Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS MEETING

Tuesday 12 January 2016 commencing at 10:00am

Venue: Institute in the Park Boardroom, Alder Hey Children's Foundation Trust

Item	Time	Items for Discussion	Owner	Board Action	Metrics	BAF Risks	Preparation
10:00				**PATIENT STORY**			
Board Business							
1.	**10.00**	**Apologies**	D Henshaw				--
2.	**10.00**	**Declarations of Interest**	All	Board Members to declare an interest in particular agenda items, if appropriate			--
3.	**10.00**	**Minutes of the Previous Meeting**	D Henshaw	To consider the minutes of the previous meeting held on **Tuesday 1 December 2015** and check for amendments and approve			Read Minutes (2015/126)
4.	**10.05**	**Matters Arising and Board Action List**	D Henshaw	To discuss any matters arising from previous meetings and provide updates and review where appropriate			Verbal
5.	**10:10**	**Key Issues/Reflections**	All	The Board to reflect on key issues.			Verbal
Excellence in Quality: Are we effective? Are we safe? Are we patient centred and caring?							
6.	**10:20**	**CQC Action Plan**	E Saunders	To approve the action plan and respond to the 2015 re-inspection report			Read Report (2015/127)
7.	**10.30**	**Serious Incidents Report**	H Gwilliams	To inform the Board of the recent serious incidents at the Trust in the last calendar month		1.1	Read Report (2015/128)
8.	**10.40**	**Corporate Report – Quality Aims**	H Gwilliams	To note delivery against quality mandatory targets within the Corporate Report for the month of October 2015		1.2	Read Report 2015/129)

Item	Time	Items for Discussion	Owner	Board Action	Metrics	BAF Risks	Preparation
The New Hospital							
9.	**10.50**	**Feedback on move to Alder Hey in the Park**	D Powell	• To receive an update on the move into AHP, key outstanding issues / risks and plan for mitigation • To receive an update towards delivery of the Children's Health Park & Campus Development		7.3	Read Report (2015/130) Verbal
10.	**11.10**	**Programme Assurance Update**	J Gibson	To receive an assurance report on the Programme of Change		7.1	Read Report (2015/131)
STRATEGIC DEVELOPMENTS							
11.	**11.20**	**Planning for 2016/17 and beyond**	L Shepherd	To review progress and agree planning process in the context of national guidance.			Read Report (2015/132)
12.	**11.45**	**Paediatric Rehabilitation – Specialist and Step-Down**	J Adams	To receive Board proposals and Vanguard submission for paediatric rehabilitation and support direction of travel.			Read Report (2015/133)
13.	**12.15**	**CHD Update**	L Shepherd	To review progress and next steps			Verbal
14.	**12.30**	**Strategic direction for Neonatal Services**	S Kenny	For discussion and approval.			Presentation
15.	**13.00**	**North West Coast Genomic Medicine Centre**	K Thompson/ A Douglas	To provide an update on the North West Coast Genomic Medicine Centre			Verbal
13.20 LUNCH							
Business Development/Financial Sustainability/Ensuring Good Governance: Compliance with mandatory requirements							
16.	**13:40**	**Integrated Assurance Report and Supporting Documents**	E Saunders	To receive and review the Integrated Assurance Report incorporating the following documents: • Board Assurance Framework	All		Read Reports (2015/134)

Item	Time	Items for Discussion	Owner	Board Action	Metrics	BAF Risks	Preparation
17.	**13:50**	**Corporate Report – Operational and Financial Performance**	J Stephens / J Adams	To note delivery against financial & operational mandatory targets within the Corporate Report for the month of October 2015		1.2	Read Corporate Report
18.	**14:00**	**Resources & Business Development Committee: Chair's Update**	I Quinlan	To receive the key issues report from the meeting held on 16 December 2015 and the minutes of the meetings held on: 28 October 2015 *(n.b no meeting held in November)*		1.1 and 6.1	Read Report (2015/135)
Great talented people: Are we well led?							
19.	**14:05**	**Workforce Race Equality Standard**	M Swindell / H Ainsworth	To receive the summary of WRES Metrics Findings for Action 2015/16			Read Report (2015/136)
20.	**14:20**	**People Strategy Update and Supporting Documents**	M Swindell	To receive an update report on the key issues relating to the workforce		4.1 and 4.2	Read Report (2015/137)
21.	**14:30**	**Staff Survey – Initial results**	M Swindell	To receive a briefing on the initial results of the staff survey			Read Report (2015/138)
22.	**14:45**	**Workforce & Organisational Development Committee: Chairs Update**	C Dove	To receive the minutes from the meeting held on 30 September 2015			Read Report (2015/139)
23.	**14:50**	**Corporate Report – People Measures**	M Swindell	To note delivery against the People targets/measures within the Corporate Report			Read Report (2015/140)
15:00	**Date and Time of Next Meeting: Tuesday 2 February 2016** at **10:00am, Institute in the Park Boardroom**						

REGISTER OF TRUST SEAL

The Trust Seal was used for the following items during **December 2015:**

- Variation of ERDF grant offer letter.

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Minutes of the last meeting held on **Tuesday 1st December 2015**
Institute in the Park Boardroom at Alder Hey

Present:	Sir David Henshaw	Chairman	(DH)
	Mrs L Shepherd	Chief Executive	(LS)
	Mrs J Adams	Chief Operating Officer	(JA)
	Miss G Core	Chief Nurse	(GC)
	Mrs C Dove	Non-Executive Director	(CD)
	Mrs J France-Hayhurst	Non-Executive Director	(JFH)
	Mr P Huggon	Non-Executive Director	(PH)
	Mr S Igoe	Non-Executive Director	(SI)
	Mrs A Marsland	Non-Executive Director	(AM)
	Mr J Stephens	Director of Finance	(JS)
	Mrs M Swindell	Acting Director of HR & OD	(MS)
	Mr R Turnock	Medical Director	(RT)
	Mr I Quinlan	Non-Executive Director	(IQ)
In Attendance:	Prof M Beresford	Assoc. Director of the Board	(MB)
	Ms L Dunn	Director of Marketing and Communications	(LD)
	Mr J Gibson	External Programme Assurance Lead	(JG)
	Mrs H Gwilliams	Director of Nursing	(HG)
	Miss J Preece	Interim Board Administrator	(JP)
	Mr D Powell	Development Director	(DP)
	Ms E Saunders	Director of Corporate Affairs	(ES)
Observing:	Mr S Erskine	Non-Executive Director, Portsmouth Hospital NHS Trust	
	Mr S Hooker	Governor, Public: North Wales	
	Mrs B Shaw	Governor, Patient: Parent and Carer	
Item 2015/145:	Mrs T Patten	Associate Director of Strategic Development	(TP)
Item 2015/154:	Mr G Lamont	Consultant Paediatric Surgeon/ Associate Medical Director (Education)	(GL)

PATIENT STORY

The Board welcomed patient, Max and his Mum to the meeting.

Max talked to the Board about his experiences across the two hospital sites, old and new, and explained that he had previously had six operations, one of which had taken place in the new hospital. One thing that Max missed in the

new build were the colourful wall murals, he did explain however that he felt the level of service had not changed and praised the care he had received.

Max's Mum echoed the comments regarding his care team and talked about how fantastic it was to be in the new building. She did raise a point however, about some toasters and TVs not working which was having a negative impact on wards and was not an acceptable position for children. She commented that that ward based kitchens appeared not to be catering to all spectrums as yet.

Max also talked proudly about his fundraising efforts for the Alder Hey Charity.

The Board thanked Max and his Mum for taking the time to come and provide their feedback and comments which were very much welcomed.

Max and his Mum were asked if they would return to the Board meeting in March 2016 to update on their experiences.

2015/145 BOARD WORKSHOP: FUTURE TRUST STRATEGY

See workshop output notes.

2015/146 DECLARATIONS OF INTEREST

None declared.

2015/147 MINUTES OF THE PREVIOUS MEETING

The Board considered the minutes of the last meeting held on Tuesday 20th October 2015.

Resolved that the Board: approved the minutes as a correct record.

2015/148 MATTERS ARISING AND BOARD ACTION LIST

2015/105 Trust Quality Report, review of wrist band compliance

HG updated on the action relating to wrist band compliance and confirmed that a further audit had been undertaken demonstrating full compliance in this area.

The Board noted the progress made and the action list was update accordingly.

EXCELLENCE IN QUALITY

2015/149 CQC RE-INSPECTION REPORT

The Board received the final reports from the CQC re-inspection 15th and 16th June 2015. LS reminded the Board that the reports did remain under embargo until the Quality Summit which was scheduled for 22nd December. However,

she was delighted to report that that the Trust had been awarded an overall rating of "good" with a rating of "outstanding" for the Caring domain.

LS alluded to the areas that had been challenged from the draft report and stated that the CQC had taken the Trust's comments away for consideration and following further scrutiny agreed to amend their rating. LS commended the CQC for listening and understanding the Trust's position in terms of delivering probably one of the most challenging agendas faced by any healthcare organisation over the last 12 months.

The Board learned that the Community Child and Adolescent Mental Health Services (CAMHS) had been subject to a separate report and had been awarded a "requires improvement" rating. The Executive Team was continuing to liaise with the CQC to address an issue that related to the wording of the report concerning waiting times which hopefully could be rectified in the next few days.

The Quality Summit meeting with all stakeholders aimed to discuss and agree any actions to take forward, following which the reports would made public. LS undertook to check however, if this could be done beforehand given the fantastic result it was important that the message didn't get lost over the festive period.

Resolved that the Board: noted the contents of the CQC re-inspection report and the overall rating of "good".

2015/150 SERIOUS INCIDENTS REPORT

The Board considered a regular report prepared by the Director of Nursing and Clinical Risk Advisor detailing the Serious Incidents that had arisen at the Trust in the last calendar month.

HG presented the report and advised of two new cases reported during September, one of which was would fall outside of the 45 working day compliance as it was subject to a multi-agency RCA, which Alder Hey was leading; a six month timescale had been given by the CCG.

Four incidents had been closed since the last report.

JS alluded to the two ongoing investigations and questioned the non-compliance with the 45 working days. HG explained that this had been a direct impact of time constraints on staff leading the investigations and had been unavoidable.

The Chair thanked HG for presenting the report.

Resolved that the Board: noted the contents of the report.

2015/151 CORPORATE REPORT

The Board considered the corporate report detailing the financial and operational performance for the Trust for the month ending 31 October 2015.

In addition, the Board considered an update report on AED performance against target. JA reported a deterioration in the position during October and stated that the Quarter 3 position for meeting the 95% target had been lost.
JA talked about the 17% increase in A&E attendances since the move to the new hospital and said that the ED team was reassessing the triage system in an attempt to get patients through the system quicker and that additional GP cover had been requested from UC24. The Chairman was disappointed that this issue had been flagged over a year ago with the CCG and support requested in anticipation of this rise. DH suggested initiating a proactive local campaign to reduce A&E attendances; the communications team agreed to take this forward.

JA informed the Board that substantive plans had been developed to recover the position in Q4 to prevent two consecutive quarters not achieving the required 95%. The Trust was working on improvement activities in collaboration both internally and with external stakeholders to ensure appropriate utilisation of Emergency Services.

The long term solution to this would be the family centre model in the community. DH suggested inviting the Chair of the Liverpool CCG Governing Body into the Trust to discuss this issue and agree a shared solution.

Financial Performance
JS provided the Board with an overview of the key financial messages within the Corporate Report and highlighted the challenges for the Trust with particular reference to the deficit position of £2.9m which was £0.3m behind plan.
Income was behind plan by £2.7m largely relating to elective activity which is behind by 4% and outpatient activity which was behind by 12%.
LS reported that recovery plans were being closely monitored and had improved the position slightly but remained concerned that year end was just four months away.

DH was disappointed to see the number of areas reporting below target, particularly sickness and mandatory training and was eager to understand what was directly related to the hospital move.
LS alluded to the data relating to CAMHS which was being reclassified.

The Chair thanked JA and JS for presenting the report.

Resolved that the Board: -
(i) noted the contents of the report; and

(ii) supported the actions being taken to mitigate risk to the trust and drive improvement.

MB left the meeting

THE NEW HOSPITAL

2015/152 FEEDBACK ON THE MOVE TO ALDER HEY IN THE PARK

The Board considered a report from the Development Director highlighting the outstanding issues and risks following the move to the new hospital.

DP outlined the process currently in place for dealing with issues relating to the building and explained that the dedicated team remained situated on the mezzanine floor of the new hospital which staff could easily access. A process was currently underway to evolve the current arrangement into a 'fix-it' team going forward.

Attention was drawn to the current list of issues within the project plan and timescale for completion. DP took the Board through some of the individual priorities that were leading to safety concerns and operational problems.

DH sought assurance around the capability and capacity to resolve these in a timely fashion. JS stated that the diagnostic process had caused delay but that once an issue had been identified, the fix time was satisfactory.

DP talked about the Interim and New Campus (formerly the 'retained estate') on which some corporate and community teams remained. Long term plans for the community model were still to be agreed with consideration to how this may look going forward, linking in with the family centre model.

LS reported that a dedicated project team had been assigned to taking forward and delivering the long term arrangements for the retained estate.

A business case for the development of a new Corporate Office block would be taken to the Resources and Business Development Committee meeting imminently.

The Chair thanked DP for presenting the report.

Resolved that the Board: noted the mitigating actions and associated timescales to resolve outstanding issues and risks following the move to the new hospital.

2015/153 PROGRAMME ASSURANCE UPDATE

The Board considered a report prepared by the External Programme Assurance Lead. The purpose of the report was to provide an update on the status and progress of the key projects that comprise the change programme at Alder Hey Children's NHS Foundation Trust.

JG drew Board members' attention to the progress of the six projects considered to be 'mission critical' by the Executive Team and explained that following successful occupation of the new hospital the Mobilisation and

Transition project had now been delivered and closed, meaning that the programme was now moving into the next phase.

He assured the Board that alongside taking forward the preceding elements of the programme, the team continued to manage implementation of phase I.

The Chair thanked JG for presenting the report.

Resolved that the Board: noted the contents of the report.

JG left the meeting.

GREAT TALENTED PEOPLE

2015/154 HEALTH EDUCATION NORTH WEST

The Board received a report prepared by Associate Medical Director (Education) outlining the feedback given to the Trust following the visit from Health Education North West (HENW) and the General Medical Council (GMC) on the 19th November 2015.

GL gave a brief outline of the main headlines from the feedback which demonstrated that in many areas the Trust was performing well in an educational sense, but there were a number of themes that should be addressed to provide evidence of improvement.

A proactive approach had been taken in addressing some of the issues that the team were already sighted on in advance of receiving the report, the action plan for which would be monitored by the Clinical Quality Assurance Committee.

The Chair thanked GL for presenting the report.

Resolved that the Board: noted the contents of the report.

2015/155 PEOPLE STRATEGY UPDATE AND SUPPORTING DOCUMENTS

The Board considered a regular report prepared by the Acting Director of HR & OD updating on delivery of the People Strategy and Staff Temperature Checks for the months of September and October 2015.

MS provided an overview of the key actions for the Board to note and reported:

- That with effect from 1 April 2016 the Trust would be bringing recruitment services, currently provided by Liverpool Women's NHS Foundation Trust, back in-house;
- Payroll Services however, would remain with current provider, ELFS Shared Services following a period of efficient service provision and significant assurance report from MIAA. A proposal to extend this

contract would be taken to the Resources & Business Development Committee in due course;

- That the Trust was now actively reporting its performance against spend on nursing agency staff to Monitor and the Trust Development Authority;
- That the Annual Staff Survey had now concluded; the response rate for which was around 35%; and
- That the flu vaccination campaign was well underway and currently stood at 67%.

The Chair thanked MS for presenting the report.

Resolved that the Board: -

(i) noted the contents of the People Strategy Progress Report; and

(ii) noted the contents of the September & October Temperature Checks.

BUSINESS DEVELOPMENT/FINANCIAL SUSTAINABILITY AND ENSURING GOOD GOVERNANCE

2015/156 INTEGRATED ASSURANCE REPORT AND SUPPORTING DOCUMENTS

The Board considered a report prepared by the Interim Governance & Risk Manager providing members with a summary of the current strategic risks and associated controls and mitigations.

ES alluded to the Trust's CQC rating of "good" and stressed the importance of maintaining internal scrutiny on the Trust's risk profile. An exercise would be undertaken in January 2016 to review assurance against current mitigating actions and identify any further actions that can be taken to reduce risks. This would support the sign-off of the effectiveness of the Trust's system of internal control in the Annual Governance Statement.

SI talked about the September and November Integrated Governance Committee meetings which had focussed primarily on risks associated with the new build. It was anticipated that the agenda would return to 'business as usual' for the January 2016 meeting.

The Chair thanked ES for presenting the report.

Resolved that the Board: noted the contents of the report.

ITEMS FOR RATIFICATION

2015/157 MAJOR INCIDENT / BUSINESS CONTINUITY PLANS

The Board received a suite of documents relating to Business Continuity and Major Incidents for ratification.

HG informed colleagues that all documents had been updated to reflect the location of the major incident meeting room in the new hospital. Specific changes were highlighted and the Board was asked to ratify:

- Major Incident Policy
- Major Incident Plan
- Business Continuity Policy
- Business Continuity Plan

Resolved that the Board: ratified the Major Incident Policy, Major Incident Plan, Business Continuity Policy and Business Continuity Plan.

ITEMS FOR INFORMATION

- **NATIONAL WHISTLEBLOWING POLICY**

  Resolved that the Board: noted the consultation document regarding a proposed single national whistleblowing policy for the NHS in England and that the Trust's policy would be reviewed in the light of the national policy at the appropriate time.

- **CLINICAL QUALITY ASSURANCE COMMITTEE**

  Resolved that the Board: noted the key issues report from the meeting held on 18 November 2015 and the minutes of the meetings held on 4 September & 21 October 2015.

- **AUDIT COMMITTEE**

  Resolved that the Board: noted the key issues report from the meeting held on 19 November 2015 which had been a very positive meeting in terms of assurance and drew particular attention to the guidance to which local auditors must have regard under Section 20(6) of the Local Audit and Accountability Act 2014.

  The Board noted the minutes from the meeting held on 25 September 2015.

- **RESOURCES & BUSINESS DEVELOPMENT COMMITTEE**

  Resolved that the Board: noted the minutes from the meeting held on 30 September 2015.

- **WORKFORCE & ORGANISATIONAL DEVELOPMENT COMMITTEE**

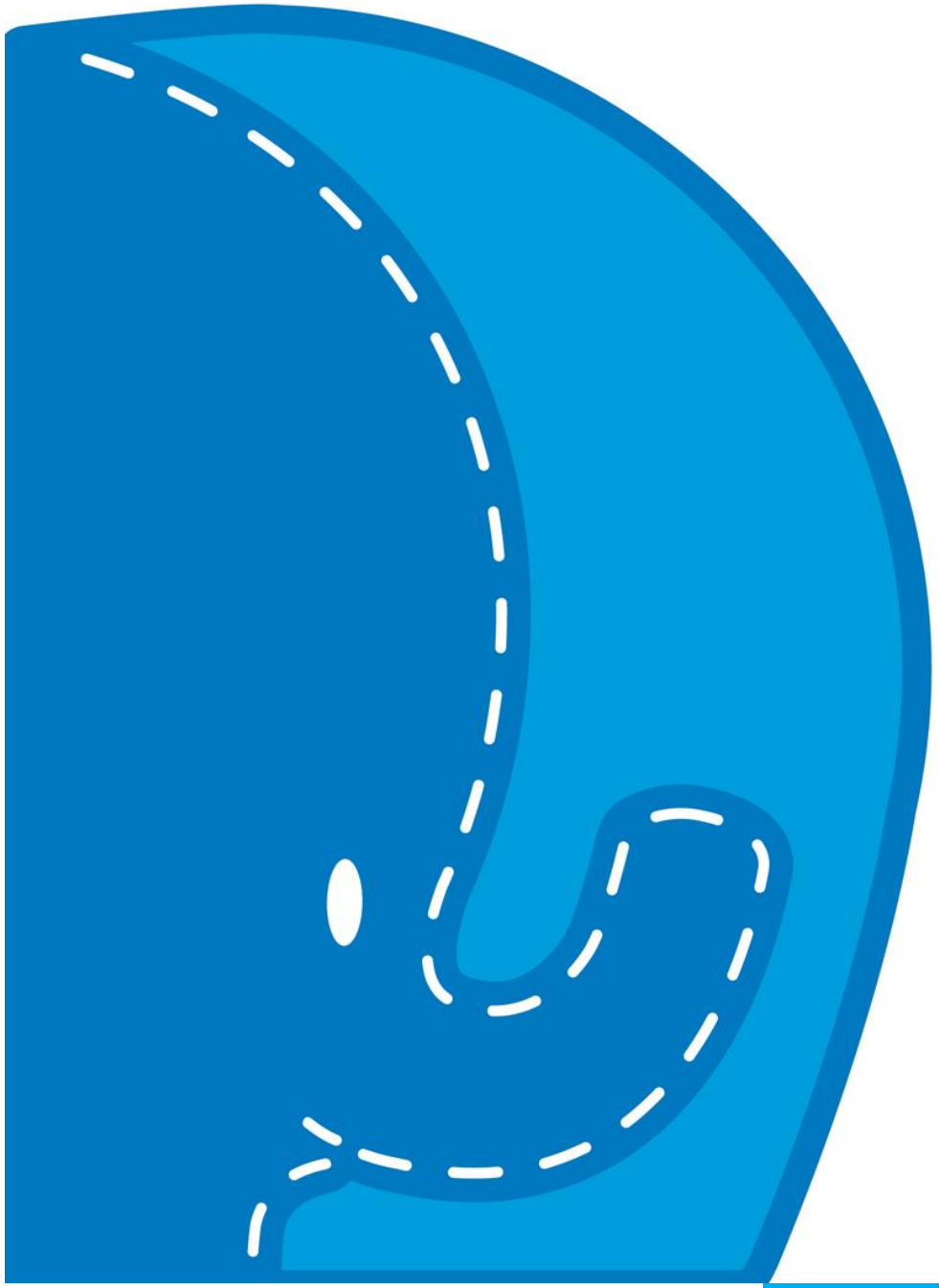
Resolved that the Board: noted the minutes from the meeting held on 30 September 2015.

DATE AND TIME OF NEXT MEETING

The next scheduled meeting of the Board of Directors will take place on **Tuesday 12th January 2016** at **10:00am** in the Institute in the Park Boardroom, Alder Hey.

ACTION LIST
(Following the October Meeting)

Date	No	Action	Who	When
23/05/14	2014/85	Board Members to block out time in diaries to undertake visits to different staff groups. 4/11 – Plan created and tied in with Comm Plan, gone out to CBU through soft launch, waiting for feedback and them come back to the Board in due course.	ALL	Ongoing
~~07/07/15~~	~~2015/105~~	~~Trust Quality Report, review wrist band compliance~~	~~HG~~	~~December 2015~~
07/07/15	2015/105	Trust Quality, scope project out on discharge project and bring back to the Board.	DG / JA	To form part of Phase 2 of HWWITF project
01/12/15	Patient story	Max and his Mum to update the Board on their experiences	JT	March 2016
01/12/15	2015/151	Campaign to be initiated to reducing A&E attendances	LD / Comms	Immediate



Alder Hey Children's NHS
NHS Foundation Trust

Board of Directors' Workshop Session

1 December 2015

Outputs

Inspired by Children

Opening comments / thoughts to be considered in the context of the new 5 Year Strategy

- Trust Vision / Ambition – where we are on the journey
- Need to think about next steps now that in new build and are seeing culture shift
- Financial landscape across the patch is very challenging ; need a step-change going forward – particularly with partnerships (overseas, NHS, community, etc.)
- Regulatory requirements and how vital these are in forming partnerships
- Hospital needs to be more efficient – still work to do around re-design of services
- Vital to have one single integrated approach to education & research
- Real focus externally now that not distracted by The Move
- Perception of Alder Hey to be managed
- Focus to be on strong value base, Brand etc. not on CIP, cost savings; staff to be integrated into

Alder Hey Children's NHS
NHS Foundation Trust

Financial Challenge

- CIP slipped by 30% (in any year)
- Potential target for 2016/17 £10m – pending review impact of 16/17 planning guidance
- Potential impact of children's tariff proposals
- Struggle to deliver elective, day case and outpatient growth plans
- low cash balances for 16/17 range £3m to £1m and this assumes full CIP delivery so high risk
- Limited funds for capital and or strategic investment

So, what do we need to do?

- Income generation strategy to be developed and delivered
- Need to be proactive in forming partnerships
    - International growth – limited by patient hotel – private model to be fully implemented (clinicians to own service fully)
    - draft rehab case worked up – bigger model to be agreed
- Family Centre Model to be taken forward and develop future state integrated community services model (Execs to look at)
- Partnership Board to look at view of delivering community services
- Workforce modernisation and development strategy

Education, Research & Innovation

So, what do we need to do?

- Vital to have on single integrated approach
- Linking in 'virtually' with Universities & create a faculty
- Visioning exercise with Edge Hill – then need to agree ££
- Big focus on raising the profile of the Alder Hey 'brand' (values based)
- Again, focus needed on partnerships and proactively developing
- Vital to maintain regulatory rating

Quality Strategy Refresh

So, what do we need to do?

- 'Clinical Cabinet' to be agreed
- Actively consult with staff – we know this works well !
- Making the hospital more efficient – more work to do on redesign of services

Working differently in the new building

So, what do we need to do?

- Establish 'Fix It Team'
- Hackathon style event to be held
- Empower staff to fix things that get in the way on a daily basis (service level)
- NEDs / Exec to partner up and speak to staff about their issues and sponsor projects to take forward

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ACTION PLAN IN RESPONSE TO CARE QUALITY COMMISSION INSPECTION REPORT – DECEMBER 2015

The Trust must:					
1. Ensure that robust arrangements are in place to govern the fit and proper persons process					
Outcome	**Actions**	**Responsibility**	**Time-frame**	**Assurance**	**Progress**
Trust arrangements are assessed as fully compliant with CQC requirements	Complete actions set out in Board assurance checklist: i. Commence cycle of interim DBS checks for existing Board members ii. Directors to complete annual declaration for 2016/17	DoCA/DoHR	i. First round (directors in post for 5 years or more) to commence January 2016 ii. April 2016	DBS check results. Full set of declarations.	Board assurance framework for FPP agreed by Board September 2015
2. Ensure that departmental risk registers are kept up to date and reviewed appropriately					
Outcome	**Actions**	**Responsibility**	**Time-frame**	**Assurance**	**Progress**
Departmental risk registers are live documents with demonstrable local ownership	Local risk registers to be reported through CBU risk and governance committees with exceptions to IGC	DoN	Ongoing	Additional reports available to CBUs allow more rigorous monitoring eg where review date lapsed	Review of all local risk registers undertaken by Risk and Governance consultant
3. Improve its risk management processes in the outpatient and diagnostic imaging departments and provide appropriate training for those delegated to manage risk					
Outcome	**Actions**	**Responsibility**	**Time-frame**	**Assurance**	**Progress**

Arrangements are consistent within the CBU, fit for purpose and well understood by all staff.	RM improvement plan to be implemented at service level	DoN/GM	Ongoing	Reports to IGC	
4. Ensure there is an appropriate process in place for checking and recording pregnancy status in adolescent female patients					
Outcome	**Actions**	**Responsibility**	**Time-frame**	**Assurance**	**Progress**
All appropriate patients are asked about pregnancy status and this is audited on a regular basis	An up to date Radiation Policy has been ratified and is in day to day use within the department	DoN	Immediate	Policy audit via Meditech 6	Complete Audits ongoing
5. Ensure that learning from incidents and complaints is shared with staff to prevent recurrent issues					
Outcome	**Actions**	**Responsibility**	**Time-frame**	**Assurance**	**Progress**
Appropriate cascade system in place for dissemination of key lessons learned from incidents and complaints	Devolved model of risk management to be rolled out. Local communications include outputs from RCAs and complaints reports – Aggregated analysis	DoN/GMs	March 2016	Monthly staff temperature check	
6. Ensure that processes are robust and effective in relation to patient emergencies in the radiology department and that first aid and resuscitation equipment is suitably available and checks completed and documented regularly					
Outcome	**Actions**	**Responsibility**	**Time-frame**	**Assurance**	**Progress**
Appropriate equipment in place and checks completed as routine	Ensure all staff are appropriately trained in emergency response within the department Location of relevant	DoHR	March 2016	Audit reports	

	equipment is understood by all users and regular monitoring is in place				
7. Ensure that adequate signage is displayed in relation to entering areas in the radiology department					
Outcome	**Actions**	**Responsibility**	**Time-frame**	**Assurance**	**Progress**
Signage is fully IRMER compliant	Light box signs in place	COO/SGL	Beginning October 2015 – move to new hospital	Bi-annual report from IRS	Complete
8. Ensure that correct hand hygiene measures are in place and that people are aware of and using the correct techniques					
Outcome	**Actions**	**Responsibility**	**Time-frame**	**Assurance**	**Progress**
Compliance rates at 100% across all staff groups	Ensure IPC training completed by all relevant staff and put in to practice consistently	MD/DIPC	Ongoing	Corporate Report Local audits	
CAMHS					
9. Take action to improve the overall waiting time from referral to assessment to intervention and to ensure that there are effective systems in place to monitor the risk of people waiting to be seen					
Outcome	**Actions**	**Responsibility**	**Time-frame**	**Assurance**	**Progress**
Waiting time to first (Choice) appointment consistently at 6 weeks	• Review of all clinical job plans to ensure capacity maximisation • Recruitment to vacancies • Introduction of documented risk screening tool in	COO/GM	January 2016	Nationally reported waiting time figures	• Job plans reviewed and choice and partnership 'clinics' introduced' enabling easier booking of appointments • All vacancies recruited to • EPR update to enable clinicians to 'check pts

	Meditech 6 • Audit of DNA's and pt cancellations • Risk mgmt. advice to referrer				in and out and order appointments • All cases risk assessed at point of triage, choice apt, 1st partnership and thereafter as apt. Risk assessment screen on EPR • Acknowledgement letter to referrer with advice re: risk management and escalation in case of deterioration

The Trust should:					
10. Provide adult safeguarding training for staff across all services					
Outcome	**Actions**	**Responsibility**	**Time-frame**	**Assurance**	**Progress**
Provision of safeguarding adult training to the relevant services	Key Training planned for 19/1/2016 across all relevant services	DoN	March 2016	Safeguarding Committee	
11. Improve staff compliance with mandatory training					
Outcome	**Actions**	**Responsibility**	**Time-frame**	**Assurance**	**Progress**
Compliance rates at 90% across all staff groups	Ensure mandatory training available in a range of formats and completed by all relevant staff	DoHR	6 months - June 2016	Corporate Reports	Currently at 84%
12. Improve staff compliance with safeguarding training					
Outcome	**Actions**	**Responsibility**	**Time-frame**	**Assurance**	**Progress**
Compliance is within trust target	Increased methods in which to complete training ie face to face and on-line training available Target low compliance areas	DoN	March 2016	Corporate Report	SG1 within Trust target SG2 & 3 showing improved position against trust target
13. Continue to recruit nursing and medical staff to address shortfalls across the surgical and critical care services					
Outcome	**Actions**	**Responsibility**	**Time-frame**	**Assurance**	**Progress**
Ongoing recruitment activity addresses shortfalls in staffing across the surgical and critical care	The senior nursing team to continue with leading	DoN/MD	Ongoing	Report Hard Truths safe staffing levels	Three intensive care consultants and one nurse consultant now

services Dedicated consultant medical cover for HDU	recruitment activities throughout 2015-16, in accordance with the ongoing recruitment strategy. Continue with the rolling programme of advertisement for general recruitment capturing post registered RSCN's Undertake regular recruitment events locally, nationally and internationally Continue to work closely with HEIs and pre-qualifying students Maintain regular reviews of staffing Establish HDU medical team				providing dedicated HDU cover Two additional consultants will start February 2016 and August 2016 respectively
14. Improve patients access and flow across critical care services					
Outcome	**Actions**	**Responsibility**	**Time-frame**	**Assurance**	**Progress**
Patient access and flow across critical care services is seamless and effective	Standard Operating Procedure (SOP) to be written and implemented in	DoN	Completed	Performance Management Group	SOP in place Nurse recruitment has led to an increase in 15

Out-of-region transfers for PICU beds reduces year-on-year Cancellation rate for cardiac surgery is less than 1%	relation to maximising capacity and patient flow across critical care. Regular review and evaluation of SOP Weekly cardiac and critical care activity Standard Operating Procedure in place for the management of PICU flow Nurse staffing levels in place to support full availability of PICU capacity		Ongoing		critical care nurses in post from December 2015, meaning 21 PICU beds are consistently open
15. Ensure that peoples medicines are given at the necessary quantities at all times and that the records reflect what has been administered to prevent the risk associated with medicines that are not administered as prescribed					
Outcome	**Actions**	**Responsibility**	**Time-frame**	**Assurance**	**Progress**
All medicines are administered appropriately	Plan point prevalence study to assess random selection of patients on each ward and confirm medicines have been recorded appropriately on MAR chart.	MD/Chief Pharmacist	April 2016	Audit results to be provided to Medicines Management and Optimisation Committee	

	MSOs to Complete point prevalence observations of practice during medicines administration				
16. Ensure that outstanding actions on the risk register are reviewed and updated across all departments					
Outcome	**Actions**	**Responsibility**	**Time-frame**	**Assurance**	**Progress**
Local risk registers are up to date and accurately reflect current risk profile within each service	Implement additional reports in Ulysses to facilitate more rigorous monitoring of risks	GMs/CDs	January 2016	Reports to CBU Boards and feedback to IGC	Reports now available: eg Movements Report which details actions which are outstanding for more than a month and risks where the review date has lapsed
17. Seek to fill vacancies on medical wards and reduce the need for locum cover					
Outcome	**Actions**	**Responsibility**	**Time-frame**	**Assurance**	**Progress**
Cover provided by permanent solution: two new academic clinical lecturers to be appointed	Complete appointment process	MD	Next three months	Posts filled	
18. Continue to recruit nursing and medical staff to address shortfalls across the surgical services					
Outcome	**Actions**	**Responsibility**	**Time-frame**	**Assurance**	**Progress**
Ongoing recruitment activity addresses shortfalls in staffing across the surgical services No consultant surgeon vacancies in Department of Paediatric Surgery	The senior nursing team to continue with leading recruitment activities throughout 2015-16, in accordance with the ongoing recruitment strategy. Continue with the	GM/CD	Ongoing	Report Hard Truths safe staffing levels	Recruitment activities mean there are no consultant surgeon vacancies

	rolling programme of advertisement for general recruitment capturing post registered RSCN's Undertake regular recruitment events locally, nationally and internationally Continue to work closely with HEIs and pre-qualifying students Maintain regular reviews of staffing Medical recruitment activities				
19. Maintain staffing levels in the Neonatal Unit according to nationally recognised guidance					
Outcome	**Actions**	**Responsibility**	**Time-frame**	**Assurance**	**Progress**
Staffing levels within the Neonatal Unit are maintained according to RCN and BAPM standards	Ensure that the surgical neonates on the unit are nursed on a nurse to patient ratio of 1:2 direct patient care, in line with the RCN and BAPM standards and the acuity of the patient. Babies ready for	DoN	Ongoing	Report Hard Truths safe staffing levels	

	stepdown to other wards or discharge home nursed on 1:3 ration in line with RCN standards.				
20. Implement policies and procedures relating to transition, to ensure there are Trust wide policies and procedures for staff to refer to when dealing with young people that are; or, should be considered for transitional pathways					
Outcome	**Actions**	**Responsibility**	**Time-frame**	**Assurance**	**Progress**
Staff adhere to policy when managing patients of transitional age	Implement policy	MD/Clinical Lead	Ongoing – Draft policy out for consultation	Transition Steering Group	
21. Ensure that work undertaken in the learning disabilities steering group and the transition steering group are linked so that information is shared and used to benefit both of these vulnerable groups of children and young people					
Outcome	**Actions**	**Responsibility**	**Time-frame**	**Assurance**	**Progress**
Improved communication between services	Merge two groups and revise terms of reference to reflect this	MD/Clinical Leads	Six months	Minutes of both groups tracking progress	
22. Continue to develop relationships with adult health and social care providers to ensure the safe and effective transition of care for young people					
Outcome	**Actions**	**Responsibility**	**Time-frame**	**Assurance**	**Progress**
Overarching Transition Framework agreement across Healthy Liverpool	Develop shared framework with relevant partners	MD/Clinical Lead	12 months	Healthy Liverpool Programme governance	
23. Ensure that appropriate systems are in place for patients or those close them to raise an alarm if they require assistance whilst in outpatient changing areas					
Outcome	**Actions**	**Responsibility**	**Time-frame**	**Assurance**	**Progress**
Pull cord alarm and an alarm button system in place in the 'changing places' room linked to security	None required	CHP team	In line with move to new facilities	Hospital certifcation	Complete

personnel					
24. Undertake a review of staffing within each area of the outpatients department to ensure that there is an appropriate system in place to determine staffing requirements					
Outcome	**Actions**	**Responsibility**	**Time-frame**	**Assurance**	**Progress**
Organisational Change undertaken within OPD Nursing team	Full Organisational Change undertaken reflecting new structure required to support OPD within new Hospital	COO/DoN	Completed October 2015	Organisational change papers Revised structures	Completed October 2015.
25. Improve communication with people for whom English is not their first language					
Outcome	**Actions**	**Responsibility**	**Time-frame**	**Assurance**	**Progress**
Alternative communication methods in place	Review Meditech 6 for options to record other languages Once MTV6 action completed initiate printing of letters into alternative language	DoN	Phase 3 MTV6	F&F test in OPD	Under discussion with IM&T and with Meditech company.
CAMHS					
26. Ensure that risk assessments are correctly recorded on the patient record system					
Outcome	**Actions**	**Responsibility**	**Time-frame**	**Assurance**	**Progress**
Evidence of risk assessment on EPR	Implementation of risk assessment tool Risk screen on EPR to capture within clinical notes		January 2016	Case note audit	Standardised risk assessment tool implemented Risk screens on EPR in development

27. Ensure that there is an effective system in place to keep staff safe when visiting people in the community					
Outcome	**Actions**	**Responsibility**	**Time-frame**	**Assurance**	**Progress**
Staff are able to safely undertake community working practices	Develop and implement CAMHS specific appendix to Trust Lone Working Policy Purchase personal alarms for community staff	DoHR	January 2016	CBU Governance / QAM	CAMHS specific Appendix to Lone Working Policy in development Requested information re: purchase of personal attack alarms
28. Ensure that there are suitable alarm systems in place in community offices where people are seen					
Outcome	**Actions**	**Responsibility**	**Time-frame**	**Assurance**	**Progress**
Clinical staff are able to raise alarm when required from within clinic rooms	Purchase personal attack alarms for all clinical staff	DoHR	Feb 2016	CBU Clinical Governance	Requested information re: purchase of personal attack alarms
29. Ensure that staff are receiving mandatory training					
Outcome	**Actions**	**Responsibility**	**Time-frame**	**Assurance**	**Progress**
All staff compliant with mandatory training requirements	Implement local plan for Mandatory training completion	DoHR	January 2016	Audit reports	Local plan in development
30. Ensure that staff know what action to take in case of fire					
Outcome	**Actions**	**Responsibility**	**Time-frame**	**Assurance**	**Progress**
All staff confident in actions to take in the event of fire	Identify designated fire Marshalls Ensure regular fire drills within community sites	COO/GM	January 2016	Fire reports to CBU Board	Recording system for weekly alarm tests now in place Request for designated for Marshalls circulated
31. Ensure that there is an effective system in place to monitor the safe storage and use of FP10 prescription pads					
Outcome	**Actions**	**Responsibility**	**Time-frame**	**Assurance**	**Progress**
Secure storage of FP10 prescription pads	Purchase lockable small storage facility	MD/CD	January 2016	CBU Governance	

	for each clinical team			Ulysses Reports	
32. Ensure adequate medicines management oversight and improve day to day medicines management practices, for example, recording dates of opening of medicines					
Outcome	**Actions**	**Responsibility**	**Time-frame**	**Assurance**	**Progress**
Robust day to day medicines management practices	Establish a system to enable recording of medicines, opening dates, expiry dates, etc	MD/DoN	January 2016	Regular internal audit	System and process to record medicines established within unit
33. Ensure that a patients medication is verified by a pharmacist or pharmacist technician upon admission					
Outcome	**Actions**	**Responsibility**	**Time-frame**	**Assurance**	**Progress**
All patient medication verified by a appropriate pharmacy representative on admission	Meet with CSS CBU lead re: pharmacy input to unit Establish arrangements with pharmacy to verify meds at point of admission		February 2016	Regular audit	
34. Ensure that medicines management practices are audited frequently in line with good practice					
Outcome	**Actions**	**Responsibility**	**Time-frame**	**Assurance**	**Progress**
Medicines management audit framework in place	Develop an audit framework in accordance with best practice guidelines		January 2016	Audit reports	
35. Ensure full compliance with the Mental Health Act and Code of Practice including records management, treatment certificates, consideration of, and decisions around consent to treatment, and good timely access to mental health act support					
Outcome	**Actions**	**Responsibility**	**Time-frame**	**Assurance**	**Progress**
Mental Health Act Code of Practice Compliance	Agree SLA with MerseyCare NHS	MD/CD	January2016	CBU Board/Trust	Meeting scheduled with MCT for 11th January

	Trust Annual training for all staff Develop information leaflet for the unit			Board	2016
36. Consider improving the identification of key information in care records such as whether the child is on the child protection register or whether the child is looked after					
Outcome	**Actions**	**Responsibility**	**Time-frame**	**Assurance**	**Progress**
Easy identification of vulnerability status within care records	CIC indicator on Meditech 6 to be amended to enable update by clinicians outside of safeguarding team	Assoc Dir IM&T	March 2016	Audit reports	Meditech team aware of changes required and included in plan for phase 3

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Tuesday 12th January 2016

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

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1. Background:

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

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

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

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

2. SIRI performance data:

SIRI (General)													
2014				2015									
Month	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**June**	**July**	**Aug**	**Sep**	**Oct**
New	1	3	1	1	1	4	1	0	5	0	3	2	2
Open	1	1	4	3	3	2	5	6	5	7	5	2	3
Closed	3	1	0	2	1	2	1	0	1	3	2	4	1
SIRI (Safeguarding)													
2014				2015									
Month	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**June**	**July**	**Aug**	**Sep**	**Oct**
New	0	1	1	0	0	1	2	0	0	0	1	0	0
Open	5	3	4	2	0	0	1	3	0	0	0	0	0
Closed	1	2	0	3	2	0	0	0	3	0	0	0	0
Total closed	**4**	**3**	**0**	**5**	**3**	**0**	**0**	**0**	**3**	**0**	**0**	**0**	**0**

3. Comments:

The recent CQC report identified that the 'Trust Board of Directors' received limited information about serious incidents. The SIRI action log will now go to CQAC sub board committee responsible for quality.

4. Recommendations:

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

New SIRI Incidents reported between the period 01/10/2015 to 31/10/2015:							
Reference Number	**Date investigation started**	**CBU**	**Incident Description**	**RCA Lead Investigator**	**Progress**	**45 working day compliance**	**Being Open policy implemented**
RCA 144 L2 2015/16 StEIS 2015/34271	28/10/2015	CS	Patient over exposed to radiation	Laura Gauntlett, Lead Radiographer	RCA report completed and sent to CCG.	Yes	Yes
RCA 145 L2 2015/16 Internal	29/10/2015	SCACC	Patient suffered burn injury as a result of chlorhexidine swab making contact with the surface of the skin	Paul Dunn, Senior Operating Practitioner and Kerry Turner, Theatre Risk and Governance Lead	Initial investigations commenced, panel meeting to be arranged.	Yes	Yes

New Safeguarding investigations reported 01/10/2015 to 31/10/2015:							
Reference Number	**Date investigation started**	**CBU**	**Incident Description**	**RCA Lead Investigator**	**Progress**	**45 working day compliance**	**Being Open policy implemented**
Nil							

On-going SIRI incident investigations (including those above)							
Reference Number	**Date investigation started**	**CBU**	**Incident Description**	**RCA Lead Investigator**	**Progress**	**45 working day compliance**	**Being Open policy implemented**
RCA 121 L2 2015/16 Internal	18/06/2015	MS	Delay in treatment of liver failure	Graham Lamont, Consultant Paediatric Surgeon	Case review undertaken by Consultant Paediatric Surgeon, meeting being held 04/01/16 with family to discuss outcome.	No – GM maintained communication with family	Yes
RCA 136 L2 2015/16 StEIS 2015/29703	11/09/2015	CS	Delay in diagnosis of CF in patient	Paul Newland, Clinical Director	Local RCA panel meeting held, report in process of being written. This will be incorporated into a multi-agency RCA.	On track - Multi Agency RCA, 6 month timescale given by CCG	Yes
RCA 138 L2 2015/16 StEIS 2015/30744	24/09/2015	BS	Hospital Acquired Infection (influenza) and omission of antiviral medication, potential contribution to deterioration/death of patient	Richard Cooke, Director of Infection, Prevention & Control	Report in quality check stage.	Yes - extended date 31/12/15	Yes

On-going Safeguarding investigations							
Reference Number	**Date investigation started**	**CBU**	**Incident Description**	**RCA Lead Investigator**	**Progress**	**45 working day compliance**	**Being Open policy implemented**
Nil							

SIRI incidents closed since last report						
Reference Number	**Date investigation started**	**CBU**	**Incident Description**	**RCA Lead Investigator**	**Outcome**	**Being open policy implemented**
RCA 117 L2 2015/16 StEIS 2015/21392	16/06/2015	SCACC	Patient injury due to treatment/procedure (Theatre)	Rachel Christopher, Senior Recovery Nurse	RCA report completed and sent to CCG.	Yes

Safeguarding investigations closed since last report
Nil

Corporate Report

Nov 2015

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Executive Summary

Nov 2015

** Throughout the report there are references to data being in revalidation. This is required following the implementation of the new hospital system to ensure accuracy of reporting.

Alder Hey Children's NHS
NHS Foundation Trust

Is there a Governance Issue?

Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15
N	N	N	N	N	N	N	N	N	N	N	N

Highlights

Improvements in mandatory training, achievement of 18 weeks RTT

Challenges

Overall activity and income is below plan for the year. ED performance against 4 hour standard

Patient Centred Services

RTT – clearance rates have improved in month as normal activity levels resume. Work continues to focus on booking in date order and challenged specialities including CAMHS waits.

ED – failed 4 hour standard in month and for Q3. Number of improvement actions in progress and engagement with primary care to resolve. Governance arrangements in place this month to place AH staff at Smithdown WIC. Attendances up 17% post hospital move.

Clinic and theatre utilisation – work ongoing to address both data quality issues with reporting and daily improvements to booking.

Cancelled operations – increase seen in month due to bed closures due to staffing and estates issues.

Excellence in Quality

At the end of November all patient safety indicators (excluding hospital acquired MRSA bacteraemia, C.difficile and Never Events) are on track to achieve the annual quality improvement targets. The clinical effectiveness indicators for patients with an estimated discharge date later than planned and acute readmissions of patients with long term conditions within 28 days have exceeded the November target. Further interrogation of the data is in progress; which will inform discussions within the relevant service groups. All other clinical effectiveness indicators are on target.

Financial, Growth & Mandatory Framework

"At the end of November the Trust is reporting a deficit position of £3.8m which is £1.3m behind plan.
Income is behind plan by £3.2m largely relating to elective activity which is behind plan by 5% and outpatient activity which is behind by 11%.
Pay budgets are £2.2m overspent relating to use of agency staffing.
The Trust is £2.2m behind the CIP target after 8 months. Cash in the Bank is £16.6m. Monitor risk rating of 2 for the month."

Great Talented Teams

Sickness shows an increase from 4.7% to 5.5% and remains above the target. Corporate induction shows an increase this month of over 10% to 91.7%. There has been an increase in mandatory training compliance of over 6% to 84%. Work continues on progressing all KPIs.

Leading Metrics

Nov 2015

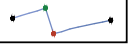
Alder Hey Children's NHS
NHS Foundation Trust

2015/129 refer to Quality Aims within

Patient Centered Services

Metric Name	Goal	Oct 2015	Nov 2015	Trend	Last 12 Months
ED: 95% Treated within 4 Hours	95.0 %	85.9 %	78.9 %	▼	
RTT: 90% Admitted within 18 weeks		87.3 %	100.0 %	▲	
RTT: 95% Non-Admitted within 18 weeks		91.0 %	87.9 %	▼	
RTT: 92% Waiting within 18 weeks (open Pathways)	92.0 %	92.1 %	92.2 %	▲	
Diagnostics: Numbers waiting over 6 weeks		2	0	▼	
Average LoS - Elective (Days)		2.8	3.0	▲	
Average LoS - Non-Elective (Days)		2.3	2.5	▲	
Daycase Rate	0.0 %	75.1 %	74.4 %	▼	
Theatre Utilisation - % of Session Utilised	85.0 %	70.9 %	75.5 %	▲	
28 Day Breaches	0.0	2	3	▲	
Clinic Session Utilisation	90.0 %	69.0 %	75.4 %	▲	
DNA Rate	12.0 %	11.8 %	10.4 %	▼	
Cancelled Operations - Non Clinical - On Same Day		18	53	▲	

Excellence in Quality

Metric Name	Goal	Oct 2015	Nov 2015	Trend	Last 12 Months
Never Events	0.0	1	0	▼	
IP Survey: % Received information enabling choices about their care	90.0 %	95.6 %	97.3 %	▲	
IP Survey: % Treated with respect	90.0 %	98.5 %	95.2 %	▼	
IP Survey: % Know their planned date of discharge	58.0 %	53.3 %	42.9 %	▼	
IP Survey: % Know who is in charge of their care	90.0 %	75.6 %	85.7 %	▲	
IP Survey: % Patients involved in play and learning	65.0 %	54.1 %	63.1 %	▲	
Pressure Ulcers (Grade 2 and above)	14.0	11	13	▼	
Total Infections (YTD)	96.0	67	73	▼	
Medication errors resulting in harm (YTD)	80.0	60	66	–	
Clinical Incidents resulting in harm (YTD)	506.0	418	473	▲	

Great and Talented Teams

Metric Name	Goal	Oct 2015	Nov 2015	Trend	Last 12 Months
Corporate Induction	100.0 %	80.9 %	91.7 %	▲	
PDR	90.0 %	90.1 %	90.1 %	–	
Medical Appraisal	100.0 %	97.1 %	97.1 %	–	
Sickness	4.5 %	4.8 %	5.6 %	▲	
Mandatory Training	80.0 %	77.2 %	84.0 %	▲	
Staff Survey (Recommend Place to Work)		54.1 %	54.1 %	–	
Actual vs Planned Establishment (%)		97.8 %	97.6 %	▼	
Temporary Spend ('000s)		1070	890	▼	

Financial, Growth and Mandatory Framework

Metric Name	Oct 2015	Nov 2015	Last 12 Months
CIP In Month Variance ('000s)	-212	0	
Monitor Risk Ratings (YTD)	2	2	
Normalised I & E surplus/(deficit) In Month ('000s)	-1570	-907	
Capital Expenditure YTD % Variance	-16.9 %	-11.3 %	
Cash in Bank ('000s)	17	17	

Exceptions

Nov 2015

Alder Hey Children's NHS Foundation Trust

Positive (Top 5 based on % change)

Metric Name	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015	Nov 2015	Last 12 Months
RTT: 90% Admitted within 18 weeks	75.2%	90.1%	90.2%	90.1%	90.3%	90.1%	90.1%	90.7%	90.0%	90.1%	87.8%	87.3%	100.0%	
DNA Rate	11.9%	15.1%	11.9%	11.4%	11.2%	11.7%	12.1%	14.2%	15.3%	14.4%	12.6%	11.8%	10.4%	
IP Survey: % Patients involved in play and learning	60.9%	63.5%	61.0%	58.9%	60.5%	58.5%	64.0%	69.4%	64.6%	66.5%	56.9%	54.1%	63.1%	
Total Infections (YTD)	95	118	131	137	147	11	19	32	38	46	57	67	73	
Medication errors resulting in harm (YTD)	94	103	115	121	129	8	20	29	33	41	54	60	66	

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

Metric Name	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015	Nov 2015	Last 12 Months
Average LoS - Non-Elective (Days)	2.6	3.0	3.0	3.0	2.6	2.7	2.8	2.6	2.8	2.6	2.4	2.3	2.5	
Daycase Rate	76.8%	82.2%	76.9%	79.6%	77.3%	76.1%	75.1%	76.2%	76.6%	73.1%	76.8%	75.1%	74.4%	
IP Survey: % Know who is in charge of their care	77.8%	78.0%	84.5%	79.2%	82.3%	82.5%	82.7%	84.2%	79.0%	79.7%	88.4%	75.6%	85.7%	
Cash in Bank ('000s)						33	29	29	27	25	17	17	17	
Clinical Incidents resulting in harm (YTD)	529	609	682	749	836	70	130	212	268	319	372	418	473	

Challenge (Top 5 based on % change)

Metric Name	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015	Nov 2015	Last 12 Months
28 Day Breaches	2	2	2	1	6	5	2	1	12	5	4	2	3	
Clinic Session Utilisation	82.5%	77.5%	83.0%	84.5%	83.3%	83.7%	90.3%	74.4%	77.8%	73.9%	69.0%	69.0%	75.4%	
Sickness						4.7%	4.6%	4.8%	4.5%	4.1%	4.9%	4.8%	5.6%	
CIP In Month Variance ('000s)						-331	-204	-232	-208	-331	-209	-212	0	
IP Survey: % Know their planned date of discharge	62.1%	42.8%	43.0%	45.8%	45.0%	47.2%	57.8%	53.1%	44.4%	52.9%	58.7%	53.3%	42.9%	

Patient Safety - Section 1

Nov 2015

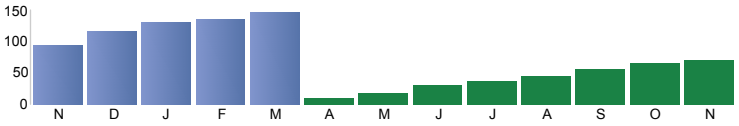
Alder Hey Children's NHS Foundation Trust

Summary

In November the total number of hospital acquired infections is on track to achieve the annual quality improvement reduction target, however the specific annual internal and contractual targets for hospital acquired MRSA bacteraemia and C.difficile where breached in April, June, July and August.

Infections

Total Infections (YTD) 72 (goal: 96.0)



Nov 14/15	Dec 14/15	Jan 14/15	Feb 14/15	Mar 14/15	Apr 15/16	May 15/16	Jun 15/16	Jul 15/16	Aug 15/16	Sep 15/16	Oct 15/16	Nov 15/16
95	118	131	137	147	11	19	32	38	46	57	66	72

Total Infections (YTD)	Hospital Acquired Organisms - MRSA (BSI) (YTD)	Hospital Acquired Organisms - C.difficile
72 (goal: 96.0)	3 (goal: 0.0)	2 (goal: 0.0)

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

Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
0	0	2	1	0

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

Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
0	0	0	2	0

Outbreak Infections 0

Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
0	0	0	0	0

Cluster Infections 0

Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
0	0	0	0

Medication Errors

Medication errors resulting in harm (YTD) 66 (goal: 80.0)

Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
41	26	29	25	12

Pressure Ulcers

Pressure Ulcers 29

Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
19	15	16	6	7

Pressure Ulcers (Grade 2 and above) 13 (goal: 14.0)

Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
3	8	5	3	5

Pressure Ulcers (Grade 3/4) 0 (goal: 1.0)

Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
1	0	0	0	0

Patient Safety - Section 2

Nov 2015

Alder Hey Children's NHS Foundation Trust

Summary

Clinical Incidents resulting in harm, Clinical Incidents resulting in moderate, severe harm or death and Readmissions to PICU within 48 hrs are all on target YTD with the exception of Never events which breached in June and October.

Never Events

Never Events — 0 (goal: 0.0)

Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
0	1	1	0	1

Incidents

Clinical Incidents resulting in harm (YTD) — 473 (goal: 506.0)

Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
236	227	212	160	101

Clinical Incidents resulting in moderate, severe harm or death (YTD) — 16 (goal: 48.0)

Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
14	19	10	4	2

Readmissions to PICU within 48 hrs (YTD) — 7 (goal: 14.0)

Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
4	4	2	3	2

Paediatric Safety Scan

Data in Revalidation

Harms — 11 (goal: 0.0)

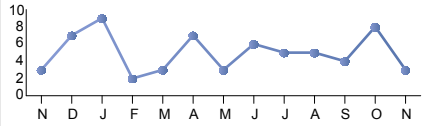
Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
21	37	87	94	23

Serious Incidents Requiring Investigation

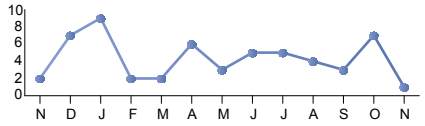
Metric Name	Oct 2015	Nov 2015	Trend	Last 12 Months
Serious Incidents Requiring Investigation (Total)	0	0	—	

Mortality

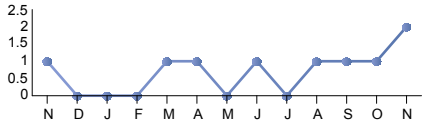
Deaths in Hospital



Deaths in Hospital - PICU



Deaths in Hospital - Other



Patient Experience

Nov 2015

Alder Hey Children's NHS Foundation Trust

Summary

Inpatient Survey

Metric Name	Goal	Oct 2015	Nov 2015	Trend	Last 12 Months
% Know who is in charge of their care	90.0 %	75.6 %	85.7 %	▲	
% Patients involved in play and learning	65.0 %	54.1 %	63.1 %	▲	
% Know their planned date of discharge	58.0 %	53.3 %	42.9 %	▼	
% Received information enabling choices about their care	90.0 %	95.6 %	97.3 %	▲	
% Treated with respect	90.0 %	98.5 %	95.2 %	▼	

Friends and Family

Metric Name	Goal	Oct 2015	Nov 2015	Trend	Last 12 Months
% Recommend Trust - Children & Young People		97.6 %	93.8 %	▼	
% Recommend Trust - Overall		94.8 %	95.2 %	▲	
% Recommend Trust - Parents		93.6 %	96.2 %	▲	

A&E Survey

No Data Available

Outpatients Survey

No Data Available

Complaints

Complaints - % Resolved within agreed timescales

50.0 % ▼ 90.0 %

Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
85.7%	90.5%	63.2%	59.1%	71.4%

Breaches

Breaches of Mixed Sex Wards (Ages 8 and over)

0 – 0.0

Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
0	0	0	0	0

CAHMS Survey

No Data Available

Clinical Effectiveness

Nov 2015

Alder Hey Children's NHS Foundation Trust

Summary

The indicators for patients with an estimated discharge date later than planned and acute readmissions of patients with long term conditions within 28 days have exceeded the November target. Further interrogation of the data is in progress, to inform discussions with the relevant service groups. All other indicators are on target

Readmissions

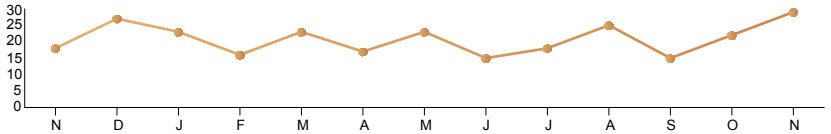
Readmissions within 48 hrs 164 (goal: 168.0)

Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
60	62	55	58	51

Acute readmissions of patients with long term conditions within 28 days 36 (goal: 8.0)

Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
17	12	9	12	15

Readmissions within 48 hrs (Non Elective)

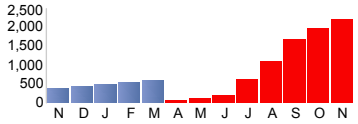


Admissions and Discharges

Acute Admissions with LTC 57

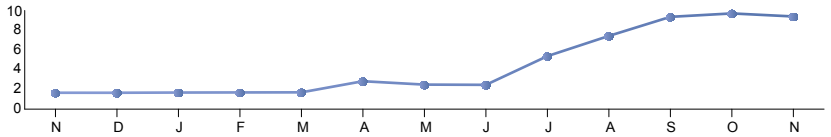
Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
147	122	109	109	97

Patients with an estimated discharge date discharge later than planned 2239 (goal: 568.0)



Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
163	168	224	1,481	534

% of patients with an estimated discharge date discharge later than planned



NICE Guidance Compliance

CInical Audit - Non-compliant NICE guidance 0

Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
1	0	0	0	0

CInical Audit - Partially compliant NICE guidance 0

Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
1	1	0	0	0

Access

Nov 2015

Alder Hey Children's NHS Foundation Trust

Summary

Following the planned reduction in activity for the hospital move activity has been increased across all POD's and is reflected in the highest level of reported admission and discharge figures for the financial year. Incomplete, cancer and diagnostic standards have been achieved with the focus on patients being treated chronologically. RTT admitted/non-admitted aggregate performance has deteriorated as planned with increased specialty fails. Access to services via Choose & Book platform continues within threshold and increased referrals noted compared to same point last year. .

18 Weeks

RTT: 90% Admitted within 18 weeks 100.0 %

Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
80.2%	90.2%	90.3%	89.3%	94.6%

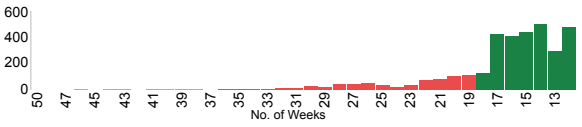
RTT: 95% Non-Admitted within 18 weeks 87.9 %

Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
91.3%	95.4%	95.2%	93.7%	89.3%

RTT: 92% Waiting within 18 weeks (open Pathways) 92.2 % *(goal: 92.0 %)*

Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
92.5%	92.7%	92.1%	92.1%	92.1%

Open Pathways Weekly Profile Nov 2015



0-18 Wks	19-36 Wks	36-51 Wks
2,716	737	52

Cancer

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

Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
100.0%	100.0%	100.0%	100.0%	100.0%

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

Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
100.0%	100.0%	100.0%	100.0%	100.0%

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

Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
100.0%	100.0%	100.0%	100.0%	100.0%

Diagnostics

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

Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
96.2%	93.0%	98.6%	100.0%	99.6%

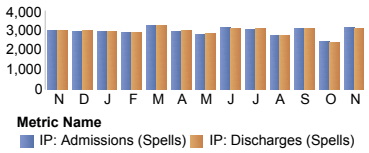
Waiting Times Failed 0

Waiting Times Passed 7

Number of Diagnostics

326

Admissions and Discharges



Provider

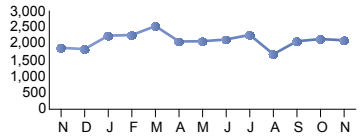
Convenience and Choice: Directly Bookable Slots TBC *(goal: 96.0 %)*

Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
93.7%	97.0%	97.0%		

Convenience and Choice: Slot Availability 99.7 % *(goal: 96.0 %)*

Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
93.8%	96.6%	99.9%		99.7%

Referrals Received (GP)



Emergency Department

Nov 2015

Alder Hey Children's NHS Foundation Trust

Summary

Achieving the 4 hours standard remains a challenge; attendances remain higher than predicted and acuity is at peak of RSV. An action plan has been created to address the pressures, which includes an extension to GP hours during the weekend and a full review undertaken of the triage process.

ED

ED: 95% Treated within 4 Hours 78.9 % (goal: 95.0 %)

Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
95.3%	97.0%	96.0%	95.3%	82.3%

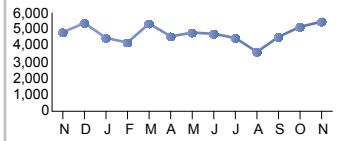
Data in Revalidation. To be released in January 2016.

ED

Data in Revalidation. To be released in January 2016.

ED: Number of Attendances

5466 Nov 2015

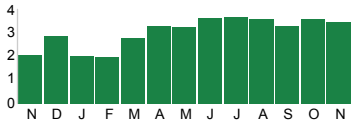


Ambulance Services

Ambulance: Acute Compliance 81.9 % (goal: 85.0 %)

Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
76.1%	78.2%	75.9%	81.9%	83.6%

Ambulance: Average Notification to Handover Time (mins) 3.5 mins (goal: 15.0 mins)



Ambulance: Patients Waiting between 30 and 45 minutes 5

Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
13.0	10.0	16.0	10.0	6.0

Ambulance: Patients Waiting between 45 and 60 minutes 0

Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
2.0	0.0	3.0	3.6	0.0

Productivity & Efficiency

Nov 2015

Alder Hey Children's NHS Foundation Trust

Summary

The planned increases of activity within the hospital continue to provide fluctuations in performance as operational processes bed in. Elective surgical activity has recommenced however bed and operational pressures within the new build resulted in a higher number of cancelled operations and low levels of theatre utilisation. OP utilisation is also improving as teams readjust to the new systems. DNA rates and Choose & Book access have improved. LOS has increased as more complex operating has recommenced within the Trust.

Length of Stay

Average LoS - Elective (Days) 3.0 ▲

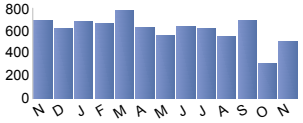
Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
3.0	2.8	2.7	2.8	2.9

Average LoS - Non-Elective (Days) 2.5 ▲

Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
2.8	2.9	2.7	2.6	2.4

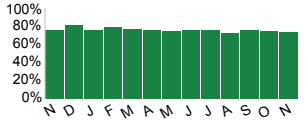
Day Case Rate

Daycases (K1) 513 ▲



Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
2,056	2,152	1,856	1,894	837

Daycase Rate 74.4 % ▼ *(goal: 0.0 %)*



Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
78.5%	77.9%	75.8%	75.6%	74.7%

Bed Refusals

Bed Refusals 1 ▲ *(goal: 0.0)*

Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
2	2	0	0	1

Theatres / Surgery

Theatre Utilisation - % of Session Utilised * 75.5 % ▲ *(goal: 85.0 %)*

Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
79.8%	81.6%	82.7%		73.5%

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

Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
0.8%	0.9%	0.9%	1.0%	1.9%

Cancelled Operations - Non Clinical - On Same Day 53 ▲

Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
53	62	60	65	71

28 Day Breaches 3 ▲ *(goal: 0.0)*

Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
8	9	8	21	5

Outpatients

Clinic Session Utilisation * 75.4 % ▲ *(goal: 90.0 %)*

Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
80.0%	83.6%	83.0%	73.3%	72.7%

OP Appointments Cancelled by Hospital % 14.4 % ▼ *(goal: 5.0 %)*

Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
15.1%	16.0%	16.4%	14.4%	15.9%

DNA Rate 10.4 % ▼ *(goal: 12.0 %)*

Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
13.1%	11.5%	12.6%	14.1%	11.1%

OP: New/Follow Up 2.3 ▲

Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
2.3	2.3	2.3	2.3	2.2

* : Data only available until the end of May

2015/129 refer to Quality Aims within

Summary

Facilities

Cleanliness Performance VH

97.0 % (goal: 98.0 %)

Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
95.0%	93.8%	94.5%	97.0%	98.5%

Cleanliness Performance H

95.0 % (goal: 95.0 %)

Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
89.4%	93.1%	94.0%	95.0%	97.5%

Cleanliness Performance S

95.0 % (goal: 85.0 %)

Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
83.9%	90.8%	86.4%	93.4%	97.5%

Cleanliness Performance L

95.0 % (goal: 75.0 %)

Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
81.8%	91.8%	70.0%	82.0%	97.5%

Facilities

Patient Food Wastage

TBC

Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16

Audit Compliance

96.4 % (goal: 85.0 %)

Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
90.0%	99.2%	100.0%	85.1%	98.2%

Estates - Other

Routine Maintenance Resolution

91.9 % (goal: 85.0 %)

Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
95.9%	96.1%	96.8%	97.7%	93.6%

PPM%

50.5 % (goal: 85.0 %)

Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
94.3%	94.8%	95.5%	96.3%	19.8%

External Regulation

Nov 2015

Alder Hey Children's NHS Foundation Trust

Summary

Quality summit will take place 22nd December 2015.

Monitor - Governance Concern

Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15
N	N	N	N	N	N	N	N	N	N	N	N

Monitor - Risk Rating

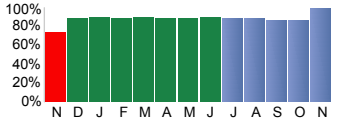
Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15
4	4	4	4	4	3	4	4	2	2	2	2

Monitor Nov 2015

Metric Name	Goal	Oct 15	Nov 15	Trend
ED: 95% Treated within 4 Hours	95.0 %	85.9 %	78.9 %	▼
RTT: 90% Admitted within 18 weeks		87.3 %	100.0 %	▲
RTT: 95% Non-Admitted within 18 weeks		91.0 %	87.9 %	▼
RTT: 92% Waiting within 18 weeks (open Pathways)	92.0 %	92.1 %	92.2 %	▲
Monitor Risk Ratings (YTD)	3.0	2	2	–
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals	100.0 %	100.0 %	100.0 %	–
All Cancers: 31 day wait referral to treament	100.0 %	100.0 %	100.0 %	–
All Cancers: 31 day wait until subsequent treatments	100.0 %	100.0 %	100.0 %	–
Hospital Acquired Organisms - C.difficile	0.0	0	0	–

Monitor - 18 Weeks RTT

RTT: 90% Admitted within 18 weeks



Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
80.2%	90.2%	90.3%	89.3%	94.6%

RTT: 95% Non-Admitted within 18 weeks

Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
91.3%	95.4%	95.2%	93.7%	89.3%

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

Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
92.5%	92.7%	92.1%	92.1%	92.1%

Monitor - All Cancers

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

Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
100.0%	100.0%	100.0%	100.0%	100.0%

All Cancers: 31 day wait referral to treament

Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
100.0%	100.0%	100.0%	100.0%	100.0%

All Cancers: 31 day wait until subsequent treatments

Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
100.0%	100.0%	100.0%	100.0%	100.0%

Monitor - A&E 4 Hour Target

Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
95.3%	97.0%	96.0%	95.3%	82.3%

Monitor - C difficile

Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
0	0	0	2	0

Monitor - Data Completeness

No Data Available

Workforce

Nov 2015

Alder Hey Children's NHS Foundation Trust

Summary

Sickness shows an increase from 4.7% to 5.5% and remains above the target. Corporate induction shows an increase this month of over 10% to 91.7%. There has been an increase in mandatory training compliance of over 6% to 84%. Work continues on progressing all KPIs.

Staff Group Analysis

Sickness Absence (rolling 12 Months)

Staff Group	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Last 12 Months
Add Prof Scientific and Technic	3.5%	3.8%	5.3%	3.7%	3.0%	3.6%	3.9%	3.2%	1.3%	2.7%	2.8%	4.3%	
Additional Clinical Services	10.4%	10.3%	9.7%	9.8%	9.3%	7.2%	5.3%	5.7%	6.4%	6.8%	7.1%	8.2%	
Administrative and Clerical	5.1%	5.9%	5.1%	4.8%	3.7%	3.9%	3.8%	3.3%	3.1%	3.5%	4.1%	4.8%	
Allied Health Professionals	3.5%	3.1%	2.5%	1.5%	1.8%	2.4%	2.0%	1.4%	1.4%	1.3%	1.4%	2.3%	
Estates and Ancillary	9.6%	8.4%	8.7%	7.5%	5.4%	6.6%	7.1%	5.6%	4.6%	5.9%	6.2%	7.5%	
Healthcare Scientists	3.5%	4.1%	5.5%	5.3%	4.8%	5.4%	4.4%	2.8%	1.0%	0.9%	1.5%	1.6%	
Medical and Dental	2.6%	3.1%	3.0%	2.8%	2.7%	2.2%	2.6%	2.1%	1.3%	1.2%	0.8%	2.4%	
Nursing and Midwifery Registered	6.7%	6.1%	5.9%	5.5%	5.0%	4.8%	5.5%	5.8%	5.1%	6.3%	5.9%	6.3%	
Trust Overall	6.2%	6.1%	5.9%	5.4%	4.8%	4.6%	4.6%	4.4%	3.9%	4.6%	4.7%	5.5%	

Staff in Post FTE (rolling 12 Months)

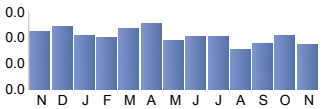
Staff Group	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Last 12 Months
Add Prof Scientific and Technic	197.0	198.6	198.1	185.2	183.8	186.0	186.8	183.4	186.4	193.0	170.2	173.7	
Additional Clinical Services	332.6	332.8	332.9	335.8	352.5	347.8	349.2	347.5	346.8	358.6	354.0	351.2	
Administrative and Clerical	520.2	525.9	521.9	535.3	530.0	531.7	535.0	544.2	538.2	534.6	532.8	532.6	
Allied Health Professionals	114.5	115.7	115.2	116.6	119.7	119.6	122.9	124.9	123.9	125.2	125.1	126.3	
Estates and Ancillary	143.4	142.4	142.1	142.1	145.3	146.8	148.0	148.4	147.4	152.4	168.8	170.8	
Healthcare Scientists	81.4	80.9	82.3	102.9	103.1	102.4	100.4	100.6	103.3	103.1	102.3	102.8	
Medical and Dental	222.1	224.0	232.6	232.4	232.0	228.4	228.2	229.2	229.6	229.2	229.0	232.2	
Nursing and Midwifery Registered	870.7	884.5	888.7	887.7	897.2	903.8	904.2	900.0	897.0	910.8	944.9	943.7	

Staff in Post Headcount (rolling 12 Months)

Staff Group	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Last 12 Months
Add Prof Scientific and Technic	223	225	225	209	207	210	211	206	209	217	191	195	
Additional Clinical Services	392	392	390	393	409	406	409	407	406	419	415	413	
Administrative and Clerical	601	607	603	618	611	614	617	629	624	618	616	617	
Allied Health Professionals	139	141	143	145	148	147	152	154	153	154	155	156	
Estates and Ancillary	188	187	186	186	185	190	192	194	193	198	212	214	
Healthcare Scientists	89	89	91	113	113	112	110	111	114	114	113	113	
Medical and Dental	258	259	269	269	272	268	266	268	268	267	268	270	
Nursing and Midwifery Registered	988	1,004	1,008	1,011	1,022	1,030	1,030	1,023	1,020	1,036	1,072	1,070	

Finance

Temporary Spend ('000s) 890



Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
4	3	3	3	2

Actual vs Planned Establishment (%) 97.6 %

Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
	93.4%	92.0%	92.0%	97.7%

Appraisals

Medical Appraisal 97.1 % (goal: 100.0 %)

Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
		97.1%	97.1%	97.1%

PDR 90.1 % (goal: 90.0 %)

Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
		45.4%	89.9%	90.1%

Training

Corporate Induction 91.7 % (goal: 100.0 %)

Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
		63.8%	87.1%	84.5%

Mandatory Training 84.0 % (goal: 80.0 %)

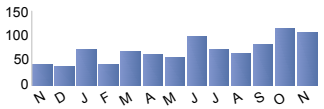
Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
		65.5%	75.8%	80.6%

Health and Safety

RIDDOR 0

Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
3	1	0	0	0

Non Clinical Incidents 110



Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
150	190	224	226	227

Operational

Metric name	ICS	MED SPECS	NMSS	SCACC
Clinic Session Utilisation	71.8%	74.5%	73.6%	83.4%
Convenience and Choice: Slot Availability	100.0%	100.0%	99.3%	100.0%
DNA Rate (Followup Appts)	12.4%	7.2%	9.1%	7.4%
DNA Rate (New Appts)	15.6%	12.7%	11.2%	8.7%
Normalised I & E surplus/(deficit) In Month ('000s)	692	1,180	1,283	-119
Referrals Received (GP)	550	319	781	332
Temporary Spend ('000s)	232	82	121	218
Theatre Utilisation - % of Session Utilised		73.4%	76.7%	74.1%

Patient

Metric name	ICS	MED SPECS	NMSS	SCACC
Average LoS - Elective (Days)	2.3	4.8	2.1	3.2
Average LoS - Non-Elective (Days)	2.0	2.5	2.2	4.5
Cancelled Operations - Non Clinical - On Same Day	1	3	29	15
Daycases (K1)	0	75	317	118
Diagnostics: % Completed Within 6 Weeks		100.0%	100.0%	100.0%
Hospital Initiated Clinic Cancellations < 6 weeks notice	33	8	49	3
OP Appointments Cancelled by Hospital %	14.5%	12.5%	14.9%	17.5%
RTT: 90% Admitted within 18 weeks		100.0%	100.0%	100.0%
RTT: 92% Waiting within 18 weeks (open Pathways)	90.9%	95.8%	89.9%	97.3%
RTT: 95% Non-Admitted within 18 weeks	82.3%	90.0%	84.9%	94.7%

Quality

Metric name	ICS	MED SPECS	NMSS	SCACC
Cleanliness Scores	99.0%	95.5%	98.7%	97.4%
Hospital Acquired Organisms - C.difficile	0	0	0	0
Hospital Acquired Organisms - MRSA (BSI)	0	0	0	0
Medication Errors (Incidents)	1	74	44	134

Workforce

Metric name	ICS	MED SPECS	NMSS	SCACC
Corporate Induction	100.0%	66.7%	100.0%	75.0%
Mandatory Training	79.1%	86.9%	86.8%	89.1%
PDR	92.2%	92.2%	80.7%	91.2%
Sickness	6.0%	5.7%	4.7%	7.6%

CBU Performance - Clinical Support

Nov 2015

Alder Hey Children's NHS Foundation Trust

Key Issues

Support Required

Operational

Metric Name	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Last 12 Months
Theatre Utilisation - % of Session Utilised	79.9%	78.4%	81.7%	86.7%	87.0%	79.0%	87.9%	85.1%				38.4%	73.4%	
Temporary Spend ('000s)	58	34	53	61	20	131	66	64	80	-5	66	67	63	
Normalised I & E surplus/(deficit) In Month ('000s)	-1,777	-1,815	-1,913	-1,806	-1,482	-1,337	-1,134	-1,228	-1,176	-1,262	-1,333	-1,068	-1,179	
Expenditure vs Budget ('000s)		0	0	0	0	0	0	0	0	0	0	0	0	

Patient

Metric Name	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Last 12 Months
Imaging - % Report Turnaround times GP referrals < 24 hrs	75.0%	88.0%	79.0%	96.0%	96.0%	95.0%	92.0%	95.0%	96.0%	97.0%	86.0%	93.0%	96.0%	
Imaging - % Reporting Turnaround Times - ED	64.0%	70.0%	52.0%	58.0%	77.0%	67.0%	80.0%	60.0%	78.0%	70.0%	76.0%	76.0%	72.0%	
Imaging - % Reporting Turnaround Times - Inpatients	71.0%	73.0%	70.0%	74.0%	83.0%	75.0%	86.0%	79.0%	90.0%	79.0%	86.0%	93.0%	81.0%	
Imaging - % Reporting Turnaround Times - Outpatients	86.0%	100.0%	93.0%	92.0%	100.0%	98.0%	97.0%	96.0%	97.0%	97.0%	96.0%	96.0%	97.0%	
Imaging - Waiting Times - MRI % under 6 weeks	86.8%	83.5%	79.8%	86.0%	81.7%	95.0%	99.0%	96.6%	97.7%	92.5%	100.0%	100.0%	95.0%	
Imaging - Waiting Times - CT % under 1 week	91.5%	88.5%	93.0%	85.0%	83.1%	90.0%	86.6%	85.0%	89.9%	85.6%	87.9%	87.9%	88.0%	
Imaging - Waiting Times - Plain Film % under 24 hours	94.2%	92.9%	94.4%	94.5%	94.4%	90.0%	94.2%	95.0%	91.7%	91.8%	95.4%	96.1%	95.0%	
Imaging - Waiting Times - Ultrasound % under 2 weeks	99.2%	98.9%	98.4%	98.8%	97.4%	90.0%	98.8%	97.8%	99.2%	99.0%	99.6%	99.6%	92.0%	
Imaging - Waiting Times - Nuclear Medicine % under 2 weeks	87.5%	81.0%	57.9%	86.4%	81.8%	94.7%	100.0%	100.0%	88.9%	81.2%	100.0%	100.0%	88.0%	
BME - High Risk Equipment PPM Compliance	85.0%	86.0%	86.0%	86.0%	89.0%	89.0%	89.0%	89.5%	88.0%	90.5%	88.0%	87.0%	89.0%	
BME - Low Risk Equipment PPM Compliance	77.0%	77.0%	75.0%	78.0%	75.0%	75.0%	75.0%	76.0%	74.0%	79.0%	87.0%	75.0%	76.0%	
BME - Equipment Pool - Equipment Availability	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%	
Pharmacy - Dispensing for Out Patients - Routine	60.0%	0.0%	60.0%	61.0%	62.0%	61.0%	55.0%	49.0%	34.0%	50.0%	57.0%	63.0%	59.0%	
Pharmacy - Dispensing for Out Patients - Complex	85.0%	0.0%	86.0%	82.0%	55.0%	67.0%	79.0%	73.0%	67.0%	57.0%	65.0%		100.0%	
Comm Therapy - % 1st Contact times following Pt opt in < 12 weeks	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	

Quality

Metric Name	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Last 12 Months
Medication Errors (Incidents)		0	0	0	0	0	0	0	0	0	0	0	0	
Hospital Acquired Organisms - MRSA (BSI)	0	0	0	0	0	0	0	0	0	0	0	0	0	
Hospital Acquired Organisms - C.difficile	0	0	0	0	0	0	0	0	0	0	0	0	0	
Pathology - % Turnaround times for urgent requests < 1 hr	89.3%	89.2%	85.6%	88.0%	85.5%	87.6%	88.9%	82.3%	76.4%	82.0%	78.2%	71.9%	75.1%	
Pathology - % Turnaround times for non-urgent requests < 24hrs	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.8%	
Reporting times for perinatal autopsies in 56 Calendar Days	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.8%	73.0%	92.9%	98.6%	98.7%	90.9%	100.0%	

Workforce

Metric Name	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Last 12 Months
Corporate Induction					71.4%	90.0%	75.0%	100.0%	40.0%	100.0%	77.8%	100.0%	
PDR					43.4%	44.9%	91.4%	91.4%	91.4%	91.4%	91.4%	91.4%	
Sickness					3.3%	3.7%	2.9%	1.7%	2.2%	2.8%	3.3%	3.4%	
Mandatory Training					69.4%	66.1%	77.4%	79.1%	80.5%	84.2%	80.3%	87.2%	

CBU Performance - ICS

Nov 2015

Alder Hey Children's NHS Foundation Trust

Key Issues

CBU continues to focus within performance in outpatients. Specific focus on clinic utilization and re-booking of short notice cancellations will be the priority. Non elective performance continues to be above plan with peak RSV predictions week 2/3 in December. Successful use of Emergency Decision Unit has benefited patient flow, has helped to manage non elective activity and reduce the number of medical outliers

Support Required

Managerial capacity still stretched due to sickness. This should be resolved by end of January

Operational

Metric Name	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Last 12 Months
Theatre Utilisation - % of Session Utilised														
Clinic Session Utilisation	74.5%	70.1%	77.5%	77.1%	75.8%	75.0%	75.9%	71.7%	74.0%	69.2%	66.7%	68.2%	71.8%	
DNA Rate (New Appts)	15.8%	21.8%	15.4%	15.5%	15.1%	13.7%	18.4%	23.1%	24.0%	21.6%	17.4%	18.7%	15.6%	
DNA Rate (Followup Appts)	10.9%	14.2%	11.4%	10.3%	11.3%	12.9%	14.1%	19.0%	17.0%	14.7%	14.0%	13.5%	12.4%	
Convenience and Choice: Slot Availability	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%						100.0%	
Referrals Received (GP)	546	537	555	652	660	488	530	615	530	388	563	561	550	
Temporary Spend ('000s)	244	297	228	303	322	211	197	269	186	178	203	260	232	
Normalised I & E surplus/(deficit) In Month ('000s)	-2,003	-2,130	-2,150	-1,902	-2,191	569	608	686	334	454	534	530	692	

Patient

Metric Name	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Last 12 Months
RTT: 90% Admitted within 18 weeks														
RTT: 95% Non-Admitted within 18 weeks	75.1%	79.1%	94.3%	90.6%	87.0%	85.5%	87.7%	95.3%	95.9%	97.7%	87.3%	89.3%	82.3%	
RTT: 92% Waiting within 18 weeks (open Pathways)	90.5%	94.5%	94.2%	93.0%	92.7%	90.8%	90.7%	91.8%	92.0%	93.9%	93.2%	93.6%	90.9%	
Average LoS - Elective (Days)	5.00		1.00	7.00	3.50	2.50	2.40	3.00	4.33	5.50	3.50	8.00	2.25	
Average LoS - Non-Elective (Days)	2.30	2.76	2.73	2.72	2.41	2.36	2.26	2.16	2.26	1.93	1.86	1.90	2.02	
Hospital Initiated Clinic Cancellations < 6 weeks notice	7	6	6	5	8	2	5	12	4	2	18	46	33	
Daycases (K1)	0	0	0	1	0	0	0	0	2	0	1	1	0	
Cancelled Operations - Non Clinical - On Same Day		0	0	0	0	0	0	0	0	0	0	0	1	
OP Appointments Cancelled by Hospital %	10.5%	12.7%	13.8%	15.2%	13.3%	11.7%	10.7%	18.4%	14.7%	14.1%	11.4%	14.4%	14.5%	
Diagnostics: % Completed Within 6 Weeks	100.0%	100.0%	100.0%					100.0%						

Quality

Metric Name	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Last 12 Months
Medication Errors (Incidents)		2	2	2	2	0	0	1	1	1	1	1	1	
Cleanliness Scores	96.3%	82.0%	96.0%	95.6%	95.7%	94.2%	96.0%	97.0%	92.5%	98.0%	96.0%		99.0%	
Hospital Acquired Organisms - MRSA (BSI)	0	0	0	0	0	0	0	0	0	0	0	0	0	
Hospital Acquired Organisms - C.difficile	0	0	0	0	0	0	0	0	0	0	0	0	0	

Workforce

Metric Name	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Last 12 Months
Corporate Induction					80.0%	85.7%	100.0%	66.7%	100.0%	100.0%	81.8%	100.0%	
PDR					14.2%	19.8%	92.2%	92.2%	92.2%	92.2%	92.2%	92.2%	
Sickness					4.9%	4.3%	4.6%	4.3%	3.1%	5.0%	5.3%	6.0%	
Mandatory Training					65.4%	62.9%	71.9%	59.4%	74.4%	75.8%	76.2%	79.1%	

CBU Performance - Medical Specialties

Nov 2015

Alder Hey Children's NHS
NHS Foundation Trust

Key Issues

Support Required

Operational

Metric Name	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015	Nov 2015	Last 12 Months
Theatre Utilisation - % of Session Utilised	81.4%	81.7%	81.4%	80.2%	83.4%	81.7%	87.9%	81.6%				55.8%	73.4%	
Clinic Session Utilisation	79.5%	73.4%	85.1%	81.7%	81.2%	80.6%	92.6%	74.6%	75.0%	73.7%	72.2%	70.1%	74.5%	
DNA Rate (New Appts)	11.4%	16.5%	14.8%	12.5%	13.9%	10.8%	11.2%	13.8%	15.6%	15.4%	11.0%	10.6%	12.7%	
DNA Rate (Followup Appts)	10.0%	13.1%	9.0%	10.4%	9.5%	10.1%	10.9%	10.8%	15.7%	14.1%	10.5%	9.5%	7.2%	
Convenience and Choice: Slot Availability	100.0%	100.0%	94.0%	100.0%	100.0%	100.0%	100.0%						100.0%	
Referrals Received (GP)	292	290	358	339	409	387	349	361	400	265	349	327	319	
Temporary Spend ('000s)	118	125	62	89	124	107	86	66	77	66	100	74	82	
Normalised I & E surplus/(deficit) In Month ('000s)	-2,495	-2,281	-2,679	-2,292	-2,663	1,097	716	894	1,237	915	572	722	1,180	

Patient

Metric Name	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015	Nov 2015	Last 12 Months
RTT: 90% Admitted within 18 weeks	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.4%	100.0%	
RTT: 95% Non-Admitted within 18 weeks	94.8%	96.1%	98.2%	96.2%	97.4%	97.6%	96.9%	94.1%	92.2%	88.4%	93.4%	90.5%	90.0%	
RTT: 92% Waiting within 18 weeks (open Pathways)	92.4%	91.2%	91.9%	93.1%	94.4%	94.9%	94.0%	94.7%	96.8%	95.3%	95.4%	93.9%	95.8%	
Average LoS - Elective (Days)	3.81	3.59	3.88	3.40	4.13	3.04	2.49	4.14	3.87	3.52	3.12	3.65	4.81	
Average LoS - Non-Elective (Days)	3.14	3.58	3.02	3.88	2.86	2.54	3.57	3.10	4.09	3.37	2.74	3.24	2.46	
Hospital Initiated Clinic Cancellations < 6 weeks notice	9	7	2	7	5	8	2	2	13	13	16	22	8	
Daycases (K1)	82	66	83	77	73	75	72	78	59	56	74	33	75	
Cancelled Operations - Non Clinical - On Same Day		0	1	1	0	3	1	0	0	0	1	2	3	
OP Appointments Cancelled by Hospital %	12.8%	14.7%	14.6%	14.6%	13.2%	16.8%	14.0%	18.3%	12.8%	12.4%	12.3%	17.0%	12.5%	
Diagnostics: % Completed Within 6 Weeks	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	66.7%	100.0%	100.0%	100.0%	100.0%	100.0%	

Quality

Metric Name	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015	Nov 2015	Last 12 Months
Medication Errors (Incidents)	50	57	65	73	78	9	16	23	33	40	46	57	74	
Cleanliness Scores	96.0%	92.5%	90.5%	90.6%	96.0%	91.0%	93.8%	94.0%	97.2%	97.0%	97.0%		95.5%	
Hospital Acquired Organisms - MRSA (BSI)	0	0	0	0	0	0	0	0	0	0	0	0	0	
Hospital Acquired Organisms - C.difficile	0	0	0	0	0	0	0	0	1	0	0	0	0	

Workforce

Metric Name	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015	Nov 2015	Last 12 Months
Corporate Induction					0.0%	100.0%	0.0%		50.0%		100.0%	66.7%	
PDR					64.0%	62.2%	92.2%	92.2%	92.2%	92.2%	92.2%	92.2%	
Sickness					4.5%	3.5%	4.7%	6.2%	5.6%	6.2%	4.3%	5.7%	
Mandatory Training					73.5%	66.0%	76.2%	81.1%	80.4%	85.8%	81.3%	86.9%	

CBU Performance - NMSS

Nov 2015

Alder Hey Children's NHS Foundation Trust

Key Issues

Delivery of activity remains one of the most significant challenges for the CBU up to end November.

The YTD income variance at Mth 8 is -£3558.
I. £1257k of this relates to Elective activity.
II. £1056k of this relates to Non Elective activity.
III. Outpatients is behind by £626k pan
Pay is overspent Year To Date – this is mostly due to temporary staff and additional Waiting List Payments (although the use of agency is decreasing and the pay position in month is variable).
PDR compliance has also dropped to 80%. Focussed work with ward/dept managers to address this will continue.

Support Required

The introduction of a Trust wide outpatient improvement project will help support the CBU to achieve the required level of outpatient activity through improvements to a number of the processes involved in booking in outpatients. In addition, speciality based workstreams will focus on improving individual specialty pathways through outpatients.

Improved theatre list utilisation is the focus of the operational and service managers within the CBU to ensure the CBU achieves its recovery plan targets.

Operational

Metric Name	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Last 12 Months
Theatre Utilisation - % of Session Utilised	84.0%	75.6%	81.5%	85.4%	85.7%	84.8%	84.4%	85.2%				73.8%	76.7%	
Clinic Session Utilisation	84.4%	79.1%	81.5%	84.5%	84.1%	85.2%	91.3%	73.8%	80.8%	72.8%	70.6%	66.5%	73.6%	
DNA Rate (New Appts)	13.1%	16.6%	16.7%	13.1%	12.4%	12.7%	11.9%	12.9%	15.0%	14.8%	11.1%	9.7%	11.2%	
DNA Rate (Followup Appts)	12.6%	14.8%	10.3%	11.3%	10.8%	11.3%	10.8%	11.4%	12.9%	12.8%	11.8%	9.3%	9.1%	
Convenience and Choice: Slot Availability	74.3%	89.4%	94.6%	96.5%	98.8%	99.6%	100.0%						99.3%	
Referrals Received (GP)	630	639	863	811	970	785	806	749	847	670	765	798	781	
Temporary Spend ('000s)	182	187	152	209	148	208	114	200	187	154	147	134	121	
Normalised I & E surplus/(deficit) In Month ('000s)	-1,677	-1,771	-1,727	-1,865	-2,343	1,417	1,777	1,496	1,779	1,295	1,736	1,498	1,283	

Patient

Metric Name	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Last 12 Months
RTT: 90% Admitted within 18 weeks	70.6%	88.2%	89.1%	88.5%	87.1%	86.9%	88.4%	87.9%	87.0%	85.8%	81.4%	82.9%	100.0%	
RTT: 95% Non-Admitted within 18 weeks	90.8%	96.8%	93.8%	94.3%	95.3%	96.7%	95.9%	94.9%	95.7%	94.2%	92.5%	93.0%	84.9%	
RTT: 92% Waiting within 18 weeks (open Pathways)	91.5%	91.4%	90.7%	91.2%	90.3%	90.3%	90.3%	89.8%	89.8%	89.6%	89.5%	89.9%	89.9%	
Average LoS - Elective (Days)	2.31	2.51	2.03	2.53	2.14	2.00	1.75	2.29	2.14	1.68	2.52	2.08	2.14	
Average LoS - Non-Elective (Days)	2.32	2.44	1.97	2.21	1.62	1.90	2.43	2.01	2.12	2.06	1.92	1.89	2.18	
Hospital Initiated Clinic Cancellations < 6 weeks notice	15	17	7	27	22	29	20	36	19	3	51	9	49	
Daycases (K1)	437	386	413	409	461	410	358	372	352	381	420	233	317	
Cancelled Operations - Non Clinical - On Same Day	12	9	5	17	13	4	17	13	21	7	11	7	29	
OP Appointments Cancelled by Hospital %	16.6%	19.5%	18.8%	16.3%	18.6%	16.1%	15.0%	22.0%	16.9%	15.3%	14.7%	18.4%	14.9%	
Diagnostics: % Completed Within 6 Weeks	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	

Quality

Metric Name	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Last 12 Months
Medication Errors (Incidents)	33	33	39	42	45	4	15	16	21	27	31	37	44	
Cleanliness Scores	91.2%	95.2%	93.5%	93.0%	93.3%	92.0%	98.0%	94.2%	94.0%	94.5%	98.3%		98.7%	
Hospital Acquired Organisms - MRSA (BSI)	0	0	0	0	0	0	0	0	0	0	0	0	0	
Hospital Acquired Organisms - C.difficile	0	0	0	0	0	0	0	0	0	0	0	0	0	

Workforce

Metric Name	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Last 12 Months
Corporate Induction					33.3%	77.8%	0.0%	0.0%	75.0%		88.9%	100.0%	
PDR					44.3%	49.3%	79.7%	79.7%	80.7%	80.7%	80.7%	80.7%	
Sickness					4.3%	4.7%	6.5%	5.8%	4.2%	3.6%	4.4%	4.7%	
Mandatory Training					70.8%	68.4%	76.1%	78.4%	80.7%	82.2%	79.7%	86.8%	

CBU Performance - SCACC

Nov 2015

Alder Hey Children's NHS Foundation Trust

Key Issues

Theatre utilisation: in November theatre utilisation has been adversely affected by critical capacity, bed capacity and short-notice cancellations resulting from the staggered admission programme. We have taken actions to improve critical care capacity and the scheduling process in theatres.
Financial position: a full recovery plan is being implemented and was shared with Executive Directors in Nov 15. The latest actions taken include securing additional income for critical care services over Winter.

Support Required

Operational

Metric Name	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Last 12 Months
Theatre Utilisation - % of Session Utilised	75.4%	71.4%	76.9%	75.9%	79.4%	79.8%	78.2%	80.3%				69.3%	74.1%	
Clinic Session Utilisation	99.5%	91.4%	101.9%	107.2%	93.6%	98.3%	112.2%	90.9%	81.6%	83.6%	78.7%	76.0%	83.4%	
DNA Rate (New Appts)	11.4%	13.4%	14.0%	13.6%	10.1%	13.2%	13.1%	12.2%	12.4%	8.7%	10.5%	12.6%	8.7%	
DNA Rate (Followup Appts)	8.8%	15.1%	10.9%	9.0%	10.9%	12.4%	12.6%	13.0%	12.0%	11.7%	10.9%	9.4%	7.4%	
Convenience and Choice: Slot Availability	86.1%	91.9%	85.3%	89.9%	99.2%	100.0%	100.0%						100.0%	
Referrals Received (GP)	299	263	347	329	386	302	282	275	368	248	289	348	332	
Temporary Spend ('000s)	394	385	342	360	446	465	361	322	345	227	250	268	218	
Normalised I & E surplus/(deficit) In Month ('000s)	-4,074	-4,054	-4,009	-3,989	-4,374	1	-70	-211	-133	-449	457	-267	-119	

Patient

Metric Name	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Last 12 Months
RTT: 90% Admitted within 18 weeks	85.6%	93.2%	92.4%	94.6%	97.4%	97.8%	94.1%	96.4%	94.8%	91.6%	95.9%	91.5%	100.0%	
RTT: 95% Non-Admitted within 18 weeks	98.8%	99.7%	99.3%	99.6%	99.4%	97.0%	97.2%	97.0%	95.1%	87.7%	95.5%	83.8%	94.7%	
RTT: 92% Waiting within 18 weeks (open Pathways)	98.1%	97.8%	97.5%	97.7%	96.9%	97.1%	98.0%	97.2%	96.0%	96.1%	96.8%	97.3%	97.3%	
Average LoS - Elective (Days)	3.75	5.36	2.94	3.54	3.42	3.67	4.47	3.25	3.57	2.67	4.46	3.38	3.22	
Average LoS - Non-Elective (Days)	3.59	4.37	4.96	4.75	3.97	4.90	4.08	4.20	4.34	4.12	4.83	3.49	4.48	
Hospital Initiated Clinic Cancellations < 6 weeks notice	2	1	1	1	0	0	0	3	0	5	4	1	3	
Daycases (K1)	163	164	178	164	223	135	111	169	188	103	181	56	118	
Cancelled Operations - Non Clinical - On Same Day	1	8	3	14	8	4	7	10	4	13	4	9	15	
OP Appointments Cancelled by Hospital %	18.2%	16.7%	18.2%	19.1%	14.0%	17.8%	19.4%	25.4%	15.6%	17.4%	15.9%	22.8%	17.5%	
Diagnostics: % Completed Within 6 Weeks	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	

Quality

Metric Name	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Last 12 Months
Medication Errors (Incidents)	100	112	129	141	158	11	29	43	60	72	95	117	134	
Cleanliness Scores	94.6%	93.3%	94.9%	92.3%	92.6%	92.9%	93.5%	96.0%	95.2%	95.9%	96.5%		97.4%	
Hospital Acquired Organisms - MRSA (BSI)	0	0	0	0	0	1	0	1	0	1	0	0	0	
Hospital Acquired Organisms - C.difficile	0	0	0	0	0	0	0	0	1	0	0	0	0	

Workforce

Metric Name	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Last 12 Months
Corporate Induction				37.5%	44.4%	70.0%	80.0%	100.0%	100.0%	88.9%	75.0%	
PDR				14.8%	17.6%	89.1%	89.1%	91.2%	91.2%	91.2%	91.2%	
Sickness				6.8%	6.2%	6.2%	6.7%	6.2%	7.3%	6.3%	7.6%	
Mandatory Training				64.6%	61.9%	73.6%	77.3%	83.1%	85.2%	81.3%	89.1%	

3. Financial Strength

3.1 Trust Income & Expenditure Report period ended November 2015

	IN MONTH BUDGET £'000	IN MONTH ACTUAL £'000	IN MONTH VARIANCE £'000	YEAR TO DATE BUDGET £'000	YEAR TO DATE ACTUAL £'000	YEAR TO DATE VARIANCE £'000	FULL YEAR BUDGET £'000	FULL YEAR FORECAST £'000	FULL YEAR VARIANCE £'000
Elective	3,923	3,038	(885)	28,556	25,629	(2,927)	43,033	41,279	(1,754)
Non Elective	2,310	2,273	(36)	19,009	18,308	(701)	28,356	26,718	(1,638)
Outpatients	2,217	1,825	(392)	16,111	14,206	(1,905)	24,293	22,193	(2,100)
A&E	418	419	1	3,159	3,197	37	4,841	4,825	(16)
Critical Care	1,979	1,961	(18)	13,956	14,093	137	21,968	21,794	(174)
Non PbR Drugs & Devices	1,517	1,610	93	12,134	11,909	(226)	18,202	17,632	(570)
Other Income	4,985	5,619	634	41,495	43,797	2,302	62,422	67,207	4,785
Total Income	***17,349***	***16,746***	***(603)***	***134,420***	***131,138***	***(3,282)***	***203,114***	***201,648***	***(1,466)***
Pay Costs	(10,800)	(11,172)	(372)	(86,655)	(88,933)	(2,278)	(129,328)	(133,384)	(4,056)
Drugs	(1,350)	(1,442)	(92)	(11,310)	(11,955)	(646)	(16,919)	(17,739)	(820)
Clinical Supplies	(1,314)	(1,471)	(157)	(10,381)	(10,451)	(71)	(15,399)	(15,239)	160
Other Non Pay	(2,320)	(2,499)	(179)	(19,092)	(17,620)	1,472	(28,856)	(27,290)	1,566
Total Expenditure	***(15,784)***	***(16,584)***	***(801)***	***(127,437)***	***(128,959)***	***(1,523)***	***(190,501)***	***(193,652)***	***(3,151)***
EBITDA	***1,565***	***161***	***(1,403)***	***6,983***	***2,179***	***(4,805)***	***12,613***	***7,996***	***(4,617)***
Capital Charges	(671)	(307)	364	(5,244)	(4,066)	1,179	(8,139)	(6,812)	1,327
Finance Income	3	7	4	32	79	47	40	90	50
Interest Expense (non-PFI/LIFT)	(82)	(81)	0	(675)	(671)	4	(1,006)	(1,000)	6
Interest Expense (PFI/LIFT)	(653)	(688)	(35)	(3,589)	(1,362)	2,227	(6,199)	(4,043)	2,156
Total Financing	***(1,402)***	***(1,068)***	***333***	***(9,476)***	***(6,020)***	***3,456***	***(15,304)***	***(11,765)***	***3,539***
Normalised Surplus/(Deficit)	***163***	***(907)***	***(1,070)***	***(2,493)***	***(3,841)***	***(1,348)***	***(2,691)***	***(3,769)***	***(1,078)***
One-off normalising items									
Government Grants/Donated Income	0	0	0	15,962	13,275	(2,687)	15,962	15,962	0
MASS/Restructuring	0	0	0	0	0	0	0	0	0
Fixed Asset Impairment	0	(1,534)	(1,534)	(68,163)	(68,163)	0	(69,840)	(71,099)	(1,259)
(Gains)/Losses on asset disposals	0	(193)	(193)	(4,741)	(4,707)	34	(4,741)	(4,732)	9
Reported Surplus/(Deficit)	***163***	***(2,634)***	***(2,797)***	***(59,435)***	***(63,437)***	***(4,002)***	***(61,310)***	***(63,638)***	***(2,328)***

Key Metrics	IN MONTH BUDGET	IN MONTH ACTUAL	IN MONTH VARIANCE	YEAR TO DATE BUDGET	YEAR TO DATE ACTUAL	YEAR TO DATE VARIANCE	FULL YEAR BUDGET	FULL YEAR FORECAST ACTUAL	FULL YEAR FORECAST VARIANCE
Normalised Income £000	17,352	16,753	(598)	134,452	131,217	(3,234)	203,154	201,738	(1,416)
Normalised Expenditure £000	(17,189)	(17,660)	(471)	(136,945)	(135,059)	1,886	(205,845)	(205,507)	338
Normalised Surplus/(Deficit) £000	163	(907)	(1,070)	(2,493)	(3,841)	(1,348)	(2,691)	(3,769)	(1,078)
WTE	2,824	2,887	(63)	2,824	2,887	(63)			
CIP £000	993	543	(451)	5,923	3,691	(2,232)	10,173	6,305	(3,869)
Cash £000	6,880	16,628	9,748	6,880	16,628	9,748			
CAPEX FCT £000	163	1,847	(1,684)	31,087	27,559	3,527	32,662	32,843	(181)
Risk Rating	2	2	0	2	2	0	2	2	0

Activity Volumes	IN MONTH PLAN	IN MONTH ACTUAL	IN MONTH VARIANCE	YEAR TO DATE PLAN	YEAR TO DATE ACTUAL	YEAR TO DATE VARIANCE	FULL YEAR PLAN	FULL YEAR FORECAST ACTUAL	FULL YEAR FORECAST VARIANCE
Elective	2,440	2,089	(351)	17,732	16,825	(907)	26,691	26,634	(57)
Non Elective	930	1,083	153	7,393	7,273	(120)	11,191	10,931	(260)
Outpatients	17,673	17,658	(15)	128,452	114,916	(13,536)	193,569	169,019	(24,550)
A&E	4,830	5,469	639	36,480	37,284	804	55,899	57,334	1,435

3.2 Trust Balance Sheet period ended November 2015

	2014/15 ACTUAL £'000	2015/16 PLAN £,000	ACTUAL TO DATE £,000	PREVIOUS MONTH £,000
Property, Plant and Non Current Assets	66,767	186,473	181,438	181,809
Cash and Cash Equivalents	36,048	6,816	16,628	16,986
Trade & Other Current Assets	78,070	13,730	17,394	20,063
Current Liabilities	(40,924)	(22,170)	(34,220)	(34,985)
Total Assets Less Current Liabilities	139,961	184,849	181,240	183,873
Non Current Provisions/Liabilities	(753)	(698)	(731)	(730)
Non Current Borrowings	(41,058)	(145,165)	(145,387)	(145,386)
Total Assets Employed	98,150	38,986	35,122	37,757
Financed by: Taxpayers' Equity	98,150	38,986	35,122	37,757

AGED DEBT ANALYSIS	TARGET PLAN %	ACTUAL IN MONTH %	PREVIOUS MONTH %	Explanation if more than 5%
% of Debtors > 90 days	5%	17%	31%	The actual debt over 90 days at the end of November is £561K - an improvement of £238K. There are 9 overdue invoices ranging in value from £10k to £61K. Debt over 90 days due from Liverpool Womens is now £236K (£205K October). Meetings have taken place between the Trusts to resolve this issue and some payments have been promised. Their account with us remains on hold. Salary overpayment invoices over 90 days amount to £98K. Without these debtors % over 90 days is 7%.

3.3 Financial Sustainability Risk Rating

2014/15 ACTUAL FSRR		2015/16 FULL YEAR FSRR	2015/16 M06 PLAN (METRIC)	ACTUAL TO DATE (METRIC)	PLAN TO DATE FSRR	ACTUAL TO DATE FSRR
4	Capital Servicing Capacity Ratio (times)	1	1	0	1	1
4	Liquidity Ratio (days)	3	-5	-4	3	3
3	I&E Margin	1	9	6	4	4
1	Variance in I&E Margin as % of Income	4	-8	-2	1	1
2	Financial Sustainability Risk Rating	2			2	2

	Financial criteria	Weight (%)	Metric	Rating categories** 1*	2***	3	4
Continuity of services	Balance sheet sustainability	25	Capital service capacity (times)	<1.25x	1.25 - 1.75x	1.75-2.5x	>2.5x
	Liquidity	25	Liquidity (days)	<(14) days	(14)-(7) days	(7)-0 days	>0 days
Financial efficiency	Underlying performance	25	I&E margin (%)	≤(1)%	(1)–0%	0-1%	>1%
	Variance from plan	25	Variance in I&E margin as a % of income	≤(2)%	(2)-(1)%	(1)-0%	≥0%

3.

2015/16 Cost Improvement Programme

1. Headlines

The Month 8 CIP performance across the Trust showed an underachievement of £451k (45%) in month and an underachievement of £2,232k (38% of the target) to date. The largest variances to date are in NMSS (£458k behind target), SCACC (£586k behind target) and Med Specs (£647k behind target). The main reason for the under performance is the slippage/delay of activity related schemes. The forecast CIP achievement for the year is £6,304k leaving a gap of £3,869k. Due to the Big Move the Trust planned an in year under achievement of £4m. The figures shown are gross and have been offset by the underachievement contingency of £2.6m at Mth 8. The CBU's and Trust are now focussed on the full year recurrent schemes and these have now been added to the report. There is currently a £3.9m recurrent shortfall.

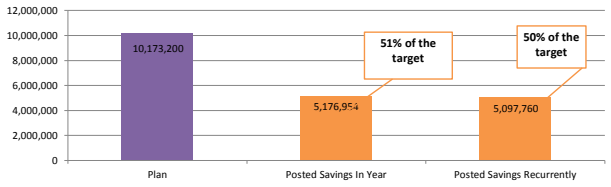
2. Performance by CBU

	In Month @ November				Year to date @ November				In Year Forecast			
CBU	Target	Actual	Var	(under)/over %	Target	Actual	Var	(under)/over %	Target	Actual	Var	(under)/over %
Other Corporate Services	3,399	19,263	15,864	467%	9,970	53,819	43,850	440%	29,567	66,596	37,029	125%
Clinical Support Services	198,179	137,809	(60,370)	-30%	1,135,283	1,179,143	43,861	4%	1,726,000	1,467,733	(258,267)	-15%
Estates	9,804	41,559	31,755	324%	63,380	171,762	108,382	171%	113,000	338,000	225,000	199%
Finance & Information	17,562	15,107	(2,455)	-14%	129,724	273,444	143,720	111%	218,471	331,564	113,093	52%
Human Resources	27,949	4,004	(23,945)	-86%	192,909	36,289	(156,620)	-81%	340,109	39,857	(300,252)	-88%
Hotel	21,736	3,390	(18,346)	-84%	122,654	12,551	(110,103)	-90%	210,000	42,731	(167,269)	-80%
Integrated Community Services	150,158	77,801	(72,357)	-48%	940,651	376,685	(563,966)	-60%	1,659,000	750,450	(908,550)	-55%
Innovation	0	0	0	0%	0	0	0	0%	0	83,333	83,333	#DIV/0!
Medical Specialties	143,703	41,565	(102,138)	-71%	989,937	342,826	(647,111)	-65%	1,700,000	549,339	(1,150,661)	-68%
Neurosciences, MSK and Specialist Surgery	200,372	80,724	(119,648)	-60%	1,122,342	664,357	(457,985)	-41%	1,964,301	1,568,133	(396,168)	-20%
Operational Services	987	928	(59)	-6%	7,371	7,424	53	1%	17,321	11,137	(6,184)	-36%
R&D	18,333	0	(18,333)	-100%	46,667	0	(46,667)	-100%	120,000	83,333	(36,667)	-31%
Risk Management	955	429	(526)	-55%	6,608	3,433	(3,176)	-48%	16,430	5,149	(11,281)	-69%
Surgery, Cardiac, Critical Care, Anaesthetic	200,255	120,199	(80,056)	-40%	1,155,058	569,114	(585,944)	-51%	2,059,000	967,186	(1,091,814)	-53%
Total	993,395	542,780	(450,615)	-45%	5,922,553	3,690,847	(2,231,705)	-38%	10,173,200	6,304,543	(3,868,658)	-38%

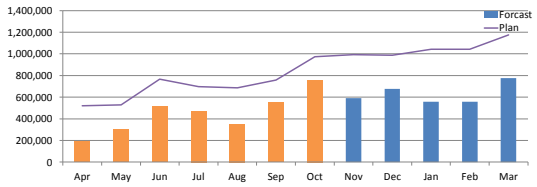
3. Performance Strategic

	In Month @ November				Year to date @ November				In Year Forecast			
Theme	Target	Actual	Var	(under)/over %	Target	Actual	Var	(under)/over %	Target	Actual	Var	(under)/over %
Improve In Hospital Activity	282,815	59,286	(223,528)	-79%	1,481,891	511,944	(969,948)	-65%	2,642,046	1,213,828	(1,428,218)	-54%
Improve Out of Hospital Activity	68,627	1,510	(67,117)	-98%	501,813	63,618	(438,195)	-87%	768,880	238,047	(530,833)	-69%
Improve Business Efficiency	386,020	481,011	94,992	25%	2,175,377	3,108,482	933,104	43%	3,794,564	4,841,976	1,047,411	28%
Deliver Strategic Plan	52,833	972	(51,861)	-98%	138,667	6,804	(131,863)	-95%	350,000	10,692	(339,308)	-97%
Improve Workforce Efficiency	833	0	(833)	-100%	6,664	0	(6,664)	-100%	190,500	0	(190,500)	-100%
GAP	202,267	0	(202,267)	-100%	1,618,140	0	(1,618,140)	-100%	2,427,210	0	(2,427,210)	-100%
Total	993,395	542,780	(450,615)	-45%	5,922,553	3,690,847	(2,231,705)	-38%	10,173,200	6,304,543	(3,868,658)	-38%

4. Posted Savings

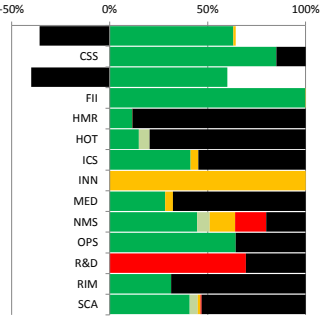


5. Risk to Delivery



6. Forecast Risk by CBU (In year)

				RAG RATING				
CBU	Target	Forecast	Gap	Green	Green/Amber*	Amber	Red	Black
Other Corporate Services	29,567	66,596	37,029	65,326	0	1,270	0	(37,029)
Clinical Support Services	1,726,000	1,467,733	(258,267)	1,467,733	0	0	0	258,267
Estates	113,000	338,000	225,000	338,000	0	0	0	(225,000)
Finance & Information	218,471	331,564	113,093	330,870	499	195	0	(113,093)
Human Resources	340,109	39,857	(300,252)	39,857	0	0	0	300,252
Hotel	210,000	42,731	(167,269)	31,502	11,229	0	0	167,269
Integrated Community Services	1,659,000	750,450	(908,550)	684,617	0	65,833	0	908,550
Innovation	0	83,333	83,333	0	0	83,333	0	(83,333)
Medical Specialties	1,700,000	549,339	(1,150,661)	481,761	0	67,578	0	1,150,661
Neurosciences, MSK and Specialist Surgery	1,964,301	1,568,133	(396,168)	878,123	124,049	254,331	311,630	396,168
Operational Services	17,321	11,137	(6,184)	11,137	0	0	0	6,184
R&D	120,000	83,333	(36,667)	0	0	0	83,333	36,667
Risk Management	16,430	5,149	(11,281)	5,149	0	0	0	11,281
Surgery, Cardiac, Critical Care, Anaesthetic	2,059,000	967,186	(1,091,814)	840,772	86,580	27,834	12,000	1,091,814
Total	10,173,200	6,304,543	(3,868,658)	5,174,847	222,357	500,376	406,963	3,868,658



7. Forecast Risk (Recurrent)

				RAG RATING				
CBU	Target	Forecast	Gap	Green	Green/Amber*	Amber	Red	Black
Other Corporate Services	29,567	62,614	33,047	60,614	0	2,000	0	(33,047)
Clinical Support Services	1,726,000	1,076,321	(649,679)	858,660	0	217,661	0	649,679
Estates	113,000	438,000	325,000	438,000	0	0	0	(325,000)
Finance & Information	218,472	238,559	20,087	238,060	499	0	0	(20,087)
Human Resources	340,109	16,001	(324,108)	16,001	0	0	0	324,108
Hotel	210,000	56,067	(153,933)	56,067	0	0	0	153,933
Integrated Community Services	1,659,000	737,402	(921,598)	591,402	0	146,000	0	921,598
Innovation	0	0	0	0	0	0	0	0
Medical Specialties	1,700,000	607,580	(1,092,420)	345,780	0	261,800	0	1,092,420
Neurosciences, MSK and Specialist Surgery	1,964,301	1,534,129	(430,172)	1,532,129	0	2,000	0	430,172
Operational Services	17,321	11,137	(6,184)	11,137	0	0	0	6,184
R&D	120,000	120,000	0	0	0	0	120,000	0
Risk Management	16,430	5,149	(11,281)	5,149	0	0	0	11,281
Surgery, Cardiac, Critical Care, Anaesthetic	2,059,000	1,334,591	(724,409)	1,048,091	22,500	99,000	165,000	724,409
Total	10,173,200	6,237,550	(3,935,650)	5,201,090	22,999	728,461	285,000	3,935,650

CBU	Target	Forecast	Gap	Green	Green/Amber*	Amber	Red	Black
Improve In Hospital Activity	2,642,046	1,546,359	(1,095,687)	1,381,359	0	40,000	125,000	1,095,687
Improve Out of Hospital Activity	768,880	259,666	(509,214)	259,666	0	0	0	509,214
Improve Business Efficiency	3,794,564	4,419,861	625,297	3,548,401	22,999	688,461	160,000	(625,297)
Deliver Strategic Plan	350,000	11,664	(338,336)	11,664	0	0	0	338,336
Improve Workforce Efficiency	190,500	(0)	(190,500)	0	0	0	(0)	190,500
GAP	2,427,210	0	(2,427,210)	0	0	0	0	2,427,210
Total	10,173,200	6,237,550	(3,935,650)	5,201,090	22,999	728,461	285,000	3,935,650

3. Financial Strength

Capital Expenditure Period ended **Nov-15**

	Prior Year Expenditure	IN MONTH BUDGET	IN MONTH ACTUAL	IN MONTH VARIANCE	YEAR TO DATE BUDGET	YEAR TO DATE ACTUAL	YEAR TO DATE VARIANCE	FULL YEAR BUDGET	FULL YEAR FORECAST	FULL YEAR VARIANCE
ESTATES CAPITAL SCHEMES	£000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
PLANNED CAPITAL - ESTATES										
Interim & Retained Estate		100	136	(36)	616	460	156	1,211	1,211	0
Demolition/Decommissioning		0	21	(21)	100	72	28	200	380	(180)
Demolition Alder Park		0	45	(45)	224	143	81	224	217	7
Project costs associated with schemes		0	103	(103)	0	106	(106)	100	100	0
CDC		63	0	63	378	0	378	630	0	630
Park Development		0	6	(6)	0	6	(6)	0	0	0
PLANNED CAPITAL - ESTATES		163	311	(148)	1,318	787	531	2,365	1,908	457
Research & Education Phase 1.	*6,877*	0	(349)	349	4,443	4,262	181	4,443	4,473	(30)
Research & Education Phase 2		0	350	(350)	900	350	550	900	900	0
RESEARCH & EDUCATION PHASE 1	***6,877***	0	1	(1)	5,343	4,612	731	5,343	5,373	(30)
ESTATES TOTAL CAPITAL	***6,877***	**163**	**312**	**(149)**	**6,661**	**5,399**	**1,262**	**7,708**	**7,281**	**427**
IM & T CAPITAL SCHEMES										
New Build IM&T	*2,302*	0	90	(90)	1,756	1,898	(142)	1,756	2,164	(408)
Door Access		0	0	0	400	102	298	400	130	270
CCTV & Mobile Technology	*0*	0	3	(3)	400	195	205	400	550	(150)
Patient Entertainment - Core	*360*	0	234	(234)	250	250	0	250	260	(10)
NETWORKING, INFRASTRUCTURE & OTHER IT	***2,662***	0	326	(326)	2,806	2,445	361	2,806	3,104	(298)
Electronic Patient Record.	*3,515*	0	107	(107)	5,712	5,850	(138)	5,712	6,132	(420)
ELECTRONIC PATIENT RECORD	***3,515***	0	107	(107)	5,712	5,850	(138)	5,712	6,132	(420)
IM & T TOTAL CAPITAL	***6,177***	**0**	**433**	**(433)**	**8,518**	**8,295**	**223**	**8,518**	**9,236**	**(718)**
ALDER HEY IN THE PARK										
Medical Equipment - Replacement Cycle	*930*	0	(96)	96	3,030	2,953	77	3,030	2,869	161
Medical Equipment - Project Specific Items (Patient Monitorin		0	0	0	700	620	80	700	727	(27)
Medical Equipment - Project Specific		0	(4)	4	0	0	0	528	342	186
Medical Equipment - Additional Rooms.		0	26	(26)	768	505	263	768	796	(28)
Medical Equipment - Category B2 Brainlab		0	300	(300)	300	346	(46)	300	439	(139)
Drills		0	0	0	208	0	208	208	200	8
Medical Equipment B1 Charity		0	0	0	0	735	(735)	0	833	(833)
Cat C Addtion		0	0	0	0	0	0	0	702	(702)
Clinical Equipment - Category B1		0	0	0	0	0	0	0	0	0
Clinical Equipment - Project Specific (Parent Beds)		0	0	0	187	226	(39)	187	226	(39)
Medical Equipment - Category B1 (Radio & Angio)	*4,509*	0	5	(5)	771	674	97	771	674	97
Non Medical Equipment - Category B2	*4*	0	0	0	329	147	182	329	147	182
Non Medical Equipment - Category C	*27*	0	(2)	2	2,325	2,981	(656)	2,325	2,981	(656)
Non Medical Equipment - Project Specific		0	20	(20)	246	462	(216)	246	462	(216)
Automated Drug Cabinets		0	0	0	333	333	0	333	333	0
CHP Equipment Budget Realignment								0	(176)	176
Outpatients		0	1,897	(1,897)	2,772	366	2,405	2,772	(1,531)	4,303
Capital Contribution PFI		0	(1,153)	1,153	2,747	2,872	(125)	2,747	5,154	(2,407)
Innovation Hub		0	0	0	280	0	280	280	0	280
ALDER HEY IN THE PARK TOTAL	***5,470***	**0**	**995**	**(995)**	**14,996**	**13,220**	**1,775**	**15,524**	**15,179**	**345**
Business Intelligence		0	107	(107)	250	257	(7)	250	250	0
Other	*0*	0	0	(0)	662	388	274	662	897	(235)
Other	***0***	**0**	**107**	**(107)**	**912**	**645**	**267**	**912**	**1,147**	**(235)**
CAPITAL PROGRAMME 15/16	***18,524***	***163***	***1,847***	***(1,684)***	***31,087***	***27,559***	***3,527***	***32,662***	***32,843***	***(181)***
Funding Adjustments (CDC)		(63)	0	(63)	(378)	0	(378)	(630)	0	(630)
AMENDED CAPITAL PROGRAMME 15/16	***18,524***	***100***	***1,847***	***(1,747)***	***30,709***	***27,559***	***3,149***	***32,032***	***32,843***	***(811)***

3. Financial Strength

3.8 CBU Financial Performance Report for the period ended November 2015

		IN MONTH BUDGET	IN MONTH ACTUAL	IN MONTH VARIANCE		YEAR TO DATE BUDGET	YEAR TO DATE ACTUAL	YEAR TO DATE VARIANCE		Comments
		£'000	£'000	£'000	%	£'000	£'000	£'000	%	
MEDICAL SPECIALTIES	INCOME	3,574	3,502	(72)	-2%	27,054	26,030	(1,025)	-4%	Overall over-performance on activity, mainly due to non-elective activity.. Under delivery on CIP.
	PAY COSTS	(1,064)	(1,151)	(87)	-8%	(8,660)	(9,075)	(415)	-5%	Overspend relates to under delivery of CIP, and high usage of bank & agency across wards
	NON PAY COSTS	(1,216)	(1,171)	46	4%	(9,504)	(9,621)	(117)	-1%	High spend on PbR dugs in month, offset by overall gain on non-PbR drugs.
	CONTRIBUTION	***1,294***	***1,180***	***(114)***	***-9%***	***8,890***	***7,334***	***(1,556)***	***-18%***	
DISTRICT SERVICES/CAMHS & COMMUNITY	INCOME	3,103	3,221	118	4%	23,673	24,335	663	3%	IAPT income offset by expenditure. Under delivery on CIP. With additional income for Eating Disorders Liverpool CAMHS
	PAY COSTS	(2,132)	(2,261)	(129)	-6%	(16,619)	(17,545)	(926)	-6%	Pay overspend on Homecare packages & IAPT offset by additional income. With additional costs for locum doctors and MAU nurse cover through bank and agency
	NON PAY COSTS	(236)	(268)	(32)	-14%	(1,883)	(2,383)	(500)	-27%	Overspend relates to under delivery of CIP, IAPT expenditure, and insulin pump expenditure offset by additional income
	CONTRIBUTION	***735***	***692***	***(43)***	***-6%***	***5,171***	***4,407***	***(764)***	***-15%***	
NEUROSCIENCE, MUSCULOSKELETAL AND SPECIALIST SURGERY	INCOME	3,916	3,012	(904)	-23%	30,217	26,659	(3,558)	-12%	Income behind plan with key areas being Neurosurgery, plastics, ortho, ENT and outpatients behind plan across the board. Work underway to look at forecasted plans and potential mitigations.
	PAY COSTS	(1,491)	(1,468)	22	1%	(12,279)	(12,518)	(239)	-2%	Pay overspend YTD due to temporary staffing and payments for additional sessions. Pay position has improved in month
	NON PAY COSTS	(164)	(261)	(97)	-59%	(1,458)	(1,860)	(402)	-28%	Non pay over spends spread across the CBU & across several areas eg drugs costs, hearing aids (some of which will be offset by income).
	CONTRIBUTION	***2,261***	***1,283***	***(978)***	***-43%***	***16,480***	***12,281***	***(4,199)***	***-25%***	
SURGERY, CARDIAC, ANAESTHESIA & CRITICAL CARE CBU (SCACC)	INCOME	4,707	4,013	(694)	-15%	34,610	31,900	(2,709)	-8%	Income underperforming mainly in 2 areas (Cardiac surgery and Neonates), with smaller variances across the CBU. Work has been done to look at forecast activity and mitigation plans.
	PAY COSTS	(3,063)	(3,186)	(123)	-4%	(24,901)	(25,460)	(560)	-2%	Temporary staffing used to cover sickness & maternity leave. Continued use of agency in theatres.
	NON PAY COSTS	(932)	(945)	(13)	-1%	(7,580)	(7,230)	350	5%	Various overspends such as drugs & costs associated with burns patients offset by underspend in theatres.
	CONTRIBUTION	***712***	***(118)***	***(830)***	***-117%***	***2,129***	***(790)***	***(2,919)***	***-137%***	
CLINICAL SUPPORT UNIT	INCOME	909	901	(8)	-1%	6,972	7,053	81	1%	Income overperformance year to date is Radiology Non Elective
	PAY COSTS	(1,531)	(1,550)	(19)	-1%	(12,233)	(12,093)	140	1%	Various CBU vacancies offset by pressure in Records Management Team - Agency 302k, Paperlight project
	NON PAY COSTS	(475)	(530)	(55)	-12%	(3,978)	(4,676)	(698)	-18%	Overspending areas are drugs, FP10's, patient appliances, send away tests, Patient Services and unachieved CIP
	CONTRIBUTION	***(1,097)***	***(1,179)***	***(82)***	***-7%***	***(9,239)***	***(9,716)***	***(477)***	***-5%***	
HOTEL SERVICES	INCOME	142	108	(34)	-24%	1,106	993	(113)	-10%	Target for LWH SLA cannot be fulfilled as Genetics have now moved off site, Car Parking £27k underachieved due to issues with the equipment
	PAY COSTS	(419)	(451)	(32)	-8%	(2,722)	(2,896)	(174)	-6%	Additional pay costs associated with the hospital move
	NON PAY COSTS	(179)	(199)	(20)	-11%	(1,470)	(1,822)	(352)	-24%	Continuing overspends in postage, Security, and provisions offset by various savings
	CONTRIBUTION	***(456)***	***(542)***	***(86)***	***-19%***	***(3,086)***	***(3,725)***	***(639)***	***-21%***	
ESTATES	INCOME	5	31	25	500%	49	56	7	14%	Target for LWH SLA cannot be fulfilled as Genetics have now moved off site
	PAY COSTS	(74)	(41)	32	43%	(519)	(435)	84	16%	Pay savings
	NON PAY COSTS	(704)	(797)	(93)	-13%	(4,410)	(4,392)	18	0%	Overspend in the month due to costs of utilities and rates costs for the old hospital
	CONTRIBUTION	***(773)***	***(807)***	***(34)***	***-4%***	***(4,880)***	***(4,771)***	***109***	***2%***	
RESEARCH & DEVELOPMENT	INCOME	347	433	86	25%	2,672	2,704	32	1%	Offset by Non Pay costs
	PAY COSTS	(184)	(189)	(5)	-3%	(1,467)	(1,590)	(123)	-8%	Offset by Income
	NON PAY COSTS	(105)	(186)	(81)	-77%	(840)	(749)	91	11%	Offset by Income
	CONTRIBUTION	***58***	***58***	***0***	***0%***	***365***	***365***	***0***	***0%***	
ALDER HEY IN THE PARK	INCOME	453	453	0	0%	4,669	4,696	26	1%	
	PAY COSTS	(161)	(241)	(79)	-49%	(1,896)	(1,830)	67	4%	
	NON PAY COSTS	(42)	37	79	188%	(767)	(860)	(93)	-12%	
	CONTRIBUTION	***250***	***249***	***(1)***	***0%***	***2,006***	***2,006***	***0***	***0%***	
CORPORATE OTHER DEPT	INCOME	0	0	0	0%	0	(1)	(1)	0%	
	PAY COSTS	(131)	(133)	(2)	-2%	(1,075)	(1,048)	27	3%	Various vacancies
	NON PAY COSTS	(42)	(29)	13	31%	(382)	(456)	(74)	-19%	Overspends in Communications and Trust Board (Legal fees and Professional fees)
	CONTRIBUTION	***(173)***	***(162)***	***11***	***6%***	***(1,457)***	***(1,505)***	***(48)***	***-3%***	
FINANCE & IMT	INCOME	(6)	(31)	(25)	-417%	(95)	18	112	118%	Overachievement in Finance CIP
	PAY COSTS	(300)	(268)	33	11%	(2,200)	(2,097)	103	5%	Overachievement in Finance CIP
	NON PAY COSTS	(269)	(295)	(26)	-10%	(1,943)	(2,223)	(281)	-14%	Overspend mainly due to IMT computer expenditure & Telephony
	CONTRIBUTION	***(575)***	***(594)***	***(19)***	***-3%***	***(4,238)***	***(4,302)***	***(64)***	***-2%***	
HUMAN RESOURCES	INCOME	55	33	(22)	-40%	412	216	(195)	-47%	Income behind plan mainly due to unachieved CIP
	PAY COSTS	(139)	(127)	12	9%	(1,137)	(1,116)	21	2%	Various vacancies
	NON PAY COSTS	(86)	(92)	(6)	-7%	(702)	(603)	98	14%	Underspend in Organisational Development, who traditionally incur more expenditure later in the year
	CONTRIBUTION	***(170)***	***(186)***	***(16)***	***-9%***	***(1,427)***	***(1,503)***	***(76)***	***-5%***	
NURSING & QUALITY	INCOME	11	103	92	836%	86	201	115	134%	Mainly NHSLA - Safety Improvement plan - offset Pay and Alder Hey MSc Child Nursing - offset Non Pay
	PAY COSTS	(144)	(160)	(15)	-10%	(1,141)	(1,197)	(56)	-5%	Mainly NHSLA - Safety Improvement plan - offset Income
	NON PAY COSTS	(25)	(113)	(88)	-352%	(219)	(487)	(268)	-122%	Various overspends in Nursing Leadership, Risk Management, Patient Experience and Infection Control Department (Bioquell Pods for CBU's) Alder Hey MSc Child Nursing - offset Income
	CONTRIBUTION	***(158)***	***(170)***	***(12)***	***-8%***	***(1,274)***	***(1,483)***	***(209)***	***-16%***	

Activity against Plan, by Specialty
2015/16 - Month 08

Medical Specialties CBU		Plan (spells/ attendances)	Actual (spells/ attendances)	Variance (spells/ attendances)	% Variance	Plan £000s	Actual £000s	Variance £000s	% Variance
Endocrinology	Elective	790	712	-78	-10%	£842	£717	-£125	-15%
Endocrinology	Non Elective	19	10	-9	-48%	£76	£57	-£19	-25%
Endocrinology	Outpatient - New	520	488	-32	-6%	£201	£189	-£12	-6%
Endocrinology	Outpatient - Follow Up	3,625	2,887	-738	-20%	£665	£535	-£129	-19%
Endocrinology	**Total**	**4,955**	**4,097**	**-858**	**-17%**	**£1,785**	**£1,499**	**-£286**	**-16%**
Haematology	Elective	212	237	25	12%	£389	£316	-£73	-19%
Haematology	Non Elective	135	75	-60	-45%	£427	£177	-£250	-59%
Haematology	Outpatient - New	174	144	-30	-17%	£75	£62	-£13	-17%
Haematology	Outpatient - Follow Up	1,274	973	-301	-24%	£271	£208	-£63	-23%
Haematology	**Total**	**1,795**	**1,429**	**-366**	**-20%**	**£1,163**	**£763**	**-£399**	**-34%**
Gastroenterology	Elective	1,239	1,141	-98	-8%	£1,565	£1,545	-£20	-1%
Gastroenterology	Non Elective	87	68	-19	-22%	£706	£432	-£274	-39%
Gastroenterology	Outpatient - New	779	652	-127	-16%	£174	£165	-£9	-5%
Gastroenterology	Outpatient - Follow Up	3,688	3,568	-120	-3%	£556	£575	£19	3%
Gastroenterology	**Total**	**5,792**	**5,429**	**-363**	**-6%**	**£3,002**	**£2,717**	**-£285**	**-9%**
Metabolic	Elective	0		0	0%	£0		£0	0%
Metabolic	Non Elective	0		0	0%	£0		£0	0%
Metabolic	Outpatient - New	40	35	-5	-12%	£15	£14	-£2	-12%
Metabolic	Outpatient - Follow Up	239	233	-6	-2%	£92	£90	-£2	-2%
Metabolic	**Total**	**279**	**268**	**-11**	**-4%**	**£108**	**£103**	**-£4**	**-4%**
Dermatology	Elective	15	25	10	71%	£12	£22	£9	74%
Dermatology	Non Elective	0		0	0%	£0		£0	0%
Dermatology	Outpatient - New	1,386	1,013	-373	-27%	£185	£140	-£45	-24%
Dermatology	Outpatient - Follow Up	5,356	4,686	-670	-13%	£502	£446	-£56	-11%
Dermatology	**Total**	**6,757**	**5,724**	**-1,033**	**-15%**	**£699**	**£608**	**-£91**	**-13%**
Nephrology	Elective	1,001	648	-353	-35%	£1,017	£484	-£533	-52%
Nephrology	Non Elective	32	50	18	56%	£135	£176	£41	30%
Nephrology	Outpatient - New	124	168	44	35%	£15	£20	£5	36%
Nephrology	Outpatient - Follow Up	2,089	1,968	-121	-6%	£248	£233	-£14	-6%
Nephrology	**Total**	**3,246**	**2,834**	**-412**	**-13%**	**£1,414**	**£912**	**-£501**	**-35%**
Oncology	Elective	3,037	4,021	984	32%	£2,170	£3,386	£1,216	56%
Oncology	Non Elective	314	543	229	73%	£839	£1,197	£358	43%
Oncology	Outpatient - New	80	58	-22	-28%	£21	£15	-£6	-28%
Oncology	Outpatient - Follow Up	2,581	2,724	143	6%	£670	£702	£32	5%
Oncology	**Total**	**6,013**	**7,346**	**1,333**	**22%**	**£3,700**	**£5,300**	**£1,600**	**43%**
Respiratory Medicine	Elective	117	124	7	6%	£193	£188	-£5	-2%
Respiratory Medicine	Non Elective	474	484	10	2%	£509	£618	£109	21%
Respiratory Medicine	Outpatient - New	486	486	0	0%	£134	£145	£11	8%
Respiratory Medicine	Outpatient - Follow Up	3,161	2,667	-494	-16%	£435	£423	-£12	-3%
Respiratory Medicine	**Total**	**4,238**	**3,761**	**-477**	**-11%**	**£1,271**	**£1,374**	**£103**	**8%**
Rheumatology	Elective	1,344	1,180	-164	-12%	£1,290	£1,169	-£121	-9%
Rheumatology	Non Elective	11	24	13	112%	£24	£60	£36	147%
Rheumatology	Outpatient - New	390	374	-16	-4%	£59	£57	-£2	-4%
Rheumatology	Outpatient - Follow Up	1,447	1,233	-214	-15%	£219	£186	-£32	-15%
Rheumatology	**Total**	**3,193**	**2,811**	**-382**	**-12%**	**£1,591**	**£1,472**	**-£120**	**-8%**
CBU Total									
Med Spec CBU	Elective	7,755	8,088	333	4%	£7,478	£7,827	£349	5%
Med Spec CBU	Non Elective	1,073	1,254	181	17%	£2,715	£2,716	£1	0%
Med Spec CBU	Outpatient - New	3,979	3,418	-561	-14%	£880	£807	-£73	-8%
Med Spec CBU	Outpatient - Follow Up	23,461	20,939	-2,522	-11%	£3,658	£3,399	-£259	-7%
Med Spec CBU	**Total**	**36,268**	**33,699**	**-2,569**	**-7%**	**£14,732**	**£14,749**	**£17**	**0%**

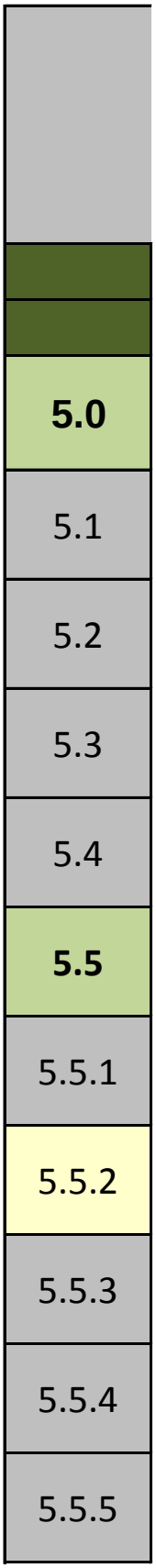
ICS CBU		Plan Spells	Actual Spells	Variance Spells	% Variance	Plan £000s	Actual £000s	Variance £000s	% Variance
Accident & Emergency	Elective	1	2	1	51%	£1	£4	£2	175%
Accident & Emergency	Non Elective	534	723	189	35%	£500	£710	£210	42%
Accident & Emergency	Outpatient - New	1,664	1,114	-550	-33%	£564	£378	-£186	-33%
Accident & Emergency	Outpatient - Follow Up	179	149	-30	-17%	£61	£50	-£10	-17%
Accident & Emergency	**Total**	**2,379**	**1,988**	**-391**	**-16%**	**£1,126**	**£1,142**	**£15**	**1%**
CAMHS	Elective	2	1	-1	-50%	£2	£1	-£1	-49%
CAMHS	Non Elective	0		0	0%	£0		£0	0%
CAMHS	Outpatient - New	1,565	2,052	487	31%	£0		£0	0%
CAMHS	Outpatient - Follow Up	7,513	8,579	1,066	14%	£0		£0	0%
CAMHS	**Total**	**9,079**	**10,632**	**1,553**	**17%**	**£2**	**£1**	**-£1**	**-49%**
Community Paediatrics	Elective	0	2	2	0%	£0	£2	£2	0%
Community Paediatrics	Non Elective	0		0	0%	£0		£0	0%
Community Paediatrics	Outpatient - New	2,405	2,038	-367	-15%	£0		£0	0%
Community Paediatrics	Outpatient - Follow Up	5,743	4,851	-892	-16%	£0		£0	0%
Community Paediatrics	**Total**	**8,148**	**6,891**	**-1,257**	**-15%**	**£0**	**£2**	**£2**	**0%**
Diabetes	Elective	0		0	0%	£0		£0	0%
Diabetes	Non Elective	0		0	0%	£0		£0	0%
Diabetes	Outpatient - New	12	58	46	386%	£3	£13	£11	386%
Diabetes	Outpatient - Follow Up	23	90	67	299%	£3	£12	£9	295%
Diabetes	**Total**	**35**	**148**	**113**	**329%**	**£6**	**£25**	**£19**	**338%**
General Paediatrics	Elective	359	293	-66	-18%	£382	£337	-£44	-12%
General Paediatrics	Non Elective	2,001	2,121	120	6%	£2,457	£2,799	£342	14%
General Paediatrics	Outpatient - New	3,573	2,823	-750	-21%	£676	£622	-£53	-8%
General Paediatrics	Outpatient - Follow Up	6,264	5,238	-1,026	-16%	£729	£677	-£52	-7%
General Paediatrics	**Total**	**12,197**	**10,475**	**-1,722**	**-14%**	**£4,244**	**£4,436**	**£192**	**5%**
CBU Total									
ICS CBU	Elective	362	298	-64	-18%	£385	£344	-£41	-11%
ICS CBU	Non Elective	2,535	2,844	309	12%	£2,957	£3,509	£551	19%
ICS CBU	Outpatient - New	9,219	8,085	-1,134	-12%	£1,242	£1,013	-£229	-18%
ICS CBU	Outpatient - Follow Up	19,722	18,907	-815	-4%	£793	£740	-£53	-7%
ICS CBU	**Total**	**31,838**	**30,134**	**-1,704**	**-5%**	**£5,378**	**£5,606**	**£228**	**4%**
A&E Attendances	**A&E Attendances**	**36,480**	**37,284**	**804**	**2%**	**£3,159**	**£3,197**	**£37**	**1%**

NMSS CBU		Plan Spells	Actual Spells	Variance Spells	% Variance	Plan £000s	Actual £000s	Variance £000s	% Variance
ENT	Elective	1,625	1,322	-303	-19%	£2,013	£1,594	-£418	-21%
ENT	Non Elective	183	175	-8	-5%	£366	£302	-£65	-18%
ENT	Outpatient - New	2,780	2,148	-632	-23%	£297	£230	-£67	-23%
ENT	Outpatient - Follow Up	5,434	4,932	-502	-9%	£481	£464	-£18	-4%
ENT	**Total**	**10,022**	**8,577**	**-1,445**	**-14%**	**£3,158**	**£2,590**	**-£568**	**-18%**
Audiology	Elective	0		0	0%	£0		£0	0%
Audiology	Non Elective	0		0	0%	£0		£0	0%
Audiology	Outpatient - New	4,878	4,811	-67	-1%	£463	£457	-£6	-1%
Audiology	Outpatient - Follow Up	1,909	2,127	218	11%	£182	£202	£21	11%
Audiology	**Total**	**6,787**	**6,938**	**151**	**2%**	**£645**	**£659**	**£14**	**2%**
Ophthalmology	Elective	401	232	-169	-42%	£385	£218	-£166	-43%
Ophthalmology	Non Elective	13	4	-9	-68%	£27	£6	-£20	-76%
Ophthalmology	Outpatient - New	2,408	2,021	-387	-16%	£354	£313	-£41	-12%
Ophthalmology	Outpatient - Follow Up	9,002	6,771	-2,231	-25%	£899	£722	-£177	-20%
Ophthalmology	**Total**	**11,824**	**9,028**	**-2,796**	**-24%**	**£1,665**	**£1,260**	**-£405**	**-24%**
Burns	Elective	52	34	-18	-35%	£132	£63	-£69	-52%
Burns	Non Elective	246	187	-59	-24%	£599	£429	-£171	-28%
Burns	Outpatient - New	247	140	-107	-43%	£48	£27	-£20	-42%
Burns	Outpatient - Follow Up	804	638	-166	-21%	£90	£73	-£17	-19%
Burns	**Total**	**1,350**	**999**	**-351**	**-26%**	**£869**	**£593**	**-£276**	**-32%**
Neurology	Elective	118	196	78	66%	£229	£383	£154	67%
Neurology	Non Elective	66	72	6	9%	£307	£475	£168	55%
Neurology	Outpatient - New	717	670	-47	-7%	£186	£187	£1	1%
Neurology	Outpatient - Follow Up	2,294	1,843	-451	-20%	£598	£513	-£84	-14%
Neurology	**Total**	**3,196**	**2,781**	**-415**	**-13%**	**£1,320**	**£1,558**	**£239**	**18%**
Paediatric Epilepsy	Elective	0		0	0%	£0		£0	0%
Paediatric Epilepsy	Non Elective	0		0	0%	£0		£0	0%
Paediatric Epilepsy	Outpatient - New	90	77	-13	-15%	£20	£17	-£3	-15%
Paediatric Epilepsy	Outpatient - Follow Up	210	173	-37	-18%	£37	£31	-£7	-18%
Paediatric Epilepsy	**Total**	**300**	**250**	**-50**	**-17%**	**£57**	**£48**	**-£10**	**-17%**
Neurosurgery	Elective	200	200	0	0%	£814	£965	£151	19%
Neurosurgery	Non Elective	237	190	-47	-20%	£1,554	£1,077	-£476	-31%
Neurosurgery	Outpatient - New	522	383	-139	-27%	£45	£34	-£11	-24%
Neurosurgery	Outpatient - Follow Up	1,747	1,715	-32	-2%	£152	£153	£1	1%
Neurosurgery	**Total**	**2,706**	**2,488**	**-218**	**-8%**	**£2,566**	**£2,230**	**-£336**	**-13%**
Oral Surgery	Elective	388	310	-78	-20%	£455	£375	-£80	-18%
Oral Surgery	Non Elective	101	74	-27	-27%	£116	£87	-£29	-25%
Oral Surgery	Outpatient - New	576	351	-225	-39%	£114	£73	-£41	-36%
Oral Surgery	Outpatient - Follow Up	1,145	548	-597	-52%	£170	£93	-£77	-45%
Oral Surgery	**Total**	**2,210**	**1,283**	**-927**	**-42%**	**£855**	**£628**	**-£227**	**-27%**
Paediatric Dentistry	Elective	867	645	-222	-26%	£515	£376	-£138	-27%
Paediatric Dentistry	Non Elective	9	11	2	27%	£10	£11	£0	1%
Paediatric Dentistry	Outpatient - New	916	763	-153	-17%	£33	£27	-£6	-17%
Paediatric Dentistry	Outpatient - Follow Up	1,422	1,049	-373	-26%	£88	£62	-£25	-29%
Paediatric Dentistry	**Total**	**3,213**	**2,468**	**-745**	**-23%**	**£646**	**£477**	**-£169**	**-26%**
Orthodontics	Elective	0	1	1	0%	£0	£1	£1	0%
Orthodontics	Non Elective	0	1	1	0%	£0	£1	£1	0%
Orthodontics	Outpatient - New	42	22	-20	-47%	£8	£4	-£4	-46%
Orthodontics	Outpatient - Follow Up	239	204	-35	-15%	£25	£20	-£5	-20%
Orthodontics	**Total**	**281**	**228**	**-53**	**-19%**	**£33**	**£26**	**-£6**	**-19%**
Plastic surgery	Elective	715	611	-104	-15%	£841	£741	-£100	-12%
Plastic surgery	Non Elective	918	705	-213	-23%	£1,202	£1,031	-£171	-14%
Plastic surgery	Outpatient - New	1,849	1,469	-380	-21%	£247	£235	-£12	-5%
Plastic surgery	Outpatient - Follow Up	4,108	3,461	-647	-16%	£421	£374	-£47	-11%
Plastic surgery	**Total**	**7,589**	**6,246**	**-1,343**	**-18%**	**£2,711**	**£2,381**	**-£330**	**-12%**
Orthopaedics	Elective	850	719	-131	-15%	£2,334	£2,011	-£324	-14%
Orthopaedics	Non Elective	597	486	-111	-19%	£1,561	£1,268	-£293	-19%
Orthopaedics	Outpatient - New	5,799	5,251	-548	-9%	£838	£759	-£79	-9%
Orthopaedics	Outpatient - Follow Up	8,940	9,716	776	9%	£897	£967	£70	8%
Orthopaedics	**Total**	**16,186**	**16,172**	**-14**	**0%**	**£5,630**	**£5,005**	**-£625**	**-11%**
Sleep Studies	Elective	199	121	-78	-39%	£363	£194	-£170	-47%
Sleep Studies	Non Elective	0		0	0%	£0		£0	0%
Sleep Studies	Outpatient - New	0		0	0%	£0		£0	0%
Sleep Studies	Outpatient - Follow Up	0		0	0%	£0		£0	0%
Sleep Studies	**Total**	**199**	**121**	**-78**	**-39%**	**£363**	**£194**	**-£170**	**-47%**
Spinal Surgery	Elective	108	88	-20	-18%	£2,080	£1,873	-£207	-10%
Spinal Surgery	Non Elective	0	3	3	0%	£0	£108	£108	0%
Spinal Surgery	Outpatient - New	169	211	42	25%	£28	£35	£7	25%
Spinal Surgery	Outpatient - Follow Up	584	787	203	35%	£60	£80	£21	35%
Spinal Surgery	**Total**	**861**	**1,089**	**228**	**27%**	**£2,168**	**£2,097**	**-£70**	**-3%**
CBU Total									
NMSS CBU	Elective	5,523	4,479	-1,044	-19%	£10,161	£8,795	-£1,365	-13%
NMSS CBU	Non Elective	2,369	1,908	-461	-19%	£5,744	£4,796	-£947	-16%
NMSS CBU	Outpatient - New	20,993	18,317	-2,676	-13%	£2,682	£2,399	-£283	-11%
NMSS CBU	Outpatient - Follow Up	37,838	33,964	-3,874	-10%	£4,099	£3,755	-£344	-8%
NMSS CBU	**Total**	**66,724**	**58,668**	**-8,056**	**-12%**	**£22,685**	**£19,746**	**-£2,939**	**-13%**

SCACC CBU		Plan Spells	Actual Spells	Variance Spells	% Variance	Plan £000s	Actual £000s	Variance £000s	% Variance
Cardiology	Elective	327	294	-33	-10%	£1,189	£1,147	-£41	-3%
Cardiology	Non Elective	86	97	11	13%	£451	£349	-£102	-23%
Cardiology	Outpatient - New	1,143	1,059	-84	-7%	£255	£239	-£16	-6%
Cardiology	Outpatient - Follow Up	3,056	2,943	-113	-4%	£452	£441	-£12	-3%
Cardiology	**Total**	**4,612**	**4,393**	**-219**	**-5%**	**£2,347**	**£2,176**	**-£171**	**-7%**
Cardiac Surgery	Elective	243	200	-43	-18%	£3,175	£2,541	-£634	-20%
Cardiac Surgery	Non Elective	87	70	-17	-19%	£1,990	£1,905	-£85	-4%
Cardiac Surgery	Outpatient - New	70	50	-20	-28%	£50	£36	-£14	-28%
Cardiac Surgery	Outpatient - Follow Up	222	167	-55	-25%	£161	£121	-£40	-25%
Cardiac Surgery	**Total**	**621**	**487**	**-134**	**-22%**	**£5,376**	**£4,603**	**-£773**	**-14%**
Gynaecology	Elective	13	7	-6	-44%	£12	£15	£3	22%
Gynaecology	Non Elective	0		0	0%	£0		£0	0%
Gynaecology	Outpatient - New	187	161	-26	-14%	£25	£22	-£4	-14%
Gynaecology	Outpatient - Follow Up	309	310	1	0%	£26	£26	£0	0%
Gynaecology	**Total**	**509**	**478**	**-31**	**-6%**	**£63**	**£63**	**-£1**	**-1%**
Paediatric Surgery	Elective	1,302	1,189	-113	-9%	£2,506	£2,232	-£273	-11%
Paediatric Surgery	Non Elective	904	831	-73	-8%	£3,049	£2,936	-£112	-4%
Paediatric Surgery	Outpatient - New	1,489	1,342	-147	-10%	£274	£247	-£27	-10%
Paediatric Surgery	Outpatient - Follow Up	3,657	2,514	-1,143	-31%	£413	£285	-£128	-31%
Paediatric Surgery	**Total**	**7,351**	**5,876**	**-1,475**	**-20%**	**£6,242**	**£5,700**	**-£541**	**-9%**
Urology	Elective	1,239	1,328	89	7%	£1,403	£1,391	-£12	-1%
Urology	Non Elective	25	18	-7	-27%	£115	£68	-£47	-41%
Urology	Outpatient - New	869	711	-158	-18%	£139	£120	-£19	-14%
Urology	Outpatient - Follow Up	1,842	1,491	-351	-19%	£171	£164	-£7	-4%
Urology	**Total**	**3,974**	**3,548**	**-426**	**-11%**	**£1,828**	**£1,743**	**-£85**	**-5%**
Neonatology	Elective	1	4	3	201%	£10	£25	£15	143%
Neonatology	Non Elective	164	85	-79	-48%	£1,378	£684	-£693	-50%
Neonatology	Outpatient - New	0		0	0%	£0		£0	0%
Neonatology	Outpatient - Follow Up	0		0	0%	£0		£0	0%
Neonatology	**Total**	**165**	**89**	**-76**	**-46%**	**£1,388**	**£709**	**-£679**	**-49%**
Paediatric Intensive Care	Elective	85	11	-74	-87%	£183	£52	-£131	-72%
Paediatric Intensive Care	Non Elective	129	141	12	10%	£363	£1,075	£711	196%
Paediatric Intensive Care	Outpatient - New	54	89	35	66%	£40	£66	£26	66%
Paediatric Intensive Care	Outpatient - Follow Up	342	449	107	31%	£236	£329	£93	39%
Paediatric Intensive Care	**Total**	**610**	**690**	**80**	**13%**	**£822**	**£1,522**	**£700**	**85%**
CBU Total									
SCACC CBU	Elective	3,210	3,033	-177	-6%	£8,478	£7,403	-£1,074	-13%
SCACC CBU	Non Elective	1,394	1,242	-152	-11%	£7,346	£7,018	-£327	-4%
SCACC CBU	Outpatient - New	3,812	3,412	-400	-10%	£784	£730	-£54	-7%
SCACC CBU	Outpatient - Follow Up	9,428	7,874	-1,554	-16%	£1,459	£1,365	-£94	-6%
SCACC CBU	**Total**	**17,843**	**15,561**	**-2,282**	**-13%**	**£18,067**	**£16,516**	**-£1,550**	**-9%**

Clinical Support CBU		Plan Spells	Actual Spells	Variance Spells	% Variance	Plan £000s	Actual £000s	Variance £000s	% Variance
Radiology	Elective	881	927	46	5%	£1,160	£1,167	£7	1%
Radiology	Non Elective	23	25	2	10%	£199	£269	£69	35%
Radiology		**904**	**952**	**48**	**5%**	**£1,359**	**£1,436**	**£76**	**6%**

Trust wide		Plan Spells	Actual Spells	Variance Spells	% Variance	Plan £000s	Actual £000s	Variance £000s	% Variance
Trust wide	Elective	17,732	16,825	-907	-5%	£27,662	£25,537	-£2,125	-8%
Trust wide	Non Elective	7,393	7,273	-120	-2%	£18,961	£18,308	-£653	-3%
Trust wide	Outpatient - New	38,002	33,232	-4,770	-13%	£5,589	£4,950	-£639	-11%
Trust wide	Outpatient - Follow Up	90,450	81,684	-8,766	-10%	£10,009	£9,259	-£750	-7%
Trust wide	**Total**	**153,577**	**139,014**	**-14,563**	**-9%**	**£62,220**	**£58,053**	**-£4,167**	**-7%**
A&E Attendances	**A&E Attendances**	**36,480**	**37,284**	**804**	**2%**	**£3,159**	**£3,197**	**£37**	**1%**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Project Title and milestones
Prioritised Operational Issues (Building)
Complete dental room works
Install ducting and power for equipment in Pathology Trace metals lab
Install hot water boiler in clean room and power supply for special feeds unit.
Plans developed for the transportation of feeds from old site to new until above installation works completed
Resolve phones and communications problems that are leading to safety concerns and operational problems:
Remove crackling/interference from hard bleeps
Ensure soft bleeps are reliable/supported by Wi-fi
Resolve switchboard crashing
Create coverage paths and enable voicemail for each specialty as required
Produce reliable telephone directory.

Implement dedicated wi-fi for staff - no longer required as changes have been implemented to the guest wi-fi
Audio visual solution installed - R & E lecture theatre
Complete installation of outstanding TVs
Resolve TV picture freezing
Commission aseptic suite leading to avoid expensive off-site/old site production
Open beds that are unavailable due mainly to drainage blocks
Open Hydrotherapy Pool (pump failure/drainage issues)
Install directional alarm panel in ICU (delay in opening final ICU pod)
Install directional alarm panel in DC Theatres (clinical risk)
Resolve door/problems and access into some key depts NICU, Pathology and ICU, leading to security concerns
Commission car park barriers (loss of income)
Cycle Centre - Commission
Get locks on drug cupboards (security concerns)
Purchase missing lockers (security concerns and loss of amenity)

Purchase missing cabinetry (security concerns and loss of amenity):
- Pathology
- Dentistry
- Pharmacy Shelving
Opening of ward play-decks (finalisation of sops)
Complete plan to resolve flow and IM&T issues in OPD leading to slow down in activity:
OPD waiting space GF- create physical segregation of wait from atrium.
Fracture clinic - create plan to resolve flow issues
Resolve snagging issues within the research/education and innovation building
Secure accreditation to scope cleaning
Resolve water temperature issues mainly on wards
Resolve key temperature issues:
- Med Prep/Isolation 1C
- Pharmacy/Hazard Room 3B - installation of fan coil unit

- Ward bedrooms
Remove fall risk into A&E garden
Resolve theatre floor damage/levels
Sort IMT connectivity to support sleep studies
Activate OPG diagnostics for dental
Commission Helipad - Windsock
Reorganise ED waiting area
Wire up PICU alarms
Resolve Pneumatic Tube operational issues
Cat 3 lobby door interlocks - make compliant
Autoclave
Cat 3 commission autoclave
HSE documentation
Install core signage to missing areas

Lifts:
- Activate phones
- Lift Signage installed
- Agree SOP with Project Co
Activate CCTV - install fibre switches
Confirmation of validation of theatres
AV installations - main hospital
Door access - theatres
Door access - imaging
Curtains sticking in all 4-bedded bays

Milestone Owner	07/09/2015	14/09/2015	21/09/2015	28/09/2015	05/10/2015	12/10/2015	19/10/2015	26/10/2015	02/11/2015	09/11/2015	16/11/2015	23/11/2015	30/11/2015	07/12/2015	14/12/2015
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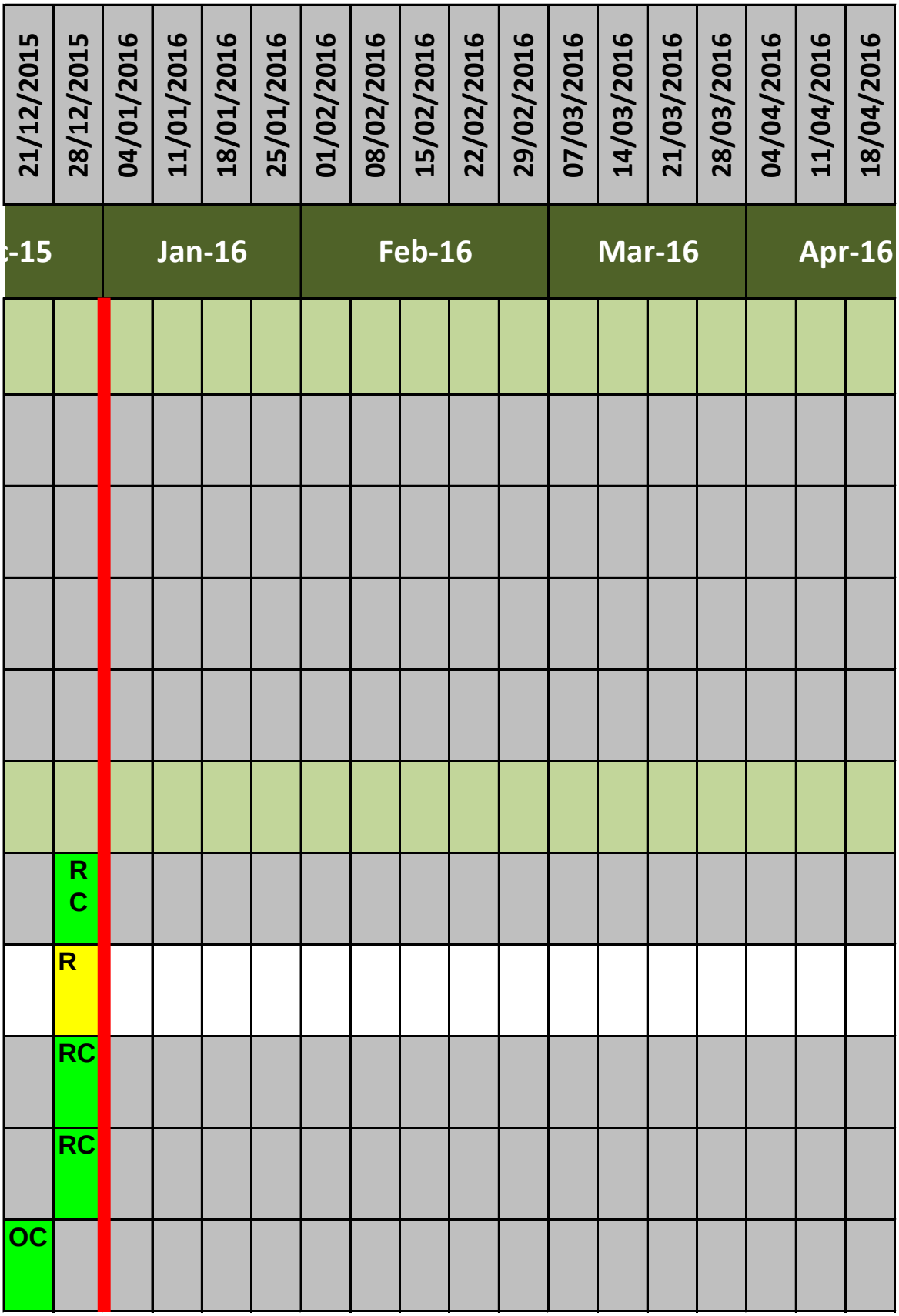
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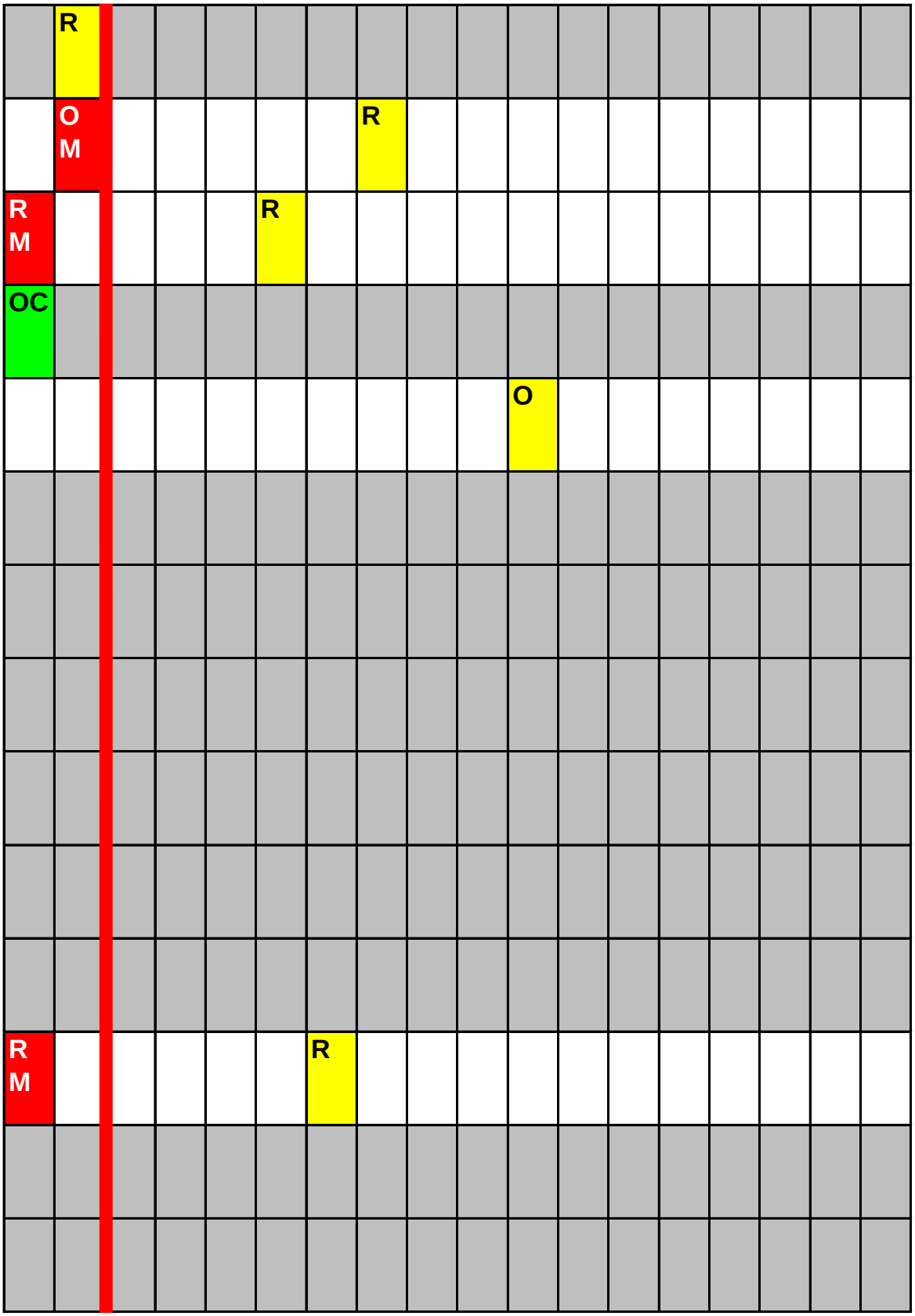
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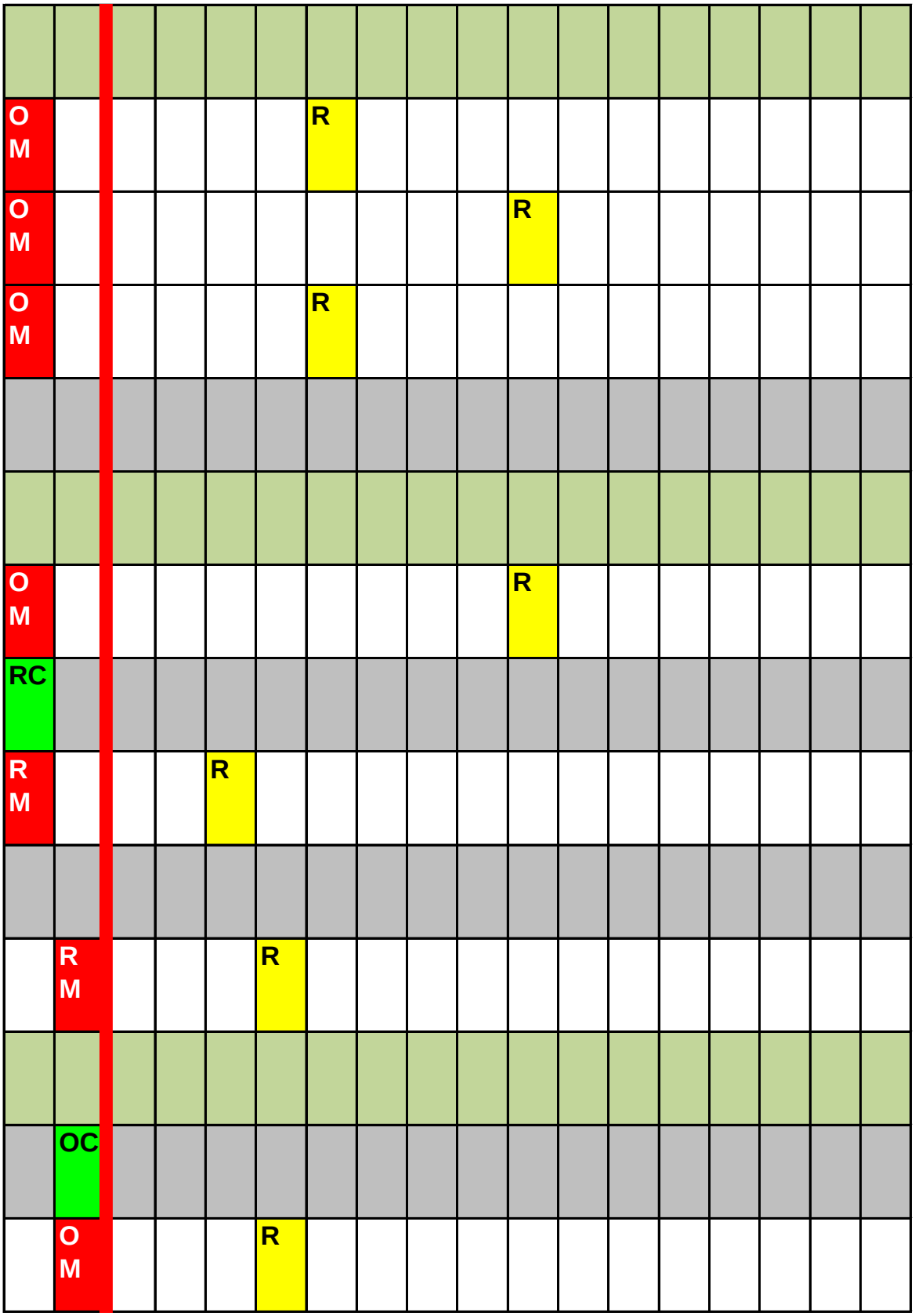
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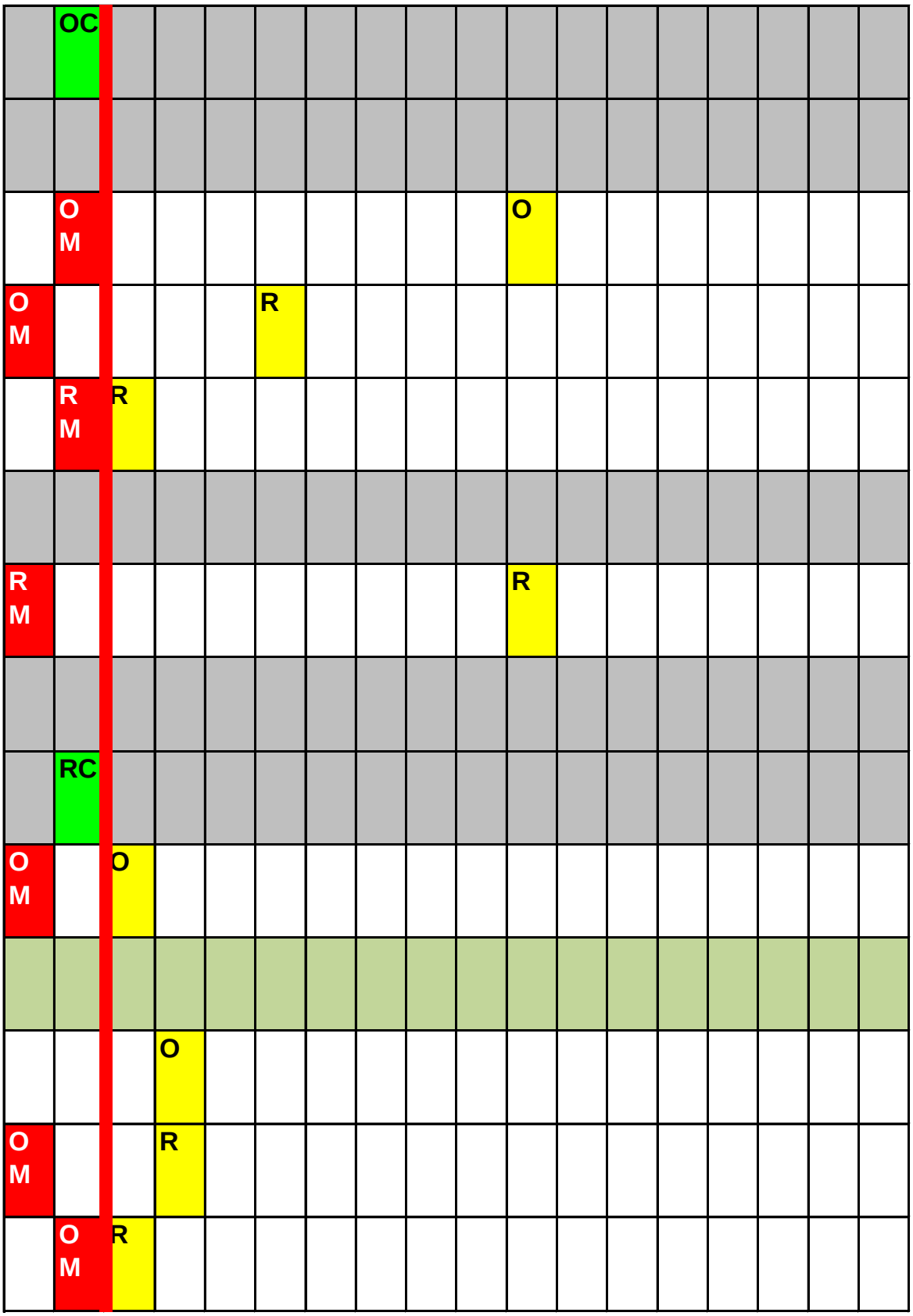
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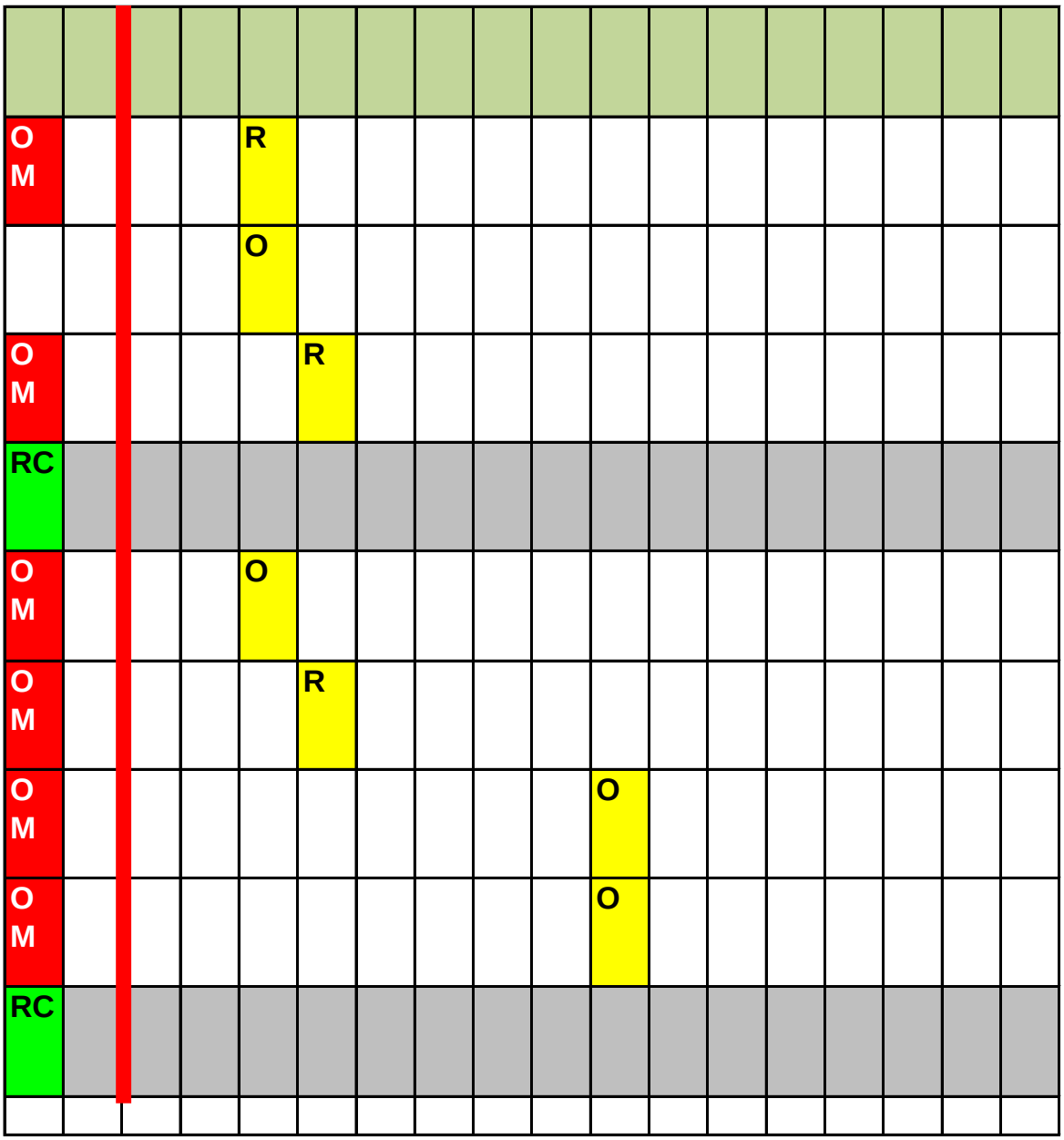
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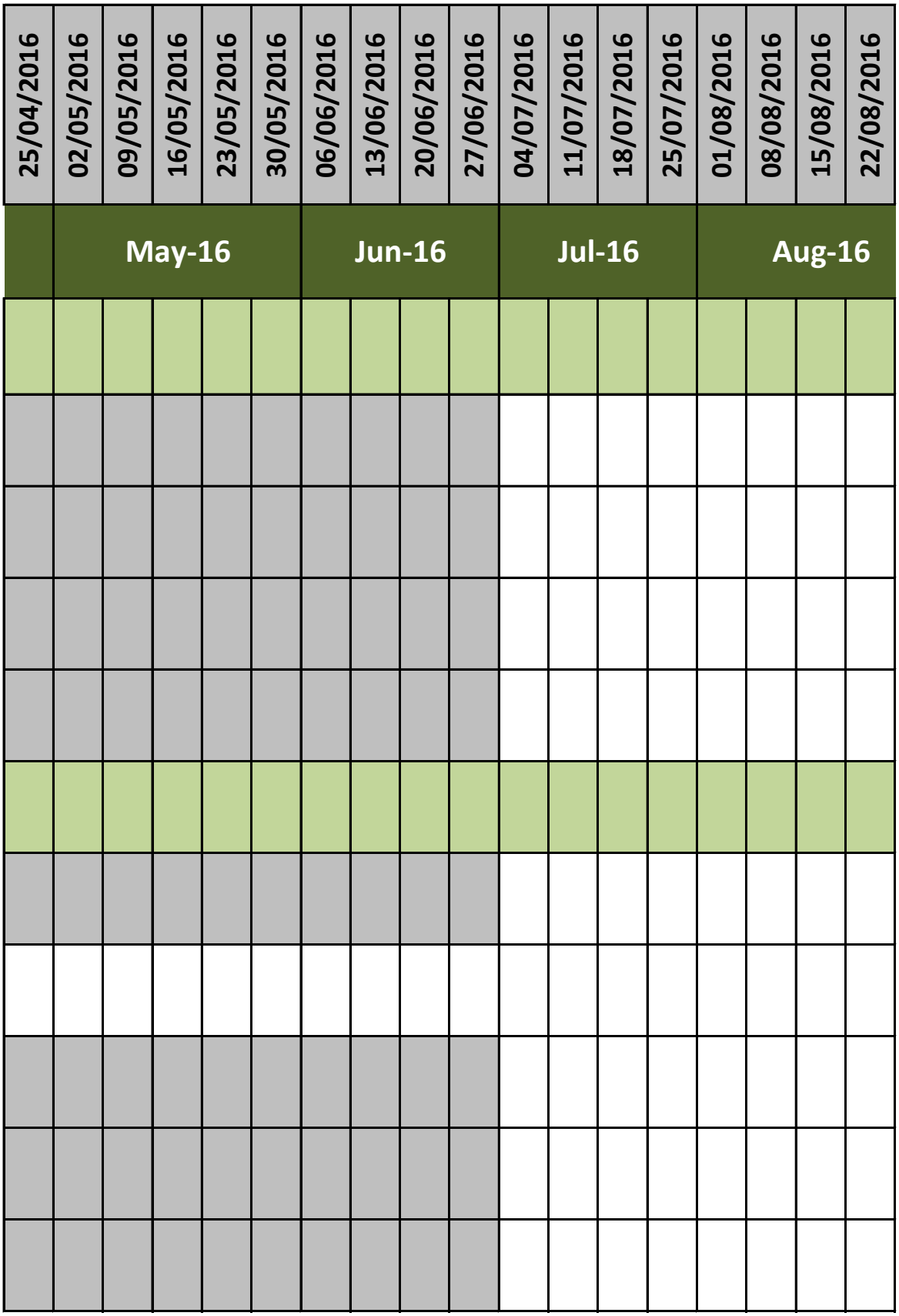
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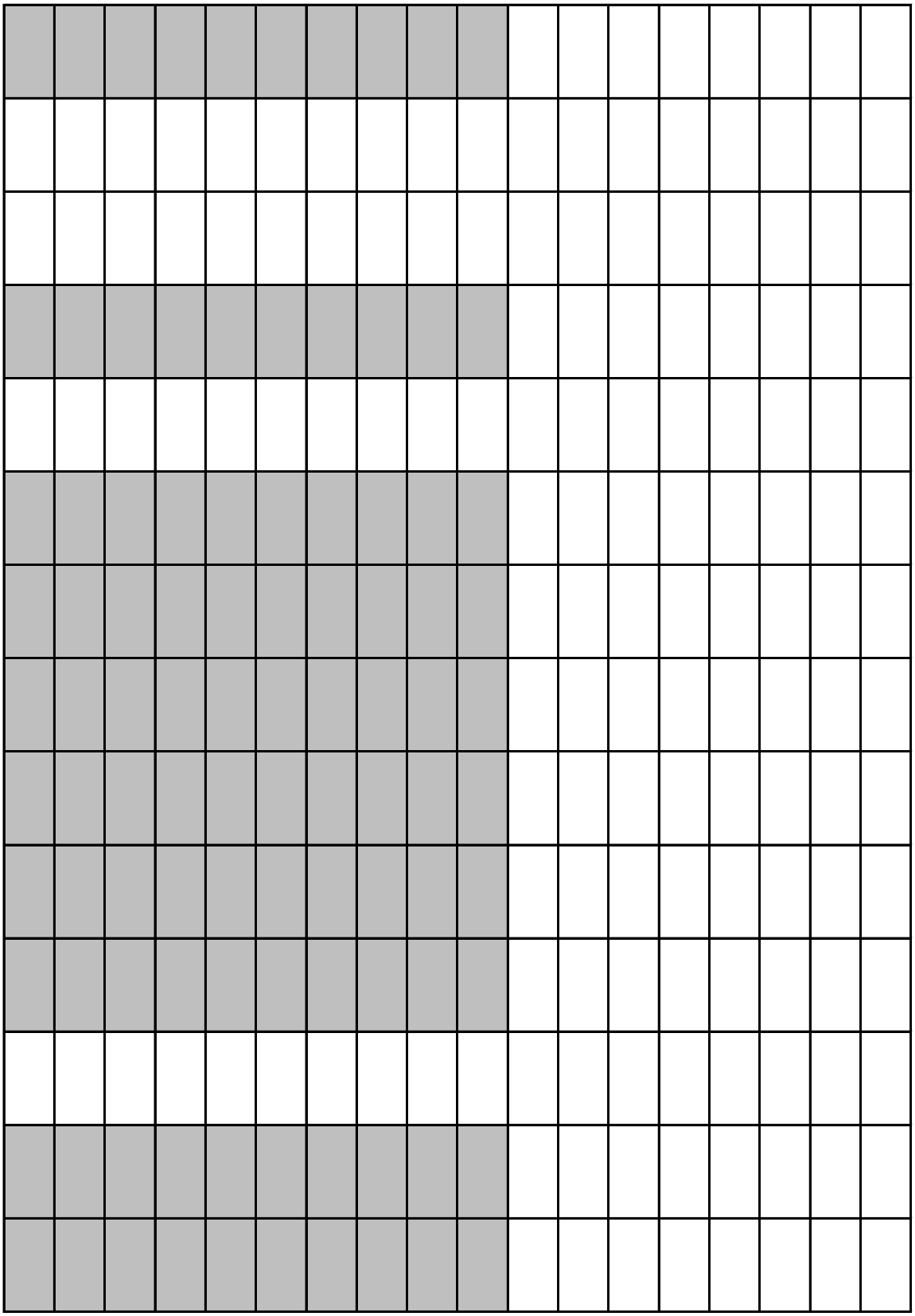

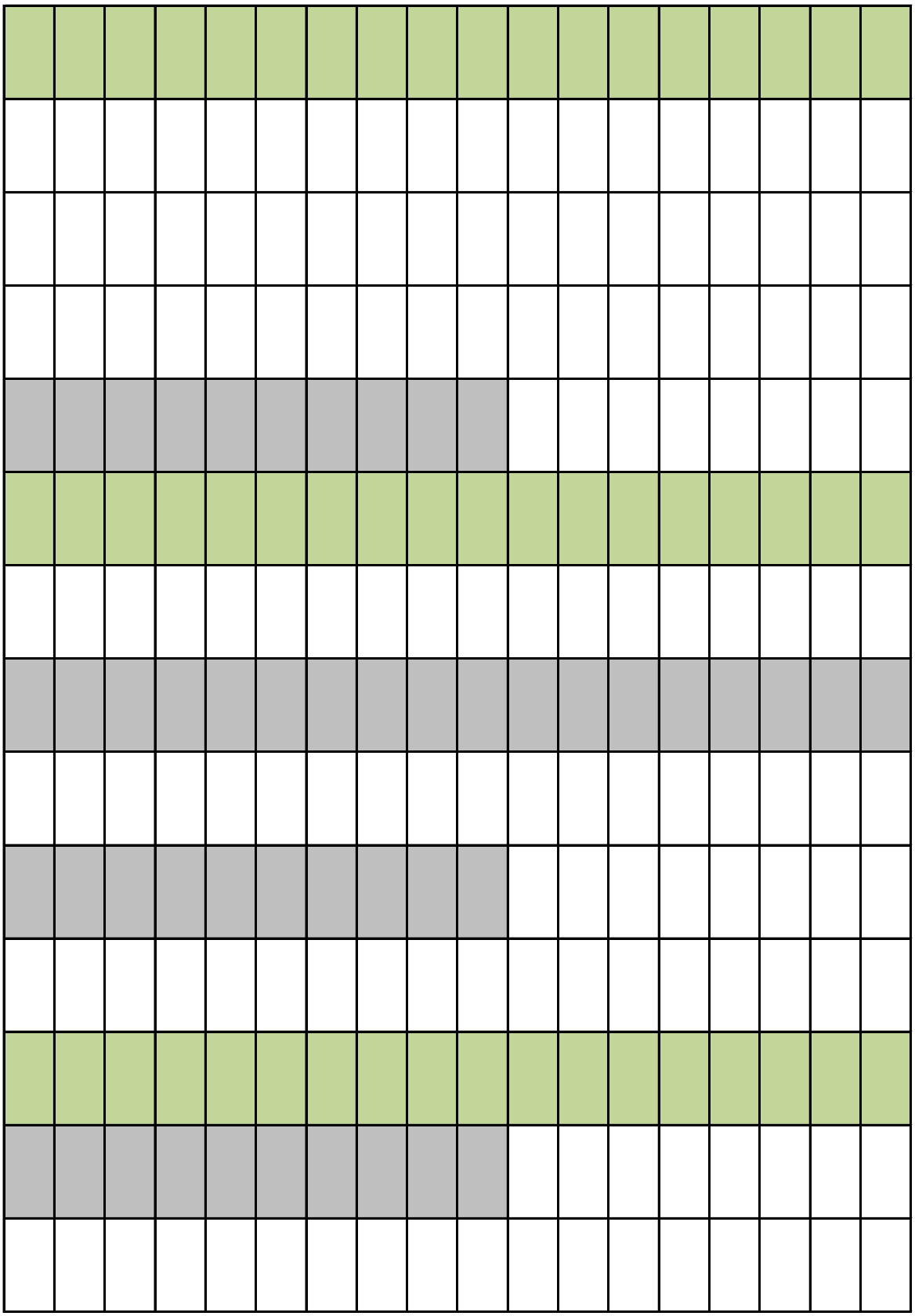

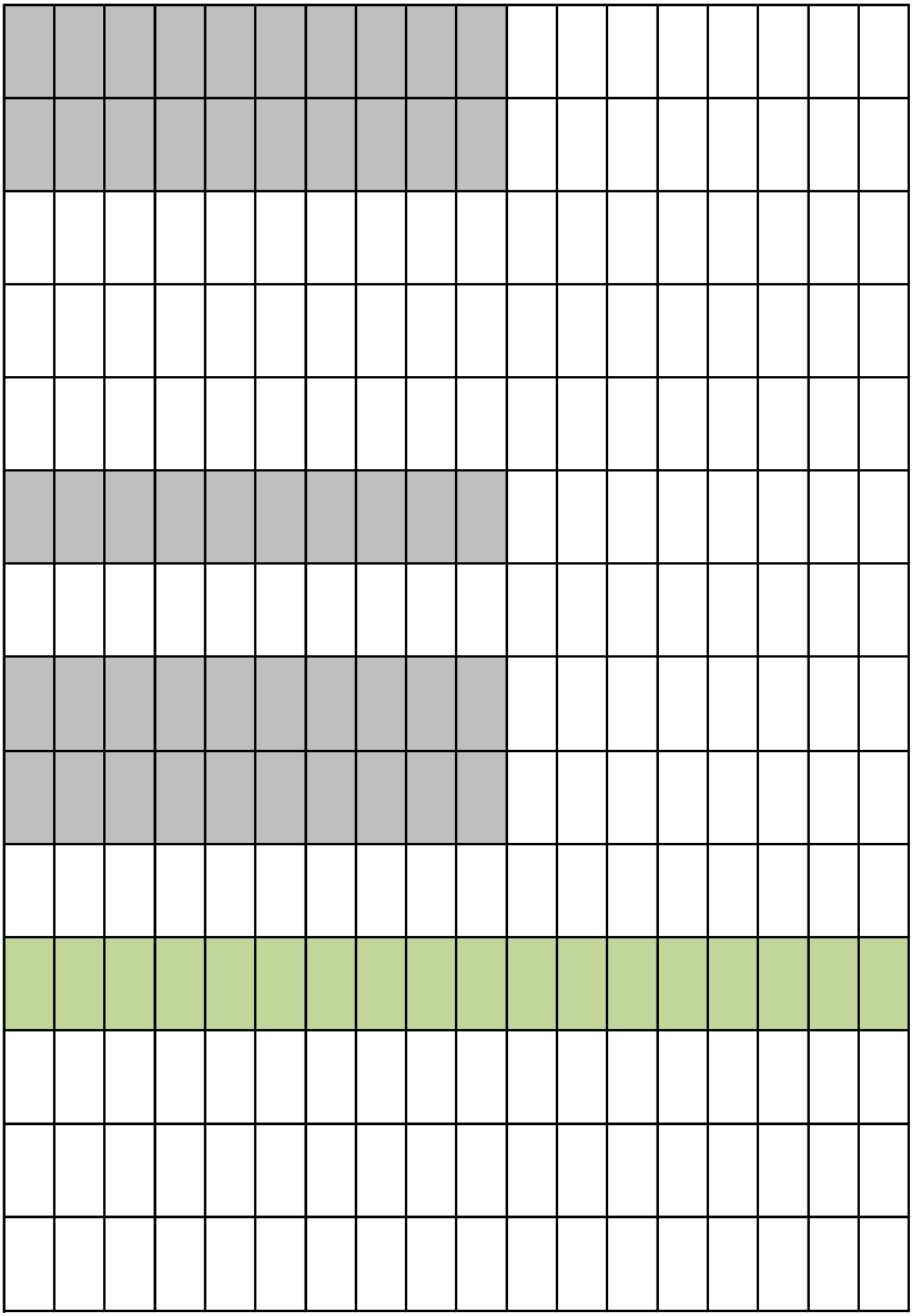

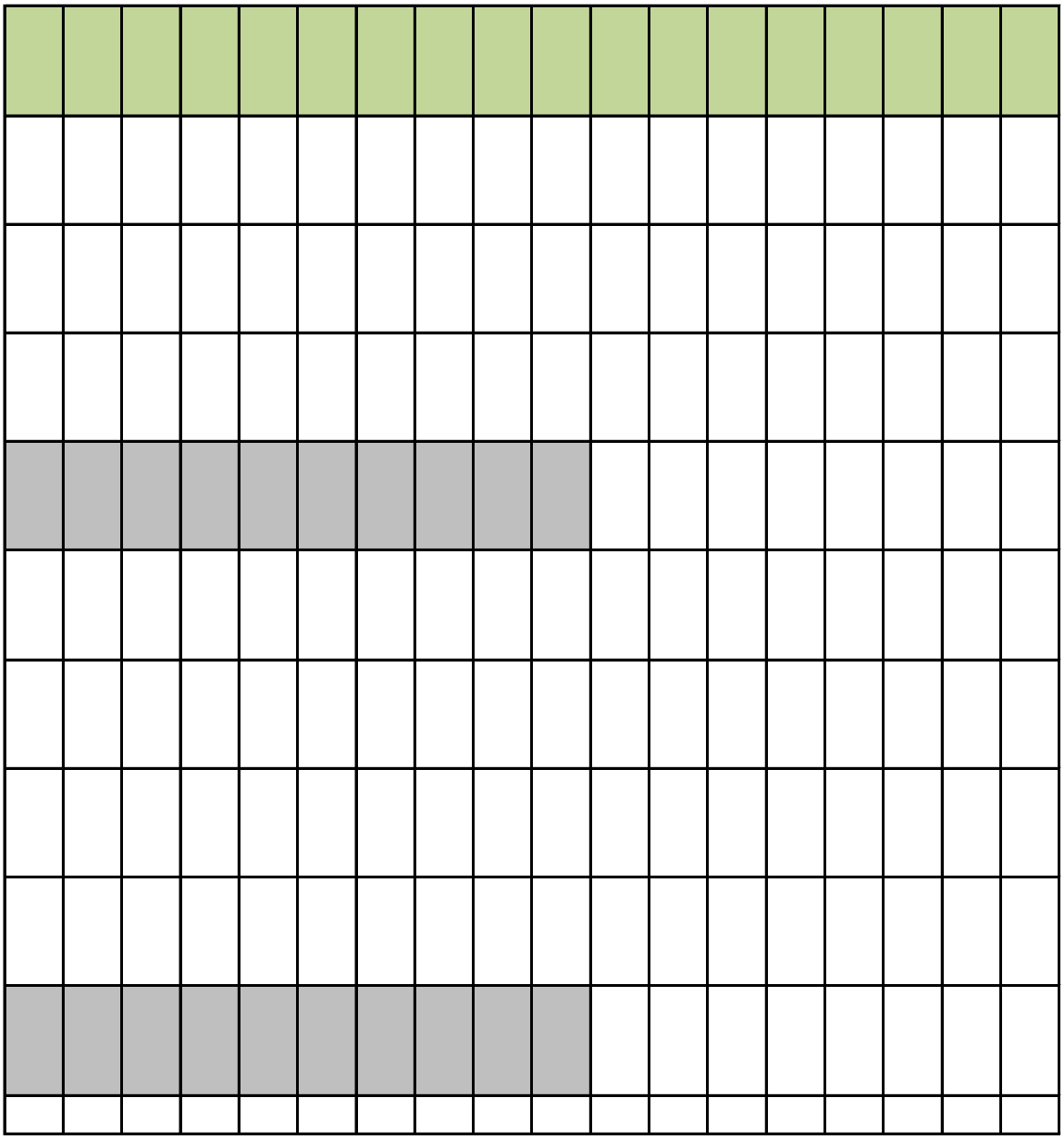

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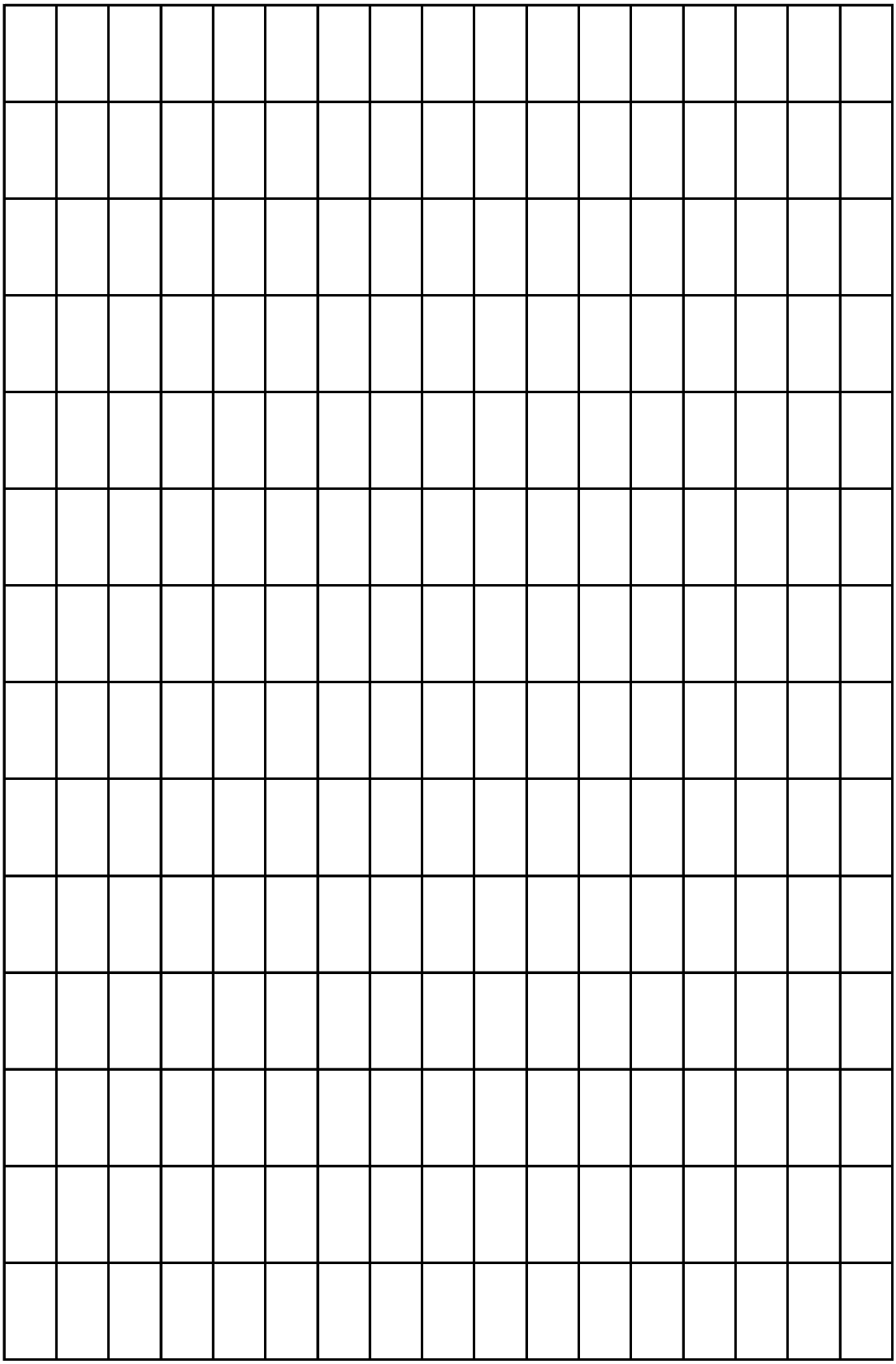
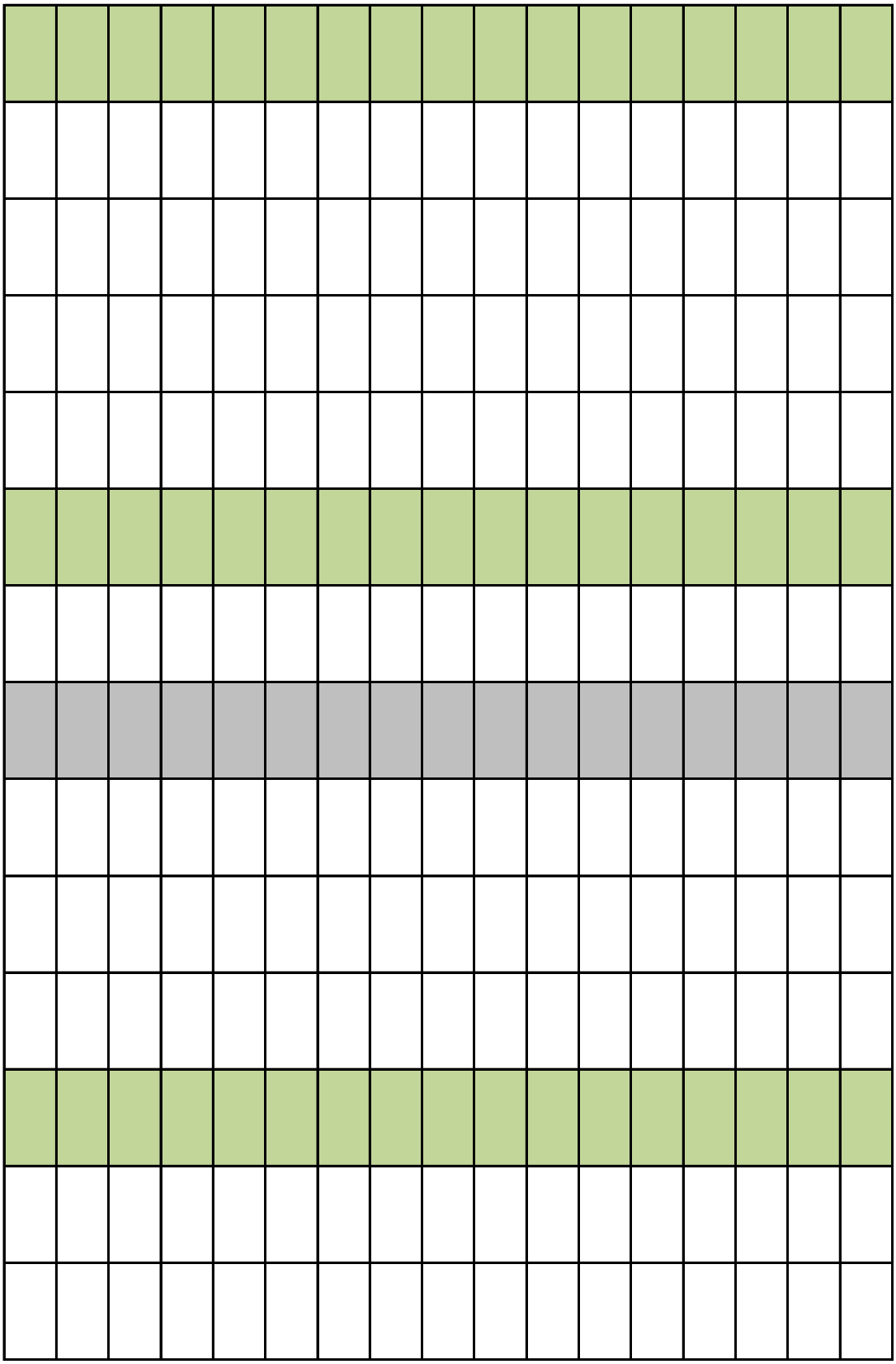
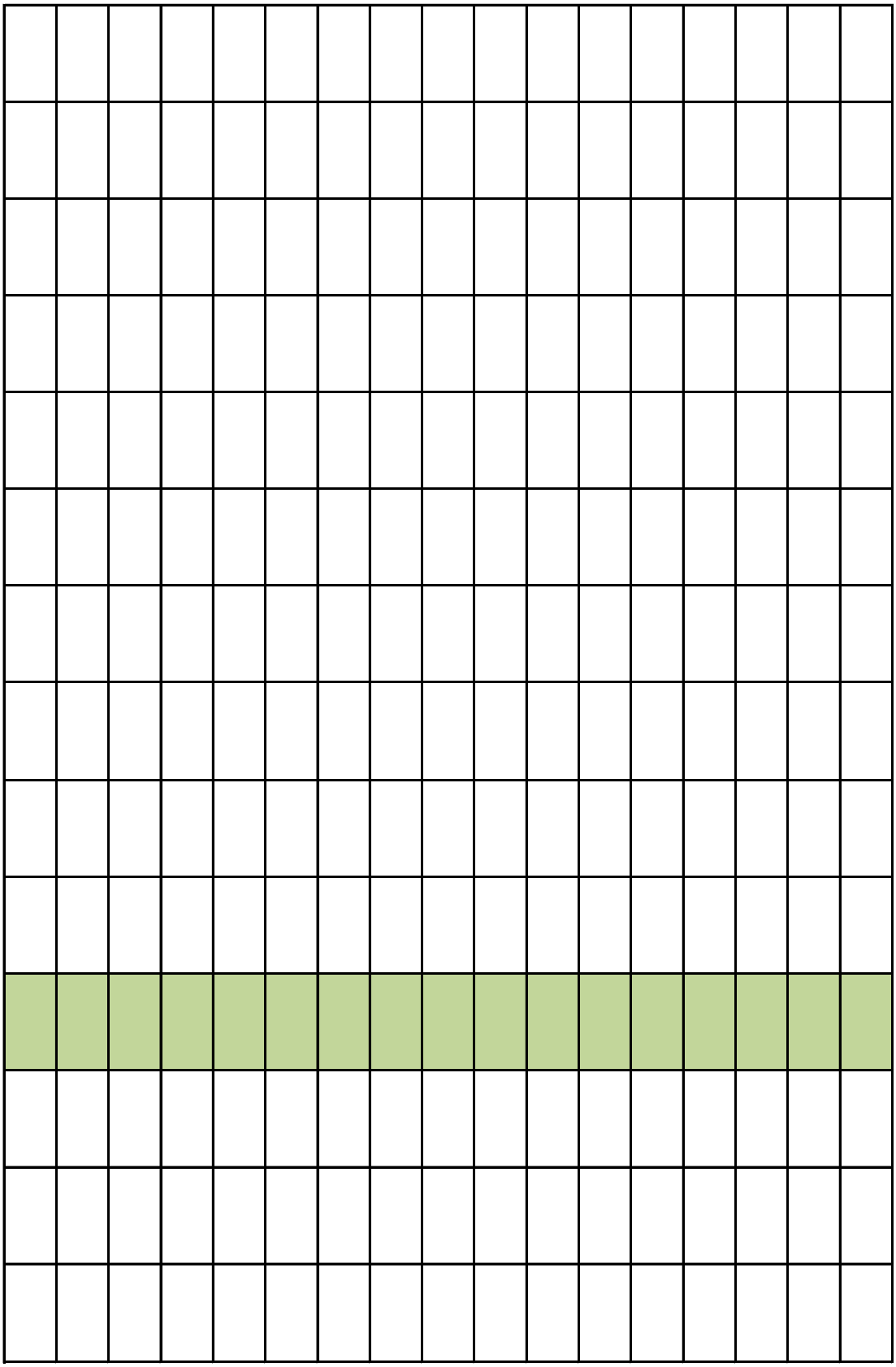
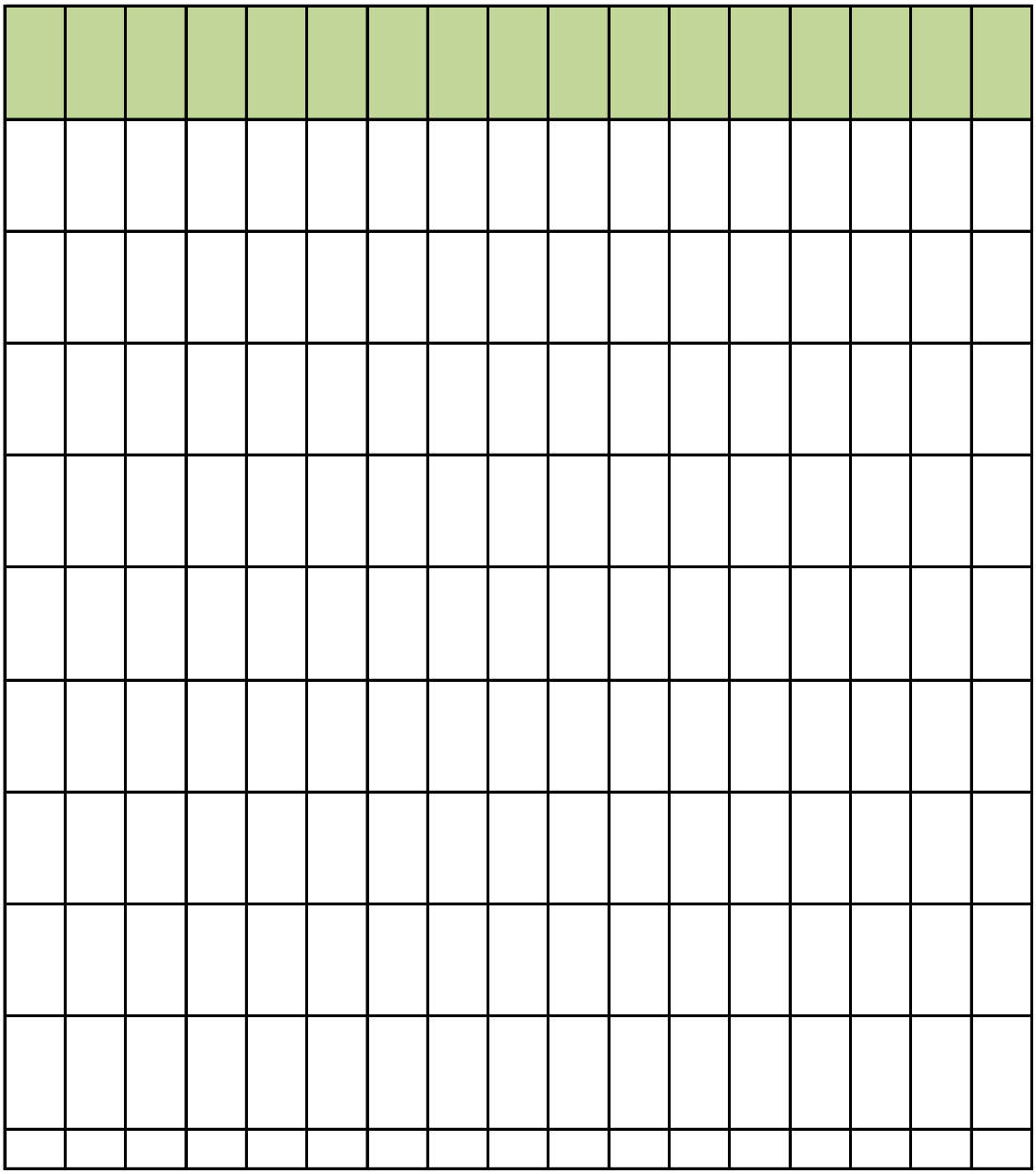








Explanation for slippage/milestones missed

Agenda Number 2016/

Alder Hey Children's NHS
NHS Foundation Trust

Board of Directors

Tuesday 12th January 2016

Report of	External Programme Assurance
Paper prepared by	External Programme Assurance
Subject/Title	Programme Assurance – Update
Purpose of Paper	To: - receive and consider a concise update on the work to define the next phase of the change programme at Alder Hey Children's Foundation Trust. Future monthly reports will cover the progress of the 'mission critical' projects and, by exception, a summary of the 'red rated' projects from amongst the remainder in the programme.
Action/Decision required	The Board is asked to: • consider the contents of the report • respond to the recommendations in the report • advise the Programme Board of directors' concerns or expectations
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivering **clinical excellence** in all of our services. Be a world class centre for children's **Research and Development.** Ensure our staff have the **right skills, competence, motivation and leadership** to deliver our Vision. To provide a **world-class facility** for our work to be made available to children locally, nationally and internationally by delivering our hospital in the park vision.

Alder Hey Children's NHS
NHS Foundation Trust

'a recognised world leader…by 2016'

Programme Assurance Update

1. Purpose

This document provides the Board of Directors with a concise update on the status and progress of the work to define the next phase of the change programme at Alder Hey Children's Foundation Trust. There is one appendix to this report, as follows:

- Appendix A is the 'programme content' showing the revised scope agreed by the Senior Leadership Team (SLT).

The report is the product of the Programme Management Office (PMO) and refers to the programme management standards previously agreed at the Trust Board and Programme Board.

All of the issues raised in the report will be before the Programme Board for action and any requests of the Board of Directors will be made explicit either through this report or direct requests from executives.

2. The Programme Scope

The second half of 2015 saw a number of conversations initiated amongst clinical leaders with the aim of cementing 'quality improvement' at the heart of the future change programme. These discussions culminated in the SLT event at Aintree on 3 Dec 15 where the scope of the next phase of the programme began to take shape. This programme scope – 'what we aim to achieve' – has been subsequently refined in meetings between the Executive Team, Programme Board and PMO.

In the programme scope shown at Appendix A, the five vertical work streams attend to changes in services in so far as they are about staff and patients and how best to promote world class safety, experience and clinical efficiency. The three horizontal work streams concern those programmes which will secure world class supporting systems, services, infrastructure and environment (and are, in that sense, cross-cutting).

The Executive Sponsors for each work stream are now leading the effort to have all thirty-three projects defined in a Project Initiation Document (PID).

3. Governance

The Trust Board is considering evolving the governance arrangements for the next phase of the programme. To that end, the responsibility for the governance and delivery of the work streams might be seen to transfer from the Programme Board

(to be disbanded once this process is complete) to the appropriate sub-Committee of the Board of Directors. If this change to governance is adopted, a suggested addendum to the ToRs will be drafted for those committees to enshrine this potential addition to their function.

Such a document is currently in 'working draft' and subject to further consideration by External Programme Assurance and the Director of Corporate Affairs.

4. Programme Assurance & PMO

It is assumed that the Trust Board will continue to sponsor a programme assurance framework to maintain focus on the 'leading indicators' of project success, as follows:

- Is an effective project team in place?
- Is the scope and approach of the project defined?
- Are the targets / benefits defined / on track?
- Is the milestone plan defined / on track?
- Are the stakeholders engaged?
- Are the risks identified and being managed?
- Is a quality & equality impact assessment underway / complete?

Assuming the assurance framework will continue to rely upon a PMO function, the Board should be cognisant that the 'External Programme Assurance' arrangements cease on 31 Mar 16 and the current budget for the Trust PMO staff expires on 30 Sep 16. Therefore, proposals are now being developed, under the auspices of the Executive Team, to ensure the continuity of the 'programme assurance framework'.

5. Recommendations

It is recommended that the Board of Directors:

- Consider the 'Programme Assurance Update' – 7 Jan 16
- Note the work in hand on the future arrangements for the 'programme assurance framework'

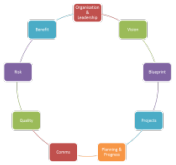
Joe Gibson
External Programme Assurance **7 Jan 16**

Appendices:

A. Next Phase 'Programme Content'

Planning for 16/17 and beyond – Progress

Working Draft v0.6



Change Programme
5 Jan 15

Trust Board

Alder Hey Children's NHS
NHS Foundation Trust

W&OD | R&BD | CQAC | R&BD | CQAC

Programme Assurance through PMO

Workforce Transformation
Melissa Swindell
Programme Steering Group

1. Right skill mix, capacity & capability
2. Staff training & education
3. Securing Engagement

Developing Our Business
Jon Stephens
Programme Steering Group

1. Strategic Partnerships
2. Private & Intnat'l Patients
3. Commercial Research & Education

Hospital Efficiency
Hilda G/Jude A
Programme Steering Group

1. Best Operative Care
2. Improving Outpatients
3. Complex Care Made Simple
4. Improving Flow

Community Services
Therese Patten
Programme Steering Group

1. Developing a Partnership Model for Comm. Services
2. Develop Comm. Serv's CBU to be partner of choice

Innovation
Rick Turnock
Programme Steering Group

1. PET System
2. Innovation Hub
3. New Ideas Scheme
4. Telehealth & Virtual Consulting Room

Developing IM&CT and EPR Jon Stephens and Cathy Fox ***Programme Steering Group*** — R&BD

1. EPR Phase 3 | 2. PACS | 3. 'Badger-net' | 4. Connectivity

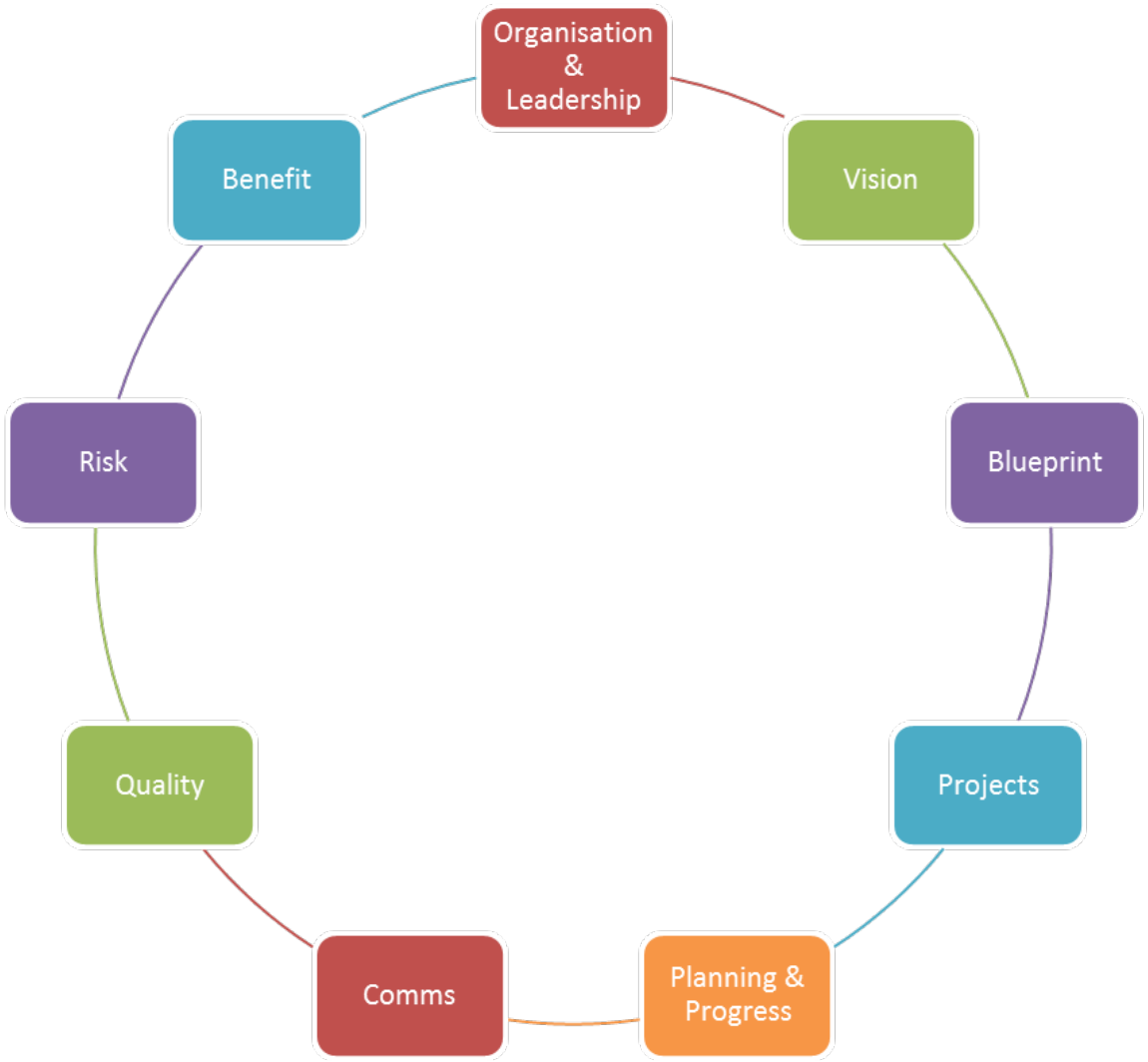
Supporting Front Line Staff Jon Stephens and Claire Liddy ***Programme Steering Group*** — R&BD

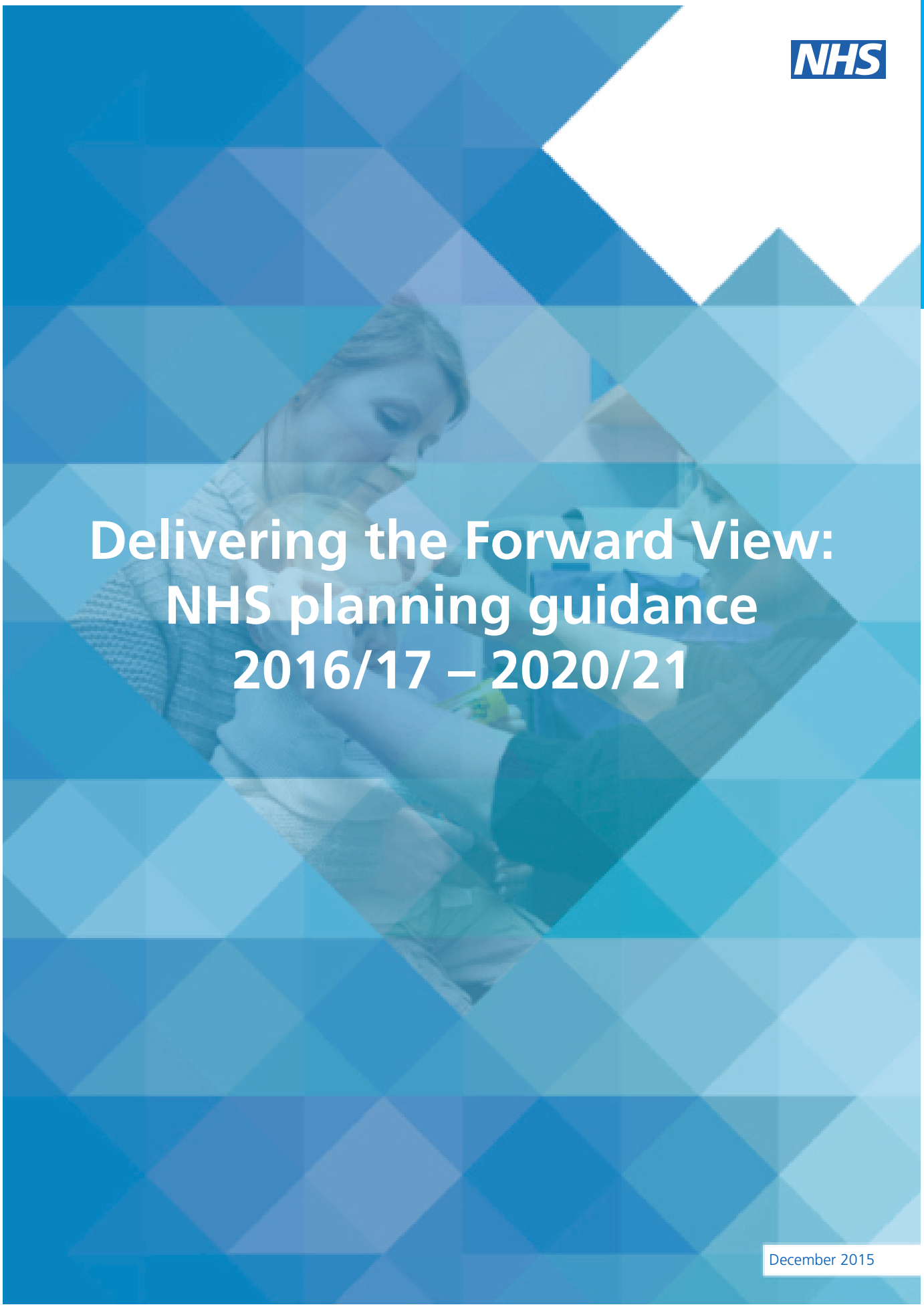
1. Procurement | 2. Coding | 3. Data Capture | 4. Overseas Patients

Park, Community Estate & Facilities David Powell and Sue Brown ***Programme Steering Group*** — R&BD

1. Decommission , Demolition and Park | 2. Interim Moves and Agile Working | 3. R&E and Community | 4. Corporate and On-site Clinical

nine domains of quality change….





Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21

December 2015

Delivering the Forward View: NHS planning guidance

2016/17 – 2020/21

Version number: 1

First published: 22 December 2015

Prepared by: NHS England, NHS Improvement (Monitor and the NHS Trust Development Authority), Care Quality Commission (CQC), Health Education England (HEE), National Institute of Health and Care Excellence (NICE), Public Health England (PHE).

This document is for: Commissioners, NHS trusts and NHS foundation trusts.

Publications Gateway Reference: 04437

The NHS Five Year Forward View sets out a vision for the future of the NHS. It was developed by the partner organisations that deliver and oversee health and care services including:

- NHS England*
- NHS Improvement (Monitor and the NHS Trust Development Authority)
- Health Education England (HEE)
- The National Institute for Health and Care Excellence (NICE)
- Public Health England (PHE)
- Care Quality Commission (CQC)

*The National Health Service Commissioning Board was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the National Health Service Commissioning Board has used the name NHS England for operational purposes.

Introduction

1. The Spending Review provided the NHS in England with a credible basis on which to accomplish three interdependent and essential tasks: first, to implement the Five Year Forward View; second, to restore and maintain financial balance; and third, to deliver core access and quality standards for patients.

2. It included an £8.4 billion real terms increase by 2020/21, front-loaded. With these resources, we now need to close the health and wellbeing gap, the care and quality gap, and the finance and efficiency gap.

3. In this document, authored by the six national NHS bodies, we set out a clear list of national priorities for 2016/17 and longer-term challenges for local systems, together with financial assumptions and business rules. We reflect the settlement reached with the Government through its new Mandate to NHS England (annex 2). For the first time, the Mandate is not solely for the commissioning system, but sets objectives for the NHS as a whole.

4. We are requiring the NHS to produce two separate but connected plans:

   - a five year Sustainability and Transformation Plan (STP), place-based and driving the Five Year Forward View; and
   - a one year Operational Plan for 2016/17, organisation-based but consistent with the emerging STP.

5. The scale of what we need to do in future depends on how well we end the current year. The 2016/17 financial challenge for each trust will be contingent upon its end-of-year financial outturn, and the winter period calls for a relentless focus on maintaining standards in emergency care. It is also the case that local NHS systems will only become sustainable if they accelerate their work on prevention and care redesign. We don't have the luxury of waiting until perfect plans are completed. So we ask local systems, early in the New Year, to go faster on transformation in a few priority areas, as a way of building momentum.

Local health system Sustainability and Transformation Plans

6. We are asking every health and care system to come together, to create its own ambitious local blueprint for accelerating its implementation of the Forward View. STPs will cover the period between October 2016[1] and March 2021, and will be subject to formal assessment in July 2016 following submission in June 2016. We are asking the NHS to spend the next six months delivering core access, quality and financial standards while planning properly for the next five years.

Place-based planning

7. Planning by individual institutions will increasingly be supplemented with planning by place for local populations. For many years now, the NHS has emphasised an organisational separation and autonomy that doesn't make sense to staff or the patients and communities they serve.

8. System leadership is needed. Producing a STP is not just about writing a document, nor is it a job that can be outsourced or delegated. Instead it involves five things: (i) local leaders coming together as a team; (ii) developing a shared vision with the local community, which also involves local government as appropriate; (iii) programming a coherent set of activities to make it happen; (iv) execution against plan; and (v) learning and adapting. Where collaborative and capable leadership can't be found, NHS England and NHS Improvement[2] will need to help secure remedies through more joined-up and effective system oversight.

9. Success also depends on having an open, engaging, and iterative process that harnesses the energies of clinicians, patients, carers, citizens, and local community partners including the independent and voluntary sectors, and local government through health and wellbeing boards.

10. As a truly place-based plan, the STPs must cover all areas of CCG and NHS England commissioned activity including: (i) specialised services, where the planning will be led from the 10 collaborative commissioning hubs; and (ii) primary medical care, and do so from a local CCG perspective, irrespective of delegation arrangements. The STP must also cover better integration with local authority services, including, but not limited to, prevention and social care, reflecting local agreed health and wellbeing strategies.

[1] For the period October 2016 – March 2017, the STP should set out what actions are planned but it does not need to revisit the activity and financial assumptions in the 2016/17 Operational Plan.
[2] NHS Improvement will be the combined provider body, bringing together Monitor and the NHS Trust Development Authority (TDA).

Access to future transformation funding

11. For the first time, the local NHS planning process will have significant central money attached. The STPs will become the single application and approval process for being accepted onto programmes with transformational funding for 2017/18 onwards. This step is intended to reduce bureaucracy and help with the local join-up of multiple national initiatives.

12. The Spending Review provided additional dedicated funding streams for transformational change, building up over the next five years. This protected funding is for initiatives such as the spread of new care models through and beyond the vanguards, primary care access and infrastructure, technology roll-out, and to drive clinical priorities such as diabetes prevention, learning disability, cancer and mental health. Many of these streams of transformation funding form part of the new wider national Sustainability and Transformation Fund (STF). For 2016/17 only, to enable timely allocation, the limited available additional transformation funding will continue to be run through separate processes.

13. The most compelling and credible STPs will secure the earliest additional funding from April 2017 onwards. The process will be iterative. We will consider:

    (i) the quality of plans, particularly the scale of ambition and track record of progress already made. The best plans will have a clear and powerful vision. They will create coherence across different elements, for example a prevention plan; self-care and patient empowerment; workforce; digital; new care models; and finance. They will systematically borrow good practice from other geographies, and adopt national frameworks;

    (ii) the reach and quality of the local process, including community, voluntary sector and local authority engagement;

    (iii) the strength and unity of local system leadership and partnerships, with clear governance structures to deliver them; and

    (iv) how confident we are that a clear sequence of implementation actions will follow as intended, through defined governance and demonstrable capabilities.

Content of STPs

14. The strategic planning process is intended to be developmental and supportive as well as hard-edged. We set out in annex 1 of this document a list of 'national challenges' to help local systems set out their ambitions for their populations. This list of questions includes the objectives set in the Mandate. Do not over-interpret the list as a narrow template for what constitutes a good local plan: the most important initial task is to create a clear overall vision and plan for your area.

15. Local health systems now need to develop their own system wide local financial sustainability plan as part of their STP. Spanning providers and commissioners, these plans will set out the mixture of demand moderation, allocative efficiency, provider productivity, and income generation required for the NHS locally to balance its books.

Agreeing 'transformation footprints'

16. The STP will be the umbrella plan, holding underneath it a number of different specific delivery plans, some of which will necessarily be on different geographical footprints. For example, planning for urgent and emergency care will range across multiple levels: a locality focus for enhanced primary care right through to major trauma centres.

17. The first critical task is for local health and care systems to consider their transformation footprint – the geographic scope of their STP. They must make proposals to us by Friday 29 January 2016, for national agreement. Local authorities should be engaged with these proposals. Taken together, all the transformation footprints must form a complete national map. The scale of the planning task may point to larger rather than smaller footprints.

18. Transformation footprints should be locally defined, based on natural communities, existing working relationships, patient flows and take account of the scale needed to deliver the services, transformation and public health programmes required, and how it best fits with other footprints such as local digital roadmaps and learning disability units of planning. In future years we will be open to simplifying some of these arrangements. Where geographies are already involved in the Success Regime, or devolution bids, we would expect these to determine the transformation footprint. Although it is important to get this right, there is no single right answer. The footprints may well adapt over time. We want people to focus their energies on the content of plans rather than have lengthy debates about boundaries.

19. We will issue further brief guidance on the STP process in January. This will set out the timetable and early phasing of national products and engagement events that are intended to make it much easier to answer the challenges we have posed, and include how local areas can best involve their local communities in creating their STPs, building on the 'six principles' created to support the delivery of the Five Year Forward View. By spring 2016, we intend to develop and make available roadmaps for national transformation initiatives.

20. We would welcome any early reactions, by Friday 29 January 2016, as to what additional material you would find most helpful in developing your STP. Please email england.fiveyearview@nhs.net, with the subject title 'STP feedback'. We would also like to work with a few local systems to develop exemplar, fast-tracked plans, and would welcome expressions of interest to the above inbox.

National 'must dos' for 2016/17

21. Whilst developing long-term plans for 2020/21, the NHS has a clear set of plans and priorities for 2016/17 that reflect the Mandate to the NHS and the next steps on Forward View implementation.

22. Some of our most important jobs for 2016/17 involve partial roll-out rather than full national coverage. Our ambition is that by March 2017, 25 percent of the population will have access to acute hospital services that comply with four priority clinical standards on every day of the week, and 20 percent of the population will have enhanced access to primary care. There are three distinct challenges under the banner of seven day services:

(i) reducing excess deaths by increasing the level of consultant cover and diagnostic services available in hospitals at weekends. During 16/17, a quarter of the country must be offering four of the ten standards, rising to half of the country by 2018 and complete coverage by 2020;

(ii) improving access to out of hours care by achieving better integration and redesign of 111, minor injuries units, urgent care centres and GP out of hours services to enhance the patient offer and flows into hospital; and

(iii) improving access to primary care at weekends and evenings where patients need it by increasing the capacity and resilience of primary care over the next few years.

23. Where relevant, local systems need to reflect this in their 2016/17 Operational Plans, and all areas will need to set out their ambitions for seven day services as part of their STPs.

The nine 'must dos' for 2016/17 for every local system:

1. Develop a high quality and agreed **STP**, and subsequently achieve what you determine are your most locally critical milestones for accelerating progress in 2016/17 towards achieving the triple aim as set out in the **Forward View**.

2. Return the system to **aggregate financial balance**. This includes secondary care providers delivering efficiency savings through actively engaging with the Lord Carter provider productivity work programme and complying with the maximum total agency spend and hourly rates set out by NHS Improvement. CCGs will additionally be expected to deliver savings by tackling unwarranted variation in demand through implementing the RightCare programme in every locality.

3. Develop and implement a local plan to address the **sustainability and quality of general practice**, including workforce and workload issues.

4. Get back on track with **access standards for A&E and ambulance waits**, ensuring more than 95 percent of patients wait no more than four hours in A&E, and that all ambulance trusts respond to 75 percent of Category A calls within eight minutes; including through making progress in implementing the urgent and emergency care review and associated ambulance standard pilots.

5. Improvement against and maintenance of the NHS Constitution standards that more than 92 percent of patients on non-emergency pathways wait no more than 18 weeks from **referral to treatment**, including offering patient choice.

6. Deliver the NHS Constitution **62 day cancer waiting standard**, including by securing adequate diagnostic capacity; continue to deliver the constitutional two week and 31 day cancer standards and make progress in improving **one-year survival rates** by delivering a year-on-year improvement in the proportion of cancers diagnosed at stage one and stage two; and reducing the proportion of cancers diagnosed following an emergency admission.

7. Achieve and maintain the **two new mental health access standards**: more than 50 percent of people experiencing a first episode of psychosis will commence treatment with a NICE approved care package within two weeks of referral; 75 percent of people with common mental health conditions referred to the Improved Access to Psychological Therapies (IAPT) programme will be treated within six weeks of referral, with 95 percent treated within 18 weeks. Continue to meet a **dementia diagnosis** rate of at least two-thirds of the estimated number of people with dementia.

8. Deliver actions set out in local plans to transform care for people with **learning disabilities**, including implementing enhanced community provision, reducing inpatient capacity, and rolling out care and treatment reviews in line with published policy.

9. Develop and implement an affordable plan to make **improvements in quality** particularly for organisations in special measures. In addition, providers are required to participate in the annual publication of **avoidable mortality** rates by individual trusts.

24. We expect the development of new care models will feature prominently within STPs. In addition to existing approaches, in 2016/17 we are interested in trialing two new specific approaches with local volunteers:
    - secondary mental health providers managing care budgets for tertiary mental health services; and
    - the reinvention of the acute medical model in small district general hospitals.

Organisations interested in working with us on either of these approaches should let us know by 29 January 2016 by emailing england.fiveyearview@nhs.net

Operational Plans for 2016/17

25. An early task for local system leaders is to run a shared and open-book operational planning process for 2016/17. This will cover activity, capacity, finance and 2016/17 deliverables from the emerging STP. By April 2016, commissioner and provider plans for 2016/17 will need to be agreed by NHS England and NHS Improvement, based on local contracts that must be signed by March 2016.

26. The detailed requirements for commissioner and provider plans are set out in the technical guidance that will accompany this document. All plans will need to demonstrate:

- how they intend to reconcile finance with activity (and where a deficit exists, set out clear plans to return to balance);
- their planned contribution to the efficiency savings;
- their plans to deliver the key must-dos;
- how quality and safety will be maintained and improved for patients;
- how risks across the local health economy plans have been jointly identified and mitigated through an agreed contingency plan; and
- how they link with and support with local emerging STPs.

The 2016/17 Operational Plan should be regarded as year one of the five year STP, and we expect significant progress on transformation through the 2016/17 Operational Plan.

27. Building credible plans for 2016/17 will rely on a clear understanding of demand and capacity, alignment between commissioners and providers, and the skills to plan effectively. A support programme is being developed jointly by national partners to help local health economies in preparing robust activity plans for 2016/17 and beyond.

Allocations

28. NHS England's allocations to commissioners are intended to achieve:

- greater equity of access through pace of change, both for CCG allocations and on a place-based basis;
- closer alignment with population need through improved allocation formulae including a new inequalities adjustment for specialised care, more sensitive adjustments for CCGs and primary care, and a new sparsity adjustment for remote areas; and
- faster progress with our strategic goals through higher funding growth for GP services and mental health, and the introduction of the Sustainability and Transformation Fund.

29. In line with our strategic priorities, overall primary medical care spend will rise by 4-5 percent each year. Specialised services funding will rise by 7 percent in 2016/17, with growth of at least 4.5 percent in each subsequent year. The relatively high level of funding reflects forecast pressures from new NICE legally mandated drugs and treatments.

30. To support long-term planning, NHS England has set firm three year allocations for CCGs, followed by two indicative years. For 2016/17, CCG allocations will rise by an average of 3.4 percent, and we will make good on our commitment that no CCG will be more than 5 percent below its target funding level. To provide CCGs with a total place-based understanding of all commissioned spend, alongside allocations for CCG commissioned activities, we will also publish allocations for primary care and specialized commissioned activity.

    NHS England will in principle support any proposals from groups of CCGs, particularly in areas working towards devolution who wish to implement a more accelerated cross-area pace-of-change policy by mutual agreement.

31. Mirroring the conditionality of providers accessing the Sustainability and Transformation Fund, the real terms element of growth in CCG allocations for 2017/18 onwards will be contingent upon the development and sign off of a robust STP during 2016/17.

Returning the NHS provider sector to balance

32. During 2016/17 the NHS trust and foundation trust sector will, in aggregate, be required to return to financial balance. £1.8 billion of income from the 2016/17 Sustainability and Transformation Fund will replace direct Department of Health (DH) funding. The distribution of this funding will be calculated on a trust by trust basis by NHS Improvement and then agreed with NHS England.

33. NHS England and NHS Improvement are working together to ensure greater alignment between commissioner and provider financial levers. Providers who are eligible for sustainability and transformation funding in 2016/17 will not face a double jeopardy scenario whereby they incur penalties as well as losing access to funding; a single penalty will be imposed.

34. Quarterly release of these Sustainability Funds to trusts and foundation trusts will depend on achieving recovery milestones for (i) deficit reduction; (ii) access standards; and (iii) progress on transformation. The three conditions attached to the transitional NHS provider fund have to be hard-edged. Where trusts default on the conditions access to the fund will be denied and sanctions will be applied.

35. Deficit reduction in providers will require a forensic examination of every pound spent on delivering healthcare and embedding a culture of relentless cost containment. Trusts need to focus on cost reduction not income growth; there needs to be far greater consistency between trusts' financial plans and their workforce plans in 2016/17. Workforce productivity will therefore be a particular priority as just a 1 percent improvement represents £400 million of savings. All providers will be expected to evidence the effective use of e-rostering for nurses, midwives, Health Care Assistants (HCAs) and other clinicians to make sure the right staff are in the right place at the right time to ensure patients get the right hours of care and minimum time is wasted on bureaucracy. This approach will enable providers to reduce their reliance on agency staffing whilst compliance with the agency staffing rules will also reduce the rates paid. In addition, providers will need to adopt tightly controlled procurement practices with compliance incentives and sanctions to drive down price and unwarranted variation. For example, all providers will be expected to report and share data on what they are paying for the top 100 most common non-pay items, and be required to only pay the best price available for the NHS.

36. Capital investments proposed by providers should be consistent with their clinical strategy and clearly demonstrate the delivery of safe, productive services with a business case that describes affordability and value for money. Given the constrained level of capital resource available from 2016/17, there will be very limited levels of financing available and the repayment of existing and new borrowing related to capital investment will need to be funded from within the trust's own internally generated capital resource in all but the most exceptionally pre-agreed cases. Trusts will need to procure capital assets more efficiently, consider alternative methods of securing assets such as managed equipment services, maximize disposals and extend asset lives. In January, the DH will be issuing some revisions to how the PDC dividend will be calculated and a number of other changes to the capital financing regime.

Efficiency assumptions and business rules

37. The consultation on the tariff will propose a 2 percent efficiency deflator and 3.1 percent inflation uplift for 2016/17 (the latter reflecting a step change in pension-related costs). This reflects Monitor and NHS England's assessment of cost inflation including the effect of pension changes. To support system stability, we plan to remain on HRG4 for a further year and there will also be no changes to specialist top- ups in 2016/17; the specialised service risk share is also being suspended for 2016/17. We will work with stakeholders to better understand the impact of the move to HRG4+ and other related changes in 2017/18. For planning purposes, an indicative price list is being made available on the Monitor website. The consultation on the tariff will also include the timetable for implementing new payment approaches for mental health.

38. As notified in Commissioning Intentions 2016/2017 for Prescribed Specialised Services, NHS England is developing a single national purchasing and supply chain arrangement for specialised commissioning high cost tariff excluded devices with effect from April 2016. Transition plans will be put in place prior to this date with each provider to transition from local to national procurement arrangements.

39. The 2 percent efficiency requirement is predicated upon the provider system meeting a forecast deficit of £1.8 billion at the end of 2015/16. Any further deterioration of this position will require the relevant providers to deliver higher efficiency levels to achieve the control totals to be set by NHS Improvement.

40. For 2016/17 the business rules for commissioners will remain similar to those for last year. Commissioners (excluding public health and specialised commissioning) will be required to deliver a cumulative reserve (surplus) of 1 percent. At the very least, commissioners who are unable to meet the cumulative reserve (surplus) requirement must deliver an in-year break-even position. Commissioners with a cumulative deficit will be expected to apply their increase in allocation to improving their bottom line position, other than the amount necessary to fund nationally recognised new policy requirements. Drawdown will be available to commissioners in line with the process for the previous financial year. CCGs should plan to drawdown all cumulative surpluses in excess of 1 percent over the next three years, enabling drawdown to become a more fluid mechanism for managing financial pressures across the year-end boundary.

41. Commissioners are required to plan to spend 1 percent of their allocations non-recurrently, consistent with previous years. In order to provide funds to insulate the health economy from financial risks, the 1 percent non-recurrent expenditure should be uncommitted at the start of the year, to enable progressive release in agreement with NHS England as evidence emerges of risks not arising or being effectively mitigated through other means. Commissioners will also be required to hold an additional contingency of 0.5 percent, again consistent with previous years.

42. CCGs and councils will need to agree a joint plan to deliver the requirements of the Better Care Fund (BCF) in 2016/17. The plan should build on the 2015/16 BCF plan, taking account of what has worked well in meeting the objectives of the fund, and what has not. CCGs will be advised of the minimum amount that they are required to pool as part of the notification of their wider allocation. BCF funding should explicitly support reductions in unplanned admissions and hospital delayed transfers of care; further guidance on the BCF will be forthcoming in the New Year.

43. Commissioners must continue to increase investment in mental health services each year at a level which at least matches their overall expenditure increase. Where CCGs collaborate with specialised commissioning to improve service efficiency, they will be eligible for a share of the benefits.

44. NHS England and NHS Improvement continue to be open to new approaches to contracting and business rules, as part of these agreements. For example, we are willing to explore applying a single financial control total across local commissioners and providers with a few local systems.

Measuring progress

45. We will measure progress through a new CCG Assessment Framework. NHS England will consult on this in January 2016, and it will be aligned with this planning guidance. The framework is referred in the Mandate as a CCG scorecard. It is our new version of the CCG assurance framework, and it will apply from 2016/17. Its relevance reaches beyond CCGs, because it's about how local health and care systems and communities can assess their own progress.

Timetable

Timetable	Date
Publish planning guidance	22 December 2015
Publish 2016/17 indicative prices	By 22 December 2015
Issue commissioner allocations, and technical annexes to planning guidance	Early January 2016
Launch consultation on standard contract, announce CQUIN and Quality Premium	January 2016
Issue further process guidance on STPs	January 2016
Localities to submit proposals for STP footprints and volunteers for mental health and small DGHs trials	By 29 January 2016
First submission of full draft 16/17 Operational Plans	8 February 2016
National Tariff S118 consultation	January/February 2016
Publish National Tariff	March 2016
Boards of providers and commissioners approve budgets and final plans	By 31 March 2016
National deadline for signing of contracts	31 March 2016
Submission of final 16/17 Operational Plans, aligned with contracts	11 April 2016
Submission of full STPs	End June 2016
Assessment and Review of STPs	End July 2016

Please note that we will announce the timetable for consultation and issuing of the standard contract separately. A more detailed timetable and milestones is included in the technical guidance that will accompany this document.

Annex 1: Indicative 'national challenges' for STPs

STPs are about the holistic pursuit of the triple aim – better health, transformed quality of care delivery, and sustainable finances. They also need to set out how local systems will play their part in delivering the Mandate (annex 2).

We will publish further guidance early in 2016 to help areas construct the strongest possible process and plan.

We will also make available aids (e.g. exemplar plans) and some hands-on support for areas as they develop their plans.

The questions below give an early sense of what you will need to address to gain sign-off and attract additional national investment.

We are asking local systems first to focus on creating an overall local vision, and the three overarching questions – rather than attempting to answer all of the specifics right from the start. We will be developing a process to offer feedback on these first, prior to development of the first draft of the detailed plans.

A. How will you close the health and wellbeing gap?

This section should include your plans for a 'radical upgrade' in prevention, patient activation, choice and control, and community engagement.

Questions your plan should answer:

1. How will you assess and address your most important and highest cost preventable causes of ill health, to reduce healthcare demand and tackle health inequalities working closely with local government?

    - How rapidly could you achieve full local implementation of the national Diabetes Prevention Programme? Why should Public Health England (PHE) and NHS England prioritise your geographical area (e.g. with national funding to support the programme)?

    - What action will you take to address obesity, including childhood obesity?

    - How will you achieve a step-change in patient activation and self-care? How will this help you moderate demand and achieve financial balance? How will you embed the six principles of engagement and involvement of local patients, carers, and communities developed to help deliver the Five Year Forward View?

2. How will you make real the aspiration to design person-centred coordinated care, including plans to ensure patients have access to named, accountable consultants?

3. How will a major expansion of integrated personal health budgets and implementation of choice – particularly in maternity, end-of-life and elective care – be an integral part of your programme to hand power to patients?

4. How are NHS and other employers in your area going to improve the health of their own workforce – for example by participating in the national roll out the Healthy NHS programme?

B. How will you drive transformation to close the care and quality gap?

This section should include plans for new care model development, improving against clinical priorities, and rollout of digital healthcare.

Questions your plan should answer:

1 What is your plan for sustainable general practice and wider primary care? How will you improve primary care infrastructure, supported in part through access to national primary care transformation funding?

2. How rapidly can you implement enhanced access to primary care in evenings and weekends and using technology? Why should NHS England prioritise your area for additional funding?

3. What are your plans to adopt new models of out-of-hospital care, e.g Multi-specialty Community Providers (MCPs) or Primary and Acute Care Systems (PACS)? Why should NHS England prioritise your area for transformation funding? And when are you planning to adopt forthcoming best practice from the enhanced health in care homes vanguards?

4. How will you adopt new models of acute care collaboration (accountable clinical networks, specialty franchises, and Foundation Groups)? How will you work with organisations outside your area and learn from best practice from abroad, other sectors and industry?

5. What is your plan for transforming urgent and emergency care in your area? How will you simplify the current confusing array of entry points? What's your agreed recovery plan to achieve and maintain A&E and ambulance access standards?

6. What's your plan to maintain the elective care referral to treatment standard? Are you buying sufficient activity, tackling unwarranted variation in demand, proactively offering patient choice of alternatives, and increasing provider productivity?

7. How will you deliver a transformation in cancer prevention, diagnosis, treatment and aftercare in line with the cancer taskforce report?

8. How will you improve mental health services, in line with the forthcoming mental health taskforce report, to ensure measureable progress towards parity of esteem for mental health?

9. What steps will your local area take to improve dementia services?

10. As part of the Transforming Care programme, how will your area ensure that people with learning disabilities are, wherever possible, supported at home rather than in hospital? How far are you closing out-moded inpatient beds and reinvesting in continuing learning disability support

11. How fast are you aspiring to improve the quality of care and safety in your organisations as judged by the Care Quality Commission (CQC)? What is your trajectory for no NHS trust and no GP practice to have an overall inadequate rating from the Care Quality Commission (CQC)?

12. What are you doing to embed an open, learning and safety culture locally that is ambitious enough? What steps are you taking to improving reporting, investigations and supporting patients, their families and carers, as well as staff who have been involved in an incident?

13. What plans do you have in place to reduce antimicrobial resistance and ensure responsible prescribing of antibiotics in all care settings? How are you supporting prescribers to enable them issue the right drugs responsibly? At the same time, how rapidly will you achieve full implementation of good practice in reducing avoidable mortality from sepsis?

14. How will you achieve by 2020 the full-roll out of seven day services for the four priority clinical standards?

15. How will you implement the forthcoming national maternity review, including progress towards new national ambitions for improving safety and increased personalisation and choice?

16. How will you put your Children and Young People Mental Health Plan into practice?

17. How quickly will you implement your local digital roadmap, taking the steps needed to deliver a fully interoperable health and care system by 2020 that is paper-free at the point of care? How will you make sure that every patient has access to digital health records that they can share with their families, carers and clinical teams? How will you increase your online offer to patients beyond repeat prescriptions and GP appointments?

18. What is your plan to develop, retrain and retain a workforce with the right skills, values and behaviours in sufficient numbers and in the right locations to deliver your vision for transformed care? How will you build the multidisciplinary teams to underpin new models of care? How ambitious are your plans to implement new workforce roles such as associate nurses, physician associates, community paramedics and pharmacists in general practice?

19. What is your plan to improve commissioning? How rapidly will the CCGs in your system move to place-based commissioning? If you are a devolution area, how will implementation delivery real improvements for patients?

20. How will your system be at the forefront of science, research and innovation? How are you implementing combinatorial innovation, learning from the forthcoming test bed programme? How will services changes over the next five years embrace breakthroughs in genomics, precision medicine and diagnostics?

C. How will you close the finance and efficiency gap?

This section should describe how you will achieve financial balance across your local health system and improve the efficiency of NHS services.

Questions your plan should answer:

1. How will you deliver the necessary per annum efficiency across the total NHS funding base in your local area by 2020/21?

2. What is your comprehensive and credible plan to moderate demand growth? What are the respective contributions in your local system of: (i) tackling unwarranted variation in care utilisation, e.g. through RightCare; (ii) patient activation and self-care; (iii) new models of care; and (iv) urgent and emergency care reform implementation?

3. How will you reduce costs (as opposed to growing income) and how will you get the most out of your existing workforce? What savings will you make from financial controls on agency, whilst ensuring appropriate staffing levels? What are your plans for improving workforce productivity, e.g. through e-rostering of nurses and HCAs? How are you planning to reduce cost through better purchasing and medicines management? What efficiency improvements are you planning to make across primary care and specialised care delivery?

4. What capital investments do you plan to unlock additional efficiency? How will they be affordable and how will they be financed?

5. What actions will you take as a system to utilise NHS estate better, disposing of unneeded assets or monetising those that could create longer-term income streams? How does this local system estates plan support the plans you're taking to redesign care models in your area?

Annex 2: The Government's mandate to NHS England 2016/17

The table below shows NHS England's objectives with an overall measurable goal for this Parliament and clear priority deliverables for 2016-17. The majority of these goals will be achieved in partnership with the Department of Health (DH), NHS Improvement and other health bodies such as Public Health England (PHE), Health Education England (HEE) and the Care Quality Commission (CQC). It also sets out requirements for NHS England to comply with in paragraph 6.2.

Read the full Mandate to NHS England

1. Through better commissioning, improve local and national health outcomes, particularly by addressing poor outcomes and inequalities.	
1.1 CCG performance	**Overall 2020 goals:** • Consistent improvement in performance of CCGs against new CCG assessment framework.
	2016-17 deliverables: • By June, publish results of the CCG assessment framework for 2015-16, which provides CCGs with an aggregated Ofsted style assessment of performance and allows them to benchmark against other CCGs and informs whether NHS England intervention is needed. • Ensure new Ofsted-style CCG framework for 2016-17 includes health economy metrics to measure progress on priorities set out in the mandate and the NHS planning guidance including overall Ofsted-style assessment for each of cancer, dementia, maternity, mental health, learning disabilities and diabetes, as well as metrics on efficiency, core performance, technology and prevention. • By the end of Q1 of 2016-17, publish the first overall assessment for each of the six clinical areas above.

2. To help create the safest, highest quality health and care service.	
2.1 Avoidable deaths and seven-day services	**Overall 2020 goals:** • Roll out of seven-day services in hospital to 100 percent of the population (four priority clinical standards in all relevant specialities, with progress also made on the other six standards), so that patients receive the same standards of care, seven days a week. • Achieve a significant reduction in avoidable deaths, with all trusts to have seen measurable reduction from their baseline on the basis of annual measurements. • Support NHS Improvement to significantly increase the number of trusts rated outstanding or good, including significantly reducing the length of time trusts remain in special measures. • Measurable progress towards reducing the rate of stillbirths, neonatal and maternal deaths and brain injuries that are caused during or soon after birth by 50 percent by 2030 with a measurable reduction by 2020. • Support the NHS to be the world's largest learning organisation with a new culture of learning from clinical mistakes, including improving the number of staff who feel their organisation acts on concerns raised by clinical staff or patients. • Measurable improvement in antimicrobial prescribing and resistance rates.
	2016-17 deliverables: • Publish avoidable deaths per trust annually and support NHS Improvement to help trusts to implement programme to improve from March 2016 baseline. • Rollout of four clinical priority standards in all relevant specialties to 25 percent of population. • Implement agreed recommendations of the National Maternity Review in relation to safety, and support progress on delivering Sign up to Safety. • Support the Government's goal to establish global and UK baseline and ambition for antimicrobial prescribing and resistance rates.

2.2 Patient experience	**Overall 2020 goals**: • Maintain and increase the number of people recommending services in the Friends and Family Test (FFT) (currently 88-96 percent), and ensure its effectiveness, alongside other sources of feedback to improve services. • 50-100,000 people to have a personal health budget or integrated personal budget (up from current estimate of 4,000). • Significantly improve patient choice, including in maternity, end-of-life care and for people with long-term conditions, including ensuring an increase in the number of people able to die in the place of their choice, including at home.
	2016-17 deliverables: • Produce a plan with specific milestones for improving patient choice by 2020, particularly in maternity, end-of-life care (including to ensure more people are able to achieve their preferred place of care and death), and personal health budgets. • Building on the FFT, develop proposals about how feedback, particularly in maternity services, could be enhanced to drive improvements to services at clinical and ward levels.
2.3 Cancer	**Overall 2020 goals:** • Deliver recommendations of the Independent Cancer Taskforce, including: o significantly improving one-year survival to achieve 75 percent by 2020 for all cancers combined (up from 69 percent currently); and o patients given definitive cancer diagnosis, or all clear, within 28 days of being referred by a GP.
	2016-17 deliverables: • Achieve 62-day cancer waiting time standard. • Support NHS Improvement to achieve measurable progress towards the national diagnostic standard of patients waiting no more than six weeks from referral to test. • Agree trajectory for increases in diagnostic capacity required to 2020 and achieve it for year one. • Invest £340 million in providing cancer treatments not routinely provided on the NHS through the Cancer Drugs Fund, and ensure effective transition to the agreed operating model to improve its effectiveness within its existing budget.

3. To balance the NHS budget and improve efficiency and productivity	
3.1 Balancing the NHS budget	**Overall 2020 goals**: • With NHS Improvement, ensure the NHS balances its budget in each financial year. • With the Department of Health and NHS Improvement, achieve year on year improvements in NHS efficiency and productivity (2-3 percent each year), including from reducing growth in activity and maximising cost recovery.
	2016-17 deliverables: • With NHS Improvement ensure the NHS balances its budget, with commissioners and providers living within their budgets, and support NHS Improvement in: o securing £1.3 billion of efficiency savings through implementing Lord Carter's recommendations and collaborating with local authorities on Continuing Healthcare spending; o delivering year one of trust deficit reduction plans and ensuring a balanced financial position across the trust sector, supported by effective deployment of the Sustainability and Transformation Fund; and o reducing spend on agency staff by at least £0.8 billion on a path to further reductions over the Parliament. • Roll-out of second cohort of RightCare methodology to a further 60 CCGs. • Measurable improvement in primary care productivity, including through supporting community pharmacy reform. • Work with CCGs to support Government's goal to increase NHS cost recovery up to £500 million by 2017-18 from overseas patients. • Ensure CCGs' local estates strategies support the overall goal of releasing £2 billion and land for 26,000 homes by 2020.

4. To lead a step change in the NHS in preventing ill health and supporting people to live healthier lives.	
4.1 Obesity and diabetes	**Overall 2020 goals:** • Measurable reduction in child obesity as part of the Government's childhood obesity strategy. • 100,000 people supported to reduce their risk of diabetes through the Diabetes Prevention Programme. • Measurable reduction in variation in management and care for people with diabetes.
	2016-17 deliverables: • Contribute to the agreed child obesity implementation plan, including wider action to achieve year on year improvement trajectory for the percentage of children who are overweight or obese. • 10,000 people referred to the Diabetes Prevention Programme.
4.2 Dementia	**Overall 2020 goals:** • Measurable improvement on all areas of Prime Minister's challenge on dementia 2020, including: o maintain a diagnosis rate of at least two thirds; o increase the numbers of people receiving a dementia diagnosis within six weeks of a GP referral; and o improve quality of post-diagnosis treatment and support for people with dementia and their carers.
	2016-17 deliverables: • Maintain a minimum of two thirds diagnosis rates for people with dementia. • Work with National Institute for Health Research on location of Dementia Institute. • Agree an affordable implementation plan for the Prime Minister's challenge on dementia 2020, including to improve the quality of post-diagnosis treatment and support.

5. To maintain and improve performance against core standards	
5.1 A&E, ambulances and Referral to Treatment (RTT)	**Overall 2020 goals:** • 95 percent of people attending A&E seen within four hours; Urgent and Emergency Care Networks rolled out to 100 percent of the population. • 75 percent of Category A ambulance calls responded to within 8 minutes. • 92 percent receive first treatment within 18 weeks of referral; no-one waits more than 52 weeks.
	2016-17 deliverables: • With NHS Improvement, agree improvement trajectory and deliver the plan for year one for A&E. • Implement Urgent and Emergency Care Networks in 20 percent of the country designated as transformation areas, including clear steps towards a single point of contact. • With NHS Improvement, agree improvement trajectory and deliver the plan for year one for ambulance responses; complete Red 2 pilots and decide on full roll-out. • With NHS Improvement, meet the 18-week referral-to-treatment standard, including implementing patient choice in line with the NHS Constitution; and reduce unwarranted variation between CCG referral rates to better manage demand.
6. To improve out-of-hospital care.	
6.1 New models of care and general practice	**Overall 2020 goals:** • 100 percent of population has access to weekend/evening routine GP appointments. • Measurable reduction in age standardised emergency admission rates and emergency inpatient bed-day rates; more significant reductions through the New Care Model programme covering at least 50 percent of population. • Significant measurable progress in health and social care integration, urgent and emergency care (including ensuring a single point of contact), and electronic health record sharing, in areas covered by the New Care Model programme. • 5,000 extra doctors in general practice.

	2016-17 deliverables: • New models of care covering the 20 percent of the population designated as being in a transformation area to: o provide access to enhanced GP services, including evening and weekend access and same-day GP appointments for all over 75s who need them; and o make progress on integration of health and social care, integrated urgent and emergency care, and electronic record sharing. • Publish practice-level metrics on quality of and access to GP services and, with the Health and Social Care Information Centre, provide GPs with benchmarking information for named patient lists. • Develop new voluntary contract for GPs (Multidisciplinary Community Provider contract) ready for implementation in 2017-18.
6.2 Health and social care integration	**Overall 2020 goals:** • Achieve better integration of health and social care in every area of the country, with significant improvements in performance against integration metrics within the new CCG assessment framework. Areas will graduate from the Better Care Fund programme management once they can demonstrate they have moved beyond its requirements, meeting the government's key criteria for devolution. • Ensure the NHS plays its part in significantly reducing delayed transfers of care, including through developing and applying new incentives.
	2016-17 deliverables: • Implement the Better Care Fund (BCF) in line with the BCF Policy Framework for 2016-17. • Every area to have an agreed plan by March 2017 for better integrating health and social care. • Working with partners, achieve accelerated implementation of health and social care integration in the 20 percent of the country designated as transformation areas, by sharing electronic health records and making measurable progress towards integrated assessment and provision. • Work with the Department of Health, other national partners and local areas to agree and support implementation of local devolution deals. • Agree a system-wide plan for reducing delayed transfers of care with overall goal and trajectory for improvement, and with local government and NHS partners implement year one of this plan.

	2016-17 requirements: • NHS England is required to: o ring-fence £3.519 billion within its allocation to CCGs to establish the Better Care Fund, to be used for the purposes of integrated care; o consult the Department of Health and the Department for Communities and Local Government before approving spending plans drawn up by each local area; and o consult the Department of Health and the Department for Communities and Local Government before exercising its powers in relation to failure to meet specified conditions attached to the Better Care Fund as set out in the BCF Policy Framework.
6.3 Mental health, learning disabilities and autism	**Overall 2020 goal:** • To close the health gap between people with mental health problems, learning disabilities and autism and the population as a whole (defined ambitions to be agreed based on report by Mental Health Taskforce). • Access and waiting time standards for mental health services embedded, including: o 50 percent of people experiencing first episode of psychosis to access treatment within two weeks; and o 75 percent of people with relevant conditions to access talking therapies in six weeks; 95 percent in 18 weeks.
	2016-17 deliverables: • 50 percent of people experiencing first episode of psychosis to access treatment within two weeks. • 75 percent of people with relevant conditions to access talking therapies in six weeks; 95 percent in 18 weeks. • Increase in people with learning disabilities/autism being cared for by community not inpatient services, including implementing the 2016-17 actions for Transforming Care. • Agree and implement a plan to improve crisis care for all ages, including investing in places of safety. • Oversee the implementation of locally led transformation plans for children and young people's mental health, which improve prevention and early intervention activity, and be on track to deliver national coverage of the children and young people's Improving Access to Psychological Therapies (IAPT) programme by 2018. • Implement agreed actions from the Mental Health Taskforce.

7. To support research, innovation and growth.	
7.1 Research and growth	**Overall 2020 goals:** • Support the Department of Health and the Health Research Authority in their ambition to improve the UK's international ranking for health research. • Implement research proposals and initiatives in the NHS England research plan. • Measurable improvement in NHS uptake of affordable and cost-effective new innovations. • To assure and monitor NHS Genomic Medicine Centre performance to deliver the 100,000 genomes commitment.
	2016-17 deliverables: • Implement the agreed recommendations of the Accelerated Access Review including developing ambition and trajectory on NHS uptake of affordable and cost-effective new innovations.
7.2 Technology	**Overall 2020 goals:** • Support delivery of the National Information Board Framework 'Personalised Health and Care 2020' including local digital roadmaps, leading to measurable improvement on the new digital maturity index and achievement of an NHS which is paper-free at the point of care. • 95 percent of GP patients to be offered e-consultation and other digital services; and 95 percent of tests to be digitally transferred between organisations.
	2016-17 deliverables: • Minimum of 10 percent of patients actively accessing primary care services online or through apps, and set trajectory and plan for achieving a significant increase by 2020. • Ensure high quality appointment booking app with access to full medical record and agreed data sharing opt-out available from April 2016. • Robust data security standards in place and being enforced for patient confidential data. • Make progress in delivering new consent-based data services to enable effective data sharing for commissioning and other purposes for the benefit of health and care. • Significant increase in patient access to and use of the electronic health record.

7.3 Health and work	**Overall 2020 goal:** • Contribute to reducing the disability employment gap. • Contribute to the Government's goal of increasing the use of Fit for Work.
	2016-17 deliverables: • Continue to deliver and evaluate NHS England's plan to improve the health and wellbeing of the NHS workforce. • Work with Government to develop proposals to expand and trial promising interventions to support people with long-term health conditions and disabilities back into employment.

#FutureNHS

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

12th January 2016

Report of:	Judith Adams, Chief Operating Officer
Paper Prepared by:	Rachel Greer, CBU General Manager Dan Grimes, CBU General Manager Andy McColl, Business Development Manager
Subject/Title:	Paediatric Rehabilitation at Alder Hey
Background Papers:	Specialist Rehabilitation Strategic case Level 2 Rehabilitation case
Purpose of Paper:	For the Board to receive the business cases presented for consideration to NHS Engalnd and Chief Officers of C&M CCGs To inform the Board of Directors of the progress towards the development and delivery of a specialist and step down rehabilitation offer at Alder Hey
Action/Decision Required:	To secure board support for the strategic development and delivery of specialist and step down paediatric rehabilitation offer.
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	All Strategic Aims
Resource Impact:	See attached cases

Executive Summary

Context

Currently there is no formal provision for both Specialist and Level 2 (Stepdown) inpatient paediatric rehabilitation services in Cheshire & Merseyside or indeed across the North West. Pathways of care and outcomes for children and young people remain variable and they stay inappropriately within acute wards in tertiary hospital beds, often for long lengths of time. There is no transitional care facility to bridge the gap between hospital and home/community care and the extended length of stay in hospital often creates an inappropriate dependency and makes discharge home more difficult.

Patients requiring specialist rehabilitation are those with complex disabilities. Such patients typically present with a diverse mixture of medical, physical, sensory, cognitive, communicative, behavioral and social problems.

Specialist rehabilitation services may be provided along three main (frequently overlapping) pathways:

- Restoration of function
- Disability management
- Neuro-palliative rehabilitation

Slow stream or step down rehab following illness or injury requires close links with tertiary services but provided outside the acute setting. This may be rehab following a) specialist surgery or treatment or following a protracted period of acute care e.g following major trauma, b) inpatient care for children with complex, long-term or exceptional healthcare needs awaiting care packages, training or environmental adaptations c) technology dependent children (non-invasive) being actively transitioned from hospital to home.

New Model of Care - Benefits to be achieved

- Reducing variability and improving outcomes and quality of care
- Achieving the aims within the Healthy Liverpool Programme and Vanguard Model, including person centred care and transforming services to improve outcomes.
- Provision of care in the right setting – with access to appropriate step down facilities to support transition from hospital to home/community.
- Re-enablement and empowering families and carers to have confidence and skills to care for children and young people with complex needs.
- Developing specific capacity and competence of the workforce around the needs of the child and family.
- Provision of care in the right setting – ensuring tertiary/acute hospital beds are available for medically unstable patients and potential business developments, acute hospital beds release circa 15 beds.
- To improve the collective commissioning, contracting and financial arrangements for rehabilitation services
- Income generation (see below)

	£000's	%
Net Income *(offset by reduction in EXBDs)* Net Expenditure *(excluding costs already being incurred in existing budgets)*	2,454 (1,817)	
Contribution	**637**	**26%**
Overheads Capital Charges	(357) (200)	
Surplus	**80**	**3.3%**

Progress to date

Specialist and Level 2 step down rehabilitation are procured and funded by both NHSE for the specialist element and CCGs for Level 2 stepdown care. A task and finish group to review the strategic case for funding a specialist rehabilitation service was established with NHSE commissioners during the course of 2015. Commissioners were concerned about benefits delivery if the whole rehabilitation pathway was not appropriately commissioned and prior to making any funding commitments wished to have confirmation from CCGs towards level 2 step down care.

Following discussions with Liverpool CCG as the co-ordinating commissioner an invitation was extended to the Trust to present the case at the joint meeting of C&M Chief Officers and Finance Directors. There was general support for the case and it was suggested that the proposal be taken forward through the paediatric workstream of the vanguard project as there was a clear strategic fit with the new models of care and transition of care into the community. Any support for the vanguard value proposition would still require commissioner support to ensure longer term sustainability but the Trust may benefit from some in year funding to test the concepts.

The specialist elements of the pathway would be delivered via rehabilitation facilities on ward 4B which during the hospital development and design stage was modified to accommodate additional therapy and rehabilitation space. Ten designated beds would be identified for this element of the pathway.

Level 2 stepdown care would be delivered out of hospital in a purpose built 20 bedded unit and in the interim the vacated neuro-medical ward on the retained estate would be suitable for this purpose with some capital development (circa £200k). This would enable delivery in 2016/17 of the new model of care but funding streams for a purpose built unit in the Park would need to be agreed beyond 2017 or alternative accommodation sought elsewhere in the community. Early discussions with Liverpool CCG have indicated some support for the capital funding to develop the retained estate as an interim measure if the revenue case is supported.

<u>Next steps and key dates</u>

- Value proposition 2 to be submitted to New Models of care Team - January 8th
- Follow up discussion with NHSE and CCG commissioners – January 18th
- Meeting of Vanguard Investment Committee - February 8th
- Expected decision – mid/end February
- Development of in house delivery plan - end January

Judith Adams

Alder Hey Children's NHS
NHS Foundation Trust

Paediatric Specialist Rehabilitation Service

January 2015

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1 INTRODUCTION

1.1 PURPOSE OF THE STRATEGIC CASE

1.1.1 This strategic case seeks support for paediatric specialist rehabilitation to be formally commissioned by NHS England at Alder Hey Children's NHS Foundation Trust.

1.1.2 Specialist rehabilitation services have historically not been commissioned although there is some level of provision across three main pathways: neurology; musculoskeletal; and burns and plastics. If formally commissioned, the specialist rehabilitation would be redesigned to ensure full compliance with national service specifications for both specialist rehabilitation and paediatric neuro-rehabilitation.

1.1.3 There is no specific inpatient provision for patients on an extended rehabilitation pathway. These two areas contribute to pressure on the current acute inpatient services at Alder Hey to bridge the gap between inpatient and community generic rehabilitation services to ensure patients do not lose gains in function by therapy being discontinued too early.

1.1.4 The key drivers for this case is as follows:

- The national and local drive for improving quality of care and outcomes through improved inpatient and outpatient specialist rehabilitation services.

- To improve the commissioning, contracting and financial arrangements for rehabilitation services for patients at the Trust.

1.1.5 This case sets out the proposal to address these issues and recommends NHS England commission a re-designed model of care for specialist rehabilitation across the Trust.

1.2 SERVICE OBJECTIVES

A review of national and local policies against current service provision identified the following key objectives as outlined in **Table 1** for the proposal to redesign the delivery specialist rehabilitation services across the Trust:

Table 1: Key Service Objectives

Objective	Description
Clinical quality and integration	
1.1	Promote an ethos of equitable, timely and appropriate specialist rehabilitation based on complexity of need not diagnosis
1.2	Ensure an integrated pathway provides supportive and active tertiary inpatient, extended and outpatient specialist rehabilitation that maximises the effectiveness of intervention and promotes optimal recovery
1.3	Ensure integrated paediatric inpatient services are provided by multidisciplinary rehabilitation teams, with a common model and approach to rehabilitation in line with best practice
1.4	Provide quality specialist inpatient and outpatient rehabilitation services, working to evidence-based best practice and reduction of duplication where apparent
1.5	Ensure specialist rehabilitation programmes are developmentally appropriate, time-limited, goal focused and multi-disciplinary
Access	
2.1	Ensure timely provision of paediatric specialist rehabilitation services
2.2	Deliver improved access to appropriate levels of specialist rehabilitation services, including inpatient, extended and outpatient services
Staffing	
3.1	Promote closer working relationships across professions and service levels (in-patient, outpatient and community) leading to improved patient care
3.2	Deliver paediatric specialist rehabilitation services through appropriate staffing numbers and expertise, taking account of national guidance
3.3	Enable paediatric specialist rehabilitation staff to work more closely with partner organisations (e.g. education and social services) to optimise community integration
3.4	Improve training, development and research opportunities to enhance specialist rehabilitation skills
Efficiency	
4.1	Reduce average length of stay to maximise efficiency and improve patient experience
4.2	Provide paediatric specialist rehabilitation services that are affordable and represent value for money to the commissioners
4.3	Maximise the best use of resources by ensuring all activity undertaken is within the scope of commissioned activity
4.4	Identify any gaps in service, financial pressures and opportunities for service developments

1.3 KEY BENEFITS

The key benefits of the redesigned specialist rehabilitation model of care have been derived from the service objectives as set out in the previous section. The benefit criteria are illustrated in **Table 2**; these can be used to assess delivery of the redesigned model of care through a benefits realisation plan. The benefit realisation plan including appropriate KPIs and measurable benefits could be included within the commissioning arrangement/contract.

Table 2: Key Benefit Criteria

Benefit	Description
Clinical quality and integration	
1.1	Access to on-going rehabilitation at a level appropriate for need throughout the patient journey
1.2	Improved integration of existing service provision to enhance patients recovery and discharge
1.3	Medical, nursing and therapy intervention emulate best practice rehabilitation care
1.4	Enhanced clinical decision making, ensuring patients are treated in the most appropriate setting
1.5	Specialist rehabilitation programmes are tailored to meet the needs of the individual and are provided at the appropriate level of care by members of the multi-disciplinary team
Access	
2.1	Timely provision of specialist rehabilitation services, ensuring waiting time targets are achieved with effective processes to provide optimum throughput of patients and facilitate improved rehabilitation outcomes
2.2	Delivery of improved access to appropriate levels of specialist rehabilitation services, ensuring there is sufficient staffing ratios in line with best practice
Staffing	
3.1	Development of professional models of intervention to provide clarity of roles and responsibilities across service levels to maximise effectiveness
3.2	Implementation of effective workforce models to meet demand and capacity requirements
3.3	Provision of specialist expertise to support professionals working within the community rehabilitation services and to other relevant agencies
3.4	Increase staff opportunities for continued professional development and research in paediatric specialist rehabilitation
Efficiency	
4.1	Maximise inpatient bed usage by focusing on a reduction in average length of stay to best practice levels
4.2	Demonstrate provision of paediatric specialist rehabilitation services that are sustainable and represent value for money to the commissioners
4.3	Demonstrate best use of resources by consolidating funding streams and monitoring performance against commissioned activity
4.4	Identification of opportunities and risks relating to the service redesign for

	paediatric specialist rehabilitation

1.4 SCOPE

1.4.1 The scope of this case focuses on the current inpatient and outpatient service delivery and the redesigned model of care for paediatric specialist rehabilitation within the Trust.

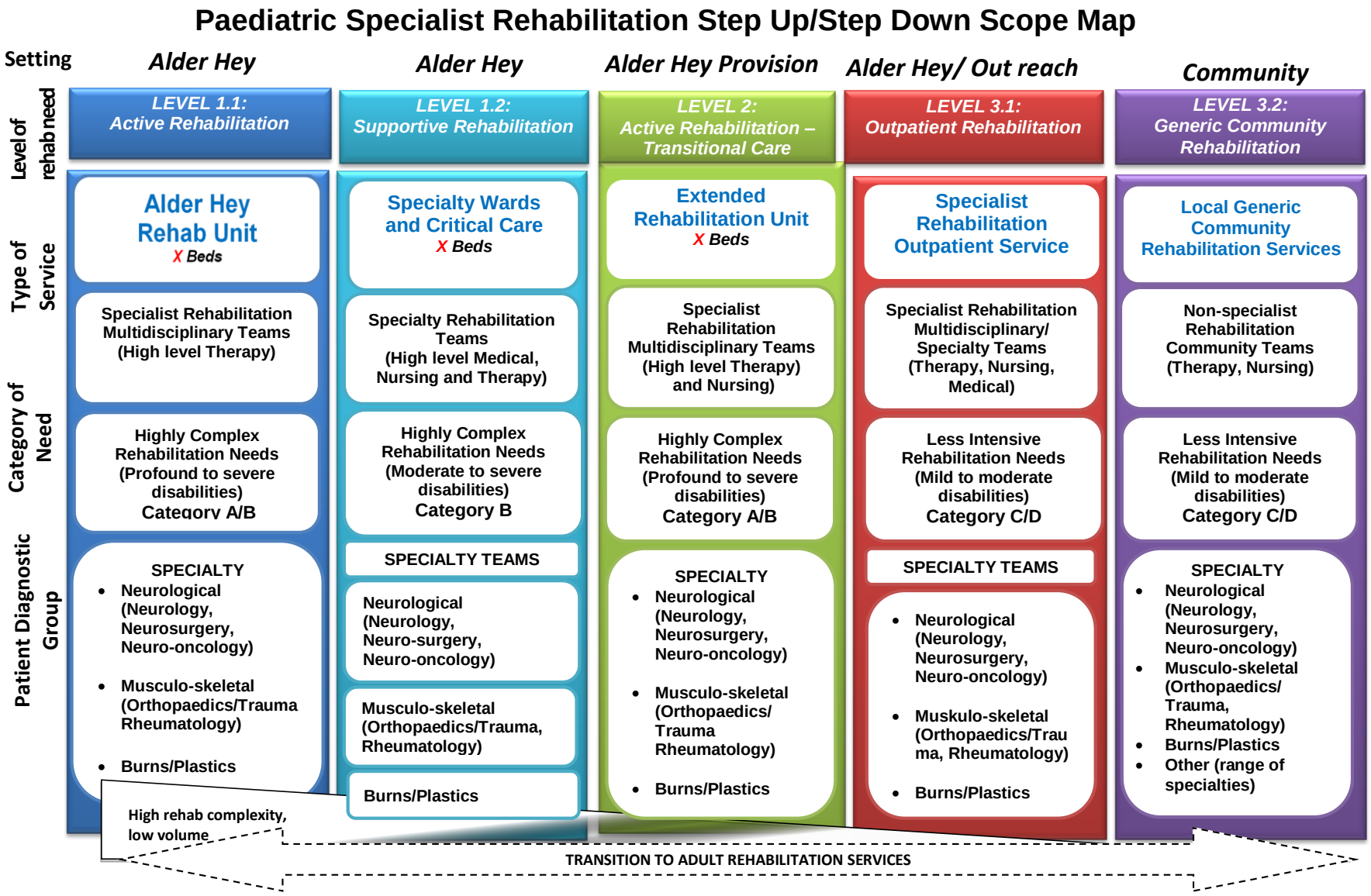
1.4.2 There is recognition that specialist rehabilitation services cut across a number of patient specialty pathways. The scope of this case acknowledges the current rehabilitation service provided, and builds on this to deliver a redesigned model of care encompassing national recognised levels of rehabilitation care that improves access and quality whilst delivering value for money. The impact of this redesign is considered in terms of required bed capacity and workforce implications. The levels of rehabilitation care considered as part of this case are listed below and set out in **Figure 1**:

- As outlined in a number of national service specifications the following levels of care should be provided by Tertiary organisations as part of their inpatient and outpatient specialist rehabilitation service provision:
    - **Specialist Rehabilitation Unit (Level 1.1):** active rehabilitation programmes led by a specialist rehabilitation multidisciplinary team for patients with highly complex rehabilitation needs. In-reach support where appropriate will be provided to the specialty wards (Level 1.2).
    - **Specialty Wards (Level 1.2):** supportive rehabilitation programmes led by specialty teams (e.g. neurological, burns and plastics, musculoskeletal and critical care) for patients with highly complex rehabilitation needs.
    - **Outpatient Rehabilitation (Level 3.1):** specialist outpatient rehabilitation delivered through outpatient clinics, day attendances or outreach. This is led by specialist rehabilitation practitioners for patients with less intensive rehabilitation needs.

1.4.3 Outside the scope of this case is extended rehabilitation and generic community rehabilitation services. These are both included as part of the redesigned model of care as they directly impact on inpatients services length of stay. An extended rehabilitation unit (Level 2) is required to support patients with complex rehabilitation needs who require oversight from Tertiary services but their ongoing rehabilitation can be provided outside of an acute hospital setting as step down care.

Without this provision, the model of care for patients cared for within the specialist rehabilitation service would be compromised.

Figure 1: Scope Map



2 STRATEGIC CONTEXT – CASE FOR CHANGE

2.1 INTRODUCTION

2.1.1 This section sets out the key national policy drivers, the local strategic direction and identified best practice that have been used in redesigning the paediatric specialist rehabilitation model of care for the Trust.

2.2 NATIONAL STRATEGIC DIRECTION – NHS CONTRACTS

2.2.1 In order to provide the national context for the delivery of paediatric specialist rehabilitation services, the following key NHS service specifications are applicable and are the key strategic drivers for the proposed redesigned model of care:

- **Paediatric Neurosciences: Neuro-rehabilitation (E09/S/d)** – this sets out the standards by which paediatric neuro-rehabilitation services will be commissioned and sets out the requirements for service delivery. One of the main aspects is the requirement to deliver both in-patient and out-patient tertiary specialist rehabilitation services as part of a comprehensive pathway with a focus on improving the quality of service provided. The specification is designed to ensure commissioners and providers consider service outcomes in the design of their rehabilitation services and details a number of outcome indicators that organisations will be measured against.

- **Paediatric Neurosciences: Neurosurgery (E09/S/a)** – this sets the standards for paediatric neurosurgical patients to have timely access to a full range of inpatient and outpatient specialist neuro-rehabilitation services.

- **Specialist Rehabilitation for Patients with Highly Complex Needs (All Ages) (D02/S/a)** – to support the commissioning and delivery of specialist rehabilitation services this specification outlines four categories of rehabilitation need (A to D) and three levels of care (1-3) based around the complexity of patient needs and resources required to deliver best practice care.

2.3 NATIONAL STRATEGIC DIRECTION – POLICY

2.3.1 Four key indicators (Lansley Test) have been nationally devised whereby any service change must provide supporting evidence that the rationale is clinically driven and engages patients and clinical commissioners.

2.3.2 **Table 3** demonstrates how the Trust has ensured these indicators are evidenced and identifies where further work is planned for the redesign of paediatric specialist rehabilitation services.

Table 3: Demonstration of Compliance with Lansley Test

Indicator	Relevance to Rehabilitation Pathway
Clinical evidence base	The service redesign has been designed and evidenced around best practice. This is demonstrated in the service model of care and pathway (see section 4) and in the development of the workforce model (see section 4.5). Professional intervention models of care are to be developed as part of the service implementation plan. The development of the service redesign has been clinically led by clinicians who are currently delivering the service at the Trust and supported by senior managers.
Support from commissioners	The strategic direction for the service redesign will be communicated with NHS England and local clinical commissioning groups (CCGs) to outline how the redesigned model of care meets best practice and improves outcomes for their patients.
Promotes improved patient experience	The key drivers for the service redesign are to provide equitable access to inpatient and outpatient services based around patient rehabilitation need. The benefits of the proposed service model of care are identified in section 1. Patient experience will be enhanced by the service model proposal by providing appropriate inpatient services based around the patient's needs; this includes a dedicated specialist rehabilitation unit for active rehabilitation, speciality wards for supportive rehabilitation and specialist rehabilitation outpatient services. The service model also identifies provision for extended rehabilitation along the pathway as an opportunity to support patients reach their optimal rehabilitation potential within a non-acute setting over an extended period.
Promotes engagement with all key stakeholders	The Trust implementation plan includes engagement with all key stakeholders to communicate the benefits and improved outcomes of a redesigned service model and pathway that is in line with best practice.

2.4 LOCAL STRATEGIC DIRECTION

2.4.1 The identification for the redesign of specialist rehabilitation services is a key component of the local strategic direction for the Trust to enhance and develop the profile of paediatric rehabilitation services.

2.4.2 The approach taken in the redesign of paediatric specialist rehabilitation services will:

- Focus on improving the quality of services and patient outcomes across the pathway;
- Provide an integrated specialist rehabilitation model for inpatient and outpatient services;
- Expand rehabilitation service capacity across the care pathway in line with projected demand;
- Enable effective partnership working with organisations (e.g. major trauma and adult specialist rehabilitation services);
- Support development of rehabilitation funding mechanisms that support the establishment of integrated services across the pathway.

2.5 BEST PRACTICE

2.5.1 This section identifies best practice in terms of delivering paediatric specialist rehabilitation services.

2.5.2 Best practice principles have been used in designing the proposed new service model of care. Some of the key elements of best practice are outlined below:

- Services should provide **integration and collaboration** between inpatient and outpatient settings, which will result in improved quality, consistency of patient care and efficiency. In order to practically implement the new model of care, workforce models will support clinical leadership and develop expertise and integrated working across all levels of the rehabilitation pathway.
- Paediatric specialist rehabilitation services should provide **patient-centred care** that focuses on the needs of the patient and family and delivers care within the appropriate setting. This includes inpatient and outpatient specialist rehabilitation services.
- Proposed service redesign should ensure the model of care and service capacity supports demand and planning for a clinically and financially **sustainable** service.

3 CURRENT REHABILITATION SERVICE PROFILE – CASE FOR CHANGE

3.1 INTRODUCTION

3.1.1 This section describes the existing service provision and the issues which drive the requirement for the proposed service redesign.

3.2 DEFINITION OF SPECIALIST REHABILITATION

3.2.1 Children and adolescents requiring specialist rehabilitation typically present with a diverse mixture of medical, physical, sensory, cognitive, communicative, behavioural and social problems, which require specialist input from a wide range of rehabilitation disciplines that are beyond the scope of generic rehabilitation services (e.g. nursing, physiotherapy, occupational therapy, speech and language therapy, psychology, dietetics, orthotics, social work, as well as specialist medical input). Timely access to the appropriate level of rehabilitation inpatient and outpatient care is essential to improve patient outcomes and experience (British Society of Rehabilitation Medicine, 2009).

3.3 CURRENT REHABILITATION SERVICE PROFILE

3.3.1 A range of conditions benefit from specialist rehabilitation. Inpatient paediatric specialist rehabilitation services have historically been provided across three main pathways: neurology; musculoskeletal; and burns and plastics. The Trust currently has almost 300 beds for access by all specialities for children and adolescents between 0-16 years. There are currently no dedicated inpatient specialist rehabilitation beds.

3.3.2 Each of the three specialty rehabilitation pathways are consultant led and supported by multi-disciplinary teams that comprise of nursing, physiotherapy, occupational therapy, speech and language therapy, dietetics, play therapy and orthotics as well as access to Psychology, Psychiatry and Education.

3.3.3 Current outpatient rehabilitation service provision is limited to an ad hoc arrangement to support patient's therapy through outpatient appointments, day attendances, and outreach to home and schools.

3.3.4 Currently there is no formal provision for inpatient extended rehabilitation services. Patients requiring extended rehabilitation (Level 2) often remain in acute paediatric beds at Alder Hey longer than necessary due to lack of provision in the community.

3.4 CURRENT SERVICE DELIVERY ISSUES AND RISKS

The key issues and risks with the current service provision are highlighted below:

3.4.1 Issues

- Fragmented service with specialist rehabilitation provided across individual diagnostic specialty pathways. This provides limited opportunity for the development of a common rehabilitation ethos and shared care models for inpatient specialist rehabilitation.
- No single pathway for specialist rehabilitation leads to a lack of a co-ordinated approach and potentially impacts on service efficiency.
- No uniform model for early identification of patients who require specialist multidisciplinary supportive or active rehabilitation potentially impacts on patient outcomes.
- Lack of clarity and inconsistency of recoding inpatient and outpatient specialist rehabilitation activity has an impact on income and data to support evidence for future contractual negotiations/ commissioning.
- Limited specialist outpatient services results in inequity of access and potentially longer lengths of stay.
- Lack of step down rehabilitation (e.g. Level 2 extended rehabilitation) potentially results in longer lengths of stay in an acute hospital bed regardless of their level of rehabilitation need.
- Due to limited specialist rehabilitation outpatient service and a lack of extended rehabilitation service provision, some patients are admitted to an acute hospital bed post discharge for a short period of review and treatment.
- No transparent system for tracking patients through their rehabilitation pathway leads to difficulties in monitoring performance and managing patient flow.
- Transfers from specialist rehabilitation inpatients to generic rehabilitation community services can often be delayed due to insufficient community provision.
- Transitions from specialist rehabilitation paediatric to adult services can often be delayed due to no formal transition pathway.
- No defined clinical leadership role for specialist rehabilitation can contribute to limited opportunity for strategic planning and service delivery across the pathway.

3.4.2 Risks

Clinical:

- Lack of a co-ordinated specialist rehabilitation pathway may impact on the delivery of best practice rehabilitation.
- Inequity of outpatient service provision may potentially impact on clinical outcomes.
- The inability to target early supportive rehabilitation to patients with complex rehabilitation needs at the earliest opportunity in their care may impact on their functional recovery and extend their length of stay.

Organisational:

- Inefficient use of acute beds has the potential to prolong length of stay and impact on waiting times for admissions.
- Current service is not formally commissioned and therefore is unable to fully meet the service standards as set out in NHS Standard Specifications.

Financial/Contractual:

- Specialist rehabilitation not formally commissioned therefore insufficient resources to invest in developing proposed model of care.
- Current activity not counted using national definitions of specialist rehabilitation.

4 PROPOSED MODEL OF CARE FOR SPECIALIST REHABILITATION SERVICES – CASE FOR CHANGE

4.1 INTRODUCTION

4.1.1 This section describes the Model of Care for specialist rehabilitation which Alder Hey proposes NHS England commission from the Trust. The workforce and finance models outlined are underpinned by a capacity and demand study and national and international workforce guidance.

4.2 PROPOSED NEW MODEL OF CARE

4.2.1 Key aims

The proposed Model of Care developed for specialist rehabilitation services aims to:

- Deliver a 10 bed inpatient specialist rehabilitation unit within the new Alder Hey in the Park development.
- A specialist in-reach and outpatient service model which allows patients to access services as they require.
- Maximise each individual's independence, function and ability;
- Build on and strengthen current inpatient and outpatient rehabilitation services to deliver optimal patient outcomes;
- Ensure the availability of specialist rehabilitation services across the care pathway are person centred, sustainable, responsive, accessible and effective.
- Provide comprehensive multidisciplinary specialist rehabilitation services that are cost effective, equitable and consistent across the Trust in line with best practice.

4.2.2 Key principles

The Model of Care for Specialist Rehabilitation aims to optimise patient outcomes by providing the 'right care at the right time and in the right place first time':

- **Right care:** ensuring the availability of staffing, skills and expertise for the management of the individual's specific health care needs;
- **Right time:** ensuring the availability and access to supportive and active specialised rehabilitation that will optimise patient outcomes;

- **Right place:** ensuring that the individual's care is provided in right setting that will best meet their specific needs;

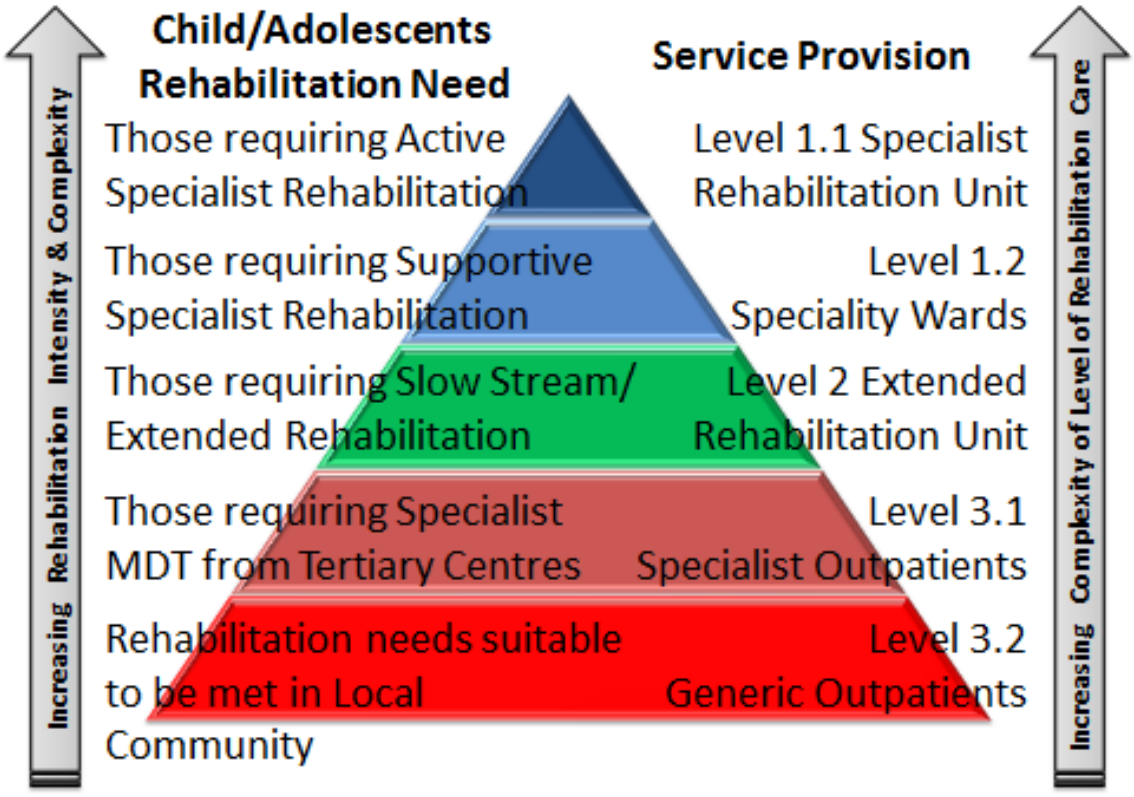
- **First time:** ensuring that the required care is provided in the most appropriate setting in a timely manner first time.

4.2.3 Paediatric Specialist Rehabilitation Model of Care

The Model of Care focuses on the provision of inpatient and outpatient specialist rehabilitation services for children and adolescents with high or moderate complexity of rehabilitation need. The Model of Care is time-limited, goal focused and developmentally appropriate.

The levels of care for the service model across inpatients and outpatients, illustrated in **Figure 2** and outlined in **Table 4,** are essential to ensure access, patient flows, service integration and meeting patient needs across the pathway.

Figure 2: Paediatric Specialist Rehabilitation Model of Care



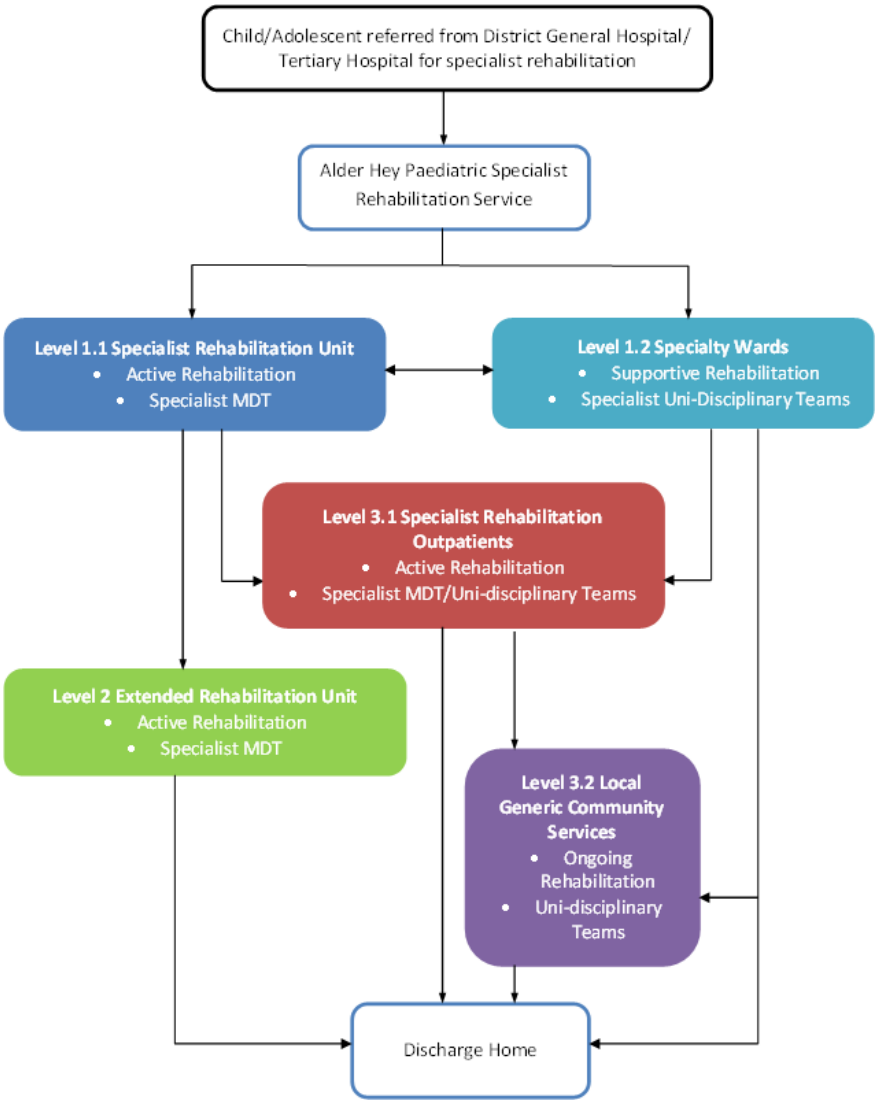
The Specialist Rehabilitation Model of Care is based on four levels of rehabilitation care, consistent with the BSRM (2010) and is described in **Table 4**.

Table 4 Paediatric Specialist Rehabilitation Levels of Care

	Level of Rehabilitation Care			
	Level 1.1	Level 1.2	Level 2	Level 3.1
Service	Specialist Rehabilitation Unit	Specialty Wards	Extended Rehabilitation Unit	Specialist Outpatients provided by ACHT
Service Type	> Rehabilitation for highly complex low volume patients with severe to profound disabilities (Category A/B) > Early active acute rehabilitation intervention with specialised expertise from a multi-disciplinary team > Provision of in-reach service to specialty wards (Level 1.2)	> Rehabilitation for highly complex low volume patients with moderate to severe disabilities (Category A/B) > Supportive rehabilitation provided for individuals with a range of conditions > Input provided includes specialist interdisciplinary rehabilitation assessment and intervention which is condition specific	> Rehabilitation for highly complex low volume patients with moderate to severe disabilities (Category A/B) > Extended period of slow stream rehabilitation for individuals with a range of conditions > Input provided includes specialist expertise from a multi-disciplinary team	> Rehabilitation for individuals with mild to moderate rehabilitation needs with a range of conditions (Category C/D) > Outpatient service for follow up from Level 1.1, 1.2, 2 includes: - Day Attendance - Outpatient clinics - MDT clinics - Outreach
Workforce	> Consultant in rehabilitation medicine supported by appropriate medical staffing >Nursing and Therapy staff with knowledge and skills in specialised rehabilitation > Clinical and Neuro Psychology provided as part of multi-disciplinary approach > Rehabilitation Co-ordinator/Key Worker for the service/pathway > UKROC Administrator support for the service/pathway	> Specialist Rehabilitation provided by diagnostic specialty teams (including Nursing, Therapy, Psychology) with relevant applied knowledge in specialist rehabilitation principles and practice > UKROC Administrator support for the service/pathway	> Specialist Rehabilitation provided by a multi-disciplinary team including nursing, Therapy and Psychology staff with specialist rehabilitation expertise > Medical input provided by General Practitioner > Access to Specialist Rehabilitation Consultant	> Care provided by staff from Specialist Rehabilitation Unit multi-disciplinary team (Level 1.1) and Specialty Wards (Level 1.2)

Access to the proposed specialist rehabilitation service would provide a co-ordinated approach through a single pathway to the appropriate level of rehabilitation care to meet the individual needs of the patient. The pathway is shown in **Figure 3.**

Figure 3: Service Pathway for Specialist Rehabilitation



4.3 PROFILE OF REHABILITATION SERVICE DEMAND

4.3.1 There is currently no national guidance available to model specialist rehabilitation inpatient bed requirements and outpatient provision; however evidence highlights that services are effective if both inpatient and outpatient provision exist as an integrated model across the care pathway.

4.3.2 A Point of Prevalence Study undertaken within the current rehabilitation inpatient and outpatient services during January and February 2014 identified an average demand for 75 patients per day requiring rehabilitation across all levels of care.

4.3.3 The results from this study have been mapped across the levels of care identified in the new rehabilitation model to inform capacity requirements for inpatient beds and specialist outpatient services. This is illustrated in **Table 5.**

Table 5: Specialist Rehabilitation inpatient Bed Capacity and Outpatient Requirements (based on Point of Prevalence Study findings)

Level of Rehabilitation Care	Min pts identified during PoPs	Max pts identified during PoPs	Average pts
Level 1.1 Specialist Rehabilitation Unit	6	9	7
Level 1.2 Specialty Wards	26	29	28
Level 2 Slow Stream Rehabilitation Unit	7	21	17
Level 3.1 Specialist Outpatients *	10	20	13
Level 3.2 Generic Community Outpatients	6	12	10

** Patients identified during the inpatient study who may have been suitable for specialist outpatient therapy.*

Highlighted Results from the Point of Prevalence Study:

- Inpatient demand modelling identified the need for 10 inpatient specialist rehabilitation beds. This supports the organisational recommendation for 10 beds in a dedicated specialist rehabilitation unit.
- Specialist rehabilitation provision on the specialty wards, with in-reach support from the specialist rehabilitation unit multi-disciplinary team was identified at 28 patients per day.
- A demand was identified for step down rehabilitation which could be provided within an extended rehabilitation unit; capacity requirements were identified for 22 beds.

4.4 ACTIVITY MODELLING

4.4.1 With a proposed capacity of 10 beds on the Specialist Rehabilitation Unit and a proposed model of care which supports an indicative length of stay of 12-weeks, each bed would equate to a maximum of 4 episodes for specialist rehabilitation per annum. Therefore, it is forecasted that up to 48 patients could be supported within the Specialist Rehabilitation Unit per annum

4.4.2 Complexity on the Specialist Rehabilitation Unit (Level 1.1) would be expected between high complexity (Rehabilitation Complexity Score 11-14) and moderate complexity (Rehabilitation Complexity Score 7-10) using RCS as part of UK-Roc returns.

4.5 WORKFORCE

4.5.1 To deliver a Level 1.1 specialist rehabilitation unit and supporting specialist outpatient service would require investment in dedicated workforce to comply with the recommendations provided by the British Society for Rehabilitation Medicine (2010) and the Australian Federation for Rehabilitation Medicine (2007) as well as the relevant NHS England Service specifications for Paediatric Neuro-rehabilitation and Specialist Rehabilitation.

4.5.2 The Trust will need to reconcile the resource requirements for the additional staffing to support the specialist rehabilitation service and the current staffing in order to identify the additional resources required.

4.5.3 In order to invest in the additional staffing required, the Trust would require the service to be formal commissioned with an agreed income stream.

4.6 FINANCE

A model for funding for specialist rehabilitation service, consistent with the local and national approach, needs to be developed in collaboration with commissioners that supports the following:

- Appropriate balance of funding across inpatients and outpatients;
- Equity of access to specialist inpatient and outpatient rehabilitation services;
- The provision of a specialist rehabilitation inpatient unit for patients with complex needs;
- The provision and expansion of specialist outpatient rehabilitation services.

4.6.1 Inpatient income.

The draft 2015/16 national tariff includes non-mandatory prices for Specialist Rehabilitation as follows:

Disease stage	Hyper-acute	Physical	Mixed	Level 2a	Level 2b
Very low	236	224	217	199	179
Low	307	289	281	224	201
Medium	378	355	346	320	288
High	491	463	450	438	395
Very high	632	596	580	558	503

It is expected that patients within the level 1.1 Specialist Rehabilitation Unit will have Very High dependency, and although a combination of Hyper-acute and Physical, it is proposed that for 2015/16 we use a price of £596+MFF per OBD.

Using the activity model described above, it is estimated that there would be 2,555 occupied bed days within the level 1.1 Specialist Rehabilitation Unit.

Using 2,555 OBDs at a price of £596+MFF would give a gross income of £1,584,100. Assuming that there is a corresponding reduction in excess bed days with an average charge of £380 per day (inc. specialist top up), this would give a net income growth of £613,200.

For 2015/16, it is proposed that patients who remain on Specialty wards (Level 1.2) will not generate any additional charge for specialised rehabilitation, and will continue to be charged based on current approach with the HRG and any excess bed days and/or specialised top up only (in line with national Payment by Results mechanism).

This case does not address the financial implications of commissioning a Slow Stream Rehabilitation Unit (Level 2), although the importance of this is noted to enable patients to flow through the pathway effectively.

4.6.2 Outpatient income

In order to deliver the specialist rehabilitation service model requires investment in specialist outpatient services which supports earlier discharge and transition from hospital to home. The PoPs study demonstrated a need for 12 day attendances / outpatients per day.

The draft 2015/16 national tariff includes non-mandatory prices for Paediatric Neurology as follows:

		CONSULTANT-LED (£)			
Treatment function	Treatment function name	WF01B *First Attendance - Single Professional*	WF02B *First Attendance - Multi Professional*	WF01A *Follow Up Attendance - Single Professional*	WF02A *Follow Up Attendance - Multi Professional*
150	Neurosurgery	308	308	126	158
400	Neurology	215	215	124	129
421	Paediatric Neurology	382	382	218	237

It is proposed that the Paediatric Neurology Follow Up price is used as an indicative tariff for specialist Outpatient Rehabilitation. Using the Follow Up price of £218+MFF per attendance, and activity forecast of 12 patients per day, then the total income for this element of the service would be £707,273.

4.6.3 Financial Summary

Table 6 summarises the total income from commissioners, based on the assumptions described above.

Table 6: Summary of Income from commissioners

Income	Activity	Price per Unit	Total (Full Year)
Inpatient	2,555 OBDs	@ £596 + MFF	£1,584,100
Outpatient	3,120 attendances	@ £218 + MFF	£707,273
Sub Total			**£2,291,373**
Reduction in Excess Bed Days	2,555 EXBDs	@ £380	(£970,900)
Total			**£1,320,473**

The gross figure of £2.3m will be invested in service delivery as follows:

Income	£m
Medical Staff	0.2
Nursing Staff	0.8
AHP Staff	0.6
Other Pay	0.1
Non Pay	0.1
Equipment	0.1
Trust Overheads	0.4
Total	**2.3**

5 PARTNERSHIPS AND STAKEHOLDERS

Table 7 identifies the potential key stakeholders who may have an interest in the redesign of paediatric specialist rehabilitation services. Engagement from the Trust with these stakeholders will ensure different perspectives are taken into account in the development and implementation of the future service model of care and service delivery for paediatric specialist rehabilitation.

Table 7: Key Partners and Stakeholders

Partners and Stakeholders	Interest
NHS England	Commissioners for Cheshire and Merseyside patients. Key stakeholders in ensuring delivery of quality paediatric specialist rehabilitation services that are value for money and meet the local health economy needs. Oversight of health services ensuring any proposals are in line with NHS strategic direction and policy.
Clinical Commissioning Groups (CCGs)	Commissioners for Cheshire, Merseyside, North Wales and Isle of Man patients. Key stakeholders in ensuring delivery of quality paediatric specialist rehabilitation services that are value for money and meet the local health economy needs.
County Councils	Commissioners of social services and education for paediatric patients in Cheshire, Merseyside, North Wales and Isle of Man.
Tertiary and District General Hospital Trusts	Providers of acute services to the local health economy.
Cheshire and Merseyside Major Trauma Network	Interested in ensuring paediatric specialist rehabilitation services are provided to ensure equitable access following major trauma
Cheshire and Merseyside Specialist Rehabilitation Network (adults)	Interested in ensuring there is a seamless handover of care between paediatric and adult specialist rehabilitation services.
Cheshire and Merseyside Critical Care Network	Interested in ensuring paediatric specialist rehabilitation services are provided to ensure equitable access following critical care.
Patients, Families and Public	Interested in ensuring paediatric specialist rehabilitation services are provided to an appropriate level of quality, are accessible in terms of responsiveness including the range of specialist support and setting.
Local MPs	Responsible for ensuring the public within the constituencies receive specialist health services
Staff	When the service redesign impacts on existing service provision.

6 RECOMMENDATIONS

1. NHS England formally commission specialist rehabilitation service at Alder Hey within the 2015/16 contract.

2. Alder Hey implements the proposed redesigned model of paediatric specialist rehabilitation services including dedicated 10 Level 1.1 inpatient beds within the new hospital from September 2015. This would also include the formal implementation of a specialist rehabilitation outpatient service

3. In order for the specialist rehabilitation service to function effectively, the extended rehabilitation service for patients with complex rehabilitation needs (Level 2) should also be commissioned. This group of patients may require oversight from the Tertiary services, but their ongoing rehabilitation can be provided outside of an acute hospital setting as step down care.

Alder Hey Children's NHS
NHS Foundation Trust

Paediatric Rehabilitation
Level 2 Service

To:	Mersey CCG Network
Prepared by:	Rachel Greer, General Manager Dan Grimes, General Manager Andrew McColl, Head of Business Development
Date:	November 2015

Executive Summary & Recommendation

This case describes the need and benefits of commissioning a Level 2 Paediatric Rehabilitation Service, to be provided by Alder Hey in a stand alone unit. This is part of a wider review and redesign of the whole Paediatric Specialist Rehabilitation pathway, and a separate business case has been submitted to NHS England to commission Level 1 and Level 3.1 rehabilitation services.

The purpose of Level 2 Rehabilitation (referred to as "Step Down" or "Slow Stream" rehab) is to provide a suitable facility for patients who no longer require hospital care, but whose rehabilitation needs cannot be met more effectively and efficiently in the outpatient, home, or other non-inpatient setting – ie transition between hospital and home/community. This will enable provision of "the right care, at the right time and in the right place".

The model of care will include patients on three main pathways:

- Restoration of function
- Disability management
- Neuro-palliative rehabilitation

Rehabilitation will be goal directed and time limited, with focus on discharge planning. The service will by multi-disciplinary – led by nursing and AHP team, with medical input and active partnership working with education and social services.

There is a wealth of research and evidence demonstrating the improvements in care as a result of receiving the right level of rehabilitation in a timely manner during a patients pathway. This includes:

- Receiving the right care, at the right time and in the right place
- Better clinical outcomes
- Improved patient experience
- Empowerment of parents/carers to meet their child's care needs at home
- Reduced length of stay in hospital
- Efficient use of capacity and resources.

Recommendation

It is recommended that a Level 2 Paediatric Rehabilitation service is commissioned and provided by Alder Hey in a purpose built stand alone unit with capacity of 20 beds (estimated £6m capital cost; alternatively use spare building capacity in the health economy).

In the interim period, Alder Hey can accommodate this service within the current neurosciences building, with capacity of 18 beds alongside therapy rooms until October 2017 (subject to appropriate refurbishment with estimated capital cost of c.£200k).

Using UKROC bed day prices as an indicative tariff, it is estimated that Alder Hey would charge commissioners a total of £2.6m per year to provide this service. However there would be a directly correlated reduction in excess bed days of c.£1.6m, meaning the net charge would be c.£1.1m spread across commissioners from the North West of England and Wales.

Contents	Page

1.0 Introduction

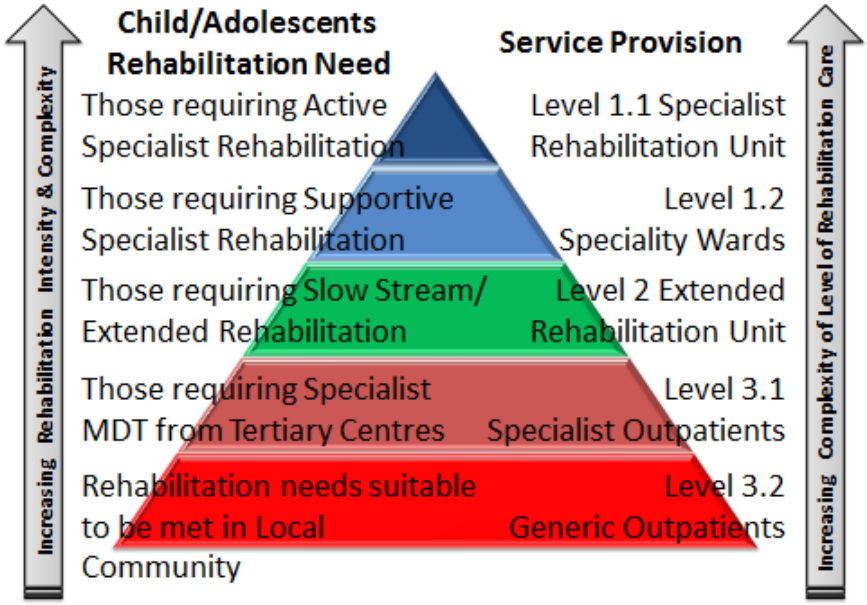
"Rehab is an active, time limited collaboration of a person with disabilities and professionals, along with other relevant people, to produce sustained reductions in the impact of disease and disability on their daily life. Interventions focus on the individual, on the physical or social environment, or a combination of both"
From 'Medical rehabilitation in 2011 and beyond' – report of joint working party of RCP and British Society of Rehabilitation Medicine.

The purpose of this paper is to gain support from the Mersey CCG Network to formally commission a standalone Level 2 Paediatric Rehabilitation Unit for children and young people. This service will support patients with complex rehabilitation needs who require oversight from Tertiary services but their ongoing rehabilitation can be provided outside of an acute hospital setting as step down care.

This case is part of a wider review and redesign of the whole Paediatric Specialist Rehabilitation pathway. A business case has been submitted to NHS England in January 2015, seeking support and investment in Level 1, and Level 3.1 rehabilitation. A joint Task & Finish group has been established with NHS England to take this work forward.

As demonstrated in Figure 1, provision of a Level 2 ("Slow Stream") Rehabilitation Service is integral to ensure that the overall rehabilitation pathway functions effectively. Definitions of each level of care are included as Appendix A.

Figure 1: Paediatric Specialist Rehabilitation Model of Care



Generally, patients requiring specialist rehabilitation are those with complex disabilities. Such patients typically present with a diverse mixture of medical, physical, sensory, cognitive, communicative, behavioural and social problems, which require specialist input from a wide range of rehabilitation disciplines (eg rehabilitation-trained nurses, physiotherapy, occupational therapy, speech and language therapy, psychology, dietetics, orthotics, social work etc.) as well as specialist medical input from consultants trained in rehabilitation medicine, and other relevant specialties (eg neuropsychiatry).

Specialist rehabilitation services may be provided along three main (frequently overlapping) pathways:

- **Restoration of function** e.g. for those recovering from a 'sudden onset' or 'intermittent' condition, where patient goals are focused not only on improving independence in daily living activities, but also on participatory roles such as work, parenting and other activities.
- **Disability management,** e.g. for those with stable or progressive conditions, where patient/family goals are focused on maintaining existing levels of function and participation; compensating for lost function (eg through provision of equipment/adaptations); or supporting adjustment to change in the context of deteriorating physical, cognitive, and psychosocial function
- **Neuro-palliative rehabilitation** focuses on symptom management and interventions to improve quality of life during the later stages of a progressive condition or profound disability, at the interface between rehabilitation and palliative care.

Since "rehab" can be used as a generic term, it is important to have a clear understanding that for this proposal rehabilitation is a dynamic, goal driven and time limited period where professionals work in partnership with patients and families. This will improve quality of life, clinical outcomes and potentially reduce the requirement and cost of future health care.

Within each Level of Care (Figure 1 above), and across the three main pathways described above, rehabilitation needs will vary from one patient to the next. There are four categories of rehab need, and this is shown in Figure 2. Further detail of the four categories of need is shown in Appendix B.

Because rehab pathways at Alder Hey are so integrated into acute pathways, without specific or dedicated facilities, rehabilitation services at Alder Hey have been historically under recognised. **This case proposes that the pathways are properly commissioned, with appropriate care provided in the right setting** – in particular provision of Level 2 Paediatric Rehabilitation services within a dedicated stand alone facility.

Figure 2: Guidance on Categorisation of Rehabilitation Need and Levels of Care

CATEGORISATION OF REHABILITATION NEED AND LEVELS OF CARE *(based on UKROC categorisation tool and draft CRG service specification for complex rehabilitation Jan 2014)*			
Category of Rehab Need	**Criteria**	**Examples**	**Levels of specialist rehabilitation services**
A	**Patients have <u>complex or profound</u> disabilities**	A combination of severe physical, cognitive, communicative disabilities or challenging behaviours	**Level 1:** Specialist Acute Rehabilitation Unit **Level 2:** Slow stream rehabilitation
	Patients have highly complex rehabilitation needs, requiring specialist facilities and a high level of input from skilled rehabilitation staff	• Intensive, coordinated inter-disciplinary intervention ≥ 5 therapies (e.g. SALT, Dietetics, Occupational Theray, Physiotherapy, Psychology, Music Therapy, Play Therapy, Orthotics) in addition to specialist rehabilitation medical/nursing care in a rehabilitation environment • Very high intensity staffing ratios, individual patient therapy sessions involving 2-3 therapies at any one time • Highest level equipment (e.g. bespoke assistive technology, ventilators) • Medium to long term programme, typically 2-4 months, but could be up to 6 months	
B	**Patients have <u>moderate to severe</u> disabilities**	A combination of moderate to severe physical, cognitive, communicative disabilities which may include mild to moderate behavioural problems .	**Level 1:** Specialist Acute Rehabilitation Unit **Level 1.2:** Specialty Rehabilitation Wards & Critical Care **Level 2:** Slow stream rehabilitation
	Patients require rehabilitation from skilled staff in a dedicated rehabilitation unit with appropriate facilities	• Intensive coordinated interdisciplinary intervention from 2-4 therapies in addition to specialist medical/nursing care • Medium length rehabilitation programme, typically 1-3 months, but could be up to 6 months • Special facilities /equipment (e.g. mobility aids, interventions supporting return to school/leisure activities	
C	**Patients have <u>mild to moderate</u> disabilities**	Patient goals are typically focused in restoration of function /independence and co-ordinated discharge planning with on-going rehabilitation in the community	**Level 3:** Outpatients/Day Attenders Specialist Rehabilitation Services **Level 3:** Generic Community Rehabilitation Services
	Patients require less intensive rehabilitation	• Intervention from 1-4 therapies • Patients require rehabilitation in the context of their specialist Multi-disciplinary treatment	
D	**Patients have a <u>wide range of conditions</u> but medically stable**	Patient goals are typically focused in restoration of function /independence and co-ordinated discharge planning with on-going rehabilitation in the community if necessary	**Level 3:** Outpatients/Day Attenders Specialist Rehabilitation Services **Level 3:** Generic Community Rehabilitation Services
	Patients require less intensive rehabilitation	• Intervention from 1-3 therapies • Short programmes	

2.0 Strategic Context

This case is aligned to a number of national and local strategies:

At a high level Alder Hey, local commissioners and national policy are congruent with the strategy to provide **"the right care, at the right time and in the right place"**. The essence of this is that patients are treated in an appropriate setting, and includes moving care outside of the acute hospital setting wherever this is appropriate.

Development and investment in Rehabilitation services has been a national and local priority over several years. In 2008 the UK Rehabilitation Outcomes Collaborative (UKROC) was established, with initial focus on neuro-rehabilitation, and has supported research and investment across the NHS (including development of tariff currencies and indicative / non mandatory prices).

Locally (Cheshire and Merseyside), there was a rehabilitation pathway review and significant investment in adult rehab services during 2012/13, which included acute, sub-acute and extended / slow stream rehabilitation services across the region. Subsequently there were 246 patients to hub and spoke units during 2013/14, with achievement of significant improvements in measurable outcomes (see Cheshire & Mersey Rehabilitation Network Annual Report for 2013/14). However, this investment from commissioners did not extend to services for children and young people, and currently **there is no recognised paediatric rehabilitation service provided in Cheshire and Merseyside** (neither through NHS or private sector provision).

Not only is there a historic lack of investment in paediatric rehab in Cheshire and Merseyside, but service provision across the country is patchy, with only isolated examples of good practice from NHS providers. There is a nationally recognised service provided by The Children's Trust in Tadworth, Surrey – although this is not an NHS organisation. Overall there is inequitable access to paediatric rehab services.

NHS England Service Specifications for 2013/14 NHS Standard Contract outlines requirements for Paediatric Neurosciences and Neurorehabilitation. Further to this, NHS England has identified Paediatric Specialist Rehabilitation within their national commissioning intentions for 2015/16. Although Level 2 slow stream rehab is outside the commissioning scope of NHS England, it is a key part of the overall pathway.

The Healthy Liverpool Programme is working to transform services, with a focus on person-centred care, and with children identified as one of six priority areas.

This proposal to develop a standalone Level 2 Slow Stream Rehabilitation Unit for children and young people **seeks to transform current service provision to better meet the needs of children and their families, with care provided in the most appropriate setting.**

3.0 Case for Change and Proposal

3.1 Current Position

Historically, rehabilitation services at Alder Hey have not been formally commissioned, although there is some level of "Restoration of function" rehab provision across neurology, musculoskeletal, burns and plastics. This existing service provision does not include a dedicated slow stream / step down (Level 2) rehab inpatient provision and instead **these patients remain (inappropriately) within the acute wards in the tertiary hospital.**

In addition, there is a cohort of patients with "complex care" needs within Alder Hey who are part of the "Disability management" and/or "Neuro-palliative rehabilitation" pathways. These patients have **no transitional care facility to bridge the gap between hospital and home/community care**, and often remain in an acute/tertiary hospital bed longer than necessary. A working definition of complexity is:

- Any child who will need to leave hospital requiring more care than when they came, or changes to their existing care arrangements.
- Any child who requires input from more than one specialist team.

The extended length of stay in hospital often **creates an inappropriate dependency and makes discharge more difficult** as parents/carers are not confident to provide care at home.

Each of these specialty "rehabilitation" pathways are consultant led and supported by multi-disciplinary teams that comprise of nursing, physiotherapy, occupational therapy, speech and language therapy, dietetics, play therapy and orthotics as well as access to Psychology, Psychiatry and Education.

Current outpatient rehabilitation service provision is limited to an ad hoc arrangement to support patient's therapy through outpatient appointments, day attendances, and outreach to home and schools.

As a result of the current clinical model, Alder Hey is only charging standard tariff (for admission) and excess bed days when a patient exceeds the trim point. Under existing contracts, an additional "Rehab tariff" is not payable as patients remain on "base wards" under the same spell, rather than being discharged into a designated rehab facility under a Rehab Consultant in a separate spell.

There are currently no dedicated inpatient specialist rehabilitation beds, although the new hospital building has facilities to provide such a unit and discussions with NHS England are ongoing regarding commissioning dedicated Level 1.1 inpatient beds, along with formal implementation of a specialist rehabilitation outpatient service.

Currently there is no formal provision for Level 2 inpatient rehabilitation services. Patients requiring this Level 2 slow stream rehabilitation often remain in acute hospital beds at Alder Hey longer than necessary, with no dedicated "step down" unit enabling appropriate transition towards discharge home.

3.2 Drivers for change

The key drivers for this case are:

- The national and local drive for **improving quality of care and outcomes** through improved specialist rehabilitation services. This includes slow stream rehab, as an integral part of the whole pathway.

- Achieving the aims within the Healthy Liverpool Programme, including **person centred care** and transforming services to improve outcomes for children and young people.

- Provision of care in the right setting – with rehabilitation patients (including patients with "complex care" needs) able to access appropriate step down facilities to **support transition from hospital to home/community setting**.

- **Re-enablement and empowering families and carers** to have confidence and skills to care for children and young people who have complex needs – supporting earlier discharge home and reducing dependency on acute hospital staff.

- Developing specific capacity and competence of the workforce **around the needs of the child and family**, rather than leave rehab patients in an acute hospital ward.

- **Provision of care in the right setting** – ensuring tertiary/acute hospital beds are available for medically unstable patients.

- To improve the commissioning, contracting and financial arrangements for rehabilitation services for **patients in Cheshire and Merseyside**.

3.3 Proposal for Future

3.3.1 Proposal and Purpose

It is proposed that CCGs in the Mersey network commission a standalone Level 2 Slow Stream Rehabilitation Unit for children and young people. This service will support patients with complex rehabilitation needs who require oversight from Tertiary services but their ongoing rehabilitation can be provided outside of an acute hospital setting as step down care.

The purpose of the unit is to provide ongoing rehabilitation to children who are born with disabilities and special needs and those who acquire disabilities though serious illness or accidents. In particular the purpose is to provide a suitable facility for patients who no longer require hospital care, but whose rehabilitation needs cannot be met more effectively and efficiently in the outpatient, home, or other non-inpatient setting – **ie transition between hospital and home/community.**

This will be achieved through:

- Focus on enabling patients and their carers to become increasingly independent in their functional abilities.
- Planning of long term rehabilitation needs with local services to ensure a seamless transfer of care at an agreed point in time.
- Provision of training, support and recommendations for ongoing rehabilitation needs to therapists providing long term support to children in their home / community setting.
- Provision of a whole family approach to the management of the patients needs ensuring that the needs of the whole family are met. This includes creating a supportive environment to reduce dependence on nursing/therapy staff and increase confidence and autonomy of parents / carers.

3.3.2 Model of Care

The model of care will be based on a **time limited and goal focussed approach, supporting discharge home** and maintaining patient flow through the whole pathway. Upon admission to the unit, patients will have clearly defined goals and a planned discharge date.

For patients whose rehabilitation follows trauma and/or surgery these goals are likely to be related to their level of function (“restoration of function” pathway), however for medical patients with complex care needs these goals may be related to training of parent/carers, making arrangements for home care packages, or adaptions of their home environment (“disability management” and “neuro-palliative rehab” pathways).

Length of stay will vary depending on the goals and needs of the patient, however it is expected that patients will be discharged within 6 months. Patients on the disability management pathway are likely to stay in the unit for approximately 12 weeks on average.

This model of care is based on the following principles:

- Goal directed, with focus on transition home.
- Case management approach with focus on discharge planning on admission.
- Family centred, empowering parent / carer as well as the patient.
- Multi-disciplinary with teams inter-relating and providing “joined up” care.

- Care led by nursing and AHP teams, with access to hospital medical team available.
- Support from specialist services via in-reach. This would include daily input from trust grade / junior doctors, weekly consultant ward rounds, and consultant input to MDT from the appropriate speciality medical teams as required.
- Active partnership working with education and social services.

With regard to emergency medical cover "out of hours" the senior nurse on the unit would be able to call a nominated consultant for review and advice. As this will be a stand alone unit, the Acute Medical team from Alder Hey would not be available to attend emergencies. In the rare event that a patient needs to be readmitted to the acute hospital, this would have to be via ambulance transfer (in the same way as if the patient was at home).

The clinical model of care described above will be underpinned by the POINT model, developed at a stakeholder event (including input from patients/families) focused on children and young people who have complex care needs. The POINT model is shown in Figure 3.

3.3.3 Admission Criteria

All patients will be elective admissions, and there will be **clearly defined criteria for admission** to the unit, with agreement at Consultant level that the patient meets the criteria. Patients following different pathways may be admitted, including:

- Slow stream or step down rehab following illness or injury. Requires close links with tertiary services but can be provided outside of an acute setting.
- Rehab following specialist surgery, treatment or a protracted period of acute care.
- Inpatient care for children with complex, long-term or exceptional healthcare needs awaiting care packages, training or environmental adaptations.
- Technology dependant children (non-invasive) being actively transitioned from hospital to home.

Admission criteria will include:

- Planned elective admissions only.
- Medically stable patients (accepting the fragility of patients with complex needs).
- Acute medical issues have been addressed.
- Patients have a "rehabilitation prescription", with well defined goals.
- Discharge plan and expected length of stay identified prior to admission.
- Patients from Specialist Level 1.1 Rehabilitation Unit have reached rehabilitation plateau, but not yet ready for discharge home.
- Patients have complex health needs (eg tracheostomy or non invasive ventilation) and require step down transition care prior to discharge home.
- Patient needs cannot yet be met within the outpatient model, home situation, or other community setting.

Direct admissions from the community or DGHs may be appropriate for patients with complex needs (where admission to an acute tertiary hospital is not appropriate), for example due to breakdown in home care package, period of respite, carer illness etc. In these instances the admission criteria must still be met (eg planned elective admission, patient medically stable etc) and the goal driven, time limited model of care must still be applied.

Figure 3: POINT Model

Measure	Consideration	Pledge
Potential	Are we clear what the child's optimal potential is? Have we set goals to achieve this potential? Is everything we do geared toward achieving these goals and reaching this potential?	**We will have one set of shared goals and outcomes for children and young people and their families.**
Organised	Do we plan care effectively? Is the plan well communicated and understood? Does everyone know their role?	**We will do person centred planning and we will plan services and pathways across agencies.**
Involved	Do we provide the family and the child the opportunity to take control of their healthcare and be involved in decision making? Do we put them in control and provide them with options where possible?	**We will listen to you, hear what you say and act on your wishes.**
Needs Based	Do we currently deliver care that considers the child and their family and their holistic health and care needs? If not – how can we re-focus care planning on that basis?	**We will have the children and their families at the centre of ALL we do.**
Together	Do in house teams work together to co-ordinate care around the child and their family? Do we work effectively with teams outside the hospital to co-ordinate care?	**We will be a team for your child wherever they are and whatever their needs.**

3.3.4 Site Location

It is proposed that the Level 2 Slow Stream Rehabilitation Unit is located on the same campus as the new Alder Hey Hospital. The service will be within a "stand alone" unit, separate from the tertiary hospital building – which is important to reinforce that **this service supports transition from hospital to home,** and patients no longer require acute hospital care.

However there are a number of benefits and synergies achieved by co-location of the unit within "the Park" on the Alder Hey campus, and there are short term and long term options available on this site.

The current neurosciences building can be refurbished to provide "interim" accommodation until October 2017. This will be available from early 2016, and contains suitable facilities including 18 inpatient beds alongside therapy rooms for active rehab.

A permanent, purpose built facility would be required from October 2017 onwards and could be included as part of the overall strategy for the campus. Alternatively there is an option to utilise spare building capacity in the local health economy, and refurbish existing buildings to accommodate the Level 2 unit.

Whilst the standalone unit could be built elsewhere, **retaining this service "in the Park" at Alder Hey would have a number of benefits** including:

- Co-location supports integrated and joined up care, between the multidisciplinary and multi specialty teams.
- Joined up working between Level 1 and Level 2 rehabilitation services.
- Appropriate patients can be identified and "pulled" into the step down rehab unit.
- Co-location supports the threshold for admitting fragile patients with complex needs – reducing length of stay in hospital.
- Supports management of the psychological impact for parents and carers, reducing their dependency on acute hospital staff and empowering them to meet the needs of the child with increased confidence.
- Easy access to specialist facilities within the hospital (eg hydrotherapy pool, gait lab, music therapy, art therapy, story teller etc).
- Access to hospital medical teams, for advice, training and development.
- The benefits of the "park" environment is ideally suited for this group of patients.
- Patients, parents and carers have access to other facilities and amenities on site, for example Ronald McDonald House.

3.3.5 Whole Pathway

Figure 4 shows how the Slow Stream (Level 2) Rehabilitation Unit fits within the wider Specialist Rehabilitation pathway, which includes services commissioned by both NHS England and CCGs:

Figure 4: Service Pathway for Specialist Rehabilitation

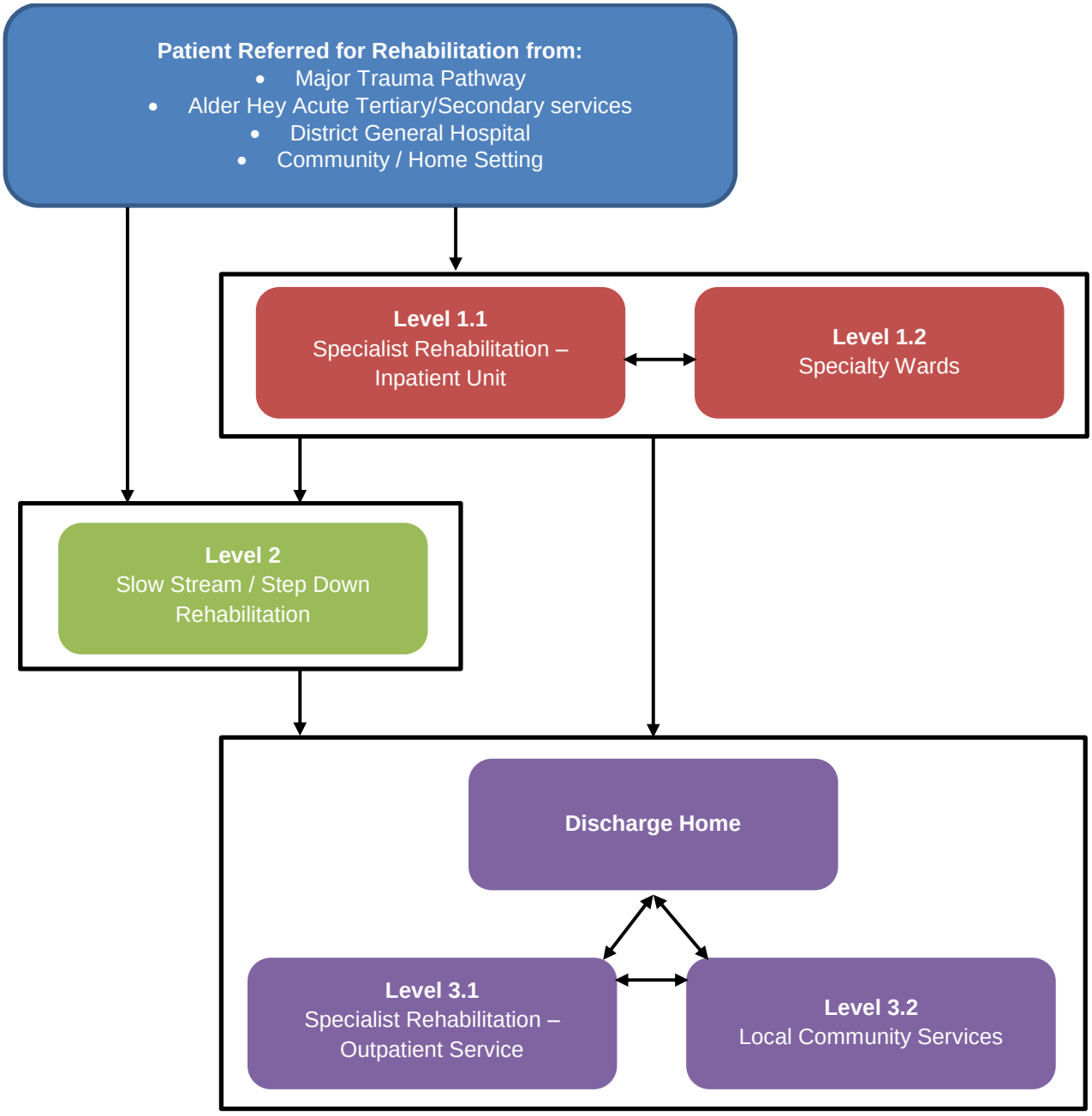


Figure 5 provides a more detailed description of Level 2 rehab care, within the context of the whole Specialist Rehabilitation Model of Care, consistent with the BSRM (2010).

Figure 5: Paediatric Specialist Rehabilitation Levels of Care

	Level of Rehabilitation Care			
	Level 1.1	**Level 1.2**	**Level 2**	**Level 3.1**
Service	Specialist Rehabilitation Unit	Specialty Wards	Extended Rehabilitation Unit	Specialist Outpatients provided by ACHT
Service Type	> Rehabilitation for highly complex low volume patients with severe to profound disabilities (Category A/B) > Early active acute rehabilitation intervention with specialised expertise from a multi-disciplinary team > Provision of in-reach service to specialty wards (Level 1.2)	> Rehabilitation for highly complex low volume patients with moderate to severe disabilities (Category A/B) > Supportive rehabilitation provided for individuals with a range of conditions > Input provided includes specialist interdisciplinary rehabilitation assessment and intervention which is condition specific	> Rehabilitation for highly complex low volume patients with moderate to severe disabilities (Category A/B) > Extended period of slow stream rehabilitation for individuals with a range of conditions > Input provided includes specialist expertise from a multi-disciplinary team	> Rehabilitation for individuals with mild to moderate rehabilitation needs with a range of conditions (Category C/D) > Outpatient service for follow up from Level 1.1, 1.2, 2 includes: - Day Attendance - Outpatient clinics - MDT clinics - Outreach
Workforce	> Consultant in rehabilitation medicine supported by appropriate medical staffing >Nursing and Therapy staff with knowledge and skills in specialised rehabilitation > Clinical and Neuro Psychology provided as part of multi-disciplinary approach > Rehabilitation Co-ordinator/Key Worker for the service/pathway > UKROC Administrator support for the service/pathway	> Specialist Rehabilitation provided by diagnostic specialty teams (including Nursing, Therapy, Psychology) with relevant applied knowledge in specialist rehabilitation principles and practice > UKROC Administrator support for the service/pathway	> Specialist Rehabilitation provided by a multi-disciplinary team including nursing, Therapy and Psychology staff with specialist rehabilitation expertise > Medical input provided by General Practitioner > Access to Specialist Rehabilitation Consultant	> Care provided by staff from Specialist Rehabilitation Unit multi-disciplinary team (Level 1.1) and Specialty Wards (Level 1.2)

3.4 Benefits to be Achieved

There is a wealth of research and evidence demonstrating the improvements in care as a result of receiving the right level of rehabilitation in a timely manner during a patients pathway. This includes:

- **Receiving the right care, at the right time and in the right place**
- **Better clinical outcomes**
- **Improved patient experience**
- **Empowerment of parents/carers to meet their child's care needs at home**
- **Reduced length of stay in hospital**
- **Efficient use of capacity and resources.**

More specifically, it is proposed that the metrics shown in Figure 6 are measured to demonstrate the effectiveness and efficiency of implementing the proposed pathway and the benefits of the slow stream rehab unit.

Figure 6: Measurable Benefits of the Level 2 Rehab Unit

Benefit to be Measured	Target
Clinical Outcomes	
- % of patients fully achieve their individual rehab goals	75%
- % of patients fully or partially achieve their individual rehab goals	100%
- % of patients have a rehabilitation passport / prescription	100%
- % of patients receive a psychological assessment (this may be undertaken in the Level 1 unit, prior to step down to Level 2).	100%
Patient Experience	
- % of patients and carers are supported by a Rehab Co-ordinator throughout their inpatient stay	100%
- % of patients and carers who agree that they were involved in planning, goal setting and making decisions regarding their rehab care	90%
- % of patients and carers reporting that opportunities for peer group support were encouraged	90%
- % of parent/carers who feel supported, and on discharge they have increased confidence to meet their child's care needs at home	90%
Efficient Use of Resources	
- % of patients with an EDD on admission	100%
- % of patients discharged on or before EDD	80%
- % of patients discharged from Level 2 unit within 180 days	95%
- Delayed discharges from Level 1 unit due to lack of Level 2 capacity	<100 days per annum
- Reduction in number of patients discharged after LoS >90 days in acute hospital, compared to baseline of 77 patients in 2014/15.	20% reduction

EDD = Estimated Date of Discharge
LoS = Length of Stay

4.0 Analysis of the Case

4.1 Demand and Capacity Analysis

4.1.1 Point of Prevalence Study

A Point of Prevalence (PoP) Study was undertaken (Jan-Feb 2014) as part of the wider Specialist Rehabilitation pathway review. This data was used to inform the business case submitted to NHS England regarding Level 1 and Level 3.1 rehabilitation services, and is summarised below in Figure 7.

Figure 7: Specialist Rehabilitation inpatient Bed Capacity and Outpatient Requirements

Level of Rehabilitation Care	Min pts identified during PoPs	Max pts identified during PoPs	Average pts
Level 1.1 Specialist Rehabilitation Unit	6	9	7
Level 1.2 Specialty Wards	26	29	28
Level 2 Slow Stream Rehabilitation Unit	**7**	**21**	**17**
Level 3.1 Specialist Outpatients *	10	20	13
Level 3.2 Generic Community Outpatients	6	12	10

** Patients identified during the inpatient study who may have been suitable for specialist outpatient therapy.*

4.1.2 Length of Stay

Given the relatively short sample period of the PoP study, a second piece of analysis has been undertaken looking at patient data over a longer period of time. This analysis is based on data of all inpatients (excluding daycases) discharged during 2014/15, and is summarised in Figure 8 below.

Figure 8: Patient Length of Stay (2014/15 Discharges)

Length of Stay	Number of Patients	% of Total Patients	Bed Days Occupied	% of Total Bed Days
0-30 days	16,337	98%	44,429	63%
31-90 days	226	1.4%	10,888	16%
91-180 days	53	0.3%	6,462	9%
181-365 days	16	0.1%	4,116	6%
>365 days	8	0.05%	4,114	6%
Total	**16,640**	**100%**	**70,039**	**100%**

Figure 8 shows that there were 77 patients discharged after more than 90 days in hospital, and **these patients represent <0.5% of total patient volume, but make up >20% of the demand for bed capacity**.

Whilst there may be some complex care patients suitable for admission who have length of stay less than 90 days, this patient cohort (LOS>90 days) is a useful "proxy" of demand for the slow stream rehabilitation unit and further analysis of this data shows that:

- In total, these 77 patients occupied 14,722 hospital bed days.

- This included 5,189 excess bed days.
- Commissioners were charged a total of £2.8m for these inpatient admissions. (HRG and EXBD income only, excluding critical care, non-PbR drugs etc).
- This charge included >£2.0m for excess bed days.
- These patients came from a broad geographical catchment, including 26 different English CCGs, as well as Wales and IOM (see Appendix C)
- The majority of these patients were classified as "tertiary", as shown in Figure 9.

Figure 9: Patients with LOS>90 days, by Commissioner

Responsible Commissioner	Number of Patients	Value
NHS England	59	£2.1m
CCG	5	£0.1m
Wales	10	£0.5m
IOM	3	£0.1m
Total	**77**	**£2.8m**

For clarity, not all of these 77 patients would not have met the admission criteria for the slow stream rehab unit (eg not medically stable, or not requiring goal focussed rehabilitation). However it is reasonable to assume that this group includes those patients who would have benefitted from a dedicated and discrete step down rehab service. Clearly, the relevant sub-group of patients would still spend some of their stay in the tertiary hospital before transfer to the slow stream rehab unit.

4.1.3 Capacity Requirement

Based on the PoP data, Figure 7 showed that there were an average of 17 patients meeting the Level 2 slow stream rehab criteria in the hospital on any given day. Using a planned occupancy rate of 85%, it is proposed that in the long term the stand alone Slow Stream Rehab Unit **should have capacity of 20 beds** *[ie 17patients / 85% occupancy = 20 beds].*

A 20 bed slow stream rehab unit provides capacity of 6,200 bed days, assuming 85% occupancy rate. Looking at the length of stay data (figure 8), in 2014/15 there were 77 patients discharged following more than 90 days in hospital, and they occupied a total of 14,722 bed days. A 20 bedded unit providing capacity of 6,200 bed days represents 42% of this total demand. Clearly these patients would still be admitted to hospital before transfer to the slow stream rehab unit and some of these patients would not meet the admission criteria. Equally some complex care patients with length of stay <90 days may be suitable for admission based on the proposed clinical model and admission criteria. Therefore this is consistent with the PoP study, and providing capacity of 6,200 bed days is considered to be appropriate.

It is noted that during the interim period (up to Oct 2017), the accommodation identified within the current neurosciences building only has available capacity of 18 beds (c.5,600 bed days, based on 85% occupancy). While additional capacity (up to 20 beds) may be required in the longer term, it is believed that 18 beds would be sufficient to commence, implement and embed the new pathway and model of care in the short term.

4.2 Financial Analysis

4.2.1 Revenue Funding from Commissioners

A set of non-mandatory prices for Specialist Rehabilitation have been published by UKROC, using a bed day currency. These prices are based on the work UKROC have undertaken relating to adult rehabilitation services. Whilst these do not necessarily reflect paediatric services precisely, they serve as a useful indicative tariff price per day for the Level 2 rehab unit.

Figure 10: 2014/15 Indicative Tariff (bed day prices)

Disease stage	Level 1a Hyper	Level 1a Physical	Level 1b	Level 2a	**Level 2b**
Very High	655	617	601	578	**521**
High	509	479	466	454	**409**
Medium	391	368	358	331	298
Low	318	299	291	231	208
Very Low	245	231	224	206	186

Figure 10 shows the indicative prices for Level 1 and Level 2 rehab services, and reflects the patient rehab needs. As described in Figure 2 and 5, patients in Level 1 and 2 inpatient services are expected to have Category A rehab or Category B rehab needs – for simplicity it is proposed that these are mapped to "Very High" and "High" in the tariff mdoel. (See Appendix B for Categories of rehab need).

As described in Appendix A, Level 2a is used in areas of the country without Level 1 services. On the assumption that NHS England commission Level 1 inpatient beds at Alder Hey, it is therefore appropriate to use Level 2b prices for the Level 2 Slow Stream unit.

Figure 11: Estimated Revenue

	Number of Bed Days	**Level 2b Tariff + MFF**	**Payment from commissioners**
Assume 40% Category A: "Very High"	2,234	£542	£1,210,828
Assume 60% Category B: "High"	3,351	£425	£1,424,175
Total	**5,585 ***		**£2,635,003**

** 18 beds x 365 days x 85% occupancy = 5,585 bed days*

Figure 11 applies the indicative tariff to an 18 bedded unit (based on capacity of interim accommodation), with an assumed 40:60 split between Category A and Category B patients. This gives an estimated **charge to commissioners of £2.6m.**

CCGs are responsible for commissioning Level 2 rehabilitation services. As stated in section 4.1.2, patients admitted to the slow stream rehab unit are likely to come from a broad geographical catchment (also refer to Appendix C). Therefore the estimated annual charge to each commissioner is presented as a range:

• Liverpool CCG	15-20%	£390-530k
• North Mersey CCGs	5-10% each	£130-260k
• Other CCGs	1-5% each	£25-130k
• Wales	10-15%	£260-390k

4.2.2 Revenue Savings for Commissioners

It is important to note that there are associated revenue savings for commissioners, and funding the slow stream unit using bed day prices will not be a net increase of £2.6m revenue to Alder Hey.

There will be a directly related reduction in excess bed days. As described in section 4.1.2, the cohort of 77 patients discharged following >90 days in hospital accounted for 5,189 excess bed days with an associated charge to commissioners of >£2.0m, at an average of £392 per excess bed day.

Using this figure of 5,189 as a proxy for expected excess bed days saved (compared to 5,585 occupied bed days in the Level 2 rehab unit) there will be a corresponding income reduction of >£2.0m. Allowing for the assumption that approximately 20% of this bed day saving will be achieved through implementation of Level 1 service, it is estimated that there will be a **revenue saving to commissioners of £1.6m** associated with the Level 2 unit.

This means that the **net increase in funding to Alder Hey is c.£1.1m**, which will be used to invest in the required staffing levels (see section 4.3).

As per Figure 9, under current commissioning arrangements the majority of this excess bed day saving will benefit NHS England, which represents a funding shift from tertiary to secondary commissioners. This reflects the level of intervention being received by patients at this stage of their treatment.

In addition there will be wider savings to the health economy as a result of providing "the right care, at the right time and in the right place". These are difficult to quantify, but should not be discounted and include:

- reduced long term health and social care interventions over the patient's life time, as a result of improved function and independence following timely rehabilitation.
- reduced risk of infection as a result of moving patients out of acute hospital setting, reducing length of stay and avoiding additional treatment costs.
- improved school attendance, and increased independence within the school setting.
- reduced reliance on full time carers, and benefits to family experience and quality of life – including improved access and participation in social / peer group activities.

4.2.3 Forecast Expenditure for Alder Hey

The majority of service delivery revenue costs will be driven by workforce requirements, which are described in section 4.3. A summary of the forecast annual expenditure is shown in

Figure 12, and this matches the estimated £2.6m revenue charge to commissioners (Figure 11). Full workforce and cost model is included as Appendix D.

Figure 12: Forecast Expenditure

Expenditure	£m
Medical Staff	0.3
Nursing Staff	0.9
AHP Staff	0.6
Other Pay	0.2
Non Pay	0.1
Indirect Costs and Overheads	
- Facilities & Estates	0.3
- Capital Charges	0.2
- Overheads	0.1
Total	**2.6**

4.2.4 Capital and Set Up costs

Phase 1:

The interim proposal to accommodate the slow stream rehab unit within the current neurosciences building means that ward space and therapy rooms are available from early 2016 – subject to some refurbishment. An estimated **£200k capital expenditure** will be required, primarily for new provision of medical gases, oxygen plan and remedial works, to convert the existing building into a suitable facility for the service.

Financial support of £200k is requested from commissioners to cover phase 1 capital costs.

Phase 2:

In the longer term (2017 onwards), a permanent purpose built facility will be required. Initial estimates are that the building would require 1,338 m^2, with detail shown in the draft Schedule of Accommodation included as Appendix E. Assuming a capital cost of £4,500/m^2 this would require **capital outlay of c.£6m.**

If an alternative option is identified with regard to utilisation of existing building capacity in the local health economy, then the capital outlay for refurbishment would depend out the current state of the buildings.

It is proposed that the Trust work together with commissioners and third parties to identify and evaluate options for funding these capital costs.

4.3 Workforce

The clinical model (as described in section 3.2.2) will be nurse and therapy led, with full multi-disciplinary team input including social services and education. The staffing model shown in Figure 13 is from NHS England Service Specification for Specialised Rehabilitation for Patients with Highly Complex Needs (ref D02/S/a) and is based on BSRM standards.

Figure 13: Minimum staffing provision for specialist inpatient rehabilitation services. Level 2 Rehabilitation Service (for every 20 beds).

Staff Group	Level 2b WTE
Medical Staff:	
- Consultant accredited in rehabilitation medicine	1.5
- Trust grade doctors (or training grades >FY1)	1.5-2.0
Nurses	24.0-30.0
Therapy Staff	
- Physiotherapists	4.0
- Occupational therapists	4.0
- Speech and language therapists	1.5-2.5
- Clinical psychologist/counselling	1.5-2.0
- Social Worker / Discharge co-ordinator	1.0-1.5
- Dietician	0.5-0.75
Clerical Staff	3.0
Plus: Trained therapy assistants, technicians, engineers and other professions as appropriate to caseload.	

It is noted that the System Resilience Group has funded a dedicated Complex Care Team with non-recurrent money in 2015/16, including:

- 0.5wte Consultant with special interest
- 2.0wte Nurse Specialists in complex care
- 1.0wte AHP (discipline to be determined)
- 1.0wte Complex care co-ordinator
- Additional speciality MDT input

In order to ensure the unit works efficiently, with effective patient flow it is recommended that the specialist nurses and complex care co-ordinator are retained on a substantive basis, in addition to the minimum staffing levels shown in Figure 13.

Facilities and estates staff would also be required, including a ward based chef, since this is a stand alone unit. A detailed workforce and cost model is included as Appendix D.

4.4 Impact on Other Service Providers

In order for the slow stream rehab unit to be effective in providing a transition from hospital to home, it is essential that other service providers are actively engaged and support patients appropriately within this unit. This includes sharing ownership of goal setting and discharge planning.

Other providers who are key stakeholders and would be active partners in this service are:

- Social Services
- Schools / Education Providers
- Community Healthcare

In particular, all patients should receive educational input from first day of admission as this is congruent with being medically stable and transitioning from hospital to home/community.

5.0 Implementation Plan

Implementation would need to be considered in line with the wider pathway development, with ongoing discussions with NHS England regarding the Level 1 inpatient unit.

Figure 14 identifies high level milestones for the approval and implementation of the proposal for a Level 2 service, as described in this case.

Figure 14: Implementation Milestones

Milestone Activity	Completion Date
Teleconference with Liverpool CCG, NHS England and Alder Hey to discuss Rehabilitation pathway	Nov 2015
Present this business case at Mersey CCG Network meeting	Dec 2015
Agreement from CCGs to proceed	**Dec 2015**
Confirmation of funding arrangements and contract variation	**Dec 2015**
Commence recruitment of additional staff	Dec 2015
Convert current neuroscience ward into (interim) dedicated Level 2 Rehabilitation Unit	Jan-Feb 2016
New staff commence in post	Mar 2016
Commence service delivery of Slow Stream Rehab in dedicated unit	**Apr 2016**
Identify Capital Funding for permanent Level 2 facility	Jan-Mar 2016
Commence Design and Build of new facility	Apr 2016
Interim accommodation close and new facility opens	**Oct 2017**

6.0 Conclusion and Recommendation

6.1 Conclusion

Historically rehabilitation services at Alder Hey have been under recognised, and pathways have not been formally commissioned or funded. In line with national and local strategy, the Trust has undertaken a review of this pathway and aligned local patient need with nationally developed models.

As a result of this review, **Alder Hey are seeking to provide improved rehabilitation services in dedicated facilities, to provide "the right care, at the right time and in the right place".** This pathway includes a Level 1.1 Specialist Rehabilitation Unit (within the main tertiary hospital) and a Level 2 Slow Stream / Step Down Rehabilitation Unit in the park, adjacent to the hospital.

This Level 2 rehab service will bridge the gap between the hospital and community setting. The model of care will be goal focused and time limited, **enabling appropriate transition for patients and their families to support their discharge home.**

Provision of properly commissioned rehab services will bring **significant benefits to patients,** including:

- Receiving the right care, at the right time and in the right place
- Better clinical outcomes
- Improved patient experience
- Empowerment of parents/carers to meet their child's care needs at home
- Reduced length of stay in hospital
- Efficient use of capacity and resources

6.2 Recommendation

It is recommended that a Level 2 Paediatric Rehabilitation service is commissioned and provided by Alder Hey in a purpose built stand alone unit with capacity of 20 beds (interim capacity of 18 beds). As part of a complete Specialist Rehabilitation pathway this will deliver significant benefits to patient experience and improved clinical outcomes, with measurable benefits identified in Figure 6 (see section 3.4).

This would be enabled by agreement to provide revenue funding on a bed day tariff basis – derived from the adult rehab prices developed by UKROC.

In addition, it is requested that commissioners provide the Trust with financial support to cover the initial capital costs (estimated at £200k) and work together to identify a funding solution for the permanent purpose built facility required from 2017 onwards.

Appendix A
The Definition of Specialist Services

The SSNDS definition No 7 set criteria for three levels of service:

- Level 1 services - providing specialised rehabilitation services serving a catchment population > 1 million and taking a selected population of patients with highly complex needs (>85% category A).

- Level 2 units - providing 'local specialist rehabilitation' for a catchment population of circa 500K and taking a mixed group of patients but predominantly category B needs

- Level 3 services - these provide rehabilitation in the context of acute or intermediate care services to Category C and D patients. These include:
    - Level 3a – rehabilitation provided in the context of other specialist services
    - Level 3b - rehabilitation provided by local generic services.

However Level 1 services did not exist in all areas of the country and in some regions, an intermediate level of service had developed serving a 'supra-district' population circa 750K, and taking a higher proportion (50%) of category A patients. These were classified by the BSRM as Level 2a services to distinguish them from local (Level 2b) services.

Appendix B
Four categories of patient need for rehabilitation services

Patients with Category A rehabilitation needs

- Patient goals for rehabilitation may include:
  - Improved physical, cognitive, social and psychological function / independence in activities in and around the home;
  - Participation in societal roles (eg work / parenting / relationships);
  - Disability management eg to maintain existing function; manage unwanted behaviours / facilitate adjustment to change
  - Improved quality of life and living including symptom management, complex care planning, support for family and carers, including neuropalliative rehabilitation
- Patients have complex or profound disabilities e.g. severe physical, cognitive communicative disabilities or challenging behaviours.
- Patients have highly complex rehabilitation needs and require specialised facilities and a higher level of input from more skilled staff than provided in the local specialist rehabilitation unit. In particular rehabilitation will usually include one or more of the following:
  - intensive, co-ordinated interdisciplinary intervention from 4 or more therapy* disciplines, in addition to specialist rehabilitation medicine/nursing care in a rehabilitative environment
  - medium length to long term rehabilitation programme required to achieve rehabilitation goals – typically 2-4 months, but up 6 months or more, providing this can be justified by measurable outcomes
  - very high intensity staffing ratios e.g. 24 hour 1:1 nurse “specialling”, or individual patient therapy sessions involving 2-3 trained therapists at any one time
  - highest level facilities /equipment e.g. bespoke assistive technology / seating systems, orthotics, environmental control systems/computers or communication aids, ventilators.
  - complex vocational rehabilitation including inter-disciplinary assessment / multi-agency intervention to support return to work , vocational retraining, or withdrawal from work / financial planning as appropriate
- Patients may also require:
  - Highly specialist clinical input e.g. for tracheostomy weaning, cognitive and/or behavioural management, low awareness states, or dealing with families in extreme distress
  - ongoing investigation / treatment of complex / unstable medical problems in the context of an acute hospital setting
  - neuro-psychiatric care including: risk management, treatment under sections of the Mental Health Act,
  - support for medicolegal matters including mental capacity and consent issues
- Patients are treated in a specialised rehabilitation unit (i.e. a Level 1 unit).
- Patients may on occasion be treated in a Level 2 unit depending on the availability of expert staff and specialist facilities as well as appropriate staffing ratios.

Patients with Category B rehabilitation needs

- Patient goals for rehabilitation may be as for category A patients
- Patients have moderate to severe physical, cognitive and/or communicative disabilities which may include mildmoderate behavioural problems
- Patients require rehabilitation from expert staff in a dedicated rehabilitation unit with appropriate specialist facilities.
- In particular rehabilitation will usually include one or more of the following:
- Intensive co-ordinated interdisciplinary intervention from 2-4 therapy disciplines in addition to specialist rehabilitation medicine/nursing care in a rehabilitative environment
- medium length rehabilitation programme required to achieve rehabilitation goals – typically 1-3 months, but up to a maximum of 6 months, providing this can be justified by measurable outcomes
- special facilities/ equipment (e.g. specialist mobility/ training aids, orthotics, assistive technology) or interventions (e.g. spasticity management with botulinum toxin or intrathecal baclofen)
- interventions to support goals such as return to work, or resumption of other extended activities of daily living, eg home-making, managing personal finances etc
- Patients may also have medical problems requiring ongoing investigation/treatment
- Patients are treated in a local specialist rehabilitation unit (i.e. a Level 2 unit).

Patients with Category C rehabilitation needs

- Patient goals are typically focused in restoration of function / independence and co-ordinated discharge planning with a view to continuing rehabilitation in the community
- Patients require rehabilitation in the context of their specialist treatment as part of a specific diagnostic group (e.g. stroke)
- Patients may be medically unstable or require specialist medical investigation / procedures for the specific condition
- Patients usually require less intensive rehabilitation intervention from 1-3 therapy disciplines in relatively short rehabilitation programmes (i.e. up to 6 weeks)
- Patients are treated by a local specialist team (i.e. Level 3a service) which may be led by consultants in specialties other than Rehabilitative Medicine (e.g. neurology / stroke medicine) and staffed by therapy and nursing teams with specialist expertise in the target condition.

Patients with Category D rehabilitation needs

- Patient goals are typically focused in restoration of function / independence and co-ordinated discharge planning with a view to continuing rehabilitation in the community if necessary
- Patients have a wide range of conditions but are usually medically stable
- Patients require less intensive rehabilitation intervention from 1-3 therapy disciplines in relatively short rehabilitation programmes (i.e. 6-12 weeks)
- Patients receive an in-patient local non-specialist rehabilitation service (i.e. Level 3b) which is led by non-medical staff.

* Therapy disciplines may include: physiotherapy, occupational therapy, speech and language therapy, psychology, dietetics, social work, orthotics, rehabilitation engineering, vocational / educational support (including play therapy in children's settings).

Appendix C
Number of Patients Discharged in 2014/15 following LOS>90days, by Commissioner

Commissioner	No. of Patients
NHS BLACKPOOL CCG	1
NHS BURY CCG	1
NHS CHORLEY AND SOUTH RIBBLE CCG	2
NHS CUMBRIA CCG	1
NHS DONCASTER CCG	1
NHS EAST LANCASHIRE CCG	3
NHS EASTERN CHESHIRE CCG	1
NHS FYLDE & WYRE CCG	1
NHS GREATER PRESTON CCG	1
NHS HALTON CCG	3
NHS HEYWOOD, MIDDLETON AND ROCHDALE CCG	1
NHS KNOWSLEY CCG	4
NHS LIVERPOOL CCG	13
NHS NORTH MANCHESTER CCG	2
NHS OLDHAM CCG	1
NHS SOUTH CHESHIRE CCG	2
NHS SOUTH SEFTON CCG	3
NHS SOUTHPORT AND FORMBY CCG	2
NHS ST HELENS CCG	7
NHS STOCKPORT CCG	1
NHS VALE ROYAL CCG	1
NHS WARRINGTON CCG	4
NHS WEST CHESHIRE CCG	1
NHS WEST LANCASHIRE CCG	1
NHS WIGAN BOROUGH CCG	3
NHS WIRRAL CCG	3
BETSI CADWALADR UNIVERSITY LHB	9
POWYS TEACHING LHB	1
ISLE OF MAN	3
TOTAL	**77**

Appendix D
Full Workforce and Cost Model

Staff Group	AfC Band	WTE	£000's
Medical Staff			
- Consultant		1.2	144
- Trust grade doctors		1.5	120
Nurses			
- Specialist in complex care	7	2.0	88
- Qualified Nurses	5-7	12.2	455
- HCA	3	13.0	340
Therapy Staff			
- Physiotherapists	5-7	4.0	141
- Occupational therapists	5-7	4.0	141
- Speech and language therapists	7	1.5	66
- Clinical psychologist/counselling	7-8a	1.5	76
- Social Worker / Discharge co-ordinator	7	1.0	44
- Dietician	7	0.5	22
- Therapy Assistants and Technicians etc.	3-4	3.5	84
Other Staff			
- Clinical Leadership and Management	7-8a	2.0	98
- Admin and Clerical	2-5	3.0	71
- Ward Based Chef	2	1.2	23
Non Pay Costs			60
Subtotal		**52.1**	**1,973**
Indirect Costs and Overheads			
- Facilities & Estates Costs			300
- Capital Charges			200
- Other			95
Total Costs			**2,568**

Appendix E
Draft Schedule of Accommodation for Purpose Built Facility

The areas of each room are taken from HBN and are in line with the new Alder Hey in the Park hospital, but slight increase for bedroom/en suite due to patient/service group. Schedule is a draft at this stage, subject to detailed design/user brief.

Departmental accommodation	Space area m^2	Quantity	Total area m^2
Single rooms with en-suite shwr/wc/wash	18.0	20	360.0
Carer's suite - sitting room/bedroom/shwr/wc/wash	27.5	2	55.0
Breast feed room	4.0	1	4.0
Baby feed store/prep room	7.0	1	7.0
Patient assisted bath/wc/wash	14.0	3	42.0
Disabled wc/wash	4.5	1	4.5
Carer's kitchen/sitting/wc	20.0	1	20.0
Play area	20.0	1	20.0
Recreation and dining room	39.0	1	39.0
Ward kitchen	20.0	1	20.0
Ward pantry	10.0	1	10.0
Dirty utility	12.0	1	12.0
Clean utility	10.0	1	10.0
Classroom	24.0	1	24.0
Teachers room	7.5	1	7.5
Therapy room	30.0	1	30.0
Treatment room	16.0	1	16.0
Interview room	7.5	1	7.5
MDT room	20.0	1	20.0
Ward Office	15.0	1	15.0
Staff base	5.0	1	5.0
Manager's office	9.0	1	9.0
Staff room	15.0	1	15.0
Staff change shwr/wc/wash	25.0	1	25.0
			0.0
Linen	5.5	1	5.5
Laundry room	8.0	1	8.0
General store	6.0	1	6.0
Resus trolley bay	6.0	1	6.0
Wheelchair/buggy bay	6.0	1	6.0
Switch cupboard	2.0	1	2.0
Subtotal			**811.0**
Plant (Generator/Sub/Heat plant/AHU)			200.0
Circulation			327.0
External space			Park
Departmental area			**1,338.0**

Alder Hey Children's NHS
NHS Foundation Trust

Board of Directors

12th January 2016

Update report on the Board Assurance Framework

1. Purpose

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

2. Review of the BAF

The BAF was discussed at and updated following the Board meeting on the 1st December 2015.

In section 3 below is a summary of the current state of the BAF and in Section 4, a brief on the changes since the last Board meeting. A Heliview diagram is included as Appendix A and the full BAF register as Appendix B.

3. Summary of BAF - at 6th January 2016

Ref, Owner	Risk Title	Risk Rating: I x L		Monthly Trend	
	(14-15 references given in brackets where different)	Current	Target	Last	Now
	STRATEGIC OBJECTIVE 1: Deliver **clinical excellence** in all of our services				
1.1 (1.1A) HG	**Maintain care quality in a cost constrained environment**	4-2	4-2	STATIC	STATIC
1.2 (1.3) JA	**Mandatory & compliance standards**	4-5	4-2	STATIC	WORSE
1.3 (1.4) MS	**Non-compliant estate**	4-3	4-1	STATIC	STATIC
1.4 (1.5) MS	**Training & development of clinical workforce**	4-3	4-1	STATIC	STATIC
1.5 (1.6) ES	**Systems to support Ward to Board reporting**	4-3	3-2	BETTER	STATIC
	STRATEGIC OBJECTIVE 2: Be a **world class** centre for children's **Research & Development**				
2.1 (2.4) JS	**Finance for Phase 2 of Research facility**	4-4	2-3	STATIC	STATIC
	STRATEGIC OBJECTIVE 3: Ensure all of our **patients** and their **families** have a **positive experience** whilst in our care				
~~3.1 JA~~	~~**Transformation programme for patient centred care**~~	~~4-3~~	~~4-3~~	STATIC	~~CLOSED~~
	STRATEGIC OBJECTIVE 4: Ensure all of our **staff** have the right **skills, competence, motivation and leadership** to deliver our vision				
4.1 MS	**Sustain workforce capability**	3-4	3-3	STATIC	STATIC
4.2 MS	**Workforce engagement and support**	3-3	3-2	STATIC	STATIC
	STRATEGIC OBJECTIVE 5: Further improve our **financial strength** in order to **continuously invest in services**				
5.1 JS	**Income & expenditure Plan**	4-4	4-2	STATIC	STATIC
	STRATEGIC OBJECTIVE 6: Be the **provider of 1st choice** for children, young people and their families				
6.1 JS	**Business development and growth**	4-3	4-2	STATIC	STATIC
6.2 JS	**EPR Implementation**	4-4	4-2	STATIC	STATIC
6.3 JS	**Sustaining national designations for specialist services**	4-3	4-2	STATIC	STATIC
6.4 JS	**Relationships with new commissioners**	4-3	4-2	STATIC	STATIC
	STRATEGIC OBJECTIVE 7: Deliver the **hospital in the park** by 2015/16				
7.1 (7.8) DP	**Capacity to deliver "day job" as well as complex development programme**	2-3	2-3	STATIC	BETTER
7.2 (7.9) CW	**Charity delivering targets for new facilities**	4-3	4-2	BETTER	-
7.3 DP	**Delivering safe and effective hospital move**	3-3	3-3	BETTER	BETTER

4. Changes since last Board meeting

The table above shows that the majority of the risks on the BAF remained broadly static. Some risks have shown significant progress against actions and these are outlined below, categorised into external and internal risks, with their owner's initials shown in brackets.

External risks

- ***Business development and growth (JS)***
  - National guidance confirms no change to specialist children's tariff top ups for 16/17 and no introduction of a marginal rate for specialist services commissioned activity for 16/17
  - Specialist commissioned services also funded for growth in 16/17; however no change tor risk rating as Trust underperformance remains a risk to establishing required base line contract values for 16/17 – contract negotiations will focus on the non-recurrent nature of underperformance linked to new EPR and hospital move.
  - Awaiting response from specialist services commissioner regarding Acute Rehab Model proposal.
- ***Mandatory and compliance standards (JA)***
  - Quarter 3 fail for ED
  - Action plan in place for Q4 achievement
  - RTT achieved
- ***Sustaining national designations- specialist services (JS)***
  - Positive feedback received re Liverpool cardiac services proposal and Trust working with partners with a view to delivering new service model from September 2016.
  - Detailed plans to be discussed at Board.
  - Discussions continuing with LWH re neonatal services
- ***Relationships with new commissioners (JS)***
  - No change
- ***Charity delivering targets for new facilities (CW)***
  - No update provided

Internal risks:

- ***Delivering safe and effective hospital move (DP)***
  - Majority of key issues dealt with or date secured. Next phase post-Xmas to clear up residual risks and establish fix-it system.
- ***Income and expenditure plan (JS)***
  - Poor financial performance in November (month 8) with £1m variance to plan taking cumulative adverse variance to plan £1.3m (£3.8m deficit v plan of £2.5m deficit).
  - Forecast reviewed and maintained at outturn deficit of £3.7m based on CBU recovery plans however, predicated on performance against plan over Q4.

  - Forecast cash balance reduced from plan of £6m to £4m reflecting deterioration in financial position and capital expenditure pressures arising from new hospital.
- ***Implement EPR (JS)***
  - No change
- ***Non complaint estate (MS)***
  - H&S Risks to continue to be reviewed and monitored through IGC
- ***Maintain care quality in a cost constrained environment (HG)***
  - Progress against development of Quality Strategy ongoing with plan to update assurance committees during the month of Jan (CQAC) and March (BoD)
- ***Sustain workforce capability (MS)***
  - Plans being drafted for additional nurse recruitment from Italy in early 2016
  - Refreshed action plan to address sickness absence to BoD in Jan 2016
  - Recruitment Manager started in post Jan 2016
- ***Training & development of clinical workforce (MS)***
  - All mandatory training topics have shown improvements
  - Learning Needs Analysis being developed for inclusion into 16/17 business planning process
- ***Workforce engagement and support (MS)***
  - Management and Leadership Development Strategy presented to Workforce and OF Committee in Dec 2015 with final strategy going in Feb 2016
  - Staff Survey initial findings to BoD in Jan 2016
- ***Finance of Phase 2 of Research facility (JS)***
  - Discussions ongoing with Edge Hill and John Moores re contribution towards phase 3 – awaiting letter and proposal from EHU
- ***Transformation programme for patient cantered care***
  - CLOSED
- ***Systems to support Board to ward reporting (ES)***
  - Work continues to embed risk management improvement plans
  - Executives now receiving notifications of key incidents for the last couple of months enabling more immediate line of sight on emerging issues
  - Overarching governance structures currently under review to reflect refresh of the Trust strategy
- ***Capacity to deliver "day job" as well as Programme (DP)***
  - Commissioning process closed / fixed date for majority of major issues

Erica Saunders
Director of Corporate Affairs
January 2016

Board Assurance Framework 2015-16

Alder Hey Children's NHS Foundation Trust

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

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

Existing Control Measures	
• Quality impact assessment of all planned changes	• Risk assessment and utilisation of risk registers in responding to incidents and other drivers.
• Quality Report performance against quality aims scrutinised at CQAC and Board.	• CBU and Corporate Dashboards in place and are part of updated Performance Framework.
• Weekly Meeting of Harm	• Programme of quality reviews (deep dives) planned across all departments. Implemented and being reported via the quality report.
• Ward dashboards	• Refresh of CQAC to provide a more performance focussed approach
• Changes to ESR to underpin workforce information -	• Develop CIP plans and align to HWWITF and operational efficiencies

Assurance Evidence	**Gaps in Controls/Assurance**
Monthly reporting to CQSG. CQAC focus on performance. Analysis of incident reports. Monthly reporting of the Corporate Report to Board. Outputs from Patient Safety Questionnaire. Monthly Quality Report. Trust removed from enhanced surveillance following review with CCG quality leads. Outputs from Quality Review Programme Workforce information now provided - starters/leavers and age profiling	Gaps in information available in timely manner to support real time understanding of quality performance Reduced investment opportunity to respond to clinical development as a result of financial situation.

Actions Required to Reduce Risk to Target Rating	**Latest Progress on Actions**
Job descriptions for HDU consultants to include IPC responsibilities.	complete
CBUs to identify medical leads to sit on IP&C Committee.	complete
Implementation of manager self-serve re ESR	complete
Significant progress achieved in incident management, analysis and learning, nurse recruitment and quality reporting.	all complete with the exception of quality reporting for which further work is underway
Need to ensure consistent input at department level	
Successful bid to "Sign up to safety" has resulted in 182k investment in support posts	Post holders commencing w/c 14 July 2015

Executive Lead's Assessment
June 2015: update to action 6 above August 2015: no change September 2015: deep dive into performance indicators to take place 'post move'. Work on developing Quality Strategy underway, including review of assurance systems and processes. Sign up to Safety launch w/c 23.11.15 October 2015: multi-disciplinary engagement sessions on developing the Quality Strategy continued during the month of October December 2015: Progress against development of Quality Strategy ongoing with plan to update assurance committees during the month of Jan (CQAC) and March (BoD)

Board Assurance Framework 2015-16

Alder Hey Children's NHS Foundation Trust

BAF 1.2	**Strategic Objective:** Deliver clinical excellence in all our services	Risk Title: Mandatory & compliance standards		
Related CQC Themes: Safe, Caring, Responsive, Well Led, Effective				
Exec Lead: Judith Adams	**Type:** Internal, Known	Current IxL: 4-5	Target IxL: 4-2	Trend: WORSE

Risk Description

Failure to deliver on all mandatory and compliance standards including those of the regulators Monitor and CQC

Existing Control Measures

• Internal Action Plan and trajectory in place for 18 weeks.	• Performance Review Group.
• CBU Performance Meetings.	• Regulatory status with: Monitor, CQC,NHSLA, ICO, HSE, CPA, HTA,MHRA etc.
• Compliance tracked through the corporate report and CBU Dashboards.	• Risks to delivery addressed through PMG, RBD & CQSG.
• IST review of 18 weeks	• Trust committed to working with NHSLA on new assessment process.
• Development of early warning indicators	• Internal and external (KPMG) review of CQC KLOEs
• Theatre and workforce improvement plan to be developed and delivered	• Seasonal beds opened all year to facilitate increased elective activity
• KPIs for Winter Resilience (1.3m funding) developed, agreed with Commissioners.	

Assurance Evidence	Gaps in Controls/Assurance
Regular reporting of delivery against compliance targets through CQSG and CQAC. Monthly reporting to the Board via the Corporate Report. Report from IST following visits to Trust Operational effectiveness measures (key risks with early warning measures) to RABD CQC Action plan reviewed at Execs and Operational Delivery Group Compliance assessment against Monitor Provider Licence to go to Board MIAA review of 18 weeks	Breach of 18 week target in Q3. Theatre and bed capacity Some areas remain fragile e.g. IG toolkit, 4 hour waits, MSE, evidence of compliance re learning disabilities declaration. Assurance required to underpin CBU reporting on CQC standards. Need clear process for 'horizon scanning' to anticipate risks and issues. Work with CCG to manage demand & develop/fully utilise existing capacity across PC Failure of CCG and local health economy to successfully deliver on agreed plans to meet reduction in ED attendances

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Theatre improvement and cancelled operations improvement plan required	Winter plan and escalation model developed and agreed - switch to increase of day surgery at peak of RSV to minimise elective impact
Plans to address gaps in high demand specialties	Further work in progress to address FU capacity shortfall. Additional clinics now planned. Further work required to improve OPD Flow, staffing and IT systems to create capacity
Review SRG plans to ensure 4 hour target met	New ED triage system in place. Medical and APNP rotas under review to extend senior cover into evening. Meeting with commissioners planned 6/1/16
Ongoing update to the CQC Action Plan	New health records committee to be established to ensure sustainability and to address longer term plan and impact of Image now and EPR
Review bed capacity and staffing model in line with design of AHP and plans for seasonal variation	Model re-run, plans to be agreed to manage outputs. For presentation at Ops Board on 30th April and actions to be agreed
Review with CCG further actions required to manage ED demand in line with agreed plans for new AHP	Sign off agreed model to support Smithdown WIC and longer term model for WIC. Progress community gen paed model to support local hubs and GPs. Progress with LA model for HV and SN to support reduced demand on urgent care.
Ensure robust booking and scheduling systems and processes to support 18 week pathway	Action plan developed to address current know issues. Actions targeted to clinical, admin and IM&T teams

Executive Lead's Assessment

March 2015: Key risks to delivery remain the plans to address peaks in activity profile created due EPR go live and hospital move which if not delivered create backlog
April 2015: Year end position on access targets achieved, diagnostics position improved and will be compliant by end May. Improvement work on health records continues with clear milestones and actions.
June 2015: Monitor compliance standards met. Removal of 18 week admitted and non admitted targets effective from July - open pathways target remains. New model of care developed for ED/EDU and approved - supported by SRG monies in interim whilst new financial/clinical model developed and evaluated. CQC re-inspection undertaken - awaiting report findings. Health records improvements against plan on track.
August 2015: no change
September 2015: Compliance with Q1 & 2 contractual and regulatory standards met, ED performance improved following Mv6 go live issues. Open

pathways remain challenging and will be further impacted by reduction in elective activity over hospital move period in addition risk of Ed performance in October will need close monitoring following hospital move. October 2015: ED Performance at risk for Q3 and for year. Attendances remain high and local health economy plans for reductions not effective. Further work required internally on flows and action plan in place. Agreement reached with CCG on support to Smithdown WIC effective immediately. Work required over Q3/4 to address FU backlog following EPR implementation and hospital move. November Qtr 3 fail for ED. action plan in place for Qtr 4 achievement. RTT achieved

Board Assurance Framework 2015-16

Alder Hey Children's NHS Foundation Trust

BAF 1.3	**Strategic Objective:** Deliver clinical excellence in all our services	Risk Title: Non compliant estate		
Related CQC Themes: Safe, Effective, Well Led				
Exec Lead: Melissa Swindell	**Type:** Internal, Known	Current IxL: 4-3	Target IxL: 4-1	Trend: STATIC

Risk Description	
Risk of enforcement action arising from safety incidents due to a failure to maintain a compliant estate and robust and embedded health & safety practices in the work place.	
Existing Control Measures	
• PPM structure aligned to critical risk areas.	• RBDC has agreed a cycle of compliance reporting on key risk areas based on up to date legislation and guidance.
• H&S Committee has oversight of risk areas.	• Prioritise backlog maintenance budget to key risk areas.
• H&S annual work plan - overseen by H&S Committee and ratified by IGC	• Monthly meetings of Estates, Health & Safety teams chaired by DSA to review common risks
• H&S Risks assessed at IGC and action take to mitigate risks.	• H&S Sub-group established to feed into weekly commissioning group to ensure all outstanding or new H&S risks are considered as part of on going CHP commissioning and maintenance processes.
• Outcomes of H&S Risk summit re CHP move absorbed into H&R Risk Register and presented to July 15 IGC	• H&S Risks re CHP move incorporated into Occupation Risk Register to be discussed at Execs and IGC in November
Assurance Evidence	**Gaps in Controls/Assurance**
Remain within HSE/CQC compliance parameters. Regular reports to RBDC on progress to mitigate top 5 risks. Reporting on Estates Compliance Dashboard to RBDC on quarterly basis. H & S Committee bi monthly reporting to IGC. Reporting to Board and IGC on assessment of key risks and investment to address critical issues. HSE visit - no major issues reported. External review undertaken of H&S - nothing adverse reported. MIAA review of PPMs and action plan	Levels of practical manual handling training improved but still below required levels. Insufficient number of people ready and willing to carry out H&S risk assessments
Actions Required to Reduce Risk to Target Rating	**Latest Progress on Actions**
Programme of intensive practical manual handling training rolled across Trust	Training rolled out 100+ people have received training since last report
H&S risk assessment training available to key areas as required	Training provided to over 30 staff priorities set for remaining staff
H&S Risk summit scheduled for 30th April	Outcomes to IGC on 15th July
Executive Lead's Assessment	
December 2015: H&S Risks continue to be reviewed and monitored through IGC	

Board Assurance Framework 2015-16

Alder Hey Children's NHS Foundation Trust

BAF 1.4	**Strategic Objective:** Deliver clinical excellence in all our services		Risk Title: Training & development of clinical workforce		
Related CQC Themes: Safe, Effective, Caring, Responsive, Well Led					
Exec Lead: Melissa Swindell		**Type:** Internal, Known	Current IxL: 4-3	Target IxL: 4-1	Trend: STATIC

Risk Description	
Failure to ensure high standards of care through lack of training/development of clinical workforce.	
Existing Control Measures	
• Compliance tracked through the corporate report and CBU Dashboards.	• Workforce Group
• Performance Review Group.	• CBU Performance Meetings.
• Mandatory training reviewed and updated in summer 2014	• OLM restructured to include key competencies
• All training records available online and mapped to competency framework	• E-learning updated in January 2015 with one click access
• Big Move mandatory training workbook used as a mechanism for all staff to update their mandatory training prior to the move. Issue of access passes were dependent upon staff having completed their workbook, which contained 6 core mandatory training subjects. The move afforded a range of training to clinical staff including systems, equipment, scenario testing and simulation.	
Assurance Evidence	**Gaps in Controls/Assurance**
Regular reporting of delivery against compliance targets via corporate and CBU reports. Monthly reporting to the Board via the Corporate Report. Reporting at ward and SG level which supports Ward to Board	Poor compliance in critical training e.g. safeguarding, transfusion, manual handling. Inability to train staff due to clinical workload and acuity preventing them leaving the clinical area. No proactive assessment of impact on clinical practice Previous actions have failed to address the problem and poor compliance is increasing. Small number of issues remain re the interface with ESR which has slowed the progress of the action plan and reducing assurance
Actions Required to Reduce Risk to Target Rating	**Latest Progress on Actions**
H&S risk assessment training available to key areas as required	Training provided to over 30 staff, priorities set for remaining staff
Review mandatory training processes	Modernising mandatory training programme rolling out. Data cleanse completed. Risk based assessment of renewal periods underway
Task and finish group to review prior action failures and identify solution.	Action plan signed off at WOD
Programme of intensive practical manual handling training rolled across Trust	Training rolled out 400+ people have received training since last report
Executive Lead's Assessment	
December 2015: Progress made since last update, all mandatory training topics have shown improvements. Learning Needs Analysis being developed for inclusion into 16/17 business planning process.	

Board Assurance Framework 2015-16

Alder Hey Children's NHS Foundation Trust

BAF 1.5	**Strategic Objective:** Deliver clinical excellence in all our services		Risk Title: Failure to provide effective systems to ensure appropriate Ward to Board reporting Systems		
Related CQC Themes: Safe, Caring, Effective, Responsive, Well Led					
Exec Lead: Erica Saunders		**Type:** Internal, Known	Current IxL: 4-3	Target IxL: 3-2	Trend: STATIC

Risk Description	
Failure to provide effective systems to ensure appropriate Ward to Board reporting	
Existing Control Measures	
• Internal and external reviews of quality and corporate governance including CQC.	• Consolidate various recommendations into one action plan.
• New assurance: CQC inspection report published 22nd December rates the Trust as 'good' in the well-led domain and notes considerable improvement in risk and governance systems and processes.	
Assurance Evidence	**Gaps in Controls/Assurance**
CBU Quality/ Risk/ Governance meetings report into IGC and CQAC. IGC and CQAC provide formal assurance to Board CQC re-inspection report. KPMG Quality Governance Framework Review report MIAA Risk Maturity Review	TOR, work plan and agenda for CBU meetings not linked directly into what is reported to Board. Still some overlap and duplication of responsibilities and reporting across the structure of various committees and fora. Sustainability of improvements to risk arrangements not fully secured
Actions Required to Reduce Risk to Target Rating	**Latest Progress on Actions**
TOR, work plan and agenda for CBU Quality meetings revised in line with those for IGC and CQAC.	Agenda and work plans agreed with CBUs Quality agenda linking into a new CBU Quality report.
IGC to feed latest view of relevant risks to each Board Committee.	Reviewing where each area/ department is accountable to and where there risks are considered. IGC provides updates to RABD and CQAC as required - need to formalise
Review of overall structure of committees and fora to drive a clearer lines of reporting and responsibilities	Mapping of existing structure: report to November Audit Committee with proposals
MIAA review of risk management maturity and follow up to previous review of risk management at local level	Demonstrable improvement evidenced in report
Executive Lead's Assessment	
August: Focus at July IGC was on development of local risk registers and further embedding of risk management arrangements following CBU self-assessment report and discussion. A clear way forward has been agreed which will continue to track through IGC and Audit Committee. September 2015: Chief Nurse leading a review of risk, governance and quality arrangement across the CBUs. IGC in September reviewed the outstanding risks emerging from the CHP Commissioning work October 2015: Senior resource agreed to support the risk management function; plan to strengthen inputs at CBU level. Regular review taking place by IGC and Audit Committee to ensure robust systems in place for ongoing compliance. December 2015: Work continues to embed risk management improvement plans; Executives have been receiving notifications of key incidents for the last couple of months enabling more immediate line of sight on emerging issues. Overarching governance structures currently under review to reflect refresh of Trust strategy.	

Board Assurance Framework 2015-16

Alder Hey Children's NHS Foundation Trust

BAF 2.1	**Strategic Objective:** Be a world class centre for children's research and development		Risk Title: Finance for Phase 2 of the Research facility		
Related CQC Themes: Responsive, Well Led					
Exec Lead: Jonathan Stephens		**Type:** Internal, Known	Current IxL: 4-4	Target IxL: 2-3	Trend: STATIC

Risk Description

Failure to raise adequate finance for the second phase of the Research & Education facility.

Existing Control Measures

• Work closely with LHP and other strategic partners in formulating new Research Strategy	
Assurance Evidence	**Gaps in Controls/Assurance**
Research Strategy Committee set up as a new Board Assurance Committee. PMO monthly reporting to the Programme Board and Board. Regular reporting on funding to the Charitable Funds Committee.	Lack of funding secured. Lack of integration with other academic partners.
Actions Required to Reduce Risk to Target Rating	**Latest Progress on Actions**
Approach Liverpool University, local authority and grant raising bodies for funding.	Joint University and Trust governance committee established to progress BRU application and business case preparation. Reporting into Trust Research Steering Committee. Business case currently being developed for review in May.
Bid for Biomedical Research Unit (6/15).	BRU bid deferred - Children's to be a key theme within Liverpool BRC bid

Executive Lead's Assessment

April 2015. Finance sub-committee now up and running with specific duty of finding funds for Phase2. Meeting w/c 30.3 will address the vision document that is to be used to approach potential funders plus the overall approach to targeting funds. A fundraiser has been appointed to work on the govt. and European grants. Funding Strategy being developed with support from stakeholders and external agency.
June 2015: Continued engagement with stakeholders draft proposal discussed with LEP.
August 2015: Update - no change engagement with stakeholder and potential funding sources continues -decision point December 2015
September 2015: Meeting with Stakeholders in October / November to firm up space requirements and funding commitments. Positive developments regarding fund raising currently being reviewed with the Alder Hey Charity. Decision point December 2015.
October 2015: no change
December 2015 update: discussions on-going with Edge Hill and John Moore's re contribution towards phase 3 - awaiting letter and proposal from Edge Hill.

Board Assurance Framework 2015-16

Alder Hey Children's NHS Foundation Trust

BAF 4.1	**Strategic Objective:** Ensure all our staff have the right skills, competence, motivation and leadership to deliver our vision	Risk Title: Sustain workforce capability		
Related CQC Themes: Safe, Effective, Responsive, Well Led				
Exec Lead: Melissa Swindell	**Type:** Internal, Known	Current IxL: 3-4	Target IxL: 3-3	Trend: STATIC

Risk Description

Failure to achieve the Trust's strategic and operational targets due to an inability to sustain workforce capability

Existing Control Measures

• Identified recruitment processes in place.	• Succession planning undertaken for the Executive Team and Medical Leadership Team.
• Development Programme for Key Employees.	• New Attendance management process to reduce short and long-term absence.
• Workforce plan established	• Attendance management training
• Positive Attendance policy	• NHSP managed bank services. NHSP II went live on the 26th October 2015 covering all administrative staff.
• Permanent nurse staffing pool	• Succession planning
• Targeted OH interventions	• Refresh of recruitment strategy in September 2014
• Early referral for stress and musculo-skeletal conditions	• Health & Wellbeing resource identified and workplan signed off at WOD in July.
• Workforce committee re-enforced and includes recruitment and education	• Working for Health initiative introduced in Feb 2015
• Workforce Planning Policy signed off at WOD June 2015	• Planned activities to ensure nurse recruitment remains at full establishment
• Decision made to bring recruitment back in house from April 2016 to improve recruitment process, cost and efficiency	• Establishment loaded into ESR and system updated to reflect new structures in Sept 2016
• Change Leader and Customer Service training programmes completed and evaluated successfully.	

Assurance Evidence	Gaps in Controls/Assurance
Monthly recruitment reports provided by HR/Payroll provider. Quarterly reports to the Board Via WOD on the Workforce Strategy, Workforce plan and absence analysis. Monthly Corporate Report (including workforce KPI's) to the Board. Reports to the Executive Team re: succession planning. Recruitment and Health and Wellbeing Strategies presented at the May WOD, workforce plan snapshot presented to April RABD, OH contract in renegotiation to include absence reduction targets. Attendance and Temp spend controls to be reviewed in workforce CIP group and at CBU performance reviews. PDR at 91% compliance across clinical areas Medical appraisal 97%	Measurement for unfilled key roles. Lack of emergency successors identified for key roles. Lack of an established establishment planning process Poor controls over costs and availability of short term cover

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
CBU's to manage against the requirements of the new attendance licy	Small improvement in time to conduct RTW
Establishment loaded into ESR	Action plan agreed with Finance - on track
Workforce planning policy published	Draft Workforce Planning policy to May RABD

Executive Lead's Assessment

December 2015: Plans being drafted for additional nurse recruitment from Italy in early 2016.
Refreshed action plan to address sickness absence presented to BoD in Jan 16
Recruitment Manager started in post Jan 16

Board Assurance Framework 2015-16

Alder Hey Children's NHS Foundation Trust

BAF 4.2	**Strategic Objective:** Ensure all our staff have the right skills, competence, motivation and leadership to deliver our vision	Risk Title: Workforce engagement and support		
Related CQC Themes: Safe, Effective, Responsive, Well Led				
Exec Lead: Melissa Swindell	**Type:** Internal, Known	Current IxL: 3-3	Target IxL: 3-2	Trend: STATIC

Risk Description
Lack of workforce engagement which impacts upon operational performance and achievement of strategic aims

Existing Control Measures	
• Internal Communications Strategy.	• Roll out of Trust Values.
• Roll out of Leadership Development and Leadership Framework	• Action Plans for Engagement, Values and Communications.
• Medical Leadership development programme	• Staff Survey Action plan being updated for 2016 taking into account 2015 survey and subsequent temperature checks
• Values based PDR process, with compliance over 90% in clinical areas.	• Staff Friends and Family test now in place for two years
• CBUs complete Staff Survey action plans	• Staff surveys analysed and followed up
• June 15 - Cross organisation staff survey steering group established to identify staff survey actions.	• Change Leader and Customer Service training completed in 2015 and reviewed positively

Assurance Evidence	**Gaps in Controls/Assurance**
Outcomes from Annual Staff Survey reported to the Board. Quarterly reporting to Board via WOD regarding Engagement, Values and Communications. PDR completion rates Monthly Engagement Temperature Check reported to the Board. Monthly Engagement Temperature Check local data now sent to CBUs on a monthly basis to enable them to analyse data locally. Ongoing consultation and information sharing with staff side and LNC	Overarching Engagement Strategy

Actions Required to Reduce Risk to Target Rating	**Latest Progress on Actions**
Personal move planning process	1000+ conversations completed by Mar 2015
Analysis of Staff Survey	Improvement in all key areas. The remaining challenge is to increase engagement with individual change programmes.
Communications Strategy published	Due April 15
Development of engagement strategy, working closely with comms team to development	

Executive Lead's Assessment
December 2015: Management and Leadership Development Strategy presented to Workforce and OD Committee in Dec, with final strategy to Workforce and OD Committee in February. Staff Survey initial findings to Trust Board in January 16

Board Assurance Framework 2015-16

Alder Hey Children's NHS Foundation Trust

BAF 5.1	**Strategic Objective:** Further improve our financial strength in order to continuously invest in our services	Risk Title: Income & expenditure plan		
Related CQC Themes: Safe, Effective, Responsive, Well Led				
Exec Lead: Jonathan Stephens	**Type:** Internal, Known	Current IxL: 4-4	Target IxL: 4-2	Trend: STATIC

Risk Description

Failure to deliver 2015/16 Income and Expenditure plan and planned Continuity of Service Risk Rating

Existing Control Measures

• Organisation-wide financial plan.	• Monitor financial regime and financial risk ratings.
• Financial systems, budgetary control and financial reporting processes.	• Recovery plan in place and focused.
• Monthly performance review meetings with CBU Clinical/Management Team and the Executive	• Financial Position (subject to regular monitoring).
• Jan 2016 : weekly meeting with CBUs to review forward look bookings for elective and day case procedures to ensure activity booked meets contract and recovery plans. Also review of status of outpatient slot utilisation	

Assurance Evidence	Gaps in Controls/Assurance
Monthly Corporate Performance Report presented to both Board and the RBDC. Specific Reports (i.e. 2 year Monitor Plan Review by RBDC) Monthly Performance Management Reporting with General Managers. Internal and External Audit reporting through Audit Committee. Daily activity tracker to support CBU performance management of activity delivery	Improved financial control and effective recovery required in identified CBU's where slippage against agreed recovery trajectories occurring Ongoing cost of temporary staff CBU recovery plans to hit yearend financial control targets to ensure delivery of overall Trust financial plan. September 2015: Month 5 (end of August) Trust normalised deficit of £1.3m which is £0.5m higher than plan. Current risk rating 2 compared to plan of 3 but skewed by profile of grant income. Underlying rating of 3. Main risks remain CIP delivery, achievement of activity & income targets and containment of pay costs within budget. Positive signs in August of reduction in temporary pay costs but too early to say this is an established trend. Forecast remains broadly in line with plan - £2.9m deficit compared to plan of £2.7m deficit predicated on CBUs delivery financial recovery plans (risk circa £2m). Forecast will be reviewed monthly taking stock of impact of move to new hospital.

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Red rated schemes update end of May £2m gap plans and initial assessment of 16/17 end of June 2015	Progressing against milestones agreed - 2015/16 gap being rolled into 2016/17 target and post move (Oct 2015) the HWWWITF work streams will shift focus to the identification and delivery of the opportunity the new hospital presents towards delivery productivity & efficiency and service development.
Need to manage emerging capital pressures to ensure overall cash resources maintained within plan.	Capital pressures prioritisation strategy and process agreed by Exec Team
Plans to address CIP shortfall - scheme PIDs to be complete by end of May	Progressing against milestones agreed

Executive Lead's Assessment

March 2015: 2015/16 plan discussed in detail at R&BD and approved by Board members. Planning a £2.7m deficit and risk rating of 2 reflecting one off risk and challenges for 2015/16, namely move to new hospital and implementation of EPR. Plan presented to Council of Governors and Senior Leadership Team. Plan includes provision for risk i.e. 40% in year slippage in CIP and short term productivity gap. Activity profiles signed off by CBUs. Contract negotiations yet to be concluded so plans may change for final submission due at Monitor in May. Month 1 results will be reported to R&BD in May.
April 2015: No change to overall position reported in April and contract negotiations now nearing completion. No contract issues for arbitration identified and agreement likely early May.
June 2015: No change to overall risk profile. Contracts with CCGs and Specialist Commissioners signed. As at Month 2 (May) Trust £0.4m behind plan, too early to signal any change to forecast outturn form planned deficit of the year of £2.7m. Trust current RR3. COO, DoF and HR Director working with CBUs to deliver financial targets and address CIP gap.
August 2015: As at Month 4 (July) Trust risk rating 4 and breakeven but £0.6m behind plan. Elective and Outpatient Income under plan by £2m to-date offset by PFI cost re-profile associated with new move date and other variances. CBU forecasting under review and challenge to ensure overall financial position maintained. Emerging capital risks requiring prioritisation.

September 2015: Month 5 (end of August) Trust normalised deficit of £1.3m which is £0.5m higher than plan. Current risk rating 2 compared to plan of 3 but skewed by profile of grant income. Underlying rating of 3. Main risks remain CIP delivery, achievement of activity & income targets and containment of pay costs within budget. Positive signs in August of reduction in temporary pay costs but too early to say this is an established trend. Forecast remains broadly in line with plan - £2.9m deficit compared to plan of £2.7m deficit predicated on CBUs delivery financial recovery plans (risk circa £2m). Forecast will be reviewed monthly taking stock of impact of move to new hospital.
October 2015: Month 7 year to date = £2.9m underlying deficit which is £0.3m behind plan. Position is benefiting from £0.8m of lower depreciation cost which is non cash so real underlying I&E cash variance of £1.1m. Delivery of planned elective activity and outpatients remains a significant challenge with underperformance to-date of £3.5m. Pay costs increased in the month of October in part as a consequence of the move. Revised forecast of £3.7m deficit (£1m higher than planned) and actions agreed with CBUs to hit recovery plan control totals in order to ensure position does not deteriorate further and can be brought back to plan by the end of March. Recovery is dependent of activity delivery and further reductions to temporary pay spend. Forecast risk rating remains a 2* and cash balance end of march 2016 = £5m (1m lower than planned). Emerging capital risks following move to the new hospital which will need to be contained to avoid further reduction to year end cash balance forecast. No change to risk rating.

December 2015: Poor financial performance in November (month 8) with £1m variance to plan taking cumulative adverse variance to plan £1.3m (£3.8m deficit v plan of £2.5m deficit). Forecast reviewed and maintained at outturn deficit of £3.7m based on CBU recovery plans however predicated on performance against plan over Q4. Forecast cash balance reduced from plan of £6m to £4m reflecting deterioration in financial position and capital expenditure pressures arising from new hospital move.

Board Assurance Framework 2015-16

Alder Hey Children's NHS Foundation Trust

BAF 6.1	**Strategic Objective:** Be the provider of first choice for children, young people and their families	Risk Title: Business development and growth.		
Related CQC Themes: Caring, Effective, Responsive, Safe, Well Led				
Exec Lead: Jonathan Stephens	**Type:** External, Known	Current IxL: 4-3	Target IxL: 4-2	Trend: STATIC

Risk Description

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

Existing Control Measures

• CBU Performance Management Framework.	• Clear trajectories for challenged specialities to deliver.
• Business Development Plan	• Specialist Commissioning contract values and CCG commissioned services contract values agreed and reflected in Trust plans agreed by the Board.
• Five year plan agreed by Board and Governors in 2014	• Review of the Specialist Commissioning Service Specification is in place.
• Service development strategy including Private / International patient proposal approved by Council of Governors as part of strategic plan sign off.	• Capacity Plan identifies beds and theatres required to deliver BD plan
• Jan 2016 :- Weekly meeting with CBUs established to review forward look re elective and day case patient bookings to ensure activity scheduled meets contract requirements	

Assurance Evidence	Gaps in Controls/Assurance
Business growth and market analysis reports considered fully by Marketing & Business Development Committee and reported regularly to RBDC. Business Development Committee and reported regularly to Board via RBDC. Business Development Plan reviewed monthly by RBDC via Contract Monitoring Report. Daily activity tracker and forecast monitoring performance for all activity.	Ability to respond swiftly to potential problems. Workforce constraints in specialised services. Commissioning plans not yet sufficiently robust. Implications of new commissioning intentions not yet fully understood. Potential delay to cardiac growth following further review of national cardiac Safe & Sustainable Plan. Potential elective under performance due to cancelled sessions

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Awaiting detailed planning guidance for 15-16 from NHS England	Planning guidance issued
15-16 tariff proposals under review and contract proposals being discussed	Tariff proposals issued and Trust approach agreed by Board in March 2015
Contracts agreed and signed	

Executive Lead's Assessment

April 2015: 2015/16 Contract negotiations with Commissioners ongoing with aim to conclude and agree early May 2015. CBUs signed of activity numbers in plans and associated profiles for the year ahead agreed. Plans factor in downtime and reduced levels associated with EPR go live and move to the new hospital. No issues contract disputes identified so far which would require mediation or arbitration and sign off likely early May 2015.
June 2015: Contracts signed with NHS England commissioners. Wales to be agreed but no issues to escalate. Increased risk of underperformance against contracts as a result of the change in EPR Go Live date. Work ongoing with CBUs to mitigate / recover July to March 2016.
August 2015: Currently under performing against specialist contracts so no contract issue from a commissioner perspective. Key action is to recover activity in line with plan. Meeting with Specialist Commissioners and CCG to discuss Trust case of need for investment of Rehabilitation services. Trust identifying key issues to be discussed with Commissioners for 2016/17.
September 2015: Currently under performing against specialist contracts so no contract issue from a commissioner perspective. Key action is to recover activity in line with plan. Meeting with Specialist Commissioners and CCG to discuss Trust case of need for investment of Rehabilitation services (Oct / Nov). Trust identifying key issues to be discussed with Commissioners for 2016/17.
October 2015: No change in terms of contracting position - emerging challenges are the tariff proposals for 2016/17 which if implemented have a gross negative financial impact of £9m (excluding any transition). Children's Alliance in correspondence with Monitor and pricing team in terms of challenging proposals before tariffs formally published for consultation in January 2016. Positive discussions continue with Commissioners regarding new Rehab model with a view to getting a definitive positon of way forward before Christmas 2015. Potential for marginal rates for specialist activity to be reintroduced in 2016/17 which would undermines strategic plan. If risk rating were to apply to 16/17 increase to 4x4. As with I&E plan need to recover activity from November onwards now in the new hospital so as not to undermine baseline activity for 16/17 contract.

December 2015 update: National guidance confirms no change to specialist children's tariff top ups for 16/17 and no introduction of a marginal rate for specialist services commissioned activity for 16/17. Specialist commissioned services also funded for growth in 16/17. However risk rating not changed as Trust underperformance remains a risk to establishing required base line contract values for 16/17 - contract negotiations will focus on the non recurrent nature of underperformance linked to new EPR and Hospital move. Awaiting response from specialist services commissioner regarding Acute Rehab model proposal.

Board Assurance Framework 2015-16

Alder Hey Children's NHS Foundation Trust

BAF 6.2	**Strategic Objective:** Be the provider of first choice for children, young people and their families	Risk Title: EPR Implementation		
Related CQC Themes: Safe, Caring, Effective, Responsive, Well Led				
Exec Lead: Jonathan Stephens	**Type:** Internal, Known	Current IxL: 4-4	Target IxL: 4-2	Trend: STATIC

Risk Description

Failure to successfully implement EPR in line with timescales and costs.

Existing Control Measures

• Key projects and progress tracked through the EPR Steering Group, Programme Board and the PMO.	• Clinical Advisory Group leading on clinical engagement.
• Forward Communications plan agreed and tracked at steering committee.	• Weekly data quality improvement plan performance monitoring.
• Revised clinical engagement model agreed and additional resource provided and medical director support	• Weekly EPR progress review with Executive Team with escalation of issues for support and resolution.

Assurance Evidence	Gaps in Controls/Assurance
PMO exception reporting to the Executive Team. PMO monthly reporting, including issues and challenges to the Board via the Programme Board Regular EPR reports presented to RBDC and SLT. MIAA providing project assurance role. Board agreed system design sign-off process EPR Steering committee review and external assurance from Meditech and Centennial Gateway review process	Insufficient clinical engagement / involvement in design. Data quality improvement required - evidence of improvement but further action being taken to ensure level of data cleansing required for go live achieved. Software issues to be resolved

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Further actions to improve clinical engagement and data quality improvement from Aug/ Sep 2014	Actions taken forward overseen by EPR steering Committee and project team supported by COO & Medical Director.
Internal comms exercise for the run up to go live	Communications now live with weekly updates, team brief, and training and departmental awareness sessions.
May 23rd 2015 Go-live plan	No change to go live as at 31st March 2015. Software issues critical for go live resolved to-date

Executive Lead's Assessment

March 2015: Key action: Progress through implementation readiness assessment gateway 1 (31st March) to be reviewed and approved by Executive team on 2nd April 2015. Significant effort in the creation and sign off of departmental and module standard operating procedures.
April 2015: EPR steering committee approved move through Gateway 2 (30th April project milestone) pending finalisation of patient safety report being reviewed by Clinical Lead and Director of Nursing which will be presented to Board on the 5th May 2015. At this stage still planning go-live 22nd/23rd May 2015. Key area of focus of remaining weeks is staff training.
June 2015: EPR went live in June as planned. Post go live update report provided to Board as part of Programme Assurance. Focus now on EPR changes required for new hospital configuration and move date. No change to risk rating to allow time for system to bed in.
August 2015: Implementation of Phase 2 Mv6 (changes required for new hospital) progressing to plan and risks being managed. Electronic Patient Care System Development Committee established which meets every Monday morning to discuss and address risks and issues being raised directly by system users, via CBUs, raise it change it and weekly meeting of harm. All issues reviewed and prioritisation for resolution agreed. Supporting Task and finish group structure agreed and established. Weekly communications update to staff. Risk rating not downgraded to reflect need to resolve issues being raised and while implementation of phase 2 progresses.
September 2015: Implementation of Phase 2 moves to the new hospital complete. Electronic Patient Care System Development Committee established which meets every Monday morning to discuss and address risks and issues being raised directly by system users, via CBUs, raise it change it and weekly meeting of harm. All issues reviewed and prioritisation for resolution agreed. Supporting Task and finish group structure agreed and established. Weekly communications update to staff. Risk rating not downgraded to reflect need to resolve issues being raised and while implementation of phase 2 progresses. Phase 3 Plan to be developed over November.
October 2015: No change, draft proposals for Phase 3 to be discussed over December
December 2015 No change

Board Assurance Framework 2015-16

Alder Hey Children's NHS Foundation Trust

BAF 6.3	**Strategic Objective:** Be the provider of first choice for children, young people and their families	Risk Title: Sustaining national designations for specialist services		
Related CQC Themes: Safe, Caring, Effective, Responsive, Well Led				
Exec Lead: Jonathan Stephens	**Type:** External, Known	Current IxL: 4-3	Target IxL: 4-2	Trend: STATIC

Risk Description

Risk to sustaining national designations for specialist services due to failure to meet all required standards.

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.
• Proactive recruitment of key Neuro role	• Resourcing of Cardiac Safe & Sustainable standards supported by SLT for 13/14.
• Post implementation review of Trauma Business Case.	• Derogations secured in relation to specialist service specs.

Assurance Evidence	Gaps in Controls/Assurance
Key developments monitored through CBU Boards. Risks highlighted to CRC. Monitored at Performance Management Group. Monthly to Board via RBDC. Review of compliance with final national specifications considered by Marketing and Business Development Group (July 2013).	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.
Actions Required to Reduce Risk to Target Rating	**Latest Progress on Actions**
Pro-active recruitment in identified areas.	Trust in discussion with Liverpool Women's re future service models for neonates and in discussion with Liverpool Heart and Chest re future model for cardiac service
Monitoring of action plans.	CF service derogation issue requires resolution - proposal to review in April 2015

Executive Lead's Assessment

March 2015:
Derogations reduced from original total of 13 down to 3. Update to be reviewed by Performance Management Group in April and specialist commissioners discussions in April 2015.
April 2015 - No change
June 2015: Trust proposals for specialist rehab being discussed with Specialist Commissioners. Trust fully engaged with NHS Providers who are leading the process for future of cardiac services. Steering group established between AH and LWH to develop and agree joint model for Neonatal Services.
August 2015: National review process re cardiac services continues. Progress to agree longer term model for Neonates with Liverpool Women's and Commissioners stalled and needs moving on. Further exec to exec discussions required.
September 2015: National review process re cardiac services continues. Trust submitted the joint Liverpool Health Economy proposal for the provision of services on the 8th October 2015 - Regional and National panel review over October / November.
Business case being developed with LWH for the establishment of neonate costs at Alder Hey - target end of October 2015. Discussions with commissioners to take place from November. This represents short term solution and
Progress to agree longer term model for Neonates with Liverpool Women's and Commissioners stalled and needs moving on. Further exec to exec discussions required.
October / November 2015: Business case being prepared with LWH for the establishment of Neonate cots at Alder Hey to be presented to specialist commissioners (aim end of November). Trust working with LWH re long term model for Neonates. Regional and National panel review of all providers cardiac service proposals deferred to December at the earliest - so no further update.
December 2015 update: Positive feedback received re Liverpool cardiac services proposal and Trust working with partners with a view to delivering new service model from September 2016. Detailed plans to be discussed at Trust Board. Discussions continuing with LWH re neo natal surgery services.

Board Assurance Framework 2015-16

Alder Hey Children's NHS Foundation Trust

BAF 6.4	**Strategic Objective:** Be the provider of first choice for children, young people and their families		Risk Title: Relationships with new Commissioners		
Related CQC Themes: Effective, Responsive, Well Led					
Exec Lead: Jonathan Stephens		**Type:** External, Known	Current IxL: 4-3	Target IxL: 4-2	Trend: STATIC

Risk Description

Risk of failure to build strong productive relationships with commissioners and providers to ensure children's agenda remains a focus and Trust children's services strategy is delivered.

Existing Control Measures

• Proactive involvement in key strategic forums and networks.	• Participation in strategic clinical networks.
• Presence on Health and Wellbeing Board.	• Pilot for integrated children care developed within CCGs/LA.
• Children's services prominent within joint strategic needs assessment and consequent plans.	• Business development team meeting regularly with CCGs and GPs.
• Director of Finance responsible for Specialist Commissioning of Alder Hey's services on behalf of NHS England.	• Trust is a key partner in Liverpool Pioneer Bid focusing on children submitted to Department of Health.
• Members of national PBR Tariff and Children's Alliance Groups.	• 5 Year strategic plan agreed and shared with key commissioners
• Clinical Services Strategy	

Assurance Evidence	Gaps in Controls/Assurance
Contract / commissioner meetings held monthly. Monthly contract report to RBDC. Board receive regular reports via RBDC on development of relationships. Outputs from Healthy Liverpool meetings and minutes from Manchester Concordat to the Board via RBDC Aligned position with Liverpool CCG re children's element of Healthy Liverpool Specialist Commissioners agreed 14/15 contract activity and finance for Alder Hey due to be agreed for 15/16.	Longer term strategic commissioning plan for children (CCG and specialist) requires developments and agreement.

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
In discussions with CCG re walk in centre support to new hospital and manage A&E / front door demand.	No progress / change in time for move date - potential elevated risk of higher A&E attendances in early months of occupation of new hospital
Trust to develop vision for community services integration and family centres	Stakeholder workshop 1st May - aim to agree family centre model. Project team agreed to work up detailed proposal and models over Q3/Q4.
Progress integration of all community services for Children and Young People	Trust engaged with CCG and LCH on future model. Awaiting outcome of NTDA review of options for services currently provided by Liverpool Community Health. Decision due 9/2015.
Progress cases for slow stream rehab and CDC	Target date July 2015, CDC case submitted awaiting outcome of CCG review during September 2015. Meeting with CCG and Specialist Commissioners being arranged to review Rehab business cases (Q3).

Executive Lead's Assessment

March 2015: No change
April 2015: - refer to actions required and progress
June 2015: Joint Alder Hey and LCC emerging vision for children and young people's community services agreed
Trust engaged with process reviewing future of LCH and shared vision with KPMG who are leading process on behalf of commissioners and NHSTDA
Positive engagement with other partners involved in developing family centres model including LWH, LCH and CCG.
August 2015: See update in progress section above.
September 2015: Process re future of Liverpool Community Health concluded and plan for the future provision of services agreed with service transfers / new provider arrangements in place by April 2017.
LCH children and Adults services grouped together into one Lot which presents a potential risk. Procurement and commissioning process to start 2016.
Trust liaising with partners re next steps strategy linking with development of family centre model.
CDC business case submitted in September but decision and review by CCG deferred - meeting planned in October / November with CCG to agree next steps. At this stage CCG not wanting to invest in new building but have indicated investment in the service is a priority.
CCG requested bid from Trust for support required in the immediate term (this winter) to manage emergency demand pressures and new A&E. This will include continuation of Alder Hey outreach services based in Smith down Rd walk in centre which were established over the move weekend.
October / November 2015: Following Board to Board meeting in November, CCG Governance arrangements for children's element of Health Liverpool programme to be strengthened and additional CCG clinical lead support to be established to help with taking forward the development of children's services across Liverpool with Alder Hey. Trust has agreed continuation of outreach services at Smith down road to help reduce pressure on A&E.
December 2015: no change

Board Assurance Framework 2015-16

Alder Hey Children's NHS Foundation Trust

BAF 7.1	**Strategic Objective:** Deliver the hospital in the park by 2015-16		Risk Title: Capacity to deliver "day job" as well as Programme		
Related CQC Themes: Safe, Caring, Effective, Responsive, Well Led					
Exec Lead: David Powell		**Type:** Internal, Known	Current IxL: 2-3	Target IxL: 2-3	Trend: BETTER

Risk Description

Risk of not having the capacity to deliver the "day job" of running the hospital as well as delivering the complex change programme, including CHP and EPR.

Existing Control Measures

• Clinical sign-off of all designs.	• Individual teams participating in change process and aware of new environment.
• Contract variations signed without significant compromise of Trust plans.	• Variations required to be authorised by Executive Design Group.
• Location plans proposed for all teams in new hospital	• Ongoing monitoring of any delays on new hospital

Assurance Evidence	**Gaps in Controls/Assurance**
Highlight report to the Programme Board and Board on a monthly basis. Weekly Executive Team meeting with the Programme Board. Assurance Committee work plans/ToRs changed to reflect respective change programme issues	Thorough understanding of impact in operational areas. Clarity over when the "pinch points are" and the operational impact of them
Actions Required to Reduce Risk to Target Rating	**Latest Progress on Actions**
Ops Board to commission analysis and detailed forward plan to show how balance can be maintained	

Executive Lead's Assessment

March 2015: Activity on commissioning new hospital being supported by clinical teams and other staff. Enough input is being secured from CBUs to allow process to be informed and effective.
April 2015: Detailed day-by-day plan now in first draft
June 2015; Dedicated 3 sessions per week issue raising and addressing process now in place.
August 2015: Weekly reports taken to Execs identifying stop-go issues. Dedicated IMT update as it represents major area of risk. Generally good and focussed attendance at commissioning sessions. Staff acclimatisation/training proceeding to plan in general. Some pressure areas due to unavailability of Neuro-MRI and emergency paging system.
September 2015: Hospital now occupied, central commissioning group established to manage issues.
October 2015: Commissioning process turned on until Christmas to try and resolve major issues for staff to allow them to concentrate on operational tasks.
December 2015: Commissioning Process closed/fixed date for majority of major issues

Board Assurance Framework 2015-16

Alder Hey Children's NHS Foundation Trust

BAF 7.2	**Strategic Objective:** Deliver the hospital in the park by 2015-16	Risk Title: Charity delivering targets for new facilities		
Related CQC Themes: Caring, Effective, Responsive, Well Led				
Exec Lead: Clare White	**Type:** External, Known	Current IxL: 4-3	Target IxL: 4-2	Trend: STATIC

Risk Description

Risk of the Alder Hey Children's Charity failing to raise target level of donations to fund key aspects of new hospital facilities.

Existing Control Measures

• Board of Trustees	• Reports to RBD Committee
• Two Trust NEDs sit on Charity Trustee Board	• Charitable Objects unchanged and focussed on the strategic needs of Alder Hey Children's Hospital
• The Chief Executive of AHCC meets regularly with the Chief Executive of the Trust	• The Charity Chairman has regular joint meetings with the Chair and the CEO of the Trust to look at emerging developments and alignment, as well as actions required by the Trust or the Charity.

Assurance Evidence	Gaps in Controls/Assurance
Reports to Board Donation Flow	Lack of clear alternative funding streams in the event that the donation target is not met. Lack of a clear process to determine future strategy, given direction of travel to independence. Lack of coherent joined up working between Trust and Charity leading to possible overlap, duplication and communication problems within both organisations and with existing/ potential donors. Charity/Trust communications meetings established with the Charity Chair, CEO, Trust Chair, CEO, CHP Project Director and Marketing Director. Meetings held monthly.

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Consider a vehicle for joint strategic decisions going forward.	Positive discussions re developing a mechanism for joint strategic decisions.
Planning for fundraising strategies post- opening of Alder Hey in the Park will take into consideration the Trust's long term vision and 5 year plan.	Meeting diarised in for September with Trust CEO and Executive and Charity Board of Trustees

Executive Lead's Assessment

March 2015: Alder Hey Charity supports elements of patient experience, research and medical equipment that are enhancements to core NHS requirements and as such should not present risks to the Trust if funding is not secured.
The Chief Executive of AHCC meets regularly with the Chief Executive of the Trust and two NEDS sit on the Trustee board. Therefore coherence of strategy should be ensured, within the boundaries of the Charity's objects.
June 2015 - the Charity has secured the majority of the funding for key elements of enhancement within the new hospital including Theatres enhancement and the Hybrid theatre, which is strategically important in relation to cardiac services. The main area outstanding is PETS which requires a coherent business case producing by BT and the CHP
August 2015: no change
September 2015: September 2015: The charity has delivered against all the main requests from the Trust for the new hospital: Theatres, Ward Chefs, Patient distraction, medical equipment, ward play areas, parent beds, and patient entertainment. Funding for a pilot of PETS has been secured through a corporate sponsor. The next phase is to secure funding for the second Phase of the research building.
October 2015: £300k funding secured for pilot phase of Digital Hospital and a further £200k pledge received. £150k secured for distraction in route to theatres. Charity secured £6m interest free loan offer from current donor and discussions with Trustees/Trust on implications of proceeding with this on other requirements for funding are underway. Decision to be taken by December 2015.

Board Assurance Framework 2015-16

Alder Hey Children's NHS Foundation Trust

BAF 7.3	**Strategic Objective:** Deliver the hospital in the park by 2015-16		Risk Title: Delivering safe and effective hospital move
Related CQC Themes: Safe, Caring, Effective, Responsive, Well Led			
Exec Lead: David Powell	**Type:** Internal, Known	Current IxL: 3-3	Target IxL: 3-3	Trend: BETTER

Risk Description	
Risk of not delivering a safe and effective hospital move on time and within budget	
Existing Control Measures	
• Clinical sign-off of all designs.	• Assurance to Trust Board via PMO
• Contract Variations required to be authorised by Programme Board and Trust Board	• Ongoing monitoring of any delays on new hospital
• Effective commissioning and mobilisation Project Boards	
Assurance Evidence	**Gaps in Controls/Assurance**
Highlight reports to the Programme Board and Board on a monthly basis. Weekly Executive Team meeting with the Programme Board.	Mitigation plans for current LOR delay. Associated commercial and legal impact of delay
Actions Required to Reduce Risk to Target Rating	**Latest Progress on Actions**
Trust to develop detailed plan for commissioning period outlining activities and access requirements	
LOR to develop plan for outstanding works not completed at handover	
Draft outline and agreement to be reached on commercial and legal impact of mitigation plan	

Executive Lead's Assessment

March 2015: Discussions under way with LOR to create detailed hand-over plan together with mitigations and associated commercial arrangements. Plan to be finalised by April 30th and summary taken to Trust Board in May.
April 2015: Proposals made by LOR now being processed ready for discussion with Board.
June 2015: Heads of terms for managing joint commissioning now agreed with associated Board Paper on risks. 1st part of building handed over in line with revised plan.
August 2015: Phase 2 and 3 of handover now achieved. Independent Certifier interim report received. Formal notification of intent ion to meet Sept 30 received from LOR/Project Co. Sign off process organised for Programme Board.
September 2015: Handover achieved
October 2015: Commissioning period until Xmas identifying key risks and issues and reporting up to Programme Board and Trust Board.
Dec 2015: Majority of key issues dealt with or date secured. Next phase post-Xmas to clear up residual risks and establish fix-it system

Alder Hey Children's NHS
NHS Foundation Trust

Agenda Item 2015/

BOARD OF DIRECTORS

Tuesday 12 January 2016

Resources and Business Development – Chairs Note

1. Purpose of the Report

The purpose of this report is to update the Board on the key issues raised at the Resources and Business Development Committee held in December 2015.

2. Key Issues

The following issues were raised and discussed at the RABD Committee held on 16 December 2015; the minutes of the meeting will be submitted to the December Board for noting.

- The Committee received a BAF Risk Review / Key Items & Risks to Operational update specifically relating to:
  - 2015/16 cost improvement programme and **noted** planned actions for improvement and recovery.
  - Workforce leading indicators and **noted** the contents of the report;
  - the implementation of the EPR system and **noted** the actions in place to monitor and mitigate risk to the Trust;
  - Strategic Themes and **noted** an update on the work ongoing.
- The Committee received an update on the Trusts performance versus contract plan for the 2015/16 financial year and **noted** Noted the underperformance of £2.7m (2.3%) in income cumulative to 31st October 2015 and the detail of 3 contract query notices and the significant modifications to tariffs for next year following impact assessments in October & November. The Committee received and **noted** an update with regards to progress against 2015/16 Business Development Plans and planning cycle for 2016/17.
- The Committee received a PFI Contract Monitoring update and **noted** the contents of the report and **approved** the direction of travel set out by the PFI team.
- The Committee received an update on the Marketing and Communications activity in November 2015 and **noted** the contents of the report.
- The Committee received the minutes of the Marketing and Business Development Committee held in December 2015 and **approved** them as an accurate record.
- The Committee received the Terms of Reference for the Marketing and Business Development Committee and approved them for another 12 months.
- The Committee received an updated on the progress of the Specialist Paediatric Rehab Offer and **noted** the next steps and actions in place to advance.
- The Committee received the Monitor Q2 feedback and **noted** it as positive.
- The Committee received the minutes of the Programme Board in held in December 2015 and **approved** them as an accurate record.
- The Committee received a report on the revised and combined business case for the New Corporate Office Block and CDC and **approved** options 4 in principal, subject to further discuss of the fine detail between Executive Directors.

3. Recommendations

It is recommended that the Board note the contents of the Chairs Update relating the key issues from the Resource and Business Development Committee held on 16 December 2015.

Alder Hey Children's NHS
NHS Foundation Trust

RESOURCES & BUSINESS DEVELOPMENT COMMITTEE
Minutes from the Meeting held on Wednesday 28 October 2015

Present:	Mr I Quinlan	Non-Executive Director (Chair)	(IQ)
	Mrs C Dove	Non-Executive Director	(CD)
	Mrs C Liddy	Deputy Director of Finance	(CL)
	Mrs L Shepherd	Chief Executive	(LS)
In Attendance:	Ms L Dunn	Director of Marketing & Comms	(LD)
	Mrs S Kelly	Head of Marketing & Comms	(SK)
	Mr A McColl	Head of Business Development	(AM)
	Mr G Wadeson	Contracts & Income Accountant	(GW)
	Miss J Preece	Quality Assurance Officer (minutes)	(JP)
	Mrs S McShane	Interim Head of HR	(SMc)
Item 15/112:	Mr R Forde	Meditech 6 Project Manager	(RF)
Item 15/119:	Mrs C Barker	Chief Pharmacist	(CB)
	Ms SM Wong	Formulary Pharmacist	(SW)
Apologies:	Mrs J Adams	Chief Operating Officer	(JA)
	Ms E Saunders	Director of Corporate Affairs	(ES)
	Mr L Stark	Head of Performance & Planning	(LSt)
	Mr P Huggon	Non-Executive Director	(PH)
	Mr J Stephens	Director of Finance	(JS)
	Mr L Murphy	Head of Contracting	(LM)
	Mrs T Patten	Associate Director of Strategic Development	(TP)

Item No	Item	Key Discussion Points	Action	Owner	Time Scale
15/110	**Minutes of the Last Meeting**	The Committee considered the minutes of the last meeting held on 30 September 2015. **Resolved** that the Committee: approved the minutes as a correct record; the action list was updated accordingly.			
15/111	**Matters Arising**	**15/82 Carter Review** Following on from the Carter Report received at the July meeting entitled 'Review of operational productivity in NHS providers: interim report June 2015', the Committee received an update on behalf of the Director of Finance. CL explained that a meeting of the Children's Alliance had been held to discuss the			

		issue regarding inappropriate benchmarking in measuring improvements in productivity for adult and children's Trusts. Agreement was reached to engage with a peer group of children's hospitals to assess the data and identify appropriate benchmarks. CL reported that she was liaising with the Countess of Chester Hospital to start looking at how the methodology can be improved to provide better estimates of efficiency for specialist trusts, or for trust with specialist units. LS welcomed the update and proactive approach being taken with regards to this piece of work and stated that this needed to link to the Trust's Corporate Performance Report. Lines of accountability within this work stream would need to be made clear from the onset ensuring ownership on the 'shop floor' in implementing improvements. CL & SK undertook to meet and discuss the message to staff. **15/106 Forward Look: Cash Pressures** LS referred to the report considered at the September meeting and stressed the need for Executive Colleagues to regroup on financial plans for the remainder of the year. She stated that a huge focus of the upcoming Exec Team time out session and Operational Delivery Board would be given to recovery plans and future programme of change. LS stated that she was very clear on the size of the challenge ahead both financially and operationally and that management teams needed to ensure that this was an inclusive process. **15/102 Incorrect classification of nursing staff on ESR to be looked into** An update would be provided at the November meeting to assure the Committee this had been corrected.		MS	25 Nov
The Committee considered the following reports for potential or actual impacts on service users, parents/carers specifically in relation to the Equality Analysis Policy:					
COMMITTEE GOVERNANCE					
15/112	**BAF Risk Review / Key Items & Risks to Operational**	• **Performance Exception Report** The Committee received a report on behalf of the Chief Operating Officer highlighting the following issues: ○ RTT Pathways Performance: clearance rates continuing to be above IST levels which is set at 10 weeks. Specialties with continued levels of backlog were Ophthalmology, gastroenterology, ENT Audiology and Community Medicine. Action plans to deliver increased capacity for			

these specialties are to be implemented over the coming months to deliver reductions in backlog.

- Last Minute Cancellations: cumulative cancellation rate at the end of September as 0.98% - this was higher than the national threshold of 0.8%. actions being taken to rectify the situation – extended opening of day case capacity – to release overnight capacity; appointment of discharge coordinators to allow for improved patient flow; use of NWTS – to facilitate transfer; ongoing theatre recruitment to increase theatre capacity; recruitment of ward staff to keep all available beds open and staffed.
- Utilisation: 89 clinics were cancelled in September which signifies a big increase; this was in part due to the move of clinic locations into the CHP along with sickness levels in the NMSS CBU. CBUs have been tasked with ensuring robust effective authorisation.

Resolved that the Committee: noted the contents of the report and remedial actions.

- **15/16 Cost Improvement Programme**

  The Committee considered a regular report prepared by the Head of Planning and Performance concerning the 2015/16 CIP Programme for month 06.

  CL provided the Committee with an overview of the report and highlighted:

  - In month shortfall of £208k; all amber and red schemes phasing was being reviewed and re-profiled and a recovery plan meeting had been scheduled with scheme leads to address.; and
  - 15/16 CIP gap £3.5m.

LS raised concern regarding the lack of contribution in-year from R&D. CL reported that the finance team were hopeful on plans for delivery for the remainder of the year. CD asked about commercial income opportunities for R&D and was advised that clear targets had now been set to increase.

LS sought assurance around delivery of the coding review CIP, which was currently rated amber, and was advised that this was linked to the pathfinder review and that full implementation of the clinical changes relating to this would commence 1 Dec 2015.

IQ alluded to the estates CIP target which had been achieved and asked if further

		opportunities would be identified. CL assured the Chair that this would indeed be the case and talked about car parking at Alder Sports which was possibly now not needed following the move. Outputs from a series of meetings held to look at potential CIP gains would be reported to the next meeting through the HWWWITF report. **Resolved** that the Committee: noted the contents of the report and actions taken for recovery of CIP plans. • **Workforce Leading Indicators** The Committee considered a regular report prepared by the Interim Director of HR & OD concerning the key issues and KPI's relating to the Alder Hey workforce. SMc provided the Committee with an update on the leading indicators relating to the workforce. ○ Sickness Absence performance stood at 4.81%; which represented an increase from the previous month. A proactive exercise was underway to address long term sickness. The Trust's Flu programme was well underway. ○ PDR Completion Rates stood at 90% against a target of 95%. Work continued to bring corporate services in line with target. ○ Agency/Bank costs were over target in month. LS raised concern over this and stressed the need remain sighted on this matter. CD stated that this issue was a main focus at the WOD Committee and subject to full scrutiny. ○ New format Trust Induction now launched with 100% of all starters completed. ○ Staff survey now issued. **Resolved** that the Committee: noted the contents of the HR Risk Plan. • **Implementation of EPR** The Committee considered a report prepared by the Meditech 6 Project Manager, the purpose of the report was to provide the Committee with a summary of the progress to date, following the go live date of 20 June 2015 RF reported that some issues continued with Phase I; task & finish groups		

continued to meet to resolve these. Most issues being addressed were operational and compliance related. The main exceptions to this were:

- How users manage orders and account registrations (Orders/Amb Orders/RCRs);
- Pathology issues (No specific T&F Group required, but progressing issues weekly)

Some challenges remained regarding compliance which related to training which Phase III of the programme would address.

LS expressed concern regarding negative feedback received on the patient booking in system and the negative effect this was causing on the flow through outpatients. RF assured the Committee that the project team was very much sighted on this and that workflow was being given a huge focus. LS went on to stress that the Executive Management Team were keen to focus on and close off Phase I issues along with the significant IT issues being experienced in the new buildings and asked that the Committee remain sighted on these. IQ agreed with this and requested that the IM&T Strategy be a focus on future agendas.

Resolved that the Committee: noted the contents of the report.

- **Strategic Themes Progress Update**

  The Committee considered a report prepared by Associate Director of Strategic Development and Head of Business Development, the purpose of the report was to provide to provide a "stock take" of the current opportunities within the five strategic themes, including an assessment of timeframes and potential revenue opportunity. This will provide an updated indication of the financial benefit, as well as assisting with work planning, prioritisation and resource allocation.

  AMc drew attention to the 5 key strategic themes and revenue contribution expected over a 5 year period which was estimated at £24.8m (recurrent full year effect).

  AMc reported that a 100% success rate was aspirational and likely to be limited by external factors, therefore horizon scanning would now be undertaken in order to identify and develop additional opportunities simultaneously. LS agreed with this proactive approach and stressed the need

		to focus on network of providers and how we can work together as well as actively perusing opportunities outside of the NHS, both internationally and with partner Universities. CD talked about Robert Hough, the Chairman of the area's Local Enterprise Partnership (LEP) and the work ongoing with Lord Heseltine to reposition and provide opportunities in economic growth for the Liverpool City Region. CD stated that there was a real opportunity to link into this work and undertook to provide an introduction for the Executive Management Team. **Resolved** that the Committee: (i) Noted the opportunity assessment of strategic themes, including potential revenue of £24.8m; and (ii) Agreed the key priorities, which had been identified through the work planning process.			
15/113	**Monitor Quarterly Submission**	The Committee considered the narrative report to accompany the submission to Monitor of the Trust's position for Quarter 2 2015/16. CL explained that in terms of the Trust's financial position the Trust would be reporting a £1.4m deficit (normalised) compared to a planned deficit of £2.6m, ahead of plan by £1.2m and a FSR of 2 which was inline with plan. For this reason, the Board would be unable to confirm that the Trust would continue to maintain a risk rating of at least 3 over the next 12 months. With regards to governance, The Board was satisfied that plans in place were sufficient to ensure ongoing compliance with all existing targets (after the application of thresholds) and as such remained green. **Resolved** that the Committee: received and **APPROVED** the Quarterly Monitoring Report for the second quarter of 2015/16.			
15/114	**Monthly Debt Write Off**	**Resolved** that the Committee noted and **APPROVED** month 07 bad debt write-off to the value of £168.68.			

BUSINESS DEVELOPMENT					
15/115	**Contract Income Monitoring**	The Committee considered a report prepared by the Head of Contracting regarding the Trust's performance versus contract plans. The purpose of the report was to provide an update on the Trusts performance versus contract plans cumulative to 31 August 2015. GW presented the Committee with summary of the report and advised members: ○ Total clinical income for the 5 months to 31st August was £70,512k which represented an underperformance of £2,224k (3.1%) compared to the profiled plan for the period of £72,736k. The main areas of underperformance were NMSS (orthopaedics) & SCACC (cardiac & neo) CBUs for which recovery plans had been implemented. ○ Clinical income had underperformed by £469k in the month which was more or less on trend for the year to date. ○ 2016/17 proposed tariffs: GW reported that work was continuing with sense-checking the 2016/17 impact assessments with Monitor and that Alder Hey remained close with this process to ensure there was both consistency with the modelling work & feedback to Monitor on the potential impact. A telecom was booked with UKCHA colleagues on the 2 November; a further update on tariff will be included in next month's report **Resolved** that the Committee: - (i) Noted the underperformance of £2,224k (3.1%) in clinical income for April to August; and (ii) The update on the potentially significant negative impact on tariffs for next year.			
15/116	**2015/16 Business Development Plans**	The Committee considered a report prepared by the Head of Business Development concerning the 2015/16 Business Development Plan. The purpose of the paper was to give the Committee assurance regarding progress against the CBU Business Development plans at the end of quarter two. AMc provided the Committee with a summary of progress and reminded colleagues that at the start of the year CBUs had identified and prioritised Business Development plans with a full year revenue growth target of £3.5m, along with a			

		further £0.4m growth from schemes categorised within "business as usual". During April-September 2015 CBUs had delivered £681k revenue growth against their Business Development plans, with a number of these schemes making a contribution to CIP targets. The revised forecast for in year delivery against 2015/16 plans remained at £1.9m revenue. In order to provide assurance that plans had been fully implemented and would be delivered on a recurrent basis, CBUs had been asked to undertake robust Benefit Realisation reviews. This would give a formal opportunity to manage implementation risks, identify corrective actions and mitigate potential under performance. The business case and investment approval process is currently being reviewed, with a revised process being developed which will include proper support and challenge to the implementation process (post-approval), operational delivery and review of Benefits Realisation, to ensure targets are achieved recurrently.			
	Marketing & Business Development Group	The Committee received a paper outlining the proposed approach in re-launching the Marketing & Business Development Group, along with revised Terms of Reference and a Work Plan for the next 12 months. AMc explained that the group had taken a six month 'pause' to account for the hospital move and implementation of EPR and would be re-launched with a change of focus to its priorities as set out in the revised Terms of Reference provided. Attention was brought to the proposed change of governance structure for the Group being renamed as the "Securing the Future Delivery Group" and reporting to the How We Work Programme Board. LS felt strongly that business development should remain under the auspices of the RABD Committee and suggested the current reporting structure remain unchanged. Committee Members agreed with this statement. **Resolved** that the Committee: - (i) Noted the key highlights from progress against the CBU Business Development plans and progress during Q2.			

15/117	**Marketing and Communications Activity Report**	The Committee received the Marketing and Communications Activity Report for the first two quarters of 2015/16. SK provided the Committee with a summary of progress April- September 2015 and highlighted the main activity / campaigns during the period: • Land of Remarkable people charity campaign, • Charity Ball; and • The move to the new hospital. Media coverage during the period encompassed: • Alder Hey in the Park updates • HRH Prince Charles visit to the new hospital • Freedom of the City • Grand National and jockey's visit, including AP McCoy's visit at his last national • Oli Safari Walk • Good Morning Britain – Well Child launch • Ambassador stories • Matalan cheque presentation • Move to Alder Hey in the Park A number of broadcast commissions were being explored detailed in the report along with internal communication activity which primarily focussed on engaging staff in the move. CD talked about the need for more extensive broadcast coverage i.e. nationally, not just locally, and stressed the need to be more proactive in taking stories out to the media. LD assured colleagues that there would be a focus on this going forward and that the team were actively developing stories to feed into the national agenda. CL recommended being more proactive in utilising social media more effectively and publicising good news stories and particularly internal communications. SK suggested that this report be brought to the Committee on a monthly basis with			

		more of an external focus. **Resolved** that the Committee:- (i) Noted the contents of the Marketing and Communications Activity Report for the first two quarters of 2015/16; (ii) **APPROVED** the recommendation to receive the report monthly.			
15/118	**Procurement Strategy Update**	The Committee received a presentation prepared by the Head of Procurement and Deputy Director of Finance detailing the Implementation of Procurement Improvements. CL drew attention to the Executive Summary describing achievements to date and was pleased to report that the Trust remained on track to achieve an eventual full in-year CIP of £885k. She went on to report that a Procurement Strategy '10 Point Plan for Better Purchasing' had been produced with all 10 points underway. Draft KPI's would be agreed by the end of Quarter 3 with reporting commencing in Quarter 4 for the procurement agenda. In response to a question from the Chair regarding further benefits realisation, CL stated that she felt more opportunities lay within an IT solution to better manage inventory and robust governance in ensuring value for money when procuring goods and services and assured the Committee that plans were in place to address these themes in the next steps of the plan. **Resolved** that the Committee: noted the contents of the presentation and progress against each of the Points in the 10 Point Plan.			
COMMITTEE ASSURANCES					
15/119	**Medicines Optimisation Strategy 2015-2018**	The Committee received the Medicines Optimisation Strategy 2015-2018. CB & SW presented the Strategy and drew attention to the six strategic challenges required over the next three years to ensure delivery of the safe and effective use of medicines in line with the broader concept of medicines optimisation.			

		CB reported that The Pharmacy team in conjunction with the revised Medicines Management Committee would provide the leadership necessary to deliver the strategy with the support of the Trust Board, Executive team, and Clinical Business Units. Specific attention was drawn to the draft medicines optimisation work plan which would be used as a mechanism for improving safety and outcomes and also exploring opportunities for potential cost savings. LS welcomed the development and implementation of the Strategy which described an abundance of opportunities and asked where the team intended to focus resources in terms of efficiency savings. CB explained that implementing and delivering an effective system around the patient was seen as the main area to improve efficiency. CL alluded to clinical variation and the need for tighter control here; CB agreed with this observation and stated that at present information was limited given the recent implementation of Meditech V6 but that, when more history was available, this would be looked at in detail. **Resolved** that the Committee: supported the strategic challenges outlined in the Medicines Optimisation Strategy 2015-2018.			
15/120	**Programme Management Office**	The Committee received and considered the minutes of the Programme Board held during July, August and September 2015. **Resolved** that the Committee: noted the contents of the minutes of the Programme Board.			
15/121	**Corporate Performance Update and Financial Summary Update**	The Committee considered a regular report and supporting financial summary updating members on the Trusts performance for the month ending 30 September 2015; month 06. CL provided members with an overview and stated that year to date the Trust was reporting a deficit of £1.4m, £1.2m ahead of plan. She reminded colleagues that the income plan was £2m less due to the impact of the move originally planned in September therefore it was anticipated this will result in a net cumulative			

		deterioration in performance against plan of circa £1m in October. ○ Cash in the Bank stood at £16.9m however, numerous pieces of equipment had now been paid for; this would therefore reduce for month 07 reporting; ○ The Trust was £1.6m behind its CIP target which was consistent with the in-year CIP slippage anticipated in the original plan; ○ The EPR project was forecasting a £0.4m overspend due to the need to retain the specialist staff to further develop the training and reporting of the current system and to sustain the system in preparation for the implementation of Phase 3, the Trust was reviewing VAT mitigation strategies in an attempt to reduce this overspend; ○ In terms of overspend relating to the new build, CL advised that approval of the PFI and OPD 'wrap in' would result in an improved forecast cash balance due to VAT recovery on the OPD scheme, partly offset by the second Beneficial Access Payment. This was pending approval however. **Resolved** that the Committee:- (i) noted the contents of the report and financial recovery plans.			
15/122	**Review the Terms of Reference**	The Committee considered the Terms of Reference for annual review and agreed: • To remove review of the Workforce Strategy as this now lay within the auspices of the Workforce & OD Committee. • A greater focus on resourcing for delivery of the IM&T Strategy be included in the Terms of Reference **Resolved** that the Committee: approved the Terms of Reference for a further 12 month period.			
	Date and Time of the Next Meeting	The next meeting of the Resources and Business Development Committee will be held on **Wednesday 25 November 2015** at **09:30am** Level 1, Room 5			

ACTION LOG
(Following Octobers Meeting)

Ref	Action	Owner	Timescale	Status
14/63	Meet to discuss suggestions for AHP re: gym and nursery.	C Dove D Powell	2014	This was ongoing – CD was keen to see the whole offer, and would report back to the Board in due course.
~~15/38~~	~~Contract Income Monitoring further clarification on Alder Hey's position with regard to community services and CQUINs.~~	~~LM~~	~~April 2015~~	~~LM updated that two schemes were now not within the funding envelope should we continue.~~
~~15/74~~	~~Marketing and Business Development Committee – Revised Terms of Reference to be submitted to the September meeting~~	~~AMc/TP~~	~~September 2015~~	~~Deferred to October meeting~~
15/81	Car Parking Policy	GD/EW	~~September 2015~~	Deferred to November meeting
~~15/82~~	~~Carter Report – A further update report would be submitted to the October meeting in relation to the Carter Report and the implications for the Trust.~~	~~JS~~	~~October 2015~~	
15/85	Strategic Estates Plan agreed a further report be submitted to the September meeting outlining the emerging pressures.	DP	September 2015	JS reported that a business case to request borrowing had been submitted however, this was not likely to be successful given that national deficit. An answer was expected in Dec 2015
15/85	Retained Estates Strategy; further work was required detailing the work and associated costs.	JW	~~October 2015~~ December 2015	
~~15/88~~	~~Workforce Leading Indicators, further breakdown of data was required to identify the drivers behind the data.~~	~~DA~~	~~September 2015~~ ~~October 2015~~	~~DA was working with finance to produce a consolidated report on temporary spend, workforce, CIP.~~
~~15/91~~	~~Agreed future report to include timetable on delivery and identified returns.~~	~~TP~~	~~September 2015~~ ~~October 2015~~	~~Template now developed; populating over the coming weeks.~~
~~15/100~~	~~Review of the Terms of Reference deferred to the September meeting~~		~~September 2015~~ ~~October 2015~~	~~Further review required to cross reference WOD; final iteration to October~~
15/102	Incorrect classification of nursing staff on ESR to be looked into	MS	Immediate	Update to November meeting

Ref	Action	Owner	Timescale	Status
15/104	• Update on 2016/17 Business Development Plans • ~~M&BD ToRs to be revised~~ • HWWWITF Phase II Update	AMc ~~AMc~~ JA	December 2015 ~~October 2015~~ November 2015	
15/106	Follow up report re cash pressures	JS	December 2015	
~~15/108~~	~~Corporate Report metrics to be agreed~~	~~JA / CL~~	~~October 2015~~	
~~15/109~~	~~Review of Terms of Reference~~	~~MS~~	~~October 2015~~	

Summary of WRES Metrics Findings for Action 2015/16

Staff Survey Data:

1. Percentage of staff reporting that they have experienced harassment, bullying or abuse from patients, relatives or the public in last 12 months is comparatively the same for white staff and figures have stayed the same from the previous year.

2. Percentage of staff reporting that they have experienced harassment, bullying or abuse from staff in last 12 months is comparatively the same as for white staff and figures have stayed the same from the previous year.

3. In Qu 23, 13% of BME staff reported that they have personally experienced discrimination at work from Manager/team leader or other colleagues although this number has significantly decreased from 20% in the previous year.

   In KF 28 of the 2014 staff survey (as reported in our EDS2 Goal 3 presentation in April 2015) 16% BME staff reported that they have experienced discrimination compared to 7% White although BME staff overall report a more positive experience of the workplace.

   Action: We are looking at ways to improve the monitoring of local decision-making in relation to managers and team leaders as well as providing additional support. We are in the process of reviewing the Trust "Respect at work" policy**.** Please also see points 7 and 8 below.

Workforce Profile Data:

4. There are very few, 9 out of 208 BME staff, in very senior manager positions compared with the percentage of BME staff in the overall workforce.

5. The Board and staff profile is under-represented locally, regionally and nationally. This number is most significantly under-represented compared to the local population.

   Action: A priority workforce objective 2015/16 is to increase the number of BME staff through improved partnership working in the community in relation to advertising vacancies and recruitment and improved access to our volunteering and apprenticeships schemes. In relation to board level and senior manager positions we will continue to seek applications from as wide a representative group as possible.

6. We are unable to report the numbers of BME staff recruited to permanent positions from short-listing.

   Action: This is possible to do utilising NHS Jobs and this data will start to be monitored from 1st September 2015.

   We currently monitor the ethnicity of staff entering formal bullying and harassment, disciplinary and grievance procedures. There are too few numbers of BME staff entering employee relations processes including disciplinary to report anything meaningful.

   Action: We will extend monitoring to a two year rolling average of the current year and the previous year for our workforce profile report 2016. We will also discuss other potential reasoning behind these figures to see if there is any other way of monitoring employee relations issues in relation to BME staff that do not reach the formal stage.

7. Relative likelihood of BME staff accessing non-mandatory training and CPD as compared to White staff. This data is not available at present.

   Action: Link OLM recording to ethnicity data held in ESR and improve system reporting capability.

8. Our findings in an equal pay audit suggested that overall Black and Minority Ethnic (BME) staff in general are paid more compared with other staff groups. However, BME staff in band 7 totalling 9 staff appears to be paid less than non-BME staff with the majority of pay discrepancies appearing to relate to staff with up to 5 years' service. The majority of BME staff is also paid at band 5.

   Action: Further analysis is required to consider the possible reasons for this.

NHS England

Briefing for NHS Boards on the NHS Workforce Race Equality

NHS workforce race equality delivers better care, outcomes and performance

Research strongly suggests that less favourable treatment of Black and Minority Ethnic staff in the NHS through poorer treatment or opportunities has significant impact on the efficient and effective running of the NHS.

1. Ethnicity adversely affects the likelihood of the best people being appointed which means that patient care is not as good as it could be.
2. There is a strong correlation between how staff are treated and higher staff turnover and absenteeism, higher mortality rates and lower patient satisfaction. (1) There is in turn a cost attached to employing new or agency staff, Employment Tribunals and disciplinary hearings all diverting NHS resources away from patient care.
3. Discrimination makes people ill which can mean NHS staff members have to take sick leave or can't work to their full capacity and use health services as patients – further cost to the health service. (2)
4. Robert Francis' report "Freedom to Speak Up", a review of whistleblowing within the NHS found that BME whistleblowers are treated significantly worse than White whistleblowers with a likely impact on patient safety. (3)
5. BME staff are also more likely to be bullied at work. Bullying impacts on whether staff report concerns and work in effective teams, also impacting adversely on patient safety. (4)
6. Organisations which have a diverse leadership are more successful and innovative than those who do not. Recently McKinsey examined data for a range of companies in Canada, UK, Latin America and USA and found, in particular, that companies in the top quartile for racial and ethnic diversity are 35 percent more likely to have financial returns above their respective national industry medians. (5) Diverse leaderships are likely to be more innovative, an important consideration for the NHS. (6)
7. Organisations that don't reflect local communities in their own leadership may fail to be sensitive to local health needs, including those linked to reducing health inequalities linked to ethnicity. (7)

NHS England

8. The Five Year Forward View says delivery of high quality, safe, patient focused care is dependent on professional commitment, strong leadership and a caring culture. We know that managing staff with respect and compassion correlates with improved patient satisfaction, infection and mortality rates, CQC ratings and trust financial performance (8). We know that bullying and discrimination are "likely to deprive staff of the emotional resources to deliver compassionate care." (9) We also know that this is especially true for the treatment of BME staff.

   "The staff survey item that was most consistently strongly linked to patient survey scores was discrimination, in particular discrimination on the basis of ethnic background." (10)

Climates of trust and respect characterise the top performing trusts, and rates of ethnic discrimination are a good marker for this. So, for example, the percentage of staff reporting their trust provides equal opportunities for career progression was related to CQC ratings of quality of care provided and use of resources as well as with levels of staff absenteeism. (11)

NHS staff survey results and patient survey results

> *"suggest that the experience of BME NHS staff is a good barometer of the climate of respect and care for all within the NHS. Put simply, if BME staff feel engaged, motivated, valued and part of a team with a sense of belonging, patients were more likely to be satisfied with the service they received. Conversely, the greater the proportion of staff from a BME background who reported experiencing discrimination at work in the previous 12 months, the lower the levels of patient satisfaction."* (12)

The evidence that Black and Minority Ethnic staff are less favourably treated in the NHS is indisputable.

One in five nurses, more than one in three doctors and one in six of all NHS staff are from black and minority ethnic (BME) backgrounds. Analysis of NHS workforce and NHS staff survey data across England shows that:

- White shortlisted job applicants are, on average, much more likely (1.74 times more likely) to be appointed than are Black and Minority Ethnic (BME) shortlisted applicants. (13)
- The proportion of NHS board members and senior managers who are BME is significantly smaller than the proportion of the NHS workforce or local communities that are from BME backgrounds. (14)
- BME NHS staff members are much more likely to be disciplined than White staff members. (15)
- NHS staff survey data shows that BME staff are more likely than White staff to experience harassment, bullying or abuse from other staff (but not from patients, relatives of the public); are more likely to experience discrimination at work from colleagues and their managers; and are much less likely to believe that the trust provides equal opportunities for career progression. (16)

Evidence suggests such inequality exists just as strongly where there are relatively small numbers of BME staff as where there are larger proportions of BME staff in the workforce.

Patients have better experience in NHS organisations where workforce race equality is good.

The case for organisations tackling workforce race discrimination is therefore **not** just about the treatment of BME **staff** but is crucially about the care of **all** patients irrespective of ethnicity. The best Boards and system leaders already understand and act on this powerful evidence.

When the NHS faces other factors adversely impacting on patient care we collate and analyse relevant data, listen to staff and patients to better understand the data, look for good practice that addresses such adverse factors and adapt that practice to our own environment.

NHS England

That is what the NHS Workforce Race Equality Standard (WRES) seeks to do.

For each of its nine indicators the Standard seeks to prompt inquiry to better understand why BME staff often receive much poorer treatment or opportunities that White staff so that the gaps in treatment and experience can be closed.

Gathering the data is an important step as "you can't change what you don't know." However it is only the first step. Understanding the data and the root causes behind it should prompt NHS organisations to seek examples where good practice has tackled such gaps successfully. Widespread anecdotal evidence suggests it is already prompting NHS employers to scrutinise their workforce and staff survey data, to start to listen to their BME staff, to ask why there are such sharp differences between the treatment and experience of white and BME staff and, above all, ask **how** they can reduce the gaps.

By using the WRES, we expect that all NHS organisations, year on year, all NHS organisations will improve workforce race equality and that these improvements will be measured and demonstrated through the annual publication of data for each of the WRES indicators. The requirement to do this forms part of CCG assurance frameworks, the NHS standard contract and the CQC inspection regime. Progress made will be benchmarked and published, organisation by organisation. As the WRES gathers momentum, published performance data will generate publicity and discussion, inside and outside organisations.

The national focus on these nine aspects of workforce race equality provides a great opportunity for NHS organisations to work together on specific interventions and to share good practice.

The costs of implementing the WRES are relatively small. It is designed to require no additional data capture or analysis beyond that which NHS organisations should already be undertaking as part of using the Equality Delivery System (EDS2) and meeting the public sector Equality Duty.

The benefits can be considerable for staff, for organisational finances and productivity, and above all for patient care. Simon Stevens NHS England CEO agrees.

> *"The chronic lack of non-white faces in senior positions meant the NHS was missing out…;. Yet diversity in leadership is associated with more patient-centred care, greater innovation, higher staff morale, and access to a wider talent pool"* (17)

NHS Providers agree:

> *"a new drive on race equality is not a diversion from the urgent strategic challenges facing trusts. Instead, we believe race equality and the wider diversity agenda can and must be a major part of the solution. In the face of our workforce challenges, it can ensure the NHS is capitalising on the best available talent and drawing on the innovation we know diverse teams can bring. And in a context where organisational success will increasingly depend on more personalised care, it can help keep NHS staff connected to the diverse needs of the communities they serve."* (18)

How NHS organisations meet this challenge will vary depending on local circumstances and the specific issues that need to be addressed. Key to progress will be learning from the growing examples of good practice across the NHS. If this approach is successful – and international evidence suggests it is the approach most likely to succeed – then it will decisively reduce inequality and poor treatment amongst the NHS workforce.

More information on the Workforce Race Equality Standard and the evidence that led to it can be found at http://www.england.nhs.uk/ourwork/gov/equality-hub/equality-standard.

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Gateway reference **03931**

Agenda Number 2015/

Alder Hey Children's NHS
NHS Foundation Trust

Board of Directors

12th January 2016

Report of:	Director of Human Resources & Organisational Development
Paper Prepared by:	Interim Director of Human Resources & Organisational Development
Subject/Title:	People Strategy Progress Update November 2015
Background Papers:	n/a
Purpose of Paper:	To present to the Board monthly update of activity for noting and/or discussion.
Action/Decision Required:	The Board is asked to note the contents of the report.
Link to: **Trust's Strategic Direction Strategic Objectives**	Great Talented People
Resource Impact:	None

Section 1 - Engagement

That we build on Alder Hey's strengths to further develop a culture that focuses on quality and the continuous improvement of the service that we provide to patients.

People Support and Engagement

People support plans are being further developed post-move in key areas; with OD attending the recent rapid improvement events being held for the wider Outpatients Team; these days identified the need for a focus on involvement and leadership to help manage necessary system/process change; and highlighted the importance of an effective management induction/development programme. There also needs to be a focus on improving behaviour within teams, which needs structured support.

Departmental training needs continue to evolve from the immediate post occupation phase of the new children's health park. L&D remain integral to the post commissioning processes to ensure these needs are addressed. There is a renewed focus on BIG MOVE workbook completion for those in the retained estate as compliance in some areas is lower than expected with the focus being upon Business Support and the aim of raising the compliance by the end of 2015.

Development of leaders

A Leadership Strategy is in development in consultation with leaders and managers across the Trust; the proposed approach - to integrate much of the work we have already achieved in this area - was approved in principle at WOD in early December 2015. The final strategy will be presented to WOD in February 2016. The coaching phase of leadership development for managers is still underway and work progresses on the provision of the management development programme which will be a key element to support us in delivering on leadership.

Improving communication and hearing the employee voice

No Temperature Check survey was undertaken in November 2015 due to the national Staff Survey. The Temperature Check survey resumed in December 2014 but results are not yet available.

The national Staff Survey closed on the 5th December 2015. The response rate for Alder Hey was 35%, down from the 45% response rate of last year and lower than the average response rate of 42%. Owing to the hospital move, the Trust were given permission to delay the distribution of the survey which gave a much shorter window within which responses could be submitted. The Trust were told to expect a lower response rate because of this.

An overview of the preliminary results is attached in Appendix 1.

Section 2 - Availability of key skills

That we always have the right people, with the right skills and knowledge, in the right place, at the right time.

Effective workforce planning

The workforce planning process will be led by service managers and the HR team, and integrated into 16/17 business planning. Key meetings will be established to discuss workforce issues in the weeks preceding business planning activity.

The workforce CIP project continues to focus on reducing the variable pay costs arising from control of agency, bank, overtime, sickness and vacancies.

The HR team are looking at ways to embed a workforce planning culture across the Trust, which will also help to maintain a reduction in bank/agency costs and support continued quality and continuity of care.

Hotel Services – Following the conclusion of the consultation process in relation to staffing structures and working practises/ patterns in the CHP, those eligible for pay protection have had it applied up to the end of March 2016; this relates to reductions in contracted hours and regular enhancements (overtime/out of hours payments). One appeal remains outstanding from a Catering staff member which Mark Devereaux, Head of Soft Facilities, is hoping to resolve informally.

Theatres – Whilst rota consultations in Anaesthetic and Recovery teams have concluded, implementation has been deferred until 1st February 2016 to enable rostering of the new on-call rota. A consultation with staff in the surgical day case service is to commence late January 2016.

Procurement Stores (Receipt & Distribution) – The organisational change process to alter the working pattern of two staff members is now being withdrawn due to the requirement for continued resource levels within standard working hours meaning their working patterns will now be unaffected.

A&E reception – An organisational change document is being finalised to commence consultation on adjustments to shift patterns. It is expected that consultation will commence before the end of January 2016.

Learning and Development

A paper was presented to WOD in early December proposing a model for implementation of apprenticeships for existing staff or staff recruited to the organisation without baseline level 2 or level 3 role specific qualifications. This was approved in principle and the implementation plan is now being developed for April 2016.

Improved recruitment strategy and planning

NHS Professionals (NHSP) – Work to transition all agency workers to framework agencies is ongoing, with the majority being procured through appropriate framework agencies at correct framework rates. The Trust is sighted on all exceptions to this rule and outliers are reported to Monitor on a weekly basis. This work has been crucial in supporting the Trust to meet the

agency framework cap applied by Monitor/TDA on 23rd November 2015. A documented process to support managers in making decisions around engaging outlier staff (and agency staff more widely) is being developed by a Task and Finish team; this also in response to the recent MIAA audit on bank and agency policy.

Section 3 - Structure & Systems

That we have a best in class HR processes, policies and collective bargaining arrangements that deliver on the things that are important to the Trust

Delivering an effective payroll and transactional HR services
The Trust have extended the payroll contract with ELFS for a further 5 years, with a fixed price contract which delivers savings to the Trust.

Improving recruitment processes
Formal notice has been provided to LWH to end the contract on 31st March 2016 and the recruitment project plan is on target. The recruitment manager will commence in post on 4th January 2016 and formal consultation will commence in January 2016 to TUPE transfer three staff from LWH to Alder Hey.

Effective Policies
An amended action plan and timeline has been agreed with the Policy Review Group (PRG). Sub groups will be primarily focusing on the following policies over the first few months of 2016: Mandatory Training; Study leave; Stress at Work; Supporting Staff involved in incident complaint/claims and Medical / Dental Leave. A current concern is the lack of attendance at PRG by staff side representatives which is impacting the ability to progress policies quickly; this matter is to be discussed at JCNC in the New Year.

Employee Relations Activity
The 14 cases currently making up the formal ER caseload comprise of disciplinary investigations, allegations of bullying and harassment, grievances and appeals, with many of these cases nearing completion or awaiting hearing dates. There are currently 5 staff suspended from the Trust and activity in relation to these cases is ongoing. The HR Team works closely with Commissioning Managers and Investigating Officers in supporting the process to ensure a quick turnaround of issues.

The HR Manager, Employee Relations, is developing supporting processes to reduce the amount of time it is taking to conclude cases, ie, from commissioning to outcome, this will include agreeing a timeline for completion and streamlined template documentation.

Corporate Report

The November Corporate Report shows three HR areas under target and showing red, which are being given immediate attention:

- Sickness absence rates
- Mandatory training compliance
- Compliance against Corporate Induction

An action plan outlining actions to be taken to address shortfalls can be found in Appendix 2.

Section 4 - Health & Wellbeing

That all Trust employees feel valued and respected by the organisation and actively contribute to the organisation's success.

Creating a healthy workforce
We have been successful in meeting the target of having over 75% of front line staff vaccinated this year, and are currently over this at 77%. We will continue to increase take up rate till the campaign finishes in February.

Promoting positive attendance
The Trust's absence rate is 5.5% for end of November 2015, which is an increase from last month (see Corporate Report for further detail).

The CIP Workforce project continues to focus on highlighting the importance of effectively managing sickness in line with the existing policy and putting in place a framework of additional management information and improving the current policy with updated training.

Mersey Internal Audit Authority has completed their review of Absence Management processes which is being submitted to the Executive Team. A number of improvements are recommended, some of which had been initiated before the report had been provided. As part of the CIP Workforce Programme, the existing Absence Management Policy is currently under review and due for completion in the first quarter of 2016.

Health & Safety

The focus of the Health and Safety Team remains the H&S risk assessment of the new hospital, R&E building and the retained estate and work progresses to mitigate and manage all risks.

Leading in Equality & Diversity

E&D objectives have been ratified by the E&D Steering Group and the E&D workplan is now underway with progress reported to WOD.

A comprehensive Equality Analysis process has been introduced with a revised policy and actions. This has now been rolled out through all Trust Governance Committees.

A HR lead has been identified to work with the E&D lead, ensuring E&D is mainstreamed into all HR policies and practices, and to oversee the implementation of any workforce related actions and workforce planning.

Appendix 1

Alder Hey Staff Survey 2015

Initial Briefing for the Trust Board

1. Background and Summary

This year, the National Staff Survey timetable coincided with the hospital move and so permission was sought from the National Co-ordination Centre for a later distribution of the survey to allow for a post-move distribution, which also meant a shorter window in which to respond.

We were therefore told to expect a lower response rate this year; this was borne out as our response rate was 35% vs the national Quality Health (QH) average of 42%. We surveyed all eligible staff this year using a mixed mode of paper and online surveys. In total, 934 staff completed the survey from across the Trust.

The timing of the survey and the context under which it was completed will have had an impact on both the response rate and the results. This will need to be factored into our communications with staff and the action planning process.

Overall, we haven't seen the improvements that we saw in the 2014 QH survey, and we are still below the national average for acute specialist Trusts[1] in many areas.

Headlines

- Our appraisal score has improved again to 80%.
- Staff are generally satisfied with the level of care they give to patients (75%) and 88% of staff believe their role makes a difference to patients.
- More staff reported that they know who the senior managers are.
- The satisfaction of communication with senior managers has improved year on year although it is still behind the national average.
- More staff than last year reported that care of patients was the organisation's top priority, although this remains lower than the national average.
- Our recommendation as a place to work score has decreased and we are below the national average.
- Our recommendation as a place to receive treatment score has improved slightly but is below the national average.
- 84% of staff think the organisation takes positive action on health and wellbeing.
- Staff reported that they generally feel less pressure to come to work when feeling ill than last year, however more people are reporting feeling unwell as a result of work related stress.

[1] Our comparators throughout this report are Acute Specialist Trusts who were also surveyed by Quality Health.

- More staff than last year reported that they satisfied with their level of pay which is the same as the national average.

- The organisation's response to reporting near misses or incidents is now slightly higher than the national average.

- There has been a significant decrease in staff reporting that they have the adequate materials, supplies and equipment to do their jobs.
- 87% of staff reported that they have never experienced bullying or harassment from managers, and 82% have reported that they have never experienced bullying or harassment from colleagues, similar to the national average.

- 93% of staff reported that they have never experienced discrimination in the workplace, although of those that reported they had, the numbers of those experiencing discrimination on the grounds of ethnic background, gender and religion has increased, whilst there has been a significant decrease in staff feeling discriminated on the grounds of disability and age.

- 60% of staff report that they work additional UNPAID hours over their contracted hours which is on a par with the national average. This is an improvement on 2014.

- 19% of respondents reported that they have a long term health problem or disability, with 47% of those who require it saying that the Trust have not made adequate adjustment to enable them to carry out their work.

- 288 Nurses responded to the survey

- 46 HCAs responded to the survey

- 89 Doctors responded to the survey

- 201 Admin and Clerical staff responded

- 84% of the respondents reported that they had face to face contact with patients

- 72% of respondents have more than 5 years' service with the Trust

Next Steps

We will be given access to the Quality Health reporting tool in January which will enable us to analyse our local results in more detail. We will engage with staff side and other staff to agree actions.

The Picker Institute, who run the national NHS Survey Co-ordination Centre, are now collating and analysing all of the data from all NHS staff survey providers, and will publish the official Staff Survey results nationally on the 23rd February 2016. We will receive this information two weeks before national publication for internal review.

Appendix 2- Corporate Report – People Measures

Action Plan – Mandatory Training, Corporate Induction & Sickness Absence Management

Priorities and recommendations are as follows:

Categorisation - Red – Action to be completed prior to year-end or sooner , Amber - Action in Progress, Green - Action Complete Risk levels – High , Medium, Low

	Key Area	Categorisation	Risk Level affecting completion	Management Action proposed or completed	Timescale	Forward Action
Mandatory Training - Core Topics						
1	6 Core topics show significant improvement with no red indicators		L	Big Move workbook has significantly improved the position month on month for all core topics. Now reporting these topics using a business intelligence model	Dec 15	Monitor and Maintain
Mandatory Training - Role Specific Topics						
2	Role specific training topics show red indicators in some areas		M	Whilst compliance has slightly improved across some role specific subjects there has been no significant, consistent upward trend as with 6 Core. **Action Jan – March 16** - Review current position via exception reports with SME's / departmental leads and reinforce role specific TNA for staff groups - Ensure there is a subject specific action plan from SME's and departmental leads in relation to improvement activities - Closer links with comms to ensure information sharing - Ensure blended learning approach similar to BIG MOVE learning is enabled where appropriate **Risk** **Time to learn** **Winter Pressures / Sickness**	Feb 16	Ensure data management system meets the requirements of this plan
Corporate Induction						
3	Staff commencing employment without attendance at corporate		M	Current escalation processes to line / recruiting manager for non-attendance at induction are not		

	induction			being prioritised. There are still (albeit fewer) staff who are attending induction in excess of three months after commencement of employment. **Action Jan – Mar 16** - To have a process signed off through WOD whereby staff cannot commence employment nor be paid without successful attendance at this event - To ensure that this process is integral to the Trusts in-house recruitment procedures without exception and that internal processes are supportive of this going forward - To ensure that all line managers are aware that there will be no mitigating circumstances for the above in all cases	Mar 16	Working with the trusts in house recruitment team early 2016 to embed processes
Sickness Absence Management – CIP Project						
4	To understand the basis of sickness absence costs		M	Determine exact cost of sickness /benchmark to measure savings on absence expenditure – these discussions are taking place with Finance (Claire Liddy/Zoe Meir)	Mar 16	Ongoing meeting with Finance Dept during January 2016
5	Provision of detailed Management Information report at CBU level highlighting cost of sickness and variable costs such as agency/overtime		M	In association with Finance Department,(Claire Liddy/Zoe Meir) to determine whether data warehouse may be able to provide additional inputs needed onto an existing report that details temporary spending **Risk - system availability/capacity**	Mar 16	Ongoing meeting with Finance Dept during January 2016
6	To highlight responsibilities of management of sickness absence		L	All managers who manage sickness have been identified and sent update/reminders of importance of managing sickness and as to the key elements of the current policy, such as regular return to work meetings, use of MSS and prompt referral to Team Prevent and management of sickness absence triggers	Nov 15	Monitor and Review
7	Implementation of update Sickness Management Policy		M	New sickness absence policy being reviewed, in draft stage, shortly to be issued to managers and staffside	Mar 16	Process of policy validation to be

				for comments, then will be submitted to Policy Review Group and WOD in line with process **Risk – Obtaining agreement to proposed changes from staffside.**		followed during Q1 of 2016
8	Review of Team Prevent Key Performance Indicators		M	Review KPIs with Team Prevent to ensure that systems and process are more robust for the management of sickness absence and for wellbeing of staff to maintain a presence in the workplace and on return to workplace following absence	Mar 16	Director of HR&OD to meet with Team Prevent senior Management during January 2016
9	Emphasis of responsibility of line management in managing sickness		M	HRBP's and HR Advisers provision of coaching and support to ensure managers know what their responsibilities are. Proposals have been submitted within the Workforce CIP Project to have management attendance at future sickness process training mandatory and to have management of sickness absence as a key responsibility within managers PDRs.	Mar 16	Proposals to be considered during Q1 of 2016
Sickness Absence Management – CBU level Actions						
10	Effective Management of Trigger reports		M	Triggers reports highlighting number of occasions that staff have had a sickness episode in excess of the policy standard level are sent to local managers. (This may lead to a sanction being issued to staff with persistent sickness levels subject to any underlying medical condition). From December 2016, within two weeks of the initial report an update report is sent to GM highlighting any key issues or non-compliance with trigger reports, in their CBUs	Dec 15	Monitor and Review
11	Review of Department Sickness levels		M	A focus is maintained on Departments in CBUs with persistent 'red' levels of sickness, ie those at 6% in CBU reports and where this occurs in more than one month to drill down and discuss issues/actions with the Depts.	Nov 15	Monitor and Review
12	CBU compliance with Team Prevent referral process		M	From January 2016 HR to review fortnightly all new sickness absences to ensure where appropriate that immediate referral has been made to Team Prevent	Jan 16	Monitor and Review

				for a review of the absence to provide support where appropriate on resumption to duties (in cases of stress/musculo-skeletal and planned surgery)		
13	Reporting of sickness Absence at CBU Boards		L	CBU reports highlighting sickness levels discussed at CBU Boards each month, highlighting additional info such as time taken to input sickness and % compliance of return to work meetings.	2015	Monitor and maintain
14	Long Term Sickness case management		M	Long Term sickness reviews are closely monitored either facilitated (with line manager) by or supported by the respective HR Adviser	2015	Monitor and Review

Agenda Number

Alder Hey Children's NHS
NHS Foundation Trust

Board of Directors
12th January 2016

Report of	Director of HR & OD
Paper prepared by	Interim Director of HR & OD
Subject/Title	Staff Survey Initial Briefing for Trust Board
Background papers	none
Purpose of Paper	To share the initial findings of the 2015 Staff Survey with the Board of Directors
Action/Decision required	For information only at this stage
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Great talented teams
Resource Impact	None

_____ Signature Title _____

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Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Tuesday 12th January 2016

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 December 2015.

2. Key Issues

The following issues were raised and discussed at the Workforce & Organisational Development Committee on the 9th December 2015; the minutes of the meeting will be submitted to the February Board for noting.

- The Committee considered the Terms Of Reference for WOD and **agreed** content.
- The Committee received an update on the development Equality process and **agreed** that a dashboard be setup to record progress.
- The Committee received an update in relation to the Leadership & Management Development Strategy and **agreed** key principles.
- The Committee received Business Case for Implementing Apprenticeship Model and **agreed** the process to be taken forward.
- The Committee **noted** the update in relation to Creating a Healthy Workforce.
- The Committee received an update People Strategy Report for October 2015 and **noted** the content of the report.
- The Committee received an update of the Workforce Leading Indicators and **noted** the content.
- The Committee received an update on Improving Mandatory training/Induction and **noted** the content.
- The Committee received an update Implementing Monitor guidance on Agency caps and **noted** the content.
- The Committee received an update on HR Audit and **noted** the content.
- The Committee received an update on National Consultation process on Whistleblowing and **agreed** an extension to the Whistleblowing policy pending national consultation.
- The Committee received the Equality, Diversity & Human Rights Policy and accompanying Equality Analysis ratified at CQSG and **noted** the content.

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 9th December 2015.

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Corporate Report – People Measures

Action Plan – Mandatory Training, Corporate Induction & Sickness Absence Management

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