Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS MEETING

Tuesday 9th January 2018 commencing at 10:00am

Venue: Small Lecture Theatre, Institute in the Park

AGENDA

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action	Preparation
Board Business						
1.	**17/18/215**	**10:15**	**Apologies:** Dr. Ryan.	Chair		--
2.	**17/18/216**	**10:16**	**Declarations of Interest.**	All	Board Members to declare an interest in particular agenda items, if appropriate	--
3.	**17/18/217**	**10:17**	**Minutes of the Previous Meeting.**	Chair	To consider the minutes of the previous meeting to check for amendments and approve held on: **5th December 2017**	Read Minutes
4.	**17/18/218**	**10:20**	**Matters Arising:** • **Action Log.**	Chair	To discuss any matters arising from previous meetings and provide updates and review where appropriate	Verbal
5.	**17/18/219**	**10:30**	**Key Issues/Reflections.**	All	The Board to reflect on key issues.	Verbal
Strategic Update						
6.	**17/18/220**	**10:40**	**Strategy Discussion – Stocktake and Priorities for 18/19.**	D Jones	Drive forward the next phase of the Trust's strategy, and discuss/agree potential areas of priority focus for 2018/19.	Verbal
7.	**17/18/221**	**11:40**	**External Environment:** **Progress against strategic themes:** - **Liverpool Women's Reconfiguration Options/Neonatal.** - **Acting as One – Proposed Memorandum of Understanding for**	L Shepherd J. Grinnell	To receive a joint report with Liverpool Women's NHS Foundation Trust on one service provider for Neonatal Services	Read Report Read Report

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action	Preparation
			Corporate Services.			
Delivery of outstanding care						
8.	**17/18/222**	**11:55**	**Serious Incidents Report.**	H Gwilliams	To inform the Board of the recent serious incidents at the Trust in the last calendar month	Read Report
9.	**17/18/223**	**12:05**	**Clinical Quality Assurance Committee: Chair's update.**	A Marsland	To receive and review the approved minutes from the meeting held: November 2017	Read report
10.	**17/18/224**	**12:15**	**Alder Hey in the Park Site Development update.**	D Powell	To receive an update on key outstanding issues / risks and plans for mitigation.	Read report
The best people doing their best work						
11.	**17/18/225**	**12:20**	**People Strategy Update:** - **Initial National Staff Survey Results for 2017.** - **Health Education England Workforce Strategy.** - **Key Issue report from December's Workforce and Organisational Committee Meeting.** - **Approved Minutes from the Workforce and Organisational Committee Meeting that took place on the 29.9.17.** - **Approved Minutes from the Workforce and Organisational Committee Meeting that took place on the 8.11.17.**	M Swindell	To provide an update on the strategy and staff survey	Read reports
1230 – 1300 LUNCH						
Strong Foundations						

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action	Preparation
12.	**17/18226**	**13:00**	**Programme Assurance update** - **Deliver Outstanding Care.** - **Growing External Partnerships.** - **Global Digital Exemplar.** - **Park Community Estates and Facilities.** - **The Best People doing their Best Work.**	J Gibson	To receive an update on programme assurance including the 2017/18 change programme	Read Report
13.	**17/18/227**	**13:10**	**Corporate Report.**	J Grinnell/ A Bateman/ H Gwilliams/ M Swindell	To note delivery against financial , operational, HR metrics and quality metrics and mandatory targets within the Corporate Report for the month of November 2017	Read report
14.	**17/18/228**	**13:20**	**2017/18 Board Assurance Framework Report.**	E Saunders	To receive the December position relating to the Board Assurance Framework	Read report
15.	**17/18/229**	**13:25**	**CQC Action Plan.** • **Correspondence from CQC in response to the Trust's request for a review of a rating.**	E. Saunders	To provide a position statement.	Read report
16.	**17/18/230**	**13:30**	**Resources & Business Development Committee:** - **Approved Minutes from the Meeting that took place on the 30.10.17.** - **Chair's update from the meeting that took place on the 13.12.17.**	I Quinlan C. Dove	To receive and review the approved minutes from the meeting held on the 30th of October 2017	Read minutes Verbal
Game Changing Research and Innovation						

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action	Preparation
17.	**17/18/231**	**13:40**	**Global Digital Exemplar (GDE).**	P Young	To update the Board on the programme	Read report
Any Other Business						
18.	**17/18/232**	**13:50**	**Any Other Business.**	All	To discuss any further business before the close of the meeting	Verbal
Date And Time Of Next Meeting (Part 1): Tuesday 6th February 2017 At **10:00am, Institute In The Park, Large Meeting Room**						

REGISTER OF TRUST SEAL
The Trust Seal was used used during **December, 2017:** - Construction contract for Morgan Sandall - Parent Company Guarantee Morgan Sandall - Deed of Novation Hopkins

Alder Hey Children's NHS
NHS Foundation Trust

Confirmed BOARD OF DIRECTORS

Minutes of the last meeting held on **Tuesday 5th December 2017 at 10:00am,**
Small Lecture Theatre, Institute in the park

Present:	Sir D Henshaw	Chairman (Chair)	(SDH)
	Mrs C Dove	Non-Executive Director	(CD)
	Mrs J France-Hayhurst	Non-Executive Director	(JFH)
	Mr S Igoe	Non-Executive Director	(SI)
	Mr J Grinnell	Director of Finance	(JG)
	Mrs H Gwilliams	Chief Nurse	(HG)
	Mrs A Marsland	Non-Executive Director	(AM)
	Dr S Ryan	Medical Director	(SR)
	Mrs L Shepherd	Chief Executive	(LS)
	Mrs M Swindell	Director of HR & OD	(MS)
	Dame J Williams	Non-Executive Director	(JW)
In Attendance:	Prof M Beresford	Assoc. Director of the Board	(PMB)
	Mrs M Barnaby	Interim Chief Operating Officer	(MB)
	Mr C Duncan	Director of Surgery	(ChrD)
	Dr A Hughes	Director of Medicine	(AH)
	Mrs D Jones	Acting Director of Strategy	(DJ)
	Mrs C McLaughlin	Director of Community Services	(CMc)
	Mr D Powell	Development Director	(DP)
	Ms E Saunders	Director of Corporate Affairs	(ES)
	Mrs K McKeown	Committee Administrator (minutes)	(KMc)
	Mrs J Tsao	Board Administrator	(JT)
	Mr M Flannagan	Director of Communications	(MF)
Observing:	Tim Crowley	Mersey Internal Audit Agency	
	Mark Borthwick	Member of the public	
	Rob Little	Account Manager, Liaison	
	Dr Senil Sharma	Clinical Fellow	
Agenda item: 192	Peter Young	Chief Information Officer	
197	Valya Weston	Head of Service/Associate DIPC	
198	Anne Hyson	Complaints Manager	
201	Kerry Turner	Listening into Action Lead	
202	Joe Gibson	External Programme Assurance	
Apologies:	Mr I Quinlan	Non-Executive Director	(IQ)
	Ms S Falder	Director of Clinical Effectiveness and Service Transformation	(SF)

Patient Story

The Thompson family were invited to attend December's Trust Board meeting to discuss their child's journey with the Trust. The family explained that their child had fallen from a first floor bedroom window and as a result of this required surgery to treat a fractured skull and a subsequent bleed on the brain. The family advised the Board that the clinical care received by their son was excellent and had played a major part in his return to good health.

The Chair queried whether the family had come up against any obstacles during their stay. The family reported that the main concern that they had had related to the lack of communication between nurses following a shift change in relation to medication. It was also pointed out that one of

the hand gel dispensers sited on entry to the ward was broken and remained this way, whilst the other dispenser was empty.

The family confirmed that their son is now back at home and his shared care has ceased. Louise Shepherd asked the family for their views on their son's shared care. The family felt that this element of their son's care had been dealt with really well, communications were good and referrals were addressed in a prompt manner. The Chairman pointed out that the Trust encourages its nurses to involve parents in the care of their child whilst in hospital and queried as to whether the family were actively encouraged to participate in caring for their son. The family confirmed that this was the case.

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

17/18/187 Declarations of Interest

There were none declared.

17/18/188 Minutes of the previous meetings held on 7th November 2017

Resolved:

The Board received and approved the minutes from the meeting held on 7th November 2017.

17/18/189 Matters Arising and Action Log

The Chair informed the Board that this would be Mags Barnaby's final meeting in her present role as Interim Chief Operating Officer and on behalf of the Board thanked her for her hard work and commitment to the Trust.

It was confirmed that the Board meeting was being observed by Tim Crowley from Mersey Internal Audit Agency and Rob Little from Liaison, a supplier to the Trust on 'workforce direct engagement'.

It was confirmed that all actions from the previous meeting have been included on the agenda.

17/18/190 Key Issues/Reflections

Louise Shepherd informed the Board of the positive meetings that have taken place with the new Chief Officer for Liverpool CCG, Jan Ledward. A further meeting is taking place on the 6th December and it was reported that Jan Ledward will be spending a day with the Trust on 7th December.

It was reported that the Integrated Partnership Board met two weeks ago to discuss progress in respect to Integrated Care/Accountable Care within the city. Louise Shepherd commented that it is vitally important to move forward with the children's agenda and confirmed that a paper will be submitted to the Integrated Partnership Board in January 2018 defining an integrated partnership for children across the city.

Research domain: A review that was commissioned by Liverpool Health Partnership has been carried out by KPMG. A further update regarding this matter will be addressed under item 6 of the public agenda.

Mags Barnaby provided an update on the 'Booking and Scheduling' review. It was confirmed that there isn't a single standard for excellence and following discussions with external consultants a decision was made not to progress down this route as it was too expensive and didn't offer anything different. It was pointed out that systems and behaviours are an issue therefore it has been agreed to conduct an audit of these

specific areas. Mags Barnaby advised that that a progress report will be submitted to the Trust Board in January 2018.

17/18/190.1 Action: MB

John Grinnell reported on the successful bid for £4k for cyber security. It was confirmed that this funding will have to be spent by the end of the 2017/18 financial year.

On behalf of the Board, Louise Shepherd thanked everyone who had been involved in attaining 'Highly Commended' at the Health Service Journal Awards in the category of Provider Trust of the Year and alluded to the positive feedback that had been received.

The Chair thanked the Executive Directors who were involved in supporting the management contract for Liverpool Community Health (LCH), for their hard work and highlighted the positive steps that have been taken with regulators as a result of the Trust's involvement with LCH.

17/18/191 Liverpool Health Partners/KPMG update

Michael Beresford provided an update on the work that has taken place in association with KPMG. The presentation that was shared with the Board gave an overview of the important opportunities that could arise as a result of an integrated approach to addressing the health of the population, by putting children at the centre. Fostering opportunities with the NHS, universities and local councils to focus on children's health and wellbeing will have a meaningful impact for the future. Professor Beresford described how risk reduction and health promotion strategies can influence health development.

It was reported that the heads of all three faculties at Liverpool University are meeting to agree a way forward with the partnership and a pan university workshop has taken place with the three faculties and the senior management team. The Board was advised of the appointment of the new Executive Pro-Vice Chancellor (EPVC) for the Faculty of Health and Life Sciences, Louise Kenny, who will be in post full time from January 2018. It was confirmed that all three of the EPVCs at Liverpool University are in full support of this work.

Michael Beresford highlighted the essence of the UN Convention on the 'Rights of the Child' at the local level along with the strong impact on social justice, and advised that Liverpool City Council has submitted a bid requesting that Liverpool becomes a Child Friendly City, of which, Liverpool University is in full support.

Michael Beresford informed the Board that Liverpool University intended to look at a number of models in order to link in with partners and confirmed that an internal review has taken place to try and align expertise and excellence against priorities to ensure they match community based organisations. Michael Beresford queried as to whether it would be beneficial to invite a member of the Liverpool Health Partners to a forthcoming Board meeting in order to articulate the benefits of working in partnership to address some of the challenges in the region. Steve Igoe highlighted the importance of promoting this work in an appropriate timeframe to ensure that this opportunity is not missed.

A discussion took place following the presentation and it was agreed that it presented a vital opportunity to have a system that puts children as the main focus of the work and it was pointed out that working with universities is key to moving forward with this work.

Christian Duncan queried the process for aligning the Divisions in respect to this work. It was agreed that a meeting should take place to discuss an approach prior to meeting with Divisional leads.

17/18/191.1 Action: ChrD

17/18/192 Global Digital Exemplar

Peter Young updated the Board on the progress towards participation in NHS England's GDE Programme and subsequent initiation of the Programme.

It was reported that the Trust has received funding as a result of the final milestones being passed in September 2017. Progress is defined as good and the organisation is starting to realise the benefits of the programme. There is a lot of pressure in terms of change which will be highlighted in the Quarter 4 report.

The Board was advised that clinical engagement/involvement has increased over the last eighteen months and as a result of listening and learning the organisation is doing things differently as it progresses with the programme.

John Grinnell advised the Board of a piece of work that is due to take place in respect to the shadowing of five clinicians carrying out their clinical work. It was agreed to conduct this exercise to ensure that the Trust keeps its focus on making the lives of frontline staff easier.

17/18/193 External Environment

Liverpool Women's NHS Foundation Trust/ Neonatal Network

The Chairman, Louise Shepherd, Steve Ryan and leads from the Neonatal team had recently visited the Neonatal Services at the Liverpool Women's Hospital. A team from Liverpool Women's is due to visit the services at Alder Hey later this month. Following the visits a report will presented to both Boards to agree a single neonatal service approach.

CAMHS Tier 4 Bid

Catherine McLaughlin informed the Board of the commencement of the seven day Crisis Response service for children who come via the Accident and Emergency Department and require mental health support.

'**Acting as One' Project**

It was reported that there are still a number of organisations yet to sign up for the 'Acting as One' project for corporate services, with Alder Hey being one of them. It was agreed to provide an update on the corporate position at January's Trust Board meeting.
Action: JG

Congenital Heart Disease

Dr.Ryan advised the Board that NHS England have agreed to Liverpool being a level 1 service provider for Congenital Heart Disease in the North West and pointed out that this will be an opportunity for improvement in respect of addressing heart congenital disease. It was reported that the majority of the care will be conducted in adult settings.

17/18/194 Serious Incidents Report

Hilda Gwilliams presented the report for October 2017. There have been no new SIRIs reported, there are four ongoing and four have been closed.

Resolved:

The Board received the Serious Incident Report and noted the progress in the management of the open incidents.

17/18/195 Clinical Quality Assurance Committee: Chair's Update
CQAC Minutes 18th October 2017
Resolved:
The Board received and noted the approved minutes from the CQAC meeting held on 18th October 2017.

17/18/196 Mortality Report Quarter 2
The Medical Director's Mortality report was submitted to the Trust Board for assurance purposes. The Board was asked to take note of the following highlights:

- The Trust now informs the LeDeR team in Bristol of any child mortality with learning disabilities.
- In relation to case 4 of hospital deaths, it was reported that an RCA was conducted as there were factors that may have played a role in the child's death and concerns had been raised that the child's deterioration post op had not been completely recognised by all members of the team.
- The Board discussed the statistical analysis of mortality and reviewed the real time monitoring of mortality, as highlighted in the report.
- It was reported that a developmental index tool is being progressed with the support of the peer group. A discussion took place around the high mortality SPMI figures displayed in the chart on page 14 of the report. It was pointed out that other NHS trusts will report different performance figures as a result of using adult derived tools. Louise Shepherd felt that this matter should be discussed further and highlighted the importance of children's trusts incorporating narrative in their reports to support figures.
- Dame Jo Williams queried the Trust's response if a member of the public questioned the reported mortality figures. Dr. Ryan described the reasons behind the figures and explained that when necessary incidents are investigated in an appropriate manner. Dr. Ryan informed the Board that when delivering complex care to very sick patients the Trust delivers on a par with other organisations. Dame Jo Williams highlighted the importance of promoting this narrative in the public domain.
- Dr. Ryan informed the Board of the positive feedback received from the Coroner following a discussion on the Trust's process for investigating deaths. A query was raised around the Coroner's expectation of the Trust. The Chairman agreed to contact the Coroner via letter to acquire this information.

17/18/196.1 Action: SR/LS
17/18/196.2 Action: SR/SDH

17/18/197 Infection Prevention and Control Quarter 2
The Board was provided with an update on Q2 and Q3 of the Infection Prevention and Control report for 2017/18. It was reported that there have been two outbreaks of measles during Quarter 3 along with an outbreak of Noro Virus on Ward 4A. The Board was advised that the Trust has received thanks from Public Health England for all of the work that Alder Hey has conducted in respect to the measles outbreak.

Following the outbreak of Noro Virus on Ward 4A, it was reported that the ward was deep cleaned on the 23rd November and has since re-opened. The Board was advised of the trial that is taking place in respect to a new ultra violet cleaning machine.

As of the 27th November, 72% of total deliverables were completed with 1% classified as red. It was confirmed that RCAs are being conducted for all of the Trust's bacteraemias and clinicians have been asked to present cases that the organisation can learn from. It

was reported that there is a process in place to review all of the Trust's hospital acquired bacteraemias.

The Board was informed that the Trust is in the process of changing providers for the hand hygiene contract and the launch of the Sure Washing Machine will take place once the new contract is fully implemented. The launch will advise 30 clinicians on how to effectively wash their hands and it was felt that it would also be beneficial to have Exec participation during the launch. In addition, the Trust is working with a company to address children's hand hygiene and education. A launch of the cuddly books project will take place during September's IPC conference and will be shared with schools and nurseries for educational purposes.

Mags Barnaby felt that a meeting should take place outside of the Board to discuss staff accountability and responsibility, following education.

17/18/197.1 Action: MB/VW

The staff flu uptake figures were reported at 64% as of the 1st December. The Chairman thanked Val Weston and her team, on behalf of the Board, for the excellent work that is taking place.

17/18/198 Complaints Quarter 2 report

The Board received the current Complaints Performance report and was provided with an update regarding previous concerns. The Board noted the reduction in formal complaints for surgery in 2017/18 compared to 2016/17. It was reported that Medicine and Community have remained the same with the majority of complaints being around treatment and procedure. A positive communication session took place mid-November to address the challenge from parents of patients.

In Q2 one complaint was not acknowledged until day four. The delay was caused by clarification as to whether this was to be investigated as an incident using the RCA process or as a complaint. There has since been a change to policy which enables the Trust to acknowledge complaints via letter or telephone.

The Board discussed lessons learnt and compliments. The Chairman queried as to whether compliments could be captured and displayed on the notice board in the Atrium. Mark Flannagan confirmed that this information could be displayed on the TV monitors that are situated in this part of the hospital.

Louise Shepherd thanked the Non-Executive Directors for the excellent piece of work that had been conducted in relation to the review of a sample of complaints and the useful feedback this had generated.

17/18/199 Alder Hey in the Park

David Powell informed the Board that the Programme is on track and advancing to demolish to M/N block has been agreed as part of Phase 1. There have been no issues with dust to date and monitoring will continue as per plan. The Chairman queried whether the Trust had received any complaints about the dust. DP confirmed that complaints were minimal and that there was nothing of concern to report.

The Board was advised that the tree charter marker national sculpture installation is due to take place in Springfield Park. It was reported that there has been a lot of community involvement to support the clearance of trees in the park.

The Trust is currently exploring and conducting a financial analysis of proposed developments and locations for community services where current premises have

received notification of end of tenancy. A financial analysis of all options is also taking place for the possible relocation of off-site premises for CAMHS (the Dewi Jones Unit) and Corporate services as well as exploring any viable options for keeping services on site.

The organisation is in the process of agreeing compensation in line with the energy contract, and it was reported that there is to be an increase in car park charges. The Trust has deferred the implementation of the additional car parking charges for as long as possible but the increase is now imminent. It was pointed out that Alder Hey still has the lowest car parking fees of any trust in the area.

Resolved:
Board received an update on the current position.

17/18/200 People Strategy update

The Board received the People Strategy update for October/November. It was reported that the Trust's staff survey response rate reached 54% which is the highest response since the organisation began surveying the whole of its staff. The final response figures will be confirmed in January/February 2018.

There has been a 5% increase since November 2017 in respect of the core mandatory training figure of 80%. There is a Trust wide push in order to achieve the target of 90% by the by end of January 2018.

The Board was advised of the activities that took place during Fab Staff Change Week along with the positive outcomes of the various sessions which culminated in staff pledging to make changes. Staff Award nominations are due to commence on the 7th of December and it was pointed out that there are some really interesting viewpoints from staff members who come into work every day with disabilities.

It was reported that sickness has increased by 5.4% during October and there are four employment tribunal cases due to be heard between December 2017 and March 2018.

A discussion took place around the streamlining of mandatory training to ensure that training is role relative. Melissa Swindell informed the Board that the Trust has conducted a piece of work to streamline a set of core skills that were mandated nationally, to ensure that staff are only doing the training that is required.

Resolved:
The Board:

- Received the People Strategy report for October/November 2017.

17/18/201 Listening into Action

The Board was updated on the organisation's Listening into Action (LiA) journey to date and it was confirmed that the bi-annual report will be available for submission during January's meeting.

Kerry Turner gave an overview of the work that has been completed/ongoing as a result of the 1st LiA Cohort. It was reported that a 2nd Cohort will commence in 2018 with existing teams from previous Cohorts.

Work is taking place to streamline the Executive Shadowing Programme and it was reported that the feedback following the Fab Staff Day has been excellent with over 200 pledges made by staff. A follow up will take place to ensure the pledges are actioned. Kerry Turner advised of the positive outcomes of LiA; from the establishment

of a Disability Network to the appointment of a new Chair/Vice Chair for Staff Side, plus many more. The Chairman queried as to whether it would be possible to compile a list of the changes that have been made. Kerry Turner agreed to action this request.

17/18/201.1 Action: KT

17/18/202 Programme Assurance Update

The Board was provided with an update on the assurance framework for the current change programme at Alder Hey. A discussion took place around the purpose of the high level plan and it was confirmed that a report will be produced on a monthly basis and submitted to the Trust Board upon request.

Joe Gibson highlighted the opportunities to improve the current status position. It was pointed out that Executive sponsorship needs to be constant and effective therefore the Executive Sponsors have held a review meeting to re-group around change programme delivery. A separate session on Quality has also taken place. The High Level 'Benefits Plan' previously used prior to the hospital move has been resurrected to provide a summary of benefits delivery.

The Chairman highlighted the importance of focussing on benefits in the next round and ensuring that inter-connectives become business as usual. Concerns were raised around the assurance for the development and delivery of agreed projects and it was felt that the loop should be closed off in respect to the achieved benefits of the new build. Louise Shepherd reported that the Programme Board has been re-instated with John Grinnell as Chair and will feed into the Trust's Board committees to offer assurance.

The Chairman requested that further details be provided to the Board in January on the outcome of the quality session and the Executive Sponsor review meeting.

17/18/202.1 Action: JG

Resolved:
The Board:

- Received the Change Programme Assurance update.

17//18/203 Corporate Report

The Corporate report for month 7, 2017/18 was submitted to the Board for information purposes. The following areas were discussed:

Financial, Growth & Mandatory Performance Framework
For the month of October the Trust is reporting a surplus of £0.3m which is £0.7m behind plan.

Income is in line with plan but shortfalls in elective and outpatient income are offset by over-performance in non-elective activity and pass through drugs and devices costs (which are offset by expenditure). Elective activity is behind plan by 13%, non-elective is ahead by 24% and outpatient activity is behind by 5%.

Pay budgets are £0.6m overspent for the month relating to use of temporary staffing and the impact of unachieved savings targets. The Trust is behind plan with the CIP target by £0.5m to date. Cash in the Bank is £10.9m. The Trust has a NHSI Use of Resources rating of 3 in line with plan.

Performance
The following points were highlighted:

- The Trust's winter plan has now formally commenced and it was reported that national discussions are taking place to address the arrangements for funding throughout the winter. Mags Barnaby informed the Board of the bid that the Trust has submitted to offset some of the costs that the organisation is incurring.
- The Trust still has higher than planned levels of Non Elective admissions for surgery and medicine in conjunction with high levels of Emergency Department (ED) attendance. This has made October a challenging month following in a similar vein from September. This has impacted upon flow which in conjunction however the mitigating actions have supported flow outwith ED. This has meant that cancelled operations have reduced and positively affects theatre utilisation. Despite this 28 day relist breaches have increased due to specialty specific challenges.
- ED 4 hour standard was not met for the month due to a small number of high volume breach days and change in counting for GP streaming.
- The ED team have conducted seven pieces of work in order to understand the cause of the problem and review the process for managing the various categories of sick patients. It was found that the issues related to performance and therefore a decision was made to make internal changes to assist with improvement. The next piece of work will analyse capacity and command in three hour blocks.

Patient Safety
The following points were highlighted:

- Medication errors with harm remain low at 13 year to date.
- There were three grade 2 or higher pressure ulcers reported in October
- The cumulative increase in clinical incidents associated with harm was flagged last month. A review of the recorded harm levels has shown this to be in minor harm incidents. Louise Shepherd raised concerns in respect to the way the organisation is presenting this information without commentary and requested that either narrative be included in the report or an alternative definition for severe harm.

17//18/203.1 Action: SR/HG

Patient Experiences
There were 10 formal complaints in October, the highest in any month this year. It was reported that there is an analysis being conducted around these figures.

Clinical Effectiveness
There was 1 MRSA bacteraemia reported in October, which is subject to a full RCA.

Resolved:
The Board received the Corporate Report for Month 7.

17/18/204 Board Assurance Framework
The Board was provided with an update on the Board Assurance Framework (BAF) for October 2017/19. The following points were highlighted:

- The risk relating to the management contract for LCH has been removed from the BAF.
- It was reported that the challenges on automation are starting to reduce.
- The Chief Operating Officer has gained agreement for children's WIC activity to be counted in ED figures; performance now disaggregated by stream to enable closer management of 'greens'; discussions are taking place with UC24 re GP slots.

- The BAF is submitted on a regular basis to the committees that feed into the Trust Board.
- Mandatory targets are of a low risk rating at the present time. The Trust will be monitoring these figures during the winter period to ensure they remain on target.

Resolved:
The Board received the content of the BAF.

17/18/205 Audit Committee Minutes

Resolved:
The Board received the approved minutes from the meeting held on 5th October 2017. The committee has focussed on previous areas of work that needed resolving. By the end of this financial year we want to draw a line on the old o/s items.

17/18/206 Any Other Business

There was no other business was reported.

Date and Time of next meeting: Tuesday 9th January 2018, at 10:00am, Large Meeting Room, Institute in the park.

Alder Hey Children's NHS Foundation Trust
Trust Board - Part 1
Action Log following the meeting on the 5.12.17

Alder Hey Children's NHS Foundation Trust

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
5.12.17	17/18/191.1	Liverpool Health Partners/KPMG update	***Integrated approach to addressing the health of the population, by putting children at the centre:*** Discuss an approach prior to aligning the Divisions with the forthcoming partnership work.	Dr. Duncan/ Michael Berseford	05.01.18		**21.12.17:** An update will be provided during January's Trust Board meeting.
5.12.17	17/18/193.1	Acting as One' Project	Provide an update on the corporate position for the 'Acting as One' project, during January's Trust Board meeting.	John Grinnell	05.01.18		**21.12.17:** This action has been included on January's Trust Board agenda. **ACTION COMPLETE**
5.12.17	17/18/196.1	Mortality Report Q2	Discuss the possibility of using narrative to support performance figures in the Mortality Report and look at linking in with other Children's Trusts to discuss the streamlining of weighting tools for performance data.	Dr. Ryan/ Louise Shepherd	05.01.18		**21.12.17:** SR spoke with Julie Grice who has recently spoken with the national Lead who regards AH's approach as leading and has asked for the Trust's documentation. AQUA are engaged and meeting with SR to plan a Board session. **ACTION COMPLETE**
5.12.17	17/18/196.2	Mortality Report Q2	Liaise with the Coroner's office via letter to confirm the Coroner's expectations of the Trust.	Dr. Ryan	05.01.18		**21.12.17:** A meeting took place on the 4.12.17 and the Trust has followed up with a letter. **ACTION COMPLETE**
5.12.17	17/18/197.1	Infection Prevention and Control Q2	*Launch of the Sure Washing Machine:* Discuss staff accountability and responsibility, following education.	Mags Barnaby/ Valya Weston	05.01.18		**21.12.17:** The Sure Wash machine is owned by the Hand hygiene company Gojo. Dates have been arranged for the company to come in and take the machine around the Trust. First date is the 18/01/2018.

Alder Hey Children's NHS Foundation Trust
Trust Board - Part 1
Action Log following the meeting on the 5.12.17

Alder Hey Children's NHS Foundation Trust

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
5.12.17	17/18/201.1	Listening into Action	Compile a list to reflect the changes that have been made as a result of Listening into Action.	Kerry Turner	02.01.18		**21.12.17:** An update was circulated to Board members on the 4.1.18.
5.12.17	17/18/202.1	Programme Assurance Update	***Change Programme Delivery:*** Provide an update during January's Trust Board on the outcome of the Exec Sponsor review meeting/Quality session.	Joe Gibson	02.01.18		**21.12.17:** This action has been included on January's Trust Board agenda. **ACTION COMPLETE**
5.12.17	17/18/203.1	Patient Safety Report	***Recorded Levels of Harm:*** Include narrative or an alternative definition for severe harm, in the Patient Safety report.	Dr. Ryan/ Hilda Gwilliams	02.01.18		The incident detail has been enhanced with clear succinct narrative defining the impact and immediate action taken. **ACTION COMPLETE**
Actions for February 2018							
5.12.17	17/18/190.1	Key Issues Reflected	***Booking Schedule Review:*** Submit a progress report to the Trust Board in January 2018.	Mags Barnaby	30.1.18		**21.12.17:** This item was discussed at Execs on the 21.12.17 and it was agreed that the report would be completed in time for submission to February's Trust Board.

Status	
Overdue	
On Track	
Closed	

Subject:	**Business case for the Implementation of a single neonatal surgical service at two-sites- Alder Hey Children's NHS Foundation Trust and Liverpool Women's NHS Foundation Trust**
Date:	January 2018
Paper Prepared by:	Jennifer Deeney, Head of Neonatal Nursing & Operations Liverpool Women's Hospital; Chloe Lee, General Manager Alder Hey Children's Hospital; Ms Joanne Minford, Consultant Paediatric Surgeon AHCH; Dr Nim Subhedar, Consultant Neonatologist LWH; Dr Bill Yoxall, Consultant Neonatologist LWH
Purpose of Paper:	The purpose of this paper is to set out: • A new model of care for neonatal services. This model of care would deliver a single service across two-sites. A partnership will be formed by Liverpool Women's Hospital and Alder Hey to deliver the new service. • To describe in detail the new Neonatal Intensive Care Unit facility that will be in Alder Hey in the Park. • The risks associated with the current service and the benefits to patients and families that will be realised from developing a new model of care.
Board are asked to:	• Consider whether the proposed new model of care is supported • Agree the preferred option for implementation • Provide feedback on the proposed direction of travel in relation to the partnership model of care transitioning to a single service • Review the financial model which is • Approve the business case proceeding to the next stage of implementation and approval, which includes submitting the business case for investment approval to NHS North of England Specialised Commissioning Team.

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Executive Summary

This case has been developed to set out the need to invest in the neonatal services that are based in Liverpool and provide care to families in the City and the North West. This investment will lead to the delivery of outstanding outcomes for babies and families. The proposal is centred on investment in the neonatal surgical service at Alder Hey Children's Hospital (AHCH), and investment in neonatal services at Liverpool Women's Hospital (LWH).

The model of care will be underpinned by a new partnership for delivering neonatal services as a single service across two sites. The enhanced service would deliver full-compliance with national standards for neonatal care and improve outcomes for babies.

The Case for Change

There are three key reasons why a new model of care for neonatal surgical babies in Liverpool is critical:

- Firstly, the unit will provide a **safer service for babies** which is compliant with national service specifications and standards.

- Secondly, the **quality of care and clinical outcomes** for babies will be improved by strengthening the joint working between both organisations in order to provide increased levels of neonatology and surgical expertise and also an appropriate environment for all babies to be nursed in the same dedicated facility.

- Thirdly, the **experience** of mothers and families will be improved by reducing the number of unnecessary transfers between hospitals by 50% (**transfers** are also **associated with mortality**).

The paper also sets out the challenges and risks associated with the current service model for surgical neonates, which is sub-optimal.

We have also taken the opportunity to set out the gaps in the clinical workforce in the neonatal service provided at LWH. We make the case for investing in neonatal services at LWH in order to deliver full compliance with the standards set out by the British Association of Perinatal Medicine (BAPM).

Strategic and Local Context

Within the North West Neonatal Operational Delivery Network (NWNODN), the Cheshire and Merseyside network does not currently comply with the NHS England service specification for Neonatal Surgery (EO2)[1]. In particular neonatal surgery takes place at Alder Hey Children's Hospital and Neonatal Intensive Care is provided at Liverpool Women's Hospital, which does not satisfy the requirement for neonatal surgery to be co-located with Neonatal Intensive Care and maternity services, resulting in current commissioner derogation. Non-compliance could result in the decommissioning of neonatal surgery which not only has a massive impact for neonates but also poses a risk to the commissioning of other specialised surgical services

such as Cardiac and Neurosurgery, resulting in a reduced standard of care for children in the North West.

The current neonatal service configuration at AHCH whereby babies requiring intensive care are cared for on a Paediatric Intensive Care Unit (PICU) before returning to LWH or referring centre shortly after any surgical procedure, is sub-standard as the care is not compliant with the required level of care for a Neonatal Intensive Care Unit (NICU) due to the lack of specialist Consultant Neonatologists and Neonatal Advanced Nurse Practitioners (ANNP's) (BAPM, 2010[2]; E02- National Service Specification: Neonates[3]).

The lack of dedicated NICU provision at AHCH also means there are a number of babies being cared for across other different locations within the hospital. For example a number of cardiac neonates are cared for on the cardiac ward which satisfies the specific cardiac requirements but there is a lack of specialist neonatology input. This highlights the case for change in order to create a wrap-around service for surgical neonates whereby they receive all of the specialist input required within one location.

The current pathway requires neonatal surgical patients to undertake high risk transfers between the Liverpool Women's Hospital (or other referring centre) and Alder Hey for surgery, frequently following a delay of several hours before surgical review takes place and transport is made available. The babies are then either returning to the referring Hospital for post-surgical intensive care or being admitted to the paediatric intensive care unit at Alder Hey.

Although a strong transfer service is in place for neonates, it should be noted that small sick neonates, with for example necrotising enterocolitis, needing surgery are transferred from level 3 intensive care units to distant Paediatric Surgical Units[4].

Despite demonstrably good surgical outcomes for neonates, there are legitimate concerns that this is not a desirable pathway for the patient or their families, and adds additional clinical risks that can be reduced or avoided. The current service provision for surgical neonates is not sustainable and it is not acceptable to wait for a serious incident to occur before making the necessary service changes.

<u>The proposal</u>

This paper sets out a three year implementation plan for the proposed new model of care for surgical neonates across a two site single service model which would address the current issues and will significantly improve the quality of care outcomes and safety of the service.

The model of care would see the establishment a new NICU facility with 24 cots at Alder Hey. The Unit would be staffed by nurses with neonatal specialty training, Advanced Neonatal Nurse Practitioners, Consultant Neonatologists, Consultant Paediatric Surgeons and therapists. The staffing levels are proposed to be fully compliant with BAPM standards.

We are proposing that LWH and Alder Hey work much more closely and in partnership in the delivery of neonatal services. Initially we are proposing a formal partnership is formed with a single leadership team and a Partnership Board responsible for implementing the new model

of care for surgical neonates. This would then evolve into a single service hosted by a single organisation.

1.0 Introduction

The aim of the paper is to set out clearly a proposal to deliver significant and sustained improvement to neonatal surgical services in Liverpool. The preferred option from NHS England specialist commissioners and the NWNODN to achieve this is:

"All neonatal surgery continued to be performed on Alder Hey Children's Hospital (ACHC) site and in collaboration with LWH the establishment of designated Neonatal intensive Care provision at AHCH and enhanced post-natal support (two site single service model)". [3]

This new model of care will improve the quality of care and outcomes for babies by:

- Providing dedicated neonatal intensive care provision at Alder Hey Children's Hospital (AHCH) with the appropriate supporting workforce
- Providing an optimal environment where babies will receive both neonatal and surgical expertise in one place
- Introducing a new clinical pathway which sees a significant reduction in unnecessary high risk transfers for babies

Following a review of the current service by NHS England specialist commissioners and the NWNODN, a Neonatal Task and Finish Group (T & F group) was established to implement the preferred option.

Performance of Current System

A review of the current neonatal service across LWH and AHCH shows there are some significant challenges and there are a number of key drivers supporting the case for change:

- There is currently no dedicated neonatal intensive care provision for neonates at AHCH
- Within the North West Neonatal Operational Delivery Network (NWNODN), the Cheshire and Mersey network does not currently meet the national service specification for neonatal surgery and requires commissioner derogation
- The neonatal service at both LWH and AHCH does not currently meet the BAPM (2010) workforce standards
- The demand for neonatal surgical capacity at AHCH is rising year on year
- Current neonatal workforce at AHCH is not the appropriate expertise required to support their specific neonatal, non-surgical needs
- A review of bed occupancy for neonates at AHCH shows that a high number of babies are being cared for in a number of different wards across the trust due to capacity issues, which is often not the appropriate environment
- The current Neonatal Surgical Unit (NNSU) at AHCH cannot currently provide care for babies requiring any level of respiratory support, this is only available on the Paediatric Intensive Care Unit (PICU)

- There are currently Cardiac neonates within the network who remain at other units pre-operatively and it is felt that their quality of care and outcomes would be improved by earlier transfer to AHCH

This paper sets out a 3 year implementation plan for the proposed new model of care for surgical neonates for a two site single service model which would address these current performance issues and will significantly improve the quality of care and outcomes, safety, and family-centeredness of the service. This will include a description of the current issues across the Cheshire and Merseyside network in relation to compliance with the national service specification, and will go on to outline the recommended implementation plan to address the areas of non-compliance by proposing a joint model of care for surgical neonates (including cardiac pre-operative neonates) between AHCH and LWH.

The proposed new model of care has been developed in partnership by AHCH, LWH and the NWNODN following a series of steering groups and workshops with input from both internal and external stakeholders and a strong clinical influence.

2.0 Strategic Context

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

2.1 National Context

The national strategic context has been stated *"to concentrate the expertise in order to maximise the most effective delivery of services"*.

It is reiterated that there is "*the desire to see the majority of care delivered as close to home as possible"* and that "*this should be within re-organised managed clinical networks of care, which* ***minimises the need for mothers and babies to travel long distances*** *to receive care*". Evidence suggests that *"networked models of care for intensive care produce the best outcomes for babies".*

2.1.1 National Service Specification

In addition, the NHS England service specification for surgical neonates[1] sets out clear expectations with regard to service delivery in the context of delivering consistent standards and equity of access to services across the country. In particular there is a requirement for neonatal surgery to be co-located with provision of Neonatal Critical Care (NICU) and maternity services, for which they provide a clear definition of the service standards.

Within the NWNODN, the Cheshire and Merseyside network does not currently meet the NHS England service specification for neonatal surgery and requires 'commissioner derogation' which requires a network-wide approach to achieving compliance. The areas of non-compliance are as follows:

- "Neonatal surgery services should take place on the same hospital site as the paediatric surgical/anaesthetic service and be co-located with the NICU specialised paediatric and maternity service" (section 3.1).
- "A Consultant surgeon (neonatal), consultant specialist paediatric anaesthetist and neonatologist should be on-call for the neonatal service at all times" (section 3.1). Furthermore "Medical care needs will be provided by access to neonatologists or, where services are not co-located, by regular support from neonatologists (e.g. daily ward rounds)" (Section 2.2).

2.2 Regional Context

2.2.1 Clinical Senate Report

An independent clinical review by the Northeast Senate of services for women and neonatal services published in September 2017[4] confirmed the need to change the way that neonatal services are delivered in Liverpool and backed proposals for the future. The review was part of the Healthy Liverpool Programme and was led by NHS Liverpool Clinical Commissioning Group.

The panel noted the following within their report:

- It should be noted that across the UK small sick neonates with for example, necrotising enterocolitis needing surgery are transferred from level 3 neonatal units to distant paediatric surgical units.
- There are considerable risks of transferring large numbers of neonatal patients between hospital sites which was highlighted.
- There are significant challenges in Neonatal services at LWH not being co-located with the neonatal surgical service at AHCH.
- The current service at Alder Hey does not and is unlikely to meet national standards.
- It was noted that it would not be feasible to carry out neonatal surgery at LWH or at the Royal Liverpool site due to the specialised nature of the skills and equipment of the trained personnel involved.
- There would need to be investment to ensure that neonatal intensive care at Alder Hey is in place in order to effectively care for the increased numbers of younger, more complex neonatal patients.

2.3 Local Context

2.3.1 Neonatal Peer Review- AHCH

In April 2016 an independent peer review[5] was undertaken at AHCH, hosted by the NWNODN. The overarching aim of the review was to improve the quality of care of neonates who may need care or treatment from the regional neonatal surgical service. The review included a thorough evaluation of the service and pathways; benchmarked against national quality standards, best practice with assessment of whether the service is truly patient and family centred.

The output was a list of recommendations for us as service providers in order to improve the offering of services for our surgical neonates in Liverpool, the main focus being to:

> **"Support the development of an integrated service between providers of the neonatal surgical pathway, using the "Single Service Model" concept."** This should include:
>
> - Single Joint Operational Policy
> - Neonatal intensive care delivered at AHCH in line with the national service specification
> - Where clinical appropriate, surgical care and treatment delivered at LWH in line with national guidance
> - One service team
> - Single protocols and guidelines
> - Single service patient information
> - Single commissioning arrangements
> - Single service workforce education and training
> - Robust data collection on activity and outcomes
> - Strong culture of research

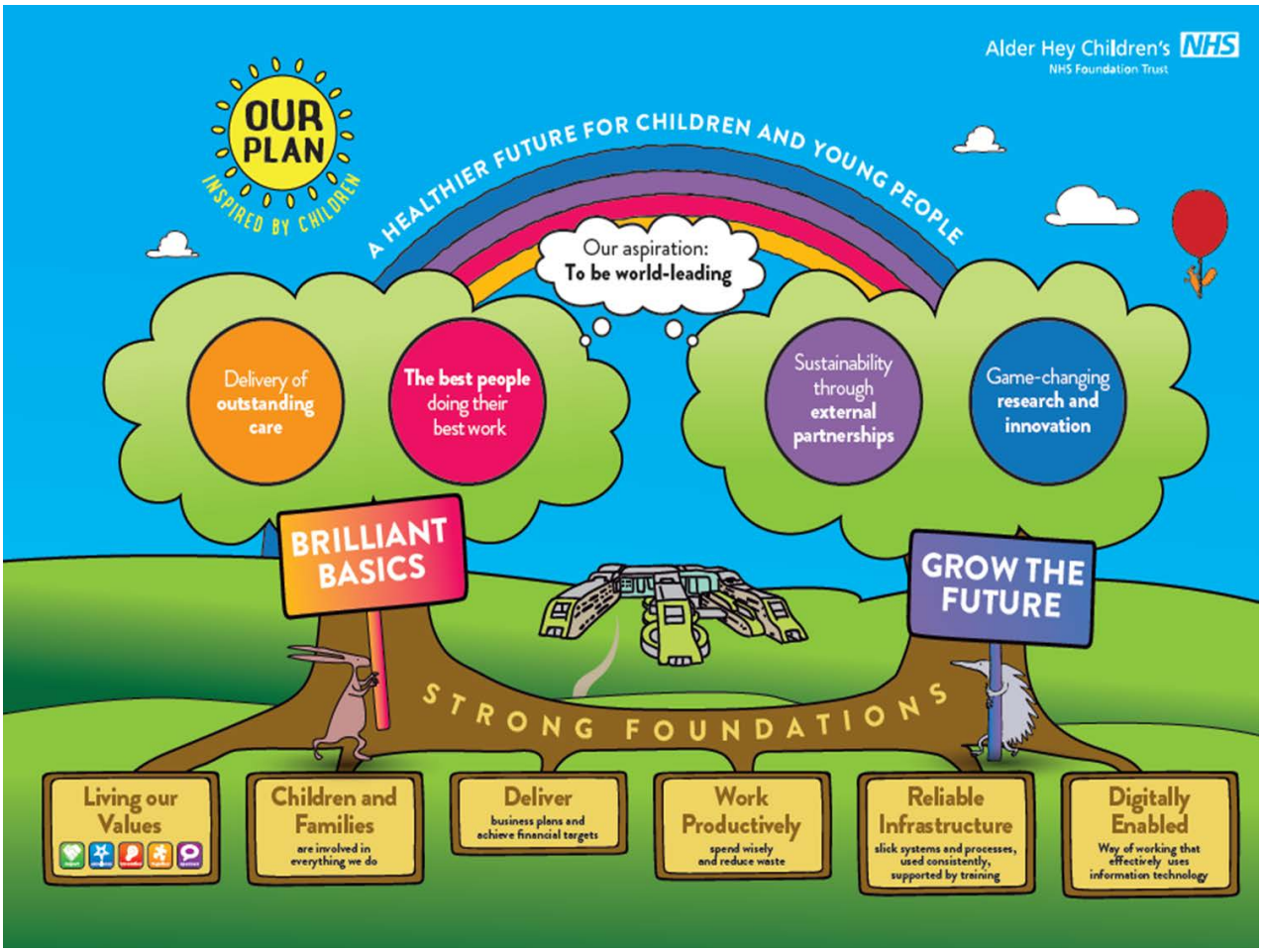
2.3.2 Strategic Vision of the Organisations

Alder Hey

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

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

The vision of Alder Hey is to deliver 'a healthier future for children and young people'. Our strategic plan is summarised below:



The proposal to enhance neonatal surgical services at Alder Hey supports the following strategic objectives:

- To deliver outstanding care
- The best people doing their best work
- Sustainability through external partnerships

Liverpool Women's NHS FT

Liverpool Women's NHS Foundation Trust is a specialist NHS Foundation Trusts in the UK dedicated to the care and well-being of women and their babies.

LWH was authorised as a Foundation Trust (FT) on 1st April 2005 and provides maternity, neonatal and gynaecology services to its patients, alongside reproductive medicine and genetics services. The Trust, located on an isolated hospital site on Crown Street in Liverpool, provides services to more than 60,000 patients each year, employing c. 1,400 clinicians and support staff. The Trust's strategy is to remain at the forefront of providing high quality clinical care to women, babies and families within a service model that achieves clinical excellence and is financially sustainable.

Liverpool Women's is currently experiencing a number of difficulties which are impeding on the ability of the Trust to deliver its ambitions of clinical and financial stability. Despite achieving a rating of 'good' from the (CQC) there are a number of services at the Trust which 'require improvement', with the current standard of service being maintained by implementation of unsustainable clinical workarounds.

The current service model and configuration of women's and neonatal services provided from the hospital is insufficient to meet national standards, which has contributed to these regulatory concerns. High risks from the current service provision include the absence of intensive care facilities, a dependence on utilising specialist services of other acute providers which are not currently provided by the Trust (such as surgery), a lack of clinical and non-clinical space, and an absence of critical clinical support services e.g. a blood bank and pathology services. These limitations are severely impacting the quality of care provided to patients, with significant examples of women and babies having to be transferred to alternative sites to receive the specialist care which they need or expert LWH consultants travelling to other hospitals to treat sick patients.

These clinical risks were recently confirmed by the independent Northern England Clinical Senate (noted in 2.2.1), which provided an external peer review of the process and findings of the Trust's and Commissioner's assessment of the sustainability of services at LWH. The Clinical Senate concluded that 'the current isolated position of both Women's and Neonatal services at LWH means both services have very significant clinical risks'. The independent Clinical Senate also recognised that the current configuration of services at the Trust and workarounds in place are unsustainable and that a change in the clinical model 'is needed to ensure safety, quality and clinical sustainability'. These views have also been supported by the local commissioner, as well as receiving strong clinical support by the clinicians within the Trust.

During 2017 the Trust submitted two business cases to commissioners and regulators with solutions to address the clinical and financial viability issues. This included a £15m expansion to the neonatal unit on Crown Street in order to address the immediate clinical risks arising within the current configuration, and a £100m business case identifying a preferred option to

co-locate with a local adult acute in a new build to address the clinical and financial sustainability issues in the medium to long term. These solutions are included within the Trust's operational plan.

Without these solutions in place the Trust will not be clinically or financially viable in the long term. The neonatal single service solution as articulated within this business case complements the work performed to date in securing clinical viability of the neonatal services and delivering improved outcomes. The work will support LWH's vision: 'To be recognised as a leader in healthcare for women, babies and their families' respectively.

3.0 Case for Change

3.1 Current Position

3.1.1 Current Configuration of Services

Neonatal care in the North West Neonatal Operational Delivery Network (NWNODN) is delivered by the 21 neonatal units in Cheshire and Merseyside, Lancashire and South Cumbria and Greater Manchester. Within the NWNODN, Neonatal Surgery is delivered at Alder Hey Children's Hospital and at the Royal Manchester Children's Hospital.

Liverpool Women's NHS Foundation Trust (LWH) and Alder Hey Children's NHS Foundation Trust (AHCH) provide neonatal care for the population of Liverpool and beyond – as part of the Cheshire and Merseyside Network within the NWNODN.

Current Provision- Liverpool Women's NHS Foundation Trust

LWH provides tertiary neonatal intensive care (NICU) serving the Cheshire and Mersey Neonatal Network (C&MNN) and working in partnership with the North West Neonatal Operational Delivery Network (NWNODN).

LWH currently supports the neonatal surgical high dependency unit at Alder Hey Children's Hospital, for pre-op and post-op surgical care for the most pre-term infants with existing antenatal surgical pathways already in place. There are approximately 1,200 babies admitted each year. The NICU has a total of 50 cots delivering the following levels of care:

- 12 Intensive Care (IC-Level 3 cots)
- 12 high Dependency (HD- Level 2)
- 20 Low Dependency (LD –Level1)
- 6 Transitional Care (TC) cots on the postnatal ward

There are currently two neonatal intensive care units in Cheshire and Mersey, LWH and Arrowe Park Hospital.

Current Provision- Alder Hey Children's NHS Foundation Trust

AHCH provide a neonatal surgical service and tertiary children's services. The neonatal surgical unit at AHCH has 9 beds, and provides care for neonatal patients up to HDU level care, with some intensive care functions such as care of babies with replogle tubes and total parenteral nutrition.

Currently care is given by neonatal surgeons supported by 3 LWH neonatology consultant sessions per week, with a dedicated neonatal surgical nurse workforce. The Paediatric Intensive Care Unit (PICU) at AHCH provides intensive care for babies requiring invasive ventilatory support or with multi-organ failure. Care is delivered by paediatric intensivists and PICU nurse workforce.

Particular strengths within the PICU include extensive experience with high frequency oscillatory ventilation, nitric oxide ventilation, and it is the regional centre for extra-corporeal membrane oxygenation (ECMO). In addition, Alder Hey is the regional centre for paediatric cardiac surgery, and cardiac neonates are co-located with general surgical neonates.

Admissions: All emergency admission decisions are made by the consultant surgeon of the week on call for general surgery (SOTW) or surgical registrar on call, in conjunction with the nurse coordinator for NNSU. Infants requiring admission for elective or semi-urgent surgery are discussed by the responsible consultant team and coordinating nurse for planned admission. Infants may be transferred from PICU when their clinical condition allows step-down to HDU level care.

AHCH does not currently have dedicated critical care provision for neonates and is provided on the Paediatric Intensive Care Unit.

3.1.2 Surgical Transfers

The current configuration of the neonatal surgical pathway is that AHCH provide neonatal surgery and LWH provide significant amounts of critical care (NICU and HDU) service, with babies being transferred between the two hospital sites, or being cared for in PICU at Alder Hey as opposed to the NICU environment. This current system is exposing critically ill babies to avoidable high risk transfers and delaying their access to specialist surgical services.

This means that patients requiring surgery are transferred to AHCH for their surgical intervention and then (other than in exceptional circumstances) infants of extreme prematurity or those that are ventilated are usually transferred back to LWH soon after surgery. It is a sub-standard level of care for a baby to be managed in a transport incubator for several hours whilst awaiting being transported across two or more sites pre and post operatively. These babies should be cared for in a NICU cot, where they can be admitted and discharged safely at a point where they are stable enough to do so or transferred in a one way manner where they can recover completely at the AHCH site.

There are legitimate concerns that this current pathway is not desirable for the patient or their families, and adds additional clinical risks that can be reduced or avoided. The two prominent risks are delay in access to specialist paediatric services and avoidable ambulance transfers due to the inability to access appropriate neonatal care in once place. To some extent these risks are only being mitigated due to our stringent systems and processes which have been put in place across the two trusts, which are not sustainable for the future.

Another significant concern with the current pathway is that despite AHCH having the facility to care for babies in the PICU facility, it is recognised that this is not the desired environment for these babies and it does not have the required wrap around specialist input that would be present on a designated NICU. AHCH is not formally commissioned as a designated Neonatal Intensive Care provider.

The risks outlined with this current service configuration are referred to in section 3.1.5.

3.1.3 Catchment Population

It is important to recognise that although many neonates requiring surgery come from LWH, significant numbers come from other units in Cheshire and Merseyside ODN, from Lancashire / Cumbria, from Greater Manchester ODN and from outside of the region such as Stoke, North Wales and the Isle of Man, at times when national neonatal surgical capacity is near capacity. Neonates requiring surgery can be subdivided into four groupings:

(1) Premature neonates. These babies may be delivered anywhere in the network although high risk babies are often delivered at LWH. If these babies require surgery, typically it is in the first two weeks of life when they develop a bowel infection called necrotizing enterocolitis. These babies typically have a spectrum of conditions associated with prematurity and require prolonged Level 3 care.

(2) Neonates with antenatally diagnosed congenital malformations such as abdominal wall herniae, orcongenital diaphragmatic herniae and babies with renal tract anomalies.

(3) Neonates with non-antenatally diagnosed congenital malformations such as intestinal obstructions.

(4) Neonates with acquired non-urgent conditions. These infants are often premature and require surgery for vascular access (which may be an emergency), hernias, scrotal pathology, abscesses.

3.1.4 Current Workforce Infrastructure

National Standards

The Toolkit for High Quality Neonatal Services (DOH, 2009) and the British Association of Perinatal Medicine (BAPM, 2010)[2] has set the national standards around neonatal nurse staffing. BAPM nursing standards have been endorsed by NHS England and included in the national neonatal service specification[1] (NHS Commissioning Board, 2013). While there is evidence from the work undertaken by the Neonatal CRG that there are insufficient nursing staff within the NWODN to deliver care in line with the Toolkit for High Quality Neonatal Services and BAPM standards. BAPM standards also state that 70% of the nursing workforce on a NICU should be Qualified in Speciality (QIS).

Current Staffing Levels across AHCH and LWH

Nursing Workforce

Optimal Neonatal Nursing Standards as outlined by BAPM (2010):

- Intensive Care 1:1(nurse: neonate ratios)
- High Dependency 2:1 (nurse: neonate ratios)
- Low Dependency 4:1 (nurse: neonate ratios)

Current Neonatal Nurse Staffing Configuration at AHCH

NICU

AHCH lacks formally designated neonatal intensive care cots, but does provide neonatal intensive care on the Paediatric Critical Care Unit. The optimal nurse staffing levels for paediatric intensive care units (PICU) are set out by both the Royal College of Nursing (RCN) (2013)[6] and the Paediatric Intensive Care Society (PICS) (2010)[7], and are summarised as follows:

- Level 1: 0.5:1 registered nurse:neonate (surgical neonates requiring close supervision and monitoring following surgery or with single system problems).
- Level 2: 1:1 registered nurse:neonate (including surgical neonates requiring intubation and ventilation).
- Level 3: 1.5:1 registered nurse:neonate (including ventilated surgical neonates on vasoactive drugs or with multiple system problems).

The defined levels of care for paediatric critical care and related registered nursing requirements are adhered to within the PICU at Alder Hey. However, it is not a prerequisite that these nurses need a neonatal speciality qualification. With activity in relation to neonatal intensive care at approximately 2 cots per day, the expectation would be that at least 10.6 wte nurses would have a neonatal speciality qualification. The current PICU establishment has 3 wte with the neonatal speciality training, suggesting that less than 1/3 of neonatal intensive care babies are looked after by a nurse with a neonatal qualification. The standard would recommend that this should be at 8 wte (80% of staff delivering neonatal intensive care must have speciality training, 70% is for overall NICU)

NNSU (Neonatal Surgical Unit)

AHCH also has a Neonatal Surgical Unit (on Ward 1C) which provides high dependency level care to babies. The surgical neonates cared for in this unit are nursed on a ratio of 1:2 (nurse: patient) direct baby care. These ratios are in line with the RCN and PICS standards and levels of care as defined above. However, because of differences in care descriptions between PICS and BAPM care criteria, the neonatal workforce on the current surgical unit does not meet the required standards (BAPM 2010)[2].

The current configuration on the NNSU means the NNSU shares a Band 7, Ward Manager with the cardiology and cardiac surgical unit. There are a team of band 6 shift leaders who are qualified in speciality and they with the rest of the team managed the ward on a day to day basis. The current NNSU establishment has 9 WTE with neonatal speciality training; to achieve the standard the expectation is that 17 WTE would carry this qualification (70% neonatal speciality training).

Education and Training

Alder Hey has recently reviewed the education and training strategy for the care of the surgical neonate and the aim is to improve patient safety and ensure high quality care is delivered to patients. A new foundation programme has been developed in the last two years, and the first cohort of registered nurses commenced on the programme in September 2015. We recognise that the field of surgical neonatal nursing has specific training requirements which we are delivering in-house as part of our foundation programme. The programme ensures that all new staff gain some training and experience in caring for surgical neonates, and this element is delivered by an Advanced Neonatal Nurse Practitioner (ANNP) from Liverpool Women's Hospital. This orientation programme ensures that all staff newly employed to Critical Care and Ward 1C will have undertaken some training to care for neonates.

Further training of the current PICU and NNSU staff in the neonatal speciality course will be required to ensure that services at AHCH meet the standards set out in BAPM and the Toolkit

Current Neonatal Nurse Staffing Configuration at LWH

The workforce with the Neonatal Intensive Care Unit (NICU) at LWH comprises of both registered and non-registered nurses. The registered staff are made up of ANNP and Nurses from a background Adult, Children, and midwifery training. Over 70% of the nurses on the unit have completed a speciality course in the care the preterm and sick babies this allows them to be registered as nurses who are qualified in speciality (QIS). LWH also has a core of nurses who have completed a Neonatal Surgical Nurse module at Birmingham Children's Hospital.

The majority of ANNP's have studied to Master's level qualification over a two year period to complete and gain required competencies. The ANNP's will have also completed a non-medical prescribing course. The level of training received by ANNP's allows them to work on the Tier 1 and Tier 2 of the medical rotas. This is fully supported by BAPM standards.

Currently, there are a small number of un-registered staff who work within the low dependency (LD) nursery and the transitional care unit (TC). They are responsible for most of the delivery of care to the babies within these areas with the only limitation being the inability to give certain medications. This is an area of nursing that needs further development.

At LWH, for newly qualified staff or those appointed without previous neonatal experience they are enrolled on the Neonatal Induction Programme, this is run jointly with St Mary's Hospital in Manchester. This programme provides these nurses with the theoretic knowledge and clinical skills required to look after the sick preterm or newborn infant with complex needs. The course runs over 6 months. All staff have an induction period of 6-8weeks, more or less dependent on the individual, and during and after this time they will work closely with their mentor and the education team.

Following a 12 month consolidation period, staff are then progressed on to the Neonatal Qualification in Speciality course (QIS) to enhance their knowledge and skills. This is run at LWH and validated by Liverpool John Moores University at Level 6, and it is a requirement that at least 70% of our staff hold this qualification. (DoH, 2009, Toolkit for High Quality Neonatal Services)[5].

There is also a requirement to have quality roles extra to the establishment; these include education, breast feeding, infection control, development care.

Medical Workforce

According to BAPM standards (2010)[2] all neonatal units should have access to doctors/ANNP's at three levels- junior, middle level and the experienced specialist.

Figure 1 outlines the skillsets required at each level:

Staffing Tier	Level of training
1	ST1-3/ANNP
2	ST3-8/ANNP
3	Medical Consultant with CCT in Paediatrics (Neonatal medicine) or CESR (via article 14) in Neonatal medicine

For all levels of unit it is not appropriate for a consultant to provide out of hours cover to two geographically separate sites simultaneously. Similarly where a consultant is working at tier 2 another consultant should provide tier 3 cover, i.e. a single consultant cannot simultaneously cover at tier 2 and tier 3 if such cover is normally provided by two separate clinicians of appropriate training and experience.

Current Medical Workforce

The current pathway (whilst not ideal) has operated effectively and safely due to the close working links between the clinical teams at AHCH and LWH. For example, the AHCH Consultant Surgeons attend LWH to undertake post-operative ward rounds and review patients alongside the LWH clinical team, as per the on call rota. The provision of a dedicated consultant surgeon for non-elective cases 'Surgeon of the week' a model running 24/7, has reduced time from referral to review.

More recently a formalised agreement has been put in place between AHCH and LWH which sees a 5PA job plan for a consultant neonatologist at AHCH. A joint appointment was made to allow the consultant neonatologists to rotate on a weekly basis into AHCH to provide:

- Neonatal ward rounds 3 x weekly for babies on the neonatal unit with input to PICU on a case by case basis which includes an IPC ward round weekly
- Service development
- Clinical governance responsibilities

This begins to address the non-compliance with the medical staffing requirements as an interim however in order to provide a recognised Level 3 NICU at AHCH and a robust joined up workforce across the two sites, we would need significant investment into the workforce- both nursing and medical (as described). In order to achieve compliance we would be required to have a consultant neonatologist on-call for the neonatal service at all times, daily

presence on site for ward rounds and other duties along with a robust surgical presence at LWH.

3.1.5 Risks with the current pathway

Whilst we can demonstrate we currently run a safe service across the 2 sites, we are aware of the existing challenges and the potential risks created by a lack of compliance and a lack of appropriate workforces.

Figure 2 below highlights the risks within the current clinical pathway for surgical neonates. Amongst the categories evidenced below there were 20 incidents logged by neonatologists during a month long audit April-May 2017 where the lack of co-location of surgery and NICU specialist services was felt to have had a direct negative impact on the care of a baby.

Figure 2: Risks present within the existing pathway

Key Risks Identified in Current Pathway	Implication for babies	Evidence	Proposed mitigation with new service model
Quality of Care	A lack of expert care available in one place for babies leads to sub-standard care	• AHCH workforce is not at the required standards for neonates, we have a lack of consultant neonatologist and ANNP input • AHCH has a lack of neonatal nurse leadership • AHCH has a lack of neonatal nurses who are able to offer respiratory support • Leads to unnecessary transfers for neonates in order to receive specialist input- either surgical or neonatal	New workforce model ensures a safe 3 tier medical workforce along with a rotation of nurses between the 2 sites to offer enhanced neonatal nursing support. Unit nurse manager and clinical input offers leadership for service All expertise available on one site
Neonatal Surgical Outcomes	A lack of co-location and therefore increased high risk transfers has an impact on surgical outcomes	• Research evidence shows that exposing pre-term babies to ambulance transport during their intensive care increases mortality and the rates of other adverse outcomes.	The new model will see a decrease in unnecessary transfers between the 2 sites by 50%.
Environment	A lack of cohorting babies within AHCH in an environment which meets the specified standard	• A review of neonatal bed occupancy at Alder Hey shows that surgical neonates can be cared for in number of locations	With the proposed new model, all surgical neonates will be cared for in one unit which offers IC and HD level care, with the necessary skills and equipment required.
Cot capacity reduction at LWH	Increased capacity issues, potential impact on babies being transferred out of region and impact	• Closure of cots due to environmental constraints	New model at AHCH will create capacity

	on clinical outcomes		
Patient and family experience less than optimal	This is already a difficult time for families and an inadequate experience can make that even more difficult to deal with. A review of RCA's and patient feedback highlighted a number of areas for improvement	• Different approaches to nursing care across the 2 sites • PICU environment very different from a NICU, parents find it difficult to adapt • Communication between the 2 sites could be improved • Sometimes a lack of MDT decision making • Clarity on preparation required pre-operatively could be improved across sites • A number of families reported their distress at the number of transfers that their baby underwent, particularly when in an emergency situation and care was not available on site.	The new model will be a single service across 2 sites and therefore care will be equitable across all neonatal surgical patients in terms of both nursing/clinical care and environment. A dedicated medical workforce working in conjunction with the surgical teams will radically improve communication and MDT decision making. A 50% reduction in transfers between the 2 sites should provide better family experience and less distress at a difficult time.
Non-Surgical Clinical Outcomes	A review of surgical and neonatal mortality and morbidity cases, along with RCA's and serious incidents logged across the 2 sites highlights areas where it was felt babies would have received a better quality of care from the co-location of services	• Treating babies across sites can cause delays in diagnostic testing- one case had a serious incident review which identified avoidable delays • Having access to specialist services/consultants on one site would be of clinical benefit to babies • A lack of 24/7 neonatology input has been referenced in a number of cases for deterioration of a neonate at AHCH • Outreach support for babies at DGH's could improve outcomes and decrease LOS • 12 hour review by a consultant for every baby could earlier identify deterioration • It is possible that a NICU at AHCH would allow for earlier surgical intervention due to earlier review • Currently no formalised out of hours/weekend process for joint review for	The new model will ensure that all babies have timely access to all support services including clinical review and diagnostic testing. A dedicated medical workforce will ensure all deteriorating neonates are appropriately assessed and treated in a timely manner. The joint workforce available on one site will also ensure there are no delays to surgical intervention. It is felt that in the future, there is an opportunity to enhance the model further by offering outreach neonatal support to DGH's in the management of neonates. The new service would offer formalised out of hours support for all neonates from both a neonatal and surgical perspective.

		babies • Concerns around management of growth in neonates has been noted as a reason for surgical delay (within AHCH and local units)	Any development care will be managed via the required expertise on site.
Pressures on transfer services	Delayed transfer for sick and complex children and neonates. Babies cannot always be moved quickly which could cause adverse clinical outcomes.	• performing approx. 80 transfers above commissioning plan per annum • One case reviewed found a baby to have 7 episodes of transfer between the 2 units • A review found a number of cases where babies had been transferred between a number of units a number of times due to specialist care not being available at one site	Creating ICU capacity at AHCH would reduce the risk of transferring critically ill babies and lead to less pressure on the transfer team.
Cohort of cardiac babies within the NWNODN who are delayed in coming to AHCH pre-op due to capacity restraints.	An in-depth review has highlighted a number of cases where care would have been improved for such babies if they were at a site where they could have joint specialist NICU and surgical care	Babies coming for complex cardiac surgery arrive the day before surgery. This is not felt to be adequate time to prepare families pre-operatively. Patients are often waiting weeks at other sites in the region, if we had increased capacity we could facilitate their procedures sooner. There are a number of cases highlighted by the review whereby babies have had delayed surgery or not been fit due to insufficient care pre-operatively elsewhere.	The new model would see babies coming to AHCH pre-operatively which would offer a better experience for the family. This new model would also irradicate any cardiac surgical delays due to lack of preparation pre-operatively to ensure that babies are at optimal health to undergo surgery.
Cohort of surgical babies within the NWNODN who are	An in-depth review has highlighted a number of cases where care would	We often experience delays in bringing babies to AHCH for surgical intervention as we often cannot identify an appropriate bed in a timely manner.	The new model of care would allow sufficient capacity for these babies to come to AHCH at the earliest opportunity which offers the best chance of both survival and optimum outcome for the baby.

delayed in coming to AHCH pre-op due to capacity restraints.	have been improved for such babies if they were at a site where they could have joint specialist NICU and surgical care	An example of this is referenced in a recent incident whereby it took 8 hours to retrieve a baby who required urgent surgical review due to lack of a PICU bed.	

Sources include: cases presented at surgical and neonatal M & M meetings 2016/17 & 2017/18; audit review by neonatology team at LWH April-May 2017. Further detail of the patients reviewed can be seen in appendix 1.

3.1.6 Patient and Family Experience

A key part of achieving our objectives with a single joined up service model for surgical neonates is to create a service that reflects the needs of our patients and families. In order to understand what is important to them AHCH and LWH jointly ran a 'Whose Shoes?' event which is a facilitated session which encourages in depth conversation around services and how they can be improved in collaboration. The event was a huge success and a graphic artist captured the output which is illustrated in **Figure 3** below.

Figure 3: Output from 'Whose Shoes?' event

Some of the key themes are described below that came from the discussions which we will use to inform decision making around our implementation model, including estates changes, staffing and support services:

- Importance of wrap around services
- Better communication including joint decision making across teams
- Currently a real difference in approach to care/environment across units
- Private and safe spaces are extremely important
- Families need to feel fully informed
- Consistency of staff is important
- Often there are many simple fixes which could make a huge difference
- Parents ability to socialise with other parents is extremely valuable
- Accommodation and private breastfeeding space
- Better structure and coordination of services
- Parents recognise staffing constraints
- Need to create a sense of normality

3.2 Drivers for change

The key drivers for change within this case are:

- The need to provide a **dedicated NICU** at AHCH in order to **improve the quality of care and outcomes** for our surgical neonates
- The need to provide an **appropriately specialised workforce** to support neonatal surgical services- including consultant neonatologists, consultant neonatal surgeons, ANNP's and a specialist neonatal workforce
- The current level of risk associated with the number of **avoidable transfers** between Alder Hey and LWH for critically ill babies
- The need to provide **formalised surgical input** at LWH for babies
- To achieve **compliance with national standards** for neonatal surgical services which represent a required safety standard
- To achieve **workforce sustainability** across the Cheshire and Mersey region for neonates

4.0 Options Appraisal

4.1 Options Appraisal for the neonatal surgical service

Following the peer review a Neonatal Task and Finish Group (T & F group) was established between the NWNODN, NHSE specialist commissioners and the two Trusts to review how a single service model for surgical neonates could be established between AHCH and LWH with the support of the network.

The group was to focus on how to implement the preferred option from the NWNODN which is, "All neonatal surgery continued to be performed on Alder Hey Children's Hospital (ACHC) site and in collaboration with LWH the establishment of dedicated Neonatal intensive Care provision at AHCH and enhanced post-natal support (two site single service model)".

The T & F group completed options appraisal using a weighted scoring system. The detailed options appraisal and methodology is set out in **Appendix A.**

> **"A Single nursing and medical workforce for the neonatal service across Alder Hey and Liverpool Women's. This includes a dedicated NICU facility (separate from the PICU) for surgical neonates at Alder Hey who require intensive care under all surgical specialties and cardiac surgery neonates for pre-operative care."**

4.2 Summary of Options

Whilst the T&F Group clearly recommended a preferred model of care, Trust Boards are asked to consider four options for implementation. The following considerations have led us to construct four options for delivery:

i. Trust Boards are asked to consider whether the proposal should address the standard of neonatal services at both sites, AHCH and LWH. If the service proposal does not include a proposal to invest in the LWH service there is a possible future scenario whereby a fully compliant neonatal surgical service is established, but at LWH staffing levels are not in line with BAPM standards.

ii. There is a strategic decision to be made by specialised commissioners as to whether they want to commission two cots for pre-operative cardiac babies. The clinical working group felt strongly that this was the optimal model of care for this cohort of neonates. This proposal would require resources, cots and staffing in regional district general neonatal or high dependency unit, to be redistributed from across the region and into the new NICU.

The four options are summarised in the table below:

	Neonatal surgical service	Neonatal service at LWH
Option 1a: dedicated NICU facility for all surgical specialties and cardiac neonates for pre-operative care	24 cots NICU	No change
Option 1b: dedicated NICU facility for all surgical specialties and cardiac neonates for pre-operative care; and delivery of BAPM standards in the neonatal service at LWH	24 cots NICU	Enhanced workforce cover to deliver BAPM standards
Option 2a: dedicated NICU facility for all surgical specialties	22 cots NICU (2 cots for pre-op cardiac excluded)	No change
Option 2b: dedicated NICU facility for all surgical specialties; and delivery of BAPM standards in the neonatal service at LWH	22 cots NICU (2 cots for pre-op cardiac excluded)	Enhanced workforce cover to deliver BAPM standards

5.0 Preferred option: the new service proposal

5.1 Future Proposed Model of Care: single neonatal service across two sites

It is proposed that the service for surgical neonates is reconfigured as a two site single service across AHCH and LWH in order to address the current issues and risks within the pathway.

This would see the development of a large dedicated NICU on the Alder Hey site with 24 cots, which would be made up of all levels of care: Special Care (SC) High Dependency (HD) and Intensive Care (IC). Taking into account the challenges around implementing such large scale changes, we would look to recommend a phased implementation approach.

The preferred option is option 1b: a dedicated NICU facility for all surgical specialties and cardiac neonates for pre-operative care; and delivery of BAPM standards in the neonatal service at LWH.

The recommendation from this group included surgical work additional to the original scope which was to also include **cardiac surgery neonates for pre-operative care**. This was clinically felt to be the right thing to do for this cohort of babies as it is felt they currently receive sub-optimal care prior to surgery. As this is outside of the original scope, the analysis will set out both the original scope of surgical activity and the additional cardiac surgery cohort.

The key elements of this are:

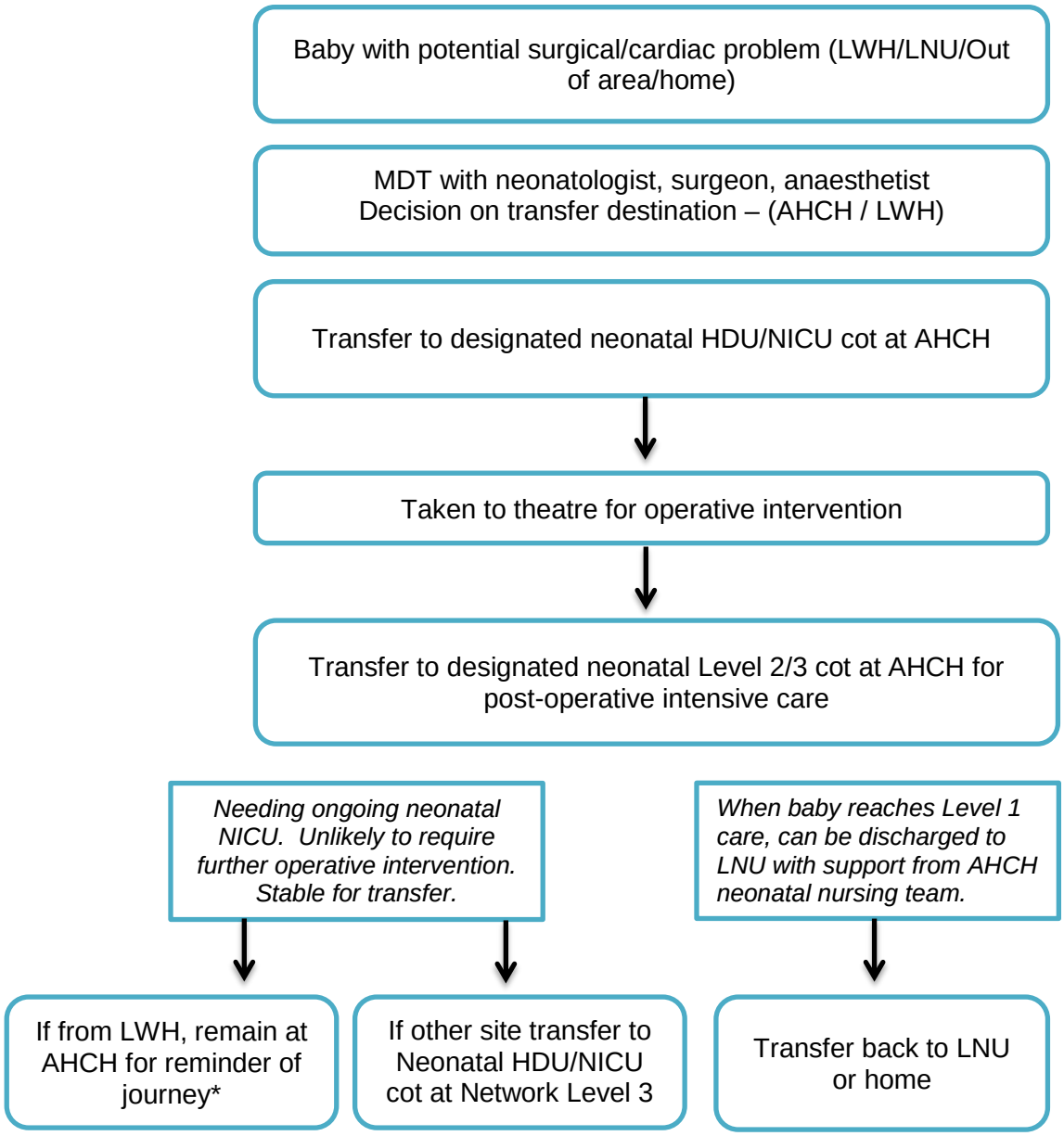
- Patients requiring major surgical interventions would still be transferred to AHCH for surgery, as they are presently, but would remain at AHCH post-operatively in formally designated intensive care cots along with designation of Neonatal HDU cots at AHCH. This would allow appropriate post-operative care at Alder Hey without the need for immediate transfer back to the Women's Hospital or one of the other neonatal centres in the region.

- The workforce proposal to support this new model would be a single one across the two sites from both a medical and nursing perspective and one which offers the appropriate expertise for all surgical neonates. This would ensure that all babies receive the same level care and also their pathway of treatment will be consistent and collaborative.

- With this proposed single service model, all neonatal surgical babies (including cardiac pre-op babies) would be house on a single dedicated unit at Alder Hey.

The proposal has been developed by clinically led working groups between AHCH, LWH and the NWNODN which involved a number of key stakeholders. A high level description of the proposed pathway for surgical neonates is described in **Figure 4** below:

Figure 4: Neonatal Critical Care Service Provided at AHCH as part of a 2 site single service model with LWH



*If there are surgical bed capacity issues it may be necessary to transfer babies back from AHCH to LWH. In this instance the bed management tool should be used.

5.2 Admissions Criteria for a Single Service Model

The joint clinical working group from AHCH and LWH have agreed the patient pathways for babies which would be included in a single neonatal service in Liverpool working across the two sites providing:

- NICU care at the LWH site
- Neonatal Care at AHCH for babies requiring surgical care (general surgery and surgical subspecialties)
- pre-operative or pre–catheter cardiac neonates
- established NICU capacity at the AHCH site, separate to the existing PICU.

These agreed pathways only include patients that require admission to Alder hey as part of their inpatient journey. Babies who have their whole stay within LWH are not considered as part of this paper.

As described in section 1, following a comprehensive review the clinical steering group felt it was appropriate to include pre-op cardiac neonates as part of the surgical pathway for a new NICU at Alder Hey, which is out of scope in the neonatal surgical service specification. This will need further discussion with commissioners, the network and our neighbouring units where these babies currently reside pre-operatively.

Appendix B shows a further breakdown of each pathway within the new service model.

5.3 Site Location

It is proposed that a Level 3 NICU is located on the AHCH within the new hospital. This scheme will involve in investment in additional hospital space and footprint in order to re-locate extant services

5.4 Benefits realisation

It is proposed that the metrics shown in **Figure 5** are measured to demonstrate the effectiveness and efficiency of implementing the proposed joint service model.

Figure 5: Key performance indicators to track delivery of benefits

Key performance indicator	Baseline performance for North West Neonatal Operational Delivery Network	Target Value
All babies born at a gestational age of <32 weeks to have their temperature taken within 1 hour of birth	97%	100%
All babies to have a documented consultation with parents by senior member of the team within 24 hours of admission by neonatal network	88%	100%
Total number of babies with Significant BPD-Bronchopulmonary Dysplasia	36%	To be agreed
All eligible babies to receive ROP screening within necessary time frame	99%	100%
Percentage of babies receiving mothers milk when discharged from neonatal network	44%	59%
Standardised assessment completed for babies	12%	34%
Reduction in unnecessary transfers between AHCH and LWH	202	101
All neonates to receive a consultant neonatologist review within 12 hours of admissions	TBC	100%

5.5 Demand and Capacity Analysis

A capacity and demand joint working group between AHCH, LWH and the NWNODN have produced a detailed analysis of the capacity requirements with a new single service model across the two sites based on the clinically agreed admissions criteria. Data has been collated from Badgernet at Cheshire and Mersey neonatal units, the Cheshire and Mersey Transport service database, AHCH Patient Administration System (Meditech) and AHCH PICAnet.

The data reflects a requirement for a 24 cot NICU at AHCH using a planned occupancy rate of 80%, which is recommended by BAPM (2010**).** A summary of the cot requirements for a new NICU at AHCH is shown in **Figure 6** below and a full breakdown is described in **Appendix C**.

Figure 6: Cot Requirements for full implementation of a single service model across AHCH and LWH including formal NICU level cots at AHCH

Level of care required	Cot requirement for new NICU unit at AHCH
Level 3 IC care	8
Level 2 HD care	15
Level 1 SC care	1
Total Cots required	24

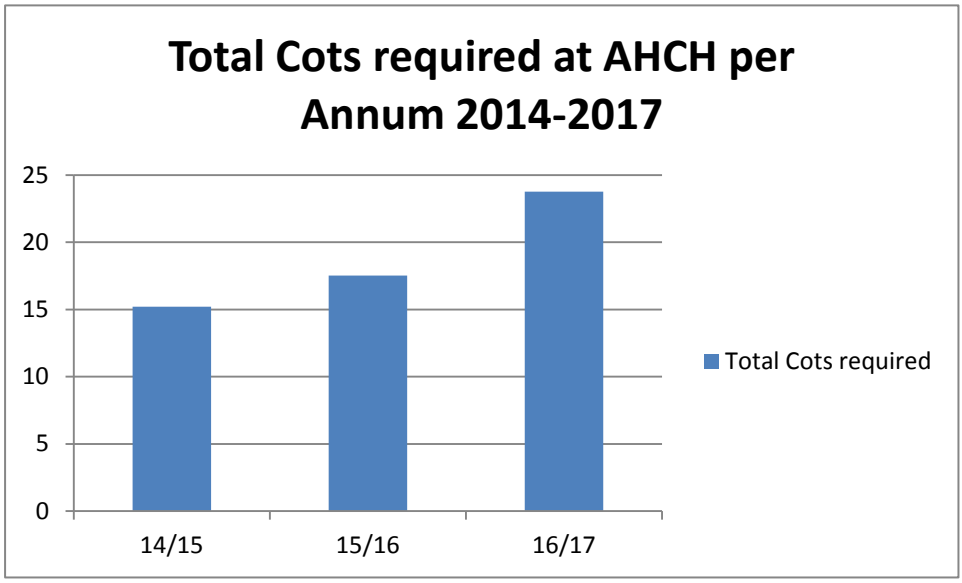
**Data based on Level 1-3 care and including: AHCH surgical patients, AHCH cardiac pre-op patients, NWNODN cardiac neonates and LWH cardiac, surgical, ROP and Broviac neonates. Please see appendix 3 for further breakdown.*

Figure 7 outlines the breakdown of where in the neonatal surgical network the activity currently sits:

Current Activity Location	Total no. of cots per annum
AH PICU	1.9
AH HDU	2
AH NNSU	9
AH ward	1.4
AH cardiac	1.3
LWH IC	2.8
LWH HD	2.3
LWH SC	0.8
Network cardiac	2.3
TOTAL	**23.8**

A review of the last three years capacity and demand data (**Figure 8**) shows a year on year increase in the total demand on special care, high dependence and intensive care cot's, highlighting the need to implement a more sustainable model for the management of surgical neonates across the region.

Figure 8: Year on year total capacity requirements for Neonates at AHCH 2014-17



**Data based on Level 1-3 care and including: AHCH surgical patients, AHCH cardiac pre-op patients, NWNODN cardiac neonates and LWH cardiac, surgical, ROP and Broviac neonates. Please see appendix 3 for further breakdown.*

5.6 Workforce Impact

The new service model will require a significant increase in both the medical and nursing workforce across AHCH and LWH.

The staffing model shown in **Figure 9** outlines the staffing requirements for the implementation of a 24 bedded level 3 NICU at AHCH based on BAPM (2010)[2] standards for neonatal services. As the service is a joint single service model across the 2 sites, the final costings for the staffing model incorporates the requirements for a single workforce and takes into account the current baseline establishments at the 2 sites. This is summarised in section 4.6.

Figure 9: Total Staffing Requirements for the Provision of a NICU at AHCH (24 cots)- 8 IC level and 16 HD level

Staff Group	Staffing req. to provide Level 3 NICU (8 IC, 16 HD) WTE
Medical Staff - Specialist Consultant Neonatologist - Staffing to provide Tier 1 & 2 (NB Tier 1 & 2 requires 16 made up of ST1-7 & ANNP's)	4.5 10.5 (ANNP's)
Nursing staff - Band 8A Unit Manager - Band 7 practice educator - Band 7 co-ordinator - Band 6 - Band 5 - Band 2- Housekeepers	1 1 5.33 42.62 42.62 5.33 **Total 99.39**
Management Support - Clinical Director - Management - Lead Nurse	2 PAs 0.2 wte 0.2 wte
Support service staff - Physiotherapy - Dietetics - SALT	1 1 0.5
Clerical staff - Ward Clerk - Pathway Coordinator	1.5 3

*****To note, Tiers 1 & 2 have been provided as ANNP's as it is unrealistic to recruit to junior doctor posts in the desired timescales.

The final costings seen in section 5.10 takes into account the current workforce across AHCH and LWH and works on the assumption that we will recruit into the current medical/nursing teams and existing on call rotas, therefore showing costs based on the net increase. It also takes into account the transfer of resources from elsewhere based on the capacity modelling, i.e. re-distributing staff from the PICU at AHCH and the NICU at LWH where we are transferring cots.

5.7 Phased Implementation of full service model

As identified in the activity modelling, full implementation would see a 24 bedded NICU established at the AHCH site, comprising of 8 NICU and 16 HDU cots, which would make up a single service with the NICU currently at the LWH site. However it is recognised that this would not be achievable without a phased implementation model, likely over a 3 year period due to financial constraints, workforce challenges and potential estates requirements.

Phase 3 in **Figure 10** outlines the high level changes required for the full 24 bedded NICU, however we would ask commissioners to consider the approval to implement **Phases 1 & 2** in order to offer more comprehensive cover for our current service and to begin the complex recruitment programme. Achieving **Phase 2** would allow AHCH to open the 16 HD level beds on the new NICU unit once a Tier 1 & 2 workforce was in place. Finally, Phase 4 reflects the additional required changes to achieve BAPM (2010)[2] standards in terms of the neonatal medical workforce across the 2 sites.

Figure 10: Outline of High Level Changes required for a Phase 1-3 implementation

Phase	Proposed High Level Changes	Proposed Timescales
1. Improvements with current model	➢ Implementation of 'Neonatal Surgeon of the Week' model ➢ Interim Ward manager to commence on 1C for Neonatal Unit ➢ Implementation plan worked up for rotation of current neonatal nursing staff between 2 sites ➢ Approval to commence complex recruitment programme for medical and nursing staff ➢ Commence ANNP training (5 per annum) in order to expand existing pool at LWH for future model ➢ Implement joint operational policy for neonates across 2 sites	January 2018 January 2018 April 2018 April 2018 TBC- date for training September 2018
2. Opening 16 HD level cots on new NICU	➢ Recruitment of 5.5 WTE ANNP's achieved in order to staff Tier 1 & 2 rota ➢ Recruitment of 8A matron for neonatal service ➢ Re-configuration of AHCH estates to facilitate new NICU ➢ Recruitment of 3 WTE out of the 4.5 WTE required consultant neonatologists to ensure on track for end of year 3 implementation ➢ Reduction in HDU level beds at AHCH and LWH as per bed modelling	April 2020 April 2020 April 2020 April 2020 April 2020
3. Full implementation of 24 bedded NICU	➢ Implementation of full 24 bedded NICU at AHCH including 8 IC cots ➢ Recruitment of 4.5 WTE required consultant neonatologists ➢ Full recruitment of required nursing workforce for new NICU ➢ Reduction in PICU bed base at AHCH as per modelling ➢ Reduction in NICU bed base at LWH as per modelling ➢ Reduction in regional NICU beds in order to transfer to AHCH as per modelling	April 2021 January 2021 April 2021 April 2021 April 2021 April 2021

5.8 Summary of Current Resource within the Network

Figure 11 summarises where the neonatal surgical activity currently sits within the network which we anticipate would be transferred to a new dedicated NICU at AHCH and therefore ceased at its current location. The summary shows at which phase in the implementation plan these resources would be transferred in order to inform contract changes. A further breakdown of this can be seen in **Appendix C**.

Figure 11: Outline of Cot phasing

	Current Staffed beds		Phase 1		Phase 2		Phase 3	
AH PICU	2		2		2		0	
AH HDU	2		2		0		0	
AH NNSU	9		9		0		0	
AH ward	1		1		0		0	
AH cardiac	1		1		0		0	
LWH IC	3		3		3		0	
LWH HD	2		2		0		0	
LWH SC	1		1		1		0	
Network cardiac	2		2		2		0	
New NICU AH	0		0		16	*HDU*	24	*16 HD 8 IC*
Total	**24**		**24**		**24**		**24**	

It is recognised that the staffing required for such a model will need to be implemented in a similar phased way to the transfer of cots and activity. **Figure 12** indicates the staffing changes required for each phase. The clinical teams have agreed a realistic recruitment programme which is reflected in the decision to open the HD level cots first within the new unit.

Figure 12: Phasing of Workforce Model required

	Total WTE req. for full 24 bedded model	Phase 1 net change (WTE)	Phase 2 net change (WTE)	Phase 3 net change (WTE)
Tier 1 & 2 (ANNP)	10.5	x	5.5	5.5
Tier 3 (Neonatologist)	4.5	x	3	4.5
Unit manager B8A	1.0	x	1	x
Practice Educator B7	1.0	x	1	1
Co-ordinator B7	5.33	x	5.33	5.33
Band 6	42.62	x	10.66	31.96
Band 5	42.62	x	31.96	10.66
Band 2 Housekeepers	5.33	x	5.33	5.33
Surgical PA's	5 PA	5	x	x
Clinical Lead	2 PA	2 PA		
Nursing Lead	0.2 wte	0.2 wte		
Management Lead	0.2 wte	0.2 wte		
Physiotherapy	1	x	1	
Dietetics	1	x	0.5	0.5
SALT	0.5	x	0.5	
Ward Clerk	1.5	x	1	0.5
Pathway Coordinator	3	x	2	3

**Unit manager in phase 1 will be a B7*
**In order to open the 16 HD cots, we would need agreed emergency cover from the AHCH team*

Despite not achieving a NICU through Phases 1 & 2, investment would provide the following benefits:

- Opening of 16 HD cots on new NICU unit supported by full Tier 1 & 2 workforce
- Increased in-reach support for PICU will start to alleviate the difference in care provided on the different units
- Joined up nursing workforce across the 2 sites which promotes consistent care for babies
- Single operational policy/set of standards ensures that all neonates receive the same care despite their location
- As highlighted, recruitment to implement the full single service model is complex and will take a few years. Starting this recruitment process now will ensure that this is achievable.

5.9 Proposed Shared Governance Arrangement

We have considered the options for delivering strong and effective governance to the new service. The governance arrangements must ensure:

- Delivery of safe and high quality care
- Strong human resource support for staff
- A clear partnership agreement is in place, in the form of a joint operational policy
- Effective contracting arrangements with commissioners
- Financial sustainability

We have also given consideration to the size and complexity of this project, and the feelings and wellbeing of our staff who work in the service. These considerations have informed a proposal that is a two-phased transition to a new model of care, organisational arrangements and governance system. This will ensure changes are made in a considered and well-planned way, with time for staff inclusion and support.

We have considered the above requirements and a summary of the governance models for each of the two phases is set out below:

Arrangement detail	Phase 1: 2018 to 2019	Phase 2: From 2020
In scope	▪ Neonatal surgical service ▪ New NICU at Alder Hey (24 cots)	▪ Neonatal surgical service at Alder Hey ▪ New NICU at Alder Hey (24 cots) ▪ Neonatal services at LWH ▪ 9 NICU cots, 10 HDU cots, 19 SCBU cots at LWH
Model	Partnership	Single service (staff employed by one organisation)
Contract held with	Alder Hey	Host provider
Management team	Single leadership team	Single leadership team
Staff employed by	Alder Hey	Host organisation
Governance system	•Joint operational policy •Neonatal Service Partnership Board •Incident management system at both sites •Risk management system at both sites	▪ Neonatal Service Partnership Board ▪ Risk management system
Accountable for governance	Alder Hey	Host provider
Responsible for governance	Alder Hey	Host provider

The structure of the governance models in the two phases are set out diagrammatically below:

Figure 13: Phase 1 Partnership Model with Shared Governance

Phase 1: Partnership model with shared governance

In scope:

- Neonatal surgical service
- New NICU at Alder Hey (24 cots)

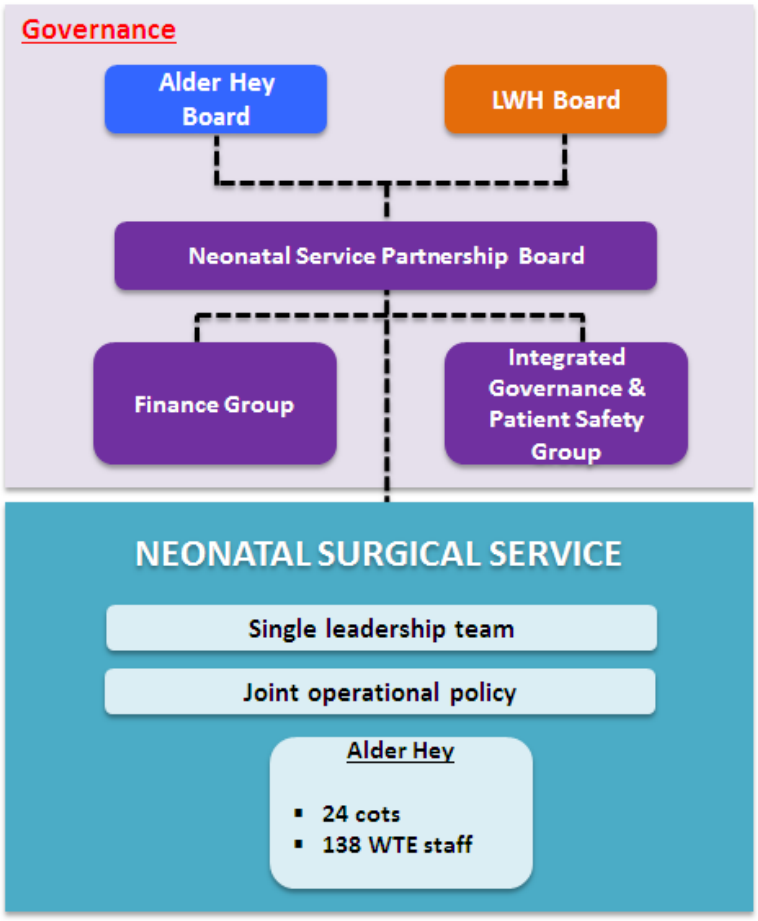
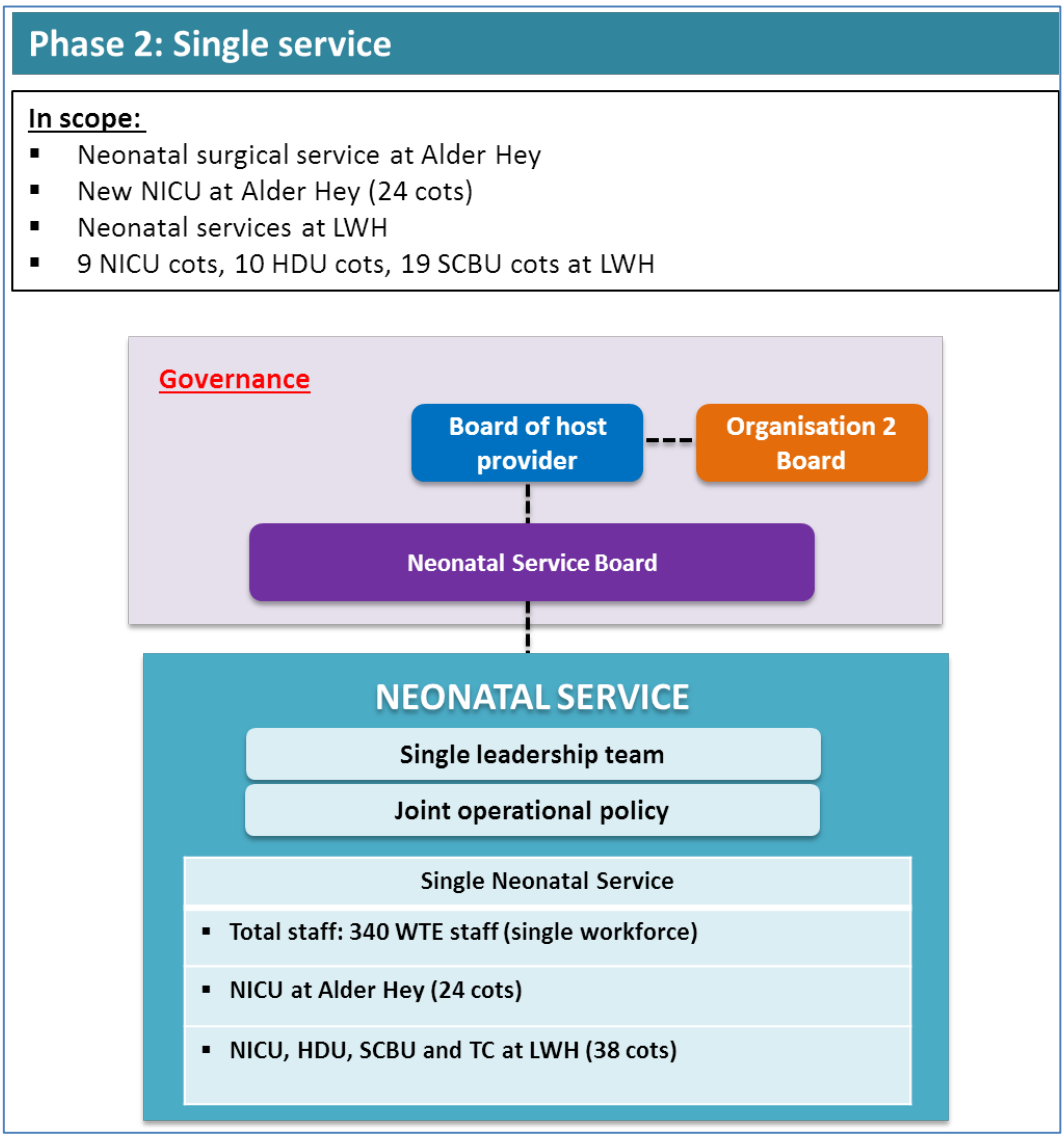


Figure 14: Phase 2, single service



5.10 Financial Analysis of Implementation

5.10.1 Summary of financial analysis

The four options for implementation, as set out in section 4.2, have been assessed financially:

A summary of the incremental costs to commissioners for each option is set out in the table below:

	Neonatal surgical service	Neonatal service at LWH	£'000 Base Cost	Cardiac 2 beds	AH BAPM	LWH BAPM	Total
Option 1a	24 cots NICU	No change	1,400	1,400	1,400	0	4,200
Option 1b	24 cots NICU	Enhanced workforce cover to deliver BAPM standards	1,400	1,400	0	1,100	3,900
Option 2a	22 cots NICU (exc cardiac)	No change	1,400	0	0	0	1,400
Option 2b	22 cots NICU (excl cardiac)	Enhanced workforce cover to deliver BAPM standards	1,400	0	0	1,100	2,500

5.10.2 Detailed financial analysis for option 1a

Option 1a has been used as the base case and has been . The financial model shows that the new 24 bed unit will be fully funded by income from Commissioners, with gross income and expenditure of £9.2m.

Description	Baseline £000's	Incremental £000's	Gross Cost £000's
Tariff Income	4,936	4,242	**9,178**
Total Income	**4,936**	**4,242**	**9,178**
Pay Costs	-3,296	-2,534	**-5,830**
Non Pay Costs	-652	-120	**-772**
Indirect Costs	-651	-229	**-880**
Contribution	**337**	**1,359**	**1,696**
Overheads**	-338	-753	**-1,091**
CNST***	0	-600	**-600**
Surplus / (Deficit)	**-1**	**6**	**5**

Assumptions

a) *Baseline expenditure and income include those due to transfer from LWH. £1,143k income and £1,143k expenditure. The value of expenditure and income transferring is £660k* less hat the contract value due to fixed costs. Therefore £660k would need to be negotiated with commissioners by LWH.*

b) *CNST has been calculated based on LWH current cost of 24 NICU beds, AH does not have a NICU currently and therefore it is assumed that AH CNST would increase by £600k. There has not been any corresponding cost reduction at LWH at this stage.*

The incremental cost (above baseline) is £4.2m, which would be an increased cost to commissioners and is primarily driven by:

- **£1.4m** **Cardiac** 2.5 additional beds @ £543k per cot (regional activity transfer)

- **£1.0m** **BAPM standards** Medical Cover
- **£0.4m** **BAPM standards** Senior Nursing Infrastructure (Ward Based)
- **£0.3m** **6 Beds** marginal costs
- **£1.1m** **Increases in** CNST and revenue consequences of capital build (PFI and Capital Charges)

Notes:

** 6 beds with associated costs will be transferred to AH from LWH, however LWH will not be able to release fix cost overheads amounting to £660k.*

*** relates to revenue impact of capital i.e. PFI lifecycle/FM and capital charge (£5m estates and revenue impact of capex. These figure require final validation*
***relates to CNST increases at Alder Hey due to the establishment of a 24 bedded NICU*

a) Contract Prices

The proposed contract prices with commissioners are calculated based on full absorption costing methodology, with assumed occupancy rate of 80%. Unfortunately there are limited benchmark prices to compare.

Unit	Price per Cot Day
NICU	1,807
HDU	1,061

b) Capital Expenditure

The Capital expenditure costs associated with the new Neonatal Unit are £6.2m.

Capital Equipment	£m
Equipment Costs	1.2
Estates / Building Costs*	5.0
Total Cost	**6.2**

Notes:
The case would require a mix of new build and reconfiguration of estates at AH and there is not the ward capacity to accommodate a 24 bedded NICU adjacent to ICU.

The total flor area of building work is [x]. The revenue consequences include the pFI FM and lifecycle along with the increased capital charges.

5.10.3 Revenue funding from commissioners

The gross running cost of opening a 24 bed Neonatal Unit at AHCH will be £9.2m. It is proposed that contract prices are set at a level to cover the full cost of the new unit:

Unit	Price per Cot Day	No of Days (80% occupancy)	Price Per Cot Per Year	Number of Cots	Total Income per Year
NICU	**£1,807**	292	**£528k**	8	**£4,222k**
HDU	**£1,061**	292	**£310k**	16	**£4,957k**
Total					**£9,178k**

Commissioners already pay AHCH £3.8m for neonatal activity within AHCH bed base (including £0.1m from Wales). Similarly, LWH receive £1.8m for activity, of which £1.1m would "transfer" to the new neonatal unit on AHCH site. This means that an **additional £3.9m funding** is due to Alder Hey is requested from commissioners to support the revenue investment required.

Contract Income	£000's
Income for 24 bed Neonatal Unit	9,178
Existing Contracts - AHCH (15.6 beds) - LWH (5.9 cots)	 (3,793) (1,143)
Net Increase Funding from Commissioners	**4,242**

The main drivers behind this additional investment are:

£1.4m	Cardiac. 2.5 additional beds @ £543k per cot (regional activity transfer	Option 1a only
£1.0m	BAPM Medical Cover	Option 1a and 1b
£0.4m	BAPM Senior Nursing Infrastructure (Ward Based)	Option 2a
£0.3m	Incremental marginal cost of 6 beds.	All options
£1.1m	Incremental CNST and revenue cost of capital	All options

For option 1 this net increase in funding of £4.2m means that the proposed prices are higher than the current contract price between NHS England and LWH.

5.10.4 Benchmark prices

NICU Benchmark	Price Per Day	Annual Cost for 8 Cots
Proposed Price	£1,807	£4,222k
AHCH (PICU)	£1,798	£4,200k
LWH	£1,188	£2,776k

HDU Benchmark	ICU	Annual Cost for 16 Cots
AHCH (Paed HDU)	£1,203	£5,620k
Proposed Price	£1,061	£4,957k
LWH	£904	£4,223k

5.10.5 Revenue Costs of a 24 cot Neonatal Unit

The gross running cost of opening a 24 bed Neonatal Unit at AHCH will be £9.2m:

	Gross Income & Expenditure			Income & Expenditure		Baseline Budget		
	WTE	£/wte	Total	NICU 8 Cots	HDU 16 Cots	AHCH 15.6 Beds	LWH 5.9 Cots	Total
Medical Workforce								
Consultant Neonatologist	4.5	110,000	**495,000**	165,000	330,000			
ANNP - Band 8a	10.5	57,000	**598,500**	199,500	399,000	46,000		46,000
Associated Medical Teams			**508,280**	169,427	338,853	508,280		508,280
Nursing Costs								
Ward Manager - Band 8a	1.0	57,000	**57,000**	19,000	38,000			0
Practice Educator - Band 7	1.0	46,000	**46,000**	15,333	30,667			0
Co-ordinator - Band 7	5.3	53,000	**282,490**	94,163	188,327			0
Nurse - Band 6	42.6	44,000	**1,875,280**	1,875,280				0
Nurse - Band 5	42.6	37,000	**1,576,940**		1,576,940	1,859,000	644,000	2,503,000
Housekeepers - Band 2	5.3	22,000	**117,260**	39,087	78,173		239,000	239,000
Ward Clerk - Band 2	1.5	20,000	**30,000**	10,000	20,000			0
AHP & Other								
Physio - Band 7	1.0	46,000	**46,000**	15,333	30,667			
Dietician - Band 7	1.0	46,000	**46,000**	15,333	30,667			
SALT - Band 7	0.5	46,000	**23,000**	7,667	15,333			
PCO - Band 4	3.0	27,000	**81,000**	27,000	54,000			
Clinical Lead	0.2	110,000	**22,000**	7,333	14,667			
Nursing Lead - Band 8b	0.2	68,000	**13,600**	4,533	9,067			
Service Management - Band 8a	0.2	57,000	**11,400**	3,800	7,600			
Non Pay								
Drugs			**351,000**	175,500	175,500	228,150	50,000	278,150
Consumables			**334,000**	167,000	167,000	217,100	50,000	267,100
Other Non Pay			**87,000**	43,500	43,500	56,550	50,000	106,550
Indirect Costs								
Imaging	24	5,000	**120,000**	60,000	60,000	78,000	25,000	103,000
Pharmacy	24	6,667	**160,000**	80,000	80,000	104,000		104,000
Pathology	24	13,333	**320,000**	160,000	160,000	208,000	54,000	262,000
Other Patient Services	24	4,167	**100,000**	33,333	66,667	65,000	0	65,000
Facilities (Portering / Domestics etc)	24	7,500	**180,000**	60,000	120,000	117,000	0	117,000
Overheads								
Equipment Maintenance			**120,000**	58,000	62,000		32,000	32,000
Estates Costs (Heating / Lighting etc)			**120,000**	40,000	80,000	78,000		78,000
CNST Premium			**600,000**	400,000	200,000			0
Other Corporate Costs			**350,000**	116,667	233,333	227,500		227,500
Capital Charges / PFI UP			**500,000**	166,667	333,333			0
TOTAL EXPENDITURE			**9,171,750**	**4,228,457**	**4,943,293**	**3,792,580**	**1,144,000**	**4,936,580**

It is recognised that there is a baseline level of expenditure at both AHCH and LWH for activity currently being delivered within the existing bed model, and a £4.9m of cost can be "transferred" from existing baseline into the new neonatal unit at AHCH:

Baseline Costs to be "Transferred" to new unit	AHCH 15.6 beds £000's	LWH 5.9 cots £000's	Total Transfer £000's
Pay Costs	2,413	883	3,296
Non Pay Costs	502	150	652
Indirect Costs	572	79	651
Cost of Service Delivery	**3,487**	**1,112**	**4,599**
Overheads	306	32	338
Gross Cost	**3,793**	**1,144**	**4,937**

5.10.6 Capital Expenditure

The Capital expenditure costs associated with the new Neonatal Unit are £6.2m.

Capital Equipment	£m
Equipment Costs	1.2
Estates / Building Costs	5.0
Total Cost	**6.2**

a) Equipment

Equipment costs for the new unit are estimated at £1.2m if assumes 100% new kit is required.

NICU	COST £
VENTILATOR	25,000
HUMIDIFIER	1,250
PATIENT MONITOR MX800	17,000
INCUBATOR	18,000
INFUSION PUMPS X 8	6,000
VOLUMETRIC PUMP X 1	1,200
DOCKING STATION - 8 WAY	950
NEOPUFF	750
BLENDER	1,000
SUCTION UNIT	120
COMPUTER ACCESSORIES	1,000
TOTAL per Cot	**72,270**
Total for 8 Cots	**578,160**

HDU	COST £
PATIENT MONITOR MX700	15,000
INCUBATOR	18,000
INFUSION PUMPS X 2	1,500
VOLUMETRIC PUMP X 1	1,200
DOCKING STATION - 4 WAY	800
NEOPUFF	750
FLOWMETER	80
SUCTION UNIT	120
COMPUTER ACCESSORIES	1,000
TOTAL per Cot	**38,450**
Total for 16 Cots	**615,200**

The 24 bed up front Capex cost could be mitigated if some transfers are made from LWH and AH. This issue requires a detailed assessment by BME teams.

b) Estates

Several options have been considered regarding the potential location of the new Neonatal unit at AHCH, all of which require re-location of other existing services to create sufficient capacity for a 24 bed unit. Refurbishment of these existing areas will also be required in order to ensure the unit is suitable for provision of neonatal care.

Provisional estimate for building costs is £5.0m which includes a blend of reconfiguration and new build.

5.10.7 Costs of delivering BAPM standards in the neonatal service at LWH

The LWH site would require investment to meet the service standards (BAPM 3rd edition) for providing level 3 Neonatal Critical Care in Medical, Nursing and Allied Health Professionals. **Appendix D** sets out the aspects of the BAPM standards that both Trusts currently do not meet.

To provide service to standard would require the following additional posts:

	WTE	£/wte	Total
AHPs			
SALT - Band 8a	0.5	57,000	**28,500**
Psychologist - Band 8a	0.5	57,000	**28,500**
Dietician - Band 8a	1.0	57,000	**57,000**
Physio - Band 8a	1.0	57,000	**57,000**
BAPM Requirements			
Band 3	5.4	22,000	**118,800**
Band 4	5.4	26,000	**140,400**
Consultant Neonatologist	3.0	130,000	**390,000**
ANNP - Band 8a	5.4	57,000	**307,800**
TOTAL	22.2		1,128,000

It would be impossible to recruit all posts immediately due to workforce shortages. It is projected that this recruitment would be phased over a period of three years due to workforce supply constraints.

6.0 Implementation and Delivery

6.1 Implementation Milestones

Figure 26 identifies high level milestones for the approval and implementation of the proposal for a Level 3 NICU at AHCH, making up a 2 site single service.

Figure 26: Implementation Milestones

Milestone Activity	Lead	Date to be completed
Present business case to AHCH and LWH executive teams	CL/AB/JD/JJ	14/12/17
Business case presented to AHCH and LWH Trust Boards	AB/JJ	w/c 08/01/18
Partnership meetings with NHSE specialist commissioners to finalise business case	AB/JJ/RJ	Feb 2018
Formal commissioning decision to be made by NHSE Specialised Commissioning (North)	RJ	March 2018
Proceed with Phase 1 implementation plans	AH/LWH	April 2017
Agree proposed implementation plan for phase 2	AH/LWH/NHSE	April 2017
Commence recruitment programme	CL/JD	April 2017
Identify capital funding for estates changes	AH/LWH/NHSE	April 2017
Commence Design and Build of new facility	AH	TBC
New facility opens at AH	AH	TBC

6.2 Implementation Risks

Figure 27: Detailed Risk of Implementation

Risk	Proposed Mitigation
Unable to recruit to nursing posts. ANNP training is a two year supernumerary post and previous recruitment attempts from LWH have shown that there is a small pool of existing trained ANNP's. Risk is a cost pressure of £45k per annum for training (plus cost of supernumerary	It is important that recruitment begins in Phase 1. A review of the recruitment timelines reflect that in a 2 year period we are likely to have 5.5 WTE ANNP's in post. The cost of the posts are within the financial analysis of this case, however the staff will

post).	not be factored into rotas until their training is complete. Any training costs would need up-front investment. This would be a quality investment and would not achieve savings. We will also have a rolling recruitment programme in order to attract those that may be trained in speciality already.
Unable to recruit to Consultant Neonatology posts. From previous attempts we are aware that the pool of qualified specialists is small.	Similarly it is important that consultant recruitment is also started within phase 1. LWH are currently out to advert for a vacancy and have 5 good candidates which reflects that we have recently had some experienced trainees qualify. This would be a good opportunity to recruit excellent candidates for our future service if the funding was available.
Staff retention could be difficult as change often creates instability.	It is important that the changes are delivered in a collaborative manner. The proposed governance agreement has been carefully planned in order to create as little unrest as possible. It is important that we continue with our communication strategy for the nursing staff and ensure nursing leadership at AHCH to provide support.
Proposed closure of beds at AHCH is difficult to operationalise	AHCH have a number of growth strategies across specialties, including a number of recent business cases which have recently been approved and are awaiting increased theatre capacity. The trust will review how this increased activity can be aligned with the available capacity freed up by this case.
Proposed estates configuration for new NICU does not offer any opportunity for future growth.	Although we can house the new unit within our current hospital foot print (with a number of estates changes), there is a risk in that the critical care floor which would include both PICU and NICU would be at capacity and there would be no room for future growth. This is a risk for a number of surgical specialties who are seeing an increasing demand for elective PICU capacity such as Spinal and Cardiac Surgery.

6.3 Exit Strategy

6.3.1 Nursing Strategy

Any newly recruited nurses will commence in post over a 3-4 year period. If within this time there is a reduction in required capacity for the new unit, or should there be any operational difficulties in implementation, the nurses would be factored into natural turnover within the wards at AHCH and LWH.

As LWH site is currently not at BAPM standards in terms of their medical workforce establishment, any recruited ANNP's would still be included within their rotas.

As this is a phased recruitment programme we would not have the risk of a high number of nurses being recruited at once.

6.3.2 Consultant Strategy

Should the new unit experience a reduction in capacity or should there be operational difficulties in implementation, the recruited consultants would still work within the rota at LWH. This would allow us to improve Neonatology input for AHCH babies even if the remained within their current environment. LWH have been granted funds to increase their consultant workforce on an annual basis to get them to BAPM standards, therefore it would be sensible to factor any new consultants into this recruitment plan.

7.0 Conclusion and Recommendation

7.1 Conclusion and Recommendation

Historically neonatal intensive care provision has been provided by our Paediatric Intensive Care Unit and is therefore lacking the appropriate neonatal medical workforce to enhance their care. This results in a lack of compliance with the national service specification for neonatal surgery. In addition, our other neonatal surgical patients under HDU care are spread across a number of different wards in the trust. Again these babies do not have the appropriate neonatal input and are sometimes nursed in an inappropriate environment.

Following a review by the NWNODN it was highlighted that there is a clear need to implement a single service model for surgical neonates which allows, "**All neonatal surgery to continue to be performed on Alder Hey Children's Hospital (ACHC) site and in collaboration with LWH to establish dedicated Neonatal intensive Care provision at AHCH and enhanced post-natal support (two site single service model)**".

The single service delivery model set out by the clinical steering group and in conjunction with the NWNODN will address the challenges posed by the current service configuration across AHCH and LWH for surgical neonates in terms of both the lack of compliance with the national service specification for surgical neonates and the sub-optimal model of care currently in place.

The provision of dedicated neonatal intensive care at AHCH along with a single neonatal unit which is part of a single service model with LWH will offer significant benefit to surgical babies:

- Firstly, we can improve the quality of care and clinical outcomes for babies by strengthening the joint working between both organisations in order to provide increased levels of neonatology and surgical expertise and also an appropriate environment for all babies to be nursed in the same dedicated facility

- Secondly, we can improve the experience of mothers and families by reducing the number of unnecessary transfers by 50% (transfers are also associated with mortality)

- Thirdly, we can provide a safer service for our babies which is compliant with national service specifications and standards

It is recommended that the new single service model (which will see a 24 bedded NICU at AHCH) is implemented in the phased approached presented in the case. This will allow us to reach the timescales for the required recruitment to the medical workforce model and also to facilitate the appropriate re-allocation of resources across the 2 sites/network.

Although outside of the original scope which was to include all surgical babies currently at AHCH and LWH, it is also recommended that we include the cardiac surgery pre-operative neonates in recognition that inclusion in the new service model would provide the optimal care pathway for these babies.

References

[1] 2013/14 NHS Standard Contract for Paediatric Surgery: Neonates (E02)

[2] Service Standards for Hospitals Providing Neonatal Care (3rd edition) (2010) British Association of Perinatal Medicine

[3] NWNODN Neonatal Surgical Service Delivery Model Options Appraisal Paper 12/09/2016

[4] Clinical Senate Report September 2017

[5] Independent Peer Review of C & M Surgical Pathway Report (June 2016)

[6] Defining Staffing Levels for Children and Young People's Services (RCN 2013)

[7] Standards for the Care of Critically Ill Children, The Paediatric Intensive Care Society (2010)

Appendices

Appendix A- Options Appraisal

Taking forward the preferred option 'All neonatal surgery continued to be performed on Alder Hey Children's Hospital (ACHC) site and in collaboration with LWH establishment of Neonatal intensive Care provision at AHCH and enhanced post-natal support (single service model)', the T&FG considered a number of operational options to configure the single service. The long list options are outlined as follows:

Option 1	No change to current arrangements
Option 2	Single nursing and medical workforce for the neonatal service. **ITU for Neonatal Surgical patients** provided at **AHCH PICU** with 'in-reach' support from the neonatal workforce covering the Neonatal Surgical HDU
Option 3	Single nursing and medical workforce for the neonatal service. ITU for neonatal surgical patients provided at AHCH **PICU with designated/ ring-fenced beds**, management of neonates on PICU under the paediatric intensive care consultants with 'in-reach' support from the Surgical HDU.
Option 4	Single nursing and medical workforce for the neonatal service. **Dedicated NICU facility** (separate from the PICU) for surgical neonates under the specialty of **paediatric surgery** who require level 3 care.
Option 5	Single nursing and medical workforce for the neonatal service. **Dedicated NICU facility** (separate from the PICU) for surgical neonates who require level 3 care under the specialty of **paediatric surgery, urology, orthopaedics, plastic surgery, neurosurgery, ophthalmic surgery, maxillofacial surgery and ENT.**
Option 6	Single nursing and medical workforce for the neonatal service. **Dedicated NICU facility** (separate from the PICU) for surgical neonates who require level 3 care under **all surgical specialties** and **cardiac surgery neonates** for **pre-operative care**
Option 7	Single nursing and medical workforce for the neonatal service. **Dedicated NICU facility** (separate from the PICU) for surgical neonates who require level 3 care under **all surgical specialties** (for neonates requiring cardiac surgery this is pre-operative care only) and **medical specialties**.

Each member of the T&FG electronically completed a weighted scoring assessment of 7 options on the long list.
A weighted scoring criteria was formulated and approved by the group. The assessment criteria used is outlined in the table below:

Assessment Criteria	Weighting
Quality	40%
a. Expected to improve survival rates for surgical neonates	0.07
b. Expected to reduce rates of morbidity for surgical neonates	0.07
c. Supports the delivery of integrated care	0.07
d. Delivers safe levels of medical cover in line with service specification	0.07
e. Improves families' experience of the service	0.07
f. Nursing team have the optimal skills to manage the patients	0.07
Feasibility	25%
g. Estate works are deliverable	0.13
h. Workforce can be put in place within 36 months	0.13
Financial	35%

i. The capital programme offers value for money	0.18
j. the revenue costs represent value for money	0.18

The scoring of the options is summarised below:

Assessment Criteria	Weighting	Option 1	Option 2	Option 3	Option 4	Option 5	Option 6	Option 7
Quality	40%							
a. Expected to improve survival rates for surgical neonates	0.07	-0.00	0.06	0.05	0.11	0.12	0.16	0.16
b. Expected to reduce rates of morbidity for surgical neonates	0.07	-0.00	0.09	0.06	0.13	0.14	0.18	0.17
c. Supports the delivery of integrated care	0.07	-0.01	0.09	0.04	0.14	0.17	0.18	0.19
d. Delivers safe levels of medical cover in line with service specification	0.07	-0.01	0.05	0.05	0.14	0.15	0.17	0.17
e. Improves families' experience of the service	0.07	-0.00	0.07	0.05	0.13	0.15	0.18	0.18
f. Nursing team have the optimal skills to manage the patients	0.07	-0.00	0.08	0.07	0.14	0.14	0.16	0.14
Feasibility	25%							
g. Estate works are deliverable	0.13	0.03	0.12	0.12	0.18	0.19	0.20	0.15
h. Workforce can be put in place within 36 months	0.13	0.03	0.16	0.16	0.14	0.11	0.11	0.07
Financial	35%							
i. The capital programme offers value for money	0.18	0.00	0.16	0.18	0.25	0.30	0.30	0.28
j. the revenue costs represent value for money	0.18	0.00	0.13	0.13	0.23	0.30	0.34	0.31
		0.01	**0.99**	**0.90**	**1.59**	**1.76**	**1.96**	**1.81**

The outcome of this work scored the preferred option to be option 6: Single nursing and medical workforce for the neonatal service. Dedicated NICU facility (separate from the PICU) for surgical neonates who require level 3 care under all surgical specialties and cardiac surgery neonates for pre-operative care.

Appendix B- Admissions Criteria (Surgical Pathways)

Admissions Criteria
and surgical pathway

Appendix C- Capacity and Demand Analysis- Surgical Neonates (including Cardiac Pre-operative neonates)

Cheshire & Mersey
Activity and cot requi

Appendix D: British Association of Perinatal Medicine (BAPM) standards

5.4 Medical staff r*equirements for a Neonatal Intensive Care Unit (NICU):*

5.4.1 All staffing roles should be limited to neonatal care at all levels, i.e. no cross cover with general paediatrics. It is anticipated that teams at each tier will be made up from the following groups:

• Tier 1: Staffing can be from paediatric ST1-3, ENNPs or ANNPs, specialty doctors.

• Tier 2: Staffing from paediatric ST4-8, specialty doctors, other non training grade doctors, ANNPs (with appropriate additional skills and training), resident neonatal consultants.

• Tier 3: Consultant neonatologists. There will be 24/7 availability of a consultant neonatologist for Tier 3.

5.4.2 Recommended numbers of staff for a Neonatal Intensive Care Unit:

• Tier 1: Separate neonatal rotas with a minimum of 8 staff.

• Tier 2: Separate neonatal rota with a minimum of 8 staff.

• Tier 3: A minimum of 7 consultants on the on call rota with resident consultants on the tier 2 rota additional to this number. All tier 3 consultants should be identified neonatal specialists. See 5.1.4.

5.4.3 For larger Neonatal Intensive Care Units special consideration should be given to the number of staff required at each tier throughout the 24 hours and giving due consideration to the time required at each handover. With increasing size, at some point, essentially the whole of the staffing structure described in 5.4.2 should be doubled. Individual units should be assessed on a patient safety basis.

BAPM STANDARDS FOR ALLIED HEALTH PROFESSIONALS

6.1 *Dietetics*

Specialist dietitians have a major role in assessing and improving the nutrition of premature infants. Data exist that document the benefit of including a neonatal dietitian within a team approach to nutritional support.[11] [12] [13]

In terms of network structure the following principles should be adopted:

• All types of neonatal units should have access to a paediatric dietitian competent in neonatal nutrition or a neonatal dietitian (to include expertise in the care of babies requiring surgery and support after discharge for those babies identified at nutritional risk).

• All paediatric dietitians caring for neonates should have access to a highly skilled specialist neonatal dietitian whose job plan contains sufficient capacity to provide advice and support across the network.

• Dietitians providing neonatal care should be experienced paediatric dietitians who have completed the British Dietetic Association Paediatric Dietetic Masters Module 2 or demonstrate an equivalent level of knowledge and skills.

• Specialist neonatal dietitians must be experienced neonatal dietitians capable of providing network support in complex neonatal and surgical dietetics and have completed the BDA Masters Paediatric Dietetic Module 5 (Neonatal Nutrition) or demonstrate an equivalent level of knowledge and skills.

• The dietetic workforce should be based on the Modernisation Taskforce Critical Care Workforce Standards[14] and provide a minimum of 0.05 – 0.1wte per intensive care cot The higher level of provision should be provided at NICU level in order to enable the provision of a network support service in addition to complex unit based nutritional support. Consideration should also be given to provision for the ongoing need for nutritional support to at risk infants after discharge.

6.2 Occupational Therapy and Physiotherapy in the NICU

6.2.1 Models of Provision:

Physiotherapy and Occupational Therapy involvement in relation to newborn care have followed different patterns across the UK. Some services have successfully utilised a joint role where the focus has been on “developmental care” whilst in other parts of the UK the roles of the individual therapists have remained separate with a focus on the contribution

that each can provide. Networks and neonatal services will need to consider which pattern of service most closely suits their needs.

6.2.2 Developmental Role:

It is widely accepted that neonatal occupational therapy (OT) and neonatal physiotherapy (PT) have a shared knowledge base and competencies in relation to the highly specialized area of a NICU. Therefore there is much overlap between the two professions when both adopt a developmental model, which is increasingly becoming the standard for care in NICU. In order to capitalise on this overlap neonatal OT and PT agree that it is necessary to be able to shift away from solely focusing on individual practice areas to a more collaborative model with other professionals, using this shared knowledge base and providing in some cases developmental leadership to the NICU team. What is unique to OT and PT in this complex area is the ability to combine comprehensive assessment with appropriate intervention. Therefore to avoid duplication and for more effective use of resources a neonatal post may be split between OT and PT to provide a comprehensive service. The number of whole time equivalents should reflect the size of the individual unit and any additional commitment to provide specialist input to the wider network. Where it is not possible to recruit both OT and PT, a neonatal therapist may be employed (either OT or PT) with the appropriate skill base, knowledge and experience to provide developmentally based neurological / neurobehavioural assessment and follow up of the high risk infant.

6.2.3 Neonatal Physiotherapy – Specialist Role:

The neonatal physiotherapist is a specialist in:

• Age appropriate movement and postural control

• Assessment and identification of gross motor dysfunction within the behavioural, environmental, and family context of the NICU.[15 16]

• Shaping the musculoskeletal system and motor organization of infants requiring intensive care and to support parents and caregivers in optimizing infant brain development during the NICU stay, relying on principles of movement science.[16]

Other areas of practice specific to physiotherapy include chest physiotherapy and the management of orthopaedic conditions such as Erb's Palsy and talipes.

There are currently no benchmarked standards regarding WTE posts per service capacity. Due to the specialist nature of the work it is recommended that the post be Band 7 or band 8A (depending on experience).

All specialist neonatal physiotherapists will need to demonstrate their on-going skills and knowledge through annual appraisal with evidence through their CPD portfolio.

6.2.4 Neonatal Occupational Therapy – Specialist Role:

The neonatal occupational therapist is a specialist in:

• Assessing the interaction of biological, developmental and psychosocial aspects of human function as expressed in daily activities and occupations.[17, 18, 19]

• Administering complex standardised neurobehavioral assessments that provide information on the infants neurobehavioural organisation, state control and self regulatory behaviours.

• The use of reliable non-invasive neurological assessments to identify early signs of neurological impairment.

• Identifying and advising on sensory issues affecting irritable babies and provide advice on developmentally supportive positioning to help prevent postural and developmental delays later in infancy.[16 17]

• Helping to sensitise parents to their infant's behavioural cues, thereby enabling appropriate interactions and levels of stimulation, and provide developmental programmes as appropriate.[17 18 20]

• Provide follow up after discharge, using evidence based standardised developmental, cognitive and motor assessments.

The neonatal occupational therapist is a key member of the multidisciplinary team who will be expected to have the appropriate specialised post-graduate training and skills.[17 18 20 21 22 23] All specialist neonatal OT's will need to demonstrate their on-going skills and knowledge through annual appraisal with evidence through their CPD portfolio.[17]

There are currently no benchmarked standards regarding WTE posts per service capacity. Due to the specialist nature of the work it is recommended that the post be Band 7 or band 8A (depending on experience).

6.3 *Speech and Language Therapy*

6.3.1 Roles/Benefits

The speech and language therapist (SLT) is a key member of the multidisciplinary neonatal team with a unique role in the assessment and management of infant feeding and swallowing.[24]

A knowledge of feeding development and early communication skills enables provision of pre-feeding intervention programmes with the aim of:

(i) reducing the potential development of aversive feeding behaviour

(ii) promoting oral feeding readiness

(iii) maximising the potential for successful oral feeding[25]

An integral part of the SLTs role is to support and provide education to the multidisciplinary team regarding optimal feeding practice and the management of infants with complex feeding and swallowing problems.

6.3.2 Network staffing model

All units should have access to the specialist SLT services. The precise staffing model will reflect the size and configuration of the network. Neonatology is an advanced practice sub speciality area within paediatric SLT. Speech and language therapists working in this specialty should have relevant post graduate paediatric experience and evidence of relevant CPD.

6.4 *Pharmacy*

6.4.1 Neonatal Pharmacy

Neonatal pharmacists play a role in the optimisation of drug therapy in the critically ill neonate through:

• Prescription monitoring

• Provision of advice on the use of off-label and unlicensed medicines, including suitable formulations, to enable safe therapy

• Pharmaceutical optimisation of intravenous therapy (for example the administration of complex infusions because of limited venous access) to ensure that medication can be administered safely and effectively

• Optimisation of parenteral nutrition

• Therapeutic drug monitoring

• Adverse drug reaction prevention, treatment, monitoring and reporting

• Minimising the potential for medication errors through guideline development, provision of medicines information, teaching of other healthcare professionals and drug interaction prevention

Networks should ensure that there are sufficient paediatric pharmacists trained in neonatal intensive care, who have time in their job plans allocated for their work on the neonatal unit[1]. It is recommended that the time allocated should be based on the ability to provide daily input of approximately 10 - 20 minutes per cot to the care of all patients as well as attendance at appropriate ward rounds and meetings (based on the recommendation of the neonatal pharmacy special interest group). The time required should also reflect the case mix of patients and various local factors such as:

• Access on site to a pharmacist experienced in neonatal and paediatric parenteral nutrition

• Provision of an aseptic preparation service for all parenteral nutrition and the majority of intravenous injections and infusions

• Access to a drug information service with experience in the problems of neonatal intensive care

• Pharmaceutical lead or input to drug-related policies, protocols and guidelines

• Responsibilities to the wider network

• Continuing education of pharmacy practitioners providing the service

Pharmacists providing neonatal care should be suitably trained and experienced and as a minimum, have successfully completed the Centre of Postgraduate Pharmacy Education paediatric distance learning pack or have equivalent levels of skills and knowledge. They must have a detailed knowledge of pharmacokinetics and dynamics in neonates and understand the development of the major metabolic pathways and how these affect common paediatric medication.

6.5 *Psychological Support*

All parents whose babies are admitted into a neonatal unit suffer stress and particularly in NICUs they may experience significant trauma with the possibility of post traumatic stress symptoms.[26] All parents should have access to a trained counsellor. In units providing intensive care this service should be available without delay from the time of admission as well as providing for ongoing support during the parents' time on the neonatal unit. The work should include specialist bereavement counselling in conjunction with the clinical team.
Additional roles include staff support and education. The level of service provided should reflect the needs of the whole network and not just babies within NICUs.

6.6 Social Services

Although social services are not normally an integral part of the "health services" associated with neonatal care, networks should ensure that they have clear arrangements to facilitate close working with the relevant local children's social work teams.

BOARD OF DIRECTORS

9th January 2018

Report of:	Memorandum of Understanding for Collaborative Working in Liverpool related to Corporate Services.
Paper Prepared by:	Claire Liddy, Director of Operational Finance.
Subject/Title:	Proposed Memorandum of Understanding for Corporate Services.
Background Papers:	Forms part of the Cheshire and Merseyside STP.
Purpose of Paper:	For information.
Action/Decision Required:	For approval.
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Strategic Partnership Working.
Resource Impact:	

Advice on initial considerations for collaborative working to consolidate corporate services across North Mersey Local Delivery System

1. Background

1.1 In October 2016, 12 organisations in the North Mersey Local Delivery System (including Trusts, Foundation Trusts and CCGs) (collectively **"the Organisations"**) set up a Corporate Services Transformation Design Group with the aim of collaboratively working to transform the approach to corporate services, aligned with the Five Year Forward View and as set out in the Cheshire and Mersey Sustainability and Transformation Plan.

1.2 The Organisations seek to collaborate to bring together NHS Trusts, NHS Foundation Trusts and CCGs to deliver region wide, efficient and consolidated corporate services that best support front line staff in delivering quality patient care. The intention being to deliver a system model that is coherent, integrated, consistent (reducing unwanted variation) and focussed on quality and value for money.

1.3 The Organisations are now reviewing governance arrangements with a view to developing a decision making model appropriate for the collaborative, developing the principles that will underpin collaborative working and the timetable for implementation in order to tackle a number of significant operational and financial challenges for collaborative corporate services across North Mersey.

1.4 This paper sets out an approach to establishing the governance framework for joint working across the Organisations. The setting up of a committee in common model has been identified as a potential way of ensuring that the Organisations have a forum for discussion and decision making in a way that meets the governance and legal requirements of each Organisation.

1.5 This note sets out:

1.5.1 a summary of the committees in common structure;

1.5.2 a work plan with steps the Organisations will need to take when setting up the joint working model; and

1.5.3 a brief outline of other collaborative models.

2. Joint working arrangements- committees in common (CiC)

2.1 The CiC model is useful where a number of NHS bodies intend to form a collaborative approach to strategic and operational opportunities.

2.2 The Organisations each create a new committee of their respective boards and then delegate powers to these committees, enabling decisions to be taken in a common forum where the GC meet together, and allowing direction for delivery and assurance of the collaborative programme. It moves further than a 'goodwill' arrangement but it is not full integration from the perspective of any loss of sovereignty. The CiC could provide strategic oversight and direction, and it will be for the organisations to decide the level at which the CiC operates and the manner in which decisions of the CiC are implemented (potentially via working groups established for relevant workstreams).

2.3 The key features of the CiC are that:

2.3.1 each Organisation remains a standalone, legally autonomous organisation;

2.3.2 each Organisation will delegate an agreed scope of decision making (to the extent this is legally permissible) to the CiC;

2.3.3 each CiC will owe duties to the Organisation that constituted it and will report to the board of such Organisation;

2.3.4 there is no delegation of powers between the Organisations therefore no one Organisation can be bound by a decision taken by the other Organisation's CiC;

2.3.5 the CiC of each Organisation will have common meeting times, meeting venues; and agendas of business (where practicable) to exercise their delegated functions;

2.3.6 each CiC makes its own separate decisions on behalf of its Organisation but in practice the decisions are discussed jointly;

2.3.7 some of the individual CiC members could be common, i.e. acting on behalf of more than one Organisation. However, common appointments must be carefully monitored in order not to inadvertently trigger a merger for the purposes of competition law and to manage any potential conflicts;

2.3.8 the usual apparatus of governance and specialist monitoring of each Organisation (for example, audit committees, quality committees and remuneration committees) will remain in place in accordance with their own governance arrangements; and

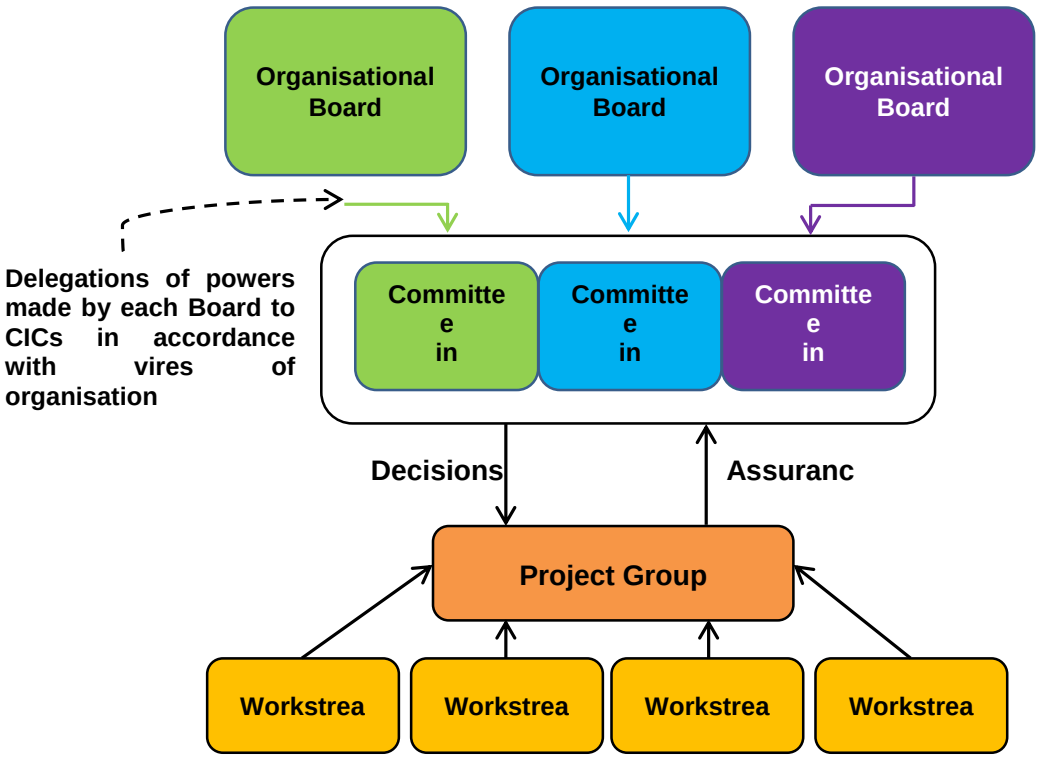
2.3.9 the CiCs could be seen an initial step towards joint working and a more integrated form could be considered as a second step.

2.4 In summary, the Organisations formally delegate decisions relating to the collaborative programme, within agreed parameters, to their designated representatives who sit with other Organisation representatives on the collective CiCs. A Memorandum of Understanding and Terms of Reference will set out a governance structure for development and delivery of the collaborative programme. Whilst the decision making will be consensual (by each respective CiC) and not legally binding on each other without agreement, the organisations will be able to agree and establish legally binding contractual joint ventures in respect of specific activities falling under the collaborative programme where agreed.

2.5 An advisory project group would sit under the CiCs to provide management support at programme and workstream level and ensure key deliverables are met.

2.6 The current Corporate Services Transformation Design Group could then be adapted to meet the requirements of the CiC or the project group.

Example Structure



Powers to delegate to committees- membership of CiC

Directors of NHS trusts and NHS foundation trusts have statutory powers to delegate their responsibilities to committees as below:

- NHS Trusts: An NHS trust may delegate any of its functions to a committee or sub-committee (subject to such restrictions as the Trust thinks fit). The committees and sub-committees do not have to include a director of the Trust; committees can consist wholly or partly of directors of the Trust or wholly of persons who are not directors of the Trust.

- NHS Foundation Trusts: An FT's constitution may provide for any powers of the FT to be delegated to a committee of directors or to an executive director.

Therefore whilst NHS trusts have wide express statutory powers to delegate, NHS Foundation Trusts may only delegate its powers to a committee of directors. The Organisations may, to ensure parity, decide that the membership of the CiC will constitute two of its directors.

3. Joint working arrangements- other (future) options

For completeness we have briefly set out the key features and legal considerations of other (non-exhaustive) options for joint working at Appendix 1 and are happy to advise further on these if required.

4. Next steps for joint working

We have set out below a summary of the steps the Organisations will need to take to set up the a working CiC model, recognising the work that has been done to date as set out in the Project Initiation Document.

	Action
1	Case for change including evidence base. (This may have already been done at STP level as to consideration of scope – this could be built on).
2	Determine scope of joint working based on case for change.

	Action
4	Agree governance structure for joint working including an indicative timetable.
3	Prepare an overarching joint working agreement (Memorandum of Understanding). This will set out details of the working of the CiCs including the background, principles of working, process for joint working and arrangements around termination of the joint working. An indicative MoU to facilitate joint working discussions is attached at Appendix 2.
4	Prepare Terms of Reference (**"ToR"**) for the CiCs and the project group – the ToRs will set out the scope of decision-making to be delegated to the committees, decisions that will be reserved to the board of directors, reporting requirements, membership of the committees and voting arrangements. The Organisations should also compile a risk register for the CiCs.
5	Check the constitutions and Standing Orders/Standing Financial Instructions of the Organisations to assess whether any constitutional amendments will be required to ensure consistency with set up and delegation limits.
6	Prepare a conflict of interest policy to set out how directors will discharge their obligations to act in the best interests of their respective trusts to deal with fiduciary duties conflict situations arising as a result of the CiC arrangements.
7	Prepare a confidentiality agreement and information sharing agreement to govern the flow of information between the Organisations.
8	Engage with stakeholders.
9	Sign off by respective Boards.

Once the Organisations have considered the joint working options we would be happy to provide more detailed advice along with initial drafts of the key documents, setting out commonly adapted solutions to key issues to assist with facilitating discussions and moving forward with the collaborative programme.

Capsticks Solicitors LLP
9 February 2017

Appendix 1

Model	Key Features	Key Legal Issues / considerations
Corporate Joint Venture	This model involves the formation of a separate legal entity, in which the Trusts both hold an interest. The legal entity is likely to take the form of a limited company (or community interest company) or limited liability partnership (although other forms may also be considered).	NHS Trusts do not have the vires to participate in a corporate joint venture. Each Trust's liability for the operations of the joint venture is limited to the funding it commits to the venture (as the corporate entity is able to ring-fence liabilities). However, the Trusts may be required to guarantee the obligations of the corporate entity. The governance structure can be set out in the entity's constitutional documents (for example articles of association for a company). Matters which are to be kept confidential (e.g. the allocation of risk and responsibility between the Trusts) can be set out in a separate shareholders agreement (or equivalent arrangement).

Model	Key Features	Key Legal Issues / considerations
		A corporate arrangement can be perceived as taking services out of the NHS (especially to staff) and there are additional administrative burdens and costs arising from being regulated by the relevant corporate laws.
Contractual Joint Venture	One Trust (whichever is nominated to act as host of the joint venture) accordingly holds the relevant contract(s). Decisions as to the joint venture's management are taken collectively (with governance structures and a liability/risk share model).	Unlike the corporate model, this model is within the vires of an NHS Trust. Liability will primarily rest with the host organisation, although the collaboration / joint venture agreement will allocate risk and responsibility between the Trusts. This agreement will also address issues including (i) mutual rights and obligations of each provider involved; (ii) changes in "host"; (iii) management and governance structure (e.g. risk share and voting); and (iv) exit arrangements.

Model	Key Features	Key Legal Issues / considerations
		The collaboration / joint venture agreement can be structured to mirror corporate structures, so in practice the Trusts will: (i) appoint representatives to a "board" (technically a contractual decision making forum rather than a board in a governance sense); (ii) hold ownership shares in the joint
Hybrid corporate model	A corporate joint venture is run in accordance with a contractual agreement which seeks to mimic shareholdings for those Organisations which are not able to hold shares at the outset (NHS Trusts), with a contractual agreement to become a shareholder at a later date i.e. on achieving Foundation Trust status.	This could be viewed as participating 'by the back door' contrary to the position on vires.

Appendix 2

Memorandum of Understanding for North Mersey

DATE **2017**

1. ALDER HEY CHILDREN'S NHS FOUNDATION TRUST

2. AINTREE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST

3. LIVERPOOL COMMUNITY HEALTH NHS TRUST

4. LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST

5. LIVERPOOL WOMEN'S NHS FOUNDATION TRUST

6. MERSEY CARE NHS FOUNDATION TRUST

7. NHS KNOWSLEY CCG

8. NHS LIVERPOOL CCG

9. NHS SOUTH SEFTON CCG

10. ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST

11. THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST

12. WALTON CENTRE NHS FOUNDATION TRUST

MEMORANDUM OF UNDERSTANDING FOR NORTH MERSEY

No	Date	Version Number	Author
1	08/02/017	1	CB
2			
3			
4			
5			
6			

CONTENTS

[review]

Date:

2017

This Memorandum of Understanding ("**MoU"**) is made between:

1. **ALDER HEY CHILDREN'S NHS FOUNDATION TRUST** of Eaton Road, Liverpool, L12 2AP;
2. **AINTREE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST** of Lower Lane, Fazakerley, Liverpool, L9 7AL;
3. **LIVERPOOL COMMUNITY HEALTH NHS TRUST** of Liverpool Innovation Park, 2nd Floor, Digital Way, Liverpool, L7 9NJ;
4. **LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST** of Thomas Dr, Liverpool L14 3PE;
5. **LIVERPOOL WOMEN'S NHS FOUNDATION TRUST** of Crown Street, Liverpool, L8 7SS;
6. **MERSEY CARE NHS FOUNDATION TRUST** of V7 Building, Kings Business Park, Prescot, Liverpool, L34 1PJ;
7. **NHS KNOWSLEY CCG** of Nutgrove Villa, Westmorland Rd, Huyton, Liverpool L36 6GA;
8. **NHS LIVERPOOL CCG** of 2 Renshaw St, Liverpool L1 2SA;
9. **NHS SOUTH SEFTON CCG** of Merton House, Stanley Rd, Bootle L20 3DL;
10. **ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST** of Prescot Street, Liverpool, L7 8XP;
11. **THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST** of Clatterbridge Road, Bebington, Wirral, CH63 4JY; and
12. **WALTON CENTRE NHS FOUNDATION TRUST** of Lower Lane, Fazakerley, Liverpool, L9 7LJ

(each a **"Party"** and together the "**Parties**").

RECITALS

1. In entering into and performing their obligations under this MoU, the parties are working towards a collaborative programme for services, aligned with the Five Year Forward View and as set out in the Cheshire and Mersey Sustainability and

Transformation Plan. In particular, this MoU is intended to support the Parties' ongoing work towards the transformation of corporate services across North Mersey.

2. The Parties have agreed to collaborate to bring together NHS Trusts, NHS Foundation Trusts and Clinical Commissioning Groups to deliver region wide, efficient and consolidated corporate services that best support front line staff in delivering quality patient care. The Parties have together formed a North Mersey Committee in Common (**"NM CiC"**) which has the specific remit of overseeing a system wide collaboration programme to define and deliver consolidated opportunities in relation to corporate services, the intention being to deliver a system model that is coherent, integrated, consistent (reducing unwanted variation) and focussed on quality and value for money (the **"NM Collaborative Programme"**).

3. This MoU is focussed on the Parties' agreement to develop the detail in relation to the function and scope of the NM CiC, developing the principles that will underpin collaborative working and the timetable for implementation in order to tackle a number of significant operational and financial challenges for collaborative corporate services across North Mersey.

Drafting Note 1

The recitals set out key background to the transaction. Whilst they do not have substantive legal effects on the agreement, it is a good place to rehearse the positive long term objectives of the project.

OPERATIVE PROVISIONS

1. Definitions and interpretation

1.1 In this MoU, capitalised words and expressions shall have the meanings given to them in this MoU.

1.2 In this MoU, unless the context requires otherwise, the following rules of construction shall apply:

1.1.1 a reference to a "**Party**" is a reference to a party to this MoU and includes its personal representatives, successors or permitted assigns and a reference to "**Parties**" is a reference to all parties to this MoU;

1.1.2 a reference to writing or written includes faxes and e-mails.

2. Purpose and effect of MoU

2.1 The Parties have agreed to work together on the development and delivery of more consolidated and collaborative corporate services in line with the Five Year Forward View. The aim is for the Parties to jointly and collaboratively organise their combined corporate function rather than delivering corporate services at an individual organisational level [as detailed in Schedule [x]]. The Parties wish to record the basis on which they will collaborate with each other in this MoU.

2.2 This MoU sets out:

2.2.1 the key objectives for the development of NM ;

2.2.2 the principles of collaboration;

2.2.3 the governance structures the Parties will put in place; and

2.2.4 the respective roles and responsibilities the Parties will have during the development and delivery of the collaboration model.

2.3 The Parties agree that, notwithstanding the good faith consideration that each Party has afforded the terms set out in this MoU, save as provided in paragraph 2.4 below, this MoU shall not be legally binding.

2.4 Paragraphs 15, 17 and 18 shall come into force from the date hereof and shall give rise to legally binding commitments between the Parties.

Drafting Note 2

The MoU is drafted so that it is not legally binding save as to its governing law, the ability to complete the document by each party signing a copy of the MoU rather than each signing the same document and the fact that all Parties bear their own costs. Agreeing terms in the MoU will, however, have moral force in binding Parties to what has been agreed and therefore careful consideration should be given to the terms set out in the document before signing.

Drafting Note 3

The Parties should consider whether, in addition to the MoU, additional documents are required to manage their relationships and the sharing of information between them. Such additional documents might include:

(i) a standalone confidentiality agreement;

(ii) a protocol to manage conflicts of interest; and/or

(iii) a protocol to manage the sharing of information in accordance with competition law requirements.

The Parties should also consider whether this MoU should be expressed as subject to any other documents.

3. Key Objectives

3.1 The Parties shall undertake the development of the NM Collaborative Programme to achieve the key objectives set out in Schedule [x] (the "**Key Objectives**").

3.2 The Parties acknowledge the current position with regard to the NM Collaborative Programme [and the contributions already made] as set out in Schedule [x].

4. Principles of collaboration

4.1 The Parties agree to adopt the following principles when carrying out the development and delivery of the NM Collaborative Programme (the "Principles"):

4.1.1 address the vision. In developing the NM Collaborative Programme the Parties seek to address the aims of the Forward View, delivering best value for the taxpayer and operating a financially sustainable system;

4.1.2 collaborate and co-operate. Establish and adhere to the governance structure set out in this MoU to ensure that activities are delivered and actions taken as required to deliver change collectively and in partnership with the local authority and the wider NHS ;

4.1.3 be accountable. Take on, manage and account to each other, the wider NHS and the North Mersey population for performance of the respective roles and responsibilities set out in this MoU;

4.1.4 be open and transparent. Communicate openly with each other about major concerns, issues or opportunities relating to the NM Collaborative Programme and comply with the seven Principles of Public Life established by the Nolan Committee (the Nolan Principles) and where appropriate the NHS Foundation Trust Code of Governance (as issued by Monitor and updated in July 2014) including implementing a transparent and explicit approach to the declaration and handling of relevant and material conflicts of interests arising;

4.1.5 adhere to statutory requirements and best practice. Comply with applicable laws and standards including procurement rules, competition law, data protection and freedom of information legislation;

4.1.6 act in a timely manner. Recognise the time-critical nature of the NM Collaborative Programme development and delivery and respond accordingly to requests for support;

4.1.7 manage stakeholders effectively; Ensure communication and engagement internally and externally is clear, coherent, consistent and credible and in line with the Parties' statutory duties, values and objectives;

4.1.8 deploy appropriate resources. Ensure sufficient and appropriately qualified resources are available and authorised to fulfil the responsibilities set out in this MoU; and

4.1.9 act in good faith to support achievement of the Key Objectives and compliance with these Principles.

5. Governance and reporting

5.1 The governance structure defined in the Project Initiation Document ("**PID**") and summarised below and at Schedule [x] of this MoU provides a structure for the development and delivery of the NM Collaborative Programme.

5.2 The governance arrangements will be:

5.2.1 based on the principle that decisions will be taken by the relevant organisations at the most appropriate level in accordance with each organisation's internal governance arrangements, in particular in respect of delegated authority;

5.2.2 shaped by the Parties in accordance with existing accountability arrangements, whilst recognising that different ways of working will be required to deliver the transformational ambitions of the NM Collaborative Programme. The Parties intend that there should be as far as permissible a single governance structure to help oversee and deliver the NM Collaborative Programme and the delivery of the Key Objectives;

5.2.3 underpinned by the following principles:

(I) the Parties will remain subject to the NHS Constitution and Mandate and retain their statutory functions and their existing accountabilities for current resources and funding flows;

(II) clear agreements will be in place between the CCG and any of the providers to underpin the governance arrangements as set out in the PID.

5.3 The governance arrangements will be reviewed [at each [monthly x] meeting] to ensure that the key deliverables are being delivered within the timeline set out in the PID and subsequent workplans

Drafting Note 4

The Parties should consider what governance structures are currently used and what additional arrangements should be put in place between them in order to progress key workstreams and the project as a whole, including allowing appropriate oversight from a governance perspective.

The governance structures should include clearly defined roles and responsibilities and should be aligned with the Project scope and the Principles. We would recommend that the structure should avoid over complexity and bureaucracy.

As providers and commissioners are involved in discussions there should be consideration of additional elements such as any procurement implications and ensuring that the limitations of the respective roles of the parties are respected.

6. Roles, Responsibilities and Reporting

6.1 The Parties shall undertake the roles and responsibilities set out in the PID to help develop the NM Collaborative Programme and meet the Key Objectives.

North Mersey Committee in Common ("NM CiC")

6.2 The NM CiC comprises senior members of the Parties and provides overall strategic oversight and direction to the development of the NM Collaborative Programme. It is chaired by [x] and will consist of [x]

6.3 The NM CiC will receive reports at each meeting from the [x] highlighting but not limited to:

6.3.1 progress throughout the period;

6.3.2 decisions required by the NM CiC;

6.3.3 issues being managed;

6.3.4 escalation of issues to the NM CiC; and

6.3.5 progress planned for the next period.

6.4 The NM CiC shall be managed in accordance with the governance arrangements in Section 5 and the Terms of Reference in Schedule [x]

North Mersey Programme Group/CST Design Group ("x")

6.5 The [x] will be led by [x] and will provide management at programme and workstream level. It will provide assurance to the NM CiC that the key deliverables are being met and that the development of the NM Collaborative Programme is within the boundaries set by the NM CiC.

6.6 As well as [x], the [x] consists of [x] The [x] shall have responsibility for the execution of the programme plan and deliverables, and therefore it can draw technical, commercial, legal and communications resources as appropriate into the [x].

6.7 The [x] shall be managed in accordance with the terms of the PID and its Terms of Reference at Schedule [x].

7. Decision Making

7.1 The Parties intend that NM CiC members will each operate under a common model scheme of delegation whereby each member will have delegated authority to make decisions on behalf of their organisation relating to matters falling under the scope of the NM CiC and the NM Collaborative Programme.

8. Escalation

8.1 If any Party has any issues, concerns or complaints about the development and delivery of the NM Collaborative Programme, or any matter in this MoU, such Party shall notify the other Parties and the Parties acknowledge and confirm that they shall then seek to resolve the issue by a process of discussion.

8.2 Subject as otherwise specifically provided for in this MoU, any dispute arising between the Parties out of or in connection with this MoU will be resolved in accordance with Schedule 3 (Dispute Resolution Procedure).

8.3 If any Party receives any formal inquiry, complaint, claim or threat of action from a

third party (including, but not limited to, claims made by a supplier or requests for information made under the Freedom of Information Act 2000) in relation to the NM Collaborative Programme, the matter shall be promptly referred to [x] in the interests of consistency and with recognition that the request remains the responsibility of the receiving Party.

9. Conflicts of interest

9.1 The Parties agree that they will:

9.1.1 disclose to each other the full particulars of any real or apparent conflict of interest which arises or may arise in connection with this MoU or the development and delivery of the NM Collaborative Programme, immediately upon becoming aware of the conflict of interest whether that conflict concerns the Parties or any person employed or retained by the Parties for or in connection with the development and delivery of the NM Collaborative Programme; and

9.1.2 not allow themselves to be placed in a position of conflict of interest or duty in regard to any of their rights or obligations under this MoU (without the prior consent of the other Parties) before participating in any action in respect of that matter.

10. Future involvement and addition of Parties

10.1 The Parties are the initial participating organisations in the development of the NM Collaborative Programme but it is intended that other providers to the North Mersey population may also be partners (including for example independent sector and third sector providers). Partner organisations may where appropriate be invited to meetings of the Programme Board as observers or through an additional stakeholders forum. If appropriate to achieve the key deliverables, the Parties may also agree to include additional party or parties to this MoU. If they agree on such a course the Parties will cooperate to enter into the necessary documentation.

11. Competition and Procurement compliance

11.1 The Parties recognise that it is currently the duty of the CCG as commissioner, rather than the providers, to decide what services to procure and how best to secure them in the interests of patients. In addition, the Parties are aware of their competition compliance obligations, both under competition law and, in particular under the Monitor Provider Licence for providers, and shall take all necessary steps

to ensure that they do not breach any of their current or future obligations in this regard. Further, the Parties understand that in certain circumstances collaboration or joint working could trigger the merger rules and as such be notifiable to the Competition and Markets Authority and Monitor and will keep this position under review accordingly.

12. Review

12.1 A formal review meeting of the NM CiC shall take place 6 months after the date of signature of this MoU.

12.2 The Programme Board shall discuss as a minimum:

12.2.1 the principles of collaboration;

12.2.2 the governance structures as set out in the PID;

12.2.3 12.2.3 the scope of the NM Collaborative Programme.

13. Term and Termination

13.1 This MoU shall commence on the date of signature by all the Parties, and shall expire on the earlier of the execution of a formal legally binding agreement between the Parties in connection with the delivery of the NM Collaborative Programme or [x].

13.2 Any Party may withdraw from this MoU by giving at least 30 calendar days' notice in writing to the other Parties.

Drafting Note 9

While the MoU is not legally binding, it is a good discipline for the Parties to consider a formal mechanism for termination of discussions. This approach requires Parties to commit fully to the process and to consider the terms of the MoU more carefully.

14. Variation

14.1 This MoU, may only be varied by written agreement of the Parties signed by, or on behalf of, each of the Parties.

15. Charges and liabilities

15.1 Except as otherwise provided, the Parties shall each bear their own costs and

expenses incurred in complying with their obligations under this MoU including in respect of any losses or liabilities incurred due to their own or their employee's actions.

15.2 No Party intends that any other Party shall be liable for any loss it suffers as a result of this MoU.

Drafting Note 10

The drafting anticipates that each Party shall be responsible for its own costs and liabilities. To the extent that the Parties have agreed joint funding of the initial stages of the Project, or that they will underwrite liabilities to some extent, then this drafting should be amended.

16. No partnership

16.1 Nothing in this MoU is intended to, or shall be deemed to, establish any partnership or joint venture between the Parties, constitute any Party as the agent of another Party, nor authorise any of the Parties to make or enter into any commitments for or on behalf of the other Parties.

17. Counterparts

17.1 This MoU may be executed in any number of counterparts, each of which when executed and delivered shall constitute an original of this MoU, but all the counterparts shall together constitute the same agreement.

17.2 The expression “counterpart” shall include any executed copy of this MoU transmitted by fax or scanned into printable PDF, JPEG, or other agreed digital format and transmitted as an e-mail attachment.

17.3 No counterpart shall be effective until each Party has executed at least one counterpart.

18. Governing law and jurisdiction

18.1 This MoU shall be governed by and construed in accordance with English law and, without affecting the escalation procedure set out in paragraph 8, each Party agrees to submit to the exclusive jurisdiction of the courts of England.

We have signed this Memorandum of Understanding on the date written at the head of this memorandum.

SIGNED by	)	.....
Duly authorised to sign for and on	)	Authorised Signatory
behalf of	)	Title:
ALDER HEY CHILDREN'S NHS		
FOUNDATION TRUST	)	DATE:

SIGNED by	)	.....
Duly authorised to sign for and on	)	Authorised Signatory
behalf of	)	Title:
AINTREE UNIVERSITY HOSPITALS		
NHS FOUNDATION TRUST	)	DATE:

SIGNED by	)	.....
Duly authorised to sign for and on	)	Authorised Signatory
behalf of	)	Title:
LIVERPOOL COMMUNITY HEALTH		
NHS TRUST	)	DATE:

SIGNED by	)	.....
Duly authorised to sign for and on	)	Authorised Signatory
behalf of	)	Title:
LIVERPOOL HEART AND CHEST		
HOSPITAL NHS FOUNDATION TRUST	)	DATE:

SIGNED by	)	.....
Duly authorised to sign for and on	)	Authorised Signatory
behalf of	)	Title:
LIVERPOOL WOMEN'S NHS		
FOUNDATION TRUST	)	DATE:

SIGNED by	)	.....
Duly authorised to sign for and on	)	Authorised Signatory
behalf of	)	Title:
MERSEY CARE NHS FOUNDATION		
TRUST	)	DATE:

SIGNED by	)	.....
Duly authorised to sign for and on	)	Authorised Signatory
behalf of	)	Title:
NHS KNOWSLEY CLINICAL		
COMMISSIONING GROUP	)	DATE:

SIGNED by	)	.....
Duly authorised to sign for and on	)	Authorised Signatory
behalf of	)	Title:
NHS LIVERPOOL CLINICAL		
COMMISSIONING GROUP	)	DATE:

SIGNED by	)	.....
Duly authorised to sign for and on	)	Authorised Signatory
behalf of	)	Title:
NHS SOUTH SEFTON CLINICAL		
COMMISSIONING GROUP	)	DATE:

SIGNED by	)	.....
Duly authorised to sign for and on	)	Authorised Signatory
behalf of	)	Title:
ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST	)	DATE:

SIGNED by	)	.....
Duly authorised to sign for and on	)	Authorised Signatory
behalf of	)	Title:
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	)	DATE:

SIGNED by	)	.....
Duly authorised to sign for and on	)	Authorised Signatory
behalf of	)	Title:
WALTON CENTRE NHS FOUNDATION TRUST	)	DATE:

Schedule 1 Key Objectives

Schedule 2 Collaborative Programme Approach

Schedule 3 Dispute Resolution

Schedule 4 Decision making?

SCHEDULE 3

DISPUTE RESOLUTION PROCEDURE

1 Avoiding and Solving Disputes

1.1 The Parties commit to working cooperatively to identify and resolve issues to their mutual satisfaction so as to avoid all forms of dispute or conflict in performing their obligations under this MoU.

1.2 The Parties believe that:

(a) by focusing on their agreed Key Objectives and Principles set out in Schedule 1;

(b) being collectively responsible for all risks; and

(c) fairly sharing risk and rewards as part of the Risk/Reward Mechanism

they reinforce their commitment to avoiding disputes and conflicts arising out of or in connection with this MoU.

1.3 A Party shall promptly notify the other Parties of any dispute or claim or any potential dispute or claim in relation to this MoU or its operation (each a '**Dispute**') when it arises.

1.4 In the first instance the Project Team shall seek to resolve any Dispute to the mutual satisfaction of each of the Parties. If the Dispute cannot be resolved by the Project Team within 10 Business Days (a **Business Day** being a day other than a Saturday, Sunday or public holiday in England when banks in London are open for business) of the Dispute being referred to it, the Dispute shall be referred to the Programme Board for resolution.

1.5 The Programme Board shall deal proactively with any Dispute on a “Best for Services in North Tyneside” basis in accordance with this MoU so as to seek to reach a majority decision. If the Programme Board reaches a decision that resolves, or otherwise concludes a Dispute, it will advise the Parties of its decision by written notice. The Parties recognise that any dispute or operation of this procedure will be without prejudice to and will not affect the statutory duties of each Party. This MoU is

not intended to be legally binding and, given the status of this MoU (as set out in clause 2), if a Party disagrees with a decision of the Programme Board or the independent facilitator, they may withdraw from the MoU at any point in accordance with clause 12.

1.6 If a Party does not agree with the decision of the Programme Board reached in accordance with paragraph 1.5 above, it shall inform the Programme Board within 10 Business Days and request that the Programme Board refer the Dispute to either the CCG or an independent facilitator in accordance with paragraph 1.7(a) below.

1.7 The Parties agree that the Programme Board, on a Best for Services basis, may determine whatever action it believes is necessary including the following:

(a) If the Programme Board cannot resolve a Dispute, it may request that the CCG (or if this is not felt appropriate select an independent facilitator to) assist with resolving the Dispute; and

(b) If an independent facilitator is selected then they shall:

(i) be provided with any information he or she requests about the Dispute;

(ii) assist the Programme Board to work towards a consensus decision in respect of the Dispute;

(iii) regulate his or her own procedure and, subject to the terms of this MoU, the procedure of the Programme Board at such discussions;

(iv) determine the number of facilitated discussions which must take place within 20 Business Days of the independent facilitator being appointed; and

(v) have its costs and disbursements met by the Parties.

(c) If the independent facilitator cannot facilitate the resolution of the Dispute, the Dispute must be considered afresh in accordance with this Schedule and only after such further consideration again fails to resolve the Dispute, the Programme Board may decide to:

(i) terminate the MoU; or

(ii) agree that the Dispute need not be resolved.

NORTH MERSEY LOCAL DELIVERY SYSTEM

'CORPORATE SERVICES TRANSFORMATION DESIGN GROUP'

PROPOSAL FOR COLLABORATION & GOVERNANCE ARRANGEMENTS

Executive summary

INTRODUCTION

The Five Year Forward View (5YFV) sets out significant transformational change for clinical care and services, with commitment to a better NHS through increased engagement with patients and patient groups, clinicians, local communities and frontline NHS leaders.

Clinical services will require the right type of support at the right time from re-designed corporate services (back office) to enable the transformation of clinical care in a realistic and sustainable way. So whilst it is important to drive out cost from corporate services, the focus must be on providing customer focused, 'fit for purpose' future models for corporate services, agile and capable of meeting the changing needs of services and organisations.

The purpose of this report is a proposal for collaboration between the member organisations of the North Mersey Local Delivery System (LDS) to deliver transformational change across corporate services led by the NM LDS Corporate Services Transformation Design Group reporting to the Cheshire & Merseyside (C&M) Back Office Programme Board under defined governance arrangements. Following legal advice, the proposed governance arrangements are as a 'Committee in Common' under a Memorandum of Understanding signed by each member organisation.

The Trust Board are asked to approve the above proposal for collaborative working to deliver transformational change across corporate services, and agree the Memorandum of Understanding.

BACKGROUND

The Five Year Forward View (5YFV) sets out how the health service needs to change, arguing for a more engaged relationship with patients, carers and citizens so that we can promote wellbeing and prevent ill-health. It represents the shared view of the NHS' national leadership, and reflects an emerging consensus amongst patient groups, clinicians, local communities and frontline NHS leaders. It sets out a vision of a better NHS, the steps we should now take to get us there, and the actions we need from others.

The 5FYFV Executive summary highlights the following:

- The NHS has dramatically improved over the past fifteen years.
- there is now quite broad consensus on what a better future should be
- radical upgrade in prevention and public health
- when people do need health services, patients will gain far greater control of their own care
- the NHS will take decisive steps to break down the barriers in how care is provided
- England is too diverse for a 'one size fits all' care model to apply everywhere. But nor is the answer simply to let 'a thousand flowers bloom'
- **Create integrated out-of-hospital care - the Multispecialty Community Provider**
- **Primary and Acute Care Systems**
- **Urgent and emergency care**
- **Smaller hospitals will have new options to help them remain viable**
- **Specialised Care**

- **Midwives will have new options to take charge of the maternity services they offer**
- **The NHS will provide more support for frail older people living in care homes**
- In order to support these changes, the national leadership of the NHS will need to act coherently together, and provide meaningful local flexibility
- We will improve the NHS' ability to undertake research and apply innovation
- it suggests that there are viable options for sustaining and improving the NHS over the next five years, provided that the NHS does its part, allied with the support of government, and of our other partners, both national and local

The seven lines in **bold are 'New Models of Care'** explained at pp. 20-26 of the 5YFV. Sustainability & Transformation Plans (STPs) are a delivery mechanism for the 5YFV, they are the practical expression of the belief that one of the most powerful ways to achieve change is by working together – across entire communities and pathways of care – to find ways to close the gaps between where we are now and where we need to be in 2020/21.

NATIONAL CONTEXT

The organisations within the NM Local Delivery System have agreed to work together to define the collaborative opportunities and creative alternatives to corporate services given the significant national drivers for change within the back office function. These are;

- Meeting the Carter target of rationalising corporate and administrative functions to ensure costs do not exceed 7% of income by April 2018, and 6% of income by 2020
- Considering the use of NHS Estate to maximise the space required by corporate services within the overall local NHS footprint,
- Commit to the Department of Health's NHS Procurement Transformation Programme (PTP) to provide increased transparency and a reduction of at least 10% in non-pay costs by April 2018;
- Delivering efficiency savings over the next 12-18 months and establishing a platform for sustainability within individual organisations
- Working with NHS Improvement & Cheshire & Merseyside STP organisations to seek opportunities for wider collaboration and consolidation

LOCAL CONTEXT
Cheshire & Merseyside Back Office Programme Board - Reducing Cost through Back Office Productivity

Following the C&M STP submission to NHSI in July 2016, discussions were held on how collaboration and consolidation of corporate services could move forward which were set out in the Corporate Services 'Case for Change' submission in October. The following vision, scope and values have been agreed by the C&M Back Office Programme Board, together with suggested 'Priorities for Action'. There is a requirement for LDS partners to decide how this is taken forward at LDS level, with a view to scaling up to STP.

Vision
The Cheshire & Merseyside Vision for Collaborative Productivity is to deliver cost effective, efficient and commercially sustainable Back Office operations to support front-line staff in delivering quality patient care.

Scope
For all Back Office services, the ambition is to collaborate at STP level, but to build to this capability in phases, recognising the organisational and operational challenges of working together at scale and across a complex footprint. The projects that will deliver are to be prioritised on the basis of deliverability, scale of benefit and time to transform.

Values

1. Reducing spend in the Back Office will enable additional spend and effort to be pushed towards front-line services.
2. Cost reduction in the Back Office is a key driver of change, but the programme must also deliver increased customer services and better user experience, reducing the time and effort clinical staff spend interacting with non-patient facing services.
3. Existing good practice in the STP footprint will be shared and form the minimum benchmark for improvement.
4. Notwithstanding this, however, national examples of best practice should form the basis of the collaborative approaches where appropriate for the local system.
5. Where appropriate, the programme will seek to maintain the Back Office activities within the NHS to provide job security and wider economic benefit to the communities in Cheshire & Merseyside.
6. For all functional Back Office services, the assumption is collaboration at STP level and narrower approaches than this will only be agreed by exception.
7. Be Agile enough to meet changing needs to services/organisations.

C&M Corporate Services – 'Priorities for Action'

Finance	HR	Procurement	Payroll
•Financial Accounts •Income Planning •Management Account •AR & AP •Internal Audit •Commercial	•Recruitment •Workforce Analytics •Business Partners •Staff Bank •L&D (inc Training) •Comms & Engagement •Occupational Health	•Buying Teams •Contract management •Catalogue management •Materials management •Strategic procurement	•Payroll
IM & T	**Legal**	**Estates & Facilities**	**Governance & Risk**
•Maintenance Team •Support Desk •Informatics Team •Telephony	•Legal Services •Complaints Handling	•Estates & Facilities •Health, fire & Safety	•Governance & Risk

North Mersey LDS - Corporate Services Transformation Design Group

Discussions held as a part of the Healthy Liverpool Programme between health providers and commissioners in the Liverpool City Region have indicated significant interest in collaborative delivery of corporate services. This recognises the broader financial challenge, the rapidly shifting NHS environment, the need to be fit for the future given broader STP discussions and the requirement to align with the Carter recommendation that incremental efficiencies can be delivered through the establishment and proper use of shared services.

The 12 organisations in the NM LDS are;

Alder Hey Children's NHS Foundation Trust
Aintree University Hospitals NHS Foundation Trust
Liverpool Community Health NHS Trust
Liverpool Heart & Chest Hospital NHS Foundation Trust
Liverpool Women's NHS Foundation Trust
Mersey Care NHS Foundation Trust

Royal Liverpool & Broadgreen University Hospitals NHS Trust
The Clatterbridge Cancer Centre NHS Foundation Trust
The Walton Centre NHS Foundation Trust
Knowsley CCG
Liverpool CCG
South Sefton CCG

Aidan Kehoe is the NM LDS lead for back office, and under the direction of the C&M STP lead for back office (Nik Khashu). The NM LDS Corporate Services Design Group was set up in October 2016 and reports to the C&M Back Office Programme Board. Membership of the NM LDS includes all DoFs and HRDs from all organisations. Terms of reference are attached.

The design group have achieved the following to date;

- Terms of Reference, vision & values agreed with mirror the C&M STP
- Leads identified for 6 work streams *(HR, Finance, IT, Legal & Governance, Procurement, Estates & Facilities)*
- 'As is' scoping exercise completed for all work streams
- 'First cut' priorities identified - transactional & 'quick wins'- procurement, training OH & payroll.
- Shared 'first cut' benchmarking data across LDS
- Keeping clear link between LDS priorities and streamlining work
- Key messages to staff and trade unions underway
- Agreed to appoint a shared Programme Manager to drive delivery

The group are in the initial diagnostic phase. Further work is required to identify transformational, transactional and 'quick win' opportunities through the appointment of a Programme Manager and development of PID(s).

By taking this approach the partner organisations will have an agreed view of collaboration opportunities and a defined roadmap through which collaboration opportunities will be progressed.

COMMITTEE TERMS OF REFERENCE	
Committee Name:	Corporate Services Transformation (CST) Design Group
Constitution:	CST Design Group will act as the programme Board for the North Mersey LDS Corporate Services Transformation Programme.
Purpose:	By working collaboratively the CST Design Group will oversee all designs and deliverables that are produced. It will report progress to the C&M STP for validation of major outputs, highlighting opportunities for wider collaboration. The CST Design Group will recommend the future design and plans for agreement by individual organisational Boards.
Membership:	The Committee shall be composed of: • Programme Senior Responsible Officer (Chair) • Programme Lead and Programme Support • HR & Finance Director level membership for all participating organisations **NB:** Fully briefed Deputies are able to represent Directors • Other Directors may be invited as and when required
Attendance:	Meetings of the Committee will routinely be attended by: • Programme Senior Responsible Officer (Chair) • Programme Lead • Director level membership for all participating organisations The Committee will invite additional attendees dependent upon the agenda items.
Quorum:	A quorum shall be at least 4 of the member organisations present.
Frequency:	Meetings will be held monthly
Duties:	• Oversee the design of the vision, infrastructure and ways of working for Corporate Services. This includes agreeing the definitions of the capabilities and functions required. • Oversee the development of a cross organisational Project Initiation Document (PID) to track and measure success, including staff engagement and communication plans. • Oversee the development of programme deliverables including the designs, implementation plans and business validated by identified design leads from supporting each work stream. • Ensure that 'bottom up' designs are consistent with the 'top down' agreed ways of working for Corporate Services. • Align changes happening within the LDS, STP and individual organisations, spotting opportunities and constraints • Oversee the development of a Corporate Services Strategy and service line agreements (SLAs). • Design organisational structures for cross-organisation/cross functional or retained organisation Corporate Services • Oversee the staff consultation process, and review and provide advice on materials and communications • Members are required to attend meetings and participate openly and transparently, with the purpose of the meeting mind
Sub Committees/Group	TBC
Reporting Arrangements:	• Key points from the Design Group will be escalated to C&M STP as appropriate • Key points will also be shared with the North Mersey Leadership Group to ensure effective communications and governance.
Date Ratified by :	October 2016
Review Date	TBC

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Tuesday 9th January 2018

Report of:	Chief Nurse
Paper Prepared by:	Chief Nurse and Clinical Risk Manager
Subject/Title:	Serious Incidents Requiring Investigation
Background Papers:	n/a
Purpose of Paper:	This report summarises all the open serious incidents in the Trust and identifies new serious incidents arising in the last calendar month.
Action/Decision Required:	For information regarding the notification and management of SIRI's.
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	By 2020, we will: ➢ be internationally recognised for the quality of our care ***(Excellence in Quality)*** ➢ be recognised for the exceptional care we provide to our children, that is technologically enabled and matched by exceptional facilities ***(Patient Centred Services)*** ➢ have a fully engaged workforce that is actively driving quality improvement ***(Great Talented Teams)***
Resource Impact	n/a

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1. Background:

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

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

Safeguarding children cases reported through StEIS are included in this report. Since 2017 NHS England have additionally requested that the Trust report Sudden Unexpected Deaths in Infancy (SUDI) and Sudden Unexpected Deaths in Childhood (SUDC) Cases onto the StEIS Database.

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

2. SIRI performance data:

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

3. Recommendations:

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

New SIRI Incidents reported between the period 01/11/2017 to 30/11/2017:								
Reference Number	**Date investigation started**	**Division**	**Incident Description**	**RCA Lead Investigator**	**72 hour review completed/ immediate actions taken and shared learning**	**Progress**	**60 working day compliance**	**Duty of Candour/ Being Open policy implemented**
StEIS 2017/27996	10/11/2017	Surgery	Patient transferred to the Trust on 11/07/17, at the time of the incident the patient was on the sepsis pathway. Patient had a blood gas taken on the 08/11/17 at 02:58, patient had a repeat blood gas taken and temperature spiked at 04:15. Patient's saturations and heart rate subsequently dropped and arrest team called at 04:35. Concern raised that blood results not acted on in a timely manner.	James Ashton, Sepsis Nurse Specialist	Yes – immediate actions taken: 1. The cardiology team cascaded to all cardiology medics, that they must review all abnormal results in person. 2. Ward manager instructed all nursing staff to escalate any concerns about patient management to the consultant on call. Lessons learned: 1. Nursing staff to escalate child's condition to consultant if they disagree with review. 2. Staff to follow the sepsis guidelines. 3. Cardiology Registrar to review patients with abnormal results in person as per sepsis policy.	Relevant investigation gathered and timeline produced. RCA panel meeting held 18/12/17. Report to be written.	Yes	Yes

New Safeguarding investigations reported 01/11/2017 to 30/11/2017: For information							
Reference Number	**Date investigation started**	**CBU**	**Incident Description**	**RCA Lead Investigator**	**Progress**	**60 working day compliance**	**Being Open policy implemented**
Nil							

On-going SIRI incident investigations (including those above)							
Reference Number	**Date investigation started**	**Division**	**Incident Description**	**RCA Lead Investigator**	**Progress**	**60 working day compliance (or within agreed extension)**	**Duty of Candour/ Being Open policy implemented**
2017/ 24137	29/09/2017	Medicine	Suboptimal care of deteriorating patient. Query sepsis pathway not followed. Complex patient with co-morbidities, known to Trust, attended for renal dialysis.Patient attended on 18/06/17, query septic during admission, staff recorded not concerned about the risk of sepsis and patient discharged as no clear cause of pyrexia. Patient returned 19/06/17 acutely unwell, patient transferred to PICU and sadly died on 23/06/17.	Andrew Riordan, Consultant in Paediatric Infectious Diseases, Jeanette White, Matron, Amanda Turton, Head of Acute Care	RCA report in final quality check stage. Following approval, report to be signed off by Chief Nurse/Medical Director.	Yes	Yes

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

SIRI incidents closed since last report						
Reference Number	Date investigation started	CBU	Incident Description	RCA Lead Investigator	Outcome	Duty of Candour/Being open policy Implemented
StEIS 2017/ 23222	19/09/2017	Surgery	Suspension of PDA stent service following near miss but well managed decomposition of a PDA stent and following previous incident in which a patient died (latter incident reported to StEIS previously, ref: StEIS 2017/9948).	Phil Raymond, Service Manager	Final report sent to CCG.	N/A – no harm caused to patients.
RCA 333 2016/17 **Internal**	28/03/2017	Medicine	The patient was brought to ED in November 2016 as an emergency with seizures and hypertension. Despite resuscitation and intensive care she died 2 days later. Subsequent post-mortem has revealed previously undiagnosed structural kidney disease which is the likely cause of the malignant hypertension. The child had presented to ED in June 2013 and October 2015 with a diagnosis of Bell's Palsy. Blood pressure should have been recorded on each of these occasions but was not recorded.	Amanda Turton, Head of Acute Care	Final report sent to family.	Yes

Safeguarding investigations closed since last report
Nil

Alder Hey Children's NHS
NHS Foundation Trust

Clinical Quality Assurance Committee
Minutes of the last meeting held on Wednesday 15th November 2017
10.00 am, Room 20, Institute in the Park

Present:	Anita Marsland	(Chair) Non-Executive Director
	Jeannie France-Hayhurst	Non-Executive Director
	Pauline Brown	Director of Nursing
	Rachel Greer	Associate COO - Community
	Hilda Gwilliams	Chief Nurse
	Lachlan Stark	Head of Planning and Performance
	Steve Ryan	Medical Director
	Erica Saunders	Director of Corporate Affairs
	Glenna Smith	General Manager – Medicine
	Adam Bateman	Acting Chief Operating Officer
	Tony Rigby	Deputy Director of Risk & Governance
	Melissa Swindell	Director of HR
	John Grinnell	Director of Finance
	Dame Jo Williams	Non-Executive Director
	Anne Hyson	Head of Quality - Medicine
	Sarah Stephenson	Head of Quality – Community
	Cathy Umbers	Associate Director of Nursing & Governance
	Will Weston	Associate Chief of Operations
	Sue Brown	Associate Director Estates

In Attendance

	Valya Weston	Head Service/ Associate DIPC
	David Porter	Consultant in Paediatrics, Infection and Immunology
	Julie Creevy	Executive Assistant (Minutes)

17/18/70 Apologies:

Louise Shepherd	Chief Executive
Mags Barnaby	Interim Chief Operating Officer
Julie Williams	Appointed Governor
Steve Igoe	Non-Executive Director
Mark Peers	Public Governor
Cathy Wardell	Associate Chief Nurse
David Walker	Interim Head of Quality - Surgery
Adrian Hughes	Director, Medicine Division

17/18/71 Declaration of Interest
None declared

17/18/72 Minutes of the previous meeting held on 18th October 2017
Resolved:

CQAC approved the minutes of the previous meeting held on 18th October 2017.

17/18/73 Maters Arising and Action Log

17/18/09 – *Confidential Enquiries – 'Finalisation agreement required between Trust Lead and Medical Records for future data requests'*. It was agreed that Cathy Umbers and Sarah Stephenson will meet offline, to ensure sufficient process is put in place for support going forward.

17/18/44 – *Clinical audit support for audits within the Trust.* Sarah Stephenson confirmed that a meeting with Mags Barnaby, Erica Saunders and herself had not yet taken place; the meeting to be progressed as soon as diaries permit November/December.

Action: SS to agree meeting date to progress this issue further.

Quality Metrics Update

Lachlan Stark confirmed that a number of meetings had taken place to scope out the process for bespoke quality metrics. LS had met with the business intelligence team; a number of senior leads had been identified. The aim is to have a format sign off during December 2017 with test phase during February 2018 and full roll out at the end of March 2018. CQAC agreed to review developments.

Action: LS to share detailed presentation with CQAC members.

Discussion took place regarding the Well Led Review and whether it would be beneficial for a position statement/mock up for December CQAC meeting, all agreed to obtain a position statement of development phase for next meeting.

AM thanked LS for his update.

17/18/74 Review of Clinical investigations in Meditech

Nik Barnes provided a position statement regarding the Review of Clinical investigations.

NB provided background detail as to why the notices were not used universally at Alder Hey. NB shared the new results process, together with the details regarding dependencies, together with details regarding a proposal for 'go live' dates.

Discussion took place on the benefit of education and awareness and ensuring a 'mini' specialty package is incorporated as part of the GDE programme.

Discussion ensued regarding ensuring that an appropriate process is in place enabling robust monitoring mechanisms to be included into the management of results and notices, whilst also recognising any associated risks. The aim would be to have generic information in place by end March,

resulting in a positive position to move forward, whilst acknowledging that ownership at team level would be required.

Action: NB sought assistance from SR to enable a letter of support to be generated.

Action: Committee agreed that it would be beneficial for NB to meet offline with SR/HG/AB to agree next steps in order to formulate an action plan to enable CQAC to review at December CQAC meeting.

AM thanked NB for his update and his continued support with regards to the Review of Clinical investigations.

Action: NB to meet offline with SR & HG to progress further.

17/18/75 CQC Action Plan

ES provided an update. ES expressed thanks to Pauline Brown and Cathy Umbers for populating the action plan and ensuring a robust response had been made to CQC. Pauline Brown confirmed that all areas within the Trust had fully contributed towards the plan. Further discussion was required at Trust Board in December 2017. ES confirmed that the ratings review request had been submitted and the CQC would respond within 50 days.

Upgrading for Surgery in the Caring domain had been agreed. The issue remained regarding the ratings in the safe domain for medicine and surgery.

ES confirmed that the new Head of Hospital Inspection for the North, Nicolas Smith, wad due to visit the Trust on 17th November.

The Trust had received a Routine Provider Information Request, which included a significant amount of data which required submission to CQC by 4th December; the information request covers all key lines of enquiry.

Action: RG requested copy of LCH Action Plan to be sent to RG & SS - ES agreed to forward action plan.

Discussion took place regarding tracking and whether a visual element should be included within the CQC Action Plan to strengthen assurance/tracking All agreed that it would be beneficial for CQAC to receive an action plan/outcomes report, whilst ensuring that an evidence column is included to review assurance by CQAC, report to be provided to CQAC on a monthly basis.

Action: Updated action plan to be shared at December CQAC meeting.

AM thanked ES for her update.

17/18/76 Sepsis Update

Dr David Porter provided his monthly sepsis update.

Key achievements are as follows:

- Meditech Sepsis pathway – 13th March 2017
- Nursing training – 99% staff trained during March 2017
- Raised profile of Sepsis
- Medical training – induction, mandatory training and e-learning during April 2017
- Sepsis nurses in post – delivering training, induction, ad-hoc
- Ward and ED liaison
- Clinical governance/case review
- Pathway form completions 14% → 84%
- CQUIN submissions made Quarter 1 & Quarter 2 – July 2017
- GOSH visit – September 2017

CQAC noted key challenges detailed below:

- Fully mitigating the risk
- Residual unpreventable morbidity/mortality
- Preventable: recognising and treating optimally could be a major challenge
- Framework – training/monitoring

Highly Complex:

- Imperfect diagnostics
- Clinical judgement, evolving scenario
- Missed/delayed treatment versus antimicrobial use, diverted
- Discussion took place regarding ED – bypassing pathway .
- ED – October 2017 – 30 patients treated for sepis
- 28 sepsis concerns were raised in October – 11 treated in ED
- 19 of 30 treated did not receive a sepsis concern (10 red flag)

Due to – evolution of symptoms and triage – too time consuming

- Average time to antibiotics for all ED treated patients was 67 minutes
- Average time for only those with full documentation was 65 minutes
- Range : 2 minutes – 3hr 10 minutes

Challenges remain as follows:-

- Meaningful targets
- Meditech
  - Multi-disciplinary ('single') form
  - Prompts/reminders
  - Better integration (with full EPR)
  - Misleading recording of sepsis actions
- Escalation
- Informatics
  - Fragmented data/problematic linking
  - Dashboard live sepsis status
- Training – no training platform – need ESR for all
- Time/staff – Obtaining informatics/CQUIN, CQC data – time consuming for team.

17/18/77 Quarter 2 DIPC report

Valya Weston presented the Quarter 2 DIPC report, key issues as follows:

- At the end of Q2 63% (48/76) of the total of deliverables had been completed. 34% (26/76) of the total deliverables were in progress (amber). 3% (2/76) were classified as red.
- At the beginning of October 2017 a new objective had been added – Gram negative bacteraemia – this objective will look at 7 deliverables, this is due to be reported in the Quarter 3 report.
- IPC staffing – admin post for IPC team
- Hand Decontamination – hand hygiene product contract is due to conclude at the end of March 2018, intention is to complete transfer to alternative hand hygiene product by January 2018.
- New hand hygiene posters had been developed, however it was currently not the correct time to roll out, a number of posters had been placed on hand towel dispensers in the interim.er it was currently not the correct time to roll out, a number of posters had been placed on hand towel dispensers in the interim period.
- Progress had been made in terms of MSA, MRSA,Ecoli bacteraemia. Ongoing whole health economy meetings, following new guidance from NHS England, with associate DIPC attending relevant meetings.
- Action plans for surgical site infections which are incorporated into Safety Board meetings.
- VW confirmed that majority of amber deliverables within the action plan are due to the current contract, and it is envisaged that these ambers would improve once the contract has concluded.
- Staff behaviours continue to be monitored in terms of hand hygiene, VW highlighted the importance of capturing children in terms of hand hygiene. IPC team are currently working with external company to develop colourful wipes for children this initiative would be presented at IPC conference next year, this will then be rolled out to nursery's and schools.
- ANTT key trainers providing training sessions, with the introduction of stickers indicating that staff are ANTT compliant.
- IV team in process of finalising 2017 training dates
- Action Plan update for Band Negative Bacteraemia – whole health economy initiative – part of North Mersey, action plan due to be presented to Trust Board in December 2017.
- IPC Team working with Lead Nurses to develop SNAP tools, with IPC team undertaking monthly audits, linking into divisions, with increased ward visibility of IPC staff.
- 4 week programme established for Medicine division during December.

AM thanked VW for her update.

17/18/78 Quarter 2 Complaints Report/Complaints Policy

Anne Hyson, presented Quarter 2 Complaints Report (July 2017-September 2017), key issues as follows:-

- The Trust received 13 formal complaints during this period, one complaint from this quarter was subsequently withdrawn from the

process at the complainant's request. As a result of the recent divisional restructure, the PALS team are unable to provide internal benchmarking data by division to demonstrate improvements or decline in numbers of negative feedback being received. Comparison will be presented for the Trusts position.

- In 2016/17 Q2 the Trust received 17 formal complaints – this is therefore a decrease of 24%. Main category of complaints received continues to be 'Treatment/procedure (67%). This related to parents questioning whether the care their child had received is appropriate. The second category of complaints received – 'Communication/consent' (16%) – parents leave the hospital and remained unclear regarding what treatment pathway their child is receiving.

- Medicine Division continue to experience higher numbers of formal complaints in comparison – there are no themes for these complaints, they appear to relate to a variety of specialty/departmental areas within the Division.

- Report against three day acknowledgement – during Quarter 2 one complaint was not acknowledged until day 4, this delay was caused by clarification whether this issue was to be investigated as in incident using the RCA process, or as a complaint.

- CQAC agreed that emailed responses/ correspondence should be accepted going forward as a formal acknowledgement from the Trust.

Key actions & lessons learnt from PALS during Quarter 2

- The main issues identified within Q2 relate to communication issues, parents contacting the PALS office asking for clarity relating to their child's treatment plan or pathway of care. The Trust ran a new education programme in October addressing communication skills, which was well attended and had resulted in positive feedback following the event. PALS team are planning to set a further date for another session in due course.

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

Discussion took place regarding lessons learnt and how the Trust disseminated shared learning. AH confirmed that shared learning is shared with CQSG, and should be detailed on Ulysses. Shared learning for medicine division is discussed at Risk and Governance meeting, however shared learning needed further strengthening through divisions. CQSG members have divisional representatives in attendance at CQSG meetings who feedback to divisions.

CQAC discussed the potential of a trust wide learning event, CQAC agreed that this would be beneficial. CQAC noted the importance of supporting

PALS staff and acknowledged that PALS staff are dealing with complaints on a daily basis, and fully recognised the personal effect this could have on PALS staff.

Action: HG & SR together with PALS to draft proposal, to be shared at December CQAC meeting to ensure that there is shared learning from complaints, and ensuring that the patient's voice is at the forefront when dealing with complaints.

Action: CQAC agreed that shared learning should be a standard monthly agenda item at the Operational Delivery Board monthly meetings, to summarise shared learning throughout the Trust. CQAC also agreed that it would be beneficial to include at Team Brief to demonstrate evidence of shared learning.

Discussion took place regarding Community Division with regards to the devolved governance structure and the significant time to manage complaints process which is detracting staff from other priorities. Issues regarding access to appointments/delays in being seen, which is mainly due to ASD pathway, with restrictions regarding timescales of pathway. A drop in session had been established for a weekly Tuesday morning with the aim of improving issue.

Community Division are working with the CCG regarding an increase in prescription/prescribing issues regarding prescribing melatonin, with the aim to transfer this to primary care.

HG confirmed that it was appropriate for the devolved governance structure to be reviewed as the PALS process needed to be reviewed. CQAC agreed that it would be beneficial for an update on framework to be presented at December CQAC meeting.

Action: HG/RG to present update at December CQAC meeting.
AM thanked AH for her update.

17/18/79 Complaints & Concerns Policy

Anne Hyson presented the Complaints & Concerns Policy. AH & Pauline Brown had met; with relevant changes made, policy had been shared with relevant staff engaged during the discussion process.

Resolved: CQAC acknowledged that emailed Trust responses should be included as a formal method of responding and that this should be included within the policy, CQAC approved the policy.

AM thanked AH for her update.

17/17/79 Programme Assurance Update

JG presented the Programme Assurance update. Overall good progress had been made in terms of Delivering Outstanding Care. Focussed

attention continued on 'Amber' areas. Executives had been requested to share benefit realisations, together with key key performance indicators and deliverables by end of 24th November with further update at December CQAC meeting. HG confirmed that several meetings had taken place with all revalidating programmes; correct level of programme management support is in place. SR confirmed that continued attention had been given to Best in Acute care with progress made to date. CQAC envisaged viewing a different presentation at December which would define benefits.

CQAC agreed that a pre meeting regarding the Dashboard would be beneficial.

Action: JG/AM/HG and SR to have pre meeting prior to next CQAC meeting.

AM thanked JG for his update.

17/18/80 Corporate Report – Quality Metrics

Patient Experience

There were 4 formal complaints in month, i.e. 31 year to date – very similar to last year's position. Cumulatively attendances remain lower than last year, although 121 attendances in September are the highest of any month this year.

All in-patient survey measures had improved during September compared with previous month. However 4 of these measures remained behind target.

The Trust had seen an increase in play and learning. CQAC noted that There is still work to do regarding 'Planned date of discharge', with the aim to build this into GDE process, to ensure planned date of discharge is known on day 1 of admission.

Friends and Family A&E responses rate had decreased, with further assistance required from volunteers to increase numbers going forward. ES stated that the new Alder hey app would also assist with obtaining responses.

Action: ES to follow up discussion with Iain Hennessey re implementing the App.

Clinical Effectiveness

There were six recorded hospital infections in September i.e. 26 infections year to date compared with 51 at this time last year. As at September 2017 MSRA and Clostridium difficile infections remain at zero for the year. There were 5 in month acute readmissions of patients with long term conditions within 48 hours of discharge, a slight improvement on the previous month. For surgical patients with an Estimated Date of Discharge (EDD), 4.1% (72 patients) were discharged later than the EDD. This had worsened slightly

compared to last month, but is an improvement when compared to the same period last year.

Patient Safety
HG confirmed that focussed attention had been given to medicine errors, indicating improved performance. HG stated that discussions had taken place regarding 'red' indicators - readmissions to PICU had been reviewed, indicating that admissions had not been related to stay in PICU, indicating that patients had not been discharged prematurely.

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

AM thanked HG for her update.

17/18/81 Board Assurance Framework

ES presented the BAF, key issues as follows:-

- ES emphasised concern regarding 1.1. – 'Failure to maintain appropriate levels of care quality in a cost constrained environment', with continued focussed efforts to address this risk.

ES asked Committee members and Executive colleagues to thoroughly review BAF.

1.3 Well Lead, Responsive, Safe – Management Contract arrangements with Liverpool Community Health Trust - CQAC agreed that this risk should now be closed. All risks were kept on track effectively whilst undertaking the LCH acquisition process.

Action: 1.3 Risk to be removed from the BAF

AM thanked ES for her update.

17/18/83 Clinical Claims Report
Michelle Perrigo presented Clinical Claims position statement, key issues as follows:-

New Clinical Reports reported to NHSR:
1st April 2017 – 30th September 2017 – 6 new claims – (pre action/early reporting – 3 – total 9)

1st October 2016 – 31st March 2017 total new claims – 6, pre action/early learning 1 – totalling 7.

The Trust had also received 4 sets of proceedings for cases since 1.10.16 were LOC and LOR had previously been sent. There are currently 46 ongoing claims registered with NHSR.

New claims within Divisions:-

- Medical Division – 3 cases
- Surgical Division – 13 cases
- Paediatric Surgery – 6 cases
- Cardiac Surgery – 2 cases
- ENT, PICU, Cleft, Plastics, Orthopaedics – 1 cases
- ED, Radiology, Oncology – 1 case

New claims breakdown:

- Delay in diagnosis/treatment continued to be the highest new claim category; MP confirmed that there were no patterns or trends for these new claims.
- One of the new 'early notification' cases is a litigant in person.
- The Trust had participated in its first mediation in relation to a clinical claim (secondary victim proceedings), which had resulted in a settlement. A trial is also arranged for the end of November regarding this claim.
- There were 2 alleged delays in communication of results to other hospitals in the last 18 months, 1 during January 2017 – alleged failure to provide MAG 3 and DMAS results to another hospital incident date February 14 and 2 – July 16 an alleged delay in providing EEC results to another Trust incident date May 1988. A lesson learning template was shared with CQSG to highlight the need for assurance to be provided.
- A full review to identify any further trends would be undertaken and detailed in the full claims report.

Inquests:

- Since 1.10.16 the Trust had been contacted to ask for information to be provided for 14 Coroners cases. This resulted in clinicians from the Trust having to provide reports in 13 of the cases.
- Clinicians and staff had attended 2 of the Inquests to provide evidence and Hill Dickinson had also provided representation for the Trust.
- Action plans and supporting evidences of completion of lessons learnt were submitted to the Coroner for the 2 inquests that were held with staff in attendance.
- The process for supporting staff through the inquest process continued to be developed.

Progress since last report:-

- A clinical claims & Inquests action log had been produced to assist with ensuring lessons learnt which is monitored and completed within

the required timescales, this had been approved by CQSG and would be added to the work plan.

- Claims lesson learned templates are in place and completed when required. These are shared with CQSG for discussion and dissemination in the divisions.
- The first divisional quarterly ongoing claims report will be ready in December along with the claims score cards to enable the divisions to be more informed about their clinical claims and monitor trends etc.
- Medical Director had agreed the circulation of a new MD report to inform key people of new claims and inquests on a monthly basis. Statement request for claims would also now contain information on appraisal requirement in keeping with complaints.

AM thanked MP for her update.

17/18/84 Any Other Business

CU advised CQAC that the Quality Ward Round information would be shared on the afternoon of 15th November 2017, and requested committee members to urgently complete and return in order for Quality Ward Rounds for 2018 to be confirmed.

17/18/85 Date and Time of Next meeting

10.00 am – **Friday** 15th December, Institute in the Park

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

9th January 2018

Report of:	Development Directorate
Paper Prepared by:	Sue Brown
Subject/Title:	Alder Hey in the Park- Site Development update
Background Papers:	N/A
Purpose of Paper:	To update the Trust Board on development progress.
Action/Decision Required:	Acknowledge and discuss.
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Strong Foundations.
Resource Impact:	N/A

ALDER HEY IN THE PARK PROJECT

HIGHLIGHT REPORT Site & Park Development	Date: 31/10/17 Report Number: 11	Period: November 2017	SRO: David Powell Author: Sue Brown
Programme 2017/18	Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17		
Week Commencing	3 10 17 24 | 1 8 15 22 29 | 5 12 19 26 | 3 10 17 24 31 | 7 14 21 28 | 4 11 18 25 | 2 9 16 23 30 | 6 13 20 27		
Decommissioning & Demolition (Phase 1 & 2)		Programme progressing on track and advance to demolish to M/N block now agreed as part of phase one. No issues with dust have arisen, monitoring continues as per plan. The management plan is in place covering both : 1. demolition of retained estate; 2. R&E II construction, levels have remained safe to date. Removal of top ashphalt layer in main car park has been completed.
Residential		The Trust placed the consultation process on hold, ongoing discussions with Mayor Anderson and LCC planners continues. Alternative development land options being considered and tested as an alternative if the scheme cannot progress as expected.
Research & Education Phase II		Research and Education phase II build remains on track, contract with Morgan Sindellhas reached final agreement now signed off. University partners yet to sign sign off financial agreements.
Alder Centre		On Track. Dicussions and regular meetings in process and progressing with the Appointed Architect and users to refine the design.Initial planning meeting taken place between Architects and planning submitted with approval expected beginning of Febuary.
Park		The 15ft sculpture, made of UK-sourced oak from the Crown Estate has now been erected in the park. The poetry competition inviting patients/ members of the public to submit poems was extremely successful receiving 500 entries from across the world, the winning entries will be permanently displayed in the park. Charity funding from Veolia has been secured to create a new permanent and accessible paths through the forest walk.
International Design & Build Consultancy		XI'AN, Confirmed re-newed progress on their scheme with design review potentially being required towards the end of Janaury, inconjunction with LWH.Jersey design review is ongoing with weekly visits to Jersey by team members gathering data from clinical design workshops. This design review and development work looks very likely to extend into 2018 and additional income should be achieved.
Community Cluster Building		First design meeting held with successful Archtects at ITPD stage in the RIBA design competition, Good progress demonstrated by all bidders and next meeting scheduled for the 19/01/2018 when users of the services will be fully engaged in the process.
Estates Strategy/Corporate Offices		Overall estates strategy has gained approval to proceed, this incorporate a number of projects mentioned above and also related to |Sotuh sefton Community CAMHS and Physiotherapy, proparties now selected and lease agreements in the process of being drawn up and reveiwed by the trust appointed legal representatives.

Alder Hey Children's NHS
NHS Foundation Trust

Board of Directors

9th January 2018

Report of:	Director of Human Resources & Organisational Development
Paper Prepared by:	Director of Human Resources & Organisational Development
Subject/Title:	People Strategy Update for October/November 2017
Background Papers:	n/a
Purpose of Paper:	To present to the Board monthly update of activity for noting and/or discussion.
Action/Decision Required:	To note the report
Link to: **Trust's Strategic Direction Strategic Objectives**	To have a fully engaged workforce that is actively driving quality improvement ***(Great Talented Teams)***
Resource Impact:	None

Section 1 - Engagement

Reward & Recognition

In response to the monthly Star Awards, a total of 17 nominations were received during October. The winner was voted for by the panel (comprising a range of staff and staff side) and arrangements are in the process of being made for presentation by an Executive Director. All past and present winners are displayed on the board in the Atrium.

The annual staff awards were launched at the end of October with the entry closing date end November. An independent judging panel comprising various members such as staff side, patient/parent rep, exec, non-exec, clinical and non-clinical personnel have now nominated 3 finalists for each of the 9 categories of whom have been invited to the event on 19th January 2018.

'Fab Change Week' was held 13th-17th November, with feedback from staff showing the event was well received. The Reward And Recognition Group will be looking to continue this as an annual event.

Staff Survey

The 2017 Staff Survey closed on 1st December and the target this year was to reach 50% response rate (last year's response rate was 39%). The Trust exceeded this by achieving a response rate of 54%. The overall response rate for Acute Specialist Trusts was 47.4%. Early analyses of results indicate improvements across a significant number of questions within the survey. The Trust will have access to the reporting portal, SOLAR, in late January, to enable a detailed analysis of responses. The Staff Survey Strategy Group are currently working up the plans for how we best use the results to improve staff experience.

Section 2 - Availability of key skills

Employee Consultations

Hotel Services

Domestics and Portering staff (Portering and Portering Supervisors) organisational change programmes were initiated on 9 June 2017 which consisted of proposed reductions of staff (Portering Supervisors) and review of shift patterns/rotas in the other groups. The three consultations were due to conclude on 24 July 2017. A number of issues were raised by staff and staffside during the consultation in each of the staffing groups and further investigation was required to be undertaken by management resulting in an extension to each of the consultations until 17th November 2017. Dates for domestics' group meetings were then scheduled for 17th November 2017 to review feedback from staff on updated draft rotas, and next steps within the consultation process to be confirmed. A further management/staffside meeting also took place relating to porters on 1st December 2017 to review a recent independent audit on work activity, which has indicated the requirement for a reduction in staff numbers in the portering service, and to agree next steps within the consultation process including timelines for completion.

As a result of above it is now anticipated that the organisational change consultations for both domestics and porters will conclude mid-January 2018, subject to a number of individual meetings to take place up to that period with relevant staff

An external review has been commissioned to focus on the structures within the Catering Department, analysing the costs and potential opportunities that may be available. Following receipt of the report, expected during January 2018, it may be necessary to undertake an organisational change process.

Home Care Service/Complex Care – Community Division

The Organisational Change of the seven Band 3 HCA's has now concluded with all at risk employees securing suitable alternative employment within the Trust.

Discharge Lounge – Medicines Division

As a result of the closure of the Discharge Lounge two nursing staff engaged within that unit are participating in an organisational change process which commenced on 12th December 2017, and is due to conclude on 12th January 2018. The outcome of the consultation would be to place both individuals at risk of redundancy and attempts to redeploy both members of staff will be undertaken by their placement on the redeployment register.

Theatres – Decontamination Services - Surgery Division

A proposed organisational change paper has been produced to review the current structure within decontamination services and how the services are best delivered. The paper outlines a proposed small-scale restructure within the team of 3 staff to realign activities. A consultation paper was shared with staff and staff side colleagues on 1st October 2017, with proposed implementation date for early in the new year.

Education, Learning and Development

Leadership

Manager HR Skills Development
The delivery of a suite of management HR skills half-day workshops commenced in October. The programme includes the following and runs twice a month:

- Recruitment & Selection
- Grievance & Disciplinary
- Performance Management
- Absence Management
- Workplace Coaching
- MSS & ESR

8 sessions have already taken place with initial evaluations and feedback being extremely positive.

Partnership Working
We have teamed up with the North West Leadership Academy and Cheshire and Merseyside health and social care organisations to develop and deliver a localised Mary Seacole (MS) Leadership programme. The programme, which is currently delivered by the National Leadership academy team, will be licenced and localised which will support us to:

- Build a richer talent pipeline of emergent leaders for the health and care system in the North West, with greater access and flexibility

- Deliver a much greater ROI (return on investment) for the health and care economy in the North West
- Support those staff from the wider public sector in integrated health and care teams to access the local MS programme through their NHS provider at the cost of £150. This is a significant reduction (from £995) making the programme more accessible to all staff wishing to pursue this as a Leadership development option.

Programme timescales are currently being agreed with the Royal Liverpool Hospital, who are hosting and running the first pilot programme to commence in January. Alder Hey will be supporting the running and facilitation of the events.

Apprenticeships

The first cohort of internally delivered apprenticeship qualifications for 17 of our existing staff, have been identified in October 2017 with Healthcare Support and Team Leading and are due to commence in January 2018. Work is still ongoing to develop this qualification portfolio further with Blackburne House as a support to ensure the apprenticeship strategy remains on track. We have appointed an expert in the field to support us with the next stage of the strategy, to employ newly recruited apprentices.

Mandatory Training

Detailed mandatory training reports by subject, department and team continue to be distributed across the Trust, with all managers expected to increase compliance with mandatory training in each of their teams, and hit the 90% compliance target by the 31st January 2018. We have seen a great deal of effort put into increasing compliance, and all areas showed an increase month on month. The core mandatory training position as of mid December is 86% and the team continue to work with managers, staff and subject matter experts to continually increase this and achieve our compliance target of 90%

Section 3 - Structure & Systems

Employee Relations Activity

By the end of November the Trust's ER activity increased to 22 cases. There are 3 disciplinary cases; 4 Bullying and Harassment cases (plus 2 cases moved to informal resolution stages); 5 grievances; 2 final absence dismissal cases; 1 formal capability cases; 3 MHPS Capability cases and 4 Employment Tribunal (ET) cases.

Employment Tribunal Cases

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

- An ET Claim relating to unlawful deduction of wages and breaches of the Agency Workers Regulations due to be heard on 7 and 8 June 2017 was postponed to allow for inclusion of an additional respondent. The Tribunal hearing is now scheduled to take place between 6th to 8th December 2017 – *(this Tribunal concluded on 7th December 2017, with the judge confirming verbally that the applicant's case has not been upheld - found in favour of the Trust)*

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

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

Corporate Report

The HR KPIs in the November Corporate Report are:

- Sickness has decreased to 5.1%
- Corporate Induction has increased to 96.9% compliance
- PDR compliance has decreased to 86.9%
- Mandatory training compliance has increased to 81.4%

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

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

9th January 2018

Report of:	Director of Human Resources & Organisational Development
Paper Prepared by:	Director of Human Resources & Organisation Development
Subject/Title:	National Staff Survey 2017
Background Papers:	n/a
Purpose of Paper:	To present to the Board the initial detailed result tables produced on 14th December 2017 by Quality Health for noting and/or discussion.
Action/Decision Required:	None
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	The Best People Doing Their Best Work
Resource Impact:	None

National Staff Survey 2017

Alder Hey Children's NHS Foundation Trust

Initial Detailed Results Tables

Produced on 14 December, 2017
by Quality Health

Survey Results

This report sets out the initial results for the 2017 NHS National Staff Survey. The National Staff Survey was undertaken by Quality Health between September and December 2017 for 124 organisations. Of these organisations, 8 fall within your comparator group - Acute Specialist Trusts.

The overall response rate for Acute Specialist Trusts is 47.4%. The response rate for your organisation is 53.9%, 1752 responses from a usable sample of 3248.

Some changes have been made to the contents of this report since last year. In addition to the response breakdowns normally provided, scores have been included for each evaluative question. Further detail on how to read your results can be found in the subsections below.

1. Reading the columns of figures

Results for each question are presented firstly as response breakdowns in the form of absolute numbers and percentage responses. The first two columns show your results from the 2016 survey, the next two columns show the same for 2017 and the final two columns show the results for your comparator group, Acute Specialist Trusts. The purpose of presenting the figures in this way is to give a direct, at-a-glance, overview of your organisation's performance over time, and compared to similar organisations.

1.1. Conventions

Percentage responses are calculated after excluding those respondents that did not answer that particular question. All percentages are rounded to the nearest whole number. When added together, the percentages for all answers to a particular question may not total 100% because of this rounding.

The number of respondents that did not answer a particular question is shown as the 'Missing' figure at the bottom of the actual number of responses. In some cases, the "Missing" figure is quite high, because it includes respondents who did not answer that question, or group of questions, because it was not applicable to their circumstances.

On some questions, there are also some figures which are italicised. These figures have been recalculated to exclude non-specific responses, or responses indicating that the question was not applicable to the participant's circumstances. Taking question 6a (I am satisfied with the quality of care I give to patients / service users) as an example, those responding "Not applicable to me" and those leaving the question blank (the 'Missing' figure) are excluded from the percentage calculation.

Where there is no 2016 data for a current survey question, dashes are displayed in the first two columns.

2. Reading the scores

For each evaluative question, scores are presented beneath the response breakdowns. The positive and negative scores for a question are shown in the green and red bands respectively. The 'base size', or number of participants contributing to the scores, is shown in the grey band at the bottom. Scores are shown for 2016 and 2017, and for your comparator group.

2. Reading the scores *(continued)*

The responses that contribute to a given score are indicated by the colour coding to the left of the response. Responses that contribute to the positive scores are colour coded green, and responses that contribute to the negative scores are colour coded red. As an illustration, if 45% were to respond 'Often' and 24% were to respond 'Always' to question 2a (I look forward to going to work), the question would receive a positive score of 69%. If 2% were to respond 'Never' and 5% were to respond 'Rarely' to the same question, a negative score of 7% would be arrived at.

Please keep in mind that in this report, percentage responses are shown to the nearest whole number. As such, they may not always equal the score when summed together.

The scores in this report have been generated using the **unweighted** data, which (aside from the application of data cleaning) represent the exact responses of staff completing the survey within your organisation. Please note that in the management report (if you've opted to receive one), scores will be generated using weighted data and will therefore be slightly different. Weighting adjusts the data so that the staff profile of your organisation reflects the staff profile of a typical organisation within your comparator group. Making these adjustments ensures that fair comparisons are drawn when benchmarking your results against other organisations within your comparator group.

3. Data cleaning

Data cleaning is undertaken on the raw survey data to ensure that incorrect or inappropriate responses are removed from certain questions. Data cleaning has been applied where there is routing (i.e. where respondents are directed to a subsequent question depending on their answer to the lead question). Sometimes there are conflicts in the answers that respondents give to these questions and the data is corrected to account for this. For example, respondents answering 'No' to Q9d (In the last three months have you ever come to work despite not feeling well enough to perform your duties?) are directed to 'go to Question 10'. If a respondent answers 'No' to Q9d and also answers Q9e-g about types of pressure to come to work when unwell, then their responses to Q9e-g will be deleted.

The data cleaning methodology has been updated by the Coordination Centre since the 2016 NHS Staff Survey. As such, cleaning has been reapplied to the 2016 data using the new instructions to ensure that results remain comparable over time. Consequently, there may be small discrepancies between the results in this report compared to what was previously supplied in 2016.

YOUR JOB

1. Do you have face-to-face contact with patients / service users as part of your job?	2016		2017		Comparator	
	n	%	n	%	n	%
Yes, frequently	727	65%	1,208	70%	5,668	63%
Yes, occasionally	206	18%	266	15%	1,643	18%
No	194	17%	256	15%	1,722	19%
Missing	11		22		100	

For each of the statements below, how often do you feel this way about your job?

2a. I look forward to going to work.	2016		2017		Comparator	
	n	%	n	%	n	%
Never	42	4%	39	2%	166	2%
Rarely	146	13%	158	9%	811	9%
Sometimes	381	34%	590	34%	2,859	32%
Often	409	36%	721	41%	3,850	42%
Always	151	13%	231	13%	1,378	15%
Missing	9		13		69	
Positive Score	**50%**		**55%**		**58%**	
Negative Score	**17%**		**11%**		**11%**	
Base	**1,129**		**1,739**		**9,064**	

2b. I am enthusiastic about my job.	2016		2017		Comparator	
	n	%	n	%	n	%
Never	17	2%	13	1%	56	1%
Rarely	60	5%	65	4%	377	4%
Sometimes	300	27%	369	21%	1,829	20%
Often	415	37%	731	42%	3,833	43%
Always	330	29%	554	32%	2,916	32%
Missing	16		20		122	
Positive Score	**66%**		**74%**		**75%**	
Negative Score	**7%**		**5%**		**5%**	
Base	**1,122**		**1,732**		**9,011**	

YOUR JOB (continued)

2c. Time passes quickly when I am working.	2016		2017		Comparator	
	n	%	n	%	n	%
Never	15	1%	20	1%	80	1%
Rarely	46	4%	62	4%	247	3%
Sometimes	240	21%	332	19%	1,593	18%
Often	416	37%	665	39%	3,401	38%
Always	403	36%	644	37%	3,680	41%
Missing	18		29		132	
Positive Score	**73%**		**76%**		**79%**	
Negative Score	**5%**		**5%**		**4%**	
Base	**1,120**		**1,723**		**9,001**	

To what extent do you agree or disagree with the following statements about your job?

3a. I always know what my work responsibilities are.	2016		2017		Comparator	
	n	%	n	%	n	%
Strongly disagree	14	1%	17	1%	66	1%
Disagree	75	7%	95	6%	462	5%
Neither agree nor disagree	95	8%	126	7%	666	7%
Agree	584	52%	871	51%	4,503	50%
Strongly agree	359	32%	598	35%	3,318	37%
Missing	11		45		118	
Positive Score	**84%**		**86%**		**87%**	
Negative Score	**8%**		**7%**		**6%**	
Base	**1,127**		**1,707**		**9,015**	

YOUR JOB (continued)

3b. I am trusted to do my job.	2016		2017		Comparator	
	n	%	n	%	n	%
Strongly disagree	11	1%	13	1%	68	1%
Disagree	37	3%	35	2%	181	2%
Neither agree nor disagree	61	5%	86	5%	497	6%
Agree	527	47%	762	45%	3,970	44%
Strongly agree	486	43%	803	47%	4,265	47%
Missing	16		53		152	
Positive Score	**90%**		**92%**		**92%**	
Negative Score	**4%**		**3%**		**3%**	
Base	**1,122**		**1,699**		**8,981**	

3c. I am able to do my job to a standard I am personally pleased with.	2016		2017		Comparator	
	n	%	n	%	n	%
Strongly disagree	32	3%	41	2%	148	2%
Disagree	143	13%	188	11%	797	9%
Neither agree nor disagree	132	12%	198	12%	945	11%
Agree	496	44%	741	44%	4,140	46%
Strongly agree	318	28%	530	31%	2,950	33%
Missing	17		54		153	
Positive Score	**73%**		**75%**		**79%**	
Negative Score	**16%**		**13%**		**11%**	
Base	**1,121**		**1,698**		**8,980**	

YOUR JOB (continued)

To what extent do you agree or disagree with the following statements about your work?

4a. There are frequent opportunities for me to show initiative in my role.	2016		2017		Comparator	
	n	%	n	%	n	%
Strongly disagree	31	3%	35	2%	159	2%
Disagree	129	11%	156	9%	683	8%
Neither agree nor disagree	200	18%	292	17%	1,438	16%
Agree	578	51%	858	49%	4,655	51%
Strongly agree	197	17%	405	23%	2,149	24%
Missing	3		6		49	
Positive Score	**68%**		**72%**		**75%**	
Negative Score	**14%**		**11%**		**9%**	
Base	**1,135**		**1,746**		**9,084**	

4b. I am able to make suggestions to improve the work of my team / department.	2016		2017		Comparator	
	n	%	n	%	n	%
Strongly disagree	38	3%	35	2%	167	2%
Disagree	99	9%	137	8%	610	7%
Neither agree nor disagree	207	18%	292	17%	1,349	15%
Agree	577	51%	857	49%	4,697	52%
Strongly agree	213	19%	416	24%	2,255	25%
Missing	4		15		55	
Positive Score	**70%**		**73%**		**77%**	
Negative Score	**12%**		**10%**		**9%**	
Base	**1,134**		**1,737**		**9,078**	

YOUR JOB (continued)

4c. I am involved in deciding on changes introduced that affect my work area / team / department.	2016		2017		Comparator	
	n	%	n	%	n	%
Strongly disagree	99	9%	95	5%	502	6%
Disagree	221	20%	312	18%	1,444	16%
Neither agree nor disagree	248	22%	417	24%	2,114	23%
Agree	414	37%	619	35%	3,396	37%
Strongly agree	148	13%	302	17%	1,608	18%
Missing	8		7		69	
Positive Score	**50%**		**53%**		**55%**	
Negative Score	**28%**		**23%**		**21%**	
Base	**1,130**		**1,745**		**9,064**	

4d. I am able to make improvements happen in my area of work.	2016		2017		Comparator	
	n	%	n	%	n	%
Strongly disagree	61	5%	61	4%	284	3%
Disagree	193	17%	238	14%	1,098	12%
Neither agree nor disagree	308	27%	480	28%	2,309	26%
Agree	442	39%	695	40%	3,879	43%
Strongly agree	127	11%	261	15%	1,470	16%
Missing	7		17		93	
Positive Score	**50%**		**55%**		**59%**	
Negative Score	**22%**		**17%**		**15%**	
Base	**1,131**		**1,735**		**9,040**	

YOUR JOB (continued)

4e. I am able to meet all the conflicting demands on my time at work.	2016		2017		Comparator	
	n	%	n	%	n	%
Strongly disagree	91	8%	118	7%	604	7%
Disagree	312	28%	468	27%	2,189	24%
Neither agree nor disagree	294	26%	420	24%	2,244	25%
Agree	365	32%	613	35%	3,339	37%
Strongly agree	65	6%	117	7%	680	8%
Missing	11		16		77	
Positive Score	**38%**		**42%**		**44%**	
Negative Score	**36%**		**34%**		**31%**	
Base	**1,127**		**1,736**		**9,056**	

4f. I have adequate materials, supplies and equipment to do my work.	2016		2017		Comparator	
	n	%	n	%	n	%
Strongly disagree	95	8%	105	6%	437	5%
Disagree	244	22%	367	21%	1,554	17%
Neither agree nor disagree	237	21%	331	19%	1,656	18%
Agree	466	41%	767	44%	4,268	47%
Strongly agree	89	8%	171	10%	1,137	13%
Missing	7		11		81	
Positive Score	**49%**		**54%**		**60%**	
Negative Score	**30%**		**27%**		**22%**	
Base	**1,131**		**1,741**		**9,052**	

YOUR JOB (continued)

4g. There are enough staff at this organisation for me to do my job properly.	2016		2017		Comparator	
	n	%	n	%	n	%
Strongly disagree	187	17%	269	15%	1,237	14%
Disagree	375	33%	559	32%	2,651	29%
Neither agree nor disagree	266	24%	373	21%	1,983	22%
Agree	255	23%	446	26%	2,587	29%
Strongly agree	47	4%	93	5%	605	7%
Missing	8		12		70	
Positive Score	**27%**		**31%**		**35%**	
Negative Score	**50%**		**48%**		**43%**	
Base	**1,130**		**1,740**		**9,063**	

4h. The team I work in has a set of shared objectives.	2016		2017		Comparator	
	n	%	n	%	n	%
Strongly disagree	33	3%	49	3%	210	2%
Disagree	84	7%	119	7%	543	6%
Neither agree nor disagree	217	19%	303	18%	1,493	17%
Agree	636	56%	955	55%	4,986	55%
Strongly agree	157	14%	304	18%	1,786	20%
Missing	11		22		115	
Positive Score	**70%**		**73%**		**75%**	
Negative Score	**10%**		**10%**		**8%**	
Base	**1,127**		**1,730**		**9,018**	

YOUR JOB (continued)

4i. The team I work in often meets to discuss the team's effectiveness.	2016		2017		Comparator	
	n	%	n	%	n	%
Strongly disagree	111	10%	124	7%	473	5%
Disagree	189	17%	295	17%	1,329	15%
Neither agree nor disagree	188	17%	264	15%	1,603	18%
Agree	488	43%	765	44%	3,961	44%
Strongly agree	157	14%	290	17%	1,674	19%
Missing	5		14		93	
Positive Score	**57%**		**61%**		**62%**	
Negative Score	**26%**		**24%**		**20%**	
Base	**1,133**		**1,738**		**9,040**	

4j. Team members have to communicate closely with each other to achieve the team's objectives.	2016		2017		Comparator	
	n	%	n	%	n	%
Strongly disagree	30	3%	37	2%	156	2%
Disagree	53	5%	78	5%	360	4%
Neither agree nor disagree	186	16%	246	14%	1,263	14%
Agree	600	53%	951	55%	4,676	52%
Strongly agree	264	23%	420	24%	2,579	29%
Missing	5		20		99	
Positive Score	**76%**		**79%**		**80%**	
Negative Score	**7%**		**7%**		**6%**	
Base	**1,133**		**1,732**		**9,034**	

YOUR JOB (continued)

How satisfied are you with each of the following aspects of your job?

5a. The recognition I get for good work.	2016		2017		Comparator	
	n	%	n	%	n	%
Very dissatisfied	88	8%	110	6%	499	6%
Dissatisfied	214	19%	268	16%	1,400	15%
Neither satisfied nor dissatisfied	322	29%	466	27%	2,240	25%
Satisfied	402	36%	690	40%	3,758	42%
Very satisfied	98	9%	194	11%	1,148	13%
Missing	14		24		88	
Positive Score	**44%**		**51%**		**54%**	
Negative Score	**27%**		**22%**		**21%**	
Base	**1,124**		**1,728**		**9,045**	

5b. The support I get from my immediate manager.	2016		2017		Comparator	
	n	%	n	%	n	%
Very dissatisfied	78	7%	77	4%	373	4%
Dissatisfied	141	13%	152	9%	827	9%
Neither satisfied nor dissatisfied	243	22%	315	18%	1,515	17%
Satisfied	430	38%	742	43%	3,792	42%
Very satisfied	233	21%	437	25%	2,547	28%
Missing	13		29		79	
Positive Score	**59%**		**68%**		**70%**	
Negative Score	**19%**		**13%**		**13%**	
Base	**1,125**		**1,723**		**9,054**	

YOUR JOB (continued)

5c. The support I get from my work colleagues.	2016		2017		Comparator	
	n	%	n	%	n	%
Very dissatisfied	12	1%	20	1%	100	1%
Dissatisfied	46	4%	58	3%	337	4%
Neither satisfied nor dissatisfied	161	14%	219	13%	1,186	13%
Satisfied	615	55%	903	52%	4,653	51%
Very satisfied	294	26%	527	31%	2,773	31%
Missing	10		25		84	
Positive Score	**81%**		**83%**		**82%**	
Negative Score	**5%**		**5%**		**5%**	
Base	**1,128**		**1,727**		**9,049**	

5d. The amount of responsibility I am given.	2016		2017		Comparator	
	n	%	n	%	n	%
Very dissatisfied	22	2%	26	2%	156	2%
Dissatisfied	108	10%	125	7%	611	7%
Neither satisfied nor dissatisfied	183	16%	273	16%	1,430	16%
Satisfied	600	53%	958	56%	4,987	55%
Very satisfied	211	19%	343	20%	1,853	21%
Missing	14		27		96	
Positive Score	**72%**		**75%**		**76%**	
Negative Score	**12%**		**9%**		**8%**	
Base	**1,124**		**1,725**		**9,037**	

YOUR JOB (continued)

5e. The opportunities I have to use my skills.	2016		2017		Comparator	
	n	%	n	%	n	%
Very dissatisfied	34	3%	54	3%	242	3%
Dissatisfied	128	11%	145	8%	788	9%
Neither satisfied nor dissatisfied	224	20%	267	16%	1,470	16%
Satisfied	565	50%	930	54%	4,695	52%
Very satisfied	175	16%	325	19%	1,842	20%
Missing	12		31		96	
Positive Score	**66%**		**73%**		**72%**	
Negative Score	**14%**		**12%**		**11%**	
Base	**1,126**		**1,721**		**9,037**	

5f. The extent to which my organisation values my work.	2016		2017		Comparator	
	n	%	n	%	n	%
Very dissatisfied	140	12%	143	8%	684	8%
Dissatisfied	255	23%	330	19%	1,578	17%
Neither satisfied nor dissatisfied	348	31%	523	30%	2,575	29%
Satisfied	309	27%	561	33%	3,175	35%
Very satisfied	73	6%	162	9%	1,016	11%
Missing	13		33		105	
Positive Score	**34%**		**42%**		**46%**	
Negative Score	**35%**		**28%**		**25%**	
Base	**1,125**		**1,719**		**9,028**	

YOUR JOB (continued)

5g. My level of pay.	2016		2017		Comparator	
	n	%	n	%	n	%
Very dissatisfied	157	14%	251	15%	1,347	15%
Dissatisfied	276	25%	459	27%	2,423	27%
Neither satisfied nor dissatisfied	299	27%	392	23%	2,174	24%
Satisfied	346	31%	528	31%	2,563	28%
Very satisfied	48	4%	96	6%	532	6%
Missing	12		26		94	
Positive Score	**35%**		**36%**		**34%**	
Negative Score	**38%**		**41%**		**42%**	
Base	**1,126**		**1,726**		**9,039**	

5h. The opportunities for flexible working patterns.	2016		2017		Comparator	
	n	%	n	%	n	%
Very dissatisfied	85	8%	95	6%	606	7%
Dissatisfied	153	14%	190	11%	1,128	12%
Neither satisfied nor dissatisfied	307	27%	435	25%	2,422	27%
Satisfied	454	40%	720	42%	3,456	38%
Very satisfied	125	11%	279	16%	1,426	16%
Missing	14		33		95	
Positive Score	**52%**		**58%**		**54%**	
Negative Score	**21%**		**17%**		**19%**	
Base	**1,124**		**1,719**		**9,038**	

YOUR JOB (continued)

Do the following statements apply to you and your job?

6a. I am satisfied with the quality of care I give to patients / service users.	2016		2017		Comparator	
	n	%	n	%	n	%
Not applicable to me	180	16%	249	14%	1,515	17%
* *Strongly disagree*	*24*	*3%*	*34*	*2%*	*145*	*2%*
* *Disagree*	*76*	*8%*	*112*	*8%*	*441*	*6%*
* *Neither agree nor disagree*	*102*	*11%*	*152*	*10%*	*702*	*9%*
* *Agree*	*471*	*50%*	*788*	*53%*	*3,945*	*52%*
* *Strongly agree*	*277*	*29%*	*407*	*27%*	*2,317*	*31%*
Missing	8		10		68	
Positive Score	**79%**		**80%**		**83%**	
Negative Score	**11%**		**10%**		**8%**	
Base	**950**		**1,493**		**7,550**	

6b. I feel that my role makes a difference to patients / service users.	2016		2017		Comparator	
	n	%	n	%	n	%
Not applicable to me	90	8%	110	6%	715	8%
* *Strongly disagree*	*9*	*1%*	*8*	*0%*	*51*	*1%*
* *Disagree*	*28*	*3%*	*21*	*1%*	*113*	*1%*
* *Neither agree nor disagree*	*88*	*8%*	*135*	*8%*	*637*	*8%*
* *Agree*	*541*	*52%*	*887*	*55%*	*4,370*	*52%*
* *Strongly agree*	*376*	*36%*	*574*	*35%*	*3,154*	*38%*
Missing	6		17		93	
Positive Score	**88%**		**90%**		**90%**	
Negative Score	**4%**		**2%**		**2%**	
Base	**1,042**		**1,625**		**8,325**	

YOUR JOB (continued)

6c. I am able to deliver the care I aspire to.	2016		2017		Comparator	
	n	%	n	%	n	%
Not applicable to me	183	16%	236	14%	1,522	17%
* *Strongly disagree*	*50*	*5%*	*65*	*4%*	*257*	*3%*
* *Disagree*	*139*	*15%*	*196*	*13%*	*785*	*10%*
* *Neither agree nor disagree*	*173*	*18%*	*263*	*18%*	*1,241*	*16%*
* *Agree*	*375*	*40%*	*669*	*45%*	*3,435*	*46%*
* *Strongly agree*	*208*	*22%*	*305*	*20%*	*1,806*	*24%*
Missing	10		18		87	
Positive Score	**62%**		**65%**		**70%**	
Negative Score	**20%**		**17%**		**14%**	
Base	**945**		**1,498**		**7,524**	

YOUR MANAGERS

To what extent do you agree or disagree with the following statements about your immediate manager? My immediate manager...

7a. ...encourages those who work for her / him to work as a team.	2016		2017		Comparator	
	n	%	n	%	n	%
Strongly disagree	49	4%	48	3%	245	3%
Disagree	91	8%	123	7%	553	6%
Neither agree nor disagree	242	22%	273	16%	1,389	15%
Agree	498	44%	831	48%	4,270	47%
Strongly agree	245	22%	461	27%	2,578	29%
Missing	13		16		98	
Positive Score	**66%**		**74%**		**76%**	
Negative Score	**12%**		**10%**		**9%**	
Base	**1,125**		**1,736**		**9,035**	

7b. ...can be counted on to help me with a difficult task at work.	2016		2017		Comparator	
	n	%	n	%	n	%
Strongly disagree	64	6%	51	3%	309	3%
Disagree	117	10%	141	8%	667	7%
Neither agree nor disagree	226	20%	300	17%	1,450	16%
Agree	446	39%	751	43%	3,831	42%
Strongly agree	277	25%	493	28%	2,774	31%
Missing	8		16		102	
Positive Score	**64%**		**72%**		**73%**	
Negative Score	**16%**		**11%**		**11%**	
Base	**1,130**		**1,736**		**9,031**	

YOUR MANAGERS (continued)

7c. ...gives me clear feedback on my work.	2016		2017		Comparator	
	n	%	n	%	n	%
Strongly disagree	78	7%	80	5%	372	4%
Disagree	166	15%	219	13%	996	11%
Neither agree nor disagree	310	27%	437	25%	2,070	23%
Agree	384	34%	622	36%	3,426	38%
Strongly agree	190	17%	374	22%	2,153	24%
Missing	10		20		116	
Positive Score	**51%**		**58%**		**62%**	
Negative Score	**22%**		**17%**		**15%**	
Base	**1,128**		**1,732**		**9,017**	

7d. ...asks for my opinion before making decisions that affect my work.	2016		2017		Comparator	
	n	%	n	%	n	%
Strongly disagree	99	9%	105	6%	552	6%
Disagree	200	18%	259	15%	1,238	14%
Neither agree nor disagree	301	27%	421	24%	2,099	23%
Agree	352	31%	606	35%	3,154	35%
Strongly agree	173	15%	344	20%	1,978	22%
Missing	13		17		112	
Positive Score	**47%**		**55%**		**57%**	
Negative Score	**27%**		**21%**		**20%**	
Base	**1,125**		**1,735**		**9,021**	

YOUR MANAGERS (continued)

7e. ...is supportive in a personal crisis.	2016		2017		Comparator	
	n	%	n	%	n	%
Strongly disagree	49	4%	43	2%	239	3%
Disagree	57	5%	71	4%	364	4%
Neither agree nor disagree	220	19%	270	16%	1,522	17%
Agree	431	38%	678	39%	3,312	37%
Strongly agree	372	33%	667	39%	3,574	40%
Missing	9		23		122	
Positive Score	**71%**		**78%**		**76%**	
Negative Score	**9%**		**7%**		**7%**	
Base	**1,129**		**1,729**		**9,011**	

7f. ...takes a positive interest in my health and well-being.	2016		2017		Comparator	
	n	%	n	%	n	%
Strongly disagree	62	5%	57	3%	328	4%
Disagree	106	9%	114	7%	606	7%
Neither agree nor disagree	259	23%	345	20%	1,804	20%
Agree	415	37%	678	39%	3,342	37%
Strongly agree	286	25%	536	31%	2,932	33%
Missing	10		22		121	
Positive Score	**62%**		**70%**		**70%**	
Negative Score	**15%**		**10%**		**10%**	
Base	**1,128**		**1,730**		**9,012**	

YOUR MANAGERS (continued)

7g. ...values my work.	2016		2017		Comparator	
	n	%	n	%	n	%
Strongly disagree	52	5%	56	3%	291	3%
Disagree	86	8%	105	6%	483	5%
Neither agree nor disagree	257	23%	345	20%	1,647	18%
Agree	465	41%	738	43%	3,823	42%
Strongly agree	266	24%	490	28%	2,776	31%
Missing	12		18		113	
Positive Score	**65%**		**71%**		**73%**	
Negative Score	**12%**		**9%**		**9%**	
Base	**1,126**		**1,734**		**9,020**	

To what extent do you agree or disagree with the following statements about senior managers where you work?

8a. I know who the senior managers are here.	2016		2017		Comparator	
	n	%	n	%	n	%
Strongly disagree	52	5%	57	3%	160	2%
Disagree	136	12%	158	9%	586	6%
Neither agree nor disagree	127	11%	172	10%	751	8%
Agree	563	50%	910	52%	4,618	51%
Strongly agree	249	22%	444	26%	2,925	32%
Missing	11		11		93	
Positive Score	**72%**		**78%**		**83%**	
Negative Score	**17%**		**12%**		**8%**	
Base	**1,127**		**1,741**		**9,040**	

YOUR MANAGERS (continued)

8b. Communication between senior management and staff is effective.	2016		2017		Comparator	
	n	%	n	%	n	%
Strongly disagree	155	14%	160	9%	687	8%
Disagree	308	27%	374	22%	1,734	19%
Neither agree nor disagree	346	31%	557	32%	2,719	30%
Agree	248	22%	504	29%	2,882	32%
Strongly agree	73	6%	140	8%	1,005	11%
Missing	8		17		106	
Positive Score	**28%**		**37%**		**43%**	
Negative Score	**41%**		**31%**		**27%**	
Base	**1,130**		**1,735**		**9,027**	

8c. Senior managers here try to involve staff in important decisions.	2016		2017		Comparator	
	n	%	n	%	n	%
Strongly disagree	158	14%	194	11%	916	10%
Disagree	323	29%	386	22%	1,889	21%
Neither agree nor disagree	351	31%	590	34%	2,871	32%
Agree	235	21%	446	26%	2,490	28%
Strongly agree	60	5%	119	7%	866	10%
Missing	11		17		101	
Positive Score	**26%**		**33%**		**37%**	
Negative Score	**43%**		**33%**		**31%**	
Base	**1,127**		**1,735**		**9,032**	

YOUR MANAGERS (continued)

8d. Senior managers act on staff feedback.	2016		2017		Comparator	
	n	%	n	%	n	%
Strongly disagree	148	13%	171	10%	807	9%
Disagree	289	26%	309	18%	1,504	17%
Neither agree nor disagree	420	37%	707	41%	3,463	38%
Agree	209	19%	426	25%	2,422	27%
Strongly agree	60	5%	118	7%	822	9%
Missing	12		21		115	
Positive Score	**24%**		**31%**		**36%**	
Negative Score	**39%**		**28%**		**26%**	
Base	**1,126**		**1,731**		**9,018**	

YOUR HEALTH, WELL-BEING AND SAFETY AT WORK

Health & well-being

9a. Does your organisation take positive action on health and well-being?	2016		2017		Comparator	
	n	%	n	%	n	%
Yes, definitely	227	20%	438	25%	3,078	34%
Yes, to some extent	720	64%	1,088	63%	5,114	57%
No	174	16%	200	12%	765	9%
Missing	17		26		176	
Positive Score	**84%**		**88%**		**91%**	
Negative Score	**16%**		**12%**		**9%**	
Base	**1,121**		**1,726**		**8,957**	

9b. In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities?	2016		2017		Comparator	
	n	%	n	%	n	%
Yes	254	23%	371	21%	1,893	21%
No	870	77%	1,361	79%	7,116	79%
Missing	14		20		124	
Positive Score	**77%**		**79%**		**79%**	
Negative Score	**23%**		**21%**		**21%**	
Base	**1,124**		**1,732**		**9,009**	

9c. During the last 12 months have you felt unwell as a result of work related stress?	2016		2017		Comparator	
	n	%	n	%	n	%
Yes	437	39%	675	39%	3,205	36%
No	691	61%	1,063	61%	5,799	64%
Missing	10		14		129	
Positive Score	**61%**		**61%**		**64%**	
Negative Score	**39%**		**39%**		**36%**	
Base	**1,128**		**1,738**		**9,004**	

YOUR HEALTH, WELL-BEING AND SAFETY AT WORK (continued)

9d. In the last three months have you ever come to work despite not feeling well enough to perform your duties?	2016		2017		Comparator	
	n	%	n	%	n	%
Yes	664	59%	961	55%	4,896	54%
No	461	41%	776	45%	4,116	46%
Missing	13		15		121	
Positive Score	**41%**		**45%**		**46%**	
Negative Score	**59%**		**55%**		**54%**	
Base	**1,125**		**1,737**		**9,012**	

9e. Have you felt pressure from your manager to come to work?	2016		2017		Comparator	
	n	%	n	%	n	%
Yes	172	26%	193	20%	1,130	23%
No	478	74%	753	80%	3,698	77%
Missing	488		806		4,305	
Positive Score	**74%**		**80%**		**77%**	
Negative Score	**26%**		**20%**		**23%**	
Base	**650**		**946**		**4,828**	

9f. Have you felt pressure from colleagues to come to work?	2016		2017		Comparator	
	n	%	n	%	n	%
Yes	141	22%	179	19%	998	21%
No	508	78%	764	81%	3,825	79%
Missing	489		809		4,310	
Positive Score	**78%**		**81%**		**79%**	
Negative Score	**22%**		**19%**		**21%**	
Base	**649**		**943**		**4,823**	

YOUR HEALTH, WELL-BEING AND SAFETY AT WORK (continued)

9g. Have you put yourself under pressure to come to work?	2016		2017		Comparator	
	n	%	n	%	n	%
Yes	617	94%	891	93%	4,521	93%
No	39	6%	64	7%	344	7%
Missing	482		797		4,268	
Positive Score	**6%**		**7%**		**7%**	
Negative Score	**94%**		**93%**		**93%**	
Base	**656**		**955**		**4,865**	

10a. How many hours a week are you contracted to work?	2016		2017		Comparator	
	n	%	n	%	n	%
Up to 29 hours	216	19%	352	21%	1,622	18%
30 or more hours	901	81%	1,349	79%	7,193	82%
Missing	21		51		318	

10b. On average, how many additional PAID hours do you work per week for this organisation, over and above your contracted hours?	2016		2017		Comparator	
	n	%	n	%	n	%
0 hours	754	70%	1,115	67%	5,983	69%
Up to 5 hours	136	13%	270	16%	1,456	17%
6 - 10 hours	108	10%	149	9%	698	8%
11 or more hours	81	8%	129	8%	534	6%
Missing	59		89		462	
Positive Score	**70%**		**67%**		**69%**	
Negative Score	**30%**		**33%**		**31%**	
Base	**1,079**		**1,663**		**8,671**	

YOUR HEALTH, WELL-BEING AND SAFETY AT WORK (continued)

10c. On average, how many additional UNPAID hours do you work per week for this organisation, over and above your contracted hours?	2016		2017		Comparator	
	n	%	n	%	n	%
0 hours	441	41%	702	42%	3,418	39%
Up to 5 hours	449	42%	730	44%	3,985	46%
6 - 10 hours	136	13%	173	10%	980	11%
11 or more hours	51	5%	57	3%	323	4%
Missing	61		90		427	
Positive Score	**41%**		**42%**		**39%**	
Negative Score	**59%**		**58%**		**61%**	
Base	**1,077**		**1,662**		**8,706**	

In the last month have you seen any errors, near misses, or incidents that could have hurt...

11a. Staff	2016		2017		Comparator	
	n	%	n	%	n	%
Yes	214	19%	293	17%	1,224	14%
No	903	81%	1,410	83%	7,695	86%
Missing	21		49		214	
Positive Score	**81%**		**83%**		**86%**	
Negative Score	**19%**		**17%**		**14%**	
Base	**1,117**		**1,703**		**8,919**	

11b. Patients / service users	2016		2017		Comparator	
	n	%	n	%	n	%
Yes	356	32%	469	28%	2,146	24%
No	748	68%	1,212	72%	6,691	76%
Missing	34		71		296	
Positive Score	**68%**		**72%**		**76%**	
Negative Score	**32%**		**28%**		**24%**	
Base	**1,104**		**1,681**		**8,837**	

YOUR HEALTH, WELL-BEING AND SAFETY AT WORK (continued)

11c. The last time you saw an error, near miss or incident that could have hurt staff or patients / service users, did you or a colleague report it?	2016		2017		Comparator	
	n	%	n	%	n	%
* *Yes, I reported it*	*213*	*54%*	*265*	*49%*	*1,194*	*50%*
* *Yes, a colleague reported it*	*149*	*38%*	*213*	*40%*	*938*	*39%*
* *Yes, both myself and a colleague reported it*	*26*	*7%*	*35*	*6%*	*164*	*7%*
* *No*	*7*	*2%*	*26*	*5%*	*97*	*4%*
Don't know	10	2%	17	3%	81	3%
Missing	733		1,196		6,659	
Positive Score	**98%**		**95%**		**96%**	
Negative Score	**2%**		**5%**		**4%**	
Base	**395**		**539**		**2,393**	

To what extent do you agree or disagree with the following?

12a. My organisation treats staff who are involved in an error, near miss or incident fairly.	2016		2017		Comparator	
	n	%	n	%	n	%
Don't know	203	18%	350	20%	1,647	18%
* *Strongly disagree*	*24*	*3%*	*31*	*2%*	*152*	*2%*
* *Disagree*	*60*	*7%*	*71*	*5%*	*360*	*5%*
* *Neither agree nor disagree*	*388*	*42%*	*500*	*36%*	*2,352*	*32%*
* *Agree*	*383*	*42%*	*635*	*46%*	*3,526*	*48%*
* *Strongly agree*	*60*	*7%*	*137*	*10%*	*948*	*13%*
Missing	20		28		148	
Positive Score	**48%**		**56%**		**61%**	
Negative Score	**9%**		**7%**		**7%**	
Base	**915**		**1,374**		**7,338**	

YOUR HEALTH, WELL-BEING AND SAFETY AT WORK (continued)

12b. My organisation encourages us to report errors, near misses or incidents.	2016		2017		Comparator	
	n	%	n	%	n	%
Don't know	45	4%	60	3%	258	3%
* *Strongly disagree*	*11*	*1%*	*11*	*1%*	*59*	*1%*
* *Disagree*	*21*	*2%*	*33*	*2%*	*121*	*1%*
* *Neither agree nor disagree*	*129*	*12%*	*124*	*7%*	*638*	*7%*
* *Agree*	*666*	*62%*	*1,004*	*60%*	*4,969*	*57%*
* *Strongly agree*	*247*	*23%*	*491*	*30%*	*2,924*	*34%*
Missing	19		29		164	
Positive Score	**85%**		**90%**		**91%**	
Negative Score	**3%**		**3%**		**2%**	
Base	**1,074**		**1,663**		**8,711**	

12c. When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again.	2016		2017		Comparator	
	n	%	n	%	n	%
Don't know	109	10%	192	11%	838	9%
* *Strongly disagree*	*28*	*3%*	*41*	*3%*	*116*	*1%*
* *Disagree*	*79*	*8%*	*82*	*5%*	*292*	*4%*
* *Neither agree nor disagree*	*310*	*31%*	*384*	*25%*	*1,674*	*21%*
* *Agree*	*460*	*46%*	*783*	*51%*	*4,344*	*53%*
* *Strongly agree*	*127*	*13%*	*238*	*16%*	*1,704*	*21%*
Missing	25		32		165	
Positive Score	**58%**		**67%**		**74%**	
Negative Score	**11%**		**8%**		**5%**	
Base	**1,004**		**1,528**		**8,130**	

YOUR HEALTH, WELL-BEING AND SAFETY AT WORK (continued)

12d. We are given feedback about changes made in response to reported errors, near misses and incidents.	2016		2017		Comparator	
	n	%	n	%	n	%
Don't know	89	8%	172	10%	791	9%
* *Strongly disagree*	*62*	*6%*	*77*	*5%*	*332*	*4%*
* *Disagree*	*147*	*14%*	*220*	*14%*	*933*	*11%*
* *Neither agree nor disagree*	*293*	*29%*	*397*	*26%*	*1,886*	*23%*
* *Agree*	*418*	*41%*	*652*	*42%*	*3,659*	*45%*
* *Strongly agree*	*107*	*10%*	*199*	*13%*	*1,345*	*16%*
Missing	22		35		187	
Positive Score	**51%**		**55%**		**61%**	
Negative Score	**20%**		**19%**		**16%**	
Base	**1,027**		**1,545**		**8,155**	

Raising concerns about unsafe clinical practice

13a. If you were concerned about unsafe clinical practice, would you know how to report it?	2016		2017		Comparator	
	n	%	n	%	n	%
* *Yes*	*903*	*91%*	*1,423*	*91%*	*7,709*	*95%*
* *No*	*84*	*9%*	*135*	*9%*	*434*	*5%*
Don't know	125	11%	165	10%	800	9%
Missing	26		29		190	
Positive Score	**91%**		**91%**		**95%**	
Negative Score	**9%**		**9%**		**5%**	
Base	**987**		**1,558**		**8,143**	

YOUR HEALTH, WELL-BEING AND SAFETY AT WORK (continued)

13b. I would feel secure raising concerns about unsafe clinical practice.	2016		2017		Comparator	
	n	%	n	%	n	%
Strongly disagree	46	4%	58	3%	289	3%
Disagree	104	9%	143	8%	506	6%
Neither agree nor disagree	276	25%	382	22%	1,795	20%
Agree	514	46%	824	48%	4,378	49%
Strongly agree	176	16%	315	18%	1,982	22%
Missing	22		30		183	
Positive Score	**62%**		**66%**		**71%**	
Negative Score	**13%**		**12%**		**9%**	
Base	**1,116**		**1,722**		**8,950**	

13c. I am confident that my organisation would address my concern.	2016		2017		Comparator	
	n	%	n	%	n	%
Strongly disagree	54	5%	82	5%	317	4%
Disagree	114	10%	138	8%	492	6%
Neither agree nor disagree	393	35%	538	31%	2,498	28%
Agree	437	39%	732	43%	4,054	45%
Strongly agree	117	10%	231	13%	1,582	18%
Missing	23		31		190	
Positive Score	**50%**		**56%**		**63%**	
Negative Score	**15%**		**13%**		**9%**	
Base	**1,115**		**1,721**		**8,943**	

YOUR HEALTH, WELL-BEING AND SAFETY AT WORK (continued)

In the last 12 months how many times have you personally experienced physical violence at work from...?

14a. Patients / service users, their relatives or other members of the public	2016		2017		Comparator	
	n	%	n	%	n	%
Never	1,038	93%	1,574	91%	8,368	93%
1-2	52	5%	115	7%	445	5%
3-5	8	1%	21	1%	96	1%
6-10	8	1%	10	1%	32	0%
More than 10	9	1%	11	1%	27	0%
Missing	23		21		165	
Positive Score	**93%**		**91%**		**93%**	
Negative Score	**7%**		**9%**		**7%**	
Base	**1,115**		**1,731**		**8,968**	

14b. Managers	2016		2017		Comparator	
	n	%	n	%	n	%
Never	1,104	100%	1,718	100%	8,896	100%
1-2	0	0%	3	0%	19	0%
3-5	1	0%	0	0%	2	0%
6-10	1	0%	1	0%	2	0%
More than 10	0	0%	1	0%	4	0%
Missing	32		29		210	
Positive Score	**100%**		**100%**		**100%**	
Negative Score	**0%**		**0%**		**0%**	
Base	**1,106**		**1,723**		**8,923**	

YOUR HEALTH, WELL-BEING AND SAFETY AT WORK (continued)

14c. Other colleagues	2016		2017		Comparator	
	n	%	n	%	n	%
Never	1,095	99%	1,694	99%	8,781	99%
1-2	8	1%	7	0%	69	1%
3-5	2	0%	3	0%	6	0%
6-10	2	0%	1	0%	3	0%
More than 10	0	0%	1	0%	4	0%
Missing	31		46		270	
Positive Score	**99%**		**99%**		**99%**	
Negative Score	**1%**		**1%**		**1%**	
Base	**1,107**		**1,706**		**8,863**	

14d. The last time you experienced physical violence at work, did you or a colleague report it?	2016		2017		Comparator	
	n	%	n	%	n	%
* *Yes, I reported it*	*24*	*35%*	*59*	*44%*	*237*	*45%*
* *Yes, a colleague reported it*	*10*	*15%*	*26*	*20%*	*112*	*21%*
* *Yes, both myself and a colleague reported it*	*2*	*3%*	*8*	*6%*	*12*	*2%*
* *No*	*32*	*47%*	*40*	*30%*	*164*	*31%*
Don't know	5	6%	7	4%	26	4%
Not applicable	8	10%	19	12%	81	13%
Missing	1,057		1,593		8,501	
Positive Score	**53%**		**70%**		**69%**	
Negative Score	**47%**		**30%**		**31%**	
Base	**68**		**133**		**525**	

YOUR HEALTH, WELL-BEING AND SAFETY AT WORK (continued)

In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from...?

15a. Patients / service users, their relatives or other members of the public	2016		2017		Comparator	
	n	%	n	%	n	%
Never	841	76%	1,306	76%	7,137	80%
1-2	165	15%	277	16%	1,242	14%
3-5	56	5%	60	3%	360	4%
6-10	18	2%	28	2%	87	1%
More than 10	27	2%	46	3%	124	1%
Missing	31		35		183	
Positive Score	**76%**		**76%**		**80%**	
Negative Score	**24%**		**24%**		**20%**	
Base	**1,107**		**1,717**		**8,950**	

15b. Managers	2016		2017		Comparator	
	n	%	n	%	n	%
Never	960	88%	1,532	90%	7,933	89%
1-2	88	8%	124	7%	667	7%
3-5	29	3%	28	2%	170	2%
6-10	3	0%	5	0%	44	0%
More than 10	9	1%	12	1%	82	1%
Missing	49		51		237	
Positive Score	**88%**		**90%**		**89%**	
Negative Score	**12%**		**10%**		**11%**	
Base	**1,089**		**1,701**		**8,896**	

YOUR HEALTH, WELL-BEING AND SAFETY AT WORK (continued)

15c. Other colleagues	2016		2017		Comparator	
	n	%	n	%	n	%
Never	887	81%	1,424	84%	7,389	83%
1-2	132	12%	196	12%	1,025	12%
3-5	52	5%	42	2%	257	3%
6-10	9	1%	14	1%	75	1%
More than 10	15	1%	15	1%	109	1%
Missing	43		61		278	
Positive Score	**81%**		**84%**		**83%**	
Negative Score	**19%**		**16%**		**17%**	
Base	**1,095**		**1,691**		**8,855**	

15d. The last time you experienced harassment, bullying or abuse at work, did you or a colleague report it?	2016		2017		Comparator	
	n	%	n	%	n	%
* *Yes, I reported it*	*129*	*35%*	*220*	*41%*	*1,056*	*40%*
* *Yes, a colleague reported it*	*16*	*4%*	*42*	*8%*	*179*	*7%*
* *Yes, both myself and a colleague reported it*	*2*	*1%*	*7*	*1%*	*31*	*1%*
* *No*	*218*	*60%*	*272*	*50%*	*1,404*	*53%*
Don't know	13	3%	19	3%	88	3%
Not applicable	26	6%	42	7%	180	6%
Missing	734		1,150		6,195	
Positive Score	**40%**		**50%**		**47%**	
Negative Score	**60%**		**50%**		**53%**	
Base	**365**		**541**		**2,670**	

YOUR HEALTH, WELL-BEING AND SAFETY AT WORK (continued)

16. Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?	2016		2017		Comparator	
	n	%	n	%	n	%
* *Yes*	*572*	*81%*	*957*	*84%*	*5,415*	*87%*
* *No*	*135*	*19%*	*180*	*16%*	*801*	*13%*
Don't know	408	37%	575	34%	2,706	30%
Missing	23		40		211	
Positive Score	**81%**		**84%**		**87%**	
Negative Score	**19%**		**16%**		**13%**	
Base	**707**		**1,137**		**6,216**	

In the last 12 months have you personally experienced discrimination at work from any of the following?

17a. Patients / service users, their relatives or other members of the public	2016		2017		Comparator	
	n	%	n	%	n	%
Yes	25	2%	37	2%	295	3%
No	1,093	98%	1,685	98%	8,658	97%
Missing	20		30		180	
Positive Score	**98%**		**98%**		**97%**	
Negative Score	**2%**		**2%**		**3%**	
Base	**1,118**		**1,722**		**8,953**	

17b. Manager / team leader or other colleagues	2016		2017		Comparator	
	n	%	n	%	n	%
Yes	71	6%	96	6%	556	6%
No	1,044	94%	1,627	94%	8,375	94%
Missing	23		29		202	
Positive Score	**94%**		**94%**		**94%**	
Negative Score	**6%**		**6%**		**6%**	
Base	**1,115**		**1,723**		**8,931**	

YOUR HEALTH, WELL-BEING AND SAFETY AT WORK (continued)

17c. On what grounds have you experienced discrimination?	2016		2017		Comparator	
	n	%	n	%	n	%
Ethnic background	11	13%	18	15%	234	31%
Missing	74		102		525	
Gender	20	24%	15	13%	151	20%
Missing	65		105		608	
Religion	5	6%	3	3%	30	4%
Missing	80		117		729	
Sexual orientation	3	4%	4	3%	29	4%
Missing	82		116		730	
Disability	4	5%	11	9%	61	8%
Missing	81		109		698	
Age	15	18%	20	17%	144	19%
Missing	70		100		615	
Other	42	49%	64	53%	264	35%
Missing	43		56		495	

YOUR PERSONAL DEVELOPMENT

18a. Have you had any training, learning or development in the last 12 months?	2016		2017		Comparator	
	n	%	n	%	n	%
* *Yes*	*725*	*66%*	*1,139*	*67%*	*6,319*	*72%*
* *No*	*372*	*34%*	*552*	*33%*	*2,437*	*28%*
Can't remember	19	2%	25	1%	138	2%
Missing	22		36		239	
Positive Score	**66%**		**67%**		**72%**	
Negative Score	**34%**		**33%**		**28%**	
Base	**1,097**		**1,691**		**8,756**	

To what extent do you agree or disagree with the following statements?

18b. My training, learning or development has helped me to do my job more effectively.	2016		2017		Comparator	
	n	%	n	%	n	%
Not applicable to me	1	0%	10	1%	45	1%
* *Strongly disagree*	*4*	*1%*	*14*	*1%*	*61*	*1%*
* *Disagree*	*24*	*3%*	*34*	*3%*	*167*	*3%*
* *Neither agree nor disagree*	*103*	*14%*	*140*	*13%*	*755*	*12%*
* *Agree*	*444*	*62%*	*662*	*59%*	*3,650*	*59%*
* *Strongly agree*	*142*	*20%*	*267*	*24%*	*1,594*	*26%*
Missing	420		625		2,861	
Positive Score	**82%**		**83%**		**84%**	
Negative Score	**4%**		**4%**		**4%**	
Base	**717**		**1,117**		**6,227**	

YOUR PERSONAL DEVELOPMENT (Continued)

18c. My training, learning or development has helped me to stay up-to-date with professional requirements.	2016		2017		Comparator	
	n	%	n	%	n	%
Not applicable to me	17	2%	33	3%	231	4%
* *Strongly disagree*	*3*	*0%*	*11*	*1%*	*48*	*1%*
* *Disagree*	*23*	*3%*	*25*	*2%*	*127*	*2%*
* *Neither agree nor disagree*	*74*	*11%*	*100*	*9%*	*575*	*10%*
* *Agree*	*461*	*66%*	*672*	*61%*	*3,564*	*59%*
* *Strongly agree*	*140*	*20%*	*285*	*26%*	*1,719*	*28%*
Missing	420		626		2,869	
Positive Score	**86%**		**88%**		**88%**	
Negative Score	**4%**		**3%**		**3%**	
Base	**701**		**1,093**		**6,033**	

18d. My training, learning or development has helped me to deliver a better patient / service user experience.	2016		2017		Comparator	
	n	%	n	%	n	%
Not applicable to me	22	3%	42	4%	347	6%
* *Strongly disagree*	*5*	*1%*	*12*	*1%*	*55*	*1%*
* *Disagree*	*25*	*4%*	*29*	*3%*	*161*	*3%*
* *Neither agree nor disagree*	*123*	*18%*	*155*	*14%*	*798*	*14%*
* *Agree*	*399*	*57%*	*621*	*57%*	*3,314*	*56%*
* *Strongly agree*	*142*	*20%*	*265*	*24%*	*1,558*	*26%*
Missing	422		628		2,900	
Positive Score	**78%**		**82%**		**83%**	
Negative Score	**4%**		**4%**		**4%**	
Base	**694**		**1,082**		**5,886**	

YOUR PERSONAL DEVELOPMENT (Continued)

19. Have you had any mandatory training in the last 12 months?	2016		2017		Comparator	
	n	%	n	%	n	%
* *Yes*	*855*	*82%*	*1,454*	*89%*	*8,197*	*96%*
* *No*	*191*	*18%*	*181*	*11%*	*385*	*4%*
Can't remember	39	4%	54	3%	152	2%
Missing	53		63		399	
Positive Score	**82%**		**89%**		**96%**	
Negative Score	**18%**		**11%**		**4%**	
Base	**1,046**		**1,635**		**8,582**	

20a. In the last 12 months, have you had an appraisal, annual review, development review, or Knowledge and Skills Framework (KSF) development review?	2016		2017		Comparator	
	n	%	n	%	n	%
* *Yes*	*905*	*83%*	*1,468*	*87%*	*7,685*	*88%*
* *No*	*184*	*17%*	*211*	*13%*	*1,068*	*12%*
Can't remember	20	2%	24	1%	140	2%
Missing	29		49		240	
Positive Score	**83%**		**87%**		**88%**	
Negative Score	**17%**		**13%**		**12%**	
Base	**1,089**		**1,679**		**8,753**	

20b. It helped me to improve how I do my job.	2016		2017		Comparator	
	n	%	n	%	n	%
Yes, definitely	134	15%	242	17%	1,541	20%
Yes, to some extent	424	47%	726	50%	3,872	51%
No	342	38%	488	34%	2,212	29%
Missing	238		296		1,508	
Positive Score	**62%**		**66%**		**71%**	
Negative Score	**38%**		**34%**		**29%**	
Base	**900**		**1,456**		**7,625**	

YOUR PERSONAL DEVELOPMENT (Continued)

20c. It helped me agree clear objectives for my work.	2016		2017		Comparator	
	n	%	n	%	n	%
Yes, definitely	222	25%	424	29%	2,594	34%
Yes, to some extent	488	54%	776	53%	3,836	50%
No	186	21%	253	17%	1,178	15%
Missing	242		299		1,525	
Positive Score	**79%**		**83%**		**85%**	
Negative Score	**21%**		**17%**		**15%**	
Base	**896**		**1,453**		**7,608**	

20d. It left me feeling that my work is valued by my organisation.	2016		2017		Comparator	
	n	%	n	%	n	%
Yes, definitely	182	20%	367	25%	2,265	30%
Yes, to some extent	408	46%	679	47%	3,426	45%
No	300	34%	402	28%	1,894	25%
Missing	248		304		1,548	
Positive Score	**66%**		**72%**		**75%**	
Negative Score	**34%**		**28%**		**25%**	
Base	**890**		**1,448**		**7,585**	

20e. The values of my organisation were discussed as part of the appraisal process.	2016		2017		Comparator	
	n	%	n	%	n	%
Yes, definitely	278	31%	626	44%	2,685	36%
Yes, to some extent	424	48%	625	44%	3,261	43%
No	186	21%	184	13%	1,572	21%
Missing	250		317		1,615	
Positive Score	**79%**		**87%**		**79%**	
Negative Score	**21%**		**13%**		**21%**	
Base	**888**		**1,435**		**7,518**	

YOUR PERSONAL DEVELOPMENT (Continued)

20f. Were any training, learning or development needs identified?	2016		2017		Comparator	
	n	%	n	%	n	%
Yes	553	63%	944	66%	4,918	66%
No	323	37%	481	34%	2,562	34%
Missing	262		327		1,653	
Positive Score	**63%**		**66%**		**66%**	
Negative Score	**37%**		**34%**		**34%**	
Base	**876**		**1,425**		**7,480**	

20g. My manager supported me to receive this training, learning or development.	2016		2017		Comparator	
	n	%	n	%	n	%
Yes, definitely	210	39%	418	45%	2,504	52%
Yes, to some extent	260	48%	409	44%	1,896	39%
No	72	13%	106	11%	437	9%
Missing	596		819		4,296	
Positive Score	**87%**		**89%**		**91%**	
Negative Score	**13%**		**11%**		**9%**	
Base	**542**		**933**		**4,837**	

YOUR ORGANISATION

To what extent do these statements reflect your view of your organisation as a whole?

21a. Care of patients / service users is my organisation's top priority.	2016		2017		Comparator	
	n	%	n	%	n	%
Strongly disagree	39	4%	38	2%	190	2%
Disagree	95	9%	107	6%	344	4%
Neither agree nor disagree	174	16%	235	14%	904	10%
Agree	501	45%	805	47%	4,071	46%
Strongly agree	299	27%	530	31%	3,410	38%
Missing	30		37		214	
Positive Score	**72%**		**78%**		**84%**	
Negative Score	**12%**		**8%**		**6%**	
Base	**1,108**		**1,715**		**8,919**	

21b. My organisation acts on concerns raised by patients /service users.	2016		2017		Comparator	
	n	%	n	%	n	%
Strongly disagree	23	2%	23	1%	140	2%
Disagree	46	4%	61	4%	161	2%
Neither agree nor disagree	269	24%	357	21%	1,429	16%
Agree	568	51%	900	53%	4,564	51%
Strongly agree	201	18%	367	21%	2,598	29%
Missing	31		44		241	
Positive Score	**69%**		**74%**		**81%**	
Negative Score	**6%**		**5%**		**3%**	
Base	**1,107**		**1,708**		**8,892**	

YOUR ORGANISATION (continued)

21c. I would recommend my organisation as a place to work.	2016		2017		Comparator	
	n	%	n	%	n	%
Strongly disagree	79	7%	81	5%	434	5%
Disagree	144	13%	155	9%	713	8%
Neither agree nor disagree	293	27%	380	22%	1,706	19%
Agree	413	37%	740	43%	3,600	40%
Strongly agree	175	16%	355	21%	2,448	28%
Missing	34		41		232	
Positive Score	**53%**		**64%**		**68%**	
Negative Score	**20%**		**14%**		**13%**	
Base	**1,104**		**1,711**		**8,901**	

21d. If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.	2016		2017		Comparator	
	n	%	n	%	n	%
Strongly disagree	27	2%	26	2%	172	2%
Disagree	34	3%	42	2%	160	2%
Neither agree nor disagree	150	14%	209	12%	812	9%
Agree	582	53%	854	50%	4,025	45%
Strongly agree	312	28%	573	34%	3,698	42%
Missing	33		48		266	
Positive Score	**81%**		**84%**		**87%**	
Negative Score	**6%**		**4%**		**4%**	
Base	**1,105**		**1,704**		**8,867**	

YOUR ORGANISATION (continued)

Patient / service user experience measures

22a. Is patient / service user experience feedback collected within your directorate / department? (e.g. Friends and Family Test, patient surveys etc.)	2016		2017		Comparator	
	n	%	n	%	n	%
* *Yes*	*568*	*85%*	*939*	*85%*	*5,313*	*90%*
* *No*	*98*	*15%*	*161*	*15%*	*604*	*10%*
Don't know	240	22%	364	21%	1,623	18%
Not applicable to me	193	18%	241	14%	1,345	15%
Missing	39		47		248	
Positive Score	**85%**		**85%**		**90%**	
Negative Score	**15%**		**15%**		**10%**	
Base	**666**		**1,100**		**5,917**	

To what extent do you agree with the following statements about feedback from patients / service users?

22b. I receive regular updates on patient / service user experience feedback in my directorate / department (e.g. via line managers or communications teams).	2016		2017		Comparator	
	n	%	n	%	n	%
* *Strongly disagree*	*43*	*8%*	*53*	*6%*	*262*	*5%*
* *Disagree*	*127*	*23%*	*162*	*18%*	*686*	*13%*
* *Neither agree nor disagree*	*118*	*22%*	*189*	*21%*	*991*	*19%*
* *Agree*	*188*	*35%*	*358*	*40%*	*2,130*	*42%*
* *Strongly agree*	*67*	*12%*	*129*	*14%*	*1,035*	*20%*
Don't know	20	4%	38	4%	164	3%
Missing	575		823		3,865	
Positive Score	**47%**		**55%**		**62%**	
Negative Score	**31%**		**24%**		**19%**	
Base	**543**		**891**		**5,104**	

YOUR ORGANISATION (continued)

22c. Feedback from patients / service users is used to make informed decisions within my directorate / department.	2016		2017		Comparator	
	n	%	n	%	n	%
* *Strongly disagree*	*33*	*7%*	*40*	*5%*	*181*	*4%*
* *Disagree*	*71*	*14%*	*98*	*12%*	*385*	*8%*
* *Neither agree nor disagree*	*169*	*34%*	*279*	*33%*	*1,374*	*29%*
* *Agree*	*174*	*35%*	*322*	*38%*	*1,940*	*41%*
* *Strongly agree*	*56*	*11%*	*98*	*12%*	*863*	*18%*
Don't know	57	10%	82	9%	500	10%
Missing	578		833		3,890	
Positive Score	**46%**		**50%**		**59%**	
Negative Score	**21%**		**16%**		**12%**	
Base	**503**		**837**		**4,743**	

BACKGROUND INFORMATION

About you

23a. Gender:	2016		2017		Comparator	
	n	%	n	%	n	%
Male	220	20%	297	17%	1,628	18%
Female	872	80%	1,380	81%	7,080	79%
Prefer to self-describe	-	-	5	0%	31	0%
Prefer not to say	-	-	30	2%	193	2%
Missing	46		40		201	

23b. Age:	2016		2017		Comparator	
	n	%	n	%	n	%
16 - 20	3	0%	8	0%	51	1%
21 - 30	131	12%	260	15%	1,528	17%
31 - 40	262	24%	430	25%	2,310	26%
41 - 50	311	28%	467	27%	2,353	27%
51 - 65	383	35%	528	31%	2,519	28%
66+	19	2%	9	1%	86	1%
Missing	29		50		286	

BACKGROUND INFORMATION (continued)

24. What is your ethnic background?	2016		2017		Comparator	
	n	%	n	%	n	%
White						
British	995	90%	1,541	91%	7,001	79%
Irish	15	1%	25	1%	168	2%
Any other White background	32	3%	42	2%	456	5%
Mixed						
White and Black Caribbean	5	0%	5	0%	44	0%
White and Black African	2	0%	1	0%	12	0%
White and Asian	3	0%	4	0%	39	0%
Any other mixed background	3	0%	9	1%	57	1%
Asian / Asian British						
Indian	24	2%	39	2%	356	4%
Pakistani	3	0%	4	0%	76	1%
Bangladeshi	0	0%	2	0%	30	0%
Any other Asian background	7	1%	8	0%	155	2%
Black / Black British						
Caribbean	1	0%	3	0%	103	1%
African	3	0%	6	0%	154	2%
Any other Black background	0	0%	1	0%	17	0%
Chinese and other ethnic background						
Chinese	3	0%	3	0%	50	1%
Any other ethnic background	4	0%	4	0%	107	1%
Missing	38		55		308	

BACKGROUND INFORMATION (continued)

25. Which of the following best describes how you think of yourself?	2016		2017		Comparator	
	n	%	n	%	n	%
Heterosexual (straight)	1,017	93%	1,575	93%	8,070	91%
Gay Man	12	1%	16	1%	93	1%
Gay Woman (lesbian)	9	1%	12	1%	74	1%
Bisexual	2	0%	8	0%	47	1%
Other	3	0%	2	0%	24	0%
I would prefer not to say	55	5%	86	5%	557	6%
Missing	40		53		268	

26. What is your religion?	2016		2017		Comparator	
	n	%	n	%	n	%
No religion	307	28%	444	26%	2,714	31%
Christian	712	64%	1,118	65%	5,044	57%
Buddhist	11	1%	8	0%	40	0%
Hindu	14	1%	24	1%	186	2%
Jewish	3	0%	6	0%	20	0%
Muslim	8	1%	15	1%	192	2%
Sikh	0	0%	0	0%	59	1%
Any other religion	10	1%	20	1%	110	1%
I would prefer not to say	41	4%	74	4%	501	6%
Missing	32		43		267	

BACKGROUND INFORMATION (continued)

27. Disability

27a. Do you have a long-standing illness, health problem or disability?	2016		2017		Comparator	
	n	%	n	%	n	%
Yes	192	18%	279	17%	1,204	14%
No	896	82%	1,402	83%	7,559	86%
Missing	50		71		370	

27b. Has your employer made adequate adjustment(s) to enable you to carry out your work?	2016		2017		Comparator	
	n	%	n	%	n	%
* *Yes*	*47*	*58%*	*105*	*73%*	*468*	*75%*
* *No*	*34*	*42%*	*38*	*27%*	*157*	*25%*
No adjustment required	109	57%	135	49%	565	47%
Missing	948		1,474		7,943	

28. How many years have you worked for this organisation?	2016		2017		Comparator	
	n	%	n	%	n	%
Less than 1 year	78	7%	113	7%	839	10%
1 - 2 years	144	13%	245	15%	1,386	16%
3 - 5 years	113	10%	252	15%	1,668	19%
6 - 10 years	205	18%	294	18%	1,603	19%
11 - 15 years	200	18%	257	16%	1,221	14%
More than 15 years	370	33%	480	29%	1,934	22%
Missing	28		111		482	

BACKGROUND INFORMATION (continued)

29. What is your occupational group?	2016		2017		Comparator	
	n	%	n	%	n	%
Allied Health Professionals / Healthcare Scientists / Scientific and Technical						
Occupational Therapy	4	0%	23	1%	84	1%
Physiotherapy	51	5%	81	5%	257	3%
Radiography	15	1%	22	1%	298	3%
Pharmacy	32	3%	47	3%	215	2%
Clinical Psychology	19	2%	28	2%	87	1%
Psychotherapy	11	1%	15	1%	25	0%
Arts therapy	2	0%	1	0%	1	0%
Other qualified Allied Health Professionals	48	4%	142	8%	372	4%
Support to Allied Health Professionals	12	1%	27	2%	148	2%
Other qualified Scientific and Technical or Healthcare Scientists	64	6%	43	3%	453	5%
Support to healthcare scientists	8	1%	8	0%	94	1%
Medical and Dental						
Medical / Dental - Consultant	93	9%	118	7%	514	6%
Medical / Dental - In Training	2	0%	3	0%	82	1%
Medical / Dental - Other	12	1%	21	1%	81	1%
Ambulance (operational)						
Emergency Care Practitioner	0	0%	1	0%	1	0%
Paramedic	0	0%	0	0%	1	0%
Emergency Care Assistant	0	0%	2	0%	2	0%
Ambulance Technician	0	0%	0	0%	0	0%
Ambulance Control Staff	0	0%	0	0%	0	0%
Patient Transport Service	0	0%	0	0%	4	0%
Public Health						
Public Health / Health Improvement	1	0%	2	0%	8	0%
Commissioning						
Commissioning managers / support staff	2	0%	2	0%	16	0%

BACKGROUND INFORMATION (continued)

29. What is your occupational group?	2016		2017		Comparator	
	n	%	n	%	n	%
Registered Nurses and Midwives						
Adult / General	18	2%	35	2%	1,148	13%
Mental health	7	1%	15	1%	41	0%
Learning disabilities	5	0%	6	0%	17	0%
Children	255	23%	388	23%	854	10%
Midwives	0	0%	1	0%	212	2%
Health Visitors	0	0%	4	0%	29	0%
District / Community	2	0%	3	0%	31	0%
Other Registered Nurses	7	1%	9	1%	75	1%
Nursing or Healthcare Assistants						
Nursing auxiliary / Nursing assistant / Healthcare assistant	75	7%	86	5%	445	5%
Social Care						
Approved social workers / Social workers / Residential social workers	1	0%	7	0%	16	0%
Social care managers	0	0%	0	0%	0	0%
Social care support staff	0	0%	0	0%	5	0%
Wider Healthcare Team						
Admin & Clerical	161	15%	242	14%	1,444	17%
Central Functions / Corporate Services	73	7%	91	5%	649	7%
Maintenance / Ancillary	40	4%	73	4%	315	4%
General Management						
General Management	41	4%	56	3%	313	4%
Other occupational group	33	3%	75	4%	395	5%
Missing	44		75		401	

30a. Do you work in a team?	2016		2017		Comparator	
	n	%	n	%	n	%
Yes	1,045	97%	1,634	96%	8,442	97%
No	36	3%	63	4%	258	3%
Missing	57		55		433	

BACKGROUND INFORMATION (continued)

30b. How many core members are there in your team?	2016		2017		Comparator	
	n	%	n	%	n	%
2-5	201	20%	286	18%	1,877	22%
6-9	220	21%	302	19%	1,807	22%
10-15	202	20%	302	19%	1,606	19%
More than 15	407	40%	738	45%	3,087	37%
Missing	108		124		756	

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

9th January 2018

Report of:	Director of Human Resources & Organisational Development
Paper Prepared by:	Director of Human Resources & Organisational Development
Subject/Title:	Health Education England Workforce Strategy
Background Papers:	n/a
Purpose of Paper:	To present to the Board the draft strategy setting out six key principles for all future workforce interventions for noting and/or discussion.
Action/Decision Required:	None.
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	The Best People Doing their Best Work
Resource Impact:	Organisations will be expected to carry out workforce impact assessment to help ensure "workforce competencies, skills and training as well as numbers are considered early in the planning phase".

Health Education England Workforce Strategy - Key Points

- Facing facts, shaping the future – a draft health and care workforce strategy to 2027

  (Health Education England, 2017)

Key points

- First national health and care workforce strategy for 25 years
- Sets out the challenge the service will face in meeting demand pressures over the next decade
- Builds on the NHS Five Year Forward View
- Sets out six key principles for all future workforce interventions
- The strategy is a draft for consultation, led by HEE.
- Local and national organisations expected to carry out workforce impact assessment to help ensure “workforce competencies, skills and training as well as numbers are considered early in the planning phase”

Current national workforce activity

- HEE has developed workforce plans to meet the Five Year Forward View vision
- National plans for priority groups e.g. cancer
- STP have developed LWABs to translate into action
- Action on new roles, eg nurse associates
- Routes into the NHS, eg apprenticeships
- Focus on being more flexible, eg ‘credentialling’ for all regulated healthcare professions
- Return to practice
- Increasing workforce supply (medical and nursing)

Why the need for a strategy?

- If no action is taken to reduce demand, the NHS will need to grow by 190,000 clinical posts by 2027 to meet demand
- Workforce has been growing, but more slowly than we need
- NHS needs a shared vision for workforce and a coherent framework for action
- Move from fixing problems to sustainable solutions

Aims

Strategy describes actions to:

- grow capacity and capability to move towards self-sustainability in workforce
- build the NHS's global reputation as a centre of excellence in healthcare education and training
- meet service requirements in the future through prevention, new technology and flexibility

Making the NHS an employer of choice

- The NHS must put people first and focus on the things that are important to staff.
- Reducing staff turnover should be a key focus, with organisations working to better understand the reasons for staff turnover
- Good people management is essential, alongside organisational culture, health and wellbeing, staff engagement and flexibility
- Leaders must be committed to doing the right thing for patients and staff within a culture of equality and diversity.
- Retention is easier when people are respected and valued.

Workforce growth

- Focus on three key areas:
  - Education - will deliver more medical school places, increased nursing undergraduate places and other priorities.
  - Retention – keeping existing staff has the most immediate impact
  - Recruitment from outside the NHS.

- Range of steps already been taken:
  - Promote careers in the NHS
  - Widen participation and opportunity
  - Expand medical and nursing supply
  - New professional roles within multi-disciplinary teams, for example physician associate
  - Creation of new roles, such as the nursing associate role
  - Increase number of apprenticeships
  - Developing the multi-disciplinary team

Global healthcare workforce

- Agreement now reached on the rights of EU nationals in the UK.
- Future arrangements being considered by MAC, including the role that EU migration plays in the health and care workforce with a report due by September 2018
- Aim to develop the NHS as a global centre of excellence for training of non UK healthcare staff.

Impact of technological innovation

- Provide staff with the skills to adapt new research, technology and innovation
- Technology review to be completed by the end of 2018 examining the impact of technological developments on:
  - How technology will change the role of clinical staff over next 20 years
  - Impact on the skills required by healthcare professionals
  - Consequences for the selection, education and training of current and future NHS staff
- HEE developing comprehensive agenda for advanced clinical practice, including upskilling of wider workforce
- Consider NHS ring-fenced workforce development funding

Six principles

A set of principles are proposed for future NHS workforce decisions, which aim to mitigate the risks associated with workforce planning:

1. Securing the supply of staff that are needed to deliver high quality care
2. Training, educating and investing in the workforce
3. Providing career pathways for all staff rather than just ‘jobs’
4. Ensuring that people from all backgrounds have the opportunity to contribute to, and benefit from, healthcare
5. Ensuring that the entire NHS is a modern model employer with flexible working patterns, career structures, and reward mechanisms
6. Ensuring that in the future service, financial and workforce planning are intertwined.

Consultation

- Consultation taking place on a series of questions based on the six principles
- Consultation is open until 23 March 2018
- NHS Employers will be gathering views to submit a collective response on behalf of employers in the NHS
- Final agreed strategy will be published in July 2018 and updated annually

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

9th January 2018

Workforce & Organisational Development Committee (WOD) – Chairs Note

1. Purpose of the Report

The purpose of this report is to update the Board on the key issues raised at the WOD Committee held in December 2017.

2. Key Issues

The following issues were raised and discussed at the Workforce & Organisational Development Committee on the 12th December 2017; the minutes of the meeting will be submitted to the March 2018 Board for noting.

- The Committee approved the reporting timetable for 2018/2019
- As the Committee was not quorate, the Terms of Reference were discussed and the Committee **noted** the changes made.
- The Committee **noted** the recommendations for The Best People Doing Their Best Work – Programme Assurance.
- The Committee received a presentation on a stocktake on LiA and **noted** the progress made.
- The Committee received a presentation on the Staff Survey results/strategy moving forward and **noted** progress made.
- The Committee received a Mandatory Training report outlining the progress made to support the Trust target to achieve 90% compliance for all Mandatory Training. The Committee **noted** the progress made and supports the ongoing efforts to reach the target.
- The Committee received an update of the Workforce Leading Indicators and **noted** the content.
- The Committee received the Board Assurance Framework 2017-18 and noted the content.
- The Committee **received** the Diversity & Human Rights Policy and EIA and agreed the policy will return following discussion at CQSG.
- The Committee **received** the Equality Analysis policy and EIA and agreed the policy will return following discussion at CQSG.

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 12th December 2017.

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Alder Hey Children's NHS
NHS Foundation Trust

ANNEX A

WORKFORCE & OD COMMITTEE
MINUTES FROM MEETING
29th September 2017

Present:	Ms C Dove	Non-Executive Director (Chair)	(CD)
	Mrs M Swindell	Director of HR & OD	(MKS)
	Mr I Quinlan	Non-Executive Director	(IQ)
In Attendance:	Mrs M Barnaby	Interim COO	(MB)
	Ms M Salcedo	HR Business Partner	(MS)
	Mrs S Owen	Head of HR	(SO)
	Ms D Brannigan	Patient Governor (Parent and Carer)	(DB)
	Mrs R Greer	ACOO – Community (Part Attendance)	(RG)
	Ms S Stephenson	HOQ – Community	(SS)
	Mrs S Brown	Associate Director of Development – Site	(SB)
	Mr R Griffiths	Deputy Director of Nursing	
Apologies:	Mr M Travis	Chair of Staff Side	(MT)
	Mrs J France-Hayhurst	Non-Executive Director	(JFH)
	Mr J Gibson	External Programme Assurance	(JG)
	Mrs H Gwilliams	Chief Nurse	(HG)
	Mr S Ryan	Medical Director	(SR)
	Mrs P Davies	Learning & Professional Development Manager	(PD)
	Mr N Davies	HR Business Partner	(ND)

Agenda Item	Key Discussion Points	Action	Owner	Timescale
17/27 Minutes of the Previous Meeting & Meeting Protocol	The Committee considered the minutes of the last meeting held on 21st June 2017 and they were **approved** as an accurate record. The Committee noted that the Marketing & Communications Director will be an attendee at future WOD Committees.			
17/28 Matters Arising, Actions	The Committee considered the following under matters arising: **17/20 Head of Planning & Performance revising Trust KPI's. Updated HR KPI's to be presented**. MKS advised that the Trust wide piece of work to review KPI's is ongoing. **16/35 People Strategy – present updated draft of the Refreshed People Strategy** MKS advised that talks will progress off-line prior to presenting at Trust Board. **17/02 Refreshed people strategy to be shared with JCNC**			

Agenda Item	Key Discussion Points	Action	Owner	Timescale
	MKS advised that the People Strategy has been shared at JCNC. Noted as complete on action list. **17/05 Apprenticeship Update & PID** Conversation re retention strategy for nursing workforce level with Chief Nurse and update on developments. MKS confirmed this had taken place. Noted as complete on action list. **16/39 Temporary Spend** To support robust monitoring of temporary spends, more detail to be brought back. MKS confirmed that this item is now monitored as part of the Change Programme. Noted as complete on action list. **17/24** Conversation with Peter Young re no response received when posting requests on Meditech. MKS confirmed that this had taken place. Noted as complete on action list. **17/26 AOB** Lack of communication to staff re structure for CBU/Divisions – liaise with Communications to issue an update to staff. MKS confirmed that this had taken place. Noted as complete on action list.			
17/29 Programme Assurance 'The Best People Doing Their Best Work'	**The Best People Doing Their Best Work – Programme Assurance Framework – September 2017** The Committee received a regular summary prepared by the Executive Sponsors of the Assurance Framework, External Programme Assessor and Assurance Team. The purpose of this assurance framework is to ensure the monitoring of robust processes for progression. All papers supporting Programme Assurance 'The Best People Doing Their Best Work' are recorded as read prior to the meeting. In the absence of the External Programme Assurance Manager, MKS gave a summary of the detail of the programme assurance framework for 'The Best People Doing Their Best Work. MKS highlighted that since the paper was put together, conversations have taken place with External Programme Assurance Manager to emphasise that the 1st two projects listed – Apprenticeships; Engagement & Communication should read as amber to reflect the latest position on the dashboard ratings. MKS also emphasised that HR, in the short term, have stepped up to support projects affected by absence of project managers due to illness. This has ultimately impacted on updating processes for the dashboard.			

Agenda Item	Key Discussion Points	Action	Owner	Timescale
17/30	**Agile Working** In-depth discussion commenced about the Agile project (dashboard rating of red). Highlights of discussions are: MKS advised that following a definitive decision on LCH bid due on 2nd October - agile plans will feed into that outcome. SB & MKS to meet in the next couple of weeks to progress the Agile Project. SB briefed the Committee on the 'desk usage' audit that had taken place on the retained estate (challenging as over embellishment of usage was fed back/with a reluctance of staff to sign up to further proposals). Other approaches were discussed i.e. review what has been achieved outside of the NHS; managing change with timelines in place; ensuring we are clear on Comms to staff; working from home; hot desking/storage. MKS gave an example of what is taking place at LCH that the Trust could capitalise on – all nurses are supplied with a lap top to enable more flexibility of working hours (check emails at home rather than come into office prior to visiting patients). It was acknowledged that this project will be a big cultural change for the Trust and noted that this project was very important piece of work and that it was imperative that the processes to support this project are ironed out. The committee **noted** the comments made.			
17/31 Progress Against the People Strategy	**Apprenticeship Update** The Committee received a verbal briefing from MKS outlining the latest developments with apprenticeships. The Committee noted there was a staff resource issue at the moment and the Head of HR has stepped in to support the process. Following implementation of this project 30 apprenticeships (our own staff) will join the Trust in October. The apprenticeship salary rates will be reviewed next and discussed with JCNC. The Trust is keen to use apprenticeships to support our diversity objectives. The Committee **noted** the comments made.			

Agenda Item	Key Discussion Points	Action	Owner	Timescale
17/32	**Staff Survey** The Committee received a report charting the key objectives for the 2017 Staff Survey and progress to date from MKS & MS – project manager for the survey. MS advised that to support the agreed objectives a Strategy group had been established to maximise response rates using best practice guidance; decide the content of the survey; ensure widespread communication, including a 'you said, we did' campaign across the organisation. The key objectives are - to increase the response rate to at least the benchmark response rate for Specialists Acute Trust; to see improvements in a number of key areas such as communication with senior managers, recognition and friends and family scores. MS outlined the decisions made to date as detailed in the report (noted as read). A detailed communications programme has been agreed aimed to engage staff to respond, with ongoing promotion. The survey is due for distribution week commencing 2nd October 2017, with completion date end November. Noted that last year's response rate was 39% (national average was 44% with acute specialist trust tending to be higher). In-depth discussion commenced about the objective of increasing response rates and the theory of improved responses to questions asked. Data relating to the response to questions asked in the Staff Survey will be released in January and MKS advised that we can then start thinking about disseminating/delving into the responses received. A further update will be brought to the next Committee. The Committee **noted** the content of the report.			
17/33	**Library Strategy** The Committee received the Library Strategy for approval. In the absence of the Medical Education & Revalidation Manager, MKS outlined the requirements. The library is required by HEE to submit an annual Library Quality Assurance Framework (LQAF) statement to the Health Care Libraries Unit. The compliance score is recorded in the LDA. There are five separate criteria with up to ten topics for which we provide evidence. One of the requirements is for the library to have an approved strategy for the service. In future the library strategy will be included in the Education Strategy once this has been finalised. As an interim measure, for the purpose of this year's submission, the current Library Strategy has been updated. The Committee noted that 98% compliance rate was achieved in 2016. The Committee discussed the utilisation of the library and noted it was an 'untapped resource'. MKS to enquire about what processes, if any, are in place for children at the library. The Committee **approved** the strategy.			

Agenda Item	Key Discussion Points	Action	Owner	Timescale
17/34	**Leadership & Management Development** The Committee received a report outlining the operational and strategic activity which has taken place since the strategy implementation 12 months ago, along with an update of planned activity for the 12 months ahead. The report was noted as read. Particular attention was brought to linking development into succession planning/progression and the requirement to review and set a standard process to support this. The Committee noted the importance of this piece of work and were assured by the progress made. The Committee **noted** the progress to date and planned activity for 2017/18.			
17/35	**Social Value Report** The Committee received a first draft of a social value report. The purpose of the report is to outline the ongoing work taking place at the Trust to delivery fairer and better health outcomes in a sustainable way, with fewer environmental and financial resources. MKS advised this was a first attempt at producing this particular type of report. As a starting point the report has established the work that the HR/OD team have been able to identify and was brought to the Committee for open discussion. A number of suggestions were put forward to support the further development of the issues. • Including learning from others, linking to wider parts of the organisation, the importance of procurement. • Review the reports produced by other institutions i.e. the Government (who have their report audited), Liverpool Museums & Liverpool University (produced very good reports). The Chair welcomed the report and acknowledged it as a first attempt to put Social Value on the agenda. All suggestions were noted with a view to CD facilitating an SV presentation to the Trust an organisation who do this successfully. The Committee **noted** the content of the report.			
17/36	**Corporate Objectives** The Committee received Corporate Objectives half year stock-take for assurance processes (objectives were agreed back in April in the Strategy). MKS gave a brief update of the corporate objectives under The Best People Doing Their Best Work theme. The objectives are noted as read. Particular attention was brought to sickness absence rates and the economic effects of sickness on the Trust. DB indicated that diversity was not visible in the corporate objectives and asked for an update at the next Committee.			

Agenda Item	Key Discussion Points	Action	Owner	Timescale
	The Committee **noted** the content of the Corporate Objectives.			
17/37 Key Workforce Risks – Review of top Workforce Risks action planning against most significant risks	**Workforce Performance Monitoring** The Committee considered a regular report prepared by the Director of HR & OD concerning the key risks relating to workforce monitoring for August 2017. The purpose of the report is to update on key targets/measures and advise of actions to support improvement. Key headlines are: Sickness absence 5.1% - the Trust is really sighted on flu vaccination for staff. Long term sickness has increased – this is harder to manage and Team Prevent (Occupational Health provider) ensures robust processes are in place. Good news story – PDR's 84% - this is testament to all the hard work the divisions have done. The Committee **noted** the content of the report.			
17/38 Legislation, terms & conditions, employment policies/EIA's – review & ratification/approval	The Committee considered the following Policies and Equality Impact Assessments for ratification and approval. **First Aid Policy** The Committee received the policy presented by Director of HR&OD. The Policy was noted as read. Discussion took place about the need of 2 methods for reporting first aid incidents i.e. Ulysses and accident books. MKS advised that she will discuss this further outside of this Committee with Amanda Kinsella and Cathy Umbers. The Committee agreed to postpone until further discussions are held. **Uniform & Dress Code Policy** This policy was brought to WOD for information purposes prior to being presented to CQAC for ratification. The Committee **noted** the content.			
17/39 AOB	None.			
Date of Next Meeting	**Wednesday 8th November 2017, 9am-11am, Room 8, Mezzanine (Rescheduled originally 25th October)**			

Action List

Minute Reference	Action	Who	When	Status
Meeting Protocol				
	Terms of Reference			
16/33 17/20	• Review of key performance indicators required against the workforce plan to ensure they reflect the workforce strategy. • Head of Planning & Performance revising Trust KPI's, Updated HR KPI's to be presented.	MKS/CD MKS	Work to be completed by April 18.	
Programme Assurance 'Developing Our Workforce'				
	Programme Assurance/progress update			
17/21	• Feedback on outcomes of Change Programme Framework • Update on identified resource for Projects AHP, Temporary Staffing and E-Rostering	JG MKS	December 2017 December 2017	
People Strategy Overview & Progress Against Strategic Aims				
	People Strategy			
16/35, 17/02	• Present updated draft of the Refreshed People Strategy • Refreshed People Strategy to be shared with JCNC.	MKS MKS	TBC March 2017	Complete
	LiA			
16/38	• Present Communications Plan	KT/Communications	TBC	
	Engagement			
15/08 16/02	• Develop Values in Procurement, values based recruitment – develop opportunities to incorporate into the Procurement processes/standards for contractors. Liaise with Deputy Director of Finance to progress to review employment opportunities.	MKS/CL	Ongoing	
	Equality & Diversity			
15/03	• Align E&D deliverables with people strategy	HA	Ongoing	Update at future meetings
17/13	• Equality Objectives Plan for 2017/18 – Quarterly Update required & Objectives to be reviewed every 6 months • Equality Metrics Report to be brought back to next Committee	HA HA/SM	1/4ly Update 6 monthly Review Ongoing	
	Leadership & Management Development Strategy			
15/31 16/03 & 16/33	• Update on progress of Leadership & Management Development Strategy	FF	September 2017	
	Apprenticeship Update & PID			
17/05	• Conversation re retention strategy for nursing workforce level with Chief Nurse and update on developments •	MKS	April 2017	**Complete**
	Corporate Objectives			

17/23	• For assurance processes update on Corporate Objectives	MKS	September 2017	
Key Workforce Risks – Review of Top Workforce Risks				
	Temporary Spend			
16/39	• To support more robust monitoring of temporary spend, more detail to be brought back.	MKS	February 2017	**Complete – now monitored as part of Change Programme**
17/24	• Conversation with Peter Young re no response received when posting requests on Meditech	MKS	September 2017	**Complete**
AOB				
17/26	• Lack of communication to staff re structure for CBU/Divisions – liaise with Communications to issue an update to staff.	MKS	September 2017	**Complete**

Alder Hey Children's NHS
NHS Foundation Trust

ANNEX A

WORKFORCE & OD COMMITTEE
MINUTES FROM MEETING
8th November 201

Present:	Ms C Dove	Non-Executive Director (Chair)	(CD)
	Mrs M Swindell	Director of HR & OD	(MKS)
	Mrs J France-Hayhurst	Non-Executive Director	(JFH)
In Attendance:	Mr J Gibson	External Programme Assurance (Part Attendance)	(JG)
	Ms M Salcedo	HR Business Partner	(MS)
	Mrs S Owen	Head of HR	(SO)
	Ms D Brannigan	Patient Governor (Parent and Carer)	(DB)
	Mrs R Greer	ACOO – Community (Part Attendance)	(RG)
	Ms S Stephenson	HOQ – Community	(SS)
	Mr R Griffiths	Deputy Director of Nursing	(RG)
	Ms E. White	Care Pathways, Policies & Guidance	(EW)
	Mr M Flannagan	Director of Communications & Marketing	(MF)
	Ms G Smith	General Manager	(GS)
	Ms H Blackburn	Medical Education & Revalidation Manager	(HB)
	Ms J Foster	Finance – Business Accountant	(JF)
	Mr S Ryan	Medical Director	(SR)
Apologies:	Mrs S Brown	Associate Director of Development – Site	(SB)
	Mr I Quinlan	Non-Executive Director	(IQ)
	Mr Will Weston	Associate COO	(WW)
	Mrs C Liddy	Operational Director of Finance	(CL)

Agenda Item	Key Discussion Points	Action	Owner	Timescale
17/40 Minutes of the Previous Meeting & Meeting Protocol	Due to unforeseen circumstances the minutes of the last meeting on 29th September 2017 were not ready for approval and will be considered for approval at the meeting scheduled for 12th December 2017. MKS advised that following a recent Staff Side election, 3 official roles have been put in place to support working partnerships: Tony Johnson – Chair, Unite Kerry Turner - Vice Chair, RCN Clare Jones - Secretary, Royal College of Dietetics MKS advised that the CEO is keen to meet with the representatives and further develop partnership working. CD acknowledged that the Committee was grateful for the part the outgoing Chair Mike Travis has played in his role of Staff Side Chair in			

Agenda Item	Key Discussion Points	Action	Owner	Timescale
	supporting WOD. The Committee **noted** the outcome of the recent Staff Side election.			
17/41 Matters Arising, Actions	None.			
17/42 Programme Assurance 'The Best People Doing Their Best Work'	**The Best People Doing Their Best Work – Programme Assurance Framework – November 2017** The Committee received a regular summary prepared by the Executive Sponsors of the Assurance Framework, External Programme Assessor and Assurance Team. The purpose of this assurance framework is to ensure the monitoring of robust processes for progression. All papers supporting Programme Assurance for the work stream 'The Best People Doing Their Best Work' are recorded as read prior to the meeting. The Committee noted that it was agreed at Programme Board on 26th October 2017 that the Agile project be removed from the programme scope to ensure that aims and objectives of the initiative are delivered through the various 'move' projects. JG alluded to the dashboard and advised that the date highlighted in red font is when information relating to individual projects was last updated on SharePoint. JG restated that significant progress needs to be made in terms of project work and documentation if any reasonable level of confidence in delivery is to be attained. JG paid particular attention to the following projects on the dashboard: • Specialist Nursing Review – no updates on SharePoint since 21st June 2017; RG advised of a re-think about how it will be implemented and he will pick up with Chief Nurse. CD emphasised the importance of workforce development for nursing as a number of key nurses will be retiring. • AHP Review – scoping requires more capacity/resource and advised taking this back to Programme Board to agree next steps; • E-Rostering – shows that a review was due at the end of July, but no further updates on SharePoint, is it going to be resource or put back until next year; RG advised that this project is going ahead and that the PID needs to be prepared. JG to copy RG into escalation and decision making processes (Execs & Programme Board). MKS advised that the Apprenticeship Project will be updated as part of a leaving remit for project lead. CD alluded to the opportunity for apprenticeship nursing in partnership with Edge Hill and the requirements for a framework to be put in place to	.		

Agenda Item	Key Discussion Points	Action	Owner	Timescale
	support this. The Committee **noted** the comments made.			
17/43 Progress Against the People Strategy	**Staff Survey** The Committee received a verbal update on progress made to date following distribution of the staff survey week commencing 2nd October. MKS informed the Committee that 40% response rate across the Trust has been received to date and advised that the Divisions are doing well with Surgery needing more focus to increase their response rates. MF advised on the Comms activity/initiatives taking place to increase response rates this year. Comms forward planning processes for 2018's staff survey are in place. For staff assurance, MF agreed to issue a Comms to emphasise that all staff survey responses are confidential/anonymous to the Trust. The Committee noted that the Trust is reaping the benefits of the 'local conversations' that took place last year, with increased visibility via Comms to help support completion of Staff Survey. JF highlighted the requirement to ensure that staff realise that when responding to Staff Survey, all constructive criticism is welcomed. The Committee noted that once data relating to responses is released in January 2018 it will be very informative to see that data explored further. The Committee **noted** the progress made.			
17/44	**Mandatory Training** The Committee received a report outlining the progress made to support the Trust's target to achieve 90% compliance, for all mandatory training subjects by end of January 2017. The Head of HR, SO outlined the factors that have previously affected the non achievement of the targets and progress made to improve compliance rates. The report is noted as read. SO advised the report will also be received at CQAC. Particular attention was brought to 'System Issues' – colleagues have utilised expertise from LCH to support improvements within the module of ESR system that manages and records training. This expertise will continue until the end of year with training provided to AH staff. IT issues regarding access to e-learning from AH desktops have been resolved. In addition electronic payslips and online ESR system which is accessible on phones, tablets and desktops has been rolled out to all staff. The system gives access to personal mandatory training records and also gives access to online learning system, so staff are able to complete mandatory training as flexibly as staff wish. Detailed compliance reports have been distributed to all teams and the L&D coordinator is meeting all managers around the Trust			

Agenda Item	Key Discussion Points	Action	Owner	Timescale
	supporting them with understanding their data and improving compliance. Discussion commenced about the recording processes in place for mandatory training (currently they are paper based registers); CD suggested that electronic registers may be easier to maintain. MKS advised that more focus is being given to mandatory training within divisional and corporate performance reviews and the status is now reported on a weekly basis to the Executive Team Meeting. Following receipt of CQC report particular emphasis is on Safeguarding Level 3 Training. RG is doing a piece of work in Re-sus to support this. MKS advised further updates will be brought back to WOD. The Committee **noted** the progress made with mandatory training and supports the ongoing efforts to reach the target.			
17/45 Key Workforce Risks – Review of top Workforce Risks action planning against most significant risks	**Workforce Performance Monitoring** The Committee considered a regular report prepared by the Director of HR & OD concerning the key risks relating to workforce monitoring for September 2017. The purpose of the report is to update on key targets/measures and advise of actions to support improvement. Key headlines are: 5% sickness 1/2% above target. PDR's tracking currently at 86%. The Committee **noted** the content of the report.			
17/46	**WRES Action Plan & Data and Reporting Template** The Committee received an action plan and data prepared by the Equality & Diversity Manager, all documents are noted as read. MKS advised that the action plan and reporting template that supports WRES standards was approved at Trust Board on 7th November 2017and prior to publication requires sign-off at WOD. Particular attention was paid to workforce race equality indicators and the implications of the data. MKS emphasised that the long term target, over 5 years, is to increase the numbers of black and minority ethnic (BME) staff employed at the Trust by 1% per year. This is in order to achieve a workforce aligned more closely to the local working population. Liverpool BME population is 11% and the Trust only has 5% BME staff. MKS acknowledged that following interventions i.e. the introduction of BME Task & Finish Group, we still have a long way to go. The WRES action plan aims to improve the employment opportunities for BME applicants and staff and the work experience of black and minority ethnic staff we employ at the Trust.			

Agenda Item	Key Discussion Points	Action	Owner	Timescale
	A number of initiatives/observations were raised: • Work together with Comms to improve diverse visuals to reflect culture (i.e. posters). • Go out into different communities/organisations • Release more information to different communities about how you can join Alder Hey and how we recruit. • Task & Finish group – regroup – network – open it up to more staff that work at Alder Hey. • Pre-employment programme, SO advised that conversations have taken place with Equality & Diversity Manager to suggest an extension of the programme to link into job centres in diverse areas. • Look at mentoring/coaching • SR advised that at Bart's they developed clinical conscious bias training, this training was very beneficial. • CD added that diversity in Liverpool is particularly not good. Take off-line, all to think about how best to progress this issue. The Committee approved the content of the reports.			
17/47 Legislation, terms & conditions, employment policies/EIA's – review & ratification/approval	The Committee considered the following Policies and Equality Impact Assessments for ratification and approval. SO advised that each policy has been through a consultation process and agreedf at the new Policy Review Group. **Disciplinary Policy** SO gave a brief outline of updates to policy. A user guide has been added along with values and behaviours and the right to curtail procedures. Other key changes are in the outcome of disciplinary section, after deliberation it was agreed to be more flexible to allow for both outcomes. The Committee **ratified** the policy. **Disciplinary EIA** The Committee **approved** the EIA **Supporting Staff Involved in Traumatic/Stressful Incidents, Complaints or Claims Policy** SO gave a brief outline of changes to the policy. Total re-write of policy. User guide			

Agenda Item	Key Discussion Points	Action	Owner	Timescale
	added. Advised that Section 9 is to be removed as this was an oversight. Discussion took place about monitoring processes in place. SR suggested it would be good to report back on usage of this policy to support processes and he would be happy to help from a medics point of view. The Committee **ratified** the policy. **Supporting Staff EIA** The Committee **approved** the EIA. **Capability Policy** SO gave a brief outline of changes to the policy. Complete re-write has been completed. A one page process has been introduced. Advised that section 9 needs removing. No significant fundamental changes. GS advised that at a recent staff intervention referral was made to the Capability policy. The support that was received from HR was really good. The Committee **ratified** the policy **Capability EIA** The Committee approved the EIA.			
17/48 AOB	SS advised that the verbal feedback was good for Customer Service Training and asked if this is something the Trust is going to continue? Discussion commenced about the requirement of Customer Service Training particularly for front line staff. The Committee noted the importance of this issue. MKS advised this will be taken off-line and progressed once reorganisation of Learning & Development has taken place. HB made reference to the Library Strategy approval. MKS confirmed that the Library Strategy was approved at Septembers WOD Committee and will go to Trust Board for information.			
Date of Next Meeting	**Tuesday 12th December 2017, 2pm-4pm, Room 6, Mezzanine.**			

Action List

Minute Reference	Action	Who	When	Status
Meeting Protocol				
	Terms of Reference			
16/33 17/20	• Review of key performance indicators required against the workforce plan to ensure they reflect the workforce strategy. • Head of Planning & Performance revising Trust KPI's, Updated HR KPI's to be presented.	MKS/CD MKS	Work to be completed by April 2018	
Programme Assurance 'Developing Our Workforce'				
	Programme Assurance/progress update			
17/21	• Feedback on outcomes of Change Programme Framework • Update on identified resource for Projects AHP, Temporary Staffing and E-Rostering	JG MKS	December 2017 December 2017	
People Strategy Overview & Progress Against Strategic Aims				
	People Strategy			
16/35,	• Present updated draft of the Refreshed People Strategy	MKS	TBC	
	LiA			
16/38	• Present Communications Plan	KT/Communications	December	
	Engagement			
15/08 16/02	• Develop Values in Procurement, values based recruitment – develop opportunities to incorporate into the Procurement processes/standards for contractors. Liaise with Deputy Director of Finance to progress to review employment opportunities.	MKS/CL	Ongoing	
	Equality & Diversity			
15/03	• Align E&D deliverables with people strategy	HA	Ongoing	Update at future meetings
17/13	• Equality Objectives Plan for 2017/18 – Quarterly Update required & Objectives to be reviewed every 6 months • Equality Metrics Report to be brought back to next Committee	HA HA/SM	1/4ly Update 6 monthly Review Ongoing	
	Leadership & Management Development Strategy			
15/31 16/03 & 16/33	• Update on progress of Leadership & Management Development Strategy	FF	September 2017	Completed
	Corporate Objectives			
17/23	• For assurance processes update on Corporate Objectives	MKS	September 2017	Completed
Key Workforce Risks – Review of Top Workforce Risks				

AOB				

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Tuesday 9 January 2018

Report of:	External Programme Assurance
Paper Prepared by:	Joe Gibson, External Assurance and John Grinnell, Executive Sponsor
Subject/Title:	Programme Assurance Summary Change Programme
Background Papers:	Reports to Trust Board sub-Committees as attached
Purpose of Paper:	To apprise the Board of the Assurance status of the change programme and the actions that have been requested of Executive Sponsors
Action/Decision Required:	For information
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	The change programme is fundamental to the Trust's strategic direction' and links to all strategic objectives.
Resource Impact:	Nil

Alder Hey Children's NHS
NHS Foundation Trust

Programme Assurance Summary
Change Programme

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

1. The assurance ratings continue to be addressed albeit the pace is too slow; therefore, we have recruited a programme and project manager to assist the Medical Division project work as well as address compliance issues across the portfolio. We expect this additional capacity to increase assurance.
2. The High Level Plan shared at the December Board continues to be refined and will be submitted, in its completed state, to the Programme Board on 25 January 2018 and, thereafter, to the Trust Board on 6 February 2018. The Plan will evidence the renewed focus on benefits and the application of programme 'gates' to describe which phase – Initiation / Design / Implementation / Sustain – each project is in.
3. The financial benefits being delivered by our change portfolio are still not meeting targets and this has formed a critical strand of the programme review to ensure that our forecasts of efficiencies derived from the programme are accurate for FY 18/19.

J Grinnell 20 Dec 17

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

1. This Board report contains assurance reports submitted to the following sub-Cttes: WOD on 12 Dec 17, R&BD on 13 Dec 17 and CQAC on 15 Dec 17.
2. The scope of the programme and the contribution to CIP benefits are shown in the following slides; the financial contributions continue to represent a key risk being significantly below target in many work streams; the gamut of efficiency measures now required to offset this shortfall are subject to a robust weekly review of delivery.
3. The overall assurance ratings continue to show a modest improvement but accelerating actions to improve the level of assurance is entirely feasible and should be the subject of increased focus and attention by Executive Sponsors, Corporate Leads and their teams.

J Gibson 20 Dec 17

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

See attached CIP status sheets. The change programme contribution to CIP has seen a significant shortfall and efficiencies are having to be found in other areas.

Change Programme

18 December 2017_v16

Trust Board

Alder Hey Children's NHS
NHS Foundation Trust

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

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

25/37 = £ indicated projects

Deliver Outstanding Care

Hilda / Steve

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

Growing Through External Partnerships

John / Steve SG

1. Single Service, 2 Site, Neonatal Service £
2. Strong Community Services Offer - Transition of New Community Services
3. International Health and Non-NHS Patients £
4. CHD Liverpool Partnership £
5. Aseptics £

The Best People Doing Their Best Work

Melissa/Hilda

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

Global Digital Exemplar

John/Steve

1. Speciality Packages £ SG
2. Voice Recognition £

RE&I

Game Changing Research & Innovation

David

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

Park, Community Estate & Facilities

David

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

Strong Foundations

John

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

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

Alder Hey Children's NHS
NHS Foundation Trust

In Year Forecast: £2.3m Shortfall

Division	Director	Target £000's	Forecast £000's	Gap £000's	% of Target
Community	Catherine McLaughlin	699	426	-273	61%
Medicine	Adrian Hughes	3,013	1,723	-1,289	57%
Surgery	Christian Duncan	2,890	2,803	-88	97%
Subtotal		**6,602**	**4,951**	**-1,650**	
Alder Hey in the Park	David Powell	406	178	-228	44%
Facilities	Hilda Gwilliams	298	73	-225	25%
Nursing & Quality	Hilda Gwilliams	97	0	-97	0%
Finance & IMT	John Grinnell	244	248	4	102%
Human Resources	Melissa Swindell	112	53	-59	47%
Other Corporate Services	Erica Saunders	112	116	4	104%
R&D	Michael Beresford	130	130	0	100%
Grand Total		**8,000**	**5,749**	-2,251	

Four Corporate Divisions Forecasting <50% of their CIP target

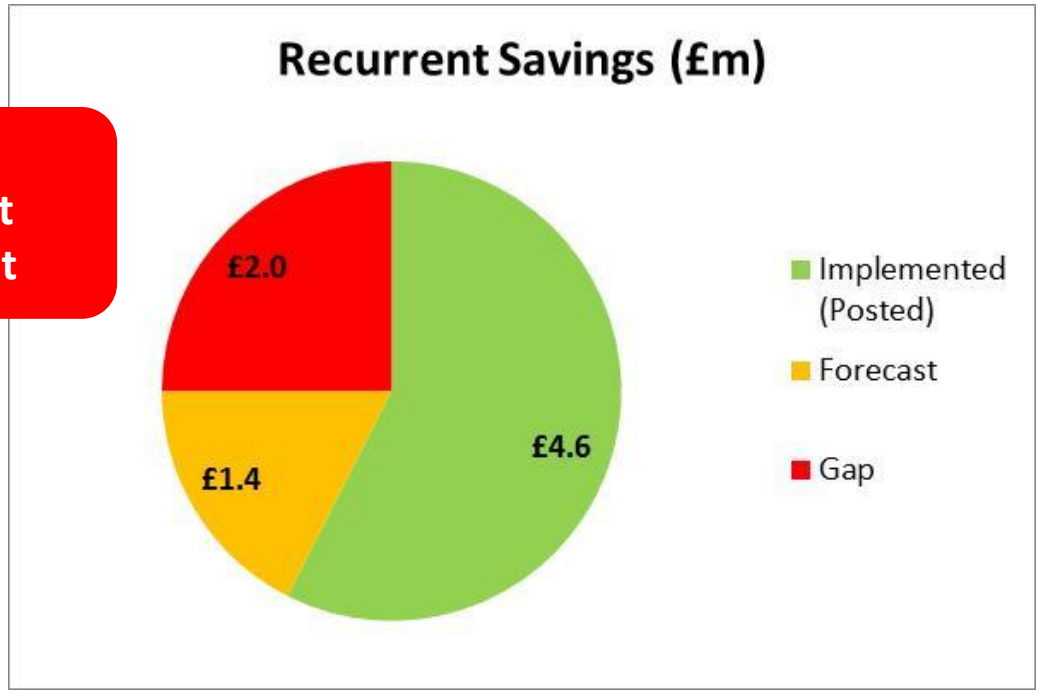
Inspired by Children

Alder Hey Children's NHS
NHS Foundation Trust

Recurrent Savings: £3.4m Risk

£2.0m - £3.4m Shortfall against Recurrent Target

£1.4m Risk subject to implementation of new schemes during Nov-Mar



Recurrent Shortfall will be carried forward to the new financial year:

2018/19 CIP Target	£6.0m
Carry Forward	£3.4m
Savings Required in 18/19	£

Inspired by Children

Corporate Report

Nov 2017

Corporate Report

Alder Hey Children's NHS
NHS Foundation Trust

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Executive Summary

Nov 2017

Alder Hey Children's NHS Foundation Trust

Is there a Governance Issue?

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

Highlights

November has seen winter pressures start with high levels of ED attendance continue. ED attendance has not just been minor patients but we have also noted increases in more complex and sicker children attending. In addition to this we have had to manage the temporary closure of 4A due to an outbreak of norovirus plus manage measles outbreaks. Hospital occupancy is up which means that we are using more of our available beds. Despite our best efforts to manage the above we have had to cancel elective operations and did not achieve the National 4 hour standard for November.

Challenges

The Trust winter plan has now formally commenced. Continuing higher than planned levels of Non Elective admissions for surgery and medicine in conjunction with high levels of ED attendance have made November a challenging month. Analysis identifies increased acuity in ED attendance also. Compounding the challenge were 2 infection control challenges with measles and norovirus. Noro outbreak temp closed 24 beds on 4A. This has severely affected flow which resulted in high levels of elective cancellation and ED breaches and reduced activity against forecast. Productivity was adversely affected and theatre productivity dropped however OP utilisation has increased and DNA rates reduced.

Patient Centred Services

Overall improvement noted in performance in metrics despite challenging operational conditions. High levels of NEL admission, ED attendance and temp. ward closure have continued to test the hospital and deterioration noted with theatre utilisation for medical and surgical areas. Increased cancelled operations on the day have also resulted from this. OP utilisation has increased and with it reduced DNA rates whilst positive caution required due to cashing up impact and requires further review. ED metrics remain in a challenged position reflecting departmental issues due to volume and acuity. Incomplete, diagnostic and cancer standards achieved despite current operational environment.

Excellence in Quality

A sustained reduction in medication errors associated with harm and in the total number of healthcare acquired infections has been seen in November, however there was one case of MRSA bacteraemia, which has had a full Post Infection Review.
November saw an improvement in 4 of the key patient experience measures, however the number of formal complaints increased to 12 in month, which is the highest in month figure this year. Cumulatively this remains slightly higher than last year.
The number of acute readmissions of patients with long term conditions was 3 in November and 46 year to date. We are currently establishing a baseline for this measure. There were also 3 in hospital deaths in November, compared to 6 deaths in the same month last year. There was an increase in number of surgical patients
that were discharged later than their planned date (57). This equates to 3.8% of surgical procedures compared to 5.7% this time last year.

Financial, Growth & Mandatory Framework

For the month of November the Trust is reporting a trading surplus of £1.2m which is £0.4m ahead of plan.

Income is ahead of plan mainly due to technical adjustments which are offset by expenditure. Shortfalls in elective income (£0.6m)is offset by over performance in non elective activity (£0.8m) and outpatients (£0.1m). Elective activity is behind plan by 9%, non elective is ahead by 21% and outpatient activity is ahead by 1%.

Pay budgets are 0.7m overspent for the month relating to use of temporary staffing and the impact of unachieved savings targets. The Trust is behind plan with the CIP target by £0.7m to date. Cash in the Bank is £6.8m. Monitor Use of Resources rating of 3 in line with plan.

Great Talented Teams

The Trust position on sickness absence of 5.1% for Nov, remains at a similar position to the previous month, only showing a marginal decrease. Similarly for PDR's the position remains static at 87%, this is explained by the compliant window for undertaking PDR's running from April –July. The core mandatory training position continues to show a month on month increase, reporting 81% as of end Nov. Maintaining this pace the trajectory would indicate that by end of January the Trust will be 90% compliant in core mandatory training.

Leading Metrics

Nov 2017

Alder Hey Children's NHS
NHS Foundation Trust

Patient Centered Services

Metric Name	Goal	Oct 2017	Nov 2017	Trend	Last 12 Months
ED: 95% Treated within 4 Hours	95.0 %	94.5 %	92.8 %	▼	
RTT: 90% Admitted within 18 weeks		89.2 %	90.4 %	▲	
RTT: 95% Non-Admitted within 18 weeks		90.3 %	90.3 %	▼	
RTT: 92% Waiting within 18 weeks (open Pathways)	92.0 %	92.2 %	92.0 %	▼	
Diagnostics: Numbers waiting over 6 weeks		0	0	–	
Average LoS - Elective (Days)		2.6	3.0	▲	
Average LoS - Non-Elective (Days)		2.0	2.0	▼	
Daycase Rate	0.0 %	71.2 %	72.2 %	▲	
Theatre Utilisation - % of Session Utilised	90.0 %	86.4 %	84.4 %	▼	
28 Day Breaches	0.0	8	5	▼	
Clinic Session Utilisation	90.0 %	85.7 %	86.3 %	▲	
DNA Rate	12.0 %	10.3 %	9.3 %	▼	
Cancelled Operations - Non Clinical - On Same Day		26	41	▲	

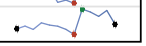
Excellence in Quality

Metric Name	Goal	Oct 2017	Nov 2017	Trend	Last 12 Months
Never Events	0.0	0	0	–	
IP Survey: % Received information enabling choices about their care	90.0 %	96.1 %	94.9 %	▼	
IP Survey: % Treated with respect	100.0 %	99.3 %	99.8 %	▲	
IP Survey: % Know their planned date of discharge	80.0 %	57.4 %	61.9 %	▲	
IP Survey: % Know who is in charge of their care	95.0 %	93.8 %	94.9 %	▲	
IP Survey: % Patients involved in play and learning	80.0 %	72.6 %	76.7 %	▲	
Pressure Ulcers (Grade 2 and above) YTD		26	30	▲	
Total Infections (YTD)	55.0	36	49	▲	
Medication errors resulting in harm (YTD)	40.0	12	16	▲	
Clinical Incidents resulting in harm (YTD)	392.0	522	621	▲	

Great and Talented Teams

Metric Name	Goal	Oct 2017	Nov 2017	Trend	Last 12 Months
Corporate Induction	100.0 %	69.2 %	96.9 %	▲	
PDR	90.0 %	87.3 %	86.9 %	▼	
Medical Appraisal	100.0 %	8.0 %	11.6 %	▲	
Sickness	4.5 %	5.3 %	5.1 %	▼	
Mandatory Training	90.0 %	75.5 %	81.4 %	▲	
Staff Survey (Recommend Place to Work)		TBC	TBC		
Actual vs Planned Establishment (%)		94.4 %	93.2 %	▼	
Temporary Spend ('000s)		918	938	▲	

Financial, Growth and Mandatory Framework

Metric Name	Oct 2017	Nov 2017	Last 12 Months
CIP In Month Variance ('000s)	-459	-433	
Monitor Risk Ratings (YTD)	3	3	
Trading Surplus/(Deficit)	317	1296	
Capital Expenditure YTD % Variance	-56.6 %	6.6 %	
Cash in Bank (£M)	10.9	6.8	

Exceptions

Nov 2017

Alder Hey Children's NHS Foundation Trust

Positive (Top 5 based on % change)

Metric Name	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Last 12 Months
DNA Rate	11.9%	14.6%	12.9%	12.7%	10.6%	12.7%	12.7%	12.5%	12.4%	13.9%	11.4%	10.3%	9.3%	
Corporate Induction	74.1%	81.5%	77.8%	77.8%	82.4%	82.9%	85.7%	79.3%	100.0%	55.6%	85.0%	69.2%	96.9%	
Cancelled Operations - Non Clinical - On Same Day	28	12	17	29	31	7	57	19	31	15	48	26	41	
Mandatory Training	75.3%	76.1%	77.2%	78.8%	75.4%	76.1%	76.0%	76.2%	78.2%	77.2%	74.4%	75.5%	81.4%	
Trading Surplus/(Deficit)	1,104	-776	535	470	5,972	-1,905	-448	-127	-270	-1,691	-456	317	1,296	

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

Metric Name	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Last 12 Months
RTT: 92% Waiting within 18 weeks (open Pathways)	92.1%	92.1%	92.4%	92.1%	92.1%	92.1%	92.1%	92.1%	92.0%	92.0%	92.1%	92.2%	92.0%	
Theatre Utilisation - % of Session Utilised	85.1%	84.1%	86.6%	87.0%	86.8%	87.2%	87.3%	88.3%	86.1%	87.5%	86.5%	86.4%	84.4%	
IP Survey: % Received information enabling choices about their care	96.4%	96.3%	98.7%	96.0%	96.0%	94.1%	94.9%	94.7%	95.7%	92.1%	96.5%	96.1%	94.9%	
Cash in Bank (£M)	5.4	6.2	5.2	7.2	6.5	6.2	5.2	3.7	11.3	10.4	9.1	10.9	6.8	
Medication errors resulting in harm (YTD)	39	44	52	57	66	1	2	3	7	9	11	12	16	

Challenge (Top 5 based on % change)

Metric Name	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Last 12 Months
28 Day Breaches	4	3	2	4	2	4	2	5	1	9	0	8	5	
Sickness	5.4%	5.5%	5.4%	5.3%	4.7%	4.5%	4.6%	4.6%	5.0%	4.9%	4.8%	5.3%	5.1%	
IP Survey: % Know their planned date of discharge	73.5%	73.1%	78.7%	72.0%	75.7%	79.4%	69.1%	65.5%	64.0%	53.9%	65.0%	57.4%	61.9%	
Pressure Ulcers (Grade 2 and above) YTD	22	26	28	29	32	2	7	12	20	22	23	26	30	
Clinical Incidents resulting in harm (YTD)	442	503	565	634	738	60	131	210	307	376	450	522	621	

Patient Safety

Nov 2017

Alder Hey Children's NHS Foundation Trust

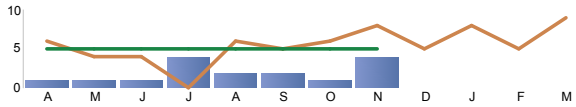
Summary

Medication errors with harm remain low at 4 in month. Work continues to further improve our reporting of all incidents whether or not they are associated with harm. There were 100 clinical incidents associated with harm. Year to date this is now 633 compared to 442 last year. There were zero never events in month, which remains at 1 year to date. Four pressure ulcers (Grade 2 and above) were reported in November, i.e. 30 ytd compared to 22 this time last year. There was 1 readmission to PICU within 48 hrs of discharge which is now 16 ytd compared to 14 last year.

17/18 16/17 Threshold

Medication Errors

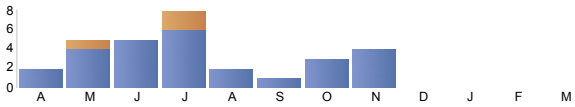
Medication errors resulting in harm (YTD) 16 (goal: 40.0)



YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	1	2	3	7	9	11	12	16				
16/17	6	10	14	14	20	25	31	39	44	52	57	66

Pressure Ulcers

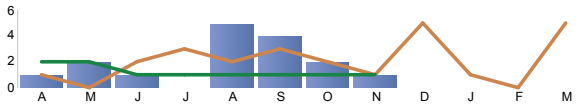
Pressure Ulcers (Grade 2 and above) YTD 30 (Est. Baseline)



YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	2	7	12	20	22	23	26	30				
16/17	3	6	8	9	11	16	18	22	26	28	29	32

Readmissions to PICU within 48 hrs

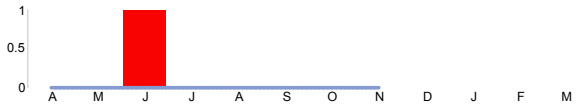
Readmissions to PICU within 48 hrs (YTD) 16 (goal: 10.0)



YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	1	3	4	4	9	13	15	16				
16/17	1	1	3	6	8	11	13	14	19	20	20	25

Never Events

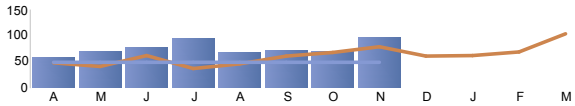
Never Events 0 (goal: 0.0)



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

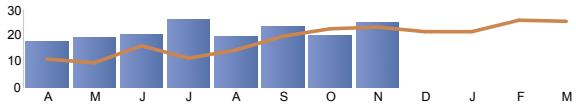
Incidents

Clinical Incidents resulting in harm (YTD) 621 (goal: 392.0)



YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	60	131	210	307	376	450	522	621				
16/17	48	89	151	188	234	295	363	442	503	565	634	738

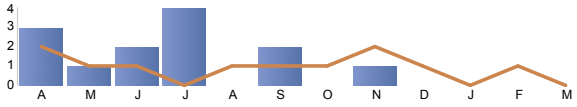
% of Total Clinical Incidents that resulted in Harm 25.4 %



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

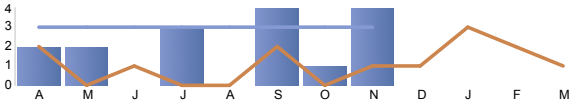
Serious incidents requiring investigation

Serious Incidents Requiring Investigation (Total) 1



YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	3	4	6	10	10	12	12	13				
16/17	2	3	4	4	5	6	7	9	10	10	11	11

Clinical Incidents resulting in moderate, severe harm or death (YTD) 16 (goal: 24.0)



YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	2	4	4	7	7	11	12	16				
16/17	2	2	3	3	3	5	5	6	7	10	12	13

Patient Experience

Nov 2017

Alder Hey Children's NHS Foundation Trust

Summary

Patient experience continue to improve overall with increases in percentages of 'patients engaged in play and learning' (76.7%); patients knowing their planned date of discharge (61.9%); patients treated with respect (99.8%); and patients knowing who is in charge of their care (94.9%). There is a slight fall in patients receiving information to help them make choices (94.9%).
No of complaints was 12 in month, the highest it has been this year, and the number of PALS contacts was 116. Cumulatively this is 816 which is slightly lower than last year.

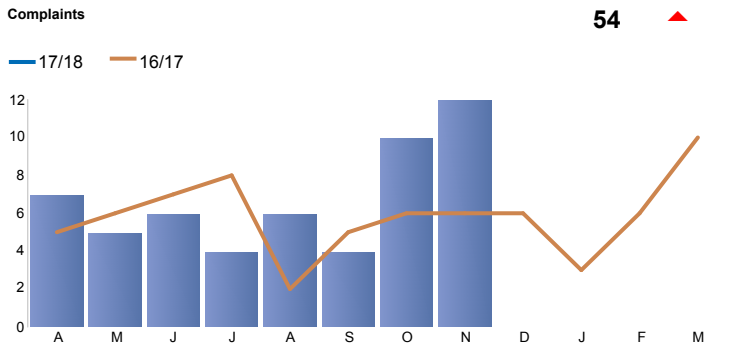
Inpatient Survey

Metric Name	Goal	Oct 2017	Nov 2017	Trend	Last 12 Months
% Know who is in charge of their care	95.0 %	93.8 %	94.9 %	▲	
% Patients involved in play and learning	80.0 %	72.6 %	76.7 %	▲	
% Know their planned date of discharge	80.0 %	57.4 %	61.9 %	▲	
% Received information enabling choices about their care	90.0 %	96.1 %	94.9 %	▼	
% Treated with respect	100.0 %	99.3 %	99.8 %	▲	

Friends and Family

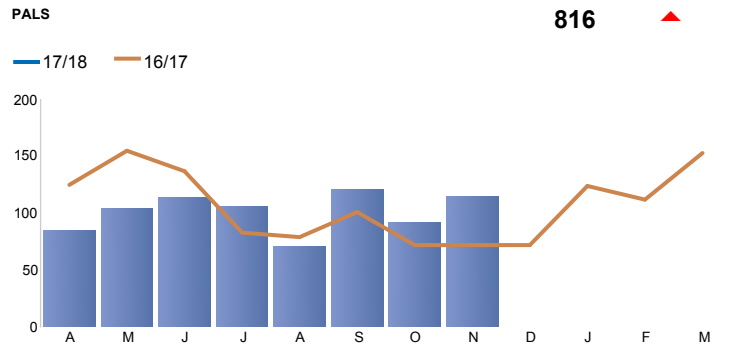
Metric Name	Required Responses	Number of Responses	Oct 2017	Nov 2017	Trend	Last 12 Months
A&E - % Recommend the Trust	250	92	95.2 %	89.1 %	▼	
Community - % Recommend the Trust	29	22	100.0 %	100.0 %	–	
Inpatients - % Recommend the Trust	300	633	97.9 %	97.5 %	▼	
Mental Health - % Recommend the Trust	27	25	94.1 %	96.0 %	▲	
Outpatients - % Recommend the Trust	400	746	95.8 %	92.0 %	▼	

Complaints



YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	7	12	18	22	28	32	42	54				
16/17	5	11	18	26	28	33	39	45	51	54	60	70

PALS



YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	86	191	306	413	485	607	700	816				
16/17	125	280	417	500	579	680	752	824	896	1,020	1,132	1,285

Clinical Effectiveness

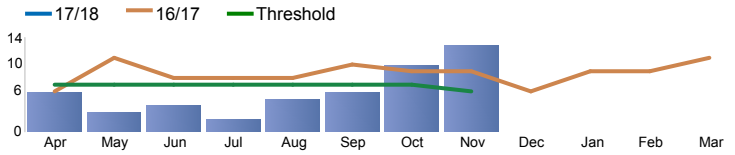
Nov 2017

Alder Hey Children's NHS Foundation Trust

Summary

There were 10 healthcare acquired infections in November, three of which were CLABSI infections including one MRSA bacteraemia. Total HAI is 43 ytd compared to 69 this time last year. C.difficile infections remains at zero. Three patients with long term conditions had an acute readmission, which is now 46 ytd. There were 3 deaths in hospital in November compared to 6 deaths in the same month last year.
Fifty seven surgical patients were discharged later than their planned date, an increase on last month. This equates to 3.8% of surgical procedures compared to 5.7% this time last year.

Infections



YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	6	9	13	15	20	26	36	49				
16/17	6	17	25	33	41	51	60	69	75	84	93	104

Total Infections (YTD)

49 (goal: 55.0) ▲

Hospital Acquired Organisms - MRSA (BSI) (YTD)

2 (goal: 0.0) –

Hospital Acquired Organisms - C.difficile (YTD)

0 (goal: 0.0) –

Outbreak Infections (YTD)

21 ▲

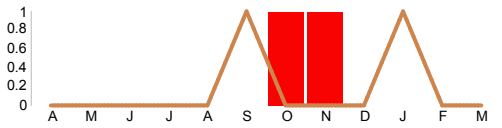
Cluster Infections (YTD)

0 –

Legend

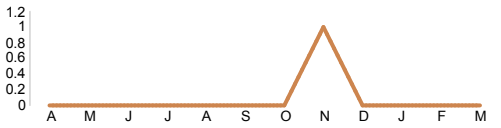
17/18
16/17
Threshold

Hospital Acquired Organisms - MRSA (BSI) 1 (goal: 0.0) –



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

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



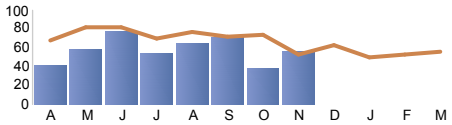
YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	0	0	0	0	0	0	0	0				
16/17	0	0	0	0	0	0	0	1	1	1	1	1

Acute readmissions of patients with long term conditions within 28 days 47 (Est. Baseline)

YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
17/18	9	11	19	24	31	39	43	47

Admissions & Discharges

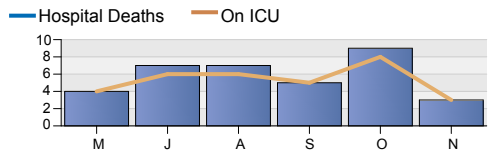
Patients with an estimated discharge date discharge later than planned (only surgical) 469 (Est. Baseline)



% of patients with an estimated discharge date discharge later than planned (only surgical) 3.8 % (Est. Baseline)

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

Mortality in Hospital



Deaths in Hospital

Actual	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	7	4	7	5	6	5	9	3				
16/17	7	8	6	6	8	2	7	6	8	4	5	9

Access

Nov 2017

Alder Hey Children's NHS Foundation Trust

Summary

Incomplete pathway, diagnostic & cancer standards achieved for November despite significant operational challenges due to Norovirus outbreak on 4a. This resulted in temp closure of 24 beds. Sustained levels of high attendance at ED for all triage categories continues to challenge flow within the department plus resultant conversion to IP admission. Activity higher than the same period last year and hospital utilisation has increased.Referrals increased against the same period last year with C&B capacity available to meet demand.

18 Weeks

RTT: 90% Admitted within 18 weeks 90.4 %

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
88.4%	88.0%	89.5%	88.3%	89.8%

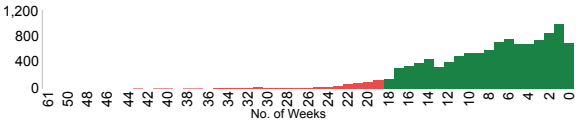
RTT: 95% Non-Admitted within 18 weeks 90.3 %

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
86.6%	88.9%	89.1%	89.2%	90.3%

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

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

Open Pathways Weekly Profile Nov 2017



0-18 Wks	19-36 Wks	36-51 Wks	52+ Wks
10,831	720	106	1

Cancer

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

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

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

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
100.0%	100.0%	96.4%	100.0%	95.0%

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

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

Diagnostics

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

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

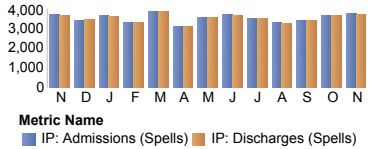
Waiting Times Failed 0

Waiting Times Passed 7

Number of Diagnostics

453

Admissions and Discharges



Bed Occupancy

Bed Occupancy (Funded Beds) 85.2 %

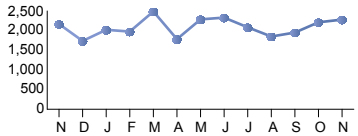
Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
80.2%	83.9%	79.8%	78.9%	83.6%

Provider

Convenience and Choice: Slot Availability 97.8 % *(goal: 96.0 %)*

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
99.2%	97.0%	98.0%	98.4%	98.7%

Referrals Received (GP)



Emergency Department

Nov 2017

Alder Hey Children's NHS Foundation Trust

Summary

ED saw a deterioration in all measures during November. 3 out of 4 weeks were red weeks and attendances were more than 500 above predictor, an 11% increase compared to Nov 2016. Half of this increase was patients in the urgent/very urgent category showing an increase in acutely unwell patients alongside an increase in minor patients. Due to staffing issues there were 14 GP sessions uncovered.

ED

ED: 95% Treated within 4 Hours — 92.8 % (goal: 95.0 %)

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
93.1%	96.7%	96.0%	95.3%	93.6%

ED: Total Time in ED (95th Percentile) — 291.0 mins (goal: 240.0 mins)

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
838.8	714.0	717.0	753.0	560.4

ED: Longest Wait Time (Hrs) — 11.7 (goal: 0.0)

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
36.0	30.6	61.3	28.5	22.7

ED: Number Treated Over 4 Hours

420

ED to Inpatient Conversion Rate

16.5 %

Nov 2017

ED

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

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

ED: 60 minute 'Time to Treat Decision' (Median) — 102.0 mins (goal: 60.0 mins)

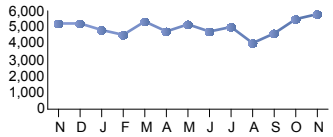
Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
239.0	227.0	247.5	206.0	186.5

ED: Percentage Left without being seen — 4.7 %

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
3.1%	2.3%	3.0%	2.8%	4.3%

ED: Number of Attendances

5799 Nov 2017



Ambulance Services

Ambulance: Acute Compliance — 79.6 % (goal: 85.0 %)

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
83.3%	90.1%	88.4%	84.2%	79.6%

Ambulance: Average Notification to Handover Time (mins) — 4.1 mins (goal: 15.0 mins)

Ambulance: Patients Waiting between 30 and 45 minutes — 6

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
5.0	11.0	9.0	4.0	7.0

Ambulance: Patients Waiting between 45 and 60 minutes — 0

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

Productivity & Efficiency

Nov 2017

Alder Hey Children's NHS Foundation Trust

Summary

Significant operational challenges in month have had an adverse impact on productivity. Infection control issues on ward 4A resulted in cancellations and reductions in capacity. Continued high levels of Non Elective admissions for surgery and medicine in conjunction with higher than planned ED attendance have made Nov a challenging month. Winter plan commenced which has supported flow which has improved productivity. Theatre utilisation has decreased slightly with increased cancellations on the day. OP utilisation has improved with reductions in DNA;s noted which may alter after cash up.

Length of Stay

Average LoS - Elective (Days) 3.0 ▲

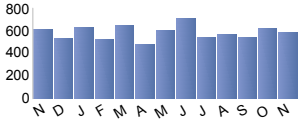
Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
3.0	2.9	3.1	3.0	2.8

Average LoS - Non-Elective (Days) 2.0 ▼

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

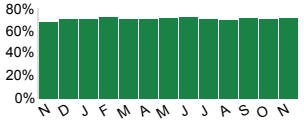
Day Case Rate

Daycases (K1/SDCPREOP) 598 ▼



Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
1,653	1,820	1,819	1,674	1,232

Daycase Rate 72.2 % ▲ *(goal: 0.0 %)*



Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
68.6%	71.2%	71.9%	70.9%	71.7%

Bed Refusals

Bed Refusals 0 – *(goal: 0.0)*

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

Theatres / Surgery

Theatre Utilisation - % of Session Utilised * 84.4 % ▼ *(goal: 90.0 %)*

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
84.8%	86.8%	87.6%	86.7%	85.4%

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

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
0.9%	1.1%	1.2%	1.4%	1.3%

Cancelled Operations - Non Clinical - On Same Day 41 ▲

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
62	77	83	94	67

28 Day Breaches 5 ▼ *(goal: 0.0)*

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
11	8	11	10	13

Outpatients

Clinic Session Utilisation * 86.3 % ▲ *(goal: 90.0 %)*

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
85.4%	85.8%	85.8%	85.1%	86.0%

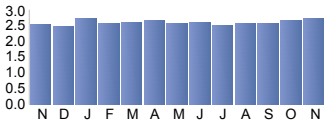
OP Appointments Cancelled by Hospital % 13.6 % ▲ *(goal: 5.0 %)*

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
14.6%	14.6%	13.3%	13.0%	13.4%

DNA Rate 9.3 % ▼ *(goal: 12.0 %)*

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
12.6%	12.0%	12.6%	12.6%	9.8%

OP: New/Follow Up 2.8 ▲



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

Facilities

Nov 2017

Alder Hey Children's NHS Foundation Trust

Summary

During November we have increased auditing of areas and this will continue until we are 100% compliant
This was another busy month with lots of terminal/deep cleans taking place including one full ward which was completely deep cleaned after being closed to admissions

Facilities

Cleanliness Performance VH 98.6 % (goal: 98.0 %)

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
96.7%	97.7%	99.7%	96.9%	97.9%

Cleanliness Performance H 95.9 % (goal: 95.0 %)

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
95.7%	94.0%	94.6%	96.0%	96.2%

Cleanliness Performance S 94.0 % (goal: 85.0 %)

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
96.3%	96.5%	90.3%	84.6%	89.8%

Cleanliness Performance L 75.0 % (goal: 75.0 %)

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
100.0%	100.0%	90.0%	75.1%	75.0%

Facilities

Audit Compliance 60.0 % (goal: 85.0 %)

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
77.0%	40.0%	6.7%	21.7%	67.5%

Facilities - Other

Routine Maintenance Resolution 90.9 % (goal: 85.0 %)

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
99.7%	96.6%	92.6%	95.7%	92.8%

PPM% 96.9 % (goal: 85.0 %)

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
94.4%	96.1%	94.8%	97.9%	97.7%

CAMHS

Nov 2017

Alder Hey Children's NHS Foundation Trust

Summary

Liverpool – Waiting times are higher than expected due to a high number of staff leaving the trust (7) and going on maternity leave (6) in 2017. We have new staff returning / starting in January 2018 and hope to work towards our target of 12 weeks by April 2018. Sefton trajectory for Jan will be 32 weeks referral to treatment – recruitment underway, expect the wait to come down to 28 weeks if fill the posts, and if the candidates are ready to start in January
Average wait for from referral to choice is 6 weeks.

Waiting Times

CAMHS: Avg Wait to Partnership Appt (Weeks)- Liverpool Specialist 19.0

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
0.0	0.0	43.0	51.0	34.0

CAMHS: Avg Wait to Partnership Appt (Weeks)- Sefton Specialist 24.0

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
0.0	0.0	43.0	51.0	34.0

Eating Disorder Pathway

Routine EDYS Pathway Average Wait in Weeks 2

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
0.0	0.0	6.0	5.0	3.9

Urgent EDYS Pathway Average Wait in Weeks 1

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
0.0	0.0	1.0	0.1	1.5

DNA Rates

CAMHS: DNA Rate - New 6.1 % ▼ *(goal: 10.0 %)*

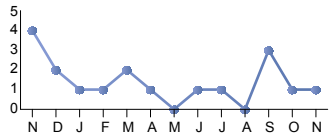
Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
13.5%	13.6%	13.8%	18.2%	10.2%

CAMHS: DNA Rate - Follow Up 12.5 % ▼ *(goal: 14.0 %)*

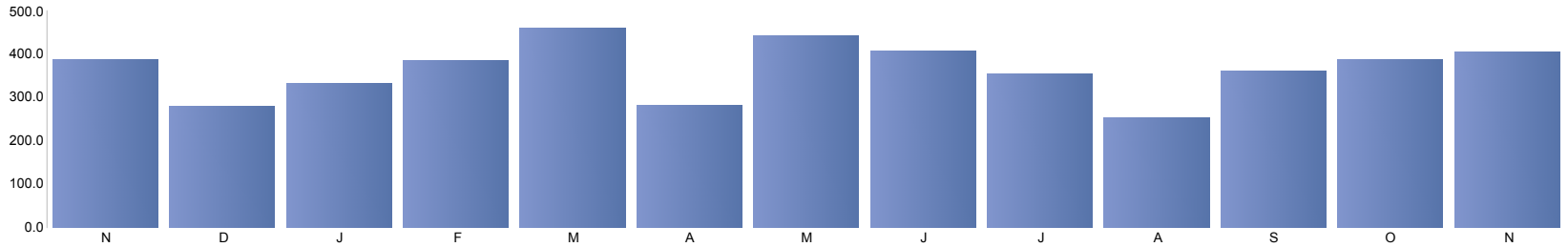
Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
16.0%	17.6%	17.7%	19.7%	12.5%

Tier 4 Admissions

CAMHS: Total Admissions to DJU 1 –



CAMHS: Referrals Received



External Regulation

Nov 2017

Alder Hey Children's NHS Foundation Trust

Summary

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

Monitor - Governance Concern

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

Monitor - Risk Rating

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

Monitor Nov 2017

Metric Name	Goal	Oct 17	Nov 17	Trend
ED: 95% Treated within 4 Hours	95.0 %	94.5 %	92.8 %	▼
RTT: 90% Admitted within 18 weeks		89.2 %	90.4 %	▲
RTT: 95% Non-Admitted within 18 weeks		90.3 %	90.3 %	▼
RTT: 92% Waiting within 18 weeks (open Pathways)	92.0 %	92.2 %	92.0 %	▼
Monitor Risk Ratings (YTD)	2.0	3	3	–
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals	100.0 %	100.0 %	100.0 %	–
All Cancers: 31 day wait referral to treament	100.0 %	92.3 %	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 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
88.4%	88.0%	89.5%	88.3%	89.8%

RTT: 95% Non-Admitted within 18 weeks

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
86.6%	88.9%	89.1%	89.2%	90.3%

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

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

Monitor - All Cancers

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

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

All Cancers: 31 day wait referral to treament

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
100.0%	100.0%	96.4%	100.0%	95.0%

All Cancers: 31 day wait until subsequent treatments

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

Monitor - A&E 4 Hour Target

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
93.1%	96.7%	96.0%	95.3%	93.6%

Monitor - C difficile

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

Monitor - Data Completeness

No Data Available

Workforce

Nov 2017

Alder Hey Children's NHS Foundation Trust

Summary

The Trust position on sickness absence of 5.1% for Nov, remains at a similar position to the previous month, only showing a marginal decrease. Similarly for PDR's the position remains static at 87%, this is explained by the compliant window for undertaking PDR's running from April –July. The core mandatory training position continues to show a month on month increase, reporting 81% as of end Nov. Maintaining this pace the trajectory would indicate that by end of January the Trust will be 90% compliant.

Staff Group Analysis

Sickness Absence (rolling 12 Months)

Staff Group	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Last 12 Months
Add Prof Scientific and Technic	5.2%	5.0%	5.9%	4.9%	3.6%	3.6%	3.9%	4.6%	4.2%	4.9%	2.8%	3.6%	
Additional Clinical Services	7.0%	6.6%	5.5%	5.6%	7.1%	7.4%	7.3%	7.7%	6.1%	5.8%	7.4%	8.1%	
Administrative and Clerical	4.7%	4.6%	5.0%	3.3%	2.8%	2.3%	2.4%	3.8%	4.4%	4.0%	4.2%	3.8%	
Allied Health Professionals	4.3%	2.3%	2.2%	3.5%	2.9%	3.2%	3.8%	3.2%	2.8%	2.7%	3.0%	2.2%	
Estates and Ancillary	10.9%	9.1%	7.4%	8.9%	10.7%	9.2%	9.1%	10.8%	14.7%	12.3%	13.2%	11.4%	
Healthcare Scientists	2.0%	1.7%	3.7%	2.3%	1.0%	3.3%	4.0%	4.6%	1.5%	2.9%	2.0%	3.0%	
Medical and Dental	1.6%	2.3%	2.4%	1.6%	1.1%	1.3%	1.3%	1.6%	1.6%	1.7%	2.2%	1.7%	
Nursing and Midwifery Registered	6.1%	6.4%	6.1%	5.5%	5.1%	5.4%	5.3%	5.1%	4.8%	5.0%	5.8%	5.7%	
Trust	5.6%	5.4%	5.2%	4.7%	4.5%	4.6%	4.6%	5.0%	4.9%	4.8%	5.3%	5.2%	

Staff in Post FTE (rolling 12 Months)

Staff Group	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Last 12 Months
Add Prof Scientific and Technic	198	198	197	201	197	199	201	200	197	199	199	196	
Additional Clinical Services	367	370	373	376	391	393	392	400	397	409	410	407	
Administrative and Clerical	573	586	589	586	611	621	618	624	626	624	622	624	
Allied Health Professionals	130	132	132	131	209	210	213	215	216	219	223	224	
Estates and Ancillary	190	189	189	189	187	185	184	184	183	182	182	180	
Healthcare Scientists	108	107	107	107	107	107	109	110	110	108	107	107	
Medical and Dental	245	245	246	243	244	243	247	242	248	250	252	249	
Nursing and Midwifery Registered	970	972	981	970	968	970	971	964	959	1,016	1,022	1,016	

Staff in Post Headcount (rolling 12 Months)

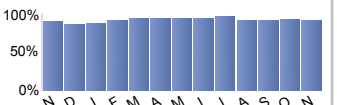
Staff Group	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Last 12 Months
Add Prof Scientific and Technic	218	218	217	221	218	220	223	223	219	220	219	216	
Additional Clinical Services	430	434	439	442	469	470	468	477	473	486	488	485	
Administrative and Clerical	670	677	679	673	700	709	708	713	714	711	709	710	
Allied Health Professionals	161	163	163	161	258	259	262	264	265	267	271	272	
Estates and Ancillary	238	236	236	236	234	231	231	230	229	228	228	226	
Healthcare Scientists	118	117	117	117	117	117	119	119	119	119	116	116	
Medical and Dental	284	284	287	284	286	286	289	284	290	294	295	294	
Nursing and Midwifery Registered	1,093	1,095	1,105	1,094	1,093	1,095	1,096	1,090	1,085	1,142	1,148	1,142	

Finance

Temporary Spend ('000s) 938 ▲

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

Actual vs Planned Establishment (%) 93.2 % ▼



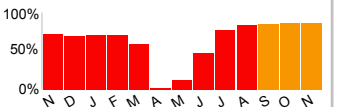
Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
88.8%	92.2%	94.8%	94.3%	93.8%

Appraisals

Medical Appraisal 11.6 % (goal: 100.0 %) ▲

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
25.5%	68.5%	76.9%	57.8%	9.8%

PDR 86.9 % (goal: 90.0 %) ▼



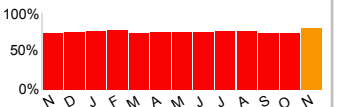
Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
72.3%	67.2%	21.0%	83.1%	87.1%

Training

Corporate Induction 96.9 % (goal: 100.0 %) ▲

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
84.0%	79.5%	82.6%	81.0%	81.7%

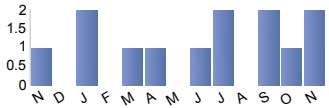
Mandatory Training 81.4 % (goal: 90.0 %) ▲



Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
75.6%	77.1%	76.1%	76.6%	78.2%

Health and Safety

RIDDOR 2 ▲



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

Performance by CBU

Nov 2017

Alder Hey Children's NHS
NHS Foundation Trust

Operational

Metric name	COMMUNITY	MEDICINE	SURGERY
Clinic Session Utilisation	77.8%	88.1%	86.8%
Convenience and Choice: Slot Availability	100.0%	97.8%	97.4%
DNA Rate (Followup Appts)	10.6%	8.3%	8.3%
DNA Rate (New Appts)	12.4%	10.0%	11.1%
Referrals Received (GP)	394	758	1,128
Temporary Spend ('000s)	167	242	383
Theatre Utilisation - % of Session Utilised		79.6%	85.2%
Trading Surplus/(Deficit)	271	1,222	2,379

Patient

Metric name	COMMUNITY	MEDICINE	SURGERY
Average LoS - Elective (Days)		3.3	2.8
Average LoS - Non-Elective (Days)		1.4	3.2
Cancelled Operations - Non Clinical - On Same Day	0	5	36
Daycases (K1/SDCPREOP)	3	74	520
Diagnostics: % Completed Within 6 Weeks		100.0%	100.0%
Hospital Initiated Clinic Cancellations < 6 weeks notice	17	30	26
OP Appointments Cancelled by Hospital %	17.0%	13.6%	13.1%
RTT: 90% Admitted within 18 weeks		92.7%	90.0%
RTT: 92% Waiting within 18 weeks (open Pathways)	96.8%	91.2%	92.0%
RTT: 95% Non-Admitted within 18 weeks	83.2%	90.1%	91.2%

Quality

Metric name	COMMUNITY	MEDICINE	SURGERY
Cleanliness Scores			
Hospital Acquired Organisms - C.difficile	0	0	0
Hospital Acquired Organisms - MRSA (BSI)	0	1	0
Medication Errors (Incidents)	44	212	350

Workforce

Metric name	COMMUNITY	MEDICINE	SURGERY
Corporate Induction	100.0%	100.0%	88.9%
Mandatory Training	80.3%	82.2%	80.9%
PDR	88.8%	85.0%	88.1%
Sickness	5.1%	5.1%	4.8%

CBU Performance - Community

Nov 2017

Alder Hey Children's NHS
NHS Foundation Trust

Key Issues

ASD Continues to be a concern after Dec 17. Paper being produced for further discussion with CCG regarding increased referral rate.

Support Required

Community Paeds - generic clinics maintain RTT, pressures in ADHD capacity for follow-up. Clinic utilisation impacted by booking in out in real time.

Operational

Metric Name	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Last 12 Months
Theatre Utilisation - % of Session Utilised														
Clinic Session Utilisation	80.5%	74.0%	75.9%	80.3%	83.0%	79.1%	81.9%	79.9%	79.2%	76.9%	86.4%	84.7%	77.8%	
DNA Rate (New Appts)	12.8%	19.0%	15.5%	12.0%	11.8%	15.8%	16.0%	19.1%	17.4%	18.0%	13.1%	15.0%	12.4%	
DNA Rate (Followup Appts)	12.3%	17.8%	16.5%	15.8%	13.3%	15.2%	14.4%	15.9%	15.2%	20.3%	15.0%	10.5%	10.6%	
Convenience and Choice: Slot Availability	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%			100.0%	100.0%	100.0%	100.0%	
Referrals Received (GP)	394	298	268	336	386	230	387	324	320	232	331	405	394	
Temporary Spend ('000s)	60	47	77	72	150	67	103	116	146	169	195	141	167	
Trading Surplus/(Deficit)	341	415	410	256	442	343	414	299	224	145	263	284	271	

Patient

Metric Name	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Last 12 Months
RTT: 90% Admitted within 18 weeks														
RTT: 95% Non-Admitted within 18 weeks	78.0%	80.2%	75.3%	73.1%	88.4%	87.9%	85.4%	91.8%	91.4%	93.1%	87.3%	87.9%	83.2%	
RTT: 92% Waiting within 18 weeks (open Pathways)	85.9%	92.3%	92.8%	93.1%	94.4%	94.0%	97.4%	94.3%	94.6%	96.5%	96.1%	96.3%	96.8%	
Average LoS - Elective (Days)	22.00										14.00			
Average LoS - Non-Elective (Days)														
Hospital Initiated Clinic Cancellations < 6 weeks notice	29	1	9	19	8	15	3	12	5	13	8	19	17	
Daycases (K1/SDCPREOP)	0	3	0	0	0	0	2	0	1	0	0	1	3	
Cancelled Operations - Non Clinical - On Same Day	0	0	0	0	0	0	0	0	0	0	0	0	0	
OP Appointments Cancelled by Hospital %	17.0%	15.4%	14.2%	20.3%	20.8%	23.1%	14.8%	18.9%	13.5%	17.3%	16.1%	15.2%	17.0%	
Diagnostics: % Completed Within 6 Weeks														

Quality

Metric Name	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Last 12 Months
Medication Errors (Incidents)	26	27	29	30	31	3	5	8	10	17	26	37	44	
Cleanliness Scores														
Hospital Acquired Organisms - MRSA (BSI)	0	0	0	0	0	0	0	0	0	0	0	0	0	
Hospital Acquired Organisms - C.difficile	0	0	0	0	0	0	0	0	0	0	0	0	0	

Workforce

Metric Name	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Last 12 Months
Corporate Induction	72.7%	87.5%	87.5%	87.5%	100.0%	82.9%		88.9%	100.0%	57.1%	100.0%	33.3%	100.0%	
PDR	81.4%	75.4%	77.2%	76.4%	67.0%	0.0%	5.7%	26.5%	71.0%	82.8%	87.4%	90.4%	88.8%	
Sickness	8.8%	7.1%	7.1%	6.9%	5.9%	5.1%	5.6%	5.7%	6.4%	6.2%	6.5%	5.4%	5.1%	
Mandatory Training	70.9%	72.1%	75.8%	78.0%	57.1%	57.1%	56.1%	55.2%	74.5%	75.3%	74.6%	75.1%	80.3%	

CBU Performance - Medicine (Part 1)

Nov 2017

Alder Hey Children's NHS
NHS Foundation Trust

Key Issues

Clinic utilisation has improved in November which is in line with a reduction in both our DNA New and F/Up rate. The team continue to work closely with the B&S workstream to improve processes to maximise out outpatient activity. We are looking at what our opportunities are to improve theatre utilisation as a Division with the theatre team. We know there are some challenges with out Waiting Times for Endocrinology and we will be putting on additional new patient clinics to reduce this.

Support Required

Operational

Metric Name	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Last 12 Months
Theatre Utilisation - % of Session Utilised	79.1%	80.1%	82.9%	79.1%	85.4%	81.1%	83.6%	84.6%	76.9%	81.8%	82.0%	81.5%	79.6%	
Clinic Session Utilisation	86.9%	83.6%	85.1%	86.8%	89.3%	86.6%	86.8%	84.6%	86.9%	87.0%	87.3%	87.2%	88.1%	
DNA Rate (New Appts)	12.5%	14.6%	14.1%	12.4%	10.0%	15.0%	12.6%	12.6%	12.9%	12.3%	10.4%	12.5%	10.0%	
DNA Rate (Followup Appts)	16.1%	18.5%	16.3%	16.8%	13.1%	16.7%	15.8%	13.9%	13.6%	15.0%	11.6%	10.2%	8.3%	
Convenience and Choice: Slot Availability	100.0%	99.6%	96.1%	86.5%	99.4%	98.0%	96.3%	100.0%	100.0%	98.0%	91.4%	99.4%	97.8%	
Referrals Received (GP)	733	563	681	594	821	577	747	792	729	636	635	723	758	
Temporary Spend ('000s)	229	164	499	341	302	290	322	222	323	326	250	186	242	
Trading Surplus/(Deficit)	491	212	74	-113	1,012	-298	108	-152	-390	-302	94	131	1,222	

Patient

Metric Name	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Last 12 Months
RTT: 90% Admitted within 18 weeks	93.1%	87.6%	92.6%	100.0%	91.5%	96.4%		95.7%	90.5%	95.5%	100.0%	94.2%	92.7%	
RTT: 95% Non-Admitted within 18 weeks	83.2%	84.7%	92.4%	89.3%	90.9%	90.9%	86.2%	88.8%	89.1%	87.3%	86.8%	89.0%	90.1%	
RTT: 92% Waiting within 18 weeks (open Pathways)	96.0%	96.7%	96.9%	96.0%	94.8%	94.9%	94.5%	94.0%	93.6%	93.3%	94.2%	92.7%	91.2%	
Average LoS - Elective (Days)	3.25	3.66	3.64	3.22	3.20	3.50	3.40	2.94	3.05	2.90	3.08	2.89	3.34	
Average LoS - Non-Elective (Days)	1.54	1.53	1.44	1.69	1.57	1.62	1.60	1.51	1.65	1.49	1.63	1.38	1.42	
Hospital Initiated Clinic Cancellations < 6 weeks notice	41	29	41	37	27	20	18	23	17	16	21	32	30	
Daycases (K1/SDCPREOP)	46	65	68	63	70	58	70	103	70	71	63	76	74	
Cancelled Operations - Non Clinical - On Same Day	8	4	6	6	3	1	3	1	2	1	2	2	5	
OP Appointments Cancelled by Hospital %	13.6%	14.2%	14.6%	15.0%	14.1%	17.4%	11.2%	13.4%	14.5%	13.4%	13.3%	14.0%	13.6%	
Diagnostics: % Completed Within 6 Weeks	99.1%	99.5%	100.0%	99.7%	99.6%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	

Quality

Metric Name	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Last 12 Months
Medication Errors (Incidents)	201	231	254	273	308	25	59	85	110	141	160	190	212	
Cleanliness Scores	97.5%	97.0%	96.8%	96.8%	99.0%									
Hospital Acquired Organisms - MRSA (BSI)	0	0	1	0	0	0	0	0	0	0	0	0	1	
Hospital Acquired Organisms - C.difficile	0	0	0	0	0	0	0	0	0	0	0	0	0	

Workforce

Metric Name	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Last 12 Months
Corporate Induction	85.0%	83.3%	75.0%	75.0%	68.8%		81.8%	61.5%	100.0%	50.0%	80.0%	70.0%	100.0%	
PDR	79.4%	77.6%	76.7%	75.7%	69.7%	2.9%	15.4%	41.3%	73.8%	79.7%	82.2%	84.0%	85.0%	
Sickness	4.6%	4.8%	4.9%	5.3%	4.5%	4.0%	4.7%	4.2%	4.6%	3.8%	4.1%	4.8%	5.1%	
Mandatory Training	76.3%	76.4%	77.3%	79.2%	79.7%	80.1%	80.0%	80.5%	79.0%	78.3%	75.7%	77.3%	82.2%	

CBU Performance - Medicine (Part 2)

Nov 2017

Alder Hey Children's NHS
NHS Foundation Trust

Key Issues

Improvement in all areas reported on 13/12/17 except for the following: 1-Pharmacy dispensing for outpatients (routine). 2-Pathology turnaround times for urgent requests. Both relate to the increasing demand over the winter period [Molecular Respiratory testing (FilmArray) is up 14% this winter –did 426 in November an all-time high].

Support Required

Patient

Metric Name	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Last 12 Months
Imaging - % Report Turnaround times GP referrals < 24 hrs	95.0%	93.0%	96.0%	97.0%	87.0%	96.0%	91.0%	92.0%	90.0%	90.0%	86.0%	97.9%	88.4%	
Imaging - % Reporting Turnaround Times - ED	87.0%	88.0%	88.0%	93.0%	90.0%	80.0%	64.0%	76.0%	83.0%	82.0%	85.0%	96.7%	96.7%	
Imaging - % Reporting Turnaround Times - Inpatients	76.0%	80.0%	86.0%	89.0%	90.0%	78.0%	74.0%	79.0%	85.0%	85.0%	79.0%	97.8%	94.4%	
Imaging - % Reporting Turnaround Times - Outpatients	93.0%	94.0%	97.0%	98.0%	94.0%	92.0%	90.0%	92.0%	98.0%	98.0%	92.0%	89.5%	90.0%	
Imaging - Waiting Times - MRI % under 6 weeks	90.0%	92.0%	92.0%	86.0%	85.0%	71.0%	81.0%	67.0%	68.0%	77.0%	79.0%	93.7%	96.8%	
Imaging - Waiting Times - CT % under 1 week	84.0%	81.0%	81.0%	77.0%	87.0%	95.0%	89.0%	87.0%	87.0%	89.0%	87.0%	93.3%	94.4%	
Imaging - Waiting Times - Plain Film % under 24 hours	94.0%	94.0%	94.0%	92.0%	93.0%	93.0%	94.0%	93.0%	94.0%	92.0%	91.0%	98.9%	100.0%	
Imaging - Waiting Times - Ultrasound % under 2 weeks	85.0%	83.0%	83.0%	81.0%	87.0%	84.0%	88.0%	90.0%	91.0%	90.0%	87.0%	95.6%	93.3%	
Imaging - Waiting Times - Nuclear Medicine % under 2 weeks	100.0%	88.0%	88.0%	84.0%	93.0%	88.0%	95.0%	89.0%	100.0%	93.0%	72.0%	100.0%	96.8%	
BME - High Risk Equipment PPM Compliance	89.7%	93.0%	91.0%	91.1%	88.0%	80.2%	91.7%	91.6%	91.2%	90.1%	84.6%	90.2%	90.1%	
BME - Low Risk Equipment PPM Compliance	79.0%	80.0%	81.0%	80.8%	79.0%	100.0%	82.0%	81.9%	80.4%	75.5%	74.6%	70.9%	76.0%	
BME - Equipment Pool - Equipment Availability	100.0%	100.0%	99.8%	100.0%	100.0%	91.4%	99.8%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Pharmacy - Dispensing for Out Patients - Routine	50.0%	51.0%	55.0%	50.0%	45.0%	57.0%	37.0%	60.0%	65.0%	63.0%	57.0%	61.0%	60.0%	
Pharmacy - Dispensing for Out Patients - Complex	97.7%	98.0%	100.0%	98.0%	98.0%	98.0%	100.0%	100.0%	96.0%	97.0%	100.0%	100.0%	100.0%	
Comm Therapy - % 1st Contact times following Pt opt in < 12 weeks	100.0%	100.0%	100.0%	100.0%	63.0%	63.0%	63.0%	54.3%	54.5%	80.0%	90.0%	100.0%	100.0%	

Quality

Metric Name	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Last 12 Months
Pathology - % Turnaround times for urgent requests < 1 hr	89.0%	87.9%	87.5%	88.7%	87.9%	89.7%	89.9%	91.0%	88.1%	88.1%	91.0%	89.1%	87.4%	
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%	99.9%	100.0%	
Reporting times for perinatal autopsies in 56 Calendar Days	100.0%	100.0%	80.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.3%	
Blood Traceability Compliance	99.6%	99.8%	99.7%	98.8%	99.6%	99.4%	100.0%	100.0%	99.5%	99.8%	99.8%	99.2%	99.5%	

CBU Performance - Surgery

Nov 2017

Alder Hey Children's NHS Foundation Trust

Key Issues

We have seen a slight increase in number of cancelled ops. The 2 key reasons for this are a lack of elective beds and a closed ward due to an IPC issue. We are investigating the opening of an additional 4 medical beds in order to reduce the number of medical outliers on the surgical wards. We are also continuing to review the capped numbers daily. We are looking to increase day case numbers further by introducing new booking guidelines in January, along with daily run rate monitoring. RTT was 92%- only issues are ENT, Spine, Pectus- all of which have actions in place for continued improvement.

Support Required

Our concerns continue around transcription turnaround times but we understand there is an established group to review which we are keen to feed into. We require support around outpatient processes in order to reduce our number of DNA's and empty slots due to less than 24 hour cancellations. In terms of medical outliers we require continued support from other divisions to reduce the number of medical outliers within surgery to support our elective programme.

Operational

Metric Name	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Last 12 Months
Theatre Utilisation - % of Session Utilised	86.1%	84.8%	87.2%	88.5%	87.1%	88.3%	87.9%	88.9%	87.7%	88.6%	87.3%	87.3%	85.2%	
Clinic Session Utilisation	87.9%	84.2%	85.4%	85.3%	88.0%	87.9%	86.2%	85.9%	86.3%	84.9%	83.5%	85.2%	86.8%	
DNA Rate (New Appts)	11.7%	13.2%	12.4%	11.9%	9.8%	10.3%	11.7%	12.4%	11.6%	12.6%	10.5%	10.5%	11.1%	
DNA Rate (Followup Appts)	9.0%	11.1%	8.8%	9.4%	8.3%	9.9%	10.1%	9.8%	10.6%	11.4%	10.3%	9.2%	8.3%	
Convenience and Choice: Slot Availability	100.0%	98.7%	100.0%	99.8%	95.3%	98.2%	99.5%	96.0%	99.0%	100.0%	100.0%	99.8%	97.4%	
Referrals Received (GP)	1,041	876	1,072	1,046	1,280	976	1,152	1,215	1,035	982	985	1,084	1,128	
Temporary Spend ('000s)	426	331	504	475	443	516	402	456	511	554	429	479	383	
Trading Surplus/(Deficit)	2,721	1,539	2,008	2,181	2,821	1,826	2,930	3,321	2,980	2,574	2,506	2,634	2,379	

Patient

Metric Name	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Last 12 Months
RTT: 90% Admitted within 18 weeks	88.9%	88.0%	86.8%	87.0%	87.2%	86.9%	90.3%	87.8%	88.8%	87.8%	85.0%	88.0%	90.0%	
RTT: 95% Non-Admitted within 18 weeks	88.6%	89.7%	92.8%	88.1%	89.1%	90.1%	89.8%	88.2%	88.1%	90.2%	90.7%	91.2%	91.2%	
RTT: 92% Waiting within 18 weeks (open Pathways)	91.3%	90.4%	90.6%	90.6%	90.9%	90.9%	90.8%	91.3%	91.2%	91.2%	90.9%	91.6%	92.0%	
Average LoS - Elective (Days)	2.88	2.73	2.17	3.26	2.62	2.58	3.57	2.57	3.10	2.90	3.02	2.36	2.75	
Average LoS - Non-Elective (Days)	2.64	2.55	3.02	2.78	2.64	2.84	3.06	2.57	2.86	2.96	2.74	2.91	3.16	
Hospital Initiated Clinic Cancellations < 6 weeks notice	72	20	30	54	22	19	23	28	35	32	26	27	26	
Daycases (K1/SDCPREOP)	570	471	562	461	582	426	540	609	472	499	485	552	520	
Cancelled Operations - Non Clinical - On Same Day	20	8	11	23	28	6	54	18	29	14	46	24	36	
OP Appointments Cancelled by Hospital %	14.6%	13.8%	14.0%	14.2%	13.7%	13.2%	11.2%	12.7%	12.0%	12.8%	11.8%	12.3%	13.1%	
Diagnostics: % Completed Within 6 Weeks	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	

Quality

Metric Name	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Last 12 Months
Medication Errors (Incidents)	334	365	394	428	475	40	96	145	187	242	274	304	350	
Cleanliness Scores	97.9%	96.0%	96.1%	96.2%	97.7%									
Hospital Acquired Organisms - MRSA (BSI)	0	0	0	0	0	0	0	0	0	0	0	1	0	
Hospital Acquired Organisms - C.difficile	1	0	0	0	0	0	0	0	0	0	0	0	0	

Workforce

Metric Name	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Last 12 Months
Corporate Induction	65.2%	71.4%	71.4%	71.4%	94.1%		90.0%	100.0%	100.0%	60.0%	71.4%	85.0%	88.9%	
PDR	63.3%	61.1%	63.4%	64.2%	45.1%	1.9%	11.2%	63.0%	87.6%	91.1%	90.1%	89.5%	88.1%	
Sickness	5.8%	5.5%	5.6%	4.9%	4.4%	4.5%	4.4%	4.7%	4.8%	4.6%	4.5%	5.0%	4.8%	
Mandatory Training	75.7%	77.0%	77.5%	78.7%	79.3%	80.6%	80.7%	81.5%	79.1%	77.0%	73.0%	73.8%	80.9%	

3. Financial Strength

3.1 Trust Income & Expenditure Report period ended November 2017

	In Month			Year to Date			Full Year		
	Budget £'000	Actual £'000	Variance £'000	Budget £'000	Actual £'000	Variance £'000	Budget £'000	Forecast £'000	Variance £'000
Clinical Income									
Elective	4,398	3,766	(632)	32,862	30,193	(2,669)	49,054	45,369	(3,686)
Non Elective	2,422	3,240	818	19,124	22,432	3,308	29,204	34,274	5,070
Outpatients	2,576	2,663	87	19,340	18,947	(393)	28,918	28,387	(531)
A&E	508	590	83	3,949	3,965	16	6,036	5,979	(57)
Critical Care	2,123	2,232	109	16,577	17,459	882	25,222	26,263	1,041
Non PbR Drugs & Devices	1,752	2,178	426	14,191	15,984	1,792	21,243	24,297	3,054
Excess Bed Days	388	346	(42)	3,105	2,748	(357)	4,658	4,020	(638)
CQUIN	261	296	35	2,089	2,152	63	3,134	3,337	203
Contract Sanctions	(10)	(7)	3	(83)	(58)	25	(125)	(80)	45
Private Patients	15	82	67	117	314	196	176	470	294
Other Clinical Income	3,162	3,913	751	24,072	25,640	1,568	36,998	39,976	2,978
Non Clinical Income									
Other Non Clinical Income	2,202	4,328	2,126	16,281	18,821	2,540	25,229	27,859	2,630
Total Income	19,797	23,628	3,832	151,624	158,596	6,972	229,748	240,151	10,403
Expenditure									
Pay Costs	(11,991)	(12,707)	(716)	(97,343)	(99,740)	(2,397)	(145,183)	(148,031)	(2,848)
Drugs	(1,584)	(1,983)	(400)	(12,859)	(14,961)	(2,102)	(19,228)	(22,453)	(3,225)
Clinical Supplies	(1,495)	(1,372)	123	(12,604)	(12,663)	(60)	(18,500)	(19,045)	(545)
Other Non Pay	(2,115)	(4,614)	(2,499)	(17,808)	(21,004)	(3,196)	(25,549)	(29,976)	(4,427)
PFI service costs	(329)	(298)	31	(2,632)	(2,466)	166	(3,948)	(3,716)	232
Total Expenditure	(17,514)	(20,974)	(3,461)	(143,245)	(150,835)	(7,590)	(212,408)	(223,221)	(10,813)
EBITDA	2,283	2,654	371	8,379	7,761	(618)	17,340	16,930	(410)
PDC Dividend	(114)	(114)	0	(910)	(911)	(1)	(1,365)	(1,365)	0
Depreciation	(540)	(501)	39	(4,305)	(3,970)	334	(6,409)	(6,075)	334
Finance Income	0	1	1	3	14	10	5	15	10
Interest Expense (non-PFI/LIFT)	(89)	(86)	3	(713)	(700)	13	(1,087)	(1,070)	17
Interest Expense (PFI/LIFT)	(675)	(675)	0	(5,399)	(5,398)	0	(8,098)	(8,098)	0
MASS/Restructuring	0	0	0	(247)	(284)	(37)	(247)	(284)	(37)
Gains/(Losses) on asset disposals	0	6	6	0	85	85	0	85	85
Control Total Surplus / (Deficit)	866	1,285	419	(3,191)	(3,404)	(213)	138	138	0
One-off normalising items									
STF Funding	0	0	0	0	93	93	0	93	93
Government Grants/Donated Income	444	1,405	961	7,516	5,585	(1,931)	12,750	7,281	(5,469)
Depreciation on Donated Assets	(175)	(175)	()	(1,396)	(1,376)	20	(2,089)	(2,069)	20
Fixed Asset Impairment	0	0	0	0	0	0	(1,536)	(1,536)	0
Reported Surplus/(Deficit)	1,135	2,515	1,380	2,928	898	(2,030)	9,263	3,907	(5,356)

Key Metrics	In Month			Year to Date			Full Year		
	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Forecast	Variance
Income £000	19,797	23,628	3,832	151,624	158,596	6,972	229,748	240,151	10,403
Expenditure £000	(18,931)	(22,343)	(3,412)	(154,815)	(162,000)	(7,184)	(229,610)	(240,013)	(10,403)
Control Total Surplus/(Deficit) £000	866	1,285	419	(3,191)	(3,404)	(213)	138	138	0
WTE	3,185	3,222	36	3,185	3,222	36			
CIP £000	974	541	(433)	4,073	3,329	(744)	8,000	5,638	(2,362)
Cash £000	2,543	6,753	4,210	2,543	6,753	4,210			
CAPEX FCT £000	2,126	2,267	(141)	16,228	9,459	6,769	29,092	24,036	5,056
Use of Resources Risk Rating	3	3	0	3	3	0	3	3	0

Activity Volumes	In Month			Year to Date			Full Year		
	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Forecast	Variance
Elective	2,606	2,363	(243)	19,663	18,154	(1,509)	29,307	26,924	(2,383)
Non Elective	1,155	1,396	241	8,916	9,943	1,027	13,769	14,866	1,097
Outpatients	18,380	18,585	205	138,705	141,818	3,113	206,735	205,896	(839)
A&E	4,747	5,794	1,047	36,940	39,545	2,605	56,463	59,631	3,168

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

	IN MONTH BUDGET	IN MONTH ACTUAL	IN MONTH VARIANCE	YEAR TO DATE BUDGET	YEAR TO DATE ACTUAL	YEAR TO DATE VARIANCE	FULL YEAR BUDGET	FULL YEAR FORECAST	FULL YEAR VAR TO REV BUDGET
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
ESTATES	**128**	**60**	**68**	**1,024**	**917**	**107**	**1,536**	**1,536**	**0**
RESEARCH & EDUCATION	**1,471**	**1,170**	**301**	**7,704**	**4,746**	**2,958**	**13,120**	**8,901**	**4,219**
ESTATES TOTAL CAPITAL	**1,599**	**1,230**	**369**	**8,728**	**5,663**	**3,065**	**14,656**	**10,437**	**4,219**
GDE, NETWORKING, INFRASTRUCTURE & OTHER IT	250	625	(375)	2,110	2,120	**(10)**	3,431	3,431	0
ELECTRONIC PATIENT RECORD	0	36	(36)	302	288	**14**	604	448	156
IM & T TOTAL CAPITAL	**250**	**662**	**(412)**	**2,412**	**2,407**	**5**	**4,035**	**3,879**	**156**
NON-MEDICAL EQUIPMENT	0	0	0	220	108	**112**	220	220	0
CHILDRENS HEALTH PARK	36	27	9	1,953	144	**1,809**	5,347	5,347	0
ALDER HEY IN THE PARK TOTAL	**140**	**10**	**130**	**3,306**	**857**	**2,449**	**7,096**	**7,096**	**0**
OTHER	137	69	68	1,662	237	**1,425**	3,185	2,348	837
OTHER	**137**	**69**	**68**	**1,662**	**237**	**1,425**	**3,185**	**2,348**	**837**
CAPITAL PROGRAMME 17/18	***2,126***	***1,972***	***154***	***16,108***	***9,164***	***6,944***	***28,972***	***23,760***	***5,212***
FINANCE LEASES	***0***	***295***	***(295)***	***120***	***295***	***(175)***	***120***	***276***	***0***
CAPITAL PROGRAMME 17/18 INC FINANCE LEASES	***2,126***	***2,267***	***(141)***	***16,228***	***9,459***	***6,769***	***29,092***	***24,036***	***5,212***

Alder Hey Children's NHS
NHS Foundation Trust

Board of Directors
Tuesday, 9th January 2018

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

Alder Hey Children's NHS
NHS Foundation Trust

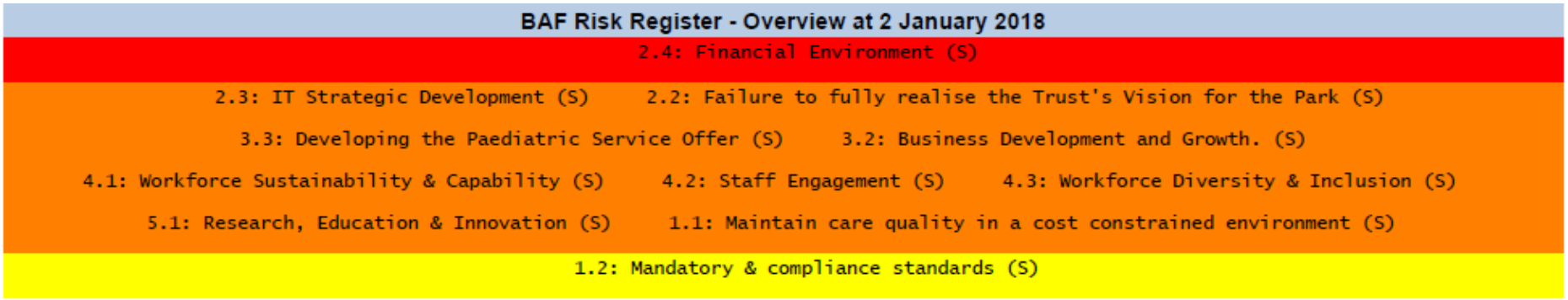
Board Assurance Framework 2017/18

1. Purpose

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

2. Review of the BAF

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



Alder Hey Children's NHS
NHS Foundation Trust

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

Changes since Dec 2017 Board meeting

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

External risks

- ***Business development and growth (DJ)***
  Refresh workshop completed November; initial suite of 18/19 priorities agreed at Exec level; focus on sustainability and growth potential. Board discussion scheduled January 2018.

- ***Mandatory and compliance standards (ES)***
  Forward plan for management of ED performance agreed by Exec Comm cell to end of calendar year, then review. Revised Single Oversight Framework taken through RBD; corporate report to be reviewed in light of updated NHSI metrics.

- ***Developing the Paediatric Service Offer (DJ)***
  Exec confirmed priorities for 18/19 are inclusive of clinical network developments; discussion and ratification planned with Board January 2018.

Internal risks:

- ***Maintain care quality in a cost constrained environment (HG)***
  Exec comm cell now focusing on leading quality metrics as well as activity and performance.

- ***New Hospital Environment (DP)***

- ***Financial Environment (JG)***
  Continued tracking of recovery through Financial Recovery Board with required improvement in Activity run rate, pay control and facilities spend during Q4 to ensure Trust meets control total. Current forecast as per Nov update.

- ***Failure to fully realise the Trust's Vision for the Park (DP)***
  Options discussed with LCC

- ***IT Strategic Development (JG)***
  Programme remains green rated with focus on ensuring clinical and operational benefits. NHSE cash flow now in agreement.

- ***Workforce Sustainability & Capability (MS)***
  New Nurse Recruitment Fair scheduled for January 18. Core Mandatory Training increased to 86%.

- ***Staff Engagement (MS)***
  Staff Survey closed 01/12/17 with 54% response rate. Initial results showing improvements across a number of areas.

- ***Workforce Diversity & Inclusion (MS)***
  A number of tactical actions have been agreed at a meeting with NED lead and BME Network reps to help progress the agenda.

- ***Research, Education & Innovation (DP)***
  Papers being finalised for agreement with Edge Hill and LJMU

Erica Saunders
Director of Corporate Affairs
January 2018

Board Assurance Framework 2017-18

Alder Hey Children's NHS Foundation Trust

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

Risk Description	
Failure to maintain appropriate levels of care quality in a cost constrained environment.	
Existing Control Measures	
• Quality impact assessment of all planned changes	• Risk assessment and utilisation of risk registers in responding to incidents and other drivers.
• Quality section of Corporate Report scrutinised at CQAC and Board.	• CBU and Corporate Dashboards in place and are part of updated Performance Framework.
• Weekly Meeting of Harm	• Programme of quality assurance ward rounds planned across all departments (c 49 locations) based on CQC KLOEs. Themes reported via CQAC.
• Refresh of CQAC to provide a more performance focussed approach	• Changes to ESR to underpin workforce information -
• New Change Programme established - associated workstreams subject to sub-committee assurance reporting	• Robust risk & governance processes from Ward to Board, linked to NHSI Single Oversight Framework
• Quality Strategy 2016-2020 implemented to deliver safe and effective services demonstrated via measurable Quality Aims and Sign up to Safety campaign	• External review on IPCC resulted in action plan to address issues identified and track improvements.
• "Our Patients at the Centre" projects subject to assurance committee monitoring (CQAC)	• Quarterly 'themes' report from Weekly Meeting of Harm shared within meeting & CQSG as multidisciplinary engagement and cross-organisational learning.
Assurance Evidence	**Gaps in Controls/Assurance**
Monthly reporting to CQSG. CQAC focus on performance. Analysis of incident reports. Monthly reporting of the Corporate Report to Board. Improved reporting - in the top 20% of NRLS nationally Ongoing national open recruitment exercise in Spring 2017 PEWS audit scores on improvement trajectory Sepsis implementation plan underway, overseen by project team; audit data showing improvement in recognition and escalation. Annual CQC patient survey results - performance better than expected for older children (positive outlier)	Reduced investment opportunity to respond to clinical development as a result of financial situation. Full electronic access to specialty performance results Meditech issues identified as key challenge to obtaining accurate Sepsis audit data without extensive manual analysis by clinical lead. Nursing maternity leave continues to rise - currently at 50 WTE per month.
Actions Required to Reduce Risk to Target Rating	**Latest Progress on Actions**
Develop and build audit programme within Meditech to ensure continuous monitoring in place and deliver CQUIN	Key stakeholders working with IM&T to build audit programme
Heads of Quality to take forward Quality Ward Accreditation Programme in 17/18 (as part of devolved governance)	Revised framework agreed. On-going work in progress. Electronic sharing of information with the public - completed programme July.
Successfully implement all Change Programme workstreams to improve efficiency and flow	16/17 year-end reports to CQAC. Actions to carry forwards into 17/18 change programme in association with PIDs and milestone trackers.
Roll out PFCC model for all appropriate services	PFCC model now forms part of transformation toolkit
Continue to maintain nurse staffing pool	Recruitment on-going. Further analysis of maternity leave factors to be undertaken (July 2017)
Clinical lead for Sepsis in dialogue with Meditech team to develop solution to systems issues re data.	Supplier response to be escalated by CIO; monthly updates to CQAC to provide assurance
Project team for CQC inspection road map established; self-assessments to be completed during January 2018.	
Executive Lead's Assessment	
OCTOBER 2017: 70 new starters have completed their preceptorship (4 weeks) and the COHORT now form part of the clinical rotas. NOVEMBER 2017: October audit results for sepsis show month on month reducing time to treatment for suspected sepsis (mean time to antibiotics now 42 minutes); D&V outbreak on 4A well managed to prevent spread; measles outbreak on 4C also contained and managed in accordance with PHE requirements. DECEMBER 2017: Exec comm cell now focusing on leading quality metrics as well as activity and performance.	

Board Assurance Framework 2017-18

Alder Hey Children's NHS Foundation Trust

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

Risk Description

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

Existing Control Measures

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

Assurance Evidence	Gaps in Controls/Assurance
Regular reporting of delivery against compliance targets through CQSG, CQAC & Board. Monthly reporting to the Board via the Corporate Report. Monitor / NHSI governance risk rating Operational effectiveness measures (key risks with early warning measures) to RABD Compliance assessment against Monitor Provider Licence to go to Board CBU / Executive performance reviews Exceptions discussed / resolved at Ops Board Quarterly Report to NHSI	Critical Care bed capacity Some areas remain fragile e.g. IG toolkit, ED 4 hour target. Assurance required to underpin Divisional reporting on CQC standards 'Horizon scanning' to anticipate risks & issues now implemented through performance review meeting Work with CCG to manage demand & develop / fully utilise existing capacity across PC Junior Doctor Rotas

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

Executive Lead's Assessment

OCTOBER 2017: ED performance currently below target for the month and the quarter; Division has a recovery plan but requires particular focus in the context of winter. Being addressed through Exec Comm Cell - weekly scrutiny.
NOVEMBER 2017: COO has gained agreement for Children's WIC activity to be counted in ED figures; performance now disaggregated by stream to enable closer management of 'greens'; discussions happening with UC24 re GP slots. Weekly Comm Cell has become routine practice with full team participation.
DECEMBER 2017: Forward plan for management of ED performance agreed by Exec Comm cell to end of calendar year, then review. Revised Single Oversight Framework taken through RBD; corporate report to be reviewed in light of updated NHSI metrics.

Board Assurance Framework 2017-18

Alder Hey Children's NHS Foundation Trust

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

Risk Description

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

Existing Control Measures

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

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

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

Executive Lead's Assessment

OCTOBER 2017: Discussions continuing with LCC Mayor. Long list of options being produced
NOVEMBER 2017: Options paper sent to LCC
DECEMBER 2017: Options discussed with LCC

Board Assurance Framework 2017-18

Alder Hey Children's NHS Foundation Trust

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

Risk Description

Failure to deliver an IM&T Strategy which will place Alder Hey at the forefront of technological advancement in paediatric healthcare

Existing Control Measures

• Key projects and progress tracked through the Clinical Systems Informatics Steering Group and RABD Committee	• Clinical Systems Informatics Project Group leading on stakeholder engagement - ad hoc groups on specific key topics as needed
• Forward Communications plan agreed and tracked at steering group.	• Board approval "Asset Owner" process in place to ensure organisational ownership of systems and system development
• Improvement scheduled training provision including refresher training and workshops to address data quality issues	• Formal change control processes now in place
• Executive level CIO in place	• Investment in IM&T Team (2016/17 budget)

Assurance Evidence	Gaps in Controls/Assurance
Regular progress reports presented to RABD and Operational Board MIAA providing assurance role Board agreed change process Participate in Digital Alder Hey programme Internal Audit Reviews	IM&T Strategy out of date - update work in progress Internal Programme Assurance Reports Resources required to deliver Strategy proposed and aspirations of Trust - review Oct 2016 - Strategy update deferred pending consultation with new restructure CBU leadership teams and outcome of Global Digital Excellence bid.

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Link to innovation partnerships in paediatric healthcare	
Conclude the review of IM&T Infrastructure	currently being reviewed in relation to GDE bid and business case
IM&T Strategy development & approval	Trust GDE bid submitted and approved by Board and NHSE Nov / Dec 2016. NHSE undertaking due diligence review pre sign off and approval of funding agreement. Full I&MT strategy to be updated Q4 2016/17
Continual improvement of MEDITECH and other clinical systems as prioritised by the Clinical Systems Informatics Steering Group	changes to software tracked by and reported to the Clinical Informatics Steering Group
Engage with iLinks programme to progress interoperability	

Executive Lead's Assessment

OCTOBER 2017: Programme remains green rated however challenges from NHSE regarding benefits realisation evidence and level of match funding
NOVEMBER 2017: programme remains green rated. Benefits workshop with NHSE undertaken. NHSE challenging cashflow forecast however near an acceptable solution.
DECEMBER 2017: Programme remains green rated with focus on ensuring clinical and operational benefits. NHSE cashflow now in agreement.

Board Assurance Framework 2017-18

Alder Hey Children's NHS Foundation Trust

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

Risk Description

Failure to deliver Trust control total and Risk rating Rating

Existing Control Measures

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

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

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

Executive Lead's Assessment

OCTOBER 2017: year to date on track. Forecast risk reduced to c £4.5m. Pressures remain in Medicine and Facilities. Recovery Plan in place with key actions tracked through Exec Commcell
NOVEMBER 2017: Forecast risk remains at £4.6m deficit (unmitigated) however recovery action plan demonstrating a mitigated position of £2.2m deficit (currently likely forecast). Further opportunities equate to further £2.2m which if realised will allow achievement of control. Financial Recovery Board in place beginning to show early signs of improved performance.
DECEMBER 2017: Continued tracking of recovery through Financial Recovery Board with required improvement in Activity run rate, pay control and facilities spend during Q4 to ensure Trust meets control total. Current forecast as per Nov update.

Board Assurance Framework 2017-18

Alder Hey Children's NHS Foundation Trust

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

Risk Description	
Risk to business development/growth due to NHS financial environment and constraints on internal infrastructure to deliver business as usual as well as maximise growth opportunities	
Existing Control Measures	
• CBU Performance Management Framework.	• Clear trajectories for challenged specialities to deliver.
• Business Development Plan	• 2016 Change Programme Projects (Strategic Partnerships & International Clinical Business and non NHS Patient Services)
• Five year plan agreed by Board and Governors in 2014	• Capacity Plan identifies beds and theatres required to deliver BD Plan.
• Service development strategy including Private / International patient proposal approved by Council of Governors as part of strategic plan sign off.	• Capacity Plan identifies beds and theatres required to deliver BD plan
• Jan 2016 :- Weekly meeting with CBUs established to review forward look re elective and day case patient bookings to ensure activity scheduled meets contract requirements	
Assurance Evidence	**Gaps in Controls/Assurance**
Business growth and market analysis reports considered fully by Marketing & Business Development Committee and reported regularly to RBDC. Business Development Committee and reported regularly to Board via RBDC. Business Development Plan reviewed monthly by RBDC via Contract Monitoring Report. Daily activity tracker and forecast monitoring performance for all activity. CIPs in new Change Programme subject to assurance and sub-committee performance management	Ability to respond swiftly to potential problems. Workforce constraints in specialised services. Early warning indicators for leading indicators. Potential delay to cardiac growth - current gap c. £0.8m forecast against 16/17 CIP target
Actions Required to Reduce Risk to Target Rating	**Latest Progress on Actions**
Workshop held in June to identofy options for bridging business development gap	Alternative schemes being developed. Report to RABD
Identify models and services to provide to non NHS patients / commercial offers	Trust currently progressing tender application for LCH paediatric community services. Timeframe: June - end Aug 2016. Financial assessment will be part of due diligence. Report to RABD and through to Board. Duscussions with surgical teams and Stoke to accelerate increase in cardiac cases
Executive Lead's Assessment	
OCTOBER 2017: LCH Bid unsuccessful NOVEMBER 2017: Strategy refresh scheduled for December 17. Acting director of strategy newly in post. Risk to be reviewed during December 17. DECEMBER 2017: Refresh workshop completed November; initial suite of 18/19 priorities agreed at Exec level; focus on sustainability and growth potential. Board discussion scheduled January 2018.	

Board Assurance Framework 2017-18

Alder Hey Children's NHS Foundation Trust

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

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

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

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

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

Executive Lead's Assessment
OCTOBER 2017: There are no further updates in terms of risk at this time (Neonates and Women's). NOVEMBER 2017: Strategy refresh during December 17 to include paediatric service offer priorities. Acting director of strategy newly in post. Risk to be reviewed during December 17. DECEMBER 2017: Exec confirmed priorities for 18/19 are inclusive of clinical network developments; discussion and ratification planned with Board January 2018.

Board Assurance Framework 2017-18

Alder Hey Children's NHS Foundation Trust

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

Risk Description	
Failure to always have the right people, with the right skills and knowledge, in the right place, at the right time	
Existing Control Measures	
• Compliance tracked through the corporate report and CBU dashboards	• Performance Review Group
• CBU Performance Meetings.	• Mandatory Training reviewed in February 2017.
• Mandatory training records available online and mapped to Core Skills Framework	• Permanent nurse staffing pool
• 'Best People Doing our Best Work' Steering Group implemented	• Attendance management process to reduce short & long term absence
• Positive Attendance Policy	
Assurance Evidence	**Gaps in Controls/Assurance**
Regular reporting of delivery against compliance targets via corporate & CBU reports Monthly reporting to the Board via the Corporate Report Reporting at ward and SG level which supports Ward to Board	Inability to train staff due to clinical workforce and acuity preventing them leaving the clinical areas. Not meeting compliance target in relation to mandatory training in specific areas No proactive assessment of impact on clinical practice Sickness Absence levels higher than target. No formalised Education Strategy
Actions Required to Reduce Risk to Target Rating	**Latest Progress on Actions**
Sickness Policy refreshed	Training for managers on Sickness Absence Policy ongoing
Recruitment & Retention Strategy to focus on specific groups	Currently being refreshed with action plan to support
Develop and support talent identified within the organisation and via local supply routes e.g. apprenticeships by leveraging networks via HEE and HENW to address future workforce supply challenges	Apprenticeship Strategy ratified and under implementation. Corporate objective agreed to support a succession planning process for business critical roles by end Dec 17
Executive Lead's Assessment	
OCTOBER 2017: Mandatory training action plan launched, with a target to achieve 90% by end Jan 18. NOVEMBER 2017: Attendance at local recruitment fair. Nurse pool staff now embedded into wards. focus on sickness absence at divisional level. continued focus on increasing mandatory training. DECEMBER 2017: New Nurse recruitment fair scheduled for January 18. Core Mandatory Training increased to 86%.	

Board Assurance Framework 2017-18

Alder Hey Children's NHS Foundation Trust

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

Risk Description

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

Existing Control Measures

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

Assurance Evidence	Gaps in Controls/Assurance
Outcomes from Annual Staff Survey reported to the Board. PDR completion rates Quarterly Engagement Temperature Check reported to the Board. Quarterly Engagement Temperature Check local data now sent to CBUs on a quarterly basis to enable them to analyse data locally. Ongoing consultation and information sharing with staff side and LNC Progress reports from LiA to Board	Reward & Recognition schemes embedded
Actions Required to Reduce Risk to Target Rating	**Latest Progress on Actions**
Revised governance arrangements that underpin effective assurance mechanisms utilising the discipline and systems provided by Programme Management methodology	Change programme monitors Listening into Action deliverables

Executive Lead's Assessment

OCTOBER 2017: Staff Survey at 39% compliance 01/11/17 - same as the overall compliance for the whole of 2016. PDR compliance at 86%. Planning underway for Fab Staff Change week in November 2017.
NOVEMBER 2017: Staff Survey 51% compliance (28/11/17). Fab Staff Change week completed, with very positive feedback from staff. PDR remains at 86%, with community over 90%.
DECEMBER 2017: Staff Survey closed 01/12/17 with 54% response rate. Initial results showing improvements across a number of areas.

Board Assurance Framework 2017-18

Alder Hey Children's NHS Foundation Trust

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

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

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

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

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

Executive Lead's Assessment
OCTOBER 2017: WRES action plan for Board approval. majority of actions are underway. BME network meetings on-going. NOVEMBER 2017: Disability Network launched, with first meeting in November. Trust attendance at local jobs fairs. DECEMBER 2017: A number of tactical actions have been agreed at a meeting with NED lead and BME Network reps to help progress the agenda.

Board Assurance Framework 2017-18

Alder Hey Children's NHS Foundation Trust

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

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

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

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

Actions Required to Reduce Risk to Target Rating	**Latest Progress on Actions**
Execute plan to increase research portfolio	Outline plan develped
Educational Partnerships to be cemented	Academy proposals agreed at execs
Develop a robust Academy Business Model	Agreed
Establish pipeline structure for sensors including finances	Proposal agreed in principle
Execute contract for RIE with back to back arrangements with the Charity and HEIs	UCLAN funding agreement signed

Executive Lead's Assessment
OCTOBER 2017: Focus on developing business plan for Innovation co. plus activating research workstream NOVEMBER 2017: Innovation Co papers taken through Board DECEMBER 2017: Papers being finalised for agreement with Edge Hill and LJMU

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

9th January 2018

Report of:	Director of Corporate Affairs
Paper Prepared by:	Erica Saunders, Director of Corporate Affairs
Subject/Title:	CQC Action Plan – April 2017 Inspection
Background Papers:	CQC Report – Summary of Findings
Purpose of Paper:	To provide a position statement.
Action/Decision Required:	For information purposes
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	By 2020, we will: ➢ be internationally recognised for the quality of our care ***(Excellence in Quality)*** ➢ be recognised for the exceptional care we provide to our children, that is technologically enabled and matched by exceptional facilities ***(Patient Centred Services)*** ➢ have a fully engaged workforce that is actively driving quality improvement ***(Great Talented Teams)*** ➢ be a world class, child focussed centre of research & innovation expertise to improve the health and wellbeing outcomes for babies, children & young people ***(International Research, Innovation & Education)*** ➢ have secured sustainable long term financial and service growth supported by a strong international business ***(Growing our Services and Safeguarding Core Business)***
Resource Impact:	N/A

ALDER HEY CHILDREN'S NHS FOUNDATION TRUST CQC ACTION PLAN

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

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

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

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				2.4 Report and disseminate all trends / themes / barriers surrounding delays in antibiotic administration to Sepsis Steering Group, CQAC and Best in Acute Care to maintain hospital oversight and inform changes in practice and policy.			**Update 24th October 2017:** Sepsis Steering Group commenced in February 2017 Regular reporting to CQAC began in April 2017 Best in Acute Care programme began in July 2017			**Complete:** 31st July 2017 and ongoing			
				2.5 Disseminate audit results to staff through Divisional leadership, risk and governance communication structure and by regular hospital Grand Round sessions									
				2.6 Submit progress and CQUIN update to CCG			**Update 24th October 2017:** Submission to CQC commenced in May 2017 First submission of CQUIN in August 2017 for Quarter 1.			**Complete:** 31st August 2017 and ongoing			
				2.7 Submit monthly report to CQC			**Update 24th October 2017:** Submissions to CQC started in May, and first submission of CQUIN in August 17 for Q1.			**Complete:** 31st August 2017 and ongoing			
3	Must	Trust	**Fit and Proper Persons** Must ensure that robust arrangements are in place to govern the fit and proper person's process	3.1 Incorporate the fit and proper persons process into the Trust Recruitment and Selection Policy	Melissa Swindell Director of Human Resources and OD	Sharon Owen Head of Human Resources	**Update 24th October 2017:** The Trust has fully incorporated the fit and proper persons process into the Trust Recruitment and Selection Policy, which was ratified on 21st June 2017		Complete	**Complete:** 21st June 2017	Workforce and Organisational Development Committee (WOD)	All relevant posts to be fully checked in accordance with the fit and proper persons requirements.	
				3.2 Devise and implement a standard operating process (SOP) to provide full clarity of the process and responsibilities			**Update 24th October 2017:** SOP has been implemented			**Complete:** 21st June 2017			

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4	Must	Trust	**Safeguarding Level 3** Must take action to ensure all staff who are involved with assessing, planning, and evaluating care for children and young people are trained to safeguarding level three in line with the safeguarding children and young people: roles and competencies for health care staff Intercollegiate Document (2014)	4.1 Cleanse ESR system to ensure all roles are aligned to correct safeguarding mandatory training competencies	Hilda Gwilliams Chief Nurse	Julie Knowles Assistant Director of Safeguarding	**Update 24th October 2017:** Cleanse of competencies against positions in ESR has already been completed and has seen a significant increase in the figures reported. The Trust has sourced systems expertise to ensure ESR is set up to accurately report against the Trust requirements		In progress	**Complete:** 31st August 2017	Workforce and Organisational Development Committee	90% compliance in Level 3 safeguarding training	
				4.2 Monitor compliance with Level 3 safeguarding training across the Trust, within Divisions, and within specific departments			**Update 24th October 2017:** A full suite of detailed mandatory training reports have been compiled and disseminated to departmental and senior managers						
				4.3 Produce and share regular detailed mandatory training reports at divisional and departmental level, reported by staff group, which show compliance with Level 3 safeguarding training down to individual staff member level			**Update 24th October 2017:** A full suite of detailed mandatory training reports have been compiled			31st January 2018			
				4.4 Dedicate additional resource from within the Safeguarding Team to lead on training			**Update 24th October 2017:** Senior lead for safeguarding training appointed			**Complete:** 31st August 2017			
				4.5 Provide designated and targeted support to those areas of low compliance and work with managers to establish action plans to achieve a minimum of 90% compliance			**Update 24th October 2017:** Senior lead for safeguarding training appointed			31st March 2018			
				4.6 Report performance monthly at community and statutory services business meetings						**Complete:** 27th October 2017 and ongoing			
				4.7 Improve access to the ESR training database to improve accuracy and responsiveness to training			**Update 24th October 2017:** Senior lead for safeguarding to have access			31st March 2017			

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5	Must	Trust	**APLS** Must ensure that there is a member of staff trained in advanced paediatric life support available in every department at all times as outlined in the Royal College of Nursing guidelines	5.1 Perform Trust wide resuscitation Training Needs Analysis against national guidance	Hilda Gwilliams Chief Nurse	Rob Griffiths Theatre Manager / Phil O'Connor Deputy Director of Nursing	**Update 23rd October 2017:** Complete		In progress	**Complete:** 30th September 2017	Resuscitation Committee Clinical Quality Steering Group Clinical Quality Assurance Committee	80% compliance against Trusts Resuscitation Policy	
				5.2 Recruit additional resuscitation training officers as required			**Update 14 December 2017:** Additional 1.2 WTE B6 resus training officers commenced. Further 1.0WTE B6 resus training officer starts on 11.12.17. B8A head of resus services interview 09.1.18			31st December 2017			
				5.3 Update Resuscitation policy			**Update 14 December 2017:** Policy updated and reviewed at resuscitation committee 6.12.17. For approval at Jan 18 resus committee meeting.			31st December 2017			
				5.4 Develop phased roll out plan to maintain compliance against RCN standard based on service need			**Update 14 December 2017:** Resuscitation training SOP approved and implemented. 18 APLS courses planned for 2018 alongside 65 PLS courses			30th November 2017			
				5.5 Review compliance monthly at Resuscitation committee and Clinical Quality Steering Group			**Update 23rd October 2017:** Complete – Standing agenda item NB: still validating data on ESR			30th November 2017			
				5.6 Deliver 80% compliance to ensure APLS trained member of staff on each identified area per shift in line with service need			**Update 14 December 2017:** From January 2018			31st January 2018 – 31st March 2019			
				5.7 Audit quarterly compliance against Resuscitation policy and phased roll out			**Update 14 December 2017:** From January 2018			31st January 2018			

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6	Must	Trust	**Mandatory training** Must ensure that compliance with mandatory training is improved, particularly for medical staff.	6.1 Cleanse ESR system to ensure all roles are aligned to correct mandatory training competencies	Melissa Swindell Director of Human Resources and OD	Sharon Owen Head of Human Resources	**Update 24th October 2017:** Cleanse of competencies against positions in ESR has already been completed and has seen a significant increase in the figures reported. The Trust has sourced systems expertise to ensure ESR is set up to accurately report against the Trust requirements		In Progress	**Complete:** 31st August 2017	Workforce and Organisational Development Committee	90% compliance in mandatory training	
				6.2 Produce and share regular detailed mandatory training reports at divisional and departmental level, reported by staff group which shows compliance down to individual staff member level			**Update 24th October 2017:** A full suite of detailed mandatory training reports have been compiled with targeted areas of low compliance being addressed			31st January 2018			
				6.3 Provide designated and targeted support to those areas of low compliance and work with managers to establish action plans to achieve a minimum of 90% compliance			**Update 24th October 2017:** L&D Officer has been meeting managers in areas where there is low compliance to establish a clear action plan that significantly increases compliance by end of January 2017			31st January 2018			
				6.4 Scope development of further e-learning packages and the roll out of the ESR portal to provide staff with further means of accessing training			**Update 24th October 2017:** E-learning packages have been made available for most of the core mandatory training subjects with a plan in place to roll out for all mandatory training subjects.			31st January 2018			
				6.5 Provide monthly Trust wide communication on mandatory training compliance			**Update 24th October 2017:** Communications has commenced and been issued trust wide on the importance of ensuring compliance with mandatory training and this will continue on a monthly basis.			31st March 2018			
				6.6 Review and update training needs analysis in mandatory training policy			**Update 14 December 2017:** Trust remains on track for target completion dates			31st December 2017			

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7	Must	Trust	**Risk assessments** Must ensure that formal risk assessments are undertaken in all departments and all identified risks are captured on the risk register where needed	7.1 Undertake formal risk assessment on all wards assessing the level of risk posed by resuscitation equipment being in different areas within the ward	Melissa Swindell Director of Human Resources and OD	Rob Griffiths Theatre Manager / Phil O'Connor Deputy Director of Nursing	**Update 30th October 2017:** Risk assessment complete as new standardised trolleys implemented Trust wide as per action 11.1		In progress	**Closed:** 29th October 2017	Integrated Governance Committee Health and Safety Committee	Formal risk assessments will be undertaken in all departments with all identified risks captured on the risk register Risk Assessments and Risk Registers will be up to date with appropriate review dates and evidence that actions identified to mitigate risk are in place in the Medical and Surgical Divisions
				7.2 Undertake formal risk assessment on all wards assessing the risk of children absconding or being abducted		Greg Murphy LSMS	**Update 23rd October 2017:** As per action 12.4			31st March 2018		
				7.3 Develop a Trust wide plan to support staff to undertake formal risk assessments in all departments in line with the Trust Risk Management Strategy and Risk Assessment policy for: • Environment • COSHH • Display Screen Equipment (DSE)		Amanda Kinsella Health and Safety Manager	**Update 14 December 2017:** H&S module required on the Trusts risk management system, Ulysses.			31st January 2018		
				7.4 Health and Safety team to upload generic Risk Assessments onto the Risk Register to prevent duplication of risk assessments and associated risks		Amanda Kinsella Health and Safety Manager	**Update 14 December 2017:** Current system not capable of delivery, health & safety team reviewing all options.			~~30th November 2017~~ Revised timescale 31 March 2018		
				7.5 Provide Divisions with generic templates for environmental and DSE risk assessments with best practice examples of how to complete		Amanda Kinsella Health and Safety Manager	**Update 27th October 2017:** Templates and examples to be circulated to Divisions and uploaded onto the Health and Safety intranet page A newsletter communication will be circulated to inform staff of the above resources			31st March 2018 and ongoing		

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				7.6 Identify staff who have had the required training and experience to undertake lead roles in Divisions for corporate Health and Safety functions and subject specific risk assessments		Amanda Kinsella Health and Safety Manager	**Update 14 December 2017:** Action complete			30th November 2017			
				7.7 In collaboration with Health and Safety team, ensure appropriate staff are trained and supported to undertake / be involved in undertaking risk assessments for environmental and DSE in line with the Trust Risk Management strategy		Amanda Kinsella Health and Safety Manager	**Update 27th October 2017:** Health and Safety team to conduct workshops to assist Division in completing Risk Assessments			31st March 2018			
				7.8 In collaboration with Health and Safety team, ensure appropriate staff are trained and supported to undertake / be involved in undertaking stress risk assessments for staff as required		Amanda Kinsella Health and Safety Manager	**Update 27th October 2017:** Health and Safety team to conduct workshops to assist Division in completing Risk Assessments			31st March 2018			
				7.9 Widely disseminate Health and Safety training schedule		Amanda Kinsella Health and Safety Manager	**Update 14 December 2017:** Training schedule for Manual handling, risk assessment and stress risk assessment training has been disseminated. Further aspect of H&S Training to be rolled out in the New Year.			30th November 2017			
8	Must	Community CAMHS	**Lone working** Must ensure that lone working practices are implemented, to ensure the safety of staff and others.	8.1 Each member of CAMHS staff to receive a copy of the Trust policy and CAMHS guideline and sign to they have read and understood the documents	Andrew Williams Director of CAMHS	Kate Brizell General Manager CAMHS	**Update 14 December 2017** Task and Finish Group set up in Sefton. Next meeting 12th December. Signed forms received for 50% of staff. Aim to get all staff by the end of December 2017.		In progress	**Complete:** 30th September 2017 ~~31st November 2017~~ Revised timescale 31st December 2017	CAMHS Clinical Governance Integrated Governance Committee	Safe and robust lone working practices are implemented and sustained	Lone Working mobile phones PADs .msg

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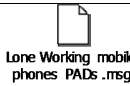
				8.2 Disseminate process for use of Trust mobile phones to all CAMHS staff			**Update 14 December 2017** SOP being developed for Liverpool CAMHS. Sefton CAMHS agreeing this process in Task and Finish group.		**Complete:** 30th September 2017 ~~31st November 2017~~ Revised timescale 31st January 2018		 Lone Working mobile phones PADs .msg
				8.3 Provide a briefing to all staff on the use of Personal Alarm Devices (PAD)			**Update 14 December 2017** Agreement on the type of devices to be used in Sefton not yet agreed – to be discussed and agreed at the next task and finish group 12th Dec 2017		**Complete:** 30th September 2017 ~~31st November 2017~~ Revised timescale 31st December 2017		 Lone Working mobile phones PADs .msg
				8.4 Test the PADs			**Update 14 December 2017** Order did not go forward due to disagreement of type of device. – to be discussed and agreed at the next task and finish group 12th Dec 2017		**Complete:** 30th September 2017 31st December 2017		

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				8.5 Set up lone worker face to face training sessions with the Trust's LSMS to train on the policy and guidance			**Update 14 December 2017** These sessions did not take place due to evacuation incident in Liverpool CAMHS and a diary conflict in Sefton. To be rescheduled for the New Year		~~15th November 2017~~ Revised timescale 31st January 2018			Lone Worker Sessions.msg RE Lone Worker Sessions.msg
				8.6 Agree process for how lone working process is to be implemented for new starters on induction			**Update 14 December 2017** CAMHS induction checklist updated to cover Lone Worker policy and process.		30th November 2017			CAMHS Induction Checklist.docx
				8.7 Audit of lone worker process			**Update 14 December 2017** Waiting agreement of local guidance in Sefton		31st January 2018			
9	Must	Community CAMHS	**Confidential information** Must ensure that the confidentiality of patient information is maintained, and that patient records are only accessible to authorised staff.	9.1 Provide keys to ensure and enable all offices can be locked if no one is in the office	Andrew Williams Director of CAMHS	Kate Brizell General Manager CAMHS	**Update 26th October 2017:** Keys issued	In progress	**Complete:** 30th September 2017	CAMHS Clinical Governance Information Governance Committee Integrated Governance Committee	Patient confidentiality will be maintained with records only accessible to authorised staff	Sefton CAMHS IG poster.pptx IG SpotCheckProforma
				9.2 Implement the 'Clear Desk' policy			**Update 26th October 2017:** Communication sent to all CAMHS Sefton staff about the Clear Desk policy		**Complete:** 31st August 2017			
				9.3 Provide confidential waste bins on floor 4 and 5 to make it easier for staff to dispose of patient information safely, securely and promptly			**Update 26th October 2017:** Confidential waste bins in place		**Complete:** 31st August 2017			

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				9.4 Undertake Information Governance spot check audits			**Update 14 December 2017** Tool for IG Spot Check agreed. Monthly spot checks by the localities commencing by the end of the year. Unannounced independent spot check by Trust IG Lead and Head of Quality being scheduled.		31st December 2017				
				9.5 Disseminate guidance on clear desk principles / safe haven procedures and secure emails to all staff			**Update 26th October 2017:** Shared at away day (May 17) and via email / business meeting		**Complete:** 31st May 2017				
				9.6 Staff to use booking schedule system to ensure that clinic rooms are used for appointments only and not personal offices in order to support lone worker practices and information governance			**Update 14 December 2017** AW to draft letter		15th December 2017				

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Medicine and Surgery

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

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							check security audit conducted in September 2017 confirmed all in place			2017			
				12.3 Issue a Trust Risk Alert reminding staff that risk assessments to be undertaken for children and young people considered to be at risk of absconding		Pauline Brown Director of Nursing	**Update 14 December 2017:** Action complete			30th November 2017			 Safety Alert - Patients at risk of abs
				12.4 Annual risk assessment of abduction risk to be undertaken on all in-patient wards with Matrons / Ward Managers		Greg Murphy LSMS	**Update 23rd October 2017:** Child abduction policy reviewed and updated on occupying the new hospital building All ward entrance/exits are covered by CCTV			31st March 2018			
13	Should	Medicine / Surgery	**Mandatory training** Expedite plans and actions to enable all staff to improve compliance with mandatory training to the trust's target of at least 90%	13.1 Disseminate Divisional mandatory training reports and specific communication produced by Learning and Development	Melissa Swindell Director of Human Resources and OD	Will Weston Associate Chief Operating Officer Medical Division Adam Bateman Associate Chief Operating Officer Surgical Division			In progress	31st December 2018 and ongoing	Workforce and Organisational Development Committee	90% compliance in mandatory training	
				13.2 In collaboration with L&D team, devise specific and targeted actions in any areas with compliance less than 90%						31st December 2018 and ongoing			
14	Should	Medicine	**Medical records** Have safe storage facilities in place for medical records on all wards to protect children and young people's confidentiality	14.1 Review system in place on Surgical Wards where CQC found that all paper based records were stored securely and were clearly identifiable at every nursing station	Hilda Gwilliams Chief Nurse	Catherine Wardell Associate Chief Nurse			In progress	31st December 2017	Information Governance Committee Integrated Governance Committee	Medical records will be safely stored to protect confidentiality	
				14.2 Implement same system on Medical Wards to ensure a safe and consistent approach throughout the hospital						31st December 2017			

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15	Should	Medicine	**Disease Specific Pathways** Have disease specific pathways in place that are based on up to date evidenced based practice and a system for assurance during the period of transition from paper to electronic pathways	15.1 Review and disseminate diabetic pathways	Steve Ryan Medical Director	Adrian Hughes Associate Medical Director Medicine	**Update 27th October 2017:** Diabetic Ketoacidosis (DKA) pathway has been reviewed and changes disseminated All other diabetic pathways are under review and being overseen by the Head of Acute Services		In progress	31st January 2018	Divisional Risk and Governance Committee Clinical Quality Steering Group Clinical Quality Assurance Committee	Specific disease pathways will be in place Trust will be assured of patient safety during transition from paper to electronic pathways	
				15.2 Design and develop a website for and with our diabetic patients and their families in order to provide comprehensive and up to date accessible information and education			**Update 27th October 2017:** Website development underway with involvement from a patient and parent			31st December 2018			
				15.3 Implement the Alder Hey Acute Asthma pathway based on the British Thoracic Society guidance issued in September 2016			**Update 27th October 2017:** Alder Hey Asthma pathway in use from November 2016. Input into BTS guidance by Alder Hey consultant. The Alder Hey pathway is being adopted by other centres nationally as best practice			**Complete:** November 2016			
				15.4 Implement the Alder Hey Bronchiolitis pathway developed in conjunction with patients and families			**Update 27th October 2017:** Alder hey Bronchiolitis pathway in use from April 2017. The pathway has a focus on empowering parents to hold and feed babies. When compared with other pathways known to the team the parental empowerment is what makes this pathway unique			**Complete:** 30th April 2017			
16	Should	Medicine / Surgery	**Appraisals** Improve staff appraisal rates to reach the at least the trust's target of 90%	16.1 Ensure the process for appraisals (PDR's) is communicated widely across the Trust so that all staff are aware of their role and responsibilities. This includes the process that there is a four month window annually (commencing April) in which to complete the PDR's across the Trust in order to manage the process effectively and ensure all staff have opportunity to reflect how Trust objectives align to their role	Melissa Swindell Director of Human Resources	Will Weston Associate Chief Operating Officer Medical Division Adam Bateman Associate Chief Operating	**Update 14 December 2017:** PDR 84% on 29/11/17. Slow, but sure improvement over the last two months. Next step is to cleanse ESR to make sure all staff listed against division of medicine are correct. ESR export sent to service and operational managers to complete and sent back to HR for validation and amendments are made week commencing 4/12/17.		In progress	30th November 2017	Workforce and Organisational Development Committee Divisional Board	90% compliance with staff appraisal rates	

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				16.2 Provide training to support managers with the process and to facilitate effective PDR's by reviewing performance for the year, reviewing achievements against agreed developments and planning of personal developments for the forthcoming year		Officer Surgical Division	**Update 30th October 2017:** Training in place			**Complete:** 31st October 2017 and ongoing			
				16.3 Produce and share regular detailed PDR reports at divisional and departmental level			**Update 14 December 2017:** PDR reminders sent out regularly e.g. 06/11/2017.			30th November 2017 and ongoing			
				16.4 Review local progress on ESR			**Update 14 December 2017:** ESR cleansing email sent out on 06/11/2017. See 16.1 for further detail.			30th November 2017 and ongoing			
				16.5 Provide designated and targeted support to those areas of low compliance and work with managers to establish action plans to achieve a minimum of 90% compliance			**Update 14 December 2017:** Clinical areas requiring my support and targeted work led by Associate Chief Nurse and Divisional HR Business Partner to address low PDR completion and relatively high sickness rates.			30th November 2017 and ongoing			
				16.6 Annual review of PDR documentation and update as required						31st March 2018			
17	Should	Medicine	**MHA Training** Consider training on the Mental Capacity Act for clinical staff being part of the mandatory training	17.1 Review the requirement / content for mandatory training on the Mental Capacity Act with Trust Learning and Development department	Melissa Swindell Director of Human Resources	Catherine Wardell Associate Chief Nurse Medical Division			In progress	31st January 2018	Clinical Quality Steering Group Clinical Quality Assurance Committee	All staff receive appropriate mandatory training	
18	Should	Medicine	**Display Screens** Ensure visual display screens on the wall behind the desk to the entrance of wards do not compromise patient confidentiality	18.1 Review practice at Information Governance Committee meeting	Hilda Gwilliams Chief Nurse	Catherine Wardell Associate Chief Nurse Medical Division			In progress	31st January 2018	Information Governance Committee Integrated Governance Committee	Relevant information to maintain patient safety and patient flow is available and patient confidentiality is not compromised	
				18.2 Benchmark practice with other paediatric hospitals / wards									
				18.3 Scope the impact that turning off the visual display screens in some medical wards has had			**Update 30th October 2017:** The electronic screen information is felt to be integral to the effectiveness of ward						

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							Board Rounds including alerting that medication administration is due					
19	Should	Medicine / Surgery	**Risk Registers** Identify review dates on all risk registers and review monitor that actions identified to mitigate risk are in place in medical services and surgical services	19.1 Review Risk Register at Divisional Board / Risk and Governance meetings or bespoke Divisional Risk Register meeting	Hilda Gwilliams Chief Nurse	Adrian Hughes Associate Medical Director for Medicine Christian Duncan Associate Medical Director for Surgery	**Update 30th October 2017:** Divisions to include Risk Register as a standing agenda item at either Divisional Board / Risk and Governance meetings Divisional Board / Risk and Governance Committee Division to monitor all risks, reviewing within the identified timescale and reviewing that actions identified to mitigate risk are in place		In progress	31st December 2018	Integrated Governance Committee	Risk Registers will be up to date with appropriate review dates and evidence that actions identified to mitigate risk are in place in the Medical and Surgical Divisions Focused assurance, that each and every risk is being managed effectively, i.e. risks clearly identified from assessment, risk rating reflects assessment of controls, gaps in controls, actions for improvement and progress with actions, review completed in line with timeframes identified on risk assessment, and escalation completed in a timely manner. Corporate risk registers to include all high risks only and linked to corporate objectives	
				19.2 Risk Managers to be identified on each risk assessment, in addition to Risk Owners			**Update 30th October 2017:** All risks currently under review as per action 19.4 and all Risk Managers will be assigned			31st December 2018		
				19.3 Ensure all staff responsible for inputting and managing risks on the Risk Register are trained and aware of their role and responsibilities			**Update 30th October 2017:** Training available within the Trust All staff identified within Division of Medicine have had training in risk management Train the trainer approach to be considered to develop risk management expertise across the Trust, and a systematic cascade of training in each Division			31st March 2018		
				19.4 Set up immediate Task and Finish group for each Division to validate risk registers attended by the senior team for each of the three Divisions			**Update 30th October 2017:** Monthly corporate meetings to support Divisions to review and progress Risk Registers have been commenced Chaired by the Associate Director of Risk and Governance. Meetings will take place for a minimum of six months to ensure significant assurance evident that risk is managed effectively and understood An additional meeting to be set up to support corporate			**Complete:** 20th October 2017 and ongoing		

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							services (for example medicines management, health and safety, infection control, information governance and records management, Governance and quality assurance, IM&T, Business Continuity) in the same way					
				19.5 Each Division to present their Risk Registers, focusing on high risks or others that may impact on the achievement of corporate objectives, at all Integrated Governance Committee meetings			**Update 30th October 2017:** Presentation of Divisional Risk Registers at Integrated Governance Committee has commenced Committee reports presented to focus on level of risk associated with the issues being presented, and actions to mitigate to achieve target risk rating. Risks elevated to 15 or above to transfer to executive responsible for associated corporate objectives, until mitigated to at least a high moderate (meaning risk score = 12) and then transfer back to original risk owner. Management of the risk locally to remain with the identified risk manager / function where risk originated as identified on the Risk Register	31st December 2017			
20	Should	Medicine / Surgery	**Ward Curtains** Consider implementing a schedule for replacing curtains in the ward areas	20.1 Update the programme for planned curtain replacement, according to risk category	Hilda Gwilliams Chief Nurse	Lesley Cooper Domestic Operations Manager	**Update 14 December 2017** Programme has been updated according to risk category Very High Risk – 3 months High Risk – 6 months Significant Risk – 12 months		In progress	30th November 2017	Infection Prevention and Control Committee	100% compliance with planned replacement programme	
				20.2 Audit compliance with updated replacement programme on a quarterly basis			**Update 14 December 2017** This is planned to commence as per date agreed, records will be stored on k drive			Quarterly commencing 31st March 2018			

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				20.3 In addition to planned replacement, replace curtains as part of an environmental deep clean and on request if visibly not clean			**Update 14 December 2017:** Curtains are replaced on an ongoing basis if not visibly clean and always when a deep clean is undertaken		30th November 2017 and ongoing			
21	Should	Surgery	**SSI** The management team should consider ways in which to improve monitoring of surgical site infections for patients who have undergone non-specialist surgery	21.1 Develop a Business Case to support the delivery of surgical site infection (SSI) data for all specialities within the Surgical Division	Steve Ryan Medical Director	Christian Duncan Associate Medical Director Surgical Division	**Update 26th October 2017:** Complete. Business case approved by Divisional Board and Investment Review Group 27th July 2017		In progress	**Complete:** 27th July 2017	Surgical Division Infection Control Board Infection Prevention and Control Committee	Improved monitoring of SSI in non-specialist surgery with associated opportunity to learn lessons, improve practice and reduce rates of infection	
				21.2 Recruit to data analyst role			**Update 26th October 2017:** Recruitment underway			31st December 2017			
				21.3 Develop the required SSI			**Update 26th October 2017:** Pending recruitment of the data analyst			31st January 2018			
				21.4 Commence SSI data collection			**Update 26th October 2017:** Pending recruitment of the data analyst			31st January 2018			
				21.5 Review and disseminate reports of SSI data findings within the Surgical Division and to the Trust through Infection Prevention and Control Committee			**Update 26th October 2017:** Pending recruitment of the data analyst			31st March 2018			
22	Should	Surgery	**CD Discard** The management team should make sure that discarded controlled drugs across all departments are recorded appropriately	22.1 Pharmacy to undertake audit of all wards every 6 months as per Medicines Management Code Section 12	Steve Ryan Medical Director	Catrin Barker Chief Pharmacist	**Update 26th October 2017:** April audit demonstrates the following improvements since the last audit: 1. Recording of wastage at ward / departmental level 57% to 82% since previous audit 2. Documenting of administration/destruction from 72% to 94% since last audit		In progress	31st April 2018	Medicines Management Committee Clinical Quality Steering Group Clinical Quality Assurance Committee	All controlled drugs discarded will be recorded appropriately	
				22.2 Share audit results with Ward Manager and Matron to establish local action plan for improvement Ward Manager or Matron to re-audit a month later to ensure actions implemented and compliance improved to acceptable standard						31st April 2018			

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				22.3 Liaise with other hospitals to check and benchmark practice for discarding controlled drugs (CD)					31st December 2017			
				22.4 Investigate whether CD books are available that allow for discards to be recorded more clearly					31st December 2017			
				22.5 Provide training to ward staff to ensure they are aware of their role and responsibilities regarding recording discards as per Medicines Management Code Section 12			**Update 14 December 2017:** Arrangements for training regarding recording discards discussed and agreed with MSO & Heads of Quality		30th November 2017 and ongoing			
				22.6 Review Medicines Management Code and update as required					31st December 2017			
23	Should	Medicine / Surgery	**MAR** The management team should consider ways in which to improve the meditech system so that it accurately reflects the time that medicines had been administered, reducing the potential risk of a medication overdose	23.1 Issue a Safety Alert advising users of the correct way to close a MEDITECH session to avoid the system closing before all data has saved	Steve Ryan Medical Director	Cathy Fox Head of Clinical Systems	**Update 25th October 2017:** Action complete. Two Safety Alerts have been sent to all users	In progress	**Complete:** October 2017	Global Digital Exemplar Programme Board Operational Delivery Board	Accurate recording of medication administration to reduce the risk of associated medication errors	
				23.2 Complete testing and sign off of Multi User Desktop. Multi User Desktop is enhanced functionality as part of Fast User Switching which allows up to four user accounts to run simultaneously on a computer. This will significantly reduce the risk of a MEDITECH session closing prematurely before data, such as medicines administration, has saved					**Complete:** 4th November 2017			
				23.3 Commence pilot of Multi User Desktop in Emergency Department and Ward 3A to support use of the ELIS system with appropriate end user support					1st December 2017			

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				23.4 Present pilot results and rollout plan to Global Digital Exemplar Programme Board on 12th December 2017. If agreed, commence rollout to all clinical areas with appropriate end user support from January 2018					31st May 2018			
24	Should	Medicine / Surgery	**Ward Co-ordinator** The hospital should find ways in which to make sure that there is always a supernumerary co-ordinator available in all areas, at all times to support staff	24.1 Undertake annual establishment of ward areas based on national standards (Royal College of Nursing / Paediatric Intensive Care Society / British Association of Perinatal Medicine), patient acuity and professional judgement	Hilda Gwilliams Chief Nurse	Pauline Brown Director of Nursing / Divisional Associate Chief Nurses			In progress	28th February 2018	Clinical Quality Assurance Committee		
				24.2 Undertake annual audit of nurse staffing against RCN core standards to identify gaps						28th February 2018			
				24.3 Review nursing model in wards where a supranumery co-ordinator is not currently being allocated						28th February 2018			
				24.4 If a gap in funded establishment is identified which is contributing to no supranumery co-ordinator, escalate to the attention of the Trust Board through bi annual nurse staffing paper						30th March 2018			
25	Should	Medicine / Surgery	**Appraisals** The management team should ensure that all staff receive a full annual appraisal in line with the trust supervision policy	25.1 Ensure the process for appraisals (PDR's) is communicated widely across the Trust so that all staff are aware of their role and responsibilities. This includes the process that there is a four month window annually (commencing April) in which to complete the PDR's across the Trust in order to manage the process effectively and ensure all staff have opportunity to reflect how Trust objectives align to their role	Melissa Swindell Director of Human Resources	Will Weston Associate Chief Operating Officer Medical Division Adam Bateman Associate Chief Operating Officer Surgical Division	**Update 14 December 2017:** PDR 84% on 29/11/17. Slow, but sure improvement over the last two months. Next step is to cleanse ESR to make sure all staff listed against division of medicine are correct. ESR export sent to service and operational managers to complete and sent back to HR for validation and amendments are made week commencing 4/12/17.		In progress	30th November 2017	Workforce and Organisational Development Committee Divisional Board	90% compliance with staff appraisal rates	
				25.2 Provide training to support managers with the process and to facilitate effective PDR's by reviewing performance for the			**Update 30th October 2017:** Training in place			**Complete:** 31st October 2017 and		

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				year, reviewing achievements against agreed developments and planning of personal developments for the forthcoming year					ongoing				
				25.3 Produce and share regular detailed PDR reports at divisional and departmental level			**Update 14 December 2017:** PDR reminders sent out regularly e.g. 06/11/2017.		30th November 2017 and ongoing				
				25.4 Review local progress on ESR			**Update 14 December 2017:** ESR cleansing email sent out on 06/11/2017. See 16.1 for further detail.		30th November 2017 and ongoing				
				25.5 Provide designated and targeted support to those areas of low compliance and work with managers to establish action plans to achieve a minimum of 90% compliance			**Update 14 December 2017:** Clinical areas requiring my support and targeted work led by Associate Chief Nurse and Divisional HR Business Partner to address low PDR completion and relatively high sickness rates.		30th November 2017 and ongoing				
				25.6 Annual review of PDR documentation and update as required					31st March 2018				
26	Should	Surgery	**Cancelled operations** The hospital should consider ways in which to reduce the number of cancelled surgical procedures, and when this does happen to facilitate a further appointment within 28 days of the cancellation	26.1 Undertake capacity and demand modelling for the surgical wards	Mags Barnaby Chief Operating Officer	Adam Bateman Associate Chief Operating Officer Surgical Division	**Update 30th October 2017:** Modelling completed for the winter period. However the 'Best in Operative Care' steering group are progressing an annual plan based on annual bed occupancy This has meant that this winter operationally the Trust has implemented maximum in patient numbers per day, per ward This should see a real reduction in on the day cancellations and will be monitored daily		In progress	**Complete:** 27th October 2017	Operational Delivery Board Forward View meeting	The hospital should consider ways in which to reduce the number of cancelled surgical procedures, and when this does happen to facilitate a further appointment within 28 days of the cancellation	
				26.2 Realign the Operating Theatre schedule to balance out the elective patients across the week					30th April 2018				

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				26.3 Implement a daily huddle to review the day ahead based on winter pressures and to review any on the day cancellations that day and identify clear actions to ensure that the patient is re-dated within 28 days			**Update 30th October 2017:** Complete, daily huddle implemented from 30th October 2017			**Complete:** 27th October 2017		
				26.4 Introduce an escalation process whereby any patients not given an appropriate date are escalated to a senior manager to resolve with clinical teams			**Update 30th October 2017:** Complete, commenced 30th October in line with the daily huddle			**Complete:** 27th October 2017		
				26.5 Implement a more robust reminder service for patients			**Update 30th October 2017:** Currently this is a manual call however via the 'GDE Programme' we are progressing a two way text reminder service			31st May 2018		
				26.6 Review why discharges are delayed, resulting in lack of bed availability, within the Surgical Division utilising Clinical Utilisation Review (CUR)			**Update 30th October 2017:** Complete. Review undertaken and supporting actions identified following the review are: • Implement Nurse led discharge process • Increased nurse led prescribing- allowing those patients awaiting TTO's to be discharged by the nursing team • Estimated discharge dates given to all patients on admission with a clear plan to achieve this. This date will be visible for families and clinical staff			**Complete:** 27th October 2017		

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Community CAMHS

No	Must/ should do	Dept	CQC action	Alder Hey action	Director	Lead	Progress	Individual action BRAG	Overall action BRAG	Target completion date	Monitoring Committee	Required outcome / output	Evidence
27	Should	Community CAMHS	**Risk Assessments** Should ensure that all risk assessments are routinely reviewed, and the outcome of these reviews is clearly documented	27.1 GDE CAMHS work to include making the process of managing and viewing the risk assessments clearer	Andrew Williams Director of CAMHS	Kate Brizell General Manager CAMHS	**Update 14 December 2017** In progress – forms designed and working with Meditech to get this incorporated into the system.		In progress	31st January 2018	CAMHS Clinical Governance	Risk assessments are routinely reviewed, and the outcome of these reviews is clearly documented	Super SOP meeting.ics
				27.2 Development of a Super SOP to incorporate the processes for risk assessment			**Update 14 December 2017** Group of key people agreed – first meeting set for 5th January 2018.			28th February 2018			CAMHS Record Keeping Audit Tool.dc
				27.3 Monthly audit of record keeping			**Update 14 December 2017** First audit of 20 records completed – audit results being written up. Some minor changes needed to audit form. Discussion of results from this first audit to be discussed at the CAMHS Governance meeting 21/12/17.			30th November 2017			
28	Should	Community CAMHS	**Furniture** Should ensure that the environment, including furniture, is clean, well maintained, and in a good state of repair	28.1 Undertake environmental risk assessments	Andrew Williams Director of CAMHS	Kate Brizell General Manager CAMHS	**Update 14 December 2017** CAMHS Sefton risk assessment – 3 rooms outstanding		In progress	**Complete:** 30th September 2017 ~~10th November 2017~~ Revised timescale 31st December 2017	CAMHS Clinical Governance	All furniture will be clean, well maintained, and in a good state of repair	Environmental Risk Assessment - Liverpo
				28.2 Risk assess whether appropriate to move furniture from current locations to new sites			**Update 14 December 2017** Cost of new furniture has been incorporated into the proposal for CAMHS Sefton's move.			31st January 2018			

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29	Should	Community CAMHS	**Design / decoration** Should ensure that the design and decoration of the environment is suitable for children and young people	29.1 Consider as part of the move from existing locations to new sites for Sefton and Liverpool. Involvement of the patient users groups to be set up	Andrew Williams Director of CAMHS	Kate Brizell General Manager CAMHS	**Update 14 December 2017** Both sets of CAMHS patient forums have been consulted and contributed to the evolving plans for the new CAMHS locations.		In progress	31st December 2018	CAMHS Clinical Governance	The design and decoration of the environment will be suitable for children and young people evidenced by the involvement of patient user groups	
30	Should	Community CAMHS	**Soundproofing** Should ensure that all rooms are adequately soundproofed	30.1 Obtain advice from the Estates department on monitoring sound proofing	Andrew Williams Director of CAMHS	Kate Brizell General Manager CAMHS	**Update 14 December 2017** Awaiting update		In progress	10th November 2017	CAMHS Clinical Governance	All rooms will be assessed for soundproofing	
				30.2 Clarify which clinic rooms currently have adequate sound proofing and those that lack sound proofing			**Update 14 December 2017** Awaiting update			31st December 2017			-
				30.3 Ensure rooms in new locations are assessed for sound proofing prior to moves			**Update 14 December 2017** Agreement of location for Sefton CAMHS – Estates requested to add testing of soundproofing to project plan.			31st December 2018			-
31	Should	Community CAMHS	**Languages** Should ensure that people are provided with information in a language or format they understand	31.1 Undertake a review of Trust current position on the translation of clinic letters / reports / patient information	Andrew Williams Director of CAMHS	Sarah Stephenson Head of Quality	**Update 14 December 2017** Awaiting response		In progress	~~30th November 2017~~ Revised timescale 31st January 2018	CAMHS Clinical Governance	Ensure that people are provided with information in a language or format they understand	
				31.2 Undertake a review of how other organisations provide information in a language or format that families can understand			**Update 14 December 2017** Awaiting response			31st December 2017			
				31.3 Implement actions based on feedback			**Update 14 December 2017** Awaiting response			31st December 2017			

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32	Should	Community CAMHS	**Staff morale** Should ensure that effective strategies are in place to improve morale	32.1 Present update reports from the two working groups (Sefton / Liverpool) to the CAMHS Board	Andrew Williams Director of CAMHS	Kate Brizell General Manager CAMHS	**Update 14 December 2017** Date requested from Sefton CAMHS as to when the Sefton working group will present		In progress	31st January 2018	CAMHS Board	Should ensure that effective strategies are in place to improve morale	CAMHS BOARD STAFF MORALE PRES STAFF MORALE REPORT 2017 FINAL Quality Update - Oct 2017.pptx Quality Update - Nov 2017.pptx
				32.2 Widely share the compliments and achievements in the monthly Quality Updates			**Update 26th October 2017:** Standing section for the Quality Updates from September 2017			**Complete:** 30th September 2017			
				32.3 Explore a Divisional 'Star of the Month'			**Update 14 December 2017** Decision made to use Trust process and use this to nominate staff from the division. Nominations being made			30th November 2018			
33	Should	Community CAMHS	**Raising concerns** Should ensure that staff feel confident in raising concerns about the service.	33.1 Monitor logging of Ulysses incidents to ensure incidents for all areas are increasing	Andrew Williams Director of CAMHS	Sarah Stephenson Head of Quality	**Update 14 December 2017** Incidents across CAMHS are increasing. Sessions held with staff at Liverpool and Sefton. Incidents are monitored and reported in the monthly Quality Update which shows the increasing levels of incident reporting.		In progress	**Complete:** 30th September 2017 and ongoing	CAMHS Clinical Governance	Enable staff to feel confident in raising concerns about the service and ensure staff know how they can raise concerns	Quality Update - Dec 2017.pptx Incident reporting process - 2017 - AH s Freedom to Speak Up.msg
				33.2 Promote the use of existing Trust mechanisms for raising concerns including 'Raise It Change It' and 'Freedom to Speak Up' through wide communications to teams			**Update 14 December 2017** Waiting on confirmation re Freedom to Speak Up roles in Community prior to sending information out across the Division			~~30th November 2017~~ Revised timescale 31st January 2018			
				33.3 Investigate option for Community Head of Quality to become a Freedom to Speak Up Champion for the Division			**Update 26th October 2017:** Initial contact made with Kerry Turner (Freedom to Speak up Trust Lead) to enquire further			~~31st October 2018~~ Revised timescale 31st January 2018			

BY EMAIL ONLY:
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18 December 2017

Request for review of a rating

Location name: Alder Hey Children's NHS Foundation Trust
Inspection ID: INS2-3608999550

Dear Ms Shepherd,

I have considered your submission against the grounds for requesting a review of ratings.

It should be noted that the grounds for a review is set out on page 46 of the NHS and independent acute hospitals provider handbook:

> The only grounds for requesting a review are that CQC did not follow the process for making ratings decisions and aggregating them. Providers cannot request reviews on the basis that they disagree with the judgements made by CQC, as such disagreements would have been dealt with through the factual accuracy checks and any representations about a Warning Notice if one was served.

A rating review involves checking whether or not CQC followed its published processes in making judgements and awarding the rating(s). A rating review does not involve a reconsideration of the evidence and ratings awarded, unless there has been a defect in the process.

Submission

You have requested a review of the ratings for Surgery's Safe key question, Medical Care's Safe key question, and Specialist community mental health services for children and young people's Well-Led key question.

You submit that the inspection team has failed to follow proper process in awarding the ratings. You submit that the inspection report reads more closely as good than as requires improvement, and that the report does not sufficiently detail the evidence for the ratings of requires improvement. You further submit that the inspection team has

not appropriately considered the evidence provided at the factual accuracy stage. You also submit that evidence has not been considered proportionately, and that the responses to factual accuracy comments relating to outstanding documents were contradictory.

Awarding the rating

The amount of positive or negative content in a report or the number of recommendations (or lack of) does not automatically reflect what the rating should be. Inspectors are trained to use their professional judgement to match their findings against the descriptors for each key question and select the rating which best fits the evidence they have collected.

Reports are then subject to a quality control process to ensure consistency in making judgements and awarding ratings. The report and ratings for Alder Hey Children's NHS Foundation Trust were reviewed by an inspection manager, a National Quality Assurance Panel, and a further National Quality Assurance Panel following the receipt of factual accuracy comments, who agreed the ratings as outlined in the inspection report. I have reviewed the quality control documents and consider proper process has been followed.

Challenging the rating

When providers receive a copy of the draft report (which will include their ratings) they are invited to provide feedback on its factual accuracy and completeness of the evidence on which the ratings are based. The factual accuracy process allows providers to challenge the evidence presented in the draft report. It is also an opportunity for the provider to highlight any evidence which they feel has not been considered by the inspector in the draft report.

The ratings review process is not a second round of factual accuracy submissions and cannot reconsider the judgements of the inspector during the factual accuracy stage.

I have reviewed your factual accuracy submissions and the inspector's responses. These responses were reviewed and signed off by an inspection manager and were also considered by a National Quality Assurance Panel before the final report was sent to you. I consider CQC gave your factual accuracy submissions proper attention, setting out what changes would be made and providing a rationale where your proposed changes were not accepted. This stage of the process was followed correctly by CQC.

Conclusion

In summary I am assured the full quality assurance process for this inspection and the reporting was followed, due consideration given to the relative weighting of the evidence collected and the aggregation principles correctly followed. As such there

are no applicable grounds for challenge and therefore your request for a review of the ratings for Alder Hey Children's NHS Foundation Trust will not proceed. The published ratings will remain the same.

I understand you will be disappointed with the outcome of this review, but this letter represents CQC's final decision on this matter.

Yours sincerely,

Ross Clark

Senior Rating Review Officer

Alder Hey Children's NHS
NHS Foundation Trust

Resource and Business Development Committee
Confirmed Minutes of the meeting held on: **Thursday 30th October 2017**, **at 1500**
Large Meeting Room, Institute in the park

Present:	Ian Quinlan (Chair)	Non-Executive Director	IQ
	Mags Barnaby	Interim Chief Operating Officer	MB
	John Grinnell	Director of Finance	JGr
	Claire Liddy	Deputy Director of Finance	CLi
	Claire Dove	Non- Executive Director	JW
In Attendance:	Mark Flannagan	Director of Communication	MF
	Rob Griffiths	Service Manager Theatres	RG
	Erica Saunders	Director of Corporate Affairs	ES
	Sharon Owens	Head of HR	SO
	Julie Tsao	Executive PA	JT
Agenda item: 78	Cathy Fox	Associate Director Informatics Officer	
79	Hilda Gwilliams	Chief Nurse	
89	Phil Raymond	Service Manager, Cardio Surgery, Critical Care	
90	Graeme Dixon	Building Services Manager	
91	Rachel Lea	Business Accountant	
Apologies:	Sue Brown	Project Manager and Decontamination Lead	SB
	David Powell	Development Director	DP
	Steve Ryan	Medical Director	SR
	Lachlan Stark	Head of Planning and Performance	LS
	Melissa Swindell	Director of HR	MS

17/18/76 Minutes of the previous meeting held on 28th September 2017
Resolved:
RABD received and approved the minutes of the previous meeting.

17/18/77 Matters Arising and Action log
All items for discussion had been included on the agenda.

17/18/78 Global Digital Excellence Programme
Cathy Fox reported the Alder Hey *Fast Follower* Trust, Clatterbridge, had completed the first part of their 'due diligence' and had been given approval to continue on to the next stages.

As reported at the last meeting Alder Hey had completed the first assurance inspection from NHS Digital. Further funding was due to be received, NHS Digital have not yet confirmed when this will be completed.

Following the inspection NHS Digital have requested further details on benefit realisation. Kerry Morgan had been appointed to this role 1 day per week, Kerry was due to go full time with this next week.

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

17/18/79 Facilities update
The Facilities Division has been assigned recovery actions totalling £500k in order to reach its new control total. Current estimates suggest the main reasons for the overspend are linked to the following areas:

- Catering
- Postage
- Security
- Car Parking

This review will focus on Postage, Security and Car Parking. A separate external Catering review has commenced on 2nd October 2017 an initial report will be presented at the December RABD.

Postage
To lower the cost of postage a decision was made for letters to be franked 2nd class instead of 1st class earlier in the year. Following this review it has come to light that a number of departments are duplicating the number of letters sent for assurance purposes. To resolve this an interactive texting service was being looked into and it was hoped a pilot would commence later this week. Letters cost 40p each were a text would cost 5p each.

Security
The contract had recently been awarded to the current providers. As the Chair specialises in security services he agreed to ask his Commercial Director to contact Hilda Gwilliams to ensure the Trust are receiving a good deal.
Action: Chair

Car Parking
Following the implementation of the new car parking system an increase to staff car park had been implemented earlier in the year. There had been a proposal to increase car parking charges to the public however this had been declined due to a number of concerns. Without an increase to visitors car parking charges a positive contribution is expected.

Resolved:
a) RABD received an update on the current position of the facilities review.
b) It was agreed a further update would be received at the December RABD with attendance from representatives leading the external catering review.

17/18/80 Performance

Month 6 was a challenging month for the delivery of activity numbers within in Medicine, with ongoing challenges with delivery of their Elective programme. Medical staffing challenges continue to be noted in specialties such as Gastro and Neurology. Non Elective activity continues to be higher than plan, and this is continuing into Month 7 which is 11% ahead of plan YTD. Improvements have been noted in the day case position for two of challenged specialities Rheumatology and Oncology and continued improvements for Nephrology where previously identified coding issues have now been resolved. Work continues within the Medical Day Case unit to improve capture and the depth of coding. Whilst this area had improved a 'deep dive' was to be carried out with capture and coding to understand on going issues. Mags Barnaby agreed to update RABD at the next meeting.
Action: MB

Out Patient booked utilisation is in excess of 100% and is monitored each week through weekly performance however DNA rates and cashing up of clinics reduced the actual utilisation down to 87% for September.

Resolved:
RABD received and noted the content of the performance report for month 6.

17/18/81 Finance report

For the month of September the Trust is reporting a trading deficit of £0.6m which is in line with plan. Income is ahead of plan by £0.1m but this is offset by expenditure which is higher than budgeted by £0.1m. The year to date position is a deficit of £5m which is ahead of plan by £0.1m. The Use of Resources risk rating is 3 which is in line with plan and cash in the bank of £9.1.

Income in month 6 is £18.9m versus a plan of £18.8m, an over achievement of £0.1m. The achievement is in relation to a non-recurrent credit note overpayment from gas/electricity providers.

Claire Liddy presented month 6 results noting the gap in month 5 of £6.3m, this had now been reduced to £3.9m.

The report highlighted the Trust's over performance with the Liverpool CCG Contract noting the CCG are reviewing why the over performance has occurred.

Resolved RABD:
Received and noted the content of the Finance report for month 6.

Corporate report
Performance
All targets for Month 6 and quarter 1 had been met.

Resolved RABD:
Received and noted the contents of the CR report for month 6.

17/18/82 Programme Assurance

RABD received the programme assurance report for:
External Partnerships – Strengthening the Stoke Partnership is to be removed from the dashboard until a decision on procurement has been made.
Global Digital Excellence – All projects are on track.
Park Community Estates and Facilities – Only the residential development remained red due to delays with the project.
Strong Foundations – projects have shown improvement.

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

17/18/83 Weekly waiting times update
Resolved:
September performance has shown resilience despite some challenging operational conditions however all NHSI core standards had been achieved.

17/18/84 Quarter 2 Monitoring report
Resolved:
Report would be submitted tomorrow, 4 hour A&E Targets had been met.

17/18/85 Marketing and Communication Activity report
Resolved:
To ensure team brief was engaging this was currently under review.

17/18/86 Monthly Debt Write Off
Resolved:
RABD approved October's write offs for £187.78.

17/18/87 Service Line Report

Following an update received at the last RABD on service reviews, RABD received a presentation on streamlining the process. Proposals included for RABD to receive three progress reports through-out the year as well as an annual update to the Trust Board.

Jason Dean explained the potential of the reviews saving finances and resources. A potential saving of £600K has been identified within cardiac services.

Resolved:
RABD received and approved further reports:

- Three times per year to RABD.
- Four reports per annum to each CBU
- Monthly reports to the Strong Foundations Group
- Annually to Board

17/18/88 Procurement Update

Resolved:
As Steve Begley was no longer available to attend it was agreed this item would be deferred until the November RABD.

17/18/89 ECMO Business Case

At the beginning of 2017/18 the Trust received formal notice of designation as a Full Paediatric Respiratory ECMO centre (we had previously provided this service on a "surge" capacity basis). As a nationally designated centre, the Trust is now able to take direct referrals and anticipate activity volume will double. This case will make a recurrent financial contribution of £262k.

Phil Raymond explained the complexity of the ECMO machines and consultant/nurse resource each machine takes. A consultant recently stayed an additional 10 hours after his shift to ensure a patient was continuously monitored on one of the machines as there was no on call consultant to cover ECMO services. It was agreed that a formal process would need putting in place to ensure this is not repeated.

It was noted the service has been awaiting accreditation before being able to put a business case in place.

Resolved:
RABD APPROVED the recommendation made by Investment Review Group and Operational Delivery Board to support increased investment in the Alder Hey ECMO Service.

17/18/90 PFI Contract Monitoring report

Settlement Deal 3 was finally signed on the 22nd September. The deal sees the Trust receive a cash amount of £500k, various works throughout the build and the undertaking of the hard FM provision of the innovation hub. August has seen some further improvement in energy and the SPV are reporting that in month they are 3% under the contractual target. This is the first time since the new build opened that energy usage has been below the threshold.

Graeme Dixon reported on the process to be implemented to ensure lights in areas that are not automatic are turned off.

Resolved:
RABD received the positive PFI report.

17/18/91 Alder Hey SPV update

The purpose of this paper is to update RABD on the progress to date of the establishment of the Trust Wholly owned Subsidiary Company (SPV), 'Alder Hey Ventures Ltd' and to provide the key points for consideration from the KPMG draft report received at the trust.

There are 4 operating models that KPMG have considered for the SPV. The principles that determine the most appropriate model relate to control of intellectual property, Tax, Workforce and TUPE implications and the ability to spin out further companies. The key features of each operating model are detailed in the paper, this will be presented at Board on 7th November 2017.

As this was a limited company a discussion was held on Directors liability, it was agreed this would be included in the Special Purpose Vehicle.

Resolved:
RABD received the proposals for approval at the November Board.

17/18/92 Terms of Reference

RABD received the terms of reference. It was agreed Non-Executive Directors would be reduced from 3 to 2 and the Chief Executive would be removed from the membership.

Resolved:
Subject to the above amendments RABD approved the terms of reference.

17/18/93 Any Other Business

No further business was reported.

Date and Time of the next meeting: Thursday 30th November at 2:00pm Room 11, Level 1 Mezzanine.

Alder Hey Children's NHS
NHS Foundation Trust

Trust Board
9th January 2018

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

Project Delivery within November

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

SOPB
The Statement of planned benefits has been completed and submitted to NHS Digital. A workshop has been held for both Clinical Leads and Service Manager by the GDE Risk and Benefits Lead and also the NHS Digital Lead. A further workshop is scheduled for January.

Specialty Packages
System development by IM&T developers completed for eight Specialty Packages, Gynaecology, Emergency Department, Rheumatology (Blood Monitoring) are live, Rheumatology, Dietetics, Transitional Care, Pre-Op and Tissue Viability are now with the Clinical teams for testing and feedback. The Standard Meditech Documents have now been completed and the Junior Doctors are writing the accompanying training materials.
Development is underway on six other Specialty Packages; this includes the finalisation of three of the four Community Paeds phases.
A total of eleven are currently gathering requirements.

Voice Recognition
The Voice Recognition project is now live within sixteen specialties. The project team are shadowing previous users to understand and concerns with the system and offer further one to one support. An Executive led review is taking place to review the approach and understand concerns. Meetings have been arranged de-brief the findings with the clinicians, Medical Director and Director of Finance.

Interoperability Proof of Concept
The team have successfully transferred data such as discharge summaries and admission data from Meditech into the portal environment which is a huge achievement and a process which we can use as a foundation for future integration within the proof of concept.

Alder Hey's CIO is the interoperability lead across the STP and a second workshop is due to be held on the 9th January to review progress made. The Trusts who are involved in the Proof of Concept are:

- Alder Hey Children's NHS Foundation Trust
- Royal Liverpool University Hospital
- Clatterbridge Cancer Centre NHS Foundation Trust
- Liverpool Heart and Chest NHS Foundation Trust
- St Helens and Knowsley Teaching Hospitals NHS Trust
- The Walton Centre NHS Foundation Trust
- Wirral University Teaching Hospital NHS Foundation Trust

GDE Prescribing Projects (Dose Range Checking and Continuous Infusions Pilot)
A Task and Finish group has been established. The continuous infusions functionality has been demonstrated reviewed and approved by the Junior Doctor group and will now be demonstrated to the nursing lead. A training package is currently being devised to support the roll-out.

There are some concerns in relation to the Dose Range Checking functionality, this was discussed at GDE Programme Board and has been raised to Meditech. A number of releases have now occurred and are being tested.

Vital Signs Integration
Vital Signs integration between Welch Allyn and Meditech is now live configured, signed off and live within MDU, the pilot is due to end on the 31sst of January, following feedback it will be further rolled out across the Trust.

Communications
The next Digital Chatroom will be held on the 25th January on the Mezzanine from 12.00 – 14.00. This will allow an opportunity over lunchtime for staff to visit the chatroom and obtain further information and ask questions about the on-going GDE projects.

The Communications department are working closely with GDE to ensure the Voice Recognition shadowing results and associated action plan is communicated Trust-wide.

Upcoming Deliverables

- NHS Digtial Assurance – On the 16th January NHS Digtial will be visiting Alder Hey to conduct the Assurance testing for the third milestone. The associated documentation has been send over the NHS Digital for review prior to this.
- PACs other O'logies project – PAC's is now live within Gait Lab and is due to go live within SaLT on the 12th January.
- Speciality Packages – A number of speciality packages are due to go live within January and early February, these include Transitional Care, Pre-Op, and Tissue Viability, Community Paeds, Dietetics and the remainder of Rheumatology.
- Meditech Standard Documents – The roll-out of Standard Documents across the Trust will commence on 4th January. Details in relation to awareness sessions and training have been circulated across the Trust.
- Voice Recognition – Results of the shadowing are due to be released early January.
- Voice Recognition – Go lives scheduled so far in January are ENT and Anaesthetics.
- Interoperability Proof of Concept (PoC) – Workshop to be held on the 9th January and a further workshop on the 6th February. Representatives including CIO's and Clinical Leads from each of the PoC Trusts will attend and provide feedback on progress.
- TCI – Theatre Pathway - Pathway re-design is underway and due to be piloted within General Surgery in February 2017.
- Point of Care Testing (POCT) – Pilot to be held in early January, training is currently underway.
- Shadowing – Further shadowing is set to take place to understand operational process, obtain baseline benefits and ensure projects interdependencies are fully understood and addressed prior to go-live of GDE projects.

Summary of Key Benefits

Project	Aim	Measurement	Baseline	Improvement	Actual

			Position	Target	Progress to Target (current)
Voice Recognition	Safer handover of care between Trust & Primary Care	Average turnaround time for letters (working days)	16 working days	3 working days (Jun-18)	65% 7.5 days
		Longest waiting letter (working days)	19 working days	5 working days (Jun-18)	64% 10 days
Fast User Switching	Improve efficiency when logging into systems in clinical areas – releasing time to care	Time taken to log into system (minutes) 4950 transactions per day	1:45 minutes	<0:10 minutes	100%
Bi-directional interface with kiosks (Intouch & Meditech)	Improve efficiency in booking in for outpatient appointments, releasing time to cash up outpatient clinics	Average time taken to add an appointment to the InTouch system (minutes) 650 transactions per month	1:00 minutes	0:00 minutes (Sep-17)	100%

An update on headline benefits from within the GDE Programme will be delivered at each GDE programme Board.

Programme Assurance

NHS Digital attended Alder Hey and completed their assurance testing for the second milestone and the funding is now underway.

A further assurance test has been scheduled for the 16th January 2018. The project documents have already been submitted for review prior to NHS Digital attending the Trust.

Fast Follower

The Alder Hey *Fast Follower* Trust, Clatterbridge Cancer Centre, are currently undergoing 'due diligence'. The funding agreement has now been submitted for feedback and approval.

Next Steps

- Continue working towards the delivery of Milestone three (February 2018). The next NHS Digital assurance testing is planned and will take place on the 16th January 2018.

- Continue to work with Specialties to identify target benefits and support the monitoring of these benefits throughout the project lifecycle.

Recommendations

The Trust Board is asked to:-

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

Peter Young

Chief Information Officer 03 January 2018