and Approach

The culture of the department will be exemplified by clinical engagement and leadership facilitated by a management style that is supportive and enabling. The department will foster honest and trusting relationships. Each leader will be equally valued and understand others' perspectives so that the work of the department can be really effective.

This will mean having open conversations about histories, each work streams priorities, the shared values and behaviours leaders will commit to living and role-modelling for others, and the 'red lines' no one is willing to cross.

Have we got the right mix of people in the room? Have we identified the 'elephants in the room' and do we have a plan to address them? Are we prepared to stand together to lead the system especially when things get difficult? Groups need to establish their common purpose to motivate people to stay working together. Sometimes this purpose will be defined by an issue that arises, e.g. a financial gap, and sometimes leaders will need to work together to define their common purpose.

Competing priorities are a common problem, but agreeing guiding principles for working together helps to establish a common purpose. Have we agreed the boundaries to our department and who is in it? Do we have a shared vision for our directorate which is specific enough to create alignment and overcome competing priorities? Have we formally agreed the guiding principles for joint working towards achieving this vision?

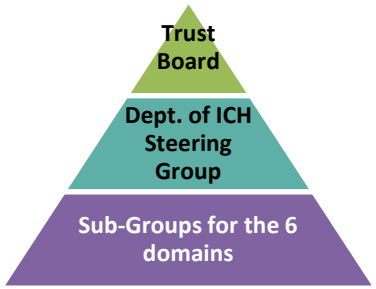
Arranging Governance

We recognise that strong governance structures are essential and the ICH leaders are committed to now dedicate the time at the beginning of the life of the new department to develop these. We recognise that if robust structures are not set out upfront, problems will arise later as decisions need to be made or challenging problems arise.

Governance will define how the departmental leads hold each other to account, make decision and comply with any relevant statutory duties. It will be defined in a written document that is kept up to date, signed up to by each of the leads and referred back to as necessary.

The Department will develop terms of reference and standard operating procedures as required by the range of ICH initiatives underway. These will agree and document how we will work together, particularly how decisions will be made and how we will hold each other to account.

The Department has a strong 'Steering Group' function currently chaired by the vice-Chair of the Trust Board. Given that the department is a new entity, it is considered a pragmatic approach to have it report directly to the Trust Board – every 3 months – until it is has matured its systems and processes; after this has been achieved the option of the department reporting into a Board sub-Committee will be considered.



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Recruitment and Retention: 'We look to attract world-leading medical professionals and researchers and we recruit from a limited global pool of such individuals. We also want to retain our current world-leading professionals. Working internationally will improve our retention rate and improve satisfaction levels.

Research and Education: Our clinical academics and other staff have a very strong portfolio of research in ICH. Our research activities and our reputation as a leading centre for research will be enhanced by increasing engagement with research activities overseas. Increased international networks will support us to maintain our role as a leading education centre and enhance the development of the Alder Hey Academy.

Revenue: Our international work will lead to additional revenue for us, forecasts are currently being adjusted as part of the annual planning round. This will be achieved through enhanced delivery of care provision to international patients both at our hospital and at the overseas partner institutions. It is envisaged that educational activities may also attract significant income-generation.

With the Department of Health's support, Alder Hey started to explore more commercial-based initiatives which led to the appointment of Angie May as lead nurse and Esme Evans as accountant for international business.

The detail of the financial benefits is currently being reported through existing departmental channels and, therefore, is not duplicated in this strategy document.

02] Health Partnerships

"WORKING INTERNATIONALLY FULLY SUPPORTS ALL ASPECTS OF OUR STRATEGIC PLAN: THE TRUST VISION: 'BUILDING A HEALTHIER FUTURE FOR CHILDREN AND YOUNG PEOPLE'; THE TRUST ASPIRATION: 'TO BE WORLD LEADING' AND OUR GOALS FOR: DELIVERY OF OUTSTANDING CARE"

- **Enhanced leadership and professional skills for NHS clinicians and managers.**
- **Enhanced reputation of the organisation amongst the public, staff and the media**
- **Greater staff satisfaction and improved retention and productivity. Staff return refreshed.**
- **Greater understanding and sensitivities of the needs of individual patients**

Health Partnerships

These are established, formal and equitable two-way health partnerships between institutions in high income and those in low income settings, with clear benefit to both partners. Examples at Alder Hey include our longstanding relationships in Malawi (currently informal), our 21 year association with Kanti Children's Hospital, Kathmandu (underpinned by a formal MOU) and several other links that are of somewhat shorter duration.

The Board support this vision

Working internationally fully supports all aspects of our strategic plan: the Trust vision: "building a healthier future for children and young people"; the Trust aspiration: "to be World leading" and our goals for: delivery of outstanding care, the best people doing their best work, sustainability through external partnerships and game-changing research and innovation.

Historically, the Board has supported the principles of ICH and pursued some aspects of it.

The investments in place

Significant investment in time and effort has already been made; there needs to be a focus on the return on investment from activities against previously defined strategic goals. It is not clear that there has been a routine approach to either tracking time and effort on international work or on the net returns.

Many staff throughout the Trust invest their own time and resources in overseas working, emphasising the value that is placed on this work by individuals throughout the organisation.

This work has not been celebrated, meaning opportunities to promote our reputation, and potentially generate income, may have been missed.

Political support

The UK government recognises the importance of addressing global health issues and its commitment to do so is summarised in a DH paper entitled "The Framework for NHS Involvement in International Development" (March 2010). This document addresses issues including the UK policy context, the key principles for effective involvement in international development, the benefits of NHS involvement in international development, the architecture for NHS activity to support developing countries and good practice for organisations, individuals and employers.

Ambition

We are hoping to re-establish a clinical link between Queen Elizabeth General Hospital, Blantyre, Malawi and Alder Hey. This is the central hospital for the Southern Region offering specialist paediatric services and has a long historical connection with Alder Hey. As part of this link, there is the potential to facilitate placements for Alder Hey staff to join the team at QECH and gain experience of working in a resource poor setting.

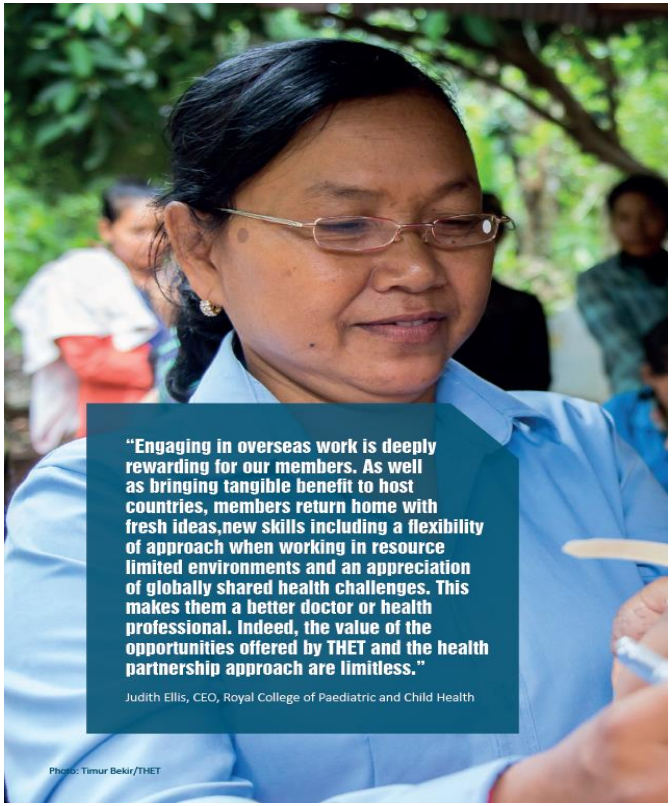
02] Health Partnerships (cont.)

"WORKING INTERNATIONALLY FULLY SUPPORTS ALL ASPECTS OF OUR STRATEGIC PLAN: THE TRUST VISION: 'BUILDING A HEALTHIER FUTURE FOR CHILDREN AND YOUNG PEOPLE'; THE TRUST ASPIRATION: 'TO BE WORLD LEADING' AND OUR GOALS FOR: DELIVERY OF OUTSTANDING CARE"

The Benefits to Alder Hey

There are well described benefits of global child work to NHS organisations which apply across all health provider roles. These include:

- Provision of better return on investment in training: staff return from visits abroad with a wide range of skills and a better ability to work in a challenging environment, and in teams, for minimal cost to the organisation.
- Enhanced leadership and professional skills for NHS clinicians and managers.
- Enhanced reputation of the organisation amongst the public, staff and the media
- Greater staff satisfaction and improved retention and productivity. Staff return refreshed.
- Greater understanding and sensitivities of the needs of individual patients.
- Greater organisation cohesion, innovation and corporate social responsibility which can embed key NHS values set out in the NHS constitution and can potentially lead to higher sustainable organisational performance and cultural competence.
- Education and research opportunities that can benefit patients in all communities.
- A greater understanding of social and ethnic diversity
- Greater understanding of global health issues and knowledge of diseases not routinely seen in the UK.
- Income generation



03] Humanitarian

"MANY STAFF THROUGHOUT THE TRUST INVEST THEIR OWN TIME AND RESOURCES IN OVERSEAS WORKING, EMPHASISING THE VALUE THAT IS PLACED ON THIS WORK BY INDIVIDUALS THROUGHOUT THE ORGANISATION. THIS WORK MUST BE CELEBRATED SO THAT WE REALISE OPPORTUNITIES TO PROMOTE OUR REPUTATION"

- **Staff return from visits abroad with a wide range of skills and a better ability to work in a challenging environment, and in teams, for minimal cost to the organisation.**
- **Enhanced leadership and professional skills for NHS clinicians and managers.**
- **Enhanced reputation of the organisation amongst the public, staff and the media.**

Humanitarian

Objectives:

- Encourage / facilitate staff wishing to undertake overseas humanitarian work by developing and promoting a sabbatical / unpaid leave policy
- Support training opportunities for overseas healthcare professionals by becoming a training centre for the international surgical training programme and developing international clinical fellowship posts
- Improved staff knowledge around the challenges of healthcare in low resource poor settings through links with REACHE North West (https://reache.wordpress.com/about/) providing clinical attachments and clinical practical training posts for North West based refugee and asylum-seeking health care professional.

There is an incredible amount of humanitarian work being undertaken by Alder Hey staff which has largely gone unrecognised. Individual staff members undertaking specific clinical work in developing countries.

Our clinicians are working in many countries to deliver high quality care and to help build infrastructure that ensures sustainable healthcare for children and young people is embedded and developed long-term.

This work is underpinned by a philanthropic approach, that is operating under the principle of collaboration and support for clinical colleagues in other countries. The knowledge and skills sharing is mutually beneficial and designed to bring best practice not only the countries involved but also to bring key learning back to Alder Hey as a way of continually improving our own approach.

Examples include Ram Dhannapuneni's regular cardiac surgery health camps in India, Caron Moores' engagement with charities providing health camps in Nepal Andrew Curran's links with India. Many of these activities involve wider teams of staff.

The benefits include, but are not limited to, the following:

- **Staff return from visits abroad with a wide range of skills and a better ability to work in a challenging environment, and in teams, for minimal cost to the organisation.**
- **Enhanced leadership and professional skills for NHS clinicians and managers.**
- **Enhanced reputation of the organisation amongst the public, staff and the media.**

03] Humanitarian (cont.)

"MANY STAFF THROUGHOUT THE TRUST INVEST THEIR OWN TIME AND RESOURCES IN OVERSEAS WORKING, EMPHASISING THE VALUE THAT IS PLACED ON THIS WORK BY INDIVIDUALS THROUGHOUT THE ORGANISATION. THIS WORK MUST BE CELEBRATED SO THAT WE REALISE OPPORTUNITIES TO PROMOTE OUR REPUTATION."

Global mental health @ Alder Hey

New NIMH global mental health collaborative award for school mental health.

RFA-MH-16-350: Research Partnerships for Going to Scale with Mental Health Interventions in Low-and Mid-Income Countries (U19).

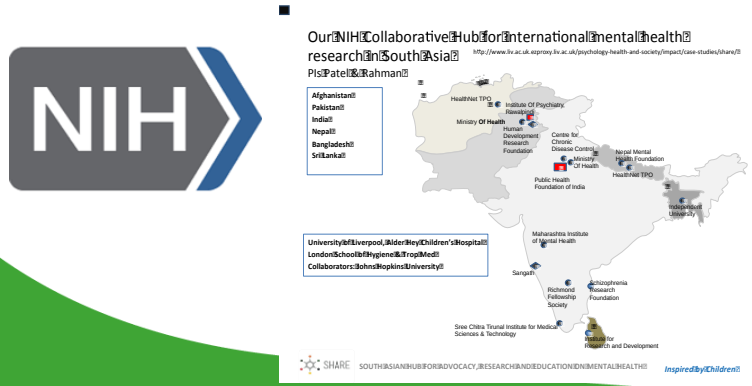
School Health Implementation Network for the Eastern Mediterranean Region: SHINE. Co-investigators :Larry Wissow – Johns Hopkins, Hesham Hamoda – Harvard/Boston Children's. Partners: WHO (Eastern Mediterranean Region); 22 Countries of the Eastern Mediterranean Region; Ministries of Health and Education; Academia and implementers; Schools and 'champion teachers'.

Maternal mental health

One in 5 women in low income countries suffers from perinatal depression. We train community health workers to counsel mothers with perinatal depression and conduct research on task-shifting strategies to make psychological care accessible.

Early child development

200 million children in low-income countries do not develop to their full potential. We develop interventions that help parents to provide optimal stimulation and nutrition to their infants in the early years; moreover, we train community health workers to deliver these interventions.



Intellectual disability and Autism

50 million children with these conditions do not have access to any form of service in South Asia. We are developing programmes to help parents manage some of these problems in the community. We are conducting research on the use of technology to assist in the training and supervision of parents in inaccessible areas.

Mental health in the humanitarian context

A third of the world's population is currently affected by natural or man-made disaster. We work with the World Health Organisation to make mental health interventions available to disaster affected individuals and build local capacity to carry out this work.

We build local expertise in child mental health

We train psychiatrists and psychologists to diagnose and manage children with mental disorders in Rawalpindi, Pakistan. We have helped establish one of the first child mental health unit in the country in Rawalpindi

We contribute to WHO and UNICEF: Evidence-Based Guidelines for Mental, Neurological and Substance Use Disorders in Low and Middle Income Countries: Summary of WHO Recommendations.

Inspired by Children

04] Commercial Activities

"EXPLORING INTERNATIONAL CLINICAL BUSINESS OPPORTUNITIES: TO GROW EXISTING OPERATIONS AND BRAND NAME BEYOND THE DOMESTIC REGION BY GROWING OUR INTERNATIONAL FOOTPRINT"

- **Delivery of recurrent income targets for Non NHS patients and international partnerships.**
- **Establishing capability to deliver commercial offers in an international market**
- **Establishing capability to expand non NHS patient activity within Alder Hey**
- **Developing corporate infrastructure to operate commercially in an international market**

Progress to date

In 2014-19 Five Year Strategic Plan, it was identified there was a need to explore international clinical business opportunities:

"To grow existing operations and brand name beyond the domestic region by growing our international footprint"

The vision for international development at Alder Hey is to achieve the organisations ambition to be amongst the top 10 children's hospitals in the world.

The international team has engaged with government trade organisations to explore potential development opportunities. These endeavours have resulted in a partnership with Al Jalila Children's Hospital (Dubai) and potential developments in China.

This process identified core areas of interest to the international market that provide the Trust with an opportunity to expand its international footprint.

- Design and build consultancy
- Education & training
- Clinical services

Objectives

The overarching objectives of the ICH Department are to

- Growth of international partnership opportunities
- Develop and deliver international partnerships
- Expansion of Non NHS patient activity at Alder Hey

Approach

- Developing corporate infrastructure to operate commercially in an international market
- Developing clinical infrastructure to operate commercially in an international market

Scope

- Establishing capability to deliver commercial offers in an international market
- Establishing capability to expand non NHS patient activity within Alder Hey
- Delivery of recurrent income targets for Non NHS patients and international partnerships.

Benefits

A number of key benefits will include a coherent international offer, a business model and a formalised governance structure. The measurable benefit on the success of the infrastructure including marketing will be the number of international visits to Alder Hey organised.

Inspired by Children

04] Commercial Activities (cont.)

"EXPLORING INTERNATIONAL CLINICAL BUSINESS OPPORTUNITIES: TO GROW EXISTING OPERATIONS AND BRAND NAME BEYOND THE DOMESTIC REGION BY GROWING OUR INTERNATIONAL FOOTPRINT"

Al Jalila Children's Hospital (Dubai) - Partnership Development Process

December 2015 Initial visits and discussions

April 2016 Entered into a MOU and undertook a series of working visits to establish phased approach to the partnership development

November 2016 Signing of initial contract for 6 month period

The initial phase of the partnership was based on knowledge sharing with Alder Hey providing a strategic advisory role to support the commencement of services at AJCH for a six-month period.

January 2017 Changes in Dubai leadership postponed the delivery of Phase 1 and a specialist advisor was introduced by Dubai Health Care Authority to support the strategic development of AJCH

Key areas of interest

Clinical governance

Management infrastructure

Clinical guidelines

Bereavement care

Remote radiology

Benefits to Alder Hey

Growth of reputation in the Mid

Revenue generation for Trust £175k

Phase 2 development

Scoping discussions took place to understand requirements of AJCH which included; epilepsy surgery , visiting neurosurgeon, orthotic service, training for PICU nurses and remote radiology. The strategic focus at AJCH has shifted to developing capacity and independence with the recruitment of expertise into the AJCH team. At present AJCH wish to proceed with remote radiology second opinion reporting.

China

Alder Hey has worked collaboratively with the Department of International Trade , Healthcare UK and UKIHMA to develop its international reputation in China.

Sichuan: December 2015 Contact from DIT Sichuan Provincial Women and Children's Hospital, Chengdu, interested in developing a collaborative relationship with Alder Hey in the areas of medicine, scientific research, education and management.

January 2016 Louise Shepherd CEO joined trade mission to China

March 2016 Team presented at conference in Chengdu

June 2016 Visit from senior leaders to AH

MOU developed with a potential opportunity initially for observerships which is awaiting final agreement.

2017/18 There have been 6 visits to Alder Hey from Senior delegations expressing an interest in developing an affiliation agreement.

Hunan: MOU in place (May 2017). Consultants attended conference (September 2017). November trade mission to China led to potential for observer ships.

X'ian Fengdong: MOU in place (March 2017). Agreement to undertake a design review of plans for paediatric aspect of new hospital build project. Potential interest in developing clinical affiliation in future.

States of Jersey

The Design and Build consultancy team have provided health care planning and design support to the new Jersey hospital design which has led to a scheme review. Ongoing support across the whole range of design services for this General Hospital scheme is continuing into 2018.

05] Research

"THE TRUST IS FOCUSED ON THE DELIVERY OF EXCELLENT AND HIGH QUALITY CARE AND THIS IS EMBODIED BY ITS STRATEGIC OBJECTIVE TO BE ONE OF THE RECOGNISED WORLD LEADERS IN CHILDREN'S RESEARCH AND HEALTHCARE"

- **To have a major beneficial impact on the lives of children and young people**
- **Strengthen and develop robust strategic partnerships with key partners directed at producing translational research that is world leading / internationally excellent in terms of originality, significance and rigour conducted in an environment of excellence in healthcare research**
- **Target robust recruitment of high achieving, internationally competitive leaders of paediatric research**
- **Establish AHFT as a competitive, major recruitment centre for national and international paediatric clinical trials**

Research

Alder Hey is a leading paediatric research centre. Our aim is to be a world class centre for research, innovation and education, and we aim to pioneer and develop new treatments for children and young people.

This is made possible by a comprehensive range of paediatric specialist and general clinical services, its expert healthcare professional workforce and its extensive access to a supra-regional population of children and young people. At any time there are over 100 clinical research studies taking place, ranging from observational studies to complex, interventional clinical trials supported by the NIHR Alder Hey Clinical Research Facility.

Alder Hey was announced as a finalist in the Clinical Research Impact category of the 2013 HSJ Awards and is the highest performing Specialist NHS Trust within the NIHR Clinical Research Network.

Our partners

Alder Hey has a number of academic partners including the University of Liverpool, Liverpool John Moores University, University of Central Lancashire, Lancaster University and Edge Hill University. Alder Hey is a member of Liverpool Health Partners and has collaborations in the UK and internationally with a large number of healthcare institutions, universities and commercial organisations.

Several of our staff hold contracts with partner academic institutions ensuring that our research across the translational spectrum is relevant and meaningful for both children & families and healthcare professionals.

Our key research aims are underpinned by a research strategy developed in collaboration with the University of Liverpool:

•To have a major beneficial impact on the lives of children and young people

•Support, consolidate and build on existing research strengths and excellence at AHFT

•Strengthen and develop robust strategic partnerships with key partners directed at producing translational research that is world leading / internationally excellent in terms of originality, significance and rigour conducted in an environment of excellence in healthcare research.

•Target robust recruitment of high achieving, internationally competitive leaders of paediatric research

•Develop talented clinicians and scientists with potential and invest in them to support growth into world-class research leaders.

•Establish AHFT as a competitive, major recruitment centre for national and international paediatric clinical trials

•To maximise the enormous potential created by the new Children's Health Park programme

•Nurture proactively a symbiotic relationship with the Alder Hey Charity

•To develop and promote new areas of research in line with the Trust's clinical, business and quality strategies.

05] Research (cont.)

"THE TRUST IS FOCUSED ON THE DELIVERY OF EXCELLENT AND HIGH QUALITY CARE AND THIS IS EMBODIED BY ITS STRATEGIC OBJECTIVE TO BE ONE OF THE RECOGNISED WORLD LEADERS IN CHILDREN'S RESEARCH AND HEALTHCARE"

Any visit to Alder Hey will leave you in no doubt of the outstanding professionalism and standard of care provided by its expert, multidisciplinary staff. The Trust is focused on the delivery of excellent and high quality care and this is embodied by its strategic objective to be one of the recognised world leaders in children's research and healthcare. Alder Hey has a proud heritage of pioneering innovation and research in children's healthcare, and today this lives on through its vibrant research portfolio which benefits children and young people in the UK and worldwide.

Under a Director of Research, Alder Hey fosters collaboration between colleagues from the NHS and academia from a broad array of professional and multi-disciplinary backgrounds. In addition to superb research and clinical expertise, Alder Hey research programmes are founded on the importance of the child and family being at the centre of what we do. Having the University of Liverpool's Institute of Child Health firmly based in the heart of the Alder Hey campus ensures that there is a healthy and productive partnership between our two organisations and that all our research is focused on one aim – improving the health and wellbeing of children and their families.

With our primary academic partner, the University of Liverpool, Alder Hey has published an Integrated Research Strategy for Child Health, setting out ambitious plans over a ten year trajectory supported by Alder Hey Children's Charity. In addition, the Trust benefits from partnerships with a range of academic partners all of which bring considerable expertise to bear, ensuring that our research endeavours are supported by the best possible methodological and scientific expertise. The Trust's research programmes are supported by significant infrastructure awards and programme/project grants from the National Institute for Health Research NIHR and other funders. Our strategy highlights existing areas of excellence and critical mass as significant research themes:

- Better, Safer Medicines for Children and Babies
- Infection
- Inflammatory Disease:
- Paediatric Oncology
- International Child Health

In addition to leading on the development of research, Alder Hey is the premier centre for the delivery of children's research studies of national and international significance and places great importance on this responsibility. We support and nurture research which sits outside established research themes aiming to develop further areas of recognised critical mass.

NHS colleagues from all professions and our expert research delivery team are essential in the execution of all our clinical research studies and without their passion and dedication, none of this would be possible. This first research review includes highlights from each of our research themes and contributions from some of our leading researchers. The content is by no means exhaustive, but intended to provide a flavour of the scope and breadth of research undertaken in response to the unmet needs of children and their families.

06] Education

"ALDER HEY NHS FOUNDATION TRUST HAS A VISION IN LINE WITH ITS 5 YEAR STRATEGIC PLAN TO DEVELOP A WORLD RENOWNED INTERNATIONAL EDUCATION ACADEMY THAT DELIVERS HIGH QUALITY ACCESSIBLE EDUCATION"

- **To establish Alder Hey within the Educational Environment**
- **To be a first class provider of Education.**
- **To develop International Education Partnerships**
- **To increase the education offering at Alder Hey in terms of range and quantity of education**
- **To provide a financial return on investment to the trust**

The Academy

Alder Hey NHS Foundation Trust has a vision in line with its 5 year strategic plan to develop a world renowned International Education Academy that delivers high quality accessible education.

To deliver this, the **project aims** to:

- Create a picture of the current offerings and scale the opportunity;
- Investigate alternative models of service delivery away from face to face structured training/lectures;
- Engage AH Clinicians to participate in the production of a portfolio of educational products for both internal and external delegates
- Investigate and develop partnership with other commercial. NHS and HEI organisations that will enhance our educational offering/
- Ensure capacity is available to deliver planned training and masterclasses;
- Design and implement a staff structure to deliver the academy;
- Agree income opportunities and investment required for service delivery via a 3 year business plan and income and expenditure model;
- Develop a robust marketing and communications plan;
- Engage with HEI's and design and launch partnerships/collaborations.

Objectives:

- To establish Alder Hey within the Educational Environment
- To be a first class provider of Education.
- To increase the education offering at Alder Hey in terms of range and quantity of education
- To provide a financial return on investment to the trust
- To provide staff with better access to training opportunities.
- To provide accessible training for staff to complete their CPD requirements in a local setting

Approach:

The Academy team and clinicians from within Alder Hey and external will work together to produce, market and deliver a portfolio of products developed from the below themes.

- Accredited Short Courses aimed at the nursing workforce
- An Alder Hey Master's in conjunction with HEI partners

06] Education (cont.)

"ALDER HEY NHS FOUNDATION TRUST HAS A VISION IN LINE WITH ITS 5 YEAR STRATEGIC PLAN TO DEVELOP A WORLD RENOWNED INTERNATIONAL EDUCATION ACADEMY THAT DELIVERS HIGH QUALITY ACCESSIBLE EDUCATION"

- Masterclasses across Paediatric specialist services
- Observer-ships for International healthcare professionals
- National Conferences in Clinical Specialities
- International bespoke paediatric educational programmes for all healthcare professionals
- International consultations for clinical institutions looking to replicate a successful Paediatric Service Model
- Commercialisation of Facilities including a Clinical Skills Lab
- On- line learning packages including Webinar and KOL lectures
- Commercial Sponsorship

Phase One:

The project will explore all aspects of Alder Hey current education offering. The first project will be to expand the range of face to face education offerings including short courses and conferences, including both existing and new programmes. The academy will also lead on development of on-line products and applications that all healthcare professionals can use to access training, replacing the requirement for face to face training session. The Head of the Academy will build the relationships with the HEI's to develop joint courses. Establish a international educational offering.

Phase Two:

Once the phase 2 R&E building is complete in September 2018, the academy will lead on the development of partnership courses with the HEI's and Divisions. The completion of the phase 2 building will create extra capacity to expand the number of courses and programmes offered to increase income. Commence the commercialisation of the facilities within Phase 2 to generate an revenue stream for the academy. Review the opportunities for a more efficient and commercial utilisation of the building. Deliver Educational programmes for international clients.

Key Points of Development for 2017:

Chinese Education Market 2017

Beijing – following Education Trade Mission

AH have been chosen to provide Clinical

Observer-ships for 40 doctors per year for 3 year contract.

AH has a further 5 opportunities to deliver HDU/Leadership and Post Grad Nurse Training for China:

- E-learning development with UOL
- Sepsis E-learning course for commercial development
- Development of Community Training course for Carers & Parents
- HDU/PICU international course

Benefits to Alder Hey

Builds reputation both in the UK and Internationally. Places Alder Hey at the forefront of paediatric Educatio**n.** Provides a platform to publicise Alder Hey expertise. Provides contribution for the Trust

07] Innovation

"ALDER HEY IS PROUD OF ITS LONG HISTORY OF PROVIDING PIONEERING AND INNOVATIVE HEALTHCARE TO CHILDREN AND YOUNG PEOPLE. AT A TIME WHEN TECHNOLOGY IS CHANGING THE WAY WE LIVE, ALDER HEY IS AT THE FOREFRONT OF DRIVING INNOVATION IN HEALTH SERVICES"

- **We are putting children first and accelerating the creation of new medicines, devices and therapies for them;**
- **The hospital has been recognised as one of the world's top 100 infrastructure projects and creates an environment where the latest devices can be developed and tested ahead of international roll-out**
- **From cognitive computing to nanotechnology we are open to ideas, wherever they come from**

Innovation

"Alder Hey is proud of its long history of providing pioneering and innovative healthcare to children and young people. At a time when technology is changing the way we live, Alder Hey is at the forefront of driving innovation in health services"

We are putting children first and accelerating the creation of new medicines, devices and therapies for them;

The hospital has been recognised as one of the world's top 100 infrastructure projects and creates an environment where the latest devices can be developed and tested ahead of international roll-out

From cognitive computing to nanotechnology we are open to ideas, wherever they come from

Innovation Service

Alder Hey Innovation Service works with clinicians, patients, industry and academia to co-create game changing innovations that improve outcomes for patients, families and staff.

Alder Hey enjoys a reputation as a leader in healthcare innovation. With our new hospital's state of the art digital infrastructure, clinical entrepreneurs, dedicated commercial innovation team and active engagement with industry, academia and local community, we set the benchmark for collaboration in accelerating innovation into healthcare.

Based in our dedicated 'Innovation Hub' at the heart of Alder Hey, we take the problems and challenges that we face on a daily basis and look to solve them with cutting edge technology and innovation. We create rapid proofs of concept and operational prototypes that are market ready much more quickly than is traditionally the case and, working with the Alder Hey research team, trial these innovations on-site as part of our full cycle innovation development process.

Our wide array of partnerships and collaborations with world leading academic departments and teams, leading technology, bioscience and healthcare organisation's and the wider clinical innovation Eco-system, locally, nationally and internationally, has already fostered some hugely exciting and ground breaking projects under our 'Grand Challenges' themes focus.

Innovation Hub

Alder Hey's dedicated Innovation Hub is a 1000m² installation underneath the hospital. Simulated clinical areas and data infrastructure allow for realistic testing, training and development of innovative healthcare technologies, within a carefully controlled environment. 3D printing facilities, virtual engineering equipment and on-site technical support allow for rapid product development and testing. By providing a space for industry, academia and clinical practice to develop technologies collaboratively, Alder Hey is pushing the boundaries of how to innovate within the NHS.

The Team

Alder Hey has an established Innovation Team whose role is to bring partners and collaborators, sponsors in industry together with clinicians, researchers and academics to create the products, devices and therapies for the future.

07] Innovation (cont.)

"ALDER HEY IS PROUD OF ITS LONG HISTORY OF PROVIDING PIONEERING AND INNOVATIVE HEALTHCARE TO CHILDREN AND YOUNG PEOPLE. AT A TIME WHEN TECHNOLOGY IS CHANGING THE WAY WE LIVE, ALDER HEY IS AT THE FOREFRONT OF DRIVING INNOVATION IN HEALTH SERVICES"

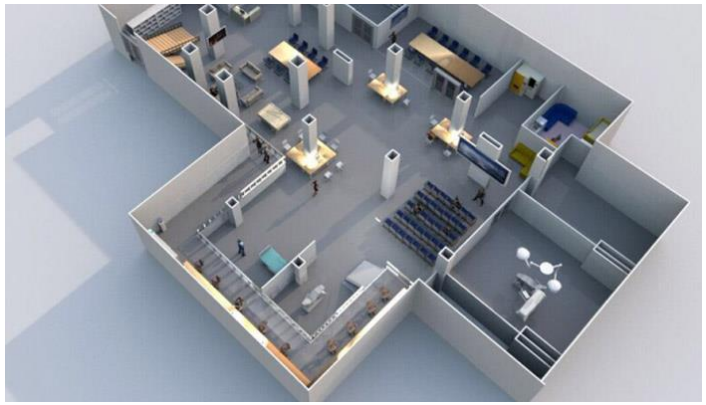
The 14 strong team is led by Mr Iain Hennessey – Clinical Director of Innovation, Consultant Neonatal & Paediatric Surgeon – and Mr Rafael Guerrero – Co-Director of Innovation, Chief of Congenital Cardiac Surgery – alongside Development Director David Powell.

The service is multi-award winning over many years, including most recently the 'Most Innovative Collaboration' Award for the 'Alder Play' project, North West Coast Research and Innovation Awards 2017; and the 'Gold Innovation Award' for Mr Iain Hennessey, Innovation Agency 2016.

Objectives and Benefits

Development of New Products

- Engaging Staff in a Culture of Innovation
- Assisting Alder Hey's Transformation of Care Agenda
- Increasing Alder Hey's Profile and Reputation
- Generating an Income Stream for Alder Hey



Product Streams

- Staff Entrepreneurship
- Sensors
- Living Hospital
- Visualisation
- Forge
- AI
- Health & Wellbeing

Partners

- NHS Staff – Innovation scouts and entrepreneurs
- Industry – Product development with SMEs & corporates
- Universities – R&D & placements
- Families – co-creation with patients and schools

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08] Delivery

"EVEN WHEN WORK STREAM STRATEGIES ARE AGREED, PROGRESS CAN SLOW DOWN IF THERE IS NO CLEAR, SHARED APPROACH TO PROGRAMME DELIVERY. THIS REQUIRES CLEARLY-DEFINED AND ALLOCATED ACTIVITIES"

- **A good communications plan for your strategy with expert help for any elements deemed controversial**
- **Creation of a shared learning spaces to allow those leading and managing 'International' initiatives to think and make sense together**
- **Ensuring affected workforces are actively engaged at every stage of delivery recognising that keeping people on board is hard work, and that time and effort will be required from senior leaders**
- **everyone needs to take responsibility and be held to account for the actions they agree to complete**

Define, implement and evolve plans

Even when work stream strategies are agreed, progress can slow down if there is no clear, shared approach to programme delivery. This requires clearly- defined and allocated activities.

Organisational cultures that are honest, resilient and agile will have the best chances of success, the Department of ICH will work hard to:

- encourage everyone needs to take responsibility and be held to account for the actions they agree to complete
- clearly identify resources and ensure they are fairly allocated – this may require re-prioritisation of existing work outcomes should be defined and captured in appropriate directorate-level key performance indicators (KPI)
- Ensure leaders regularly review progress and adapt approaches to meet changing needs.

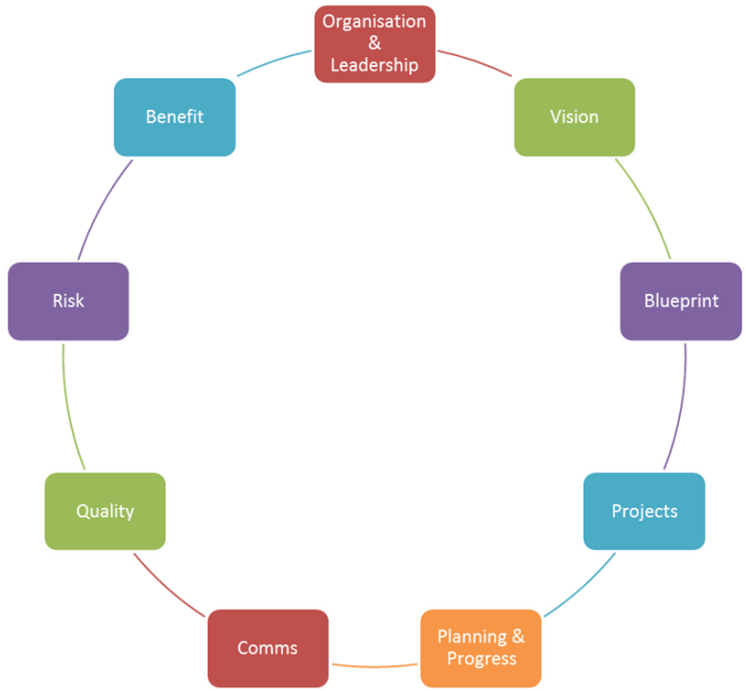
Planning and delivery: top tips

Define, implement and evolve plans

- Make sure you have a good communications plan for your strategy – get expert help if the changes are going to be controversial.
- Create shared learning spaces to allow those leading and managing change to think and make sense together.
- Make sure that the affected workforces are actively engaged at every stage of delivery – keeping people on board is hard work, and the time and effort required from senior leaders to do this shouldn't be underestimated.

Managing Successful Programmes

The Department of ICH will use the domains of the 'Managing Successful Programmes' standard to bring focus and tempo to the delivery



Inspired by Children

08] Delivery

"INTERNATIONAL CHILD HEALTH WILL BE INTEGRATED INTO STRATEGIC PLANNING, LEADING TO ALDER HEY ESTABLISHING A REPUTATION AS A TRULY GLOBAL ORGANISATION, RATHER THAN JUST A VERY GOOD CHILDREN'S HOSPITAL"

Organisation and Leadership

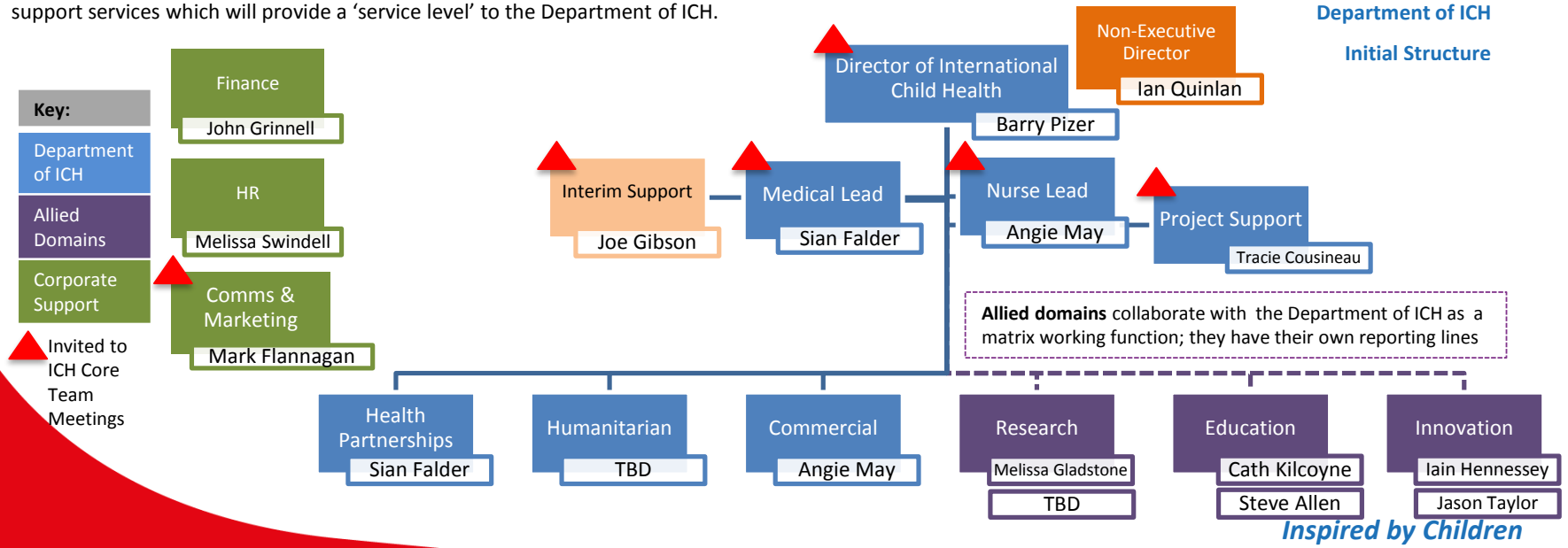
Given the now impressive portfolio of International Child Health (ICH) initiatives, this 'function' needs to be given a concrete 'form' within the organisation. The creation of a Department of International Child Health (Department of ICH) will address this need in a compelling yet pragmatic way.

The primacy of clinical leadership and engagement will be enshrined in the appointment of the first Clinical Director of ICH, Dr Barry Pizer. He will be assisted by two (or more) senior colleagues within ICH who will take specific responsibility for particular geographies and services offers. Following the 'three at the top' logic of the Alder Hey divisional structure the Department of ICH will also have a Nurse lead, Angie May, and a Medical Lead, Sian Falder; there will also be some management support, currently an interim appointment, to assist the Clinical Director. These leaders will have project management and administrative resources at their disposal as well as dedicated support from the Communications and Marketing Team. The Department of ICH will hold monthly meetings to include, predominantly, senior clinical colleagues to direct and drive the various initiatives with sufficient corporate linkages to underpin support to the Department of ICH. The Department will report quarterly to the Trust Board thus ensuring a direct governance route with appropriate transparency of risks and issues while also providing some leverage for the Department of ICH to garner the resources and decisions it needs to advance the Alder Hey reputation globally.

The initial structure of the Department of ICH is shown opposite in terms of domains of activity for which it has sole responsibility (Partnerships, Humanitarian and Commercial) and those domains for which it is a conduit to the international arena (Research, Education and innovation). The structure also shows the support services which will provide a 'service level' to the Department of ICH.

Department of ICH

Initial Structure



08] Delivery

"INTERNATIONAL CHILD HEALTH WILL BE INTEGRATED INTO STRATEGIC PLANNING, LEADING TO ALDER HEY ESTABLISHING A REPUTATION AS A TRULY GLOBAL ORGANISATION, RATHER THAN JUST A VERY GOOD CHILDREN'S HOSPITAL"

Vision

The Vision for the Department of ICH is to:

- Contribute to improving the health of the World's children
- Have an established, international paediatric brand with a reputation for excellence
- Be a proven partner with a track record of international delivery
- Balanced portfolio of income-generating and philanthropic activities in many areas of paediatric health delivery.
- International Child Health will be fully integrated into strategic planning and Trust development, leading to Alder Hey establishing a reputation as a truly global organisation, rather than just a very good children's hospital.

Blueprint

The summaries of the 6 domains of ICH at sections 2-7 of this document represent the initial blueprints for the programmes of work currently underway.

The Department of ICH will focus its work on the delivery of those programmes and ensuring that the capabilities are in place to assure that delivery. Where further resources are required to generate or extend those clinical (or managerial) capabilities the normal Trust systems and processes will apply.

Projects

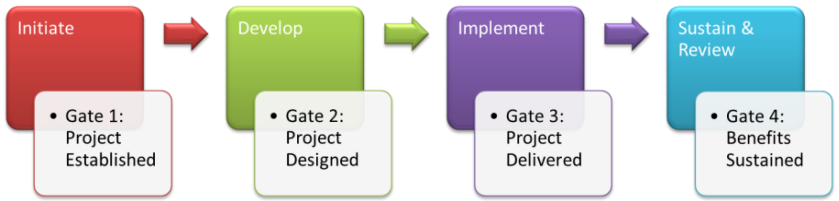
Due to the diverse nature of the activities that comprise the ICH portfolio, only certain initiatives will be configured as 'projects'. Moreover, where a 'project' is considered to be an approach that may add value, the project management will be tailored to ensure a lean approach that manages risk while promoting delivery at the optimum pace (good tempo promotes enthusiasm).

The mobilisation plans for the next 2 years (see Appendix n) form the work programme of the department and will be managed and measured accordingly. Plans will evolve and change to take account of changes in the external environment and emerging opportunities.

Planning and Progress

The outline plans for the Department of ICH were shared with the Trust Board in October 2017 and have now been honed to provide the Gantt chart view at Appendix n. The delivery will be driven by the department ensuring that, across the Trust, everyone who needs to take responsibility does so and be held to account for the actions they agree to complete.

Progress against these plans will be managed through the Department of ICH monthly meetings were timely decisions will be made , obstacles removed, and risks managed to promote timely amend effective delivery of all plans. That progress will be transparent to the REI & ICH sub-Committee and, ultimately, the Trust Board. The Department of ICH will produce an annual report to summarise its achievements and successes.



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Communications, Marketing and Engagement

The conviction that recognition is a fundamental pillar of the vision and goals of the Department of ICH has been clear from the outset. Realising this ambition will rely upon clear and consistent communication with staff, patients and external organisations both at home and overseas. Therefore, the creation of a good communications plan for this strategy (with expert help for any elements deemed controversial) is being developed and will be monitored at the Department of ICH meetings.

The Department of ICH will sponsor the creation of shared learning spaces to allow those leading and managing 'International' initiatives to think and make sense together; these will be both virtual (using SharePoint and similar tools) and tangible in terms of joint workshops to agree marketing plans.

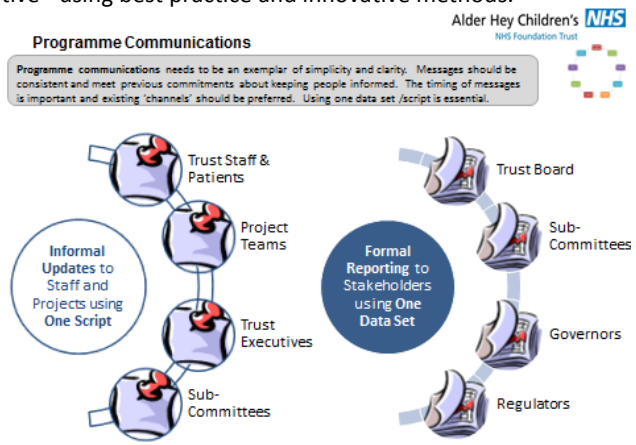
Ensuring affected workforces are actively engaged at every stage of delivery recognising that keeping people on board is hard work, and that time and effort will be required from senior leaders. Department of ICH will, via the Director of Communications & Marketing, ensure that sufficient frequency and quality of communication and engagement regarding ICH initiatives is presented to and involves the workforce.

As well as the support provided by communications and engagement team, the delivery of departmental communications and engagement will require the input and time of senior clinical and managerial staff from each of the six core domains of activity. They will need to act as advocates and represent programmes of work at a variety of meetings and events, as well as be spokespersons for media relations work.

Wherever possible, the programme will use one 'data set' and one 'script' to address all interested parties; this concept is illustrated opposite. This will ensure that the principles above that relate to consistency and cost-effectiveness are the default position.

The following principles will underpin the programme's approach to communication and engagement.

- Planned, timely, and targeted.
- Clear, consistent and accessible – e.g. using plain English.
- Cost-effective – using resources to best effect.
- Diverse - providing a range of opportunities for people to engage.
- Straightforward – avoiding gimmicks and over-complicated design or wording.
- Open and honest – proactive and avoiding misleading information and false promises.
- Respectful – showing respect for the audience, avoiding unfair stereotypes, and acknowledging the different needs of individuals and populations.
- Innovative - using best practice and innovative methods.



08] Delivery

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Quality

The progress of those initiatives classified as projects will be 'quality controlled' by means of invoking decisions points to: establish, design, implement and sustain the positive change that is being sought. The progress through these decisions, or 'gates', will be reported to the Department of ICH meetings and any issues resolved in that forum. Examples might be delays is getting an MoU signed off or problems with operational responses to private patient referrals.

The rationale for these 'check points' is to enable the department to transparently appraise the progress of delegated project work and assist project teams in bringing their aspirations to fruition. Again, it will only be applied to project work and not to 'task and finish groups' or discrete pieces of work.

Risks

The risks generated and confronted by the ICH clinicians are manifold. They range from issues of insurance and indemnity through to reputational and brand exposure in different cultural and political environments.

Therefore, a serious managerial focus on identification, evaluation, mitigation and monitoring of risks is a crucial component of the work of the Department of ICH. The Trust risk management protocols will be followed and risks logged on the Ulysses system. The risks will be escalated, where appropriate, to the Integrated Governance Committee following the usual channels for other divisions and departments.

Benefits

The range of benefits from the ICH work is best expressed as the 'four R's':

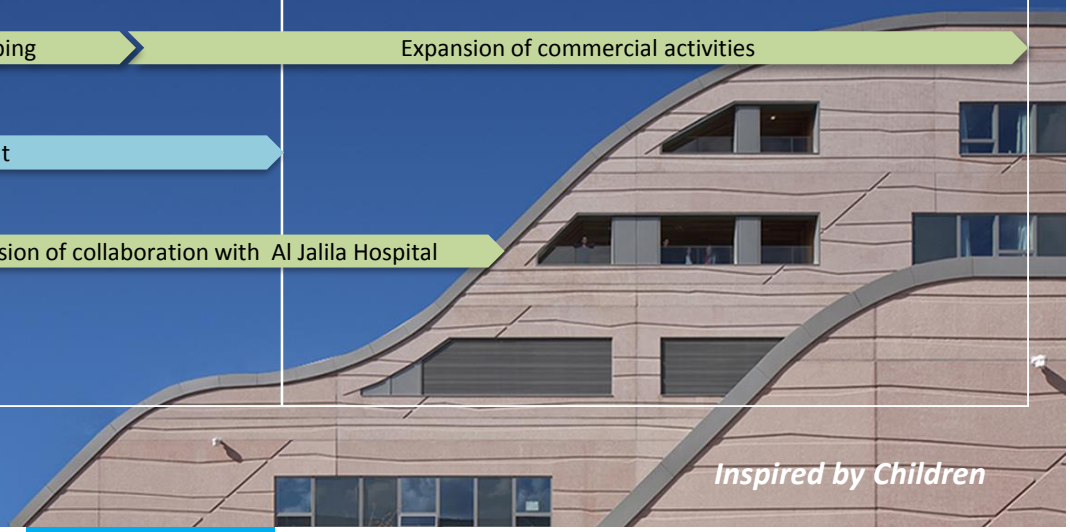
- **Reputation:** One of Alder Hey's five key strategic aims, expressed in the Strategic Plan 2014-2019, was to "to grow existing operations and brand name beyond the domestic region by growing our international footprint." Enhanced participation in international activities will greatly enhance our ambition to be recognised as a world leading children's hospital.
- **Recruitment and Retention:** 'We look to attract world-leading medical professionals and researchers and we recruit from a limited global pool of such individuals. We also want to retain our current world-leading professionals. Working internationally will improve our retention rate and improve satisfaction levels.
- **Research and Education:** Our clinical academics and other staff have a very strong portfolio of research in ICH. Our research activities and our reputation as a leading centre for research will be enhanced by increasing engagement with research activities overseas. Increased international networks will support us to maintain our role as a leading education centre and enhance the development of the Alder Hey Academy.
- **Revenue:** Our international work will lead to additional revenue for us, forecasts are currently being adjusted as part of the annual planning round. This will be achieved through enhanced delivery of care provision to international patients both at our hospital and at the overseas partner institutions. It is envisaged that educational activities may also attract significant income-generation.

Key:
- General
- Comms
- Partnership
- Commercial

08] Delivery – Gantt Chart 1

Phase 0: Establish Department of ICH	Phase 1: Short-term delivery	Phase 2: Medium-term delivery
3 mths – to Apr 18	12 mths – to Apr 19	24 mths - to Apr 20

- Department of ICH Initial Strategy
- Department of ICH Public Strategy
- Dept of ICH Est.
- Board agree Department of ICH
- MoU QE Central Hospital Malawi → Scoping with QE CH Malawi → Activities with QE CH Malawi
- R&BD agree PP policy
- Map other MoU opportunities → Pursue new MoU partnerships
- Mapping Department of ICH activities
- Implement Risk Assessment
- Department of ICH Comms Plan
- Agree scope with Board → Scoping → Expansion of commercial activities
- Roll Out Plan
- Comms Lead Appt.
- Brand Development
- Marketing Pack
- Develop ICH Webpages
- Expansion of collaboration with Al Jalila Hospital
- 2nd contract with Al Jalila Hospital

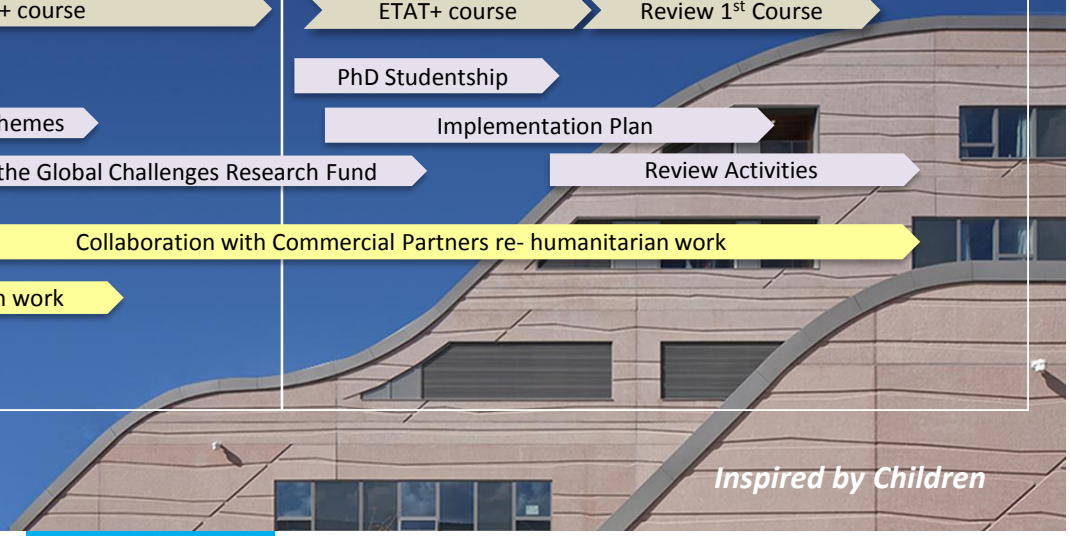


Inspired by Children

Key:
- Education
- Research
- Humanitarian
- Innovation

08] Delivery – Gantt Chart 2

Phase 0: Establish Department of ICH	Phase 1: Short-term delivery	Phase 2: Medium-term delivery
3 mths – to Apr 19	12 mths – to Apr 19	24 mths - to Apr 20
	Engagement with Partners re Education (e.g. RCPCH)	
	Department of ICH Education Strategy	
	Host 3-4 RCPCH Visiting Fellows	Host 3-4 RCPCH Visiting Fellows
	1 or 2 LSTM MSc Students (Nepal +/- other)	1 or 2 LSTM MSc Students (Nepal +/- other)
	Develop AH International Fellowship Programme	Start of International Fellowship Programme
	Business plan: AH/LSTM Leadership in Global Child Health	Global Child Health; Review 1st Course
	Business plan: ETAT+ course	ETAT+ course; Review 1st Course
	Department of ICH Research Strategy	PhD Studentship
	Mapping and prioritisation of research themes	Implementation Plan
	Exploring opportunities through the Global Challenges Research Fund	Review Activities
Review mapping process and Implementation plan	Collaboration with Commercial Partners re- humanitarian work	
	Developing a theme to our humanitarian work	
	Department of ICH Innovation Strategy	



Inspired by Children

This strategy will evolve according to the requirements of the organisation and the Department of International Child Health. As outlined at the start, strategy development is a continuous process and evolution will involve:

- **recommitting** to an existing strategy
- **refreshing** it if the environment has changed
- **recreating** it if the environment has significantly changed

Evolution will be easier if there is strong leadership and a departmental culture where staff:

- are involved in defining and committed to a clear vision for their local area
- have clear priorities and objectives that are linked to organisational performance
- are treated consistently, inclusively and with compassion
- are continually learning, improving quality and innovating together
- feel connected within and between teams across the organisation.

Strategy development: Top tips

Having a good understanding of your technical data is important – but analysis can lead to paralysis and is sometimes used to block progress.

It's worth agreeing how much analysis is enough for your purpose, and to cross-check findings with non-technical data sources.

Don't pick too many things to work on – choosing what not to do is as important as choosing what to do.

Improvement science methodologies can be really helpful for thinking about how to review and design services.

There is no one right way – what matters is that you pick one and own it.

This strategy document seeks Board ratification for the establishment of the Department for International Child Health (ICH) at Alder Hey

Inspired by Children

Alder Hey Children's NHS
NHS Foundation Trust

Board of Directors
Tuesday 10 April 2018

Report of	Chief Operating Officer / Development Director
Paper prepared by	Progress Report – HCP Letter outlining concerns from Chief Executive Ulysses Risk – Development Director
Subject/Title	Pipe Corrosion – Heating System Failure
Background papers	N/A
Purpose of Paper	To update on the Board on the issue relating to pipework corrosion at Alder Hey Children's Hospital and actions taken to mitigate the risk.
Action/Decision required	The Board is asked to discuss and note the mitigation measures and next steps
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	➢ Delivery of outstanding care ➢ The best people doing their best work ➢ Sustainability through external partnerships ➢ Game-changing research & innovation
Resource Impact	Potential impact on activity Consideration of legal resources required to manage this risk

Alder Hey Children's NHS
NHS Foundation Trust

Direct Dial: 0151 252 5412
Email: karen.critchley@alderhey.nhs.uk
Email: louise.shepherd@alderhey.nhs.uk

Eaton Road
Liverpool
L12 2AP

Telephone: 0151 228 4811
www.alderhey.com

2 March 2018

FAO: Stuart Wilkinson (Project Co Representative)

Dear Stuart,

RISK TO THE SAFETY OF CHILDREN, FAMILIES & STAFF FROM HEATING SYSTEM FAILURE

As you are aware the issue of pipework corrosion was raised by Project Co. and the Trust in June 2017 (with reference to Estates and Facilities Alert, Ref: EFA/2016/001) and a proposal made by Project Co. to undertake a full review and action plan on 5 July.

Whilst we have been waiting for this review to happen the number of leaks experienced in the pipework has escalated rapidly and we have now experienced serious incidents with threat to the safety of children and staff.

The most recent event occurred on Tuesday 27 February 2018. Two paediatric inpatient wards and the radiology department suffered heating failure. There was significant disruption to patient care and two significant near misses. Firstly, large quantities of water spread close to the electrical system that supports the Paediatric Intensive Care Unit. Thus, a fire and electrical failure scenario presented. Plans were draw up to evacuate the sickest and most acutely unwell children in the hospital. Secondly, temperatures dropped in Radiology which could have led to irreversible damage to our imaging equipment.

These events of Tuesday 27 February 2018 should be a siren-call to take immediate action to address this significant health and safety risk.

We have conducted an urgent risk assessment and concluded that there is a significant and likely risk to the safety of children, families and staff as a result of pipework corrosion eliciting a failure in the hospital's heating system, with a potential catastrophic outcome.

We are writing to you to ask for the following actions to be progressed immediately:

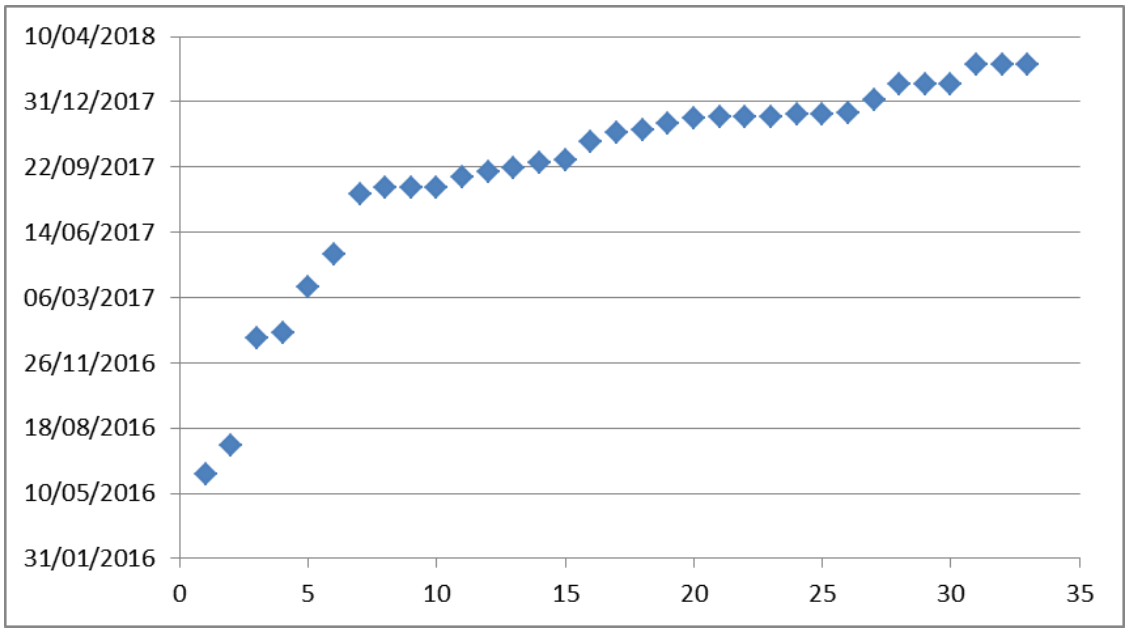
Proposed mitigations to the risk of heating system failure are put in place.

A thorough inspection of the heating system and pipework is undertaken within a timescale that reflects the urgency and scale of the situation.

A programme and plan for the replacement of the corrosive pipework is put in place with a view to commencement as soon as is practically possible.

I would be grateful if you could urgently escalate this issue to your board and reply to this letter by Friday 9 March 2018 laying out setting out how you will work with us to progress resolution to this risk.

The reason I am intervening personally is that I believe that the seriousness of the situation has not resulted in the degree of urgency required, the graph below shows the growing incidence of failure since the issue was first raised and the longer we leave it, the greater the chance of a catastrophic incident.



Given the importance of the above can you please raise as a matter of priority within your board and report back within 7 days of receipt of this letter.

Yours sincerely

Louise Shepherd
Chief Executive CBE

(By hand & email: Stuart Wilkinson SWilkinson@laingorourke.com)

ALDER HEY (SPECIAL PURPOSE VEHICLE) LIMITED

Alder Hey Pipework Corrosion

Progress Update
27th March 2018

Overview

This paper is intended to provide an update on progress to date with the investigation, identification and management of issues as a result of identified pipework leakage from the following closed hydronic systems serving the hospital:

- Low Temperature Hot Water (LTHW)
- Chilled Water (CHW)
- Ground-source Heat Pump (GSHP)

Investigation Scope

In order to determine the probable root cause for the pipework corrosion issues experiences at Alder Hey Children's Hospital.

Investigations so far have indicated that there are instances of corrosion occurring along the bottom edge of the pipework on the mild steel distribution pipework (Geberit Mapress pipework), however these investigations were unable to determine the root cause.

Corrosion of pipework occurs generally due to the following causes:

- Chemical – the water within the pipework becomes corrosive.
- Galvanic – there is a contact with dissimilar metals within an electrolytic liquid.
- Microbiological – the water contains microbiological organisms which consume pipework elements.
- Hydraulic – the water velocity within the pipework is excessive resulting in wear (erosion) or pitting due to cavitation.

In order to determine the probable cause there are three investigation streams:

- Engineering – in order to determine whether there is an underlying issue with the building systems a study will be performed to assess whether there are inadequacies within the systems, particularly the filtration systems and water velocity following concerns raised by IFM following water sampling results.
- Water Quality – in order to determine whether there is an underlying issue with either the chemical or microbiological constituents of the water, water sampling will be performed.
- Metallurgical – in order that the constituents of the corrosion can be determined, together with any metallic residue, samples will be taken of the pipework serving the systems.

Progress

Appointments are in place with the following consultants:

- Engineering – WYG
- Water Quality – IWS
- Metallurgical – BRE

WYG scope have commenced their investigation and have attended site to gain an overview and access to documents; additionally, a log-in to e-docs has been arranged to facilitate access to all information. Their investigation is progressing steadily and we are awaiting their initial findings, however finalisation of the process has been delayed due to staff sickness.

The IWS appointment has been extended to include an initial baseline condition sweep prior to the sample taking process; IWS attended site and this sample sweep was performed on the 26th March 18; the sample analysis period is approximately 10 days and therefore results are anticipated to be available WC 9th April 2018.

Confirmation of the sample extraction programme is being finalised by CHt following a site survey to confirm extraction points. A review of areas was performed between CHt, IFM and the Trust Health and Safety and a number of observations were made which are being incorporated into the sampling programme.

The GSHP system is the critical system experiencing the majority of the failures and therefore the focus of the sample taking will prioritise this system. The first stage of this process is the installation of a side-stream filter to clean up the water quality to enable the water treatment regime to be enhanced; The design for the installation is progressing however the installation of the filter has been delayed due to cost issues. An alternative solution may need to be progressed to flush the system prior to re-dosing; this does however increase the likelihood of pipework failures.

Key Issues

Key issues are the finalisation of the sample extraction programme and commencement of physical works.

Mitigation measures are being progressed to eliminate the risk of water ingress adversely impacting the electrical system, this includes the sealing or penetrations and masking of electrical distribution equipment. Initial remedial measures are in place and further measures are being investigated.

Next Steps

- Receipt of IWS baseline sample report and recommendations for remedial works.
- Commencement of works.
- Finalisation of WYG report.

Risk Register

Alder Hey Children's NHS Foundation Trust

Risk Register	2018--19		Risk Title: Risk of pipe burst due to corrosion		
Ref: 1388	Risk Owner: David Powell	Originating BU / Programme: Business			
Reporting Committee: H&S		Where Risk Managed: Corporate			
Internal	Link to Quality AimsH&S				
Strategic Objective: Delivery Of Outstanding Care			Current IxL 5-4	Target Residual - Appetite for Risk 2-3	Trend: New Risk

Description	Causes	Consequences
Pipe work corrosion in non potable water (no drinkable).	Corrosion found in steel pipe work for heating and ventilating	Substantial water leaks resulting:- 1. Significant Business Interruption to critical clinical services. 2. Financial implications, reduced capacity etc. 3. Potential decanting of wards, etc.

Existing Set of Controls

• Rapid response from Interserve to resolve any leaks. The agreement with Interserve and SPV is to prioritise any incidents of burst pipes so as to to ensure minimum disruption.

Effectiveness of Existing Controls: Could Improve

Actions to Reduce Risk to Target Residual Rating

Actions to Reduce Risk to Target Residual Rating	Resp.	Imp. Date	Progress Since Last Review
Works delayed due to external providers not yet signing contract	Graeme Dixon	31/01/2018	Appointed specialist.
Sampling project currently being commissioned via HCP(SPV) which will remove sections of 36 pipes from the Low Temperature Hot Water (LTHW) - Chilled Water (CHW) - Ground-source Heat Pump (GSHP systems, which will then be analysed to incorporate three investigation streams: - Engineering - in order to determine whether there is an underlying issue with the building systems a study will be performed to assess whether there are inadequacies within the systems, particularly the filtration systems and water velocity following concerns raised by IFM following water sampling results. - Water Quality - in order to determine whether there is an underlying issue with either the chemical or microbiological constituents of the water, water sampling will be performed. - Metallurgical - in order that the constituents of the corrosion can be determined, together with any metallic residue, samples will be taken of the pipework serving the systems.	Graeme Dixon	30/06/2018	

Alder Hey Children's NHS
NHS Foundation Trust

TRUST BOARD REPORT

MORTALITY ASSESSMENT AT ALDER HEY
Medical Director's Mortality Report

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

Section two is the Quarter 3 Mortality report which includes a review of statistical analysis in PICU and Cardiac Surgery, followed by more detailed analysis of the place of death, teams involved and specifics about expected v observed deaths.

Section 1: Report from the Hospital Mortality Review Group (HMRG) Jan-Dec 2017

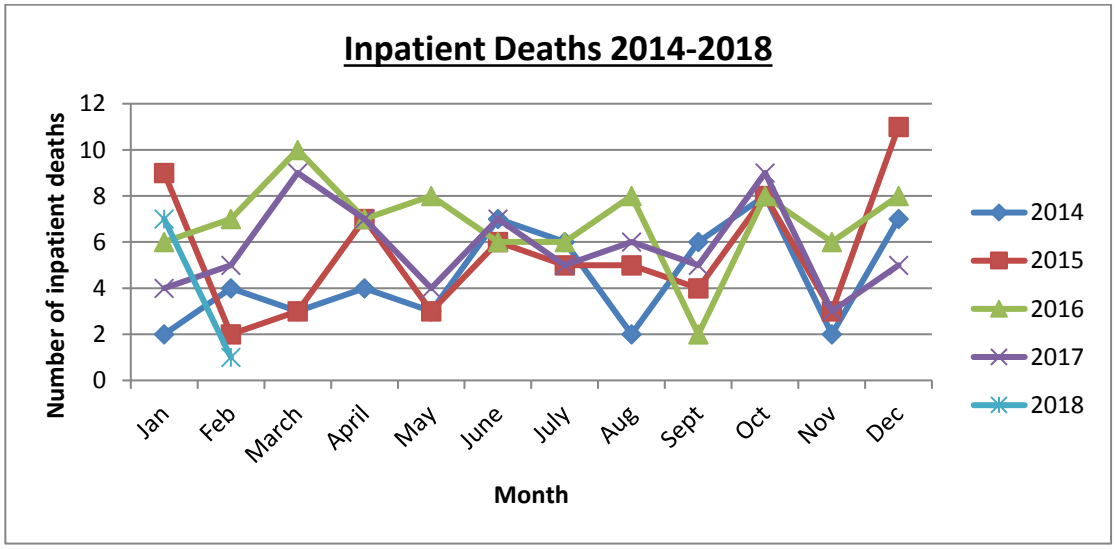
This is still a period of change for the hospital mortality group as we continue to evolve our mortality review process following the document "Learning, Candour and Accountability: review of the way NHS Trusts review and investigate deaths" (Dec 2016). There have been a number of documents since trying to ensure there is effective mortality review and learning across organisations following a death.
The Alder Hey mortality review process was rewritten following these documents and national meetings. It was agreed across the Trust and the new process began in February this year.
The majority of the deaths in AHCH occur in PICU where there is a robust mortality process which is well established and has been for many years. Other teams who rarely have a death are the teams which we are trying to engage aiming for the same review process across the Trust regardless of where the child dies.
We are unusual as an organisation as we review every death due to our numbers being lower than the DGH's or adult Trusts. This ensures that we have assessed our care for every child and family so that we maintain a high level of care. The Hospital Mortality Group by undertaking a second review makes the process more independent than just a departmental review. The Hospital mortality review group is made up of people with a wide variety of expertise, experience and is a multi-disciplinary group.
Over the last year, the group has engaged with the bereavement team to provide the family's feedback on their child's care over the last admission and any previous care at AHCH. This is being done very sensitively as it is important that the review process is constructive for the family and helps their

grieving. Some families may choose not to engage, and it may be appropriate at different times for them after their child's death.
The HMRG is linking in with other networks such as trauma and neonates.

To continue to develop the process;

1) Ongoing engagement with the families
2) Identification of mortality leads across the Trust (underway)
3) RCA findings to be shared with the teams involved in a timelier manner
4) Sharing of HMRG reviews with referring hospitals, GPs, CDOP process
5) Learning is the main area that needs to be developed. Currently learning points are communicated after the monthly meetings and the intranet aspect is being utilised more effectively. There needs to be more effective communication across the governance pathway and we need to explore different possibilities to ensure the learning is effective.
6) External peer review with other Paediatric hospitals
7) Re – introduce the review of deaths within 30 days of being discharged from the Trust. Currently we still monitor these but they do not have a formal review.

Nationally the paediatric mortality review process has not been finalised and there is still considerable uncertainty about a number of aspects about the initial proposal. At the meetings there was a lot of interest in the process we are operating in AHCH, and a number of organisations and NHS England asked for our policy and for information about our process.



Looking at the in-patient deaths over the last 4 years there is always variation but it does tend to balance out over the year. When there has been a peak, the hospital mortality group reviewed the cases quickly to check there were no concerning issues or factors.

Summary Table

Number of deaths (Jan. 2017 – Dec. 2017)	69
Number of deaths reviewed	58
Departmental/Service Group mortality reviews within 2 months (standard)	58/69 (84%)
HMRG Primary Reviews within 4 months (standard)	45/64 (70%)
HMRG Primary Reviews within 6 months	46/52 (88%)

The HMRG is performing well with 70% of the reviews within the 4-month target that we set ourselves and 88% within 6 months. The 4-month target can be difficult/impossible to achieve if it is a coroner's case and if the RCA's are prolonged. The group is of the opinion that it is important to have all the relevant information to achieve a useful and complete review. Therefore, it is appropriate to wait, and it is unlikely that we will every achieve 100%. The standard of 4 month is useful so reviews are done in a timely manner and if there is a concerning trend it will be identified in a reasonable time period. The outstanding cases are related to RCA's or coroner's cases.

When there was a delay in releasing 2 RCAs to the teams involved HMRG asked the Medical Director to intervene and he then organised the RCAs to be available to the teams. The cases could then be discussed at the next meeting but missed the 4-month target.

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

Discordant Conclusions of the HMRG vs the Departmental/service group reviews

Since the previous mortality report there have been 4 cases where there have been discrepancies between the service group and HMRG reviews. In one of the cases, the care was considered to be better than rated in the service group review. In another of the cases, the organisational issues were considered to be worse than the service group review. In the other 2 cases the HMRG reviewers decided there were aspects of care that were less than adequate and different management may have altered the outcome as oppose to the service reviews where they were rated as adequate.

Potentially modifiable factors and actions

Since the last Trust Mortality report, there have been 3 in-hospital deaths where there are factors which may have played a role in the child's death.

1) One was a child who was brought into Emergency Department (ED) in cardiac arrest. Patient had been noted to be lifeless at home with their face was covered. Basic life support was started at home and the child arrived in asystole. Advanced resuscitation was continued in ED and there was return of circulation 5 minutes after arrival. Patient was transferred to Paediatric Intensive Care Unit (PICU) although very unstable on an adrenaline infusion and pupils were fixed and dilated. Unfortunately, patient started fitting and a CT scan showed severe ischaemic changes (in accordance with lack of oxygen to the brain). Despite full intensive care and multiple neurology reviews, patient had irreversible widespread brain injury. A few days after admission to PICU, bloods and urine toxicology came back positive. On PICU, patient remained comatose with irregular respiratory drive and brain dysfunction. There were multiple discussions with the family and they agreed to withdraw care.
There were no concerns about the care provided in Alder Hey Hospital but this was potentially avoidable death prior to cardiac arrest.

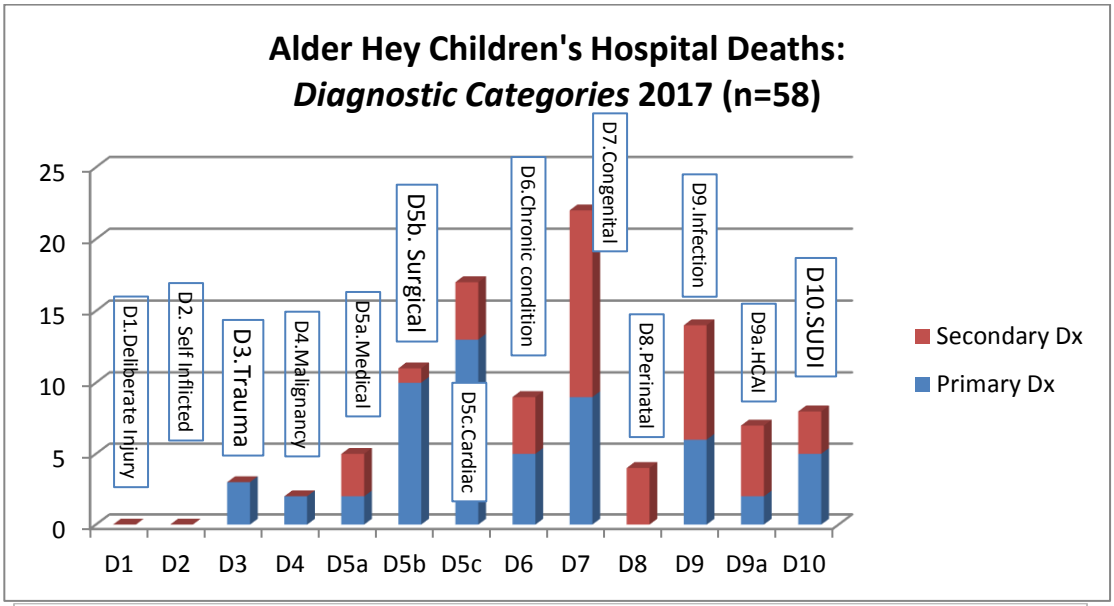
2) A patient with long-standing health problems, whilst being admitted with respiratory problems, was noted to have large tonsils and was listed for an elective adeno-tonsillectomy. The patient required oxygen overnight and had a slight temperature but was considered for discharge the day after surgery. Just prior to discharge the patient deteriorated and it was thought that to have a chest infection (CXR – showed changes). Antibiotics were started which were changed from Co-amoxiclav to cefotaxime and then to teicoplanin and ciprofloxacin. The patient continued to deteriorate on HDU and arrested 48 hours post operation, straight after intubation. Despite all possible treatment it

was not possible to resuscitate the patient. After death, a positive test result was felt to explain the long term health problems but it was not thought to be the cause of death.
An RCA was completed which found that there had been insufficient medical reviews. The PEW's score was high at one point but there were significant delays in recognising the patient's condition. Comments were made that the view of microbiology results on Meditech were limited so all results were not visible. There was no handover from the daytime to the night team and a high lactate was explained by squeezing rather than a true result. The opinions of the nursing team were not taken full account of and the Sudden Unexpected Death in Infancy (SUDI) protocol was not activated.
There was a delay in the RCA findings being available to the people involved and the HMRG asked the Medical Director to intervene to clarify the procedure for dealing with an overlap between the mortality review and RCA processes . This clarification will assist in any similar future situations.
The Group reviewed this as potentially avoidable death.

3) A child who as a neonate had required admission to SCBU for treatment and monitoring and was discharged home and a month later had an out of hospital cardiac arrest. The patient was co-sleeping with the parents. The patient had fed well and then when the alarm went off for the next feed it was noticed that they were floppy, pale and not breathing. Parents started cardiopulmonary resuscitation and the ambulance crew continued resuscitation. On arrival to AHCH resuscitation continued. Cardiac output returned after at least 42 minutes. The patient was so unstable that when transferred by North West Transport Service they required hand ventilation and multiple inotropes on PICU. The patient deteriorated on PICU and following discussion with the family the decision was made to withdraw care.
This was an avoidable death due to the co-sleeping. There is an on-going safe to sleep campaign in Merseyside.

Primary Diagnostic Categories

The chart below shows the deaths by primary diagnostic categories.



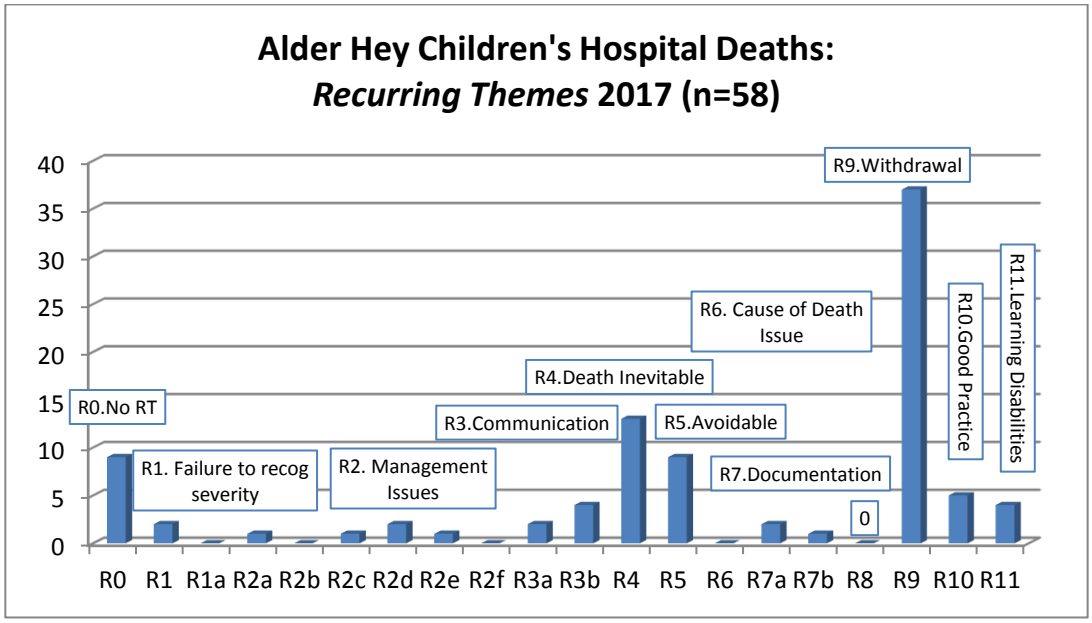
Diagnostic/Disease Categories (based on CEMACH categories - ref. *Arch Dis Child* 2011;96:922-6 + 927-31)

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

The commonest diagnostic category is cardiac with 25% this can be partially explained by a number of babies that come to Alder Hey for cardiac assessment and then are found to be inoperable or no real treatment options. This has resulted in discussion in the HMRG meetings as to whether it is appropriate and necessary to bring the babies and families to AHCH so isolating some of the families from their support network. The feedback from the cardiologists is that they can do a far more detailed assessment and the cases can be extremely complex and need considerable discussion. The next highest group is surgical 19% and there are a number of explanations for this. The surgical team here takes referrals for line accesses across the region where they are finding it extremely difficult to obtain an intravenous line. The surgical team provides a central line so solving the problem but a number of

these babies are precarious with many being extremely premature and with a number of complex issues. These babies may deteriorate either en route to AHCH or on arrival and then unfortunately pass away whilst here. There is another group of surgical patients with very similar issues and these are the babies who are referred as ?NEC – necrotising enterocolitis. This is a condition which typically occurs in premature babies and is characterised by variable damage to the intestinal tract. The first line treatment is intravenous antibiotics and resting the bowel but if they deteriorate they may need an operation. They are therefore referred to AHCH and the group did notice that there were a number of babies which were too unstable to even make it to theatre. There has been feedback via the neonatal network as to whether it is appropriate to refer these babies to AHCH if they are so unstable with multiple co-morbidities.

Primary Recurrent Themes



Recurring Themes

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

The commonest theme is withdrawal of care in 71% of cases which shows that the intensive care team are providing the best possible care until they feel all treatment options are futile, then with full agreement of the family and the other teams involved withdraw intensive care and ensure that the child has as peaceful a death as possible. Although these are difficult discussions, it is important that the team is proactive thus preventing unnecessary suffering and it done in a very caring and compassionate way.

The next commonest theme is that death is inevitable in 25% of cases so regardless of the care provided in AHCH the child unfortunately was going to die. There are other cases where the child is clearly extremely poorly but the decision that the condition or illness is not survivable is not made until detailed assessment has been made and these are not put in this category.

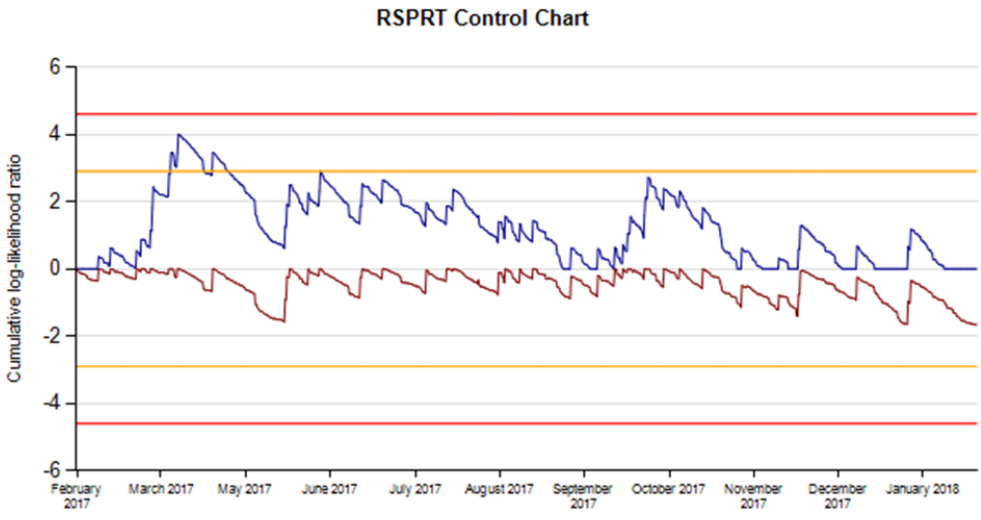
In accordance with national recommendations we are recording children with learning difficulties in our mortality process and this is 8% for this quarter. The national guideline was to 4 years of age but we have reported younger ages as there are some conditions where the child will clearly have learning difficulties. The impact on the family and their interaction with medical practitioners may well have occurred from a very young age so it is important to record these and ensure there are no issues.

Section 2: Quarter 3 Mortality Report: October 2017 – December 2017

1) Statistical analysis of mortality:

a) RSPRT (Risk-adjusted resetting probability ratio test)

In the RSPRT (Risk-adjusted resetting probability ratio test) Plots present the mortality of your unit cumulatively, based on what is predicted by PIM2 score. Between the orange lines is a 'safe zone' with the variability you might expect day to day. Between the red lines at the top of the chart can be regarded as a 'warning zone'.



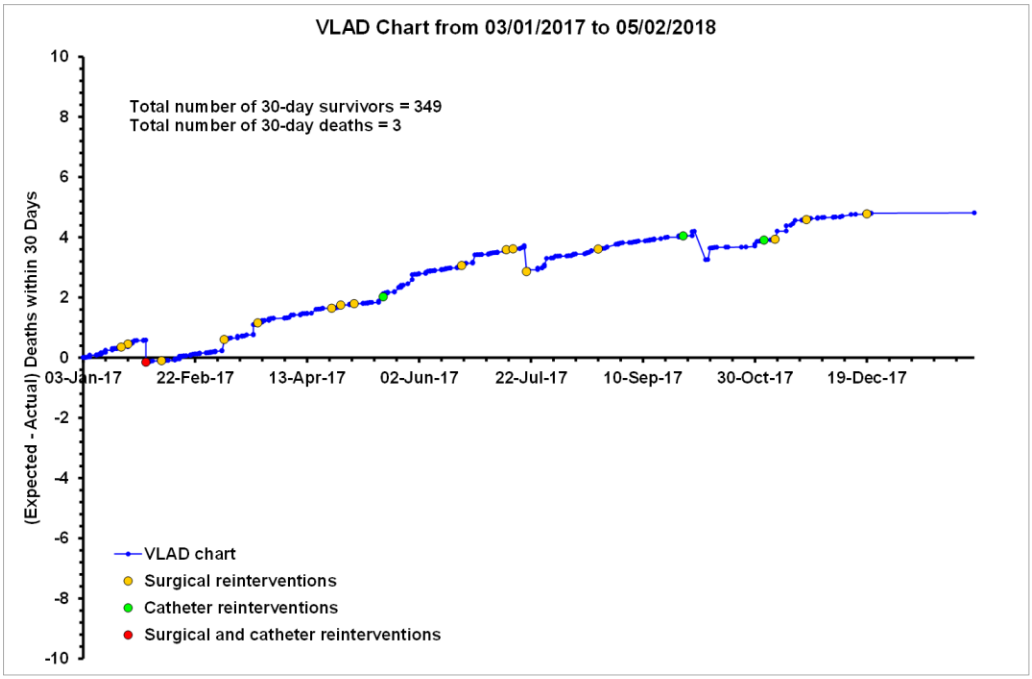
Until there is a death, the top line stays flat and the bottom line gradually drops. When a death occurs, the top line moves up and the bottom line moves

closer to zero. When either line touches the red line, the graph resets to zero.
This data is nationally validated because generated by PICANet.
In the above RSPRT chart - RSPRT resets in mid-March 2017 but since April 2017 has remained in the 'safe zone' till date. We had n= 6 deaths in March 2017 and all the deaths have occurred in the patient group who belonged to "Death inevitable on PICU admission" in retrospect- (n=3 Out of hospital cardiac arrest, n=2 Preterm VLBW neonates with NEC + MOSF , n=1 Restrictive cardiomyopathy + MOSF). The second peak occurred between September and October where we had n=13 deaths. One death was of that a child with fulminant meningococcal sepsis who had refractory shock who died despite Extra-corporeal life support (ECLS). Rest of the n=12 deaths occurred in the patient groups who belonged to "Death inevitable on PICU admission (in retrospect) and multiple co-morbidities which have obviously impacted on the RSPRT trends. All PICU deaths + RSPRT trends are discussed in the following month and monitored regularly.

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

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

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

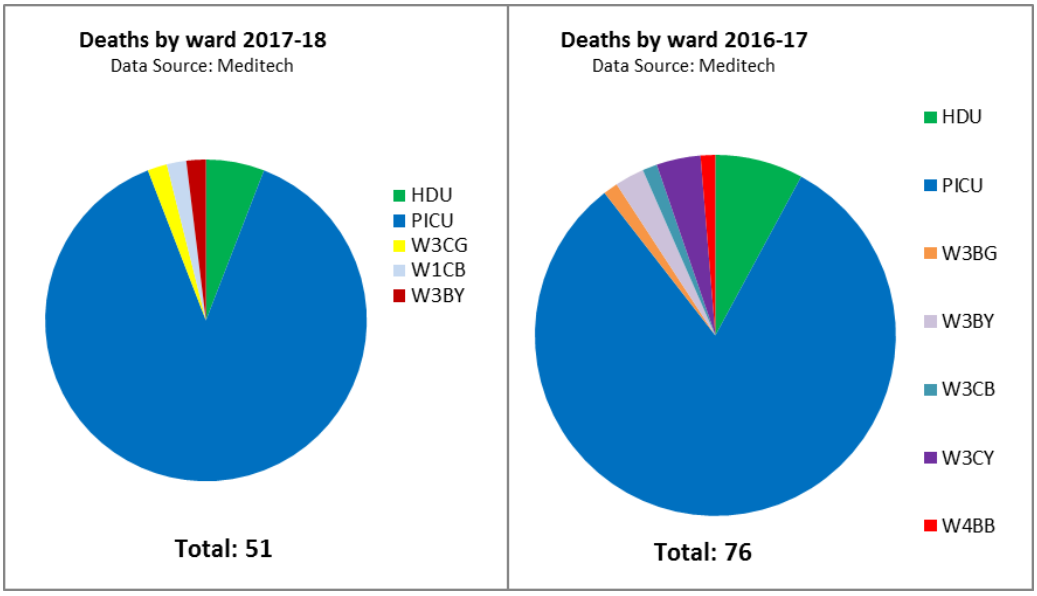


The VLAD chart above shows mortality is occurring lower than expected for the twelve months from January 2017 to December 2017. The survival rate at 30 days was 99.1% against an expected rate of 97.8%.

2) Real time monitoring of mortality

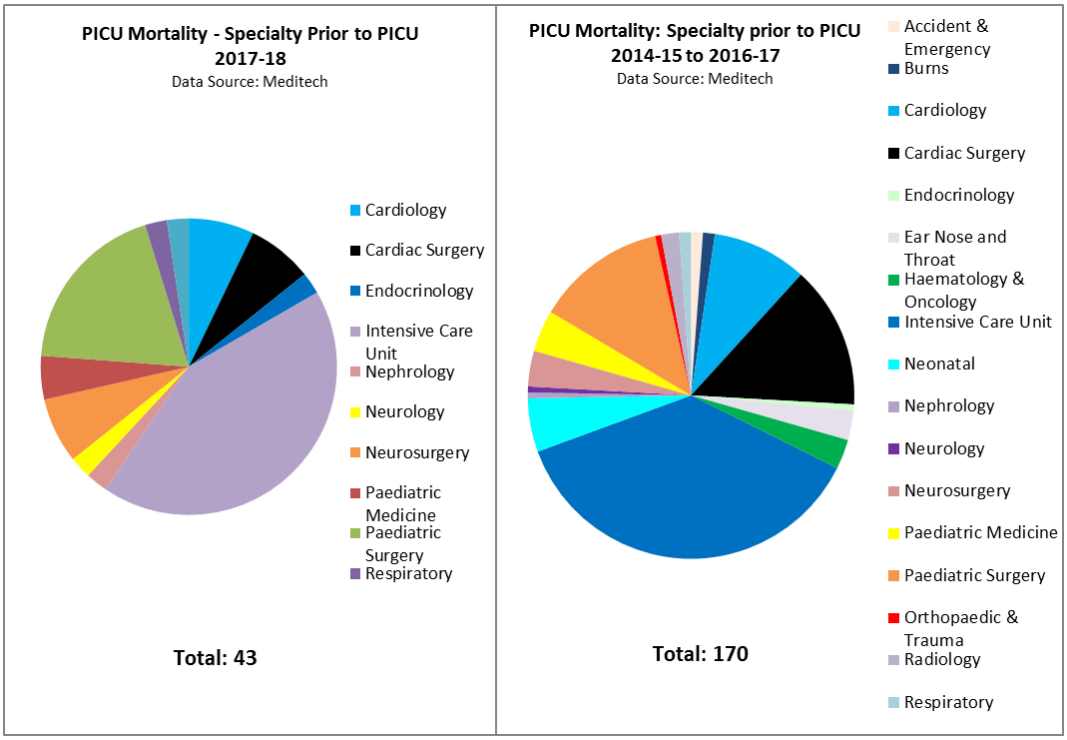
Mortality is now being monitored in real time and analysed by year, ward, specialty, deaths within 30 days from admission and over 30 days from admission.

i) Below are the charts showing mortality by ward for 2017-18, and the previous year 2016-17.



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

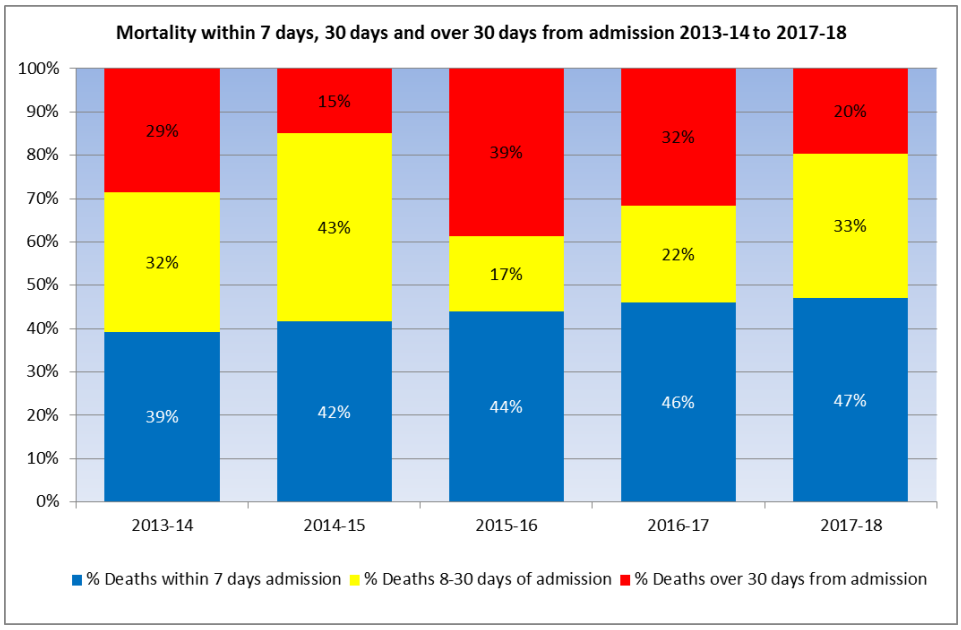
ii) Below are the charts showing mortality by specialty prior to PICU for 2017-18, and the previous 3 years 2014-15 to 2016-17.



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

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

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



The chart shows that usually the highest percentage of deaths occurs within 7 days of admission, around 40-44% of deaths occur within this time frame. In the current year 47% occurred within 7 days of admission, 33% occurred within 8-30 days from admission, and 20% deaths occurred over 30 days from admission.

3. External Benchmarking

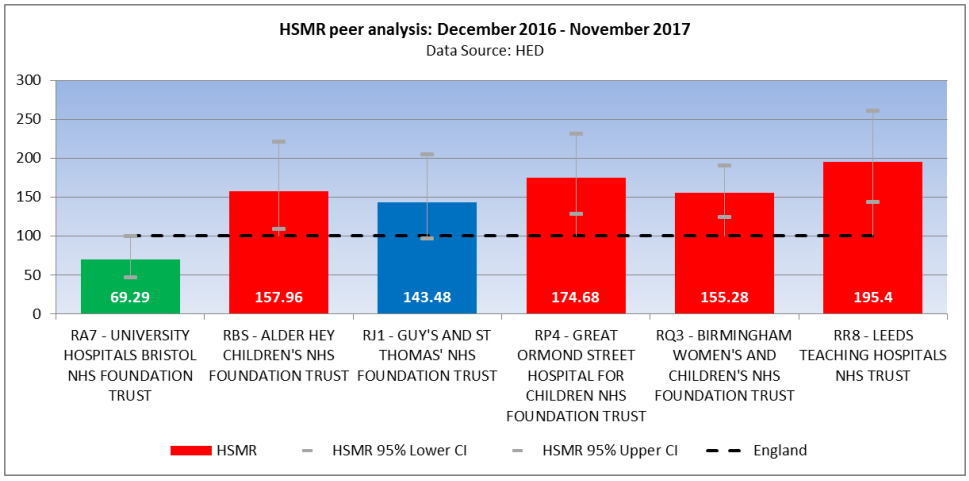
a) Hospital Standardised Mortality Ratio (HSMR) – HED

HED allows the Trust to monitor and benchmark a number of hospital performance indicators including mortality. The HSMR is the ratio of the observed number of in-hospital deaths divided by the number that is expected, and is based on 56 diagnoses. Although the scores are based on a

basket of diagnoses that are more commonly found in adults, it allows a comparison of the performance of Alder Hey against other Trusts.

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

The chart below compares HSMR for Alder Hey against its peers for the period December 2016 to November 2017.

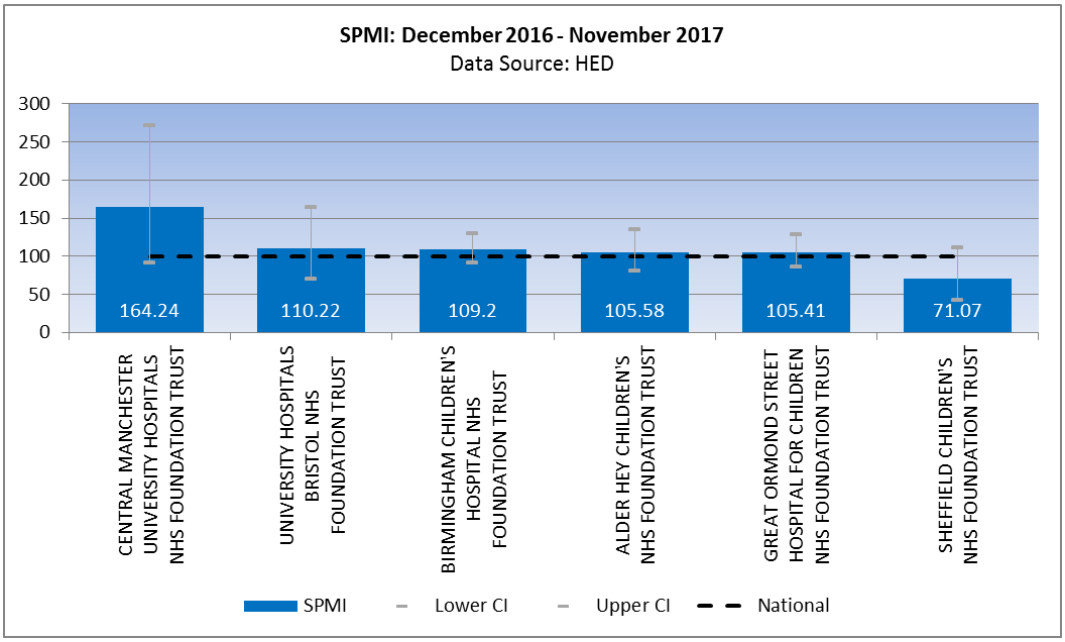


A figure of 100 means that the outcome is completely expected compared to England. A figure greater than 100 indicates the risk of the outcome is greater than expected. A figure less than 100 indicates the risk of the outcome is less than expected.

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

HED has developed a Standardised Paediatric Mortality Index (SPMI); this is a paediatric specific ratio of the observed to expected in-hospital deaths (multiplied by 100). A value of greater than 100 indicates higher mortality level than the average NHS performance, and a value of less than 100 indicates lower mortality level. The expected deaths are calculated from logistic regression models with a case-mix of: age, sex, ethnicity, trust type, emergency surgery flag, chronic condition flag, paediatric risk category,

paediatric life-limiting conditions flag and diagnosis group. Diagnosis groups where there are less than 10 death events are excluded from the model. Children up to and including the age of 15 are included. The model is available in pre-release and the most recent data available is for the period 1 December 2016 to 30th November 2017.



The chart shows that Alder Hey has a higher mortality level than the average NHS performance with 64 deaths against 60.6 expected deaths.

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

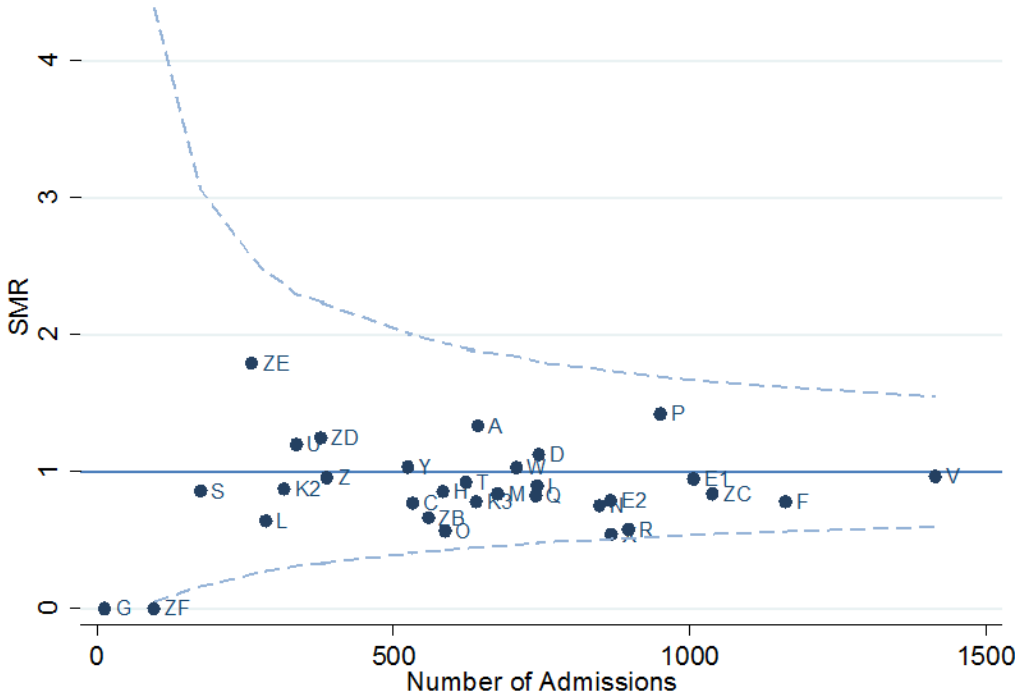
As previously reported Alder Hey benchmarks externally for PICU (http://www.picanet.org.uk/documentation.html), congenital cardiac disease http://nicor4.nicor.org.uk and oncology.

PICU

It is important to recognise that 85-90% of our deaths occur in PICU as in other children's trusts. In the most recent PICANet report (2017 Annual Report of the Paediatric Intensive Care Audit Network January 2014-December 2016), mortality is displayed in funnel plots. The Standardised Mortality Ratios (SMRs) for each organisation are plotted against the number of admissions. The risk adjusted SMR is the ratio of the observed number of deaths in the population against the expected number of deaths predicted by PIM3. Control limits are displayed on the funnel plots; variation within these limits is termed common-cause variation; variation outside of these limits is special-cause variation. Points above the upper control limit indicate higher

than normal mortality; highlighting the need for further investigation into the mortality rate.

The chart below is taken from PICANet's most recent report, and shows the PICU SMRs by organisation with 99.9% control limits, 2016: PIM3 adjusted.



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

Conclusions

The HMRG is functioning well and is continuing to adapt and improve according to national recommendations. We continue to review every in-patient death in HMRG and the majority of deaths have at least one departmental/service group review in addition.in the deaths where concerns were raised the medical director acted rapidly to support the group's requests to ensure that the learning from the RCA's was accessible.

There is clearly considerable amount of work to be done to improve the process and increase engagement and communication across the Trust. There is awareness of the limitations in our process and we are working to address them. Learning from deaths is the key goal and we are now trying to ensure that this occurs across the organisation. It will be a slow process but we are trying to establish robust processes.

The statistics relating to paediatric deaths are difficult as they are so many variables and different figures cover slightly different aspects.

The Trust that is the most comparable to AHCH is probably Birmingham children's Hospital NHS Foundation Trust and we are comparable to them with both SPMI and HSMR which is reassuring.

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

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

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

10 April 2018

Clinical Quality Assurance Committee (CQAC) – Chairs Note

1. Purpose of the Report

The purpose of this report is to update the Board on the key issues raised at the CQAC held on 21st March 2018.

2. Key Issues

The following issues were raised and discussed at the Clinical Quality Assurance Committee on 21st March 2018; the minutes of the meeting will be submitted to the May 2018 Board for noting.

- Committee **received** a comprehensive update on the progress made against the Sepsis workstream
- Committee **received** the CQC Action Plan and noted progress against actions sitting within its remit
- Committee **received** Quality Improvement Programme update on Sepsis, Outpatients, Best in Operative Care, Best in Acute Care & Best in Community Care
- Committee **received** a presentation detailing the current performance, successes, challenges faced and future improvement plans for the transition to adult services
- Committee **received** the Patient Led Assessments of the Care Environment (PLACE) assessment and associated action plan
- Committee **received** the Month 10 Corporate Report and noted performance against the quality KPIs
- Committee **received** Board Assurance Framework, and would continue to receive regular monthly updates at CQAC
- Committee **received** a verbal update on the issue relating to coeliac disease missed diagnoses within the community and assurances around actions being taken to address this matter
- Committee **received** the Clinical Quality Steering Group key issues report and notes of previous meeting, and would continue to receive regular monthly key issues report, together with notes from CQSG

3. Recommendations

It is recommended that the Board **note** the contents of the Chairs Update relating to the key issues from the Clinical Quality Assurance Committee held on 21st March 2018.

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Alder Hey Children's NHS
NHS Foundation Trust

Clinical Quality Assurance Committee
Minutes of the last meeting held on Wednesday 21st February 2018
10.00 am, Large Meeting Room, Institute in the Park

Present:	Anita Marsland	(Chair) Non-Executive Director
	Hilda Gwilliams	Chief Nurse
	Lachlan Stark	Head of Planning and Performance
	Matthew Peak	Director of Research
	Tony Rigby	Deputy Director of Risk & Governance
	Jeannie France-Hayhurst	Non-Executive Director
	Adam Bateman	Acting Chief Operating Officer
	Mark Flannagan	Director of Communications
	Joe Gibson	Programme Director
	Steve Ryan	Interim Medical Director
	Cathy Umbers	Associate Director of Nursing & Governance
	Denise Boyle	Associate Chief Nurse, Surgery
	Anne Hyson	Head of Quality - Medicine
	Adrian Hughes	Director, Medicine Division
	Christian Duncan	Director, Surgical Division
	Cath McLaughlin	Director, Community Services Division

In Attendance

David Porter	Consultant
Glenna Smith	General Manager – Medicine
Valya Weston	Associate Director Infection Prevention Control
Julie Creevy	Executive Assistant (Minutes)

17/18/115 Apologies:

Louise Shepherd	Chief Executive
John Grinnell	Director of Finance
Pauline Brown	Director of Nursing
Steve Igoe	Non-Executive Director
Erica Saunders	Director of Corporate Affairs
Melissa Swindell	Director of HR
Dame Jo Williams	Non-Executive Director
Mark Peers	Public Governor
Julie Williams	Governor
Will Weston	Associate Chief of Operations
Sarah Stephenson	Head of Quality
Cathy Wardell	Associate Chief Nurse, Medicine

17/18/116 Declaration of Interest
None declared

17/18/117 Minutes of the previous meeting held on 17th January 2018
Resolved:
CQAC approved the minutes of the previous meeting held on 17th January 2018.

17/18/118 Maters Arising and Action Log

17/18/44 – Clinical Audit for support audits within the Trust - HG stated that this action is being addressed.

17/18/78 –Learning from complaints proposal, HG indicated that that this action is being addressed.

17/18/92 – Sepsis – 'MS to address training' – this action had been actioned and is to be removed from the action log.

17/18/82 – HG confirmed that discussions had taken place with Meditech team from America and that a scheduled update would be provided at the next meeting.

Action: J Grinnell/P Young to forward meditech update to CQAC members confirming agreed timescales.

Action: Meditech update to be provided at March meeting.

17/18/100 – 'Representation at CQSG meeting' – HG confirmed that this item had been actioned and is to be removed from the action log.

17/18/106 – 'Quality metrics - Expediting a start date for K Bell' – HG confirmed that this item had been actioned and is to be removed from the action log.

17/18/106 – Quality metrics – 'Ward Accreditation agenda item for February CQAC meeting' – this item to be removed from the action log.

17/18/108 – 'Sepsis – ensuring Sepsis team are involved in any meditech issue meetings in discussion with meditech', - this item had been actioned and item to be removed.

17/18/109 CQC Action plan - 'Transitiion update' - to be provided at March CQAC meeting.

ES & PB to 'devise relevant CQC action plan - update to Committee Chairs' – verbal update to be provided at March CQAC meeting.

'CQC action plan to be refined within the outcome column' – update to be provided at next CQAC meeting.

17/18/116 – 'PLACE report & advocacy' - CQAC to receive PLACE report at its March meeting.

17/18/117 – 'PoC liaising with appropriate personnel regarding policy relating to external visitors' – POC had emailed appropriate personnel to address this issue, further update to be received from PoC at March meeting.

17/18/119 Quality Improvement Programmes 2017/Proposed Updates

J Gibson presented the Programme Assurance update, key issues as follows:-

Sepsis

CQAC noted key benefits achieved as follows:-

- Sepsis pathway roll out completed on 30th June 2017
- 100% of patients are being screened by a nurse
- Averaging between 60-80% of patients receiving intravenous antibiotics within 60 minutes of diagnosis for high risk patients.
- Robust nursing training and induction training.

Next Steps

- Mandatory eLearning package – 1st April 2018
- Community Nursing Training – 31st March 2018
- Electronic Pathway Review – To be confirmed

Key Challenges

- Accessing junior doctors for training via ESR – work continuing with Melissa Swindell, Director of HR and L&D team to address this.
- IT challenges regarding the pathway and information gathering on meditech, which the team are working on, with support received by Dr. Steve Ryan, Medical Director, John Grinnell, Director of Finance and the IT team.

CQAC acknowledged that there are still some challenges, however significant progress continued to be achieved.

Sepsis Update by D Porter:-

- Average time to administration of antibiotics – ED 65 minutes, with Inpatients – 47 minutes.
- CQAC noted that there were no nursing escalation delays.
- The numbers of patients for inpatient are lower than the Trust expected.

AM thanked DP for his update.

Exeprience in Outpatients

- Forecast for Month 9, equated to 75 decrease in PALS Concerns
- 50% increase of volume of patients in coding
- Improving 93% score in friends and family test, that patients are likely or extremely likely to recommend OPD, - rate to 98%
- 30% reduction at Month 9 on patient correspondence .
- Reduction in short term absence – 291 days at Month 9 against the target of 300

HG stated that digital support with regards to patient perspective was welcomed.

Key challenges were noted as follows:-

- Admin resource remained a challenge for the project, ideally requiring the following:-
- 1 band 3 for a 6 month period for back fill or short notice cancellations and traffic from text reminders.
- x2 fixed term 12 month to support the e-referral CQUIN (deadline April 2018, paper switch off October 2018).
- Waiting list initiatives – extra resource required to cope with increased number of WLI's.

Outpatients - CQAC noted that this workstream had made significant progress and had significant assurance.

Best in Operative Care

- Paper based emergency surgery process – ELIS operational in all specialties.
- Human factors training - 55% of staff had been trained as at end of January 2018.
- 3349 children had accessed pre-op services upto Month 9 17/18. This is on track to exceed 38% increase target for children accessing pre op services. Pre op business case by February 2018.
- As at Month 8 – zero never events.

Next Steps

- Data collection of Surgical Site Infection is planned to commence on 1.3.2018.
- Improvement in materials management service – Delivery of £150k savings by the end of March 2018.
- Annalysis and communitication of staff survey results are due March 2018.

Key challenges as follows:-

- Booking & Scheduling – lack of visibility of theatre waiting lists,

with further work planned with GDE team.

- Staff development – HR to work with theatres regarding ESR data department as information not readily available on ESR.
- Continued avoidable hospital cancellations – recovery plan required.

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Best in Acute Care

- Sepsis management – Sepsis Pathway had been completed.
- Medical model for complex Orthopaedic Patients – a joint plan had been devised and finalised.
- No Additional support for deteriorating and acutely unwell patients on the wards – a Business Case had been completed.

- A vision had been developed and presented to key stakeholders across the Trust regarding introduction of a new model to support tertiary and acute patients.

Next Steps

- Business Case to be presented to Investment Review Group, followed by presenting to Operational Delivery Board in April 2018.
- Medical Management of complex patients - new model to be introduced for Orthopaedics in April 2018.

Key challenge - regarding costs associated with the introduction of a number of these critical workstreams to improve patient safety, and recruitment of key nursing and medical posts with the required skills.

Action: AB agreed to share slides with CQAC members.

Best in Community Care

CQAC noted that this workstream will be developed during 2018/19 to include development of the community nursing service and improvements in neurodevelopmental paediatric pathways.

- 28% reduction in patient length of stay over 30 days
- Repatriation Policy had now been embedded
- Reduction in length of stay on 3C – average length of stay 7.5 in May 2018
- Melatonin prescribing changes, which had also been discussed as a quality issue at Clinical Quality & Performance meeting, as a quality issue, as this issue impacts Children & Young People. CM envisaged financial savings would not be evident until 2019. Issues around prescribing for transitional aged patients.
- Neonates
- Pathway discharge
- CQAC noted that given the Length of stay project commenced in November, significant progress had been made within 4 month period.

Next Steps

- Length of Stay – rolled out of 'My Plan' across the Trust.
- Length of Stay –key workers for patients with a LOS post 10 days.
- Length of Stay – Commence 'internal MDTs from Day 7

No key challenges to note.

AM thanked JG, together with Exec Leads for updates received. J Gibson stated that Executive focus is imperative, together with ensuring that no further slippage is experienced.

17/18/120 Refreshed Month 9 Corporate Report – Quality Metrics

Patient Safety

- There were 3 medication errors in December, which is 19 cumulatively. This remains signficiantly lower than the 44 errors in 2016/17.
- There were no never events in December, and clinical incidents resulting in harm were down from 88 reported in November 2017 to 52 in December 2017.
- There were 2 reported serious incidents requiring investigation in December, one related to an in hospital death and the other related to the Grade 3 pressure ulcer.

Patient Experience

- There were 5 complaints in month, down from 12 in November 2017.
- PALS attendances had decreased to 98 in comparison to 119 in November 2017. Total numbers of both complaints and PALS are similar to last year.
- In patient survey trends vary each month, currently performing well. AM thanked HG for the update.

Clinical Effectiveness

- Infections are down in month from 13 in November to 9 in December. There were no hospital acquired MRSA or C Diff infections in December. The numbers of hospital mortalities had decreased, compared to last year.

Corporate Report Refresh

LS presented the refreshed Corporate Report.

LS confirmed that progress continued to be made regarding the refreshed corporate report and summarised Phase 1 and Phase 2. Refreshed report had been standardised with Exec leads of Dr Ryan & Hilda Gwilliams identified leads for quality.

Timeline as follows:-

- Metrics confirmation scheduled and completed by the deadline of 24th January 2018
- Business intelligence design and build commenced from 5th February
- Style review and sign off by 21st February 2018
- Test build and parallel run scheduled from April 2018
- Communication plan

CQAC noted the significant improvement and progress currently made regarding the refreshed Corporate report which was well received by CQAC.
AM thanked LS and supporting team for continued support in refreshing the Corporate Report.

17/18/122 Getting It Right First Time (GIFT)

S Kenny presented the GIFT update for Paediatric Surgery & Urology.
Key issues as follows:-

- NHS Challenges
- Variation in healthcare
- Substantial variation in costs between acute hospitals
- GIRFT Implementation pathway during a 3 year period, with Trust supported by a national network of 7 impelemtnation teams.
- Huge variation between trusts in litigation averages with General Surgery: £17-£477, Urology: £4 - £117, Vascular: £1 – 6,353 and Obs & Gynae: £55 - £6,896.

- With lower back pain surgery costing >£100m per annum with little evidence of efficacy.
- GIFT Orthopaedic Pilot estimated impact to date include £50m savings over two year period and improved quality of care with 50,000 beds freed up annually by reduced length of stay for hip and knee operations, £4.4M estimated savings per annum from increased use of cemented hip replacements for patients aged over 65 and 75% of Trust have renegotiated the costs of implant stock and reduced use of loan kits.
- General Surgery – A total opportunity for £160M savings annually including £32m from improving enhanced recovery to shorten length of stay.
- The need to overhaul quality and capture of clinical data and overcome barriers to addressing variation. That consultant led assessments in EDs could cut admissions by 30%, improving EDs sustainability and freeing up bed capacity. Cost savings of 59% for a basket of surgical supplies.
- Specialist Trusts – variation in capabilities – with Alder Hey performing well, maternity remains an issue.

SK confirmed that clinically focussed discussions had taken place and continue to take place across 140 Trusts, with 1634 surgeons and 409 managers.

CQAC to receive further updates as appropriate.

AM thanked SK for informative update.

17/18/123 Ward Accreditation Programme

Jacqui Allen presented the Ward Accreditation Programme which was aimed at engaging staff, empowering leaders and engaging with patients and families.

Progress to date

- Assessment tool had been reviewed.
- Initial pilot assessment of inpatient wards undertaken.
- CQAC noted the awards and review schedule
- 13 wards/departments assessments had been completed, with 6 wards receiving silver, 6 bronze and 1 rated as white.
- Areas for improvements – themes were noted, together with good practice themes identified.

Next steps:-

- Revision of the assessment tool following the initial pilot.
- Procedure guidance notes for each aspect of the assessment.
- Undertake next round of assessments March – May 2018.
- Develop assessment tool for off site services/CRF and community nurses.

Action: JR to circulate presentation to Divisions, and to meet with Divisions regarding linking into Corporate Vision, as it would be beneficial to discuss at Divisional board meetings.

AM thanked JR for her update.

17/18/124 Quality Assurance Round Update

C Umbers presented the Quality Assurance round update.

- Quality Assurance rounds had been implemented across the Trust in September 2017, with 13 assurance rounds completed to date to enable a focussed review at ward/department/specialty level addressing quality, including celebrating areas of good practice, learning from improvement and any actions being taken at a local level to address areas of concern.

- Rolling 12 month programme demonstrated the plan to complete 51 assurance rounds by year end. Schedule had been disseminated Trust wide and is available on the Governance & Quality Assurance web page.
- Template used by teams to complete quality assurance round is split into CQC five key lines of enquiry and includes a section for staff to highlight what makes them proud and also identify any areas of concern.

Key themes as follows:-

- All thirteen services being very clear about vision for their service, which is aligned with the Trust vision, in terms of building a healthier future for children and their families.
- All inpatient wards hold daily safety huddles.
- All services had demonstrated a good understanding of CQC 5 key lines of enquiry, and the content of presentations demonstrated this clearly.
- All services demonstrated strong emphasis on team working.
- The management of risks is at the centre of services and good evidence demonstrated of checks and balances being in place, with the ethos of the need for continuious improvement.
- The culture across the Trust is open, honest and encourages staff to speak out about mistakes and problems.
- Many of the services had achieved national recognition because of their innovation and outstanding work.
- Strong evidence of excellent leadership across services visited, and good understanding of purpose and direction the services will be taking going forward.
- Strong emphasis on recognising staff achievements.
- Good evidence of communication via newsletters, briefings, governance meetings and safety alerts.

AM thanked CU for her update.

17/18/125 Quality Improvement Programme Plans for 2018/19

AB presented the QI approach, which had been inspired by Children, which was a clear consise plan on a page with further ongoing work to continue with approach.

AB stated that divisions are currently focusing on priorities for 2019 with 5 key priorities:-

- Brilliant booking and waiting list system – to continue to make improvements for families.
- Outaptients – to have a visible way of tracking for patients and staff regarding how often patients are seen.
- Comprehensive Mental Health – continued work regarding how the Trust influences external partners with focus on Tier 3 and Tier 4, requires governance and support. CM currently producing supporting paper.
- Best in Operative Care
- Models of Care – changes required regarding patients between General Paeds and Specailty Teams – development of teams for these children and redefining current teams around these children
- Patient Flow – with significant work progressed regarding flow.

Each initiative to have a workstream within the Programme.

Action: CQAC to receive further update at April 2018 meeting.

AM thanked AB for his update.

17/18/127 CQC Action Plan and Update

HG presented the CQC action plan. HG stated that all actions had been completed and action plan contained embedded evidence.

AM thanked HG for her update.

17/18/128 CQC 2016 Children & Young People Inpatient and Day-case survey

HG stated that positive feedback had been received, - the Trust had received 34,708 completed questionnaires – a response rate of 26%. and had been placed in the Trusts achieving 'better than expected results' bracket.

Action plan to be developed, and would be presented at April CQAC meeting with dedicated time to fully review this item further.

Action: Action plan to be received at April CQAC meeting.

AM thanked HG for her update.

17/18/129 Quarter 3 Complaints Report

A Hyson presented the Q3 Complaints Report.

- Trust received 27 formal complaints during this period. This was an increase compared to 2016/17.
- Main category received is jointly shared between 'Treatment/procedure' – 41% and 'Communication/Consent'–41%.Other category is Access/Admission/Transfer/ Dischargeat 18%.
- 14 complaints were upheld within this quarter and 2 were upheld. 1 complaint was partially upheld and 9 complaints are still ongoing.
- Upheld complaints from July 2016 are uploaded onto Trust external facing web page.
- PHSO – one complaint under review.
- In Q3 2017-2018 PALS contact had remained static at 311 contacts (Q2 -309). With a new process to be developed.
- Compliments are now recorded on the Ulysses system and shared with relevant teams.

Action: AH to update CQAC at next Complaints update re local changes.

AM thanked AH for her update.

17/18/129 Quarter 3 Infection Control Report

V Weston presented the Quarter 3 report.
Total number of acquired bacteraemia for Quarter 3

- MRSA – 2 (PICU, 3C)
- MSSA – 4 (3C, 2x3B, 4B)
- E-coli – 2 (1C, 3C)
- Klebsiella – 4 (3A, PICU, 2x4B)
- Pseudomonas – 1 –(PICU)
- Outbreaks – 3
- November – A measles outbreak, 16 cases identified from the community. 1 hospital acquired case (staff member).
- Norovirus outbreak on Ward 4A, 19 patients and 11 staff affected (no specimen communication), lessons learned for future, with staff requiring praise for expert management in deep cleaning of the ward.
- Norovirus outbreak on Ward 4B with 13 patients affected and 14 staff members. Ward closed from 13-18th December 2017. (2 patients were laboratory confirmed cases).
- At the beginning of October 2017 a new objective was added regarding Gram negative bacteraemia, therefore taking the number of deliverables to 82.

- IPC Doctor – Consultant Microbiologist – Advert had been actioned, disseminated and shortlisting is envisaged at the end of March 2018.

CQAC received and noted the IPC workplan.

AM thanked VW for her update and welcomed a deep dive of IPC and requested update at May 2018 CQAC meeting. CQAC acknowledged the signicant improvements within the IPC workplan and thanked VW and her team for continued improvements.

Action: IPC Deep dive – update for May 2018 meeting

17/18/130 6 Monthly Clinical Claims Report

Michelle Perrigo presented the Clinical Claims Report.

- The Trust held an event on 23rd January 2018 were staff were invited to meet with and hear presentations about the work of NHSR and to learn how clinical claims link with patient safety.
- Since the last Clinical Claims report, 2 lessons learnt from clinical claims templates had been completed, one of which was presented to CQSG, the other being shared at Divisional Governance meetings. A lessons learnt from clinical claims and inquests action log had been introduced and would be further developed in response to feedback.
- In December 2017 the Trust received contribution notice from NHS Resolution regarding overall rise in CNST contributions for Trusts.
- Majority of claims (67.8%) of claims were resolved without formal proceedings with less than 1% going to trial.

1.10.2016-31.3.2017:-

- 7 new clinical claims,
- 22, requests for records for potential clinical negligence claims,
- 42 ongoing claims registered with NHSLA
- 9 closed clinical claims

1.4.2017 – 30.9.2017:-

- 9 new clinical claims
- 47 requests for records for potential clinical negligence claims
- 46 ongoing claims registered with NHSLA
- 4 closed clinical claims

The Trust received 3 sets of proceedings for cases were Letters of Claim andResponses had previously been sent. One of these (catheter migrated into patients bowel) went to trial in November with staff from the Trust providing evidence. The case was dismissed at trial and the judge ordered the CSOL pay the defendents costs of the action.

The Trust had also participated in its first claims mediation meeting to resolve the claim and reach agreement on the damages to be paid.

AM thanked MP for her update.

17/18/140 2017 National Staff Survey results

M Flannagan presented the staff survey results.

- CQAC noted 11% increase compared to previous survey results.

- 64% of responses would recommend Alder Hey as a place to work.
- There are also a number of areas whereby improvements hadn't been demonstrated - work related stress.

Further ongoing discussions would take place during March/April to address issues.

AM thanked MF for his update.

17/18/141 MHRA Update

MP stated that the MHRA report had been received and the Trust had submitted its response in a timely manner. No critical findings had been reported, with 3 major findings and a number of minor additional findings.

MP stated that CQAC members would be provided with a further update, sharing any remedial actions, together with update on actions, once further information is received from MHRA.

Action: CQAC to receive further update once received by MHRA.

AM thanked MP for his update.

17/18/142 Board Assurance Framework

HG stated that Risk is regarding Building Strong Foundations which is incoropated into the financial plan which had been shared with NHSI.
No significant change to note.

AM thanked HG for her update.

17/18/143 CQSG key issues report

CU presented the CQSG key issues report.

- Challenges raised regarding SIRI action log and lessons learned had made significant improvements with 95% completion of outstanding actions.
- Safeguarding – reasonable assurance demonstrated in Q2 – 83% compliance with prevent training against the Trust target of 90%.
  CQAC received and noted CQSG key issues report, and thanked CQSG committee members for continued support.

17/18/125 Date and Time of Next meeting -

10.00 am – Wednesday 21st March 2018, Large meeting room, Institute in the Park.

Alder Hey Children's NHS
NHS Foundation Trust

INTEGRATED GOVERNANCE COMMITTEE
Meeting date: 16th February 2018
Time: 10:00-12:00
Venue: room 14 Level 2

Next meeting to be held on 14th March 2018
Venue: Institute Large Meeting room, time 13:00

Present:	Mr S Igoe	Non-Executive Director**(Chair)**	(SI)
In Attendance:	Mr A Bateman	Chief of Operations	(AB)
	Ms E Saunders	Director of Corporate Affairs	(ES)
	Mrs M Swindell	Director of HR & OD	(MS)
	Mrs A Chew	Head of Operational Finance	(AC)
	S Stephenson	Head of Quality (Community)	(SS)
	Mrs C Wardell	Assoc. Chief Nurse (Medicine)	(CW)
	Mrs A Kinsella	Health & Safety Manager	(AK)
	Mrs E Menarry	EP and Business Continuity Manager	(EM)
	Miss L Calder	Quality Assurance Facilitator *(minutes)*	(LC)
	Mrs C Umbers	Assoc. Dir. Nursing & Governance	(CU)
	Mr T Rigby	Deputy Dir. of Risk & Governance	(TR)
	Mrs J Keward	Infection Control Nurse	(JK)
	Mrs S Brown	Assoc. Dir. (Development)	(SB)
	Mrs P Brown	Director of Nursing	(PB)
	L Fearnehough	Head of Technical Services	(LF)
	Miss J Preece	Governance Manager	(JP)
	Mrs L Robinson	Quality Assurance & Compliance Manager (Med)	(LR)
	Mr A McColl	Assoc. Chief of Operations	(AM)
	Ms K Morgan	Deputy Head of Information	(KM
	Mrs A Turton	Head of Acute Care	(AT)
	Mrs L Edwards	Quality Assurance Manager	(LE)
	Mr G Dixon	Operational Lead (Building Services)	(GD)
	Mr M Devereaux	Head of Facilities and Soft Service	(MD)
	Mrs C Barker	Chief Pharmacist	(CB)
	Ms C Orton	Assoc. Chief Operating Officer (Research)	(CO)
	Mrs D Boyle	Assoc. Chief Nurse (Surgery)	(DB)
	Mrs J Hutfield	Compliance, Risk and Contracts Manager	(JH)
	Jo Noblet	Clinical Lead EPRR/ED Sister	(JN)

Apologies:	Mr D Powell	Development Director	(DP)
	Mrs A Hyson	Head of Quality (Medicine)	(AH)
	Mr W Weston	Assoc. Chief of Operations (Medicine)	(AB)
	Mr J Grinnell	Director of Finance	(JG)
	Mr S Ryan	Medical Director	(SR)
	Ms L Baker	Information Governance Manager	(LB)
	Mr A Williams	Director of CAMHS	(AW)
	Mrs H Gwilliams	Chief Nurse	(HG)
	Ms J Gwilliams	Clinical Risk Manager	(JG)
	Mrs D Walker	Pharmacy	(DW)
	Mrs R Greer	Assoc. Chief of Operations(Community)	(RG)

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
Housekeeping						
	1.	**Apologies for absence**	Noted			
17/18/85	**2.**	**Minutes of previous Meeting**	The Committee considered the minutes of the previous meeting of the Integrated Governance Committee held on 16th February 2018. The Committee **APPROVED** the minutes as a correct record.			
	2.2	**Action list**	**Resolved** that: the Committee agreed all actions from 10th January 2018.The IGC Terms of Reference were approved by the committee.		SI/CU	
	3.	**Risk Register Management Reviews**				
17/18/86	**3.1**	**Surgery Division**	Andy McColl (AM) presented the risk management report for Surgery. AM focused on the high risks (corporate) from the Surgical Division for this reporting period. **Part 1** Risks from the Surgical Divisions report were highlighted as follows: • Total number of risks = 80 • Number of new risks identified since the last reporting period		AM	

			= 4 • Number of risks closed and removed from the risk register =18 • Number of risks with an overdue review date = 2 • Number of risks with no agreed action plan = 8 • Number of high/extreme risks escalated to the Executive Team = 3 AM advised there has been a reduction in the surgical division moderate risks from 51% of all risks to 43.75% compared to the last reporting period. There are 3 high risks with a score of 15: 1306 – Concerns around junior doctor's shortages in surgery has been reduced from a risk score of 15 to 12. Risk 1276 – Medical Equipment Replacement strategy – This is not an immediate risk. This will be picked up via the business planning round. SR is to attend the meeting next week to discuss mitigation. Risk 964 – planning and scheduling of elective lists is not sufficiently robust to prevent errors occurring. It still remains a risk as to how quickly meditech changes can be made but GDE business team are fully supportive. There is a business case for pre-op surgery due to be presented in February 2018, if passed this will allow the risk to be reduced. Risk 424 – risk of transmission of vCJD – Implementation of risk reduction measures date has been pushed back to April 2018, to ensure all correct equipment is in place and the remaining equipment has been purchased. SI suggested to pick this up outside of IGC. The reporting period showed 8 risks without an action plan in place, however as of this week there is only 1 outstanding risk without an action plan and this will be addressed. **Part 2: Best in operative care:** There are 4 risks which have been consolidated into 1 risk.	Action – risk 424 to be picked up outside of IGC		Immediate

			AM advised the committee that although there is ongoing work required, the division are comfortable with the progress, and expect further work to be completed prior to the next reporting period. Issues identified in terms of process management are expected to be resolved by the next IGC meeting. **Resolved** that: the Committee NOTED the contents of the paper			
17/18/87	**3.2**	**Medical Division**	Cathy Wardell (CW) presented the risk management report for Medicine. Risks from the report were highlighted as follows: • Total number of risks = 137 • Number of new risks identified since the last reporting period = 7 • Number of risks closed and removed from the risk register = 14 • Number of risks with an overdue review date = 24 (18%) as from today 16th Feb this is down to 2% • Number of risks with no agreed action plan = 21 • Number of high/extreme risks escalated to the Executive Team = 6 CW focused on the high risks from the Medical Division for this reporting period. Risk 865 – Limitations of Meditech 6 EPMA System – downtime MAR chart is less clear compared to the electronic MAR chart. Every month the downtime in Meditech 6 we are exposed to this risk. CB to look at printing off the electronic copy to use for the downtime. The Task & finish group dose checking is ready to be piloted. There is a lack of resilience from pharmacy. Meditech 6 to help alert when doses are incorrect. CB needs clarification from Martin Levine (IM&T) as to the printers being networked to the infrastructure both on and off site clinics. SI has suggested for this risk to be picked up outside of IGC and JG to lead on addressing.	Action - risk 865 to be picked up outside of IGC and JG to lead on addressing	WW/CW	Immediate

			CW advised the committee that the Medical Division are satisfied with progress, while recognising that ongoing work is required to enable assurance of effective management of risk across the division. **Resolved** that: the Committee NOTED the contents of the paper			
17/18/88	**3.3**	**Community Division**	SS presented the risk management report for Community. Risks from the report were highlighted as follows: • Total number of risks = 50 • Number of new risks identified since the last reporting period = 10 • Number of risks closed and removed from the risk register = 3 • Number of risks with an overdue review date = 1 • Number of risks with no agreed action plan = 3 • Number of high/extreme risks escalated to the Executive Team = 5 • Changes in the risk profile or categories of risk being reported that need to be brought to the attention of the Integrate Governance Committee = 0 SS presented the risk management report and focused on the high risks (corporate) identified for community. Risk 1534 – Harm to child due to staff not reviewing safeguarding information held on the CCI flag due to overuse of the flag. There is a local SOP in place for management of uploading local authority notifications of child protection plans, open and closed and 'looked after child status'. Risk 1466 – Single handed Dietetic Service(s) for both Sefton & Liverpool transferred from LCH. Business continuity proposal across Liverpool and Sefton is being developed and a fixed term post is currently out to recruitment. Risk 1542 – Clinical risk due to no agreed plan of roles and		RG/SS	

			responsibilities of health professionals and school staff in a medical emergency in special schools. Senior nurses from Alder Hey to assist the physio manager in developing a plan to define roles and responsibilities in an emergency situation. SS presented the corporate risks reduced on the risk register: 803 – Limited assurance regarding waiting time information in CAMHS / Neurodevelopmental Paediatrics as information not easily available to support monitoring requirements. Reduced from corporate risk due to improvements made to meditech and BI reporting. 902 - Inadequate connectivity in community sites and outreach venues for clinicians to view patient records electronically. Reduced due to work of community sub group and roll out of devices. 1157- Community Division ability to achieve financial balance during 2017/18 and identify achievable Cost Improvement Plan. Reduced from corporate risk based on updated financial proposals e.g. physio led community rehab for patients undergoing spinal surgery SS expressed her concern around corporate risk 952 that originally sat with Mags Barnaby and now under Adam Bateman. ES advised to have a resolution of ownership outside of IGC. (Adam Bateman is the risk owner) SS advised the committee that the division are confident they are keeping on top of all risks in terms of effective management. **Resolved** that: the Committee NOTED the contents of the paper	Action SS, AB, CU to resolve who the owner is		Immediate
17/18/89	**3.4**	**Infection Control Service**	JK presented the risk management report for Infection Prevention Control. Risks from the report were highlighted as follows: • Total number of risks = 17 • Number of new risks identified since the last reporting period		VW/JK	

			(25/10 - 18/12) = 1 • Number of risks closed and removed from the risk register = 0 • Number of risks with an overdue review date = 2 • Number of risks with no agreed action plan = 0 • Number of high/extreme risks escalated to the Executive Team = 0 • Changes in the risk profile or categories of risk being reported that need to be brought to the attention of the Integrate Governance Committee = 0 • VW presented the risk management report and focused on the high risks (corporate) identified for Infection Control. Risk 1394 – Awaiting appointment of Infection Control Doctor – No microbiologist appointed hence regroup with relevant stakeholders to look at alternatives to straightforward Alder Hey appointment e.g. partnership approach. Risk 640 – Risk of Hospital acquired Pseudomonas due to Pseudomonas in the water supply. This is being managed through the Trust water safety group. There is also a SOP for cleaning sinks, water sampling in patient areas and labelling of sinks. Risk 1439 – Risk of long stay patients acquiring vaccine preventable diseases. There have been conversations with NHSE and I.T. Systems across the Northwest. It has been difficult to acquire patient vaccine information held by GP's and there isn't a central place where the information is held. VW and team to carry on working on this to resolve. 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			

17/18/90	**3.5**	**Facilities**	MD presented the risk management report for Facilities. Risks from the report were highlighted as follows: Total no of risks 6, new risks since last report 0, risk closed and removed 1, risks overdue 0, no of risks with no agreed action plan 0, high risks need escalating to execs for their support 0 (high risks). Risk 1514 - Bleeps have now been moved to I.T risks. All the risks for facilities are showing low or moderate and all have action plans in place. MD advised the committee that although there is ongoing work required, Facilities are satisfied with the progress at this point.		MD	
17/18/91	**3.6**	**IM&T**	LF presented the risk management report for IM&T. Risks from the report were highlighted as follows: Total no of risks 24, new risks since last report 2, risk closed and removed 0, risks overdue 2, number of risks with no agreed action plan 0, high risks need escalating to execs for their support 1 (high risks -corporate). Risk 1514 – This risk has been updated due to a number of incidents regarding failed Emergency Bleep calls. There is a telephony task and finish group set up as well as 'speak Easy' task and finish group established in order to validate a baseline of current communication systems and any gaps or risks associated with them and action plans in place associated with trying to resolve/mitigate these. LF 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		PY/LF	
17/18/92	**3.7**	**HR**	MS presented the risk management report for HR. Risks from the		MS	

			report were highlighted as follows: Total no of risks 8, new risks since last report 0, risk closed and removed 5, risks overdue 0, no of risks with no agreed action plan 0, high risks need escalating to execs for their support 0 (high risks). MS advised the committee that HR have done a lot of work on their risks through a deep cleanse on the risk register and Human Resources are satisfied this reflects their current position. **Resolved** that: the Committee NOTED the contents of the paper			
17/18/93	**3.8**	**Finance**	JG presented the risk management report for Finance. Risks from the report were highlighted as follows: There are 7 risks identified on the finance risk register. 0 new risks since last report 0, risk closed and removed 0, risks overdue 0, no of risks with no agreed action plan 0, high risks need escalating to execs for their support 0 (high risks). Risk 1082 – Reassessed by manager as current risk rating 6. Risk 386 - Reassessed by manager as current risk rating 9. Risk1168 - Reassessed by manager as current risk rating 6. JG advised the committee that Finance hope to close the Capita Management risk. There are no risks overdue, and no risk with an agreed action plan. CU advised the committee if any risks have been closed or downgraded it would be good to show on your Risk Management Report. SI also advised this would be good to have on the report and he will discuss with CU. JG advised the committee that the Finance department are satisfied with the progress at this point.	CU/SI to discuss section on RMR of closed or downgraded risks	JG	Immediate

			Resolved that: the Committee NOTED the contents of the paper			
17/18/94	**3.9**	**Estates**	JH presented the risk management report for **Estates**. Risks from the report are highlighted as follows: Total no of risks 26, new risks since last report 0, risk closed and removed 1, risks overdue 0, no of risks with no agreed action plan 0, high risks need escalating to execs for their support 0 (high risks). Risk 1529 – Alarm panel showing disablement Risk 1530 – Maintenance Records inaccurate and lacking in detail. Risk 1549 – Flammable store in very close proximity to the medical gas storage (Helium, Nitrogen and CO2) and the liquid o2 storage units. Risk 1409 – Fire breaks glass - New Hospital. This is currently sitting at 16 on the risk register as we are non-compliant and cannot take off the register until Interserve confirm remedial work has been completed. The fire safety officer is awaiting confirmation from Interserve that the identified risk has had remedial works carried out to eradicate the risk and once confirmed can be closed. JH advised the committee that the Estates department are satisfied with the progress at this point. **Resolved** that: the Committee NOTED the contents of the paper SB presented the risk management report for **Building Services**. Risks from the report were highlighted as follows: Risks on register for Building services. There are 11 risks identified - new risks since last report 0, risk closed and removed 0, risks overdue 0, no of risks with no agreed action plan 0, high risks need escalating to execs for their support 2		DP/JW/SB	

			(high risks).			
17/18/95		**Building Services**	Risk 825 – Internal Balconies. The horizontal handrail there facilitates climbing thus resulting in the risk of a potential fall from the balcony. There was a near miss with patient escaping via the wall. AK advised this is a major piece of work to complete and will cost in the region of £1 million. Awaiting on the quote from the external representative and once received will forward to the Executive Directors. MS advised the committee she has met up with GD, DP & JG to discuss the risk with the balconies. We have explored all options and this contractual solution is the only way forward. We have recognised the risk and mitigations are in place. This cannot be downgraded from a 15 until work complete as this could be catastrophic when we have patients/young people in the Trust with challenging behaviour. CDM and the design to be reviewed by an external Health & Safety representative and we will translate into a plan and provide solutions around cost. SI has advised there needs to be a solution to this by the next IGC on 16th February 2018. Risk 640 – Risk of hospital acquired infection due to Pseudomonas in water supply in the child health park SB advised the committee that although there is ongoing work required, Building Services are satisfied with the progress at this point. **Resolved** that: the Committee NOTED the contents of the paper			
17/18/96		**Directorate Projects**	SB presented the risk management report for **Development Directorate Projects** and advised that this is the first report submitted by the Development Directorate in line with the revised format. Risks from the report were highlighted as follows:			

			Risks on register for Development Directorate. There are 26 risks identified - new risks since last report 3, risk closed and removed 1, risks overdue 0, no of risks with no agreed action plan 2 (team to address), high risks need escalating to execs for their support 4 (high risks). Risk 1259 - Public reaction to outline planning submission for residential. Agreed mitigation is to widen local communication and media connections. Risk 1257 - Insufficient income from sales of land to meet trust requirements, as we may not get the increment that we hoped for from the sale. Agreed action is for the land to be independently assessed for a sale price. Options are under consideration in partnership with LCC. Risk 1244 - Public and local MP/Councillor reaction to planning submission for residential. We are working closely with a local residents group 'The friends of Springfield Park'. Through media connections and local community contacts we ensure there is a communication plan working with the communications dept. Risk 1245 - Planning objection to residential Scheme may effect contributions to the maintenance of the park. We are liaising with MP councillors and involved in talks on the residential housing development. There is also a need for further engagement with local residents. SB advised the committee that all 4 high risks will remain high for future months as all interconnected to site development and planning permission. SB advised the committee that even though ongoing work to complete the Development Directorate are satisfied with the progress at this point. **Resolved** that: the Committee NOTED the contents of the paper			

17/18/97	**3.10**	**Health & Safety**	AK presented the risk management report for Health & Safety. Risks from the report were highlighted as follows: Total no of risks 12, new risks since last report 0, risk closed and removed 0, risks overdue 0, no of risks with no agreed action plan 0, high risks need escalating to execs for their support 3 (high risks). Risk 795 – Water Safety Compliance within CHP. Water Safety Group are currently considering the commission of a baseline sampling across clinical areas in order to identify a full picture of legionella contamination, in view of recent positive samples. JG asked is there anything formal on this? AK advised all systems were signed off but we never got a baseline on this. The risk profile has changed as the control measures are not working. There is a baseline meeting this week to look at areas to sample in the trust. The focus will be clinical areas initially. Risk 1544 – Identified pipework leakage from the following: Low temperature hot water, chilled water and ground source heat pump. There is a sampling project currently being commissioned via HCP(SPV) which will removed sections of 36 pipes from identified areas, which will then be analysed to incorporate 3 investigation streams. Engineering in order to determine whether there is an underlying issue with the building systems to assess inadequacies within the system, water quality to determine whether there is underlying issue with chemical or microbiology constituents of the water and metallurgical in order that the constituents of corrosion can be determined. AK advised all samples will have been taken by May/June 2018 and we will have an idea of the extent of corrosion from there. GD advised the conditions between zone 1 and the ground source are different as ground source the pipework is made from pressed steel and the pipework is not the same working higher up the levels of the CHP. This is a complex piece of work and could have the same problems in future if not dealt with correctly. AK Advised the frequency of leaks have progressed and we are looking at 3 streams of water to be investigated by the contractors.		MS	

			AK advised the committee that Health & Safety are satisfied with the progress at this point. **Resolved** that: the Committee NOTED the contents of the paper			
17/18/98	**3.11**	**Business Preparedness & Associated reports**	Preparedness & Associated reports. Risks from the report were highlighted as follows: Total no of risks 13, new risks since last report 1, risk closed and removed 1, risks overdue 0, no of risks with no agreed action plan 0, high risks need escalating to execs for their support 0 (high risks). EM updated the committee of a new risk and two risks that were removed from the risk register. Risk 1438 – Telecommunication gaps have the potential to delay major incident response and since February 218, reduced mobile phone signal in the Trust. The mobile phone signal in the Trust has been adversely affected due to external issue outside of the trust's control. The Chief Operating Officer Adam Bateman is aware of this issue and has set up a 3 x weekly Task & Finish Group to identify and implement solutions. Risk 1151 – Exercise Black Start (generator test) – the generator test was successfully completed on 6th February 2018. A debrief meeting was held on the same day with local learning identified. A meeting will be organised to complete actions from the lessons learnt then the risk can be closed. This exercise will take place annually. Risk 1376 – Decontamination Training. Joanne Noblet, Clinical Lead EPRR/AD Sister advised the committee that the study days have been rolled out. To date 5 study days have been held with a total of 22 staff members attended. On average there have been 4 members of staff attend each training day (20% plus staff trained). If we were to have a mass casualty we would not be compliant. This was raised at the Emergency Preparedness Group for this committee to endorse and CW will promote through the Divisions to encourage staff attendance at the training. EM is satisfied with management of risks on register in this area.		MS	

			Resolved that: the Committee NOTED the contents of the paper			
17/18/99	**3.12**	**Information Governance**	ES presented the risk management report for Information Governance. Risks from the report were highlighted as follows: Total no of risks 8, new risks since last report 0, risk closed and removed 1, risks overdue 0, no of risks with no agreed action plan 0, high risks need escalating to execs for their support 0 (high risks). Risk 381 closed Feb 2018 – Mechanisms and procedures now exist to ensure information is sent securely and are satisfied sufficiently robust. Failure to use these would mean non-compliance with Trusts policy which is a risk in its own right. Risk 1286 – Lack of planning by areas in relation to risk records in retained estate archive rooms may lead to financially inefficient methods of storing of records. ES is confident that all risks have controls in place and is happy content with the current position. **Resolved** that: the Committee NOTED the contents of the paper		ES	
17/18/100		**Medicines Management & Pharmacy**	CB presented the risk management report for Medicines Management & Pharmacy. Risks from the report were highlighted as follows: Total no of risks 37, new risks since last report 3, risk closed and removed 4, risks overdue 3, no of risks with no agreed action plan 0, high risks need escalating to execs for their support 1 (high risks). Risk 1344 – Pharmacy cold store. There has been no back up cold store refrigeration. Pharmacy had 2 cold stores in the design of CHP, one being classed as the back-up refrigeration, however both are in use. There have been 2 cold store failures resulting in a significant financial loss to the trust. An application to Capital planning group is in progress. CU advised this will remain a risk until the back-up refrigeration is installed.		CB	

			CB advised the committee that the outpatient hatch maintenance work has now been complete with a special thank you to GD and team. CB advised Medicines management & Pharmacy has a number of residual risks. CU suggested discussing these risks with CB outside of IGC. **Resolved** that: the Committee NOTED the contents of the paper	Action - CB/CU to meet to discuss residual risks		Immediate
17/18/101		**Global Digital Excellence Programme**	KM presented the risk management report for Global Digital Excellence Programme reports. Risks from the report were highlighted as follows: Total no of risks 13, new risks since last report 0, risk closed and removed 2, risks overdue 0, no of risks with no agreed action plan 2 (mitigations in place), high risks need escalating to execs for their support 0 (high risks). KM advised the committee that GDE have reduced 3 risk, 11 have action plans in place. KM also informed the committee that GDE report regularly to NHS Digital. KM advised the committee GDE have no risks above moderate risk and is happy with management of risks on register in this area. **Resolved** that: the Committee NOTED the contents of the paper		KM	
17/18/102		**Clinical Research Division**	Charlie Orton (CO) presented the risk management report for Clinical Research reports. Risks from the report were highlighted as follows: Total no of risks 6, new risks since last report 0, risk closed and removed 0, risks overdue 0, no of risks with no agreed action plan 0 (mitigations in place), high risks need escalating to execs for their support 0 (high risks). Changes in risk profile or categories of risk being reported that need to be brought to attention of IGC = 3 CO advised the committee that Clinical Research have 3 high risks			

			and are highlighted as follows: Risk 59 – Slow Growth in commercially funded research: There is a lack of commercial income to fund staff salaries, infrastructure costs and further investment in staff and contribution to Trust CIP. Potential failure of national performance management metrics. The financial model is unable to invest money into this. This is corporate level and has been an ongoing issue for some time. Risk 72 – Research capacity of clinical staff and consultant PA's. The research division offer 70 consultants support in research. Steve Ryan, Medical Director is very supportive of clinical research. We have the inability to further develop and support academic work. The cause is an inability to reinvest research income into posts which will increase capacity to deliver and design research studies, in particular, commercial research to develop and invest in future research. Research volume is a key indicator of the CQC monitoring of research in trusts, which will come into force in 2018. Therefore enabling consultants to contribute to research delivery is under scrutiny from CQC. Risk 51 – Research medical records. Scanning and/or keeping records this was a poorly run project and records were destroyed. Since 2016 it is a legal requirement that the Trust cannot destroy documentation. Risk 59 and risk 72 should these be scored at the current score of 16? SI advised the research report was helpful and the scoring gives quantitative assumptions. We need to look at these as timelines that are outstanding for research in the Trust. These two risks are high but not in the context of harm to patients. It would be helpful to have a multi Trust view of these risks. MS advised it would be a good idea to have a meeting to look at this and MS has offered her support. CO expressed the support would help to get Research risks managed and in line with the Trusts risks. ES advised there is an element of mediation around this matter and would be good to get a meeting in the diary and AB to be involved in this meeting. All services around research are clinical and these risks should be reviewed and looked at within the next week. **Resolved** that: the Committee NOTED the contents of the paper	Action CO to set up a meeting with MS/AB		Immediate

17/18/103	**4.**	**Corporate Risk Register Review**	CU presented the Corporate Risk Register Review. CU informed the committee that there are 551 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 551 compared to 584 for the previous reporting period. 42 (7.62%) of the Trusts risks are rated as' High/Extreme' risks compared to 69 (11.8%) for the previous reporting period. (Corporate risk register) 356 (64.6%) of the Trusts risks are rated as 'Moderate', compared to 379 (64.9%) for the previous reporting period, of which 159 (28.85%) risk rated 12 (high moderate) compared to 185 (31.85%) risk rated 12 for the previous reporting period. 124 (22.50%) of the Trust risks rated are as 'low risk' compared to for the 108 (18.5%) previous reporting period. 25 (4.53%) of the Trust risks rated as 'very low risk' compared to 21 (3.5%) for the previous reporting period. 269 (46.06%) risk assessments have an overdue review date compared to 268 (47%) for the last reporting period. All 42 high/extreme risks that have been escalated to the CRR; 6 (14.28%) in the Medical Division, 2 (4.76%) in the Surgical Division. 5 (11.90%) in Community services. 3 (7.14%) in Research Division. 26 (61.90%) in Corporate Services. **Assurance Concerns** 87 (15.79%) risk assessments past expected review date 105 (17.71%) risks do **not** have controls. 76 (13.79%) risks do **not** have actions. 500 (60.75%) **overdue** actions (total open actions = 823)		CU	

			CU advised in summary the committee need to be mindful of risks rated high or extreme. We all have responsibility to regularly check these are rated at correct score and that they are being managed effectively in terms of actions and mitigations. However CU advised we are heading in the right direction in terms of managing risks. CU advised of the assurance concerns, as clearly staff are reviewing the risks, but the high number of actions that appear to be past their review date would suggest otherwise. CU also brought to the committee's attention that it would appear from a random sample review that staff are writing their updates into the action section of the risk assessment form and adding in the due date on the date of the review and this is causing the data to show a higher number of overdue actions than there actually is. Work is currently progressing to improve the format of the risk assessment form to make it more user friendly for staff. CU advised she is happy to meet staff to provide additional risk management/register training sessions as required. SB advised she would like to meet for guidance. **Resolved** that: the Committee NOTED the contents of the paper	Action – CU/SB to meet for guidance on completing risks		Immediate
17/18/104	**5.**	**Board Assurance Framework (BAF)**	ES presented the Board Assurance Framework. ES advised going forward if anyone has any thoughts/ideas into strategic plan to speak to ES or Jill Preece. We need to feel we have the right level of risks for the Trust. ES asked for committee members to look at BAF risks and if any changes to let ES know. **Resolved** that: the Committee NOTED the contents of the paper	Action - committee members to update ES of any changes required on BAF report	ES	Immediate
	7.	**Policies**				
17/18/105		AH Anti-Fraud Policy	ES presented the AH Anti-Fraud Policy. ES advised the committee this policy was approved in July 2017, however the title/name on the policy has now changed. SI asked the committee are they happy with the changes to the policy? All			

			committee agreed. **Resolved** that: the Committee RATIFIED the Anti-Fraud Policy			
	8.	**Ad Hoc Reports**				
17/18/106	**9.**	**CQC Plan**	ES presented the CQC Plan. ES talked the committee through the content of the CQC Plan. ES asked for leads to run through hefty areas on the plan to ensure completion of target dates. Abduction risk – There is some mitigation there and ES asked committee members to comment on where we go to with this? Lone Working – There are lone working issues in community and divisions are working on this. There is a robust policy in place. Confidentiality – There has been a spot check by LB and there needs to be a focus on the rest of the Trust. SI advised this will be a standing item on the agenda until this piece of work is completed.	Action - leads to check plan target dates are completed Action - CQC Plan a standing item on agenda		Immediate Immediate
	10.	**Any other business**				
Date and Time of Next Meeting			The next meeting of the IGC will be held on Wednesday 14th March 2018, 1:00pm. Institute Large Meeting Room .			

INTEGRATED GOVERNANCE COMMITTEE
ACTION LIST – February 2018

No	Item	Owner	When	Status
17/18/44	Align ESR with Local Blood Transfusion Training Figures	M Swindell	14th March 2018	MS to update the IGC Meeting on 14th March IGC. SI has asked can a sheet of A4 be produced to action matters arising to complete this piece of work.
17/18/86	Risk of transmission of vCJD	A McColl	Immediate	AM to pick risk 424 outside of IGC
17/18/87	Limitations of Meditech 6 EPA System	C Wardell	Immediate	CW to pick risk 865 outside of IGC and JG to lead on
17/18/88	Resolution of ownership of risk 952	S Stephenson	Immediate	Resolution of ownership outside of IGC. SS, AB and CU.
17/18/93	Closed or downgraded risks included on risk report	C Umbers/S Igoe	Immediate	CU/SI to discuss section on risk management report
17/18/100	Residual risks	C Barker	Immediate	CU and CB to discuss residual risks outside of IGC
17/18/102	Risks 51, 59 and 72	C Orton	Immediate	CO to set up a meeting with MS/AB
17/18/103	Guidance on risk management	CU	Immediate	CU to meet SB to offer guidance on completing risks. **Actioned**
17/18/104	BAF report/strategic plan	E Saunders	Immediate	Committee members to update ES of any changes required on the BAF report
17/18/106	CQC Plan CQC plan target date	E Saunders	Immediate	LC to include the CQ Plan as a standing item on IGC Agenda. **Actioned** Leads to check plan target dates are completed

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Tuesday 10th April 2018

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

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1. Background:

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

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

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

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

2. SIRI performance data:

	SIRI (General)										
	2017/18										
Month	**Apr**	**May**	**Jun**	**July**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**
New	3	1	2	4	0	2	0	1	2	4	0
Open	2	4	4	6	8	5	3	1	1	3	3
Closed	2	1	0	1	2	3	4	2	1	0	4
Safeguarding											
Month	**Apr**	**May**	**Jun**	**July**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**
New	0	0	0	1	0	0	0	0	0	0	0
Open	0	0	0	0	0	0	0	0	0	0	0
Closed	0	0	0	0	0	0	0	0	0	0	0
Total closed	**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 01/02/2018 to 28/02/2018:								
Reference Number	**Date investigation started**	**Division**	**Incident Description**	**RCA Lead Investigator**	**72 hour review completed/ immediate actions taken and shared learning**	**Progress**	**60 working day compliance**	**Duty of Candour/ Being Open policy implemented**
Nil								

New Safeguarding investigations reported 01/02/2018 to 28/02/2018: 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 2018/2696	30/01/2018	Medicine	Patient's Consultant informed via Ormskirk Hospital of child's death on 22/01/2018. Patient diagnosed with congenital hyperinsulinism, Beckwith Weidemann Syndrome and	Jo Blair, Endocrinology Consultant and Joanne Kendrick, Ward Manager, 3C	Initial RCA panel meeting held 26/02/2018. RCA investigation on hold, awaiting results of post-mortem.	Yes	Duty of Candour completed including letter sent to family. In addition, Chief Nurse and patient's Consultant met with family to

			Gastroesophageal Reflux Disease. Patient seen in outpatients by Consultant 13/12/2018, mother had issues with feeding and referral to Speech and Language Therapy Team (SALT) was made. No reports of choking episodes or difficulty swallowing. Although the referral stated urgent, the appointment did not occur. Following review of baby's care, the Consultant reported the incident and decision taken that this was a serious incident that required further investigation.				discuss any concerns or questions they wish to be addressed.
StEIS 2018/1590	18/01/2018	Surgery	Child transferred from Whiston Hospital on 23/10/2017 due to secondary scalding episode and trauma to buttock from a smashed ceramic mug. The patient was operated on 24/10/17 to repair laceration to buttock and was discharged on 27/10/17. Patient attended Emergency Department 27/12/2017, reviewed by surgical doctor who noted left sided foot drop. On review of case, it is felt that there was a missed laceration to the nerve in the buttock during initial investigation and	Sarah Wood, Consultant Surgeon and Dianne Topping, Senior Nurse	RCA panel meeting held 16/03/2018. Further statements to be gathered and further panel meeting to be held.	Yes	Duty of Candour completed including letter sent to family.

			surgery. If this was recognised during initial surgery, patient would not have had a secondary nerve graft procedure.				
StEIS 2017/30500	13/12/2017	Surgery	Unexpected death of neurosurgical patient.	Rachael Hanger, Theatre Matron and Simon Kenny, Consultant Surgeon	Expecting independent review report in the next 4 weeks. CCG being updated fortnightly on position.	Yes	Duty of Candour completed including letter sent to family. In addition, Medical Director and Chief Nurse met with family to discuss any concerns or questions they wish to be addressed.

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	Division	Incident Description	RCA Lead Investigator	Outcome	Duty of Candour/Being open policy Implemented
StEIS 2018/928	10/01/2018	Surgery	Grade 3 pressure ulcer to patient's scalp. Scalp peripheral venous long line (PVL) left in situ 18/12/2017, wound under the hub	Jayne Peters, High Dependency Unit Manager	Final report sent to CCG.	Yes

			of scalp line 23/12/2017, redressed and cleaned, PVL left in situ for 13 days. Tissue viability referral made 04/01/18 due to skin being red and query petechial rash, reviewed by Burns Specialist on the 09/01/2018 and confirmed as grade 3 pressure ulcer.			
StEIS 2018/99	02/01/2018	Surgery	Grade 3 pressure ulcer. Upon assessment of the patient, found the right nostril with the endotracheal tube (ETT) in situ had a grade 3 pressure ulcer.	Dianne Topping, Senior Nurse/Interim Head of Quality, Surgery	Final report sent to CCG.	Yes
StEIS 2017/31185	21/12/2017	Surgery	Pressure ulcer to left heel. Referral to plastics team following review by senior nurse with expert knowledge in relation to tissue viability. Confirmation received that this is a grade 3 pressure ulcer 21/12/2017.	Kelly Black, Surgical Matron	Serious incident closed from StEIS following CCG review of 72 hour review and responses to initial queries raised. Pressure ulcer deemed unavoidable.	Yes
StEIS 2017/27996	10/11/2017	Surgery	Patient transferred to the Trust on 11/07/17, at the time of the incident the patient was on the sepsis pathway. Patient had a blood gas taken on the 08/11/17 at 02:58, patient had a repeat blood gas taken and temperature spiked at 04:15. Patient's saturations and heart rate subsequently dropped and arrest team called at 04:35. Concern raised that blood results not acted on in a timely manner.	James Ashton, Sepsis Nurse Specialist and Jane Ratcliffe, Consultant	Final report sent to CCG.	Yes

Safeguarding investigations closed since last report
Nil

Alder Hey Children's NHS
NHS Foundation Trust

Board of Directors
Tuesday 10/04/2018

Report of	Development Director
Paper prepared by	Associate Development Director
Subject/Title	Development Directorate Report - Alder Hey in the Park, and Estate Developments
Background papers	Nil
Purpose of Paper	The purpose of this report is to update the Trust Board and Development Project progress.
Action/Decision required	The Board is asked to acknowledge the content of the report; the progress achieved and acknowledge areas where support may be required.
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	➢ Delivery of outstanding care ➢ Sustainability through external partnerships
Resource Impact	Capital projects

ALDER HEY IN THE PARK PROJECT

HIGHLIGHT REPORT Site & Park Development																																				SRO: David Powell Author: Sue Brown
Programme 2017/18	Apr-17				Aug-17				Sep-17				Oct-17					Mar-18					Apr-18			May-18					Jun-18					
Week Commencing	3	10	17	24	7	14	21	28	4	11	18	25	2	9	16	23	30	6	13	20	27	3	10	17	24	1	8	15	22	29	5	12	19	26		
Decommissioning & Demolition (Phase 1 & 2)																																				Programme progressed as plan and concludes this month. Additional work has been agreed within the budget to prepare land levels in preparation for the Alder centre, Community Cluster and temporary car park schemes. Next phase not due to commence until 2019/20.
Residential																																				The Trust remains in discussion with LCC regarding appointment of First Step as the preferred bidder, this is lilley to occurr within OJEU process following on from very recent discussion and acknowledgment of legal advice.
Research & Education Phase II																																				Research and Education phase II build is reported to be on track but there has been an early warning notice from MS on potential delay of up to 4 weeks due to the extensive changes needed in accomadating the University requriements within the building. Contract with Morgan Sindellhas reached final agreement has been now signed off.Some University partners have yet to sign financial agreements.
Alder Centre																																				Construction tender returns currently under review and assessment by AHMM and Trust Advisors, some negotiation on costing may be required and could potentially lead to some slight slippage on the delivery plan.Dicussions and regular meetings in process and progressing with the Appointed Architect and user involvement continues.
Park																																				Park project coordinator post has been vacant for the last month, however new person recently appointed in the last week, awating start date confirmation. This has resulted in some slippage on project development, which is hopefully to be resolved by new appointee. The lancashire Wildlife trust has recently in completed installation of a new foot path with disabled access into the forest area, this was sposered by the Veolia trust.
International Design & Build Consultancy																																				Jersey design work has been confirmed for the next 6 months bringing income into the Trust and enhancing our reputation. Meeting has also occurred with BDP with the intention to develop an MOU and partnership agreement with them particulary in relationship to their existing offcies and business in Shanghi and the Far East.
Community Cluster Building (Neuro-developmental Hub)																																				Design competiton has completed and a proposal to the Trust Board is being made on the 10th April to progress to full design workup and award of design contract. Pid has been written and placed on sharepoint, this is to be prersented at the next programme Board in April.The option to phase in the development of a larger and fit for purpose DEWI Jones Unit at an earlier phase is under discussion currently and a external bid for funding has been made by the Community Services Division.
Estates Strategy/Corporate Offices																																				The plan submitted to the board and approved in December 2017 has been under some review with regards to keeping as many serives on site as possible (3 services were planned to move off site). A pressure has developed in view of maintaining an additonal service on site to support other Clinical service developmentts and support divisional operational planning, this presents some challenges against the planned accomodation for 2020. The plan therefore is subject to some review by the senior and executive team, with the apporach to Agile working requiring specific focus and resource. Also a review of Medical Record Services has been commissioned to analyse the long term projection /requirment for space and storage.
Sefton Services (Relocations)																																				Plans to relocate some Sefton Services due to noitce served on current buildings is progressing on track to deliver in June 2018. Lease agreement for Sefton Carers Building and Burlington House are due to complete this month and refurbishment work will commence. Users fully enagaed in the process and CAMHS young people invloved in design and choice of furniture /fittings .

Alder Hey Children's NHS
NHS Foundation Trust

Board of Directors

10th April 2018

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

1. Staff Engagement

Reward & Recognition

In response to the monthly Star Awards, Alder Hey winners for January are Ms Sujata De, ENT Consultant on Ward 4B and for February the "Looked after Children's Team" Development Paediatrics, with presentations in progress. March's selections are being collated from the nomination committee at the time of writing. All past and present winners continue to be displayed on the board in the Atrium.

The Reward and Recognition Team are also in the preparation of celebrating 70 years of the NHS summer event alongside our Fab Change week. It is anticipated that we will use the park as our location for the celebrations.

Staff Survey

The National 2017 Staff Survey has now been shared, published and presented to Trust board. Divisions and depts. will imminently receive the detail pertinent to their respective areas to commence facilitated discussions with staff on the outputs of the survey.

It shows a very positive picture of improvement since the 2016 survey, with 18 of 32 key findings better than in 2016, but we remain focused on continuous improvements, and our action plans will be addressing local and corporate areas.

2. Workforce Sustainability and Capability

Education, Learning and Development

Apprenticeships

Apprenticeship Week on 5th March 2018 was a successful week for the Trust in promoting the apprenticeship offer. Liverpool City Region Apprenticeship Hub supported Alder Hey and subsequently advertised the success of the Trust Apprenticeship Week in their regional newsletter.

60 expressions of interest were received over the week and the follow up process has since seen over 25 applications ready to be processed. The Trust has appointed Wirral Met College to deliver Business Administration and Leadership and Management Apprenticeships at various levels. The future plan will be that Alder Hey as an Employer Provider will be resourced to deliver these apprenticeship programmes in-house.

Our Apprenticeship Delivery Manager is continuing to meet with Divisional and department leads to help promote apprenticeships and communicate the benefits of the programme to their staff; in doing so this will also place emphasis on the requirement to fulfil our public duty of 2.5% of the organisation undertaking apprenticeships, which is approx. 75 learners per year.

Mandatory Training

Core mandatory training as of end of March is above target at 91.24% and overall mandatory is 90.25%. Whilst these figures remain above the Trust target they have dropped in compliance since the previous reporting month. This has been a result of a number of annual training courses expiring in February. The team are continuing to address the issue

with weekly reports being generated for dept. leads to keep on top of compliance. The HR & OD department will be working closely with all Subject Matter Experts (SME's) and the newly recruited L&D manager, who is due to commence on 30th April to ensure a comprehensive approach to the quality and delivery of mandatory training.

Workforce Diversity

The BME and Disability Networks continue to actively develop, and we remain sighted on our goals to increase the diversity of our workforce, agreeing a set of tactical actions with the Chair of the Workforce and OD Committee in December to practically move the agenda forward. A key strand of this will be a focus on apprenticeships.

The Trust has published the Gender Pay Gap Report, which is a separate item on the Board agenda for April 18.

Employee Consultations

Hotel Services

The perter service Organisational Change consultation has been extended to explore any further options with full trade union engagement to bring about a satisfactory conclusion and it is anticipated that consultation closure will now take place during April 2018.

Home Care Service/Complex Care – Community Division

The original Organisational Change of seven Band 3 HCA's has now concluded, with confirmed redundancy following the LCH TUPE transfer. Confirmation of new posts issued and pay protection allocation instigated where appropriate.

Home care Service #2

As a result of a further decrease in patient numbers this has led to Organisational Change involving 3 HCA's , one of which to date has secured a suitable alternative position.

Staff side have had the opportunity to review the paper and attend the formal consultation which ended February and the Trust's re-deployment has been initiated due for review mid-April.

Crisis Care – Community Division

The competing pressures of planned and unplanned work streams upon the team have seen the necessity for unplanned work to be prioritised. The current Alder Hey model established is the Single Point of Access (SPA). Alder Hey has been successful in a bid for additional crisis care monies; based on the provision of an out of hours phone line and the extension of ward based assessments at weekends. This additional funding and refocus of provision provides the opportunity to create a dedicated team that will assist young people who are in crisis in addition to allowing young people, who have been admitted following self-harm to be safely discharged in a timely manner. A consultation document has been produced and staff side have had the opportunity to review the paper and the formal consultation is currently underway. Formal consultation meeting was held on 27th February 2018 and is open until 16th April 2018.

Employee Relations Activity

The Trust's current ER activity increased to 25 cases. There are 9 disciplinary cases; 5 Bullying and Harassment cases; 1 grievance; 4 final absence dismissal cases; 1 formal capability cases; 3 MHPS Capability cases and 2 Employment Tribunal (ET) cases.

Employment Tribunal Cases

- The ET Claim relating to unfair dismissal and wrongful dismissal, due to be heard on 7th, 8th 9th February has been postponed a second time. A directions hearing is scheduled on 24th April and witness availability has been requested for next 12 months.

- The ET claim relating to constructive / unfair dismissal and disability discrimination was part heard week commencing 26th February. The claimant withdrew during the ET by the second day.

- An ET Claim dated 10th October 2017 relating to disability discrimination and protected disclosure is scheduled to go ahead. Notification has now been confirmed of a hearing at Liverpool Employment Tribunal from Monday 12th November until Friday 30th November 2018 over three weeks. Key personnel have been requested to ensure diary availability.

Corporate Report

The HR KPIs in the February Corporate Report are:

- Sickness rates have decreased to 5.5%
- PDR compliance decreased to 82.8%
- Mandatory training compliance increased to 94.6%

Actions to address shortfalls are being addressed by members of the HR & L&D team with the management teams, with a specific focus on sickness absence. 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.

Alder Hey Children's NHS
NHS Foundation Trust

Gender Pay Gap Report

30 March 2018

Gender Pay Gap Report

Introduction

The purpose of this paper is for the Operational Board to note the Trusts first Gender Pay Gap report 2018 produced to meet the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 which came into force on the 31st March 2017.

Gender Pay Gap legislation requires all employers of 250 or more employees to publish their gender pay gap as at 31st March 2017. Alder Hey Children's NHS Foundation Trust employs just over 3,000 staff in a range of clinical and non-clinical roles.

This report includes the statutory requirements of the Gender Pay Gap legislation but also provides further context to help understand and contextualise the data. It is important to recognise that the gender pay gap differs to equal pay. Equal pay is in relation to pay differences between men and women who carry out the same job for different pay, which is unlawful. The gender pay gap shows the difference in average pay of all men and the average pay of all women employed by the Trust. It is therefore possible to have genuine pay equality but still have a gender pay gap.

Alder Hey Children's NHS Foundation Trust supports the fair treatment and reward of all staff irrespective of gender and we are committed to creating a culture that is transparent, diverse and inclusive. The Trust has historically annually reported gender related data of its workforce and published this on its website.

The Trust uses the national job evaluation framework, Agenda for Change, for most levels of staff to determine appropriate pay bandings; this provides a clear process of paying employees equally for the same or equivalent work. The Electronic Record System (ESR) has been used to generate the information.

In common with most healthcare organisations, women make up the majority of the Trust workforce, with 83% female and 17% male employees.

Timescales

The figures must be calculated using a specific reference date – 'the snapshot date'. The snapshot date for public sector organisations is 31 March 2017. The information will demonstrate the pay gap between male and female employees as at 31 March in the previous year. For example, 31 March 2017 data must be published by 30 March 2018 and on an annual basis thereafter.

Mandatory Calculations

The legislation requires the Trust to publish six calculations, viewable on the national government website, for the overall workforce:

Salary:

1. the mean (average) pay gap
2. the median pay gap
3. the proportion of male and female staff in each salary quartile band

Bonus:

4. the mean bonus pay gap
5. the median bonus pay gap
6. the proportion of male and female employees receiving a bonus payment

Gender Pay Gap Report

Gender Pay Gap Data

Gender	Average Hourly Rate	Median Hourly Rate
Male	23.8128	16.0013
Female	15.9132	14.0201
Difference	7.8997	1.9812
Pay Gap %	**33.1740**	**12.3814**

1. Mean Gender Pay Gap

The **mean** pay gap is the difference between the average hourly earnings of men and women.

The data tells us that, on average, female employees earn 33% less than male employees.

2. Median Gender Pay Gap

The **median** gender pay gap is the difference between the midpoints in the ranges of hourly earnings of men and women. It takes all salaries in the sample, lines them up in order from lowest to highest, and picks the middle-most salary.

The median data tells us that female employees earn 12% less than male staff.

(The basic pay data includes Clinical Excellence Awards payments that are paid to eligible medical staff)

The mean gender pay gap for the whole of the Public Sector economy (according to the October 2017 Office for National Statistics (ONS) Annual Survey of Hours and Earnings (ASHE) figures) is 17.7%. At 33% the Trust's mean gender pay gap is therefore above that of the wider public sector . This is reflective of the pattern from the wider UK healthcare economy; traditionally the NHS has had a higher proportion of females in the workforce which tend to be in the lower bandings, and a predominantly male workforce in the higher banded Medical & Dental professions, although at Alder Hey this is a section of the workforce with a higher proportion of males that the overall, 53% compared to 47% females.

3. Proportion of Men and Women in each Salary Quartile Band

To understand how the grade balance impacts pay, the hourly pay of all staff has been arranged in order then divided into four equal parts. The chart below shows the proportion of males and females in each pay quartile; the lower quartile includes the lowest paid staff per hour and the upper quartile includes the highest paid staff per hour.

Number of employees | Q1 = Low, Q4 = High

Quartile	Female	Male	Female %	Male %
1	622.00	135.00	**82.17**	**17.83**
2	665.00	92.00	**87.85**	**12.15**
3	667.00	90.00	**88.11**	**11.89**
4	548.00	209.00	**72.39**	**27.61**

Gender Pay Gap Report

There are a higher percentage of males in the upper pay quartile compared to the percentage in each of the lower pay quartiles.

Gender Pay Gap - Bonus Average & Median Pay

Gender	Average Pay	Median Pay
Male	12,426.96	8,950.75
Female	7,856.39	4,476.59
Difference	4,570.57	4,474.16
Pay Gap %	**36.78**	**49.99**

Bonus Pay, whilst also forming part of basic pay for the purposes of calculating the mean and median average gender pay gap, is only paid to eligible consultant medical staff in the form of Clinical Excellence Awards. These awards recognise and reward individuals who demonstrate achievements in developing and delivering high quality patient care over and above the standard expected of their role, with a commitment to the continuous improvement of the NHS. The CEA's are administered within the Trust on an annual basis.

4. **The Mean Bonus Gender Pay Gap**

The data tells us that on average bonus pay, female employees earn 37% less than male employees.

5. **The Median Bonus Gender Pay Gap**

The data tells us that on median bonus pay, female employees earn 50% less than male staff.

6. **The Proportion of Males and Females Receiving a Bonus Payment**

Gender	Employees Paid Bonus	Total Relevant Employees	%
Female	33.00	2661	**1.24**
Male	58.00	562	**10.32**

The data in the above chart shows the total number of staff paid bonuses against the total number of staff in the organisation. In reality, only eligible medics are able to apply for Clinical Excellence Awards, which is shown as below:

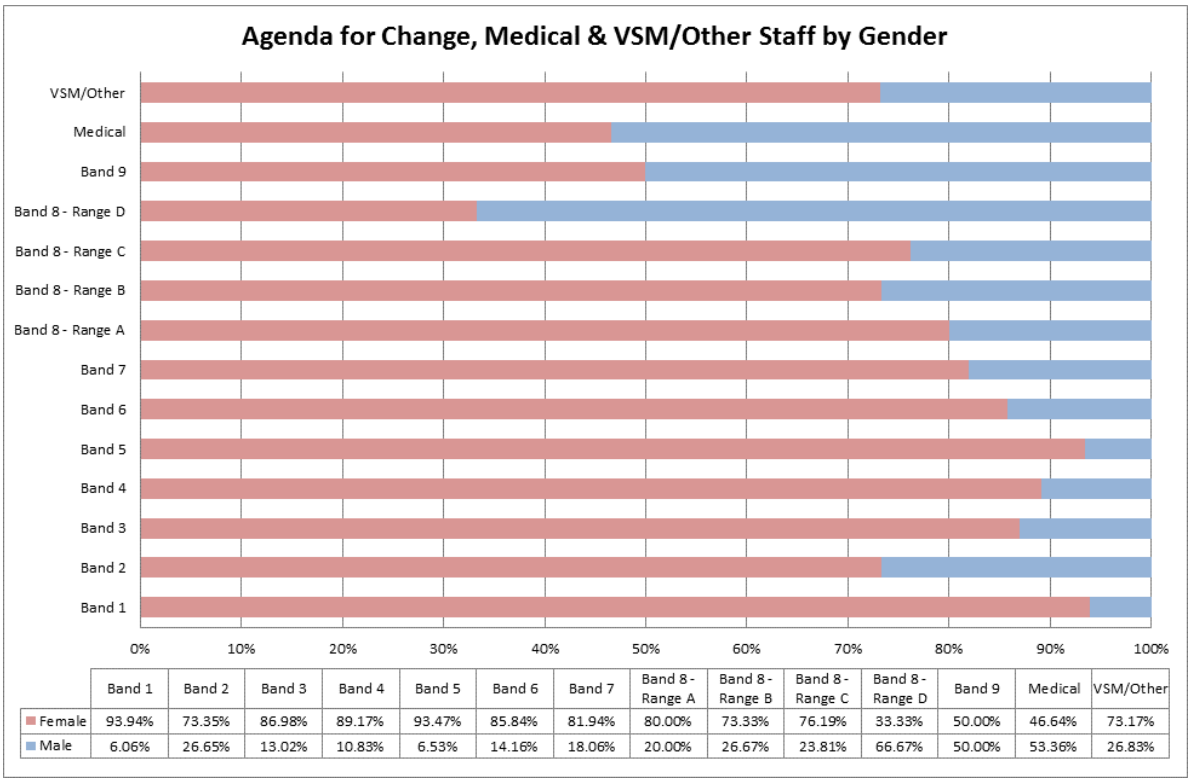
Gender	Employees Paid Bonus	Total Relevant Employees (eligible medical staff only)	%
Female	33.00	117	**33%**
Male	58.00	129	**44.96%**

Benchmarking our Results

Trust	Mean Hourly Rate Pay Gap	Median Hourly Rate Pay Gap	Mean Bonus Pay Gap	Median Bonus Pay Gap	% of men paid bonus	% of women paid bonus
Alder Hey Children's	33.1%	12.4%	36.8%	50%	10.32%	1.24%
Sheffield Children's	20.2%	9.3%	46.5%	14.8%	6.9%	1.3%
Great Ormond Street	21.5%	15%	14.9%	44.6%	6.6%	1.4%
Birmingham Women's and Children's	26.9%	15.8%	31.2%	13.3%	1.4%	1%
Countess of Chester	28%	9%	36.5%	50%	5%	1%
Merseycare	10.1%	4.1%	45.5%	27.5%	4.2%	2.2%
Aintree	30.9%	17.4%	41.6%	34.4%	7%	0.7%

Understanding our Results (non-statutory data)

Alder Hey staff are employed on a number of different national contractual terms and conditions; Agenda for Change Bands 1-9, Medical and Dental, and Very Senior Managers (VSM). The total gender split across the Trust is 83% female, 17% male, and the chart below shows the gender differences between grades and staff groups, with the biggest variation to this being within AfC Band 8d and 9, and Medical staff.



	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8 - Range A	Band 8 - Range B	Band 8 - Range C	Band 8 - Range D	Band 9	Medical	VSM/Other
Female	93.94%	73.35%	86.98%	89.17%	93.47%	85.84%	81.94%	80.00%	73.33%	76.19%	33.33%	50.00%	46.64%	73.17%
Male	6.06%	26.65%	13.02%	10.83%	6.53%	14.16%	18.06%	20.00%	26.67%	23.81%	66.67%	50.00%	53.36%	26.83%

Gender Pay Gap Report

Agenda for Change Breakdown

Gender	Avg. Hourly Rate	Median Hourly Rate
Male	14.4033	12.3718
Female	14.4357	13.4536
Difference	-0.0325	-1.0818
Pay Gap %	-0.2254	-8.7445

Quartile	Female %	Male %	Female	Male
Lower	81.68	18.32	477.00	107.00
Lower Middle	86.72	13.28	581.00	89.00
Upper Middle	88.84	11.16	557.00	70.00
Upper	85.96	14.04	539.00	88.00

The majority of our employees are on national Agenda for Change Terms and Conditions. An analysis of salary within AfC staff only, above, reveals that there is no mean pay gender gap, and that there is actually a small median gender pay gap for males of 8.74%.

Medical and Dental Breakdown

Gender	Avg. Hourly Rate	Median Hourly Rate
Male	50.5028	49.1297
Female	42.0041	42.3489
Difference	8.4987	6.7809
Pay Gap %	16.8281	13.8020

Quartile	Female %	Male %	Female	Male
Lower	59.32	40.68	35.00	24.00
Lower Middle	56.67	43.33	34.00	26.00
Upper Middle	49.15	50.85	29.00	30.00
Upper	20.00	80.00	12.00	48.00

Whilst there is a more even gender split within this staff group, 53% males to 47% females, there remains a mean gender pay gap of 16.82%, and a median gap of 13.8%. We do know that, at Alder Hey, more male medical staff have a longer length of service than female medical staff, which impacts upon salary.

Conclusion and Declaration

The Trust has calculated the gender pay gap data in line with the government's gender pay gap reporting regulations ahead of submission of 30th March 2018. Alder Hey's mean gender pay gap is 33%, and the median is 12%. The gender pay gap is significantly reduced, and indeed skewed in the opposite direction for males, when medical staff are removed from the calculations.

Although not mandatory, the Trust has produced a narrative that explains the calculations and provides an organisational context.

The reasons for a gender pay gap are multi-factorial; terms and conditions, length of service, gender mix, pension, flexible working arrangements and salary sacrifice commitments will all have an impact upon the overall gender pay gap results.

The Trust will undertake a detailed analysis of the results and take steps to reduce the gender pay gap.

Recommendation

The Operational Board are asked to approve the report to enable it to be published on the Trust and government website.

Trust is committed to ensuring an equitable workforce and steps taken to reduce gender pay gap will be incorporated into Trust Equality Objectives and monitored by the Workforce and Organisational Development committee on a quarterly basis.

Resources and Business Development Committee
Minutes of the meeting held on: Monday 5th March 2018 at 1:00pm in Meeting Room 4

Present		Ian Quinlan (Chair)	Non-Executive Director	(IQ)
		Adam Bateman	Interim Chief Operating Officer	(AB)
		Claire Dove	Non-Executive Director	(CD)
		John Grinnell	Director of Finance	(JG)
		Melissa Swindell	Director of HR and OD	(MS)
		Claire Liddy	Director of Operational Finance	(CL)
In attendance		Mark Flannagan	Director of Communications	(MF)
		Karen McKeown	Committee Administrator (*minutes*)	(KMC)
		Erica Saunders	Director of Corporate Affairs	(ES)
Agenda Item:	**130**	Jennifer Wood	GDE Programme Manager	(JW)
	134	Joe Gibson	Interim Programme Director	(JG)
	142	Graeme Dixon	Building Services Manager	(GD)
Apologies		Hilda Gwilliams	Chief Nurse	(HG)
		Phil O'Connor	Deputy Director of Nursing	(POC)
		Lachlan Stark	Head of Planning & Performance	(LS)

17/18/128 Minutes from the meeting held on the 29.1.18

The Resources and Business Development Committee received and approved the minutes of the meeting held on the 29th January 2018.

17/18/129 Matters Arising.

Action Log

Action 17/18/100.1: *Board Assurance Framework (Risk relating to the funding for Research, Education and Innovation)* – A meeting has been scheduled to discuss the governance relating to the Research, Education and Innovation Committee. It was reported that further work is also required at Corporate risk level.

Action 17/18/115.1: *Finance Report* – A meeting has been scheduled for the 6.3.18 in order to discuss income/funding with the Trustees of the Charity Board.

Action 17/18/115.2: *Finance Report (update on CIPs and Targets) – This item has been included on March's Committee agenda.*

Action 17/18/122.1: Health Education Learning Agreement – This item has been deferred until the 28.3.18.

Action 17/18/123.1: *Catering Position update* **–** This item has been included on March's Committee agenda.

Action 17/18/126.1: *PFI Contract Monitoring* **-** This item has been included on March's Committee agenda.

17/18/130 Global Digital Excellence (GDE) Programme including Benefit Tracker.

The Committee was provided with an update on the progress of the GDE Programme to date. Jenny Wood reported on speciality packages, the shadowing of clinicians that has taken place in order to understand their concerns about voice recognition, and the achieved milestone assurance that has allowed the Trust to draw down on funds.

John Grinnell informed the Committee that the GDE Programme will be more benefits driven in 2018/19 and will also be key to the Trust's Operational Programme. Claire Liddy highlighted the importance of having an overarching budget position in the report in order to keep sight of the financials. Tracking also needs to commence to keep abreast of the required £800k savings to ensure that software costs are funded once the GDE programme ends in 2020.

Ian Quinlan queried as to whether the Trust has started to release the required £800k per annum. Jenny Wood reported that this has commenced, all projects have been accurately baselined and there is funding available via NHS Digital for a three year period which will enable the Trust to become self-sufficient.

Following discussion it was agreed to incorporate an overarching budget in monthly reports along with tracked benefits.

17/18/130.1 Action: JW

Resolved:
The Resources and Business Development Committee noted the GDE Programme update

17/18/131 Performance/Run Rate

The Committee was provided with an overview of the activity summary for the Medical and Surgical Division during month 10.

Ian Quinlan queried the reason for the reduced level of elective activity during month 10 for the Surgical Division. Adam Bateman advised of the challenges that have been experienced, pointing out that the Medical Division has turned a corner with the support of the Surgical Division. A proportion of bed base has been relinquished to Medicine in order to support non-elective at the Front Door but this has caused a cap on electives.

John Grinnell reported that one of the biggest challenges on income for the Trust has been the reduction of high value cardiac operations. This is due to issues around the turn-over of beds/staffing levels and it was pointed out that Critical Care has struggled to support the Cardiac Division. The Committee was advised that a strategic review of Cardiac is imminent as intervention is required to sustain this area of work and support the elective programme.

A discussion took place around the effect the reduced activity will have on the Trust's year-end figures. John Grinnell informed the Committee of the of the constraints on bed capacity in PICU as a result of patients with highly complex needs, and reported that the Trust will see a drop in performance during

February due to long stay patients who will remain with Alder Hey during the month of February. It was reported that work is taking place to agree fixed year-end deals and the Executive Team are looking at a solution for a new Critical Care unit.

Adam Bateman informed the Committee of the contingency plans that have been implemented to offset income against cardiac and improve the forecast for the Surgery Division; additional high value work has taken place in Spinal, Outpatient clinics have taken place each Saturday and a review of Theatres has been conducted to reduce waste and expired stock.

John Grinnell felt that a comparison of 16/17 and 17/18 figures for activity should be conducted to provide the Committee with an overall view and understanding of both sets of figures and the reason for the the different output.

17/18/131.1 Action: AB

Ian Quinlan queried as to why the Trust couldn't provide additional beds. Adam Bateman reported that the organisation had installed four supplementary beds on Ward 4B which were supported by agency nurses in order to carry out extra elective cases.

John Grinnell pointed out that from a long-term plan the Trust requires extra capacity. The workforce is one of the organisation's risk areas from a demand and capacity perspective and it will be necessary to look at critical care plans to address patient numbers.

Adam Bateman informed the Committee of the recent investment in the Cardiac Ward to reduce blockages but pointed out that the organisation hadn't foreseen the amount of complex long-term patients requiring care on ICU which has had an effect on elective patients. The Committee was informed that a comprehensive review is going to be conducted by the Executive Team to address these issues from a clinical and capacity element.

Resolved
The Resources and Business Development Committee noted the contents of the performance report for month 10.

17/18/132 Finance report

For the month of January the Trust reported a trading surplus of £1.7m which is ahead of plan by £0.2m. Income is ahead of plan by £1.8m but this is offset by expenditure which is higher than budgeted by £1.6m. The year to date position is a deficit of £1.6m which is ahead of plan by £0.2m. The Use of Resources risk rating is 3 which is in line with the plan and the cash in the bank is £6.7m.

An update was provided to the Committee on the work that is taking place to address the risks and disputes of the Trust's four main contracts.

The Month 10 CIP performance across the Trust shows an overachievement of £0.1m. For the year the Trust is forecasting savings of £6.4m against a target of £8m. The main gaps are in Medicine (£0.9m), Facilities (£0.2m) and Community (£0.2m). There is also a recurrent gap of £1.6m relating mainly to Medicine (£0.8m), Community (£0.4m) and AHP (£0.3m).

At the end of January 2018, the cash balance was £6.7m, higher than plan of £1.8m. This is mainly due to a delay in the Capital Programme and Working Capital balances. The latest forecast is to over-achieve a control total with month and cash balances of at least £5m and a forecast cash positon for March 2018 of £7.3m. It was reported that the Trust has drawn down a new loan of £2.85m during March in order to complete the Research and Education building. This was done before the end of the 2017/18 financial year in case the ruling changes in 2018/19.

The Committee discussed the areas of work that are being progressed to achieve a control total which will enable the Trust to apply for the 2 for 1, for example, Charity swap out, land sale, PFI deal for Service Failure Point Raise, energy compensation and Revenue to capital transfer and Equity accounting for innovation subsidiary. It was agreed to submit a report on the STF incentive scheme in order to provide on update.

17/18/132.1 Action: CL

Claire Liddy presented the 2018/19 draft budget to the Committee for discussion. It was reported that the draft budget will be submitted to the Trust Board for approval on the 6.3.18 and to NHSI in its draft form w/c 12.3.18. Dialogue took place around the possible risk relating to an increase in salary for staff and the risk relating to equipment. Claire Liddy confirmed that neither of these risks will be ranked above 12 and pointed out that the Trust is in the process of engaging with the Charity re funds for equipment. Following discussion it was agreed that the final version of the 2018/19 budget will be presented to the Committee following submission to NHSI on the 30.4.18.

17/18/132.2 Action: CL

Resolved

The Resources and Business Development Committee noted the contents of the Finance Report for month 10.

17/18/133 Board Assurance Framework

The Board Assurance Framework (BAF) was submitted to the Committee for assurance purposes. Erica Saunders provided an update on the changes to the BAF since January's Trust Board meeting and highlighted the following key points:

- The Emergency Department (ED) performance is on recovery trajectory to year end. Comm cell meetings are taking place to address tactics for recovery.
- Financial recovery is showing a £2m gap to control although mitigating actions to close the gap are progressing. One of the key risks is concluding commissioner year-end discussions. It was reported that the financial recovery risk has been ranked as red.
- Further focus is required on controls, business development, REIC and the top five priorities for 2018/19.
- A discussion took place around an additional spend for CJD and it was queried as to whether a report is going to be submitted to the Committee for visibility purposes. Erica Saunders reported that this critical item has been included in the Corporate Risk Register and is being addressed from a medical perspective.

Resolved:
The Resources and Business Development Committee noted the contents of the BAF for month 10.

17/18/134 Programme Assurance

The Committee was appraised of the assurance status of the Change Programme and the following points were highlighted and discussed:

- It was reported that there has been an improvement in ratings across the Change Programme projects.
- *GDE* - A benefits process is to be applied to GDE in order to measure the delivery of a project.
- *Growing Through External Partnerships* - Further work is to take place around CHD Partnerships and Aseptic in terms of identifying and measuring clear benefits of the work in hand.
- *Park, Community Estate and Facilities* - Challenge is required to address the two projects that have been risk ranked as red; Park and Residential Development. This matter is to be discussed with David Powell.

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

17/18/135 Weekly Performance Update

The weekly performance report was submitted to the Committee for information and assurance purposes. It was reported that performance is strong with the exception of ED of which a plan is in place to address this area of work.

Resolved:

The Resources and Business Development Committee noted the contents of the Weekly Performance Meeting report.

17/18/136 Marketing and Communications Activity Report
Resolved:
The Resources and Business Development Committee received and noted the contents of the Marketing and Communications Activity report for month 10.

17/18/137 Corporate Report
Resolved:
The Resources and Business Development Committee received and noted the contents of the Corporate report for month 10.

17/18/138 Health Education Learning Agreement
It was agreed to defer this item until the next meeting.
Action: MS

17/18/139 Monetary Cost of Sickness Absence

Melissa Swindell advised the Committee of the £1.6m cost that the Trust has incurred up to December 2017 as a result of staff sickness. This figure incorporates salaries for staff members who are absent due to sickness and agency costs to cover staff sickness.

A discussion took place around the work that needs to take place to address long-term sickness and the Trust's outlier position. Clare Dove felt that the cost to the organisation was staggering.

17/18/140 Catering Position Update

The Trust has received a report from the external reviewer following a review of the Trust's Catering department. It was confirmed that work is taking place with finance on the recommendations from the review and an update will be provided during the next Committee meeting.
Action: HG

17/18/141 Monthly Debt Write Off
Resolved:
The Resources and Business Development Committee approved January's write off of £2,888.44

17/18/142 PFI Contract Monitoring

Graeme Dixon provided an energy update for January 2018 highlighting that the Trust is 19% over target for this period of time. It was confirmed that Phil Morgan will attend the next committee meeting to give an update, from a technical perspective, on the kit that is being used for combined heating and the deficiencies being experienced. Feedback will also be provided following an energy meeting. It was reported that the Trust will be challenging efficiency figures for 2016/17.

John Grinnell advised of the issues relating to pipe corrosion across the hospital. It was reported that there have been 41 leaks to date due to the use of low grading steel, therefore, what had commenced as erosion has become corrosion. Teams are presently working on this matter with Health and Safety, and a letter has been drafted to SPV with a seven day response timeline requesting a plan of action to address the issues that have been raised. The Committee was advised of the risks to patient and staff safety along with the greater issue in the event that a total refit is required. The Trust is in the process of contacting Stoke and Birmingham to request their advice following their experience of a similar situation.

17/18/143 Any Other Business

The Committee was advised of the new 'Model Hospital' initiative. Following discussion, it was agreed to submit the dashboard during the next meeting and invite relevant leads.
17/18/143.1 Action: CL

Erica Saunders informed the Committee of the completion of the Well Led report following a review by MIAA and confirmed that the report is ready to be circulated

more widely. Following a recommendation, the Trust is going to review the committees that feed into the Board along with the divisional structure.

Date and Time of Next Meeting: Wednesday 28th March 2018, 9:30am-1:00pm,

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 a change programme is now in the midst of a transition from the 17/18 to the 18/19 programme
2. The Executive Team has decided to invest in the embryonic Delivery Management Office (DMO) which is being increased in capacity – from 2 to 5 posts – this on the evidence of the positive contribution the DMO is making to the programme management across the work streams
3. The Programme Board has become a well attended and business like forum where change programme progress is challenged and supported . The Programme Board is challenging executive sponsors to make sure benefits are identifiable, deliverable and ambitious.
4. The scope of the change programme for FY 18/19 is now being finalised, the 'pipeline' projects that can seen on the attached scope; initiatives for which programme management will not be value adding will be removed from the scope.

J Grinnell 3 Apr 18

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

1. This Board report contains assurance reports submitted to the following sub-Cttes: **CQAC on 21 Mar 18 and R&BD on 4 Apr 18.**
2. The scope of the 18/19 programme and the contribution to CIP benefits continue to represent a key risk being , currently, projected at significantly below target in many work streams; the work to quickly improve these projections is being managed at the weekly 'Financial Sustainability Board', this Board has delegated authority from the Programme Board.
3. The assurance focus now should be twofold: firstly, ensuring that the project management (and thereby overall ratings) for all existing projects shows the necessary grip and rigour to underpin delivery; secondly, that the new projects are rapidly brought up to an acceptable standard of project management, providing the leading indicators of a successful implementation.

J Gibson 3 Apr 18

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

See CIP status at slide 3 of this pack. In sum, the 17/18 change programme contribution to CIP has seen a significant shortfall and efficiencies are having to be found in other areas.

Change Programme

PROPOSED PROGRAMME 18/19

Trust Board

Alder Hey Children's NHS
NHS Foundation Trust

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

Programme Assurance Framework, DMO & Delivery Board

Growing Through External Partnerships
John — SG

1. International Health & Non-NHS Patients
2. CHD Liverpool Partnership
3. Aseptics

Imminent Pipeline
- Neonatal Services

Pipeline

The Best People Doing Their Best Work
Melissa/Hilda — SG

1. Portering

Imminent Pipeline
- Apprenticeships
- Engagement & Communication (Y2)
- Temporary Staffing
- E-Rostering
- Sickness

Pipeline
- AHP Workforce Reviews
- Agile Working

Deliver Outstanding Care
Hilda / Steve

1. Sepsis
2. Best in Outpatients (Y3)
3. Brilliant Booking & Scheduling
4. Comprehensive Mental Health
5. Patient Flow

Imminent Pipeline
- Models of Care
- Model Hospital

Pipeline
- 7 Day Services Incl. OOH)
- Neuro-development Paediatrics Medication Review

Global Digital Exemplar
John/Steve — PB

1. Speciality Packages
2. Voice Recognition

Strong Foundations
John — SG

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

6. Catering

Park, Community Estate & Facilities
David — SG

1. Decomm. & Demolition
2. R&E 2
3. Alder Centre
4. Park
5. Residential Devel.
6. International Design & Build Consultancy
7. Retained Estate

8. Community Cluster

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*

CIP Status – Month 11 FY17/18

		Year to Date			In Year Forecast			Recurrent Savings		
Division	Director	Target £000's	Achieved (Posted) £000's	Gap £000's	Target £000's	Forecast £000's	Gap £000's	Target £000's	Forecast £000's	Gap £000's
Community	Catherine McLaughlin	625	414	-211	699	457	-242	699	249	-450
Medicine	Adrian Hughes	2,597	1,928	-668	3,013	2,122	-891	3,013	2,147	-866
Surgery	Christian Duncan	2,565	2,635	70	2,890	2,905	15	2,890	2,652	-238
Subtotal		**5,787**	**4,978**	**-809**	**6,602**	**5,483**	**-1,118**	**6,602**	**5,048**	**-1,554**
Alder Hey in the Park	David Powell	354	258	-95	406	324	-82	406	158	-248
Facilities	Hilda Gwilliams	262	54	-208	298	86	-212	298	528	230
Nursing & Quality	Hilda Gwilliams	82	0	-82	97	0	-97	97	0	-97
Finance & IMT	John Grinnell	214	187	-28	244	209	-35	244	298	54
Human Resources	Melissa Swindell	101	70	-31	112	76	-36	112	92	-20
Other Corporate Services	Erica Saunders	100	105	5	112	116	4	112	112	0
R&D	Michael Beresford	117	117	0	130	130	0	130	130	0
Grand Total		**7,017**	**5,768**	**-1,249**	**8,000**	**6,424**	**-1,576**	**8,000**	**6,366**	**-1,634**

	Year to Date			In Year Forecast			Recurrent Savings		
Workstream	Target £000's	Achieved (Posted) £000's	Gap £000's	Target £000's	Forecast £000's	Gap £000's	Target £000's	Forecast £000's	Gap £000's
Deliver Outstanding Care	533	144	-389	587	157	-430	587	160	-427
Growing Through External Partnerships	146	63	-83	159	69	-90	159	69	-90
The Best People Doing Their Best Work	358	11	-348	402	22	-381	492	276	-216
Game Changing Research and Innovation	209	117	-92	230	130	-100	230	130	-100
Solid Foundations	3,240	3,355	115	3,592	3,717	125	3,592	3,663	71
Subtotal: Strategic Workstreams	**4,486**	**3,690**	**-796**	**4,970**	**4,094**	**-875**	**5,060**	**4,297**	**-763**
Business as Usual	2,531	2,078	-453	3,030	2,329	-701	2,940	2,069	-871
Unidentified	0	0	0	0	0	0	0	0	0
Grand Total	**7,017**	**5,768**	**-1,249**	**8,000**	**6,424**	**-1,576**	**8,000**	**6,366**	**-1,634**

Programme Assurance Summary
Global Digital Exemplar

Alder Hey Children's NHS
NHS Foundation Trust

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

The comments relating 'Voice Recognition' below exemplify the need to ensure positive benefits realisation is at the heart of the GDE programme. As previously stated, benefits realisation of the opportunities offered by GDE needs to be managed within the operational divisions yet governance and facilitated by the GDE Programme Board; resulting in tangible, measurable benefits, identified and delivered.

As previously stated, 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.

Claire Liddy, Director of Operational Finance – 27 March 2018

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

The continuing lack of evidenced financial contribution to the CIP programme remains a concern.

The GDE Programme Board continues to maintain high standards of governance and the documentary evidence to support the programme management assurance process is of a high quality. The latest position shows all 3 strategic level projects have comprehensive evidence on SharePoint.

However, the 'Voice Recognition' project (see previous report) continues to be 'amber' rated; this is related to the issue surrounding the realisation of benefits – an operational issue for the Trust to resolve under the auspices of the GDE programme governance.

Joe Gibson, External Programme Assessment – 27 March 2018

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

Alder Hey Children's NHS
NHS Foundation Trust

Sub-Committee	R&BD	Report Date	27 March 2018
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 status	An effective project team is in place	Scope and Approach is defined	Targets / benefits defined/on track	Milestone plan is defined/on track	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	Comments for attention of the Project Team, Steering Group and sub-Committee
4.0 Global Digital Exemplar 17/18													
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 6 February 2018.**
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. Project Plan tab of 'Project Controls' appeasr to cease in December 2017. Risk protocols vis-à-vis national and Trust sytsems are now harmonised and finalised. **Last updated 15 February 2018.** 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, these have not been realised as planned. Project Plan is being kept up to date and the overall standard of the workbook is excellent. Comms/engagement activities detailed in PID, evidence required where possible. Risks detailed in workbook. EA/QIA has been signed and uploaded. **Last updated 27 March 2018.**

Financial Reporting: Refer to CIP update report

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)

As per the observations in the previous report: the CHD Partnerships sand Aseptics continue to work to identify and measure clear benefits of the work in hand; the aim is that the goals of each project to be expressed in terms of measurable objectives.

Executive Sponsors should continue to encourage project teams to strive for green rated assurance and delivery.

Claire Liddy, Director of Operational Finance – 27 March 2018

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

As stated in the previous update: the continuing shortfall in the financial contribution to the CIP programme is an issue albeit at this stage of the financial year there is little prospect of the recovery happening through these partnership propositions which are dependent – by definition – on external factors.

The International & Non-NHS Patients project will be updated once the arrangements for the Department of International Child Health have been finalised; the project has also drafted the first elements of a project closure report.

Joe Gibson, External Programme Assessment – 27 March 2018

Sub-Committee	R&BD	Report Date	27 March 2018
Workstream Name	Growing Through External Partnerships	Executive Sponsor	John Grinnell

Alder Hey Children's NHS
NHS Foundation Trust

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

Current Dashboard Rating:

Project Ref	Project Title	Project Description	Executive Sponsor Assures the project	OVERALL PROJECT RAG status	An effective project team is in place	Scope and Approach is defined	Targets / benefits defined/on track	Milestone plan is defined/on track	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	Comments for attention of the Project Team, Steering Group and sub-Committee
2.0 Growing Through External Partnerships 17/18													
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 to July 2017. PID complete. Milestone Plan last updated 27 March and shows some slippages hence the amber rating; a forward looking plan for 18/19 is being developed (and a closure report prepared on SharePoint). Details/evidence of comms to be provided where possible, significant evidence of engagement now on SharePoint. Risks now on Ulysses. EA/QIA complete. **Last updated 27 March 2018.**
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, following NHSE decision on 30 Nov 17, project documentation will now be developed to provide a mobilisation plan. Risk Regsiter, Action Notes and 'February 2018' update uploaded. Actions Plans need to be tracked / kept up to date. **Last updated 27 March 2018.**
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		●	●	●	●	●	●	●	●	List of project team names avaibale (Sep 17) and notes of meetings to 9 Oct 17. Scope is decribed by the DRAFT Business Case Form on SharePoint: 'Proposal for Commissioning, Validation and Licensing of the Pharmacy Aseptic Services Unit'. Targets and benefits are now included on a separate tracker and realisation will commence in Apr 18. Gantt chart in place, with some missed milestones, but is being closely tracked. Some evidence of stakeholder engagement now uploaded. Audit of Aseptic Services has been uploaded to SharePoint. EA/QIA signed off. Evidence of meetings to September 2017. **Last updated 23 March 2018.**

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)

As stated in previous assurance reports:

- The 'Neuro-Developmental Hub' project needs to be scoped in terms of rationale and objectives and the documentation posted on SharePoint.
- The work stream needs to bring the documentation to a standard that will attain green ratings for all projects

Claire Liddy, Director of Operational Finance – 27 March 2018

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

The work stream ratings have deteriorated since the February report: latest position shows 7 projects with evidence on SharePoint and, of those: 1 green rated, 3 amber and 3 red. The Executive Sponsor should set a date by which all projects will be green rated.

Of the three red rated projects:
- 'Residential Development' is blocked due to circumstances (planning permission) beyond the control of the project team.
- 'Park', is red rated due to delays on the plan and lack of revised milestones for missed objectives.
- 'International Design & Build Consultancy' is red rated due to lack of project documentation and evidence of planning.

Joe Gibson, External Programme Assessment – 27 March 2018

Financial Reporting: Refer to CIP Update report

Sub-Committee	**R&BD**	**Report Date**	**27 March 2018**
Workstream Name	Park, Community Estate and Facilities.	**Executive Sponsor**	**David Powell**

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

Alder Hey Children's NHS
NHS Foundation Trust

Current Dashboard Rating:

Project Ref	Project Title	Project Description	Executive Sponsor Assures the project	OVERALL PROJECT RAG status	An effective project team is in place	Scope and Approach is defined	Targets / benefits defined/on track	Milestone plan is defined/on track	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	Comments for attention of the Project Team, Steering Group and sub-Committee
5.0 Park, Community Estate & Facilities 17/18													
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 area; however, demolition now achieved). Details of communication/engagement activities to be confirmed and evidence provided where possible. Risks now on Ulysses, some require review. **Last updated 27 March 2018.**
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) now over 4 months from original milestone date and some other 'outstnading' milestones are yet to be updated. 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 27 March 2018.**
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 procurement of contrator has now been completed (although some 5 months off track). Evidence of Comms/ Engagement activities. Risks to be confirmed on Ulysses. EA/QIA complete. **Last updated 27 March 2018.**
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 multiple actions that have missed deadlines with extended delays and many with no revised milestones. Risks on Ulysses - need confirmation these are up to date. EA/QIA complete. **Last updated 14 February 2018.**
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 - now beyond 6 months - with planning permission and public consultation milestones missed; revised milestones are now 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 27 March 2018.**
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 5 February 2018.**
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. Milestone plan shows numerous delays with an average of some 2 months; two milestones on Sefton CAMHS not updated. 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 27 March 2018.**
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.**

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)

Inventory Management and Procurement Projects are now examining any final 'stretch' potential for their targets for CIP contribution in FY18/19.

The Energy project aims should now also be considering the potential for achieving greater savings at the earliest possible date (stretching targets) as agreed at the recent Financial Sustainability Board; this should lead to the Executive Sponsor developing an ambitious strategy for future energy consumption and sustainability.

Claire Liddy, Director of Operational Finance – 27 March 2018

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

Ratings for the three projects remain green.

As requested in the previous report, the Executive Sponsors have now initiated planning for FY18/19 and the projects will be formally established through the programme Board.

Joe Gibson, External Programme Assessment – 27 March 2018

Programme Assurance Framework
Strong Foundations (Completed by Assurance Team)

Alder Hey Children's NHS
NHS Foundation Trust

Sub-Committee	R&BD	Report Date	27 March 2018
Workstream Name	Strong Foundations	Executive Sponsor	John Grinnell/ David Powell

Current Dashboard Rating:

Change Programme Dashboard - Assurance

Alder Hey Children's NHS
NHS Foundation Trust

Programme Assurance (Joe Gibson)

				PROJECT RAG RATING									
Project Ref	Project Title	Project Description	Executive Sponsor Assures the project	OVERALL PROJECT RAG status	An effective project team is in place	Scope and Approach is defined	Targets / benefits defined/on track	Milestone plan is defined/on track	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	Comments for attention of the Project Team, Steering Group and sub-Committee
7.0 Strong Foundations 17/18													
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. Detailed POD available with precise metrics. Plan updated to November 17. Evidence of stakeholder engagement uploaded although this appears relatively narrow. EA/QIA now signed off. **Last updated 26 March 2018.**
RABD 7.2	Procurement CIP	The Procurement CIP scheme is an annual project aimed at ensuring that best value is obtained in respect of the supply of all goods and services purchased by the Trust.	John Grinnell		🟡	🟢	🟢	🟢	🟡	🟢	🟢	🟢	Documentation relevant to this specific type of project now on SharePoint. Evidence of stakeholder engagement now uploaded but not extensive. EA/QIA to be signed off. **Last updated 26 March 2018.**
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. Evidence provided concerning risks. EA/QIA to be signed off and scanned copy uploaded. **Last updated 26 March 2018.**

Financial Reporting: Refer to CIP Update report

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 £157k which is behind the target of £587k by £430k. The executive sponsors are requested to review the saving potentials arising from these quality improvements as a matter of urgency, converting the opportunities into savings.

It is now critical that the new projects are scoped (PIDs) and benefits defined by the March 2018 Programme Board.

Claire Liddy, Director of Operational Finance – 14 Mar 18

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

- The Projects that is red rated: 'Best in Operative Care' is not projected to achieve the planned benefits in the timescales and the plans are significantly out of date on SharePoint.
- The amber rated projects are: 'Best in Community Care'; 'Best in Acute Care'; and 'Deteriorating Patient'.
- The 'Outpatients' project retains a green assurance rating.

The refreshed 18/19 Programme has been aligned with the strategy refresh and the next CQAC meeting will receive reports on the following projects:

- **Sepsis**
- **Best in Outpatients**
- **Brilliant Booking & Scheduling**
- **Comprehensive Mental Health**
- **Patient Flow**
- **Models of Care**

Joe Gibson, External Programme Assessment – 14 Mar 18

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

Alder Hey Children's NHS
NHS Foundation Trust

Sub-Committee	CQAC	Report Date	14 Mar 18
Workstream Name	Delivering Outstanding Care	Executive Sponsor	Hilda Gwilliams/Steve Ryan

Current Dashboard Rating (Pt 1):

Project Ref	Project Title	Project Description	Executive Sponsor Assures the project	OVERALL PROJECT RAG status	An effective project team is in place	Scope and Approach is defined	Targets / benefits defined/on track	Milestone plan is defined/on track	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	Comments for attention of the Project Team, Steering Group and sub-Committee
1.0 Deliver Outstanding Care 17/18													
CQAC 1.2	Experience in Outpatients	The project will improve patient & staff experience; understand demand and capacity; improve flow and environment	Hilda Gwilliams		🟢	🟢	🟡	🟢	🟡	🟢	🟢	🟢	SG documents available to January 2018. PID completed. Benefits defined - tracking/dashboard uploaded 5 Dec 17. Milestone Plans are currently being maintained up to date (wuith some missed milestones but within acceptable limits). Comms/ engagement activities, most recent evidence is the Dec 17 'Team Brief', so a new update is required. Risks available on Ulysses. **Last updated 14 March 2018.**
CQAC 1.3	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	Christian Duncan		🟢	🟢	🔴	🔴	🟢	🟢	🟢	🟢	Steering Group notes available on SharePoint. PID available. Targets/benefits defined in PID, tracking shows that benefits are unlikely to be realised by the planned date. All areas (tabs) of the Milestone Plans to be fully defined/populated, for some workstreams this has not been done since Jun/Aug 17. Comms tracker available. Risks available on Ulysses. EA/QIA complete. **Last updated 16 February 2018.**
CQAC 1.7	Best in Community Care	The aim of this project is to ensure the development and sustainability of clinical pathways between hospital and home, that are child and family centric and both clinically and financially efficient, maximising whole system resources wherever possible.	Steve Ryan (Hilda Gwilliams)		🟡	🟡	🟡	🟡	🟡	🔴	🟢	🟢	Initial Project Documentation now uploaded to SharePoint. Further development required in all domains, with particular emphasis on 'Risks'. EA/QIA signed off and uploaded. **Last updated 28 February 2018.**

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

Alder Hey Children's NHS
NHS Foundation Trust

Sub-Committee	CQAC	Report Date	14 Mar 18
Workstream Name	Delivering Outstanding Care	Executive Sponsor	Hilda Gwilliams/Steve Ryan

Current Dashboard Rating (Pt 2):

Project Ref	Project Title	Project Description	Executive Sponsor Assures the project	OVERALL PROJECT RAG status	An effective project team is in place	Scope and Approach is defined	Targets / benefits defined/on track	Milestone plan is defined/on track	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	Comments for attention of the Project Team, Steering Group and sub-Committee
1.0 Deliver Outstanding Care 17/18													
CQAC 1.7	**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 are a number of workstreams underpinning this strategy:1. Resuscitation; 2. Deteriorating Parient; 3. Medical Management of Complex Surgical Patients.	Steve Ryan (Hilda Gwilliams)										Draft PID uploaded and incorporates the following projects/workstreams: Deteriorating Patient/Sepsis; Medical Management of Complex Surgical Patients (and also covers: Resuscitation, 7 Day Services, PEWS and Outreach). The PID includes the scope with benefits information being posted by 'project'. The high level planning milestones in the PID now need to be turned into a Gantt Chart. Minutes/notes of meetings are present, as is identification of high level stakeholders. **Last updated 5 February 2018.**
CQAC 1.7.1	**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 December 2018. PID complete. Benefits defined, tracking/reporting of benefits has commenced. The key target, Time to Antibiotic Presecription from Diagnosis is against a threshold of 90%. Milestone Plan last updated on SharePoint 28 Nov but several missed milestones in evidence. Comms/ Engagement Plan available, evidence has been provided for certain activities. Risks to be updated on Ulysses. EA/QIA complete. **Last updated 6 February 2018.**

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

Sub-Committee	CQAC	Report Date	14 Mar 18
Workstream Name	Delivering Outstanding Care	Executive Sponsor	Hilda Gwilliams/Steve Ryan

Financial
Reporting: at Month 11

	Year to Date			In Year Forecast			Recurrent Savings		
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Corporate Report

Feb 2018

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Executive Summary

Feb 2018

Alder Hey Children's NHS Foundation Trust

Is there a Governance Issue?

Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18
N	N	N	N	N	N	N	N	N	N	N

Highlights

Despite the continued high levels of ED attendance with more complex and sicker children attending we have continued to deliver robust ED performance at 92.6%. We continue to achieve diagnostic, incomplete pathway and cancer standards despite NHSE directives to cancel all elective activity. We have reduced cancelled ops on the day and have had only 2 x 28 day breaches and have continued to see robust operational performance despite the winter challenges. Winter plan remains in place to support Flow and maintain hospital activity.

Challenges

Significant challenges remain around the maintenance of flow and ED attendance. Despite the implementation of the Trust winter plan we have not achieved the 4hr standard despite implementation of the actions. Significant challenges remain with maintaining primary care streaming with 50% of shifts unfilled by UC24 for Feb. Team are working to backfill with non-GP medical staff and APNP but gaps remain. A consequence of reducing EL IP activity is our 18 week backlog has increased which will require focus to reduce down post winter plan. EL & cardiac activity below plan due to capacity challenges.

Patient Centred Services

slight deterioration noted in performance metrics for February reflective of challenging operational conditions. Continuing high levels of ED attendance have challenged A&E and we have seen our performance reduce slightly to 92.6%. STF funds are linked to M12 pass therefore achievement of 95% plans are being refined and implemented. All other NHSI core standards have been achieved for Feb. Winter plan still operational which does have an adverse affect on metrics as IP activity is kep low to maintain hospital occupancy <93%. This does also mean that we manage cancellations on the day to a much lower number. we haver had 2 x 28day breaches due to limited capacity on the day. OP utilisation is low and requires further divisional review however we have had half term impact. Theatre utilisation has also reduced notably with medical specialties. DNA rates have increased in line with seasonal variation but will be a part of the brilliant booking workstream.

Excellence in Quality

February showed excellent results in the patient safety domain, with zero grade 3 and above pressure ulcers, zero never events, zero incidents of moderate harm and above, and zero SIRIs declared in month. Plus there were 4 medication errors resulting in harm, which maintains a significant cumulative reduction compared to last year.
There were 4 infections recorded in February, which is 72 year to date compared to 93 this time last year. There were zero MRSA bacteraemia and zero C. difficile infections in month. For sepsis metrics, the percentage of ED patients receiving antibiotics within 1 hour was 42.3% (deterioration), whilst for in-patients this was 86.4% which is an improvement and the highest performance this year. There was 1 in-hospital death this month compared to 5 in February last year

Financial, Growth & Mandatory Framework

For the month of February the Trust is reporting a trading surplus of £0.5m which is in line with plan.

Income is ahead of plan by £1.1m. Shortfalls in elective income (£0.3m) are offset by over performance in non elective activity (£0.4m). Elective activity is behind plan by 11%, non elective is ahead by 18% and outpatient activity is behind by 9%.

Pay budgets are 0.6m overspent for the month relating to use of temporary staffing and the impact of unachieved savings targets. The Trust is behind plan with the CIP target by £1.2m to date. Cash in the Bank is £10.2m. Monitor Use of Resources rating of 3 in line with plan.

Great Talented Teams

The PDR window for 18/19 will open again in April and all Divisions are encouraged to ensure all PDR's are diarised (April to July) - from end of July it is expected that compliance is at least 90% . Sickness has seen a decrease in Feb to 5.6%, which is still higher than the Trust threshold of 4.5%. A task and finish group is currently being set up to address issues affecting sickness and health and wellbeing. An area of focus will be on areas of high absence and putting strategies in place to address this. Mandatory training for Feb is 94.6% higher than the Trust Target of 90%.

Leading Metrics

Feb 2018

Alder Hey Children's NHS Foundation Trust

Patient Centered Services

Metric Name	Goal	Jan 2018	Feb 2018	Trend	Last 12 Months
ED: 95% Treated within 4 Hours	95.0 %	93.6 %	92.6 %	▼	
RTT: 90% Admitted within 18 weeks		89.7 %	89.2 %	▼	
RTT: 95% Non-Admitted within 18 weeks		89.3 %	91.3 %	▲	
RTT: 92% Waiting within 18 weeks (open Pathways)	92.0 %	92.2 %	92.1 %	▼	
Diagnostics: Numbers waiting over 6 weeks		0	3	▲	
Average LoS - Elective (Days)		3.0	3.0	▲	
Average LoS - Non-Elective (Days)		2.1	2.0	▼	
Daycase Rate		72.6 %	74.2 %	▲	
Theatre Utilisation - % of Session Utilised	90.0 %	87.2 %	85.6 %	▼	
28 Day Breaches	0.0	0	2	▲	
Clinic Session Utilisation	90.0 %	85.6 %	83.4 %	▼	
DNA Rate	12.0 %	10.0 %	11.1 %	▲	
Cancelled Operations - Non Clinical - On Same Day		19	18	▼	

Excellence in Quality

Metric Name	Goal	Jan 2018	Feb 2018	Trend	Last 12 Months
Never Events	0.0	0	0	–	
IP Survey: % Received information enabling choices about their care	90.0 %	94.4 %	94.7 %	▲	
IP Survey: % Treated with respect	100.0 %	100.0 %	99.4 %	▼	
IP Survey: % Know their planned date of discharge	80.0 %	52.1 %	59.0 %	▲	
IP Survey: % Know who is in charge of their care	95.0 %	93.6 %	90.9 %	▼	
IP Survey: % Patients involved in play and learning	80.0 %	78.3 %	79.6 %	▲	
Pressure Ulcers (Grade 3 and above)		2	0	▼	
Total Infections (YTD)	73.0	68	72	▼	
Medication errors resulting in harm	6.0	2	5	▲	
Clinical Incidents resulting in minor harm & above		84	80	▼	

Great and Talented Teams

Metric Name	Goal	Jan 2018	Feb 2018	Trend	Last 12 Months
Corporate Induction	90.0 %	TBC	94.0 %		
PDR	90.0 %	87.3 %	82.6 %	▼	
Medical Appraisal		24.0 %	52.1 %	▲	
Sickness	4.5 %	6.4 %	5.5 %	▼	
Mandatory Training	90.0 %	89.2 %	94.6 %	▲	
Staff Survey (Recommend Place to Work)		64.0 %	64.0 %	–	
Actual vs Planned Establishment (%)		93.2 %	94.9 %	▲	
Temporary Spend ('000s)		833	926	▲	

Financial, Growth and Mandatory Framework

Metric Name	Jan 2018	Feb 2018	Last 12 Months
CIP In Month Variance ('000s)	54	-410	
Monitor Risk Ratings (YTD)	3	3	
Trading Surplus/(Deficit)	1726	519	
Capital Expenditure YTD % Variance	-57.2 %	-91.7 %	
Cash in Bank (£M)	6.7	10.2	

Exceptions

Feb 2018

Alder Hey Children's NHS Foundation Trust

Positive (Top 5 based on % change)

Metric Name	Feb 2017	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Last 12 Months
Average LoS - Elective (Days)	3.4	2.8	3.0	3.6	2.7	3.2	2.9	3.1	2.6	3.0	3.6	3.0	3.0	
Corporate Induction	77.8%	82.4%	82.9%	85.7%	79.3%	100.0%	55.6%	85.0%	69.2%	96.9%	77.3%		94.0%	
Medical Appraisal	64.8%	87.0%	77.7%	77.7%	33.3%	79.2%	81.0%	8.0%	8.0%	11.6%	13.6%	24.0%	52.1%	
Total Infections (YTD)	93	104	6	9	13	15	20	26	36	49	58	68	72	
Clinical Incidents resulting in minor harm & above	69	104	60	70	78	97	65	73	72	88	52	84	80	

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

Metric Name	Feb 2017	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Last 12 Months
RTT: 90% Admitted within 18 weeks	88.9%	87.9%	89.6%	90.3%	88.8%	89.1%	89.0%	86.8%	89.2%	90.4%	89.6%	89.7%	89.2%	
Daycase Rate	72.4%	70.7%	71.1%	71.9%	72.6%	70.9%	70.2%	71.5%	71.2%	72.3%	74.2%	72.6%	74.2%	
Theatre Utilisation - % of Session Utilised	87.0%	86.8%	87.2%	87.3%	88.3%	86.1%	87.5%	86.5%	86.4%	84.4%	85.8%	87.2%	85.6%	
Trading Surplus/(Deficit)	470	5,972	-1,905	-448	-127	-270	-1,691	-456	317	1,296	88	1,726	519	
Cash in Bank (£M)	7.2	6.5	6.2	5.2	3.7	11.3	10.4	9.1	10.9	6.8	8.2	6.7	10.2	

Challenge (Top 5 based on % change)

Metric Name	Feb 2017	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Last 12 Months
28 Day Breaches	5	2	4	2	5	1	9	0	8	5	5	0	2	
Clinic Session Utilisation	85.1%	87.9%	86.7%	85.9%	85.0%	85.7%	84.7%	83.9%	85.5%	86.8%	83.0%	85.6%	83.4%	
PDR	71.1%	59.2%	2.1%	12.4%	48.3%	78.7%	84.7%	86.2%	87.3%	86.9%	87.3%	87.3%	82.6%	
Sickness	5.3%	4.7%	4.5%	4.6%	4.6%	5.1%	5.0%	4.9%	5.4%	5.3%	5.8%	6.4%	5.5%	
IP Survey: % Know their planned date of discharge	72.0%	75.7%	79.4%	69.1%	65.5%	64.0%	53.9%	65.0%	57.4%	61.9%	62.5%	52.1%	59.0%	

Patient Safety

Feb 2018

Alder Hey Children's NHS Foundation Trust

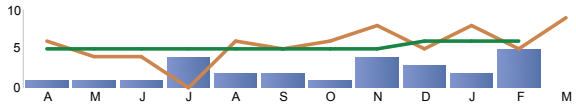
Summary

February showed excellent results in the patient safety domain, with zero grade 3 and above pressure ulcers, zero never events, zero incidents of moderate harm and above, and zero SIRIs declared in month. Plus there were 4 medication errors resulting in harm, which maintains a significant cumulative reduction compared to last year.

17/18 16/17 Threshold

Medication Errors

Medication errors resulting in harm — 5 (goal: 6.0)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	1	1	1	4	2	2	1	4	3	2	5	
16/17	6	4	4	0	6	5	6	8	5	8	5	9

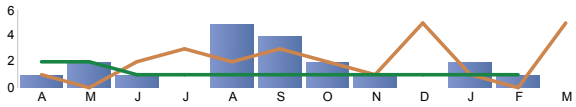
Pressure Ulcers

Pressure Ulcers (Grade 3 and above) — 0 (Est. Baseline)

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

Readmissions to PICU within 48 hrs

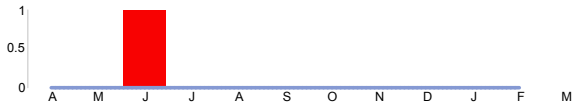
Readmissions to PICU within 48 hrs — 19 (goal: 13.0)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	1	2	1	0	5	4	2	1	0	2	1	
16/17	1	0	2	3	2	3	2	1	5	1	0	5

Never Events

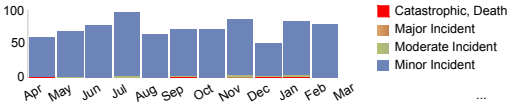
Never Events — 0 (goal: 0.0)



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

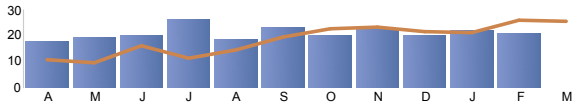
Incidents

Clinical Incidents resulting in minor harm & above — 80



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	60	70	78	97	65	73	72	88	52	84	80	
16/17	47	41	62	37	46	60	68	79	61	61	69	104

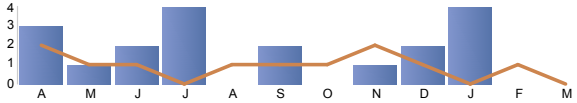
% of Total Clinical Incidents that resulted in Minor Harm & above — 21.2 %



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

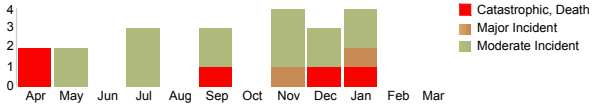
Serious incidents requiring investigation

Serious Incidents Requiring Investigation (Total) — 0



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	3	1	2	4	0	2	0	1	2	4	0	
16/17	2	1	1	0	1	1	1	2	1	0	1	0

Clinical Incidents resulting in moderate harm, major/severe harm or death — 21



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	2	2	0	3	0	3	0	4	3	4	0	
16/17	2	0	1	0	0	2	0	1	1	2	2	1

Patient Experience

Feb 2018

Alder Hey Children's NHS Foundation Trust

Summary

Complaints have remained high over the winter, with 14 reported in February, the highest in any month this year. PALS attendances have also remained high with 144 in February. The percentage of families 'recommending' Alder Hey through the F&F Test has dropped below threshold in outpatients and in A&E, whilst the number of responses in community and mental health remain low.
Our inpatient questionnaire feedback has improved in 3 out of the 5 questions, and work continues to improve all measures to reach their threshold.

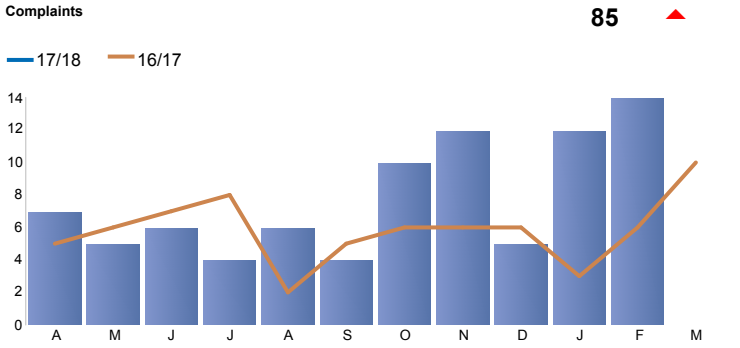
Inpatient Survey

Metric Name	Goal	Jan 2018	Feb 2018	Trend	Last 12 Months
% Know who is in charge of their care	95.0 %	93.6 %	90.9 %	▼	
% Patients involved in play and learning	80.0 %	78.3 %	79.6 %	▲	
% Know their planned date of discharge	80.0 %	52.1 %	59.0 %	▲	
% Received information enabling choices about their care	90.0 %	94.4 %	94.7 %	▲	
% Treated with respect	100.0 %	100.0 %	99.4 %	▼	

Friends and Family

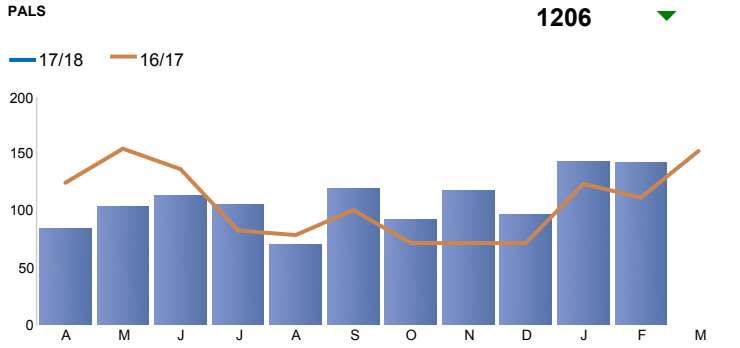
Metric Name	Goal	Number of Responses	Jan 2018	Feb 2018	Trend	Last 12 Months
A&E - % Recommend the Trust	87%	277	89.8 %	85.6 %	▼	
Community - % Recommend the Trust	96%	22	87.5 %	100.0 %	▲	
Inpatients - % Recommend the Trust	96%	620	97.3 %	96.6 %	▼	
Mental Health - % Recommend the Trust	88%	29	77.8 %	82.8 %	▲	
Outpatients - % Recommend the Trust	94%	853	96.1 %	91.8 %	▼	

Complaints



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	7	5	6	4	6	4	10	12	5	12	14	
16/17	5	6	7	8	2	5	6	6	6	3	6	10

PALS



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	86	105	115	107	72	121	94	119	98	145	144	
16/17	125	155	137	83	79	101	72	72	72	124	112	153

Clinical Effectiveness

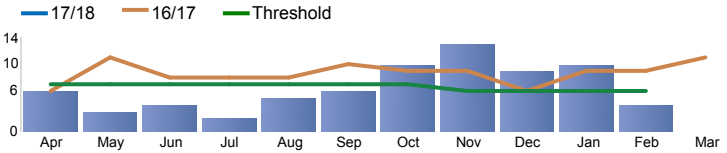
Feb 2018

Alder Hey Children's NHS Foundation Trust

Summary

There were 4 infections recorded in February, which is 72 year to date compared to 93 this time last year. There were zero MRSA bacteraemia and zero C. difficile infections in month. For sepsis metrics, the percentage of ED patients receiving antibiotics within 1 hour was 42.3% (deterioration), whilst for in-patients this was 86.4% which is an improvement and the highest performance this year. There was 1 in-hospital death this month compared to 5 in February last year.

Infections



YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	6	9	13	15	20	26	36	49	58	68	72	
16/17	6	17	25	33	41	51	60	69	75	84	93	104

Total Infections (YTD)

72 ▼ (goal: 73.0)

Hospital Acquired Organisms - MRSA (BSI) (YTD)

4 ▼ (goal: 0.0)

Hospital Acquired Organisms - C.difficile (YTD)

0 – (goal: 0.0)

Outbreak Infections (YTD)

34 –

Cluster Infections (YTD)

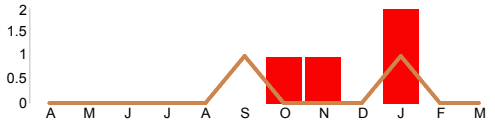
0 –

Legend

17/18
16/17
Threshold

Hospital Acquired Organisms - MRSA (BSI)

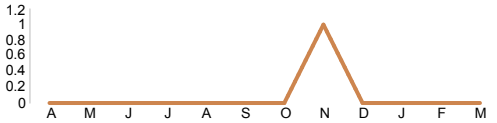
0 ▼ (goal: 0.0)



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

Hospital Acquired Organisms - C.difficile

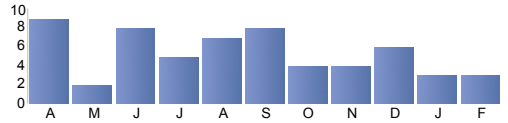
0 – (goal: 0.0)



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

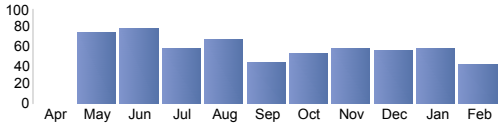
Acute readmissions of patients with long term conditions within 28 days

59 (Est. Baseline)



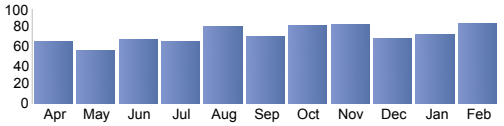
YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
17/18	9	11	19	24	31	39	43	47	53	56	59

Sepsis: % Patients receiving antibiotic within 60 mins for ED



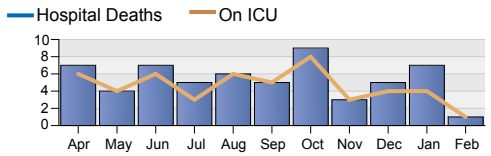
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
17/18		76.5%	80.8%	59.1%	68.8%	44.4%	54.5%	60.0%	57.1%	60.0%	42.3%

Sepsis: % Patients receiving antibiotic within 60 mins for Inpatients



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
17/18	66.7%	57.1%	69.6%	66.7%	82.6%	72.4%	83.7%	85.4%	70.3%	74.1%	86.4%

Mortality in Hospital



Deaths in Hospital

Actual	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	7	4	7	5	6	5	9	3	5	7	1	
16/17	7	8	6	6	8	2	7	6	8	4	5	9

Access

Feb 2018

Alder Hey Children's NHS Foundation Trust

Summary

Incomplete, diagnostic & cancer standards achieved for Feb. Winter plan remains active within which DC & IP TCI's are being managed to maintain occupancy levels sufficient to support ED outflow. ED attendance continues to remain high with increased acuity resulting in a higher than planned level of NEL admissions. This knocks into the EL programme despite planning assumptions and cancellations. Hospital has remained operationally busy which reflects high levels of occupancy. Choose & Book capacity available to meet referral demand which has increased against the same period last year.

18 Weeks

RTT: 90% Admitted within 18 weeks 89.2 %

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

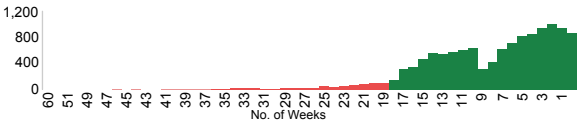
RTT: 95% Non-Admitted within 18 weeks 91.3 %

Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
88.9%	89.1%	89.2%	90.1%	90.3%

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

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

Open Pathways Weekly Profile Feb 2018



0-18 Wks	19-36 Wks	36-51 Wks	52+ Wks
11,879	812	97	2

Cancer

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

Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
100.0%	100.0%	100.0%	97.4%	100.0%

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

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

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

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

Diagnostics

Diagnostics: % Completed Within 6 Weeks 99.3 % *(goal: 99.0 %)*

Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
99.8%	100.0%	100.0%	99.9%	99.7%

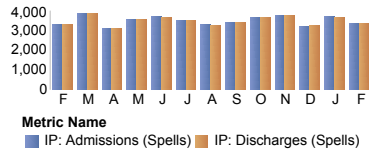
Waiting Times Failed 2

Waiting Times Passed 5

Number of Diagnostics

461

Admissions and Discharges



Bed Occupancy

Bed Occupancy (Funded Beds) 84.4 %

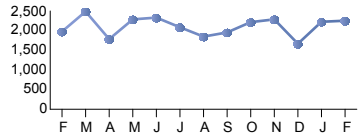
Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
83.9%	79.8%	78.9%	81.4%	84.8%

Provider

Convenience and Choice: Slot Availability 98.2 % *(goal: 96.0 %)*

Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
97.0%	98.0%	98.4%	98.8%	98.2%

Referrals Received (GP)



Emergency Department

Feb 2018

Alder Hey Children's NHS Foundation Trust

Summary

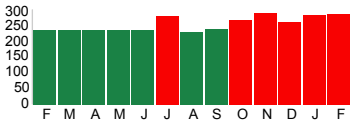
Increased attendances and acuity. Admission numbers above predicted impeding flow and causing back log in ED.
Actions to rectify: Additional medical and nursing staffing shifts in place in ED and for specialist review. Additional escalation beds in the system, increased bed management officers in ED. Social media communications to inform public of increased pressure and alternatives to ED attendance
Anticipated recovery date: March 2018

ED

ED: 95% Treated within 4 Hours — 92.6 % (goal: 95.0 %)

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

ED: Total Time in ED (95th Percentile) — 288.0 mins (goal: 240.0 mins)



Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
714.0	717.0	753.0	824.4	573.2

ED: Longest Wait Time (Hrs) — 11.1 (goal: 0.0)

Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
30.6	61.3	28.5	33.6	24.4

ED: Number Treated Over 4 Hours

338

ED to Inpatient Conversion Rate

17.2 %

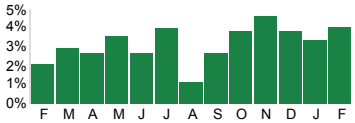
Feb 2018

ED

ED: 60 minute 'Time to Treat Decision' (Median) — 100.0 mins (goal: 60.0 mins)

Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
227.0	247.5	206.0	266.5	199.0

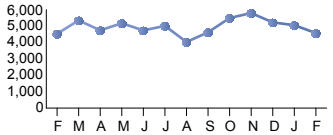
ED: Percentage Left without being seen — 4.1 % (goal: 5.0 %)



Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
2.3%	3.0%	2.8%	4.1%	3.7%

ED: Number of Attendances

4574 Feb 2018

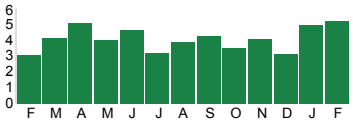


Ambulance Services

Ambulance: Acute Compliance — 84.8 % (goal: 85.0 %)

Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
90.1%	88.4%	84.2%	79.3%	81.7%

Ambulance: Average Notification to Handover Time (mins) — 5.3 mins (goal: 15.0 mins)



Ambulance: Patients Waiting between 30 and 45 minutes — 1

Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
11.0	9.0	4.0	10.2	3.0

Ambulance: Patients Waiting between 45 and 60 minutes — 0

Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
2.0	2.0	1.0	1.0	0.0

Productivity & Efficiency

Feb 2018

Alder Hey Children's NHS Foundation Trust

Summary

Feb. continues with the winter plan in place and ongoing ED attendance & NEL challenges to manage. A reduced number of elective IP TCI's and increased numbers of DC patients is reflected through the metrics. Winter plan supports flow with reduced on the day cancellations and 3 x 28 day breaches. ED attendance remains high with increased acuity. Theatre utilisation reduced through both surgical/medical use. Gynae/Ophthal/Oral/Onc/Rheum markedly reduced. OP utilisation only 80%; reflects seasonal trends following increased cancellations and increased DNA's. Booking work will begin to address

Length of Stay

Average LoS - Elective (Days) 3.0 ▲

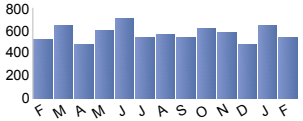
Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
2.9	3.1	3.0	3.0	3.0

Average LoS - Non-Elective (Days) 2.0 ▼

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

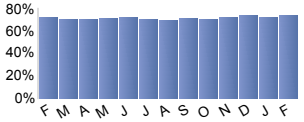
Day Case Rate

Daycases (K1/SDCPREOP) 546 ▼



Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
1,820	1,819	1,674	1,724	1,202

Daycase Rate 74.2 % ▲



Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
71.2%	71.9%	70.9%	72.5%	73.3%

Bed Refusals

Bed Refusals 0 ▼ *(goal: 0.0)*

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

Theatres / Surgery

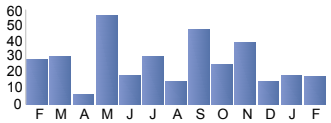
Theatre Utilisation - % of Session Utilised * 85.6 % ▼ *(goal: 90.0 %)*

Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
86.8%	87.6%	86.7%	85.5%	86.5%

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

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

Cancelled Operations - Non Clinical - On Same Day 18 ▼



Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
77	83	94	81	37

28 Day Breaches 2 ▲ *(goal: 0.0)*

Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
9	11	10	18	2

Outpatients

Clinic Session Utilisation * 83.4 % ▼ *(goal: 90.0 %)*

Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
85.8%	85.8%	84.8%	85.3%	84.5%

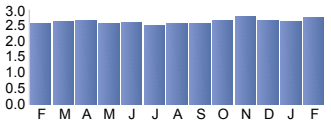
OP Appointments Cancelled by Hospital % 15.5 % ▲ *(goal: 5.0 %)*

Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
14.7%	13.4%	13.1%	13.6%	14.6%

DNA Rate 11.1 % ▲ *(goal: 12.0 %)*

Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
11.0%	11.8%	12.4%	11.5%	10.6%

OP: New/Follow Up 2.8 ▲



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

Facilities

Feb 2018

Alder Hey Children's NHS Foundation Trust

Summary

During February 2018 the Domestic Services re-organisation was concluded and new working rosters commenced. This month the number of cleaning audits completed has increased. The information obtained from the audits has helped the Supervisors to focus on areas that have not achieved the required standard by having the faults rectified and ensuring standards are maintained.

Facilities

Cleanliness Performance VH 99.0 % (goal: 98.0 %)

Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
97.7%	99.7%	96.9%	98.2%	98.8%

Cleanliness Performance H 98.0 % (goal: 95.0 %)

Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
94.0%	94.6%	96.0%	96.3%	97.2%

Cleanliness Performance S 93.3 % (goal: 85.0 %)

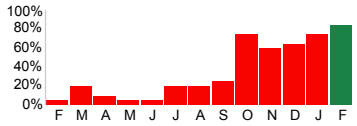
Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
96.5%	90.3%	84.6%	91.8%	93.3%

Cleanliness Performance L 75.0 % (goal: 75.0 %)

Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
100.0%	90.0%	75.1%	75.0%	84.5%

Facilities

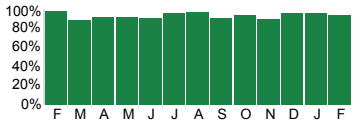
Audit Compliance 85.0 % (goal: 85.0 %)



Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
40.0%	6.7%	21.7%	66.7%	80.0%

Facilities - Other

Routine Maintenance Resolution 94.9 % (goal: 85.0 %)



Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
96.6%	92.6%	95.7%	94.2%	96.1%

PPM% 91.8 % (goal: 85.0 %)

Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
96.1%	94.8%	97.9%	97.5%	95.5%

CAMHS

Feb 2018

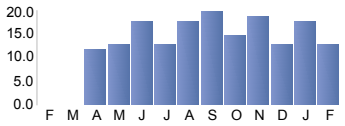
Alder Hey Children's NHS Foundation Trust

Summary

The wait for a choice appointment still remains a problem with the wait across both localities at 20 week. Additional funding has been secured from the Liverpool and Sefton CCG and a review of all the patient currently waiting is to be undertaken to risk assess were conditions may have escalated.
EDYS remains 100%RTT

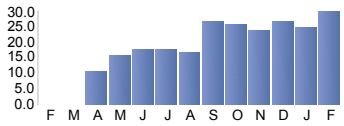
Waiting Times

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



Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
0.0	43.0	51.0	47.0	31.0

CAMHS: Avg Wait to Partnership Appt (Weeks)- Sefton Specialist 30.0



Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
0.0	43.0	51.0	47.0	31.0

Eating Disorder Pathway

Routine EDYS Pathway Average Wait in Weeks 3

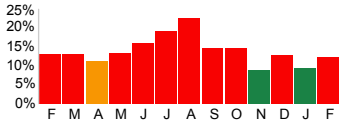
Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
0.0	6.0	5.0	6.1	6.6

Urgent EDYS Pathway Average Wait in Weeks 1

Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
0.0	1.0	0.1	2.2	1.6

DNA Rates

CAMHS: DNA Rate - New 12.5 % (goal: 10.0 %)



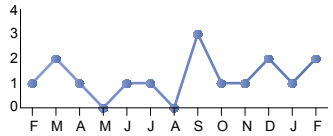
Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
13.6%	13.8%	18.9%	12.3%	10.8%

CAMHS: DNA Rate - Follow Up 15.1 % (goal: 14.0 %)

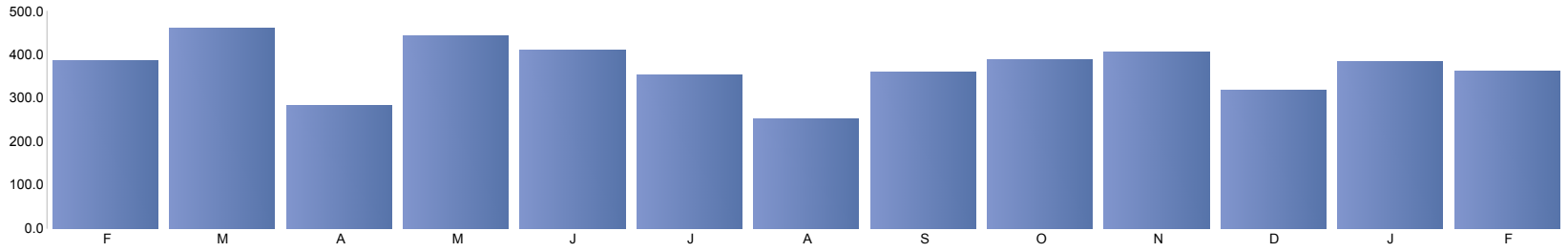
Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
17.6%	17.7%	20.8%	16.9%	14.2%

Tier 4 Admissions

CAMHS: Total Admissions to DJU 2



CAMHS: Referrals Received



External Regulation

Feb 2018

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 NHS Improvement Single Oversight Framework.

NHSI - Governance Concern

Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18
N	N	N	N	N	N	N	N	N	N	N

NHSI - Risk Rating

Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18
2	3	3	3	3	3	3	3	3	3	3	3

NHSI Feb 2018

Metric Name	Goal	Jan 18	Feb 18	Trend
ED: 95% Treated within 4 Hours	95.0 %	93.6 %	92.6 %	▼
RTT: 90% Admitted within 18 weeks		89.7 %	89.2 %	▼
RTT: 95% Non-Admitted within 18 weeks		89.3 %	91.3 %	▲
RTT: 92% Waiting within 18 weeks (open Pathways)	92.0 %	92.2 %	92.1 %	▼
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	–

NHSI - 18 Weeks RTT

RTT: 90% Admitted within 18 weeks

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

RTT: 95% Non-Admitted within 18 weeks

Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
88.9%	89.1%	89.2%	90.1%	90.3%

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

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

NHSI - All Cancers

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

Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
100.0%	100.0%	100.0%	97.4%	100.0%

All Cancers: 31 day wait referral to treament

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

All Cancers: 31 day wait until subsequent treatments

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

NHSI - A&E 4 Hour Target

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

NHSI - C difficile

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

NHSI - Data Completeness

No Data Available

Workforce

Feb 2018

Alder Hey Children's NHS Foundation Trust

Summary

The PDR window for 18/19 will open again in April and all Divisions are encouraged to ensure all PDR's are diarised (April to July) - from end of July it is expected that compliance is at least 90% . Sickness has seen a decrease in Feb to 5.6%, which is still higher than the Trust threshold of 4.5%. A task and finish group is currently being set up to address issues affecting sickness and health and wellbeing. An area of focus will be on areas of high absence and putting strategies in place to address this. Mandatory training for Feb is 94.6% higher than the Trust Target of 90%.

Staff Group Analysis

Sickness Absence (rolling 12 Months)

Staff Group	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Last 12 Months
Add Prof Scientific and Technic	4.9%	3.6%	3.6%	3.9%	4.6%	4.2%	4.9%	2.8%	3.6%	4.4%	4.0%	3.7%	
Additional Clinical Services	5.6%	7.1%	7.4%	7.3%	7.7%	6.1%	6.0%	7.6%	8.0%	8.7%	8.4%	7.2%	
Administrative and Clerical	3.3%	2.8%	2.3%	2.4%	3.7%	4.4%	4.1%	4.3%	4.1%	4.7%	5.2%	4.5%	
Allied Health Professionals	3.5%	2.9%	3.2%	3.8%	3.2%	2.8%	2.7%	3.0%	2.4%	2.4%	4.1%	4.0%	
Estates and Ancillary	8.9%	10.7%	9.2%	9.2%	10.8%	14.7%	12.3%	13.2%	11.4%	10.2%	12.8%	12.7%	
Healthcare Scientists	2.3%	1.0%	3.3%	4.0%	4.6%	1.5%	2.9%	2.0%	3.2%	2.2%	0.9%	1.6%	
Medical and Dental	1.8%	1.2%	1.7%	1.7%	2.0%	1.9%	1.7%	2.4%	2.1%	3.0%	2.9%	2.1%	
Nursing and Midwifery Registered	5.5%	5.1%	5.4%	5.3%	5.1%	4.8%	5.0%	6.1%	5.8%	6.7%	7.5%	6.2%	
Trust	4.7%	4.5%	4.6%	4.6%	5.1%	5.0%	4.9%	5.4%	5.3%	5.8%	6.4%	5.5%	

Staff in Post FTE (rolling 12 Months)

Staff Group	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Last 12 Months
Add Prof Scientific and Technic	201	197	199	201	200	197	199	199	196	197	198	201	
Additional Clinical Services	376	391	393	392	400	397	408	409	405	403	404	411	
Administrative and Clerical	586	612	622	619	625	627	625	623	625	627	634	634	
Allied Health Professionals	131	209	210	213	215	216	219	223	224	223	221	226	
Estates and Ancillary	189	187	185	184	184	183	182	182	180	180	180	180	
Healthcare Scientists	107	107	107	109	110	110	108	107	107	107	108	111	
Medical and Dental	243	244	243	247	241	248	249	251	247	247	251	253	
Nursing and Midwifery Registered	970	968	970	972	965	960	1,019	1,025	1,019	1,008	999	998	

Staff in Post Headcount (rolling 12 Months)

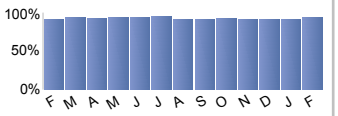
Staff Group	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Last 12 Months
Add Prof Scientific and Technic	221	218	220	223	223	219	220	219	216	218	220	223	
Additional Clinical Services	442	469	470	468	477	473	485	487	483	480	482	490	
Administrative and Clerical	673	701	710	709	714	715	712	710	712	713	718	718	
Allied Health Professionals	161	258	259	262	264	265	267	271	272	271	269	274	
Estates and Ancillary	236	234	231	231	230	229	228	228	226	226	227	227	
Healthcare Scientists	117	117	117	119	119	119	119	116	116	116	118	121	
Medical and Dental	284	286	286	289	284	290	293	294	292	291	295	297	
Nursing and Midwifery Registered	1,094	1,093	1,095	1,097	1,091	1,086	1,146	1,152	1,146	1,134	1,123	1,122	

Finance

Temporary Spend ('000s) 926

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

Actual vs Planned Establishment (%) 94.9 %



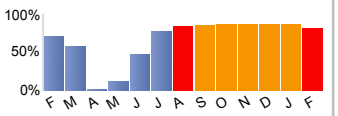
Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
92.2%	94.8%	94.3%	93.5%	94.1%

Appraisals

Medical Appraisal 52.1 %

Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
68.5%	76.9%	57.8%	11.1%	41.4%

PDR 82.6 % (goal: 90.0 %)



Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
67.2%	21.0%	83.1%	87.2%	85.0%

Training

Corporate Induction 94.0 % (goal: 90.0 %)

Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
79.5%	82.6%	81.0%	80.6%	94.0%

Mandatory Training 94.6 % (goal: 90.0 %)

Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
77.1%	76.1%	76.6%	80.9%	91.9%

Performance by CBU

Feb 2018

Alder Hey Children's NHS
NHS Foundation Trust

Operational

Metric name	COMMUNITY	MEDICINE	SURGERY
Clinic Session Utilisation	68.4%	89.0%	83.5%
Convenience and Choice: Slot Availability	100.0%	96.3%	99.2%
DNA Rate (Followup Appts)	16.8%	8.8%	9.0%
DNA Rate (New Appts)	20.9%	11.1%	11.9%
Referrals Received (GP)	344	772	1,136
Temporary Spend ('000s)	136	276	434
Theatre Utilisation - % of Session Utilised		80.6%	86.4%
Trading Surplus/(Deficit)	377	809	1,891

Patient

Metric name	COMMUNITY	MEDICINE	SURGERY
Average LoS - Elective (Days)		3.2	2.9
Average LoS - Non-Elective (Days)		1.6	2.9
Cancelled Operations - Non Clinical - On Same Day	0	0	18
Daycases (K1/SDCPREOP)	0	66	472
Diagnostics: % Completed Within 6 Weeks		99.8%	92.6%
Hospital Initiated Clinic Cancellations < 6 weeks notice	10	55	58
OP Appointments Cancelled by Hospital %	14.0%	18.3%	14.1%
RTT: 90% Admitted within 18 weeks		92.7%	88.4%
RTT: 92% Waiting within 18 weeks (open Pathways)	96.5%	93.0%	91.3%
RTT: 95% Non-Admitted within 18 weeks	90.6%	88.7%	92.6%

Quality

Metric name	COMMUNITY	MEDICINE	SURGERY
Cleanliness Scores		98.1%	98.4%
Hospital Acquired Organisms - C.difficile	0	0	0
Hospital Acquired Organisms - MRSA (BSI)	0	0	0
Medication Errors (Incidents)	8	30	44

Workforce

Metric name	COMMUNITY	MEDICINE	SURGERY
Corporate Induction	100.0%	96.2%	88.2%
Mandatory Training	96.8%	94.7%	93.5%
PDR	83.9%	81.5%	83.3%
Sickness	5.6%	4.6%	5.3%

CBU Performance - Community

Feb 2018

Alder Hey Children's NHS Foundation Trust

Key Issues

We have appointed new consultant. On-going issues with data quality and the backlog of follow up patients being seen in a timely manner. Job planning with all doctors has commenced and review of templates.

Support Required

NA

Operational

Metric Name	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Last 12 Months
Theatre Utilisation - % of Session Utilised														
Clinic Session Utilisation	80.3%	83.0%	79.1%	81.9%	79.9%	79.2%	76.9%	80.1%	83.3%	80.7%	73.5%	75.0%	68.4%	
DNA Rate (New Appts)	12.1%	12.1%	15.8%	16.1%	19.3%	17.5%	18.4%	13.3%	15.5%	13.4%	15.4%	14.2%	20.9%	
DNA Rate (Followup Appts)	15.4%	13.4%	14.9%	13.9%	16.0%	15.2%	19.8%	17.5%	14.0%	13.7%	15.2%	12.4%	16.8%	
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)	336	385	230	387	324	321	232	331	405	394	271	339	344	
Temporary Spend ('000s)	72	150	67	103	116	146	169	195	141	167	131	146	136	
Trading Surplus/(Deficit)	256	442	343	414	299	224	145	263	284	271	247	211	377	

Patient

Metric Name	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Last 12 Months
RTT: 90% Admitted within 18 weeks														
RTT: 95% Non-Admitted within 18 weeks	73.1%	88.4%	87.9%	85.4%	91.8%	91.4%	93.1%	87.3%	87.9%	83.2%	90.0%	89.1%	90.6%	
RTT: 92% Waiting within 18 weeks (open Pathways)	93.1%	94.4%	94.0%	97.4%	94.3%	94.6%	96.5%	96.1%	96.3%	96.8%	97.3%	97.3%	96.5%	
Average LoS - Elective (Days)								14.00				20.00		
Average LoS - Non-Elective (Days)														
Hospital Initiated Clinic Cancellations < 6 weeks notice	19	8	15	3	12	5	13	8	19	17	19	10	10	
Daycases (K1/SDCPREOP)	0	0	0	2	0	1	0	0	1	3	0	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 %	20.0%	20.5%	22.8%	14.5%	19.0%	13.5%	17.3%	16.2%	15.2%	17.0%	17.2%	12.7%	14.0%	
Diagnostics: % Completed Within 6 Weeks														

Quality

Metric Name	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Last 12 Months
Medication Errors (Incidents)	1	1	3	2	3	2	7	9	11	7	2	2	8	
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	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Last 12 Months
Corporate Induction	87.5%	100.0%	82.9%		88.9%	100.0%	57.1%	100.0%	33.3%	100.0%	100.0%		100.0%	
PDR	76.4%	67.0%	0.0%	5.7%	26.5%	71.0%	82.8%	87.4%	90.4%	88.8%	90.4%	90.4%	83.9%	
Sickness	6.9%	5.9%	5.1%	5.6%	5.7%	6.4%	6.3%	7.0%	5.8%	5.6%	6.7%	6.0%	5.6%	
Mandatory Training	78.0%	57.1%	57.1%	56.1%	55.2%	74.5%	75.3%	74.6%	75.1%	80.3%	86.7%	89.8%	96.8%	

CBU Performance - Medicine (Part 1)

Feb 2018

Alder Hey Children's NHS Foundation Trust

Key Issues

Continued improvements in clinic utilisation, which reflects the sustained attention to utilisation. There is also sustained improvements in our DNA rate. We are also seeing improvements in our RTT, but there is still work to be done in this area, from the highs earlier in the year.

We have seen improvements in our financial position, which have continued in to Feb, and we continue to work on this, but we are experiencing challenges within our senior clinical workforce which is affecting activity.

Sickness has reduced in Feb from the highs in Nov, Dec and Jan.

Support Required

None

Operational

Metric Name	Feb 2017	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Last 12 Months
Theatre Utilisation - % of Session Utilised	79.1%	85.4%	81.1%	83.6%	84.6%	76.9%	81.8%	82.0%	81.5%	79.6%	82.5%	79.9%	80.6%	
Clinic Session Utilisation	86.5%	89.0%	86.5%	87.1%	84.7%	87.1%	87.0%	86.6%	86.9%	88.5%	86.5%	87.8%	89.0%	
DNA Rate (New Appts)	12.4%	10.0%	15.0%	12.6%	12.6%	12.9%	12.3%	10.5%	13.4%	10.6%	14.0%	11.1%	11.1%	
DNA Rate (Followup Appts)	11.8%	8.8%	12.1%	11.9%	10.5%	10.6%	11.2%	11.2%	11.2%	8.9%	10.2%	8.2%	8.8%	
Convenience and Choice: Slot Availability	86.5%	99.4%	98.0%	96.3%	100.0%	100.0%	98.0%	91.4%	99.4%	97.8%	100.0%	99.7%	96.3%	
Referrals Received (GP)	594	821	577	747	792	729	636	635	724	758	563	743	772	
Temporary Spend ('000s)	341	302	290	322	222	323	326	250	186	242	207	211	276	
Trading Surplus/(Deficit)	-113	1,012	-298	108	-152	-390	-302	94	131	1,222	346	1,176	809	

Patient

Metric Name	Feb 2017	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Last 12 Months
RTT: 90% Admitted within 18 weeks	100.0%	91.5%	96.4%		95.7%	90.5%	95.5%	100.0%	94.2%	92.7%	85.3%	83.2%	92.7%	
RTT: 95% Non-Admitted within 18 weeks	89.3%	90.9%	90.9%	86.2%	88.8%	89.1%	87.3%	86.8%	89.0%	90.1%	85.2%	80.6%	88.7%	
RTT: 92% Waiting within 18 weeks (open Pathways)	96.0%	94.8%	94.9%	94.5%	94.0%	93.6%	93.3%	94.2%	92.7%	91.2%	92.6%	92.9%	93.0%	
Average LoS - Elective (Days)	3.22	3.20	3.50	3.40	2.94	3.05	2.90	3.06	2.91	3.33	4.06	3.54	3.22	
Average LoS - Non-Elective (Days)	1.69	1.57	1.62	1.60	1.51	1.65	1.49	1.63	1.39	1.41	1.50	1.75	1.57	
Hospital Initiated Clinic Cancellations < 6 weeks notice	37	27	20	18	23	17	16	21	32	30	41	26	55	
Daycases (K1/SDCPREOP)	63	70	58	70	103	70	71	63	76	74	49	58	66	
Cancelled Operations - Non Clinical - On Same Day	6	3	1	3	1	2	1	2	2	5	2	0	0	
OP Appointments Cancelled by Hospital %	15.3%	14.4%	17.8%	11.5%	13.7%	14.8%	13.7%	13.6%	14.3%	13.5%	15.4%	15.5%	18.3%	
Diagnostics: % Completed Within 6 Weeks	99.7%	99.6%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.8%	

Quality

Metric Name	Feb 2017	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Last 12 Months
Medication Errors (Incidents)	19	35	25	34	27	25	31	19	29	22	27	28	30	
Cleanliness Scores	96.8%	99.0%		97.0%			96.0%	96.0%	97.6%	95.4%	97.8%		98.0%	
Hospital Acquired Organisms - MRSA (BSI)	0	0	0	0	0	0	0	0	0	1	0	2	0	
Hospital Acquired Organisms - C.difficile	0	0	0	0	0	0	0	0	0	0	0	0	0	

Workforce

Metric Name	Feb 2017	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Last 12 Months
Corporate Induction	75.0%	68.8%		81.8%	61.5%	100.0%	50.0%	80.0%	70.0%	100.0%	70.0%		96.2%	
PDR	75.7%	69.7%	2.9%	15.4%	41.3%	73.8%	79.7%	82.2%	84.0%	85.0%	84.0%	84.0%	81.5%	
Sickness	5.2%	4.5%	4.0%	4.7%	4.2%	4.6%	3.8%	4.1%	5.0%	5.3%	5.1%	5.7%	4.6%	
Mandatory Training	79.2%	79.7%	80.1%	80.0%	80.5%	79.0%	78.3%	75.7%	77.3%	82.2%	86.6%	88.9%	94.7%	

CBU Performance - Medicine (Part 2)

Feb 2018

Alder Hey Children's NHS
NHS Foundation Trust

Key Issues

As anticipated, imaging turnaround times challenged in February due to a high number of ED attendances. On the whole, performing better than same time last year. MRI turnaround time still a concern, but improved. Similar position for urgent pathology turnaround times. Non-urgent pathology turnaround times still 100%.

Support Required

Patient

Metric Name	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Last 12 Months
Imaging - % Report Turnaround times GP referrals < 24 hrs	97.0%	87.0%	96.0%	91.0%	92.0%	90.0%	90.0%	86.0%	97.9%	88.4%	97.0%	99.0%	99.0%	
Imaging - % Reporting Turnaround Times - ED	93.0%	90.0%	80.0%	64.0%	76.0%	83.0%	82.0%	85.0%	96.7%	96.7%	78.0%	99.0%	86.0%	
Imaging - % Reporting Turnaround Times - Inpatients	89.0%	90.0%	78.0%	74.0%	79.0%	85.0%	85.0%	79.0%	97.8%	94.4%	78.0%	94.0%	79.0%	
Imaging - % Reporting Turnaround Times - Outpatients	98.0%	94.0%	92.0%	90.0%	92.0%	98.0%	98.0%	92.0%	89.5%	90.0%	95.0%	96.0%	93.0%	
Imaging - Waiting Times - MRI % under 6 weeks	86.0%	85.0%	71.0%	81.0%	67.0%	68.0%	77.0%	79.0%	93.7%	96.8%	96.0%	73.0%	88.0%	
Imaging - Waiting Times - CT % under 1 week	77.0%	87.0%	95.0%	89.0%	87.0%	87.0%	89.0%	87.0%	93.3%	94.4%	84.0%	85.0%	81.0%	
Imaging - Waiting Times - Plain Film % under 24 hours	92.0%	93.0%	93.0%	94.0%	93.0%	94.0%	92.0%	91.0%	98.9%	100.0%	91.0%	92.0%	89.0%	
Imaging - Waiting Times - Ultrasound % under 2 weeks	81.0%	87.0%	84.0%	88.0%	90.0%	91.0%	90.0%	87.0%	95.6%	93.3%	85.0%	84.0%	87.0%	
Imaging - Waiting Times - Nuclear Medicine % under 2 weeks	84.0%	93.0%	88.0%	95.0%	89.0%	100.0%	93.0%	72.0%	100.0%	96.8%	83.0%	92.0%	90.0%	
BME - High Risk Equipment PPM Compliance	91.1%	88.0%	80.2%	91.7%	91.6%	91.2%	90.1%	84.6%	90.2%	90.1%	89.2%	87.6%	84.7%	
BME - Low Risk Equipment PPM Compliance	80.8%	79.0%	100.0%	82.0%	81.9%	80.4%	75.5%	74.6%	70.9%	76.0%	77.7%	80.4%	81.5%	
BME - Equipment Pool - Equipment Availability	100.0%	100.0%	91.4%	99.8%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Pharmacy - Dispensing for Out Patients - Routine	50.0%	45.0%	57.0%	37.0%	60.0%	65.0%	63.0%	57.0%	61.0%	60.0%	61.0%	58.0%	51.0%	
Pharmacy - Dispensing for Out Patients - Complex	98.0%	98.0%	98.0%	100.0%	100.0%	96.0%	97.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Comm Therapy - % 1st Contact times following Pt opt in < 12 weeks	100.0%	63.0%	63.0%	63.0%	54.3%	54.5%	80.0%	90.0%	100.0%	100.0%	100.0%	100.0%	94.1%	

Quality

Metric Name	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Last 12 Months
Pathology - % Turnaround times for urgent requests < 1 hr	88.7%	87.9%	89.7%	89.9%	91.0%	88.1%	88.1%	91.0%	89.1%	87.4%	87.6%	87.7%	88.0%	
Pathology - % Turnaround times for non-urgent requests < 24hrs	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.9%	100.0%	100.0%	100.0%	100.0%	
Reporting times for perinatal autopsies in 56 Calendar Days	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.3%	100.0%	100.0%	100.0%	
Blood Traceability Compliance	98.8%	99.6%	99.4%	100.0%	100.0%	99.5%	99.8%	99.8%	99.2%	99.5%	100.0%	99.8%	99.6%	

CBU Performance - Surgery

Feb 2018

Alder Hey Children's NHS Foundation Trust

Key Issues

It has been a challenging month for Surgery with NEL bed pressures which has this has affected both theatre utilisation and activity through patient cancellations.

Clinic utilisation is down, but DNA for follow up activity is under 10% and is reducing for news. The team are working with the booking team to help support activity in OPD. There has also been an improvement in RTT and we are getting closer to 92%.

For the first time this year mandatory training has exceeded 90%.

Support Required

N/A

Operational

Metric Name	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Last 12 Months
Theatre Utilisation - % of Session Utilised	88.5%	87.1%	88.3%	87.9%	88.9%	87.7%	88.6%	87.3%	87.3%	85.2%	86.4%	88.3%	86.4%	
Clinic Session Utilisation	85.3%	88.2%	87.9%	86.0%	85.9%	86.2%	84.9%	83.2%	85.2%	87.0%	82.9%	86.2%	83.5%	
DNA Rate (New Appts)	11.9%	9.8%	10.3%	11.7%	12.4%	11.6%	12.6%	11.8%	12.3%	12.6%	12.7%	11.5%	11.9%	
DNA Rate (Followup Appts)	9.4%	8.3%	9.9%	10.1%	9.8%	10.6%	11.4%	11.3%	10.9%	9.1%	11.0%	8.9%	9.0%	
Convenience and Choice: Slot Availability	99.8%	95.3%	98.2%	99.5%	96.0%	99.0%	100.0%	100.0%	99.8%	97.4%	98.7%	97.1%	99.2%	
Referrals Received (GP)	1,046	1,280	977	1,152	1,215	1,035	980	988	1,087	1,134	832	1,143	1,136	
Temporary Spend ('000s)	475	443	516	402	456	511	554	429	479	383	331	408	434	
Trading Surplus/(Deficit)	2,181	2,821	1,826	2,930	3,321	2,980	2,574	2,506	2,634	2,379	1,819	2,524	1,891	

Patient

Metric Name	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Last 12 Months
RTT: 90% Admitted within 18 weeks	87.0%	87.2%	86.9%	90.3%	87.8%	88.8%	87.8%	85.0%	88.0%	90.0%	90.5%	90.7%	88.4%	
RTT: 95% Non-Admitted within 18 weeks	88.1%	89.1%	90.1%	89.8%	88.2%	88.1%	90.2%	90.7%	91.2%	91.2%	91.6%	92.9%	92.6%	
RTT: 92% Waiting within 18 weeks (open Pathways)	90.6%	90.9%	90.9%	90.8%	91.3%	91.2%	91.2%	90.9%	91.6%	92.0%	91.3%	91.4%	91.3%	
Average LoS - Elective (Days)	3.26	2.62	2.58	3.57	2.57	3.10	2.91	3.03	2.35	2.76	3.30	2.62	2.89	
Average LoS - Non-Elective (Days)	2.78	2.64	2.84	3.06	2.57	2.86	2.96	2.74	2.90	3.16	3.18	2.67	2.89	
Hospital Initiated Clinic Cancellations < 6 weeks notice	54	22	19	23	28	35	32	26	27	26	37	24	58	
Daycases (K1/SDCPREOP)	461	582	426	540	609	472	499	485	552	521	435	590	472	
Cancelled Operations - Non Clinical - On Same Day	23	28	6	54	18	29	14	46	24	35	13	19	18	
OP Appointments Cancelled by Hospital %	14.2%	13.7%	13.2%	11.2%	12.7%	12.0%	12.8%	11.8%	12.3%	13.1%	13.2%	12.9%	14.1%	
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%	95.0%	100.0%	92.6%	

Quality

Metric Name	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Last 12 Months
Medication Errors (Incidents)	34	47	40	56	48	42	55	32	30	46	25	39	44	
Cleanliness Scores	96.1%	97.7%				97.6%	93.9%		95.5%	97.4%	98.3%	97.7%	98.4%	
Hospital Acquired Organisms - MRSA (BSI)	0	0	0	0	0	0	0	0	1	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	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Last 12 Months
Corporate Induction	71.4%	94.1%		90.0%	100.0%	100.0%	60.0%	71.4%	85.0%	88.9%	77.8%		88.2%	
PDR	64.2%	45.1%	1.9%	11.2%	63.0%	87.6%	91.1%	90.1%	89.5%	88.1%	89.5%	89.5%	83.3%	
Sickness	4.9%	4.4%	4.5%	4.4%	4.7%	4.8%	4.6%	4.5%	5.0%	4.7%	5.9%	6.4%	5.3%	
Mandatory Training	78.7%	79.3%	80.6%	80.7%	81.5%	79.1%	77.0%	73.0%	73.8%	80.9%	85.8%	89.3%	93.5%	

Alder Hey Children's NHS
NHS Foundation Trust

Board of Directors
Tuesday 10 April 2018

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

Board Assurance Framework 2017-18

Year End Review

1. Introduction

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

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

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

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

2. Key issues

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

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

This report provides a comparison of the BAF at the start and end of 2017/18; an analysis of progress thorough the year, potential changes for next year and finally a table that shows links between the BAF and associated corporate risks.

3. BAF at start of financial year 2017-18 (April 2017)

BAF Risk Register - Overview at 26 April 2017
3.1: Financial Environment (S)
2.2: Failure to fully realise the Trust's Vision for the Park (S) 3.3: Developing the Paediatric Service Offer (S)
3.2: Business Development and Growth. (S) 4.1: Workforce Sustainability & Capability (S) 2.3: IT Strategic Development (S)
4.2: Staff Engagement (S) 4.3: Workforce Diversity & Inclusion (S) 2.1: New Hospital Environment (S)
5.1: Research, Education & Innovation (W) 1.1: Maintain care quality in a cost constrained environment (S)
1.2: Mandatory & compliance standards (S)

4. BAF at end of financial year 2017-18 (April 2018)

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

5. Comparison of ratings: start and end of financial year (April 2017 and March 2018)

Ref	Risk Title	Risk Rating: I x L	
		Current: Apr 17 : **Mar 18**	Target: Apr 17: **Mar 18**
STRATEGIC PILLAR: Delivery of Outstanding Care			
1.1 (HG)	**Maintain care quality in a cost constrained environment**	4-2 = 4-2	4-2 = 4-2
1.2 (ES)	**Mandatory & compliance standards**	5-1 = 5-1	3-1 = 3-1
STRATEGIC PILLAR: Game-Changing Research & Innovation			
2.1 (DP)	**Research, Education & Innovation**	4-2 = 4-2	4-1 = 4-1
2.2 (DP)	**Failure to fully realise the Trusts Vision for the Park**	4-3 = 4-3	4-2 = 4-2
2.3 (JG)	**I.T. Strategic Development**	3-4 = 3-4	3-3 = 3-3
STRATEGIC PILLAR: Sustainability through External Partnerships			
3.2 (MB)	**Business Development & Growth**	4-3 = 4-3	4-2 = 4-2
3.3 (MB)	**Developing the Paediatric Service Offer**	4-3 = 4-3	4-2 = 4-2
3.4 (JG)	**Financial Environment**	**5-4 > 4-4**	3-4 = 3-4
STRATEGIC PILLAR: The Best People doing their Best Work			
4.1 (MS)	**Sustain Workforce Capability**	4-3 = 4-3	4-2 = 4-2
4.2 (MS)	**Staff Engagement**	**3-3** = 3-3	**3-2** > 3-1
4.3 (MS)	**Workforce Diversity & Inclusion**	3-3 = 3-3	3-1 = 3-1

6. Analysis of the risk ratings

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

Of the eleven risks on the BAF 10 didn't change their current rating during the course of the year.

Financial Environment remains the biggest risk to the Trust, but has seen a decrease in score from 20 (*catastrophic x likely*) to 16 *(major x likely)*

The risk relating to the new hospital environment closed in-year (Oct 2017) due to successful move and effective system for clearing major structural and commissioning issues.

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

7. Summary of BAF - at 5 April 2018

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

Ref, Owner	Risk Title	Risk Rating: I x L		Monthly Trend	
		Current	Target	Last	Now
STRATEGIC PILLAR: Delivery of Outstanding Care					
1.1 HG	**Maintain care quality in a cost constrained environment**	4-2	4-2	STATIC	STATIC
1.2 ES	**Mandatory & Compliance Standards**	5-1	3-1	STATIC	STATIC
STRATEGIC PILLAR: Game-Changing Research And Innovation					
2.1 DP	**Research, Education & Innovation**	4-2	4-1	STATIC	STATIC
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
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
3.4 JG	**Financial Environment**	5-4	4-4	STATIC	STATIC
STRATEGIC PILLAR: The Best People Doing Their Best Work					
4.1 MS	**Workforce Sustainability & Capability**	4-3	4-2	STATIC	STATIC
4.2 MS	**Staff Engagement**	3-3	3-1	STATIC	STATIC
4.3 MS	**Workforce Diversity & Inclusion**	3-3	3-1	STATIC	STATIC

8. Changes since March 2018 Board meeting

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

External risks

- ***Business development and growth (MB)***
  Draft Clinical and Sustainability Strategy Presentation to Trust Board in April 2018. Final Strategy to May Board. Scope of service growth required for sustainability requires further clarification.

- ***Mandatory and compliance standards (ES)***
  Target achieved for the month (97.4%) and just missed for the year (94.8%). All other national targets met

- ***Developing the Paediatric Service Offer (MB)***
  Neonatal Business Case finalised and presented to Commissioners in March. Awaiting Commissioner response. Draft Clinical and Sustainability Strategy re-scheduled to April 2018 Board. Key partnerships in addition to those for CHD and Neonatal Services, being developed. Will be part of final clinical and sustainability strategy to be submitted to Trust Board for Approval in May 2018

Internal risks:

- ***Maintain care quality in a cost constrained environment (HG)***
  Joint working with LWH in relation to neonatal surgical services has seen the development of a bid to HEE to enable the registered nurse staff to undertake ANNP course.

- ***Financial Environment (JG)***
  Year-end risk associated with concluding specialist commissioner discussions. New Year Financial Plan well developed with key risks relating to delivery of efficiency programme and specialist commissioner contract

- ***Failure to fully realise the Trust's Vision for the Park (DP)***
  Community cluster design competition completed. Re-engagement with LCC planned to secure cover for housing development.

- ***IT Strategic Development (JG)***
  Programme continues to deliver against objectives with full draw down of NHSE finding. Focus now on 18/19 delivery and support of operational clinical objectives

- ***Workforce Sustainability & Capability (MS)***
  Mandatory Training compliance showing an upward trajectory at 94.6%. During National Apprenticeship Week, we received over 70 expressions of interest for staff to take up an apprentice

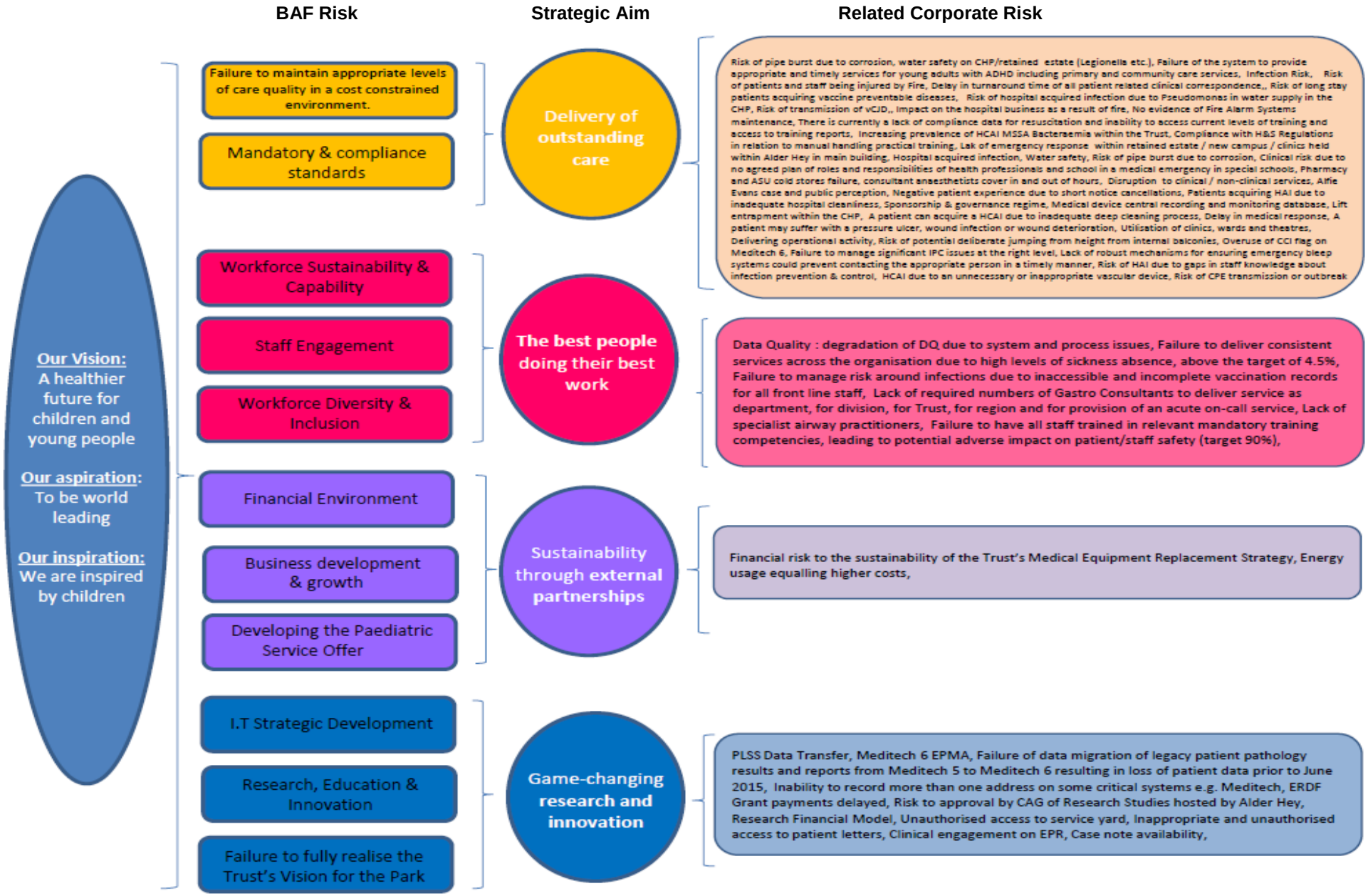
- ***Staff Engagement (MS)***
  Reward and Recognition Group progress with plans for 2018, including formal and informal recognition events. Executive shadowing programme ongoing.

- ***Workforce Diversity & Inclusion (MS)***
  Gender Pay Gap Report published and approved by Ops Board, to be received by Trust Board in April 18.

- ***Research, Education & Innovation (DP)***
  Restructure of commercial system proposed

Erica Saunders
Director of Corporate Affairs
April 2018

9. Links between BAF and corporate risks – as at March 2018



Board Assurance Framework 2018-19

Alder Hey Children's NHS Foundation Trust

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

Risk Description	
Failure to maintain appropriate levels of care quality in a cost constrained environment.	
Existing Control Measures	
• Quality impact assessment completed for all planned changes	• Risk assessment and utilisation of risk registers in responding to risks.
• Quality section of Corporate Report performance managed at Clinical Quality Assurance Committee and Trust Board.	• Division and Corporate Dashboards in place and monitored consistently via performance framework
• Weekly Meeting of Harm monitors incidents, including lessons learned, immediate actions . Escalation process in place	• Programme of quality assurance rounds, developed and implemented across all services, aligned to Care Quality Commission, Key lines of enquiry (KLOE).
• Annual nursing workforce assurance report presented to Board, aligned to Nursing and Midwifery Council Standards.	• Continuous monitoring of professional re validation compliance for the workforce via Electronic Staff Record (ESR)
• Quality Improvement Change Programme established - associated workstreams subject to sub-committee assurance reporting.	• Governance including risk processes from Ward to Board, linked to NHSI Single Oversight Framework
• Quality Strategy 2016-2020 implemented to deliver safe and effective services, with measurable Quality Aims.	• Acute Provider Infection Prevention and Control framework implemented and monitored internally and externally via the Clinical Commissioning Group External review on Infection Prevention and Controlresulted in action plan to address issues identified and track improvements.
• Internal Nursing pool established and funded	• Nursing leadership in alignment with Royal College of Nursing and Midwifery Standards.
• Annual inpatient Patient Survey reports	
Assurance Evidence	**Gaps in Controls/Assurance**
Impact assessments monitored via the Performance Board Risk assessments etc. monitored via the Integrated Governance Committee Clinical Quality Assurance Committee and Trust Board Quality monitor the quality section of Corporate Report. Performance framework monitored via Performance Board Weekly meeting of Harm outcomes including lessons learned reviewed by Executive team and by exception the Trust Board. Quality Assurance Rounds available on Trust Governance and Assurance web page for viewing accessible for all staff and shared across divisions. Annual Nursing workforce report to Board, including fill rate compliance. Nursing re validation report via Clinical Quality Assurance Committee. Governance and Risk monitored via the Integrated Governance Committee Infection Prevention and Control 'Acute Providers Framework' reports are monitored via the Trust Board. Quality performance monitored via the Clinical Quality Performance Group (external monitoring via Clinical Commissioning Group) NRLS national reports (incidents) Annual CQC patient survey results - performance monitored via Trust Board.	National reduction in post graduate education training Budget. Reduced investment opportunity to respond to clinical development as a result of this reduction. Nursing maternity leave continues to rise - currently 10 WTE above the expected rise. Reduced student nurse higher education applications due to funding changes nationally.
Actions Required to Reduce Risk to Target Rating	**Latest Progress on Actions**
please work with the divisions HR Business Partners to reduce the sickness rate to the expected trust standard.	Sickness policy recently reviewed and updated Sickness data produced monthly by HR and reviewed at Divisional Board meetings and corporately via WOD. Progress monitored at Matrons and ACN meetings with the Ward Managers. Action plans are in place at ward and departmental level HR support is in place for Managers across the Divisions
Please ensure nursing educational budget is sufficient to meet post graduate nurse education and development requirements. Please advise of plan	
Please ensure the opportunity for development of non-registered staff to commence registered nurse training programme is implemented and funded.	Opportunities for non registered nurses to undertake apprenticeships with funding drawn down from the levy. This will form part of our overarching apprenticeship offer and will also form a core part of our workforce strategy for nursing
HR sickness policy updated	

Executive Lead's Assessment
JANUARY 2018: Nurse recruitment day successful, additional 31 WTE recruited. Advanced nurse practitioners, in training, funded by the Trust. FEBRUARY 2018: working with John Moores University to develop new MSc programme MARCH 2018: Joint working with LWH in relation to neonatal surgical services has seen the development of a bid to HEE to enable the registered nurse staff to undertake ANNP course.

Board Assurance Framework 2018-19

Alder Hey Children's NHS Foundation Trust

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

Risk Description

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

Existing Control Measures

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

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

Actions Required to Reduce Risk to Target Rating	**Latest Progress on Actions**
Plans to ensure performance sustained across the year need to be embedded and maintained	Operational teams sighted on ensuring and maintaining flow across the hospital via weekly performance, bed meetings etc.
Review bed capacity and staffing model for seasonal variation	Winter Plan revised and widely shared, highlighting 'red weeks' and including seasonal capacity projections.
Ensure divisional governance embedded and working effectively to reflect ward to board reporting	All matron roles now filled; new Head of Quality for Surgery appointed.
ED plan for March approved at Operational Board in February based on additional medical shifts in ED, additional specialty doctor cover and to staff the four additional beds in ED.	

Executive Lead's Assessment

JANUARY 2018: ED performance on recovery trajectory to year end.
FEBRUARY 2018: ED plan for March agreed at Ops Board.
MARCH 2018: Target achieved for the month (97.4%) and just missed for the year (94.8%). All other national targets met.

Board Assurance Framework 2018-19

Alder Hey Children's NHS Foundation Trust

BAF 2.1	**Strategic Objective:** Game-Changing Research And Innovation	Risk Title: Research, Education & Innovation		
Related CQC Themes: Responsive, Well Led				
Exec Lead: David Powell	**Type:** Internal, Known	Current IxL: 4-2	Target IxL: 4-1	Trend: STATIC

Risk Description

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

Existing Control Measures

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

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

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Educational Partnerships to be cemented	Academy Head appointed
Execute plan to increase research portfolio	Commercial research plan in implementation
Develop a robust Academy Business Model	Model in implementation
Establish pipeline structure for workstreams including finances (sensors, virtual reality, AI)	Heads of Terms agreed with Crucible. Acorn paperwork received for authorisation
Execute contract for RIE with back to back arrangements with the Charity and HEIs	LJMU Contract now agreed internally

Executive Lead's Assessment

JANUARY 2018: Academy and Innovation portfolios now moving forward. More focus now on increasing research portfolio.
FEBRUARY 2018: Commercial agreements around innovation moving forward
MARCH 2018: Restructure of commercial system proposed

Board Assurance Framework 2018-19

Alder Hey Children's NHS Foundation Trust

BAF 2.2	**Strategic Objective:** Sustainability Through External Partnerships		Risk Title: Failure to fully realise the Trust's Vision for the Park		
Related CQC Themes: Responsive, Well Led					
Exec Lead: David Powell		**Type:** Internal, Known	Current IxL: 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**
Secure approval for plans to increase Park footprint	Consultation held with local residents regarding plans to expand Park
Approval of Business Case at LCC / Discuss park Heads of Terms with LCC	On hold-Dependent upon residential scheme (revised target date no April 2018)
Income generation opportunities to be thoroughly explored (grant applications) and reconcile requirement for funding versus available	Draft Business Case prepared. First grant application successful.
Appoint new park project lead	Job advertised
Executive Lead's Assessment	
JANUARY 2018: Residential development is on hold whilst approach to housing is discussed with LCC. Plans are now in discussion to increase Park footprint and enhance existing areas. FEBRUARY 2018: Plans underway to extend Park. MARCH 2018: Community cluster design competition completed. Re-engagement with LCC planned to secure cover for housing devt.	

Board Assurance Framework 2018-19

Alder Hey Children's NHS Foundation Trust

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

Risk Description

Failure to deliver an IM&T Strategy which will place Alder Hey at the forefront of technological advancement in paediatric healthcare

Existing Control Measures

• Key projects and progress tracked through the Clinical Systems Informatics Steering Group and RABD Committee	• Clinical Systems Informatics Project Group leading on stakeholder engagement - ad hoc groups on specific key topics as needed
• Forward Communications plan agreed and tracked at steering group.	• Board approval "Asset Owner" process in place to ensure organisational ownership of systems and system development
• Improvement scheduled training provision including refresher training and workshops to address data quality issues	• Formal change control processes now in place
• Executive level CIO in place	• Investment in IM&T Team (2016/17 budget)
• GDE Programme Board in place & fully resourced - Chaired by Medical Director	• Clinical Engagement in IT Roadmap

Assurance Evidence	Gaps in Controls/Assurance
Regular progress reports presented to RABD and Operational Board & Trust Board MIAA providing assurance role Board agreed change process Participate in Digital Alder Hey programme Internal Audit Reviews NHSE tracking of GDE Programme	IM&T Strategy out of date - update work in progress to produce Roadmap Internal Programme Assurance Reports

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Conclude the review of IM&T Infrastructure	action complete - new structure agreed and being recruited to
IT Roadmap to be concluded	Meeting held with Meditech to agree how we work more effectively going forward and have more onsite presence

Executive Lead's Assessment

JANUARY 2018: Programme continues to be green. NHSE cashflow now in agreement
FEBRUARY 2018: NHSE confirmed year end targets achieved an cashflows released. Significant progress on key projects achieved. VR rollout has met some challenges with a working group in place to establish a new timeline. Issues escalated with Meditech per recent Board discussions.
MARCH 2018: Programme continues to deliver against objectives with full draw down of NHSE finding. Focus now on 18/19 delivery and support of operational clinical objectives

Board Assurance Framework 2018-19

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

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

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

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Development of the international agenda	
Operational Business Planning underway - to contain forecasts regarding growth opportunities	

Executive Lead's Assessment

JANUARY 2018: Strategic refresh underway. Growth plan target for NHS planned growth and commercial ambition by 2020 under agreement at Board level; individual schemes under development through Business Planning cycle 18/19
FEBRUARY 2018: Clinical and Sustainability Strategy for planned growth in provision of services and income shared at TB workshop in February 2018 and supported in principle. Clinical and Sustainability Strategy scheduled for Trust Board April 2018.
MARCH 2018: Draft Clinical and Sustainability Strategy Presentation to Trust Board in April 2018. Final Strategy to May Board. Scope of service growth required for sustainability requires further clarification.

Board Assurance Framework 2018-19

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

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

Executive Lead's Assessment
JANUARY 2018: key partnerships scheduled for Board away day 6 Feb 2018. FEBRUARY 2018: This is integral to the Trusts Clinical and Sustainability Strategy scheduled for Trust Board April 2018 MARCH 2018: Neonatal Business Case finalised and presented to Commissioners in March. Awaiting Commissioner response. Draft Clinical and Sustainability Strategy re-scheduled to April 2018 Board. Key partnerships in addition to those for CHD and Neonatal Services, being developed. Will be part of final clinical and sustainability strategy to be submitted to Trust Board for Approval in May 2018

Board Assurance Framework 2018-19

Alder Hey Children's NHS Foundation Trust

BAF 3.4	**Strategic Objective:** Sustainability Through External Partnerships	Risk Title: Financial Environment		
Related CQC Themes: Safe, Effective, Responsive, Well Led				
Exec Lead: John Grinnell	**Type:** Internal, Known	Current IxL: 4-4	Target IxL: 4-3	Trend: STATIC

Risk Description
Failure to deliver Trust control total and Risk rating Rating

Existing Control Measures	
• Organisation-wide financial plan.	• Monitor financial regime and financial risk ratings.
• Financial systems, budgetary control and financial reporting processes.	• Capital Planning Review Group
• Monthly performance review meetings with Divisional Clinical/Management Team and the Executive	• Financial Position (subject to regular monitoring).
• Weekly meeting with divisions to review forward look bookings for elective and day case procedures to ensure activity booked meets contract and recovery plans. Also review of status of outpatient slot utilisation	• Financial Recovery Board in place
• CIP subject to programme assessment and sub-committee performance management	

Assurance Evidence	**Gaps in Controls/Assurance**
Monthly Corporate Performance Report presented to both Board and the RABD. Specific Reports (i.e. NHSI Plan Review by RABD) Monthly Performance Management Reporting with General Managers. Internal and External Audit reporting through Audit Committee. Daily activity tracker to support divisional performance management of activity delivery Pay cost control 10 point plan introduced aimed at forecasting and tracking actions to reduce pay cost overspend run rate - updates to Execs, R&BD. Full electronic access to budgets & specialty performance results	Divisions improved financial control and effective recovery required in identified where slippage against agreed recovery trajectories occurring Ongoing cost of temporary staff Divisional recovery plans to hit yearend financial control targets to ensure delivery of overall Trust financial plan. 'Grip' on CIP Recovery Plan still demonstrating £2M gap although mitigating close gap consolidated Conclude commissioner year-end discussions

Actions Required to Reduce Risk to Target Rating	**Latest Progress on Actions**
Conclude commissioner year end positions	
implement divisional recovery plan	
Focus on activity delivery	superseded by recovery programme
Tracking actions from Financial Recovery Board	Activity tracking in place
Plans to address CIP shortfall - scheme PIDs to be complete by end of May - progressing against milestones agreed	superseded by recovery programme

Executive Lead's Assessment
JANUARY 2018: Financial recovery now showing £2M gap to control although mitigating actions to close gap progressing. Key risk is concluding commissioner year-end discussions FEBRUARY 2018: Key risk to year end remains concluding commissioner contract overperformance agreements and any further impact of the winter on our elective activity programme. MARCH 2018: Year-end risk associated with concluding specialist commissioner discussions. New Year Financial Plan well developed with key risks relating to delivery of efficiency programme and specialist commissioner contract

Board Assurance Framework 2018-19

Alder Hey Children's NHS Foundation Trust

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

Risk Description

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

Existing Control Measures

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

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

Actions Required to Reduce Risk to Target Rating	**Latest Progress on Actions**
This risk has no actions in place.	

Executive Lead's Assessment

JANUARY 2018: Nurse recruitment event successful. Core Mandatory training increased to 88%. Appointment of Apprenticeship Delivery Manager.
FEBRUARY 2018: Successful ESFA Inspection, meaning the Trust are in a position to deliver apprenticeships. Core Mandatory Training increased to 93%.
MARCH 2018: Mandatory Training compliance showing an upward trajectory at 94.6%. During National Apprenticeship Week, we received over 70 expressions of interest for staff to take up an apprentice

Board Assurance Framework 2018-19

Alder Hey Children's NHS Foundation Trust

BAF 4.2	**Strategic Objective:** The Best People Doing Their Best Work		Risk Title: Staff Engagement		
Related CQC Themes: Safe, Effective, Responsive, Well Led					
Exec Lead: Melissa Swindell		**Type:** Internal, Known	Current IxL: 3-3	Target IxL: 3-1	Trend: STATIC

Risk Description

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

Existing Control Measures

• Internal Communications Strategy in development by new incumbent into Director of Communications role	• Roll out of Leadership Development and Leadership Framework
• Action Plans for Engagement, Values and Communications.	• Medical Leadership development programme
• Staff Temperature Check Reports to Board (quarterly)	• Values based PDR process
• People Strategy Reports to Board (monthly)	• Listening into Action methodology
• Staff surveys analysed and followed up (shows improvement)	• Reward and recognition schemes in place: Annual Awards, Star of the Month and quarterly Long Service Recognition Event, Annual Fab Staff Change Week.

Assurance Evidence	Gaps in Controls/Assurance
Outcomes from Annual Staff Survey reported to the Board. PDR completion rates Quarterly Engagement Temperature Check reported to the Board. Quarterly Engagement Temperature Check local data now sent to Divisions on a quarterly basis to enable them to analyse data locally. Ongoing consultation and information sharing with staff side and LNC Progress reports from LiA to Board	None recorded.

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
This risk has no actions in place.	

Executive Lead's Assessment

JANUARY 2018: Plans are in place to communicate and share staff survey results with wider workforce, and a plan is developed for taking action on results. Annual Staff Awards held on the 19th January, recognising many staff for the excellent contribution.
FEBRUARY 2018: Staff Survey communicated with staff, and actions in place to share bespoke details for teams to action plan
MARCH 2018: Reward and Recognition Group progress with plans for 2018, including formal and informal recognition events. Executive shadowing programme ongoing.

Board Assurance Framework 2018-19

Alder Hey Children's NHS Foundation Trust

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

Risk Description	
Failure to proactively develop a future workforce that reflects the diversity of the local population, and provide equal opportunities for career development and growth for existing staff.	
Existing Control Measures	
• Equality, Diversity & Human Rights Group	• WOD Committee ToR includes duties around diversity and inclusion, and requirements for regular reporting.
• Workforce Plan established	• Staff Survey results analysed by protected characteristics, where possible and actions taken by E&D Lead.
• Workforce Planning Policy signed off at WOD June 2015	• Equality Analysis Policy
• Equality, Diversity & Human Rights Policy	• BME Network established, sponsored by Director of HR & OD
• Disability Network established, sponsored by Director of HR & OD	• Actions taken in response to the WRES
• Action plan specifically in response to increasing the diversity of the workforce.	
Assurance Evidence	**Gaps in Controls/Assurance**
Monthly recruitment reports provided by HR to divisions Quarterly reports to the Board via WOD on diversity and inclusion issues Monthly Corporate Report (including workforce KPIs) to the Board Taking forward actions for LiA - enabling achievement of a more inclusive culture Equality Impact Assessments undertaken for every policy & project Workforce Race Equality Standards EDS Publication	LGBTQ Network not yet in place Comprehensive TNA needs further development
Actions Required to Reduce Risk to Target Rating	**Latest Progress on Actions**
Workforce Planning Policy	Draft policy produced, however future work is to focus on identifying priority workforce needs in light of current financial position
Establish LGBTQ network	
Newly appointed L&D Manager to work with E&D Manager to develop TNA	
Executive Lead's Assessment	
JANUARY 2017: Staff Survey published, analysis of data underway FEBRUARY 2018: BME staff survey data being analysed for trends and hotspots. MARCH 2018: Gender Pay Gap Report published and approved by Ops Board, to be received by Trust Board in April 18.	

Alder Hey Children's NHS
NHS Foundation Trust

Board of Directors

10 April 2018

By-Election Results

In February 2018 the Trust issued by-election notifications for the following vacancies:

Constituency	
Patient: Merseyside	X 1
Patient: Parent/Carer	X 2
Public: Cumbria & Lancashire	X 1
Staff: Nurses	X 1

Further to the deadline for nominations (20 February), the following constituency was uncontested:

Elected unopposed:

Patient: Parent & Carer x2	**Craig Arnold** **Kate Burnell**

No nominations were received for the following seats:
Public: Cumbria & Lancashire
Patient: Merseyside

These will roll-over into the summer 2018 election.

Two nominations were received for the staff : nurses constituency. A full ballot commenced on Monday 12 March 2018 which concluded on Tuesday 3 April 2018.

Declaration of results was published on Wednesday 4 April 2018 indicating Mike Travis as successful candidate.

All term lengths are for 3 years.

Erica Saunders
Director of Corporate Affairs

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Tuesday 10th April 2018

Report of:	Director of Corporate Affairs
Paper Prepared by:	Director of Corporate Affairs LiA Lead
Subject/Title:	*Freedom to Speak Up* Update Report
Background Papers:	Report from the Mid Staffordshire NHS Foundation Trust Public Inquiry *Freedom to Speak Up* Inquiry Report *Freedom to Speak Up* Guardian Survey 2017
Purpose of Paper:	To provide the Board with an update in relation to the *Freedom to Speak Up* Review and Recommendations from the *Freedom to Speak Up* Guardian Survey 2017 and our current position against NGO recommendations from the inspection of two trusts following concerns raised in relation to speaking out processes and procedures
Action/Decision Required:	The Board is asked to: • Note the Trust's position; • Continue to support the direction of travel
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	**Excellence in Quality** **The Best People Doing Their Best Work**
Resource Impact:	Not yet identified

Alder Hey Children's NHS
NHS Foundation Trust

Freedom to Speak Up Framework – Progress Update

1. Purpose of the Report

The purpose of this paper is to provide a progress update with regard to implementation of the framework to support the prescribed *Freedom to Speak Up* Guardian role at the Trust and the key findings and recommendations from the 2017 *Freedom to Speak Up* Survey.

2. Recommendation

The Board is asked to note the updated position and to endorse the planned direction of travel to integrate this initiative with the Trust's existing arrangements for raising concerns.

3. Background

The development of the Freedom to Speak Up Guardian role was a recommendation made by Sir Robert Francis in '*Freedom to Speak Up*' in 2015.The role is not centrally funded and trusts are expected to implement the role according to the local needs and resources. The National Guardian's Office have not issued detailed guidance with regard to this role, hence the need for a national survey to understand how the role is being implemented, who is being appointed and to ask the new network of guardians for their thoughts on Freedom to Speak Up within their trust.

The results of the survey did identify some areas for further consideration, which will be kept under review to ensure that the Guardian/advocates roles are properly resourced, embedded and used as intended.

4. Progress to date

There are now eight Freedom to Speak Up Advocates at Alder Hey working locally to support the role of Guardian. The Communications team have publicised the FTSU role whilst also promoting our 'soft launch' approach to the wider raising concerns 'universe' within the Trust. Four of the advocates have attended the National Guardian's Office training, delivered by Public Concern at Work. Places are limited on this course but we continue to monitor availability to secure a place for the remaining four advocates. Monthly Freedom to Speak Up meetings are planned throughout the year, to support training and development. Networking continues, with attendance at the North West regional network meetings and the annual National Guardians conference.

Further actions are set out in the project plan below.

5. Referrals to the Guardian/Advocates - Quarter 4 to date

Number	Referral Source	Theme	Action Taken
3	Individuals raised concern. 2 waived their anonymity 1 remained anonymous	Bullying and Harassment	Raised issues with Director of HR, who contacted one of the individuals. Plan in progress for resolution.

6. Raise It, Change It

The most well-used mechanism for raising general concerns within the organization continues to be *Raise It, Change It*, launched in May 2014 in response to particular issues within the Theatres department at that time. In the last year over 130 issues have been raised by staff through this route directly with the Chief Executive; responses to those issues which are likely to be of interest to staff in general are published on the Trust's intranet. In the last year some of the themes to emerge from *Raise It, Change It* have been: workforce issues including working conditions, equipment and technology; questions about Trust facilities, in particular catering and parking provision; and questions regarding the distribution of resources.

7. Next Steps

To identify a range of intelligence to support the monitoring of speaking up processes and culture within the Trust and any further recommendations from NGO case reviews as they arise.

Erica Saunders
Director of Corporate Affairs
March 2018

Kerry Turner
LiA Lead

Alder Hey Children's NHS
NHS Foundation Trust

FTSU Project Plan

Area	Progress	Action/next steps
Understand national and local position	• Attendance at the national FTSU conference • Link to local FTSU network established	• FTSU Advocate attended national conference – focus on learning re measuring effectiveness and visibility and reach. Output will be fed back to working group • Continued participate in local network meetings • Attending training session for MHFA ,which was identified as a training need through the North West Regional network group (Note-MHFA training is now being delivered within the Trust)
Supporting staff raising concerns	• FTSU advocate attended MHFA training • MHFA train the trainer identified within the organisation	• Aim to develop an internal MHFA training programme to train current FTSU champions
Identification of FTSU 'Advocates'	Eight identified FTSU Advocates, with a further 2 having expressed an interest, each Division is represented	Aim to recruit representation from our BME workforce and our Disability workforce, through the network groups.
Training	Participation in national training programme attended by 4 of the 8 Advocates, currently waiting for further dates to be released from the NGO	To develop internal training programme for any future FTSU Advocates, working with colleagues within the North West regional to develop this programme
Mapping exercise undertaken to set out existing framework for raising concerns;	The whistleblowing procedure is now in circulation which clearly describes how concerns can be raised.	To ensure staff are aware of the different mechanisms available for raising concerns (raising concerns 'universe')
Communications plan	• FTSU communications have been launched and are easily identifiable on the intranet • FTSU role and process is	Design 'Having the courage to Speak Up' posters which would demonstrate our culture of open, honest and supportive and include images of our FTSU

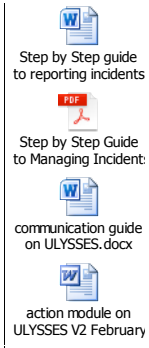
	included in all induction days	Guardian/Advocates with contact details
National Guardians Office Case Studies	Review of NGO case studies and recommendations	To implement any recommendations from the 2 case studies
To imbed recommendations identified from NGO case reviews,to include a range of intelligence to support monitoring speak up processes and culture	• NHS Staff Survey • Exit interviews	
Support external whistleblowers to find alternative employment in NHS	FTSU champion trained to participate in the 'Whistle-blowers Support Programme' and sits on the national Whistle-blowers Support Scheme Design and Monitoring group	To identify resources available that whistleblowers have access too, to assist in the return to employment within the NHS

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	Individual action BRAG	Overall action BRAG	Target completion date	Monitoring Committee	Required outcome / output	Evidence
1	Must	Trust	**Serious Incidents** 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	**Update January 2018:** Draft revision completed	Complete	In progress	**Complete:** 20 December 2017 – and ongoing	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.	Management of Incidents Incorporati
				1.2 Align the Trust mortality and morbidity review process with incident management process			**Update January 2018:** completed	Complete		**Complete:** 20 December 2017			
				1.3 Relaunch of the Trust Incident management including serious incident framework via intranet, team brief, governance processes 'Board to Ward'			**Update March 2018:** Trust incident management including serious incident policy completed and on Trust intranet.	Complete		**Complete:** 10 February 2018			
				1.4 Review and update of the Ulysses incident management module in the Trust Electronic Risk Managed system			Initial review completed. Plan in place to increase super users (Ulysses technical experts) across Divisions, awaiting identified staff confirmation from Divisions to enable training progress.	Complete		**Complete:** 20 December 2017 – and ongoing			
				1.5 Develop and implement step by step guides to support staff understanding of mandatory requirements in terms of process including timeliness of actions			**Update January 2018:** Draft completed	Complete		**Complete:** 20 December 2017			

ALDER HEY CHILDREN'S NHS FOUNDATION TRUST CQC ACTION PLAN

				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			**Update March 2018:** Partially completed – Step by step guides developed and on Trust intranet.		~~28 February 2018~~ Revised timescale: May 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			**Update March 2018:** Partially completed – incident management a standing item at governance meetings.		~~28 February 2018~~ Revised timescale: May 2018			
				1.8 Development of regular lessons learned and actions taken newsletter to be published widely across Trust including Trust intranet			**Update March 2018:** Developed and available on Trust intranet.	Complete	**Complete:** 28 February 2018			
2	Must	Trust	**Sepsis** 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	Complete	In progress	**Complete:** 31 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	

ALDER HEY CHILDREN'S NHS FOUNDATION TRUST CQC ACTION PLAN

				2.2 Continuous monitoring and audit of sepsis management in Emergency Department and inpatient wards with associated monthly reports			**Update January 2018:** Reports have been provided monthly for both ED and Inpatients since May 2017, and despite the CQC no longer requesting the data, this continues to be produced. The Sepsis Nurses have been presenting case reviews since August 2017, with more structured case reviews introduced from December 2017, which included themes for delays in treatment.	Complete		**Complete:** 31st November 2017 – and ongoing	Sepsis policy	
				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 January 2018:** The Sepsis Nurses have been presenting case reviews since August 2017, with more structured case reviews introduced from December 2017, which included themes for delays in treatment. Additionally the COO has introduced weekly updates on the number of cases that were treated within 60mins for Exec Comm Cell.	Complete		**Complete:** 31st November 2017		
				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		**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			**Update January 2018:** Updates were provided to the Divisions in September 2017, and the team presented to Grand Round on 20th October 2017. An update was also presented to the Infection Prevention & Control Committee on 12th December 2017.	Complete		**Complete:** December 2017		

ALDER HEY CHILDREN'S NHS FOUNDATION TRUST CQC ACTION PLAN

				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		**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		**Complete:** 31st August 2017 and ongoing			
3	Must	Trust	**Fit and Proper Persons** 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	**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		**Complete:** 21st June 2017			
4	Must	Trust	**Safeguarding Level 3** 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	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	Complete	In progress	**Complete:** 31st August 2017	Workforce and Organisational Development Committee	90% compliance in Level 3 safeguarding training	

			competencies for health care staff Intercollegiate Document (2014)	4.2 Monitor compliance with Level 3 safeguarding training across the Trust, within Divisions, and within specific departments			**Update March 2018:** Information provided to the CQC during their inspection visit to the trust in February did demonstrate that the trust was compliant with level 1, 2 and 3 safeguarding children training. Targeted training to individuals / departments with lower compliance continues to be a high priority for the safeguarding team. Options available for flexible learning are highlighted within the January safeguarding newsletter which went out trust wide. This message will be supported quarterly when safeguarding newsletters are produced (next due April 18). The safeguarding Trainer continues to work very closely with the L&D department to ensure compliance is being captured. Monthly monitoring continues.	**Subject to Monthly monitoring**		No completion date as training compliance tasks will renew on an annual basis (or three yearly depending on training cycle)		
				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 March 2018:** No change in-month however ward managers are receiving regular monthly ward/ service department specific reports which is assisting with monitoring and oversight of compliance	**Subject to Monthly monitoring**		No completion date as training compliance tasks will renew on an annual basis (or three yearly depending on training cycle)		

ALDER HEY CHILDREN'S NHS FOUNDATION TRUST CQC ACTION PLAN

				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	**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 March 2018:** The dedicated specialist nurse has been and continues to 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. This is evidenced through the improvements in particular areas across the trust that were showing low compliance		31st March 2018				
				4.6 Report performance monthly at community and statutory services business meetings				Complete	**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	**APLS** 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	Complete	**Complete:** 30th September 2017	Resuscitation Committee; Clinical Quality Steering Group; Clinical Quality Assurance	80% compliance against Trusts Resuscitation Policy		In progress
				5.2 Recruit additional resuscitation training officers as required			**Update February 2018:** New leadership structure in place – complete.	Complete	31st December 2017				

ALDER HEY CHILDREN'S NHS FOUNDATION TRUST CQC ACTION PLAN

				5.3 Update Resuscitation policy			**Update March 2018:** Resuscitation Policy ratified by CQSG on 13.2.18	Complete	~~31st December 2017~~ ~~31 January 2018~~ **Complete:** Feb 2018	Committee	Resuscitation Policy - C23.pdf	
				5.4 Develop phased roll out plan to maintain compliance against RCN standard based on service need			**Update 14 December 2017:** Resuscitation training SOP approved and implemented. 18 APLS courses planned for 2018 alongside 65 PLS courses	Complete	**Complete:** 30th November 2017			
				5.5 Review compliance monthly at Resuscitation committee and Clinical Quality Steering Group			**Update 23rd October 2017:** Complete – Standing agenda item NB: still validating data on ESR	Complete	**Complete:** 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 February 2018:** Work in progress from January 2018		31st January 2018 – 31st March 2019			
				5.7 Audit quarterly compliance against Resuscitation policy and phased roll out			**Update February 2018:** Resuscitation policy complete, awaiting ratification by CQSG. Audit commenced for the following: 1) Checking resuscitation trolleys 2) Emergency bleep test	Complete	31st January 2018			Safety Alert Checking Resuscitatic
6	Must	Trust	**Mandatory training** 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	Complete	**Complete:** 31st August 2017	Workforce and Organisational Development Committee	90% compliance in mandatory training	

ALDER HEY CHILDREN'S NHS FOUNDATION TRUST CQC ACTION PLAN

				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	Complete		**Complete:** 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	Complete		**Complete:** 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 February 2018:** Exercise required to finalise the position on the e-learning packages for all core subjects.			~~31st January 2018~~ Revised timescale 31st March 2018 for the e-learning completion			
				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.			31st March 2018			
				6.6 Review and update training needs analysis in mandatory training policy			**Update January 2018:** Policy ratified	Complete		**Complete:** December 2017			P80. Mandatory Training Policy - M31 I
7	Must	Trust	**Risk assessments** Must ensure that formal risk assessments are undertaken in all departments and all identified risks are captured on the risk	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	Complete	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	

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			register where needed	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	register	
				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	**Update March 2018:** Plan discussed at Workforce and OD Committee February 15th 2018. This will address actions in 7.3, 7.5, 7.7, 7.8, 7.9	Complete	~~31st January 2018~~ **Complete** 15 Feb 2018	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	
				7.4 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 February 2018:** In progress.		~~30th November 2017~~ Revised timescale 31 March 2018		
				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 March 2018:** See 7.3		**Complete** 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	**Update 14 December 2017:** Action complete	Complete	30th November 2017		

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				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 March 2018:** See 7.3	Complete		**Complete** 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 March 2018:** See 7.3	Complete		**Complete:** 31st March 2018			
				7.9 Widely disseminate Health and Safety training schedule		Amanda Kinsella Health and Safety Manager	**Update 14 December 2017:** Training schedule for Manual handling, risk assessment and stress risk assessment training has been disseminated. Further aspect of H&S Training to be rolled out in the New Year.	Complete		**Complete:** 30th November 2017			
8	Must	Community CAMHS	**Lone working** 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 14 December 2017** Task and Finish Group set up in Sefton. Next meeting 12th December. Signed forms received for 50% of staff. Aim to get all staff by the end of December 2017.	Complete	In progress	~~30th September 2017~~ ~~31st November 2017~~ **Complete:** Revised timescale 31st December 2017	CAMHS Clinical Governance Integrated Governance Committee	Safe and robust lone working practices are implemented and sustained	Lone Working mobile phones PADs .msg

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				8.2 Disseminate process for use of Trust mobile phones to all CAMHS staff			**Update 14 December 2017** SOP being developed for Liverpool CAMHS. Sefton CAMHS agreeing this process in Task and Finish group.	Complete	30th September 2017 ~~31st November 2017~~ **Complete:** Revised timescale 31st January 2018		Lone Working mobile phones PADs .msg
				8.3 Provide a briefing to all staff on the use of Personal Alarm Devices (PAD)			**Update 14 December 2017** Agreement on the type of devices to be used in Sefton not yet agreed – to be discussed and agreed at the next task and finish group 12th Dec 2017	Complete	30th September 2017 ~~31st November 2017~~ **Complete:** Revised timescale 31st December 2017		Lone Working mobile phones PADs .msg
				8.4 Test the PADs			**Update 14 December 2017** Order did not go forward due to disagreement of type of device. – to be discussed and agreed at the next task and finish group 12th Dec 2017	Complete	~~30th September 2017~~ **Complete:** 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 February 2018** Sessions have been booked with the LSMS	Complete	~~15th November 2017~~ **Complete:** 31st January 2018		Lone Worker Sessions.msg RE Lone Worker Sessions.msg

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				8.6 Agree process for how lone working process is to be implemented for new starters on induction			**Update 14 December 2017** CAMHS induction checklist updated to cover Lone Worker policy and process.	Complete		**Complete:** 30th November 2017			CAMHS Induction Checklist.docx
				8.7 Audit of lone worker process			**Update February 2018** Audit tool being produced to audit implementation of guidance. First Audit to be completed April 2018.			~~31 January 2018~~ ~~28 February 2018~~ Revised timescale 31 April 2018			
9	Must	Community CAMHS	**Confidential information** 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	Complete	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	Sefton CAMHS IG poster.pptx IG SpotCheckProforma
				9.2 Implement the 'Clear Desk' policy			**Update 26th October 2017:** Communication sent to all CAMHS Sefton staff about the Clear Desk policy	Complete		**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		**Complete:** 31st August 2017			
				9.4 Undertake Information Governance spot check audits			**Update February 2018** Independent spot checks completed for Liverpool and Sefton by the IG Manager	Complete		~~31st December 2017~~ **Complete** 31 January 2018			
				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		**Complete:** 31st May 2017			
				9.6 Staff to use booking schedule system to ensure that clinic rooms are used for			**Update February 2018:** Letter sent to all CAMHS staff	Comp		~~15th December~~			

				appointments only and not personal offices in order to support lone worker practices and information governance			by AW, Director of Mental Health		~~2017~~ **Complete:** 31st January 2018			

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Medicine and Surgery

No	Must / should do	Dept	CQC action	Alder Hey action	Director	Lead	Progress	Individual action BRAG	Overall action BRAG	Target completion date	Monitoring Committee	Required outcome / output	Evidence
10	Should	Medicine / Surgery	**Resuscitation roles** 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 January 2018:** Commenced in December 2017, plug programme developed for delivery across all clinical departments	Complete		**Complete:** 30th November 2018			
				10.3 Update Trusts Resuscitation policy and re-issue to all staff			**Update March 2018:** Resuscitation Policy approved 13.2.18	Complete		~~31st December 2017~~ ~~31 January 2018~~ **Complete:** February 2018			Resuscitation Policy - C23.pdf
				10.4 Audit staffs understanding of their roles and responsibilities during a resuscitation attempt			**Update March 2018:** Audit to be discussed at March Resus committee meeting.			~~28th February 2018~~ Revised timescale 31 March 2018			
11	Should	Medicine / Surgery	**Resuscitation Equipment** 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	Complete	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 January 2018:** Trolleys are checked twice daily (start of day and night shift) by the nursing staff on the ward (they are sealed so only the top contents and the seal intact) after each use and a full contents check once a month. Draft	Complete		~~31st December 2017~~ Revised timescale 31 January 2018			Resus Trolley deployment list.xlsx Trolley Defibs cheking audit (2).xlsx

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							SOP to be ratified at January's resus committee meeting. Compliance is audited weekly by the resus team and issues highlighted to W.M / Sister and now incident reported. Audit is reviewed monthly at resus committee. As compliance increases this will be reviewed but whilst relatively new we will continue auditing weekly.						Resuscitation Policy - C23 Formatted For R
12	Should	Medicine / Surgery	**Absconsion / abduction** 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 February 2018:** The current guidance available has been reviewed by a working group on 8th January 2018 consisting of nursing, safeguarding, security and risk management staff and it has been agreed to devise a standalone absconsion policy. Currently clear guidance is available in the Leave of Absence / Absence without Leave Policy for patients under the Mental Health Act, and a specific section in the Safeguarding Procedures however it is anticipated that the new standalone policy will enhance the guidance. The new policy will go to Clinical Quality Steering Group for approval in March 2018 and then Integrated Governance Committee for ratification.		In progress	~~31st January 2018~~ Revised timescale: 31 March 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		**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	**Update December 2017:** Action complete	Complete		**Complete:** 30th November 2017			 Safety Alert - Patients at risk of abs
				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 2018			
13	Should	Medicine / Surgery	**Mandatory training** 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	Melissa Swindell Director of Human Resources and OD	Will Weston Associate Chief Operating Officer Medical Division Andy McColl Associate Chief Operating Officer Surgical Division			In progress	31st December 2018	Workforce and Organisational Development Committee	90% compliance in mandatory training	
				13.2 In collaboration with L&D team, devise specific and targeted actions in any areas with compliance less than 90%						31st December 2018			
14	Should	Medicine	**Medical records** 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	This has been actioned and responsibility given to ward managers who are presently looking at different note trolleys as well as the ones on surgical wards.	Complete	In progress	**Complete:** 31st December 2017	Information Governance Committee Integrated 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			**Update January 2018:** Revised timescale 31 January 2018 **Update February 2018:** Trollies or storage system in place. Ward Managers & Staff vigilant in not leaving notes around.	Complete		~~31st December 2017~~ **Complete:** 31 January 2018			

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15	Should	Medicine	**Disease Specific Pathways** 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 electronic pathways	15.1 Review and disseminate diabetic pathways	Steve Ryan Medical Director	Adrian Hughes Associate Medical Director Medicine	**Update 27th October 2017:** • Revised DKA guideline has been in operation since May 2017. • The newly diagnosed guideline has been rewritten and has been emailed out to the diabetes team who have made no further changes, this should be ready to use as soon as it can be released. • The Hyperglycaemia guideline has been rewritten and is awaiting team approval (this also forms part of the surgical guideline) • The Type 2 guideline is a new document and is currently in draft form, I'm aiming to have this available for use later in the summer.		In progress	• **Complete** • Timescale April 2018 • Timescale April 2018 • Timescale July 2018	Divisional Risk and Governance Committee Clinical Quality Steering Group Clinical Quality Assurance Committee	Guidelines.pptx Specific disease pathways will be in place Trust will be assured of patient safety during transition from paper to 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			
				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		**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	Complete		**Complete:** 30th April 2017			

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							makes this pathway unique	Complete	In progress				
16	Should	Medicine / Surgery	**Appraisals** 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~~ Andy McColl Associate Chief Operating Officer Surgical Division	**Update 14 December 2017:** PDR 84% on 29/11/17. Slow, but sure improvement over the last two months. Next step is to cleanse ESR to make sure all staff listed against division of medicine are correct. ESR export sent to service and operational managers to complete and sent back to HR for validation and amendments are made week commencing 4/12/17.	Complete		**Complete:** 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		**Complete:** 31st October 2017 and ongoing			
				16.3 Produce and share regular detailed PDR reports at divisional and departmental level			**Update 14 December 2017:** PDR reminders sent out regularly e.g. 06/11/2017.	Complete		**Complete:** 30th November 2017 and ongoing			
				16.4 Review local progress on ESR			**Update February 2018:** Clinton completes, which will allow for easier and more accurate analysis of target areas.	Subject to Monthly monitoring		30th November 2017 and ongoing No completion date – subject to monthly monitoring			

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				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 March 2018:** Performance at the end of August was reported at 91.1% - ie target achieved by close of the PDR window. Figures in ESR have shown slight reduction to 89.5% at the end of January, but new round of PDRs will not start until April in line with Trust timetable. From April onwards, a new window of PDRs will commence, and managers will be provided with local data and support to ensure compliance in all areas by end of July 2018.	Subject to Monthly monitoring		30th November 2017 and ongoing No completion date – subject to monthly monitoring			
				16.6 Annual review of PDR documentation and update as required						31st March 2018			
17	Should	Medicine	**MHA Training** 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	**Update March 2018:** C Wardell liaising with J Knowles to action this.		In progress	~~31st January 2018~~ Revised timescale April 2018	Clinical Quality Steering Group Clinical Quality Assurance Committee	All staff receive appropriate mandatory training	
18	Should	Medicine	**Display Screens** 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	**Update March 2018** Privacy Impact Assessment undertaken. Consideration to be given to relevance of display screens.		In progress	~~31st January 2018~~ Revised timescale March 2018	Information Governance Committee Integrated Governance Committee	Relevant information to maintain patient safety and patient flow is available and patient confidentiality is not compromised	PIA Screening V1 - electronic whiteboard
				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									
19	Should	Medicine / Surgery	**Risk Registers** Identify review dates on all risk registers and review monitor that actions identified to mitigate risk are in place in medical	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	**Update 30th October 2017:** Divisions to include Risk Register as a standing agenda item at either Divisional Board / Risk and Governance meetings		In progress	31st December 2018	Integrated Governance Committee	Risk Registers will be up to date with appropriate review dates and evidence that actions	

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			services and surgical services		Christian Duncan Associate Medical Director for Surgery	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			identified to mitigate risk are in place in the Medical and Surgical Divisions Focused 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. Corporate risk registers to include all high risks only and linked to corporate objectives
				19.2 Risk Managers to be identified on each risk assessment, in addition to Risk Owners		**Update 30th October 2017:** All risks currently under review as per action 19.4 and all Risk Managers will be assigned		31st December 2018	
				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)	**Complete**	**Complete:** 20th October 2017 and ongoing	

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							in the same way	Complete	In progress				
				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 January 2018** 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. **Work ongoing** 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 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	Complete		**Complete:** 31st December 2017 **Remains in progress**			
20	Should	Medicine / Surgery	**Ward Curtains** 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	**Update 14 December 2017** Programme has been updated according to risk category Very High Risk – 3 months High Risk – 6 months Significant Risk – 12 months	Complete	In progress	**Complete:** 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			**Update 14 December 2017** This is planned to commence as per date agreed, records will be stored on k drive			Quarterly commencing 31st March 2018			

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				20.3 In addition to planned replacement, replace curtains as part of an environmental deep clean and on request if visibly not clean			**Update 14 December 2017:** Curtains are replaced on an ongoing basis if not visibly clean and always when a deep clean is undertaken	Complete		**Complete:** 30th November 2017 and ongoing			
21	Should	Surgery	**SSI** 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	Complete	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 January 2018:** We have now recruited 1.4WTE site surveillance officers into post with anticipated start dates of mid Feb. We have a quote approved for the creation of a database and a working group is established to complete the content and functionality reviews of this.			~~31st December 2017~~ Revised timescale end Feb- mid March 2018			
				21.3 Develop the required SSI			**Update February 2018:** • Staff have been recruited and are in post, one started 12/02/18, the 1.0 FTE starts first week of March.	Complete		31st January 2018			
				21.4 Commence SSI data collection			**Update February 2018:** • Data collection to commence mid-March, with a view to look retrospectively back until Jan to provide a complete year overview. • The database is in first draft stage and our theatre matron met with the developer to review yesterday afternoon. • The plan is to be live mid-March. • There is a roll out plan to attend speciality meetings to feedback			~~31st January 2018~~ Revised timescale March 2018			

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							data to specialities from April.						
				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				
22	Should	Surgery	**CD Discard** 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)			**Update March 2018:** Disposal processes at ward level still to be clarified by CD lead pharmacist. Pharmacy SOPs updated and reviewed at pharmacy senior team leaders meeting on 27th Feb 2018.			31st December 2017 – and ongoing			CD in theatre template.docx Controlled Drugs in Theatres_April2016 (Ward Controlled Drugs Oct 2016.pptx
				22.4 Investigate whether CD books are available that allow for discards to be recorded more clearly			**Update January 2018** Only suitable when wards mostly giving injections.		Complete	**Complete:** 31st December 2017			

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				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			**Update January 2018:** Training package sent to ward managers for use	Complete		30th November 2017 and ongoing			
				22.6 Review Medicines Management Code and update as required			**Update January 2018:** The MMC has been reviewed and reflects the current legally required processes for management of CDs.	Complete		**Complete:** 31st December 2017			
23	Should	Medicine / Surgery	**MAR** 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	Complete	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 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				Complete		**Complete:** 4th November 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			**January 2018:** Pilot commenced. Now in the process of reviewing the outcome of the pilot and next steps for the roll-out.	Complete		**Complete:** 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			

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24	Should	Medicine / Surgery	**Ward Co-ordinator** 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	**Update March 2018:** In November 2017, the National Quality Board published improvement tools specifically for the care of children and neonates: Safe, Sustainable and Productive Staffing: An improvement resource for children and young people's in-patient wards in acute hospitals / neonatal care. A review of all ward establishments will take place from February to June 2018 in line with the new NQB improvement tools and the findings will be reported back to Trust Board in September 2018		In progress	~~28th February 2018~~ Review findings to Board Sept 2018	Clinical Quality Assurance Committee		

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				24.2 Undertake annual audit of nurse staffing against RCN core standards to identify gaps			**Update March 2018:** An audit against the RCN standards has been repeated in February 2018 involving the Ward Managers, Matrons and Associate Chief Nurses for all in patient and day case wards. A previous audit of compliance against the core standards conducted in February 2017 demonstrated Trust compliance with 11 standards, partial compliance with 3 standards and no compliance with one standard. The recent audit has demonstrated an improvement against the standards compared to February 2017 with one standard moving from a RAG rating of Red no compliance to Amber partial compliance following the appointment of Matrons, and a comprehensive review of resuscitation training incorporating identified service need for APLS trained nurses on each shift. Audit result forms part of Trust Board Nursing Workforce paper to be presented at March 2018 Board	Complete		**Complete:** 28th February 2018			

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				24.3 Review nursing model in wards where a supranumery co-ordinator is not currently being allocated			**Update March 2018:** Nursing model reviewed as part of the RCN audit. Improved position. PICU, HDU, Ward 4A and Ward 1C Neonatal (day only) already had funded establishment above the baseline bedside funded establishment for a supernumery shift co-ordinator. In 2017 funded establishment increased on Ward 1C Cardiac (day only) to enable supernumery shift co-ordinator. Additional funding now agreed for Ward 3A which will enable a supernumery co-ordinator 24 hours per day. All Ward Managers supernumery. All wards now benefit from presence of a supernumery Matron. All wards allocate a nurse to take charge and co-ordinate the shift. This model requires nurses on the shift to increase the number of patients they care for to facilitate a supernumery co-ordinator, or the co-ordinator cares for patients as well as taking charge of the ward	Complete		**Complete:** 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			**Update March 2018:** Identified gap to be escalated for the attention of the Trust Board through the Trust Board Nursing Workforce paper to be presented at March 2018 Board			30th March 2018			

ALDER HEY CHILDREN'S NHS FOUNDATION TRUST CQC ACTION PLAN

25	Should	Medicine / Surgery	**Appraisals** 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~~ Andy McColl Associate Chief Operating Officer Surgical Division	**Update December 2017:** PDR 84% on 29/11/17. Slow, but sure improvement over the last two months. Next step is to cleanse ESR to make sure all staff listed against division of medicine are correct. ESR export sent to service and operational managers to complete and sent back to HR for validation and amendments are made week commencing 4/12/17.	Complete	In progress	**Complete:** 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		**Complete:** 31st October 2017 and ongoing	
				25.3 Produce and share regular detailed PDR reports at divisional and departmental level			**Update December 2017:** PDR reminders now sent out regularly e.g. 06/11/2017.	Complete		**Complete:** 30th November 2017 and ongoing		
				25.4 Review local progress on ESR			**Update March 2018:** Waiting for appraisal window to open on first April. Booking appraisals into the calendar currently	Subject to Monthly monitoring		No completion date as training compliance tasks will renew on an annual basis (or three yearly depending on training cycle)		
				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 March 2018:** Targeted work continues by Associate Chief Nurse and Divisional HR Business Partner to address low PDR completion and relatively high sickness rates.	Subject to Monthly monitoring		No completion date as training compliance tasks will renew on an annual basis (or three		

ALDER HEY CHILDREN'S NHS FOUNDATION TRUST CQC ACTION PLAN

											yearly depending on training cycle)		
				25.6 Annual review of PDR documentation and update as required							31st March 2018		
26	Should	Surgery	**Cancelled operations** 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~~ Andy McColl 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	Complete	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		**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		**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			31st May 2018			

ALDER HEY CHILDREN'S NHS FOUNDATION TRUST CQC ACTION PLAN

							reminder service							
				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		**Complete:** 27th October 2017			

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Community CAMHS

No	Must/ should do	Dept	CQC action	Alder Hey action	Director	Lead	Progress	Individual action BRAG	Overall action BRAG	Target completion date	Monitoring Committee	Required outcome / output	Evidence
27	Should	Community CAMHS	**Risk Assessments** 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	**Update February 2018** Work in on going – process is in test mode currently – aiming for full implementation in May.		In progress	~~31st January 2018~~ Revised timescale May 2018	CAMHS Clinical Governance	Risk assessments are routinely reviewed, and the outcome of these reviews is clearly documented	Super SOP meeting.ics
				27.2 Development of a Super SOP to incorporate the processes for risk assessment			**Update March 2018** Progress being made – to confirm target date for first draft at the next CAMHS governance meeting.			~~28th February 2018~~ Revised timescale April 2018			CAMHS Record Keeping Audit Tool.dc
				27.3 Monthly audit of record keeping			**Update 14 December 2017** First audit of 20 records completed – audit results being written up. Some minor changes needed to audit form. Discussion of results from this first audit to be discussed at the CAMHS Governance meeting 21/12/17.	Complete		**Complete:** 30th November 2017			
28	Should	Community CAMHS	**Furniture** 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 14 December 2017** CAMHS Sefton risk assessment – 3 rooms outstanding	Complete	In progress	~~30th September 2017~~ ~~10th November 2017~~ **Complete:** 31st December 2017	CAMHS Clinical Governance	All furniture will be clean, well maintained, and in a good state of repair	Environmental Risk Assessment - Liverpo
				28.2 Risk assess whether appropriate to move furniture from current locations to new sites			**Update February 2018** Meetings progressing regarding move – proposed move of June 18.	Complete		**Complete:** 31st January 2018			

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29	Should	Community CAMHS	**Design / decoration** 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	**Update January 2018** Work is ongoing with the patient groups. Sefton move to take place first.	Complete	In progress	31st December 2018 - ongoing	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	**Soundproofing** 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 January 2018** Estates have designed the partitioning to clinic rooms in Burlington to have a 'severe' duty acoustic value of 51 db	Complete	In progress	**Complete:** 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 9 February 2018** Due to false ceilings and walls no consultation rooms are soundproof. Move to new location in June 18	Complete		~~31st December 2017~~ **Complete:** 31st January 2018			-
				30.3 Ensure rooms in new locations are assessed for sound proofing prior to moves			**Update February 2018** Will be tested prior to move in June 18.			~~31st December 2018~~ Revised timescale June 2018			-
31	Should	Community CAMHS	**Languages** 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 March 2018** Trust policy being reviewed and updated.		In progress	~~30th November 2017~~ ~~31 January 2018~~ Revised timescale end of April 2018	CAMHS Clinical Governance	Ensure that people are provided with information in a language or format they understand	

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				31.2 Undertake a review of how other organisations provide information in a language or format that families can understand			**Update February 2018** Completed	Complete		~~31st December 2017~~ **Complete:** 31st January 2018			
				31.3 Implement actions based on feedback			**Update March 2018** Need to confirm all correspondence has been updated.			~~31st December 2017~~ ~~31st January 2018~~ Revised timescale End of April 2018			
32	Should	Community CAMHS	**Staff morale** 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 February 2018** To go to March 18 Board	Complete	In progress	~~31st January 2018~~ **Complete:** 28 February 2018	CAMHS Board	Should ensure that effective strategies are in place to improve morale	CAMHS BOARD STAFF MORALE PRES STAFF MORALE REPORT 2017 FINAL Quality Update - Oct 2017.pptx Quality Update - Nov 2017.pptx
				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		**Complete:** 30th September 2017			
				32.3 Explore a Divisional 'Star of the Month'			**Update 14 December 2017** Decision made to use Trust process and use this to nominate staff from the division. Nominations being made	Complete		**Complete:** 30th November 2018			
33	Should	Community CAMHS	**Raising concerns** 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 14 December 2017** Incidents across CAMHS are increasing. Sessions held with staff at Liverpool and Sefton. Incidents are monitored and reported in the monthly Quality Update which shows the	Complete	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	Quality Update - Dec 2017.pptx

ALDER HEY CHILDREN'S NHS FOUNDATION TRUST CQC ACTION PLAN

							increasing levels of incident reporting.				can raise concerns	 Incident reporting process - 2017 - AH s
				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			**Update February 2018** Quality Update and Integrated Governance meeting in February 2018	Complete	~~30th November 2017~~ Revised timescale **Complete:** 31st January 2018		
				33.3 Investigate option for Community Head of Quality to become a Freedom to Speak Up Champion for the Division			**Update February 2018** Two FTSU identified for Community Division. Details on Trust intranet page.	Complete	~~31st October 2018~~ **Complete:** 31st January 2018			 Freedom to Speak Up.msg

ALDER HEY CHILDREN'S NHS FOUNDATION TRUST CQC ACTION PLAN

Amber action from 2015 inspection Action Plan

21. Continue to develop relationships with adult health and social care providers to ensure the safe and effective transition of care for young people						
Outcome	**Actions**	**Responsibility**	**Time-frame**	**Assurance**	**Progress**	
Overarching Transition Framework agreement across Healthy Liverpool	Develop shared framework with relevant partners	MD/ Clinical Lead	12 months	Healthy Liverpool Programme governance	**Update March 2018:** Established collaborative working was previously in place within the context of 'Healthy Liverpool' forums and Aintree regarding the transition of patients with complex neuro disabilities. Both the Alder Hey and the Aintree business cases were submitted to LCCG commissioners. The AHFT case was submitted on the 17th June 2015. The Healthy Liverpool working group met an impasse in terms of aligning and supporting the two Complex Patient Transition business cases from Aintree and Alder Hey Children's Hospital in the Summer of 2016. Both business cases related to the transition preparation and transfer of care from paediatric services to adult health services for patients with complex neuro-disabilities. The business cases were handed over to Specialist NHSE Commissioners at this time. A meeting on the 24th January 2017 with NHSE specialist commissioners and Alder Hey Transition team, led to the development of a two year CQUIN, to support the gathering of very detailed information about this patient group, the planning and preparation of patients from this cohort to be transition ready. To date all milestones within the CQUIN to Q3 have been achieved or surpassed NHSE expectations. It is anticipated we will achieve Q4. NHSE specialist commissioner met with AHFT Transition team again on 24th January 2018 to go through some queries on the CQUIN. We have yet to meet to plan the detail of the 2018-2019 part of the CQUIN, although some actions were requested at the meeting on 23rd January 18. To date we have achieved this year: • Appropriate central database for current complex patients is operational • Ongoing work with BI, meditech 6 (standard documents & IMO) and clinical coding is underway to identify a unique patient identifier system to ensure robust coding for contracts that identifies patients of transition age with complex neuro-disability who are likely to be difficult to transition. This should be completed when transition in meditech is fully operational. However this will always require minimal manual validation • All patients over the age of 14 years have drafted 10 steps transition pathway plan, a health information passport and a transition care plan. • All patients over the age of 18 years with the above plans have identified non-clinical transition preparation clinic dates scheduled before the end of June 2018. (exit strategy meetings) • Most patients over the age of 18 years with the above plans have identified clinical transition preparation clinics identified. (plans are to align these exit strategy meetings/clinics for the future) • Engagement and dialogue with Aintree University Hospital NHS Foundation Trust is ongoing to propose plans, outline their needs in order to support this Trust to accept care of this complex cohort of YP • Internal Trust governance mechanisms are in place to ensure highlight reports are shared with the Board and actions agreed • Action plan has been updated quarterly and milestones achieved • All patients have been categorised into phases using palliative care funding review criteria, as at 1st February 2018 ➢ Stable ➢ Unstable ➢ Deteriorating	

ALDER HEY CHILDREN'S NHS FOUNDATION TRUST CQC ACTION PLAN

					➢ Dying • Letters from MD/Exec lead for Transition have been forwarded to all adult Trusts, requesting identification of transition leads for AHFT to communicate with. These letters have been sent on 3 different occasions. NHSE have a copy of this letter. To date only two Trusts have responded Aintree and St Helens and Knowsley (Whiston) • Work towards the planning for transition of patients from paediatric specialist physiotherapy to adult physiotherapy remains ongoing • AHFT MD/Exec Lead for Transition has forwarded letters to date the letters have gone to ➢ Aintree ➢ Royal & Broadgreen ➢ Whiston ➢ Liverpool Women's ➢ Liverpool Heart and Chest ➢ Mersey care ➢ Requested to have a letter sent to Wirral- Arrow Park • 10 steps transition pathway and preparation implemented into four additional specialities this year in parallel to working on the Complex patient CQUIN, and picking up some CAMH's/community paediatrics work that has migrated to the Transition team since the departure of the 0.5 WTE Transition project/nurse lead in April 2017. This post was a WTE jointly funded by AHFT and Mersey care. • End of year report is almost written, to be finalised end of March 2018	

Alder Hey Children's NHS
NHS Foundation Trust

Trust Board
10th April 2018

Subject/Title	Global Digital Excellence (GDE) Programme Update
Paper prepared by	Peter Young, Chief Information Officer Cathy Fox, Associate Director 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

1.0 Executive Summary

The purpose of this paper is to provide the Board with an update on the progress of the Trusts Global Digital Exemplar (GDE) Programme; especially the achievement of Milestone Three and measures in place to achieve Milestone Four.

2.0 Update of Progress

Since the previous update to Board work has continued to ensure phase four milestones are achieved; primary areas of work include:

Interoperability Proof of Concept

The Platform is a single information sharing platform initially across Cheshire and Mersey, but with a view to further deployment into Lancashire and beyond. The platform provides a unified interoperability approach to facilitate transfers of care between providers and primary care.

An initial proof of concept is underway with:

- Liverpool Heart and Chest Hospital NHS Foundation Trust,
- Alder Hey Children's NHS Foundation Trust,
- Royal Liverpool NHS Foundation Trust,
- St Helens and Knowsley Hospitals Trust,
- Walton Centre for Neurology and Neurosurgery,
- Wirral University Teaching Hospital NHS Foundation Trust,
- Clatterbridge Cancer Centre NHS Foundation Trust.

An approach to consent has been agreed and is based on the iLinks agreement.

Work is now underway to develop a business case, communications and branding for the platform alongside engagement with further Trusts such as the North West Ambulance Service.

There are now six sites feeding patient demographics into the test platform. The sites are now validating this data and will then start the process of integrating discharge summaries for validation.

A workshop will be held on the 17th April for both Clinical and Technical Leads to discuss, progress and further develop the project.

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

Speciality Packages - Digitisation

The Speciality Package Project was developed as an opportunity to achieve hospital-wide, digitally supported, service transformation and quality improvement aims. The use of digitised clinical pathways formed one element of the process.

Eight specialities are now live:

- Gynaecology
- Emergency Department
- Rheumatology
- Community Matrons
- Pre-Op
- Dietetics
- Transition
- Standard Documents

All of the above specialities have developed specific clinical pathways to promote standardised, evidence based care.

Speciality Package - Outcomes

The Clinical Intelligence Portal is aimed at providing visibility of data developed within Meditech as part of the Speciality Package process.

Business intelligence software has been utilised to provide clinical teams with a user friendly interface summarising tables of data gathered routinely during usual clinical workflows and completion of clinical pathway documentation.

Clinicians are able to access data, which is updated daily, that is organised by pathway type and is relevant to the key clinical outcomes identified at the outset of the pathway development process. Data presentation is configurable and can be displayed at various levels allowing assessment of key service level metrics, as well as clinical outcome data at individual patient level. A variety of visual formats can be used to present data.

The Portal currently has data from:

- CAMHS
- Community Matrons
- Rheumatology
- Vascular Access
- Transition
- Sepsis

Work is on-going to obtain data from the remaining specialities which are live.

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

Point of Care Testing

Point of care testing ensures the integration of external Blood Glucose, Urinalysis and CO2 results into Meditech.

A pilot took place to ensure the process was fully tested. The pilot was successful and functionality has now been deployed to all machines.

Benefits baseline: Information Governance; the Trust is not MHRA compliant. The Trust cannot audit users of the devices to ensure they are trained.

3.0 Upcoming Deliverables

- Requirements gathering and digitisation of eighteen Speciality Packages by Milestone 4,
- Further integration of the seven sites involved in the Proof of Concept,
- A workshop will be held by the Chief Clinical Information Officer to understand the details required within Meditech for the progression of the TCI – Theatre Pathway,
- Further development of the Bed Management Module within Meditech to enhance patient flow,
- Review of Clinical Intelligence Portal and further gathering of outcome requirements.

4.0 Summary of Key Benefits

Project	Aim	Measurement	Baseline Position	Improvement Target	Actual Progress to Target (current)
Specialty Packages	Reduced variation in clinical practice	Number of digitised patient pathways	0	18 Mar-2018	19 Mar-2018
Specialty Packages	Increased income from outpatient procedure coding	Actual income received above plan for outpatient procedures	N/A	N/A	£387,716 above plan at Feb-2018
ED Specialty Package	Increased income – Emergency Care Data Set Early Adopter site	Funding received for being an Early Adopter site.	N/A	£20,000 Funding Mar-2018	£20,000 Funding Mar-2018

5.0 Milestone Assurance

On the 16th January NHS Digital attended the Trust to complete its Milestone Three assurance testing process. The feedback was positive and as a result the relevant staged funding has been made available.

The Programme is now working towards the implementation of projects within Milestone Four; these include:

- Deployment of Eighteen Speciality Packages,
- Implementation of the STP Platform Proof of Concept,
- Development of PACS for use in EEG,
- Full integration of Welch Allyn Vital Signs into Meditech.

6.0 Next Steps

- Continue working towards the delivery of Milestone four (May 2018).
- Continue to work with Specialties to identify target benefits and support the monitoring of these benefits throughout the project lifecycle. Further work is underway to integrate these into the divisions and ensure benefits realisation processes are in place.

7.0 Recommendations

The Trust Board is asked to:-

1. Note the progress with the GDE Programme and ongoing work to progress towards the four milestone, due 31st May 2018.

Peter Young
Chief Information Officer

4th April 2018

ALDER HEY CHILDREN'S HEALTH PARK LIAISON COMMITTEE

Title	**Liaison Committee Meeting Minutes**	
Date / time	Wednesday 14th February 2018, 14:00	
Location	Mezzanine Meeting Room, Level 1, Alder Hey Children's NHS Foundation Trust, Eaton Road, Liverpool L12 2AP	
Present	**Trust:**	David Powell (Development Director) **DP** Rachel Lea (Associate Director of Development) **RL** Graeme Dixon (Trust Head of Building Services) **GD**
	Project Co Directors:	Alan Travis (Explore Investments Ltd) **AT** Tristan Meredith (Interserve Developments) **TM**
	Other Project Co Attendees:	Stuart Wilkinson – (Project Co Representative) **SW** Laura Joseph-Chamberlain – (Interserve FM) **LJC**
Apologies	James Heath (John Laing Investments Ltd) **JH**	

Item	**Discussion**	**Action**
1.0	**Quorum** – the meeting was quorate as defined within clause 12.1 of the PA.	
2.0	**Previous Minutes dated 16th January 2018** – The previous minutes were accepted as an accurate record of the meeting. The status of the actions from the previous meeting were discussed as follows.	
2.1	(3.2) Pipework corrosion – see item 3.2 below.	
2.2	(3.3) Green roof – see item 3.3 below.	
3.0	**Key Issues / Hot Topics**	
3.1	Endoscope Washer Disinfectors – Trust Withheld Sum Disagreement: AT advised that Project Co were considering their position.	
3.2	Pipework Corrosion: SW advised that the consultant signatures were being pursued for the metallurgical (BRE) and water testing (IWS) appointments. WYG have visted site	

	and commenced their review of the engineering design. The revised anticipated date for issue of the final report is June 2018, with provisional results expected one month post-sampling. A revised programme will be produced once the remaining consultants are on board. A number of leaks have occurred in the last period with the majority occurring on the ground source heat pump system in corridors or plant rooms. The leaks are being fixed promptly as per the agreed working protocol between IFM and LORC to minimise operational disruption. Project Co and IFM met with the Trust's H&S representative on 9th Feb to discuss the current approach and plans going forward.	**SW**
3.3	Green Roof: Project Co has discussed the recommendations of the expert report with LORC, who have agreed to undertake remedial works. Project Co is awaiting confirmation of LORC's proposals and anticipate completion of the works by Spring 2018. AT has agreed to assist SW in escalating this issue to obtain LORC's response.	**SW / AT**
3.4	Energy: SW circulated Concept's revised project plan at the meeting. The programme has been delayed due to meter information issues and the arrangement of interviews with the key parties. Concept's plan is targeting the issue of a validation report to confirm the historic reconciliation and responsibility for excess consumption, during w/c 19th Feb. The second key milestone is the issue of a future action plan, by w/c 12th Mar. All parties advised that they were satisfied with Concept's performance to date. DP queried whether Concept were looking into boiler performance. SW confirmed that Concept had been investigating the boilers and would be reporting on this in due course. RL requested an updated on the Excluded Energy in relation to the retail units, as the Trust were keen to recover costs by the end of their financial year. RL queried if the Trust or Project Co should recover the costs from the retail tenants. SW agreed to investigate and for Project Co to provide an update.	**SW**
3.5	Subcontractors: LJC advised as follows: • IFM are to replace Schindlers with Otis as their lifts subcontractor by 24th Feb 2018; and • IFM are to move to Pharmagraph instead of Atlas for the Pharmagraph sub-contract. IFM continue to manage Atlas closely, although they remain problematic due to poor communication.	

4.0	**SFP Uplift**	
4.1	It was noted that the Trust has issued a response to the Project Co shareholders offer. AT noted that the September 2017 settlement deed action for Project Co and the Trust to agree an SFP uplift remained outstanding. AT advised that Lenders were pursuing the Project Co, as it is currently in default due to its breach of the 6 month rolling SFP threshold under the Common Terms Agreement. DP referred to a previously issued 'probation' list, containing a list of ongoing points, such as energy, end of lines cold water temperatures, green roof, lifts and drainage. DP suggested that this list should be re-visited with route maps put in place where they were not in place already. GD raised issues with the Zone 1 drainage system, due to incorrect falls and a "plateau". GD advised that the Trust were implementing warning signage in toilets throughout the area. LJC advised that the toilet flushing could be increased in key areas. SW advised that the SFPs for December 2017 and January 2018, although not yet formally agreed, appear to show an improved trend in performance compared to October and November 2017. DP stated his interpretation of a Trust staff customer satisfaction survey was that contract performance was at six out of ten but there is an upward swing from previous. AT expressed his disappointment at this feedback. DP advised that the Trust had seen a positive improvement in the performance of Project Co over the last two months in particular, with things being done quicker than previously.	
5.0	**Any Other Business**	
5.1	DP noted that there is some concrete façade panel cracking. AT pointed out that the panels in question were decorative cladding and not structural. SW advised that LORC have been asked to survey the panels and provide an appropriate remedial plan. DP requested a report which could be shared as a communication piece within the Trust.	**SW**
5.2	AT advised that a new General Manager, Andrew Saunders, has been appointed from Carillion, to replace SW who has been in the post on a interim basis. Timescales for the new GM's introduction to the project are still to be confirmed.	
6.0	**Next Meeting**	

6.1	Wednesday 21st March 2018 at 14.00. ***Post Meeting Note:*** ***Revised meeting date Tuesday 27th March 2018 at 11.00.***	

ALDER HEY CHILDREN'S HEALTH PARK LIAISON COMMITTEE

AGENDA

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