BOARD OF DIRECTORS PUBLIC MEETING

Tuesday 4th December 2018 commencing at 10:00

Venue: Large Meeting Room, Institute in the Park

AGENDA

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action	Preparation
PATIENT STORY (10.00 am-10.10am)						
	18/19/224	**1010**	**Relaunch of Patient Forum**	L Cooper	To update the Board on the plans of the relaunch	Presentation
1	**18/19/225**	**1020**	**Apologies**	Chair	To note apologies.	For noting
2	**18/19/226**	**1021**	**Declarations of Interest**	All	Board Members to declare an interest in particular agenda items, if appropriate.	For noting
3	**18/19/227**	**1022**	**Minutes of the Previous Meeting**	Chair	To consider the minutes of the previous meeting to check for amendments and approve held on: **Tuesday 6th November 2018**	Read Minutes
4	**18/19/228**	**1023**	**Matters Arising:** - **Action Log** - **Specialist Trust Alliances**	Chair L Shepherd	To discuss any matters arising from previous meetings and provide updates and review where appropriate. To receive the final draft proposal	Read Attachment Read report
5	**18/19/229**	**1025**	**Key Issues/Reflections**	All	Board to reflect on key issues.	Verbal
Strategy Update						
6.	**18/19/230**	**1030**	**Operational Plans – half year progress reports** **Divisional Update** - **Surgery** - **Medicine** - **Community** - **Research** - **Corporate Services**	Divisional Leads	To provide an update on progress to date against the 2018/19 Trust Strategy and Operational Plan.	Presentation
Delivery of Outstanding Care						
7	**18/19/231**	**1200**	**Inspiring Quality**	A Bateman S Falder	To present the business case.	Read report

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action	Preparation
				J Minford		
8	**18/19/232**	**1215**	**Global Digital Exemplar (GDE)**	P Young	To update the Board on the programme.	Read report
9	**18/19/233**	**1220**	**Alder Hey in the Park Site Development update** - **Dewi Jones Business Case**	D Powell L Cooper	To receive an update on key outstanding issues / risks and plans for mitigation. To present the business case	Read report
Lunch (12:30-13:00)						
10	**18/19/234**	**1300**	**Serious Incidents Report**	H Gwilliams	To inform the Board of the recent serious incidents at the Trust in the last calendar month.	Read report
11	**18/19/235**	**1310**	**Position Statement for Complaints & PALS, Quarter 2**	A Hyson	To receive the position statement for Q2, 2018/19.	Read report
12	**18/19/236**	**1320**	**Infection, Prevention and Control Report, Quarter 2**	Jo Keward	To receive the position statement for Q2, 2018/19.	Read report
13	**18/19/237**	**1335**	**Clinical Quality Assurance Committee: Chair's update:** - **Chair's verbal update from the meeting that took place on the 17.10.18** - **Approved minutes from the meeting took place on the 19.09.18**	A Marsland	To receive the approved minutes from the 19.09.18	Read approved minutes
14	**18/19/238**	**1340**	**Integrated Governance Committee** - **Chair's verbal update from the meeting that took place on the 20th November 2018** - **Approved Minutes from the meeting held on 12th September 2018**	A Bateman	To receive the approved minutes.	Read approved minutes
The Best People Doing Their Best Work						

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action	Preparation
15	18/19/239	1345	**People Strategy: including an update on the 2018 NHS Staff Survey:** - **Key Issues report from the Workforce Organisational Development Committee meeting that took place on the 23.10.18.**	M Swindell C Dove	To provide an update.	Read report
16	18/19/240	1355	**Interim Responsible Officer**	C Duncan	To inform the Board Terry Hankin, Deputy Medical Director at Whiston is interim responsible officer until Nicki Murdock commences her Medical Director post in January 2019.	Verbal
17	18/19/241	1400	**Well-led Board Development Plan**	E Saunders	To receive an update on the actions agreed at the Board Workshop with AQuA/ MIAA	Read report
Sustainability Through External Partnerships						
18	18/19/242	1410	**Joint Neonatal Partnership – Alder Hey and Liverpool Women's Hospital.**	A Bateman	To update the Board on progress.	Read report
Game Changing Research and Innovation						
19	18/19/243	1420	**Register of shareholder interests**	J Grinnell	To provide a monthly report.	Report
Strong Foundations						
20	18/19/244	1430	**Programme Assurance update:** - **Deliver Outstanding Care.** - **Growing External Partnerships.** - **Solid Foundations.** - **Park Community Estates and Facilities.**	J Grinnell	To receive an update on programme assurance including the 2018/19 change programme.	Read Report

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action	Preparation
21	**18/19/245**	**1440**	**Resources & Business Development Committee:** - **Approved minutes from the meeting held on 28th November 2018**	I Quinlan	To receive the approved minutes.	Read report
22	**18/19/246**	**1445**	**Audit Committee:** - **To receive a verbal update from the meeting held on 22nd November 2018** - **Approved minutes from the meeting held on 20th September 2018.**	K Byrne	To receive a verbal update and approved minutes	Read report
23	**18/19/247**	**1450**	**Corporate Report.** - **Monthly update by Executive Leads.**	J Grinnell/ H Gwilliams/ M Swindell	To note delivery against financial, operational, HR metrics and quality metrics and mandatory targets within the Corporate Report.	Read report
24	**18/19/248**	**1500**	**Board Assurance Framework**	Executive leads	To receive an update.	Read report
Any Other Business						
25	**18/19/249**	**1505**	**Any Other Business.** - **Corporate Meeting Dates 2019/20**	All	To discuss any further business before the close of the meeting.	Verbal Enclosed
Date And Time Of Next Meeting: Tuesday 8th January 2019 at 10:00am, Large Meeting Room, Institute in the Park.						

REGISTER OF TRUST SEAL
The Trust Seal was not used during the months of **November 2018**

Alder Hey Children's NHS
NHS Foundation Trust

PUBLIC MEETING OF THE BOARD OF DIRECTORS

Minutes of the meeting held on **Tuesday 6th November 2018 at 10:00am,**
Large Meeting Room, Institute in the Park

Present:	Sir D Henshaw	Chairman	(SDH)
	Mr. A. Bateman	Chief Operating Officer	(AB)
	Ms K Byrne	Non-Executive Director	(KB)
	Mr J Grinnell	Director of Finance	(JG)
	Mrs H Gwilliams	Chief Nurse	(HG)
	Mrs A Marsland	Non-Executive Director	(AM)
	Mr I Quinlan	Vice Chair (Chair)	(IQ)
	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)
	Prof M Beresford	Assoc. Director of the Board	(PMB)
	Ms L Cooper	Director of Community Services	(LC)
	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)
	Prof L Kenny	Executive Pro Vice Chancellor	(PLK)
	Mrs J Tsao	Committee Administrator (minutes)	(JT)
	Ms J Minford	Director of Clinical Effectiveness and Service Transformation	(JM)
	Mr D Powell	Development Director	(DP)
	Ms E Saunders	Director of Corporate Affairs	(ES)
Agenda item	Ms C Fox	Programme Director for Digital	(CF)
	Mrs K Turner	Trust Lead for Listening into Action	(KT)
	Mr J Gibson	Programme Director	(JGI)
	Mrs N Deakin	Programme Manager	(ND)
Apologies:	Mrs J France-Hayhurst	Non-Executive Director	(JFH)
	Mrs C Dove	Non-Executive Director	(CD)
	Dr A Hughes	Director of Medicine	(AH)

Patient Story
The Board welcomed Katrina, mum of patient Grace to the Board. Grace has cerebral palsy, which resulted in Grace requiring a prescribed feed (high calorie milk). Whilst this plan was working for Grace, Katrina asked to try an alternative option of blending food in a high tech blender and feeding this to Grace instead of the milk. Katrina noted how Grace's health had improved following this change.

Grace had recently had spinal surgery. Whilst on ICU the staff had advised Katrina that for a number of reasons Grace would be unable to have blended food and would be fed the prescribed milk.

Katrina said she would like the Trust to consider taking a more flexible approach within critical care she and would be extremely willing to provide support to staff to understand and implement this. It was agreed that Katrina and Hilda Gwilliams would take this forward together.

18/19/196 Declarations of Interest

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There were none to declare.

18/19/197 Minutes of the previous meetings held on 2nd October 2018

The Board went through the minutes from the meeting held on 2nd October 2018. Louise Shepherd referred to item 18/19/181 and asked for the wording to be changed to 'unavoidable factors' to more accurately describe the issue.

Resolved:

Subject to the above amendment the Board approve the minutes of the last meeting as a true and accurate record.

18/19/198 Matters Arising and Action Log

18/19/181.1 As agreed at the October Board Christian Duncan provided an update on the two deaths identified as having potentially avoidable factors.

The first case related to a Road Traffic Accident. The second avoidable issue occurred in the referring Trust. Christian Duncan agreed to contact Julie Grice as chair of HMRG regarding the wording of the report and to liaise with other trusts as required.

The Board noted items completed and any ongoing items are on the agenda.

18/19/199 Key Issues/Reflections

Adam Bateman updated the Board on downtime of the Trust's computer systems required to resolve a number of issues. The downtime was carried out through the night in order to have as little impact as possible to core hours of working. On behalf of the Board, Adam thanked all those involved.

Erica Saunders reminded Board that the Annual Members' Meeting would be held on Monday 12th November 2018 at 5:00pm. As Sir David's final term of office ends early next year this would be the his last AGM and he would be making the keynote address reflecting upon his eight years at Alder Hey.

Professor Michael Beresford, updated the Board on 17 applications received from the Trust for Honorary Consultant posts. Professor Louise Kenny noted the high quality of applications from Alder Hey. A further opening of applications was due to commence later in the year with the hope of annual opening thereafter.

Professor Kenny informed the Board of an application for £5m to fund a birth cohort for Liverpool. She emphasised the importance for the city to receive this funding and agreed to keep the Board updated.

18/19/200 Strategic Plan Dashboard

Mags Barnaby provided a proposal for the development of a one page dashboard to track the board's strategic priorities for the next 3 years. Anita Marsland welcomed this but queried if it would represent another substantial piece of work for the teams already providing a significant amount of performance information. Mags Barnaby assured the Board the data was already available.

The Board reviewed the progress update against the four strategic themes. Dame Jo Williams asked for *Inspiring Quality* to be included. It was agreed a revised version would be presented at the next Board in December 2018.

Louise Shepherd reported that the *Inspiring Quality* document had been due to come to this meeting however it had been agreed that further work was required and it would therefore be presented at the December Board.

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The Executive lead for each theme summarised key areas of progress for year one of the strategy thus far. In terms of the People strategy, Melissa Swindell noted the current number of apprenticeships is 46, fewer than the target of 50 apprenticeship roles for the year. A discussion was held on asking staff in these roles to share their stories. Melissa agreed to look into this.

The Chair thanked the Executive team for the update; it was agreed to provide a further progress report at the end of the year.

Specialist Trust Alliance
Louise Shepherd reminded the Board of the developing Specialist Trust Alliance, which comprises four Merseyside Specialist Trusts working together. It was hoped that in the future the trusts would be able to share resources and joint roles.

Louise Shepherd also reported on the recent Board to Board meeting with the Liverpool Women's NHS Foundation Trust, noting a joint focus to develop a research strategy.

Alder Hey had recently been informed of successful bids for two children's hubs. These hubs were to be based in Speke and Aintree.

Lisa Cooper, Director of Community and CAMHS reported on her view of the service since coming into post. Whilst internally the service was working well, further work was required externally with other organisations. Jeannie France-Hayhurst noted institutions tackling a number of issues including increasing incidence of self-harm among young people and asked if there was anything additional the Trust could do to support. Lisa Cooper advised the team does support a number of external services.

18/19/201 Serious Incident Report
The Board received and noted the contents of the Serious Incidents report for September 2018. During this reporting period there were four serious incidents, no never events and one previous never event closed. The following points were highlighted and discussed:

Hilda Gwilliams updated the Board on the Never Event (wrong site surgery) reported in the August report. The never event was the removal of the incorrect tooth. The report outlined lessons learnt.

Resolved:
The Board received the Serious Incident report for September 2018.

18/19/202 Global Digital Exemplar
Cathy Fox updated the Board noting milestone 4 had previously been met and the funding attached to this milestone had been received. The team continues to ensure phase five milestones are achieved. The Board noted the challenges associated with meeting milestone five.

Resolved:
The Board received the update on GDE Programme.

18/19/203 Alder Hey in the Park Site Development Update
Plans submitted for planning permission for the early reinstatement of the first phase of park near the Oncology building. The team are continuing to work on the overall design while awaiting the outcome of the application. Meetings continue with

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universities to consider the development of an outside research lab in Springfield Park, utilising the space and working with park users for environmental and health and well being research within university semester subjects. Looking ahead, dates have been agreed to host a Nature Conference in October 2019.

The Community Building and Dewi Jones Unit have been undergoing an affordability exercise market test following creeping building costs nationally. This exercise is due to complete week commencing 5th November.

An update was provided in relation to the plans for the temporary car park. David Powell's team had 6 weeks to resolve this with the City Council.

Resolved:
The Board noted the Alder Hey in the Park Site Development update.

18/19/204 Clinical Quality Assurance Committee

The Board noted Anita Marsland's verbal update from the Clinical Quality Assurance Committee that took place on 17th October.

Resolved:
The Board received and noted the approved minutes from the Clinical Quality Assurance Committee meeting that took place on 19th September.

18/19/205 People Strategy Update

The Board received and noted the contents of the People Strategy report for September 2018. The following points were highlighted and discussed:

- As of the 31st October our National Staff Survey completion rate is 43%, which has already surpassed both the 2015 and 2016 survey response rates with still over a month to go to reach our goal of 60%.
- Communications continued to be circulated on a weekly basis to divisions and departments and screen savers have been uploaded onto desk tops as a reminder. The organisation receives official response rates on a weekly basis but the Trust is able to access information as and when required.
- Applications for the Annual Star Awards have opened with the event to be held in February 2019.
- For the second year running staff had been awarded an additional day's leave for their support during the challenging year.
- Staff Fab Week was held during 15th to 19th October 2018 and was well received by both the staff and those organisations and individuals who ran stalls for the events. We will be running 'Fab' events across community sites to ensure maximum coverage.
- Sickness rates have decreased slightly this month compared to last month to 4.98% in month.
- Core Mandatory training compliance is at 90%
- The PDR window closed at the end of September with compliance at 88.84%.
- The Board was informed of two Employment Tribunals.

Resolved:
The Board received and noted the People Strategy update for September 2018.

18/19/206 Freedom to Speak up

Following completion of the self review tool completed in August 2018 the Board received progress against the action plan following the assessment.

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Kerry Turner informed the Board of the Junior Doctors Induction she would be attending later today to inform them of project and invite a representative to join the team of FTSU Advocates.

Resolved:
The Board received and noted progress to date. It was AGREED a further update would be received at the January Board.

18/19/207 Process to appoint Trust Chair

As the Chair's final term of office was due to end in February 2019, the Board received the process to be undertaken to recruit to this role, which would be supported by Gatenby Sanderson. Board members were asked to contact Erica Saunders with any comments on the job description and person specification.

Resolved:
The Board received the process to recruit the Trust Chair.

18/19/208 Joint Neonatal Partnership

Adam Bateman provided an update on the Neonatal Partnership and ambition to create a single service across the two Trusts in response to the North West Neonatal Network.

A new ward manager had been appointed and had implemented a infection prevention process.

The paper went through the three key reasons why a new model of care for neonatal surgical babies in Liverpool is critical:

- safer service for babies
- quality of care and clinical outcomes
- The experience of mothers and families will be improved by reducing the number of unnecessary transfers between hospitals by 50% (transfers are also associated with increased morbidity and mortality).

On behalf of the Board Mags Barnaby congratulated Adam Bateman and the team for progress to date.

Resolved:
The Board noted the update provided on the Joint Neonatal Partnership.

18/19/209 Register of shareholder interests

Resolved:
A monthly update will be provided to Trust Board of all company shareholdings that the Trust have an interest in, identifying any changes made in the last reporting period and highlighting any areas of note.

18/19/210 Programme Assurance Update

Joe Gibson introduced Natalie Deakin to the Board, Natalie would be taking over the management of the programme in the new year.

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

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

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3._Draft_Board_Minutes_-_Public_-_6_Nov_18

18/19/211 Corporate Report

The Trust is reporting a trading surplus for the month of £6.4 which is ahead of plan by £0.3m. Income is ahead of plan by £0.2m and expenditure is underspent by £0.1m in the month. The Use of Resources risk rating is 2 in line with plan and cash in the bank of £20m.

The clinical utilisation target for Alder Hey is 90%, for the month of September 84% was reached.

An update was received on the new booking systems, this was still under review and further opportunities would be undertaken this month.

Hilda Gwilliams updated the Board on the three areas below:
Safe - The Board received an update on clinical incidents to date.

Caring – The team were currently looking at affordable options of interactive play.

Effective – Sepsis continues to be the main focus at CQAC, Anita Marsland briefed the board on the issues reported at the monthly meeting. The Board asked for assurance to be received at the December Board.

18.19.211.1 Action: HG

Resolved:
The Board received and noted the contents of the Corporate Report for month 6.

18/19/212 Board Assurance Framework (BAF)

The Board received the BAF update for October 2018. Erica Saunders highlighted the following points:

- Closure of 7 inpatient beds due to delayed transfer of care has had an adverse effect on patient flow. The Board noted this has now been resolved.
- It was agreed to include the tariff risk posed by latest proposed changes.

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

18/19/213 Any Other Business

Mags Barnaby
The Board noted this would be Mags Barnaby's last Board meeting. On behalf of the Board the Chair thanked Mags for her support and contribution, wishing Mags well in her next venture.

Date and Time of next meeting: Tuesday 4th December 2018, 10:00am, Large Meeting Room, Institute in the park.

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Alder Hey Children's NHS Foundation Trust
Trust Board - Part 1
Action Log following the meeting on the 4.9.18

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
Actions for December 2018							
4.9.18.	18/19/148.1	Infection, Prevention and Control Report, Q1	Liaise with the Governance Department when developing the Isolation App.	Valya Weston	4.12.18.	On agenda	27.9.18 - An update will be provided during December's Trust Board meeting on the
4.9.18.	18/19/148.2	Infection, Prevention and Control Report, Q1	Include additional narrative in the report to provide the Board with assurance on actions and progress.	Valya Weston	4.12.18.	On agenda	27.9.18 - An update will be provided during December's Trust Board meeting on the 4.12.18.
3.7.18	18/19/103.1	Quality Improvement Update	Submit the draft Inspiring Quality business case to the Trust Board in October.	Adam Bateman/ Sian Falder/ Jo Minford	4.12.18.	On agenda	
Actions for January 2019							
			Matt Hancock, Secretary of State for Health and Social Care is opening the RE2 Bulding on 22.01.18 a session with the GDE team is to be organised	Mark Flannagan/ Peter Young	08.01.19		
3.7.18	18/19/118.1	Listening into Action	*Disability Network Groups* - Provide an update to the Trust Board in November 2018.	Chairs of the Network Groups	6.11.18.		01.11.18 - Deferred to the January meeting.
6.11.18	18/19/211	Corporate report	Sepsis continues to be the main focus at CQAC, Anita Marsland briefed the board on the issues reported at the monthly meeting. The Board asked for assurance to be received at the December Board.	Hilda Gwilliams	4.12.18.		28.11.18 - Deferred to the January meeting.
Actions for March 2019							
4.9.18.	18/19/154.1	2018 Annual Report for the Framework of Quality Assurance for Responsible Officers and Revalidation	Liaise with Melissa Swindell, Medical HR and the Medical Education Team to look at resolving the issue around the management/inputting of data relating to new recruits.	Graham Lamont	5.3.19.		27.9.18 - An update will be provided during March's Trust Board meeting on the 5.3.19.
4.9.18.	18/19/154.2	2018 Annual Report for the Framework of Quality Assurance for Responsible Officers and Revalidation	Discuss the possibility of accessing/triangulating information relating to complaints, incidents and PALS concerns to enable doctors to use this data as part of the reflective element of the appraisal process.	Graham Lamont	5.3.19.		27.9.18 - An update will be provided during March's Trust Board meeting on the 5.3.19.

Alder Hey Children's NHS Foundation Trust
Trust Board - Part 1
Action Log following the meeting on the 4.9.18

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
Status							
Overdue							
On Track							
Closed							

Draft for Discussion

Towards One Liverpool…A Specialist Alliance

1 Introduction

Four Specialist Acute Trusts in Liverpool/Wirral have come together to form an Alliance to drive the future development of specialist health services, research and innovation for the people of Cheshire and Merseyside, the North West, North Wales and the wider UK.

This Alliance is an **important next step towards** Liverpool's declared intention of **bringing all acute services closer together** under **"One Liverpool"** to drive up standards of care, secure consistent, equitable access and delivery for all our patients across Cheshire and Merseyside, support our workforce more effectively, drive innovation and research to enable the future development of life sciences and inward investment into the City Region.

It **supports the proposed merger of The Royal and Aintree Hospitals**, with whom we will continue to work extremely closely to further join up services within Liverpool and more widely across Cheshire and Merseyside. It also **enhances Liverpool Health Partners'** recently revised clinical research strategy by creating a **strong specialist voice** within that partnership.

Alder Hey, Clatterbridge Cancer Centre, Liverpool Heart and Chest, and The Walton Centre already provide excellent CQC-rated health services from our centres in Liverpool/Clatterbridge and through networks with hospitals across the North West/North Wales. We are key contributors to health research through Liverpool Health Partners and are at the centre of driving new innovation/digital technologies in our region. We currently employ 7,400 staff and have a combined revenue budget of £630m (which is mostly specialist commissioned) serving a population of up to 8m across the North West and Wales.

2 Our Aim

Our aim is to pool this knowledge, expertise and resource and work together to drive the delivery of truly world leading specialist services, research, education and innovation through:

- Common approaches to developing **excellent standards of care and digitally-enabled pathways** to support the delivery of and access to specialist expertise for the entire population as close to home as possible;

- Further strengthening and broadening our existing clinical collaborations with partners in Liverpool and beyond (e.g. in cancer, congenital heart, neonatal and neurosciences) to develop **single, seamless all-age specialist services** for all patients in Cheshire and Merseyside;

- **Supporting the clinical workforce** across Cheshire and Merseyside and beyond to deliver these pathways and standards with specialist **education, training** and practical experience, exploring rotation and other approaches through our Centres and Academies to **attract and retain the best talent**;

- **Driving research excellence** in partnership with UoL/partner HEIs/the AHSN to promote Liverpool Health Partners' strategy and put Liverpool firmly on the map for health research, innovation and education;

- Pooling our current expertise and efforts in **innovation** to create a centre of excellence in **partnership with industry, HEIs and the LEP** that drives inward investment in life sciences and new technologies;

- Collaborating to explore **national and international opportunities for growth;**

- Bringing together our corporate services expertise and resources to develop **common approaches to quality improvement and transformation** of services and drive **better value from procurement, digital/IT, finance and HR** for the NHS in Liverpool

- Making it easier to do business with specialist Trusts together for **commissioners , PLACE based care**, suppliers and other key stakeholders

3 Benefits

- With the **Royal and Aintree, a clear, shared vision** and roadmap for the **future development of specialist services and research**, including for rare and complex conditions, in Liverpool and the wider Region;

- **World leading clinical outcomes** and higher standards of care, **delivered consistently and in partnership** with our neighbouring hospitals, GPs and HEIs through **agreed standard pathways which are digitally-enabled** and available to the entire population we serve;

- **Pooled expertise** in **quality improvement** and **innovation**;

- **Shared best practice** approach to **specialist clinical governance** e.g. use of unlicensed medication and delivering services across networks;

- Attract and retain the **best talent** to Liverpool/Cheshire&Merseyside;

- Substantial growth in world leading health-related research that addresses the real needs of the population we serve and gives more **patients access to clinical trials;**

- Significantly **increased inward investment into life sciences/technology**/ health delivery models in Liverpool through closer relationships with industry, HEIs, government;

- Further enhancing Liverpool's reputation through **international business development**;

- **Better value for money** through combining corporate services and expertise;

Governance

The Trusts have stated their intent to work collaboratively as an Alliance to realise this shared ambition. Our governance model will aim to enable us to collaborate to realise the shared aims and benefits listed above on behalf of our patients, families and staff, whilst still recognising the unique, specialist history and offer of each institution, allowing each to retain its identity and self-governing constitution.

At the same time, we will continue to collaborate closely with our wider partners in Liverpool to develop a "One Liverpool" model of acute care for the City and Region.

LSA v4

20/11/18

A plan for delivery in 2019- 2021

Date: December 2018

Authors: Inspiring Quality Steering Group

The Inspiring Quality Steering Group membership is, in no particular order, as follows:

Tony Rigby, Jo Minford, Sian Falder, Adam Bateman, Stefan Verstraelen, Anna Schugal, Kerry Turner, Sarah Stephenson, Anne Hyson, Melissa Swindell and Mark Flannagan

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   - 3.2 Why Inspiring Quality matters

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   - 4.1 Our vision
   - 4.2 Measuring progress
   - 4.3 Do everything *with* children and families
   - 4.4 Communicate safely
   - 4.5 Transform patient care through digital technology
   - 4.6 Build a culture of Inspiring Quality

5. **How will we deliver it?**
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   - 5.2 Key enablers
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6. **References**

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1. Foreword

Despite increasing pressures on the NHS, hospitals which maintain a focus on continuous quality improvement have demonstrated consistent, high quality care. According to the Care Quality Commission these organisations feel different, with a culture where each day people are proactively seeking out ways to improve care for patients.

Alder Hey has a strong history of quality improvement and, over the years, many improvements using several different methodologies have been made. More recently, Global Digital Exemplar work, the Innovation Hub and Listening into Action have been focus areas and produced improvements in clinical pathways (for example, sepsis), novel technological solutions and staff engagement in improvement work.

Alder Hey remains committed to providing care of the highest quality. To realise our goal of Delivering Outstanding Care for Children our next step must be to systematise improvement, always done together with children and families, so that it is a consistent part of everyone's work every day. To understand better what this meant we held a Quality Improvement Summit in May 2018 bringing families and a broad range of staff from across the organisation together to define what good quality is, and how we can achieve it.

Alder Hey is Inspired by Children, and from our Summit we have built our vision for Inspiring Quality. Alder Hey will be a children's hospital that always does everything with its children and families. We will be the safest children's hospital in the NHS and one which delivers on a promise of outstanding outcomes for children.

In developing a plan to realise this vision, we will need to challenge, and in some instances transform, some of our current ways of thinking and working. We will do everything with children and families, ensure we are always communicating safely, use digital technology to transform patient care, and build a Trust-wide culture of Inspiring Quality.

Evidence shows that organisations that have successfully embarked on such a journey have had the absolute support and commitment of their Board, including the appropriate financial investment, recognising the benefits for patients, families, staff and the long term organisational development.

These proposals are not a quick fix. Sustainable change can, at times, be a slow process and requires persistence. But the goal is an outstanding NHS Trust which puts children and families completely at the centre of whatever it does and delivers a healthier future for children and young people.

Finally, we would like to thank all of the people, including families and colleagues, who have contributed so thoughtfully to this plan.

Sian Falder Jo Minford
Co-directors, Clinical Effectiveness & Service Transformation

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2. Executive Summary

Alder Hey has delivered some **outstanding achievements over recent years**; reducing harms and infections and leading the way in research, innovation and digital working.

Inspiring Quality is a **systematic** and **comprehensive approach** to **delivering outstanding care** through the best people doing their best work and thus supports the Trust's vision to deliver a healthier future for children and young people. Empirical evidence from around the world shows that quality improvement can save and improve lives and increase staff satisfaction.

Inspiring Quality has **three clear and ambitious aims**: firstly, to put children first; secondly, to be the safest Children's Trust in the NHS; thirdly, to achieve outstanding outcomes for children.

This will require Alder Hey to **change how we work** in four key ways. Firstly, we will **do everything *with* children and families**. This will include designing pathways and services together. We will provide training on Patient and Family Centred Care to explore how we can really put children centre-stage of their care. We will also, where appropriate, ask children to set goal-based outcomes for their care and we will provide a system for recording and measuring what they report. Secondly, we will **communicate safely**. We will deliver a safety culture built upon openness and continual learning. Children and families will play a central role in this. Thirdly, we will **transform patient care through digital technology.** We will harness the opportunities of our Global Digital Exemplar programme. This will include the adoption of evidence-based digital pathways. We will work with the **Innovation Hub** to pioneer the use of artificial intelligence in children's healthcare, bringing innovative changes to the bedside. Fourthly, we will focus on people and **build a Trust-wide culture of Inspiring Quality.** Our approach to improving quality in Alder Hey will be to empower teams to take a systematic approach to daily improvement. We will create an **Inspiring Quality Faculty** which will provide staff with support and opportunities for development. Leaders will receive training that focuses on compassionate and inclusive leadership adopting a coaching approach which will run through our leadership development programmes.

We will manage Inspiring Quality as a **transformational change** with a clear implementation plan that is inclusive and organisation-wide. The plan will be enabled though **regular communication**, the fostering of **sustainable external partnerships** and **collaboration with researchers.** The Division of Research has expertise in health services research which will help us to evaluate the effectiveness of our improvement interventions and to support us to systematically capture outcomes reported by children. Consistent with our Strategic Plan, we will foster strong external partnerships including those with SickKids Toronto, the University of Liverpool and commercial organisations.

All this will require significant resource: time, people, leadership and money. Investment will be sought from Global Digital Exemplar funding and the Alder Hey Charity. The **investment is significant**, but the prize is much bigger: **an outstanding Trust that is rated the safest children's Trust in the NHS.**

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3. An introduction to Inspiring Quality

Alder Hey is committed to providing high quality care for our children and young people. The Care Quality Commission recognised this by rating us as 'Outstanding' for caring.

Our vision is to deliver consistent, high quality care, through our 'best people doing their best work', to bring about a healthier future for children and young people. Inspiring Quality is our approach to achieving this.

Over the course of the past two years Alder Hey has delivered some outstanding achievements that are benefiting children and young people. Firstly, in our pursuit of safe care we have used evidence-based interventions and put in place systems to reduce surgical site infection and improve the care we give to children with sepsis. We have achieved a 75% reduction in the number of medication errors leading to harm and a 45% reduction in hospital-acquired infections.

In focusing on the experience of care, we introduced, with success, Listening into Action as a means to empower staff in making improvement. We have held Whose Shoes workshop events to facilitate conversations between staff and families, and to co-produce solutions. 'Hackathons' have taken place bringing together staff with industry partners to design innovations that will improve the safety and quality of care we give to children.

We now want to build on this excellent work to continue to bring about improvements by creating the next iteration of Inspiring Quality: a resourced plan that takes a systematic, organisation-wide approach to improving quality, involving children and families at all stages and with a clear plan for delivery.

3.1 How the Inspiring Quality plan was developed

In May 2018 we held an Inspiring Quality Summit which was attended by a broad range of over 100 staff, parents, students and external partners. During the Summit, we considered how we could show what we meant by putting children and families first, how we could improve patient safety and how we could achieve outstanding outcomes for children. Ideas were captured by a graphic artist on a giant poster which vividly represents the foundation ideas of Inspiring Quality.

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Subsequently, we have held two workshops with senior leaders in Alder Hey to further develop these ideas. The Children & Young People's Forum produced a video to explain their views on what should be important in Inspiring Quality:

https://m.youtube.com/watch?v=GAqL_orlvzw&feature=youtu.be

We have also held discussions with colleagues at SickKids, The Hospital for Sick Children, Toronto, Canada; East London NHS Foundation Trust and Salford Royal NHS Foundation Trust. The Inspiring Quality Steering Group at Alder Hey collated all this information and used an impact-effort matrix to prioritise the ideas, feedback and suggestions we have received.

3.2 Why Inspiring Quality matters

The NHS is facing unprecedented pressures and Alder Hey is not immune from these. Whilst we have many examples of excellence at Alder Hey, the challenge is to make sure that all patients reliably receive excellent care. The reliability of NHS clinical systems is assessed at 81% to 87% (Burnett et al, 2012). There is clearly scope for improving the reliability with which we deliver healthcare.

Quality improvement can be defined as a systematic approach that uses specific techniques to improve quality (Health Foundation, 2013). The evidence base for quality improvement (QI) delivering positive impacts in health care is mixed (Dixon-Woods & Martin, 2016). There is no 'one size fits all' strategy and we must heed the lessons from quality improvement which have been applied less successfully.

Nonetheless, there is empirical evidence that adopting a systematic approach to QI can make a huge difference to the lives of patients and staff:

- In 2006 the Institute for Healthcare Improvement (IHI) programme for reducing preventable deaths saved 122,300 lives, far surpassing its goal of saving 100,000 lives.
- In 2015 Ashford and St Peter's Hospitals NHS Foundation Trust started its quality improvement journey and in 2017 they won the Healthcare People Management Association Excellence Award for excellence in employee engagement.
- Between 2008 and 2014 Salford Royal maintained its position in the top tenth percentile for risk adjusted mortality, achieved a 100% reduction in MRSA blood stream infections and halved the number of cardiac arrests.

We aim to be the safest paediatric hospital in the NHS. We want to deliver outstanding care in all areas and for Alder Hey to be rated as an Outstanding Trust by the Care Quality Commission. Inspiring Quality will play a central role in this.

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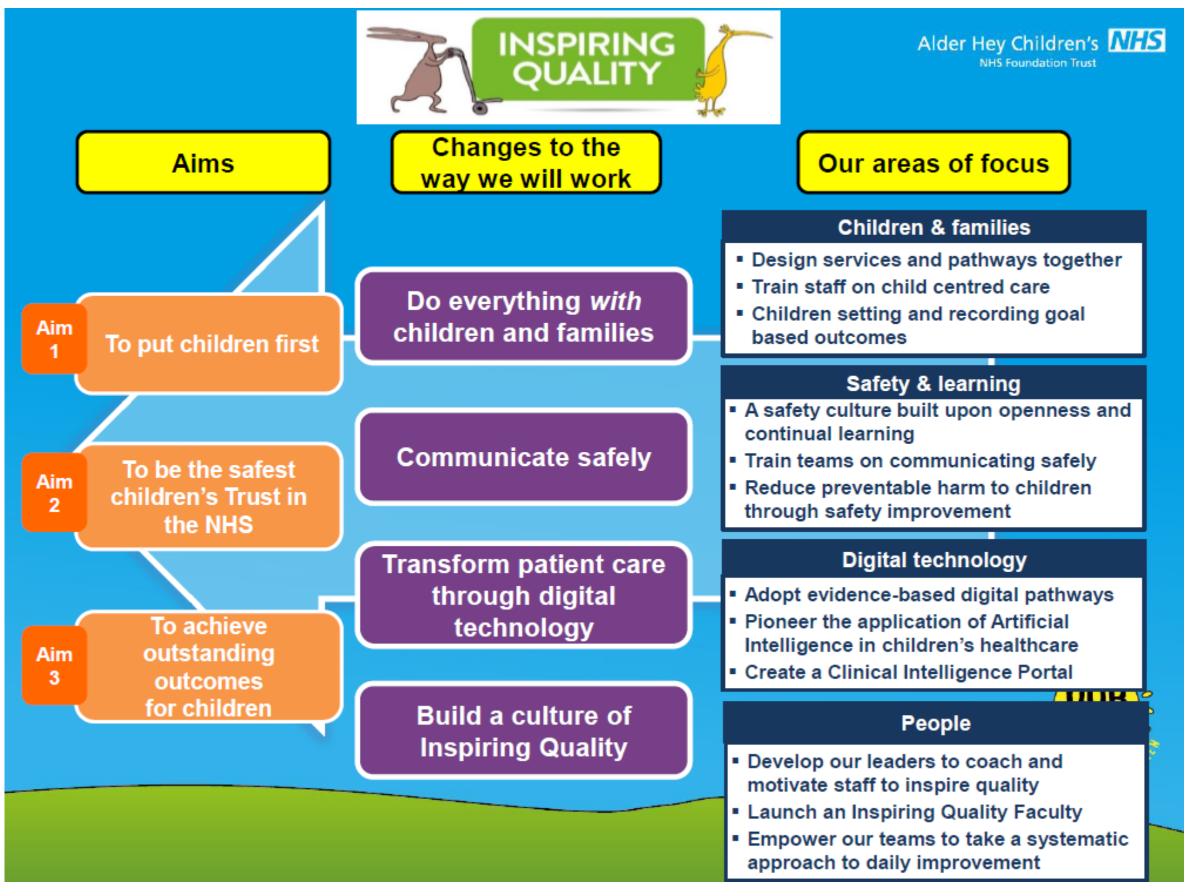
4. Inspiring Quality at Alder Hey: what the future looks like

4.1 Our vision



The **aims of Inspiring Quality** are to:

1. Put children first
2. Be the safest children's Trust in the NHS
3. Achieve outstanding outcomes for children

To achieve our aims, we will adopt four key **changes to the way we work**. These are:

- Do everything *with* children and families
- Communicate safely

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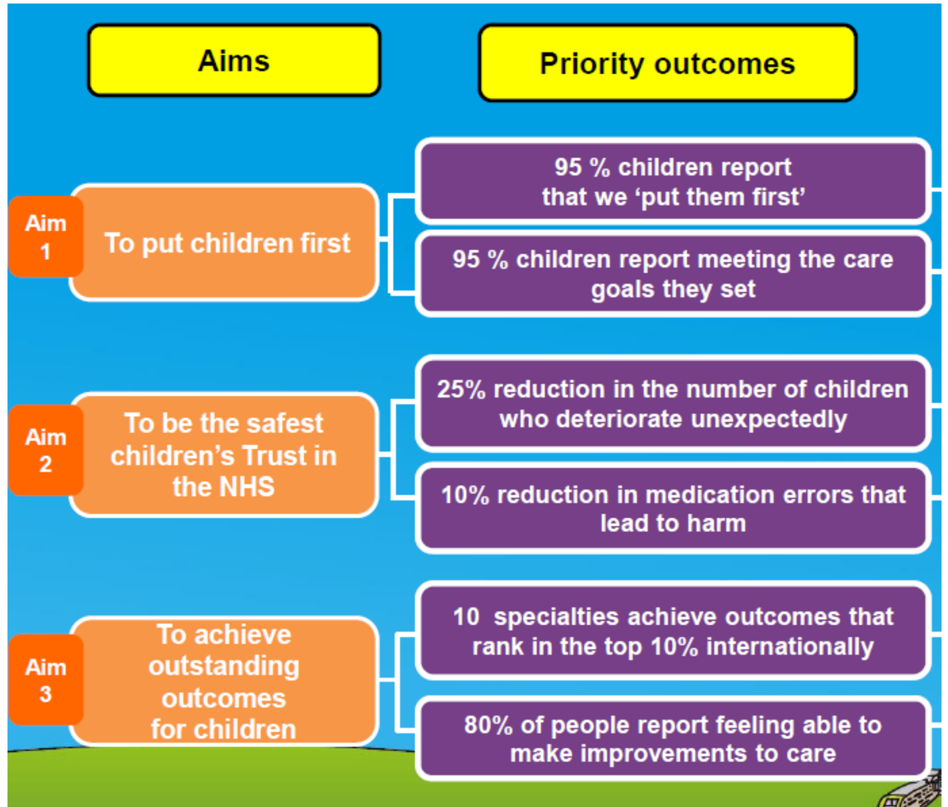
- Transform patient care through digital technology
- Build a culture of Inspiring Quality

4.2 Measuring progress

We have identified priority outcomes for delivery in 2019- 2021 that we will use to track our progress in achieving the three Inspiring Quality aims:



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4.3 Do everything *with* children & families

	High impact changes	What will progress look like?	
		Measure	Goal
1.	Design services and pathways together	Number of pathways & improvements designed with children and families	20 in year 1
2.	Train staff on child & family centred care	Number of staff trained in child & family centred care	680 staff by year 2
3.	Children to set their own care goals (using a Goal Based Outcome Tool)	Number of specialities that use the Goal Based Outcome Tool in their practice Systematic collection and reporting of patient reported-outcomes and experience	4 specialties by year 2 500 by Year 2

What does this mean?

'Doing everything *with* children and families' means working in equal partnership with children and families to design services and pathways together. It is also about learning and acting upon the feedback we receive from children and families.

How will we do it?

i. **Design services and pathways together**

Experience-based co-design is an approach that enables staff and patients (or other service users) to design services and/or care pathways together in partnership. We will set up an inclusive group of children, parents and staff. This group will explore and set the direction for how we practically co-ordinate and set up meaningful co-design of services and achieve change jointly.

We will use facilitation tools such as Whose Shoes® and the Patient and Family Centred Care (PFCC) methodology (https://www.pointofcarefoundation.org.uk/resource/patient-family-centred-care-toolkit/introduction/what-is-pfcc-and-why-is-it-needed/) to support healthcare professionals, children and families to come together to develop pathways and services.

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ii. Train staff on child & family centred care

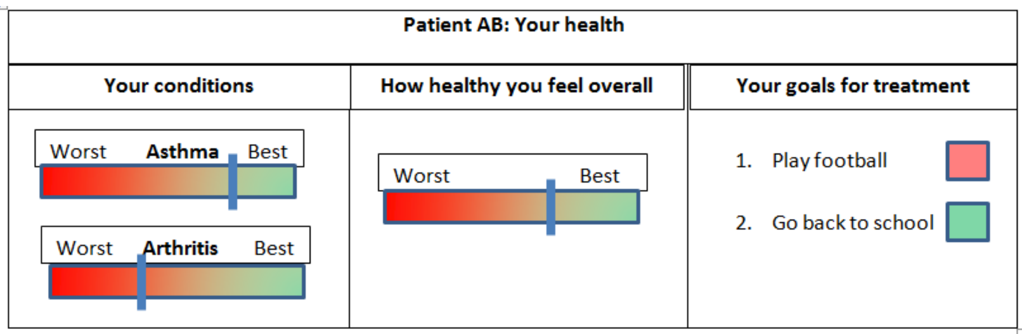
We should not second-guess what patients and families want from their care because we cannot always fully understand their experience of care, or their perspective. It is our duty to be actively curious, using all our 'senses' to look, listen and feel, using patient shadowing, active listening and asking for feedback, and recognising the role of empathy in compassionate care. We will offer learning opportunities to staff so they are supported to understand the care experience; and what matters to individuals and groups of patients. This can help staff to develop pathways, services and solutions which supports the delivery of compassionate, child centred care that is efficient and effective.

iii. Children setting and recording goal based outcomes

We will work with teams and a research fellow to explore the application of goal based outcomes in Alder Hey. Asking children and young people what their goals are can be a powerful way to facilitate shared decision making and more personalised care. It helps centre care around what matters to the child or young person. A goal-based outcome tool has been successfully used in Child and Adolescent Mental Health Services for some years and this is an emerging research focus for other specialties.

Having empowered children to set care goals, it is important that we subsequently check and collect data on the delivery of these goals and outcomes. In the NHS there has been more recent focus on collecting Patient Reported Outcome Measures (PROMs). PROMs are '*a measurement of any aspect of a patient's health status that comes directly from the patient (i.e., without the interpretation of the patient's responses by a physician or anyone else).'* They can be generic or disease-specific and can measure a variety of aspects of care including quality of life and cost effectiveness. By collecting them, together with patient reported experience measures (PREMs), we can capture what really matters to patients.

The combination of patients setting their own goals and the collection of patient reported outcomes could be used, for example, as an overall indicator for a patient's progress in their own eyes, as illustrated below (adapted from Valderas 2016).



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Alder Hey Case Study: co-designing the bronchiolitis pathway

Our bronchiolitis pathway was co-designed with parents and staff. Through this joint work the team identified some key recommendations. For instance, aiming to prevent routine nebulised treatments for infants <12 months, to introduce and wean off oxygen in a systematic way, to encourage parents and carers to participate in the care of their infants and to provide with appropriate information about the natural history. of bronchiolitis and to have consistent advice about feeding and evidence-based feeding support.

A year on year comparison of 10 months (April 2017 to January 2018) data demonstrated that the total admitted patients reduced from 632 to 592 patients, the average length of stay reduced from 3.6 to 3.1 days (or part thereof) and because of this, the total bed days reduced from 2247 to 1827.

What are the benefits?

Significant improvements in quality of services can be achieved by including patients in improvement work and healthcare decision-making.

Research into the impact of experience-based care design in cancer care demonstrated that it can improve efficiency, reduce unnecessary steps in pathways, reduce over-investigation, and improve compliance with treatments thereby making a positive impact on outcomes (Adams et al, 2014).

The benefits of involving patients include effects on the design of new projects or services, on NHS governance, on research design and implementation and on citizenship and equity. However, the economic evaluation of this has so far been limited.

The rewards for being a vanguard in the use of PROMs in clinical practice is the accumulation of the richest and biggest set of child reported outcome data in the world. This data could be subsequently used to improve patient–clinician communication, patient satisfaction, symptom management and control and quality of life.

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4.4 Communicate safely

> **"The manner in which doctors articulate a safe care environment is as important as what they actually do to patients"**
>
> **(Kenward, 2015, BMJ)**

	High impact changes	What will progress look like?	
		Measure	Goal
1.	Creating a safety culture	Safety culture assessments and learning plans	50 completed by year 2
2.	Train teams in communicating safely	Number of people trained in communicating safely domains	784 by year 2
3.	Reduce preventable harm to children through safety improvement	Safety improvement taskforce to reduce medication errors	10% reduction by year 2

What does this mean?

Communication came up as a central theme with both staff and parents at the Inspiring Quality Summit. Safe, effective communication is crucial to improving patient safety. It includes not just the obvious issues of exchange of information and medical hand-over but also the way we make patients feel, how we work together as teams and with families, how we invite feedback and how we feel safe to raise and escalate concerns. It also includes how we collect information about our performance and effectively disseminate the findings of investigations when things don't go as planned.

> **Alder Hey Case Study: deficiencies in communication and escalation associated with the death in care of a child**
>
> An 11 year-old boy tragically died following a planned operation, when an intravenous drip had inadvertently leaked into surrounding tissues causing a severe injury to the boy's neck and face. A root cause analysis showed communication and escalation processes during his care meant that the seriousness of his condition was not recognised and treated at the earliest opportunity.

Inadequate verbal and written communication is recognised as being the most common root cause of serious errors in both clinical and operational work. There are some fundamental barriers to effective communication in healthcare, including hierarchy, gender, ethnic background and individual and group differences in communication styles, but these are often unrecognised.

The importance of human factors is highlighted by a recent review of 12 level-2 root cause analysis (RCA) investigations into the unexpected clinical deterioration of children at Alder Hey over the last

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3 years. The key themes for learning were loss of situational awareness related to critical message communication and appropriate and effective escalation.

How will we do it?

i. A safety culture built upon openness and continual learning

Our biggest strengths in the delivery of safe care are our staff and patients, who can be relied on to be honest if they feel safe to bring up concerns, feel passionately about safety and often have ideas about what should and can be done to improve. Our patient and carer voices are an essential asset in monitoring the safety and quality of care.

We will improve our safety culture by developing a performance-aware, resilient workforce, working with children, families and external partners.

Development of a safety culture starts at the top. We will implement a **high-level daily safety briefing**, involving the Executive on-call and key leaders in the clinical and operational workforce. Routine safety huddles across the organisation will become part of a systematic way of identifying and addressing problems before they lead to harm.

We will support staff through the implementation of **Schwartz Rounds**. These are an evidence-based forum for hospital staff from all backgrounds to come together to talk about the emotional and social challenges of caring for patients. This offers a safe environment in which to share experiences and improve psychological well-being.

Through a review of our **incident reporting** and root-cause analysis processes, we can make it easier and a more positive experience to explore situations that do not go as planned with more effective dissemination of lessons learned.

We will encourage child and family safety challenge (e.g. 'have you washed your hands?') and work towards **child and family reporting of incidents**, and involvement at investigation panels. We will commit to use the information we receive from children and families for improvement and share findings and recommendations with them.

ii. Train teams on communicating safely

Communicating well and safely encompasses a variety of domains – talking to patients, sharing medical information and escalating concerns.

For those who have challenging conversations during their work, with patients, families or colleagues, an **advanced communication course** may help them seek informed consent, break bad news, deal with collusion and handle conflict. Systematic tools such as **SBAR** (Situation, Background, Analysis, Response) and **PACE** (Probe, Alert, Challenge, Escalate) will be adopted as standard methods to improve handover, sharing of information between healthcare professionals and escalation. Underpinning a safety culture is the need for situational awareness and **human factors training** will be at the core of safety improvement.

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This training will require initial input from external partners but with a train-the-trainers approach, we will be able to continue this in-house; we already have local expertise. We recognise that staff will have differing needs based on their roles and experience and training will be co-ordinated to maximise impact and reduce time away from clinical duties.

iii. Reduce preventable harm to children

Alder Hey has robust assurance mechanisms for tracking and monitoring a range of safety metrics and ensuring that we remain a safe organisation. There are a number of current programmes addressing areas of particular focus in the safety arena at any given time. In addition, we are working with external partners to understand better and improve our safety parameters, for example, 'Civil Eyes' (http://civil-eyes.com/childrens/) and 'Getting it Right First Time' (http://gettingitrightfirsttime.co.uk/).

Being the safest children's Trust in the NHS is commensurate with reducing, and ultimately eliminating, preventable harms. The Inspiring Quality approach is to take a 'narrow and deep' look at specific areas over a defined time period to bring about improvements in safety. For 2019-21, we have identified deterioration in patients and medication errors as significant areas warranting this narrow and deep approach.

We will set up a **safety improvement taskforce** which will consider aggregated analysis of information sources to help identify and set priorities with individuals, teams and divisions for reducing harm in these areas. This may include communication strategies, huddle boards and data analysis. We will develop relationships with additional external safety organisations such as Paediatric International Patient Safety and Quality Community (PIPSQC), Institute for Healthcare Improvement (IHI) and Patient Safety forums, to gather examples of best practice.

What are the benefits?

It is estimated that the cost of poor communication to the NHS is over £1 billion per year and it can lead to poor adherence to medication regimens, repeat visits to clinics, disputes and ultimately litigation (McDonald, 2016). Research evidence tells us that good communication and patient centred care is strongly associated with safe healthcare (Doyle et al, 2013). Good communication between patient and healthcare worker results in patients being more able to follow medical recommendations and manage their own health better. Good communication among team members can have a profound effect on biological and functional health outcomes as well as patient satisfaction and experience of care. Further, communication among healthcare team members influences the quality of working relationships, job satisfaction and has a significant impact on patient safety.

By establishing a taskforce with clear responsibilities for ensuring a system wide approach to the communicating safely domain, there will be clear organisational governance around clinical effectiveness and improved performance, collaborative reduction in patient harm, recognition and

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mitigation of clinical risk, and the establishment of a fair and just culture which will ultimately establish Alder Hey as the safest children's hospital in the NHS.

We will through our work on communicating safely reduce preventable harms to children. We will for the first two years focus on a 25% reduction in deterioration in children which leads to an unplanned admission to PICU, and a 10% reduction in medication errors that lead to harm.

4.5 Transform patient care through digital technology

	High impact changes	What will progress look like?	
		Measure	Goal
1.	Adopt evidence-based digital pathways	Specialties have at least one digital pathway that conforms to PEDMAPs	100% of specialties in Year 2
2.	Pathways and services improved following the use of Artificial Intelligence (AI) to analyse feedback from children and young people via the Alder Play App	Number of feedback messages received by children and analysed using AI Number of improvements to pathways or services based on machine learning	1,000 messages by Year 2 5 by Year 2
3.	Create a Clinical Intelligence Portal	Number of specialties able to access clinical outcomes on the dashboard	20 in Year 1

What does this mean?

Alder Hey is one of 16 hospitals that have been selected to be a Global Digital Exemplar (GDE) hospital, moving from a predominantly paper-based system to an electronic one offers an opportunity to transform our approach to patient care. Digital technology enables us to collect increasing amounts of information electronically, as part of routine care, and will allow us to analyse data in real-time. This will have considerable benefits for staff and children, enabling prospective outcome monitoring, timely moderation of treatment and pathways and facilitating data collection for research studies.

Through digital technology we will transform our patient pathways (the care plans that detail essential steps in care of the patient with a specific clinical problem) and revolutionise the way things work across Alder Hey. By collaborating with other specialties, and linking with partners in primary and secondary care, we will reduce unnecessary steps, improve patient experience and reduce costs.

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Artificial intelligence (AI) is the theory and development of computer systems able to perform tasks normally requiring human intelligence, such as visual perception, speech recognition, and decision making. It is widely reported that AI is set to bring a paradigm shift to healthcare and there are already many applications, for example in personal health, screening and diagnosis, decision making, treatment, research, and training. Alder Hey has been working successfully in this field with a variety of partners solving healthcare challenges using both established and emerging technologies. For instance, advanced sensors to measure blood biochemistry without accessing a blood vessel, thereby reducing distress and risk of infection; virtual/augmented reality for preoperative planning which could lead to improved outcomes and the Alder Hey App. Our "Ask Oli" Chatbot was the first deployment of AI for patient experience in a hospital setting.

As the UK's first Cognitive Hospital, partnering with the Science and Technology Facilities Council's Hartree Centre and Watson, we have the world's first commercially available cognitive computing system. Coupled with developments in technologies like natural language processing and using powerful mobile devices such as smartphones, we are set to make use of this information for the benefit of our patients and staff. This means the hospital environment can be personalised before a child arrives, e.g. choice of colour in a room, choice of music or TV programmes.

How will we do it?

i. Adopt evidence-based digital pathways

We will establish strong clinical leadership in the GDE programme to ensure that, as teams move to digital records, they review the steps in the care their patients receive and adopt a standard approach to pathways; they will be Person-centred, Evidence-based, Data-driven, Metric-defined and Accessible (PEDMAPs). We will include children, families and wider health partners in the design of pathways to streamline patient flows across primary, secondary and community care. We will co-ordinate our timetable with the specialty packages in the GDE programme. Some of this work has already started.

We will ensure that there is robust governance of pathways including a Pathway Guiding Group for sign off, a maintained repository of pathways, a document management system and a central source of access. Our pathways will be evidence-based, referenced, up to date and standardised.

ii. Pioneer the application of Artificial Intelligence in children's healthcare

Great patient experience is at the heart of our vision and mission. Improving patient experience has an inherent value to children and families and is an important measure in its own right; patients with better care experiences often have better health outcomes. The Alder Play App already allows children to ask questions of their visit and plan ahead. These developments genuinely contribute to improving their experience and demonstrate how we can really put children and families first.

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The capabilities of the App will be further developed to empower children and young people in managing their own healthcare. Interaction with the Patient Portal (currently in development) means that they can access their own records and see information about their care. These technologies could be a means to facilitate children completing patient-reported outcome measures and setting their own goals prior to appointments. We will use the App to collect feedback from children and families and ensure we act on this feedback to make positive changes.

iii. Create a Clinical Intelligence Portal

Data is critical to improvement in healthcare. Our GDE programme means that data can be made available in real-time, rather than just being a record of past events: it can be used to improve care as it is delivered, collect and analyse meaningful outcomes and facilitates regular audit and quality improvement.

We are taking an integrated approach to building a Clinical Intelligence Portal, accessible through the Intranet, which presents teams with a bespoke dashboard of this relevant real-time data to enable them to improve service delivery, clinical care and outcomes. This central portal is the interface between the clinician and the complex data analytics behind the dashboard, and will also enable easy access to clinical guidelines and policies, links to patient safety information and Inspiring Quality resources.

Alder Hey Case Study: evidence-based acute asthma pathway

Our **acute asthma pathway** was revised and streamlined so that it best suited the needs of the children and families. Medical research was systematically reviewed. A new pathway was developed which incorporated a change in the steroid we use (from prednisolone to dexamethasone) to reduce side effects, with fewer doses and at 10% of the previous cost. This change won a national award for innovation in pharmacy, and is now being followed by most other trusts in the UK. We have also cut down the amount of X-rays we do – these used to be done in 30% of asthmatic children, and now are just done in 8%.

What are the benefits?

The aims of adopting a PEDMAPs approach to clinical pathways are to standardize care, improve outcomes and reduce costs. Clinical pathways can support the delivery of evidence-based care and reduce variation and inefficiencies, for example, reduce duplication, waiting times and unnecessary investigations. It is also an opportunity to embed truly person-centred care, join up specialties and reduce silo working.

Through AI we will the way we interact and use Big Data. Through machine learning of the data supplied through the Alder Play App we will understand how to improve pathways and services in line with the feedback from children and families. We will continue to identify technologies that could improve how the data in processed and visualised. We will consider applications that contribute to harm reduction such as medication dosing and adherence, patient

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flow and capacity and staff scheduling. We will consider how best to ensure the adoption of technology in a way that isn't too stressful for staff.

We have a priority outcome for 10 specialties to rank in the top 10% internationally for outcomes. The Clinical Intelligence Portal will support teams to measure and benchmark their outcomes. This data will help recognise areas of best practice. It will also support us to prove our status as amongst the best internationally, or identify areas for improvement.

4.6 Build a culture of Inspiring Quality

	High impact changes	What will progress look like?	
		Measure	Goal
1.	Through the delivery of the leadership strategy, develop our leaders to coach, engage and motivate staff to Inspire Quality	Strong Foundations programme launched. Coaching programme defined and delivered.	85 trained by end of year 2.
2.	Launch the Inspiring Quality Faculty to support, train and develop staff in a range of improving quality tools and techniques	No of staff trained in Inspiring Quality	784 staff by year 2
3.	Systematic approach to daily improvement	Inspiring Quality huddle boards and daily routines leading to 'resolved' issues	Embed in 10 teams in year 1 100 resolved issues

What does this mean?

We need to create the conditions that are required for Inspiring Quality to thrive at Alder Hey. We believe that the three most critical success factors that need to be in place for us to achieve our Inspiring Quality aims are:

1. leadership capability and capacity which will support a culture of continuous quality improvement and change
2. a method to involve, inform, support and develop all of our staff to build organisational wide capacity and capability in quality improvement
3. a mechanism to develop and sustain 1) and 2) for the long term

We want Inspiring Quality to be the catalyst that changes the narrative about what we do and how we do things across the whole organisation. This will require us to be bold, to make some brave decisions and do some things differently. This strategy prompts us to think about managing change across emerging themes such as everyone having a shared purpose; making sense of change through emotional connections and storytelling; viral (grass roots) creativity; using open approaches that build and nurture relationships.

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Our people and leadership plans will be designed and developed to meet the aims and aspirations as set out above.

How will we make this happen?

i. Develop our leaders to coach and motivate staff to inspire quality

The quality of leadership is a key influence on the ability of Trusts to improve; leaders need to be seen to lead, and drive a culture of improvement across the whole organisation (Care Quality Commission, 2018).

The Alder Hey Leadership Strategy provides a framework which defines the attributes of an Alder Hey leader:

- Actively seeks out difference in others
- Knows that teams need to be safe and cared for and that this is their job
- Understands that they need support to grow and thrive
- Need to be human
- Can make connections with others
- Understands that self-management is critical
- Recognises and promotes talent
- Sees both creativity and standardisation as their role
- They are hopeful, but know they can't do it alone
- Will challenge with courage and kindness
- Engages, coaches and Inspires Quality across their teams every day

The Inspiring Quality Faculty (see point ii. below) will help develop and deliver an in-house leadership programme – 'Strong Foundations' - to our leaders at every level. This will have significant focus on self-management, self-awareness & resilience, cultural competence, improvement methods, wellbeing, everyday coaching conversations and 'person in the policy'. Peer support, action learning sets and clinical supervision will all be developed to help and support our leaders in realising the Inspiring Quality aims.

ii. Launch an Inspiring Quality Faculty

An Inspiring Quality Faculty will be formed to deliver learning and development to staff. The Faculty will comprise of experts and coaches in quality improvement. Some of the faculty members will be from external partner organisations.

The four areas below will provide the framework for a comprehensive training and development plan for the whole organisation.

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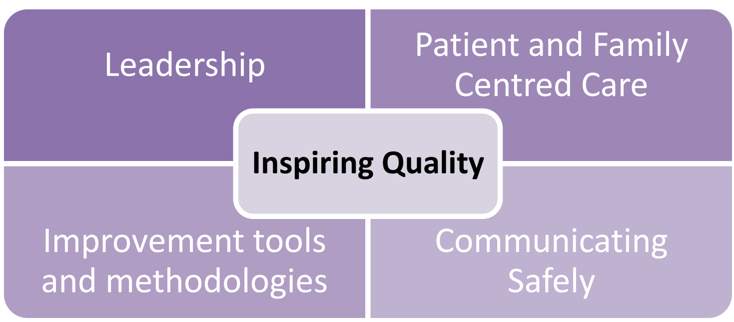

This is an ambitious development plan, which we envisage rolling out over a three year period to ensure maximum coverage and learning. The approach will be to identify cohorts of staff who will work together to learn the Inspiring Quality tools, techniques and approaches, and will support each other through action learning sets, coaching and other informal networks

The training and development programme will be a combination of:

Learning through doing	Learning through others	Learning through study
'On the job'	*'social'*	*'formal'*
• On the job tasks • Specific improvement projects • Cross-dept/function projects • Visibility • Patient shadowing/journey • Improvement boards	• Seeking feedback • Action learning sets • Peer networks • Mentor/coach • Shadowing • Networking • Cohorts	• E-learning • Reading • Instructor-led training • Conferences

NHS Improvement (2018) has a dosing formula which can be used to plan different levels of training on quality improvement to staff. Based on Alder Hey's 3,400 staff, the following diagram sets out the 'dosing formula' recommended by NHS Improvement):

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TRAINING PLAN FOR QUALITY IMPROVEMENT

Training	Level
Frontline Introduction to Inspiring Quality. Model for improvement and patient & family centred care **Number**= 50%/ 1,700 WTE **Time-frame**= 680 over 2 years	Frontline
Leaders Model for improvement, patient & family centred care and compassionate and inclusive leadership **Number**= 5%/ 170 WTE **Time-frame**= 85 over 2 years	Leaders
Coaches Deep understanding of QI tools, plus coaching high performing teams **Number**= 0.5%/ 17 **Time-frame**= 17 in year 1	Coaches
Experts Shape training and culture. Troubleshoot. Deliver teaching to staff. **Number**= 0.05%/ 2 WTE **Time-frame**= 2 in year 1	Expert

iii. Empower our teams to take a systematic approach to daily improvement

Inspiring Quality is the Alder Hey approach to comprehensive and *systematic* continuous quality improvement. The primary responsibility for delivering safe and high quality care rests with the teams that are delivering that care (Alderwick et al, 2017) and it is the clinical teams who often

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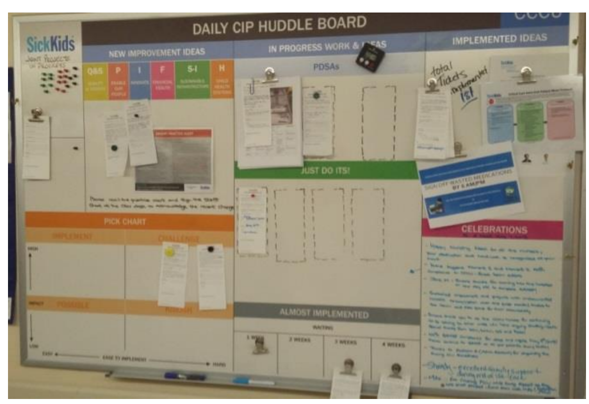
know best how care can be improved. It is important to build in routines to help staff to work in the new systematic way. These routines will include:

Inspiring Quality huddle boards will be an Alder Hey version of the boards that are active in SickKids, Canada as shown in the photo.



The huddle boards are a place to exchange ideas and information. Staff can use them to register improvement ideas. They are a visual way of tracking solutions, outcomes and recognising success. For huddle boards to be effective, staff must feel empowered to make the changes happen.

'High Five' Boards, which have been introduced in the High Dependency Unit, with .

Listening into Action (LiA) has been adopted by Alder Hey as the preferred method for listening to staff and empowering them to make changes, and signals that Trust leaders and managers support clinical teams and consider quality improvement a high organisational priority. LiA will continue to be a mechanism to bring about change and a driver to involve children and families in Inspiring Quality.

What are the benefits?

Most health organisations that have used quality improvement approaches report some benefits – especially at the beginning of an initiative, when staff engagement and motivation are high. Those hospitals at the forefront of adopting a whole-organisation approach to quality improvement are known for their track-record in demonstrating improvement across many aspects of care, such as Cincinnati Children's Hospital in the States and Salford Royal NHS Foundation Trust in the U.K.

The Care Quality Commission (2018) found that in the Trusts they have rated as outstanding, a culture of quality improvement was embedded throughout the organisation.

Through Inspiring Quality we aim to make quality improvement everyone's business. Through supporting and empowering our teams to make daily improvements we would like to see 80% of staff feeling able to make improvements to care.

Alder Hey Case Study: visit to SickKids, Toronto, to observe quality improvement in action

In May 2018, a small team of senior leaders from Alder Hey visited SickKids, Canada. Sick Kids has employed Lean methodology to focus on daily continuous improvement at the frontline. This approach is deployed in 65 departments, has resulted in over 4,000 small-scale problems being solved and staff engagement scores increased by 12% after implementation.

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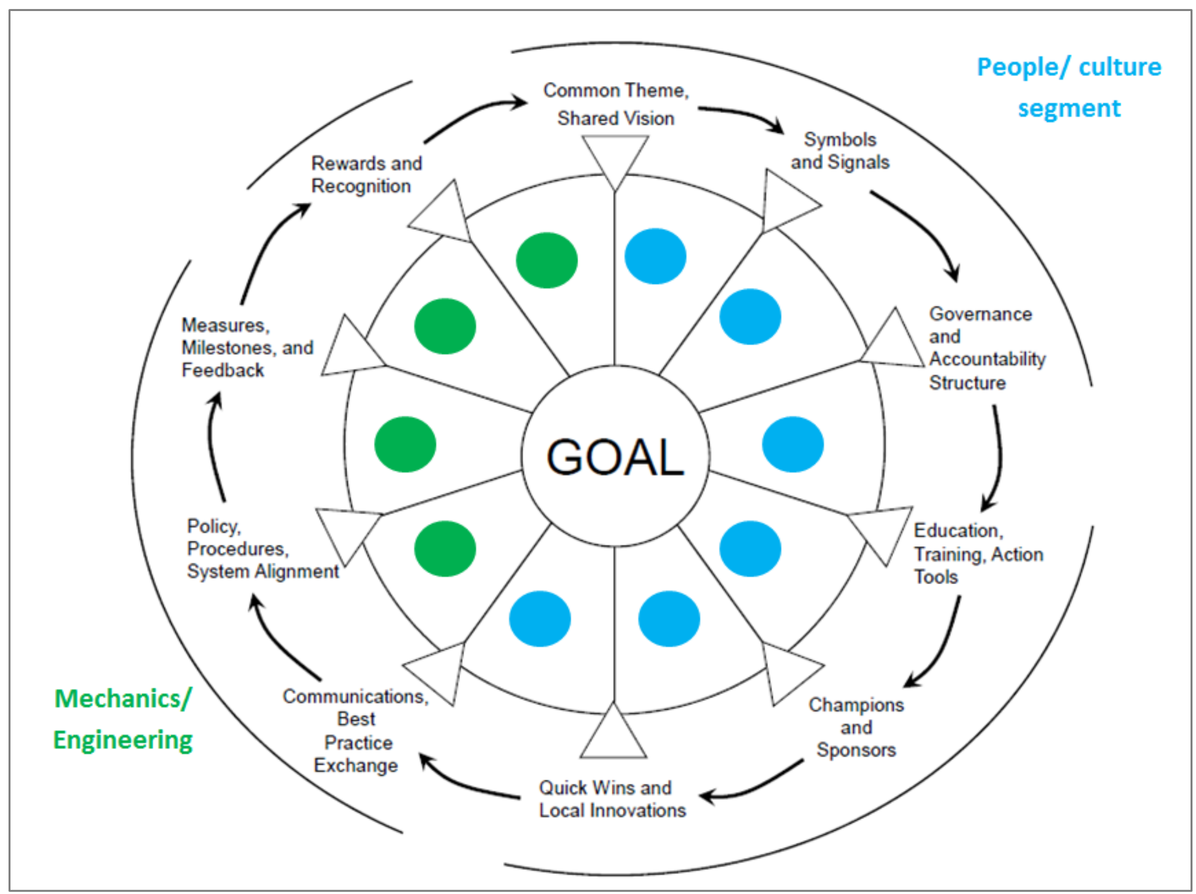
5. How will we deliver it?

5.1 Framework for delivery

The Change Wheel (Kanter, 2011) is a model that helps plan for the implementation of large-scale, transformational change. For the wheel of change to revolve actions are required in each spoke. We are looking to change some of Alder Hey's underlying code (which some call 'the way things are done around here', others call it 'the organisation's DNA') so that we have a new pattern of working that will help us to achieve our three Inspiring Quality aims.

The Change Wheel model is below:



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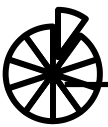
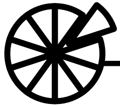


Common theme/ shared vision

High impact changes

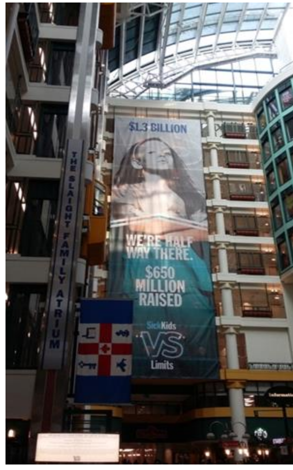
- Our **common theme** is **Inspiring Quality**
- The Inspiring Quality **vision** is to provide **outstanding care** for children and young people through the **best people doing their best work**
- **Roadshows** that get out to every team to share the vision and how teams can get involved
- A **video** of why Inspiring Quality matters, what it is and how people can get involved
- A dedicated **social media platform** where information is exchanged and constructed



Symbols & Signals

High impact changes

- **Inspiring Quality Faculty & Hub**
- [Highly visible] **Child & parent only parking** on the ground floor and first floor
- Inspiring Quality **mural** in the Atrium



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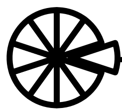
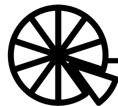


Governance & Accountability Structure

High impact changes

- **Accountable Executive Director** for Inspiring Quality
- Inspiring Quality **Cabinet** (appointed members) with collective responsibility for delivery
- Cabinet works directly with the **Children & Young People's Forum**
- Cabinet accountable to **Clinical Quality Advisory Committee** (CQAC) sub-committee of the Board
- **Children** and **families** are **members** of the Cabinet



Education[1], Training, Action Tools

High impact changes

- Development and leadership offer to staff based on a dosing strategy that will see staff groups receive a level of training on:
    1. Child & family centred care
    2. Compassionate and inclusive leadership
    3. Communicating safely
    4. Improving quality
- Action tools[2] will be provided as templates with a supporting 'how to' video:
    1. Inspiring Quality huddle boards
    2. Safety status sheets
    3. Departments setting their own Inspiring Quality goals

[1] Kanter states that "education is necessary to communicate the why and what of change. (The Why can sometimes be more important than the What; once people understand the goal and its rationale, they are better able to envision and carry out new actions.)"

[2] Action tools help people relate the change to their own day-to-day work by giving them models or templates.

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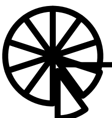
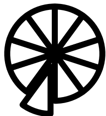


Champions & Sponsors

High impact changes

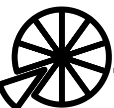
- **Train Executive sponsors**
- **Train coaches**
- **Appoint** members of the **Cabinet**
- **Appoint Inspiring Quality Experts** in a cross-section of the organisation
- Remunerate/ reimburse families who are members of the Cabinet



Quick Wins & Local Innovations

High impact changes

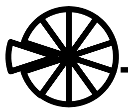
- **Families** enabled to **report incidents** and near misses
- **High Five boards**
- **Patient experience feedback** kiosks, mobile and email. Questions include "Did we meet your care goals?"



Communications, Best Practice Exchange

High impact changes

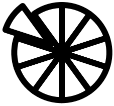
- A dedicated **social media platform** where information is exchanged and constructed, including video posts providing updates and celebrations
- Celebration and **recognition events** with poster presentations from early adopters
- **Learning sets** for best practice exchange
- **Annual report** on progress and outcomes



Policy, Procedures, System Alignment

High impact changes

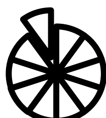
- At **induction** all **new starters** will be briefed on **Inspiring Quality**
- **Personal Development Reviews** and **appraisals** will be assess individual and team contributions to Inspiring Quality
- All **investment cases** must demonstrate **meaningful engagement with children** and families prior to approval



Measures, Milestones & Feedback

High impact changes

- Our **progress** against Inspiring Quality goals will be projected as a large visual on the wall of the atrium
- Delivery Management Office will provide oversight and assurance, including tracking delivery against milestones and benefit measures
- The Clinical Intelligence Portal will publish data on outcomes against goals



Rewards and Recognition

High impact changes

- Inspiring Quality **Star Award**, **presented** to staff by **children**
- Inspiring Quality **recognition badges** presented at **bi-annual recognition events**
- **Promoting our work** for local, national and international recognition

5.2 Key Enablers

5.2.1 Research

The work of the Clinical Research Division and Inspiring Quality has significant mutual interest and opportunities for collaboration. The Inspiring Quality aims will only be realised through effective joint working. There is high quality evidence of a link between research volume and patient outcomes publications (Boaz et al, (2015), Downing et al (2015); and Jonker and Fisher (2018)).

The areas of focus for our collaboration will be:

- **Health Services Research***:* this is a branch of research which focuses on the evaluation of health system interventions. In the development and implementation of the Inspiring Quality programme, we will seek opportunities to evaluate the impact of discrete and Trust-wide changes and interventions as part of quality improvement programmes. We will apply a health services research approach in areas where there is an existing research strength in Alder Hey. For instance, in medication safety to reduce errors, and the Dynamic Electronic Tracking and Escalation to reduce Critical Care Transfers (DETECT) study.

- **Engaging Children, Young People (CYP) and Families:** Within the research arena, Liverpool has over ten years' experience of leading national and international initiatives for patient and public involvement/engagement for CYP and families. This includes developing novel methodologies for PPI/E programmes. The Inspiring Quality programme will draw on Liverpool's rich expertise in PPI/E to translate knowledge and methods from the research arena into the quality framework.

- **Research methodologies for quality data:** Validated PROMS may be available for some paediatric diseases and conditions and generic PROMs for children and young people where disease-specific PROMS are absent. There is a growing research literature on the methods to administer and facilitate reporting of PROMs, including technology-mediated methods. The decision as to which PROM(s) to use requires careful consideration and knowledge of the methods of validation. Where no disease-specific PROM is available, development of a new PROM is a possibility, but this is a research process in its own right and we will consult with colleagues in the University of Liverpool and MRC Methodology Hub to identify candidate PROMs for development/validation and seek funding to achieve this.

- **Goal based outcomes:** the development and validation of Goal Based Outcomes is an emerging area and their development and evaluation within the Inspiring Quality programme will need to be carried out in the context of a robust research proposal. There is expertise locally and nationally in methods for the selection of outcomes from effectiveness trials for application in clinical practice. We will aspire to a programme of outcome selection and validation which, with data from PROMs and PREMs, will offer specialities a means of understanding the quality of their service.

5.2.2 External Partnerships

We recognise the value of external partnerships in sustaining this plan. Much of our improvement work will involve collaboration with external partners. Key external partnerships include:

- **International partnership with SickKids:** Initially we will continue to develop a bilateral partnership with SickKids Hospital, Toronto. Subsequently, we will develop alliances with other leading healthcare providers who have a strong ethic of quality improvement. This will mean shared support, learning and development. We envisage staff visits and placements, project specific collaborations and information exchange.

- **Training & development with commercial partners:** Our partnerships will include commercial and third-sector partners. For example, work through Whose Shoes workshops and the Point of Care Foundation brings a patient perspective to service improvement.

- **Education and research institutions:** We will consult with colleagues in the University of Liverpool and Medical Research Council Methodology Hub to identify candidates for PROMs for development/validation and seek funding to achieve this. The research agenda has been developed with the University of Liverpool and other partners. Our innovation initiatives have been brought about by linking with industry leaders.

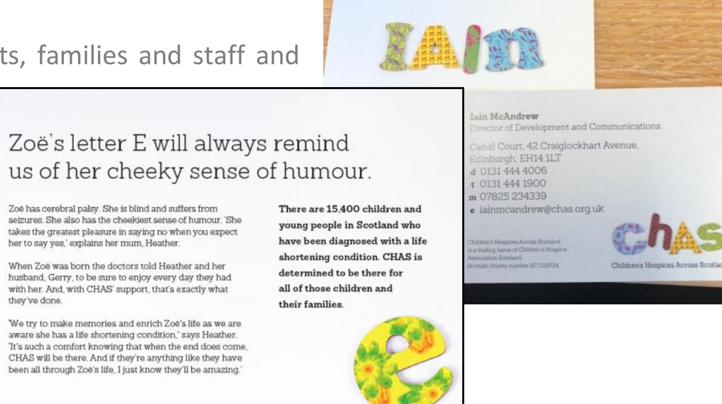
5.2.3 Communication plan

How the Inspiring Quality approach is understood by our staff and children is absolutely central to success. It is vital that we continually share our vision, activities and progress in a positive and engaging way.

In the CQC's words, our staff are Outstanding. We will build upon this to create a social movement around Inspiring Quality. We will start a conversation that never ends and continues to evolve by using a variety of ways to explore: What is Inspiring Quality? What will success look like? Who is involved?

How will we do it?

We will use stories as told by patients, families and staff and conduct "vox pop" interviews that give us the words and experiences of these individuals, to be used via an IQ YouTube channel based within the existing Alder Hey YouTube feed.



We will aim to inspire people through the following:

- A special 'Inspiring Quality News' (via email and some hard copies) for all staff.
- An 'Inspiring Quality roadshow' across all Alder Hey sites.
- Dedicated YouTube channel within the existing Alder Hey YouTube feed
- Champions wearing "Ask me about Inspiring Quality" badges
- Conversations about what Inspiring Quality means for non-clinical staff (catering, corporate, etc.).
- Bringing staff, patients and families together in mini-IQ summits – by the bedside, at the desk, over coffee – that continue the process begun in the first Summit in May 2018
- Working with the Children & Young People's Forum to explore new ideas in support of IQ e.g. adapting the existing *Hello my name is* campaign and producing an Alder Hey friendly version.

For those who visit our Alder Hey building, we will engage them from the first point of entry:

- Volunteers will "doorstep" visitors to ask about what IQ means to them
- Everyone who visits will receive an "IQ and You" leaflet or similar
- Visuals will create a sense of something happening, and we will seek an impactful approach to this using highly visible methods

- We will provide feedback in a visual way
- This will create a community that continually learns and shares, we will generate peer to peer conversations. There are many useful tools such as Slack, Zinc and Yammer. This allows quick information flow and notifications and is used by companies, including Heinz, KLM, Tesco and Shell.

5.3 Resource Plan

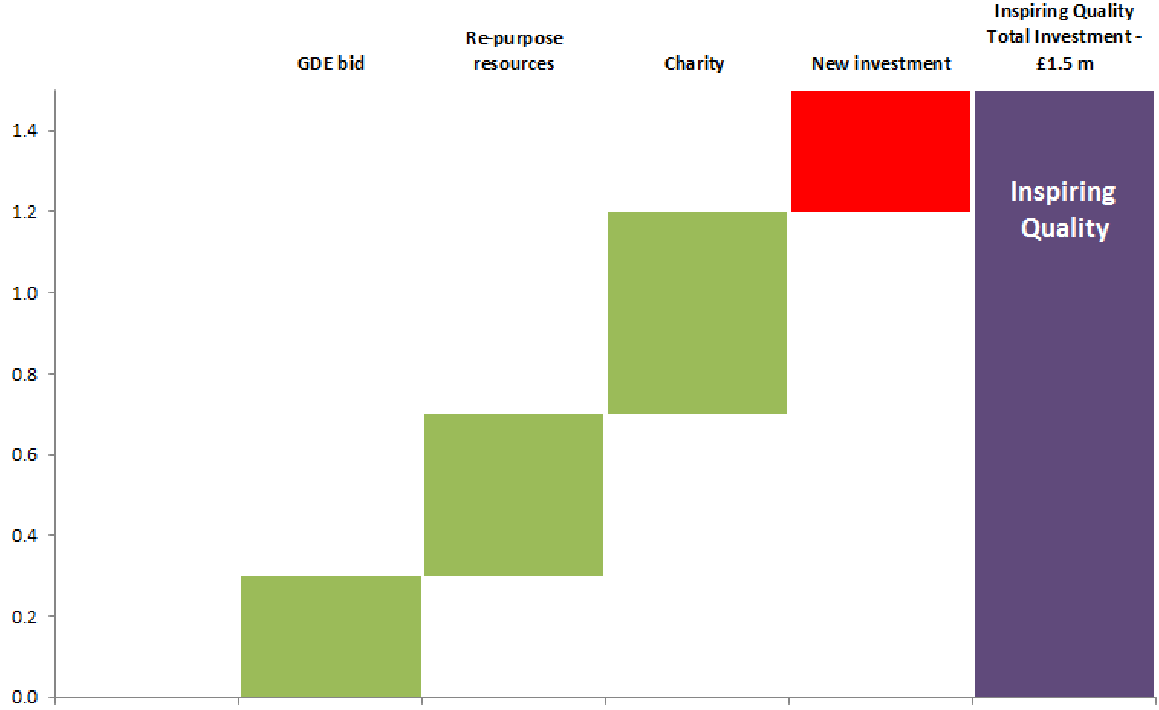
The level of investment requested to develop, enhance and sustain Inspiring Quality is £1.51 m. The expenditure is itemised in the table below:

Aspect of Plan	High impact change	Role or item if non-pay	WTE	Band	Financial year 2019-20	Financial year 2020-21
Do everything with children & families	Design services and pathways together	Whose Shoes Events	N/A	N/A	8	8
		Allowance for families	N/A	N/A	10	10
		Meridian patient feedback system	N/A	N/A	24	24
	Children setting and recording goal based outcomes	Clinical Fellow	1	N/A	56	56
		Developer	0.5	7	24	24
		Statistician	1	7	48	48
		Data entry officer	2	4	55	55
Communicate safely	Safety improvement taskforce (to deliver safety culture, training and prevent harm)	Improving Safety of Care Expert	1	8D	102	102
		Lead Consultant	0.3	N/A	36	36
		Improving Safety of Care Specialist	1	8B	73	73
		Improving patient safety coaches	1.5	7	72	72
		Clinical Fellow	0.5	ST 5-7	28	28
		Data Analyst	0.5	6	20	20
		Administrator	1	4	27	27
Transform patient care through digital technology	Adopt evidence-based digital pathways	Developer	0.5	7	0	0
		Data Analyst	0.5	6	20	20
	Pioneer application of Artificial Intelligence	*separate investment plan*	N/A	N/A	0	0
	Create a Clinical Intelligence Portal	Data Analyst	0.5	6	20	20
		Data Quality Officer	0.5	4	14	14
		Information Analyst	0.75	7	36	36
Build a culture of Inspiring Quality	Launch an Inspiring Quality Faculty	External training provider	N/A	N/A	235	235
		Training materials	N/A	N/A	100	100
		Quality Improvement Expert	1	8C	87	87
	Empower our teams to take a systematic approach to daily improvement	Professional leave	N/A	N/A	114	114
		Inspiring Quality coaches	1.5	7	72	72
		Huddle boards	N/A	N/A	26	0
Delivery Framework	Delivery team	Senior delivery manager	1	8C	87	87
		Project Manager	1	6	40	40
Enablers	External partnerships	International Partnership (SickKids)	N/A	N/A	60	60
	Communications	External agency	N/A	N/A	20	20
		Production costs (video)	N/A	N/A	7	7
		Software (digital platform)	N/A	N/A	8	8
					1,512	**1,486**

We have benchmarked this level of investment with organisations that are advanced and now experienced in systematic quality improvement:

Organisation	Financial resource £'000
Salford Royal NHS Foundation Trust	1,000 (only year 1 financial information available)
East London NHS Foundation Trust	1,508 (year 4 cost)

We believe that a credible funding strategy can be implemented to source the majority of this investment through external and existing resource; thus only a minority of the total investment request would require funding from new internal monies.



Additionally, there will be financial savings associated with safer, higher quality care. As there are challenges in directly releasing cash associated with these savings we have not used these savings to offset the level of investment requested.

Benefit	Baseline number	Level of benefit	Financial value (recurrent per annum) £'000	Date full benefits realised from
Reduction in bed days on PICU associated with unplanned admissions to PICU from inpatient deterioration	1,626 [3]	25 % reduction n= 406	848	January 2021
Reduction in medication errors associated with harms [4]	43	10% n= 4	61	January 2020
Total			909	

[3] Data source: 6 months data from the DETECT study on unplanned admissions to PICU. At Alder Hey there were 87 unplanned admissions to PICU from inpatient wards in April 2018- September 2018. These admissions were associated with 813 bed days. This data has been extrapolated to reflect an estimated annual figure.

[4] It is well proven that medication errors have a cost to healthcare systems. See, for example, Elliott R, Camacho E, Campbell F, Jankovic D, Martyn St James M, Kaltenthaler E, Wong R, Sculpher M, Faria R, (2018). Prevalence and Economic Burden of Medication Errors in The NHS in England. Rapid evidence synthesis and economic analysis of the prevalence and burden of medication error in the UK. Policy Research Unit in Economic Evaluation of Health and Care Interventions. Universities of Sheffield and York.

6. References

Adams M, Maben J, Robert G. (2014) Improving patient-centred care through Experience-based Co-design (EBCD): an evaluation of the sustainability and spread of EBCD in a cancer centre: final executive report [Internet]. London: King's College London.

Alderwick, H., Charles, A., Jones, B. and Warburton, W. (2017). 'Making the case for quality improvement: lessons for NHS boards and leaders'. *The King's Fund*.

Boaz A, Hanney S, Jones T, Soper B. (2015) Does the engagement of clinicians and organisations in research improve healthcare performance: a three-stage review? *British Medical Journal.* (Source: https://bmjopen.bmj.com/content/5/12/e009415)

Burnett S, Franklin B D, Moorthy K, Cooke M W, Vincent C. (2012) How reliable are clinical systems in the UK NHS? A study of seven NHS organisations. *BMJ Qual Saf*; 21 : 466 – 72 .

Care Quality Commission (2018) Quality improvement in hospital trusts: Sharing learning from trusts on a journey of QI.

Dixon-Woods, M. & Martin, G. (2016) Does quality improvement improve quality? Future Hospital Journal 2016 Vol 3, No 3: 191–4. (Source: http://sites.bu.edu/ciis/files/2016/10/Dixon-Woods.pdf)

Doyle C, Lennox L and Bell D (2013) A systematic review of evidence on the links between patient experience and clinical safety and effectiveness. *British Medical Journal.* (Source: https://bmjopen.bmj.com/content/3/1/e001570)

Downing et al. (2016) High hospital research participation and improved colorectal cancer survival outcomes: a population based study. *Gut*. Oct 19. pii: gutjnl-2015-311308. doi: 10.1136/gutjnl-2015-311308

Health Foundation (2013) Quality Improvement Made Simple. (Source: https://www.health.org.uk/sites/health/files/QualityImprovementMadeSimple.pdf)

Jonker & Fisher (2018) The correlation between National Health Service trusts' clinical trial activity and both mortality rates and care quality commission ratings: a retrospective cross-sectional study. *Public Health*; **157:** 1-6. (Source: https://doi.org/10.1016/j.puhe.2017.12.022)

Kanter R (2011) The Change Wheel: Elements of Systemic Change and How to Get Change Rolling. Harvard Business School Background Note 312-083. *Harvard Business School.*

McDonald A (2016) A long and winding road: Improving communication with patients in the NHS. Marie Curie. (Source: https://www.mariecurie.org.uk/globalassets/media/documents/policy/campaigns/the-long-and-winding-road.pdf)

NHS Improvement (2018) Building capacity and capability for improvement: embedding quality improvement skills in NHS providers.

Trust Board
4 December 2018

Subject/Title	Global Digital Excellence (GDE) Programme Update
Paper prepared by	Peter Young, Chief Information Officer Cathy Fox, Programme Director for Digital Kerry Morgan, GDE Programme Manager
Action/Decision required	The Board is asked to note the updated progress of the Trusts GDE Programme the achievement of Milestone Four and the commencement of Milestone 5
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; the achievement of Milestone 4 and the commencement of Milestone 5.

2.0 Update of Progress

Since the previous update to the Board on 6 November 2018 The Trust continues to ensure phase five milestones are achieved; primary areas of work include:

Specialty Packages

We are now live within 20 specialties with an additional 2 due to go-live in November; Immunology and Infectious Diseases and Breastfeeding Service. 12 are in development and 6 are actively collecting requirements. We are required to deliver 33 specialties by 31st January 2019 for milestone 5. In order to achieve this 16 packages have been identified for focussed effort to get to live. Clinical time requirements have been defined and shared with Associate COOs. A weekly dashboard has been developed; this will be shared with the executive led weekly oversight group to monitor progress and escalate any issues where needed.

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

Share2Care – Regional Interoperability

Progress is well underway with transitioning the portal into live. All 7 sites are connected to the platform; most sites will be live in November. A decision on hosting and infrastructure is expected to be made in November. Connectivity with the LPRES platform (Lancashire & South Cumbria STP) has been successfully tested.
Plans are underway to expand the platform to an additional 10 organisations across Cheshire and Merseyside STP as early as possible in 2019.

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.

Patient Portal

The Trust has aligned with NHS England and NHS Digital to progress the NHS App into secondary care paediatrics. This in line with the national strategy and will overcome the information governance concerns in relation to patient registration and consent. Alder Hey hosted a workshop on 14 November with Kainos, NHS App Developers and agreed the

next steps in interfacing the App to the e-Xchange clinical portal. A meeting will be held with Citizen ID (NHS Log-in) to discuss proxy authentication and the complex scenarios that can be faced in secondary care paediatrics. A call will be held between Alder Hey, Forcare (e-Xchange provider) and Kainos to discuss further development of the NHS App for use in the secondary care paediatrics and giving Kainos back-end access to the e-Xchange data. Alder Hey has agreed to provide resource needed to complete this e.g. IG, Rainbow, and Records advice. A baseline survey will be sent to all clinicians to collate their feedback on the patient portal.

Benefits baseline: Information is not readily available to patients; average turnaround time from submitting a Patient Access Request to receiving their record is 21 calendar days. Average PALS and Complaints relating to communication failures, conflicting information and query regarding appointments is 72 per quarter.

3.0 Summary of Key Benefits

Project	Aim	Measurement	Baseline Position	Improvement Target	Actual Progress to Target (current)
Booking & Scheduling– Bi-directional texting	Improve efficiency in clinic utilisation	DNA rates for specialties live	10.3% Jan-Sep 2017	Reduction	9.2% Jan-Sep 2018
Play Specialists Specialty Package	Increased income – improved recording of activity	Additional income received for activity	£7,931 Jul-Sep 2017	Increased income	£11,606 Jul-Sep 2018
Bi-directional interface with Kiosks	Improve patient experience booking in for outpatient appointments added on the day	Number of appointments added on the day	Appointment not available in InTouch Required concierge assistance	Appointments available in Intouch	3,277 Appointments available in Intouch Jul-Sep 2018

4.0 Milestone Assurance

The next assurance testing has been arranged for 9th January 2019. Work is underway to provide NHS Digital with all Project Documentation.

5.0 Next deliverables

Work will now commence with the next tranche. By January 2019 Milestone 5 will deliver:

- HIMSS assessment – 11th December 2018

- Medical records electronic document production - patient summary report including 18 further specialities
- Bedside medication verification - Pilot
- Complete a total of 33 Speciality Package deployment
- GS1 Barcode deployment - Patient ID's & Pharmacy
- Deployment of MESH - National Requirement
- PDS Connectivity

6.0 Recommendations

The Board are asked note the progress of the Trusts GDE Programme; the finalisation of Milestone 4 and on-going progress towards Milestone 5.

Peter Young
Chief Information Officer 27 November 2018

ALDER HEY IN THE PARK PROJECT

HIGHLIGHT REPORT Site & Park Development	SRO: David Powell Author: Sue Brown

Programme 2018/19	Jul-18					Aug-18				Sep-18				Oct-18					Nov-18				Dec-18				Jan-19					Feb-19				Mar-19				Apr-19					May-19			
Week Commencing	3	10	17	24	31	7	14	21	28	4	11	18	25	2	9	16	23	30	6	13	20	27	4	11	18	25	1	8	15	22	29	5	12	19	26	5	12	19	26	2	9	16	23	30	7	14	21	28

Item	Commentary
The Park	Starting to now plan for a programme of events to take place from January 2019, planting and management will also be promoted within the park and local community. The development team are currently looking at launching a competition to design the Worlds best play area, it is hoped we can secure some sponsorship to cover a more ambitious plan in line with the Unicef Child friendly city. Some potential organisations have been approached to assess interest in the project and design of the park. Engagement continues through design groups and the friends of Springfield Park, of which a number of young people are now members and participating in the discussions and debates.
Future Site Development	Currently this work is more focused on exploring opportunities and will commence once we know where we are with the future land use.
New Schemes: Institute Phase II	Universities are preparing for occupancy across various dates between now and January 2019. The project manager continues to work with the Architectural Advisor and Morgan Sindell to rectify the snagging issues since occupation of the building. Student access to the new tempory car park is being organised at the current time, it is anticipated the trust will be able to use this car park once planning is approved , expected Jan 2019
New Schemes: The Alder Centre	RABD approved plan to appoint Whitefield and Brown as the construction contactor based on a final cost of £1.988M which is funded via a LIBOR bid and charitable monies .Pre-start site meeting was held on 6th November , further geological studies are required before they can break ground, these are in progress currently with W&B expected to set up on site before Christmas and commence construction in January.
New Schemes: Community Cluster	The Community Building and Dewi Jones Unit have been undergoing an affordability exercise market test following creeping building costs nationally, this exercise was due to complete week commencing 5th November. Due to further increase in costs reported back from Gleeds, additional work has been requested to bring the cost down, it is now expected that the information will be available and fed back towards the end of November . Stage three development of 1:50 room layouts and data sheets continues with user involvement. Feedback from LCC on planning l is expected in January 2019.
Site Clearance-Demolition Phase 2	Programme planned to commence February 2019
Site Clearance-relocation of on-site services/corporate teams	The agreed corporate services moved as per plan over the month of September and October. Planning for further onsite relocations specifically for the community services who will eventually move into the newly planned Community Cluster developments in 2021 are progressing at the current time. the aim is to move staff and CAMHS services into the current Neurology building . CBU mgmt. and the development team now have fortnightly meetings in place and are working up the internal move plan which will commence early in the new year. It is anticipated this will complete for April 2019. Additional long term planning will be required for a number of other services including Medical Records, Transcription, Scheduling and Booking, estates and the development team. Ongoing progress on the police station refurbishment will allow a move for IM&T in Jan/Feb 2019, we are just awaiting dates for completion of works from the police.
Site Clearance: Temporary car park	Car park in situ, just requires barrier control and lighting, Barrier being ordered this month, lighting will be ordered once planning approved. Planning submitted for temporary car park and new park phase 1. Planners are currently reviewing and have requested additional plans on the phasing of the park, plus a review of the Trusts 2013 Travel Plan . Further feedback from the planner san highways will then be expected for January 2019.

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BOARD OF DIRECTORS

Tuesday 04 December 2018

Report of:	Community & Mental Health Division
Paper Prepared by:	Lisa Cooper, Director Community & Mental Health Division Rachel Greer, Associate Chief Operating Officer Kerry Lythgoe, Divisional Business Accountant
Subject/Title:	Relocation and Expansion of Dewi Jones Unit Strategic Outline Case
Background Papers:	Attached paper
Purpose of Paper:	The purpose of this report is to provide a strategic outline case for the proposed move and redevelopment of the current Dewi Jones Unit to the Alder Hey site. This report sets out the strategic drivers for change and outlines the rationale for Alder Hey Children's NHS Trust undertaking this project.
Action/Decision Required:	Trust Board are asked to approve this outline case
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Supports the following strategic objectives: • Delivery of outstanding care • The best people doing their best work • Research and innovation
Resource Impact:	Final investment to be confirmed approx.. £7.4m

Relocation and Expansion of Dewi Jones Unit
Strategic Outline Case

Summary Information

Division:	Community & Mental Health
Clinical Director:	Lisa Cooper
Associate COO:	Rachel Greer
Accountant:	Kerry Lythgoe
Prepared by:	Lisa Cooper/Rachel Greer/Andrew Williams
Clinical Lead:	Andrew Williams
Executive Sponsor:	John Grinnell
Date:	05 November 2018

Document Version Control:

Version	Date created	Brief Summary of Change	Author/ Updated by
1	13/06/18	Initial case developed	Rachel Greer
2	19/07/18	Finance section completed	Kerry Lythgoe
3	28/09/18	Review and update	Lisa Cooper
4	16/10/18	Update finance	Kerry Lythgoe
5	01/11/18	Update exec feedback	Rachel Greer/Lisa Cooper

Investment Value	CBU Board	IRG	ODB	R&BD Committee	Trust Board
<£100k	Recommend	✓			
£100k - £0.5	Support	Recommend	✓		
£0.5 - £1m	Support	Review	Recommend	✓	
>£1m	Support	Review	Recommend	Recommend	✓

(✓ = Approval point)

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1. Report Purpose

The purpose of this report is to provide a strategic outline case for the proposed move and redevelopment of the current Dewi Jones Unit to the Alder Hey site. This report sets out the strategic drivers for change and outlines the rationale for Alder Hey Children's NHS Trust undertaking this project.

The final draft Strategic Outline Case was approved by the Trust Executive Team in November 2018.

The Trust Board is asked to review and approve the strategic outline case for the redevelopment of the current Dewi Jones Unit for approval.

2. Executive Summary

The Dewi Jones Unit is a CAMHS Tier 4 unit which offers comprehensive and intensive packages of care to reflect an individual child's needs either as an inpatient, day patient or outpatient. This includes delivering step-up and step-down care as part of a holistic bio-psychological approach. The Dewi Jones Unit is located at the Alder Park site in Waterloo 7 miles from the main Alder Hey Hospital site. Previously the unit had been co-located with the acute hospital but from estate which was not fit for purpose and prior to the rebuild of the acute hospital.

The move into the Alder Park site provided the opportunity for the unit to expand its bed base up to a possible 9 inpatient beds, provided more outside space and additional space within the unit for children and young people and family therapy and improved school facilities. The unit was then able to achieve CQC registration for Mental Health residential care and played a large part in the service meeting QNIC (Quality Network for inpatients CAMHS) standards enabling accreditation. The NHS England commissioned contract states that units are required to be QNIC accredited.

The increase in beds from 7 to 9 had proved difficult to achieve due to a number of operational challenges associated with operating within a standalone facility.

In 2015, Alder Hey Hospital moved into a new state of the art building as part of a children's health park campus. This facility offers children and young people and families the opportunity to receive their care from an environment designed specifically around their needs. As the children's health park campus is developed, we now have the opportunity to consider moving the unit onto the campus and providing a similar experience for young children admitted with the most serious mental illnesses.

In addition to that the current Dewi Jones Unit cannot meet the NHS England service specification for Tier 4 CAMHS inpatient as it is a standalone facility. The unit cannot flex capacity to meet current fluctuations in demand and the estate does not support new ways of working or models of care.

In order to address the current challenges facing the service and design a service which can accommodate and sustain the increasing demand for Tier 4 provision, a proposal has been developed which will see an increase in beds from 7 to 12 and the delivery of an integrated pathway of care between both the Tier 4 service and local Tier 3 CAMHS services.

The options available to support this development are:

- Option 1: New build on Alder Hey Children's Health Park - a children's mental health campus
- Option 2: Utilise existing ward within current Alder Hey main hospital building
- Option 3: Leased facility offsite
- Option 4: Do nothing

The preferred option is Option 1 - a new build of 12 beds on the main hospital site, close to but not fully integrated within the acute hospital is the recommended option for the future provision of the children's Tier 4 inpatient.

This option would:

- Comply with NHS England service specification for children's inpatient mental health beds allowing Alder Hey to continue to provide Tier 4 CAMHS services
- Reduce the current risks facing the service associated with operating in an offsite location
- Mitigate the current financial challenge of running the service
- Provide a mutually beneficial relationship between acute paediatric services and the inpatient children and young people's mental health service.
- Working with other children and young people units across Cheshire and Merseyside footprint as part of Mental Health STP, deliver new models of care in line with Mental Health Five Year Forward View (MH5YFV)
- Increase the number of beds available and support the development of a more networked model of care.
- Provide a North West centre of excellence for children's CAMHS services.

3. Strategic Context

This strategic outline case (SOC) proposes the relocation of the Dewi Jones Unit, from the current site at Alder Park, Waterloo, to the Alder Hey Children's Health Park campus in West Derby. The document sets out:

- Overview of Alder Hey Children's NHS Foundation Trust and the Community Division
- Overview of current inpatient unit at Alder Park
- The strategic drivers for a new unit which meets the national service specification
- The options considered for the new facility
- The outline financial considerations

In addition, this SOC explains why the preferred option to build a new facility on the Alder Hey Children's Health Park is the most beneficial.

3.1 About Alder Hey Children's NHS Foundation Trust

Alder Hey Children's NHS Foundation Trust is a provider of specialist healthcare to over 275,000 children and young people each year. We have a state-of-the-art hospital, Alder Hey in the Park, which opened in 2015. Alder Hey has a presence at a number of community outreach sites and in collaboration with other providers, our clinicians help deliver care closer to children and young peoples' homes by holding local clinics at locations from Cumbria to Shropshire, in Wales and the Isle of Man. The Trust is rated by the Care Quality Commission (CQC)

The Trust employs a workforce of 3,246 staff who work across our community and hospital sites. As a teaching and training hospital, we provide education and training to around 540 medical and over 500 nursing and allied health professional students each year.

During 2018/19, delivery against the Trust's vision: 'Alder Hey, A Healthier Future for Children and Young People' will be achieved through an overall programme of work which is focussed on:

- Delivery of outstanding care
- The best people doing their best work
- Sustainability through external partnerships
- Game changing research and innovation

To support the achievement of the Trust's planning assumptions, leveraging the synergies created through the clinically led Divisional structures and support via a formal transformational approach and methodology will be critical. This is supported by established Programme Management Office (PMO) assurance processes.

The overall plan is described within the diagram below.

There are five key operational priorities agreed as critical to the delivery of the ambitions set out in the 'Delivery of outstanding care' programme of work. These are:

- Brilliant Booking and Scheduling
- Children and young people Flow
- Best in inpatient Care
- Comprehensive Mental Health Care
- Models of Care

The proposed relocation of the Dewi Jones unit is a key component of the Comprehensive Mental health programme of work and will be managed and assured through the Trust programme management approach. This ensures that each programme has a specific Project Initiation Document and milestone plan attached which is formally monitored through the programme governance structure.

All of these programmes of work will be clinically led with management support and clear Executive sponsorship.

3.2 Community and Mental Health Division at Alder Hey

The Community and Mental Health Division at Alder Hey provides a range of both physical and mental health services across Liverpool, Sefton and Knowsley. The division has a total headcount of 450 staff working in a range of different services.

The Division has agreed a set of objectives for 2018/19 which align with the overall operational objectives of the organisation but are developed for the local context within which services are delivered. The division works in partnership with other children's healthcare providers, the two local authorities, as well as the third sector to deliver improved outcomes for children.

A summary of the 2018/19 Community and Mental Health Division objectives are outlined below:

Delivering outstanding care	**The best people doing their best work**	**Sustainability through external partnerships**	**Game-changing research & innovation**
Develop role of community & mental health services within child & family centred pathways *children should be cared for at home or as close to home as possible* Improve service responsiveness *Monitor, measure and improve waiting times for all services* Deliver services from facilities which are fit for purpose & designed around the needs of children and young peoples and families *Critical review of community estates and IM&T*	Invest to ensure resilient staffing levels Use of apprenticeship posts & ensure that staff can access training opportunities Staff engagement through… • LiA • Innovative communication • Involving people! Recruitment & retention improvements through flexibility and innovation	Key partner in the transformation of community services for children in Liverpool Development of network approach to delivery of Tier 4 CAMHS services with other providers Deliver new pathways in Sefton for Neurodevelopmental paediatrics	Grow the research profile within the division Increase the number of staff and children and young peoples participating in research Innovate to solve problems in community Use technology within home environment to support children to be cared for at home

The relocation and expansion of the Dewi Jones unit will support both the delivery of outstanding care objective as it will ensure that the facilities from which we deliver services are fit for purpose and designed around the needs of children and young peoples and families. It will also support the development of our external partnerships. Working together as a network of Tier 4 providers and with local CAMHS services to develop clear pathways of care and reduce the overall length of stays and reduce out of area placements.

3.3 National and local context

In July 2016, NHS England published '*Implementing the Mental Health Forward View'* which set out clear deliverables for putting the recommendations of the independent Mental Health Taskforce Report into action by 2020/21.

The publication of *Stepping Forward to 2020/21* in July 2017 also provided a roadmap to increase the mental health workforce needed to deliver these recommendations and take steps towards making parity between mental and physical health a reality.

Specifically, NHS England and CCGs are required to make continued investments in CAMHS services such that they deliver against regional implementation plans to ensure that by 2020/21, children and young people stays will only take place where clinically appropriate, will have the minimum possible length of stay, and will be as close to home as possible to avoid inappropriate out of area placements, within a context of 150-180 additional beds nationally.

3.4 Regional Context

To ensure that all children who require Tier 4 care in the North West can be accommodated within the North West, the development of new models of care is required. Working with partners in NHS England and the other children's provider in North West, we are developing a proposal under an MOU agreement, to consolidate children's beds on a single site and increase overall capacity to meet the required level of demand.

Based on current levels of activity within the North West the predicated level of demand for children's Tier 4 beds is 12, this includes children who are managed as out of area placements,. This is based on activity over 2 years which indicated that across the North West the average bed occupancy was 9.67 (min 7 and max 13) at 85% occupancy would result in an overall need for 11.4 or 12 beds.

There are only six CAMHS units for children and young people aged up to 13 years, in England which poses challenges in terms of transitional support for children and families prior to and after discharge. An increase in capacity within the Dewi Jones Unit would support the development of a centre of excellence with new models and approaches to the delivery of care. This would also improve the process for transition to ensure that therapeutic gains are maintained on discharge and that children's care can be returned to community services in a safe and timely way.

There have been a number of high profile incidents of children and young people who were waiting to access a children's Tier 4 bed due to lack of availability nationally which suggests that there are, on occasion, insufficient NHS commissioned beds or local flexibility, leading to children being supported for longer than necessary on paediatric wards or in the community.

3.5 New Models of Care

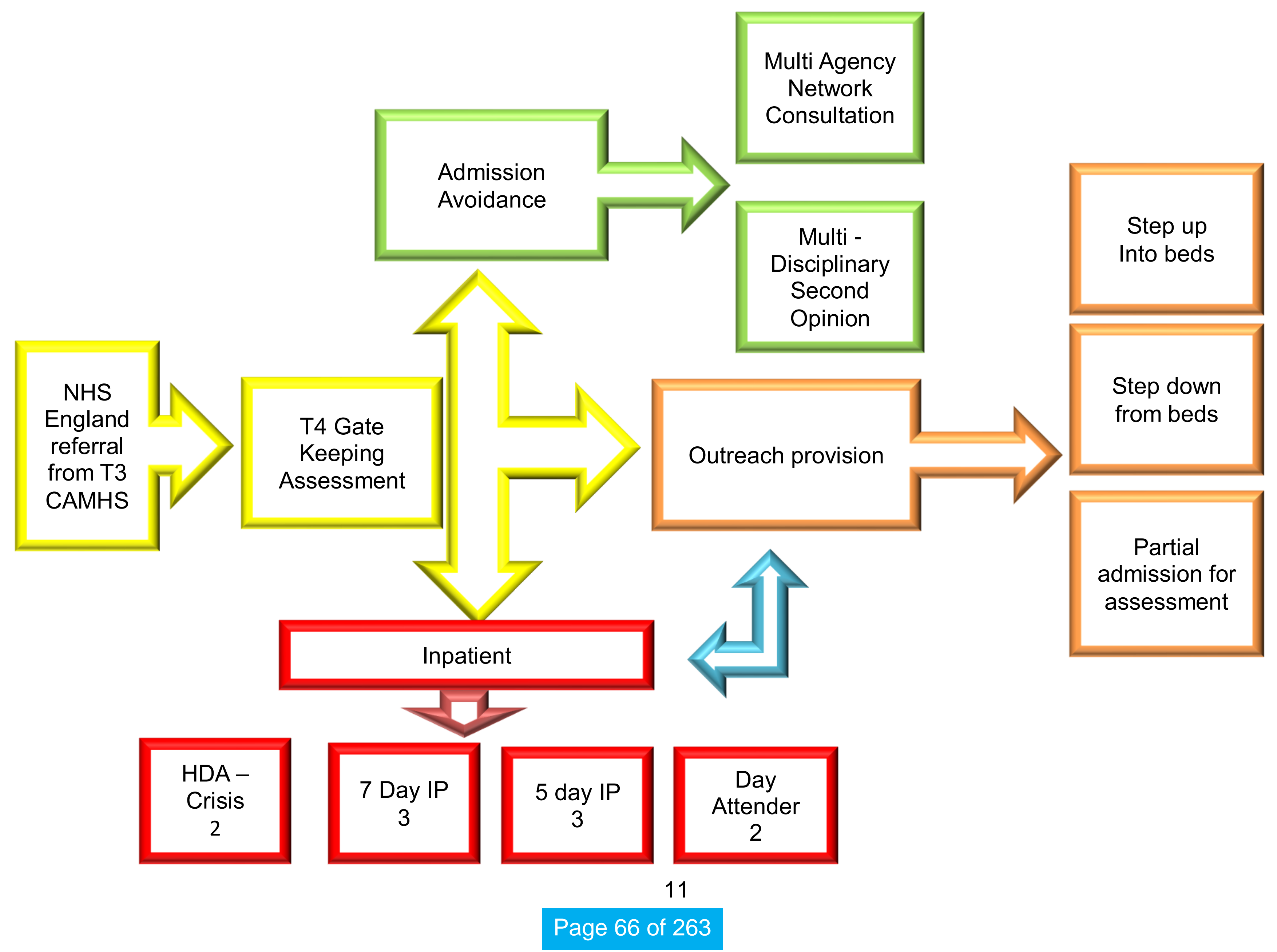
Within Cheshire and Merseyside, the STP CAMHS sub group are developing new models of care for Tier 4 services as part of a national review of Tier 4 services. Whilst the 'new models' are being developed to address challenges in Tier 4 adolescent provision, there is synergies with the work required to work in a different way across the children's Tier 4 provision. The aim of the new models of care work is to:

- Enable and facilitate a 'whole system approach' to mental health services for children and young people where children, young people and families are at the heart of service delivery.
- Ensure ownership within, and across, the Cheshire & Merseyside system for our young people, including the management of children and young people flow.
- Improve children and young people experience through the creation and monitoring of seamless pathways to ensure the right care, in the right place (close to home), and at the right time
- Reduce reliance on inpatient provision through the development of high quality alternatives to prevent of admission where this is in the best interests of individual children.
- Reduce length of stay through intensive in-reach interventions.
- Build capacity across the whole children and young people mental health system including greater co-production with children, young people, families, education, employment & social care services, third sector and faith organisations.
- Promote, enable and facilitate early identification, prevention and recovery based approaches to care and support.
- Sustain outcomes achieved for children and young people to prevent re-referral and /or re-admission.
- Ensure the best use of the valuable resources available – both financial and human resource across the footprint.
- Reduce variability in processes, ensure consistency in pathways and equity of provision
- Improve data, knowledge and intelligence systems to guide future innovation and improvement

In order to deliver the ambition set out in the new models of care, a proposed operational model for the service has been developed. This model and new set of pathways has been developed in partnership with the clinical team and shared with NHS England for review and comments.

The new model describes a fully integrated approach to Tier 4 pathways which includes: a referral and gatekeeping function, a 12 bedded inpatient unit and pathways to support outreach based care and admissions avoidance.

The proposed pathway for patient referral, assessment, treatment and discharge is shown below:



In order to determine the level of provision required, a scoring system has been developed to support decision making. This indicator system identifies the risk, the intensity, severity, complexity and chronicity of the child as well as the demonstrated level of engagement with other services. This information will be used to determine the pathway which is best suited to the individual child's need.

For each of the new elements of the model and pathways of care, further work to agree the contract currency is required.

3.6 Development of Private Patients Service

In line with the Trust's vision to support the delivery of services to private patients where their treatment may be funded by health insurers, sponsored by international bodies or patients' own funds, it is envisaged that the development of the Dewi Jones Unit may provide potential opportunities within this market. This element of work will need further work to ensure that this is managed appropriately with no impact on NHS funded care.

4. Proposed Impacts and Outcomes

4.1 Children, young people and families

A purpose built modern environment, which is visibly part of Alder Hey in the park, sends the message to young people and the community that mental health is an Alder Hey priority. Investment in the provision of a high quality mental health facility also demonstrates wider NHS support for children's mental health.

Children admitted into Tier 4 CAMHS care will often have very complex needs including additional paediatric medical needs which are currently difficult to access from the current site. There are a number of children who need to move between a CAMHS Tier 4 bed and a medical bed which presents additional risk in their care as transfer by ambulance is usually required.

It is not unusual for some of these children to require emergency interventions which is not possible within a Tier 4 unit and therefore requires them to attend the paediatric emergency department for care. This presents additional risk to children and young people who require an ambulance (or occasionally police) transfer.

There is no provision for parent and/or family accommodation adjacent to the Dewi Jones Unit. Family therapy/interventions are a significant part of treatment for these young people and will require frequent visits to the unit by family members. Some families have to travel long distances to support this.

4.2 Workforce

Co-location with community CAMHS allows treatment teams to work together more promptly, more regularly and facilities new ways of working (shared appointments and co-working) enabling faster discharge and better handover of care.

Dewi Jones staff will be more integrated into the wider CAMHS workforce and be part of new models of care as they are developed.

Families will be able to come to one location for their specialist health appointments, providing increased convenience and support improved compliance in care. Access to family facilities within the Ronald McDonald unit will support families to stay close to the unit when required and enable family therapy to take place at convenient times and in accordance with children and young people need.

Staff will be more integrated into the wider Alder Hey workforce, benefitting from onsite staff support initiatives and senior staff will no longer waste time travelling to the Alder Hey site for corporate meetings and events which consistently erode time which could be better used for children and young people care.

Increasing the bed base would enable investment in additional clinical staff due to the improved economies of scale and allow greater access for young people and support an increased number to be cared for locally. Currently the unit has the capacity to manage a maximum of 48 children per year, through an increase in the bed numbers and a different model of care this would increase to a potential maximum of 125 children per year or an increase of 77.

The Mental Health Five Year Forward View sets out a challenge to the NHS to increase provision of Tier 4 children's beds to enable care close to home, a reduction in overall lengths of stay and reduced delays in admission. This proposed development supports the achievement of this ambition and will lead to a reduction in out of area placements for children from within the North West.

The development of a mental health campus on the Alder Hey site would support improved flow through the acute hospital by ensuring greater access to more mental health trained staff. This could reduce a number of extended delays in A&E when children in mental health crisis are brought by other agencies (Police) as a designated place of safety.

In addition to increased bed provision, more space and co-location with community CAMHS services, the development of more flexible and intensive community working can be achieved through the input of staff to cases currently managed in the community. This means potential admission avoidance and prevention and would enable timely discharges.

A detailed workforce plan has been developed to support the increases in bed numbers from 7-12 and to ensure that staffing levels meet the safer staffing requirements and the standards set out in the Quality Network for children and young people CAMHS (QNIC)

The workforce plan sets out the staffing levels required to meet the needs of the unit and enhance the quality of service provision by increasing the overall size of the therapy workforce improving resilience and supporting service development.

It is assumed that a move to the Alder Hey Children's Health Park would have a positive impact on staff based on current feedback gained through regular Listening events with staff on the unit and exit interviews.

It is also assumed a reduction in bank and agency costs through greater resilience and support provided from the acute site.

Co-location provides opportunities for building the workforce, paediatric placements, shadowing opportunities and this will form the basis for us to work with education providers and HEIs to improve our training offer to staff. Continued investment in workforce and training is critical to building the CAMHS workforce of the future.

4.3 Commissioners

Communication with key stakeholders and other mental health organisations has taken place during 2017/18. NHS England are supportive of the ambition to both relocate the Dewi Jones Unit and increase the overall bed base to ensure that the current high quality service provided is able to continue to meet the needs of children and young people from a unit which meets their specification and is able to accommodate the demand from across the North West.

In order to mitigate the impact of the increase in bed capacity for children's Tier 4 beds in the North West, it is anticipated that the costs of this will be met from a repatriation of out of area placements (outside of the North West).

To support the models of care set out in the case, a new contract currency is required.

4.4 Information and Technology

IM&T is an important enabler to fully align with and support the delivery of high quality children and young people care. As a Global Digital Exemplar site, Alder Hey has aspires to be a technology led, quality focussed organisation.

The Community and Mental Health Division is driving the adoption of improved IM&T across all services, and the Trust continues to invest in technology and business intelligence solutions which are focussed on improving health outcomes and performance improvement.

The development of specific speciality digitally enabled packages of care will support both the recording and monitoring of clinical information and at individual children and young people and unit level.

Trust wide IM&T projects are critical to the division to improve the productivity of its workforce. The benefits / outcomes we plan to deliver via the new care strategy will not be delivered without the successful delivery of the following Trust projects:

- Development of Dewi Jones speciality package (paperless electronic children and young people record)
- Implementation of a children and young people portal.

- Delivering new technology at scale to support agile and remote working
- Delivering new business intelligence systems that teams and managers will use in real time to manage resources.

5. Options Appraisal

5.1 Overview of options

As part of the Business Case development, the Trust has undertaken an options appraisal. The options available to support this development are:

- Option 1 - New build on Alder Hey Children's Health Park
- Option 2 - Utilise existing ward within current Alder Hey main hospital building
- Option 3 - Leased facility offsite
- Option 4 - Do nothing

The preferred option is Option 1 as this would deliver:

- Purpose built facility which meets the needs of the most complex children with mental health needs
- Meets the required building standards as set out in both service specification and quality standards for children and young people units (QNIC)
- Supports the requirement to deliver new ways of working in line with MH5YFV
- Supports greater integration with other mental health and physical health services for children as part of a children's health park and mental health campus

5.2 Option 1: New build within Alder Hey Children's Health Park

NHS England service specification for Tier 4 children and young people's units states that 'the unit must not be in an isolated or standalone facility' Link here

Option 1 provides the opportunity to design a purpose built facility designed around the needs of children and their families, whilst also meeting the needs of the NHS England Service Specification by being located on site with Alder Hey Children's Hospital.

The unit would fully meet the design specifications set out in both the NHS England service specification and the QNIC quality standards for children and young people's units. The unit would be within the children's health park campus, designed specifically to meet the needs of children and families with dedicated outside space. In addition, the closeness of the unit to the main hospital building would offer mutually beneficial service improvement opportunities.

The unit would increase the mental health presence on the Children's Health Park site, to support the care of children admitted acutely with mental health conditions, and support children and young people on the Dewi Jones Unit with medical needs as the full range of tertiary medical specialties would be available for advice and support if required.

The unit would form part of an overall mental health campus as it would be co-located within the community cluster building which would also include a specialist education facility, community CAMHS service, Eating Disorder service and CAMHS crisis care team as well as neurodevelopmental paediatrics and acute psychology services.

The unit could be sized according to the future demand. Based on current demand modelling this is likely to be 12 beds. The current operating loss of the service would be mitigated by an increase in beds and a move to a build within the Alder Hey Children's Health Park.

5.3 Option 2: Utilise existing ward within current Alder Hey Hospital building

A CAMHS children and young people unit within the main hospital building could provide a more easily deliverable solution in that the building already exists. The linkages with other paediatric services would be improved immediately and the potential to expand to support more aspects of acute mental health in children and young people e.g. inpatient eating disorder beds would be possible.

However, the environment in the newly built Alder Hey Hospital was not designed for the specific needs of acute mental health children and young peoples. There would be no direct access to outside space and access to other facilities within the newly built Alder Hey Hospital would require children and young peoples to access parts of the hospital, for example the main atrium, which could be problematic for children and young people with sensory issues.

The cost of refurbishment within the newly built Alder Hey Hospital as a PFI build would be prohibitive.

There is currently no identified space within the acute hospital building which this service could move into, which would result in the displacement of another clinical service.

5.4 Option 3: Other leased /refurbished facility

A review of available properties in the local area has been carried out and there are no buildings available which could meet the needs of a 12 bedded children and young people's unit.

A leased building would also mean that many of the risks currently facing the unit by operating in an offsite location would not be fully mitigated and this solution would not principally meet the requirement that the unit is not a standalone facility.

The optimum co-location for children and young people's units is with other paediatric services given the specific needs of this children and young people population. In addition, the cost of refurbishment of another facility to the standard required for a Children's mental health unit could be prohibitive.

5.5 Option 4: Do nothing

The do nothing approach is not an option as this will not meet the standards set out in the NHS England service specification for children and young people's units. Doing nothing may also result in Alder Hey no longer being the provider of choice for Tier 4 CAMHS services.

If the unit stays in its current location, the current challenges and risks facing the service could not be fully mitigated. An increase in bed numbers could reduce some of the operating costs but not all and the safety and quality risks would remain the same.

In order to maintain the building in a reasonable state of repair, the cost of maintenance is £150k per year. Over the life of the building, there is a lifecycle and backlog maintenance cost estimate of £9m.

Current space breaches building standards and the specification requirements. There are challenges to the safety of children caused by working in a unit which is spread over two floors. There is insufficient outside space to allow children to play.

5.6 Summary of options against key criteria

Below is a summary of the proposed options:

	NHS England Service Specification	QNIC standards	Affordable Cap/Rev	New ways of working MH5YFV	Integration mental / physical health
Option 1 – New Build within Alder hey children's health park	✔	✔	✔	✔	✔
Option 2 – Utilise existing ward within Alder Hey	✔	✔	X	✔	✔
Option 3 – other leased / refurbished facility	✔	✔	X	X	X
Option 4 – Do nothing	X	X	X	X	X

The preferred option is Option 1 as this would deliver:

- Purpose built facility which meets the needs of the most complex children with mental health needs and NHS England Service Specification
- Meets the required building standards as set out in both service specification and quality standards for children and young people units (QNIC)
- Affordable service model and achievable with capital funding available
- Supports the requirement to deliver new ways of working in line with MH5YFV
- Supports greater integration with other mental health and physical health services for children as part of a children's health park and mental health campus

6. Finance and Affordability

Alder Hey has projected income of £217m for 2018/19 and projected control total £32.2m Surplus. The Trust delivered a £22m adjusted net surplus in 2017/18 and has a good financial track record as shown in below:

Cost Category	2016/17	2017/18	2018/19 (Forecast)
	£million	£million	£million
Income	222.6	264.6	271
Operating expenditure	(200.0)	(221.4)	(238.8)
Adjusted Net Surplus/Deficit	**4.6**	**22.0**	**32.2**

The Trust has continually met its financial plan over the past two years and in 2017/18 generated a control total surplus of £22m, which is an overachievement of £21.9m on planned control total. The trust had a cash balance of £12.2m at the end of 2017/18.

The trust successfully delivered a state of the art £250m hospital in 2015 through a PFI partnership. It has a proven track record of delivering large scale capital projects. The trust completed £16.8m of capital investments in 2017/18 including the development of the Research and Education building phase 2.

6.1 Financial Impact of Proposed Dewi Jones Unit

The current Dewi Jones Unit is based off site in Waterloo on Alder Hey estate and is a 7 bedded unit funded by NHS England. Costings have been undertaken to identify the capital and revenue costs of the proposed new build facility on the Alder Hey site.

The expansion to 12 beds and on site move will improve our bed day costs by £222 per day, along with an improvement on control total of £455k

(See Appendix 1 for Revenue and Control Total Impact)

6.1.1 Capital Costs of new facility

The cost of the proposed 12 bedded unit on the Alder Hey site has been estimated on current market rates. The estimated capital cost of the build is £7.370m as shown below:

Capital Elements	£s
Construction Costs	3,212,330
Kit & IMT (incl Furniture 7 Fittings)	737,029
Enabling	368,514
VAT	1,474,057
Fees	884,434
Development	92,129
Other	601,925
Total	**7,370,418**

As the project progresses through the RIBA stage 1 and 2 with an informed design specification capital costs will be updated. The capital costs include contingency and risk to reflect the current build market.

As the build will be on the current Alder Hey site there is no land purchase costs required.

6.1.2 Revenue Costs of New facility

The revenue impact of the new facility on the Alder Hey site and increase in capacity has been modelled based on current costs and staff costs for the increased capacity. The revenue impact is shown below.

	£m
Current Revenue Costs (7 bedded unit)	1.284
Repatriation of Beds (4)	0.735
Additional Costs for Additional Beds	0.183
Total Costs (12 bedded unit)	**2.202**

The unit requires a number of key roles to comply with QNIC standards. These are currently in place for the 7 beds and will not need additional investment with the increase to 12 beds. The main additional costs are front line staffing to reflect the increase in bed capacity. It is assumed there will be some non-pay savings from moving from the current build to the new build mainly due to improved utility costs and efficiencies resulting from the unit being co-located with the main Alder Hey Hospital building removing the need for local security, cleaning and catering

contracts along with transport costs. The increase in beds from 7 to 12 will result in a reduction in the current cost per day from £851 per bed day to £628 per bed day.

The case does assume additional income from commissioners £183k but this is the result of additional beds, along with repatriation of activity for 4 beds from the North West £735k (revenue neutral to commissioners). The increase in income for 12 beds along with a reduced cost per bed day results in the unit improving the contribution per bed day by £222.

It is estimated that the Trust backlog maintenance costs will reduce by £50k per annum as a result of this investment. The backlog maintenance we are currently incurring is as a result of the age and condition of the current facilities and also regular repairs to walls and structures as a result of children and young people actions. It is expected that a purpose built facility would not suffer damage in the same way due to modern purpose built design features.

The Trust is currently working with specialised commissioning to secure firm financial commitment to the relocation and increase in capacity.

6.1.3 Capital Funding

The proposed new build is part of Alder Hey's 10 year capital programme and the trust board are fully supportive of the new facility being co-located with the main hospital. The trust has a number of capital financing options available to fund the new build:

- Cash
- Part loan/ part cash
- STP capital bid
- Charity Contribution
- Council Loan

The trust recently submitted a capital bid in June 2018 to the Sustainability Transformation Health and Care Partnership (STP) to secure capital funding for the new build. The bid is currently going through the prioritisation process with Department Health & Social Care and the outcome will be known in autumn of 2018.

6.1.4 Revenue Funding

Revenue funding for the Dewi Jones unit is funded through contracted specialised commissioning. NHS Specialised commissioning has confirmed their strategic support to the relocation and increase in capacity of the Dewi Jones unit.

The trust can demonstrate the cost benefit from the additional funding arising from this scheme. These amount to the equivalent of approx. £1.6m per annum benefit to the health economy and will arise from the both the unit being more efficient and having a reduced bed day cost plus the more efficient use of acute beds. For example if a Tier 4 children and young people is medically unwell they are currently transferred to the main Alder Hey site and admitted to an acute bed for medical care.

In 2017/18 150 bed days were occupied by Tier 4 CAMHS children and young peoples at Alder Hey and a similar number at other DGH's whilst children and young peoples waited for a bed in a suitable Tier 4 CAMHS unit.

In future, if the Tier 4 unit was on site, the children and young peoples would be able to remain in their more appropriate Tier 4 bed setting and be reviewed by medical consultants on a regular basis due to the proximity of the unit thereby keeping the acute bed free and assisting with the children and young people flow in the main hospital.

The current unit is commissioned on a bed day basis based on number of in children and young peoples with a 6 week assessment period the service are in discussion with commissioners to change and improve our models of care incorporating community and school based work, day case and outreach. The changes in models of care are estimated to improve our length of stay from 6 weeks to a 4 week average thereby allowing us to increase children and young people throughput.

The key improvement to the Statement of Comprehensive Income will arise from the improvements generated as a result of the efficiencies generated from moving the service onto the Alder Hey site and increasing the bed capacity.

6.2 Trust Risk Rating

The scheme will not change the trusts Use of Resources (UoR) rating over the next five years which are detailed below:

	2019/20	2020/21	2021/22	2022/23	2023/24
TRUST RISK RATING	3	2	2	2	2

6.3 Financial Assumptions

A number of assumptions have had to be made when calculating the financial impact on Alder Hey. The number and level of assumptions will reduce as the project moves towards financial close, the current assumptions are:

- Revenue costs savings will be materialised
- Cost benefit assumptions are supported by commissioners
- Commissioners will fully fund the revenue consequences of the new build.

6.4 Risks

The number and level of assumptions that have to be made at this stage of the project all give a level of risk when determining the affordability of the project. The major risks at this stage are:

- The additional revenue costs of the project are greater than the funding available from commissioners.
- Commissioners retract commitment to additional revenue funding
- Estimated build costs increase
- Capital availability to trust. The trust has an ambitious capital programme

The Trust will seek to progress the scheme as quickly as possible as a means of mitigation against the identified risks above.

7. Timescales and deliverability

7.1 Milestone Plan

The table below describes the anticipated major milestones and delivery date for this development. These dates are dependent on a number of external factors and will be subject to the development of a comprehensive programme plan

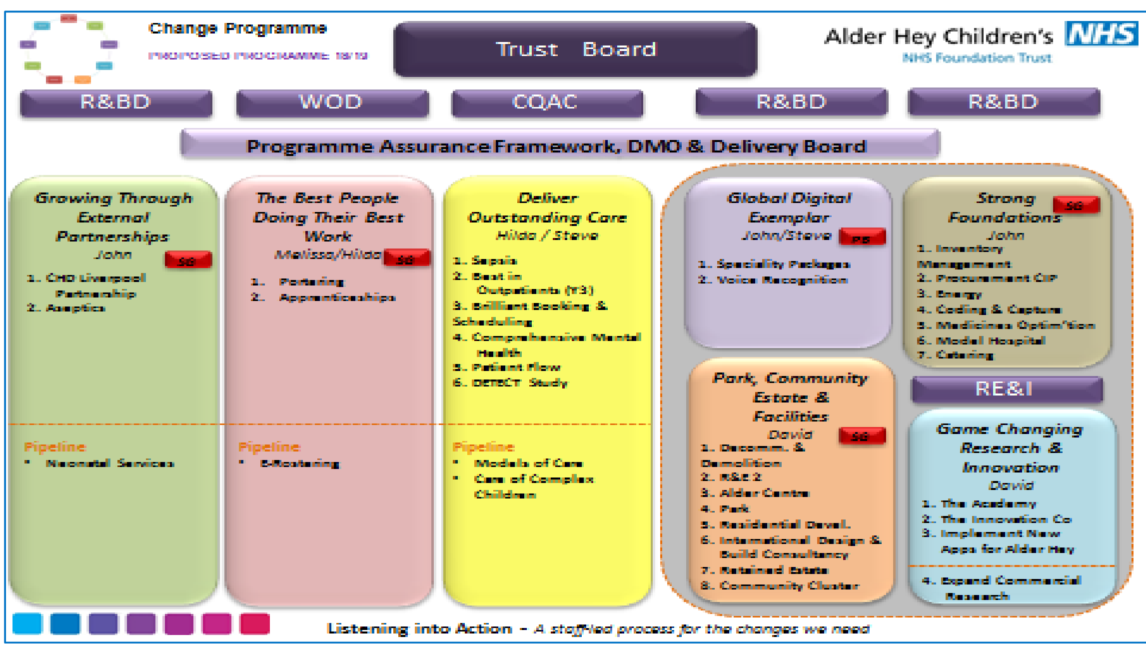
Milestone	Anticipated date
Submission of STP capital bid	31/05/18
Development of Strategic Outline Case	18/06/18
Approval of case through Investment Review Group	November 2018
Approval of case through Operational Delivery Group	November 2018
Trust Board approval	December 2018
Design complete	November 2018
Outline planning permission obtained	November 2018
Work commences onsite	January 2019
Completion of build	January 2020
Move into new unit	February 2020

7.2 Project Governance

A project plan has been developed for this project which is part of the overall Comprehensive Mental Health programme of work, which is a key operational priority for the Trust for 2018/19. The project board for the Comprehensive Mental Health programme meets monthly and reports into the Trust programme Board and, via the programme management office, into the Trust Board. The project will be run using proven project management tools.

The Comprehensive metal health programme of work fits into the wider Trust objective to ***Deliver Outstanding Care*** and assurance is provided through the Trust Clinical Quality Assurance Committee.

The diagram below outlines the governance arrangements that have been put in place in respect of the trust's major capital builds:



7.3 Potential Risks to Project

The following potential risks have been identified to the project:

- Potential Failure to translate design – this will be mitigated by ensuring that the service specification and design are robust and fully costed.
- Default by contractor - Mitigated through ensuring contract is robust and penalties for non-delivery.
- Changes in volume and demand - Mitigated through detailed demand modelling including demographic and population based needs assessment.
- Timeliness of scheme delivery - Mitigated through detailed project planning timescales including contingency.
- Reputational risk related to safety within the unit - Mitigated through ensuring adequate staffing available.
- Recruitment risk - Mitigated through timely recruitment and effective training programme

7.4 Implications of approval not being given

Without the relocation of the Dewi Jones Unit to a site with other health services, the unit will remain as a standalone facility and will therefore not meet the NHS England service specification and may not be commissioned from Alder Hey.

The unit is currently configured to deliver planned children and young people care for children with complex mental health needs. Developing the service to support more urgent and emergency admissions or more networked care is difficult without access to other paediatric medical services or community CAMHS

8. Next Steps

During Quarter 3, 2018/19, the project team will continue to develop the design option for the relocation of the Dewi Jones Unit within the Community cluster building.

As part of STP, the development of new models of care for Tier 4 provision across Cheshire and Merseyside is being developed as partnership between all providers. This case will be presented to the STP CAMHS subgroup for approval.

The Trust Board is asked to review and approve the strategic outline case for the redevelopment of the current Dewi Jones Unit for approval.

Appendix 1 – Financial Appraisal

Revenue cost of DJU onsite vs offsite

	1718 7 beds £s	New Build 12 beds £s
Income	1,284,165	2,200,512
Direct Costs	1,554,183	1,989,493
Overheads	184,348	210,825
Total	**-454,366**	**194**
Bed days (80% Occupancy)	2044	3504
Income per bed day	628	628
Cost per Bed day	851	628
Surplus / (deficit) per bed day	**-222**	**0**
Revenue improvement per bed day		222

	£
PDC	171,402
Depreciation (assumes 80 years in line with AH)	61,215
Total	**232,617**

Impact on Control Total

	Current	Future 12 beds	Impact on Control Total
Income	1,283,723	2,200,512	916,789
Expenditure	1,738,541	2,200,318	-461,777
Surplus / (-) Deficit	**-454,818**	**194**	**455,012**

Capital

Cost build up per square metre	% on cost	£
Construction cost		2,755
Kit and IMT	10%	632
Enabling	5%	316
VAT	20%	1,264
Fees	12%	759
Trust costs	1.25%	79
Other	8.17%	516
Grand Total		**6,321**

1166 Sq M Build	
Total	**7,370,286**

* Assumes the Kit and IMT covers all furniture & fittings

BOARD OF DIRECTORS

Tuesday 4th December 2018

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

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1. Background:

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

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

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

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

There are three levels of investigation identified within the NHS, where regulation 20 applies, as follows:
- Level 1 (60 working days to complete) – This is a concise Internal Investigation, suitable for less complex incidents usually at moderate harm level (meaning short term harm), and managed by individuals or a small group.

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

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

Current position

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

During this reporting period there were no serious incidents. There were no safeguarding incidents reported.

Table 2 shows the cumulative position; three ongoing serious incident investigations in total, which comply with external requirements, including the regulatory requirement for duty of candour.

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

Table 4 shows the closed SIRIs for this reporting period.

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

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

Table 2 Ongoing serious incidents requiring investigation (cumulative):

On-going SIRI incident investigations							
Reference Number	**Date investigation started**	**Division**	**Incident Description**	**RCA Lead Investigator**	**Progress**	**60 working day compliance (or within agreed extension)**	**Duty of Candour applied**
StEIS 2018/21325	31/08/2018	Surgery	**Never Event** (wrong implant) – Fixation of left supracondylar humerus fracture. Incident: 1.6mm wires taken in error rather than 2mm wires.	Paula Clements, Theatre Matron and Chris Talbot, Trauma and Orthopaedic Consultant	RCA report written; report in quality check stage (x2).	Yes	Yes – including Duty of Candour letter.

			Stable fixation achieved utilising 1 x 1.6mm and 1 x 2mm wire. Clinical decision made not to replace 1.6mm wire following check regarding stabilisation of joint. No harm to the patient.				
StEIS 2018/21324	31/08/2018	Surgery	Incident: Oral medication given via endotracheal tube which was mistaken for an orogastric tube. No harm to the patient.	Dianne Topping, Senior Nurse	Final report sent to CCG 08/11/2018.	Yes	Yes – including Duty of Candour letter.
StEIS 2018/21323	31/08/2018	Surgery	**Never Event** (wrong site surgery) Incident: removal of wrong tooth. Patient seen in theatre for dental extractions as part of orthodontic treatment plan. Prior to the theatre date, she was seen in clinic for assessment/consent. The agreed treatment plan was confirmed when clerking prior to theatre. Initial plan was extraction of upper 4/4 and lower 5/5 + surgical removal of supernumerary tooth. While on the waiting list for theatre, patient saw a community dentist for restoration of UL6 under	Kate Holian, General Manager Surgical Division, Dr Madhavi Seshu, Consultant Orthodontist	RCA report in quality check stage.	Yes	Yes – including Duty of Candour letter.

			sedation. Her community dentist thought her UL6 had poor prognosis and queried with the orthodontist whether the UL6 was one of the teeth to be removed as a part of the orthodontic treatment plan before finishing final restoration. The Orthodontist then reviewed the treatment plan and sent a letter to the Trust requesting this change (to remove heavily restored UL6 instead of sound UL4). An outpatient appointment was booked in September after this letter was received by the Trust however the patient was listed and scheduled for theatre in July. After the theatre procedure was finished and the patient was in recovery, it was incidentally noticed that there were further letters from the orthodontist requesting the change in the treatment plan. The letters requesting a change to the original management plan were				

			sent after the patient was first seen for consultation and were not utilised as part of the preoperative planning leading to incorrect tooth extraction.				

Table 3 Moderate harm incidents:

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

Table 4 Closed SIRIs:

Reference Number	Date investigation started	Division	Incident Description	Lead Investigator	Progress	60 working day compliance	Duty of Candour applied
StEIS 2018/15654	25/06/2018	Surgery	The patient with an antenatal diagnosis of Hypoplastic Left Heart Syndrome (HLHS), Mitral Atresia, Ventricular Septal Defect and Hypoplastic Arch with Coarctation, born at 40 weeks of gestation in Burnley; was transferred to Ward 1C on day one of life.	Ian Street, ENT Consultant Surgeon and Jan Taylor, Sister.	Final report sent to CCG and family.	Yes	Yes

			The patient was transferred to theatre on the 15/06/2018 for a Norwood-Sano procedure and had an uneventful post-procedure recovery in the Paediatric Intensive Care Unit (PICU). The patient transferred from PICU to Ward 1C on 20/6/2018 at 19.00, 5 days post op Norwood-Sano procedure. The patient was clerked in by the SHO at 21.30 to do bloods, stop the Milrinone and take the Central Venous Line (CVL) out (due to the swollen leg). During the evening patient started to deteriorate (Paediatric Early Warning - PEW score 7 at 1.00 am) and the patient was reviewed at 1.30am by the cardiac registrar and an appropriate clinical plan was initiated; the patient made small improvements and the PEW score improved from 7 to 6. At 5.00am, the patient began to deteriorate again (PEW 7) and by 7.00am the PEW was recorded as 9. The SHO was bleeped – the SHO spoke with the registrar; clinical plan					

			outlined. The cardiac registrar reviewed the patient at 8.30am. The patient's temperature spiked and advice was taken from the Infectious Diseases (ID) Consultant by the ST2 doctor on the ward round. The patient then had a full septic screen, including a lumbar puncture (LP). Shortly following the LP, the patient became apnoeic and lost cardiac output. An arrest call was made at 9.58am. The patient was intubated on the ward and transferred to PICU; the patient was in Pulseless Electrical Activity (PEA) on arrival to PICU and put on Extracorporeal Membrane Oxygenation (ECMO).				

END

Alder Hey Children's NHS
NHS Foundation Trust

Report of	Chief Nurse
Paper prepared by	Head of Quality – Corporate Services Trust Complaints and PALS Lead
Subject/Title	Quarter 2 2018 – 2019 Complaints & PALS report
Background papers	n/a
Purpose of Paper	To receive the Current Complaints Performance report and update regarding previous concerns.
Action/Decision required	The Group are asked to note the report.
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Deliver **Clinical Excellence** in all of our services
Resource Impact	None

Quarter 2:- July 2018 – September 2018

Complaints summary

The Trust received 38 formal complaints during this period. Two complaints from this quarter was subsequently withdrawn from the process , one was an error in the administrative process and should not have been logged and the second had been received from a Clinical Commissioning Group as a formal complaint however when we engaged with Mum we were able to resolve the issues immediately and the complaint was withdrawn at Mums request.

In 2017/18 Q2 the Trust received 12 formal complaints – this is therefore a significant increase of 26 additional complaints received in Q2 2018-19.

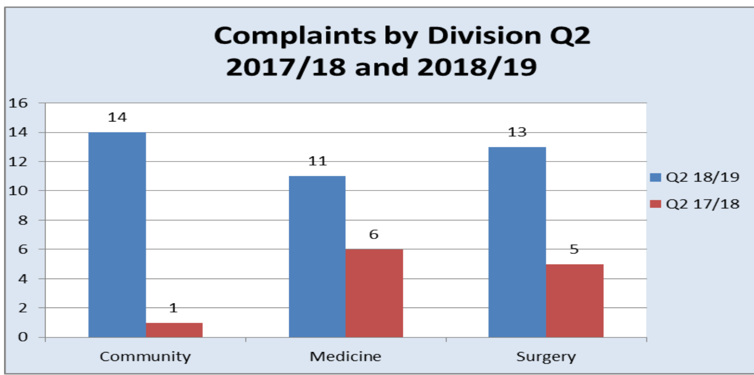
The main category of complaints received in this quarter are:-
Access, Admission, Transfer, Discharge - 4 (13%)
Consent, Communication, Confidentiality - 3 (10%)
Medication – 1 (3%)
Staffing issues – 1 (3%)
Treatment/Procedure – 27 (71%)

This quarter looking into the main category in more detail, there has been a shift back to the main concern relating to medical care. There are also unusually three that relate to attitude of staff.

Alleged Failure In Medical Care	18
Alleged Failure In Nursing Care	1
Attitude Of Staff - Medical	2
Attitude Of Staff - Nursing	1
Communication Failure - Medical	5
Communication Failure - Nursing	1
Communictaion Failure - AHP	1
Diagnosis Incorrect	1
Diagnosis Not Made/failure	1
Medication Incorrectly Administration	1
Operation Cancelled	1
Operation Delayed	1
Tests Results Not Available	1
Waiting Time For Appointment	3

Complaints by Division in Quarter 2

The following graph demonstrates the amount of complaints received within each Division during Quarter 2 2018 – 19 and includes a comparison from the same time period in 2017/18.



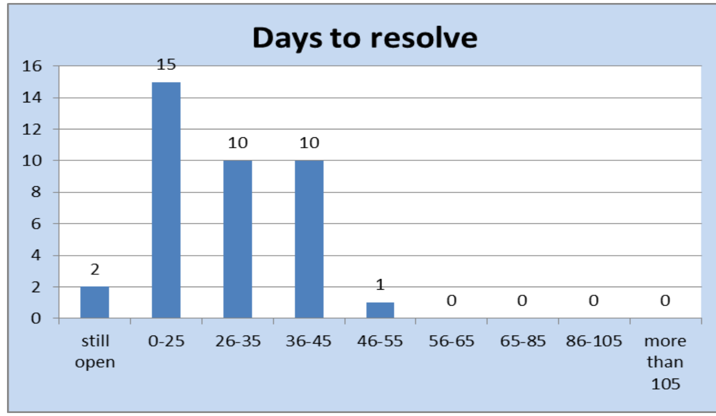
Report against three day acknowledgement

The Trust has three working days to formally acknowledge a complaint; this can be in an email or by phone. The Trust has a generic formal complaint acknowledgement letter that is sent out to the complainant; this includes a named contact for the complainant to contact should they require to do so (including the direct phone number) and the date the response is expected to be with them. The letter also includes information relating to the services offered by Healthwwatch Advocacy.

In Q2 all complaints were acknowledged within 2 days - 16% on the same day, all within target time. Despite the rise in complaints received this year, all complaints have met the acknowledgement target of three working days.

The Trusts internal timeframe for responding to complaints is 25 working days, however if the complaint is complex and multi organisational we can discuss this with the complainant and negotiate an extended timeframe with them and agree a new date for response.

The graph below now shows the timeframes the Trust has responded to a formal complaint within Q2 .



Withdrawn complaints –
Two complaints were withdrawn this quarter.

One complaint was incorrectly re logged as a formal complaint when Mum contacted us to advise she hadn't received any contact from her first complaint. The explanation for this was that the letter posted out to Mum had not been received via Royal mail therefore a copy was reposted and the duplicated logged complaint was withdrawn from the system.

Second withdrawn complaint came in to us initially via St Helens CCG , when the Service Manager and Consultants liaised with Mum they were able to offer support to Mum who was then very satisfied and the complaint was withdrawn at Mums request.

Complaint outcome

19 complaints where upheld within this quarter and 11 where not upheld. 4 complaints partially upheld and 2 complaints are still ongoing

There are 2 second stage complaints and already have outcomes from the first stage.
All complainants are fully up dated regarding any delays in response timeframes.

Referrals to Parliamentary & Health Service Ombudsman

One contact from the PHSO this quarter – this case is not progressing as the Ombudsman where informed Alder Hey had never received a complaint from this family as they had been instructed.

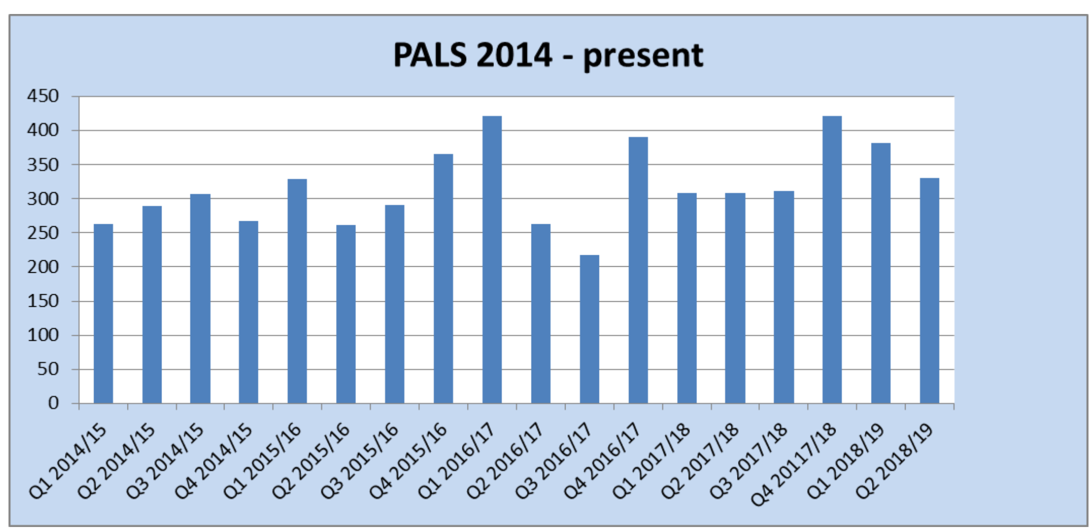
One case from quarter 1 we currently have not received any update from the PHSO regarding this and are still awaiting to hear their decision whether to investigate or not.

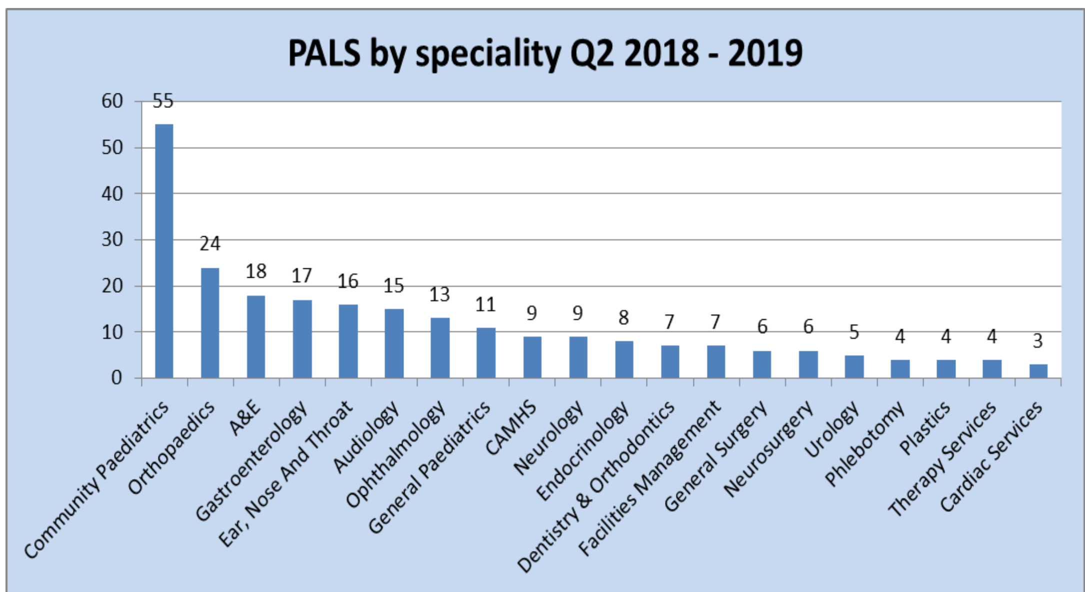
PALS summary

In Q2 2018 -2019 PALS contacts received total 330, in comparison to the same quarter in 2017/18 this is a very slight increase of 22 .

PALS concern are received in a variety of methods, phone call, email, written and face: face. Phone calls and face: face account for 66% of the contacts whilst the written concerns account for 33%

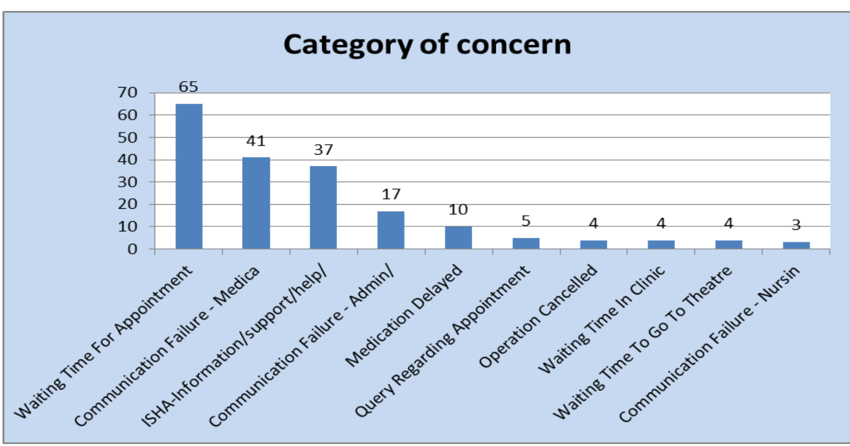
Fig 3- PALS contacts from 2014/15 – Q2 2018/19
The table shows a slight downward trend of contacts into the PALS team in the last 2 quarters.





The table above clearly demonstrates the amount of PALS contacts received by specialities - Community Paediatrics remains the highest area but this is the third quarter in succession they have reduced their total number of contacts. This quarter also sees Gastroenterology drop to fourth highest in the table above.

The table below shows the categories in more details – the highest area of concern relates to waiting time for appointments, with communication failure (medical) being the second highest.



Key actions & lessons learnt from PALS during Quarter 2

The main issues identified within Q2 relates to appointments management –waiting times.

The specialities that have issues relating to these categories are:-

Waiting time for apt
Community Paeds
Audiology
ENT
Ophthalmology
Othopaedics

This is the third consecutive quarter that we have seen a continued reduction in concerns raised about cancellations of appointments –
Q4– 45
Q1- 24
Q2–15

The Community Division now have a plan to understand the history of their PALS increases and have recently held a meeting including the Service Manager, Head of Quality, Associate Chief Nurse and PALS & Complaints officer to discus and agree a way forward that will ensure the Division understands the theme of the concerns being received and has in place a strategy to deal with the concerns compassionately and effectively.
Actions include:

- Scrutiny of Community PALS to assist in developing scenarios to share as examples with staff in training sessions and how these where managed by teams within the Division.
- Explore options for Customer Service Training
- Discuss with Corporate team options for levels of PALS concerns in Ulysses
- Explore options for PALS to support families who are raising concerns with links to voluntary organisations, support groups etc.
- To be able to provide on the spot information for families making contact and not to require to seek support from the Management team by having appropriate system access and an understanding of booking processes

PALS and complaints are communicated and fed back to senior staff at the three Divisional Integrated Governance meetings to ensure appreciation of current trends are fully disseminated and actions can be taken to look at specific areas of concern.

Compliments

Compliments are now recorded on the Ulysses system and shared with the relevant teams.

Three compliments have been recorded this quarter on Ulysses: - see below, these have all been shared with the relevant teams and staff

Mum called into PALS office
Would like to compliment the chef Tommy on Ward 4C
Mum and patient have been very pleased with the food and service provided.
Mum said the food has been restaurant quality
Mum says all of her son's care on 4C has been good.

The Grandparents of Melissa have requested that we pass on their thanks to all staff who have helped and contributed in Melissa's care.
Melissa who is thirteen was admitted to ICU/Ward 1B after having a heart attack and is on the road to recovery and they cannot thank the staff enough. They state everyone has been wonderful and they really appreciate everything that has been done for her.

I am writing this in relation to a recent visit to Alder Hey with my nephew.
My nephew has multiple disabilities his name Reuben age 5.
I attended ED with his mum on 6th July 2017.
We were so impressed with the advanced nurse practitioner Katie Barnes.
She was rushed off her feet but still managed to be amazingly kind and empathetic.
She is a credit to your Hospital and the nursing profession. We want to thank her for her compassion and friendliness and inform her that her hard work is much appreciated.

We also had an outpatient appointment on the 17th July 2017 with urology nurse specialist Sarah Doyle.
Sarah was so inviting and kind. She was an expert in her field and really did treat us with an empathetic concerning manner.
She is a devoted professional who really made a difference. She again is a credit to the nursing profession and we thank her very much for her expert consultation.

Staff support

Within Quarter 2, the PALS team have valued the opportunity to be included in the staff debrief session's arrangement after the incident experienced in the Trust earlier in the year. These sessions have taken place away from the office and provided a safe environment to discuss any issue relating to cases and how they have been dealt with them. The PALS staff have found these session very helpful and the team have agreed to continue with them as a mechanism for ongoing support.

A Hyson
Head of Quality - Corporate Services
& Trust Complaints and PALS Lead.

Alder Hey Children's NHS
NHS Foundation Trust

IPC REPORT
Q2 2018-19
(1st April 2018 – 30th September 2018)

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

The work plan for 2018-19 consists of 14 objectives and a total of 118 deliverables. To date ***72%*** (85/118) of the total of deliverables have been completed. ***21%*** (25/118) of the total deliverables are in progress (amber). ***0%*** are classified as red. 7% (8/118) are classified as grey as these are new objectives that have not yet been progressed. Please see table 2 below for RAG rating.

Reporting Period	No of objectives	No. of deliverables	Red	Amber	Green	Grey *New
Q1	14	118	0% (0)	25% (30)	59% (70)	16% (18)
Q2	14	118	0% (0)	21% (25)	72% (85)	7% (8)

Table 1: Deliverables RAG rating

Tables 2 and 3 below shows the total number of hospital acquired bacteraemia each quarter for 2018-19 compared to 2017-18. Table 4 shows the cumulative total for Q1/Q2 2017-18 compared to 2018-19.

Bacteraemia	Q1 17-18	Q1 18-19
MRSA	0	⟷ 0
MSSA	3	↓ 1
E.coli	1	⟷ 1
Klebsiella	1	⟷ 1
Pseudomonas	0	↑ 1
Cdiff	0	⟷ 0
Outbreaks	0	⟷ 0

Table 2: Hospital acquired bacteraemia Q1 2017-18 and 2018-19

Bacteraemia	Q2 17-18	Q2 18-19
MRSA	0	⟷ 0
MSSA	4	↓ 1
E.coli	1	↑ 2
Klebsiella	0	↑ 1
Pseudomonas	1	↓ 0
Cdiff	0	⟷ 0
Outbreaks	0	⟷ 0

Table 3: Hospital acquired bacteraemia Q2 2017-18 and 2018-19

Bacteraemia	Cumulative 17-18	Cumulative 18-19
MRSA	0	⟷ 0
MSSA	7	↓ 2
E.coli	2	↑ 3
Klebsiella	1	↑ 2
Pseudomonas	1	⟷ 1
Cdiff	0	⟷ 0
Outbreaks	0	⟷ 0

Table 4: Hospital acquired bacteraemia 2017-18 and 2018-19

For 2018-19 we have agreed target for each of the metrics set out below in table 5 for hospital acquired cases.

Metric	Target 2018-19
HA - MRSA (BSI)	*Zero Tolerance*
C.difficile	*Zero Tolerance*
MSSA	*25% Reduction from 17-18*
CLABSI (ICU Only)	*10% Reduction from 17-18*
Gram-Negative BSI	*10% Reduction from 17-18*

Table 5: 2018-19 Targets

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

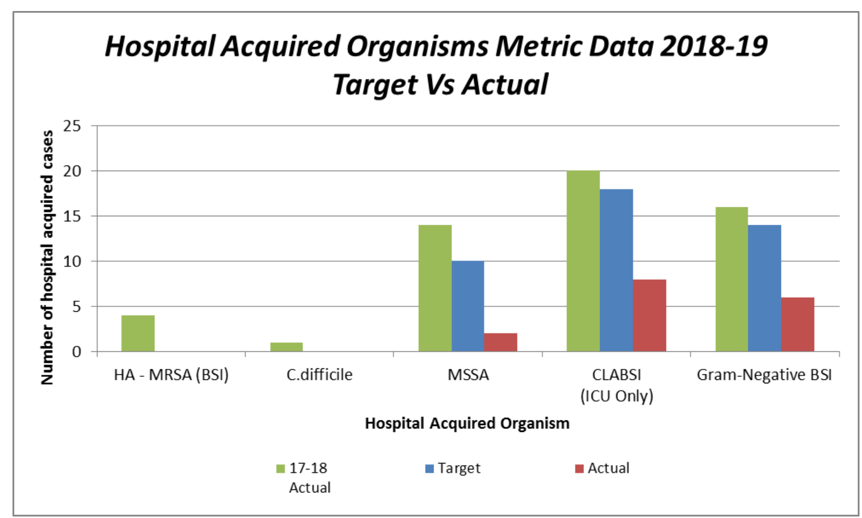


Table 6: Metric Data Actual VS Target.

Infection Prevention & Control Annual Work Plan 2018-2019

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

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

Infection Prevention & Control Annual Work Plan 2018/19

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

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

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

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

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

IPC Code & Trust Values	Plan & Priority Activities 2018-19	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
								Trust in Infection Control Week (15th October 2018). *Update: Due to Industry partner reorganisation plans have halted associate DIPC to seek alternative Industry Partner.*
			Present finding of the pilot study to the Trust, and at the Infection Prevention Society Conference – October 2018.					***Q1** – Awaiting commencement of pilot study.* ***Q2** – As above to be progressed once alternative industry partner has been found.*
			Write up study for publication.					***Q1** – Awaiting commencement of pilot study.* ***Q2** – As above to be progressed once alternative industry partner has been found.*
			If pilot successful – to introduce scheme across the Trust.					***Q1** – Awaiting commencement of pilot study.* ***Q2** – As above to be progressed once alternative industry partner has been found.*
	To scope and implement new and innovative hand hygiene signage across the Trust.	IPC Team	To explore the feasibility of introducing new and innovative hand hygiene signage across the Trust.					***Q1** – ADIPC to approach hand hygiene industry partner to scope feasibility of developing new signage.* *Q2 – Roll out of new hand hygiene products across the Trust now completed, including increased signage in public areas.*
	To explore new hand hygiene audits tools and technology incorporating the use of Protective Personal Equipment (PPE)	Hand Hygiene audit tools – IPC Team	IPC team to source, trial and decide on new hand hygiene tool.					***Q1** – IPC to discuss new hand hygiene alternatives. IPC hand hygiene summit to be organised.* ***Q2** – Industry partner in process of setting up system to fit Trust requirements. Training sessions organised for users in Sept and Oct 2018 with launch to follow.*
		New Technology – IPC Team and data analyst (CQ)	IPC team and CQ – to investigate how new tool can be recoded and results disseminated across the Trust.					***Q1** – IPC to discuss new hand hygiene alternatives. IPC hand hygiene summit to be organised.* *Q2 – Summit has taken place. Industry partner in process of setting up system to fit Trust requirements. Training sessions organised for users in Sept and Oct 2018*

IPC Code & Trust Values	Plan & Priority Activities 2018-19	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
								with launch to follow.
	To ensure that the non-compliance with hand hygiene proforma is utilised throughout the Trust.	DIPC, Associate DIPC and IPC Team	IPC team to scope how non-compliance can be reported across the Trust.					***Q1** – IPC to discuss new hand hygiene alternatives. IPC hand hygiene summit to be organised.* ***Q2** – Discussions have taken place to scope out new non-compliance proforma. To be trialled on a medical ward.*
			IPC team to communicate the process via the Link Nurse/Representatives and the governance structures					***Q1** – IPC to discuss new hand hygiene alternatives. IPC hand hygiene summit to be organised.* ***Q2** – To be progressed following proforma. Lead IPC Nurse to liaise with identified link nurses in the medical division.*
	Introduction of new hand hygiene audit technology as part of monthly audit indicators	Lead Infection Prevention & Control Nurse, IPC Team& link nurses	Dissemination of new hand hygiene audit technology to link personnel through meetings and training					***Q1** – To be scheduled into Link Nurse Programme.* ***Q2** – Summit has taken place. Industry partner in process of setting up system to fit Trust requirements. Training sessions organised for users in Sept and Oct 2018 with launch to follow.* *Update: Now completed.*
	To ensure that hand hygiene technique assessments are recorded as a mandatory field on an annual basis for all clinical staff and reflected in ESR.	Associate DIPC and Learning and Development.	To explore the feasibility of putting hand hygiene compliance on the ESR system for all clinical staff on an annual basis.					***Q1** – Meeting arranged with Head of Learning and Development 5th July 2018.* ***Q2** – Awaiting feedback from L&D. Reminder sent to L&D awaiting reply.*
			Once hand hygiene assessments are recorded on ESR. To develop a monitoring system across the Trust.					***Q1** – Awaiting meeting with L&D.* ***Q2** – Awaiting feedback from L&D. Reminder sent to L&D awaiting reply.*
			Include compliance in IPC Dashboards to provide assurance.					***Q1** – Awaiting meeting with L&D.* ***Q2** – Awaiting feedback from L&D. Reminder sent to L&D awaiting reply.*
4. Policies								
IPC code 1,2,3,4,5,6,7,8,9 & 10	Review and update IPC policies as required.	IPC Team	Monitored reviewed and updated as part of the IPCT meetings on a bi-weekly basis.					

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

IPC Code & Trust Values	Plan & Priority Activities 2018-19	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
	Provide and update Key Trainer training on an annual basis.	ANTT Specialist Nurse assisted by BBraun.	Key trainer training days are provided 6 times per year.					
	Liaise with St Helens and Knowsley Trust regarding standardising ANTT rotational staff assessments	Associate DIPC/SM	To develop a SOP to standardise ANTT assessments for rotational staff recognising from other Trusts within the last 12 months.					***Q1*** *– SOP discussions have taken place to be progressed.* ***Q2*** *– Meetings have taken place across the North West with regard to standardising ANTT training. Permission has been granted by National ANTT authors to progress standardisation across the whole of the North West.*
	Plan to expand this process to cover other Trusts in the North West	Associate DIPC/SM	To progress the work started with Whiston to other Trusts in the region through the North West IV Forum.					***Q1*** *– ADIPC progressing this work through NW IV Forum group.* ***Q2*** *– Meetings have taken place across the North West with regard to standardising ANTT training. Permission has been granted by National ANTT authors to progress standardisation across the whole of the North West.*
	Liaise with ANTT experts to review and refine existing processes.	Associate DIPC/SM	Attend annual ANTT conference and to attend North West IV Forum meetings.					***Q1*** *– ANTT Lead to attend conference in November 2018.* ***Q2*** *– ANTT place booked on Conference. New ANTT lead Nurse to attend conference on 2nd Nov 2018.*
6. Vascular Access								
IPC Code: **Trust Values:**	Improving patient flow for vascular access.	Lead Nurse IV	Initiation of GDE project – the use of digital technology to implement evidence based practice to improve patient care delivery.					***Q1*** *– GDE work complete and will be launched at the beginning of September 2018.* ***Q2*** *– GDE work now live.*
			Implementation of IV access team assessment from receipt of Meditech referral					***Q1*** *– GDE work complete and will be launched at the beginning of September 2018.* ***Q2*** *– GDE work now live.*
	Implementation of vessel health and preservation.	Lead Nurse IV	Initiation of GDE project incorporating VHP decision tool.					***Q1*** *– GDE work complete and will be launched at the beginning of September 2018.*

IPC Code & Trust Values	Plan & Priority Activities 2018-19	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
								Q2 *– GDE work now live.*
	Improve workload awareness in vascular access team.	Lead Nurse IV ANS IV	Introduction of daily workload planner.					
	Widen accessibility of teaching and training for MDT	IV Team and Learning and Development	Introduction of ward based workshop/training updates to keep staff educated in the best evidence based vascular access practice.					***Q1*** *– Dates to be scheduled workshop content completed.* ***Q2****- Completed*
			Training drop in sessions in clinical skills room accessible to MDT.					***Q1*** *– To be reviewed following workshop implementation.* ***Q2*** *– Drop in sessions commenced but did not work. Therefore piloting targeted training sessions organised through PDNs.*
			Records to kept by IV team and sent to L&D for recording on ESR.					***Q1*** *– Attendance records kept by IV Team for all training. Meeting to be scheduled with ESR Lead to discuss process.* ***Q2*** *– Awaiting meeting with L&D.*
	Review of Sharps safety and vascular access	IV Team ADIPC	Review of butterfly needles and clinical trials.					***Q1*** *– This will be reviewed following the cannula review. IV Team have started to obtain butterfly needles for review.* ***Q2*** *– Reviewed. Awaiting decision and feedback from IV Forum for trial. Table top review session organised for safety products in December 2018.*
			Review of cannula and clinical trials.					***Q1*** *– Review underway. Workshop taking place July 2018 to discuss. Plan to take to table top exercise open to the Trust for evaluation.* ***Q2*** *– Reviewed. Awaiting decision and feedback from IV Forum for trial. Table top review session organised for safety products in December 2018.*
			Revisit innovative sharps disposal					***Q1*** *– Delay due to workload of IV Team and IPC Team. Meeting to be scheduled with company.* ***Q2*** *– Discussed at Sharps Safety Group. Product not suitable for entire Trust. A ore targeted trial introduction to be*

IPC Code & Trust Values	Plan & Priority Activities 2018-19	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
								progressed.
			Exploration of possible introduction of pre filled saline syringes.					***Q1*** *– These are being trialled July 2018 in A&E, Radiology and Community.*
	Review of vascular access dressings.	IV Team	Explore dressing options					***Q1*** *– New 3M peripheral vascular access dressings being implemented across the Trust July 2018 with exception of Theatres.*
			Undertake clinical trial					
			Implementation of new dressing for peripheral vascular access.					***Q1*** *– New 3M peripheral vascular access dressings being implemented across the Trust July 2018 with exception of Theatres.* ***Q2*** *– Completed except for Theatres.*
7. Training								
IPC Code: 1,2,3,4,5,6,7,8,9 & 10 **Trust Values:** Excellence Openness Respect Together Innovation	To ensure that IPC staff are kept updated with IPC evidence based practice.	Lead IPC Nurse	To ensure that a member IPC Team attends the North West Infection Prevention Society (IPS) meetings at least once per year.					***Q1*** *– Dates to be arranged.* ***Q2*** *– Unable to attend September meeting due to Geography (Cumbria). ADIPC and Specialist IPC Nurse attended IPS Conference October 2018.*
		Associate DIPC	To regularly attend local HCAI whole health economy meetings.					
		Associate DIPC/Lead IPC Nurse	To attend local and national IPC/relevant conferences as the service will allow					
		Lead IPC Nurse	To attend Vaccinator training or undertake on line update					***Q1*** *– Lead IPC booked onto training.*
	To ensure that Trust staff are kept updated with IPC evidence based practice: Please see plan below.							
	Induction	Lead Nurse IPC/CO	At least once per month					

IPC Code & Trust Values	Plan & Priority Activities 2018-19	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
	Mandatory	IPC Team	For all clinical staff yearly (monthly sessions) & work book.					
			To develop a new E-Learning package to replace monthly sessions and workbook for clinical staff.					***Q1*** *– IPC Team to be training in setting up e-learning packages.* ***Q2*** *– Team meetings have commenced to progress.* *Update: New innovative E-Learning package has been developed by an Industry partner. Alder Hey have been asked to be one of the first to trial specific e-learning packages for staff.*
			Non-clinical 3 yearly – work book					
			To develop a new E- Learning package to replace the work book. Following the same principles developed from the Clinical E-Learning package.					***Q1*** *– To be progressed once clinical staff package is developed.* *Update: New innovative E-Learning package has been developed by an Industry partner. Alder Hey have been asked to be one of the first to trial specific e-learning packages for staff.*
	ANTT Key Trainers	SM	Bimonthly					
	Volunteer IPC Training	CO/VL	Quarterly					
	Hotels Services IPC training	VL	At least once per quarter					
	Link Personnel	IPCT	Monthly					
	Fit Testing Key Trainers	CO	Updated Annually – records of staff training reported through IPC Dashboards					***Q1*** *– Training sessions continue. However update from wards and departments remains sporadic.* ***Q2*** *– Fit testing compliance now forms part of the monthly dashboard.*
	Flu vaccinator Training	Lead Nurse IPC	Annual (4 sessions per year)					***Q1*** *– Training sessions arranged prior to flu season.* ***Q2*** *– Completed*
	Ad hoc training	IPCT	As required					
8. Audit								
IPC Code:	To provide assurance to	Lead IPC Nurse/	All findings are communicated to the					

IPC Code & Trust Values	Plan & Priority Activities 2018-19	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
1,2,3,4,5,6,7,8 & 9 **Trust Values:** Excellence Openness Respect Together Innovation	the board and relevant committees of adherence to high quality IPC practices.	IPC Specialist Nurse/IPC clinical assistant follow the audit plan The Audit programme is revised on a yearly basis. Further audits are undertaken by the IPC Team as set out in the work plan and as the service requires.	relevant clinical staff and reported via the IPC dashboards and discussed at divisional governance meetings and the IPCC. All lessons learnt are disseminated to the relevant staff and other agencies as Appropriate in a timely manner.					
9. Antimicrobial Prescribing								
	Antimicrobial Stewardship (AMS) ward rounds	Antimicrobial Pharmacist	AMS ward rounds (x3/week)					
	AMS Committee meetings		AMS Committee (meet at least quarterly)					
	Introduction of AMS training to all clinical staff in the Trust.	Antimicrobial Pharmacist (AT) Sepsis Nurse Specialist – James Ashton (JA)	AMS training to be introduced across the Trust – currently delivered to junior doctors on induction but not to nurses. To introduce AMS training into					***Q1*** *– Initial discussions have taken place with Learning and Development.* ***Q2*** *– Induction programme agenda discussed and to be progressed.*

IPC Code & Trust Values	Plan & Priority Activities 2018-19	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
		OPAT Nurse Specialist – Ruth Cantwell (RC).	induction training.					
			To introduce AMS training into mandatory training					***Q1*** *– Initial discussions have taken place with Learning and Development.* ***Q2*** *– Awaiting feedback from L&D*
10.Communication								
IPC Code: 1,2,3,4,5,6,7,8,9 & 10 **Trust Values:** Excellence Openness Respect Together Innovation	IPC bi-monthly report	Lead Nurse IPC	IPC bi-monthly report reported through the IPCC.					
	IPC Dashboard	IPC Data Analyst	Monthly dashboard distributed Trust wide reported through Divisional Governance meetings and IPCC.					
	Communication with the Whole Health Economy	ADIPC	To attend HCAI/IPC meetings across the local area.					
	Communication with other Trusts and agencies such as Public Health England (PHE) and NHS England	IPCT	To attend local meetings. Communication and information gathering with other Trusts and agencies to assist in IPC investigations.					
	To keep Infection Prevention and Control Intranet page up to date with relevant information	IPC Administrator	Ensure that the IPC intranet pages are kept up to date on a monthly basis or as necessary.					
	To ensure that Paediatric Infection Prevention and Control remains high on the agenda at a national	Associate DIPC	Associate DIPC to communicate specific paediatric needs to Infection Prevention Society (IPS) through representation on the IPS Board.					

IPC Code & Trust Values	Plan & Priority Activities 2018-19	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
	level.							
	Communication with other Paediatric Trusts and other hospitals/healthcare facilities caring for paediatric patients. Scoping Paper for the Paediatric Special	Associate DIPC/CO	Commencement of the national IPS Paediatric Forum to share best evidence based practice, benchmarking and innovative projects. To include meetings face to face and virtual and a national annual conference.					
11. Information Technology								
IPC Code: 1,2,3,4,5,6,7,8,9 & 10	To continue to enhance the use of Meditech to assist the IPC team in monitoring HCAI	IPC Team, IT team and Pathology IT Manager.	Set up regular meetings to explore how the Meditech system can assist IPC.					***Q1** – Ad hoc meetings have taken place. Diary of regular meetings to be developed.* ***Q2** – Meetings convened and ongoing.*
Trust Values: Excellence Openness Innovation Together	To develop opportunities to enhance epidemiological surveillance systems and monitoring opportunities within the Trust	Consultant Infectious Diseases/ADIPC/ Data Analyst	To instigate a working group to explore possibilities to enhance the surveillance systems and reporting across the Trust.					***Q1** – ADIPC to organise initial meeting.* ***Q2** – Awaiting arrival of IPC Doctor. Update: Meeting organised for 29th Oct to progress.*
			To develop a business case to develop the enhanced surveillance system agreed.					***Q1** – To be progressed through working group.* ***Q2** – To be progressed through working group.*
12. Interface with relevant groups								
IPC Code: 1,2,3,4,5,6,7,8,9	IPC to attend and provide expert opinion							

IPC Code & Trust Values	Plan & Priority Activities 2018-19	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
& 10	for topics related to IPC.							
Trust Values: Excellence Openness	Escalate issues to DIPC as necessary.	Associate DIPC	Regular meetings with DIPC					***Q1*** *– IPC review equipment as requested. However IPC not always involved in the process.* ***Q2*** *– ADIPC to highlight process through Divisional meetings.*
Respect Together Innovation	To review new equipment /environmental utilisation	IPCT	Ad hoc meetings as required.					
	Decontamination	Lead Nurse IPC Associate DIPC to attend as required.	To attend scheduled meetings. To provide expert advice and support as required.					
	Water Safety	Associate DIPC	To attend scheduled meetings. To provide expert advice and support as required.					
	Health & Safety/IPC/Interserve & Building services	Associate DIPC/Lead Nurse IPC	To attend scheduled meetings. To provide expert advice and support as required.					
	Hotel services	Lead Nurse IPC Associate DIPC to attend when required.	To attend scheduled meetings. To provide expert advice and support as required.					
	Ward managers/matrons	Lead Nurse IPC Associate DIPC or IPCT to attend when required.	To attend scheduled meetings. To provide expert advice and support as required.					

IPC Code & Trust Values	Plan & Priority Activities 2018-19	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
	Health and Safety	Lead Nurse IPC	To attend scheduled meetings. To provide expert advice and support as required.					
	Integrated Governance Committee	DIPC/Associate DIPC/ Lead Nurse IPC	To attend scheduled meetings. To provide expert advice and support as required.					
	Medical Devices Committee	DIPC/ CO	To attend scheduled meetings. To provide expert advice and support as required.					
	Trust Quality meetings • ***CQAC*** • ***CQSG*** • ***CQPG***	Associate DIPC Lead Nurse IPC to deputise. IPCT to attend ad hoc for training purposes.	To attend scheduled meetings. To provide expert advice and support as required.					
	Theatre Safety Board	LM/CO	To attend scheduled meetings. To provide expert advice and support as required.					
		Associate DIPC/ LM/CO	To assist in the introduction of the OneTogether programme.					***Q1*** *– OneTogether programme instigated and progressing.* ***Q2*** *– IPC Lead for Theatre to progress and feedback to Surgical Division Board.*
	Trust Board	DIPC/ Associate DIPC	To attend scheduled meetings. To provide expert advice and support as required.					
13. Gram Negative Bacteraemia								

IPC Code & Trust Values	Plan & Priority Activities 2018-19	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
IPC Code: 1,3,4,5,6,7,8 & 9 **Trust Values:** Excellence Innovation Respect Together Openness	Adherence with regards to Gram Negative Blood Stream Infections (GNBSIs) targets	DIPC/ Associate DIPC	To attend whole health economy meetings to develop robust action plans to tackle gram negative bacteraemia reduction targets.					
		IPC Data Analyst	Ecoli, Klebsella spp, Pseudomonas aeruginosa bacteraemia data to be recorded on the MESS system.					
		DIPC/ Associate DIPC	PIR reviews to be commenced for all named gram negative bacteraemia.					
		Associate DIPC/IPC Data Analyst	Trust wide situation reports to be developed to share lessons learnt.					***Q1**-Situation reports for 2017-18 completed and to be disseminated. Monthly sit reps to be shared going forward.* ***Q2** - Completed*
		Associate DIPC	PIR reviews to be shared across the whole health economy and NHSI.					***Q1**-Situation reports for 2017-18 completed and to be disseminated. Monthly sit reps to be shared going forward.* ***Q2** - Completed*
14. Community								
IPC Code 1, 2, 3, 4, 5, 6, 8, 9. 10 **Trust Values** Respect Excellence Innovation Together	To ensure that a high quality Infection Prevention Service (IPC, Tissue Viability and IV services) is delivered to Community Services	Sarah Stephenson (SS) – Quality Lead for Community, Associate DIPC, Lisa Cooper (LC) Director of Children & Young People Community &	To scope out the provision and requirements for Infection Prevention Services for Community Services. To include an audit programme, specific training – mandatory and ad hoc, advisory services and Link personnel updates and requirements. To include what is achievable able with the existing team resources.					***Q1**-Work has begun to scope out requirements for community.* ***Q2** – Meetings have commenced. Areas for immediate consideration addressed. Training to commence once personnel is organised.*
			Impact assessment on the existing					***Q1** - To be progressed once scoping exercise is completed.*

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

Trust Wide Infection Prevention and Control Action Plans

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

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

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

Alder Hey Children's NHS
NHS Foundation Trust

Clinical Quality Assurance Committee
Minutes of the last meeting held on Wednesday 17th October 2018
10.00 am, Large Lecture Theatre, Institute in the Park

Present:	Anita Marsland	(Chair) Non-Executive Director
	Hilda Gwilliams	Chief Nurse
	Dame Jo Williams	Non-Executive Director
	Jeannie France-Hayhurst	Non-Executive Director
	Lisa Cooper	Director of Children & Young People Community & Mental Health
	Tony Rigby	Deputy Director of Risk & Governance
	Erica Saunders	Director of Corporate Affairs
	Adrian Hughes	Director, Medicine Division
	Christian Duncan	Director, Surgical Division
	Matthew Peak	Director of Research
	Denise Boyle	Associate Chief Nurse, Surgery
	Pauline Brown	Director of Nursing
	Louise Shepherd	Chief Executive
	Cathy Umbers	Associate Director of Nursing and Governance
	Stefan Verstraelen	Head of Quality – Surgery
	John Grinnell	Deputy Chief Executive/Director of Finance
	Joe Gibson	Programme Assurance Director
	Mags Barnaby	Interim Director of Strategy
	Melissa Swindell	Director of HR & OD
	Jo Minford	Co-Director of Transformation

In Attendance:

	David Porter	Consultant
	James Ashton	Sepsis Nurse Specialist
	Glenna Smith	General Manager – Medicine
	Jennifer Vose	Service Manager
	Karen Kay	Head of Complex Care
	Elvina White	Care Pathways, Policies and Guidance Manager
	Jacqui Rogers	Transition Service Lead Nurse
	Karen Critchley	Executive Assistant (Minutes)

18/19/079 Apologies:

	Cathy Wardell	Associate Chief Nurse, Medicine
	Lachlan Stark	Head of Planning & Performance
	Jo McPartland	Consultant Paediatric Pathologist
	Mark Flannagan	Director of Communications and Marketing
	Sarah Stephenson	Head of Quality – Community
	Phil O'Connor	Deputy Director of Nursing

18/19/80 Declaration of Interest
None declared

18/19/81 Minutes of the previous meeting held on 18th July 2018

Resolved:
CQAC approved the minutes of the previous meeting held on 19th September 2018.

18/19/82 Matters Arising and Action Log

Action Log

18/19/72 – DIPC Report – Flu Lead – HG confirmed that SR had made contact with the flu lead. It was noted that an additional member of nursing staff had been identified to support delivery of the vaccination programme. **Issue closed.**

18/19/76 – CQSG Key Issue – Nutritional Steering Group Assurance Report – It was noted that Lisa Cooper, Divisional Director – Community Services, had agreed to support CQSG in providing assurance around standards of nutrition.

It was reported that there had been no medical representation at the last CQSG meeting. KC agreed to raise this with AH and CD. Once Medical Director representation had been confirmed, HG would discuss Clinical Director attendance.

JW briefed CQAC following a recent Quality visit to Waterloo. She said this had been a positive experience. However, a lead for infection control in the community had not been identified. HG said that SR had been looking into this issue and agreed to obtain an update from AH/CD. Similarly, HG and LC would discuss nursing input into corporate areas.

Matters Arising

Resus Update – PB said that all wards had now achieved RCN standards and above in relation to APLS training. 90% of front line staff had been trained and there would now be a focus on specialist nurses, senior nurses, etc. Divisional Directors were urged to encourage staff to participate in training. A report would be submitted to the next meeting of RABD. It was anticipated that the time frame for training set out in the CQC action plan would be achieved.

Wi-Fi Update – JG confirmed that a community roll-out plan was now in place. LC said that community connectivity was being addressed. It was agreed that an update would be provided to the next meeting.

18/19/83 Inspiring Quality – A Plan for Delivery in 2019-2021

JM and TR briefed CQAC on the progress to date and future plans relating to Inspiring Quality - the aims being:

- To put children first;
- To have no preventable harms or deaths;
- To achieve outstanding outcomes for children.

In order to achieve the aims, four key changes had been identified:

- To do everything with children and families
- Communicate safely
- Use real-time data to improve outcomes
- Build continuous quality improvement

Priority outcomes for the three aims had been agreed.

JM said it was important that the continuous quality improvement plan aligned with the Trust's strategy. In advance of the Board meeting, further thought would be given to the links with research and innovation. JW asked that the resource requirements be clearly set out in the iteration for Board consideration.

It was agreed that any comments/suggestions for inclusion in the final Plan be discussed with JM.

18/19/84 Stranded Children Update

KK gave an update on children and young people with medical complexity with a length of stay beyond 30 days. She was pleased to report an improved position which had resulted from the additional resource, scrutiny and support put in place. Whilst a length of stay beyond 30 days had previously been addressed, children with a LOS of 21 days were now being looked at.

KK went on to set out two risks requiring attention/a decision:

- Parent/carer training provided via a Well Child Nurse due to end in June 2019. HG said that a business case was being developed to address this issue.
- Allocation of a Social Worker from Liverpool City Council – though it was noted this had been escalated to the relevant director for resolution.

It was noted that KK was leaving the Trust and this was the last CQAC that she would attend. On behalf of the Committee, AM thanked her for the report and the support she had given to addressing these important issues. She wished KK well for the future.

It was agreed that CQAC would receive an update in January 2019.

18/19/85 Sepsis Update

DP & JA updated on progress. It was noted that there had not been any significant improvement in the time to administration of antibiotics over recent months. The various reasons for this were explained. Teams were focussing on achieving the 90% target for inpatients receiving antibiotics within 1 hour by September 2019. CQAC was concerned about this lengthy timeframe and it was agreed that HG would look at the resources required to bring this forward.

MIAA would be undertaking an audit around Sepsis processes. JG agreed to review the TOR.

Sepsis guidelines have been updated. Issues associated with the App not being available on Apple devices were being explored and JG agreed to pursue this.

It was noted that the implementation of standard documentation had now been delayed until end of November. Sepsis status would be included.

The status boards had not yet been introduced but this was being progressed.

Meditech training in place for both hospital and community staff. A quick reference escalation plan/guide was now in place.

Joe G said that the assurance framework was not currently aligned to the benefits/progress described today. In order to address this it was agreed that a member of the DMO team would join the monthly Sepsis meetings. Discussion ensued on how this key safety issue could be closely monitored and lessons learned. It was agreed that the Exec Comm Cell meeting could be used for this purpose. CU suggested that Ulysses could be utilised for 72 hour reviews and it was agreed to investigate this further outside of the meeting. AM agreed to discuss further with CD/AH how progress with Sepsis could be reported to CQAC going forward.

18/19/86 Programme Assurance Update

JG asked CQAC to note the update circulated with the agenda. There were no further items requiring CQAC focus at this time.

18/19/87 CQC Action Plan Update

CQAC noted the updated action plan circulated with the agenda prior to the meeting. ES assured the committee that actions were continuously being reviewed and completed. She was optimistic that all of the actions would be completed at the point of the CQC engagement meeting scheduled for December.

18/19/88 Patient Information Leaflet – Policy

EW reminded CQAC that the policy had been ratified in May. However, subsequent organisational changes had impacted and the policy had not been implemented. She described the new process to approve patient/corporate information leaflets at divisional level. Whilst leaflets are currently aimed at parents/carers, going forward there would be a focus on them being child and young person friendly.

It was also noted that attention was being given to providing leaflets in different languages.

CQAC ratified the Patient Information Leaflet Policy

18/19/89 Corporate Report - Metrics

HG provided an update by exception.

- Two Never Events – Noted that the NHS Serious Incident Framework and Never Event Framework had been followed to assure the standard of investigations and that lessons learned are implemented.
- Reducing Medication Errors – HG briefed CQAC on issues detected through the weekly safety meeting relating to wrong site administration and overdoses. A review group had been established to look closely at the issues and changes that can be made to prevent further incidents.
- Friends and Family Test – Positive responses recommending A&E have continued to increase. Feedback in OPD had raised issues around seating and communication of waiting times. Actions were being put in place to address them.
- Complaints – Whilst there had been a spike in complaints, there was not a common theme.
- PALS – Whilst there had been an upward trend in August, there had been a reduction in contacts from the same period last year.

18/19/90 Transition Update

JR presented an update. She confirmed that non-clinical transition preparation is being delivered for all patients with complex neuro-disabilities 14 years – 16 years. Steps were being taken to identify patients aged 17. JR reported that Alder Hey was currently treating 56 patients over the age of 17. In response to a request from NHSE, the suggested milestones for the CQUIN had been put forward for consideration. Transition had now been included in Meditech, though uptake had been slow.

JR was pleased to report on local and international conferences where the Trust had presented on the 10 steps transition pathway.

It was noted that all of the milestones for last year's CQUIN had been achieved.

HG raised concerns around stakeholder engagement in transition. JF described changes within the Team that would allow her to dedicate more time to this important aspect and to drive forward improvements in partnership.

The report was noted and it was agreed that updates would be presented to CQAC quarterly with the next report being in January 2019.

18/19/91 Board Assurance Framework

CQAC noted the Board Assurance Framework circulated with the agenda. ES said that there was one identified gap in controls/assurance around the linking of risks and regular assurance updates. ES was in the process of addressing this.

18/19/92 EoLC/Palliative Care – Action Plan

GS and JV updated CQAC on progress against the CQC action plan. JV said that the service aimed to provide care in the most appropriate place. She gave an overview of the team comprising 6 Specialist Care Nurses and 1 Consultant. Strong links had been forged with Claire House Hospice and the Consultant there. Next steps would be to review and benchmark the Trust against guidelines and then to develop/cost the model of care. GS said that whilst NICE guidelines

recommended 24/7 palliative care cover, that would not be possible with a single-handed consultant. AH said that discussions would be taken forward within the future models of care programme and that complex care needs to be seamless with Palliative Care. These challenges would be raised at the Board to Board meeting with Specialist Commissioners.

18/19/93 Clinical Quality Steering Group – Key Issues Report

DB presented the key issues report. None of the issues required CQAC action but were set out for information purposes.

Health Watch Summary Report – Whilst most of the comments therein were complimentary, some of the themes had been formulated into an action plan:

- Sofas – Not comfortable for parents when sleeping
- Noise levels on wards
- Range of food in Tree Tops
- Toy
- Parking

DB said that a report/action plan on these themes would be submitted to CQAC in November.

CQSG had received a presentation on NICE compliance. It was proposed that the compliance report be brought to CQAC quarterly.

CQSG had received a presentation on interpreting and translation services and the benefits of a device that had been trialled for this purpose. This had proved positive and it was a proposed that a patient story be presented to CQAC.

AM thanked DB for the report and said that she would be discussing alignment between CQSG and CQAC agenda items going forward.

18/19/94 Any Other Business

Review of the meeting – AM said that this would be a routine item on future agenda for this meeting

18/19/95 Date and Time of Next meeting -
10.00 am – Wednesday 21 November 2018, Large meeting room,
Institute in the Park.

INTEGRATED GOVERNANCE COMMITTEE
12th September 2018
Time: 10:00-12:00
Venue: Institute in the Park, Lecture Theatre 4

Present:

Mr S Igoe	Non-Executive Director **(Chair)**	(SI)
Mr J Grinnell	Director of Finance	(JG)
Mr S Ryan	Medical Director	(SR)
Mrs M Swindell	Director of HR & OD	(MS)
Mrs E Saunders	Director of Corporate Affairs	(ES)
Mrs P Brown	Director of Nursing	(PB)
Ms N Deakin	Change Programme Manager	(ND)
Ms H Thompson	IM&T GDE Project Manager	(HT)
Ms L Whitfield	Quality & Governance Support Surgery	(LW)
Mr D Houghton	Senior Project Manager	(DH)

In Attendance:

Mrs C Umbers	Assoc. Dir. Nursing & Governance	(CU)
Mr T Rigby	Deputy Dir. of Risk & Governance	(TR)
Mr G Dixon	Operational Lead (Building Services)	(GD)
Ms S Stephenson	Head of Quality (Community)	(SS)
Mrs C Barker	Chief Pharmacist	(CB)
Mr M Devereaux	Head of Facilities and Soft Services	(MD)
Ms J Noblett	Clinical Lead for EPRR	(JN)
Mrs R Douglas	Assoc. Chief Nurse Community	(RD)
Mrs A Kinsella	Health & Safety Manager	(AK)
Mr A McColl	Assoc. Chief of Operations (Surgery)	(AM)
Mrs J Hutfield	Compliance, Risk & Contracts Manager	(JH)
Mr A Hughes	Director of Medicine Division	(AH)
Mrs J Fitzpatrick	Information Governance Manager	(JF)
Mrs L Cooper	Research Governance & Quality Lead	(LC)
Ms L Fearnehough	Head of Technical Services	(LF)
Mrs V Weston	Assoc. Dir. of Infection Prevention & Con	(VW)

Apologies:

Mr D Powell	Development Director	(DP)
Mr A Bateman	Chief of Operations	(AB)
Mrs R Greer	Assoc. Chief of Operations (Community)	(RG)
Mrs L Robinson	Quality Assur & Compliance Manager	(LR)
Mrs E Menarry	EP and Business Continuity Manager	(EM)
Mr M Flannagan	Director of Communications	(MF)
Mr J Williams	Head of Estates and Capital Planning	(JW)
Mrs C Orton	Assoc. Chief Operating Officer (Research)	(CO)
Mrs J Ruddick	Head of Quality (Medicine)	(JR)
Mrs D Boyle	Assoc. Chief Nurse (Surgery)	(DB)
Mr S Verstraelen	Head of Quality (Surgery)	(SV)
Ms K Morgan	Deputy Head of Information	(KM)
Mrs H Gwilliams	Chief Nurse	(HG)
Mrs C Wardell	Assoc. Chief Nurse (Medicine)	(CW)
Mr W Weston	Assoc. Chief of Operations (Medicine)	(WW)
Mrs J Keward	Infection Control Nurse	(JK)
Mr A Williams	Director of CAMHS	(DW)

APPROVED

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			Housekeeping			
	1.	**Apologies for absence**	Noted			
18/19/51	**2.**	**Minutes of previous Meeting**	The Committee considered the minutes of the previous meeting of the Integrated Governance Committee held on 11th July 2018. The Committee **APPROVED** the minutes as a correct record.			
	2.2	**Action list**	**Resolved** that: the Committee agreed all actions from 11th July 2018.		SI/CU	
	3.	**Risk Register Management Reviews**				
18/19/52	**3.1**	**Surgery Division**	Andy McColl (AM) presented the risk management report for Surgery. AM focused on the high risks from the Surgical Division for this reporting period. Risks from the Surgical Divisions report were highlighted as follows: • Total number of risks = 64 • Number of new risks identified since the last reporting period = 7 • Number of risks closed and removed from the risk register =20 • Number of risks with an overdue review date = 28 • Number of risks with no agreed action plan = 3 • Number of high/extreme risks escalated to the Executive Team = 4 There are 4 high risks with a score of 15 & above: Risk no 1701 (score 16) – Loss of access to patient data records held in MD Analyse. We need a robust data to back up I.T. If this		AM	

APPROVED

APPROVED

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			fails we will lose clinical data. Risk no 1431 (score 15) – Lack of specialist airway practitioners, Consultant Anaesthetic cover in and out of hours – A risk plan has been composed and mitigations are in place and this risk score will reduce. Risk no 964 (score 15) – Planning and scheduling of elective lists is not robust enough to prevent errors occurring and Patients are not being listed quickly enough. The risk is poor patient experience due to extended fasting times. Also Operational risk of poor productivity and inability to deliver activity plan. Risk 424 – risk of transmission of vCJD – This risk is closer to being resolved by using two sets of instruments. We are awaiting a further 5% of the instruments to eliminate this risk. The risk will continue to be monitored in line with policy until the issues have been resolved.		AM	
			AM advised there is 1 risk that remains as a score of 15 and this is the Ceiling Tiles. The executives are aware of this risk and it is being addressed. SI advised this is one of the issues for H&S to address with Interserve.			
			JG advised it would be helpful to hear more about the waiting list risks and the action plans. CU asked could a list of actions that have been completed be produced and uploaded to the risk register so there is clarity of what actions have been closed. Also to include all the minutes of meetings that have taken place including email trails which would give the bigger picture and support clarity about the management and its effectiveness. AM to update IGC Nov 18.	AM to produce action list of completed actions for risk 964, including minutes of meetings and email trail.		20th Nov 18
			AM advised the surgical division will keep updating their risks on a monthly cycle or more frequently as required, to ensure actions and mitigations are in place.			
			AM advised the committee that although there is ongoing work required, the division are comfortable with the progress to date.			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			Resolved that: the Committee NOTED the contents of the paper			
18/19/53	3.2	**Medical Division**	Adrian Hughes (AH) presented the risk management report for Medicine. Risks from the report were highlighted as follows: • Total number of risks = 103 • Number of new risks identified since the last reporting period = 10 • Number of risks closed and removed from the risk register = 15 • Number of risks with an overdue review date = 21 • Number of risks with no agreed action plan = 10 • Number of high/extreme risks escalated to the Executive Team = 3 AH focused on the high risks from the Medical Division for this reporting period. Risk no 1169 score 20 – Fragile medical workforce within the Haematology Service – Inability to run complex and acute care within the trust due to insufficient clinical cover caused by sickness or gaps in service. One consultant is on sick leave. One has just returned from sick leave, however will be going off on maternity leave. There have been some changes made and we are in the process of recruiting a locum Haematologist, however there are still risks remaining, until locum in place. Risk no 1668 score 15 – Test results not picked up by clinicians in timely manner. Clinical Lead for IT is due to meet with the Rheumatology Team to start a pilot on notifications. Risk no 906 score 9 – SALT (Speech and Language Therapy) notes being stored on retained estate – This risk score has gone up however not sure this risk should be this high. Mandy Burns has		WW/CW	

APPROVED

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			been sighted on this risk. ES advised there are issues around this paperwork/notes being held on the retained estate and there are considerable Information Governance implications, though there is a solution in place. The live notes are being actioned with the scanning that is taking place. They are slightly behind completing this work however, there are actions in place. AH 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			
18/19/54	**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 = 7 • Number of risks closed and removed from the risk register = 14 • Number of risks with an overdue review date = 3 • Number of risks with no agreed action plan = 1 • Number of high/extreme risks escalated to the Executive Team = 1 • 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 identified for community. Risk 1524 – Lack of appropriate services to transition patients with ADHD. Risk of harm due to inappropriate care or advice provided to		RG/SS	

APPROVED

Item No	Item	Key Point Discussions	Action	Owner	Time Scale
			patients by paediatricians with lack of clinical knowledge about this age group. There are between 600-700 patients waiting to be transferred to adult services. SS to contact Sefton CCG as there has been a decision made and they will confirm what level this risk sits at. There has been progress made and there will be shared care with Pharmacy/CAMHS and South Sefton to mitigate this risk. **New risks**: Risk no 1671 – Clarion alarm system - Sefton CAMHS – Panel and speaker have now been re-sited. Risk no 1674 – Risk of contracting legionella at Burlington House – The flushing has now been completed. Risk no 1690 – Safe drop off area within Dewi Jones unit car park – This has been actioned and can now be closed. 1698 – No Mental Health Liaison for A&E and Wards – Closed. Risk no 1700 – Failure to achieve the benefits from the CAMHS NHS Test Bed Project – Closed. Risk no 1702 – Issues with connectivity to AHH systems in Burlington House/Community – IT have been working on this and SS is awaiting an update from them. Risk no 1703 – Staffing issues within the administration team at Sefton CAMHS – This risk should close fairly quickly. Rose Douglas advised Community are starting to see a drop in the amber risks by working with the services. The risk revalidation meetings have proven to be beneficial and helped management to deliver across the service. CU advised the committee that the revalidation meetings are mandatory and need to be attended by the divisions/corporate functions. Recently there were 4 meetings cancelled in one day. CU advised the expectation is that the teams will prioritise and attend the meetings planned in the diary (12 months ahead) and for everyone to come prepared for the meeting. The validation meetings will continue until the necessary assurance is evidence that risk is being managed effectively and the culture is that it is prioritised by all and	Risk 1524 to be included on the risk register Risk revalidation meetings are mandatory		Immediate Immediate

APPROVED

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			actions demonstrate this. 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			
18/19/55	3.4	**Infection Control Service**	VW presented the risk management report for Infection Prevention Control. Risks from the report were highlighted as follows: • Total number of risks = 13 • Number of new risks identified since the last reporting period = 0 • Number of risks closed and removed from the risk register = 0 • Number of risks with an overdue review date = 0 • Number of risks with no agreed action plan = 0 • Number of high/extreme risks escalated to the Executive Team = 1 • 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. Risk no 795 score 16 – Water Safety on CHP/Retained Estate (Legionella etc.). Trust should encourage further water usage across the Trust and increase flushing. The Water Safety Group has agreed to outsource help/advice for ADIPC on water safety. The Trust know what the risk is and it is being managed through filters fitted on the system and is being actively monitored and controlled. There was a Water Safety Meeting on 10th Sept 18 and we are making progress in ensuring mitigating controls are in place. Risk no 1725 score 12 – Mattress provision and local management – Mattresses require regular inspection for signs of internal/external		VW/JK	

APPROVED

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			damage and signs of contamination. There is a lack of availability of correct pressure relieving mattresses and there are delays of 12 hours for the air mattresses when needed. Medical devices and tissue viability are currently looking at improved management of mattresses. There are visits arranged to go to a mattress supplier who will be able to supply new mattresses and take away old as and when required. Public Health England will want a solution to this issue. SR to speak to DP to resolve this issue. VW advised that the risks have become static lately however the high risks have been reduced and are now mostly amber. VW will provide further progress to the risks at the IGC Nov 18. 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	Risk 1725 mattresses SR to speak to DP to resolve		Immediate
18/19/56	**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). MD advised the committee that there are no further developments to report for Facilities and he is satisfied with their progress at this point. **Resolved** that: the Committee NOTED the contents of the paper		MD	
18/19/57	**3.6**	**IM&T**	LF presented the risk management report for IM&T. Risks from the report were highlighted as follows:		PY/LF	

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Item No	Item	Key Point Discussions	Action	Owner	Time Scale
		Total no of risks 25, new risks since last report 1, risk closed and removed 2, risks overdue 7, no of risks with no agreed action plan 3, high risks need escalating to execs for their support 3 (high risks). Risk no 1210 score 16 – Failure of data migration of legacy patient Pathology results and reports from meditech 5 to meditech 6 resulting in loss of patient data prior to June 2015. This is historical data not the current system and the functionality is not good however mitigations are in place to minimise the risk. Risk no 947 score 16 – Meditech Infrastructure does not have hot fail over site (Disaster Recovery Platform) – Risk to be reported through BAF. 1187 score 16 – Server infrastructure no longer replicated to a secondary site - Risk to be reported through BAF. The two risks above are the primary structure of how to house everything if Meditech fails. A piece of work needs implementing around the resilience of the Meditech infrastructure. LF advised that 72% of risks have been reviewed as there has not been much traction at this time due to annual leave. 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			
18/19/58	**3.7**	**HR** MS presented the risk management report for HR. Risks from the report were highlighted as follows: Total no of risks 5, new risks since last report 0, risk closed and removed 0, risks overdue 0, no of risks with no agreed action plan 0,		MS	

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Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			high risks need escalating to execs for their support 0 (high risks). MS advised the committee that HR have 1 new risk, risk no 1721 CQUIN which is not meeting targets. This however is not a high risk (score 9) and there are no significant issues to raise to the committee. and their current position is showing assurances are in place. **Resolved** that: the Committee NOTED the contents of the paper			
18/19/59	**3.8**	**Finance**	JG presented the risk management report for Finance. Risks from the report were highlighted as follows: There are 2 risks identified on the finance risk register. 0 new risks since last report 0, risk closed and removed 3, risks overdue 0, no of risks with no agreed action plan 0, high risks need escalating to execs for their support 0 (high risks). JG advised the committee that Finance have no issues to be raised to the committee and there are no risks out of review date or overdue. JG advised the committee that the Finance department are satisfied with the progress at this point. **Resolved** that: the Committee NOTED the contents of the paper		JG	
18/19/60	**3.9**	**Estates**	JH presented the risk management report for **Estates**. Risks from the report were highlighted as follows: Total no of risks 18, new risks since last report 0, risk closed and removed 5, risks with a reduced risk score 7, risks overdue 0, no of risks with no agreed action plan 0, high risks need escalating to execs for their support 0 (high risks).		DP/JW/SB	

APPROVED

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			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 score 16 – Fire break glass - New Hospital. The fire safety officer John Spark (JS) to confirm if this remedial work has been completed once confirmed can be closed. JH advised the committee there are a number of overdue fire risks which will be reviewed and closed when JS the Fire Officer returns from annual leave. There are assurances of effective risk management. 61% of risks have been reviewed and 39% awaiting review which will be updated shortly. **Resolved** that: the Committee NOTED the contents of the paper			
18/19/61		**Building Services**	GD presented the risk management report for **Building Services**. Risks from the report were highlighted as follows: Risks on register for Building services. There are 13 risks identified - new risks since last report 1, 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 no 1388 – (Score 20) – Pipe Corrosion. To date there are now confirmed 46 pin holes since occupation of CHP. Increased frequency of burst and subsequent issues has led to the risk being increased. David Powell to meet with the specialist consultant			

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Item No	Item	Key Point Discussions	Action	Owner	Time Scale
		appointed by SPV. The pipe corrosion was discussed and minuted at the recent Liaison Committee Meeting and will be taken to the next (RABD) Resource and Business Development Committee. Further mitigations are needed. GD to provide an update at the next IGC in September 2018. Risk no 825 – (Score 15) – Internal Balconies. On the horizontal handrail there is potential for climbing, resulting in the risk of potential fall from the balcony. The Trust is in talks with companies to look at the glass balustrades and removal of the handrails. The design of the glass balustrades didn't need the addition of handrails in situ. If the handrails are taken away this will remove the risk. Howard Davies Health and Safety) and Amanda Kinsella have reviewed the legislation which states there is no requirement for the handrails. JG requested that he and MS see the piece of work and email trail around the legislation and for this to be taken to the Exec Meeting. Report back to next IGC Risk no 1709 – (Score 16) - Falling Ceiling Tiles – GD advised the committee that he will go into more detail on the high risks in the H&S item 18/19/63. GD 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			

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Item No	Item	Key Point Discussions		Action	Owner	Time Scale
18/19/62		**Development Directorate Projects**	Dave Houghton (DH) presented the risk management report for report for **Development Directorate Projects.** Risks from the report were highlighted as follows: Risks on register for Development Directorate. There are 23 risks identified - new risks since last report 3, risk closed and removed 6, risks overdue 1, no of risks with no agreed action plan 5 (team to address), high risks need escalating to execs for their support 0 (high risks). DH advised the Development Directive reported there are financial implications due to the potential short fall in income to complete the Institute in the Park Building (phase 2). If the Universities do not sign the contracts this could have an impact on the overall estate strategy and the retained estate re-provision. GD advised this risk is relatively low and just needs finalisation. **Resolved** that: the Committee NOTED the contents of the paper		DP/JW/SB	
18/19/63	**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 = 7, new risks since last report = 0 Risk closed and removed = 0. Risks with an overdue date = 0, No of risks with no agreed action plan = 0, No of high risks need escalating to execs for their support = 0 (high risks) Changes in the risk profile or categories in risk being reported that need to be brought to the attention of the Integrated Governance Committee = 1		MS	

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Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			AK advised that H&S has the same number of risks as the last reporting period. Manual handling will have been closed by the next IGC in Nov 18. This has had a great deal of impact to people/staff. Risk no 799 - Failure to control contractors. Work is being carried out and the Trust is not aware the contractors are on site. The contractors are not following the 'Control of Contractors Policy'. The procedure for contractor checks they would send in method statements and they would also be asked to provide DBS checks however the contractors we are talking of there is no authorisation for them to be on site and the Trust is non-compliant. We are monitoring this as it is causing a risk to the Trust. CU asked is this being reported through the risk register on Ulysses as we need to have a true figure on this issue? SI advised for AK to produce an A4 sheet of issues, what we did to address them and present at IGC Nov 18. JG advised that outstanding challenges for H&S risks associated with the building and estates were presented to the last Trust Board meeting. It was agreed that it would be helpful to have a report so the committee had an oversight as there are a number of issues that have been on-going for some time. Underlying causes of the risks are associated with the building, the building maintenance and finances with external partners. In order to control and manage these risks an executive lead and a project lead were identified for each risk. There were formal letters sent to Project Co outlining concerns. Exec led H&S Meetings were held in July and Aug 18 to discuss oversight of the remedial actions required. JG advised AB has started making progress on some of the issues. It was agreed to set up task & finish group with exec leads of ES, AB and work with GD to get an exec process in place. Project Co are attending Trust Board in Oct 18.	SI advised for AK to produce an A4 sheet of issues, what we did to address them and present at IGC Nov 18. AK to produce a report of all on-going issues to be presented at IGC Nov 18.		

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Item No	Item	Key Point Discussions	Action	Owner	Time Scale
		Risk no 795 Water safety – There is a list of what has been completed so far and what actions we can take. The major issue is the water flow speed. This risk has a residual score of 12 and will remain at this score until the core issue is resolved. There is a series of recommendations of how to action and the Water Safety Group will explore implementation of these further mitigations on an urgent basis. Risk no 1712 - Fire and smoke spread from gaps in compartmentation – Fire compartment works have been completed and inspection verifies compliance. The fire escape evacuation plans in place needs modifying which we are working on with local fire leads. A meeting took place on 10th Aug 18 with the fire service however they asked for an extension. This risk will be signed off once all work works have been completed. Risk no 1709 – Ceiling tiles – due to displacement of tiles the ceiling system is now not fitted to original specification; tiles have been dislodged by contractors undertaking other work. GD advised a lay grid needs to be fitted to stop the tiles from dropping. There are a few mitigations in place, however all ceiling tiles may need replacing. Risk 1388 – Pipework corrosion – To date there are now confirmed 46 pin holes since occupation of CHP. Some or all of the pipework will need replacing. There is a meeting with Project Co Monday 17th Sept 18. SI asked are there areas we not seeing that may need replacing in the next 5 years. GD advised the report produced does cover these questions. There are mitigations in place, however further mitigations are needed. Risk no 825 – Glass balustrades/balconies – GD advised we are awaiting the report from Project Co to confirm the integrity of the glass without the handrails.			Nov 18

APPROVED

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			Dry Canyon – There is no DRA (Design Risk Assessment) and risk assessment has identified a 20 ft. drop without barriers. The installation of the design work commenced this morning 12th Sept 18. Once complete we will be able to review and conduct a further assessment and hopefully open in 1 week. GD to obtain a design risk assessment from the architects BDP. Risk no 1667 – Ventilation – This is a considerable piece of work that needs completing, with the Director of Interserve, who is involved. All areas that have been tested have failed. It was advised that SR has been involved in the work to the ventilation system in Intensive Care. SI advised the committee there are different levels of risks on the register some more complex than others however we need resolutions to all of these risks. 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	GD to obtain design risk assessment report to IGC Nov 18 GD to add Dry Canyon risk to register		Immediate
18/19/64 **18/19/65**	**3.11**	**Business Preparedness & Associated reports**	CU presented the Business Preparedness & Associated reports. Risks from the risk management report were highlighted as follows: Total no of risks 14, 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). CU advised that Business Preparedness and Emergency planning risks are managed very well and consistently monitored Emergency Preparedness Committee, chaired by Director of Nursing, Pauline Brown (PB). The CBRNE/HAZMAT training compliance is on the increase. This has been managed effectively with good supporting	Business plan review PB to bring to IGC Nov 18	MS	Nov 18

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Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			assurance evidence, available on the risk register. JN advised that there are 2 more training days in the diary for Sept 18 and is confident this can be closed from the risk register in Oct 18. PB advised there is an assessment taking place to review the Business Plan and this will come to IGC in Nov 18. This requires an ANN review and this will confirm all divisions/areas have been signed off. CU is satisfied with management of risks on the register in this area. **Resolved** that: the Committee NOTED the contents of the paper			
18/19/66	**3.12**	**Information Governance**	Jo Fitzpatrick (JF) 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 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). Joanne Fitzpatrick (JF)) advised that the Information Governance Tool Kit changed in May 18. The tool kit is used to look for evidence for security awareness. The assurances in place don't seem to be efficient and we need to understand the escalation process. The MIAA most recent report showed improvements from the last assessment. ES advised it would be good for a group meeting outside of IGC to discuss and ES/JG to provide an update at the next IGC Nov 18. JG to look into and find out if this is a theme as position has changed. JS advised the committee that the validation meetings were helpful. **Resolved** that: the Committee NOTED the contents of the paper	ES/JF to provide an update on toolkit issues at IGC Nov18 ES/JF to arrange a group meeting outside of IGC to	ES	

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Item No	Item	Key Point Discussions		Action	Owner	Time Scale
				discuss toolkit.		
18/19/67		**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 24 (16 open; 8 residual), new risks since last report 1 (risk no 1689), risk closed and removed 4 (1349, 252, 625, 1689), risks overdue 0, no of risks with no agreed action plan =0 high risks need escalating to execs for their support 1 (1869) however this risk now closed (high risks). Risk no 1689 – ASU technical agreement (now closed) – Technical agreement has been received and signed and all documentation is now in place. This risk was closed on 30th Aug 18 in advance of external audit. CB to send an amended report to IGC Nov 18. Risk no 1344 (score 8) – Pharmacy and ASU cold stores failure. - CB advised Pharmacy are just waiting on confirmation of an installation date from manufacturer and Interserve to install backup refrigeration system. Risk no 944 (score 9) – Trust security access to the laboratory – CB advised an alarm has been fitted in outpatient pharmacy and inpatient pharmacy will be fitted 20th Sept 18. This is the highest risk for pharmacy and these changes will show on next report submitted to IGC meeting Nov 18. CB advised the committee that the trend to risks is showing as low and she is satisfied with management of risks on register in this area. CB advised the committee that recent training has been helpful for her team in terms of understanding risk management and also	CB will update IGC Nov 18 of risk position	CB	Nov 18

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Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			commented that the risk validation meetings were helpful. **Resolved** that: the Committee NOTED the contents of the paper			
18/19/68		**Global Digital Excellence Programme**	Hannah Thompson (HT) presented the risk management report for Global Digital Excellence Programme reports. Risks from the report were highlighted as follows: Total no of risks 14, new risks since last report 0, risk closed and removed 3, risks overdue 1, no of risks with no agreed action plan 1 (mitigations in place), high risks need escalating to execs for their support 0 (high risks). Changes in the risk profile of categories of risk being reported that need to be brought to the attention of the Integrated Governance Committee = 1 previous reported risk no 1621 has been reduced from 15 to 10. HT advised the committee GDE is happy with management of risks on register in this area. **Resolved** that: the Committee NOTED the contents of the paper		KM	
18/19/69		**Clinical Research Division**	Lucy Cooper (LC) presented the risk management report for Clinical Research Division. Risks from the report were highlighted as follows: Total no of risks 6, new risks since last report 2, risk closed and removed 2, risks overdue 0, no of risks with no agreed action plan 0, high risks need escalating to execs for their support 0 (high risks). Changes in risk profile or categories of risk being reported t need to be brought to attention of IGC = 0 Risk reference 59: **Slow growth in commercially funded research** Risk score 8, this risk was first identified on the 7th January			

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Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			2013. Risk reference 72: **Research capacity of clinical staff and Consultant PAs.** Risk score 8, this risk was first identified on 15th November 2013. Risk Reference 56: **Research Financial Model** Risk score 12, this risk was first identified on 5th November 2013 Risk Reference 632: **Trust 10 year research strategy** Risk score 12, this risk was first identified on 3rd February 2015 Risk Reference 1718: **Clinical Research Facility (CRF space)** Risk Score 6, this risk was first identified on 31st August 2018 Risk Reference 1717: **Information Governance Toolkit for Research** Risk Score 6, this risk was first identified on 31st August 2018 LC advised that all risks have been reviewed with an action plan and there are none specifically that needed to be highlighted to the committee today. Part of the clinical research space is being used by Ophthalmology to store some of their equipment however Clinical Research will need this space back before the winter months. LC advised that starting 17th Sept 18 they have a new Risk Monthly Meeting to ensure they are providing a thorough review of risks in a timely manner. JG asked if all the studies needed ethical approval before studies take place. LC advised that every study has approval from External bodies MHRA, HRA, Ethics Committees before a study is in place.			

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Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			LC advised the committee that the risk validation meetings are helpful LC advised the committee Clinical Research have work to complete however happy with management of risks on register in this area. **Resolved** that: the Committee NOTED the contents of the paper			
18/19/70		**Change Programme**	Natalie Deakin (ND) presented the risk management report for Change Programme. Risks from the report were highlighted as follows: Total no of risks 27, new risks since last report 27, 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). Changes in risk profile or categories of risk being reported t need to be brought to attention of IGC = 0 ND advised that prior to Aug 18 only a small proportion of risks linked to projects on the Trust Change Programme were recorded on Ulysses and others were detailed on separate risk registers saved on SharePoint. This did not allow the Trust to have a complete overview of all Trust risks in one place. It was agreed that all risks associated with projects on Change Programme be recorded in one location the Ulysses System and that all projects be aligned with a division. The risks associated with the projects would form a part 2 of the divisions risks reported to IGC. There are 27 risks on our register and all showing as moderate (not all these risks are new). CU advised the divisions and relevant corporate functions will be taking ownership of these risks going forward and will be including risks for their specific areas as part 2 of their risk management reports to IGC. This integration will ensure the risks are not managed in isolation from the rest of the business of the division and it is expected ownership in the appropriate place will	Relevant Change programme risks are to be included as part 2 for	ACOO's	

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Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			ensure consistent management and effectiveness in terms of assurance. JG added it is appropriate to have this link and the IGC meeting gives us further assurance and provides visibility. **Resolved** that: the Committee NOTED the contents of the paper	the divisions risk registers		
18/19/71	**4.**	**Corporate Risk Register Review**	CU presented the Corporate Risk Register Review. **CU advised the committee that there are 474 risks on the current Trust risk register including 21 high risks compared to 515 inclusive of 19 high / extreme for the previous reporting period.** 21 (4.43% of the Trust risks are rated as' High/Extreme' risks compared to 19 (3.73%) for the previous reporting period. 336 (70.89%) of the Trusts risks are rated as 'Moderate', compared to 347 (68.17%) for the previous reporting period, of which 119 (35.4%) risk rated 12 (high moderate) compared to 134 (26.01%) for the previous reporting period. 105 (22.15%) of the Trust risks rated are as 'low risk' compared to for the 123 (24.17%) previous reporting period. 9 (1.90%) of the Trust risks rated as 'very low risk' compared to 2 (4.52%) for the previous reporting period. There are currently 21 high risks on the CRR; • BAF - 2 (9.5%) • Medical Division - 3 (14.2%) • Surgical Division 5 - (23.8%) • Community Division - 1 (5.26%) • Research Division - 0 (0 %) • Corporate Services - 10 (47.6%) • Change Programme - 1 (4.76%)			

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Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			CU advised the committee there are assurance concerns both on the Trust and corporate risk register and these have been discussed in detail with the risk owners and managers at the monthly risk validation meetings. This is in addition to the concerns raised at the meeting today via the Division and corporate function reporting. **Assurance concerns Trust risk register** • 139 (29.14%) risk assessments have an **overdue** review date, compared to 164 (31.60%) for the last reporting period. • 58 (12%) risks do **not** have controls compared to 83 the last reporting period. • 42 (8.81%) risks do **not** have actions compared to 67 (12.91%) for the last reporting period. • 314 (45.44%) **overdue** actions compared to 360 (48.32%) for the same reporting period from last report. • **Assurance concerns corporate risk register (21 High risks)** • 7 (33.3%) overdue review • 13 (61.9%) overdue actions • 2 (9.5%) no controls identified • 11 (52.3%) initial and current risk rating is the same • 1 (0.23%) no initial risk rating identified • 2 (9.5 %) initial risk rating is higher than the current risk rating CU advised there is further work required to address the consistent static position of moderate and high moderate risks across most services. As previously highlighted this has been picked up by CQC			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			and more recently by the MIAA, although the MIAA final conclusion was that the Trust position is 'substantial assurance'. However the MIAA report shows that while the Trust has very good systems and processes, and is clearly aware of where the issues are, the behaviours in terms of managing risk needs to be improved in those areas where deficits are persistent. It is the role of leaders and managers to ensure the culture supports effective management of risk. **Resolved** that: the Committee NOTED the contents of the paper			
18/19/72	**5.**	**Board Assurance Framework (BAF)**	ES presented the Board Assurance Framework. ES advised the committee of the update to the BAF for the previous reporting period. We need the identification of gaps in controls, highlight the IM&T structure, the majority of strategic risks to carry on doing what we are doing. ES asked the committee if these were the issues we should action and be sighted on or are there others. The committee agreed that the current BAF risks are appropriate. **Resolved** that: the Committee NOTED the contents of the paper		ES	
18/19/73		**CQC Plan**	ES presented the CQC Plan. ES presented the CQC Action Plan and thanked the committee for providing the updates to the plan. Identifying via assurance committees. The first update has not been completed to plan but going forward this will be updated and all items will have been completed. A request has gone out for the services to update plans and these need submitting by 13th Sept 18. If we are behind on anything it would be helpful to know. **Resolved** that: the Committee NOTED the contents of the paper		ES	
	7.	**Policies**				

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Item No	Item	Key Point Discussions		Action	Owner	Time Scale
	8.	**Ad Hoc Reports**				
	9.					
	10.	**Any other business**	SI expressed a thank you for all the work that has been completed to enable the Trust achieve its current position The MIAA report 'substantial assurance' was very positive, however this is not a destination it is a journey and we need to continue with the good work. There is still a lot of work to complete, however there has been a real positive trajectory particularly over the past 12 months and we need to keep working at this to continually improve. ES advised the committee that this is the last IGC meeting that Steve Igoe will chair and on behalf of everyone ES thanked Steve for his excellent work including keeping us all in line and showing us clarity and excellent guidance. ES thanked Steve for all the work he has provided for Alder Hey over the years he has been in post.			

Date and Time of Next Meeting	The next meeting of the IGC will be held on Tuesday 20th November 2018, 10:00am. Institute, Large Meeting Room

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INTEGRATED GOVERNANCE COMMITTEE
ACTION LIST – September 2018

No	Item	Owner	When	Status
18/19/52	Risk 964	A McColl	20th Nov 18	AM to produce action list of completed actions for risk 964, including minutes of meetings and email trail.
18/19/54	Risk 1524	S Stephenson	Immediate	SS to include on the risk register.
18/19/	Risk revalidation meetings are mandatory	All Divisions/functions	Immediate	Risk revalidation meeting are mandatory and all meetings in the diary need to be attended. Committee members are fully engaged
18/19/55	Risk 1725	S Ryan/D Powell	Immediate	SR to speak to DP in relation to Mattress provision and local management. Update 27.09.18 Valya Weston is overseeing this action and will liaise with D Powell. Update 20.11.18
18/19/63	Dry Canyon Dry Canyon risk to be added to risk register	G Dixon	20th Nov 18 Immediate	GD to obtain design risk assessment report. Update 20. GD to add risk to risk register.
18/19/63	Produce a report of all issues Risk 799	A Kinsella	20th Nov 18 20th Nov 18	AK to produce a report of all on-going issues to be presented at IGC Nov 18. Risk 799 AK to produce an A4 sheet of issues & what we did to address and present at IGC Nov 18.
18/19/64	Business plan review PB to bring to IGC Nov 18	P Brown	20th Nov 18	PB to include with papers for IGC Nov 18.
18/19/67	Risk 1689	C Barker	20th Nov 18	CB to submit an amended report showing update of risk position to IGC.
18/19/66	Toolkit group meeting	E Saunders/J Fitzpatrick	Immediate	ES/JF to arrange a group meeting outside of IGC to discuss toolkit.

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	Update on toolkit		20th Nov 18	ES/JF to provide an update on toolkit issues at IGC Nov 18.
	Graph/trend report	L Calder	Immediate	LC to email an updated Graph/Trend report to Divisions/functions to prepare future reports.
18/19/70	Change Programme	ACOO's	Immediate	Risks are to be included as part 2 for the divisions risk registers.

Board of Directors

6th November 2018

Report of:	Director of Human Resources & Organisational Development
Paper Prepared by:	Director of Human Resources & Organisational Development
Subject/Title:	People Strategy Update for October 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

The Staff Fab Week for our Community Services is to be held on 6th December 2018 at Sefton Carers Centre, Waterloo from 9am till 1pm. This is as a follow on from the main site Fab Staff week held mid-October which was well received by both the staff and those organisations and individuals who ran stalls for the events.

The Trust's first Christmas market will be held on 30th November 2018 10am until 3pm to coincide with the Trust Nativity later the same day. There will be a number of stalls in the atrium such as Clinique, Lush, Partylite Candles, Honey Stall, Children's clothes, Handmade Christmas Cards and Festive Decorations & Wreaths.

The annual Star Awards have been officially launched with the deadline for nominations on 7th December 2018. Judging is due week commencing 17th December 2018 and the panel will include representation from executives, parents, patient and regular Star Award committee members. Invitations will be issued around 21st December 2018 to all the shortlisted nominees and the nominator. The event is scheduled Friday 8th February 2018 as last year, at the Titanic.

Staff Survey

The 2018 Staff Survey has just 3 days left to run at the time of writing and is due to close on the 30th of November 2017.

The previous 3 years' response rates can be seen below including the 2018 target:

2015	2016	2017	2018 (Target)
35%	39%	54%	60%

As of the 28th November our completion rate is 57%, which has already surpassed both the 2015 and 2016 survey response rates and is just 3% below our target of 60%.

The team are continuing to work closely with Communications in promoting the 2018 Staff Survey regularly with various campaigns both electronically and via posters and flyers as well as providing regular updates to senior leaders within the organisation to encourage their teams to complete their surveys.

As well as the above there are regular prize draws being run every 2 weeks linked to our current completion rates and the team have been visiting wards and departments to encourage staff to complete their surveys and offer chocolates to those who have completed them.

Improving Staff Wellbeing

The Trust continues to focus on supporting and improving staff health and wellbeing. The wellbeing steering group continue to meet monthly and are generating excellent ideas and incentives to improve staff wellbeing and improving mental health.

We are committed to supporting and changing how we think and act about mental health and intends to sign the Time to Change employer pledge. The aim of Time to Change is to empower people to challenge stigma and speak openly about their own mental health

experiences, as well as changing the attitudes and behaviours towards those of us with mental health problems. As part of this pledge we will be committing to introducing 100 Mental Health Champions from across the organisation, who will act as ambassadors and champions for all aspects of Health and Wellbeing

The Trust continues to work with NHSI on the national programme of improving employee health and wellbeing and will be working in conjunction with the Economic Evaluation team in conducting research on the impact of deprivation on sickness absence. The NHSI team will also be joining the Wellbeing Steering Group at one of their meetings in the New Year.

2. Workforce Sustainability and Capability

Agenda for Change New Pay Deal

Work has now commenced on the removal of the Band 1 salary scale, and we are working in partnership with Trade Union colleagues to deliver this project. Work is commencing on a review of the appraisal system in light of the changes to incremental progression which will come into force on the 1st April 2019.

Band 1 Staff

NHS Employers have stated that the band 1 pay scale within the NHS will be phased out. As of October 2018, the Trust will no longer advertise roles at a band 1. The HR team are working in partnership with staffside and following guidance from NHS Employers.

Within Alder Hey there are 3 groups of staff identified that are currently on a band 1 and they sit within Hotel Services.

- Domestic Assistants
- Catering Assistants
- Linen Assistants

Education, Learning and Development

Apprenticeships

The table below shows apprenticeship starts to date:

	Medicine	Surgery	Corporate	Community	Total
Leadership & Management L7	2	2	3	1	8
Healthcare Science Practitioner	3				3
Nurse Associate	3	1			4
Accountancy L7 & L3			5		5
Business Administration L2/L3/ L4	3	1	4	1	9
Healthcare Pharmacy L2/ L3	7				7
Leadership & Management L5	3	6	1		10

Medical Administration	1				1
Engineering Maintenance		1			1
Total	22	10	11	2	**47**

We are progressing well with our target towards having 50 learners by the end of March.

Mandatory Training

Mandatory training figures as of mid-November are 89.98% for Core Mandatory Training and 88.69% for Overall Mandatory Training.

The team have continued to ensure that staff and managers are aware of outstanding requirements and provided additional communication directly to individual's outstanding mandatory training.

As well as the emphasis on reporting, we rolled out 6 new national e-Learning packages for staff to update their mandatory training last month and are working with subject matter experts to agree or develop updated content for the remaining topics.

Library Update

The Library & Knowledge service has successfully bid for £23k from the Health Care Libraries Unit to develop an APP for staff and trainees to coordinate learning experiences and to update the e-Learning room in the library to support training.

The annual submission against national standards for libraries, the Library Quality Assurance Framework (LQAF) has been assessed and we have maintained 96% compliance.

Employee Consultations

Hotel Services

Portering:

Following a further review meeting with management and the trade unions that took place on 20th June 2018,it was provisionally agreed at that meeting that management would trial some proposed changes to working practises for a three month period with full staff engagement. Proposals have now been issued to trade union representatives for the implementation of the trial period, planned to be in place by end of November 2018.

Employee Relations Activity

The Trust's current ER activity has increased and stands at 38 formal cases. There are 8 disciplinary cases (3 through fast track); 4 Bullying and Harassment cases; 1 grievance; 20 sickness absence cases at final stage, 1 formal capability case; 2 MHPS Capability cases and 2 Employment Tribunal (ET) cases.

An agreement has been reached with Staff side colleagues to commence bi-monthly case reviews; these will be carried out in partnership with HR and Trade Unions in order to learn from cases and improve processes and practice. This is a very positive step forward for partnership working across the Trust.

Employment Tribunal Cases

- A tribunal is scheduled for 11th-14th December for an ET Claim relating to unfair dismissal and wrongful dismissal.

- An ET Claim relating to disability discrimination and protected disclosure was held at the Liverpool Employment Tribunal on 12th November 2018, concluding on 23rd November involving a total of 13 Trust witnesses. A supportive programme was instigated for those attending as witnesses. The ET has now concluded, however a decision was made to deliver the outcome in writing, this may take a further 8 weeks to receive the outcome.

Corporate Report

The HR KPIs in the October Corporate Report are:

- Sickness rates have decreased slightly this month compared to last month to 5.6% in month.
- Core Mandatory training compliance is at 90%
- PDR compliance is at 90%

BOARD OF DIRECTORS

4th December 2018
Workforce & Organisational Development Committee
(WOD) – Chairs Note

1. Purpose of the Report

The purpose of this report is to update the Board on the key issues raised at the WOD Committee held in October 2018.

2. Key Issues

The following issues were raised and discussed at the Workforce & Organisational Development Committee on the 23rd October 2018; the minutes of the meeting will be submitted to the January 2019 Board for noting.

- The Committee **noted** the ratings (Apprenticeship & Portering Service) for The Best People Doing Their Best Work – Programme Assurance.
- The Committee received a presentation outlining the Leadership Strategy and **ratified** the approach.
- The Committee received a presentation re Health & Wellbeing outlining the key principles and actions in a Mental Health & Employer Pledge Action Plan and **noted** the progress made.
- The Committee received a report outlining the developments to support the Trust focus on Health and Wellbeing and noted the progress made.
- The Committee received a report outlining the interventions put in place to support Sickness and noted the progress made.
- The Committee received a draft report outlining the progress made to complete the 2018 Education and Training Self-Assessment report and **approved** the report.
- The Committee received a presentation outlining the latest developments in the Apprenticeship and **noted** the progress made.
- The Committee received a Staff Survey report and **noted** the progress made to increase completion rates for this year.
- The Committee received a report outlining the latest developments for Mandatory Training and **noted** the progress made.
- The Committee received a report outlining the proposals for consideration re the future remuneration of individuals on non-AfC contracts and **approved** the recommendations.
- The Committee received the Board Assurance Framework September 18 and **noted** the content.
- The Committee received an update of the Workforce Leading Indicators for August 18 and **noted** the content.
- The Committee **ratified** the following policies and approved EIA's:

  Consultant and SAS Doctors Procedure for Leave
  Consultant and SAS Doctor Job Planning
  Special Leave
  Medical Staff Covering Absent Colleagues Procedure
  Pension Contribution Alternative Award (pending final comments from LNC&JCNC)

3. Recommendations

It is recommended that the Board note the contents of the Chairs Update relating to the key issues from the Workforce and Organisational Development Committee held on 23rd October 2018.

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BOARD OF DIRECTORS

Tuesday, 4 December 2018

Report of	Director of Corporate Affairs
Paper prepared by	Director of Corporate Affairs
Subject/Title	Well Led Review – Board Development Plan
Background papers	Well Led Framework – June 2018 MIAA/AQuA Well Led Review – Feb 2018 report
Purpose of Paper	To receive an update on the actions agreed at the Board Workshop with AQuA/ MIAA
Action/Decision required	The Board is asked to discuss and note progress
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	Not yet identified.

BOARD OF DIRECTORS

Well Led Review – Board Development Plan

KLOE	Development Area identified at Board Workshop	Action	Lead	By when
1. Leadership	**Visibility**: Effective Quality Ward Rounds. Important to sustain, communicate, get feedback and monitor where we are on the programme. **Board Development:** System leadership and collaboration are key. Clinical Leads need formal support as Board members. Recognised challenge of a new Chair. **Leadership**: The modelling of coaching is important - 'Coaching for Quality'. **Earned autonomy:** Balance between autonomy and direction is a challenge. Taking responsibility of QI at a local level is necessary. Need to support people with managing risks. **Board Diversity:** Programme of mentor support for BME. NHS Leadership Academy Diversity Programme. **QI**: Developing the QI approach but a model is needed	• Schedule of visits to be reviewed at Executive Team and reported to CQAC • Review programmes available for Board members eg via NHS Providers and formalise arrangements. Schedule whole Board development events for 2019/20. • *Inspiring Quality* strategy incorporates organisation wider leadership approach • Review of Divisional model with external support • Ensure we connect with local/national resources as part of people strategy • *Inspiring Quality* outlines proposed model ; requires formal Board endorsement	HG ES/MS MS/JP ES/LS MS/ES AB	Dec 18 Between Oct 18 and April 19 Dec 18 Jan 19 March 19 Dec 18
2. Vision and Strategy	**Vision:** Need to socialise strategic direction with senior clinicians and other leaders **Strategy**: Need to develop a methodology to enable Alder Hey to articulate our core strengths and role within the system.	• Agree a range of activities and forums to enable strategic conversations at key times in the year, including via Divisions • Via development of *Sustainability through External Partnerships* pillar	LS/MDs LS/DJ	March 19 and ongoing
3. Culture	**Autonomy and ownership:** Spring clean of systems and process led by Listening in Action and Exec sponsor plus senior person from each Division to work with Kerry Turner. Support services, need to work with Kerry Turner and link QI. Include a review of the	• Links to *Inspiring Quality* implementation and review of Divisional Model; devise plan via LiA • Corporate Governance Manual review underway • Trust-wide preparation for next inspection in train;	AB/MS/KT ES/CL	April 19 Jan 19

	Scheme of Delegation. **CQC:** Target those teams that are emerging as disengaged via Staff Survey, etc. Divisions to focus on middle managers and create a plan for change.	targeted work will be part of this based on latest intelligence	ES/CU/ HG	Dec 19 to March 19
4. Roles, system and accountability	**Clarity of Board roles**: need to give more visibility to this issue e.g. more on website and photographs around the hospital. **Committee Operation:** agreed to progress a review of committee structure and ToRs with a view to reducing the number of meetings. Further work on meeting behaviours. Explore options of replacing some meetings e.g. huddles. Information and agendas need to be in a standard format. **Quality and risk**: this links to strengthening the leadership of committees and challenging attendance. **QI (Board assurance and engagement)**: CQAC; accreditation process, Quality Ward Rounds currently provide assurance. Aim is to replicate the Toronto model with a Centre of Excellence Hub, reintroduce divisional stock takes to Board, and strengthen LiA feedback.	• Ensure information kept up to date via agreed platforms • MIAA engaged to support process to arrive at a new structure; links to review of Divisional model • See above • Work required to draw these strands together – links to Quality Governance/Well Led Framework	MF ES ES/HG	Dec 18 March 19 Jan 19
5. Risk and performance	**WL Risk Issues:** BAF/Risk Register is more embedded but needs slimming down and to become action-focused. Accepted development needs on recording of risks and this is being reviewed. Risk appetite is an aspect to explore. **Div Perf Mgt:** Ownership needs strengthening. **CQC risk issues**: There needs to be a collective focus on the Trust's top three risks and to stop over processing. Improvement will come from being action-focused, clearly defining how we describe critically ill	• RM improvement plan presented to Audit Committee September 18 – next phase to be focused on consistency and effective use of Ulysses • Will form part of review of Divisional model • Trust-wide preparation for next inspection in train; current action plan progressing well towards completion; need to build in horizon scanning and intelligence/learning from other trusts	CU/ES ES/AB HG/ES	March 19 March 19 March 19

	children, education and learning.			
6. Information	**Committee scrutiny and assurance:** New report, improved mapping, portal, capability and IT use reflect how the Trust has moved on. Need to further refine SMART, being action and priority focused, and holding to account. More focus on data connected to quality outcomes is taking place in committees and exec meetings **QI**: Need to balance strategy versus operational KPIs. Development programme on how we all use information (do middle managers use it systematically?). What is our target model and how do we achieve accessibility and consistency?	• New Corporate Report metrics well received but will be kept under review *Inspiring Quality* sets out how we will measure improvement as part of proposed QI model; a detailed delivery plan will need to be developed as the work progresses	JG/HG AB	6 to 12 months
7. Engagement	**Stakeholder engagement:** Internally this needs to be made relevant to 'my role'. Develop a strategy and method to build an embedded stakeholder map including mutual gain criteria for relatives, customers i.e. a relationship system. **Governors**: NHSP on site bespoke training for governors. **Clinical Cabinet:** governance needs refresh and review. **QI**: patient voice needs to be better incorporated.	• Children and families at the heart of *Inspiring Quality* approach; supporting plans to be developed once Board has signed off strategy • Complete and plan developed • Links to *Inspiring Quality* implementation and review of Divisional Model • Children and families at the heart of *Inspiring Quality* approach	AB AB/ES AB	Dec 18 to March 19 March 19 Dec 18
8. Learning, improvement, innovation	**Strategy:** Research and Innovation has a timeline for review and development including creating internal opportunities. This will include alignment to QI. Timing of research needs to match ambition. Flexible enough to react (horizon scanning).	• Research Strategy reviewed and relaunched at Board; now need agreement re governance of REI as a whole: discussions underway with Research Division to design fit for purpose performance and assurance structure; education governance requires review.	LS/MB/ES/MP/MS	March 19

Neonatal Single Service
Board Update

Introduction

This short paper provides an update for Trust Boards on the Neonatal Partnership and ambition to create a single service across the two Trusts in response to the North West Neonatal Network Review.

Trust Boards are asked to note progress.

Progress in the Past month

Since the last Board update in October progress has been made in a number of areas.

Following submission of the Single Service Business Case over the summer, on 6th November NHSE wrote to Alder Hey Trust indicating support for 19 of the beds within the expanded Neonatal Unit at Alder Hey and in order to make a decision on the full 24 beds in the business case further information was requested regarding the care currently provided at Alder Hey for babies in non-neonatal environments. A joint response on 15th November provided this information and requested that, to limit further delay, NHSE respond by 30th November as both Trusts were proceeding as agreed and incurring financial risk. The Joint response highlighted the need to achieve the BAPM (British Association of Perinatal Medicine) standards, evidenced best practice for all neonatal babies.

A subsequent response from NHSE sought evidence to support the case for 5 of the proposed beds through identifying sub optimal outcomes from current practices, in particular the beds that would support improved pre-op preparation for Cardiac surgery at Alder Hey. Both Alder Hey Trust and the North West Neonatal Network are currently pulling together data to respond to this further request.

Discussions have begun with Wirral University Hospitals regarding potential future collaboration over Neonatal services within the North West Neonatal network. These discussions are strategic and at an early stage. The Single Service across the two Trusts, supported by the North West Neonatal Network, is accepted as a fixed point within these discussions.

Following an initial Single Service Delivery Group and recent Partnership Board an implementation structure has been agreed, governance, roles descriptions and early objectives (to January) with leads being appointed for the following three workstreams:

- Single Team: recruitment, education, structure & culture,
- Single Infrastructure: common EPR, consistent estate, consistent medical devices.
- Single Way of Working: clinical guidelines, operational processes and policies, clinical governance, audit, performance monitoring.

Initial risk and communication plans are in development.

As part of developing the implementation structure the overall ambition for the Single Service has been described in a high level diagram, outlining the rationale, the key activities and outcomes. This is shown below:

Neonatal Single Service
Board Update

Next Steps

The next steps are to complete the establishment of the implementation structure and focus on the initial set of objectives by the end of January 2019. .

The next Neonatal Partnership Board is due to take place on 30th January 2019.

Steve Sewell
November 2018

Register of Company Shareholdings
As at 31st October 2018

A monthly update will be provided to Board of all company shareholdings that the Trust have an interest in, identifying any changes made in the last reporting period and highlighting any areas of note.

Company Register as at 31st October 2018:

Name	Date of Incorporation	AH Director	Shareholdings	Company No	Address	Nature	Purpose	Filing	Status
Alder Hey Ventures LTD	27.06.17	David Powell	100% wholly owned subsidiary	10837212	AH	Commercial No employees	Commercial, innovation, product development and exploit IP	Confirmation statement: 12.07. YE: 30.06.18 Accounts due: 27.03.19	'Active' Not used Not consolidated
Alder Hey Living Hospital LTD	24.04.17	John Grinnell Sir David Henshaw David Powell	50% JV with Alder Hey Children's Charity AH significant control	10835638	AH Charity	Commercial No employees	App development and commercialisation	Confirmation statement: 23.04.18 YE: 31.03.18 Accounts due: 31.12.18	'Active' used Equity investment materiality
Alder Hey Sensors Ltd	18/05/2017	No	30.10%	10188710	Boundary Street, Liverpool	Commercial	App development and commercialisation	Managed through 3rd party	Active
Alder Hey Medical Ltd	18/05/2017	No	30.10%	10188794	Boundary Street, Liverpool	Commercial	App development and commercialisation	Managed through 3rd party	Active
Alder Hey Digital Ltd	18/05/2017	No	30.10%	10189548	Boundary Street, Liverpool	Commercial	App development and commercialisation	Managed through 3rd party	Active

Name	Date of Incorporation	AH Director	Shareholdings	Company No	Address	Nature	Purpose	Filing	Status
Alder Hey Diagnostics Ltd	18/05/2017	No	30.10%	10189060	Boundary Street, Liverpool	Commercial	App development and commercialisation	Managed through 3rd party	Active
Alder Hey Analytics Ltd	30/06/2017	No	30.10%	10259396	Boundary Street, Liverpool	Commercial	App development and commercialisation	Managed through 3rd party	Active
Cofoundery Enterprise 02 Ltd	27/04/2017	No	30.00%	10746202	Boundary Street, Liverpool	Commercial	App development and commercialisation	Managed through 3rd party	Active
Cofoundery Enterprise 04 Ltd	27/04/2017	No	30.00%	10746341	Boundary Street, Liverpool	Commercial	App development and commercialisation	Managed through 3rd party	Active
Physiopal Digital Ltd	27/06/2018	No	30.00%	10838856	Boundary Street, Liverpool	Commercial	App development and commercialisation	Managed through 3rd party	Active
Remedy Medpass Ltd	27/04/2018	No	30.00%	10746292	Boundary Street, Liverpool	Commercial	App development and commercialisation	Managed through 3rd party	Active
Vericell	27/04/2018	No	30.00%	10746420	Boundary Street, Liverpool	Commercial	App development and commercialisation	Managed through 3rd party	Active
Cofoundery Enterprise 08 Ltd	27/04/2018	No	30.00%	10746455	Boundary Street, Liverpool	Commercial	App development and commercialisation	Managed through 3rd party	Active

Changes made since last reporting period:

Alder Hey have now become a shareholder as at 18th May on companies house for Acorn Partners Ltd. This has been established as a 3 way shareholding with a venture capitalist (Deepbridge Capital) and a software developer (We Are Nova) following a master agreement signed in 2016.

Name	Date Alder Hey SH	AH Director	Shareholdings	Company No	Address	Nature	Purpose	Filing	Status
Acorn Partners LTD	18.05.2018	No	27.5%	1018842	Boundary Street, Liverpool	Commercial	App development and commercialisation	Managed through 3rd party	Active

The following 5 companies have been set up on company's house through the ACORN partnership and Alder Hey will become shareholders.

Name	Date of Incorporation	AH Director	Shareholdings	Company No	Address	Nature	Purpose
Cofoundery Enterprise 33 Ltd	Alder Hey not yet a shareholder	No	Alder Hey not yet a shareholder	11112790	Boundary Street, Liverpool	Commercial	App development and commercialisation
Cofoundery Enterprise 35 Ltd	Alder Hey not yet a shareholder	No	Alder Hey not yet a shareholder	11112815	Boundary Street, Liverpool	Commercial	App development and commercialisation
Cofoundery Enterprise 37 Ltd	Alder Hey not yet a shareholder	No	Alder Hey not yet a shareholder	11112938	Boundary Street, Liverpool	Commercial	App development and commercialisation
Hygenie	Alder Hey not yet a shareholder	No	Alder Hey not yet a shareholder	11055776	Boundary Street, Liverpool	Commercial	App development and commercialisation
Cofoundary Enterprise 36	Alder Hey not yet a shareholder	No	Alder Hey not yet a shareholder	11112857	Boundary Street, Liverpool	Commercial	App development and commercialisation

Programme Assurance Summary
Change Programme

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

1. It is important for sub-committees to home in on those projects that are still attracting red ratings (for governance or assurance) and, together with the Executive Sponsors, take action to bring the assurance to an acceptable level.
2. With 4 months remaining in the financial year, every effort should be made - across all work streams - to exploit every opportunity for further benefits. The challenge and support required to monitor and advance the CIP programme towards its target is conducted at the weekly 'Sustainability Delivery Group', a forum aligned with the Programme Board. It should be noted that the current level of contribution from the change programme remains a risk.
3. The Programme Board, together with the DMO, continues to keep the programme scope under review to identify any projects that should be considered 'out of scope' for the assurance framework as they are standard operational issues that should be reported as such.

J Grinnell 26 Nov 18

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

1. This Board report comprises extracts from the assurance dashboard covering 5 of the 7 themes of the change programme as reporting to the Board sub-Committees: CQAC 21 November and R&BD 28 November.
2. Of the 23 projects rated in this report 52% are green rated with 22% amber and 26% red rated. These assessments show a marginal improvement over the past month; however, too many important initiatives are yet to sustain the Alder Hey standards of programme management. Therefore, Executive Sponsors should support their project teams to attain greater confidence in delivery.
3. The DMO has now developed the dashboard to give 2 overall ratings for each project: the first overall rating is for 'governance' of the project, the second overall rating is for 'delivery'. This distinction should assist Executive Sponsors and sub-Committees to focus on the pertinent issues.

J Gibson 26 Nov 18

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

The CIP status – including the contribution from the change programme – is at slide 3 of this pack.

Change Programme 18/19

Trust Board

Programme Assurance Framework, DMO & Delivery Board

R&BD

Growing Through External Partnerships

John

1. CHD Liverpool Partnership (SG)
2. Aseptics

Imminent Pipeline

- Neonatal Services

WOD

The Best People Doing Their Best Work

Melissa/Hilda

1. Portering (SG)
2. Apprenticeships
3. Catering

Imminent Pipeline

- E-Rostering
- AHP 2023 & Beyond

CQAC

Deliver Outstanding Care

Hilda / Steve

1. Sepsis
2. Best in Outpatients (Y3)
3. Brilliant Booking & Scheduling
4. Comprehensive Mental Health
5. Patient Flow
6. DETECT Study
7. Models of Care

Park, Community Estate & Facilities

David

SG — R&BD

1. Decomm. & Demolition
2. R&E 2
3. Alder Centre
4. Park
5. Hospital Moves
6. Community Cluster
7. Residential Development

Game Changing Research & Innovation

David

RE&I

1. The Academy
2. Developing Apps and Products with Acorn Partnership
3. Expand Commercial Research
4. The Innovation Co. Project

Strong Foundations

John

SG — R&BD

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

Global Digital Exemplar

John/Steve

R&BD — PB

1. Speciality Packages
2. Voice Recognition

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

Programme Contribution to CIP Status – as at 6th November 18

Weekly CIP Tracker as at 6th November 2018 by work stream

Workstream	Exec Sponsor	In Year Forecast			Risk Rating (In Year)					
		Target £000's	Forecast £000's	Gap £000's	Implemented (Posted) £000's	Fully Developed £000's	Plans in Progress £000's	Opportunity £000's	Gap £000's	Total £000's
Deliver Outstanding Care	Adam B/Hilda G	2,500	1,125	**-1,375**	906	95	123	125	1,250	**2,500**
Growing Through External Partnerships	Margaret Barnaby	800	0	**-800**	0	0	0	0	800	**800**
The Best People Doing Their Best Work	Melissa Swindell	1,000	755	**-245**	680	0	75	50	195	**1,000**
Game Changing Research and Innovation	David Powell	500	0	**-500**	0	0	0	0	500	**500**
Strong Foundations	John G/Claire L	2,200	1,550	**-650**	1,349	18	183	302	348	**2,200**
Park, Community Estate & Facilities	David Powell	0	18	**18**	18	0	0	0	-18	**0**
Global Digital Exemplar (GDE)	Peter Young	1,000	137	**-863**	137	0	0	0	863	**1,000**
Subtotal: Strategic Workstreams		**8,000**	**3,584**	**-4,416**	**3,091**	**113**	**380**	**477**	**3,939**	**8,000**
Divisional Business		-1,043	1,758	**2,801**	1,705	53	0	362	-3,163	**-1,043**
Unidentified		0	0	**0**	0	0	0	0	0	**0**
Grand Total		**6,957**	**5,342**	**-1,615**	**4,796**	**166**	**380**	**839**	**776**	**6,957**

Key points to note:

- CIP Schemes identified as at 6th November 2018 as fully developed (green) is £4.9m or 69%.
- Value of schemes in progress (amber) is at £0.4 m or 5%.
- The forecast outturn is £5.3m or 76% achievement
- The forecast outturn is £6m. There are a number of schemes being further developed are:
  - GDE
  - Procurement
  - Medicines
  - Outpatients project

Programme Assurance Summary

Delivering Outstanding Care

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

The programme aims to improve both quality and sustainability benefits continue to lack sufficient definition in terms of metrics; this is shown in the assurance ratings for 'benefits identification and delivery'. In particular, the sustainability gap has widened since the last report with a reported achievement of £1.125m CIP against the target of £2.5m – so a 45% delivery of the agreed savings.

The Sepsis project continues to attract ratings which give cause for concern in both the governance and delivery domains. Critically, the metrics of success for both training and core measures continue to fall short or are not being reported.

Executive Sponsors are again requested to expedite the actions necessary to bring the projects into an improved assurance status.

Claire Liddy, Director of Operational Finance – 9 Nov 18

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

The overall ratings from the 'Delivering Outstanding Care' have changed this month with 4 green rated, 1 amber and 2 red rated projects. Moreover, the repeated concerns around the tracking and attainment of benefits for 6 out of the 7 projects are not resulting in any evidenced action. The sub-Committee should discuss and agree with Executive Sponsors how this might be resolved.

For the Sepsis project, it is essential the revised approach formulated by the Executive Sponsor starts to improve the evidence across all of the assurance domains. The sub-Committee should review the evidence and ratings with a supportive stance yet critical eye.

Joe Gibson, External Programme Assessment – 9 Nov 18

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

Sub-Committee	CQAC	Report Date	9 Nov 18
Workstream Name	Delivering Outstanding Care	Executive Sponsor	Gwilliams/Bateman/McLaughlin

Current Dashboard Rating (sheet 1 of 2):

Assurance Group	Project Title	Project Description	Executive Sponsor Assures the project	OVERALL PROJECT GOVERNANCE	An effective project team is in place	Scope and Approach is defined	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	OVERALL PROJECT DELIVERY	Targets / benefits defined/on track	Milestone plan is defined/on track	Comments for attention of the Project Team, Steering Group and sub-Committee
1.0 Deliver Outstanding Care 18/19														
CQAC	**Best in Outpatient Care**	The Best in Outpatients Project aims to deliver an outstanding experience of outpatient services for children, families and professionals as well as safely increase the number of patients we see in clinic	Hilda Gwilliams	🟩	🟢	🟢	🟡	🟢	🟢	🟢	🟥	🔴	🟢	The project team is now fully in place and good minutes of Steering Group available (to 31 Oct 2018) and Project Leads meeting (to 16 Aug 18) with action notes tracked; a future schedule of meetings has been planned. The PID is detailed and clear but at least two of the targets are not achieving the required levels; it is noted that the next results from the 'clinician satisfaction' metric are due on 22 Oct 18 (last reported April 18). There is a comprehensive milestone plan being tracked. A risk register is held and is up to date. There is a planned approach to stakeholder engagement but a lack of evidence as to whether planned actions have been delivered. **Last updated 5 Nov 18.**
CQAC	**Brilliant Booking and Scheduling**	To provide a booking system that puts patients and families first and meet the needs of clinicians that use it.	Adam Bateman	🟩	🟢	🟡	🟢	🟢	🟢	🟢	🟧	🟡	🟡	Project team meetings are scheduled and documented up to 19 Oct 18. The PID still requires work to fully define benefits. Benefits tracking plans are comprehensive but with some baselines still to be established. The Gantt Project Plans are now complete - Main plan plus one each for Gastro and Spinal; these are being closely tracked but with several milestones delayed. There is a comprehensive suite of stakeholder engagement updated to 4 Oct 18. The risk register is detailed with risks last reviewed on 9 Oct 18. EA/QIA signed off and uploaded. **Last updated 5 Nov 18.**
CQAC	**Comprehensive Mental Health**	Deliver improvements in mental health services to better meet the needs of children and young people. Be recognised as leading the way for CAMHS services nationally	Cath McLaughlin	🟩	🟢	🟢	🟡	🟢	🟢	🟢	🟩	🟢	🟢	Comprehensive Mental Health project team meetings: the Steering Group (evidence to 6 Sep 18) forms part of the CAMHS board agenda on first Thursday of each month while meetings to discuss each work stream and the milestones happen on a fortnightly basis (evidence to 5 Nov 18). There is a comprehensive PID (although the PID high level milestones should project out to the end of the project cycle) and benefits are defined. A good milestone plan is in place and being tracked. A stakeholder analysis has been completed but further evidence required of wider stakeholder engagement. A Ulysses risk log has been completed and has risk review dates completed. A signed EA/QIA has been uploaded. **Last updated 6 Nov 18.**
CQAC	**Patient Flow**	Improve our processes to enable timely implementation of clinical decisions, and support patients through their pathway efficiently: minimising delays and reducing time spent in hospital. This project consists of 3 workstreams; Expanding Day Surgery, Expanding Pre-Op Assessment and SAFER Bundle.	Adam Bateman	🟩	🟢	🟢	🟡	🟢	🟢	🟢	🟧	🟡	🟢	Evidence of SAFER Task Force evidence, for 3A & 4C and 3C & Burns up to 30 October 2018. The PID refinement of benefits and high level milestones was completed on 31 Oct 18. A benefits 'dashboard' has been uploaded on 6 Nov 18 with many trajectories now positive. A detailed milestone plan has been uploaded for SAFER and is being tracked. Stakeholder engagement evidence is limited, additional evidence is now required. A comprehensive risk register is being updated on a monthly basis. An EA/QIA has been signed. **Last updated 6 Nov 18.**

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

Sub-Committee	CQAC	Report Date	9 Nov 18
Workstream Name	Delivering Outstanding Care	Executive Sponsor	Bateman/Gwilliams

Current Dashboard Rating (sheet 2 of 2):

Assurance Group	Project Title	Project Description	Executive Sponsor Assures the project	OVERALL PROJECT GOVERNANCE	An effective project team is in place	Scope and Approach is defined	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	OVERALL PROJECT DELIVERY	Targets / benefits defined/on track	Milestone plan is defined/on track	Comments for attention of the Project Team, Steering Group and sub-Committee
1.0 Deliver Outstanding Care 18/19														
CQAC	**Models of Care**	**What:** Consultant led delivery of patient pathways is currently suboptimal for some patients. Care is not always organised around needs of the following patient cohorts: 1) Complex patients (Surgery & Medicine) 2) HDU 3) Specialities 4) General Paediatrics 5) Medical Management of Non-Complex Surgery Patients **Why:** To improve consistency of the management of deteriorating and high dependency patients (in terms of consultant lead, patient pathway and time of day / day of week)	Adrian Hughes	Red	Amber	Amber	Red	Amber	Red	Red	Red	Red	Red	Brief notes of 'EDU Model' delivery group of 1 Nov 18 with an 'Outline' of the model. Brief notes of the 'HDU Model' meeting of 1 Nov 18. Documents outlining 'Pathways and Thresholds' also available but no indication of the status of these papers. 'ED and EDU' notese of a meeting of 24 Jul 18 available. There are 4 slide packs but no PIDs or detailed description of how new MOC will be deployed (approach and scope). There are some analyses in the benefits folder but no clear metrics for success. There is a single slide high level plan Oct 18 - Apr 20 but no detailed/trackable milestone planning in evidence. No evidence of stakeholder engagement and communications. There is a detailed risk register but risks not reviewed since 19 Jan 18. **Last updated 2 Nov 18.**
CQAC	**Sepsis**	To improve working within and across clinical teams.	Hilda Gwilliams	Red	Red	Amber	Amber	Red	Green	Green	Red	Red	Amber	Sepsis Steering Group minutes available to 13 Jun 18 with no record of the next meeting due 15 Aug 18. PID complete but needs to be updated to reflect change control around new targets; these new targets need to be signed off at Programme Board. Benefits defined, tracking/reporting of benefits has commenced but last up-dated figures are December 2017. From the benefits tracker on SharePoint: Time to Antibiotic Presecription from Diagnosis is against a threshold of 90% was at 63% (ED ONLY) and 73% (Inpatients ONLY) and target was for both to be 90% by March 2018. However, there is also data to August 2018 showing time to prescription for High Risk at 71.8% and for Low/Mod/High at 72.2%. E-Learning Record (Oct 18) is showing 42% achievement. Training record log for Sep 18 shows many areas reaching a 70% threshold for nurses but no records for dcotors. Milestone Plan for 2018/19 has been uploaded and last updated 16 Oct but needs further meaningful milestones beyond March 2019. The communications plan 2018-20 gives a high level list of activities but there is no tracked (for completion) milestone plan. Evidence now on SharePoint of risks on Ulysses system (last update June 2018). EA/QIA complete. **Last updated 16 Oct 18.**
	DETECT Study	Using smart technology to reduce critical deterioration	Hilda Gwilliams	Amber	Green	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Evidence of project team meetings has been uploaded to SharePoint up to the minutes of the meeting of 4 Sep 18. A high level description of the scope is available in a 7 slide pack and a detailed PID has now been completed; however, the metrics are still required for the measurement of benefits. A detailed Gantt Chart is available (uploaded 17 Jul 18) and will now need tracking on SharePoint. There are materials uploaded which indicate stakeholder engagement, including presentation to Grand Round 5 Oct 18, but there is no communications plan in evidence. There is a risk register and it would benefit from being in Trust standard format. An EA/QIA has been drafted and needs sign-off. **Last updated 19 Oct 18.**

Programme Assurance Summary

Growing Through External Partnerships

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

The Sustainability Delivery Group needs to address the issue that the contribution to the CIP effort from this work stream remains at zero at month 8.

The executive sponsor is requested to address the status of the CHD Liverpool Partnership as there can be no assurance of delivery in the absence of evidence being forthcoming.

Claire Liddy, Director of Operational Finance – 22 Nov 2018

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

CHD Liverpool Partnership continues to attract a red rating due to the continuing lack of any comprehensive assurance evidence from the for the programme. The executive sponsor should liaise with the project team to ensure that any relevant documentation should be uploaded, without delay, to the SharePoint site.

The re-scheduled Aseptics project is now being maintained to a satisfactory standard; however, there continue to be challenges to the schedule and benefits delivery that the project should work to remedy.

Joe Gibson, External Programme Assessment – 22 Nov 2018

Sub-Committee	R&BD	Report Date	22 Nov 2018
Workstream Name	Growing Through External Partnerships	Executive Sponsor	John Grinnell

Programme Assurance Framework

Growing Through External Partnerships (Completed by Assurance Team)

Current Dashboard Rating:

Assurance Group	Project Title	Project Description	Executive Sponsor Assures the project	OVERALL PROJECT GOVERNANCE	An effective project team is in place	Scope and Approach is defined	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	OVERALL PROJECT DELIVERY	Targets / benefits defined/on track	Milestone plan is defined/on track	Comments for attention of the Project Team, Steering Group and sub-Committee
R&BD	**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.	Christian Duncan	Red	Amber	Green	Amber	Amber	N/A	N/A	Amber	Amber	Red	Minutes of meetings and governance structure were uploaded to SharePoint but evidence of recent meetings is lacking. Following NHSE decision on 30 Nov 17, project documentation has been developed to provide a mobilisation plan. Milestone Plan uploaded, with tabs for various work streams, but is not being tracked on SharePoint since June 2018. Benefits need to be further refined with evidence on SharePoint. Risk Register uploaded and risks not reviewed since 5 Apr 18. **Last updated 18 Jun 18.**
R&BD	**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.	Mags Barnaby	Green	Green	Amber	Green	Green	Green	Green	Amber	Amber	Amber	Minutes of the Quality Management Meeting of the Aseptics Services Department are available and up to date to 6 Sep 18. Scope is described by the 'Proposal for commissioning, validation and licensing of the Pharmacy Aseptic Services Unit' dated 16 March 2018' together with a 'Project Overview Document' dated 14 Jun 2018. Targets and benefits are being closely tracked but not yet reaching aspired thresholds and are amber rated by the project. A 'Project Milestone Plan' is in place and being tracked up to 5 Nov 2018. The 'External Audit Action Plan' needs to be updated. Inceasing levels of evidence of stakeholder engagement now being uploaded. Audit of Aseptic Services has been uploaded to SharePoint. EA/QIA signed off. **Last updated 7 Nov 2018.**

Programme Assurance Summary
Global Digital Exemplar

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

The CIP tracker (see slide 3) now shows an initial £137k forecast GDE contribution to savings in 2018/19. The work to further these financial benefits needs to continue throughout the programme life-cycle. There is a role for the 'Sustainability Delivery Group', by exception, in assisting the programme to resolve this issue.

During November, there has been a continuing flow of evidence from the GDE Programme and 'Voice Recognition' project; however, there has been no new assurance evidence from the 'Speciality Packages' project and this should be resolved by the project team.

Claire Liddy, Director of Operational Finance – 22 Nov 2018

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

The GDE 'Statement of Projected Benefits' continues to estimate £2.08m cash realising benefits for 2018/19. The Trust CIP tracker is now forecasting the first contribution of £137k from the GDE initiatives; clearly there needs to be a continued focus on closing this gap between expectation and delivery.

The 'Voice Recognition' project (see previous reports) remains 'amber' rated, due to the difficulty in realising the planned benefits, albeit there continues to be a high standard of project management.

Joe Gibson, External Programme Assessment – 22 Nov 2018

Programme Assurance Framework

Global Digital Exemplar (Completed by Assurance Team)

Sub-Committee	R&BD	Report Date	22 Nov 2018
Workstream Name	Global Digital Exemplar	Executive Sponsors	John Grinnell / Steve Ryan

Current Dashboard Rating:

Assurance Group	Project Title	Project Description	Executive Sponsor Assures the project	OVERALL PROJECT GOVERNANCE	An effective project team is in place	Scope and Approach is defined	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	OVERALL PROJECT DELIVERY	Targets / benefits defined/on track	Milestone plan is defined/on track	Comments for attention of the Project Team, Steering Group and sub-Committee
R&BD	GDE	Create exemplars that can inspire others by really showing how information technology can deliver both improved patient outcomes and enhanced business effectiveness	John Grinnell	Red	Green	Green	Amber	Red	Green	Green	Red	Red	Amber	Programme Board Minutes and Agenda in evidence up to 18 Sep 2018. GDE Action Log uploaded to 14 Aug 18. PID of 28 Jun 17 v8 available. Overall benefits profile and schedule has now been finalised, 'Strategic Owner' column on SoPB still requires updating to reflect current trust executive appointments; internal CIP Tracker shows just £137k forecast in 2018 against a target of £1m, while the SoPB proposes £2.08m cash realising benefits in 2018/19 (VfM Tracker). Milestone Plan on Dashboard, dated 17 Sep 2018, shows some delivery dates missed; several milestones have RAG ratings that do not reflect the % delivery status. Stakeholder evidence has been uploaded with a register updated to Aug 2018 with Newsletters to 3 Aug 2018. Risk protocols vis-à-vis national and Trust sytsems have been harmonised but not updated on SharePoint since 29 May 18. **Last updated 20 Nov 18.**
R&BD	Speciality Packages	Delivery of electronic clinical documentation workflow designed to reflect best practice protocols and pathways	John Grinnell	Amber	Amber	Green	Amber	Green	N/A	N/A	Amber	Amber	Amber	Overall benefits profile and schedule is shown on the SoPB tracker; internally, there are no financial benefits yet reported for 2018. Project Plan last updated with a pdf copy of the Speciality Package Project Plan of 8 Aug 2018; however, this does not indicate the status or % completion of tasks. Stakeholder engagements entered to 8 Jun 18. Risk protocols vis-à-vis national and Trust systems are now harmonised and finalised. Risks and issues aggregated at GDE programme and updated at 21 Aug 2018. **Last updated 19 Sep 2018.** QIA/EA will be assured and assessed at project level.
R&BD	Voice Recognition	Deploy voice recognition solution in Medisec and Meditech	John Grinnell	Green	Green	Green	Green	Green	Green	Green	Red	Red	Amber	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 15 Nov 2018.**

Programme Assurance Summary
Park, Community Estate and Facilities

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

The Programme Board now needs to provide a date by which the ‘Community Cluster’ will be fully mobilised so that assurance can be provided that the planning and design are on track.

Elsewhere, the executive sponsor and Programme Board need to confirm to the DMO that the planned re-fresh and re-organisation of the work stream has been agreed; this will bring further clarity to the development of the final stages of implementing the full ‘Alder Hey in the Park’ vision.

Claire Liddy, Director of Operational Finance – 22 Nov 2018

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

The proposed plan, to replace the current workbooks, will cover 4 main areas:

- Park
- Site clearance
- Schemes (includes all new developments)
- Future state-Opportunities developments

Confirmation is required, from the Strategic Programme Manager, that the planned re-structure of this work stream - with a new breakdown of the programmes of work – has been agreed with the executive sponsor and endorsed by the Programme Board.

Joe Gibson, External Programme Assessment – 22 Nov 2018

Sub-Committee	**R&BD**	**Report Date**	**22 Nov 2018**
Workstream Name	Park, Community Estate and Facilities.	**Executive Sponsor**	**David Powell**

Programme Assurance Framework

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

Current Dashboard Rating:

Assurance Group	Project Title	Project Description	Executive Sponsor Assures the project	OVERALL PROJECT GOVERNANCE	An effective project team is in place	Scope and Approach is defined	Stakeholders engaged	Child and Family Involvement	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	OVERALL PROJECT DELIVERY	Targets / benefits defined/on track	Milestone plan is defined/on track	Comments for attention of the Project Team, Steering Group and sub-Committee
R&BD	**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 that all planned activities have now completed; confirmation required of the milestones dates for future activity. Details of communication/engagement activities to be confirmed and evidence provided where possible. Risks now on Ulysses but no updates to SharePoint. EA/QIA now over 2 year old (Apr 16) and needs review and re-signing. **Last updated 7 May 2018.**
R&BD	**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												Progress Meeting Notes available to April 2018. The R&E Commissioning Plans and Mobilisation Plans are also available to 9 Oct 2018. PID available, benefits to be confirmed. Milestone Plan continues to show some significant delays with key milestones running late but is being tracked as recently as 11 Sep 18. There is a key dependency on the 'Agile' initiative. 'Red Issues' Log uploaded to 25 Oct 2018, risks to be entered on Ulysses. Deatils of Catering options are also on SharePoint. EA/QIA completed and signed off. **Last updated 25 October 2018.**
R&BD	**Alder Centre**	To plan, develop and construct the new Alder Centre within the park setting	David Powell												Steering Group meeting notes not updated. 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); it is understood that construction that was due to start at the beginning on June (according to plans on SharePoint) has not yet commenced. Finalisation of design has been completed with start of build scheduled 2 months later than showing on the plan. Evidence of Comms/ Engagement activities. Risks to be confirmed on Ulysses. EA/QIA complete. **Last updated 28 Aug 2018.**
R&BD	**Park**	To set up a JV with LCC & the local community to create a world class Springfield Park that complements & adds value to the New Alder Hey in the Park & the local area	David Powell												Steering Group reports available to 21 November 2018 and governance structure in place (notes from Steering Group should also be uploaded). Updated PID on SharePoint showing comprehensive suite of benefits and high level milestones through to end of project life cycle. An indication of progress against benefits targets (RAG rating or % confidence level achieved would be useful). There is a new and detailed Milestone Plan together with a PowerPoint to illustrate high level milestones; there is also an extremely informative 'Springfield Park Update' available. A comprehensive 'Engagement Ops Plan' is in evidence (this would benefit from status indicators). A Risk Register has been uploaded to 22 Jun 18 with a copy of the BAF submission of Sep 18. EA/QIA complete. **Last updated 21 Nov 2018.**
R&BD	**Hospital Moves**	To re-provide a high standard of working accommodation for those teams and services currently lodged in interim facilities on the retained estate	David Powell												Minutes of the 'Hospital Moves Steering Group' are available to 14 Aug 2018 and there is an agenda for the meeting planned for 16 Oct 2018. The PID dated 9 Jan 18 is available on SharePoint and provides a comprehensive summary of scope and approach. A high level critical path has been uploaded as well as an option for external provision of space. There is now a detailed Milestone Plan now uploaded onto SharePoint but many missed milestones are without as revised date for completion. A risk register is being maintained (important to have dates for 'risk raised' and 'last reviewed'). EA/QIA signed, important to review during the project as different accommodation options are decided upon. **Last updated 8 Nov 18.**
R&BD	**Community Cluster**	This project is currently at the exploratory and feasability stage and will be rated once fully launched	David Powell												Draft PID uploaded 1 Feb 2018, 'Initiation' Slides uploaded 27 Mar 2018, Design Spec uploaded 27 Sep 18. All other project documentation yet to be developed. **Last updated 27 Sep 2018.**

Programme Assurance Summary

Strong Foundations

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

The 'Energy' project still remains to be considered for removal from the framework, as discussed at the recent Trust Board meeting, as it does not have the attributes of a project.

The 'Catering' project has now attained a green rating and the efforts of the project team should be recognised for achieving this rating so soon after the project launch; the financial recovery depends on the successful implementation of the review findings.

Claire Liddy, Director of Operational Finance – 22 Nov 2018

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

The assurance evidence for the Catering project has now merited a green rating.

As previously requested: the 'Energy' project should be considered by the Programme Board for it's inclusion in the assurance framework as it lacks the fundamentals for project work.

Overall, the projects continue to maintain a good standard of assurance evidence – in terms of working project documents - and this fact is reflected in the positive ratings.

Joe Gibson, External Programme Assessment – 22 Nov 2018

Programme Assurance Framework

Strong Foundations (Completed by Assurance Team) - Current Dashboard Rating:

Sub-Committee	R&BD	Report Date	22 Nov 2018
Work stream Name	Strong Foundations	Executive Sponsor	John Grinnell/ David Powell

Assurance Group	Project Title	Project Description	Executive Sponsor Assures the project	OVERALL PROJECT GOVERNANCE	An effective project team is in place	Scope and Approach is defined	Stakeholders engaged	Child and Family Involvement	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	OVERALL PROJECT DELIVERY	Targets / benefits defined/on track	Milestone plan is defined/on track	Comments for attention of the Project Team, Steering Group and sub-Committee
R&BD	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	N/A											Documentation relevant to this specific type of project now on SharePoint. Detailed POD available with precise metrics. Plan updated, benefits profile shows project is on track to realise full benefits as projected. Evidence of stakeholder engagement has been uploaded (albeit relatively narrow). EA/QIA now signed off. **Last updated 7 Sep 18.**
R&BD	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	N/A											Documentation relevant to this specific type of project now on SharePoint. Plan last updated 2 Aug 18. Evidence of stakeholder engagement now uploaded but not extensive. EA/QIA signed off. **Last updated 7 Sep 18.**
R&BD	Medicine Optimisation	To deliver the trust MO strategy and deliver quality improvements and financial benefits	Adrian Hughes	N/A											Team structure now complete and actions notes of Steering Group available up 13 Jul 18. POD now uploaded, needs to show phasing of savings across the year to allow coherent feed into Trust CIP tracking. Plan uploaded, needs completion; tracking and completion of milestones for actions and benefits needs to be clear. Good stakeholder engagement evidence is emerging. A risk register has been uploaded. EA/QIA complete. **Last updated 14 Sep 18.**
R&BD	Coding and Capture	To ensure the AH delivers a above average depth of coding and complies with the business rules whilst maximising income	Claire Liddy	N/A											Project team structure now complete. Minutes of Steering Group available up 1 Aug 18. POD uploaded and benefits baselines still to be established. Detailed benefits tracker uploaded, with savings starting to flow and forecast to meet target. Detailed Milestone Plan in evidence, tracked and up to date, with project actions over the full project cycle. Evidence of continuing stakeholder engagement needs to be uploaded. Risk register in place and last reviewed on 1 Aug 18. It has been confirmed that the QIA signed of at end of 2017 applies to the 18/19 programme (and will be reviewed in Dec 18). **Last updated 12 Sep 18.**
R&BD	Energy	To bring down energy cost and ensure budget forecast matches contractual target. Forecast budget for next 12 months for all fuels in line with contractual usage.Once the contractual target of 46.7 G has been achieved look at ways of reducing further by means of energy awareness for staff.	David Powell	N/A											Evidence of team meetings is available to June 18. An 'Energy Reconciliation Report FY16/17' has been uploaded on 20 Sep 18 but it is not clear whether this is old or new infromation to be acted upon. The POD available available on SharePoint gives no details of financial benefits expected for 2018/19. The project plan for 18/19 contains only 6 actions (2 of these relate to usage monitoring and 2 relate to a compensation claim; more detail is required if this is to be considered a project). Evidence provided concerning risks is limited to the single BAF entry. QIA signed off for the 18/19 programme. **Last updated 20 Sep 18.**
R&BD	Catering	To implement the recommendations from the Independent Catering review to improve the overall food service delivery at Alder Hey whilst reducing the financial loss current operating within the Catering Department.	Hilda Gwilliams	N/A											Evidence is available for the project 'Steering Group' meetings up to 19 Sep 18. The extensive and detailed 'Review of Catering Services – Final Version' dated January 2018 is serving as a detailed PID. There is a detailed 'Catering Project Benefit Tracker 2019/20' in development with evidence of supporting surveys and templates. A comprehensive Gantt chart plan has been prepared arising from the review, it is being monitored, and is largely on track. More evidence will be required in terms of stakeholder engagement. Risks have been identified and are being managed. An EA/QIA has been drafted for signature. **Last updated 21 Nov 18.**

Resources and Business Development Committee
Draft Minutes of the meeting held on: Wednesday 24th October 2018 at 9:30am in Large Meeting Room, Institute in the Park

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)
	Claire Liddy	Director of Operational Finance	(CL)
In attendance	Sue Brown	Associate Director for Development	(SB)
	Mags Barnaby	Interim Director of Strategy	(MB)
	Erica Saunders	Director of Corporate Affairs	(ES)
	Julie Tsao	Committee Administrator (*minutes*)	(JT)
Apologies	Mark Flannagan	Director of Communications	(MF)
	Phil O'Connor	Deputy Director of Nursing.	(POC)
	Melissa Swindell	Director of HR and OD	(MS)
Agenda Item:			
4	Graeme Dixon	Head of Building Services	(GD)
4	Hilda Gwilliams	Chief Nurse	(HG)
8	Joe Gibson	External Programme Assurance	(JG)
8	Kerry Morgan	GDE Benefits and Risk Lead	(KM)

18/19/92 Apologies

The Chair noted the apologies received from Mark Flannagan, Phil O'Connor and Melissa Swindell.

18/19/93 Minutes from the meeting held on 26th September 2018

Resolved:
The Committee received and approved the minutes of the meeting held on the 26.9.18.

18/19/94 Matters Arising and Action log

RABD went through the action noting completed actions and agreed a timescale for any areas requiring a further update.

18/19/95 Top 5 Risks/Key Priority Areas for 2018/19.

CIPs
The Committee was informed that the forecast outturn for CIP achievement as at the 15th September is £5.2m or 75% delivery, this is slightly lower compared to last month.

Since the last meeting the value of amber rated schemes had reduced by £1m. A further action was to reduce the high risk black and red schemes.

Pipeline schemes in progress include medicines optimisation, procurement, outpatient project and GDE that will support an additional £0.8m CIP delivery to increased projected FOT of £6.0m by end of the calendar year.

2019/20 CIP target setting was in progress, it was agreed that an update on the recurrent position would be presented in December 2018.

18/19/95.1 Action: Sara Naylor

Capital Programme

Month 6 saw an in month underspend against the submitted NHS Improvement plan of £1,039k due to profiling of schemes, with the programme currently underspent for the year by £2,907k. Total year to date capital spend is £8,303k, against a plan of £11,210k.

The Trust now forecasts to NHSi that a capital programme of £23.081m will be delivered in 2018/19. This is lower than the planned programme of £23.977m due to slippage of the Alder Centre and Community Cluster schemes into 2019/20.

There are emerging issues within Estates across many of the overall estates projects. These are currently under review and work to mitigate these risks is ongoing.

Elective Programme

Adam Bateman submitted a number of slides in order to provide an update on elective activity at month 6. The following points were highlighted and discussed:

- One patient had taken capacity of 8 beds due to high complex requirements. RABD noted the challenge this had caused the department. The hospital would be able to claim a reimbursement from Liverpool Council.
- Mobile bi-directional reminder and cancellations service – Surgery reported additional £16.5k income from re-filling cancelled slots in September.
- Winter planning:
    - new Theatre scheduling process for day case to maimise theatre capacity.
    - Dentistry - Contracted number of lists offered to Pennine in order for them to be re-utilised by internal specialties
    - Anaesthetics - comprehensive recruitment plan including, additional support from visiting consultants, clinical fellows positions and agency staffing options.
- Following engagement with CAMHS and introducing a number of new processes both patients awaiting assessment and addmissions had been reduced.

PFI

John Grinnell reported Project Co had attended the October Board providing members with actions and proposed timescales to repair or replace the corroded pipe work.

The PFI team were awaiting a formal list of outstanding issues due to be received by the end of October 2018.

Catering
Following the last update at RABD £450k overspend at the end of the financial year had been reported.

Since the meeting an action plan had been agreed to reduce the overspend by £55k. It was agreed the actions taken would be emailed to RABD following the meeting.
Action: JT completed.

Hilda Gwilliams agreed to present a further update at the January RABD.
18/19/95.2 **Action: HG**

18/19/96 Finance Report
The Trust is reporting a trading surplus for the month of £6.4 which is ahead of plan by £0.3m. Income is ahead of plan by £0.2m and expenditure is underspent by £0.1m in the month. The Use of Resources risk rating is 2 in line with plan and cash in the bank of £20m.

NHSE (spec comm) Contract
Following over performance against the agreed contract due to higher patient cases in respiratory and traumas a process with a set forecast was to be completed and rolled out over the next couple of months.
18/19/96.1 **Action: CL**

A HRGV4 risk had been identified in relation to the Welsh Contract. NHSI are aware this risk is not included in the Control Total.

Divisional Forecast
The revised Trust control total is a surplus of £32.2m.

The divisions have submitted forecasts at month 6 of £29.3 surplus which represents a variance to plan of £2.9m. The Divisions have been asked to provide a recovery plan to bridge the £2.9m gap.

Resolved:
The Committee noted the contents of the Finance report for month 6.

18/19/97 10 Year Capital Outlook
Following discussions at the last RABD meeting Claire Liddy presented the revised 10 year capital plan.

The plan presented the Trust's cash requirement based on capital request. The report concluded the Trust needed to improve its underlying trading position to improve cash reserves available for investment.

The Chair reported on a company used in a previous role called Lean that had supported a business in making sigficant savings. Adam Bateman responded on Inspiring Quality paper that was due to be presented at Board in December and included similar strategies and safety aspects.

RABD agreed the 6 areas to be prioristed and require further action are:

- Receive decision from STP Capital
- Estates stock take exercise & turnaround plan
- IT & Medical 3 and 10 year plan options
- Charity business plan
- Board Prioritisation exercise Medical v IT v Estates
- 10 year clinical sustainability plan – Target £5m surplus by 21/22

Resolved:
RABD received a further update on the 10 year capital outlook.

18/19/98 **Plan to address non pay issues**
Resolved:
A breakdown of the non pay position by division for month 6 was received.

18/19/99 **Programme Assurance**
The programme assurance summary was received. RABD focused on projects with an overall red rating:

Growing through external partnerships
CHD Liverpool Partnership – As the tender had been won by the Trust and was going well it was agreed that this project would no longer be reported on.

Strong Foundations
Energy – Since circulation of the report actions had been taken and the project was on track.

Park, Community, Estates and Facilities
Decomission and Demolition
For reference Sue Brown agreed to submit a closure report of completed actions. Phase 2 was agreed to commence in the new year.
18/19/99.1 **Action: SB**

Global Digital Exemplar
GDE
Going forward Kerry Morgan agreed to also include CIP Benefits.
18/19/99.2 **Action:KM**

Global Digital Exemplar – Monthly report
Since the last update received in September, progress for phase five milestones to be achieved continues.

The Statement of Planned Benefits for the GDE Programme has been updated and submitted to NHS Digital for review. The Trust facilitated a national WebEx for NHS Digital and all GDE sites explaining our approach to benefits management. We received positive feedback on our practical and pragmatic approach to benefits.

The Trust has aligned with NHS England and NHS Digital to progress the NHS App into secondary care paediatrics. This in line with the national strategy and will overcome the information governance concerns in relation to patient registration and consent. A workshop with App developers and NHS Digital is to be held in November to discuss use cases, workflows and interfacing the App to

the e-Xchange clinical portal.Erica Saunders asked for Jo Fitzpatrick, Information Governance Manager to be invited.

Resolved:
RABD noted the progress of the Trusts GDE Programme; the finalisation of Milestone 4 and on-going progress towards Milestone 5.

18/19/99.3 **Action: KM**

18/19/100 **Marketing and Communications Activity Report**
Resolved:
RABD received and noted the contents of the Marketing and Communications Activity report.

18/19/101 **Board Assurance Framework (BAF)**
Resolved:
RABD received and noted the BAF cover report for month 6.

As the incorrect BAF report had been circulated assurances were provided that the version circulated at the October Board would be filed.

18/19/102 **Terms of Reference for Operational Steering Group**
Resolved:
RABD received the Operational Steering groups terms of reference. RABD noted the group was still under review and would be made aware of any relevant changes.

18/19/103 **NHSI Q2 Narrrative report**
Resolved:
RABD received the above report noting access target data would be included in the final version submitted on Friday 26th October 2018.

18/19/104 **Corporate Report**
RABD received and noted the Corporate report for month 6. Adam Bateman noted open pathways standard, cancer standard and diagnostic standard were all achieved. Waiting List size had reduced.

Resolved:
The Committee received and noted the Corporate Report for month 6.

18/19/88 **Monthly Debt Write Off**
RABD received the proposed monthly debt write-off for October 2018.

RABD discussed the £16k patient write off noting the unsuccessful efforts made for payment.

Resolved:
RABD approved the proposed monthly debt write off for October 2018.

18/19/105 **PFI Monitoring Contract**
A piece of work had highlighted the ventilation flow on three wards within Dentistry was not compliant with the HTM guidance. Graeme Dixon advised that whilst the areas identified are not complient it did not cause concern for staff or patients health and safety. Adam Bateman asked for the Microbiologist to be informed of the current position.

18.19.105.1 **Action: GD**

There would however be a large cash penalty to Project Co for the non compliance. Due to this RABD was asked whether further areas should be tested. John Grinnell agreed to decide this outside of the committee with Graeme Dixion.

18.19.105.2 **Action: JG**

Improvements in fire stopping are in place and an independent report has been commissioned on the works to date as well as outstanding issues. A full RA has been completed by Interserve and the Trust has discussed and responded. The MFRS have now removed the order of fire stopping works.

The Chair queried a section of the report as the current wording gave assurances to work in progress, it was agreed this would be reviewed.

18.19.105.3 **Action: GD**

Resolved:
The Committee noted the Building Services report for month 6.

18/19/106 **Neuro Building**

Sue Brown presented a proposal on retaining the Neuro building. Sue Brown informed RABD the reasons behind the changes to the plan agreed 12 months ago. For reference the benefits have been included below:

- Allows proposal of utilising Neuro to accommodate clinical services with community cluster development compliant layout with minimal alterations etc
- Allows, with reconnection of Neuro to central CHP plant, cheaper electricity costs
- Allows retention of medical records on site (All records stored on interim estate to be centralised to Oncology) allowing time to formulate/agree future state/need (Accepting solution for future state may require further expenditure)
- Allows the Alder Centre & Team Prevent to remain in Oncology until the new build is available
- Allows shut down of O1/cardiac/ICH builds as planned
- Allows planned decommissioning/demolition phasing
- Allows capex saving of circa £250k on possible costs

Resolved:
RABD APPROVED the request to retain former Neuro modular block at a cost of £291K.

18/19/107 **Alder Centre**

Sue Brown requested the approval from RABD to move forward and award a contract to enable construction of the proposed Alder Centre following the design and procurement process run by RIBA and following discussion and agreement on the recommendations presented to the executive team on the 4th October 2018.

A query was raised around demonstrating other options were not valid. John Grinnell assured RABD the framework was compliant.

Resolved:

RABD APPROVED a contract with Whitefield and Brown on the basis of the budget as set out in Table 1. This will enable work to commence on site by the beginning of November 2018.

Sue Brown agreed to update RABD on progress at the Janauary meeting.

18/19/107.1 **Action:SB**

18/19/108 **Alder Hey Site Development Procurement – Community Cluster**

Sue Brown presented a paper with a recommendation on the procurement route for the building contractor on the community Hub/cluster via a single stage tender with a target price and specification refinement for approval as it provides an opportunity to tune the scheme to respond to price and planning challenges, overall this provides more flexibility than other options considered.

Resolved:
RABD Approved the recommendation.

18/19/109 **Any Other Business**

There was none to discuss.

Date and Time of Next Meeting: Wednesday 28th November 2018, Large Meeting Room, Institute in the Park, 9:30am-12:30pm,

Audit Committee

Draft Minutes of the meeting held on **Thursday 20th September 2018**
Room 7, Mezzanine

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

18/19/35 Minutes of the previous meeting held on 18th May 2018

Resolved:
Subject to the following amendments, the Audit Committee received and approved the minutes from the meeting held on the 18.5.18.

- **18/19/22** A typographical error to be corrected: this item should read 2017/18, not 2017/17.
- **18/19/24** ELFS: Erica Saunders rather than Louise Cobain presented the 2017/18 Director of Audit Opinion and Annual Report for ELFS Shared Services.

18/19/36 Matters Arising and Action List

Action 24.1 *Director of Audit Opinion and Annual Report, 2017/18 - ELFS Shared Services* **-** The requested update was provided. **ACTION COMPLETE**

Action 25.3 *Ernst and Young External Audit Year-end Report for 2017/18* – the agreed wording for the final opinion regarding CQC ratings was provided by Erica Saunders. **ACTION COMPLETE**

18/19/37 Progress Report - MIAA

Maria McMahon-Joseph presented the Internal Audit progress report. The Committee was advised that this report provides an update in respect of the assurances provided, key issues raised and progress against the Internal Audit Plan for 2018/19.

The report had rated Discharge Planning and Data Quality (admission, discharge and transfer) as limited assurance, while Risk Management is rated substantial assurance.

For Data Quality, there are 3 high risks and 2 medium risks raised. Maria McMahon-Joseph suggested a review of the validation process by the Data Quality Steering Group to pick up on earlier missing data; she reported that a discussion with management regarding the findings and follow up responses is expected by the end of this month prior to the next Audit Committee meeting.

It was reported that the Risk Management process within the Trust has developed and improved to a very significant and positive position and the resource dedicated to monthly validation of risk registers has made a positive and significant difference.

18/19/37.1 Action: Exec Lead

Management to submit Internal Audit findings to the appropriate subcommittee to ensure the issues are communicated to management and Trust Board.

18/19/38 Follow-up Audits - MIAA

Maria McMahon-Joseph reported on the current position with regard to the remaining historical audit recommendations; more evidence had been provided by area leads but the close down of individual recommendations is an on-going process. Further reports will be brought to the Committee until items are closed. Maria McMahon- Joseph also reported that a positive meeting had taken place between Internal Audit and Trust Directors which clarified the reasons for the outstanding items and provided assurance that ongoing reviews are taking place to keep on track.

18/19/38.1 Action: MMJ

Maria McMahon-Joseph agreed to revise the format of the table of overdue recommendations to include the context, identify the part that is outstanding and the revised deadline and the issues with implementation such as external dependencies.

18/19/39 Counter Fraud Progress Report

Virginia Martin presented the Internal Audit Anti-Fraud Progress Report. The Committee received and noted the outcomes for consideration. It was suggested to start a data protection exercise within all departments issuing privacy notices.

MIAA will assist with providing the procedures and information for guidelines about anti-fraud training and put in place training for staff to recognise Fraud.

It was reported that the current anti-fraud service is progressing as planned with one element rated amber due to outstanding data from the Trust. The data has now been received and will be updated.

Resolved:

Audit Committee received MIAA Anti-Fraud progress report for April 2018 to September 2018.

18/19/40 Fraud Taxonomy

Resolved:

This Item will no longer be on the agenda as NHS Counter Fraud Authority (NHSCFA) have not issued fraud statistics so there is no 'Fraud Taxonomy' to provide to Audit Committee.

18/19/41 Ernst and Young Technical Update

Caroline Davies presented the Health Sector Briefing Paper. Claire Liddy commented that it was important to involve the Finance Team if any issues are identified arising from the audit process; the timeframe has been confirmed for the end of year audit preparation and on site work. This will be March/ April 2019 in accordance with national timetabling. The Finance Team and Internal Audit to ensure all reports are ready by this timescale.

18/19/41.1 Action: CL

It was agreed that Claire Liddy will assess the potential impact of FRS9 and FRS15 and produce a document for Audit Committee.

18/19/42 Register of Shareholder Interests

Claire Liddy presented the Company Shareholdings Register as it stands at 31st August 2018. She reported that an update of all company shareholdings will be provided to Audit Committee and Trust Board on a monthly basis. The aim is to identify the changes made in the last reporting period and highlight areas of note.

It was suggested and agreed to add the commercial reasons for the shareholdings and individual directors to the information update. The Innovation Board will provide the day to day management and over sight of all agreements.

Innovation: The Committee agreed that an Internal SOP (governance manual for Innovation Board) is needed to report to Trust Board and Audit Committee in compliance with Companies House

Corporation Tax: Innovation will not be subjected to corporate tax

Governance: The Committee agreed the following membership to be reviewers:

- Executive Directors: Louise Shepherd and Erica Saunders.
- Non-Executive Directors: Ian Quinlan and Kerry Byrne.

18/19/42 .1 Action

Claire Liddy agreed to present detailed information regarding the percentage of each shareholding for the next meeting.

18/19/42 .2 Action

The Committee suggested having a specific workshop on the Acorn Model. Claire to prepare a report to be presented for discussion in the next Audit Committee meeting.

18/19/42 .3 Action

The Committee agreed to include an update on Innovation as a regular agenda item.

Resolved:

The Committee suggested and agreed that Innovation to be included in Internal Audit's scope of work for consideration in the Annual Audit Plan for 2019/20.

18/19/43 Corporate Governance Manual

Claire Liddy presented the Corporate Governance Manual to the Committee highlighting the amendment on page 128 to ensure sufficient drug supply for business continuity purposes.

Resolved:

The Committee approved the amendment to the Corporate Governance Manual.

17/18/44 NHS Improvement Quarterly Submission, Q1

Resolved:

The Committee received and noted the contents of the NHS Improvement Quarterly Submission for Q1.

18/19/45 Board Assurance Framework (BAF)

Resolved:

The Audit Committee received and noted the contents of the Board Assurance Framework for August 2018.

18/19/46 Cyber Baseline Assessment

The Committee received the Cyber Baseline Assessment submitted by Leanne Fearnehough and agreed to defer presentation to November Audit Committee.

18/19/46.1 Action: Leanne Fearnehough to attend in November

18/19/47 Review of Losses and Special Payments

The Audit Committee received the Losses and Special Payments Paper for April - August 2018 and 2017 to enable comparison to the previous year. Claire Liddy queried the data regarding the private patients and agreed to review for the next meeting.

The Committee agreed there has been a significant improvement compared to last years and to continue improving on internal control with help from MIAA.

The Committee noted the significant rise on personal injury claims and legal costs. It was agreed for MIAA to help review and compare the details across their client base to identify mitigations and actions required.

Resolved:

The Committee received and noted the review of losses and special payments.

18/19/48 Risk Management Improvement Plan

Cathy Umbers presented to the Committee the Risk Management Improvement Plan that included a scoping exercise reviewing the following:

- Trust Risk Strategy
- The Board Assurance Framework
- Corporate risk register
- Divisional risk registers
- Corporate services risk registers
- Ward/Department risk registers
- Look back at the Integrated Governance Committee agendas and minutes
- Look back at previous reviews and actions for improvement.

Cathy reported that the MIAA Audit in 2018/19 was rated 'Substantial Assurance'; she added this is a positive review, but the highest level of assurance is achievable through targeting staff for training, ensuring bespoke training for different staff in different divisions while working on recommendations to improve assurance.

Resolved:
The Committee noted and agreed the recommendations presented as actions for improvement.

18/19/49 Audit Committee Terms of Reference
Resolved:
The Committee received and approved the amended Terms of Reference.

18/19/50 Any Other Business
There was none to discuss.

18/19/51 Meeting Review
All agreed it was a positive meeting. This was Steve Igoe's final Audit Committee before the expiry of his final term of office. Steve gave special thanks to all members for their input and contribution to the Audit Committee.

On behalf of the Audit Committee, Anita Marsland paid tribute to Steve Igoe for his contribution to the success of the Trust over the last eight years.

Date and Time of next meeting: Thursday 22nd November 2018, at 14:00, Room 7 on the Mezzanine.

NHS
Alder Hey Children's
NHS Foundation Trust
Corporate Report October 2018
BRILLIANT BASICS
GROW THE FUTURE

How Did We Do?

Executive Summary **Month: October** **Year: 2018**

Delivery of Outstanding Care

Safe

The safe domain highlights strong performance in relation to pressure ulcers (grade 3 and 4) with none reported since June, no severe or catastrophic harm incidents year to date and strong incident reporting sustained.

Highlight

- On track to achieve trajectory in relation to incidents of moderate harm, 6 year to date which is an improvement in comparison to the same time period last year.
- 100% compliance with CQC regulation 20, Duty of Candour year to date.

Challenges

- Incidents resulting in minor harm remain static, divisional teams analysing and reviewing themes including lessons learned to ensure improvements are implemented and embedded. Monthly monitoring within the divisions and corporate level.

The Best People Doing their Best Work

Caring

Health Watch Liverpool undertook a city wide Emergency Department, patient experience audit in July 2018. The Trust has received the report and a task & finish group has been established to triangulate all sources of feedback internally and externally to ensure a robust action plan is in place to improve CYP experience.

Highlight

- Inpatient areas have sustained continuous improvement in since April over achieving the 95% target in relation to 'recommend the Trust'

Challenges

- Emergency Department continues to be a challenging environment compounded in month closure of acute beds in ward 4C, significantly limiting the flow and access to inpatient beds.

Delivery of Outstanding Care

Effective

The ED 4 hr standard was not achieved in October and dropped significantly relative to our strong underlying performance. 7 beds on Ward 4C remained closed until 24 October. This was longer than anticipated. Since then all beds have re-opened and ED performance has improved.

We are focused on increasing clinic utilisation and we expect it to increase from December when we intentionally overbook appointments beyond 100% to compensate for DNAs; lift restrictions on some ‘protected’ slots where; and backfill short-notice cancellations.

A full update will be given to Board in January which will demonstrate our plans for addressing the challenges.

Highlight

- No patient waited more than 28 days having had an operation cancelled
- Transcription turnaround for typing is 1.5 days

Challenges

- Emergency Department waiting time standard
- Clinic Utilisation
- Sepsis management

Delivery of Outstanding Care

Responsive

We have in place, through our Winter Plan, enhanced arrangements in to deal with emergency pressures and simultaneously ensure the majority of our elective programme continues to function. Thus supporting continued delivery of access standards.

The SAFER bundle will be rolled out to additional wards in Q4 in order to increase awareness of planned dates of discharge.

Highlight

- Delivered 31 day cancer standards and referral to treatment waiting time

Challenges

- % of patients who know their planned date of discharge

The Best People Doing their Best Work

Well Led

The Trust continues to face challenges in meeting its elective forecast as we have seen a growth in non-elective demand. Strengthened patient flow co-ordination is in place and the 'winter ready' plan also looks to protect elective capacity.
Sickness levels have increased. Work is underway supported by NHSi focussing on staff wellbeing which includes localised training packages to support managers in helping to manage absences. Consequently temporary spend has increased to £1m per month.

The Trust delivered an in month surplus of £3m (Including PSF match) although this was £0.46m behind plan. The main challenges are CIP delivery, elective throughput and non pay overspends. We are currently forecasting a £1.6m gap from divisions in meeting the control total. An action plan is being developed to bridge this gap. We continue to flag risks relating to commissioner overperformance with discussions underway to understand the size of this risk further. Cash balances remain at £20m and capital forecast spend is on plan although there remain risks over future spend profiles. Our regulatory rating is 1 (the best) however is influenced by PSF match funding.

Highlight

- Liquidity levels
- PDR levels being met
- Staff fill rates met reflecting positive nurse recruitment

Challenges

- Delivering our CIP & Control total
- Continues challenges in meeting elective plans
- Sickness levels

Game Changing Research and Innovation

Research and Development

The Trust is entering a new phase of partnership with several higher education institutions, including its primary academic partner, the University of Liverpool (UoL). Following the completion of the UoL report on the review of clinical research in Liverpool, paediatrics/child health has been rated as a priority investment area. Within the Trust, plans have been presented to the Trust Board outlining the steps needed to ensure that the research function within Alder Hey is adequately configured and resourced to respond to the opportunities for growth and development offered by UoL, and other academic partners. This includes strengthening the breadth and depth of clinical research leadership, including within the Clinical Divisions.

Highlight

- Six months of baseline data are now available from the NIHR-funded DETECT study which is focused on the use of paediatric early warning scores to detect the deteriorating child in hospital. The data were presented at an October Grand Round and well received. The pre-electronic system intervention data are a rich source of information for managers and clinicians.

Challenges

- Overall study performance within the NIHR Clinical Research Network portfolio is challenging. Director of Research and Clinical Lead for Research to hold meetings with NW Coast Speciality Leads for Children and Paediatric Cancer to understand causes of under-performance. Internal meetings have taken place and we hope to increase the rate of recruitment in the last 4 months of the year but because we haven't been able to open DETECT (a potential large recruiter) we don't think we will achieve our target.

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Delivery of Outstanding Care

SAFE

Alder Hey Children's NHS
NHS Foundation Trust

	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Last 12 Months	RAG			Comments Available
Total no of incidents reported Near Miss & Above	426	464	326	453	456	514	413	447	489	433	449	454	479		>=427	>=383	<383	✔
Clinical Incidents resulting in minor harm & above	71	88	51	84	82	93	83	77	91	85	82	94	100		<=65	<=72	>72	✔
Clinical Incidents resulting in moderate, semi permanent harm	0	2	2	2	0	1	0	1	1	1	1	2	0		<=1	N/A	>1	✔
Clinical Incidents resulting in severe, permanent harm	0	0	0	0	0	0	0	0	0	0	0	0	0		0	N/A	>0	✔
Clinical Incidents resulting in catastrophic, death	0	0	0	0	0	0	0	0	0	0	0	0	0		0	N/A	>0	✔
Pressure Ulcers (Category 3)	0	0	1	2	0	0	0	1	0	0	0	0	0		0	N/A	>0	✔
Pressure Ulcers (Category 4)	0	0	0	0	0	0	0	0	0	0	0	0	0		0	N/A	>0	✔
Medication errors resulting in harm	1	4	3	2	5	6	4	2	4	3	4	4	2		<=2	N/A	>2	✔
Never Events	0	0	0	0	0	0	0	0	0	0	2	0	0		0	N/A	>0	✔

CARING

	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Last 12 Months	RAG			Comments Available
Friends & Family A&E - % Recommend the Trust	95.2%	89.1%	90.9%	89.8%	85.6%	86.4%	85.4%	82.6%	83.9%	86.3%	88.2%	85.5%	80.0%		>=95 %	>=90 %	<90 %	✔
Friends & Family Community - % Recommend the Trust	100.0%	100.0%	100.0%	87.5%	100.0%	97.7%	100.0%	96.8%	96.4%	92.2%	100.0%	100.0%	93.2%		>=95 %	>=90 %	<90 %	✔
Friends & Family Inpatients - % Recommend the Trust	97.9%	97.5%	97.3%	97.3%	96.6%	96.8%	93.7%	95.5%	94.9%	97.0%	97.0%	98.3%	98.2%		>=95 %	>=90 %	<90 %	✔
Friends & Family Mental Health - % Recommend the Trust	94.1%	96.0%	100.0%	77.8%	82.8%	100.0%	87.5%	82.6%	88.9%	100.0%	89.9%	89.4%	84.7%		>=95 %	>=90 %	<90 %	✔
Friends & Family Outpatients - % Recommend the Trust	95.8%	92.0%	97.7%	96.1%	91.8%	89.3%	90.3%	88.6%	86.9%	85.5%	89.7%	90.0%	90.3%		>=95 %	>=90 %	<90 %	✔
Complaints	10	12	5	12	13	5	8	11	11	12	14	11	11		<=8	<=10	>10	✔
PALS	94	119	98	145	145	129	151	126	99	101	100	125	132		<=85	<=94	>94	✔

Alder Hey Children's NHS
NHS Foundation Trust

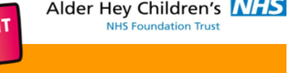
Delivery of Outstanding Care

EFFECTIVE

	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Last 12 Months	RAG			Comments Available
Sepsis: Patients treated for Sepsis - A&E	54.5%	60.0%	57.1%	60.0%	42.3%	60.9%	66.7%	55.6%	57.1%	65.5%	68.2%	54.5%	65.4%		>=90 %	N/A	<90 %	✔
Sepsis: Patients treated for Sepsis - Inpatients	83.7%	85.4%	70.3%	74.1%	86.4%	79.2%	76.0%	72.7%	78.9%	71.4%	72.5%	75.7%	70.2%		>=90 %	N/A	<90 %	✔
No of children that have suffered avoidable death - Internal	0	0	0	0	0	0	0	0	0	0	0	0	0		0	N/A	>0	✔
% Readmissions to PICU within 48 hrs	2.9%	2.4%	0.0%	2.4%	1.5%	4.1%	3.6%	2.5%	2.7%	6.5%	0.0%	2.7%	1.0%		<=3 %	N/A	>3 %	✔
Hospital Acquired Organisms - MRSA (BSI)	1	1	0	2	0	0	0	0	0	0	0	0	0		0	N/A	>0	✔
Hospital Acquired Organisms - C.difficile	0	0	0	0	0	1	0	0	0	0	0	0	0		0	N/A	>0	✔
Hospital Acquired Organisms - MSSA	2	0	2	0	3	0	0	1	0	0	0	1	2		<=1	N/A	>1	✔
Hospital Acquired Organisms - CLABSI - ICU Only	2	1	6	2	4	2	2	2	2	0	1	0	2		<=2	N/A	>2	✔
Hospital Acquired Organisms - Gram Negative BSI	2	3	2	1	1	3	2	0	1	0	1	2	2		<=1	N/A	>1	✔
Bed Occupancy (Accessible Funded Beds)	85.1%	88.8%	78.9%	88.2%	89.3%	89.6%	90.3%	84.9%	88.5%	83.9%	76.2%	79.9%	85.8%		<=89 %	<=93 %	>93 %	✔
ED: 95% Treated within 4 Hours	94.5%	92.8%	94.1%	93.6%	92.6%	97.2%	95.3%	95.0%	95.6%	96.5%	98.4%	93.7%	90.9%		>=95 %	N/A	<95 %	✔
Average LoS - Elective (Days)	2.61	2.97	3.60	2.94	2.98	3.21	2.79	2.87	2.89	3.13	2.80	2.79	3.05		<=2.6	N/A	>2.6	✔
Average LoS - Non-Elective (Days)	2.01	1.98	1.97	2.10	1.99	2.10	1.96	2.01	2.01	1.85	2.03	1.73	2.05		<=2.0	N/A	>2.0	✔
Theatre Utilisation - % of Session Utilised	86.4%	84.4%	86.0%	87.2%	85.6%	86.2%	88.2%	88.6%	87.9%	89.3%	87.0%	86.6%	86.8%		>=90 %	>=80 %	<80 %	✔
On the day Elective Cancelled Operations for Non Clinical Reasons	26	40	15	24	25	37	26	33	44	35	18	12	28		<=22	N/A	>22	✔
28 Day Breaches	8	5	5	0	3	8	10	5	6	6	7	1	0		0	N/A	>0	✔
Clinic Session Utilisation	84.9%	86.2%	82.5%	85.1%	83.7%	83.8%	83.3%	83.6%	84.8%	82.1%	82.7%	84.1%	82.8%		>=90 %	>=85 %	<85 %	✔
Did Not Attend Rate	12.0%	10.6%	12.2%	10.4%	10.7%	11.3%	10.6%	11.5%	12.1%	12.4%	13.5%	10.8%	11.5%		<=12 %	<=14 %	>14 %	✔
Transcription Turnaround (days)	12.50	13.00	18.50	23.00	26.00	28.50	15.00	6.00	4.50	4.00	1.00	4.00	1.50		<=3	<=5	>5	✔

Delivery of Outstanding Care

RESPONSIVE



	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Last 12 Months	RAG			Comments Available
IP Survey: % Received information enabling choices about their care	96.1%	94.9%	94.7%	94.4%	94.7%	93.1%	94.8%	91.6%	96.2%	94.7%	94.7%	96.3%	96.4%		>=95 %	>=90 %	<90 %	✔
IP Survey: % Treated with respect	99.3%	99.8%	99.4%	100.0%	99.4%	99.8%	97.7%	98.8%	99.7%	99.7%	99.6%	99.5%	99.6%		100 %	>=95 %	<95 %	✔
IP Survey: % Know their planned date of discharge	57.4%	61.9%	62.5%	52.1%	59.0%	60.1%	60.5%	76.1%	63.7%	65.7%	60.6%	55.3%	60.2%		>=90 %	>=85 %	<85 %	✔
IP Survey: % Know who is in charge of their care	93.8%	94.9%	90.6%	93.6%	90.9%	91.6%	91.3%	90.9%	92.7%	94.7%	91.6%	94.9%	92.2%		>=95 %	>=90 %	<90 %	✔
IP Survey: % Patients involved in play and learning	72.6%	76.7%	76.4%	78.3%	79.6%	75.0%	74.9%	77.8%	74.4%	73.1%	74.8%	73.7%	74.3%		>=90 %	>=85 %	<85 %	✔
RTT: Open Pathway: % Waiting within 18 Weeks	92.2%	92.0%	92.0%	92.2%	92.1%	92.1%	92.1%	92.0%	92.1%	92.0%	92.0%	92.1%	92.1%		>=92 %	>=90 %	<90 %	✔
Waiting List Size							13,235	13,238	12,879	12,962	12,925	12,884	12,961		<=12905	N/A	>12905	✔
Waiting Greater than 52 weeks	0	1	0	1	2	1	0	0	0	0	0	0	0		0	N/A	>0	✔
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals	100.0%	100.0%	92.9%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.7%		100 %	N/A	<100 %	✔
All Cancers: 31 day diagnosis to treament	92.3%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100 %	N/A	<100 %	✔
All Cancers: 31 day wait until subsequent treatments	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100 %	N/A	<100 %	✔
Diagnostics: % Completed Within 6 Weeks	100.0%	100.0%	99.8%	100.0%	99.3%	99.8%	99.8%	99.8%	99.2%	99.3%	99.0%	99.8%	99.8%		>=99 %	N/A	<99 %	✔
Number of Super Stranded Patients (21+ Days)	26	33	29	35	27	33	35	28	33	30	33	30	33		<=32	N/A	>32	✔
PFI: PPM%	88.0%	98.0%	100.0%	98.0%	100.0%	98.0%	98.6%	99.0%	99.0%	96.0%	98.0%	100.0%	98.0%		>=98 %	N/A	<98 %	✔

The Best People doing their best Work

WELL LED

	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Last 12 Months	RAG			Comments Available
CIP In Month Variance (£'000s)	-459	-433	-149	54	-410	864	-248	104	153	-238	-137	175	-174		>=0%	>=-20%	<-20%	✔
Control Total In Month Variance (£'000s)	-688	418	218	243	17		-426	154	285	29	-396	359	-463		>=0%	>=-20%	<-20%	✔
Capital Expenditure In Month Variance (£'000s)	1,623	-141	2,329	1,184	3,161	-887	1,090	-333	1,701	-462	-129	2,907	-751		>=-5%	>=-10%	<-10%	✔
Cash in Bank (£'000s)	10,872	6,753	8,171	6,712	10,201	12,244	12,406	10,455	9,455	23,910	21,519	20,023	20,315		>=0%	>=-20%	<-20%	✔
Income In Month Variance (£'000s)	-16	3,837	455	1,893	1,080	19,658	218	591	425	998	741	263	624		>=0%	>=-20%	<-20%	✔
Pay In Month Variance (£'000s)	-647	-716	-426	-538	-605	546	-17	-7	-38	-111	-311	51	-372		>=-1%	>=-20%	<-20%	✔
Non Pay In Month Variance (£'000s)	-24	-2,703	189	-1,111	-458	1,368	-627	-431	-102	-858	-825	95	-715		>=0%	>=-20%	<-20%	✔
NHSI Use of Resources	3	3	3	3	3	1	3	3	3	3	3	2	2		<=3	N/A	>3	✔
AvP: IP - Non-Elective							190	124	112	134	148	170	111		>=0	N/A	<0	✔
AvP: IP Elective vs Plan							-86	-25	-103	-85	-46	-65	-70		>=0	N/A	<0	✔
AvP: Daycase Activity vs Plan							-97	-112	-96	-214	64	-162	-223		>=0	N/A	<0	✔
AvP: Outpatient Activity vs Plan							708	391	589	334	1,518	726	984		>=0	N/A	<0	✔
PDR	79.7%	80.1%	79.6%	79.7%	76.1%	76.4%	1.3%	11.3%	31.1%	64.7%	82.3%	88.8%	90.1%		>=90 %	>=85 %	<85 %	✔
Medical Appraisal												100.0%	100.0%		>=95 %	>=90 %	<90 %	✔
Mandatory Training	73.6%	80.5%	86.2%	88.9%	94.1%	92.9%	92.1%	92.0%	92.1%	91.6%	88.6%	88.1%	89.7%		>=90 %	>=80 %	<80 %	✔
Sickness	5.4%	5.3%	5.9%	6.3%	5.5%	4.7%	4.4%	4.6%	4.8%	5.3%	5.2%	5.4%	5.6%		<=4.5 %	<=5 %	>5 %	✔
Short Term Sickness	1.7%	1.5%	1.7%	2.1%	1.7%	1.5%	1.3%	1.2%	1.3%	1.5%	1.3%	1.4%	1.5%		<=1.5 %	N/A	>1.5 %	✔
Long Term Sickness	3.7%	3.8%	4.2%	4.2%	3.9%	3.2%	3.1%	3.4%	3.5%	3.8%	4.0%	4.0%	4.1%		<=3 %	N/A	>3 %	✔
Temporary Spend ('000s)	918	938	761	833	926	1,067	977	973	947	901	1,082	820	998		<=800	<=960	>960	✔
% of Correct Pay Achieved	99.5%	99.6%	98.0%	99.6%	99.3%	98.9%	99.8%	99.4%	99.5%	99.5%	99.5%	99.4%	99.4%		>=99.5 %	>=99 %	<99 %	✔
Staff Turnover	10.9%	11.0%	11.5%	11.5%	11.5%	11.0%	10.8%	11.2%	11.0%	11.5%	10.8%	11.3%	11.2%		<=10 %	<=11 %	>11 %	✔
Safer Staffing (Shift Fill Rate)	93.2%	96.2%	93.9%	95.9%	94.2%	95.0%	96.4%	96.5%	94.8%	95.0%	93.9%	93.1%	93.2%		>=90 %	N/A	<90 %	✔
Domestic Cleaning Audit Compliance	75.0%	60.0%	65.0%	75.0%	85.0%	90.0%	90.0%	85.0%	65.5%	97.5%	85.0%	93.8%	60.0%		>=85 %	N/A	<85 %	✔
Performance Against Single Oversight Framework Themes	0	0	0	0	0	0	0	0	0	0	0	0	0		0	<=1	>1	✔

Game Changing Research & Innovation

R&D

Alder Hey Children's NHS Foundation Trust

GROW THE FUTURE

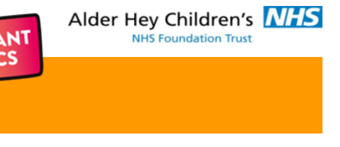
	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Last 12 Months	RAG			Comments Available
Number of Open Studies - Academic	0						148	153	159	159	156	115	143		>=50	N/A	<50	✔
Number of Open Studies - Commercial	0						34	33	34	34	37	27	31		>=5	N/A	<5	✔
Number of New Studies Opened - Academic	0						5	2	5	7	2	3	6		>=4	N/A	<4	✔
Number of New Studies Opened - Commercial	0						3	0	0	1	2	3	2		No Threshold			
Number of patients recruited	0						272	308	245	288	249	238	195		>=417	N/A	<417	✔

7.1 - QUALITY - SAFE

	Description	Performance	Threshold		Trend	Management Action (SMART)
Incidents: Reducing Harm	**Clinical Incidents resulting in moderate, semi permanent harm** Incidents reported resulting in moderate harm. The threshold is based on achieving a 10% reduction on the period Apr 17 - Mar 18 (16). 18/19 aim is 12 or less, annually. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	0	R A G	>1 N/A <=1		No Action Required
Incidents: Increasing Reporting	**Total no of incidents reported Near Miss & Above** Total number of Incidents reported. The threshold is based on increasing on last year for the period Apr 17 - Mar 18 (4,241) 18/19 aim is more than last year for the same month to demonstrate a learning culture. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	479	R A G	<383 >=383 >=427		No Action Required
Incidents: Reducing Harm	**Clinical Incidents resulting in minor harm & above** Incidents reported resulting in minor, moderate, major or catastrpohic (death) harm. The threshold is based on achieving a 10% reduction on the period Apr 17 - Mar 18 (913). 18/19 aim is 10% less than last year for the same month. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	100	R A G	>72 <=72 <=65		Weekly 'Patient Safety Meeting review and monitoring progress with actions. Monthly Head of Quality analysis reports including lessons learned presented to Divisional Governance Assurance Committee and Clinical Quality Steering group.

Delivery of Outstanding Care

7.2 - QUALITY - SAFE



	Description	Performance	Threshold	Trend	Management Action (SMART)
Incidents: Reducing Harm	**Clinical Incidents resulting in severe, permanent harm** Incidents reported resulting in major harm. The threshold is based on this event never occuring. 18/19 aim is zero annually. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	0	R >0 A N/A G 0	Chart (Oct-17 to Oct-18): Actual, Average, UCL, LCL, UWL, LWL, Green	No Action Required
Incidents: Reducing Harm	**Clinical Incidents resulting in catastrophic, death** Incidents reported resulting in major harm. The threshold is based on this event never occuring. 18/19 aim is zero annually. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	0	R >0 A N/A G 0	Chart (Oct-17 to Oct-18): Actual, Average, UCL, LCL, UWL, LWL, Green	No Action Required
Reducing Pressure Ulcers	**Pressure Ulcers (Category 3)** Pressure Ulcers of Category 3. The threshold is based on this event never occuring. 18/19 Aim is zero annually. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	0	R >0 A N/A G 0	Chart (Oct-17 to Oct-18): Actual, Average, UCL, LCL, UWL, LWL, Green	No Action Required

Delivery of Outstanding Care

7.3 - QUALITY - SAFE

Alder Hey Children's NHS
NHS Foundation Trust

	Description	Performance	Threshold		Trend	Management Action (SMART)
Reducing Medication Errors	**Medication errors resulting in harm** Medication errors reported resulting in minor, moderate, major or catastrpohic (death) harm. The threshold is based on achieving a 25% reduction on the period Apr 17 - Mar 18 (32). 18/19 aim is 2 avg per month, or less, per month (less than 24 annually) **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	2	R A G	>2 N/A <=2	Chart (Oct-17 to Oct-18): Actual, Average, UCL, LCL, UWL, LWL, Green	A further number of 10 fold errors have occurred this month, again relating to the prescribing and administration of medicine. None of these errors have caused harm. A Cluster Review panel has reviewed the incidents to identify common themes (e.g. drug) and optimise learning to prevent re-occurrence. Information regarding; correct formulation choice, utilisation of correct vial size and re-iteration of the administration guidelines has been cascaded. Work is ongoing regarding training of staff to understand human factors and to complete independent observations of practice. AMR (MSO)"
Reducing Pressure Ulcers	**Pressure Ulcers (Category 4)** Pressure Ulcers of Category 4. The threshold is based on this event never occuring. 18/19 Aim is zero annually. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	0	R A G	>0 N/A 0	Chart (Oct-17 to Oct-18): Actual, Average, UCL, LCL, UWL, LWL, Green	No Action Required
Never Events	**Never Events** Never Events. The threshold is based on this event never occuring. 18/19 aim is zero annually. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	0	R A G	>0 N/A 0	Chart (Oct-17 to Oct-18): Actual, Average, UCL, LCL, UWL, LWL, Green	No Action Required

The Best People doing their best Work

8.1 - QUALITY - CARING

	Description	Performance	Threshold	Trend	Management Action (SMART)
Friends & Family	**Friends & Family A&E - % Recommend the Trust** Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on exceeding the National average in Nov 17. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	80 %	R <90 % A >=90 % G >=95 %		Lack of communication around waiting times and staff attitude continues to be a source of frustration for our families. Although processes have been put in place to address the issues they are not always followed. The issues have been added to the Trusts high level feedback action plan and will be monitored by the patient experience/quality lead and the Head of Quality. Weekly walk around quality assessments have been introduced, feedback will be given to the department by the Head of Quality.
Friends & Family	**Friends & Family Community - % Recommend the Trust** Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	93.15 %	R <90 % A >=90 % G >=95 %		Feedback has been shared with the division. The issues raised have been added to the FFT action log for the head of quality and the patient experience/quality lead to monitor.
Friends & Family	**Friends & Family Inpatients - % Recommend the Trust** Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	98.25 %	R <90 % A >=90 % G >=95 %		No Action Required

The Best People doing their best Work

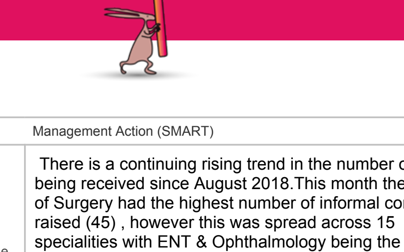
8.2 - QUALITY - CARING

Alder Hey Children's NHS
NHS Foundation Trust

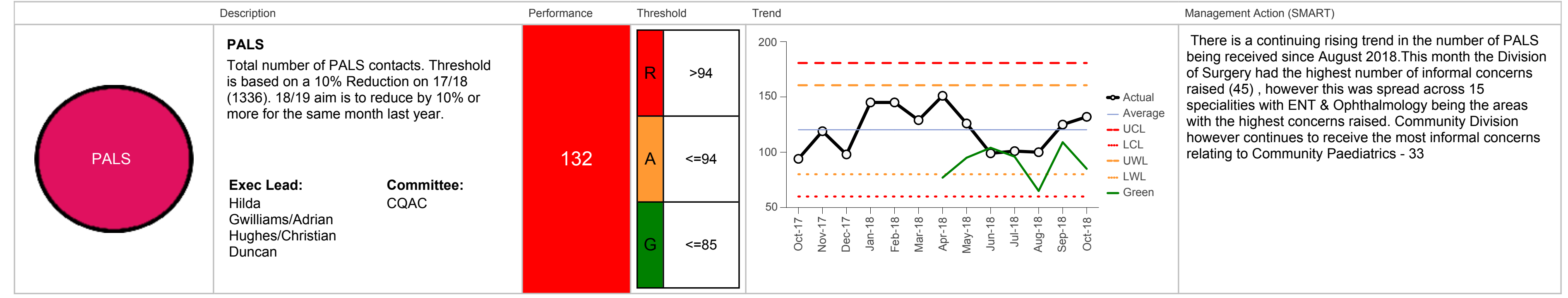
	Description	Performance	Threshold	Trend	Management Action (SMART)
Friends & Family	**Friends & Family Mental Health - % Recommend the Trust** Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	84.75 %	R <90 %; A >=90 %; G >=95 %		A Crisis Care team that offers advice, consultation, and direct intervention 7 days a week has been in place for several weeks, this may have had a positive impact on the results. This service and the actions that have been implemented to collect higher numbers of family friend's test feedback will enable us to have a broader measure of any ongoing trends or concerns. The patient experience/quality lead will continue to feed back all FFT results, the head of quality will monitor and discuss the findings at the DIG meetings.
Complaints	**Complaints** Total complaints received. The threshold is based on achieving a 25% reduction on the period Apr 17 - Mar 18 (90). 18/19 aim is to reduce by 25% or more for the same month last year. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	11	R >10; A <=10; G <=8		The number of complaints received remains fairly consistent. The breakdown for the complaints by Division is - Surgery – 3, Medicine – 6, Community – 2, Business support- 1
Friends & Family	**Friends & Family Outpatients - % Recommend the Trust** Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	90.32 %	R <90 %; A >=90 %; G >=95 %		Positive feedback continues to grow. 'The best positive care project' has developed an action plan to address the issues that arise each month. Many of these issues have been addressed and further improvements into the service are being implemented. This includes lack of play, communication around waiting times in clinics extra seating areas. The patient experience/quality lead and head of quality have introduced a weekly walk around quality assessment. Feedback will be shared by the head of quality at the divisional integrated governance meeting. The head of quality will monitor the actions

The Best People doing their best Work

8.3 - QUALITY - CARING



Alder Hey Children's NHS
NHS Foundation Trust



	Description	Performance	Threshold		Trend	Management Action (SMART)
PALS	**PALS** Total number of PALS contacts. Threshold is based on a 10% Reduction on 17/18 (1336). 18/19 aim is to reduce by 10% or more for the same month last year. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	132	R	>94		There is a continuing rising trend in the number of PALS being received since August 2018.This month the Division of Surgery had the highest number of informal concerns raised (45) , however this was spread across 15 specialities with ENT & Ophthalmology being the areas with the highest concerns raised. Community Division however continues to receive the most informal concerns relating to Community Paediatrics - 33
			A	<=94		
			G	<=85		

Delivery of Outstanding Care

9.1 - QUALITY - EFFECTIVE

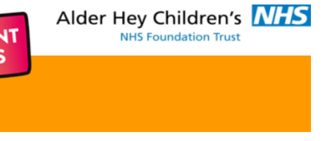
	Description	Performance	Threshold	Trend	Management Action (SMART)
Mortality	**No of children that have suffered avoidable death - Internal** Total number of children that have suffered avoidable death with issues relating to care provided in Alderhey. Figures provided by HMRG group. The threshold for 18/19 is zero. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	0	R >0 A N/A G 0	Chart Oct-17 to Oct-18 (Actual, Average, UCL, LCL, UWL, LWL, Green)	No Action Required
Sepsis	**Sepsis: Patients treated for Sepsis - A&E** Percentage of Sepis Patients receiving antibiotic within 60 mins for ED. 18/19 aim is 90%. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	65.38 %	R <90 % A N/A G >=90 %	Chart Oct-17 to Oct-18 (Actual, Average, UCL, LCL, UWL, LWL, Green)	Work done by ED sepsis nurse comparing Oct 17 to Oct 18. No huge difference in attendances of admissions however large increase in number of children treated for sepsis. This could be due to other potential diagnosis such as bronchiolitis/RSV where symptoms can look the same. Clinicians work hard to ensure they think of all differentials and sepsis is now thought of much more. Discussion had regarding sepsis simulation training for clinicians to help with this complex issue. Discussed at sepsis steering group
Sepsis	**Sepsis: Patients treated for Sepsis - Inpatients** Percentage of Sepis Patients receiving antibiotic within 60 mins for Inpatients. 18/19 aim is 90%. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	70.21 %	R <90 % A N/A G >=90 %	Chart Oct-17 to Oct-18 (Actual, Average, UCL, LCL, UWL, LWL, Green)	Reasons for delays/>60 mins seem to have moved from getting antibiotics prescribed to now administration times from nurses. Work to be done on the wards with managers and nurses to express the importance of once IV Antibiotics prescribed it should be a priority for them to be given. It should be noted other factors may be impacting on this data such as real time documentation, IT systems/computers, nursing skill mix/nurses trained in giving IVAB.

9.2 - QUALITY - EFFECTIVE

	Description	Performance	Threshold		Trend	Management Action (SMART)
PICU Re-admissions	**% Readmissions to PICU within 48 hrs** % of discharges readmitted to PICU within 48hrs sourced from PICANet [Paediatric Intensive Care Audit Network]. Threshold agreed with PICU is based on the reported range nationally from all UK PICUs, most recent published range (16/17) was 0-3% averaged over a calendar year. Data is presented as monthly incidence for the purpose of this report. Annual average for this site was 2.4% **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	0.98 %	R A G	>3 % N/A <=3 %	Actual, Average, UCL, LCL, UWL, LWL, Green; Oct-17 to Oct-18	No Action Required
Reducing Infections	**Hospital Acquired Organisms - MRSA (BSI)** The threshold is based on this event never occuring. 18/19 Aim is zero annually. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	0	R A G	>0 N/A 0	Actual, Average, UCL, LCL, UWL, LWL, Green; Oct-17 to Oct-18	No Action Required
Reducing Infections	**Hospital Acquired Organisms - C.difficile** The threshold is based on this event never occuring. 18/19 Aim is zero annually. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	0	R A G	>0 N/A 0	Actual, Average, UCL, LCL, UWL, LWL, Green; Oct-17 to Oct-18	No Action Required

Delivery of Outstanding Care

9.3 - QUALITY - EFFECTIVE



	Description	Performance	Threshold	Trend	Management Action (SMART)
Reducing Infections	**Hospital Acquired Organisms - CLABSI - ICU Only** Hospital Acquired Organisms - CLABSI on ICU Ward Only. 18/19 aim is to reduce by 10% or more. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	2	R >2 A N/A G <=2		No Action Required
Reducing Infections	**Hospital Acquired Organisms - MSSA** Hospital Acquired Organisms - MSSA . 18/19 aim is to reduce by 25% or more. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	2	R >1 A N/A G <=1		Action plan continues. Cumulatively we still remain under target.
Reducing Infections	**Hospital Acquired Organisms - Gram Negative BSI** Gram - Negative BSI to include E Coli, Klebsiella and Pseudomonas . 18/19 aim is to reduce by 10% or more. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	2	R >1 A N/A G <=1		Reviews of all hospital acquired cases continue to extract any lessons learned. Cumulatively we still remain under target.

Delivery of Outstanding Care

10.1 - QUALITY - RESPONSIVE

	Description	Performance	Threshold	Trend	Management Action (SMART)
Inpatient Survey: Respect	**IP Survey: % Treated with respect** Percentage of children / families that report being treated with respect. Thresholds are based on previously defined local targets. The 18/19 is 100%. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	99.60 %	R <95 % A >=95 % G 100 %		Feedback continues to be monitored by the patient experience/quality lead and shared at the DIG meetings by the head of quality.
Inpatient Survey: Choices	**IP Survey: % Received information enabling choices about their care** Percentage of patients / families that report receiving information to enable them to make choices. Thresholds are based on previously defined local targets. The 18/19 aim is 95% or above. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	96.39 %	R <90 % A >=90 % G >=95 %		No Action Required
Inpatient Survey: Date of Discharge	**IP Survey: % Know their planned date of discharge** Percentage of children / families that report knowing their planned date of discharge. Thresholds are based on previously defined local targets. The 18/19 aim is 90% or above. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	60.24 %	R <85 % A >=85 % G >=90 %		The Safar Project has identified that consultants are to communicate with the ward staff, meditech is to be completed and the date of discharge is to be fedback to the CYP and their families. Assurance is required that these methods of communication are being carried out to ensure that all families have been told an estimated date of discharge. The way in which the question is asked has been challenged to ensure the correct answer is given.

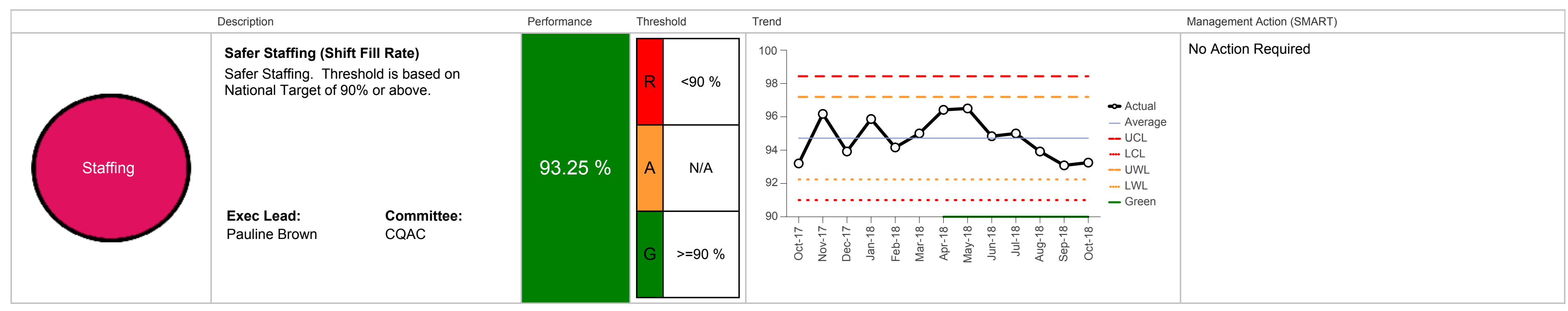
10.2 - QUALITY - RESPONSIVE

Alder Hey Children's NHS Foundation Trust

	Description	Performance	Threshold	Trend	Management Action (SMART)
Inpatient Survey: Play and Learning	**IP Survey: % Patients involved in play and learning** % of children / families that report engaging in play / learning. Thresholds are based on previously defined local targets. The 18/19 aim is 90% or above. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	74.30 %	R <85 % A >=85 % G >=90 %	Chart (65–95; Oct-17 to Oct-18; Actual, Average, UCL, LCL, UWL, LWL, Green)	It has been identified that more play is required on the wards. The introduction of a bleep holder should a play specialist be required for distraction has been implemented. A working group has been set up to scope what is required so we can focus on the real basics of play ensuring we have the right people and resources to deliver an excellent play service. PlayStations and tablets have been delivered to all wards this week. We should start to see an increase in CYP involved with play. We are looking into how the questions are being interpreted.
Inpatient Survey: In Charge of Care	**IP Survey: % Know who is in charge of their care** % of children / families that report knowing who is in charge of their care. Thresholds are based on previously defined local targets. The 18/19 aim is 95% or above. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	92.17 %	R <90 % A >=90 % G >=95 %	Chart (86–98; Oct-17 to Oct-18; Actual, Average, UCL, LCL, UWL, LWL, Green)	Each patient has an allocated nurse; it has been identified that all CYP or their families are informed who is in charge of their care, but CYP and families do not always remember. Further training has taken place for the staff and volunteers asking the family friends test questions to ensure the correct answers are being inputted. Patient experience/quality lead will monitor the responses; the head of quality will continue to discuss the feedback at the DIG meetings.

The Best People doing their best Work

11.1 - QUALITY - WELL LED



	Description	Performance	Threshold		Trend	Management Action (SMART)
Staffing	**Safer Staffing (Shift Fill Rate)** Safer Staffing. Threshold is based on National Target of 90% or above. **Exec Lead:** Pauline Brown **Committee:** CQAC	93.25 %	R	<90 %		No Action Required
			A	N/A		
			G	>=90 %		

Delivery of Outstanding Care

12.1 - PERFORMANCE - EFFECTIVE

Alder Hey Children's NHS
NHS Foundation Trust

	Description	Performance	Threshold		Trend	Management Action (SMART)
Bed Occupancy	**Bed Occupancy (Accessible Funded Beds)** Percentage of funded beds that are occupied in accessible wards 3A, 4A, 3C and 4C, this is based on 3 occupancy readings measured throughout the day. Threshold is based on National NHS Guidance on safe staffing and occupancy levels. **Exec Lead:** Adam Bateman **Committee:** RABD	85.77 %	R A G	>93 % <=93 % <=89 %		No Action Required
LoS: Elective	**Average LoS - Elective (Days)** Average Elective Length of Stay (days). 18/19 aim is to not increase Length of Stay for the same month last year. **Exec Lead:** Adam Bateman **Committee:** RABD	3.05	R A G	>2.6 N/A <=2.6		Increase in elective Length of Stay has been due to the discharge of a small number of complex patients. As the focus remains on discharging these patients a degree of volatility will remain within this metric.
ED 4 Hour Standard	**ED: 95% Treated within 4 Hours** Threshold is based on National Guidance set by NHS England at 95%. **Exec Lead:** Adam Bateman **Committee:** RABD	90.91 %	R A G	<95 % N/A >=95 %		Despite detailed winter plans being in place the benefit of all of the programmed extra capacity was negated with the shutting down of 8 beds on 4c. The extra attendance through ED and reduced In-Patient capacity contributed to reduced outflow from the department. Staffing challenges within ED have also contributed to the issues. The capacity on 4C is now available and has supported outflow. Staffing still requires careful monitoring. The winter ready campaign is underway to raise awareness.

Delivery of Outstanding Care

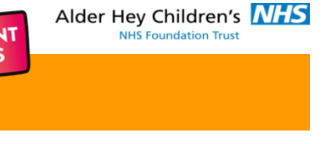
12.2 - PERFORMANCE - EFFECTIVE

Alder Hey Children's NHS
NHS Foundation Trust

	Description	Performance	Threshold		Trend	Management Action (SMART)
LoS: Non-Elective	**Average LoS - Non-Elective (Days)** Average Non Elective Length of Stay (days). 18/19 aim is to not increase Length of Stay for the same month last year. **Exec Lead:** Adam Bateman **Committee:** RABD	2.05	R A G	>2.0 N/A <=2.0		Non elective length of stay increases have been spread across a range of medical and surgical specialties. Whilst the trend has increased this is within seasonal norms and is at the same period as last year. Winter planning assumptions have been based upon this LOS. Specialties are currently reviewing to gauge any underlying challenges
Theatre Utilisation	**Theatre Utilisation - % of Session Utilised** Threshold is based on the productive theatre improvement measures at greater than or equal to 90% utilisation of theatres. **Exec Lead:** Adam Bateman **Committee:** RABD	86.75 %	R A G	<80 % >=80 % >=90 %		Improvement in month, however target of 90% not achieved due to impact of patient cancellations in October described above. A day surgery utilisation group commenced in October to review empty and underutilised sessions and ask specialties to list additional patients.
Cancelled Operations	**On the day Elective Cancelled Operations for Non Clinical Reasons** Performance is measured for on the day cancelled elective operations for non clinical reasons. This based on National Guidance. Threshold aims to reduce cancellations by 25% based on 17/18 overall performance. **Exec Lead:** Adam Bateman **Committee:** RABD	28	R A G	>22 N/A <=22		20/28 patients cancelled due to no bed. Revised patient flow meetings (Patient Flow: In Control) with senior manager presence and focus on early discharges and advanced planning of elective activity commenced 15th October 2018. A forward look for TCI's is in place, with emphasis on maximising the day surgery unit to reduce potential cancellations.

Delivery of Outstanding Care

12.3 - PERFORMANCE - EFFECTIVE



	Description	Performance	Threshold		Trend	Management Action (SMART)
DNAs	**Did Not Attend Rate** The target of 12% is a local target aligned to outpatient improvement workstreams (Hybrid Booking, Patient Demogrpahic Checking and bidirectional automate text reminders). **Exec Lead:** Adam Bateman **Committee:** RABD	11.50 %	R A G	>14 % <=14 % <=12 %	Chart: Actual, Average, UCL, LCL, UWL, LWL, Green (Oct-17 to Oct-18)	No Action Required
Clinic Utilisation	**Clinic Session Utilisation** Threshold is based on a resonable expectation utilising clinics at 90% or greater to take into account short notice cancellations and DNAs. **Exec Lead:** Adam Bateman **Committee:** RABD	82.77 %	R A G	<85 % >=85 % >=90 %	Chart: Actual, Average, UCL, LCL, UWL, LWL, Green (Oct-17 to Oct-18)	Clinic utilisation has deteriorated however validation is currently way as cashing up of clinics concludes which this metric is sensitive to. Brilliant Booking workstream has now recommenced following October when ¼ of the Booking & Scheduling team were absent. This has knocked into the improvement work but has now recommenced from November.
Operation Breaches	**28 Day Breaches** Standard is when a patients operation is cancelled by the hospital last minute for non-clinical reasons, the hospital will have to offer another binding date with 28 days. This is based on national guidance. **Exec Lead:** Adam Bateman **Committee:** RABD	0	R A G	>0 N/A 0	Chart: Actual, Average, UCL, LCL, UWL, LWL, Green (Oct-17 to Oct-18)	No Action Required

Delivery of Outstanding Care

12.4 - PERFORMANCE - EFFECTIVE

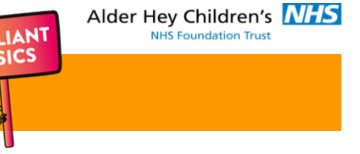
	Description	Performance	Threshold		Trend	Management Action (SMART)
Stranded Patients	**Number of Super Stranded Patients (21+ Days)** National measure as part of the 18/19 NHSI plan. The target is to reduce the number of stranded patients 21 or more days from March 2018. This excludes patients on ICU/HDU/NEO and Cardiac HDU. **Exec Lead:** Adam Bateman **Committee:** RABD	33	R A G	>32 N/A <=32		Business Case approved for additional resource to support delayed discharges and reduced LoS above trim point. This will enable earlier planning and coordination for those CYP in hospital 10 days plus. Numbers of patients to remain in AH as a place of safety pending social care decision making re: residence. Delay in care packages continues to impact on LoS and we are working with commissioners to address this.
Transcriptions	**Transcription Turnaround (days)** Days from dictation to typing clinic letters for services transcribed by Transcription service. Based on working day average. This is also monitored externally by our local commissioners. **Exec Lead:** Adam Bateman **Committee:** RABD	1.50	R A G	>5 <=5 <=3		Average turn around from Dictation to Letter Transcribed is 2 working days. Work is under way to improve turnaround of Transcribed to signed - Ops Manager working with Clinical Leads in each area to identify bottlenecks in singing, PCO's and Ops Managers being trained in extended use of Medisec System to help support Clinicians and Task & Finish group being established with Clinicians to identify improvements.

Delivery of Outstanding Care

13.1 - PERFORMANCE - RESPONSIVE

	Description	Performance	Threshold		Trend	Management Action (SMART)
Waiting Times	**Waiting Greater than 52 weeks** Total number of more than 52 weeks for first treatment. The threshold is based on this event never occuring. 18/19 aim is zero annually. There is a financial and contractual penalties in the failure to achieve this. **Exec Lead:** Adam Bateman **Committee:** RABD	0	R A G	>0 N/A 0		No Action Required
Waiting Times	**Waiting List Size** National threshold as part of the 18/19 NHSI plan. The target is to reduced the total waitlist size from March 2018. **Exec Lead:** Adam Bateman **Committee:** RABD	12961	R A G	>12905 N/A <=12905		As in previous years winter knocks into the elective plan and reduced levels of activity result despite detailed winter planning however this is expected. A consequence of this inevitably is a rise in the size of the waiting list and we have again seen this for 18/19. We are not anticipating the increase to be as great as in previous years due to mitigating winter plan actions
RTT	**RTT: Open Pathway: % Waiting within 18 Weeks** Percentage of patients waiting within 18 weeks. Threshold is based on previous national target of 92%, this is applied in order to maintain monitoring of measure. **Exec Lead:** Adam Bateman **Committee:** RABD	92.12 %	R A G	<90 % >=90 % >=92 %		No Action Required

13.2 - PERFORMANCE - RESPONSIVE

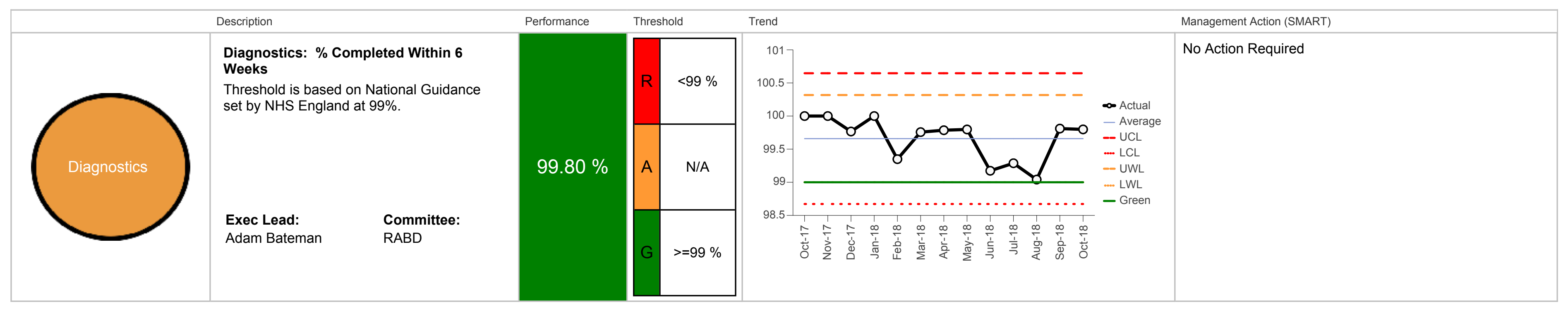


	Description	Performance	Threshold	Trend	Management Action (SMART)
Cancer RTT	**All Cancers: 31 day wait until subsequent treatments** Threshold is set at 100% which a stretch target set higher than national performance. **Exec Lead:** Adam Bateman **Committee:** RABD	100 %	R <100 % A N/A G 100 %	Actual 100 (Oct-17 to Oct-18)	No Action Required
Cancer RTT	**Cancer: 2 week wait from referral to date 1st seen - all urgent referrals** Threshold is set at 100% which a stretch target set higher than national performance. **Exec Lead:** Adam Bateman **Committee:** RABD	96.67 %	R <100 % A N/A G 100 %	Chart Oct-17 to Oct-18	Unfortunately there was 1 breach of the two week wait Oncology Pathway in October 2018. This breach occurred due to an oversight in training for a member of the administrative staff who manage booking patients into their appointment slots. This particular patient had been given an appointment date within the two week wait period, however this was cancelled by the parents and the patient was rebooked into the next available slot which was much beyond the two week wait deadline. This was picked up by the oncology MDT Coordinator and the patient was seen 3 days post their breach target.
Cancer RTT	**All Cancers: 31 day diagnosis to treament** Threshold is set at 100% which a stretch target set higher than national performance. **Exec Lead:** Adam Bateman **Committee:** RABD	100 %	R <100 % A N/A G 100 %	Chart Oct-17 to Oct-18	No Action Required

Chart legend: Actual, Average, UCL, LCL, UWL, LWL, Green. X-axis: Oct-17, Nov-17, Dec-17, Jan-18, Feb-18, Mar-18, Apr-18, May-18, Jun-18, Jul-18, Aug-18, Sep-18, Oct-18.

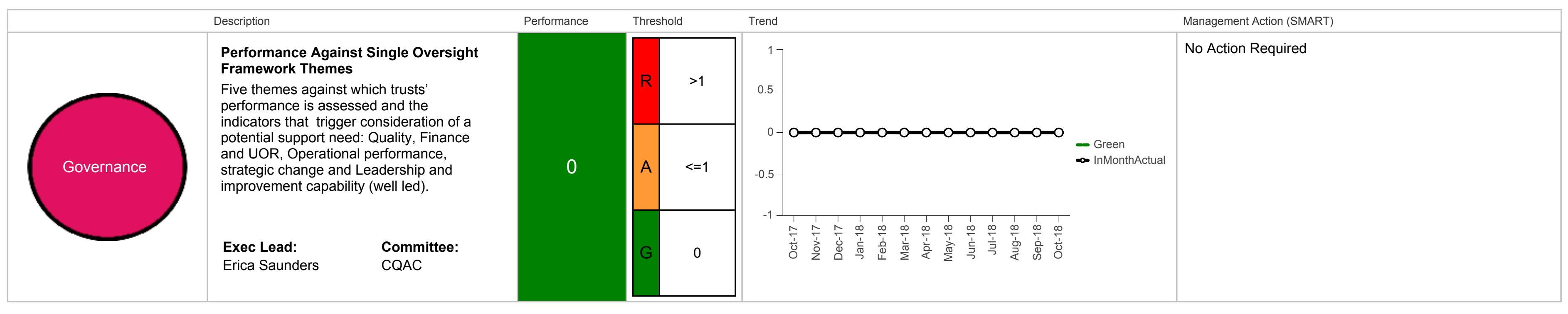
Delivery of Outstanding Care

13.3 - PERFORMANCE - RESPONSIVE



	Description	Performance	Threshold	Trend	Management Action (SMART)
Diagnostics	**Diagnostics: % Completed Within 6 Weeks** Threshold is based on National Guidance set by NHS England at 99%. **Exec Lead:** Adam Bateman **Committee:** RABD	99.80 %	R: <99 % A: N/A G: >=99 %		No Action Required

14.1 - PERFORMANCE - WELL LED



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

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15.1 - FINANCE - WELL LED

	Description	Performance	Threshold	Trend	Management Action (SMART)
Finance	**Control Total In Month Variance (£'000s)** Variance from Control Total plan. Variation between months is usual and the threshold of + or - 20% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	-463	R <-20% A >=-20% G >=0%		The Trust generated a surplus of £3m in October which was £0.5m behind the plan. It is essential that the Trust achieves its year to date plan by the end of December in order to secure all the allocated funding.
Finance	**CIP In Month Variance (£'000s)** Variance from Sustainability plan (CIP). Variation between months is usual and the threshold of + or - 20% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	-174	R <-20% A >=-20% G >=0%		The CIP plan is currently £0.2m behind plan. The forecast CIP for the year is £5.3m which is £1.6m behind the plan. It is important that the Trust achieves its CIP in order to hit the financial plan for the year.
Finance	**Capital Expenditure In Month Variance (£'000s)** Variance from capital plan. Variation between months is usual and the threshold of + or - 5% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	-751	R <-10% A >=-10% G >=-5%		The trust exceeded its capital plan for the month of October by £0.8m. However this is due to a timing issue and cumulatively is underspent in the year by £2.2m. The capital plan is forecast to be underspent for the year by £1.7m

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15.2 - FINANCE - WELL LED

	Description	Performance	Threshold		Trend	Management Action (SMART)
Finance	**Income In Month Variance (£'000s)** Variance from income plan. Variation between months is usual and the threshold of + or - 20% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	624	R A G	<-20% >=-20% >=0%		No Action Required
Finance	**Pay In Month Variance (£'000s)** Variance from pay plan. Variation between months is usual and the threshold of + or - 20% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	-372	R A G	<-20% >=-20% >=-1%		In the month of October pay costs exceeded plan by £0.4m This position is expected to improve from November.
Finance	**Cash in Bank (£'000s)** Variance from Cash plan. Variation between months is usual and the threshold of + or - 20% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	20,315	R A G	<-20% >=-20% >=0%		No Action Required

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15.3 - FINANCE - WELL LED

	Description	Performance	Threshold		Trend	Management Action (SMART)
Finance	**Non Pay In Month Variance (£'000s)** Variance from non pay plan. Variation between months is usual and the threshold of + or - 20% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	-715	R A G	<-20% >=-20% >=0%		In October non pay costs exceeded the budget by £0.7m. This was partly due to expenditure within Theatres and Critical Care relating to the high number of patients treated in the month.
Finance	**AvP: IP - Non-Elective** Actvity vs Plan for Inpatient Non-Elective Activity. The threshold is based on achieving plan or higher. **Exec Lead:** John Grinnell **Committee:** RABD	111.37	R A G	<0 N/A >=0		No Action Required
Finance	**NHSI Use of Resources** NHSI Use of Resources Metric indicates financial sustainability of the Trust. This varies from 1 to 4 with 1 being the highest score possible and 4 being the lowest **Exec Lead:** John Grinnell **Committee:** RABD	2	R A G	>3 N/A <=3		No Action Required

15.4 - FINANCE - WELL LED

	Description	Performance	Threshold	Trend	Management Action (SMART)
Finance	**AvP: Outpatient Activity vs Plan** Actvity vs Plan for Outpatient activity. The threshold is based on achieving plan or higher. **Exec Lead:** John Grinnell **Committee:** RABD	984.14	R <0 A N/A G >=0		No Action Required
Finance	**AvP: IP Elective vs Plan** Actvity vs Plan for Inpatient Elective activity. The threshold is based on achieving plan or higher. **Exec Lead:** John Grinnell **Committee:** RABD	-70.20	R <0 A N/A G >=0		The most significant adverse variance was in ENT, down 41 spells.
Finance	**AvP: Daycase Activity vs Plan** Actvity vs Plan for Daycase activity. The threshold is based on achieving plan or higher. **Exec Lead:** John Grinnell **Committee:** RABD	-223.22	R <0 A N/A G >=0		The most significant adverse variance was in dentistry, down 75 spells.

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16.1 - HR - WELL LED

	Description	Performance	Threshold		Trend	Management Action (SMART)
Training	**Mandatory Training** This is a Trust target that measures the 6 core mandatory training modules that are required of all staff (Safeguarding L1, Moving and Handling, Information Governance, Equality and Diversity, Fire Safety and Health and Safety) **Exec Lead:** Melissa Swindell **Committee:** WOD	89.71 %	R A G	<80 % >=80 % >=90 %		Work is ongoing by the L & D Team to contact employees on an individual basis to improve the Trust position for Mandatory Training. E-Learning packages are now available for all core subjects making training even more accessible. The HR Team continue to monitor progress on a weekly basis.
Personal Development	**PDR** Trust target, measuring compliance of staff Personal Development Reviews (Non medical). The Trust compliance period is set to be achieved in the first 4 months of each year (April -July). **Exec Lead:** Melissa Swindell **Committee:** WOD	90.05 %	R A G	<85 % >=85 % >=90 %		No Action Required
Appraisal	**Medical Appraisal** Trust Target for compliance for medical staff, which is on a rolling 12mth period. **Exec Lead:** Melissa Swindell **Committee:** WOD	100 %	R A G	<90 % >=90 % >=95 %		No Action Required

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16.2 - HR - WELL LED

	Description	Performance	Threshold		Trend	Management Action (SMART)
Sickness	**Sickness** % of staff who have been absent from work due to sickness, this is broken down into LTS & STS in further metrics **Exec Lead:** Melissa Swindell **Committee:** WOD	5.58 %	R	>5 %		Sickness has continued to increase across the Divisions. Overall there has been a 1.3% increase in Gastrointestinal sickness since September (9.8% of absences), absence due to back problems have also gone up by 0.6% and now account for 4.4% of Trust sickness. HR Advisors and Business Partners are reguarly meeting with their Divisions to tackle reasons for increased sickness absence.
			A	<=5 %		
			G	<=4.5 %		
Sickness	**Short Term Sickness** % of Trust staff who have been absent from work due to sickness lasting less than 28 days **Exec Lead:** Melissa Swindell **Committee:** WOD	1.51 %	R	>1.5 %		See commentary for Trust Sickness
			A	N/A		
			G	<=1.5 %		
Sickness	**Long Term Sickness** % of Trust staff who have been absent from work due to sickness lasting 28 days or more **Exec Lead:** Melissa Swindell **Committee:** WOD	4.08 %	R	>3 %		See commentary for Trust Sickness
			A	N/A		
			G	<=3 %		

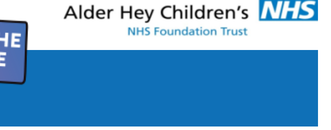
The Best People doing their best Work

16.3 - HR - WELL LED

	Description	Performance	Threshold	Trend	Management Action (SMART)
Payroll	**% of Correct Pay Achieved** An agreed service Level target with the Trust payroll provider. **Exec Lead:** Melissa Swindell **Committee:** WOD	99.45 %	R <99 % A >=99 % G >=99.5 %		The % of correct pay has remained static but still below our SLA of 99.5%. Bi-Monthly contractual meetings take place between ELFS, HR and Finance to ensure any issues are picked up and remedied promptly.
Staff Turnover	**Staff Turnover** Trust Target which is based on a rolling 12mth period **Exec Lead:** Melissa Swindell **Committee:** WOD	11.23 %	R >11 % A <=11 % G <=10 %		The number of leavers dropped to 28 in October. MEdicine had the highest number of leavers (11), There were 10 leavers from the Nursing & Midwifery Staff Group of which 3 left to relocate.
Temporary Spend	**Temporary Spend ('000s)** Indicates the expenditure on premium temporary pay spend and monitors the reduction. **Exec Lead:** Melissa Swindell **Committee:** WOD	998.06	R >960 A <=960 G <=800		Temporary spend is being reported to weekly sustainability group. The main reason for temporary spend is sickness which remains higher than our target. A senior group facilitated by HR has been set up to review health and wellbeing which is expected over time to reduce rates of absence and in turn temporary spend. Other temporary spend is a result of hard to fill positions, the exploration of a Doctors bank is currently being looked into

Game Changing Research & Innovation

17.1 - RESEARCH & DEVELOPMENT - WELL LED



	Description	Performance	Threshold		Trend	Management Action (SMART)
Clinical Research	**Number of Open Studies - Academic** Number of academic studies currently open. **Exec Lead:** Matthew Peak **Committee:** REIC	143	R	<50		No Action Required
			A	N/A		
			G	>=50		
Clinical Research	**Number of New Studies Opened - Academic** Number of new academic studies opened in month. **Exec Lead:** Matthew Peak **Committee:** REIC	6	R	<4		No Action Required
			A	N/A		
			G	>=4		
Clinical Research	**Number of Open Studies - Commercial** Number of commercial studies currently open. **Exec Lead:** Matthew Peak **Committee:** REIC	31	R	<5		40 approaches have been made since april 18. However 50% did not get a response from a consultant. Several were unachievable due to CIVAS. A more detailed understanding of why is required as is improved performance in accepting more of these is required.
			A	N/A		
			G	>=5		

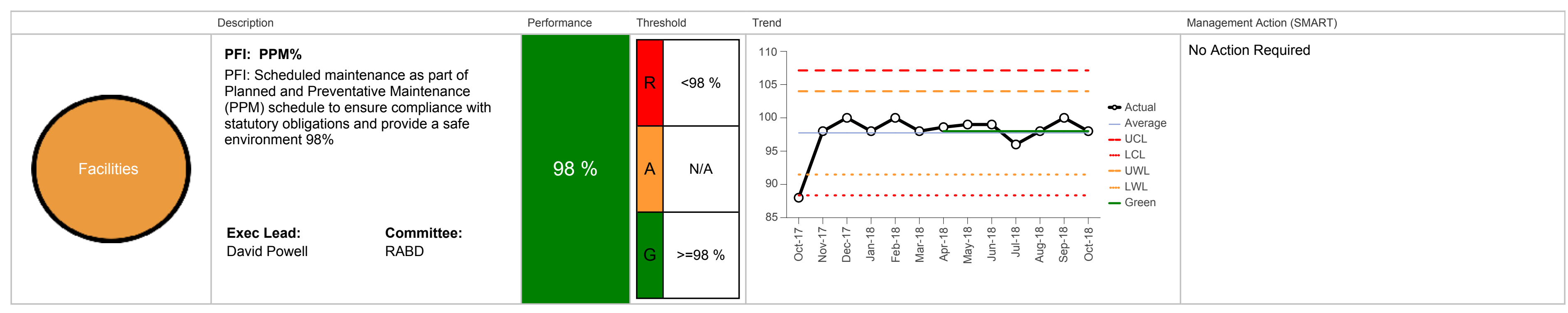
Game Changing Research & Innovation

17.2 - RESEARCH & DEVELOPMENT - WELL LED

	Description	Performance	Threshold	Trend	Management Action (SMART)
Clinical Research	**Number of New Studies Opened - Commercial** Number of new commercial studies opened in month. **Exec Lead:** Matthew Peak **Committee:** REIC	2	No Threshold	Chart: Oct-17 to Oct-18; legend: Actual, Average, UCL, LCL, UWL, LWL, Green	
Clinical Research	**Number of patients recruited** Number of patients recruited in month. **Exec Lead:** Matthew Peak **Committee:** REIC	195	R <417 A N/A G >=417	Chart: Oct-17 to Oct-18; legend: Actual, Average, UCL, LCL, UWL, LWL, Green	Data submitted but it is not displaying. However recruitment is below expectations and we are undertaking a performance review.

Delivery of Outstanding Care

18.1 - FACILITIES - RESPONSIVE

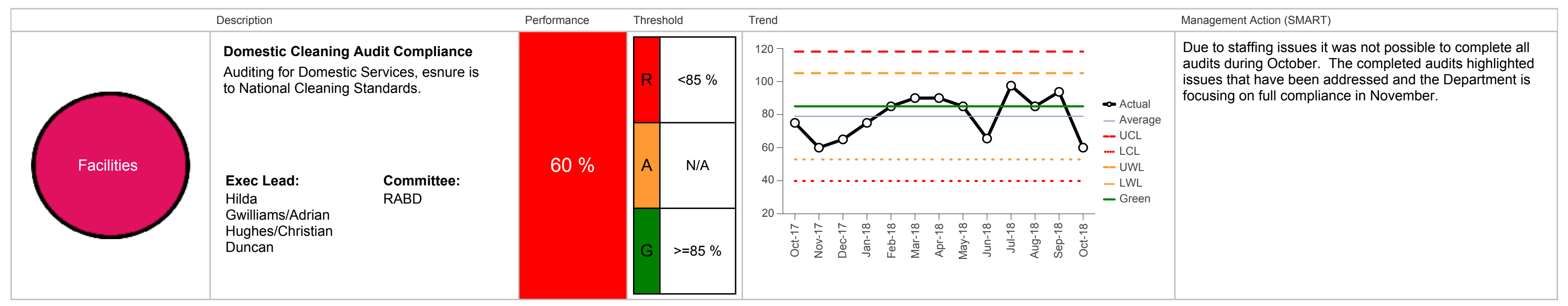


	Description	Performance	Threshold		Trend	Management Action (SMART)
Facilities	**PFI: PPM%** PFI: Scheduled maintenance as part of Planned and Preventative Maintenance (PPM) schedule to ensure compliance with statutory obligations and provide a safe environment 98% **Exec Lead:** David Powell **Committee:**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

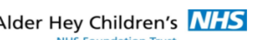
The Best People doing their best Work

19.1 - FACILITIES - WELL LED

Alder Hey Children's NHS
NHS Foundation Trust



	Description	Performance	Threshold		Trend	Management Action (SMART)
Facilities	**Domestic Cleaning Audit Compliance** Auditing for Domestic Services, esnure is to National Cleaning Standards. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** RABD	60 %	R	<85 %		Due to staffing issues it was not possible to complete all audits during October. The completed audits highlighted issues that have been addressed and the Department is focusing on full compliance in November.
			A	N/A		
			G	>=85 %		



All Divisions

SAFE

	COMMUNITY	MEDICINE	SURGERY	RAG
Total no of incidents reported Near Miss & Above	44	166	226	No Threshold
Clinical Incidents resulting in minor harm & above	2	18	70	No Threshold
Clinical Incidents resulting in moderate, semi permanent harm	0	0	0	No Threshold
Clinical Incidents resulting in severe, permanent harm	0	0	0	0 N/A >0
Clinical Incidents resulting in catastrophic, death	0	0	0	0 N/A >0
Pressure Ulcers (Category 3)	0	0	0	0 N/A >0
Pressure Ulcers (Category 4)	0	0	0	0 N/A >0
Medication errors resulting in harm	1	1	0	No Threshold
Medication errors resulting in moderate, sever harm or death	0	0	0	0 N/A >0
Never Events	0	0	0	0 N/A >0
Acute readmissions of patients with long term conditions within 28 days	0	4	0	No Threshold

CARING

	COMMUNITY	MEDICINE	SURGERY	RAG
Complaints	1	6	1	No Threshold
PALS	36	34	27	No Threshold

EFFECTIVE

	COMMUNITY	MEDICINE	SURGERY	RAG
Readmissions to PICU within 48 hrs	0	0	0	No Threshold
% of acute readmissions within 48 hrs of discharge (exc Oncology)	0.0%	1.8%	0.8%	<=1.0 % N/A >1.0 %
Readmissions within 48 hrs	0	42	14	No Threshold
Outbreak Acquired Organisms - Other	0	0	0	0 N/A >0
Hospital Acquired Organisms - MRSA (BSI)	0	0	0	0 N/A >0
Hospital Acquired Organisms - C.difficile	0	0	0	0 N/A >0
Hospital Acquired Organisms - MSSA	0	0	2	No Threshold

All Divisions

	COMMUNITY	MEDICINE	SURGERY	RAG		
Hospital Acquired Organisms - RSV	0	2	3	No Threshold		
Hospital Acquired Organisms - CLABSI - ICU Only			2	No Threshold		
Outbreak Infections	0	0	0	No Threshold		
Referrals Received (Total)	958	2,053	3,592	No Threshold		
ED: 95% Treated within 4 Hours		90.9%		>=95 %	N/A	<95 %
Average LoS - Elective (Days)		2.89	2.97	No Threshold		
Average LoS - Non-Elective (Days)		1.56	3.14	No Threshold		
Theatre Utilisation - % of Session Utilised		82.3%	87.4%	>=90 %	>=85 %	<80 %
Cancelled Operations - Non Clinical - On Same Day (%)	0.0%	0.2%	2.0%	<=0.8 %	N/A	>0.8 %
On the day Elective Cancelled Operations for Non Clinical Reasons	0	2	26	No Threshold		
28 Day Breaches	0	0	0	0	N/A	>0
Clinic Session Utilisation	82.0%	83.1%	82.8%	>=90 %	>=85 %	<85 %
OP Appointments Cancelled by Hospital %	17.7%	14.5%	13.5%	<=5 %	<=10 %	>10 %
Did Not Attend Rate	10.4%	12.1%	11.5%	<=12 %	<=14 %	>14 %
Incomplete Pathway Forms in Outpatients	1,074	5,467	10,146	No Threshold		
Referral Turnaround (days to log)	4.83	3.63	4.74	No Threshold		
Referral Turnaround (Consultant to Action)	9.20	3.99	4.61	No Threshold		
Coding average comorbidities	2.00	3.47	3.60	No Threshold		
CAMHS: DNA Rate - New	4.4%			<=6 %	<=8 %	>8 %
CAMHS: DNA Rate - Follow Up	12.7%			<=10 %	<=16 %	>16 %

RESPONSIVE

	COMMUNITY	MEDICINE	SURGERY	RAG		
IP Survey: % Received information enabling choices about their care		95.1%	97.3%	>=95 %	>=90 %	<90 %
IP Survey: % Treated with respect		99.5%	99.7%	100 %	>=95 %	<95 %
IP Survey: % Know their planned date of discharge		56.7%	62.7%	>=90 %	>=85 %	<85 %
IP Survey: % Know who is in charge of their care		91.6%	92.5%	>=95 %	>=90 %	<90 %

All Divisions

	COMMUNITY	MEDICINE	SURGERY	RAG		
IP Survey: % Patients involved in play and learning		72.9%	75.3%	>=90 %	>=85 %	<85 %
RTT: Open Pathway: % Waiting within 18 Weeks	87.1%	89.9%	93.6%	>=92 %	>=90 %	<90 %
Waiting List Size	1,112	3,199	8,650	No Threshold		
Waiting Greater than 52 weeks	0	0	0	0	N/A	>0
Diagnostics: % Completed Within 6 Weeks		99.8%	100.0%	>=99 %	N/A	<99 %
Number of Stranded Patients (7+ Days)		34	18	No Threshold		
Number of Super Stranded Patients (21+ Days)		24	9	No Threshold		
CAMHS: 2 Appointments within 6 weeks	0			No Threshold		
Urgent EDYS Pathway Average Wait in Weeks	0	0	0	No Threshold		
Routine EDYS Pathway Average Wait in Weeks	0	0	0	No Threshold		
Routine Eating Disorders (EDYS) Pathway Average Wait in Days	17.00			No Threshold		
Urgent Eating Disorders (EDYS) Pathway Average Wait in Days	2.00			No Threshold		
CAMHS: Avg Wait from referral to Partnership Appt (Weeks)- Liverpool Specialist	16.00	0.00	0.00	No Threshold		
CAMHS: Avg Wait from referral to Partnership Appt (Weeks)- Sefton Specialist	24.00	0.00	0.00	No Threshold		

WELL LED

	COMMUNITY	MEDICINE	SURGERY	RAG		
Control Total In Month Variance (£'000s)	54	-115	0	>=0%	>=-20%	<-20%
Income In Month Variance (£'000s)	43	116	449	>=0%	>=-20%	<-20%
Pay In Month Variance (£'000s)	21	-90	-187	No Threshold		
Non Pay In Month Variance (£'000s)	-10	-140	-262	>=0%	>=-20%	<-20%
AvP: IP - Non-Elective		97	14	>=0	N/A	<0
AvP: IP Elective vs Plan	0	-37	-35	>=0	N/A	<0
AvP: OP New	36.51	-326.94	122.53	>=0	N/A	<0
AvP: OP FollowUp	189.38	-65.20	358.87	>=0	N/A	<0
AvP: Daycase Activity vs Plan		-109	-114	>=0	N/A	<0
AvP: Outpatient Activity vs Plan	226	-392	481	>=0	N/A	<0

All Divisions

	COMMUNITY	MEDICINE	SURGERY	RAG		
PDR	93.0%	89.2%	90.0%	>=90 %	>=80 %	<85 %
Mandatory Training	92.5%	89.4%	88.6%	>=90 %	>=80 %	<80 %
Actual vs Planned Establishment (%)	91.7%	97.8%	99.8%	No Threshold		
Sickness	4.0%	5.1%	6.7%	<=4.5 %	<=5 %	>5 %
Attendance (HR)	96.0%	94.9%	93.3%	>=95.5 %	>=90 %	<90 %
Short Term Sickness	1.1%	1.7%	1.7%	<=1.5 %	N/A	>1.5 %
Long Term Sickness	3.0%	3.5%	5.0%	<=3 %	N/A	>3 %
Temporary Spend ('000s)	131	217	529	No Threshold		
Staff Turnover	13.7%	10.0%	11.4%	<=10 %	<=11 %	>11 %
Safer Staffing (Shift Fill Rate)	98.0%	95.5%	91.3%	>=90 %	>=80 %	<90 %

Medicine

SAFE	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Last 12 Months	RAG
Acute readmissions of patients with long term conditions within 28 days	4	4	6	3	3	0	1	1	4	0	3	2	4	No Data Available	No Threshold
CARING															
Complaints	1	5	2	3	4	3	0	7	4	3	3	5	6		No Threshold
PALS	20	27	30	37	30	39	51	31	27	28	23	21	34		No Threshold
EFFECTIVE															
Hospital Acquired Organisms - MRSA (BSI)	0	1	0	2	0	0	0	0	0	0	0	0	0		0 N/A >0
Hospital Acquired Organisms - C.difficile	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Referrals Received (Total)	1,820	1,896	1,522	1,896	1,850	1,959	1,837	1,945	2,007	1,898	1,564	1,667	2,053	No Data Available	No Threshold
ED: 95% Treated within 4 Hours	94.5%	92.8%	94.1%	93.6%	92.6%	97.2%	95.3%	95.0%	95.6%	96.5%	98.4%	93.7%	90.9%		>=95 % N/A <95 %
Average LoS - Elective (Days)	2.89	3.33	4.06	3.54	3.22	3.17	3.23	2.66	4.01	3.84	2.85	3.18	2.89		No Threshold
Average LoS - Non-Elective (Days)	1.39	1.41	1.50	1.75	1.57	1.50	1.52	1.55	1.59	1.28	1.45	1.35	1.56		No Threshold
Theatre Utilisation - % of Session Utilised	81.5%	79.6%	82.5%	79.9%	80.6%	83.5%	75.4%	75.6%	78.6%	83.0%	77.8%	84.7%	82.3%		>=90 % >=80 % <80 %
Clinic Session Utilisation	85.4%	86.6%	84.4%	85.3%	86.9%	85.2%	83.9%	82.4%	84.3%	81.4%	81.1%	84.5%	83.1%		>=90 % >=80 % <85 %
OP Appointments Cancelled by Hospital %	14.0%	13.3%	15.3%	15.2%	17.6%	17.5%	13.5%	14.1%	12.8%	16.3%	15.6%	13.9%	14.5%	No Data Available	<=5 % <=10 % >10 %
Did Not Attend Rate	11.8%	9.7%	11.5%	9.5%	9.6%	11.1%	10.1%	11.0%	12.6%	12.3%	13.5%	12.0%	12.1%		<=12 % <=14 % >14 %
Coding average comorbidities	3.43	3.42	3.92	3.86	3.49	3.34	3.52	3.35	3.54	3.40	3.52	3.54	3.47	No Data Available	No Threshold
RESPONSIVE															
RTT: Open Pathway: % Waiting within 18 Weeks	92.7%	91.2%	92.6%	92.9%	93.0%	89.8%	90.0%	90.2%	89.5%	89.7%	90.2%	91.1%	89.9%		>=92 % >=90 % <90 %
Diagnostics: % Completed Within 6 Weeks	100.0%	100.0%	100.0%	100.0%	99.8%	100.0%	99.8%	99.8%	99.1%	99.3%	99.0%	99.8%	99.8%		>=99 % N/A <99 %
WELL LED															
Control Total In Month Variance (£'000s)	-464	529	-52	611	461		127	122	408	223	75	178	-115		>=0% >=-20% <-20%
AvP: IP - Non-Elective							130	53	63	93	106	149	97		>=0 N/A <0
AvP: IP Elective vs Plan							-29	-11	-43	-28	-24	-47	-37		>=0 N/A <0
AvP: OP New							-82.43	-196.04	-8.23	-243.27	-177.22	-130.14	-326.94	No Data Available	>=0 N/A <0
AvP: OP FollowUp							-57.36	-169.18	-55.63	-425.23	-1.92	-38.24	-65.20	No Data Available	>=0 N/A <0
AvP: Daycase Activity vs Plan							0	-13	-43	-83	107	-45	-109		>=0 N/A <0
AvP: Outpatient Activity vs Plan							-140	-365	-64	-669	-179	-168	-392		>=0 N/A <0
PDR	84.0%	85.0%	84.0%	84.0%	81.5%	81.5%	2.2%	13.4%	35.5%	67.2%	85.5%	88.6%	89.2%		>=90 % >=85 % <85 %
Mandatory Training	77.3%	82.2%	86.6%	88.9%	94.7%	93.8%	92.7%	92.8%	92.4%	91.3%	87.9%	87.6%	89.4%		>=90 % >=85 % <80 %
Sickness	5.0%	5.3%	5.1%	5.6%	4.9%	4.3%	3.8%	4.0%	4.3%	5.7%	5.0%	5.2%	5.1%		<=4.5 % <=5 % >5 %
Temporary Spend ('000s)	186	242	207	211	276	316	246	276	196	227	261	212	217		No Threshold

Surgery

SAFE

	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Last 12 Months	RAG
Acute readmissions of patients with long term conditions within 28 days	0	0	0	0	0	0	0	0	0	0	0	0	0	No Data Available	No Threshold

CARING

	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Last 12 Months	RAG
Complaints	3	0	2	2	3	2	1	2	1	5	3	1	1		No Threshold
PALS	21	25	16	26	24	20	25	36	28	20	22	27	27		No Threshold

EFFECTIVE

	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Last 12 Months	RAG
Hospital Acquired Organisms - MRSA (BSI)	1	0	0	0	0	0	0	0	0	0	0	0	0		0 / N/A / >0
Hospital Acquired Organisms - C.difficile	0	0	0	0	0	1	0	0	0	0	0	0	0		0 / N/A / >0
Referrals Received (Total)	3,515	3,522	2,668	3,340	3,490	3,680	3,771	4,087	3,830	4,241	3,348	3,205	3,592	No Data Available	No Threshold
Average LoS - Elective (Days)	2.36	2.76	3.30	2.62	2.88	3.14	2.40	2.94	2.55	2.68	2.72	2.66	2.97		No Threshold
Average LoS - Non-Elective (Days)	2.90	3.17	3.18	2.67	2.89	3.31	2.63	2.78	2.63	2.61	2.72	2.49	3.14		No Threshold
Theatre Utilisation - % of Session Utilised	87.3%	85.2%	86.6%	88.3%	86.4%	86.8%	90.5%	90.6%	89.5%	90.4%	88.7%	86.9%	87.4%		>=90 % / >=80 % / <80 %
Clinic Session Utilisation	85.2%	87.0%	83.0%	86.2%	83.5%	85.1%	84.2%	85.0%	86.0%	82.8%	83.9%	84.4%	82.8%		>=90 % / >=80 % / <85 %
OP Appointments Cancelled by Hospital %	12.3%	13.2%	13.3%	13.0%	14.0%	12.7%	11.2%	12.2%	12.2%	12.3%	12.6%	14.4%	13.5%	No Data Available	<=5 % / <=10 % / >10 %
Did Not Attend Rate	11.4%	10.2%	11.6%	10.2%	10.1%	10.3%	9.6%	10.6%	11.1%	12.0%	12.8%	10.0%	11.5%		<=12 % / <=14 % / >14 %
Coding average comorbidities	3.13	3.18	3.06	2.99	3.18	3.24	3.11	3.31	3.50	3.63	3.65	3.66	3.60	No Data Available	No Threshold

RESPONSIVE

	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Last 12 Months	RAG
RTT: Open Pathway: % Waiting within 18 Weeks	91.6%	92.0%	91.3%	91.4%	91.3%	92.6%	92.3%	92.5%	93.1%	92.9%	92.7%	93.1%	93.6%		>=92 % / >=90 % / <90 %
Diagnostics: % Completed Within 6 Weeks	100.0%	100.0%	95.0%	100.0%	92.6%	94.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		>=99 % / N/A / <99 %

WELL LED

	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Last 12 Months	RAG
Control Total In Month Variance (£'000s)	-506	-610	-489	-634	-715		-167	32	-23	81	-63	-308	0		>=0% / >=-20% / <-20%
AvP: IP - Non-Elective							60	70	48	40	42	21	14		>=0 / N/A / <0
AvP: IP Elective vs Plan							-58	-16	-61	-59	-23	-18	-35		>=0 / N/A / <0
AvP: OP New							386.34	504.63	424.48	200.35	486.90	120.89	122.53	No Data Available	>=0 / N/A / <0
AvP: OP FollowUp							157.57	-282.75	-442.28	-85.76	557.68	99.62	358.87	No Data Available	>=0 / N/A / <0
AvP: Daycase Activity vs Plan							-99	-101	-57	-132	-43	-120	-114		>=0 / N/A / <0
AvP: Outpatient Activity vs Plan							544	222	-18	115	1,045	221	481		>=0 / N/A / <0
PDR	89.5%	88.1%	89.5%	89.5%	83.3%	83.3%	1.1%	10.0%	33.5%	64.4%	83.6%	90.7%	90.0%		>=90 % / >=85 % / <85 %
Mandatory Training	73.8%	80.9%	85.8%	89.3%	93.5%	91.5%	90.2%	89.9%	90.9%	90.3%	87.2%	87.8%	88.6%		>=90 % / >=85 % / <80 %
Sickness	5.1%	4.8%	6.0%	6.3%	4.9%	4.0%	4.3%	4.8%	5.5%	5.5%	5.7%	6.0%	6.7%		<=4.5 % / <=5 % / >5 %
Temporary Spend ('000s)	479	383	331	408	434	514	468	420	480	445	509	373	529		No Threshold

Community

SAFE

	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Last 12 Months	RAG
Acute readmissions of patients with long term conditions within 28 days	0	0	0	0	0	0	0	0	0	0	0	0	0	No Data Available	No Threshold

CARING

	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Last 12 Months	RAG
Complaints	3	1	1	3	2	0	2	2	3	4	5	3	1		No Threshold
PALS	28	28	14	33	50	33	32	28	20	22	26	43	36		No Threshold

EFFECTIVE

	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Last 12 Months	RAG
Hospital Acquired Organisms - MRSA (BSI)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Hospital Acquired Organisms - C.difficile	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Referrals Received (Total)	1,231	1,126	974	1,151	1,033	1,001	858	1,091	848	1,077	658	687	958	No Data Available	No Threshold
Clinic Session Utilisation	82.8%	80.2%	73.3%	77.7%	75.7%	72.2%	75.2%	79.1%	78.2%	79.4%	80.2%	79.3%	82.0%		>=90 % >=85 % <85 %
OP Appointments Cancelled by Hospital %	15.2%	16.8%	17.0%	12.3%	13.5%	17.2%	16.1%	10.8%	16.8%	16.2%	23.3%	22.6%	17.7%	No Data Available	<=5 % <=10 % >10 %
Did Not Attend Rate	14.0%	13.4%	15.7%	12.6%	14.1%	14.4%	14.5%	14.5%	14.2%	13.9%	15.6%	11.2%	10.4%		<=12 % <=14 % >14 %
Coding average comorbidities	3.00	3.50		5.00		3.33	5.00	2.33		2.33	8.00	4.00	2.00	No Data Available	No Threshold

RESPONSIVE

	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Last 12 Months	RAG
RTT: Open Pathway: % Waiting within 18 Weeks	96.3%	96.8%	97.3%	97.3%	96.5%	96.7%	97.1%	96.1%	95.3%	92.2%	92.7%	87.3%	87.1%		>=92 % >=90 % <90 %

WELL LED

	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Last 12 Months	RAG
Control Total In Month Variance (£'000s)	-64	-72	-86	-161	43		-108	-70	30	62	-144	87	54		>=0% >=-20% <-20%
AvP: IP Elective vs Plan							0	0	0	0	0	0	0		>=0 N/A <0
AvP: OP New							-25.37	-25.35	-35.17	-75.43	-84.03	-73.35	36.51	No Data Available	>=0 N/A <0
AvP: OP FollowUp							275.02	350.12	348.57	239.44	5.42	68.01	189.38	No Data Available	>=0 N/A <0
AvP: Outpatient Activity vs Plan							250	325	313	164	-79	-5	226		>=0 N/A <0
PDR	90.4%	88.8%	90.4%	90.4%	83.9%	83.9%	0.4%	9.3%	31.9%	58.8%	78.7%	87.9%	93.0%		>=90 % >=85 % <85 %
Mandatory Training	75.1%	80.3%	86.7%	89.8%	96.8%	95.7%	95.4%	95.0%	94.1%	94.2%	92.7%	91.2%	92.5%		>=90 % >=85 % <80 %
Sickness	5.8%	5.8%	6.9%	6.2%	6.0%	6.1%	4.8%	5.2%	3.9%	3.5%	3.4%	4.1%	4.0%		<=4.5 % <=5 % >5 %
Temporary Spend ('000s)	141	167	131	146	136	202	166	180	142	131	154	125	131		No Threshold

BOARD OF DIRECTORS

Tuesday, 4 December 2018

Report of	Director of Corporate Affairs
Paper prepared by	Director of Corporate Affairs
Subject/Title	2018/19 Board Assurance Framework Update (November 2018)
Background papers	Well Led Review – Board Development Plan
Purpose of Paper	To receive an update on the actions agreed at the Board Workshop with AQuA/ MIAA
Action/Decision required	The Board is asked to discuss and note progress
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	

Board Assurance Framework 2018-19

BAF 1.1	Strategic Objective: Delivery Of Outstanding Care		Risk Title: Achievement of Outstanding Quality for Children and Young People as defined by the Care Quality Commission (CQC) regulations.		
Related CQC Themes: Safe, Caring, Effective, Responsive, Well Led					
Exec Lead: Hilda Gwilliams		**Type:** Internal, Known	Current IxL: 3-3	Target IxL: 2-2	Trend: STATIC

Risk Description

Not having sufficiently robust, clear governance systems and processes and people in place supported by the expected culture and values that underpin learning for improvement

Existing Control Measures

• 1. Quality impact assessment completed for all planned changes (NHSe). Change programme assurance reports monthly	• 2. Risk registers including corporate register inform Board assurance.
• 3. Quality section of Corporate Report including incidents, complaints, infection control including sepsis, friends and family test, best in acute care, best in surgical care, performance managed at Clinical Quality Assurance Committee and Trust Board.	• 4. Division and Corporate Quality & Safety Dashboards in place and monitored consistently via performance framework. This includes safety thermometer i.e. infections, falls, pressure ulcers, medication, workforce 'Hard Truths', sickness, appraisals, etc.
• 5. Weekly Meeting of Harm monitors incidents, including lessons learned, immediate actions for improvement and sharing Trust wide.	• 6. Programme of quality assurance rounds, developed and implemented across all services, aligned to Care Quality Commission, Key lines of enquiry (KLOE).
• 7. Annual clinical workforce assurance report presented to Board, aligned to Relevant Professional Standards.	•
• 8. Quality Strategy 2016/2021, Quality Improvement Change Programme established - associated workstreams subject to sub-committee assurance reporting.	• 9. Governance including risk processes from Ward to Board, linked to NHSI Single Oversight Framework
•	• 10. Acute Provider Infection Prevention and Control framework and associated dashboards and action plans for improvement.
• 11. Internal Nursing pool established and funded	• 12. Nursing leadership in alignment with Royal College of Nursing and Midwifery Standards.
• 13. Annual Patient Survey reports and associated action plans	• 14. Trust policies underpinning expected standards
• 15. CQC regulation compliance	

Assurance Evidence	Gaps in Controls/Assurance
1. Annual QIA assurance report and change programme assurance report 2. Risk assessments etc and associated risks monitored via the Integrated Governance Committee. Trust Board informed via Integrated Governance Committee minutes. Divisional Integrated Governance Committee minutes. 3. Clinical Quality Assurance Committee, Trust Board and Divisional Governance minutes 4. Corporate report/quality section, Trust Board and Divisional Quality Board minutes. 5. Minutes from Trust Board, Clinical Quality Assurance Committee, Executive Committee, Weekly patient safety group, Clinical Quality Steering Group, Divisional Integrated Governance Committees. Also MIAA audit report. 6. Reports and minutes from Clinical Quality Assurance Committee and Divisional Integrated Governance Committees. 7. Annual Medical Appraisal Report and Nurse staffing report to Trust Board biannually and associated minutes. 8. Board and sub-board committees minutes and associated reports. 9. TO BE ADDED 10. IPC action plan and Trust Board, Clinical Quality Assurance Committee, Integrated Governance Committee, Divisional Quality Board minutes. 11. Nursing Workforce report and associated Board minutes. 12. Nursing Workforce report and associated Board minutes. 13. Patient survey reports and associated action plans, Trust Board, Clinical Quality Steering Group, Workforce and Organisational Development Committee, Divisional Quality Board minutes. 14. Audit committee reports and minutes. 15. CQC action plan monitoring via Board and sub board committees	15. CQC regulation breaches.

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Robust action plan to be developed, implemented and monitored via the Trust Board, Board subcommittees and individual services.	Good progress being made continues to be monitored monthly via CQAC

Executive Lead's Assessment

Nov 2018: CQC action plan continues to address the areas for improvement and is monitored via Trust Board and CQAC, good progress.

Board Assurance Framework 2018-19

BAF 1.2	Strategic Objective: Delivery Of Outstanding Care	Risk Title: Achievement of national and local mandatory & compliance standards		
Related CQC Themes: Safe, Caring, Responsive, Well Led, Effective				
Exec Lead: Erica Saunders	Type: Internal, Known	Current IxL: 3-3	Target IxL: 4-1	Trend: STATIC

Risk Description

Failure to meet targets and internal performance metrics due to poor flow and lack of capacity to fulfil activity plans and respond to increasing demand

Existing Control Measures

• Operational Delivery Board taking action to resolve performance issues as they emerge	• Emergency Planning & Resilience meetings in 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.	• Refresh of Corporate Report undertaken for 2018/19

Assurance Evidence	Gaps in Controls/Assurance
Regular reporting of delivery against compliance targets through assurance committees & Board. Monthly reporting to the Board via the Corporate Report. NHSI quality concern rating Operational effectiveness measures (key risks with early warning measures) to RABD Compliance assessment against NHSI Provider Licence to Board Divisional/Executive performance reviews Exceptions discussed / resolved at Ops Board Quarterly review meeting and report to NHSI	Critical Care bed capacity Some areas remain fragile e.g. ED 4 hour target. Assurance required to underpin Divisional reporting on CQC standards Work with CCG to manage demand & develop / fully utilise existing capacity across PC Proactive management of patient flow making better use of trend analysis data

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Monitor the use of surgical beds to ensure full activity plan delivered; review activity profile through winter months.	Elective programme being monitored on a weekly basis however significant pressure from NEL orthopaedic cases experienced during June has proved challenging.
Plans to ensure performance sustained across the year need to be embedded and maintained	New Models of Care review findings presented and agree at Ops Board September; action plan agreed.
New model to deliver required number of CCAD cases agreed at Board on 22/5/18. COO to lead implementation.	Additional HDU capacity to support new cardiac model planned for November

Executive Lead's Assessment

APRIL 2018: All compliance targets achieved at end of April. Trust is projecting a financial risk rating of 1. No governance concerns
MAY 2018: No compliance concerns at this stage in the month
JUNE 2018: All external mandatory targets met; focus required to ensure elective programme remains on track given demand pressures
AUGUST 2018: All key national indicators met for the month; transcription issues resolved.
SEPTEMBER 2018: ED 4 hour target currently red (tracking at 93% for the month to date); mitigation plan agreed at Exec Comm Cell. Mitigation plans include: Staff an additional 11 beds for Winter (9 inpatient beds, 2 high-dependency beds); enhanced staffing levels in ED- nurse practitioners and medical shift cover; investment of 0.5m in additional capacity and services such as mental health liaison team, in-reach community nursing team and rapid laboratory testing.
OCTOBER 2018: Closure of 7 inpatient beds due to delayed transfer of care has had an adverse effect on patient flow. The week commencing 15/10 presented a very challenging 'red week' with impact on 4 hour target achievement for month and quarter. . Debrief process held to inform improvement plan ready for next identified red week in winter plan. Actions include additional assessment area, enhanced surge management and revised escalation policy. On the 26/10 closed inpatient beds re-opened.
NOVEMBER 2018: Processes to manage 'red' weeks now in place; ED performance improved to 94.7% YTD. Submission to be made to NHSI re exceptional circumstances created during closure of 7 beds in the autumn.

Board Assurance Framework 2018-19

BAF 1.3	**Strategic Objective:** Delivery Of Outstanding Care		Risk Title: New Hospital Environment		
Related CQC Themes: Safe					
Exec Lead: David Powell		**Type:** Internal, New	Current IxL: 4-4	Target IxL: 4-2	Trend: WORSE

Risk Description

Sale of PFI Project co. whilst a number of commissioning risks are still present could lead to lack of focus and problems in maintaining safe environment

Existing Control Measures

• Monthly issue meetings	• Monthly liaison meetings
• Regular reports to IGC	• Liaison minutes reported to Trust Board monthly
• Building Management Services Risk Register	

Assurance Evidence	Gaps in Controls/Assurance
Maintenance of Issues List Issues Review Meeting Escalation to Liaison meeting Red Button escalation mechanism Help Desk monitoring reports	Some repeat/overlap reporting Some lack of clarity over risk ownership/H&S role

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Replacement programme for pipe work to be agreed with builder	Report received from Project Co. Agreed to present at October Board
COO updating Action Plan to address key water safety issues	
Interserve developing water safety action plan	Project Co. agreement to scope out water cross-over test. Exercise planned for sept 2018
Whole Hospital review of fire stopping	
Review of various risk elements and consolidation into single report with external validation.	
Complete Fire Notice action plan	
Create action Plan for addressing ceiling tile falls	Proposed plan submitted to Project co. for consolidation
Complete fire stopping work	

Executive Lead's Assessment

APRIL 2018: Clutch of commissioning issues still to be resolved including pipework corrosion, water temperatures, delay in achieving operating theatre temperature control. Are currently under review with some attendant action plans still requiring completion.
Next steps-complete reviews and agree all action plans for outstanding issues.
MAY 2018: Interim report on Pipework received. Commercial plan meeting in diary for June. Fire-stopping review under way
JUNE 2018: Consolidated report in production; review meeting with Project Co and refresh of action plan. Outcome to be reported 24/07/2018
AUG 2018: review of consolidated report with sub plans for fire and ceilings
Sept 2018: completion of fire action plan and 90% of fire-stopping works
Oct 2018 Project Co presentation to Trust Board on pipework review
Nov 2018 Fire stopping work complete; pipework action plan tbc

Board Assurance Framework 2018-19

BAF 2.1	**Strategic Objective:** The Best People Doing Their Best Work	Risk Title: Workforce Sustainability		
Related CQC Themes: Safe, Effective, Responsive, Well Led, Well Led, Well				
Exec Lead: Melissa Swindell	**Type:** Internal, Known	Current IxL: 3-3	Target IxL: 3-2	Trend: STATIC

Risk Description
Failure to deliver consistent, high quality patient centred services due to not having the right people, with the right skills and knowledge, in the right place, at the right time.

Existing Control Measures	
• Workforce KPIs tracked through the corporate report and divisional dashboards	• Bi-monthly Divisional Performance Meetings.
• Mandatory training fully reviewed in 2017, with a new system of reporting linked to competencies on ESR; enabling better quality reporting.	• Mandatory training mapped to Core Skills Framework. Online portal enables all staff to see their compliance on their chosen IT device.
• Permanent nurse staffing pool	• HR Workforce Policies
• Attendance management process to reduce short & long term absence	• Wellbeing Steering Group established
• Large-scale nurse recruitment event 4 times per year	• Training Needs Analysis linked to CPD requirements
• Apprenticeship Strategy implemented	• Engaged in pre-employment programmes with local job centres to support supply routes
• Engagement with HEENW in support of new role development	• People Strategy

Assurance Evidence	**Gaps in Controls/Assurance**
Regular reporting of delivery against compliance targets via corporate & divisional reports Monthly reporting to the Board via the Corporate Report Reporting at ward level which supports Ward to Board Reporting to HEE People Strategy report monthly to Board Programme Board reporting	Not meeting compliance target in relation to mandatory training in some areas Sickness Absence levels higher than target. Lack of standard methodology to workforce planning across the organisation

Actions Required to Reduce Risk to Target Rating	**Latest Progress on Actions**
ensure a minimum of 50 learners enrolled on apprenticeship pathways.	

Executive Lead's Assessment
Oct 2018: Workforce Planning training delivered by NHSI in September, plan to roll out to divisions via HR. Proposal (Nov 18) for the Trust to sign up to the time to change pledge to promote postive actions in relation to mental health. Mental Health concerns is the top reason of absence in the organisation.

Board Assurance Framework 2018-19

BAF 2.2	**Strategic Objective:** The Best People Doing Their Best Work	Risk Title: Staff Engagement	
Related CQC Themes: Safe, Effective, Responsive, Well Led			
Exec Lead: Melissa Swindell	**Type:** Internal, Known	Current IxL: 3-3	Target IxL: 3-1	Trend: STATIC

Risk Description

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

Existing Control Measures

• People Strategy	• Wellbeing Strategy implementation
• Action Plans for Staff Survey	• Values and Behaviours Framework
• Staff Temperature Check Reports to Board (quarterly)	• Values based PDR process
• People Strategy Reports to Board (monthly)	• Listening into Action Guidance and Programme of work
• Staff surveys analysed and followed up (shows improvement)	• Reward and recognition schemes in place: Annual Awards, Star of the Month and quarterly Long Service Recognition Event, Annual Fab Staff Change Week.
•	• BME and Disability Staff Networks

Assurance Evidence	Gaps in Controls/Assurance
Monthly People Strategy Report to Board Outcomes from Annual Staff Survey reported to the Board. Staff Survey local departmental conversations PDR completion rates Values and Behaviours Framework Quarterly Engagement Temperature Check reported to the Board. Quarterly Engagement Temperature Check local data sent to Divisions on a quarterly basis to enable them to analyse data locally. Ongoing consultation and information sharing with staff side and LNC Progress reports from LiA to Board Wellbeing Strategy progress reported to WOD Board/sub-Board Committee minutes Minutes of Staff Networks Engagement through Editorial Board leadership for Alder Hey Life	Internal Communications Strategy and Plan Refreshed Leadership Strategy

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Framework now completed awating sign off	
L&D manager to undertake a review of the methodology, with a view to launching new system in June 18	Staff Survey will be used for Q3 data. Currently speaking with other local organisations to see how they complete this requirement to see if there is a 'norm' or best practice. Plan to launch revised process for Q4 (Jan-March-19)
Group to be established and to roll-out the approach to HWB across the organisation	
New AH Life launched. E News refresh planned. Star campaign around staff survey, flue and awards started - i.e. common theme of peer to peer action requests/	
Please prepare outline strategy for discussion at away day on the 9th July 18.	

Executive Lead's Assessment

OCT 2018: Staff Survey underway as of 25th October responde rate is 40%. Leadership strategy presented at the October WOD Committee.

Board Assurance Framework 2018-19

BAF 2.3	**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: 3-4	Target IxL: 3-1	Trend: STATIC

Risk Description

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

Existing Control Measures	
• Wellbeing Strategy	• WOD Committee ToR includes duties around diversity and inclusion, and requirements for regular reporting.
• Wellbeing Steering Group	• Staff Survey results analysed by protected characteristics and actions taken by E&D Lead.
• HR Workforce Policies	• Equality Analysis Policy
• Equality, Diversity & Human Rights Policy	• BME Network established, sponsored by Director of HR & OD
• Disability Network established, sponsored by Director of HR & OD	• Actions taken in response to the WRES
• Action plan specifically in response to increasing the diversity of the workforce, and improving the experience of BME staff who work at Alder Hey	•
•	•

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

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Establish LGBTQ network	No progress due to capacity issues. Revised timeline for completion.

Executive Lead's Assessment

OCT 2018: expert resource identified to support the diversity and race agenda and LGBT network due to be launched in Nov.

Board Assurance Framework 2018-19

BAF 3.1	**Strategic Objective:** Sustainability Through External Partnerships	Risk Title: Failure to fully realise the Trust's Vision for the Park	
Related CQC Themes: Responsive, Well Led			
Exec Lead: David Powell	**Type:** Internal, Known	Current IxL: 3-3	Target IxL: 3-2	Trend: STATIC

Risk Description

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

Existing Control Measures	
• Business Cases developed for various elements of the Park & Campus	• Monitoring reports on progress
• Heads of Terms agreed with LCC for joint venture approved	• Redevelopment Steering Group
• Monthly reports to Board & RABD	

Assurance Evidence	Gaps in Controls/Assurance
Approved Business Cases for various elements of the Park & Campus approved Every Project has a dedicated Project Manager assigned to it End user consultation events held Highlight reports to relevant assurance committees and through to Board Stakeholder events held/reported back to Trust Board Representation at Friends of Springfield Park Group Monthly Board report	Fully reconciled budget with Plan. Risk quantification around the development projects.

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Secure approval for plans to increase Park footprint	Planning for Park extension submitted 31/07/2018
Approval of Business Case at LCC / Discuss park Heads of Terms with LCC	On hold-Dependent upon residential scheme (revised target date no April 2018)
Create plan for demolition and phasing	
Organise Park design session with Friends of Springfield Park	

Executive Lead's Assessment

APRIL 2018: New Park manager appointed
MAY 2018: Meeting arranged with Friends of Springfield Park to agree 1st park extension.
JUNE 2018: 2nd round of user meetings on Community Cluster. Commissioning Programme for Institute under way. Implemented bi-weekly control group meetings on the Institute commissioning
Aug 2018: Planning application for park extension. Handover of Institute Phase 2
Sept 2018: Plan agreed for retraction of site following opening of Institute
Nov 2018: Agreement to secure design input into new park with community groups

Board Assurance Framework 2018-19

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

Risk Description

Risk to service sustainability development/growth due to NHS financial environment and constraints on internal infrastructure to deliver business as usual as well as maximise growth opportunities. External opportunities for partnership may not be fully optimised

Existing Control Measures

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

Assurance Evidence	Gaps in Controls/Assurance
Marketing and Business Development Committee has been refreshed as a Growth Through Sustainable Partnerships Group. First meeting planned July 2018 . Business Development Plan reviewed monthly by RBDC via Contract Monitoring Report. Daily activity tracker and forecast monitoring performance for all activity. CIPs in new Change Programme subject to assurance and sub-committee performance management	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 Growth through Partnerships to be included as part of Strategic elements of business planning in the next planning cycle

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Development of the international agenda	

Executive Lead's Assessment

APRIL 2018. Final Clinical and Sustainability Strategy to July Board.
MAY 2018: Detailed discussion at Execs (17 May). Further work up of detailed proposals for 18/19 to be completed by end of June and for July Trust Board.
JUNE 2018: Clinical sustainability strategy to be finalised at Board meeting on 3rd July. AUG 2018: Trust Board agreed Clinical Sustainability Strategy which was re-named Strategic Plan 2018-2021
OCT 2018: Sustainable Partnerships Group established and reports to RABD. November Board to receive draft strategic plan dashboard. Bi-monthly update to Board.
November 2018 Clinical Network event with Manchester Children's Hospital. Single service model for neurosciences supported. Refreshed Network Partnership Board to be held in February 2019.

Board Assurance Framework 2018-19

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 for working with key partners to develop children's services and reduce variation across the City region and beyond

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 refreshed 'Sustainability Through External Partnerships Steering Group'. Monthly to Board via RABD & Board Compliance with final national specifications Single Neonatal Services Business Case approved by NHS England	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. Go live due beginning of September 2018.

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Development of a single neonatal service business case across Alder Hey & LWH	Governance model developed and agreed by both trusts and NHS England including delivery model and work streams. MoU drafted and due to be approved by both boards in July 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. Partnership achieved November 2017.	
Strengthening the paediatric workforce	6 monthly audit of 7-day standards is subject to external scrutiny. Global Digital Excellence has improved measurement capability. Adrian Hughes is now leading as one of the top 5 Operational Priorities known as 'New Models of Care'. In addition, junior doctor numbers were bolstered during the winter which improved cover and consultant arrangements.
Agreement of key partnerships for sustainability 2018/19 achieved on 30th November 2017. Actions now in planning and delivery phase, with Executive Oversight provided by the CEO Oversight Group, and planning delivery through the joint CHIG Group. Delivery will take up to two years. In addition to support the Strategic Plan identify which existing and new Partnerships need to be strengthened and grown	

Executive Lead's Assessment

APRIL 2018: Trust Board Workshop to be scheduled for June 2018 to consider growth and sustainability scenarios to inform clinical and sustainability strategy.
MAY 2018: Workshop held on 17 May and next steps agreed
JUNE 2018: CEO now chair of Children's Transformation Board; Single Neonatal Service model moving to implementation phase. Level 1 CHD partnership in place and due to go live beginning of September 2018. Successful Go Live for CHD Partnership undertaken.
OCT 2018: Plan to review this risk assessment prior to the next Board meeting. The neonatal business case for 24 cots not fully approved, 19 cots approved. Aim to have full approval of 24 cots by March 2019.

Board Assurance Framework 2018-19

BAF 3.4	Strategic Objective: Sustainability Through External Partnerships	Risk Title: Financial Environment	
Related CQC Themes: Safe, Effective, Responsive, Well Led			
Exec Lead: John Grinnell	Type: Internal, Known	Current IxL: 4-4	Target IxL: 4-3	Trend: STATIC

Risk Description

Failure to deliver Trust control total and financial risk rating

Existing Control Measures

• Organisation-wide financial plan.	• 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 Weekly Financial Sustainability delivery meeting papers Board 2 Board with Spec comm	Divisions improved financial control and effective recovery required in identified where slippage against agreed recovery trajectories occurring Ongoing cost of temporary staff Divisional recovery plans to hit yearend financial control targets to ensure delivery of overall Trust financial plan. 'Grip' on CIP CIP Position improved however Divisional forecasts still showing a potential £7m gap

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Tracking actions from Financial Recovery Board	on target
Develop fully worked up CIP programme - Progress has been made however still forecasting £1m under target	Reviewed at financial sustainability group 2.7.18 Further work to take place as part of Q1 review and in July. Review again at expected completion date

Executive Lead's Assessment

JUNE 2018: Key risks highlighted as delivery of CiP (£2.5m gap), elective run rates/winter plan delivery and other emerging cost pressures. Total Divisional risk equates to c£8m and will be through divisional recovery supported by an effective winter plan and identification of non-recurrent measures. Mitigation plan to be tracked through RABD
AUG 2018: CIP identified has plateau at £5m against £6.8m plan. Efforts continue with £6m looking deliverable. Main concerns now relate to Divisional forecast gap of £6.8m and level of Spec Comm over performance which is now subject to a formal activity notice.
SEPT: CIP identified increased identified to £5.5m with £6m a key next phase we aim to get to by end of Sept. Divisions have reduced forecast gap which now stands at £3.5m. Work on-going to further reduce this deficit. Key risks remains commissioner over performance which is material. A new risk related to estates capital spend overspends (unmitigated estimate £6m-£9m). Work has started to prepare a capital recovery plan and reduce value of risk.
October: CIP gap remains at £1.5m with focus on closing the gap to £1m. Divisions forecasting £2.8m shortfall against original control total. Financial Recovery being overseen by Monday Sustainability Group. Board to Board with spec comm agreed next steps on this financial year however remains a risk. Still to finalise payment terms with Welsh commissioners - meeting with Senior representatives of NHSi to progress.

Board Assurance Framework 2018-19

BAF 4.1	**Strategic Objective:** Game-Changing Research And Innovation		Risk Title: Research, Education & Innovation		
Related CQC Themes: Responsive, Well Led					
Exec Lead: David Powell		**Type:** Internal, Known	Current IxL: 3-3	Target IxL: 3-2	Trend: STATIC

Risk Description
Failure to exploit new opportunities in research, innovation & education due to incomplete management systems.

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

Assurance Evidence	Gaps in Controls/Assurance
Research Strategy Committee set up as a new Board Assurance Committee Research, Education and Innovation Committee established Secured ERDF funding for Innovation Team Innovation Board established	Sporadic meetings of RIE committee Governance structure for Innovation Board to be agreed Re-energise Research governance processes Reporting frameworks and standards for all services to be agreed/harmonised

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Develop a robust Academy Business Model	Framework refresh
Establish pipeline structure for work-streams (Acorn and Crucible)	Legal work complete on Crucible Contract
Execute contract for RIE with back to back arrangements with the Charity and HEIs	Final Documentation with solicitors prior to completion before move in to Institute Phase 2
Agree incentivisation framework for staff and teams	
Create new vision for integrated themes	

Executive Lead's Assessment
APRIL 2018: REI committee refreshed and re-launched MAY 2018: Revised plan for 2017/18 innovation activity JUNE 2018: Innovation Refresh 2nd session AUG 2018: Innovation prioritisation exercise Sept 2018: presentation of innovation re-set to Innovation Board Oct 2018: Review of Acorn Launch of crucible Launch of Alder Play Nov 2018: Execs review of RIE arrangements

Board Assurance Framework 2018-19

BAF 4.2	Strategic Objective: Game-Changing Research And Innovation		Risk Title: IT Strategic Development		
Related CQC Themes: Safe, Caring, Effective, Responsive, Well Led					
Exec Lead: John Grinnell		Type: Internal, Known	Current IxL: 3-3	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	• Monthly update to Trust Board on GDE Programme
• GDE Programme Board in place & fully resourced - Chaired by Medical Director	• Clinical Engagement in IT Roadmap
• NHSE external oversight of GDE programme	• Resilience of underlying infrastructure
• A plan is now in place to develop new strategy and roadmap to present to board in Autumn 2018 including plan for user engagement. Plan will include the current GDE programme and beyond, as well as review of Meditech offerings beyond current contract.	• Operational & Clinical oversight of the programme needs enhancing

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 GDE Programme Board tracking delivery - Chaired by MD Plan presented to Ops Board June 18 Implementation of weekly Oversight group	IM&T Strategy out of date - update work in progress to produce Roadmap for October 19 Resilience of underlying infrastructure - replacement being installed

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Replacement equipment procured - equipment is now installed however delay in ensuring appropriate electrical back up in place which is being rectified	
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

APRIL 2018: ImageNow and bed management module key next phases of the programme. Clinical Advisory Group in place supporting these developments. Real progress being made on STP wide intra-operability platform
MAY 2018: No material changes to report in-month
JUNE 2018: Replacement underlying infrastructure ordered; Excellent feedback from NHSE on benefits realisation
AUG 2018: Replacement infrastructure in situ. Continued positive feedback from NHSE. Programme on track with revised approached for VR in place.
SEPT: Progress with NHSE milestones remains positive with full funding schedule in place. Recent positives include the roll of out of a sepsis module in standard documentation and interoperability piece. Gap in Programme Manager a concern with plans in place to mitigate.
OCT: Programme Manager now in place. Risks relating to January go live of standard Docs and number of pathways to be completed discussed at Execs. Enhanced support given to GDE to include weekly oversight Group with Executive presence.

CORPORATE MEETINGS CALENDAR 2019/20

Day	TUE	WED	WED	WED	THUR	THUR	Please see below	TUE/WED	THUR
Meeting	**Trust Board**	**Clinical Quality Assurance Committee**	**Integrated Governance Committee**	**Resource and Business Development Committee**	**Research, Education, Innovation Committee**	**Audit**	**Council of Governors**	**Workforce Organisational Development Committee**	**Executive Team**
Room	**Institute in the Park Large Meeting Room**	**Institute in the Park Large Meeting Room**	**Institute in the Park Large Meeting Room**	**Institute in the Park Large Meeting Room**	**Please see below**	**Institute in the Park Large Meeting Room**	**Institute in the Park Large Meeting Room**	**Room 5 Mezz**	**Executive Meeting Room**
PA Support	**Julie Tsao, Committee Admin**	**Julie Creevy , PA to Medical Director & Chief Nurse**	**Lesley Calder, PA Governance and Quality Assurance**	**Julie Tsao, Committee Admin**	**Julie Tsao, Committee Admin**	**Julie Tsao, Committee Admin**	**Julie Tsao, Committee Admin**	**Jackie Friday PA to Director of HR**	**Karen Critchley PA Chief Executive**
Time	**10:00-16:00**	**10:00-12:30**	**See below:**	**09:30-13:00**	**13:00-16:00**	**14:00-16:00**	**17:00-19:00**	**14:00-16.00**	**9:30-13:00**
April	2nd	17th		24th		18th		24th	4,11,18,25
May	7th and **28th	15th	22nd **14:00-16:00**	22nd	9th	23rd			2,9,16,23,30
June	--	12th**		26th			17th	26th	6,13,20,27
July	2nd	17th	10th **10:00-12:00**	24th	11th				4,11,18,25
August	--	21st**		28th				21st	1,8,15,22,29
September	3rd	18th	11th **10:00-12:00**	25th	12th	19th	16th		5,12,19,26
October	1st	16th		23rd				23rd	6,13,20,27
November	5th	20th	20th **14:00-16:00**	27th	14th	21st			7,14,21,28
December	3rd	18th		11th			9th	11th	5,12,19,26
January	7th	15th	22nd **13:00-15:00**	22nd	9th	16th			2,9,16,23,30
February	4th	12th		26th				26th	6,13,20,27
March	3rd	18th	11th **10:00-12:00**	25th	12th		16th		5,12,19,26

*CEO to attend (AGS)
**Trust Board to approve the Annual Accounts

**CQAC Venue: Large Lecture Theatre, Institute in the park
**CQAC Venue: Lecture Theatre 4, Institute in the park

Thursday, November 29, 2018