BOARD OF DIRECTORS PUBLIC MEETING

Tuesday 3rd July 2018 commencing at 10:00

Venue: Large Lecture Theatre, Institute in the Park

AGENDA

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action	Preparation
PATIENT STORY (12:30pm-12:45pm)						
Delivery of Outstanding Care – Part 1						
1	**18/19/103**	**12:45**	**Quality Improvement Update:** - **Inspiring Quality.**	A Bateman/ S Falder/ J Minford	To receive an update.	Presentation
Board Business						
2	**18/19/104**	**12:55**	**Apologies.**	Chair	To note apologies.	For noting
3	**18/19/105**	**12:56**	**Declarations of Interest.**	All	Board Members to declare an interest in particular agenda items, if appropriate.	For noting
4	**18/19/106**	**12:57**	**Minutes of the Previous Meeting.**	Chair	To consider the minutes of the previous meeting to check for amendments and approve held on: **22nd May 2018.**	Read Minutes (Page 6 to 14)
5	**18/19/107**	**13:00**	**Matters Arising:** - **Action Log.**	Chair	To discuss any matters arising from previous meetings and provide updates and review where appropriate.	Read Attachment (Page 15 to 17)
6	**18/19/108**	**13:05**	**Key Issues/Reflections.**	All	Board to reflect on key issues.	Verbal
Strategy Update						
7	**18/19/109**	**13:15**	**Strategic Plan 2018-21**	M Barnaby	For approval	Attachment (Page 18 to 19)
Delivery of Outstanding Care – Part 2						
8	**18/19/110**	**13:25**	**Serious Incidents Report.**	H Gwilliams	To inform the Board of the recent serious	Read report

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action	Preparation
					incidents at the Trust in the last calendar month.	(Page 20 to 27)
9	18/19/111	13:35	**Care Quality Commission:** - **CQC Inspection report.** - **CQC Action Plan - exception report.**	H Gwilliams	To receive the report from the CQC inspection undertaken in February 2018 To provide the Board with progress to date (position to end of May).	Read reports (Page 28 to 75) (Page 76 to 87)
10	18/19/112	13:50	**Mortality report Quarter 4.**	S Ryan	To receive the quarterly report.	Read report (Page 88 to 103)
11	18/19/113	14:00	**Global Digital Exemplar (GDE).**	P Young	To update the Board on the programme.	Read report (Page 104 to 107)
12	18/19/114	14:15	**Alder Hey in the Park Site Development update.**	C Liddy	To receive an update on key outstanding issues / risks and plans for mitigation.	Read report (Page 108)
13	18/19/115	14:25	**Clinical Quality Assurance Committee: Chair's update:** - **Chair's verbal update from the meeting that took place on the 18.7.18.** - **Approved minutes from the meeting took place on the 20.6.18.**	A Marsland	To receive the approved minutes from the 16.5.18.	Read approved minutes (Page 109 to 122)
14	18/19/116	14:30	**Integrated Governance Committee:** - **2017/18 Annual Report.** - **Approved minutes from the meeting that took place on the 14.3.18.**	S Igoe	To receive the 2017/18 annual report for the Integrated Governance Committee and the approved minutes from the 14.3.18.	Read report and approved minutes (Page 123 to 129) (Page 130 to 149)
The best people doing their best work						
15	18/19/117	14:35	**People Strategy Update:** - **Wellbeing Strategy.**	M Swindell	To provide an update and receive the approved minutes from the 24.4.18.	Read report (Page 150 to 153) Presentation

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action	Preparation
			- **Action Plan for the diversity agenda.** • **Chair's verbal update from the Workforce Organisational Development Committee meeting that took place on the 26.6.18.** • **Approved minutes from the Workforce Organisational Development Committee meeting that took place on the 15.2.18 and the 21.5.18.**			Read report (Page 154 to 158) Verbal Read approved minutes (Page 159 to 179)
16	**18/19/118**	**14:50**	**Listening into Action.** - **BME Network Group** - **Disability Network Group**	F Ashif/ M Eccleston/ H Ainsworth	For information and discussion.	Presentation
17	**18/19/119**	**15:05**	**HEE Annual Assessment Visit Feedback:** - **Action plan to address training for junior doctors.**	G Lamont	To provide an update	Read report (Page 180 to 188)
18	**18/19/120**	**15:15**	**Freedom to Speak Up Guidance:** - **Self-review**	M Swindell/ K Turner	To provide an update.	Read report (Page 189 to 205)
Sustainability Through External Partnerships						
19	**18/19/121**	**15:25**	**Joint Neonatal Partnership – Alder Hey and Liverpool Women's Hospital**	A Bateman/ S Ryan/ H Gwilliams/ J Grinnell	To update the Board on progress. To approve the draft Memorandum of Understanding	Presentation Read Report (Page 206 to 215)
20	**18/19/122**	**15:35**	**Provider Alliance Plan.**	M Barnaby/	For information and discussion.	Report

Alder Hey Children's NHS
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VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action	Preparation
				J Haywood		(Page 216 to 267)
Game Changing Research and Innovation						
Strong Foundations						
21	**18/19/123**	**16:00**	**Proposed Change to Trust Constitution: Amalgamation of two public constituencies.**	Chairman	For ratification.	Read report (Page 284 to 383)
22	**18/19/124**	**16:05**	**Programme Assurance update:** - **Deliver Outstanding Care.** - **Growing External Partnerships.** - **Solid Foundations.** - **Park Community Estates and Facilities.**	J Grinnell	To receive an update on programme assurance including the 2018/19 change programme.	Read Report (Page 384 to 404)
23	**18/19/125**	**16:15**	**Corporate Report.** - **Introduce the new reporting process** - **Monthly update by Executive Leads.**	J Grinnell/ H Gwilliams/ M Swindell	To note delivery against financial, operational, HR metrics and quality metrics and mandatory targets within the Corporate Report for the month of May 2018.	Read report (Page 405 to 453)
24	**18/19/126**	**16:25**	**Board Assurance Framework**	Executive leads	To receive an update.	Read report (Page 454 to 471)
Delivery of Outstanding Care - Part 3						
25	**18/19/127**	**16:35**	**Infection, Prevention and Control Annual Report.**	S Ryan	To receive the annual report.	Read report (Page 472 to 516)
Any Other Business						
26	**18/19/128**	**16:40**	**Any Other Business.**	All	To discuss any further business before the close of the meeting.	Verbal
For information and Noting: • **The Mayor's Growth Plan**						

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action	Preparation
• **One Liverpool Plan**						
Date And Time Of Next Meeting: Tuesday 4th September 2018 at 10:00am, Large Meeting Room, Institute in the Park.						

REGISTER OF TRUST SEAL
The Trust Seal was not used during the month of **June 2018.**

PUBLIC MEETING OF THE BOARD OF DIRECTORS

Minutes of the meeting held on **Tuesday 22nd May 2018 at 10:15am,**
Meeting Room 1, Innovation Hub

Present:	Sir D Henshaw	Chairman	(SDH)
	Mr. A. Bateman	Chief Operating Officer	(AB)
	Mrs J France-Hayhurst	Non-Executive Director	(JFH)
	Mr J Grinnell	Director of Finance	(JG)
	Mrs H Gwilliams	Chief Nurse	(HG)
	Mr S Igoe	Non-Executive Director	(SI)
	Mrs A Marsland	Non-Executive Director	(AM)
	Mr I Quinlan	Vice Chair (Chair)	(IQ)
	Dr S Ryan	Medical Director	(SR)
	Mrs L Shepherd	Chief Executive	(LS)
	Mrs M Swindell	Director of HR & OD	(MS)
	Dame J Williams	Non-Executive Director	(JW)
In Attendance:	Mrs M Barnaby	Interim Director of Strategy	(MB)
	Ms S Falder	Director of Clinical Effectiveness and Service Transformation	(SF)
	Mr M Flannagan	Director of Communications	(MF)
	Dr A Hughes	Director of Medicine	(AH)
	Mrs K McKeown	Committee Administrator (minutes)	(KMc)
	Mrs. C. McLaughlin	Director of Community Services	(CMc)
	Ms J Minford	Director of Clinical Effectiveness and Service Transformation	(JM)
	Ms E Saunders	Director of Corporate Affairs	(ES)
Agenda item: 10	Ms. A. Hyson	Head of Quality	(AH)
12	Mr P Young	Chief Information Officer	(PY)
14	Mr. G. Lamont	Consultant Paediatric Surgeon	(GL)
18	Mr J Gibson	External Programme Assurance	(JG)
Apologies:	Prof M Beresford	Assoc. Director of the Board	(PMB)
	Mrs C Dove	Non-Executive Director	(CD)
	Mr C Duncan	Director of Surgery	(ChrD)
	Mr D Powell	Development Director	(DP)

Patient Story

Sam has volunteered at the hospital for two years and has three children who are patients at Alder Hey. Sam's three children have additional needs and as a result of this she has attended numerous appointments with them at the hospital over the last eleven years. During this time Sam has had both positive and negative experiences and she has played a major part in the implementation of the Be Kind project. Sam is currently a member of the steering group as a parent/volunteer to try and help Alder Hey become more autism and learning disability friendly.

Sam advised the Board of the initiative that is being progressed by the Be Kind scheme to have a haven room on each ward. Sam pointed out that if patients are calm they are more likely to see the person they are scheduled to see and the clinician can move forward with treatment. Sam informed the Board that patient experiences are improving in the Outpatients Department as a result of the training that is being provided to staff by the steering group.

The Chairman thanked Sam for sharing her story with the Board.

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18/19/71 Apologies

The Chair noted the apologies received from Michael Beresford, Claire Dove, Christian Duncan and David Powell.

18/19/72 Declarations of Interest

There were none to declare.

18/19/73 Minutes of the previous meetings held on 1st of May 2018

Resolved:
The Board received and approved the minutes from the meeting held on the 1st of May 2018.

18/19/74 Matters Arising and Action Log

This item was not discussed.

18/19/75 Key Issues/Reflections

Louise Shepherd provided an overview of the team's visit to Sick Kids Children's Hospital in Toronto. It was reported that the level of research and ambition was exceptional and it was felt that Alder Hey could develop a partnership with this hospital and learn from them.

Jo Williams informed the Board of the community session that took place which showcased some inspirational work. Following reflection upon the presentation that was shared at the session it was felt that at some point it will be necessary to establish a leadership role in relation to children and young people. Jo Williams queried as to how the Trust is going to collaborate with local councils and housing associations in respect to children with long-term conditions. Louise Shepherd informed the Board of the work that is happening around the Children's Transformation Plan which will look at establishing ways for partners to work together to address these types of issues.

The Chairman felt that the amount of litter in the car park was dreadful and action was required to address this matter.

Anita Marsland thanked the Exec Team for inviting the NEDs to the Quality Summit, which was an excellent event and paid tribute to the parents who contributed a huge amount to the effectiveness of day. Anita Marsland asked about the next steps following the summit. Louise Shepherd felt that a lot of good learning had come about as a result of the summit and reported that the Executive Team is looking at how the organisation can implement the learning to ensure the delivery of quality improvements. A further update will be provided at July's Trust Board.

18/19/75.1 Action: SF/JM

Louise Shepherd provided an update on the outcomes of the LHP Board meeting that took place on the 21.5.18. It was reported that following feedback from a clinical service review the University of Liverpool has been looking at its priorities. Michael Beresford has been working towards enabling children's research to link with maternity, which is a key area for the university moving forward. Louise Shepherd highlighted the importance of prioritising the areas of research that the Trust wishes to progress and confirmed that a group is going to be established to drive this area of work forward.

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The Chairman informed the Board of the forthcoming priorities for NHS Improvement to re-organise the health service in line with HEA, and highlighted the issues with the national structure. It was agreed that the Chairman and Mags Barnaby would meet to discuss this matter in more detail.

18/19/75.2 Action: SDH/MB

18/19/76 2017/18 Draft Annual Report and Accounts

The Trust Board received the draft Annual Report and Accounts for 2017/18 and discussed its content. Jo Williams congratulated all those involved in compiling the Annual Report.

A discussion took place around the approval of the accounts. Steve Igoe informed the Board that the Trust has had positive opinions from both sets of auditors of the robustness of the control system over the last twelve months. It was reported that the Audit Committee met on the 18.5.18 with external auditors and discussed Issues relating to the inclusion of assumed income relating to a commercial transaction at the year-end. Whilst the transaction had not been completed as at the year-end the Audit Committee had discussed and understood the risk adjusted assumption that had been assumed. On behalf of the Audit Committee, Steve Igoe assured the Board that the Committee has addressed this matter in-depth, confirmed that it is a valid assumption and recommended that the Board sign off the 207/18 accounts.

Anita Marsland pointed out that as a result of Steve Igoe engaging and chairing the meeting it was robust and thorough in the management of this matter. John Grinnell confirmed that the PFI issue was dealt with transparently.

Quality Account - Steve Igoe reported that the limited assurance work completed on the Quality Account had also received a clean opinion, with only one minor recommendation given by Ernst & Young. This was the best outcome of any audit of indicators to date.

Erica Saunders informed the Board that there will be a couple of changes to the remuneration tables before completion of the final version of the Annual Report which will be submitted to NHS Improvement on 29th May. The Board was also made aware of the challenges in respect to the NHS Pensions Agency, who have issued an apology.

The Chairman thanked Erica Saunders and her team for the hard work that has taken place to compile the 2017/18 Annual Report.

Resolved:

The Trust Board approved the Annual Report and Accounts and the Quality Account for 2017/18.

18/19/77 Joint Neonatal Partnership

An update was provided to the Board following the most recent Joint Neonatal Partnership Board. It was reported that NHS England will be submitting the business case to their regional team at the beginning of June, prior to implementation. A decision is required in respect to the Quality Standards and further work is required around the practicalities of joined working arrangements/governance models. A joint project lead who won't be aligned to either organisation will be required to progress this work. It was pointed out that this is a significant piece of work, of which, the Liverpool Women's are fully engaged with.

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

18/19/78 Cardiac Post-Operative Care Model

Adam Bateman presented an overview of the new model of care for post-operative cardiac patients. The Board discussed the process for designing a new model, the actions that have taken place to identify a preferred model of care and the benefits associated with having a post-operative cardiac unit. Information was provided on the features and detail of the new model along with the steps required for implementation

Steve Ryan informed the Board of the enthusiasm and support that has been received for the new model with an understanding that there is a lot of work to do. It was pointed out that this leading edge work hasn't been done in England to date and will be game changing for the Trust. Louise Shepherd commended the work that has taken place and highlighted the importance of linking this in with neonatal.

18/19/79 Serious Incident Reports

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

StEIS 2018/2696: An RCA meeting has taken place and there were no gaps in care identified, therefore, the RCA is on hold until the outcome of the post-mortem becomes available. A further update will be provided during July's Trust Board.

StEIS 2018/1590: This case is on-going and a further update will be provided at July's Trust Board.

StEIS 2017/30500: Following an independent expert review, it was confirmed that the care provided by Alder Hey did not contribute to any harm to the patient. A lessons learned session will take place with the team even though there were no deficits in care.

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

18/19/80 Position Statement for Complaints and PALS

The Board received the complaints and PALS position for May 2018. It was reported that the Trust has seen an increase in overall activity in 2017/18, 320,826 episodes compared to 284,381 in 2016/17. The complaints this year are 0.025% of the total activity. PALS concerns in 2017/18 have seen an increase in contacts compared to the previous year – 1349 to 1296. Q4 saw a very sharp increase – the highest on record for the last 5 years.

Following a review of the themes of PALS contacts for the year it was identified that 65% of the contacts made to the PALS office come in via the phone/face to face and 35% come in by email/letter. Out of the total number of PALS concerns raised 33% relate to delay in appointments, cancellation of appointments and waiting times

Community Paediatrics receive 20% of complaints relating to pathway of referrals. The Board was informed that a dedicated PALS officer has been appointed to the

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Community Division to manage parental concerns and expectations. It was noted that wards 3A and 4C receive the largest proportion of inpatient related complaints.

The Board was informed of the new process for dealing with complaints at local level. A guide for staff has been compiled to support the new process and posters have been put up around the hospital asking people to engage with the Trust. From a leadership and visibility perspective Ward Managers are conducting walkabouts, with Band 6 and 7 staff being the contact on the ward for patients/parents regarding complaints. It was reported that there has been a good uptake by staff for training around complaints/issues.

Currently there are 16 live complaints of which three are very complex. Due to the complexity of one particular case, the Trust is unable to address it in 25 days.

Anita Marsland informed the Board that CQAC receive regular updates on complaints and asked for the work that the team does to be recognised.

John Grinnell highlighted the complaints being received by PALS around waiting times for Sefton patients accessing the Trust's community services. It was reported that work is taking place with commissioners around the pathway for Sefton patients.

Adrian Hughes pointed out that the trend for complaints increasingly involves receipt of letters from solicitors and it takes time to deal with these type of questions.

Resolved:
The Board received and noted the complaints and PALS position for May 2018

18/19/81 Clinical Quality Assurance Committee

Anita Marsland provided the Board with an update from the meeting that took place on the 16.5.18. It was reported that attendance/engagement at committee meetings is excellent and having regular updates on Sepsis has been beneficial.

Resolved:

The Board received a verbal update from the meeting that took place on the 16.5.18 and noted the approved minutes from: 18.4.18.

18/19/82 GDE

The Board was provided with an update on the progress of the Trust's Global Digital Exemplar (GDE) Programme along with the achievement of Milestone Three and the measures in place to achieve Milestone Four.

Louise Shepherd informed the Board of the progress that has been made between a number of trusts in Cheshire and Merseyside who are now securely sharing patient information, including views of discharge summaries from participating trusts. Further work will continue in order to link it to primary care records. This area of work is being supported by a local digital team in Liverpool and has been picked up via STP as a key part of what they are trying to do. Louise Shepherd confirmed that this work will continue regardless of the Trust winning the bid.

John Grinnell informed the Board of the progress that has been made with the development of the patient portal. Following discussion it was agreed to provide a more granular report during September's Trust Board on the detail of the patient portal.

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18/19/82.1 Action: PY

Hilda Gwilliams queried the process for showcasing the patient portal outside of the organisation and suggested that Peter Young liaise with Mark Flannagan to address this matter. It was reported that the patient portal is being showcased at the I Links conference in July 2018.

18/19/82.2 Action: PY

Resolved:

The Board received and noted the update on the progress of the Trust's GDE Programme.

18/19/83 People Strategy Update

Workforce Organisational Development Committee Annual Report for 2017/18.

Resolved:

The Trust Board received and noted that the *Workforce and Organisational Development Committee Annual Report for 2017/18.*

People Strategy Update

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

- Annual workforce Profile – analysis of staff survey results across the country by the AUKUH has ranked Alder Hey as most improved across the range of questions. The Divisions continue working locally on their action plans.
- Core mandatory training as of the end of April is above target at 93.1% and overall mandatory is 89.79%. The Board was advised that the new Learning and Development manager is reviewing the quality of training content.
- Sickness absence rates have decreased to 4.52% in month and the cumulative position is 5.12%. There has been a steady decrease for three consecutive months now.
- A Health and Wellbeing group has been established to address the support that staff require now and in the long term. A plan for supporting staff has been compiled and a variety of mechanisms have been put in place to date. The Board was advised of the bid that has been submitted to the Charity for psychology team support for staff.

Jo Williams queried the retention of BME staff. Melissa Swindell reported that this has not been raised as an issue but pointed out that there is a piece of work around the diversity agenda. Following discussion it was agreed to submit the plan for the diversity agenda to July's Trust Board meeting.

18/19/83.1 Action: MS

Resolved:

The Trust Board noted the People Strategy update for April 2018.

18/19/84 Ground Round – HEE Annual Assessment Visit Feedback

Graham Lamont submitted a presentation to the Trust Board to provide feedback on the outcome of the HEE North West visit to Alder Hey. In general feedback

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was positive and the majority of trainees confirmed that they would recommend taking on jobs at Alder Hey. A discussion took place around the issues relating to out of hours service delivery, teaching, rotas and patient safety in paediatrics and dental.

The Chairman felt that the feedback received was very similar to the outcome of the last assessment and queried the issues relating to training. Graham Lamont assured the Board that the group is working hard and reported that sometimes the way in which rotas are scheduled does not always enable trainees to make the most of the opportunities available.

Jo Williams queried the meaning of the observation 'rota too service orientated' and felt that this points towards a potential systemic problem. Graham Lamont reported that this relates to gaps in some rotas which become an issue when it is long term with no permanent fix due to supply issues. It can also be challenging to guarantee some consultants to teach in specific weeks. Jo Williams pointed out that the Trust's vision refers to putting patients first. Graham Lamont informed the Board that none of the trainees are averse to delivering service but pointed out that they are here to be developed into the next generation of consultants. Steve Ryan reported that long-term the Trust has a good line of sight, consultants are working outside of hours and there have been fewer gaps over the last six months.

Louise Shepherd informed the Board of the work that is being conducted by Melissa Swindell and Graham Lamont in order to gain sight at Board level. The Chairman requested that a copy of the plan for progressing this work be submitted to the Board in July.

18/19/84.1 **Action: GL**

Resolved:
The Trust noted the feedback from the 2018 HEE Annual Assessment visit.

18/19/85 **Freedom to Speak Up Guidance**

The Board was informed that NHS Improvement has released additional guidance and a self-review tool for Freedom to Speak Up in NHS trusts and NHS Foundation trusts. The content of the guidance was noted and it was agreed to submit the completed self-review to the Trust Board in July.

18/19/85.1 **Action: ES/KT**

Resolved:
The Board received and noted the guidance for boards on Freedom to Speak Up.

18/19/86 **Board Self Certification**

Resolved:
The Board received and approved the Self-Certification of Compliance with the Trust's Provider Licence, together with the annual self-assessment as assurance evidence for the Board.

18/19/87 **Programme Assurance Update**

The Board was provided with a copy of the Alder Hey promotional pack and was advised of the electronic link that is available to either download or share this information. It was reported that further copies are available via Karen Critchley.

A discussion took place around the importance of having a real focus/grip on the workstreams to ensure that benefits are delivered. Joe Gibson raised his concerns

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in respect to the lack of updates being loaded onto share point and pointed out that Exec sponsorship is critical to unblocking issues, holding people to account and getting the right things in place.

Resolved:

The Board received and noted the update provided on the assurance status of the change programme.

18/19/88 Corporate Report
Resolved:
The Board received and noted the contents of the Corporate Report for month 1, 2018/19.

18/19/89 Board Assurance Framework

The Board was provided with an overview of the contents of the BAF for May 2018. Erica Saunders advised that the risks relating to pipe corrosion and water contamination have been included in the BAF. These risks have been assigned to David Powell but Adam Bateman is closely aligned on these issues. The details of these two risks will be discussed in-depth at the Integrated Governance Committee and it was agreed to circulate the outcome of these discussions to the Board.
Action: DP/AB

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

18/19/90 CQC Action Plan

The Trust Board received the CQC Action Plan for April 2018. It was reported that this plan it also submitted to CQAC and the IGC on a monthly basis. Erica Saunders informed the Board of the focus on expediting the actions that haven't been closed to date and it was agreed to submit an exception report in July.
18/19/90.1 Action: ES

Resolved:
The Board noted April's update.

18/19/92 Research, Education and Innovation Committee

The Board received and noted the 2017/18 Annual Report for the Research, Education and Innovation Committee. A discussion took place around the inconsistency of attendance at meetings and the lack of connection between the three arms of the committee. It was agreed that Ian Quinlan, Sir David Henshaw and Louise Shepherd would meet to discuss the way forward for the Research, Education and Innovation Committee.
18/19/92.1 Action: IQ/SDH/LS

The Board noted the approved minutes from the meeting that took place on the 11.1.18.

Resolved:
The Board received and noted the 2017/18 Annual Report for the Research, Education and Innovation Committee along with the approved minutes from the meeting that took place on the 11.1.8.

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18/19/93 Any Other Business

It was noted that the Trust won the 'Building of the Decade' award.

Jo Williams requested that page numbers for each individual item of the Board pack be included on the agenda.

18/19/93.1 Action: KMC

Date and Time of next meeting: Tuesday 3rd July 2018, 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 22.5.18

	A	B	C	D	E	F	G	H
1	**Meeting date**	**Ref**	**Item**	**Action**	**By whom?**	**By when?**	**Status**	**Update**
2	**Actions for May 2018**							
3	6.3.18.	17/18/275.2	Change Programme.	***Delivering Outstanding Care*** - Review the support being received by clinicians in the Outpatients department.	Hilda Gwilliams.	22.5.18.		**22.5.18 -** An update will be provided on the 3.7.18 around the outcome.
4	10.4.18.	18/19/11.1	Mortality Report	Discuss possible ways to see if the benchmarking of performance indicators can produce more meaningful data/statistics, for example, using alternative peer groups when benchmarking.	CQAC/ Steve Ryan	3.7.18.		**22.5.18 -** An update will be provided on the 3.7.18.
5	10.4.18.	18/19/22.1	New Pay Deal.	Feedback to be provided on the new pay deal report following discussion at the Workforce Organisational Development Committee.	Melissa Swindell	22.5.18.		**22.5.18 -** An update will be provided on the 3.7.18.
6	1.5.18.		Patient Story.	*Oncology Ward* - Look into the funding via the Charity to convert a bathroom into a breakout space for children aged between 7-12.	Jo Williams/ Jeannie France-Hayhurst	22.5.18.		**22.5.18 -** An update will be provided on the 3.7.18.
7	1.5.18.	18/19/47.1	Arts Programme and Next Steps.	Discussion to take place between Vicky Charnock and Michael Beresford around the possibility of a work experience programme being devised between the University of Liverpool and Alder Hey to support the	Vicky Charnock/ Michael Beresford	22.5.18.		**22.5.18 -** An update will be provided on the 3.7.18 around the outcome.
8	22.5.18	18/18/75.1	Key Issues	*Quality Summit* - Provide an update to the Board on the agreed process for implementing the Quality Summit learning to support the delivery of quality improvements.	Sian Falder/ Jo Minford	3.7.18.		**22.5.18 -** An update will be provided on the 3.7.18.
9	22.5.18	18/18/75.2	Key Issues	Discuss the issues with the national NHS structure in more detail, outside of the meeting.	Sir David Henshaw/ Mags Barnaby	3.7.18.		**22.5.18 -** An update will be provided on the 3.7.18 around the outcome.
10	22.5.18	18/19/82.1	GDE	Provide a more granular report on the details of the patient portal during July's meeting.	Peter Young	4.9.18.		**22.5.18** - This action has been included on July's agenda. **ACTION COMPLETE**

Alder Hey Children's NHS Foundation Trust
Trust Board - Part 1
Action Log following the meeting on the 22.5.18

	A	B	C	D	E	F	G	H
1	Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
11	22.5.18	18/19/82.2	GDE	Liaise with Mark Flannagan to discuss the showcasing of the patient portal outside of the organisation.	Peter Young	3.7.18.		**22.5.18 -** An update will be provided on the 3.7.18 around the outcome.
12	22.5.18	18/19/83.1	People Strategy Update	Submit the action plan for the diversity agenda, during July's meeting.	Melissa Swindell	3.7.18.		**22.5.18** - This action has been included on July's agenda. **ACTION COMPLETE**
13	22.5.18	18/19/85.1	Freedom to Speak Up	Submit the completed self-review tool for Freedom to Speak Up, during July's Trust Board.	Erica Saunders	3.7.18.		**22.5.18** - This action has been included on July's agenda. **ACTION COMPLETE**
14	22.5.18	18/19/90.1	Board Assurance Framework	Circulate the outcome of the discussion at May's IGC in respect to the pipe corrosion risk and the water contamination risk.	Adam Bateman/ David Powell	3.7.18		**22.5.18 -** An update will be provided on the 3.7.18 around the outcome.
15	22.5.18	18/19/91.1	CQC Action Plan	Submit an exception report during July's meeting.	Erica Saunders	3.7.18.		**22.5.18** - This action has been included on July's agenda. **ACTION COMPLETE**
16	22.5.18	18/19/93.1	Research Education and Innovation Committee	Meeting to be scheduled in order to discuss a way forward for the Research, Education and Innovation Committee.	Ian Quinlan/ Sir David Henshaw/ Louise Shepherd			**22.5.18 -** An update will be provided on the 3.7.18 around the outcome.
17	22.5.18	18/19/94.1	Any Other Business	*Trust Board Documentation* - Include page numbers on the agenda for each item.	Karen McKeown	3.7.18.		**22.5.18** - July's Board pack will include page numbers on the agenda for each item. **ACTION COMPLETE**
18	**Closed Actions**							

Alder Hey Children's NHS Foundation Trust
Trust Board - Part 1
Action Log following the meeting on the 22.5.18

	A	B	C	D	E	F	G	H
1	Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
19	6.3.18.	17/18/242.1	Matters Arising and Action Log	***Booking and Scheduling Review Update*** - Provide a further update to the Trust Board on the 1.5.18.	Adam Bateman	1.5.18.		**10.4.18** - This action has been included on May's Trust Board agenda. **ACTION CLOSED**
20	6.3.18.	17/18/263.1	Draft Financial Plan 2018/19	Present the final version of the 2018/19 Financial Plan to the Trust Board on the 22.5.18.	John Grinnell	22.5.18.		**10.4.18** - This action will be addressed via the NHSI Operational Plan for 2018-19. **ACTION CLOSED**
21	1.5.18.	18/19/46.1	Joint Neonatal Partnership - AH & LWH.	The Board will be provided with a further update on the Joint Neonatal Partnership on the 22.5.18.	Louise Shepherd	22.5.18.		**22.5.18 -** This item has been included on July's agenda. **ACTION COMPLETE**
22								
23	**Status**							
24	Overdue							
25	On Track							
26	Closed							
27								

BOARD OF DIRECTORS

Tuesday 3rd July 2018

Report of:	Executive Team
Paper Prepared by:	Margaret Barnaby
Subject/Title:	Strategic Plan 2018-2021
Background Papers:	Included in Trust Board Workshop July
Purpose of Paper:	Summarises the Trust's Strategic Aims and Objectives for 2018-2021 to meet the Trust's mission of a Healthier Future for Children and Young People.
Action/Decision Required:	Trust Board to consider and approve the Strategic Plan 2018-2021
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	The Strategic Plan sets out the Trust's Strategic Direction and Strategic Objectives for 2018-2021
Resource Impact:	To support financial sustainability

'A Healthier Future for Children and Young People' Final Draft 28 June 2018

Strategic Plan 2018-2021

Delivering outstanding care	Supporting the best people to do their best work	Sustainability through External Partnerships	Game-changing research & innovation
Strategic Aims			
Aim 1 – Children and families first every time Aim 2 – Outstanding outcomes for children Aim 3 – No patient deteriorates due to avoidable factors	Aim 1 - 80% of staff would recommend Alder Hey as a place to work. Aim 2 - Our leaders will coach, engage and support staff to deliver the highest quality of care Aim 3 – We will develop a sustainable workforce plan for the future	Aim 1 – we will join up care with health, social care , the third sector and academia for children and families we support Aim 2 – We will work in partnership to enhance sustainable paediatric services and continuous improvement Aim 3 – We will grow specialist paediatric services to meet the needs of children and families	Aim 1 – Co-Create a large-scale academic partnership in the city focussed on children's (and women's) health Aim 2 – This Partnership will put Liverpool on the world map as a renowned specialist academic centre in children's (and women's) health Aim 3 –This Partnership will make a major contribution in children's (and women's) health in the city of Liverpool
Strategic Objectives			
1. Alder Hey will be Inspired by Quality which is led from the front line 2. Introduce digital pathways to improve patient care across all specialties 3. Further improve patient services focused on 5 key priorities: Brilliant patient booking systems; Comprehensive Mental Health; Best in Outpatient Care; Patient Flow; Best in Acute Care 4. Achieve outstanding performance in all CQC domains at every level 5. Deliver the new Alder Centre 6. Develop our Health Park vision	1. Our workforce must reflect the diversity of the communities we serve, and we will improve the experience of our staff from diverse backgrounds. 2. We will have identified supply pipelines for all key staffing groups, working in partnership with our local HEIs 3. Deliver at least 50 apprenticeship starts through the Academy each year 4. Implement the Wellbeing Strategy, supporting staff to improve all aspects of their health and wellbeing - with a focus on a reduction in sickness absence 5. Build line, clinical and system leadership capability; focused on supporting quality improvement	1. Deliver single neonatal service in partnership with Liverpool Women's Hospital 2. Deliver all-age Coronary Heart Disease Services in partnership with Liverpool Heart and Chest, Royal Liverpool University and Liverpool Women's Hospitals 3. Deliver Liverpool Children's Integrated Transformation Plan 4. Increase specialist child health services regionally, nationally and Internationally 5. Lead the co-creation of new models of care for paediatric mental health with the Mental Health and LD Programme as part of the Cheshire and Merseyside Sustainability and Transformation Partnership 6. Develop regional paediatric/ neonatal services as part of Women's and Children's Partnership (STP),	1. Establish a joint core team from Alder Hey and UoL to co-create a Strategic Plan to ensure clinical and non-clinical services are best organised to offer children, young people and families every opportunity to take part in clinical research studies 2. Strengthen our position to attract and appoint internationally renowned leaders and new talent in paediatric research for example a Joint Director of the Academy 3. Contribute to specialist paediatric education through the Alder Hey Academy. 4. Co-Create with staff a new set of Innovation Products, whilst Alder Play is rolled out. 5. Integrate front line and research activity through an increasing number of clinicians involved in research 6. Contribute to Liverpool Health Partner Themes relevant to 'Starting Well'.

Building on Strong Foundations

Living our values: Respect, Excellence, Innovation, Openness, Together
Children and families involved in everything we do
Number 1 for Productivity in paediatric services in the North West

BOARD OF DIRECTORS

Tuesday 3rd July 2018

Report of:	Chief Nurse
Paper Prepared by:	Chief Nurse and Clinical Risk Manager
Subject/Title:	Duty of Candour and Incident management, including all incident investigations of moderate harm or above.
Background Papers:	Seven Steps to Patient Safety. National Patient Safety Agency 2004. Health and Social Care Act 2008 (Regulated Activities). Regulation 20 'Duty of Candour'. Serious Incident Framework. Supporting learning to prevent recurrence. NHS England 2015. Serious Incident Framework. Frequently asked questions NHS England 2016. Incident Investigation reports.
Purpose of Paper:	To provide Board assurance of compliance with external regulation, and national guidance, in respect of incident management, including duty of candour.
Action/Decision Required:	Note and approve current assurance position.
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	• **Patient Safety Aim** – Patients will suffer no harm in our care. • **Patient Experience Aim** – Patients will have the best possible experience • **Clinical Effectiveness** – Patients will receive the most effective evidence based care.
Resource Impact	n/a

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1. Background:

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

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, sets specific requirements for registered organisations such as Alder Hey NHS Foundation Trust, about the incidents that must be reported to the CQC. The Trust has a responsibility to report to the CQC serious incidents that relate to patient safety/patient harm. In addition, the Trust has a statutory duty to apply Duty of candour for all moderate and above harm incidents.

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

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

There are three levels of investigation identified within the NHS, where regulation 20 applies, as follows:

- Level 1 (60 working days to complete) – This is a concise Internal Investigation, suitable for less complex incidents usually at moderate harm level (meaning short term harm), and managed by individuals or a small group.

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

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

Current position

Table 1 shows the Trust's 2017/18 performance for serious incidents requiring investigation (SIRI). All moderate harm and above incident investigations are monitored via the monthly performance assurance meetings with individual Divisions, focusing on the management of investigations, including lessons learned and assurance of progress with actions for improvement. In addition, a monthly report of progress with actions, from SIRI investigations is presented to the Clinical Quality Steering Group, with exceptions reported to Clinical Quality Assurance Committee.

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

Table 2 shows there are three ongoing serious incident investigations, which comply with external requirements, including application of duty of candour.

Table 3 shows the Trust had one moderate harm incident during this reporting period, and the management of this investigation is compliant with external requirements, including application of duty of candour.

Table 1 SIRI performance data:

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

Table 2

On-going SIRI incident investigations							
Reference Number	**Date investigation started**	**Division**	**Incident Description**	**RCA Lead Investigator**	**Progress**	**60 working day compliance (or within agreed extension)**	**Duty of Candour applied**
StEIS 2018/11892	11/05/2018	Surgery	Grade 3 Pressure Ulcer - The patient was admitted to PICU at Alder Hey from Nobles Isle of Man on 30.03.2018 following high speed road traffic collision (RTC). The patient was a pedestrian and was hit by a car at 60mph. The patient sustained traumatic injuries.	Paula Clements, Clinical Lead, Theatres	Information gathering and investigation underway.	N/A	Duty of Candour completed including letter sent to family.

			Patient reviewed by plastic surgery registrar 09.05.2018, pressure ulcer on heel identified as grade 3.				
StEIS 2018/2696	30/01/2018	Medicine	Patient's Consultant informed via Ormskirk Hospital of child's death on 22/01/2018. Patient diagnosed with congenital hyperinsulinism, Beckwith Weidemann Syndrome and Gastroesophageal Reflux Disease. Patient seen in outpatients by Consultant 13/12/2018, mother had issues with feeding and referral to Speech and Language Therapy Team (SALT) was made. No reports of choking episodes or difficulty swallowing. Although the referral stated urgent, the appointment did not occur. Following review of baby's care the Consultant reported the incident and decision taken that this was a serious incident that required further investigation.	Jo Blair, Endocrinology Consultant and Joanne Kendrick, Ward Manager, 3C	Final report sent to CCG.	Yes	Duty of Candour completed including letter sent to family.

StEIS 2018/1590	18/01/2018	Surgery	Child transferred from Whiston Hospital on 23/10/2017 due to secondary scalding episode and trauma to buttock from a smashed ceramic mug. The patient was operated on 24/10/17 to repair laceration to buttock and was discharged on 27/10/17. Patient attended Emergency Department 27/12/2017, reviewed by surgical doctor who noted left sided foot drop. On review of case, it is felt that there was a missed laceration to the nerve in the buttock during initial investigation and surgery. If this was recognised during initial surgery, patient would not have had a secondary nerve graft procedure.	Sarah Wood, Consultant Surgeon and Dianne Topping, Senior Nurse	RCA report quality checked, further work being undertaken. Complex case	No	Duty of Candour completed including letter sent to family.

Table 3

Duty of Candour Incidents (excluding SIRI's)							
Reference Number	**Date investigation started**	**Type of investigation**	**Incident Description**	**Lead Investigator**	**Progress**	**60 working day compliance**	**Duty of Candour applied**
27828	15/03/2018	RCA Level 1	Patient on ECMO required bronchoscopy, showed foreign body in airway was the tip of an inline suction catheter. Patient required further bronchoscopy and retrieval of foreign body. Incident reported to MHRA in line with best practice.	Bron Robinson, Clinical Nurse Manager, ICU	Investigation progressing.	No	Duty of Candour completed including letter sent to family.

**Level 1 investigation*

Closed SIRIs

Duty of Candour Incidents (excluding SIRI's)							
Reference Number	**Date investigation started**	**Division**	**Incident Description**	**Lead Investigator**	**Progress**	**60 working day compliance**	**Duty of Candour applied**
StEIS 2017/30500	13/12/2017	Surgery	Unexpected death of neurosurgical patient.		Independent review completed, shared with CCG and family.	Yes	Yes

END

Alder Hey Children's NHS Foundation Trust

Inspection report

Alder Hey Hospital
Eaton Road, West Derby
Liverpool
Merseyside
L12 2AP
Tel: 01512284811
www.alderhey.nhs.uk

Date of inspection visit: 6 to 28 Feb 2018
Date of publication: This is auto-populated when the report is published

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

This report is a summary of our inspection findings. You can find more detailed information about the service and what we found during our inspection in the related Evidence appendix.

Ratings

Overall rating for this trust	Good
Are services safe?	**Requires improvement**
Are services effective?	**Good**
Are services caring?	**Outstanding**
Are services responsive?	**Good**
Are services well-led?	**Good**

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Summary of findings

Background to the trust

Alder Hey Children's NHS Foundation Trust became a foundation trust in August 2008. The trust provides care for more than 270,000 children, young people and their families. The trust also leads research into children's medicines, infection, inflammation and oncology.

The hospital contains 270 inpatient beds, 48 of which are in intensive care, high dependency and the burns unit. In addition, there are 16 operating theatres, including 12 for inpatient use and four for day surgery. The theatre suite has integrated operating theatres. Seventy-five percent of the beds are single occupancy with en-suite facilities, climate control and strip lighting for the child or young person to control. Each room contains a sofa bed so that parents are able to stay with their child.

Inpatient rooms offer natural light and many have views of the park. There are separate, dedicated areas, including outdoor space, for children and young people on each ward to allow them to socialise, play and relax. In addition, there is a kitchen situated on every ward with a ward based chef to ensure that each child is given a freshly prepared, healthy meal of their choice.

The hospital also features charitably funded cutting-edge lifesaving equipment, including integrated operating theatres, an intra-operative 3T MRI scanner, CARTO system, brain Lab navigation technology and the latest in x-ray technology, an orthopedic imaging system (EOS).

The trust's outpatients department consists of a number of services based over three floors within a new hospital building. Services include clinics such as physiotherapy; phlebotomy; dental; occupational therapy; ear, nose and throat; fracture; cardiology; respiratory; cystic fibrosis; and ophthalmology. It also includes a general paediatric clinic. The outpatient service has a number of administrative functions such as medical records, transcription services, and booking and scheduling. These services are based within the old estate next to the new hospital

There is a research and education centre built alongside the hospital which is being extended. The work of this centre will involve partnership working with a local university and will allow researchers to develop safer, better medicines for use with children, infection, inflammation and oncology.

Overall summary

Our rating of this trust stayed the same since our last inspection. We rated it as Good

What this trust does

Alder Hey Children's NHS Foundation Trust has a broad range of hospital and community services for children, including direct referrals from primary care as well as inpatient and community child and adolescent mental health services to support young people between the ages of 5 and 14 years. The trust is a designated national centre for head and face surgery as well as a centre of excellence for heart, cancer, spinal and brain disease.

Alder Hey Children's Hospital provides a full range of acute services which include: acute medicine, accident and emergency, acute frailty unit, and surgical services. In addition to these services, the trust provides specialist services for Merseyside, Cheshire, South Lancashire, and North Wales. These specialist services include: major trauma, complex obesity, head and neck surgery, upper gastrointestinal cancer, hepatobiliary, endocrine services, respiratory medicine, rheumatology, ophthalmology, and alcohol services.

Summary of findings

The hospital is a recognised major trauma centre and is one of four national children's epilepsy surgery service centres. Alder Hey hospital is the only national centre of excellence for childhood lupus and the only experimental arthritis treatment centre for children.

The trust provides paediatric palliative care services and works in partnership with Claire House Hospice as well as eight other hospices. The paediatric palliative care team also works with all the community children's nursing teams across Merseyside and Cheshire (Merseyside and Cheshire Children's Palliative Care Network).

The trust delivers a range of community based services to children and young people across Liverpool and Sefton in a variety of community settings including home visits, at schools and health centres. Services are delivered in localities across the trust's geographical footprint. These are North, Central and South Liverpool, and North and South Sefton.

The children and adolescent mental health services (CAMHS) directorate, which was not included in our inspection, provides mental health services including psychiatric assessment, single point of access and crisis care, eating disorder services and the trust's Fresh CAMHS which offers a range of therapies and interventions to help children or young people who are struggling with how they are feeling, thinking, or the way they are doing things

Key questions and ratings

We inspect and regulate healthcare service providers in England.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against service providers that break the regulations and help them to improve the quality of their services.

What we inspected and why

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

Between 6 and 9 February 2018 and 26 to 28 February 2018 we inspected some of the services provided by this trust at the hospital and in the community as part of our ongoing inspection programme.

Our comprehensive inspection of NHS trusts has shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, all trust inspections now include inspection of the well-led key question at the trust level. Our findings are in the section headed is this organisation well-led?

We did not aggregate the ratings for community services and diagnostic services during this inspection. This was because the community service was a new service for the trust and diagnostic services was an additional service.

What we found

Our rating of the trust stayed the same. We rated it as good because:

- We rated the hospital as requires improvement for safe and good for effective, responsive and well-led. We rated caring as outstanding. We rated five of the trust's services at this inspection. In rating the trust we took into account the current ratings of the services not inspected this time.
- We rated well-led at the trust level as good.

Summary of findings

- Our decisions on overall ratings take into account, for example, the relative size of services and we use our professional judgement to reach a fair and balanced rating.
- It was agreed that we would rate but not aggregate the ratings for community services or diagnostic imaging services in the hospital.

Overall trust

Our rating of the trust stayed the same. We rated it as good because:

- We rated well-led as good because the trust had a vision for what it wanted to achieve with plans to turn it into action. Staff throughout the trust were aware of the vision and values. There was an experienced and stable leadership team who were committed to improving services, through learning research and innovation. The trust had made improvements to the fit and proper person process since the last inspection.
- The trust had an experienced and stable leadership team with the skills and commitment to provide high quality services. The trust was committed to improving services when things go well and when they go wrong. They promoted training and research.
- Although the trust had an up to date policy for duty of candour we found that this was not always being applied consistently when it had been required.
- Although there was a system in place for identifying and managing risks we found that these were not always being managed in a timely way. There was limited evidence of discussion and challenge at key executive led meetings and there were examples of when actions from meetings did not have targeted completion dates.

Are services safe?

Our rating of safe went down. We rated it as requires improvement because:

- Although there was a mandatory training policy and procedures in place across the trust not all staff were up to date with some key modules, such as infection control and safeguarding.
- Records were not always secured in all areas of outpatients and there was a risk that unauthorised people could easily see patient identifiable information. Although records were clear and available they were not always up to date in all services.
- Patient notes were not always transcribed in line with trust guidelines to ensure medical records were up to date.
- Whilst medicines management was good in the majority of services, there were areas where medicines were not stored in line with policy and administration records of medicines was not always in line with best practice.
- Staffing levels and skill mix were planned and reviewed but staffing levels remained a challenge in critical care due to cover for maternity and sick leave.

However:

- Staff recognised and responded appropriately to changes in risks to people who used services. They took a holistic view of people’s needs in managing day to day risks.
- Staff took a proactive approach to safeguarding and focused on early identification and response to any signs of allegations of abuse.
- Staff understood and fulfilled their responsibilities to raise concerns and report incidents. There was ongoing progress to a zero harm culture.

Summary of findings

Are services effective?

Our rating of effective stayed the same. We rated it as good because:

- People's care and treatment was planned and delivered in line with current evidence based guidance and best practice. Information about patients care and treatment was collected and their outcomes monitored. Outcomes for people who used the service were positive and generally met the expectations of the services.
- Staff had the necessary skills and qualifications to deliver effective care and treatment and there was a clear and appropriate approach for supporting and managing staff when their performance was below the standard expected.
- There was good multidisciplinary working and staff were able to access the information they needed in the majority of services provided.

However:

- Staff in some services had limited understanding of their roles and responsibilities under the Mental Capacity Act 2005 for children over the age of 16.
- Outcomes in outpatient services were monitored internally but not benchmarked against other providers or national audits where appropriate.

Are services caring?

Our rating of caring stayed the same. We rated it as outstanding because:

- People who used the services at the trust were respected and valued as individuals and were partners in their care. Staff were fully committed to working in partnership with people.
- Feedback from patients and their relatives was positive about the way they were treated by staff and there was a strong visible person-centred culture. People's emotional and social needs were highly valued by staff.
- Staff responded compassionately to help and support patients and we saw that privacy and dignity was maintained whilst providing care. Staff were motivated to provide care that was kind and enabled patients to maintain their independence.

Are services responsive?

Our rating of responsive stayed the same. We rated it as good because:

- The majority of services were planned and delivered in a way that met the needs of the local population. The majority of times it took into account patient's individual needs.
- Reasonable adjustments were made and action taken to remove barriers when people found it hard to use or access services.
- Waiting times from referral to treatment were within the agreed targets for the majority of services and people were informed if there was any delay to their care or treatment.
- People were able to raise a concern or complaint and there was openness and transparency in how complaints were dealt with. Improvements were made to the quality of care as a result of complaints or concerns

However:

- There were significant waiting times for the autistic spectrum disorder and attention deficit hyperactivity disorder pathways.
- Patient leaflets were not always written in a way that children could easily understand.

Summary of findings

- 'Did not attend' rates for outpatients was consistently above the England average despite attempts to reduce this and there were a number of cancelled clinics.

Are services well-led?

Our rating of well-led stayed the same. We rated it as good because:

- Leaders at every level prioritised safe, high quality care and had the skills and experience which was maintained through effective development and succession processes.
- The trust proactively engaged and involved staff and had processes in place to ensure that the voice of staff was heard and acted on. There was effective engagement with patients and those who used services in the majority of areas.
- There was a strong focus on continuous improvement and learning at all levels in the organisation. Innovation was supported and celebrated across all services. There was a proactive approach to seeking out and embedding new models of care through research.
- Financial pressures were managed so they did not compromise the quality of care delivered.
- There was a clear statement of vision and values and an overall strategy for the trust but not all services had an underpinning strategy to improve services for example diagnostic imaging services. Staff in the majority of areas understood the vision and values.

However:

- Whilst we found that staff across the trust were open and honest and there were processes in place to meet the duty of candour requirements this was not always being consistently applied.
- Risks and serious incidents were not always dealt with in a timely way to eliminate and reduce them and a number of risks did not have an action identified to mitigate the risk.
- Although there were arrangements for governance and performance it was not always clear how some groups reported into the overall trust level governance structure. There was little of evidence of discussion and challenge when required and actions to make improvements had not always been made in a timely way.
- Services did collect and manage information well but it was not always clear how this information was being used to make improvements.
- Although staff satisfaction was good in the majority of services, there were areas where this was mixed.

Acute services

Critical care

- Our overall rating of critical care was good. This was because there was a culture of learning from incidents. Record keeping was good and safety was monitored and maintained. There was a good understanding of safeguarding procedures and processes and staff were aware of their responsibilities.
- Medical staffing on the critical care unit met national requirements and nursing care was delivered on a one to one basis in line with national guidance. Staff had the skills and knowledge to deliver high quality care and were passionate and enthusiastic in monitoring and benchmarking care in line with current guidelines.
- Feedback from all the people we spoke with about critical care was positive and patient's individual needs and preferences were central to the planning and delivery of tailored services, including vulnerable patients and those with specific long term needs. Staff went the extra mile to make sure patients' care was of the highest quality, timely and compassionate.

Summary of findings

- However, overall staffing levels in critical care and bed availability remained a challenge since the last inspection. The service experienced delays in discharges and transfers out of the service.

End of life care

- Our overall rating of end of life services was good. This was because although end of life services had managers with the right skills and abilities but there was no non-executive lead for the service which was the same as at the last inspection.
- End of life services worked to a network strategy and there was a service review programme in place at the time of the inspection. Following the inspection an operational plan had been developed to further improve the quality of services.
- Staff in the palliative care team were up to date with safeguarding training and understood how to protect patients from abuse. They kept up to date records which were available to staff providing care for the patient.
- The consultant in end of life care was knowledgeable and kept up to date with national guidance. All staff were highly motivated and inspired to offer care that was kind and promoted people's dignity. They were fully committed in working in partnership with people taking account patient's individual needs. Medical cover in end of life services was not in line with national guidance for out of hours cover although there was an experienced team of critical care and specialist consultants who service out of hours medical rotas.

Outpatients

- Our rating of outpatient services was required improvement. This was because the service failed to keep all records secure and accessible only by authorised people. There were numerous occasions when we witnessed this. There was a delay in transcribing routine clinic letters which meant there was a risk that records were not always kept up to date.
- In the outpatient department staff did not ensure that toys in waiting areas were properly cleaned and there were other examples of poor infection control throughout the service. There was little in the way of stimulation for children and the waiting areas were cramped. We also found that one of the phlebotomy rooms was unsuitable and a breast feeding room had been converted to a storage cupboard.
- The outpatient service 'did not attend rate' had been consistently above the England average and steps taken to reduce this had not always been successful. The service did not engage well with patients who used the service or collaborated with partner organisations effectively.
- However, staff in the outpatient department understood their responsibilities for protecting patients from abuse and could articulate the process they would follow. There were also good examples of multidisciplinary working to benefit patients. Staff in the service showed compassion when treating patients and provided emotional support when needed.
- The outpatient service had an improvement plan in place and some of this work had already been undertaken. There was a good positive culture in the service and a clear vision for what the service and its staff wanted to achieve.

Diagnostic imaging

- Our overall rating for diagnostic imaging was good. This was because staff working in the service had appropriate training in the use of radiation and the associated risks. There were good standards of cleanliness and hygiene and the department was well designed and maintained.

Summary of findings

- Staff in diagnostic services responded appropriately to the changing risks of people who used the service. There was sufficient staff with the right skills to ensure people received safe, effective care and treatment. They had all the information needed and there was good multidisciplinary working.
- In diagnostic services staff had a good understanding of consent and ensured this was obtained in line with legislation and guidance.
- We found staff in diagnostic service treated people with kindness, dignity and respect and gave emotional support when needed. They communicated well and provided an environment which was appropriate and patient centred.
- There was good leadership both in radiology and with radiologists. There were clear and effective processes for managing risks, issues and performance. This also supported learning, continuous improvement and innovation.
- Although there were occasions when the resuscitation equipment in diagnostic services was not checked in line with policy this had significantly improved since the last inspection.
- Whilst there were play specialist available to assist patients who were having a procedure in the diagnostic services, these had to pre-booked in advance and were not always available when needed.

Community services

Community services for children and young people

- We rated community services as good. There were sufficient skilled staff that provided compassionate care that took into account individual patient needs that was based on national guidance and best practice. There was effective multidisciplinary working across all specialities in the community.
- Staff across community services recognised and reported safety incidents and there was a defined management and governance structure that enabled the learning from incidents to be shared, together with identifying, investigating and mitigating risks.
- Senior leaders and managers of the community services encouraged an open and transparent culture and supported staff to improve services and engage with patients and families.
- However, we found that medicines administered by some community services staff were not recorded in patients' medicines administration records and there were no clear guidelines to support staff in administering as and when required medication or over the counter medicines to children.
- In community services we also found there was a lack of knowledge and awareness of the Mental Capacity Act and obtaining informed consent. Systems for protecting young people over the age of 16 were not embedded. Staff knowledge or use of pathways to identify potential sepsis was limited.

Ratings tables

The ratings tables in our full report show the ratings overall and for each key question, for each service and for the whole trust. They also show the current ratings for services or parts of them not inspected this time. We took all ratings into account in deciding overall ratings. Our decisions on overall ratings also took into account factors including the relative size of services and we used our professional judgement to reach fair and balanced ratings.

Whilst community services were rated during this inspection they were not taken into account in deciding the overall ratings for the trust. This is because it was a new service for the trust. We also rated diagnostic services but did not aggregate the ratings as this was an additional service.

Summary of findings

Outstanding practice

We found examples of outstanding practice in services across the trust.

For more information, see the outstanding practice section below.

Areas for improvement

We found areas for improvement including five breaches of legal requirements, across four regulations, that the trust must put right. We also found 55 things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve the quality of services.

For more information, see the outstanding practice section below.

Action we have taken

We issued requirement notices to the trust. That meant the trust had to send us a report saying what action it would take to meet these requirements in order to be compliant with the relevant regulations.

Our action related to breaches of legal requirements in outpatient services, end of life care, community children's services and trust wide.

For more information on action we have taken, see the sections on areas for improvement and Regulatory action.

What happens next

We will make sure that the trust takes the necessary action to improve its services. We will continue to monitor the safety and quality of services through our continuing relationship with the trust and our regular inspections

Outstanding practice

The hospital had invested in an orthopedic imaging system (EOS) which is an innovative ultra-low dose x-ray imaging system that scans a patient whilst they were standing upright. Alder Hey Hospital was the first paediatric hospital in the UK to have this scanner. This really benefited children who needed to be imaged frequently. With the orthopedic imaging system (EOS) the consultants could make more informed diagnoses and create individualised treatment plans for children with musculoskeletal disorders.

The dental clinic demonstrated a number of innovations which included the wide awake club for children with autism to receive care at quieter times, and acclimatisation sessions for patients' with learning disabilities. The clinic included a nurse who was a learning disability champion, and staff had received training in interacting with children with individual needs. Staff within the clinic had been nominated for an award for how the deal with children with individual needs.

We found multi-disciplinary team working with the cardiac team in providing extracorporeal membrane oxygenation was outstanding. Staff supported one another in providing high quality evidence based care.

We saw staff caring for children in a professional and exemplary manner. Some patients had stayed on the unit for a protracted amount of time and staff continued to care for the patients highly complex needs.

The community services division worked with colleagues in the trust's acute hospital teams on a 30 day plus length of stay project. The project identified suitable children, who had been admitted as inpatients for longer than 30 days, and brought together a range of acute and community teams, including social care, to provide a wraparound service which enabled children to be discharged out of hospital to home. At the time of the inspection, the service had enabled approximately 46 children, who may otherwise have remained as inpatients, to be discharged.

Summary of findings

The physiotherapy team had developed workshops and fitness and exercise groups for children with disabilities within a local gym (from a national chain) to encourage and include children with disabilities in fitness and exercise.

The trust was involved in a number of innovative programmes. These included producing 3D models of parts of the anatomy following scans of children. This allowed medical staff to have a clearer outline of the children's condition before any procedures were undertaken and meant that children who had to undergo surgery were potentially in theatre for shorter periods of time. The trust had also developed a virtual reality programme of a heart.

An interactive application was launched in November 2017 which featured gaming and augmented reality. This was designed to provide entertainment but also distraction for the patient whilst undergoing procedures in the hospital. Young patients were able to select their own avatar to explore the hospital before they arrived.

The trust had an innovation laboratory were staff and patients were encouraged to put forward ideas to help improve patient care. These were then taken forward by the trust.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve the quality of services.

Action the trust MUST take to improve

Trust wide

- The trust must ensure that there are effective systems and processes to make sure that the requirements of the duty of candour are met fully on all occasions when a notifiable incident has occurred. (Regulation 20).

Acute services

Outpatient services

- Ensure that there are robust and effective processes in place for ensuring patient records remain secure in all areas of the outpatient department and assure itself that staff follow this process; and that notes are transcribed in line with trust guidelines to ensure medical records are up to date. (Regulation 17).

Community services

Community services for children and young people

- Ensure that accurate and complete records of the administration of medicines are maintained where relevant and that practice in the management of medicines by unsupervised health care assistant staff is monitored and supported. (Regulation 17).
- Ensure the trust's policy, standard operating procedures, and relevant guidance for the safe management of medicines are reviewed against current best practice guidelines and covers all necessary areas of medicine administration, including as per required need and over-the-counter medicines administration. Ensure these are available to community staff. (Regulation 12).
- Ensure staff knowledge and awareness of the Mental Capacity Act 2005, including the application and implications for ensuring valid informed consent is obtained from patients aged over 16 years of age. The service must also ensure that do not attempt resuscitation orders are appropriately reviewed and documented for all relevant patients who reach, or are past, the age of 16. (Regulation 11).

Summary of findings

Action the trust SHOULD take to improve

We told the trust that it should take action either to comply with minor breaches that did not justify regulatory action, to avoid breaching a legal requirement in future, or to improve services.

Trust wide

- Ensure that all services have up to date strategies or improvement plans in place.
- Ensure that all risks across services are managed in a timely way and any controls and actions identified and recorded as outlined in the risk management strategy.
- Consider the recording of discussion and challenge of executive led meetings and actions from the meetings are completed in a timely way.
- Consider identifying a specific action to improve the ethnic diversity of the executive board
- Consider how all groups feed into executive led committees.
- Consider how to make best use of information to make improvements.
- Ensure that all actions from meetings are recorded and implemented in a timely way.
- Ensure that they are fully compliant with the appropriate Lampard recommendations.
- Ensure that complaint responses are managed in line with the trust policy.
- Ensure that all serious incidents are reported in line with trust policy and national guidance.

Acute services

Critical care

- Continue to review its staffing levels.
- Ensure the service’s new cleaning schedules are monitored.
- Continue to review its patients whose stays maybe classed as delayed or long term.
- Formally monitor the services delayed discharges and reasons for their delays.

End of life services

- The service should ensure that they are fully compliant with relevant NICE guidance for out of hours access to a Paediatric Palliative Care consultant.
- The service should ensure that all risks are identified and managed in a timely way and all performance indicators are monitored to improve standards.
- The service should ensure it has oversight of clinical incidents recorded in other speciality areas but related to palliative care, so that any themes and trends are identified and lessons can be learned.
- The service should review their systems for recording personal resuscitation plans and advance care plans on the electronic system to ensure staff across the hospital can access them.
- The service should ensure that information systems to record case management information are managed appropriately.
- The service should ensure that staff have a good understanding of their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.

Summary of findings

- The service should consider ways to improve engagement with people who use the service regarding planning of services and feedback on their experience.
- The service should ensure that the operational plan for 2018 is fully embedded and implemented across the service.

Outpatient services

- Review the phlebotomy rooms on the ground floor to better meet the needs of patients and staff using this facility.
- Ensure that medicines are stored securely and that staff understand how to monitor those that require refrigeration.
- Consider improving the signposting in the department.
- Improve staff compliance with mandatory training.
- Improve staff compliance with safeguarding training.
- Assure itself that all frontline staff are briefed on the outcome of complaints and investigations.
- Improve engagement with patients, staff, the public and local organisations.
- Ensure that all consultants consistently use the system to track patient flow.
- Ensure that all patient leaflets are written in a child friendly way.
- Consider checking staff competencies on a regular basis.
- Ensure that all items on the departmental risk register are regularly reviewed and updated.

Diagnostic Imaging

- Ensure that hand gel is available within the corridors and entrance to the department, accessible to both staff and service users.
- Consider the safety of lone working staff and review the access to the staff panic for staff safety.
- Ensure staff follow the departments own protocol and ensure that staff within the department record the three points of identification on the post procedure screen of the Radiology information system.
- Consider efforts to join the Imaging Services Accreditation Scheme with the Royal College of Radiologists and the College of Radiographers, in order to gain additional support and make continuous improvements.
- Consider a chaperone service for patients attending for an ultra sound. To reduce the risk of radiologist/sonographer being vulnerable to allegations.
- Re-introduce information leaflets to be included with the patient's appointment letters that are in pictorial format.
- Include the mental health, learning disability and additional health needs of children on the referral to the department.
- Introduce a performance dashboard for the department, to include 'did not attend data' and waiting times, to allow the department to be more responsive to patients and department needs.
- Consider having a vision and strategy specific for the service.
- Review the departments risk register and ensure that arrangements for identifying, recording and managing risks are actioned in a timely manner to reduce risk.

Summary of findings

Community services

Community services for children and young people

- The service should consider how it can ensure staff are aware of the principles of safeguarding vulnerable adults, and to report safeguarding incidents accordingly, where these apply to potential safeguarding needs of young people (over age 16) or young adults (over age 18) in its care.
- The service should ensure that all staff within the community children, young people and families service have an appropriate awareness of and ability to recognise, manage and escalate care and treatment for deteriorating children, including those who may be at risk of developing sepsis, and to ensure this is embedded within the relevant policy for deteriorating patients.
- The service should consider allocating a case co-ordinator to provide oversight of the case for each child accepted onto the autistic spectrum disorder / attention deficit and hyperactivity disorder pathways for assessment and diagnosis.
- The service should consider how it can reduce the time taken to issue post-clinic/review consultant letters to patients and families, particularly where a change of medicine or dosage has been made.
- The provider should consider how it can improve out-of-hours staff knowledge of the Homecare service, the needs of patients receiving care, and the nature of treatment provided within the service.
- The service should consider how it can enable Homecare staff to report incidents directly.
- The service should consider the implementation of a clinical review of Homecare records to ensure care and treatment is provided consistently in a safe manner.
- The service should ensure that all staff should be able to access relevant do not attempt cardiopulmonary resuscitation records, if in place.
- The service should continue to review, develop and implement relevant and measurable patient outcome standards across all the service's specialisms.
- The service should consider how it can improve staff's sense of inclusion for the wider geographic locations in Sefton.
- The service should ensure that transportation of equipment, blood and pathology samples is carried out in line with the trust's policy.
- The service should consider how it can ensure patient care plans identify individualised personal goals.
- The service should consider how it can increase response rates for patient and family surveys such as the NHS Friends and Family test.
- The service should consider how it can more readily make available information leaflets in other languages.
- The service should consider how it can make information leaflets 'child friendly'.
- The service should consider how it can improve the management of complaints to ensure complaints are responded to in line with the trust's complaints policy.
- The service should consider how it can more effectively record and monitor informal complaints.
- The service should improve effective operation of referral, triage, assessment and diagnosis processes within the autistic spectrum disorder and attention deficit hyperactive disorder pathways to reduce pathway waiting times, to improve the experience of patients waiting for triage and those accepted to the pathways, and to mitigate any pathway related health and safety risks to patients.

Summary of findings

Is this organisation well-led?

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a trust manages the governance of its services – in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.

We rated well-led at trust level as good because:

- The trust had a vision for what it wanted to achieve and workable plans to turn it into action.
- The trust had an experienced and stable leadership team with the skills and commitment to provide high quality services. They recognised the training needs for managers at all levels and worked to provide development opportunities for the future of the organisation.
- The board and leadership team had developed a set of vision and values that were embedded throughout the organisation. Staff throughout the trust were aware of the vision and values.
- The trust was committed to improving services by learning from when things go well and when they go wrong, promoting training and research. They used innovation well.
- The trust engaged well with patients in the majority of services, staff, the public and local organisations to plan and manage appropriate services.
- The trust had made improvements to the fit and proper person process. The trust had updated their recruitment policy to reflect this and checks for all executives and non-executives had been fully completed.

However:

- Although the trust had an up to date policy for the duty of candour which met the requirements of the Health and Social Care Act 2008. Between January 2017 and January 2018, we found that duty of candour had not been applied consistently on all occasions as required.
- Although the trust had an overall strategy which was underpinned by divisional strategies, we found that not all services throughout the trust had an internal strategy to make further improvements. An example of this was in end of life services.
- The trust had systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. However, we found that there were a number of risks that did not have an action identified to mitigate the risk and a number of overdue actions across all risk registers. There were also a number of risks that did not have identified controls as outlined in the risk management strategy.
- There was a governance structure throughout the trust. However, it was not always clear as to how some groups reported in to the executive led committees so that oversight was maintained and performance was challenged when required.
- The trust had not always collected, analysed, managed and used information well to support all its activities. Although a large amount of information was presented at executive led committees, it was not always clear how the information was being used to make improvements.
- The trust had now always reported and serious incidents in a timely way in line with trust policy and national guidance.

Ratings tables

Key to tables					
Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	→←	↑	↑↑	↓	↓↓
Month Year = Date last rating published					

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement ↓ Jun 2018	Good →← Jun 2018	Outstanding →← Jun 2018	Good →← Jun 2018	Good →← Jun 2018	Good →← Jun 2018

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute	Requires improvement ↓ Jun 2018	Good →← Jun 2018	Outstanding →← Jun 2018	Good →← Jun 2018	Good ↓ Jun 2018	Good →← Jun 2018
Community	Good Jun 2018	Requires improvement Jun 2018	Good Jun 2018	Good Jun 2018	Good Jun 2018	Good Jun 2018
Mental health	Requires improvement Apr 2017	Good Apr 2017	Outstanding Apr 2017	Good Apr 2017	Requires improvement Apr 2017	Requires improvement Apr 2017
Overall trust	Requires improvement ↓ Jun 2018	Good →← Jun 2018	Outstanding →← Jun 2018	Good →← Jun 2018	Good →← Jun 2018	Good →← Jun 2018

The rating for the well-led key question is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions take into account the ratings for different types of service. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Ratings for Alder Hey Children's Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good Aug 2014	N/A	Good Aug 2014	Good Aug 2014	Good Aug 2014	Good Aug 2014
Medical care (including older people's care)	Requires improvement Apr 2017	Good Apr 2017	Good Apr 2017	Good Apr 2017	Good Apr 2017	Good Apr 2017
Surgery	Requires improvement Apr 2016	Good Apr 2017	Outstanding Apr 2017	Good Apr 2017	Requires improvement Apr 2017	Requires improvement Apr 2017
Critical care	Good →← Jun 2018	Good →← Jun 2018	Outstanding →← Jun 2018	Good →← Jun 2018	Good →← Jun 2018	Good →← Jun 2018
Neonatal services	Good Aug 2014	N/A	Good Aug 2014	Good Aug 2014	Good Aug 2014	Good Aug 2014
Transition services	Good Jun 2015	Good Jun 2015	Good Jun 2015	Good Jun 2015	Good Jun 2015	Good Jun 2015
End of life care	Good →← Jun 2018	Good →← Jun 2017	Outstanding →← Jun 2018	Good →← Jun 2018	Good ↓ Jun 2018	Good ↓ Jun 2018
Outpatients	Requires improvement Jun	N/A	Good Jun 2018	Requires improvement Jun 2017	Good Jun 2018	Requires improvement Jun 2018
Diagnostic imaging	Good Jun 2018	N/A	Good Jun 2018	Good Jun 2018	Good Jun 2018	Good Jun 2018
Overall*	Requires improvement ↓ Jun 2018	Good →← Jun 2018	Outstanding →← Jun 2018	Good →← Jun 2018	Good →← Jun 2018	Good →← Jun 2018

*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Ratings for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for children and young people	Good Jun 2018	Requires improvement Jun 2018	Good Jun 2018	Good Jun 2018	Good Jun 2018	Good Jun 2018
Overall*	Good Jun 2018	Requires improvement Jun 2018	Good Jun 2018	Good Jun 2018	Good Jun 2018	Good Jun 2018

*Overall ratings for community health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Ratings for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Child and adolescent mental health wards	Good Jun 2015	Good Jun 2015	Outstanding Jun 2015	Good Jun 2015	Good Jun 2015	Good Jun 2015
Specialist community mental health services for children and young people	Requires improvement Apr 2017	Good Apr 2017	Good Apr 2017	Good Apr 2017	Requires improvement Apr 2017	Requires improvement Apr 2017
Overall	Requires improvement Apr 2017	Good Apr 2017	Outstanding Apr 2017	Good Apr 2017	Requires improvement Apr 2017	Requires improvement Apr 2017

Overall ratings for mental health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Acute health services

Background to acute health services

Alder Hey Children's NHS Foundation Trust has a broad range of hospital services to support young people between the ages of 5 and 14 years. It also provides children's community health and children's community and inpatient mental health services.

Alder Hey Children's Hospital provides a full range of acute services which include: acute medicine, accident and emergency, acute frailty unit, and surgical services. In addition to these services, the trust provides specialist services for Merseyside, Cheshire, South Lancashire, and North Wales. These specialist services include: major trauma, complex obesity, head and neck surgery, upper gastrointestinal cancer, hepatobiliary, endocrine services, respiratory medicine, rheumatology, ophthalmology, and alcohol services.

The hospital is a recognised major trauma centre and is one of four national children's epilepsy surgery service centres. Alder Hey hospital is the only national centre of excellence for childhood lupus and the only experimental arthritis treatment centre for children.

The trust provides paediatric palliative care services and works in partnership with Claire House Hospice as well as eight other hospices. The paediatric palliative care team also works with all the community children's nursing teams across Merseyside and Cheshire (Merseyside and Cheshire Children's Palliative Care Network).

We inspected critical care, end of life, outpatients and diagnostic imaging services.

Summary of acute services

We rated the acute services as

Alder Hey Children's Hospital

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Key facts and figures

Alder Hey Children's NHS Foundation Trust became a foundation trust in August 2008. The trust provides care for more than 270,000 children, young people and their families. The trust also leads research into children's medicines, infection, inflammation and oncology.

The hospital contains 270 inpatient beds, 48 of which are in intensive care, high dependency and the burns unit. In addition, there are 16 operating theatres, including 12 for inpatient use and four for day surgery. The theatre suite has integrated operating theatres. Seventy-five percent of the beds are single occupancy with en-suite facilities, climate control and strip lighting for the child or young person to control. Each room contains a sofa bed so that parents are able to stay with their child.

Inpatient rooms offer natural light and many have views of the park. There are separate, dedicated areas, including outdoor space, for children and young people on each ward to allow them to socialise, play and relax. In addition; there is a kitchen situated on every ward with a ward based chef to ensure that each child is given a freshly prepared, healthy meal of their choice.

The hospital also features charitably funded cutting-edge lifesaving equipment, including integrated operating theatres, an intra-operative 3T MRI scanner, CARTO system, brain Lab navigation technology and the latest in x-ray technology, an orthopedic imaging system (EOS).

The trust's outpatient department consists of a number of services based over three floors within a new hospital building. Services include clinics such as physiotherapy; phlebotomy; dental; occupational therapy; ear, nose and throat; fracture; cardiology; respiratory; cystic fibrosis; and ophthalmology. It also includes a general paediatric clinic. The outpatient service has a number of administrative functions such as medical records, transcription services, and booking and scheduling. These services are based within the old estate next to the new hospital

There is a research and education centre built alongside the hospital which is being extended. The work of this centre will involve partnership working with a local university and will allow researchers to develop safer, better medicines for use with children, infection, inflammation and oncology.

Summary of services at Alder Hey Children's Hospital

Good

Summary of findings

Our rating of services stayed the same. We rated them as good.

We did not aggregate the diagnostic services at this inspection as it was an additional service which was inspected with outpatients before.

A summary of services at this hospital appears in the overall summary above.

Critical care

Good

Key facts and figures

The critical care services (the service) are commissioned for 21 level two and three paediatric intensive care beds and 15 level two high dependency beds.

Level three and level two refers to the acuity of a patient. A level three patient will likely be ventilated and need intensive, 24-hour one-to-one care. A level two patient is considered to be high dependency and requires significant nurse input and is usually cared for on nurse to patient ratio of two to one.

PICU is a major trauma centre for the North West of England and North West Wales regions and is a commissioned extracorporeal membrane oxygenation provider (the extracorporeal membrane oxygenation machine provides lifesaving heart and lung technology to patients).

As part of the inspection we spoke with eight parents and 38 members of staff including, nurses, doctors, consultants, managers and support staff. Care and treatment was reviewed as well as 12 patient care records and medication prescription records to support our decision on ratings.

We inspected the service between 6 and 10 February 2018. Our inspection was unannounced (staff did not know we were coming). As part of the inspection we reviewed information provided by the trust about staffing, training and monitoring of performance.

We last inspected critical care in June 2015. We rated the service as Good.

Summary of this service

Our rating of this service stayed the same. We rated it as good.

For a summary of this service see overall trust summary section.

Is the service safe?

Good

Our rating of safe stayed the same. We rated it as good because:

- The service could demonstrate a culture of learning from incidents with a number of examples of changes being made following an incident. These incidents of learning were shared throughout the hospital.
- We saw records to confirm risks to people who used services were appropriately assessed and their safety monitored and maintained.
- Infection prevention and control policies and protocols were in place and regularly audited. A sepsis tool was also incorporated within the paediatric early warning score (PEWS) chart to help staff identify and escalate a patient when sepsis was detected.
- Staff had a good understanding of safeguarding and were aware of their responsibilities in relation to safeguarding children. The service worked with other agencies to share relevant safeguarding information.

Critical care

- The environment was clean, tidy and well maintained. Equipment was checked regularly and medicines were stored appropriately
- There were ten consultant intensivists providing medical care to the service. Medical staff cover in all critical care areas met the requirements of the Faculty of Intensive Care Medicine.
- Nursing care was delivered on a one to one basis with additional staff to support supernumerary working allowing time for the use of robust safety checks and training time.
- There were effective processes in place to assess and escalate deteriorating patients.
- Staff on the high dependency unit used the paediatric early warning score to identify deteriorating patients.
- Staff we spoke with, minutes of meetings, monitoring data and audit of the services practices demonstrated good governance processes for the service and they were being reviewed to further enhance the processes.
- Risks had been identified and were reviewed monthly with evidence of actions taken and risks reduced.
- The service regularly took part in national and international research programmes which supported the development of innovative and new ways of working and improving standards of care for patients.
- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- There was good leadership at unit and above. Staff spoke highly of their line managers and told us they felt listened to.
- We saw collaborative working between the medical team, nursing staff, pharmacy, physiotherapy, occupational therapy and dietitian teams. There was a real sense of listening to individual's actions and treatment regimes.

However:

- At the last inspection in June 2015 staffing levels across the service were challenging. Staffing had increased by 8% but there was still an acknowledgment there was a high level of sickness and maternity leave to cover.
- General cleaning schedules were not documented so it was difficult to know which areas needed additional cleaning.

Is the service effective?

Good

Our rating of effective stayed the same. We rated it as good because:

- Staff had the skills, knowledge and experience to deliver effective care and treatment to patients.
- Staff were passionate and enthusiastic in using external evidenced based standards and information to monitor and benchmark their practice.
- Patients were treated according to national guidance, including those from the National Institute of Healthcare Excellence Core Standards for Intensive Care Units and PICANet. Policies and procedures were based on current national guidelines.
- The service monitored the effectiveness of care and treatment through continuous local and national audits and presented their data at national and international conferences.

Critical care

- Staff were proud about their joint working relationships with other professionals. There were numerous examples of staff working in a multi-disciplinary way to the benefit of improving patient care.
- There were effective processes in place to ensure that patient's nutritional needs were met.
- There were effective processes in place to ensure patients' pain relief needs were met and well managed across the service.
- Patients were cared for by appropriately qualified nursing staff. New staff and student nurses received induction to the service and were trained using specific competencies before being able to care for patients independently.
- The service made sure staff were competent for their role. Managers appraised staffs' work performance and held supervision meetings with them to provide support and to monitor the effectiveness of the service.
- Staff were aware of the requirements of their responsibilities as set out in the Mental Capacity Act and Gillick competence.

Is the service caring?

Our rating of caring stayed the same. We rated it as outstanding because:

- Patients were at the centre of the service and the highest quality care was a priority for staff.
- The parents we spoke with told us their children were treated with dignity and respect and had all their care needs met by kind and caring staff that went the "extra mile." Feedback from all parents we spoke with all spontaneously mentioned how positive their experiences had been.
- The service was responsive to children and young people's needs. Staff worked in a flexible manner in order to ensure all patients were looked after when demand increased.
- The level of information given to parents was often in depth and at times complex. Staff managed to communicate with the parents in a way they could understand and took their time to ensure parents understood what was being said.
- Patients were treated with respect and dignity when receiving care and support from staff.
- Staff provided emotional support to patients and their families. Staff were aware of the emotional aspects of care for patients living with long term conditions and provided specialist support where this was needed.
- All staff we observed and spoke with could demonstrate how they involved patients in their care. This included joint care planning and multidisciplinary meetings.

Is the service responsive?

Good

Our rating of responsive stayed the same. We rated it as good because:

- There was a two-year plan in place for critical care services.
- There were daily bed meetings which looked at demand, capacity and staffing issues to ensure there were sufficient resources to support elective surgery.

Critical care

- Patient's individual needs and preferences were central to the planning and delivery of tailored services, including vulnerable patients and those with specific long-term needs.
- The services were flexible, provided choice and ensured continuity of care at a time that suited the patients Staff went the extra mile to make sure patients' care was of the highest quality, timely and compassionate.
- The service had research based policies and protocols for admission, transfer and discharge pathways.
- Multi-disciplinary team working was exemplary both internally and externally with NHS organisations.

However:

- At the last two inspections in May 2014 and June 2015 bed availability in critical care was affected by the number of patients requiring long term ventilation or respiratory care. We found this still to be the case at this inspection.
- The number of times the service had been unable to admit to the unit had increased over the year and currently stood at 24 times. This was the highest the service had experienced.
- The service experienced delays in discharges and transfers out of the service.

Is the service well-led?

Good

Our rating of well-led stayed the same. We rated it as good because:

- Staff we spoke with, minutes of meetings, monitoring data and audit of the services practices demonstrated good governance processes for the service and they were being reviewed to further enhance the processes.
- Risks had been identified and were reviewed monthly with evidence of actions taken and risks reduced. There was an open, transparent no blame culture. Staff were empowered to lead the way in making improvements to the service with the support of senior staff.
- The service regularly took part in national and international research programmes which supported the development of innovative and new ways of working and improving standards of care for patients.
- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- Staff were supported by their leaders and managers. There was a very high level of satisfaction with staff telling us they were proud of the organisation and enjoyed working within their teams.
- There was good leadership at unit level and above. Staff spoke highly of their line managers and told us they felt listened to.
- We saw collaborative working between the medical team, nursing staff, pharmacy, physiotherapy, occupational therapy and dietitian teams. There was a real sense of listening to individual's actions and treatment regimes.
- We found a culture of continuous improvement and service development. There was a commitment to developing staff. Staff were passionate about improving services for patients.

However:

- Governance meetings on the unit had only just commenced and required further time to embed in the service
- The high dependency unit had no system to capture activity and clinical outcomes.

Critical care

Outstanding practice

We found areas of outstanding practice in this service. See the Outstanding practice section above.

Areas for improvement

We found areas for improvement in this service. See the Areas for improvement section above.

End of life care

Good

Key facts and figures

Alder Hey Children's NHS Foundation Trust provides paediatric palliative care services and works in partnership with Claire House Hospice as well as eight other hospices. The paediatric specialist palliative care team also works with all the community children's nursing teams across Merseyside and Cheshire (Merseyside and Cheshire Children's Palliative Care Network).

End of life care encompasses all care given to patients who are approaching the end of their life and following death. It may be given on any ward or within any service in a trust. It includes aspects of essential nursing care, specialist palliative care, and bereavement support and mortuary services.

Specialised palliative care for children is provided to children with life-threatening or life-shortening conditions representing an extremely wide range of diagnoses (in excess of 300) and there is an overlap with those with severe disabilities and complex needs. At Alder Hey Children's NHS Foundation Trust the specialised palliative care team worked in split roles between palliative care (including end of life care) and oncology outreach.

A high proportion of in patient deaths (>90%) occur in paediatric intensive care. The "extended" paediatric palliative care team incorporates the full consultant delivered critical care team and the input of consultants dealing with patients with long-term neuromuscular conditions and those patients requiring long-term ventilation. The former have advanced skills and a high level experience in short-term provision of effective end-of-life care developed in partnership with parents and families. In the latter case palliative care planning and provision may occur over many years and the consultants again have relevant experience and skills. In the critical care setting there is embedded input from the Claire House Hospice team who ensure full engagement with families with planning. There are also opportunities for families to meet with the bereavement care team when death is anticipated to ensure effective communication with families.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity. We inspected end of life services between 6 and 9 February, 2018. During this time we spoke with 31 members of staff at different levels, including nurses, doctors, porters and managers. We attended three meetings, spoke with four family members and reviewed eight electronic patient records and eight prescription records.

We visited seven wards, the Alder Centre, the bereavement suite, the mortuary and the sanctuary.

Summary of this service

Our rating of this service went down. We rated it as good.

For a summary of this service see the overall trust summary section.

Is the service safe?

Good

Our rating of safe stayed the same. We rated it as good because:

End of life care

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. All staff in the specialist palliative care team were up to date with their training on how to recognise and report abuse and they knew how to apply it. They were all trained to Safeguarding Level 3 in line with the intercollegiate guidance, Safeguarding children and young people: roles and competences for health care staff (2014).
- The service had suitable premises and equipment and looked after them well. The mortuary was in good order and well maintained.
- The specialist palliative care team had enough nursing staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.
- Staff kept appropriate records of patients' care and treatment, including prescription records. The patient records we reviewed were clear, up-to-date and available to all staff providing care.
- There was an electronic incident reporting system in place and staff knew how to use it. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

However:

- There was only one consultant in the service which meant they could not meet NICE Guidance 64 regarding access to a specialist paediatric palliative care.
- Although clinical incidents were reported by members of the team these were not assigned to the specialist palliative care team. This meant that the team may not have oversight of all clinical incidents related to their service.

Is the service effective?

Good

Our rating of effective stayed the same. We rated it as good because:

- The service provided care and treatment based on national guidance and there was evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- The consultant for paediatric palliative care was knowledgeable and up to date with national initiatives and was involved with them, for example a point prevalence study to identify numbers of children requiring specialist palliative care.
- Members of the specialist palliative care team knew what was included in the current National Institute for Health and Care Excellence guidance and were working to ensure their documentation reflected the current standards. We saw evidence of this in current and proposed future documentation.
- Staff gave patients enough food and drink to meet their needs and manage their health. They used special feeding and hydration techniques when necessary. Pain relief was managed well and documented appropriately.
- The service monitored the effectiveness of care and treatment and used the findings to improve them. We saw evidence of local audit activity and of actions taken to improve practice following audits.
- Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.

End of life care

- Good links with other services and teams were evident. There was close liaison with local community teams, local hospices, GPs and consultants from other specialities. We also saw reference to multidisciplinary working with midwives with additional mental health training, social workers, the safeguarding team and a children's cancer support group (CHICS).
- There was input on the wards from different disciplines and services including play specialists, educational psychology, and child and adolescent mental health services when appropriate.

However:

- There was a database in place which had the potential to record detailed case management information but this had historically been populated manually by the consultant who no longer had the capacity to manage this on their own. This meant that valuable information which could inform the service was potentially not being captured.
- Not all staff had received their annual appraisal. However, the trust informed us that the medical appraisals tended to occur in the last three months of the financial year.
- Staff had limited understanding of their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. Staff we spoke with had not undertaken mental health training and it was not part of the mandatory training programme.

Is the service caring?

Outstanding

Our rating of caring stayed the same. We rated it as outstanding because:

- There was a strong, visible person-centred culture. Staff were highly motivated and inspired to offer care that was kind and promoted people's dignity. Relationships between people who used the service, those close to them and staff were strong, caring, respectful and supportive.
- We spoke with a parent who described the ward staff as wonderful and supportive and said they were respectful of their child and provided privacy and dignity. One parent described a "lovely relationship" with the specialist paediatric palliative care consultant and was appreciative of their honesty.
- Staff recognised and respected the totality of people's needs. They took people's personal, cultural, social and religious needs into account, and found innovative ways to meet them. We observed lengthy discussions in the multidisciplinary team meeting of how to best meet patients' and their families' needs.
- People's emotional and social needs were seen as being as important as their physical needs. The specialist palliative care team offered immediate support following the death of a child who they had cared for. Alongside this, practical and emotional support for families could be accessed from the Alder Centre where there were two bereavement support teams. This support was available over the longer term.
- There was a spiritual care team based in the sanctuary at the hospital. The sanctuary was a space for all users of the hospital regardless of their religious or spiritual belief. There were opportunities to write messages for children who were very poorly or who had died.
- People who use services and those close to them were active partners in their care. Staff were fully committed to working in partnership with people and we saw evidence of this. Staff we spoke with from the specialist palliative care team and supporting services were, without exception, passionate and committed to providing the best care and support to patients and families that they possibly could.

End of life care

Is the service responsive?

Good

Our rating of responsive stayed the same. We rated it as good because:

- The trust planned and provided services in a way that met the needs of local people. The specialist palliative care service accepted referrals from professionals involved in the care of children or young people with life threatening, life shortening or life limiting conditions. Involvement with the child and family could start before the child was born and continue until the child reached the age where they would transition into adult services.
- The service worked in partnership with other services and agencies including nine regional hospices. The team conducted joint visits to support and empower whichever local teams and services were needed to support children known to them.
- The service took account of patients' individual needs and most children and young people achieved their preferred place of care. Access to other services, such as clinical psychology, the child and adolescent mental health team and the safeguarding team was available within the hospital.
- There was a school on the hospital premises; all wards had a classroom and were allocated a qualified teacher. All children admitted, including those receiving palliative and end of life care, were seen by a teacher and all long term patients had a devised plan of education.
- There was a comprehensive rapid discharge pathway in place, with an emphasis on safety.

Is the service well-led?

Good

Our rating of well-led went down. We rated it as good because;

- The service had managers at a local level, with the right skills and abilities to run a service providing quality sustainable care.
- The team felt positive about being part of a care group working across all part of the hospital service area for example haematology.
- Staff we spoke with in the specialist palliative care team said they were open and honest with families when things went wrong.
- Mortuary staff said they had arrangements with another hospital, should an environmental issue arise whereby their facilities were out of use.
- There was a monthly mortality review meeting which was well supported by staff from across the hospital. Findings from this meeting were taken to the clinical quality steering group for further action where appropriate.

However:

- Although there was a service review in progress with a remit to develop a new model for specialist palliative care but this was in the early stages at the time of our inspection.
- There was no clear work plan for the specialist palliative care team around how much time was dedicated to oncology outreach and how much to end of life care. This meant that some members of the team felt over-stretched.

End of life care

- Representation at board level for palliative care services was through the medical director and the lead for mortality but there was no non-executive director lead for palliative or end of life care
- Consultant cover for the end of life service was provided by consultants from other speciality areas as well as by the Paediatric Palliative Care consultant. This did not permit the service to fully meet NICE guidance 61 regarding access to a palliative care consultant.
- We were not assured that systems implemented to clearly identify a child's status in terms of the Spectrum of Children's Palliative Care Needs were robust. They relied heavily on the availability of the consultant to complete them.
- The service had systems for identifying risks but plans to reduce them were unclear. The risk register had only one risk for end of life which did not have any actions identified and recorded to mitigate the risk until during the inspection.
- There was limited engagement with patients, staff and the public to manage end of life care services. There were no specific patient surveys for the service.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Outpatients

Requires improvement

Key facts and figures

The trust's outpatient's department consisted of a number of services based over four floors within a new hospital building. Services included various clinics such as physiotherapy; phlebotomy; dental; occupational therapy; ear, nose and throat; fracture; cardiology; respiratory; cystic fibrosis; and ophthalmology. It also included a general paediatric clinic. The outpatient service also had a number of administrative functions such as medical records, transcription services, and booking and scheduling. These services were based within the old estate next to the new hospital.

There were 208,740 outpatient's appointments for the 12 months to September 2017, the majority of which were follow-up appointments.

We plan our inspections based on everything we know about services including whether they appear to be getting better or worse.

We inspected the outpatient department between 6 and 8 February 2018. Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity. As part of the inspection we reviewed information provided by the trust about staffing, training and monitoring of performance.

During the inspection the inspection team visited three floors of the outpatient department within the new building, and some of the administrative functions within the old estate. The inspection team spoke with 16 patients and carers who were using the service, and 40 staff members including the lead nurse, nurses, healthcare assistants and administrative staff. We reviewed ten patient records. We did not review any complaint files as there had been no formal complaints in the 12 months prior to the inspection.

We previously inspected outpatients jointly with diagnostic imaging in July 2015, so we cannot compare our new ratings directly with previous ratings.

Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement.

For an overall summary of this service see the trust overall summary section.

Is the service safe?

Requires improvement

Our rating of safe stayed the same. We rated it as requires improvement because:

- The service did not ensure that everyone completed mandatory training in key areas. Staff had not met the trust's target for infection prevention (level 2), and there was no formal safeguarding supervision.

Outpatients

- The service did not control infection risk well. The department did not act in accordance with the trust's toy cleaning policy, there was no formal cleaning rota for the toys, and there was a lack of hand hygiene information for patients and staff. We observed a broken hand gel dispenser and another that was empty. We also witnessed unattended blood samples in a corridor, urine testing taking place near skin prick testing equipment, and allergens being left on patient trolleys.
- Some aspects of the premises were not suitable. Waiting areas were cramped and noisy when busy, and there was little in the way of stimulation or entertainment for children and young people waiting for appointments. We also witnessed unlocked storage cupboards that contained cleaning fluids.
- There were high sickness and vacancy rates within the department.
- Although records were securely transported to the department, we observed records left unsecured and unattended on trolleys outside consultation and treatment rooms. Unauthorised people could easily see the patient identifiable information.
- Staff did not keep appropriate records of patients care. Although the records we reviewed were clear and available for all staff providing care, they were not always up-to-date. This was due to delays of 23.75 days in transcribing consultation notes which is in excess of the trust's three day target.
- The service did not store medicines appropriately. We observed out of date medication in some clinic areas and medication stored in unlocked refrigerators and cupboards. Staff did not know the temperature range medicines should be stored at or what to do if the temperatures fell outside of that range.

However:

- The service mandatory training policies were up to date and there was a formal induction programme for new staff.
- Staff under stood how to protect patients from abuse. There were clear process for reporting safeguarding concerns and other incidents, and staff knew how to follow them. Staff were also aware of the duty of candour.
- There was a formal process for ordering papers records for clinics.
- The service prescribed, gave and recorded medicines well, and the pharmacy facilities were appropriate.
- The service planned for emergencies and staff understood their roles if one should happen. There were fully equipped resuscitation trolleys on each ward and staff knew the location of them. Staff were also aware of the 2222 system.

Is the service effective?

We inspected the effective domain but did not give a rating in line with our guidance.

- Staff of different kinds worked together as a team to benefit patients. There was good multidisciplinary working and collaboration amongst teams, especially in the cystic fibrosis and dental clinics.
- Staff we spoke to understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They could explain the consent process and understood Gillick competency.
- All staff had yearly appraisals and these were mostly up to date, and student nurses had a formal training schedule that helped provide broad experience of the outpatient department.
- There were examples of health promotion with different clinics within the department.

However:

Outpatients

- The service did not benchmark its performance or the effectiveness of its care and treatment against other providers or national audits.
- The service did not routinely ensure staff were competent in their roles. There was no formal reassessment of staff competencies and not all staff had regular one to one meetings with their manager.
- Whilst staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005, the service did not provide staff with formal training in mental capacity.
- Nursing staff did not routinely assess or record patient pain scores.
- The follow-up to new appointment rate was worse than the England average.
- The service did not provide mandatory training in learning disabilities or autism.

Is the service caring?

Our rating of caring stayed the same. We rated it as good because:

- Staff cared for patients with compassion and feedback from patients confirmed that staff treated them well. We observed positive interactions between staff and patients and that patient's privacy and dignity was maintain on most occasions.
- The outpatient department's webpage provided good information in a child friendly format about what to expect at the different clinics.
- Staff provided emotional support to patients to minimise their distress. This included acclimatisation sessions for children with learning disabilities, and a wide awake club for children with autism.

However:

- Although we observed staff involving patients and those close to them in decisions about their care and treatment, the majority of the literature provide to patients about their treatment was mostly designed for parents or carers.

Is the service responsive?

Requires improvement

Our rating of responsive stayed the same. We rated it as requires improvement because:

- The service did not always plan and provide services in a way that met the needs of local people. A breast feeding room had been converted to a storage cupboard, the signposting in the department was confusing, and there was no formal patient or parent forum. We found waiting areas were cramped, especially for wheelchairs and pushchair, and there were no sensory rooms available for patients with individual needs.
- The service did always not take account of patients' individual needs. The phlebotomy rooms on the ground floor were not big enough and had insufficient room for family groups or for reclining chairs. Staff found the layout of the phlebotomy rooms awkward and they had concerns about patient safety. The department had no dedicated play specialist.

Outpatients

- The service did not ensure there was a formal process for sharing learning from complaints with all staff on the front line.
- Over a 12 month period to September 2017, the 'did not attend rate' for outpatients was consistently above the England average, despite attempts to reduce this.
- There were a high number of clinics cancelled and at times 30% of patients had to wait over 30 minutes to see a consultant.
- Patient leaflets were not always written in way that children could easily understand.

However:

- The cystic fibrosis team demonstrated how it tried to meet the needs of patients with complex and long term conditions, and the dental department provided services to minimise the number of patient appointments.
- The service had taken some steps to help people access the service when they needed it. It had partially rolled out a hybrid booking and scheduling system; was ensuring people were seen urgently after two week cancer referrals, and most patients had their first definitive treatment within 31 days of diagnosis.
- The service took complaints seriously and investigated them. There were clear processes for staff and patients to follow.

Is the service well-led?

Good

Our rating of well-led improved. We rated it as good because:

- Managers across the trust promoted a positive culture that supported and valued staff, creating a common purpose based on shared values. The majority of staff we spoke to told us that the leadership were visible and approachable and staff felt comfortable raising concerns. Staff said that the culture within the outpatient department had improved over the last 12 to 18 months.
- The trust collected, analysed, managed and used information reasonably well, including the corporate risk register, to support its activities.
- The majority of staff were up to date with their personal development reviews.
- A clear governance structure meant that issues were being reported at divisional and board level.
- The department included a quality manager that provided support for incident investigations.
- The service had a vision for what it wanted to achieve and workable plans to turn it into action with involvement from staff.
- The risks that sat at corporate level on the risk register that relate to the outpatient department were up to date.

However:

- The trust did not engage well with patients, staff, the public and local organisations to plan and manage appropriate services, or collaborate with partner organisations effectively. Whilst the BME and Disability engagement groups had recently been formed, there were no patient or parent groups directly feeding into the work of the outpatient department. There was also no formal benchmarking of service provision against other providers.
- There is a lack of formal succession planning for staff at all levels within the outpatient department.

Outpatients

- There were no staff recognition programmes specific to the outpatient department.
- There were insufficient staff facilities within the department.
- Not all the risks from the outpatient improvement project were up to date or had associated actions.

Outstanding practice

We found areas of outstanding practice in this service. See the Outstanding practice section above.

Areas for improvement

We found areas for improvement in this service. See the Areas for improvement section above.

Diagnostic imaging

Good

Key facts and figures

Alder Hey's Diagnostic Imaging department is in a central location on the ground floor of the hospital. The department preforms around 73,000 examinations each year including X-rays, magnetic resonance imaging (MRI) scans and ultrasounds. The team consists of specialists including; Radiographers and Sonographers, imaging department assistant, clerical staff, PACS manager, Consultant Radiologists and Radiology Registrar.

We inspected the Diagnostic Imaging department and looked at radiology in theatres. The inspection was unannounced as part of our second phase of inspecting acute Trusts and to enable us to observe routine activity.

The inspection of Diagnostic Imaging services was undertaken by two inspectors from CQC, and a diagnostic imaging manager. We looked at;

- X-Ray rooms
- Gamma Camera
- DEXA Scanner
- Ultrasound
- Biometry
- Fluoroscopy Room
- OPG Dental machine
- Digital mammography
- Reporting rooms
- Theatres
- EOS room orthopedic imaging system (EOS) room

During our inspection we spoke to 26 members of staff which included consultants, radiologist, radiographers, sonographers, administration staff and domestics. We also spoke to two patients and nine parents/carers.

Summary of this service

We have not inspected this service before. We rated it as good.

For al summary of this service see the overall trust summary section.

Is the service safe?

Good

We have not inspected this service before. We rated it as good because:

Diagnostic imaging

- The service provided mandatory training in key skills to all staff. Its mandatory training policies were up to date and there was a formal induction programme for new staff. However, not all staff were compliant with infection prevention and control training.
- We saw evidence of the PAUSE check list being used in the department. The checklist should facilitate a pause for thought and discussion before carrying out any invasive procedure within the busy working environment of a radiology department.
- Audits were carried out within the department for hand hygiene, the last audit showed 100% compliance.
- The department carried out risk assessments of all its equipment. These were completed and up to date.
- Film badge dosimeters were issued to staff and worn at all times. These badges were used to measure how much radiation staff received.
- The x-ray rooms had illuminated warning signs to indicate when in use. The doors also had warning signs and contact details for the radiation protective supervisor. This was an improvement from the last inspection
- The magnetic resonance imaging unit sent out a patient safety check list whenever a child was to attend an appointment and quality assurance programmes were in place.
- The imaging service ensured that females who were or maybe pregnant always informed a member of staff before they were exposed to any radiation in accordance with IR(ME)R. This was an improvement from the last inspection.
- Radiologists followed good practice for unexpected findings by backing up the results on the electronic system with a phone call to the referrer.
- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.
- The department did not use agency staff and bank staff were always their own staff that were familiar with working in the department.
- The trust had an up to date medicines management policy which was available to all staff on the intranet.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. We saw evidence of lessons learned and themes identified.

However:

- For staff safety there was a panic button but there was only one available which was not easily assessable.
- Staff used cleaning and testing checklists in each diagnostic room but we found gaps in the recording of some of these checks.
- There were occasions when the resuscitation equipment was not checked in line with policy, though this had significantly improved since the last inspection of the service.
- The drugs fridge temperature in the anaesthetic room was monitored and recorded but staff did not know whether the temperature was within the correct range.
- Radiographers were able to administer a small number of medicines themselves by following a patient group direction (PGD) but none were signed by the individuals authorising at the time of the inspection.
- It was reported in the departments risk register that the current levels of radiographic staffing within main x-ray were not sufficient to safely man all areas effectively.

Diagnostic imaging

Is the service effective?

We inspected effective but did not give a rating:

- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.
- The radiology department actively carried out a number of audits in order for them to make improvements where required.
- The service monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.
- All radiologists in the department conducted their own reports, therefore there were no competencies of external agencies to check.
- There was a dedicated porter for Radiology who carried a bleep to be contacted by the unit when required.

However:

- The service did not participate in the Imaging Services Accreditation Scheme due to lack or time and resources.

Is the service caring?

Good

We have not inspected this service before. We rated it as good because:

- All staff we saw on our visit were encouraging towards the children, sensitive and had a supportive attitude.
- Distraction techniques were used by staff in order to encourage children onto the equipment and in the majority of cases children were successfully scanned without the use of a general anaesthetic.
- The trust planned and provided services in a way that met the needs of local people.
- Staff communicated well with people so that they understood their care, treatment and condition.
- We saw that all staff had read the local rules (IRR 99) and signed accordingly. The purpose of these local rules is to ensure that work is carried out in accordance with the Ionising Radiation Regulations 1999 (IRR99) and relevant guidance documents.
- We saw good multidisciplinary team working in theatres with staff communicating and organising well together when using the Bi-plane hybrid equipment.

However:

- No information leaflets were sent out to patient's with appointment letters to help support people through their appointment.
- The service did not have a chaperone service in place for some intimate examinations undertaken and relied on parents or guardians.

Diagnostic imaging

Is the service responsive?

Good

We have not inspected this service before. We rated it as good because:

- The trust planned and provided services in a way that met the needs of local people.
- The environment was appropriate and patient centred.
- Translation services were readily available to the department.
- The department was meeting the six week diagnostic test for national standards for both Diagnostic Monthly and not Diagnostic Monthly reportable examinations.
- The department had a rolling rota of reporting allocated to consultant radiologists on each day; reports were prioritised based on clinical information and urgency.
- People could access the service when they needed it. Waiting times to admit treat and discharge patients were in line with good practice.
- The radiology department had no reported complaints between 1 February 2017 and 31 January 2018.
- We saw a big emphasis on allowing children to feel comfortable in the environment prior to their appointment.
- We reviewed the turnaround times for 2016 and 2017 and the department had demonstrated improvements of turnaround times during 2017.

However;

- Play specialist were available to assist the department with patients but we were told that they had to be pre-booked in advance and were not always available when needed.
- The department did not audit ‘did not attend figures’ to improve access to appointments.

Is the service well-led?

Good

We have not inspected this service before. We rated it as good because:

- The trust had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care.
- There was a strategy in place for the replacement of the equipment and was planned with medical engineering for future replacement, via a managed service contract.
- The culture encouraged openness and honesty at all levels.
- There was a strong emphasis on the safety and well-being of staff with regards to radiation protection.
- The service had systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.
- The service has tested back up emergency generators in case of failure of essential services.

Diagnostic imaging

However:

- There was no vision statement on the trust website or in the radiology department specific to the service. We requested this from the trust post inspection but we did not receive any evidence.
- There were arrangements for identifying, recording and managing risks, issues and mitigating actions but they were not always robust. We found one risk on the register which had been there since February 2016 without action.

Outstanding practice

We found areas of outstanding practice in this service. See the Outstanding practice section above.

Areas for improvement

We found areas for improvement in this service. See the Areas for improvement section above.

Community health services

Background to community health services

Alder Hey Children's NHS Foundation Trust (the trust) delivers a range of community based services to children and young people across Liverpool and Sefton in a variety of community settings including home visits, at schools and health centres. Services are delivered in localities across the trust's geographical footprint. These are North, Central and South Liverpool, and North and South Sefton. All the community services are managed through the hospital.

We have not inspected these services before and therefore we have not aggregated the ratings in to the trust rating overall ratings.

Summary of community health services

Good

We had not rated this service before. We rated it good overall because we rated safe, caring, responsive and well led as good and effective as requires improvement.

The trust provides community services for children and young people only.

Community health services for children and young people

Good

Key facts and figures

Alder Hey Children’s NHS Foundation Trust (the trust) delivers a range of community based services to children and young people across Liverpool and Sefton in a variety of community settings including home visits, at schools and health centres. Services are delivered in localities across the trust’s geographical footprint. These are North, Central and South Liverpool, and North and South Sefton.

The community division is clinically led by a divisional director, supported by clinical directors and service managers. The division provides care and treatment within four specialism areas; neurodevelopmental paediatrics, community therapies, community nursing, and children and adolescent mental health services.

The neurodevelopmental paediatric directorate provides services including neurodevelopment paediatrics, autistic spectrum/attention deficit hyperactivity disorder (ASD/ADSD) assessment, neuro-disability, and specialist genetic clinics. This directorate also provide statutory services for looked after children and adoption, designated doctors, and had a lead role in safeguarding in the trust’s Rainbow Centre.

The community therapies directorate provides services including physiotherapy, occupational therapy, dietetics, speech and language therapy, continence, ASD/ADHD nursing, and also included the hearing impairment network.

The community nursing directorate provides community matron and community nursing services for children with complex care needs and acute care needs.

The children and adolescent mental health services (CAMHS) directorate, which was not included in our inspection, provides mental health services including psychiatric assessment, single point of access and crisis care, eating disorder services and the trust’s Fresh CAMHS which offers a range of therapies and interventions to help children or young people who are struggling with how they are feeling, thinking, or the way they are doing things

The community children, young people and families’ services have not previously been inspected at this trust.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity. We visited the trust’s community children, young people and families' services as part of our unannounced inspection between 5 and 9 February 2018. We inspected the whole core service and looked at all five key questions. We spoke with 13 children and carers and 68 staff from different disciplines, including support staff, healthcare assistants, allied health professionals, nurses, doctors, managers and senior managers. We observed daily practice and viewed 42 sets of records across all the services we visited. Before and after our inspection, we reviewed performance information about the trust and reviewed information provided to us by the trust.

Summary of this service

We have not rated this service before. We rated it as good.

For a summary of this service see the overall trust summary section.

Is the service safe?

Good

Community health services for children and young people

We have not rated this service before. We rated safe as good because:

- The service provided mandatory training in key skills to all staff.
- The service controlled infection risk well. Staff kept equipment and the premises clean. They used control measures to prevent the spread of infection.
- The service had suitable premises and equipment and generally looked after them well.
- Staff kept appropriate, clear and up-to-date records of patients' care and treatment. There were varying arrangements in place to provide the correct information that staff needed to deliver consistently safe care and treatment to patients.
- Staffing levels and skill mix were planned, implemented and reviewed to keep people safe. Managers monitored staffing caseloads.
- Staff understood their role in reporting safety incidents. When things went wrong, staff apologised and gave patients honest information and suitable support, although incident themes were not consistently recognised.

However:

- The service had systems for the dispensing, administration and storages of medicines in line with the trust policy and the standard operating procedure for the Homecare service. However, gaps in the operating procedure meant that managers could not be assured that the management and administration of medicines to patients in their own homes by Homecare staff safely met the needs of the patients. This was a breach of regulation relating to the proper and safe management of medicines.
- Delays of up to 28 days in consultant clinic letters being sent to patients' GPs, including letters communicating changes in doses of medicines, meant there was a risk of medicines changes not being managed effectively.
- Staff understood their role in recognising and preventing potential abuse. There were systems in place to ensure that children were appropriately protected. However, staff knowledge and systems were not fully developed and embedded for young people over the age of 16.
- Safety performance measures were not routinely collated or monitored across the service.

Is the service effective?

Requires improvement

We have not rated this service before. We rated effective as requires improvement because:

- Patients' care and treatment outcomes were not consistently collected, monitored or used to improve care across all the community children, young people and families' specialisms
- The arrangements for patients' rights to be protected under the Mental Health Act 1983 and the Mental Capacity Act 2005 were not effective. Mental capacity assessment records were not always completed accurately or with sufficient detail. Discussions with patients' relatives or advocates were not always undertaken in order to fully explore the patient's best interests and obtain valid consent. This was a breach of regulation on the provision of care and treatment with the consent of the relevant person.
- Although staff provided pain relief if needed and adjusted care and treatment plans accordingly, there was inconsistent use of formal pain assessment across the services or guidance for the administration of pain relief.

However:

Community health services for children and young people

- The service provided care and treatment based on national guidance and comprehensive assessment of patients' needs.
- Staff monitored and met children's nutritional and hydration needs.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.
- Staff of different kinds worked together as a team to benefit patients and to meet the range and complexity of patients' needs. Doctors, nurses and allied healthcare professionals supported each other to provide good care.

Is the service caring?

Good

We have not rated this service before. We rated caring as good because:

- Staff responded compassionately when patients or their relatives needed help. Support was given by caring staff as and when required by patients to meet their individual needs.
- Staff recognised the impact a person's care, treatment or condition had on their wellbeing both emotionally and socially. Patients and their relatives who used services were given appropriate and timely support to cope emotionally with their care, treatment or condition.
- Patients' personal, cultural, social and religious needs were determined, although they were not consistently recorded for in order to meet individual needs.

Is the service responsive?

Good

We have not rated this service before. We rated responsive as good because:

- The service planned and provided services in a way that met the needs of local people.
- The service took account of patients' individual needs.
- People could access the service when they needed it. Waiting times from referral to treatment and arrangements to accept, treat and discharge patients were, for the majority of community services, within agreed targets.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.

However:

- There were significant and lengthy waiting times from referral to assessment, diagnosis and treatment for patients accessing the autistic spectrum disorder and attention deficit hyperactivity disorder pathways.

Is the service well-led?

Good

Community health services for children and young people

We have not rated this service before. We rated well-led as good because:

- The service had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care.
- The service had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.
- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- The service used a systematic approach to continually improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.
- The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.
- The service engaged with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.
- The service was committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation.

However:

- The service collected, managed and used information to support all its activities, using secure electronic systems with security safeguards. However, as not all services within the community division had access to all of the systems, there was a risk that staff did not always have access to all information about their patient.

Outstanding practice

We found areas of outstanding practice in this service. See the Outstanding practice section above.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

For more information on things the provider must improve, see the Areas for improvement section above.

Please note: Regulatory action relating to primary medical services and adult social care services we inspected appears in the separate reports on individual services (available on our website www.cqc.org.uk)

This guidance (see goo.gl/Y1dLhz) describes how providers and managers can meet the regulations. These include the fundamental standards – the standards below which care must never fall.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour

Our inspection team

Carolyn Jenkinson, Head of Hospital Inspection, and a lead inspection manager and inspector led this inspection. An executive reviewer supported our inspection of well-led for the trust overall. The team included seven inspectors, fifteen specialist advisers, and an expert by experience.

Executive reviewers are senior healthcare managers who support our inspections of the leadership of trusts. Specialist advisers are experts in their field who we do not directly employ. Experts by experience are people who have personal experience of using or caring for people who use health and social care services.

Board of Directors

Tuesday 3rd July 2018

Report of	Director of Corporate Affairs Chief Nurse
Paper prepared by	Governance Manager Divisional Leads
Subject/Title	CQC Action Plan Exception Report
Background papers	2017 CQC Inspection Report Monthly updates of CQC Action Plan
Purpose of Paper	To inform the Board of the latest position with regards to the remaining ongoing actions on the 2017 CQC Action Plan by exception
Action/Decision required	The Board is asked to note the remaining 'must do' and 'should do' actions and note the process for monitoring these going forward.
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	➢ Delivery of outstanding care ➢ The best people doing their best work ➢ Sustainability through external partnerships ➢ Game-changing research & innovation
Resource Impact	N/A

BOARD OF DIRECTORS

2017 CQC Action Plan

1. **Purpose**
   The purpose of this paper is to inform the Board of the latest position with regards to the ongoing actions on the 2017 CQC Action Plan.

2. **Summary**
   Excellent progress has been made towards closing all actions on the CQC Action Plan.

   Just three 'must do' actions remain ongoing which will be monitored by their owners through to completion.

   Twenty 'should-do' actions remain ongoing with timescales for completion in the coming months sitting at divisional level. Going forward, these are to be managed through divisional governance meetings.

   A summary of all ongoing actions is attached for reference.

3. **Recommendation**
   The Board is asked to note the remaining 'must do' and 'should do' actions and note the process for monitoring these going forward.

Jill Preece
Governance Manager
July 2018

ALDER HEY CHILDREN'S NHS FOUNDATION TRUST CQC ACTION PLAN

EXCEPTION REPORT AS AT END JUNE 2018

MUST DO's

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
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	7.2 Undertake formal risk assessment on all wards assessing the risk of children absconding or being abducted	Melissa Swindell Director of Human Resources and OD	Greg Murphy LSMS	**Update June 2018:** The risk assessments have commenced and will be undertaken on an annual basis or before if any physical changes are implemented in the ward / department A generic absconsion risk assessment has been produced to aid the process which ward / departmental managers can make bespoke to their area. These will be completed by all departments by 31st July 2018	G	In progress	Revised timescale: ~~19 June 2018~~ 31st July 2018	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	
				7.4 Health and Safety team to upload generic Risk Assessments onto the Risk Register to prevent duplication of risk assessments and associated risks	Melissa Swindell Director of Human Resources and OD	Amanda Kinsella Health and Safety Manager	**Update June 2018** Generic risk assessments saved as attachments within Ulysses' risk register module	G	Complete	~~30th November 2017~~ End June 2018	IGC	See above	

ALDER HEY CHILDREN'S NHS FOUNDATION TRUST CQC ACTION PLAN

SHOULD DO's

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 for **all** staff	Hilda Gwilliams Chief Nurse	Rob Griffiths Theatre Manager Phil O'Connor Deputy Director of Nursing	**Update June 2018:** On target to achieve 90% training compliance with Resuscitation policy by March 2019 100% compliance achieved for having an APLS trained member of staff on every shift where required. Overall APLS compliance is on target to deliver 90% by March 2019.		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	
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 June 2018:** Absconsion policy devised and approved by Policy Ratification Group. Policy for ratification at Integrated Governance Committee on 11th July 2018 and will then be disseminated		In progress	31st July 2018	Health and Safety Committee		

ALDER HEY CHILDREN'S NHS FOUNDATION TRUST CQC ACTION PLAN

				12.4 Annual risk assessment of abduction risk to be undertaken on all in-patient wards with Matrons / Ward Managers	Hilda Gwilliams Chief Nurse	Greg Murphy LSMS	**Update June 2018:** The risk assessments have commenced and will be undertaken on an annual basis or before if any physical changes are implemented in the ward / department A generic absconsion risk assessment has been produced to aid the process which ward / departmental managers can make bespoke to their area. These will be completed by all departments by 31st July 2018		**In progress**	~~31st March 2018~~ Revised timescale: 31st July 2018			
13	Should	Medicine / Surgery	**Mandatory training** Expedite plans and actions to enable all staff to improve compliance with mandatory training to the trust's target of at least 90%	13.1 Disseminate Divisional mandatory training reports and specific communication produced by Learning and Development	Melissa Swindell Director of Human Resources and OD	Will Weston Associate Chief Operating Officer Medical Division Andy McColl Associate Chief Operating Officer Surgical Division	**Update June 2018** Reported at June 2018 that Trust achieving target for core mandatory training		**Complete**	31st December 2018	Workforce and Organisational Development Committee	90% compliance in mandatory training	Via WOD
				13.2 In collaboration with L&D team, devise specific and targeted actions in any areas with compliance less than 90%					**Complete**	31st December 2018	Workforce and Organisational Development	90% compliance in mandatory training	

ALDER HEY CHILDREN'S NHS FOUNDATION TRUST CQC ACTION PLAN

											Committee		
15	Should	Medicine	**Disease Specific Pathways** Have disease specific pathways in place that are based on up to date evidenced based practice and a system for assurance during the period of transition from paper to electronic pathways	15.1 Review and disseminate diabetic pathways	Steve Ryan Medical Director	Adrian Hughes Associate Medical Director Medicine	**Update 27th October 2017:** • Revised DKA guideline has been in operation since May 2017. • The newly diagnosed guideline has been rewritten and has been emailed out to the diabetes team who have made no further changes, this should be ready to use as soon as it can be released. • The Hyperglycaemia guideline has been rewritten and is awaiting team approval (this also forms part of the surgical guideline) • The Type 2 guideline is a new document and is currently out for consultation.		**Complete**	• **Complete** • **Complete** • Complete • Timescale July 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	Guidelines.pptx Newly Diagnosed Diabetes Pathway.pd

ALDER HEY CHILDREN'S NHS FOUNDATION TRUST CQC ACTION PLAN

				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	Steve Ryan Medical Director	Adrian Hughes Associate Medical Director Medicine	**Update 27th October 2017:** Website development underway with involvement from a patient and parent		**In progress**	31st December 2018			
16	Should	Medicine / Surgery	**Appraisals** Improve staff appraisal rates to reach the at least the trust's target of 90%	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	Melissa Swindell Director of Human Resources	Will Weston Associate Chief Operating Officer Medical Division ~~Adam Bateman~~ Andy McColl Associate Chief Operating Officer Surgical Division	**Update June 2018:** The PDR window runs from April-July. Divisions are making progress and receive weekly compliance reports from HR.		**In progress**	~~30th November 2017 and ongoing~~ April to July 2018	Workforce and Organisational Development Committee Divisional Board	90% compliance with staff appraisal rates	
20	Should	Medicine / Surgery	**Ward Curtains** Consider implementing a schedule for replacing curtains in the ward areas	20.2 Audit compliance with updated replacement programme on a quarterly basis	Hilda Gwilliams Chief Nurse	Lesley Cooper Domestic Operations Manager	**Update June 2018** Schedule devised and quarterly audits to commence and report to Infection Control Committee		**Complete**	Quarterly	Infection Prevention and Control Committee	100% compliance with planned replacement programme	
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	21.5 Review and disseminate reports of SSI data findings within the Surgical Division and to the Trust through Infection Prevention and Control Committee	Steve Ryan Medical Director	Christian Duncan Associate Medical Director Surgical Division	**Update beginning of Apr 2018:** Electronic database now developed.		**Complete**	~~31st March 2018~~ Revised timescale 30 June 2018	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	

ALDER HEY CHILDREN'S NHS FOUNDATION TRUST CQC ACTION PLAN

22	Should	Surgery	**CD Discard** The management team should make sure that discarded controlled drugs across all departments are recorded appropriately	22.3 Liaise with other hospitals to check and benchmark practice for discarding controlled drugs (CD)	Steve Ryan Medical Director	Catrin Barker Chief Pharmacist	**Update beginning of April 2018:** Reminders about disposal at ward level have been sent out. A CD audit of compliance is being completed to check response. Details on alternative CD books have been obtained. PICU and HDU are to try using the Theatre style CD books.		Complete	31st December 2017 – and ongoing	Medicines Management Committee Clinical Quality Steering Group Clinical Quality Assurance Committee	All controlled drugs discarded will be recorded appropriately	
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	23.4 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	Steve Ryan Medical Director	Cathy Fox Head of Clinical Systems	**Update beginning of May 2018:** The rollout of the Multi –user desktop solution to resolve this problem has been paused whilst an unintended consequence with another application was investigated and resolved. It has now been resolved and the rollout has re-started and will be complete across the organisation by the end of September.		In progress	~~31st May 2018~~ Revised timescale Sept 2018	Global Digital Exemplar Programme Board Operational Delivery Board	Accurate recording of medication administration to reduce the risk of associated medication errors	

ALDER HEY CHILDREN'S NHS FOUNDATION TRUST CQC ACTION PLAN

24	Should	Medicine / Surgery	**Ward Co-ordinator** The hospital should find ways in which to make sure that there is always a supernumerary co-ordinator available in all areas, at all times to support staff	24.1 Undertake annual establishment of ward areas based on national standards (Royal College of Nursing / Paediatric Intensive Care Society / British Association of Perinatal Medicine), patient acuity and professional judgement	Hilda Gwilliams Chief Nurse	Pauline Brown Director of Nursing / Divisional Associate Chief Nurses	**Update June 2018:** Annual ward establishment reviews underway and due for completion by end of August 2018. Report back to Trust Board outlining position scheduled for Sept 2018		In progress	~~28th February 2018~~ Sept 2018	Clinical Quality Assurance Committee		
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	25.5 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	Melissa Swindell Director of Human Resources	Will Weston Associate Chief Operating Officer Medical Division Andy McColl Associate Chief Operating Officer Surgical Division	**Update June 2018:** See 16.5		In progress	April to July 2018	Workforce and Organisational Development Committee Divisional Board	90% compliance with staff appraisal rates	
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	26.2 Realign the Operating Theatre schedule to balance out the elective patients across the week	Adam Bateman Chief Operating Officer	Andy McColl Associate Chief Operating Officer Surgical Division	**Update beginning of May 2018:** No tangible progress to date with realigning the Operating Theatre schedules, due to clinics, consultant job plans etc. Pressures are currently alleviated by capping elective procedures. The Best in Operative Care Group have		In progress	~~30th April 2018~~ Revised timescale: Aug 2018	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	

ALDER HEY CHILDREN'S NHS FOUNDATION TRUST CQC ACTION PLAN

							decided that a theatre schedule review would be one of their work streams in the coming year.						
				26.5 Implement a more robust reminder service for patients	Adam Bateman Chief Operating Officer	Andy McColl Associate Chief Operating Officer Surgical Division	**Update beginning of June 2018** The Trust is currently testing a bi-directional text messaging service which will inform parent of their child's procedure and will provide them with the ability to confirm / request to reschedule their procedure via text.		**Complete**	31st May 2018 Complete			

ALDER HEY CHILDREN'S NHS FOUNDATION TRUST CQC ACTION PLAN

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
30	Should	Community CAMHS	**Soundproofing** Should ensure that all rooms are adequately soundproofed	30.3 Ensure rooms in new locations are assessed for sound proofing prior to moves	Andrew Williams Director of CAMHS	Kate Brizell General Manager CAMHS	**Update June 2018** Will be tested prior to move by 30th June 18.		**Complete**	~~31st December 2018~~ Revised timescale 30th June 2018			

ALDER HEY CHILDREN'S NHS FOUNDATION TRUST CQC ACTION PLAN

Amber action from 2015 inspection Action Plan

21. Continue to develop relationships with adult health and social care providers to ensure the safe and effective transition of care for young people					
Outcome	**Actions**	**Responsibility**	**Time-frame**	**Assurance**	**Progress**
Overarching Transition Framework agreement across Healthy Liverpool	Develop shared framework with relevant partners	MD/ Clinical Lead	12 months	Healthy Liverpool Programme governance	**Update June 2018:** Meeting with Aintree on the 22nd June 2018. A date for Whiston has been requested. Non clinical transition preparation is ongoing for all the over 18 year old patients with complex neuro-disabilities, and all these patients have dates up to June 2018. Fully achieved Q1-Q4 of the Complex CQUIN 2017-2018. A meeting has been agreed to take place within the next couple of weeks with NHSE to plan milestones for 2018-19 complex patient CQUIN Transition into Meditech 6 is designed and went live, although how we deliver transition/meditech training, this has been added to the Transition training The end of year report is to be finalised by the end of the month. The Transition team with Edge Hill met again last week, and have finalised the MCA, DOL's and Best interest patient and parent information leaflet. This has been forwarded out to colleagues for feedback The 3rd annual North West Collaborative Transition Conference, planned for the 29th June 2018, all places are full (120) Delegates to attend free. The 4th Transition conference is booked to take place in June 2019, at Aintree Clinical sciences department Continue to implement Transition Trust wide attempting to implement into 6 specialities this year including the complex CQUIN. Transition continues to excel in achieving EDS2 equality and diversity standards.

TRUST BOARD REPORT

MORTALITY ASSESSMENT AT ALDER HEY
Medical Director's Mortality Report

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

Section two is the Quarter 4 Mortality report which includes a review of statistical analysis in PICU and Cardiac Surgery, followed by more detailed analysis of the place of death, teams involved and specifics about expected v observed deaths.

Section 1: Report from the Hospital Mortality Review Group (HMRG)

Summary Table

2017

Number of deaths (Jan. 2017 – Dec. 2017)	69
Number of deaths reviewed	68
Departmental/Service Group mortality reviews within 2 months (standard)	60/69 (87%)
HMRG Primary Reviews within 4 months (standard)	52/69 (75%)
HMRG Primary Reviews within 6 months	64/69 (93%)

2018

Number of deaths (Jan. 2018 – Dec. 2018)	20
Number of deaths reviewed	4
Departmental/Service Group mortality reviews within 2 months (standard)	11/14 (79%)
HMRG Primary Reviews within 4 months (standard)	
HMRG Primary Reviews within 6 months	

The HMRG is performing well with 75% of the reviews within the 4-month target that we set ourselves and 93% within 6 months. The 4-month target can be difficult/impossible to achieve if it is a coroner's case and if the RCA's are prolonged. The group is of the opinion that it is important to have all the relevant information to achieve a useful and complete review. Therefore, it is

appropriate to wait, and it is unlikely that we will every achieve 100%. The standard of 4 month is useful so reviews are done in a timely manner and if there is a concerning trend it will be identified in a reasonable time period. The outstanding cases are related to RCA's or coroner's case
Mortality reviews and ensuring that there is learning from each death remains a priority on the national agenda and over the next few months the paediatric process should be confirmed. It is unclear how this will impact on the way that mortality reviews are currently undertaken in Alder Hey and there may need to be changes to our processes if indicated.

Internally there are still a number of improvements that are being made to our mortality review process:

1) We continue to engage with the bereavement team to ensure that the families are able to have a voice in the process if they wish to and can raise any issues about the care of their child or factors that impacted on them whilst in the Trust. This has to be done sensitively and compassionately so it is taking us time to embed in the process. The feedback we obtain will be invaluable.

2) We are still striving for engagement across the Trust in the process. The teams whose areas have the highest mortality rates for example PICU are very efficient in their review process, but it is the teams who only have an occasional death who we also need to ensure that they are aware and utilize the process correctly.

3) One aspect that we are focusing on is ensuring that the learning points raised from the monthly meetings are communicated effectively across the Trust.

4) The group is trying to improve engagement out of the Trust and improve communication. We plan to do this by inviting interested parties to our meetings and releasing our reviews to the GP's and DGH's involved.

5) The Community team are keen that any deaths involving their patients are reviewed by the HMRG and come under the mortality process. Currently this only happens if the children die in Alder Hey but more usually they are in the community or a hospice. This group would cover a number of the children with more complex issues and needs and often have had considerable input by the trust. It would be beneficial to us as a Trust to ensure that the care we are providing is the best that we can possibly achieve. It may be difficult practically due to the notes

being in a number of different places, but we are working on the practical issues to make this and achievable goal.

2017

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

2018

Month	Number of Inpatient Deaths	HMRG Review Completed	Dept. Reviews within 2-month timescale	HMRG Reviews within 4-month timescale	HMRG Reviews within 6-month timescale	Discrepancies HMRG- Dept	HMRG Review - Death Potentially Avoidable
Jan	7	2	4			1	1
Feb	1		1				
March	6	2	6				

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

Since the previous mortality report there has been 1 case where there have been discrepancies between the service group and HMRG reviews. The service group review recorded the care as adequate but the HMRG review decided that aspects of care were less than adequate but did not alter outcome.

Potentially modifiable factors and actions

Since the last Trust Mortality report, there have been 2 in-hospital deaths where there are factors which may have played a role in the child's death. In future the plan is to improve the statistics in the above table to distinguish clearly whether the potentially avoidable factor was internal i.e. related to Alder Hey care or external i.e. issues relating to care outside Alder Hey e.g. child protection. In both of these cases there were issues with the care outside Alder Hey that the group believed could have been improved.

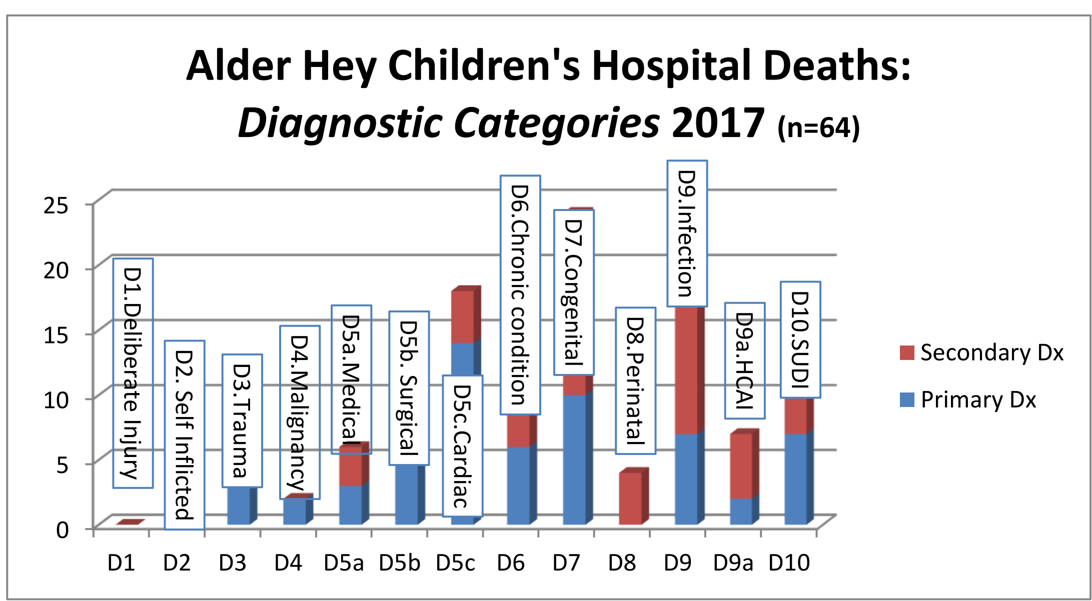
1) One was a child who attended AHCH after drinking camphor oil (an essential oil). Immediately after ingestion started choking and conscious level dropped rapidly. The patient required intubation on arrival in AHCH and required continuing care on the intensive care unit. Despite maximal ventilatory support the patient continued to deteriorate and was placed onto Extra Corporeal Membrane Oxygentation. There was much discussion with other centres across the UK to manage the child optimally as it was such a rare and unusual presentation. The child started fitting and a CT scan showed that there was an extensive area of ischemic infarct. Over the next few days multiple treatments were attempted: high dose steroids, lung lavage amongst them. However, the child continued to deteriorate despite every possible effort and after much discussion the decision was made to withdraw care. In view of the lack of literature on the ingestion of camphor oil the group decided that feedback to NHS England would be wise so there is more information available relating to its toxicity. This is potentially avoidable as without the ingestion there would not have been the sequalae.

2) Second case was a young child who was involved in a serious RTA (car vs HGV) and transferred to AHCH via helicopter as the trauma centre. The child was in cardiac arrest at scene but due to resuscitation undertaken by the paramedics (thoracostomies, intubated with LMA, and intraosseous lines) a pulse was regained. On AHCH the child was profoundly hypotensive and inotrope infusions commenced. CT scans were undertaken which showed

catastrophic and unsurvivable injuries. The whole trauma team were present including neurosurgery and were in full agreement.

Primary Diagnostic Categories

The chart below shows the deaths by primary diagnostic categories.



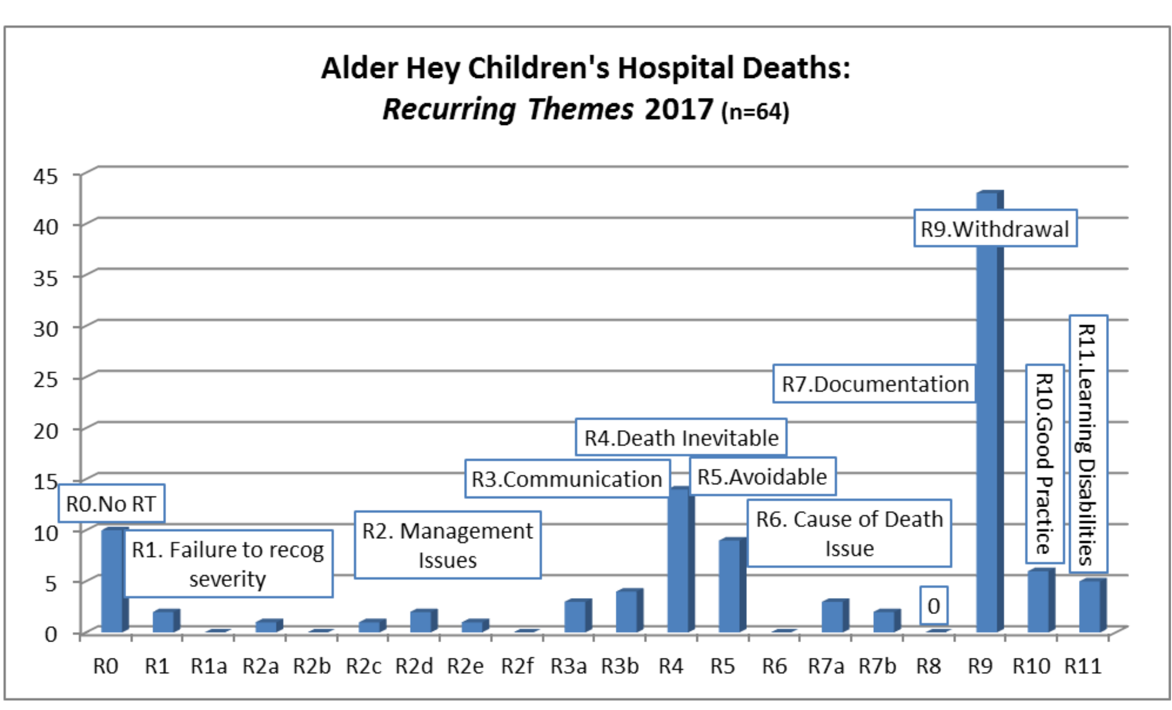
Diagnostic/Disease Categories (based on CEMACH categories - ref. *Arch Dis Child* 2011;96:922-6 + 927-31)

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

The commonest diagnostic category is cardiac with 22% this can be partially explained by a number of babies that come to Alder Hey for cardiac assessment and then are found to be inoperable or no real treatment options. This has resulted in discussion in the HMRG meetings as to whether it is appropriate and necessary to bring the babies and families to AHCH so isolating some of the families from their support network. The feedback from the cardiologists is that they can do a far more detailed assessment and the cases can be extremely complex and need considerable discussion. The next

highest group is surgical 19% and there are a number of explanations for this. The surgical team here takes referrals for line accesses across the region where they are finding it extremely difficult to obtain an intravenous line. The surgical team provides a central line so solving the problem, but a number of these babies are precarious with many being extremely premature and with a number of complex issues. These babies may deteriorate either en route to AHCH or on arrival and then unfortunately pass away whilst here. There is another group of surgical patients with very similar issues and these are the babies who are referred as possible necrotising enterocolitis. This is a condition which typically occurs in premature babies and is characterised by variable damage to the intestinal tract. The first line treatment is intravenous antibiotics and resting the bowel but if they deteriorate they may need an operation. They are therefore referred to AHCH and the group did notice that there were a number of babies which were too unstable to even make it to theatre. There has been feedback via the neonatal network as to whether it is appropriate to refer these babies to AHCH if they are so unstable with multiple co-morbidities.
11% of the children are sudden unexplained deaths which means that as the name implies they were completely unexpected deaths and this may cover child protection issues amongst other things.
There have only been 4 cases discussed in 2018 and therefore we have not shown the graphs or discussed them because the numbers are too low to allow useful analysis.

Primary Recurrent Themes



Recurring Themes

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

The commonest theme is withdrawal of care in 67% of cases which shows that the intensive care team are providing the best possible care until they feel all treatment options are futile, then with full agreement of the family and the other teams involved withdraw intensive care and ensure that the child has as peaceful a death as possible. Although these are difficult discussions, it is important that the team is proactive thus preventing unnecessary suffering and it done in a very caring and compassionate way.

The next commonest theme is that death is inevitable in 22% of cases so regardless of the care provided in AHCH the child unfortunately was going to die. There are other cases where the child is clearly extremely poorly but the decision that the condition or illness is not survivable is not made until detailed assessment has been made and these are not put in this category.

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

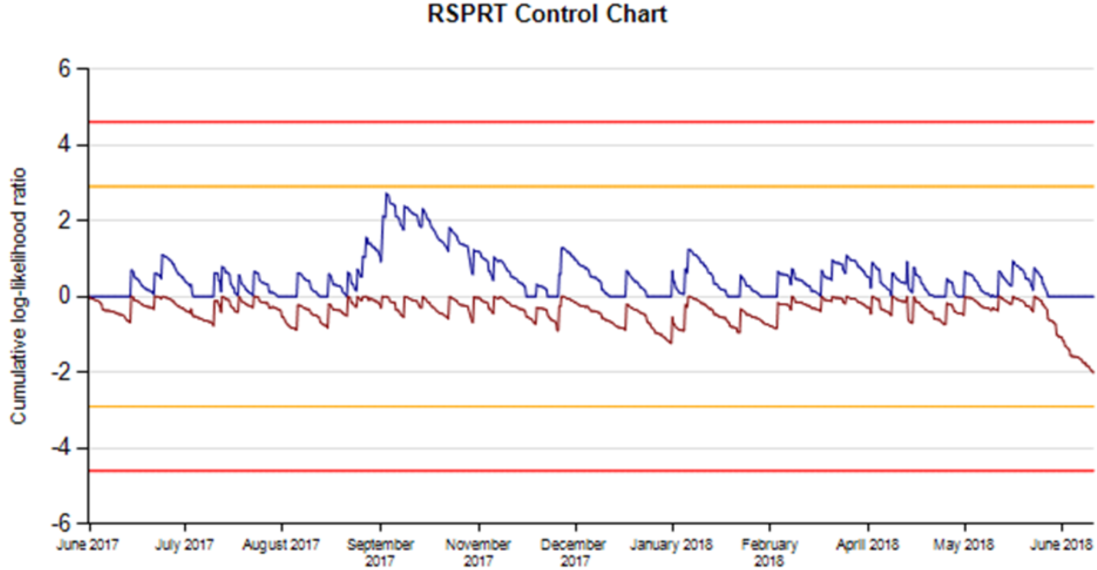
For the same reason above we have not provided analysis of the data from 2018 at this stage as the cases so far reported are minimal – 4. As reviews are completed and sufficient information is available, analysis will be undertaken.

Section 2: Quarter 4 Mortality Report: January 2018 – March 2018

1) Statistical analysis of mortality:

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

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

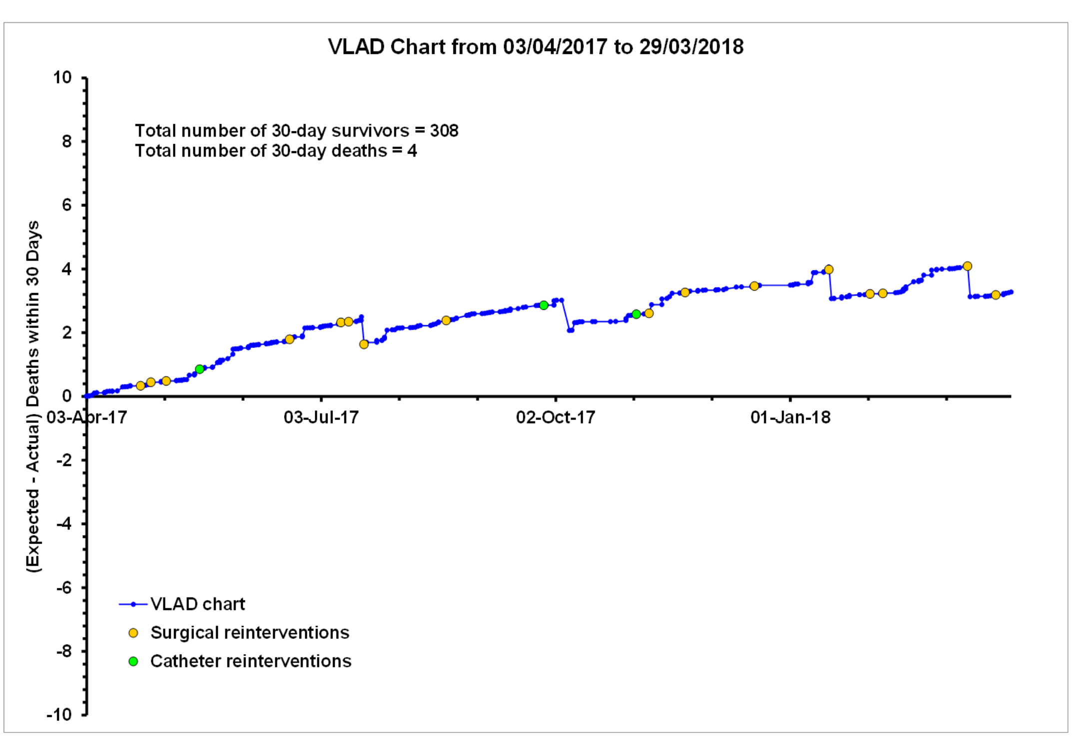


Until there is a death, the top line stays flat and the bottom line gradually drops. When a death occurs, the top line moves up and the bottom line moves closer to zero. When either line touches the red line, the graph resets to zero.
This data is nationally validated because generated by PICANet.
The above RSPRT chart indicates that we have been in "Safe Zone" between June 2017 and June 2018. Between September 2017 and October 2017 there was a peak with 13 deaths in two months. Of the 13 deaths, 11 of them belonged to the "Death inevitable on PICU admission" group in retrospect. The other 2 deaths belonged to the group of chronic patients with multiple co-morbidities. All PICU deaths + RSPRT trends are discussed in the following month and monitored regularly.

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

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

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

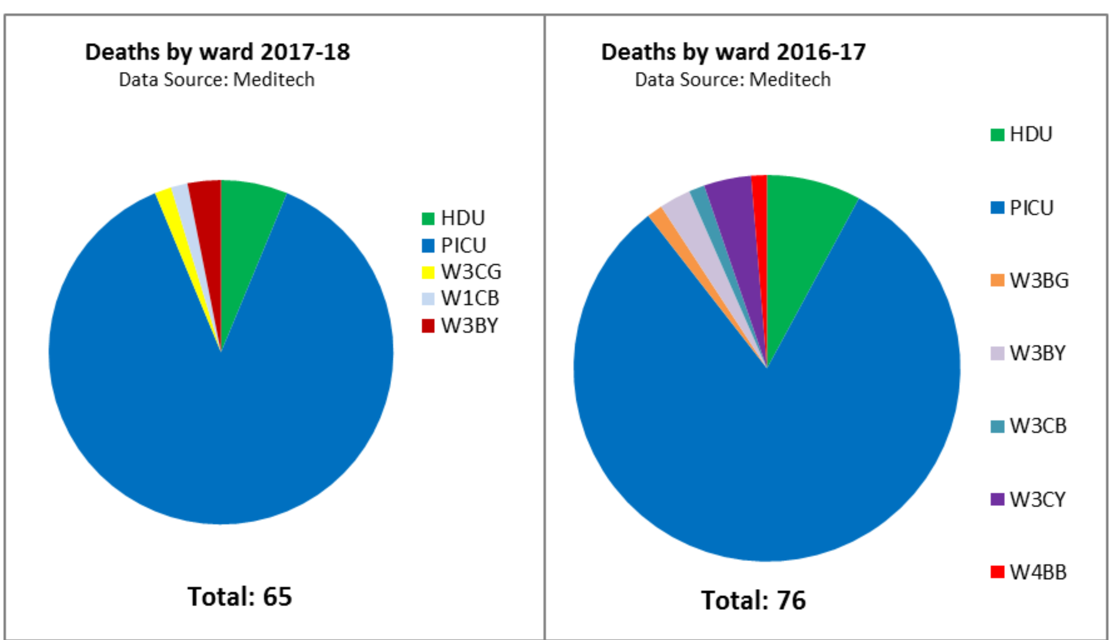


The VLAD chart above shows mortality is occurring lower than expected for the twelve months from April 2017 to March 2018. The survival rate at 30 days was 98.7% against an expected rate of 97.8%.

2) Real time monitoring of mortality

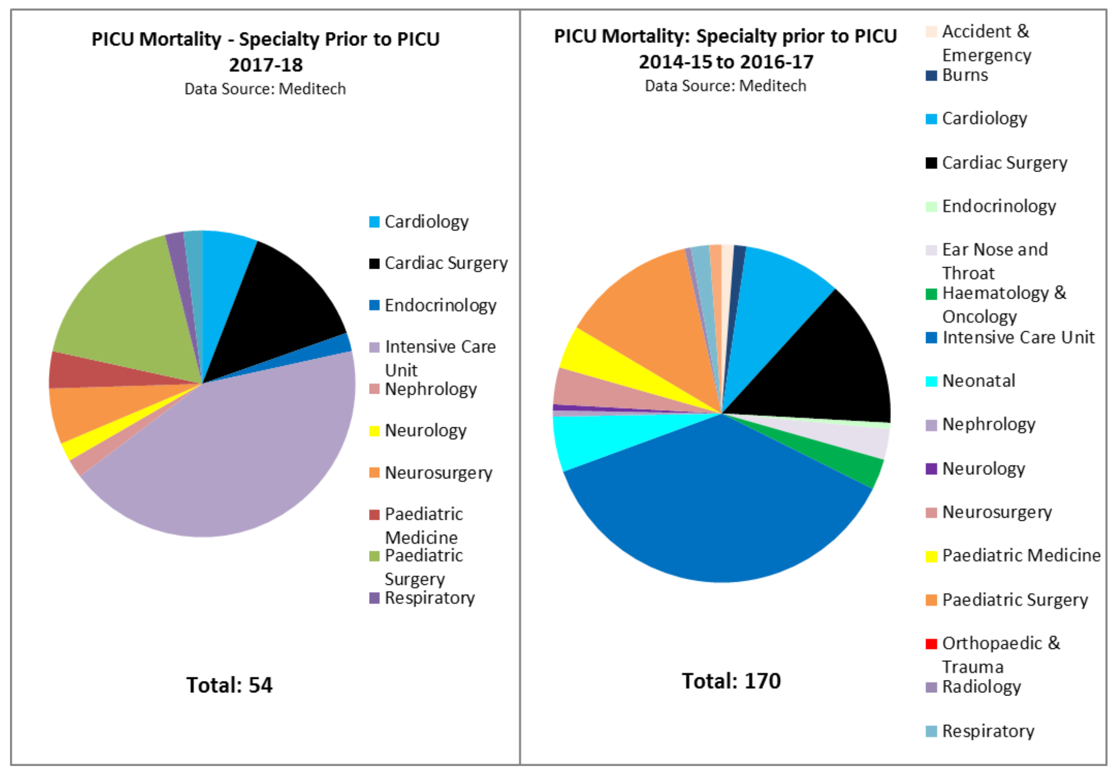
Mortality is now being monitored in real time and analysed by year, ward, specialty, deaths within 30 days from admission and over 30 days from admission.

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



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

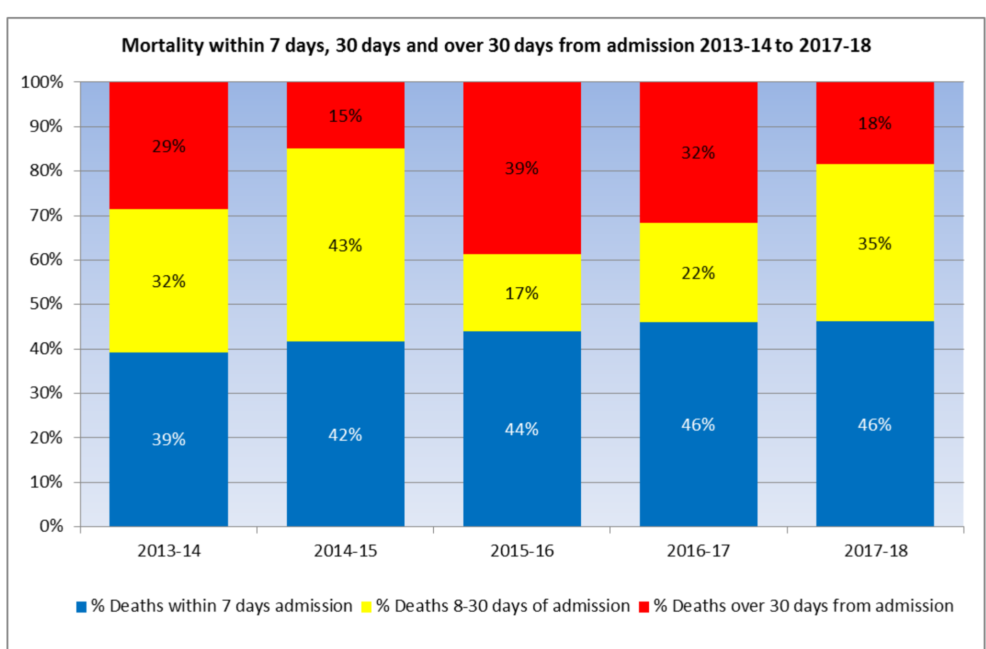
ii) Below are the charts showing mortality by specialty prior to PICU for 2017-18, and the previous 3 years 2014-15 to 2016-17.



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

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

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



The chart shows that usually the highest percentage of deaths occurs within 7 days of admission, around 44-46% of deaths occur within this time frame. In the current year 46% occurred within 7 days of admission, 35% occurred within 8-30 days from admission, and 18% deaths occurred over 30 days from admission.

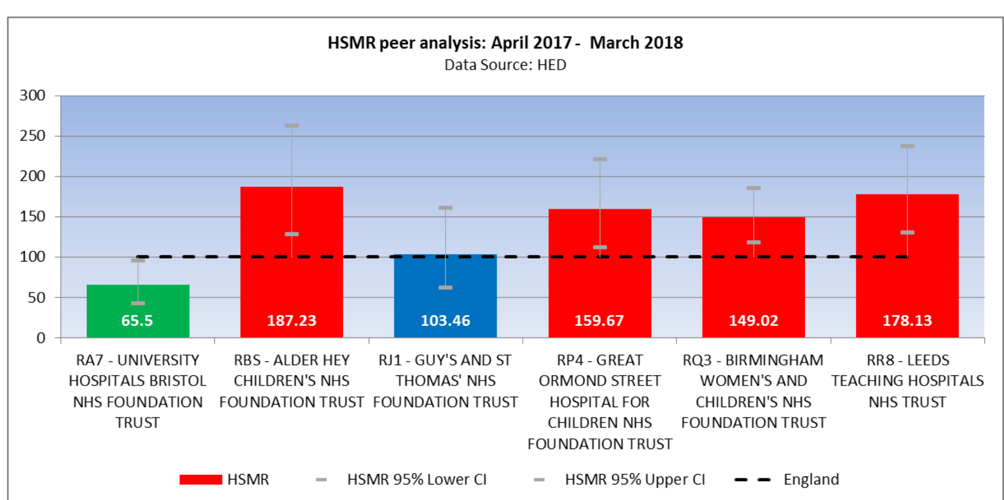
3. External Benchmarking

a) Hospital Standardised Mortality Ratio (HSMR) – HED

HED allows the Trust to monitor and benchmark a number of hospital performance indicators including mortality. The HSMR is the ratio of the observed number of in-hospital deaths divided by the number that is expected, and is based on 56 diagnoses. Although the scores are based on a basket of diagnoses that are more commonly found in adults, it allows a comparison of the performance of Alder Hey against other Trusts.

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

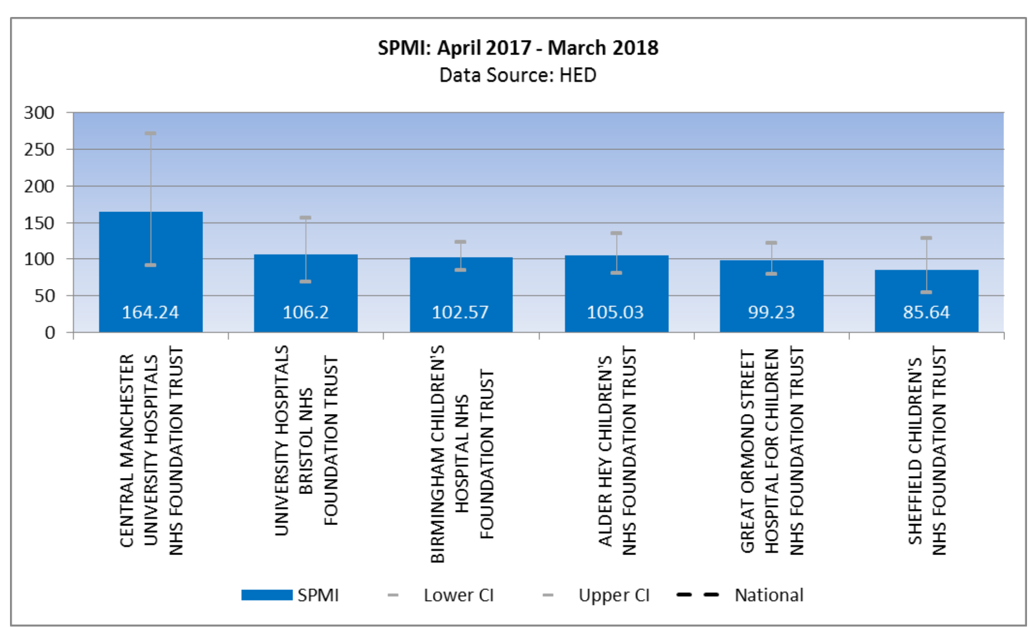
The chart below compares HSMR for Alder Hey against its peers for the period April 2017 to March 2018.



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

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

HED has developed a Standardised Paediatric Mortality Index (SPMI); this is a paediatric specific ratio of the observed to expected in-hospital deaths (multiplied by 100). A value of greater than 100 indicates higher mortality level than the average NHS performance, and a value of less than 100 indicates lower mortality level. The expected deaths are calculated from logistic regression models with a case-mix of: age, sex, ethnicity, trust type, emergency surgery flag, chronic condition flag, paediatric risk category, paediatric life-limiting conditions flag and diagnosis group. Diagnosis groups where there are less than 10 death events are excluded from the model. Children up to and including the age of 15 are included. The model is available in pre-release and the most recent data available is for the period 1st April 2017 to 31st March 2018.



The chart shows that Alder Hey has a higher mortality level than the average NHS performance with 60 deaths against 57.1 expected deaths. However Alder Hey's SPMI is similar to the hospital's with similar work load – Birmingham and Bristol.

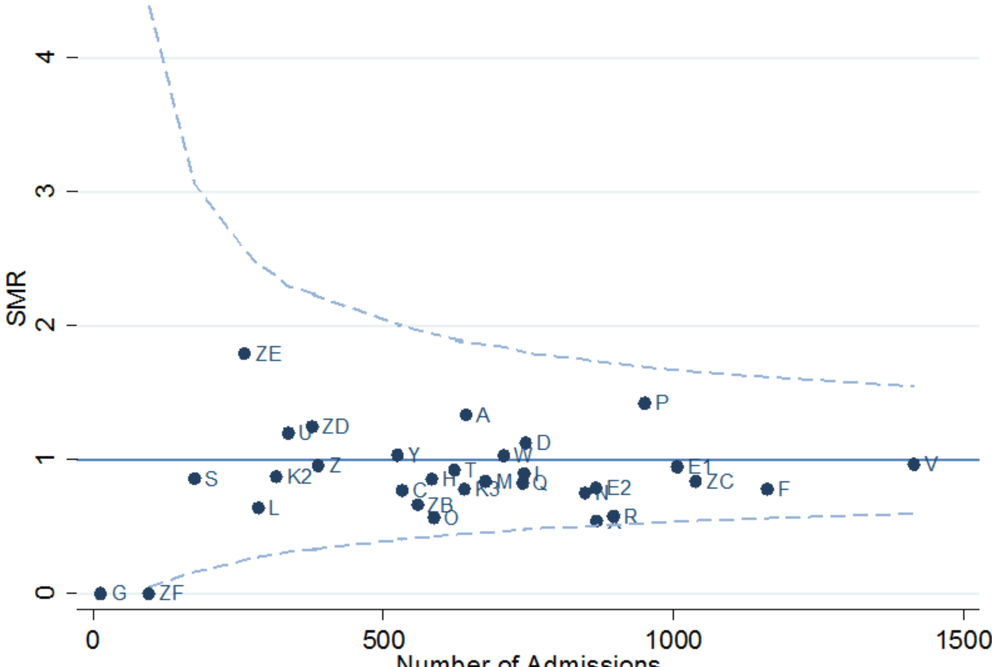
b) External benchmarking against comparator organisations for specific patient groups in addition to HED.

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

PICU

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

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



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

Conclusions

The HMRG is functioning well and is continuing to adapt and improve according to national recommendations. We continue to review every in-patient death in HMRG and the majority of deaths have at least one departmental/service group review in addition.
There is clearly considerable amount of work to be done to improve the process and increase engagement and communication across the Trust. Learning from deaths is the key goal and we are now trying to ensure that this occurs across the organisation.
The statistics relating to paediatric deaths are difficult as they are so many variables and different figures cover slightly different aspects.
The Trust that is the most comparable to AHCH is probably Birmingham children's Hospital NHS Foundation Trust and we are comparable to them with both SPMI and HSMR which is reassuring.

Alder Hey uses VLAD charts to monitor the trend in mortality in cardiac surgery; the latest chart shows observed mortality is lower than expected

mortality. All cardiac surgery patient deaths will be reviewed in the Cardiac M&M meetings and also the HMRG.

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

Trust Board

3rd July 2018

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

1.0 Executive Summary

The purpose of this paper is to provide the Board with an update on the progress of the Trusts Global Digital Exemplar (GDE) Programme; especially the achievement of Milestone Three and measures in place to achieve Milestone Four.

A full update on the GDE Journey thus far and associated achievements will be given at Trust Board.

2.0 Update of Progress

Since the previous update to Board on 22nd May 2018 work has continued to ensure phase four milestones are achieved; primary areas of work include:

Statement of Planned Benefits

The Statement of Planned Benefits for the GDE Programme has been updated and submitted to NHS Digital for review. NHS Digital have made contact with the Risk and Benefit Lead to state that Alder Hey are the leading exemplars for baselining, monitoring and realising benefits alongside our unique, collaborative approach with the Finance Department.

As a result of this positive feedback we have been asked to facilitate a WebEx explaining the process we have adopted to the other GDE and Fast Follower Sites.

GDE Pharmacy Project – Continuous Infusions

After a successful pilot of plasmalyte (+ glucose) prescriptions on Meditech; further continuous infusion fluids have now been digitised and are available to be prescribed and administered in Meditech. This has meant that 100% of clear fluids can now be electronically prescribed.

Now this next step has been accomplished, work has started to bring complex intravenous infusions onto Meditech.

Share2Care – Regional Portal

Progress is well underway with transitioning the portal into live. Six Sites have now completed both Technical and Clinical User Acceptance Testing of the Portal. This ensures the group that users are happy with the contents and functionality provided.
The group are now looking at next steps to ensure further information can be published in the portal such as Labs Results and Clinic Letters.

Benefits baseline: Pre-implementation survey undertaken. Findings identified that 0% of clinicians are able to access clinical information they need easily; 0% are satisfied with the current process for accessing clinical information from other Trusts. Time taken to collate information from other Trusts ranges from hours to days.

E-Consent

E-Consent will provide a means for patients and/or Legal Guardian to consent to treatment electronically. This will ensure an electronic signature can be given and consent can also be emailed to the patient and/or Legal Guardian.

A Task and Finish Group has now been established to review the deployment of E-Consent across the Trust. The Lead for E-Consent is Harriet Corbett, Consultant Urologist, Harriet has agreed for Urology to be the first pilot speciality for E-Consent and work is now underway to ensure a successful workflow is established.

Benefits baseline: E-consent taken in paper format; baseline timings to complete form to be calculated. Patient experience to be monitored throughout the pilot.

3.0 Upcoming Deliverables,

- Review of PACs deployment within EEG and Speech and Language Therapy to ensure full usage,
- Support the deployment of Bi-Directional Texting and the emailing of letters,
- Progress the deployment of Voice Recognition via a Clinical Advisory Group,
- Preparation for Milestone 4 assurance which is due on the 25th July,

4.0 Summary of Key Benefits

Project	Aim	Measurement	Baseline Position	Improvement Target	Actual Progress to Target (current)
PACS and other 'ologies SALT	Improve clinical compliance with Information Governance Legislation	Compliance with legislation around data storage	Uncompliant	Compliant Jun-2018	Compliant Jun-2018
CAMHS Specialty Packages	Increased income – Children & Young People Mental Health Currency Development Project	Funding to be received for participation in the pilot.	N/A	£6,293 Jun-2018	£6,293 Jun-2018
Specialty Packages	Improved efficiency in preparing paper light casenotes for scanning outpatients	Number of specialties with paper light casenotes removed	N/A	1Specialty Jun-2018	Gynae removed Jun-2018

5.0 Milestone Assurance

- A review of current GDE Milestones has been carried out against Trust Operational Priorities and other associated Projects. As a result of this review a decision has been made to realign the milestones; and milestone assurance will be carried out in July, as opposed to May, 2018.

- The next assurance testing has been arranged on the 25th July 2018 and work is underway to provide NHS Digital with all Project Documentation.

6.0 Recommendations

The Trust Board are asked note the progress of the Trusts GDE Programme; the finalisation of Milestone Three and on-going progress towards Milestone Four (31st July 2018).

Peter Young
Chief Information Officer 27th June 2018

ALDER HEY IN THE PARK PROJECT

HIGHLIGHT REPORT Site & Park Development																											SRO: David Powell Author: David Houghton
Programme 2017/18	Mar-18				Apr-18				May-18					Jun-18				Jul-18					Aug-18				
Week Commencing	6	13	20	27	3	10	17	24	1	8	15	22	29	5	12	19	26	3	10	17	24	31	7	14	21	28	
The Park																											New Park project coordinator Rachel Clint now in post. Progress so far includes agreement with park group for the early reinstatement of the first phase of park near Oncology. This approval allowed the submission of planning drawings for park and temporary car park to LCC. Meetings have taken place with universities to consider the development of an outside research lab in Springfield park utilising the space and park users for environmental and health and well being research within university semester subjects. new benches have been chosen and approved by the local parks group and will be installed in the coming months. A brief is being developed for interactive interpretation boards in the forest area to be funded by the Veolia trust.
Decommissioning & Demolition (Phase 1 & 2)							Completed																				Programme progressed as plan and has completed on schedule. Additional work has been agreed within the budget to prepare land levels in preparation for the Alder centre, Community Cluster and temporary car park schemes. Next demolition phase not due to commence until 2019/20.
Future development																											The future development of the North East of the site is still on pause.
Institute Phase II																											Building completion & handover delayed until August 6th. four weeks behind schedule. Trust is arranging early access agreements for Trust commissioning from July so occupancy can still be achieved in September. University lease agreements still to be signed but University user group meetings have commenced successfully with operational policies, furniture choices and AV and IM&T requirements being confirmed and scheduled into commissioning plan. Negotiation continues to reduce additional costs to meet available budget via value engineering and contract negotiation particularly in relation to delays.
Alder Centre																											Following the high cost within building tender returns discussions and regular meetings have continued with architects AHMM and QS to reduce building costs to match available funding. Work has continued with input from Trust Advisors and has generated a large number of value engineered cost reductions but has not met the original target cost. new budget figures being finalised and funding options for shortfall discussed with charity. Design ready, site ready, builder ready but start of scheme on site delayed until final costs are fully covered.
International Design & Build Consultancy																											Jersey design work continues for the next 6 months bringing income into the Trust and enhancing our reputation. Discussion continue with BDP with the intention to develop an MOU and partnership agreement with them particularly in relationship to their existing offices and business in Shanghai and the Far East. Healthcare planning assistance has been requested by Leeds for their new Children' hospital.
Community Cluster Building (Neuro-developmental Hub)																											A range of user workshops with Cullinan Architects has developed the Community Building up to level two design. This freezes the room and department locations and sizes which have all been accepted by the user representatives. Stage three will see the development of 1:50 room layouts and data sheets. DEWI Jones Unit is still in stage two development and designs are developing well with good user involvement and support. Independent QS assessment is being utilised to track affordability as the scheme develops. Ground levels are being adjusted by demolition contractor in readiness for undercroft parking and commencement on site at beginning of 2019
Site clearance																											The agile working group has met regularly to develop and test a plan to accommodate all corporate staff in the Institute phase 2. Operational policies, furniture choices and IT access and equipment are all under review and expected to have a budget impact to accommodate 156 staff into 80 desks with a mix of static and agile. It is expected that this will tests and prove the basics of agile working principles that can be utilised in other buildings across the Trust. The review of Medical Record Services is still awaited to inform the long term projection /requirement for space and storage.
Sefton Services (Relocations)																											Sefton Physio Services have moved to new premise prior to final notice date served on current building. Services are operational with transferred equipment. New furniture install due July 11th to complete the works. Refurbishment works in Burlington House is in progress with CAMHS move scheduled for end of July. Users fully engaged in the process and CAMHS young people involved in design and choice of furniture and fittings Essential changes within the detailed design of the scheme to control access and egress, privacy and dignity and patient choice of therapy furniture have created a cost pressure on the budget expected to be circa £25 on a total of £340k

Alder Hey Children's NHS
NHS Foundation Trust

Clinical Quality Assurance Committee
Minutes of the last meeting held on Wednesday 16th May 2018
10.00 am, Large Meeting Room, Institute in the Park

Present:	Anita Marsland	(Chair) Non-Executive Director
	Hilda Gwilliams	Chief Nurse
	John Grinnell	Director of Finance
	Pauline Brown	Director of Nursing
	Dame Jo Williams	Non-Executive Director
	Jeannie France-Hayhurst	Non-Executive Director
	Steve Ryan	Interim Medical Director
	Cathy Umbers	Associate Director of Nursing & Governance
	Tony Rigby	Deputy Director of Risk & Governance
	Lachlan Stark	Head of Planning Performance
	Steve Igoe	Non-Executive Director
	Erica Saunders	Director of Corporate Affairs
	Melissa Swindell	Director of HR
	Adrian Hughes	Director, Medicine Division
	Christian Duncan	Director, Surgical Division
	Rachel Greer	Associate Coo- Community Division
	Denise Boyle	Associate Chief Nurse, Surgery
	Anne Hyson	Head of Quality - Medicine
	Will Weston	Associate Chief of Operations
	Sarah Stephenson	Head of Quality – Community Division
	Mark Flannagan	Director of Communications
In Attendance:		
	David Porter	Consultant
	Glenna Smith	General Manager – Medicine
	Valya Weston	Associate DIPC
	Tricia Roberts	
	Phil O'Connor	Deputy Director of Nursing
	Julie Creevy	Executive Assistant (Minutes)
18/19/018	**Apologies:**	
	Louise Shepherd	Chief Executive
	Mark Peers	Public Governor
	Mags Barnaby	Interim Director of Strategy
	Jacqui Ruddick	Head of Quality, Medicine Division
	Stefan Verstraelen	Head of Quality, Surgery Division
	Matthew Peak	Director of Research
	Cath McLaughlin	Director, Community Services Division
	Adam Bateman	Acting Chief Operating Officer
	Julie Williams	Governor
	Cathy Wardell	Associate Chief Nurse, Medicine
	Jo McPartland	Consultant Paediatric Pathologist

18/19/19 Declaration of Interest
None declared

18/19/20 Minutes of the previous meeting held on 18th April 2018
Resolved:
CQAC approved the minutes of the previous meeting held on 18th April 2018.

18/19/21 Matters Arising and Action Log

17/18/78 Complaints – AH had identified an appropriate process which was going to be trialled, with Trust Board receiving an update on 22nd May 2018, following discussion at Trust Board paper will be presented at June CQAC meeting.

Action: Complaints position statement paper to be presented to June CQAC meeting.

17/18/80 – Quality Metrics – play app – this item to be removed from action log, presentation due to May CQAC meeting.

17/18/130 – HG confirmed that Acute Care Team Business case had been developed earlier in the year. HG had met with team week commencing 7th May 2018, to discuss additions regarding benefits and activity, with the aim for any outstanding additions to be resolved regarding activity data by the next CQAC meeting. The business case being presented at Investment Review Group. Further meeting with Hilda Gwilliams and supporting team is scheduled for 21st May 2018 to discuss further.

17/18/132 & 18/19/09 – Programme Assurance Update - Committee agreed that this item to be closed and removed from action log.

18/19/05 – 'Super Stranded Children' – Committee agreed that the Community Division would need to give some thought to CQAC receiving a case example. Committee agreed that it would be beneficial to receive a case example on a three month basis/once available.

Action: Community Division to provide case example at August CQAC/ meeting, (should there not be a meeting in August if high apologies are received – to be deferred to September meeting.

18/19/15 – COSH Management – MS stated that she had discussed COSH management with Amanda Kinsella, MS highlighted to the committee that additional resources would be required, which would be addressed during the next few months. COSH training had also been scheduled to take place for a 12 month period. SI confirmed that this action is reported through Integrated Risk Governance Committee and that this action could be removed from CQAC action log, given that progress is tracked through IRG.

18/19/16 AOB – Cleanliness – HG confirmed that she had fedback comments to Facilities team & building team regarding cleanliness. HG confirmed that there are dedicated resources for equipment and cleanliness. HG stated that external contracting team were due on site on 15th May 2018 to address repair of flooring within car park, unfortunately external contracting team did not arrive on site, and D Powell and his team are currently following up an alternative date and time for contractors to attend on site to address issue.

18/19/16 – AOB – Quality Summit – HG confirmed that the Quality Summit had been well attended on 14th May – this item could now be removed from the action log.

18/19/22 Alder Hey Play App

Tricia Roberts presented an update on progress regarding the Alder Hey Play App which had been designed to enable three primary aims:-

- Familiarise the child with the hospital environment
- Reward child for positive health behaviours
- Distract them during down time or when procedures are taking place

- Vision was to ensure a companion that is there for the child at every step of the way in order to reassure, entertain and empower patients, parents and carers, to help to build connections with Alder Hey family.

- App included 4 main sections:-
  - My stuff – games/swop my buddy/sticker store
  - Explore Alder Hey – 360 images of the main hospital areas, accompanied by the child's buddy
  - Learn – earn stickers by learning
  - Explore – earn stickers by exploring

Recognition:-

- March 2017, Alder Play had received the "Most Innovative Collaboration" at the NHS North West Coast Innovation and Research Awards
- On April 7th 2018, Alder Play was featured as an "Inspiring Story" on the Apple Store resulting in over 2,000 downloads in a single day.
- In April 2018, Alder Play received a Graphite Pencil Award as a winner in the digital design for platform and apps at the D&AD Awards.

TR requested senior staff to download and for senior staff to champion the app. TR stated that training would be given and encouraged staff to receive training.

JFH stated that the team should regularly review user's reviews.

Next Steps as follows:-

- Tactical Delivery Stream 1 – Communication and Engagement
- Tactical Delivery Stream 2 – Development and Evaluation would commence in due course.

- Tactical Delivery Stream 3 – Continous development, TR stated that the Trust had submitted a bid for £750,000.
- Tactical Delivery Stream 4 – Adoption and spread via GDE and NHS Digital, with the team hoping to link to electronic record.
- Tactical Delivery Stream 5 – Commercialisation – Devolved nations, Private & International

CQAC noted progress made with regards to the Alder Hey Play app.

AM thanked TR for her update.

18/19/23 DIPC Quarter 4 Report

V Weston presented Quarter 4 Infection IPC Report, key issues as follows:-

- Quarter 3 the Trust had 2 cases (PICU, 3C) MRSA bacteraemia and Quarter 4 – 2 cases (3C) MRSA bacteraemia – both cases were involving the same patient and related to infected portacath, team are managing vascular access.
- MSSA Quarter 3 – 4 cases (3C, 2x3B, 4B) with Quarter 4 – 3 MSSA cases – (1C Cardiac, 2 PICU). Action plans had been developed with the Trust identified by Public Health England as an outlier for MSSA bacteraemia. Significant work had taken place regarding ANTT training for staff.
- E Coli – Quarter 3 – 2 cases -(1C, 3C), with Quarter 4 – 2 cases (PICU).
- Klebsiella – Quarter 3- 4 cases -(3A, PICU, 2x4B) with Quarter 4 – 1 (PICU or 1C Cardiac).
- Pseudomonas – Quarter 3 – 1 case - (PICU), with Quarter 4 – 2 cases 2 - (3A, PICU).
- Cdiff – Quarter 3 - O cases, with Quarter 4 – 1 case (3A) – RCA had been completed, patient is out of area, currently awaiting CCG review.
- Hand Hygiene Day on 2nd May 2018 had been extremely positive with the team planning for the next Hand Hygiene Day in 2019.

VW stated that the Infection Prevention Control team are working with the Sepsis team in order to roll out antimicrobial learning to all staff.

SR stated that the Trust needed to ensure zero tolerance with regards to process regarding hand washing/bare below elbows/mobilisation etc. to ensure zero tolerance is adhered to with regards to cleanliness. Discussion took place regarding training for nursing staff, VW agreed to arrange a follow up discussion with P Brown to address issue regarding antimicrobial training.

Action: VW to liaise with PB regarding training for nurses.

SR asked whether VW had an update regarding Flu campaign. VW confirmed that Jo Keward was leading on the Flu campaign, and that Jo

had a number of discussions to date with regards to planning for the campaign with the team aiming for a continued improvement this year. Discussion took place regarding training for nursing staff, VW agreed to arrange a follow up discussion with P Brown to address issue regarding training.

At the end of Quarter 4 86% (71/83) of the total of deliverables had been completed. 14% (14/83) of the total deliverables are in progress.

LS stated that there is significant opportunity to further develop Infection Control information within the corporate report and this should be aligned to the next phase of the Corporate Report.

CQAC received and noted the Quarter 4 DIPC report.
AM thanked VW for her update.

18/19/24 Sepsis Update

Key issues progress

- IT
  - Development of 'sepsis status'
  - Data linkage
  - Standard documents
  - Outstanding: short term update to standard documents
  - Algorithm error

- Informatics
  - Testing 'sepsis status' data
- ELearning
  - Package on ESR
  - Comms & final tweaks
- CQUINs, DETECT/VitalPAC

- CQUIN 18-19 /2a Screening

Previously:-
  - 100% compliance in 17-18 for ED and Inpatients
  - 'Screening' = PEWS + nursing sepsis assessment *(integral to PEWS)*
- From April 2018…
  - NEWS2 phased integration *(not applicable to paediatrics)*
  - 'Screening' = 'senior clinical decision-maker ' in 2018-19
- Impact
  - Likely failure to achieve 100% in 2018-19

- Next steps
  - Standard documentation – medical 'screening' documentation
  - SSG: determine approach
  - Negotiation on CQUIN 2a measures with commissioners

- **Detetc Study/Vital PAC, next steps:-**

  - Finalise the specification for VitalPAC

- Close liaison (MT / VitalPAC)
- Explore opportunities to run 'sepsis status' in ED

CQAC noted progress to date and key achievements:-

- Pathway Development roll out
- Delivery of CQUIN goals
- Sepsis team established
- Improved awareness
- eLearning package
- Focussed work on key obstacles and key team

18/19/25 Confidential enquiries/national guidance assurance report

S Stephenson presented the Clinical Audit & National Confidential Enquiries Report, key issues as follows:-

- Trust Clinical Audit Plan 2017/18 – Progress with national audits was maintained in 2017/18, however auditing of Trust policy compliance provided difficult due to lack of policy ownership, monitoring processes not clearly defined and capacity to complete policy compliance audits. Registration of the national Neonatal Audit would take place now that the neonatal BadgerNet system is established.

  HG stated the importance of Divisional Leads populating information within the action plan to ensure the completion dates are updated in a timely manner.

  SS highlighted the importance of all teams using standard documentation to ensure that data extraction could be completed in a timely and accurate manner.

- Proposed Trust Clinical Audit Plan 2018/19 – Following discussion with the Medical Director, the Clinical Audit Policy had been updated to reflect that in the financial year 2018/19, the Trust Clinical Audit Lead will work the Deputy Director of Risk & Governance, the Trust's Clinical Effectiveness Leads and the Business Intelligence team to develop processes and resources to allow for regular auditing of clinical activity in line with the priorities outlined in the Care Quality Commission (CQC). Regulations and the Trust's Quality Contract with the Clinical Commissioning Group (CCG) using information recorded on the Meditech system.

- Progress to be made with regards to evidencing Clinical Audit representation at Divisional meetings to ensure that the Trust is evidencing that the ToR are being adhered to.

- In order to enable this work to take place, the Trust Clinical Audit Plan for 2018/19 focusses on the national and local high priorities audits. Where necessary, audits may be scheduled for later in the year to allow for developmental work to take place.

Confidential Enquiries 2017/18

- Data was submitted to all the relevant confidential enquiries.
- Submission of data to MBRRACE-UK Perinatal Mortality Surveillance continued to have clinical oversight from Dr. Julie Grice as Chair of the Hospital Mortality Review Group (HMRG).
- **Areas of Development – Develvement of clinical audit**
  The three clinical divisions had had local clinical audit plans in place in 2017,18, however the monitoring of these plans within Divisions had not been consistent. In 2018/19 work needs to continue in order to ensure that all three divisions are monitoring and reporting on progress of Division Clinical Audit plans as their Integrated Governance Committees.

RCPCH Clinical Audit Training

Clinical Audit training was provided at the request of the Royal College of Paediatric Child Health (RCPCH) to visiting fellows from developing countries in April 2018. This was the third time RCPCH had requested training from Alder Hey.

Use of digital data to support clinical audit

With the move to digital patient records continuing, it is important that the processes for conducting clinical audit changes to make optimum use of the valuable clinical data available to provide 'real time' audit data to support quality improvement. This would reduce the impact on clinician's time and enable audits to be completed in a more timely way.

Policy compliance monitoring

In line with the updated Clinical Audit Policy, clinical audit resources should not be used for routine policy monitoring purposes, except where a specific clinical audit had been specified. Existing monitoring processes should be used where possible, supported by meditech data where relevant. Policy compliance monitoring would be scheduled on a separate plan to the Trust Clinical Audit Plan, to be overseen by the Trust Clinical Audit Lead.

CQAC received the Confidential enquiries/national guidelines assurance report.

CQAC APPROVED the proposed Trust Clinical Audit Plan for 2018/19

SS confirmed that this would be the last Confidential enquiries/national guidance assurance report that she would provide to the committee, and that future reports would be provided by Liz Edwards.

18/19/26 CQC Action plan

CQAC received the CQC action plan and noted progress made to date.

18/19/27 Programme Assurance/progress update

J Gibson provided a Programme Assurance update, key issues as follows:-

- Both the quality and sustainability benefits of the revised work stream are at significant risk given the assurances rating, J Gibson reiterated previous concern expressed regarding the critical importance that the new projects were fully scoped (PIDs) with benefits defined and project

documentation completed by April 2018 Programme Board with Exec sponsor requested to review standards of project working and evidence and resolving issues.

- New projects were completing their 'Initiation' phases and generating all initial project documents during April 2018. Full assurance rating commenced on 1st May 2018 and, from the partial evidence available, the overall ratings were mainly red. JG highlighted the importance that urgent focus be brought to bear to bring the governance and delivery to an improved standard.

- **Best in Outpatient Care -** (new phase)- HG confirmed that the project had been reviewed and that some of the indicators had been redefined. HG confirmed that there is currently a gap within Leadership/matron role/operational role. HG confirmed that progress could be made on a number of the smaller issues. HG highlighted that there would be a delay during May/June given that leadership support would not be in place until July 2018.

- **Brilliant Booking & Scheduling** (new project) **-** LS confirmed that the Hybrid booking programme was well established, and had been rolled out to 4 specialties, Business Case had been presented to Investment Review Group w/c 14th May 2018, resulting in a small number of admin staff to support brilliant booking. Risk assessment had been completed. LS confirmed that the EA, QIA would be addressed on 18th May 2018. LS stated that this project should move to Amber/Green for the next CQAC meeting.

- **Comprehensive Mental Health (new project)** - RG confirmed that there had been significant work taken place in order to readdress the current ratings, RG confirmed that she envisaged that many of the current issues would turn to amber/green for the next meeting. RG stated however that she was not confident that all would be turned green for the next CQAC meeting.

  Patient Flow (new project) – W Weston stated that he had met with N Deakin on 15th May 2018, and that he was confident that outstanding issues would move to amber/green for the next meeting.

- **Sepsis** – HG stated that the Sepsis information would see a marked improvement for the next CQAC meeting and that progress would be made in terms of housekeeping and uploading necessary supporting documentation.

- **DETECT Study** – Using Smart technology to reduce critical deterioration – provisional amber rating as project only recently initiated at April 2018 Programme Board. Full ratings will commence in June 2018.

SI asked for clarification of when the Trust is expected to be on plan. HG confirmed that there would be a reforecast and full update at the next CQAC meeting.

SI reminded all of the importance of promptly evidencing supporting documentation onto SharePoint, in order that all have visibility of progress made.

Action: Exec leads to urgently address ratings, with a full detailed position statement/update to be received at 20th June 2018 CQAC meeting.

AM thanked J Gibson for his update.

18/19/28 Quarter 4 Complaints Report

A Hyson presented the Quarter 4 Complaints report, key issues as follows:-

- The Trust received 31 formal complaints during this period. One complaint from this quarter was subsequently withdrawn from the process by the Head of Quality, Division of Medicine as this was a patient safety incident and investigated using a Root Cause Analysis – mum was satisfied with this proposed method of investigating. Zero complaints started as an informal concern (PALS) within this reporting period compared to 6 last quarter.

  In 2016/17 Quarter 4 the Trust received 20 formal complaints – an increase of 11 complaints received in Quarter 4 2017-18 (31).

  The main category of complaints received in the quarter are:-
  - Access, Admission. Transfer, Discharge - 6 (19%)
  - Consent, Communication, Confidentiality – 6 (19%)
  - Environmental/Structural Issue – 1 (3%)
  - Treatment/Procedure – 18 (58%)

  With the main complaint category relating to parents questioning whether the care their child has received is appropriate and clear remains.

  In Quarter 4 all complaints were acknowledged within 2 days – 26% on the same day.

  Withdrawn complaints – related to SO03452 relating to incident that occurred with child's Gastrostomy tube insertion – After initial investigation it was apparent that this was a clinical incident. A subsequently RCA level 1 had been undertaken with full agreement with parent, parent had received a call and letter summarising the RCA findings and identifying actions required to prevent issue recurring.

  Complaints outcome - 14 complaints were upheld within this quarter and 2 were not upheld. 1 complaint was partially upheld and 9

complaints are ongoing – 2 are second stage complaints and already have outcomes from the first stage.

- All complainants are fully updated regarding any delays in response timeframes.
- Upheld complaints from July 2016 are now uploaded onto the Trusts external facing web page.

Referrals to Parliamentary & Health Service Ombudsman – One contact from the PHSO this quarter – information sent and decision made not be investigate therefore case had been closed.

PALS

- In Quarter 4 2017-18 PALS contacted had significantly increased to 421. The number of contacts within a quarter had not been experience since the time the Trust moved into the new hospital. There are a number of contacts within PALS that are dealt with/assistance provided but are not formally logged on Ulysses. There are also some concerns that may take several hours to investigate with a variety of required communications.
- PALS concerns are received in a variety of methods, phone calls, emails, written and face to face. Phone calls and face to face equate to 65% of the contacts, whilst the written concerns account to 35%.
- Further work required to look at main issues/themes within Quarter 4 to review high categories and fully understood the root of the issue and to review what the Trust can do to enable improved patient experience to decrease the number parents raising concerns about appointments.
- Compliments are recorded on the Ulysses system and shared with relevant teams.

RG stated that there is a significant issue regarding waiting times at Sefton. Team had met with CCG on 15th May 2018, to discuss the demand issue, the Trust is constrained by the number of staff, together with significant demand.

Community Division now have a dedicated PALS officer to support the division.

RG stated that a recent meeting had taken place with S Ryan and Z Bassi to discuss the issue regarding ADHD patients who are beyond the age of transition to address current issues.

HG stated that Exec Team are all aware of current waiting time appointment/issues relating to Community Division. HG confirmed that A Bateman & H Gwilliams are reviewing the situation and plan to undertake a mapping exercise in order to agree recovery plan. CQAC welcomed a ‘deep dive’ approach into issues currently faced by Community Division.

CQAC agreed it beneficial for an informal review of complaint information/correspondence.

Action: AH/JC to agree appropriate timing.
AM thanked AH for her update.

8/19/29 KIRKUP report

ES presented the KIRKUP report. E Saunders stated that following discussion with H Gwilliams assurance could be provided to CQAC that the Trust did not inherit any of these services/cases.
Alder Hey inherited 120 staff, with all staff having received extensive support on arrival, and staff were fully embedded within the Trust. A mini staff survey had been undertaken which provided positive feedback. Issue was well handled and was well led. Feedback would be provided at a Trust wide learning session scheduled on 11th June 2018.

SI queried whether there was any shared learning regarding different levels of experience for staff when Alder Hey team left Liverpool Community Health. ES confirmed that there was a remarkable difference for staff.

HG stated that there was an historic incident relating to prison service which was handed back to Merseycare. HG had shared the external review with Trust solicitors, but incident handed back to Merseycare.

AM thanked ES for her update.

18/19/30 Corporate Report – Quality metrics

HG presented the Corporate Report Quality metrics, key issues as follows:-

- **Patient Safety** – March maintained zero grade 3 and above pressure ulcers, along with zero never events. There were 3 readmissions to PICU in month. There were 94 incidents with associated harm reported in month, 2 of which were of moderate harm. There were 6 medication errors resulting in harm, given 32 for this year, compared to 60 last year. This has maintained and overachieved the sign up to safety three year targets to reduce harm from the medication errors by 50%.
  HG stated that focus would be given to continue to review Pressure ulcers and a group would be established to review.
- **Patient Experience** – There were 5 complaints in March, a marked reduction on the previous month. This is 90 complaints for the year compared to 70 last year. There was a slight reduction in PALS attendance to 129 in March. A&E and Outpatients remain slightly behind the Family & Friends target, whilst inpatients, community and mental health are ahead of target, although the number of responses in mental health remained low. Inpatient satisfaction showed improvement in 3 out of 5 questions, although “knowing the planned date of discharge’ remains the poorest performing measure.
- **Clinical Effectiveness** – There were 4 infections recorded in March, which is 84 for the year, a significant reduction compared to 104 infections last year. There were zero MRSA bacteraemia, which remains at 4 year to date and after 15 months without a C.difficile infection, there was one infection in March, which is the subject of an investigation. The

percentage of patients receiving antibiotics within 1 hour increased to 61% whilst for in-patients this dropped to 79%. There were 6 hospital deaths in March 2018, given 65 for the year, as opposed to 74 in the previous year.

AM thanked HG for her update.

18/19/31 Quality Account

TR presented the Quality Account and requested formal approval of the Quality Account 2017/18.

CQAC noted the contents within the Quality Account.

Next Steps:-

- Final sign off by CQAC – 16th May 2018
- Sign off by Trust Board – 22nd May 2018
- Insert commentary from Health watch and Clinical Commissioning Group
- Complete Statement of Directors responsibilities
- Insert Auditors statement from Ernst & Young
- Send to NHS Improvement prior to the end of May 2018
- Incorporate into Annual Report
- Publish on NHS Choices before 30th June 2018

CQAC APPROVED the Quality Account for 2017/18.

AM thanked TR for his update.

18/19/32 Board Assurance Framework

ES presented the Board Assurance Framework. ES confirmed that there had been no significant additions, with no issues to raise presently.
AM thanked ES for her update.

18/19/33 Review progress against the NHSI Quality Framework

ES presented the Self-Assessment against the Quality Governance Framework position as at April 2018. ES confirmed that the framework is regularly reviewed in order to maximise responsiveness, ensuring correct clinical infrastructure. ES confirmed that 2019 audit Plan would be shared with MIAA to test.
CQAC received and noted Self-Assessment.
AM thanked ES for her update.

18/19/34 External Visits Register

ES presented the External Visits Registers for 2017/18. ES confirmed that the register currently detailed 22 regulatory visits. J Preece is working with divisions to regularly update the register as and when appropriate.
ES reminded all of the importance of Divisions updating J Preece and providing appropriate action plans in order for the register to be frequently updated.

CQAC received and noted the contents of the External Visits Register.
AM thanked ES for her update.

18/19/35 Clinical Quality Steering Group key issues report
PoC presented the CQSG key issues report.
CQSG Key issues as follows:-

- CQUIN progress particularly in relation to the Paediatric Network care initiative as it continues to be at a high risk of non-delivery. – P O'Connor had meet with Leads from Surgery together with Service Manager, Paediatric Network had sent out a proposal, the Trust is currently waiting on a response from NHSE.
- Audit of Safe Receipt of Medications – An Audit tool had been established for the day and evening pharmacy porter. Key issues identified in the audit were that the porter was delayed in accessing theatres and that CD bags did not have safety tags attached. Key outcomes included changing the audit to also consider porters role and that of Pharmacy.
- Divisional Dashboards – Medicine - POC confirmed that the catastrophic incident reported in January relating to a delay in speech and language appointment - PM had downgraded this incident.

CQAC received and noted Clinical Quality Steering Group key issues report.

AM thanked POC together with CQSG members for continued support to CQAC.

18/19/36 Clinical Quality Steering Group Annual Report
PoC presented the Clinical Quality Steering Group Annual Report, key issues as follows:-

- CQAC noted the constitution, purpose and membership of the Clinical Quality Steering Group.

Achievements as follows:-

- An extreme thorough review of the CQSG work plan had been undertaken during 17/18 and had subsequently been revised. Reviewing the work plan had included capping the numbers of monthly reports and ensuring a balanced flow of presentations across the year, whilst ensuring adequate amounts of time are available for discussion.
- Divisional Governance structure feeding into CQSG during the year. Heads of Quality had devised draft reporting dashboard to provide assurances around the quality key performance indicators, this continues to evolve.
- Monthly key issues report submitted to CQAC had been received favourably by CQAC Chair, to provide assurance to CQAC.
- Policy compliance continued to steadily increase though the year and currently stands at its highest. A policy ratification

committee outside of CQSG had been established in order to free up time at CQSG for report review.

- CQSG had met its responsibilities through self-assessment and review of the agreed work plan.
- CQSG ToR had been reviewed to reflect organisation structure changes.
- CQSG had complied with good governance practice and had fulfilled its responsibilities in accordance with its ToR and 2017/18 work plan. The CQSG ToR will be reviewed by CQSG in 2018/19 and if necessary a revised work plan would be agreed thereafter.

CU highlighted the lack of medical engagement at CQSG and the requirement to ensure clinical representation, HG confirmed that she would discuss this off line with Medical Director.

Action: H Gwilliams to feedback to S Ryan to aid medical engagement going forward.

CQAC received and noted the contents of the CQSG Annual Report.
AM thanked PoC for his update and extended thanks to CQSG members.

18/19/37 Any other business

JFH shared her experience regarding car parking and highlighted that some front of house staff would benefit from improved customer care skills.

Action: HG confirmed that she would feedback to appropriate personnel and that she would also ask the appropriate facilities team to look into pressures regarding car parking.

18/19/39 Date and Time of Next meeting -

10.00 am – Wednesday 20th June 2018, Large meeting room, Institute in the Park.

Integrated Governance Committee - Annual Report 2017/18 - DRAFT

The Integrated Governance Committee

The purpose of the Integrated Governance Committee is to:

- Ensure processes, structures and responsibilities are in place for identifying and managing risks at all levels of the organisation from wards and departments to Board Committees.
- Ensure the maintenance of a comprehensive corporate risk register, with risks prioritised with appropriate action plans in place and managed.
- Develop a culture of risk awareness across the Trust.
- Ensure the Trust maintains a Board Assurance Framework (BAF) that is reviewed by the Committee, and presented to the Trust Board at each of their meetings.
- Ensure each Division, Corporate Function and The Change Programme maintain an up-to-date risk register, and are actively managing the identified risks.
- All Division's, Corporate Departments and the Change Programme are subject to review and challenge of their progress in embedding risk management, in line with the Committees work programme.
- Ensure the Trust has an up-to-date Risk Management Strategy, BAF Policy and associated policies that comply with relevant regulatory, legal and code of conduct requirements.
- Approve policies and procedures required for effective Governance including Risk Management and practice.
- Support the ongoing embedding of good Governance, including effective Risk Management across the Trust by initiating and overseeing training and awareness initiatives across the Trust.
- Advise on mandatory training requirements for Governance including Risk Management.
- Ensure any learning from the identification of risks, incidents and action plans are communicated throughout the Trust.

Constitution

The Membership comprises one Non-Executive Director, who currently chairs the committee, Executive Directors, plus Associate Director of Nursing and Governance, Associate Chiefs of Operations x3, Associate Chief Nurses x3, Head of Building Services, Head of Interim Estates and Capital Planning, Head of Soft Services (Facilities), Division Heads of Quality x 3, Deputy Director of Risk & Governance, Information Governance Manager, Business Continuity Manager, Chief Pharmacist, Health and Safety Manager

IGC meets bi-monthly and the schedule of attendance for 2017-18 is shown in Appendix A, There was one additional meeting held this year in February.

The Board is provided with assurance monthly about progress with the governance including risk management agenda. The minutes from each IGC meeting is provided to the proceeding Board showing the key issues and outcomes from the Committee meeting. In addition the Board Assurance Framework (BAF) is provided to the Board at each meeting.

Achievements in 2017/18

Trust wide review of risk management systems processes and outcomes, to determine Trust position, in term of compliance with the risk management strategy. The findings prompted a revision of the management of risk and the following changes have been successfully implemented.

- Development and implementation of task and finish group to validate risk registers across the organisation. This included Executive Directors, Senior Corporate Managers, the senior team for each of the Divisions and a fourth for corporate services including, Medicines Management & Pharmacy, Health and Safety, Infection Control, Information Governance & Records Management, IM&T, Business Continuity & Emergency Preparedness, Estates & Building Services, Human Resources, Finance, GDE project, Research and Facilities (soft services).
- The Trust has continued risk validation meetings monthly with Divisions and Corporate Functions, ensuring support is provided, challenge where required, and management of risks from 'ward to board' is consistent.
- Development and implementation of risk management reporting template for IGC risk management reports, to ensure consistency of risk reporting and enable IGC committee be assurance of consistent progress with the management of risk
- Each Division and Corporate Service present their risk register reports for scrutiny at each IGC, focusing on high risks, and other lower level risks that may impact on the achievement of Corporate Objectives. Moreover, there is an emphasis on assurance, that each and every risk is being managed effectively, i.e. risks clearly identified from assessment, risk rating reflects assessment of controls, gaps in controls, actions for improvement and progress with actions, review completed in line with timeframes identified on risk assessment, and appropriate escalation completed in a timely manner.
- All additional reports presented to the committee concentrating on level of risk associated with the issues being presented, and actions to mitigate those risks to enable achievement of target risk rating.
- The Corporate risk register is presented for scrutiny at each IGC meeting and include all high risks, which are clearly linked to Corporate Objectives.
- The BAF is updated and presented for scrutiny at each IGC meeting.

- Additional IGC meeting held to accelerate risk management learning, development, and associated assurance.
- Clear lines of accountability and responsibility for the ownership and management of risk identified and embedded.
- Risks elevated to 15 or above transferred to relevant executive, until mitigated to at least a high moderate (meaning risk score = 12), and at that point transfer back to local risk owner. Management of the risk locally, remains with the identified risk manager/function where risk originated as identified on the register.
- Risk 'Management training including training on the risk register provided to groups and individuals as and when required and on request.
- Governance and Quality Assurance web page developed on the Trust intranet, to support staff
- A significant number of new reports have been developed on the Ulysses risk management system to support staff. Additional staff support has been provided through the development of risk management 'step by step guides', including action guide, communication guide, guide to the risk register and risk matrix assessment guide. All guides available on the governance and quality assurance web page on the intranet.
- Significant reduction in high risks achieved across the Trust.
- The Committee approved and monitored its annual work programme and the effectiveness of each meeting is assessed by the Chair and Director of Corporate Affairs. The meeting is subject to scrutiny by Internal Audit as part of their annual audit plan and ongoing review of the risk management systems and processes.

Assurance Statement

Based on the information provided, the Committee members can confirm that the assurance framework is fit for purpose and that the control environment is operating at a satisfactory level with areas to improve on highlighted below. IGC also agrees to the declaration reported to the Board in respect of the Annual Governance Statement.

Committee Priorities for 2018/19

Whilst the Committee has performed its duties as delegated by the Board it has identified a number of areas to focus on during 2018/19:

- The Committee will continue to hold Directors and others to account for the effective management of governance and risk through support and challenge to provide assurance to the Trust Board that all necessary actions to support the achievement of the corporate objectives is being applied effectively.
- Continue to monitor the effectiveness of the devolved governance model and receive assurance that risk management is owned and managed locally and that this is providing an effective ward to board system of governance.

- Support the ongoing enhancement and functionality of the Ulysses risk management module as well as further development as required.
- The Committee will ensure a coherent and integrated approach to Governance including risk management & governance through the Risk Management Strategy and associated policies.

Steve Igoe
Committee Chair
24 May 2018

APPENDIX A

IGC - RECORD OF ATTENDANCE 2017/18

Quorum: Chair or nominated deputy, two Executive Directors (one of whom is a clinical lead)
(if the Medical Director cannot attend then, one of the Clinical Directors should deputise for them)*

Members

	24 May 2017	11 Jul 2017	27 Sept 2017	1 Nov 2017	10 Jan 2018	16 Feb 2018	14 Mar 2018	TOTAL
Mr S Igoe **(Non-Executive Director)**	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	7/7
Mr S Ryan **(Medical Director)**	✓	✓	X	✓	✓	X	X	4/7
Mrs P Brown **(Director of Nursing)**	✓	✓	X	✓	✓	✓	X	5/7
Mags Barnaby **(Interim Chief Operating Officer)**	✓	X	X	X	X	N/A	N/A	1/5
Adam Bateman **(Chief of Operations)**	N/A	N/A	N/A	N/A	N/A	✓	X	1/2
Mrs M Swindell **(Interim Director of HR)**	✓	✓	✓	✓	✓	✓	✓	7/7
Miss E Saunders **(Director of Corporate Affairs)**	✓	✓	✓	✓	✓	✓	✓	7/7
Mr J Grinnell **(Director of Finance)**	✓	✓	✓	✓	✓	X	✓	6/7
Mr D Powell **(Development Director)**	✓	X	X	X	X	X	X	1/7

Attendees

	24 May 2017	11 Jul 2017	27 Sept 2017	1 Nov 2017	10 Jan 2018	16 Feb 2018	14 Mar 2018
Cathy Umbers – Associated Director of Nursing & Governance	✓	✓	✓	✓	✓	✓	✓
Andy McColl - Associate Chief of Operations (Surgery)	n/a	n/a	n/a	n/a	✓	✓	✓
Adam Bateman – Associate Chief of Operations (Surgery)	X	X	✓	✓	n/a	n/a	n/a
Denise Boyle – Associated Chief Nurse (Surgery)	X	X	X	X	X	✓	X
Will Weston – Associate Chief of Operations (Medicine)	✓	Deputy	Deputy	Deputy	Deputy	Deputy	✓
Cathy Wardell – Associated Chief Nurse (Medicine)	X	✓	✓	✓	✓	✓	X
Andrew Williams – Director of CAMHS	n/a	Deputy	Deputy	Deputy	X	Deputy	Deputy
Rachel Greer – Associated Chief of Operations	X	✓	✓	✓	Deputy	✓	✓
Catrin Barker – Chief Pharmacist	X	X	X	X	X	✓	✓
Charlie Orton – Associated Chief Operating Officer (Research)	X	X	X	X	X	✓	X
Valya Weston – Associate Director of Infection Prevention and Control	X	✓	✓	✓	Deputy	Deputy	Deputy
Liz Edwards – Divisional Head of Quality (Surgery)	n/a	n/a	n/a	n/a	n/a	✓	✓
Claire Liddy – Deputy Director of Finance	X	X	✓	✓	Deputy	Deputy	Deputy
John Williams - Assistant Director of Estates	Deputy	X	Deputy	✓	Deputy	Deputy	Deputy
Sue Brown – Associate Director (Development)	✓	X	✓	X	✓	✓	X
Mark Deveraux - Head of Soft Services	X	✓	✓	✓	X	✓	✓
Tony Rigby – Deputy Director of Risk & Governance	X	X	✓	X	X	✓	✓
Graeme Dixon –Operational Lead (Building Services)	X	✓	Deputy	✓	X	✓	✓
Sarah Stephenson - Head of Quality (Community)	✓		✓	✓	✓	✓	✓

Dave Walker – Divisional Head of Quality (Surgery)	**n/a**	**n/a**	**n/a**	**n/a**	X	X	X
Anne Hyson - Head of Quality (Medicine)	✓	✓	✓	✓	X	X	✓
Lesley Robinson – Quality Assurance & Compliance (Medicine)	X	X	✓	X	✓	✓	X
Elaine Menarry – EP & Business Continuity Manager	✓	✓	✓	✓	✓	✓	✓
Amanda Kinsella – Health & Safety Manager	✓	✓	✓	✓	✓	✓	✓
Liz Baker – Information Governance Manager	X	✓	✓	✓	X	X	X
Kerry Morgan – Deputy Head of Information	X	X	X	✓	✓	✓	✓
Cathy Fox – Head of Informatics	X	X	✓	✓	**Deputy**	**Deputy**	**Deputy**
Jill Preece – Governance Manager	✓	**n/a**	**n/a**	**n/a**	✓	✓	✓

INTEGRATED GOVERNANCE COMMITTEE
14th March 2018
Time: 13:00-15:00
Venue: Institute in the Park, Large Meeting Room

Present:

Mr S Igoe	Non-Executive Director **(Chair)**	(SI)
Mr J Grinnell	Director of Finance	(JG)
Ms E Saunders	Director of Corporate Affairs	(ES)
Mrs M Swindell	Director of HR & OD	(MS)

In Attendance:

Mrs A Hyson	Head of Quality (Medicine)	(AH)
Mrs A Kinsella	Health & Safety Manager	(AK)
Mrs E Menarry	EP and Business Continuity Manager	(EM)
Miss L Calder	Quality Assurance Facilitator (Minutes)	(LC)
Mrs L Edwards	Quality Assurance Manager	(LE)
Mr T Rigby	Deputy Dir. of Risk & Governance	(TR)
Mrs L Robinson	Quality Assur & Compliance Manager	(LR)
Mr A McColl	Assoc. Chief of Operations (Surgery)	(AM)
Ms K Morgan	Deputy Head of Information	(KM)
Mr G Dixon	Operational Lead (Building Services)	(GD)
Mrs A Chew	Head of Operational Finance	(AC)
S Stephenson	Head of Quality (Community)	(SS)
Mr M Devereaux	Head of Facilities and Soft Services	(MD)
Mrs C Barker	Chief Pharmacist	(CB)
Ms J Gwilliams	Clinical Risk Manager	(JG)
Mr W Weston	Assoc. Chief of Operations (Medicine)	(WW)
Mrs R Greer	Assoc. Chief of Operations (Community)	(RG)
Ms J Preece	Governance Manager	(JP)
Mrs J Keward	Lead Nurse, Infection Prevention	(JK)
Mrs J Hutfield	Compliance, Risk & Contracts Manager	(JH)
Mrs L Fearnehough	Head of Technical Services (IM&T)	(LF)

Apologies:

Mr D Powell	Development Director	(DP)
Mr S Ryan	Medical Director	(SR)
Mrs L Robinson	Quality Assur & Compliance Manager	(LR)
Mrs C Orton	Assoc. Chief Operating Officer (Research)	(CO)
Prof M Peak	Director of Research	(MP)
Mrs H Gwilliams	Chief Nurse	(HG)
Mrs V Weston	Infection Control & Prevention	(VW)
Mrs D Walker	Head of Pharmacy	(DW)
Ms L Baker	Information Governance Manager	(LB)
Mrs C Wardell	Assoc. Chief Nurse (Medicine)	(CW)
Mrs C Umbers	Assoc. Dir. Nursing & Governance	(CU)
Mrs S Brown	Assoc. Dir. (Development)	(SB)
Mrs P Brown	Director of Nursing	(PB)

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Item No	Item	Key Point Discussions		Action	Owner	Time Scale
Housekeeping						
The meeting was noted as not quorate.						
	1.	**Apologies for absence**	Noted			
17/18/106	**2.**	**Minutes of previous Meeting**	The Committee considered the minutes of the previous meeting of the Integrated Governance Committee held on 16th February 2018. The Committee **APPROVED** the minutes as a correct record.			
	2.2	**Action list**	**Resolved** that: the Committee agreed all actions from 16th February 2018.		SI/CU	
	3.	**Risk Register Management Reviews**				
17/18/107	**3.1**	**Surgery Division**	Andy McColl (AM) presented the risk management report for Surgery. AM focused on the high risks from the Surgical Division for this reporting period. Risks from the Surgical Divisions report were highlighted as follows: • Total number of risks = 78 • Number of new risks identified since the last reporting period = 5 • Number of risks closed and removed from the risk register =10 • Number of risks with an overdue review date = 3 • Number of risks with no agreed action plan = 1 • Number of high/extreme risks escalated to the Executive Team = 3 AM advised there has been a significant reduction in the surgical division overdue risks currently showing as 3, compared to		AM	

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Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			December 17 which was showing as 47 risks. We continue to have critical care showing the most risks however the surgical division is in a much better position. There are 3 high risks with a score of 15: 1306 – Concerns around the junior doctors' shortage in surgery has been reduced from a risk score of 15 to 12. Risk 1276 – Medical Equipment Replacement strategy – SR, BL and JG met to discuss and there has been some progress on this. We need 1 million to buy the new equipment. BL advised it's not essential to replace all equipment. The replacement items have been ordered. We have made good progress on this however it will still show as a risk of 15 until the ordered items are received. Risk 964 – The key actions of pre-op service case unit went to the Operational Board. AM not had the feedback yet. The main reason this is sitting at a risk of 15 is due to the delays in patients going to theatre. Risk 424 – risk of transmission of vCJD – Implementation date has been pushed back to April 2018 to ensure all correct equipment is in place and the remaining equipment has been purchased. JG advised the gross and net score has stayed the same, are you taking any mitigated actions? AM advised the risk is because we are still not compliant as whilst risk is identified it's not mitigated yet. We have reduced the scale of the problem we need to review and implement the progress. AM advised the committee that although there is ongoing work required, the division are comfortable with the progress and expect further work to be completed prior to the next reporting period. **Resolved** that: the Committee NOTED the contents of the paper			Immediate
17/18/108	**3.2**	**Medical Division**	Anne Hyson (AH) presented the risk management report for Medicine. Risks from the report were highlighted as follows:		WW/CW	

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Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			• Total number of risks = 138 • Number of new risks identified since the last reporting period = 13 • Number of risks closed and removed from the risk register = 12 • Number of risks with an overdue review date = 12 (9%) • Number of risks with no agreed action plan = 18 • Number of high/extreme risks escalated to the Executive Team = 3 AH focused on the high risks from the Medical Division for this reporting period. Risk no 1210 – Failure of date migration of Legacy Patient Pathology results and reports from Meditech 5 to Meditech 6 resulting in loss of patient data prior to June 2015. Exec support is needed to ensure the migration of data is completed before Meditech 5 is closed. The migration process needs to be included in the GDE Project discussions so that a clear plan of action is agreed and implemented with appropriate timelines in place. Risk no 1144 – Delay in turnaround time of all patient related clinical correspondence of just over 2 weeks, resulting in incomplete patient records. Potential delay in patient treatment plans. 4 key points plan were approved at Ops Board on 25th Jan 18. Actions commencing but current rating and status remains as is with 11,500 in backlog and turnaround time is an average of 25-35 working days. Risk no 1344 – Pharmacy and ASU cold stores failure. There have been 4 failures to date including latest on 7th Feb 18. The policy carries an excess of £20k per claim. If cold stores keep failing,	Action BST to contact interserve and		Immediate

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			possibility Insurers (NHSR) will refuse to indemnify unless resolution sought. Interserve to obtain report from Green Cooling (Manufacturers of equipment) for report regarding failures. CB advised she is still awaiting a decision Costings to be sought for back- up system. CB advised she is still awaiting a decision from Interserve. BST to advise. AH advised the committee that the Medical Division are satisfied with progress, while recognising that ongoing work is required to enable assurance of effective management of risk across the division. **Resolved** that: the Committee NOTED the contents of the paper	advise CB		
17/18/109	**3.3**	**Community Division**	SS presented the risk management report for Community. Risks from the report were highlighted as follows: • Total number of risks = 51 • Number of new risks identified since the last reporting period = 6 • Number of risks closed and removed from the risk register = 4 • Number of risks with an overdue review date = 5 • Number of risks with no agreed action plan = 6 • Number of high/extreme risks escalated to the Executive Team = 1 • Changes in the risk profile or categories of risk being reported that need to be brought to the attention of the Integrate Governance Committee = 0 SS presented the risk management report and focused on the high risks identified for community. SS presented the corporate risks reduced on the risk register down		RG/SS	

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Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			to 1 risk: Risk 1524 – Lack of appropriate services to transition patients with ADHD. Risk of harm due to inappropriate care or advice provided to patients by paediatricians with lack of clinical knowledge about this age group. Letter has been sent to the CCG and a meeting is being arranged. SS advised the committee that the division are confident they are keeping on top of all risks in terms of effective management. **Resolved** that: the Committee NOTED the contents of the paper			Immediate
17/18/110	**3.4**	**Infection Control Service**	JK presented the risk management report for Infection Prevention Control. Risks from the report were highlighted as follows: • Total number of risks = 17 • Number of new risks identified since the last reporting period = 3 (2 added by IPC and 1 acquired regarding water safety). • Number of risks closed and removed from the risk register = 3 • Number of risks with an overdue review date = 0 • Number of risks with no agreed action plan = 0 • Number of high/extreme risks escalated to the Executive Team = 3 • Changes in the risk profile or categories of risk being reported that need to be brought to the attention of the Integrate Governance Committee = 0 • JK presented the risk management report and focused on the high risks identified for Infection Control. .		VW/JK	

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Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			Risk 1439 – Risk of long stay patients acquiring vaccine preventable diseases. There have been conversations with NHSE and I.T. Systems across the Northwest. It has been difficult to acquire patient vaccine information held by GP's and there isn't a central place where the information is held. VW and team to carry on working on this to resolve. Risk 640 – Risk of Hospital acquired Pseudomonas due to Pseudomonas in the water supply. This is being managed through the Trust water safety group. There is also a SOP for cleaning sinks, water sampling in patient areas and labelling of sinks. There is ongoing work being completed to resolve. Risk no 795 – Water Safety on CHP/Retained Estate (Legionella etc). Trust should encourage further water usage across the Trust and increase flushing. JK advised the Water Safety Group is completing wider sampling of the system. JK advised infection control is a hard area to reduce risks as this can be catastrophic to the patients. JK advised the committee that although there is ongoing work required, the Infection Control team are satisfied with the progress at this point. **Resolved** that: the Committee NOTED the contents of the paper			
17/18/111	**3.5**	**Facilities**	MD presented the risk management report for Facilities. Risks from the report were highlighted as follows: Total no of risks 7, new risks since last report 1, risk closed and removed 0, risks overdue 0, no of risks with no agreed action plan 0, high risks need escalating to execs for their support 0 (high risks).		MD	

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Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			New risk no 1440 – Unauthorised Access to Service Yard. This risk was transferred over from Health & Safety. Gantry in the delivery yard needs to be made more secure and safe. MD advised this risk will be on the register for some time until completion of work is carried out. MD advised the committee that although there is ongoing work required, Facilities are satisfied with the progress at this point.			
17/18/112	**3.6**	**IM&T**	LF presented the risk management report for IM&T. Risks from the report were highlighted as follows: Total no of risks 24, new risks since last report 0, risk closed and removed 1, risks overdue 2, no of risks with no agreed action plan 0, high risks need escalating to execs for their support 1 (high risks). Risk 1514 – This risk has been updated due to a number of incidents regarding failed Emergency Bleep calls. There is a telephony task and finish group set up as well as 'speak Easy' task and finish group established in order to validate a baseline of current communication systems and any gaps or risks associated with them and action plans in place associated with trying to resolve/mitigate these. Risk no 865 - Limitation of EPMA functionality within Meditech V6. It was decided at IGC Meeting on 16th Feb 18 that this should be transferred over to IM&T. This was actioned on 3rd March, however this risk has yet to be reviewed by the Head of Clinical Systems to bring mitigation down. LF advised the committee that although there is ongoing work required, the IM&T are satisfied with the progress at this point. **Resolved** that: the Committee NOTED the contents of the paper		PY/LF	
17/18/113	**3.7**	**HR**	MS presented the risk management report for HR. Risks from the		MS	

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			report were highlighted as follows: Total no of risks 4, new risks since last report 0, risk closed and removed 4, risks overdue 2, no of risks with no agreed action plan 0, high risks need escalating to execs for their support 0 (high risks). MS advised the committee that HR have had a thorough review of the risk register and there are no risks to be escalated. Human Resources are satisfied this reflects their current position. **Resolved** that: the Committee NOTED the contents of the paper			
17/18/114	**3.8**	**Finance**	JG presented the risk management report for Finance. Risks from the report were highlighted as follows: There are 6 risks identified on the finance risk register. 0 new risks since last report 0, risk closed and removed 1, risks overdue 0, no of risks with no agreed action plan 0, high risks need escalating to execs for their support 0 (high risks). JG advised the committee that Finance have no new risks identified and there are no risks overdue and no risk with an agreed action plan. JG advised the committee that the Finance department are satisfied with the progress at this point. **Resolved** that: the Committee NOTED the contents of the paper		JG	
17/18/115	**3.9**	**Estates**	JH present the risk management report for **Estates**. Risks from the report are highlighted as follows: Total no of risks 26, new risks since last report 0, risk closed and		DP/JW/SB	

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Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			removed 0, risks overdue 0, no of risks with no agreed action plan 0, high risks need escalating to execs for their support 0 (high risks). JH advised the committee that there are no changes since the last reporting period and Estates are still showing 4 high risks. Risk 1529 – Alarm panel showing disablement? Risk 1530 – Maintenance Records inaccurate and lacking in detail.? Risk 1549 – Flammable store in very close proximity to the medical gas storage (Helium, Nitrogen and CO2) and the liquid o2 storage units. Risk 1409 – Fire break glass - New Hospital. This is currently sitting at 16 on the risk register as we are non-compliant and cannot take off the register until Interserve confirm remedial work has been completed. The fire safety officer is awaiting confirmation from Interserve that the identified risk has had remedial works carried out to eradicate the risk and once confirmed can be closed. JH advised the committee that the Estates department are satisfied with the progress at this point. **Resolved** that: the Committee NOTED the contents of the paper			
17/18/116		**Building Services**	GD presented the risk management report for **Building Services**. Risks from the report were highlighted as follows: Risks on register for Building services. There are 11 risks identified - new risks since last report 0, risk closed and removed 0, risks overdue 0, no of risks with no agreed action plan 0, high risks need escalating to execs for their support 2 (high risks).			

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Item No	Item	Key Point Discussions	Action	Owner	Time Scale
		Risk no 1544 – Corroded Pipework within CHP. This has been transferred from Health & Safety to Building Services for them to manage. GD advised there was a meeting last week to discuss a list of further mitigation and will know further information by Friday 16th March 18. Risk 825 – Internal Balconies. The horizontal handrail there is facilitates for climbing, resulting in the risk of potential fall from the balcony. There was a near miss with patient escaping via the wall. GD advised this is a major piece of work to complete as is the corroded pipework risk. We are still waiting on decisions. MS advised to speak to GD outside of the IGC meeting. Risk 640 – Risk of hospital acquired infection due to Pseudomonas in water supply in the children' health park. Present sampling has taken place in high risk clinical areas such as critical care. This risk is being managed through the Trust water safety group. There is ongoing work being completed to resolve. GD advised the committee that although there is ongoing work required, Building Services are satisfied with the progress at this point. **Resolved** that: the Committee NOTED the contents of the paper	Action GD & MS to speak about risk 825 outside of IGC Meeting		Immediate
17/18/117		**Directorate Projects**	JH presented the risk management report for **Development Directorate Projects**. Risks from the report were highlighted as follows: Risks on register for Development Directorate. There are 24 risks identified - new risks since last report 3, risk			

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Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			closed and removed 2, risks overdue 1, no of risks with no agreed action plan 3 (team to address), high risks need escalating to execs for their support 0 (high risks). JH advised the committee that of the 24 risks 96% have been reviewed in accordance with the agreed review date and 1 risk requires review. Of all 24 risks 21 (88%) have agreed actions with an agreed action plan, 75% of agreed actions have timescales for delivery. Some of the timescales are challenging to be predicted due to on-going discussions with Liverpool City Council; however this score had improved from the 25% in the last reporting period. JH advised the committee that even though ongoing work to complete the Development Directorate are satisfied with the progress at this point. **Resolved** that: the Committee NOTED the contents of the paper			
17/18/118	**3.10**	**Health & Safety**	AK presented the risk management report for Health & Safety. Risks from the report were highlighted as follows: Total no of risks = 7, new risks since last report = 0 Risk closed and removed = 4 (795 – Water Safety transferred to Infection Control register, 1544 – Corroded Pipework transferred to Building Services register, 801 – DBS closed, actions completed. 1440 – Service Yard transferred to Facilities register). Risks merged into existing risk – 1 (794 merged into risk no 809 as they both specifically refer to the Welfare Regulations). Risks with an overdue date = 0, No of risks with no agreed action plan = 0, No of high risks need escalating to execs for their support = 0 (high risks)		MS	

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			Changes in the risk profile or categories in risk being reported that need to be brought to the attention of the Integrated Governance Committee = 3 Due to control and mitigations the following risk scoring profiles have been reduced: Risk no 809 – Welfare Regulations from 12 to 9 Risk no 799 – Control of Contractors from 16 to 12 Risk no 1386 – Lifts from 16 to 12 . SI asked the committee of a general question of the fact some risk have moved around. Is everyone comfortable picking up the transferred risks and are risks sitting with the right people? Committee members concerned were in agreement. AK advised the committee that Health & Safety are satisfied with the progress at this point. **Resolved** that: the Committee NOTED the contents of the paper			
17/18/119 **17/18/119 a**	**3.11**	**Business Preparedness & Associated reports**	Preparedness & Associated reports. Risks from the report were highlighted as follows: Total no of risks 13, new risks since last report 0, risk closed and removed 0, risks overdue 0, no of risks with no agreed action plan 0, high risks need escalating to execs for their support 0 (high risks). EM advised the committee that there are no risks for escalation into the Corporate Risk Register. All up to date except the review dates. However in line with risk no 1376 NHS England EPRR core Standards annual audit and visit risk rated as 12. It was agreed that the CBRNE/HAZMAT training compliance report would be submitted to each Integrated Governance Committee meeting until there is		MS	

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Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			assurance that the Emergency Department staff are up to date with their CBRNE/HAZMAT training. This compliance report is available as Appendix A. Since the last reporting period only one training date has been secured, as a poor turnout only 1 staff member attended. We are now looking at Saturdays for training days, however the training room in Radiology is unavailable so we are looking to find another venue. EM is satisfied with management of risks on register in this area. **Resolved** that: the Committee NOTED the contents of the paper			
17/18/120 **17/18/121**	**3.12**	**Information Governance** **GDPR**	ES presented the risk management report for Information Governance. Risks from the report were highlighted as follows: Total no of risks 8, new risks since last report 0, risk closed and removed 1, risks overdue 0, no of risks with no agreed action plan 0, high risks need escalating to execs for their support 0 (high risks). Risk 1286 – Lack of planning by areas in relation to risk records in retained estate archive rooms may lead to financially inefficient methods of storing of records. ES advised there are sufficient controls in place to reduce this risk from 15 to 12. ES advised the committee that a significant number of actions have already been taken to ensure the Trust is compliant with GDPR, based on the preparation guidance developed by the ICO '12 steps to take now'. We are now raising awareness using PC screensavers and Liz Baker (LB) is providing training sessions to make staff aware. There is a lot of work for updating the policy framework. ES advised the committee that a lot of progress has been made to date and note the residual actions taken so far. ES is confident that all risks have controls in place and is happy		ES	

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Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			where they sit. **Resolved** that: the Committee NOTED the contents of the paper			
17/18/122		**Medicines Management & Pharmacy**	CB presented the risk management report for Medicines Management & Pharmacy. Risks from the report were highlighted as follows: Total no of risks 38, new risks since last report 1, risk closed and removed 2, risks overdue 0, no of risks with no agreed action plan 0, high risks need escalating to execs for their support 1 (high risks). (Risk no 865 Limitations of EPMA System, Risk Manager Martin Levine, Risk Owner John Grinell). JG updated on the background to the risk on 1st March 2018 and awaiting comment from ML. Following the review of Pharmacy and Medicines Management risk register. It was decided that the following risks should be reassigned to departments/closed/considered as residual risks: Reassigned = 1 risk no 865 Closed = 1 risk no 1384 Residual = 13 Risk 1344 – Pharmacy cold store. There has been no back up cold store refrigeration. Pharmacy had 2 cold stores in the design of CHP, one being classed as the back-up refrigeration, however both are in use. There have been 2 cold store failures resulting in a significant financial loss to the trust. An application to Capital planning group is in progress led by the building services team. Risk 1589 – Antimicrobial App. There are issues with updating Apple phones and we are mitigating the risk by sending out reminder to staff. CB advised the committee she is satisfied with management of risks on register in this area.		CB	

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Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			Resolved that: the Committee NOTED the contents of the paper			
17/18/123		**Global Digital Excellence Programme**	KM presented the risk management report for Global Digital Excellence Programme reports. Risks from the report were highlighted as follows: Total no of risks 13, new risks since last report 0, risk closed and removed 2, risks overdue 0, no of risks with no agreed action plan 3 (mitigations in place), high risks need escalating to execs for their support 0 (high risks). Changes in the risk profile of categories of risk being reported that need to be brought to the attention of the Integrated Governance Committee = 3 have decreased risk scores. KM advised the committee that GDE have 3 risks with no agreed action plan but assured there are mitigations in place and they are being managed. KM advised the committee GDE have no risks above moderate risk and is happy with management of risks on register in this area. **Resolved** that: the Committee NOTED the contents of the paper		KM	
17/18/124		**Clinical Research Division**	There was no representative from the Clinical Research Division to present the risk management report. Risks from the report were highlighted as follows: Total no of risks 6, new risks since last report 0, risk closed and removed 0, risks overdue 0, no of risks with no agreed action plan 0 (mitigations in place), high risks need escalating to execs for their support 0 (high risks). Changes in risk profile or categories of risk being reported that need to be brought to attention of IGC = 3			

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Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			SI advised the committee that there is no representative from the Clinical Research division to present the report however after reading the report they are in a much better position than last month. **Resolved** that: the Committee NOTED the contents of the paper			
17/18/125	**4.**	**Corporate Risk Register Review**	ES presented the Corporate Risk Register Review. ES informed the committee that there are 542 risks on the Trust risk register, and the detail is reflected in the Division and corporate functions risk registers. The total number of risks on the risk register is 542 compared to 551 for the previous reporting period. 24 (4.42%) of the Trusts risks are rated as' High/Extreme' risks compared to 42 (7.62%) for the previous reporting period. 365 (64.6%) of the Trusts risks are rated as 'Moderate', compared to 356 (64.6%) for the previous reporting period, of which 155 (29%) risk rated 12 (high moderate) compared to 159 (28.85%) risk rated 12 for the previous reporting period. 123 (22.69%) of the Trust risks rated are as 'low risk' compared to for the 124 (22.50%) previous reporting period. 17 (3.1%) of the Trust risks rated as 'very low risk' compared to 25 (4.53%) for the previous reporting period. All 24 high/extreme risks that have been escalated to the CRR; 3 (12.5%) in the Medical Division, 3 (12.5%) in the Surgical Division. 2 (8.3%) in Community services. 0 (0%) in Research Division. 16 (66.6%) in Corporate Services. **Assurance Concerns**		CU	

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			115 (21%) risk assessments past expected review date, compared to 269 (46.06%) for the last reporting period. 71 (13%) risks do **not** have controls, compared to 105 (17.71%) for the last reporting period. 78 (14.4%) risks do **not** have actions, compared to 76 (13.79%) for the last reporting period. 462 (56.90%) **overdue** actions, compared to 500 (60.75%) for the previous reporting period. ES advised the committee that statistics received show significant improvement in reviewing. High risks still require a lot of work and reviewing. Evaluation of where risks will sit, how they are described and controls as this is not being completed and risks were rated higher than should have been. This is a learning curve for us all and this is evident of where risks sit in the room. Are we all convinced of where the Fire risks sit? JH advised the committee that she speaks to John Spark on a regular basis and actions will be updated on the risk register. SI advised the committee there is still work to be done on this as we need to make sure the information is up to date and clearly articulate mitigations are in place. ES commented on the committee's hard worked and the need to keep up the good work. **Resolved** that: the Committee NOTED the contents of the paper			
17/18/126	**5.**	**Board Assurance Framework (BAF)**	ES presented the Board Assurance Framework. ES advised the committee that the BAF controls have become a little out of date and we intend to get this into an updated format before the year end. Risk title Research, Education & Innovation is an area that has not as much details as others risk titles. **Resolved** that: the Committee NOTED the contents of the paper		ES	
17/18/127		**CQC Plan**	ES presented the CQC Plan.		ES	

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Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			ES advised the committee that work has continued in this area and most activity has been picked up .Going forward Committee to continually look at all areas especially CQAC. ES advised this should be reduced significantly by the next IGC meeting May 18. **Resolved** that: the Committee NOTED the contents of the paper			
	7.	**Policies**				
	8.	**Ad Hoc Reports**				
	9.					
	10.	**Any other business**	SI advised the committee it would be appreciated that all future reports are submitted in a timely manner.	All to submit reports as set out in the committee timetable		

Date and Time of Next Meeting	The next meeting of the IGC will be held on Wednesday 24th May 2018, 2:00pm. Institute, Large Meeting Room

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INTEGRATED GOVERNANCE COMMITTEE
ACTION LIST – March 2018

No	Item	Owner	When	Status
17/18/44	Align ESR with Local Blood Transfusion Training Figures	M Swindell	~~14th March 2018~~ 24th May 2018	MS advised the committee that a new ESR expert will be starting 2nd April 18 and they will work with TS once in post. We need new ESR Expert to start before we can try and address the Blood Transfusion. SI advised MS to bring this back to IGC once new person in post.
17/18/86	Risk of transmission of vCJD	A McColl	11th July	AM advised he has met CU to discuss a solution around compliance. We need to clarify we have the right implementation around decontamination and keep separate to the instruments. AM advised we should have a resolution by June 18
17/18/116	Risk no 825 – Internal Balconies	G Dixon	Immediate	Action GD & MS to speak about risk 825 outside of IGC Meeting.
17/18/108	Risk no 1344 - Pharmacy and ASU cold stores failure	A Kinsella	Immediate	BST to chase progress with interserve.
	Risk Management Report submission	ALL	All future IGC meetings	SI advised the committee it would be appreciated that all future reports are submitted in a timely manner.

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Board of Directors

3rd July 2018

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

1. Staff Engagement

Reward & Recognition

The monthly Star Awards for April are currently with the committee team and being reviewed.

The Reward and Recognition group is currently under review to clarify the purpose and to reaffirm commitment for the year ahead; and how the work of this group interlinks with the work of the newly established Staff Wellbeing Steering group.

Arrangements have been made to celebrate 70 years of the NHS on 5th July 2018 which includes competitions, re-introduction of the Fab Staff Week from 2nd to 6th July 2018 with wards /teams invited to host their own themed parties.

Staff Survey

Local teams continue to undertake conversations about their staff survey data, and actions are being collated across divisions.

Improving staff Wellbeing

The Trust will ensure particular focus over the coming year and beyond is given to improving the wellbeing of our staff. A wellbeing steering group has been set up with representatives from Occupational Health, management, staff side, Counselling, Chaplaincy and others to put in place effective initiatives and support to improve staff wellbeing. The inaugural meeting is due to take place on 2nd July 2018 and this group will report to the Workforce and Organisational Development Committee (WOD).

Alder Hey has also been invited to be part of a national staff health and wellbeing improvement programme being led by NHS Improvement in order to improve the health and wellbeing of our workforce and to reduce sickness absence rates. The first workshop took place on 31st May 2018 in Birmingham and the Trust is in the process of undertaking a full action plan for NHSI which complements the actions of the Wellbeing steering group.

2. Workforce Sustainability and Capability

Education, Learning and Development

Apprenticeships

In order to progress the apprenticeship agenda further, the team have recruited two additional members of staff to support the management, administration and professional assessment and teaching of learners. We have a cohort of 40 learners ready to embark on their apprenticeships in a range of subjects:

1. Management
2. Customer Service
3. Business Administration
4. Health Care Support Services

The team continue to work with managers and staff to promote apprenticeships, and we will be hosting another major awareness session in the Atrium September, with representatives from local colleges who can also deliver apprenticeships in attendance.

Mandatory Training

Core mandatory training as of end of May has reduced slightly but remains above the 90% Trust target, overall mandatory training has also dropped slightly to 89%. Weekly reports continue to be produced by the HR&OD team with specific focus on areas of reduced or lower than expected compliance.

Workforce Diversity

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

Employee Consultations

Hotel Services

The Porter service Organisational Change consultation has been extended to explore any further options with full trade union engagement to bring about a satisfactory conclusion. An offer, which the trade unions agreed to make to the portering group was rejected, and a further review meeting with management and the trade unions is to take place on 20th June 2018 to seek a resolution.

Crisis Care – Community Division

Consultation has concluded on the out of hour's crisis care provision for Single Point of Access (SPA). A counter proposal from staff side has been submitted, agreed with staff side and circulated to staff as the final. This counter proposal has requested an additional WTE to support the rota and is being considered by management, outcome to be confirmed within the next two weeks. The counter proposal has been approved and is part of the final change paper which has circulated by management. The new service will be in operation from early July. Recruitment to fill full the service is now underway.

Employee Relations Activity

The Trust's current ER activity stands at 24 cases. There are 9 disciplinary cases (1 through fast track); 4 Bullying and Harassment cases; 2 grievances; 3 final absence dismissal cases 1 formal capability cases; 3 MHPS Capability cases and 2 Employment Tribunal (ET) cases.

Employment Tribunal Cases

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

- An ET Claim relating to disability discrimination and protected disclosure is scheduled to go ahead will be heard at the Liverpool Employment Tribunal in November 2018.

Corporate Report

The HR KPIs in the April Corporate Report are:

- Sickness rates have increased slightly this month compared to last month (4.52%) to 4.58% in month and the cumulative position is 5.17%.
- Mandatory training compliance dipped slightly in month to 92%, but remains above compliance threshold.
- The PDR window opened again in April, and compliance is expected to reach 90% by the end of July. Current rates of compliance are lower than anticipated, so work is ongoing with the divisions to ensure an improving position.

Workforce Equality, Diversity, Inclusion (EDI) Action Plan

Trust Board July 2018

1. Introduction

Following a discussion at the Board meeting in June 2018, a request was made for the EDI action plan to be presented to Board the following month. The Trust already has a number of identified objectives in relation to the EDI agenda and these are linked to the many statutory and regulatory obligations placed upon the Trust (EDS2, WRES, Equality Act, Public Sector Equality Duty). For the purpose of this report however, the actions are specifically related to the discussion and challenge that was given during the June Board in the desire to see accelerated improvements in two key areas:

- The experience of BAME staff working at Alder Hey
- Increasing the diversity of the Alder Hey workforce to truly represent the community we serve.

2. Purpose of the report

The purpose of this report is to provide the Board with the refreshed Diversity action plan as described above.

3. Recommendations

The Board are requested to support the implementation of the action plan.

4. Performance Management and Review

Progress on achieving the objectives in the action plan will be reported bi-monthly to the Workforce and OD Committee and 6 monthly to the Board.

Appendix 1

2017 Staff Survey data relating to questions in the Workforce Race Equality Scheme (WRES)

No	Question	Trust 2016	Trust 2017	Sector Median
KF25	% staff experiencing harassment, bullying, abuse from public in last 12 months	White 24% BME 30%	White 24% BME 24%	White 22% BME 17%
KF26	% staff experiencing harassment, bullying, abuse from staff in last 12 months	White 24% BME 30%	White 21% BME 28%	White 22% BME 26%
KF21	% believing organisation provides equal opportunities for career progression or promotion	White 81% BME 64%	White 85% BME 75%	White 88% BME 75%
Q17b	In last 12 months have you personally experienced discrimination at work from manager/team leader/other colleagues	White 6% BME 18%	White 5% BME 11%	White 6% BME 14%

Appendix 2 – Diversity Action Plan 2018/2019

1. Improve the experience of BME Staff at Alder Hey

ACTION	DETAILS	RESPONSIBLE
Tackle bullying and harassment of and by staff and support staff to respectfully and successfully challenge problem behaviours.	• Promote 'Freedom to Speak Up' to all staff • Encourage the take up of roles such as the Freedom to Speak Up Champion from our cohort of BME staff • Use 'Fab Staff Change Week' in October 18 to specifically promote anti-bullying • Training of managers to understand the impact and signs of bullying and harassment	Director of Workforce and OD
Further development of the BME Network	• Support the ongoing running of network; ensure members are given time off to attend; promote and communicate the key areas of work to the rest of the organisation; encourage new membership; ensure Board level profile	E&D Lead
Promote and support inclusive leadership at all levels of the Trust	• Include cultural competence training in the Leaders Programme and evaluate the impact. • Improve the understanding and recognition of managers and leaders of hidden and unconscious bias and its potential impact on patient care and staff experience • Training managers in modern and unbiased recruitment methods	OD Team
Ensure that the recruitment interview process is bias free	• Internal audit of recruitment interview process to seek to identify reason(s) for the reduced likelihood of shortlisted BME candidates being appointed by comparison to shortlisted white candidates. Identify action as appropriate. • Explore the potential of recruiting and training cultural ambassadors to support the selection process. • Implement exit interview process and undertake audit of leavers	Recruitment Manager E&D Lead

Engage in local and national Initiatives to support and promote career development and leadership opportunities for BME staff	• Engage with RCN Cultural Ambassadors Programme • Run the Merseyside Reciprocal Mentoring Programme	Director of HR & OD E&D Lead

2. Increase the diversity of the workforce to truly represent the community we serve

ACTION	DETAILS	RESPONSIBLE
Work with local HEIs to increase the diversity of students training with us	• Agree a plan with HEIs to bring a diverse number of students to the hospital that reflect our communities	Director of Workforce and OD Chief Nurse
Engage with local community groups and develop great relationships with them to promote Alder Hey as an employer	• Identify all local community groups and work with them to understand their local and cultural needs and to promote opportunities for training, recruitment, placements etc • Run a publicity campaign within communities, schools, community groups, housing association to let them know of the opportunities available in the Trust.	Director of Workforce and OD
Supporting people into work	• Ensure our apprenticeship scheme is one of our key drivers in employment of staff from diverse backgrounds • Continue with the pre-employment programme, with a particular focus on supporting people from BME backgrounds • We hold a series of outreach speaking events with some of our member on the BME steering groups in schools and other organisations to discuss the opportunities	E&D Lead Apprenticeship Manager Recruitment Manager

Give new BME starters a reason to stay!	• Review induction processes, and ensure we promote an inclusive and culturally sensitive organisation. Promote the benefits that are on offer such as childcare etc	OD Team
Ensure that the recruitment interview process is bias free	• Internal audit of recruitment interview process to seek to identify reason(s) for the reduced likelihood of shortlisted BME candidates being appointed by comparison to shortlisted white candidates. Identify action as appropriate. • Explore the potential of recruiting and training cultural ambassadors to support the selection process. • Use the networks we already have to get referrals from existing BME staff	Recruitment Manager E&D Lead Line Managers
Include diversity in the Alder Hey Branding	• Review of all of our marketing and communications collateral to ensure it reflects a diverse workforce, families and patients	Communications
Engage in national and local initiatives to support BME representation in the workplace	• Take part in the BME Board mentor programme • Implement a work experience scheme for young BME people	Director of HR & OD OD Team

ANNEX A

WORKFORCE & OD COMMITTEE
MINUTES FROM MEETING
15th February 2018

Present:	Ms C Dove	Non-Executive Director (Chair)	(CD)
	Mrs M Swindell	Director of HR & OD	(MKS)
	Mr I Quinlan	Non-Executive Director	(IQ)
	Mr M Flannagan	Director of Communications & Marketing	(MF)
	Mr A Hughes	Divisional Director – Medicine (deputy for SR)	(AH)
	Mrs P Brown	Director of Nursing – (deputy for HG)	(PB)
In Attendance:	Mr J Gibson	External Programme Assurance (Part Attendance)	(JG)
	Ms E. White	Care Pathways, Policies & Guidance	(EW)
	Mr A Bateman	COO	(AB)
	Mrs K Turner	Trust LiA Lead	(KT)
	Mr T Johnson	Staff Side Chair	(TJ)
	Ms G Thomas	Apprenticeship Delivery Manager	(GT)
	Ms M Salcedo	HR Business Partner	(MS)
Apologies:	Mrs J France-Hayhurst	Non-Executive Director	(JFH)
	Ms Dot Brannigan	Patient Governor (Parent & Carer)	(DB)
	Mrs H Gwilliams	Chief Nurse	(HG)
	Mr S Ryan	Medical Director	(SR)
	Ms H Ainsworth	Equality & Diversity Manager	(HA)
	Mrs R Greer	Associate COO – Community	(RG)
	Mrs S Owen	Head of HR	(SO)
	Mr N Davies	HR Business Partner	(ND)
	Mr P O'Connor	Deputy Director of Nursing	(PO'C)

Agenda Item	Key Discussion Points	Action	Owner	Timescale
18/01 Minutes of the Previous Meeting & Meeting Protocol	The Committee considered the minutes of the meeting held on 12th December 2017 and they were **approved** as an accurate record. Introductions were made to the Committee. **Review of WOD Terms of Reference 2018** The Committee received the updated terms of reference. The Committee **approved** the terms of reference.			
18/02 Matters Arising, Actions	The Committee considered the following under matters arising:			

Agenda Item	Key Discussion Points	Action	Owner	Timescale
	17/13 Equality Metrics Report The Committee noted that due to the national issues with ESR, this report will be presented at the next WOD in April 2018. **17/55 Report on Sickness Management Costs** The Committee noted that due to the national issues with ESR and CQC visit, this report will be presented at the next WOD in April 2018.			
18/02 Programme Assurance 'The Best People Doing Their Best Work'	**Programme Assurance Framework – February 2018** 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. JG gave a summary of the report and advised that the Programme Board has now agreed that the following projects should be placed in the programme 'pipeline' until sufficient capacity and capability is in place to decide upon as credible launch date for each of the projects. This will be progressed at the February 2018 Programme Board. Project closure reports, including data on the benefits delivered, are awaited by the Programme Board from Domestics and Specialist Nurse Review Projects. MKS advised that Gerry Thomas the new Apprenticeship Delivery Manager, has joined the Trust and added that evidence of progress around this model will be updated on Sharepoint to inform the dashboard and assurance processes. Apprenticeship update will be a regular agenda item going forward. The Committee **noted** the comments made.			
18/03 Progress against the People Strategy	**People Strategy** The Committee received a presentation from the Director of HR&OD. The presentation outlined how Alder Hey will look to improve the health & wellbeing of children and young people throughout the world by 2020. This will be achieved by inspiring our talented workforce to actively drive quality improvement; supporting the ongoing development of a positive and healthy culture, in which our people can give their best and by investing in our people . The presentation was discussed at the recent February 2018 Trust Board Strategy Day and approved and endorsed by the			

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Agenda Item	Key Discussion Points	Action	Owner	Timescale
	Board. The copy of the presentation was noted as read. Two areas of focus to inform the direction of travel are: **Supply of Workforce** • Have we got enough people with the right skills, doing the right things for our patients and their families • Have we got a pipeline of talent identified – from schools through HEIs? • Are we thinking enough, and being creative enough, about the future workforce we are going to need? • Are we taking advantage of all of the opportunities available – i.e. apprenticeships. **Culture of Workforce** • Are we creating a culture of continuous improvement that engages all staff? • Are we developing the right leadership qualities and skills in our people? • Are we developing our staff in the right way? • Are we caring for our people and allowing them to flourish? • Are we making Alder Hey a brilliant place to work? MKS advised that further updates, to include measurables, will be brought back to the next meeting in April 2018. CL added that how all the above links into the Staff Survey has been adopted by the Board. The Committee **noted** the content of the presentation.	Update on progress	MKS	April 2018
18/04	**Quality Health Report** The Committee received the Quality Health Management Report for the Staff Survey 2017. The Director of HR&OD gave the Committee a summary of the content. The report is noted as read. MKS informed the Committee that analysis for the average data is derived from 8 Acute Specialist Trusts contracted to Quality Health, as such the national average for sectors may differ. The national report is due for publication w/c 19th February 2018. Overall the report tells us we have made significant improvements since 2016, although we still lag behind our comparators. MKS outlined the 'next steps' particular attention was brought to: • Communications of Staff Survey Results to be issued to staff. • Marketing & Communications Director to present a paper to February's Operational Delivery Board. • Discussion will take place at Operational Delivery Board to drill down deeper into the data (what can we learn from Radiology).			

Agenda Item	Key Discussion Points	Action	Owner	Timescale
	• A breakdown of responses to Staff Survey by Dept/Division/Banding. The Committee **noted** the content of the report.			
18/05	**Refreshed HR KPR's for Approval** The Committee received a review of HR KPI's for inclusion in the Corporate Report from March 2018. The plan is to also update Local Divisional Reporting and create a standardised dashboard, with target improvement measures for all divisions and corporate areas. This will include the core HR KPI's, plus additional indicators for Absence & Wellbeing, Diversity & Inclusion, Recruitment, Induction and Labour Date. The Head of Performance Planning is overall lead of the project for the Trusts Corporate Report. The Director of HR&OD gave the Committee a summary of the content and sought approval from the Committee of the proposed HR KPI's changes and the content of additional indicators on the standardised dashboard. The review is noted as read. MKS outlined the amendment/revisions/targets and additional reporting of HR KPI's. Particular attention was brought to Corporate Induction and it was recommended that this KPI be monitored via the HR dashboard/local divisional reporting section of the Corporate Report and the target re-set at 90%. Discussion took place around the practicality of the current practice of holding the Corporate Induction one day/Monday each month and this taking place on the first day of staff joining the Trust. The Committee **approved** the review of HR KPI's/Local Divisional Reporting Dashboard	Agree to look at this as an action	MKS	TBC
18/06	**Employment & Health &Safety Policy Review** The Trust received two reports prepared by the Acting Deputy Director of HR & OD outlining the latest progression made to support the update of both Employment & Health & Safety Policies. The purpose of both papers is to provide the Committee with an updated position in respect of the progress of the policies and to seek approval of the action plan to address expired policies. The following policies are affected: **Employment policies** Organisational Change, Pay Protection, Professional Registration, Learning Activity Support Study Leave, Flexible Working, Retirement, Special Leave, Volunteer & Work Experience Polies.			

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Agenda Item	Key Discussion Points	Action	Owner	Timescale
	Health & Safety Policies Display Screen Equipment & Health & Safety Policies The Committee discussed the reasoning behind the postponement and it was agreed that a sensible approach would be to extend the policies. The Committee agreed that the policies will have an extension to the expiry date of 6th months to September 2018. The Committee **approved** the content of the action plan.			
18/07	**Mandatory Training Update** The Committee received a report produced by the Acting Deputy Director of HR & OD. The report outlines the progression made to support the Trust target of 90% compliance of all recognised mandatory training subjects, with HR & OD team placing particular focus on addressing compliance for core mandatory training. MKS advised that the HR & OD team have worked with department/professional leads and subject matter experts to increase compliance, with the current position over all (as of 9th February 2018) for core mandatory training at 93% compliant. MKS outlined the next steps with the HR & OD team continuing to address all areas of compliance to ensure that not only is this maintained but where possible increased, specifically for medical staffing and for roles specific training. MKS advised that the new Learning & Development Manager has been appointed and will join the Trust soon. The Committee **noted** the significant progress made with mandatory training.			
18/08	**CQC Action Plan February 2018 (reflecting January 2018 position)** The Committee received workforce elements of the CQC Action Plan for monitoring purposes (full plan is monitored at CQAC). The purpose of the CQC action plan is for the Trust to address issues raised, ensure the appropriate action is taken and monitor progress through to completion. The workforce elements taken from the CQC Action Plan and monitored by the Committee are: **Fit & Proper Person (Trust)** Must ensure that robust arrangements are in place to govern the fit and proper person's process. **Safeguarding Level 3 (Trust)** Must take action to ensure all staff who are involved with assessing, planning and evaluating care for children and young people are trained to safeguarding level three in line with the safeguarding and children and young people: roles and competencies			

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Agenda Item	Key Discussion Points	Action	Owner	Timescale
	for health care staff Intercollegiate Document (2014). **Mandatory Training (Trust)** Must ensure that compliance with mandatory training is improved, particularly for medical staff. **Mandatory Training (Medicine/Surgery)** Expedite plans and actions to enable all staff to improve compliance with mandatory training to the Trust's target of at least 90% **Appraisals (Medicine/Surgery)** Improve staff appraisal rates to reach at least the Trust's target of 90% **Appraisals (Medicine/Surgery)** The management team should ensure that all staff receive a full annual appraisal in line with the Trust supervision policy. **Health & Safety** A number of actions have been taken in order to address actions 7.3, 7.5, 7.7, 7.8 and 7.9 in the action plan. MKS provided a summary of these actions, which includes: • A schedule of training has been planned to support staff with undertaking risk assessments, including stress and DSE • Generic risk assessment templates are all available on the intranet, and attached to specific policies • H&S team bespoke support for undertaking risk assessment, particularly for complex risk assessments. MKS acknowledged the importance of the Committee being sighted on progress and confirmed that the targets dates set for conclusion are either on track or completed. The Committee **noted** the progress made.			
18/09	**Apprenticeships Update** The Committee received a report prepared the Apprenticeship Delivery Manager. The report outlined the progress made to support apprenticeships at the Trust since gaining Employer Provider Status in May 2017. The report was noted as read. GT noted that 4 apprenticeship qualifications have been identified that can be delivered in house and advised that 16 individuals are about to start their apprenticeship journey at end of February 2018. In order for the Trust to realise its vision and fully exploit the Levy, it is important to identify external Apprenticeship Training Providers			

Agenda Item	Key Discussion Points	Action	Owner	Timescale
	to support the long term aim. Meetings are currently being arranged with external Providers and Colleges to confirm what they can deliver for us that we can't deliver ourselves. The Committee acknowledged the requirement to agree/decide what areas in the Trust require more focus i.e. staff at risk/nursing to ensure the utilisation of the Levy (noted that after two years any money not utilised is returned to the Treasury). MKS advised that a paper on Apprenticeships pay has been discussed with Staff Side with the preferred option being Annex U. TJ acknowledged there are lots of benefits associated with apprenticeships scheme at the Trust, but that we need to ensure that some roles are not devalued. GT advised that Merseycare are the only other Employer Provider in LCR and meetings will take place to share best practice. A launch date for Apprenticeship Week has been identified as 6th March and a number of initiatives planned. The Committee noted the progress made to support the Apprenticeship Strategy.			
18/10 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 Director of HR & OD concerning the key risks relating to workforce monitoring for December 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 sees an increase from 5% in December to 5.09% in January 2018, target is set at 4.5%. National ESR issues have delayed some reporting of sickness. MSal advised that the revised policy, post implementation, did see a reduction in sickness. The Committee acknowledged the significant financial impact that sickness has on the Trust and it was agreed the MKS will prepare a paper to be presented at RABD outlining the cost of sickness. The Committee **noted** the content of the report	Sickness cost to be presented at RABD	MKS	March 2018
18/11	**Board Assurance Framework 2017-18** The Committee received the Programme Assurance Framework (BAF) for January 2018 previously presented to February 2017 Board. The purpose of the report is to outline workforce risks under 'The Best People Doing Their Best Work' work stream (Risk Title: Workforce Sustainability & Capability) and to provide Board assurance on latest progress to support the risks. The papers are noted as read, and the risk description related to the CQC themes Safe, Effective Responsive, Well led are:			

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Agenda Item	Key Discussion Points	Action	Owner	Timescale
	• Failure to always have the right people, with the right skills and knowledge, in the right place, at the right time. • Failure to improve workforce engagement which impacts upon operational performance and achievement of strategic aims. • Failure to proactively develop a future workforce that reflects the diversity of the local population. The Committee **noted** the content of the Board Assurance Framework.			
18/12 Legislation, terms & conditions, employment policies/EIA's – review & ratification/approval	The Committee considered the following Policies and Equality Impact Assessments for ratification/approval. The Committee **ratified** the following policies and **approved** the EIA's. Equality Diversity & Human Rights Equality Analysis Alcohol & Substance Misuse Mandatory Training Induction The Committee **ratified** the following Health & Safety policies and **approved** the EIAs Personal Protective Equipment Latex COSHH **Slips Trips & Fall Policy** A further Health & Safety policy was deferred and will be brought back to the next Committee. This is to allow for the review of Appendices B&C by PB. **Equality Analysis Template & Step-Wise Guide** The Committee approved the template & Step-Wise Guide. **Quality Assessment Template & Step-Wise Guide** The Committee approved the template & Step-Wise Guide.			
	Sub Committee Minutes The Committee received the minutes of the following Committees for information.			

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Agenda Item	Key Discussion Points	Action	Owner	Timescale
	JCNC – 29th November 2017 Health & Safety 13th December 2017 LNC – 21st November 2017 TJ referred to the Health & Safety Committee and suggested that the number of Health & Safety Staff Side representatives in attendance is inadequate and requires addressing. Also the circulation list for this Committee needs a review. CL suggested the Terms of Reference for this Committee is looked at.			
18/13 AOB	PB advised that an annual report on nurse staffing will be presented to the March 2018 Board and will present it to WOD in April for information. IQ referred to the People Strategy presented earlier (page 21), one of the four key enablers of engagement - makes reference to the Trust Values. Before the move to the new hospital the Trust Values were visible on the walls all around the hospital. MF advised that a number of noticeboards are due to be located around the hospital and he will ensure the Trust Values are added to all noticeboards along with other information to ensure staff are well informed. MF advised that the Head of Marketing & Communications Operations is looking at publications such as Alder Hey Life to review consistency around how they reflect our Values etc. MKS added that the Trust Values are discussed at Trust Induction. The Committee noted that Maria Salcedo was leaving the Trust next month and conveyed their thanks to Maria for all she had contributed.	Annual Nurse Staffing report to be presented	PB	April 2018
Date of Next Meeting	**Tuesday 24th April 2018, 1pm-3pm, Room 6, Mezzanine.**			

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Action List

Minute Reference	Action	Who	When	Status
Meeting Protocol				
	Terms of Reference			
17/49	• Issue virtual 2018 Terms of Reference to membership for approval	MKS	ASAP	Complete
16/33 17/20 17/50	• 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. • Present refreshed HR KPI's for approval ahead of inclusion in the wider Trust KPI's piece of work	MKS/CD MKS MKS	Work to be completed by April 2018 February 2018	 Complete
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, 18/03	• Present updated draft of the Refreshed People Strategy • Alder Hey will look to improve the health & wellbeing of children and young people throughout the world by 2020 – presented in February 2018 – update to include measurables	MKS MKS	February 2018 **April 2018**	Complete
	LiA			
16/38 17/52	• Present Communications Plan • LiA update	KT/Communications KT	December June 2018	
	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 **April 2018**	
18/05	• Corporate Induction – review current practice of holding on a set day as opposed to the 1st day of commencement in post.	MKS	TBC	

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Key Workforce Risks – Review of Top Workforce Risks				
	Workforce Performance Monitoring			
17/55 18/10	• Report on sickness management and costs • Report on sickness costs to be presented to RABD	MKS MKS	**April 2018** **March 2018**	
AOB				
18/13	• Annual Nurse Staffing report to be presented	**PB**	**April 2018**	

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ANNEX A

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WORKFORCE & OD COMMITTEE
MINUTES FROM MEETING
21ST May 2018

Present:	Ms C Dove	Non-Executive Director (Chair)	(CD)
	Mrs M Swindell	Director of HR & OD	(MKS)
	Mr I Quinlan	Non-Executive Director	(IQ)
	Mr M Flannagan	Director of Communications & Marketing	(MF)
	Mr A Hughes	Divisional Director – Medicine (deputy for SR)	(AH)
	Mrs P Brown	Director of Nursing – (deputy for HG)	(PB)
	Mrs J France-Hayhurst	Non-Executive Director	(JFH)
In Attendance:	Mrs S Owen	Acting Deputy HR Director	(SO)
	Mrs K Turner	Trust LiA Lead	(KT)
	Ms Dot Brannigan	Patient Governor (Parent & Carer)	(DB)
	Ms H Ainsworth	Equality & Diversity Manager	(HA)
	Mr A McColl	Associate COO (Part Attendance)	
Apologies:	Mr T Johnson	Staff Side Chair	(TJ)
	Mr A Bateman	COO	(AB)
	Mrs H Gwilliams	Chief Nurse	(HG)
	Mr S Ryan	Medical Director	(SR)

Agenda Item	Key Discussion Points	Action	Owner	Timescale
18/14 **Minutes of the Previous Meeting & Meeting Protocol**	The Committee considered the minutes of the meeting held on 15th February 2018 and they were **approved** as an accurate record. **Review of WOD Annual Report 2017-2018** The Committee received the annual report, prior to formal approval at Trust Board. The paper was noted as read. Particular attention was brought to the poor attendance at this Committee. It was acknowledged that strategically there are a lot of key workforce developments taking place and it is imperative that attendance improves. The Committee **approved** the annual report.			
18/15 **Matters Arising, Actions**	The Committee considered the following under matters arising: **18/05 Corporate Induction** The Committee noted that the new Learning & Development Manager in conjunction with Communications, will be conducting a review of the current practice of holding Corporate Induction on a set day as opposed to the 1st day of commencement in			

Agenda Item	Key Discussion Points	Action	Owner	Timescale
	post. CL asked if, following CQC inspection, is there is a plan in place for PDR/Mandatory Training. MKS confirmed that the Learning & Development Manager will be reviewing all processes. AMcC of the Surgery Division confirmed the process for PDR's/Mandatory Training has been cascaded, and that all Clinical Leads have had PDR's in April with rollout to department leads in place. Statistics relating to this are discussed divisionally at monthly meetings. SO added that HR are generating a weekly report on PDR/Mandatory Training to inform the Divisions of latest developments. **17/55 Workforce Performance Monitoring** The Committee noted that a report on sickness costs had been presented to RABD.			
18/16 **Programme Assurance 'The Best People Doing Their Best Work'**	**Programme Assurance Framework – April 2018** 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. In the absence of External Programme Assurance representative, MKS gave a summary of the report and advised that e-Rostering and Temporary Staffing have now moved into the imminent pipeline and should be fully mobilised and work continues to escalate. Current dashboard rating shows an overall rag status of amber for apprenticeships and portering with apprenticeship seeing some milestone plan shifting due to changes in the department and further negotiations taking place with portering. A review of 18/19 project proposals is under way as some do not fit in the framework (i.e. sickness – should come under 'business as usual'). MKS outlined the work taking place to identify efficiency schemes to deliver/support the £1M target. Both herself and the Associate FD of Operational Finance are meeting with the Divisions to review workforce requirements as each Division will have different prerequisites (i.e. Community require innovative recruitment processes). The Committee **noted** the comments made.			
18/17 **Progress against the People Strategy**	**18/19 HR Operational Plan** The Committee received a presentation outlining the proposed plans for HR going forward. MKS outlined the challenges and ambitions to be reached by 2021, with			

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Agenda Item	Key Discussion Points	Action	Owner	Timescale
	particular reference to 18/19 objectives related to the following key themes; Future Shape of Workforce; Leadership & Wellbeing. Work continues to define approach/delivery while being really clear on what the drivers are 3 years from now. MKS referred to the Staff Survey and advised that nationally the Trust has been ranked as the most improved Trust as analysis undertaken by communication that has been issued nationally by Associate of UK University Hospitals (AUKUH). MKS outlined the staff changes in HR&OD to strengthen the service available to support the Best People Doing the Best work model and to enable progression of the business agenda. HR&OD will continue to work closely with the Divisions 'three at the top' and departmental managers (business partnering) to help build capabilities, plan and manage talent and develop approaches that achieve shared organisational objectives and support financial targets. Further updates will be brought to the Committee The Committee **noted** the content of the presentation.			
18/18	**Staff Survey – NHS Report** The Committee received the 2017 National NHS Staff Survey results for Alder Hey for information. MKS advised that following local action planning discussions with the Divisions, an update will be brought back to the next Committee. MKS added that the Staff Survey summary of all key findings shows improvements since the 2016 survey along with improved staff response rates (39% 2016, 45% 2017). It was noted that the ranking with other acute Specialists Trusts shows Alder Hey performance as behind other Specialists Trust, but there is frustration as Acute Specialists Trusts are grouped together for comparison with no recognition differing responsibilities. The Committee reflected on page 7 of the report that highlights the five key findings for which the Trust compares least favourably with other Acute Specialists Trusts in England. Particular attention was brought to health and wellbeing of staff after recent high profile events, MKS advised of the provision in place to support staff. The Committee **noted** the content of the report.	Update on Staff Survey discussion with Divisions.	MKS	June
18/19	**Nurse Workforce Report & Presentation** The Committee received a report and presentation prepared by the Chief Nurse. PB advised the report and presentation had been received at Trust Board in March 2018. Moving forward an update will be brought to the Committee bi-annually. The report provides the required assurance that the Trust has safe nurse staffing levels across all in-patient and day case wards and appropriate systems in place to			

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Agenda Item	Key Discussion Points	Action	Owner	Timescale
	manage the demand for nursing staff along with informing the Committee of proposed business cases to enable workforce improvements in 2018. The report is noted as read. The presentation reflected on safer staff levels requirements, audits against RCN core standards 2018 with comparisons to 2017, recruitment statistics of front line nursing staff wte in 2017/18 with specific targeted recruitment for specialists and hard to recruit areas outlined. PB reported that there are approximately 7 leavers a month (approx. 40 nurses on maternity leave just now). Leaving/retention processes are being reviewed with recruitment. The age profile of wider front line nursing staff was reflected on and the Committee noted 57 wte front line staff/specialist nurses (age 51-55) will achieve retirement age in the next 5 years. The overall vision is to have zero vacancies and 40 wte in a 'nursing pool'. PB outlined the workforce developments in 2017, that saw the appointment of matrons across all Divisions; an increased number of 6 Advanced Nurse Practitioner trainees and the pilot of a new Nursing Associate role. Developments so far in 2018 has seen clinical educators apply new NMC standards for nurse training with clear focus on ensuring nurses clinical competence is enhanced. Further proposed developments in 2018 are introduction of an Acute Care Team, E-rostering and a programme to mobilise and maximise nursing leadership across C&M. CD suggested that it would be good to see the diversity reflected in the statistics. The Committee **noted** the content of the report and presentation.			
18/20	**Staff Health & Wellbeing Priorities** The Committee received a report from the Acting Deputy Director of HR outlining the Health & Wellbeing agenda at the Trust for 2018/19. SO advised that the HR&OD teams will work with all Divisions and Corporate areas to help steer and support the delivery of that agenda. SO added that the purpose of this paper is to inform the Committee of the plans and milestones to successfully delivery the agenda for 2018-19. Future progress reports will be brought to the Committee. The report is noted as read. SO informed the Committee that, as set out in the HR&OD operational plan 18/19, the primary objectives for the delivery of improved health and wellbeing are: • Define the Trust's approach to wellbeing and implement the plan. • Build on the work of the reward and recognition group to develop the R&R plan to include retention. • Work with Staff Side colleagues on a new approach to support sickness absence in the workplace, with a view to having a new policy in place in 2018. • Implement the plan to increase diversity by a minimum of 2% by March 19 and to provide a better experience for staff from a wide range of backgrounds, utilising apprenticeships and working with HEI's to support this aim.			

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Agenda Item	Key Discussion Points	Action	Owner	Timescale
	• Respond to the 2017 Staff Survey. Led by local discussions and action planning. Particular attention was paid to the current position with the NHS Staff Survey for 2017 showing a more positive response on a number of areas although it does also highlight areas for improvement and ongoing development. The Trusts current rate of sickness absence is 5% which is 0.5% higher than the Trust target of 4.5% and requires specific focus placed on reducing levels of sickness absence and putting appropriate supportive initiatives and measures in place to achieve this. There are already a range of initiatives in place across the organisation to support wellbeing, undertaken by many teams, managers and services and this requires a clear strategy to ensure this can be successfully delivered. SO advised that it is recommended that the action plan be derived from the CIPD's five domains of wellbeing model to help map the work plan for the Trust and address the overall wellbeing agenda. The Committee **approved** the development.			
18/21	**Equality Diversity Annual Workforce Profile** The Committee received the annual Workforce Profile Data report presented by the Equality and Diversity Manager for approval. The Committee noted the report is to be presented at May 2018's Trust Board. The purpose of this report is for the Trust to evidence its commitment to the principles of the NHS constitution and compliance with the general equality duty across our service functions. The report has produced data on the content of the Electronic Staff Record to include age, gender, ethnicity, disability, sexual orientation and religion and belief. Employee relations data relating to the last 2 years January 2016 to January 2018 is included in this report in addition to data for flexible working, training and recruitment data. HA outlined the key findings of the report (noted as read). The Trust system that holds staff information was updated to 'Electronic Staff Record (ESR) Enhanced' with effect from 1st April 2017. This enables staff to personally update their equality demographic data and should result in improved quality of data for future reporting. Work continues on how best to report data relating to the BME network to the Committee to enable the Trust to monitor profile, recruitment, career progression and promotion and staff experience in relation to this group of staff to progress the workforce race equality standard (WRES) action plan. HA acknowledged that the format of this report has remained static and advised that the content will be reviewed going forward, influenced by working with a new ESR lead and the greater capacity of new HR team members and the impact of the			

Agenda Item	Key Discussion Points	Action	Owner	Timescale
	Health & Wellbeing agenda. Priorities for 2018/19 are: • Improve the quality of staff equality demographic data by reducing the number of non-disclosures across the protected characteristics. • To consider how we monitor non-mandatory training opportunities by protected characteristic. • To review and broaden the content of this report to reflect workforce initiatives taken in response to data/information, stakeholder engagement and mandatory reporting requirements. The Committee reflected on the content of the document with particular attention brought to future requirements to support the report - recruitment – delve into the data to understand the ratio of shortlisted BME applicants; keep sighted on recruitment trainee nurses via universities and support offered. It was agreed to invite representative from BME Group and Apprenticeship Manager to present in June The Committee **agreed** the content for publication of the Workforce Profile Data.	Invite BME chair to present to Committee Invite Apprenticeship Manager to present to Committee	HA MKS	June June
18/22 **Key Workforce Risks – Review of top Workforce Risks action planning against most significant risks**	**Key Workforce Risks KPIs** The Committee considered a regular report prepared by the Acting Deputy HR Director concerning the key risks relating to workforce monitoring for March 2018. The purpose of the report is to update on key targets/measures and advise of actions to support improvement. Key headlines are: SO advised that work continues to develop the dashboard and will include BME and apprenticeship monitoring. Sickness absence is currently 5.07 with the target set at 4.5%, the HR team are working to improve sickness absence and the policy is being reviewed. Core mandatory training is higher than target set at over 90%. Trust induction will see improvement now we have the new Learning & Development Manager in place. The Committee **noted** the content of the report.			
18/23	**Board Assurance Framework – April 2018** The Committee received the Programme Assurance Framework (BAF) for January 2018. The purpose of the report is to outline workforce risks under 'The Best People Doing Their Best Work' work stream (Risk Title: Workforce Sustainability & Capability) and to provide Board assurance on latest progress to support the risks. The papers are noted as read, and the risk description related to the CQC themes Safe, Effective Responsive, Well led are:			

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Agenda Item	Key Discussion Points	Action	Owner	Timescale
	• Failure to always have the right people, with the right skills and knowledge, in the right place, at the right time. • Failure to improve workforce engagement which impacts upon operational performance and achievement of strategic aims. • Failure to proactively develop a future workforce that reflects the diversity of the local population. The Committee **noted** the content of the Board Assurance Framework.			
18/24	**CQC Action Plan April 2018 (reflecting March 2018 position)** The Committee received workforce elements of the CQC Action Plan for monitoring purposes (full plan is monitored at CQAC). The purpose of the CQC action plan is for the Trust to address issues raised, ensure the appropriate action is taken and monitor progress through to completion. The Committee noted the developments of the workforce elements of the CQC action plan. The Committee **noted** the progress made.			
18/25 **Legislation, terms & conditions, employment policies/EIA's – review & ratification approval**	**Gender Pay Gap – 30th March 2018** The Committee received the Gender Pay Gap report prepared by the Director of HR&OD. The purpose of the report is to note the Trusts first Gender Pay Gap report for 2018 produced to meet the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 which came into force on the 31st March 2017. This report includes the statutory requirements of the Gender Pay Gap legislation but also provides further context to help understand and contextualise the data. The Committee noted the importance of recognising that the gender pay gap differs to equal pay. Equal pay is in relation to pay differences between men and woman who carry out the same job for different pay, which is unlawful. The gender pay gap shows the difference in average pay of all men and the average pay of all women employed by the Trust. It is therefore possible to have genuine pay equality but still have a gender pay gap. The Committee noted that the Operational Board are asked to approve the report to enable it to be published on the Trust and Government website. Steps to reduce gender pay gap will be incorporated into the Trust Equality Objectives and monitored by this Committee on a quarterly basis. The Committee **noted** the content.			
18/26	**New Pay Deal** The Committee received a report issued by NHS Improvement outlining the proposals of NHS Terms and Conditions of Service contract refresh. The Director of			

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Agenda Item	Key Discussion Points	Action	Owner	Timescale
	HR&OD gave a brief outline of the proposals relating to the 3 year pay deal. The new proposals will see significant structural pay reforms, a new pay progression framework, along with minor changes to some terms and conditions. The Committee noted that the unions will go out to ballot on 6th June 2018. The Committee noted the content of the report.			
18/27	**Sub Committee Minutes** The Committee received the minutes of the following Committees for information. JCNC – 30th January 2018 JCNC – 27th February 2018 LNC – 1st February 2018 The Committee **noted** the content.			
18/28 AOB	**Communications** CD invited the Director of Marketing & Communications to give an update on Communication developments to support the Trust at next meeting.	MF to present a communication update to Committee	MF	June 2018
Date of Next Meeting	**Tuesday 26th June 2018, 3pm-4pm, Room 6, Mezzanine.**			

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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		Ongoing
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		Ongoing Ongoing
People Strategy Overview & Progress Against Strategic Aims				
	People Strategy			
18/03	• Alder Hey will look to improve the health & wellbeing of children and young people throughout the world by 2020 – presented in February 2018 – update to include measurables	MKS	April 2018	**Complete**
	LiA			
16/38 17/52	• Present Communications Plan • LiA update	KT/Communications KT	December 2017 June 2018	
	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	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 **September 2018**	Ongoing
18/05	• Corporate Induction – review current practice of holding on a set day as opposed to the 1st day of commencement in post. The Committee noted on 21st May that the new Learning & Development Manager will be reviewing in conjunction with Communications	MKS	TBC	Ongoing
18/21	• Following discussion about the annual workforce profile – invite the BME Chair and Apprenticeship to next meeting to update the Committee.	MKS	June 2018	
	Staff Survey			
18/18	• Update on Staff Survey discussions with Divisions.	MKS	June	
Key Workforce Risks – Review of Top Workforce Risks				
	Workforce Performance Monitoring			
17/55	• Report on sickness management and costs	MKS	**April 2018**	**Complete**

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18/10	• Report on sickness costs to be presented to RABD	MKS	**March 2018**	**Complete**
AOB				
18/13	• Annual Nurse Staffing report to be presented	**PB**	**April 2018**	**Complete**
18/28	• Present a Communication update to the Committee	**MF**	**June 2018**	

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Agenda Number

Alder Hey Children's NHS
NHS Foundation Trust

Board of Directors
Insert day, Date and Time

Report of	Medical Education Board
Paper prepared by	G Lamont H Blackburn
Subject/Title	Report following HEENW Assessment visit
Background papers	Agenda for Visit : 3rd May 2018 Action Plan submitted : 25th May 2018 Medical education structure RABD report March 2018 HENW Letter
Purpose of Paper	To inform Board of outcome of Visit and Action Plan
Action/Decision required	To note
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Links across Strategic Foundations including 'Reliable Infrastructure' and 'Working Productively' themes
Resource Impact	Not applicable in this report

________________________________ Signature Title ____________________

Alder Hey Children's NHS
NHS Foundation Trust

Report from Medical Education Board regarding HEENW Assessment Visit 3rd May 2018

1. PURPOSE OF THE REPORT

This report is provided to update the Board on the progress following the Assessment visit carried out by Health Education England North West (HEENW) on 3rd May 2018.

2. RECOMMENDATIONS

The Board are asked to note the contents of the report and support the approach being taken to improve the educational experience of the junior doctors at Alder Hey.

3. BACKGROUND

HEENW are the commissioners for health service education across the North West. In Medical Education terms, they commission both undergraduate and postgraduate medical training within the Trust and provide the finance to underpin the training. This latter aspect is managed by a number of SLAs, collectively grouped under the Learning and Development Agreement (LDA).

HEENW undertake regular review visits looking at the provision of post graduate medical training, and it is the latest visit that took place on 3rd May 2018 that this paper refers to.

Over several years the structure and nature of the assessment visit has been evolving and they view their current processes as being in the form of exception visits. In other words, taking account of information from various sources including GMC surveys, CQC reports, previous HEENW visit reports and Trust response, College reports, and other sources they request to meet with specific groups of trainees and trainers, looking to understand how the Trust are providing education.

The visiting team, overall, identified many positive aspects of the training experience during their visit, however they focused on two 2 specific areas that they felt needed urgent attention; concerns regarding dental trainees and also some concerns about general out of hours cover. An action plan was requested to address these concerns; this was developed with the relevant teams, submitted on time and is attached with this report. Internally, follow up with the teams is planned to review progress against the action plan prior to the end of July 2018.

4. ANALYSIS OF ACTION PLAN

While the issues raised by the assessment team with regards dental training are potentially significant, the solutions do seem workable and would provide for an enhanced training experience, and as such are likely to be seen as acceptable at HEENW.

To address some long standing concerns in relation to the paediatric medical workforce which can have a substantial impact on trainee experience, the Divisional

Director for Medicine is leading a major piece of work. The aim, as well as facilitating higher quality care, is to definitively improve the educational experience of our trainees.

5. EDUCATION GOVERNANCE

We recognise that Education Governance is an area which requires strengthening across the organisation, in particular providing the Board with assurance on the high quality of multi professional teaching. To this end, we have been developing a more comprehensive infrastructure and governance framework to support trainees of all professions.

With regards Medical Education, following active recruitment, we have appointed a medical education team (see Appendix 3) to support the delivery of medical education and we now have sufficient numbers of Educational Supervisors required to support the processes for individual trainees.

The nursing team have successfully developed a business case which has increased the leadership and support given to student nurses and AHPs on placement, and crucially, support for their mentors. This resource is also supporting the medical students on placement, leading to a truly multi-disciplinary learning environment. In addition, the Trust has recently identified a named lead for Allied Health Professionals who will support this section of the workforce in development education and learning opportunities.

A new Education Governance Framework has recently been agreed with the Director of HR and OD and the Medical Director, alongside the Terms of Reference for the refreshed Education Governance Committee which will report into the Workforce and OD Committee. This multi-disciplinary Committee will oversee the quality of education delivery, and ensure that education is key role on the agenda of the individual Divisions.

6. CONCLUSIONS

Alder Hey provides a very positive experience for the majority of postgraduate medical trainees; indeed some of our feedback in recent months has been exemplary. We are aware that there are a number of systemic issues that can adversely impact on the educational experience but our ongoing actions and governance arrangements are designed to address these risks, to ensure all trainees have an extremely positive experience at Alder Hey.

Action Plan – Postgraduate Educational Monitoring Visit

Trust Name: Alder Hey Children's NHS Foundation Trust

Date of Visit:	4 May 2018
Date Action Plan required:	25 May 2018
Response compiled by:	16 May 2018

Please do not embed any documents. Documented evidence should be referenced in the action plan and made available on request.

Number	HEE Quality Standards	Requirements
1	**1.1; 3.3**	**The Trust must investigate, review and set out plans to address any issues with;** **a) The surgical list pathway and the mechanism by which dental trainees alert others to relevant issues affecting consent or patient safety;** **b) The administration of follow-up clinics, particularly the booking system to ensure that patients undergoing multiple procedures have all the necessary follow-ups;** **c) The supervision of trainees involved in any surgical "piggy-backing" procedures, to ensure they supervised in line with standards.**

Trust response

We have met with the DCTs as a result of the report to understand the issues further. As a result we have taken on board the issues raised andworked with the DCTs on a range of solutions which we have agreed within the Paediatric Dentistry services.

Corrective action	How will you demonstrate quality improvement?	Timeline	Responsibility
a) Surgical List Pathway The role of the DCT will change within the pathway.	Review of clinic templates to ensure DCT activity has ceased	Ongoing activity and review at 6 weeks	Sharon Lee/Susana Dominguez Gonzalez/J Chamberlain

The DCT will undertake the pre-operative preparation including consent where appropriate, and then take part in the theatre huddle and receive supervised training in theatre with the consultant. The required clinic activity will be phased out over the next 6 weeks. The activity from the clinics will be provided by our speciality dentist.	Review with DCTs attendance in theatre, number of cases recorded in logbook, and any reflections on their experience of the process through educational supervision process .	From 2 months to end of placement Ongoing at ES meetings thereafter	Sharon Lee/Susana Dominguez Gonzalez/Rod Llewellyn / DCT trainees
How will you sustain quality improvement? We will review all our actions both within the team and with the DCT's to get feedback from them about any progress. By auditing and reviewing this process we hope to make things better for our DCT's training and experience here and also better for our patients.		Timeline 2 months in this placement and ongoing for future rotations	Responsibility Sharon Lee/Susana Dominguez Gonzalez/Jeanette Chamberlain
b) Outpatient processes In meeting with the DCT's the main issue seems to be getting follow up appointments	. Baseline audit to identify extent of problems	6 weeks	DCT /Jeanette Chamberlain

from when they have seen patients in A&E, as there is a lack of clarity in the process	Design and implement a new process of how we manage our follow up patients from A&E and cascade that to the department. And on basis of audit agree an initial target for improvement We have also asked the Meditech team to come to the department to offer some bespoke training to the department so everybody is clear how to use the system and to order follow up's.	2 months Date to be confirmed	Sharon Lee/Susana Dominguez Gonzalez/J Chamberlain /DCT Sharon Lee/Susana Dominguez Gonzalez/J Chamberlain
c) Piggy Backs. DCT's were not aware that they **should not** be doing Piggy Backs on a Monday or a Friday when there is not consultant cover	. Revised process to be agreed with DCT and written into the DCT handbook so it is explicit. (The only reason a Piggy Back should happen on a Monday and a Friday is when there is a request to review patient's teeth under anaesthetic (EUA). If there is a treatment plan in place which has been previously agreed with the Consultant, this would be fine to do. Redesign of the process for requesting Piggy Backs for treatment which we are in the process of communicating with the wider organisation.	6 weeks 2- 3 months	Sharon Lee/Susana Dominguez Gonzalez/Jeanette Chamberlain Sharon Lee/Susana Dominguez Gonzalez/J Chamberlain /DCT

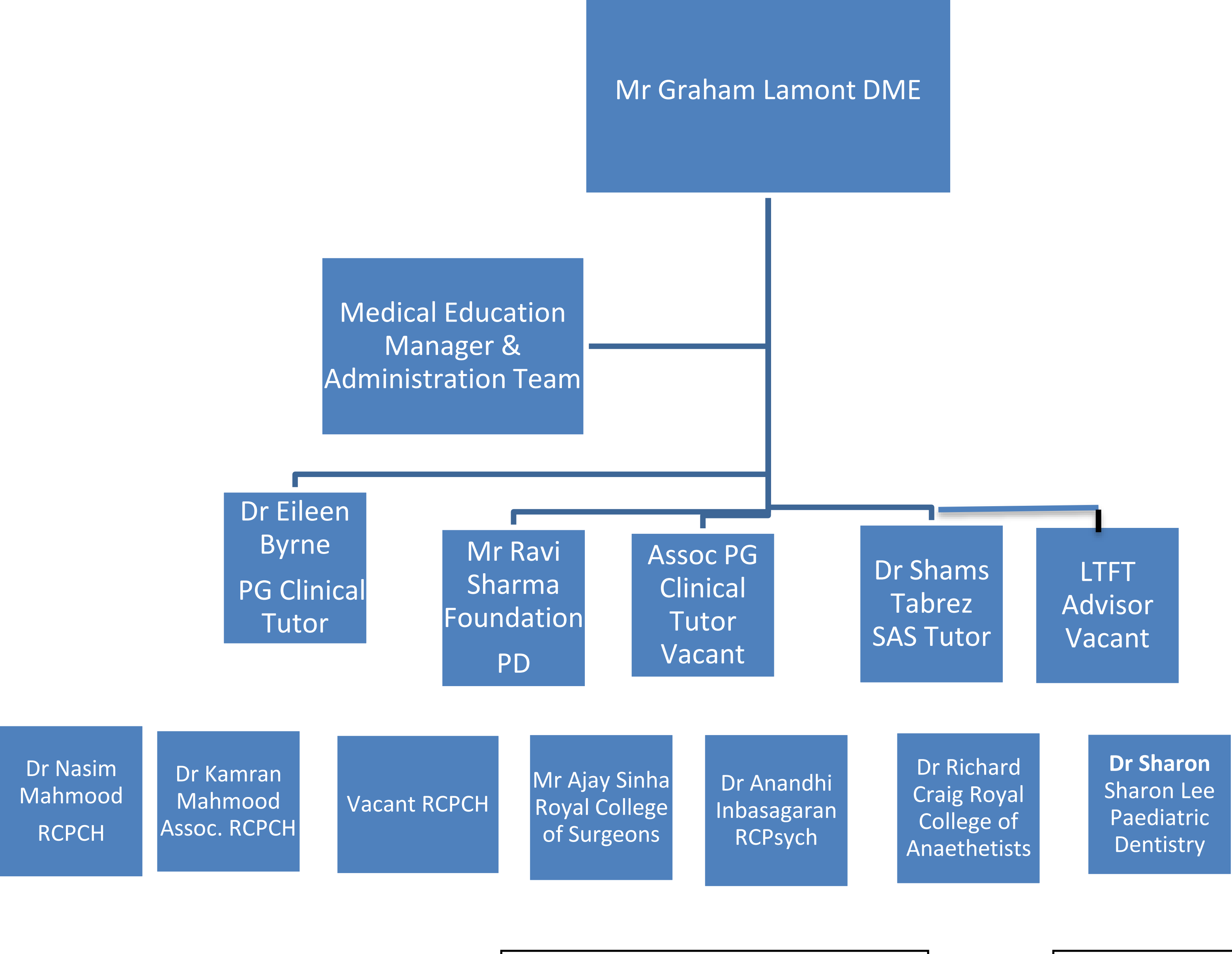
Number	HEE Quality Standards	Requirements
2	1.1	**The Trust must review the arrangements for out-of-hours paediatric cover and provide assurances that individual trainees on-call are not expected to respond to emergencies for both groups of patients.**

Trust response

During the past 12 months actions to reduce occurrences of gaps on the out of hours rota have proven mostly successful with an ongoing action plan in place working to eradicate instances of on call trainees responding to both specialist and acute emergency admissions. During the current rotation period there have been two occasions of trainees covering both patient cohorts. This is a significant reduction compared to last year.

Corrective action	How will you demonstrate quality improvement?	Timeline	Responsibility
Recruitment of 3 Trust employed doctors to tier 1 rota	Reduction in number of additional out of hours shifts worked per trainee above core rota	September 2018	Service Manager Acute Care Lead Consultant – Out of Hours Rota
Recruitment of 3 Trust employed doctors to tier 2 rota	Reduction in number of additional out of hours shifts worked per trainee above core rota	September 2018	Service Manager Acute Care Lead Consultant – Out of Hours Rota
Refinement of the Escalation Policy to include clearly defined actions, emphasis on joint decision making and escalation process for times of	Timely, appropriate notification of rota issues and efficient implementation of actions to reduce likelihood of rota gap on shift	June 2018	Service Manager – Acute Care

disagreement			
Introduce robust use of the DRS rota management system	Reduce delay in action of rota changes	September 2018	Medical Staffing HR Manager
Finalise clear process for reporting absence and disseminate to teams	Accurate reporting of absence	June 2018	Service Manager – Acute Care
How will you sustain quality improvement?		**Timeline**	**Responsibility**
Monitoring of all actions through the Out of Hours Forum	Achievement of actions within determined timescales	Monthly	Director of Division of Medicine
Elicit feedback from trainees	Respond in a timely manner to concerns and issues	Monthly	Director of Division of Medicine



Division of Medicine 58 Educational Supervisors

Division of Surgery 66 Educational Supervisors

Division of Community 12 Educational Supervisors

National Guardian
Freedom to Speak Up

Freedom to Speak Up self-review tool for NHS trusts and foundation trusts

May 2018

How to use this tool

Effective speaking up arrangements help to protect patients and improve the experience of NHS workers. Having a healthy speaking up culture is evidence of a well-led trust.

NHS Improvement and the National Guardian's Office have published a guide setting out expectations of boards in relation to Freedom to Speak Up (FTSU) to help boards create a culture that is responsive to feedback and focused on learning and continual improvement.

This self-review tool accompanying the guide will enable boards to carry out in-depth reviews of leadership and governance arrangements in relation to FTSU and identify areas to develop and improve.

The Care Quality Commission (CQC) assesses a trust's speaking up culture during inspections under key line of enquiry (KLOE) 3 as part of the well-led question. This guide is aligned with the good practice set out in the well-led framework, which contains references to speaking up in KLOE 3 and will be shared with Inspectors as part of the CQC's assessment framework for well-led.

Completing the self-review tool and developing an improvement action plan will help trusts to evidence their commitment to embedding speaking up and help oversight bodies to evaluate how healthy a trust's speaking up culture is.

Self review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	How is the board assured it is meeting the expectation? Evidence
Our expectations			
Leaders are knowledgeable about FTSU			
Senior leaders are knowledgeable and up to date about FTSU and the executive and non-executive leads are aware of guidance from the National Guardian's Office.		None identified	Board Reports New Guidance Shared with Board May 2018
Senior leaders can readily articulate the trust's FTSU vision and key learning from issues that workers have spoken up about and regularly communicate the value of speaking up.		Include NGO case reviews in future Board papers	AH vision re FTSU set out in Board papers September 2016
They can provide evidence that they have a leadership strategy and development programme that emphasises the importance of learning from issues raised by people who speak up.		Learning and Development Programme to include sessions on FTSU via corporate induction and essential skills for managers	Trusts vision supports the values and use of Behavioural Framework
Senior leaders can describe the part they played in creating and launching the trust's FTSU vision and strategy.		Ensure new directors briefed on FTSU vision	Board Papers

Leaders have a structured approach to FTSU			
There is a clear FTSU vision, translated into a robust and realistic strategy that links speaking up with patient safety, staff experience and continuous improvement.		FTSU to be referenced in both Quality and People strategies alongside LiA etc.	Board papers
There is an up-to-date speaking up policy that reflects the minimum standards set out by NHS Improvement.		Review Whistleblowing Policy at due date (Oct 2019)	National policy adopted and approved by WOD October 2016
The FTSU strategy has been developed using a structured approach in collaboration with a range of stakeholders (including the FTSU Guardian) and it aligns with existing guidance from the National Guardian.		FTSU to be referenced in both Quality and People strategies alongside LiA etc.	Board papers demonstrate regular briefings on national developments to assist alignment
Progress against the strategy and compliance with the policy are regularly reviewed using a range of qualitative and quantitative measures.		To be included in reporting to Board going forward	Trust position against first national survey reported to Board in October 2017
Leaders actively shape the speaking up culture			
All senior leaders take an interest in the trust's speaking up culture and are proactive in developing ideas and initiatives to support speaking up.		Development of FTSU Advocate hosted drop in sessions	Raise It, Change It Weekly meeting of harm LiA

They can evidence that they robustly challenge themselves to improve patient safety, and develop a culture of continuous improvement, openness and honesty.		Continue to promote initiatives underpinning quality improvement culture	Ward Accreditation Quality Assurance Rounds Quality Summit
Senior leaders are visible, approachable and use a variety of methods to seek and act on feedback from workers.		Maintain regular visibility visits for all board members	Latest from Louise Louise's Blog Executive Shadowing Programme Quality Assurance Rounds
Senior leaders prioritise speaking up and work in partnership with their FTSU Guardian.		Case studies to be discussed at Board where appropriate	Learning from Incident reporting
Senior leaders model speaking up by acknowledging mistakes and making improvements.		Continue to promote initiatives underpinning quality improvement culture	Board papers including SIRI and Mortality reports
The board can state with confidence that workers know how to speak up; do so with confidence and are treated fairly.		Test through regular temperature checks	NHS Staff Survey demonstrates a steady Improvement

Leaders are clear about their role and responsibilities			
The trust has a named executive and a named non-executive director responsible for speaking up and both are clear about their role and responsibility.		None identified	Board nominated SID as FTSU Guardian in October 2016. Executive lead identified in Whistleblowing Policy
They, along with the chief executive and chair, meet regularly with the FTSU Guardian and provide appropriate advice and support.		Regular joint meetings to be established	Separate meetings currently take place on an ad-hoc basis
Other senior leaders support the FTSU Guardian as required.		None identified	When needed on individual cases
Leaders are confident that wider concerns are identified and managed			
Senior leaders have ensured that the FTSU Guardian has ready access to applicable sources of data to enable them to triangulate speaking up issues to proactively identify potential concerns.		Programme of regular data triangulation to be established	Data is accessible. Access to appropriate leads when required
The FTSU Guardian has ready access to senior leaders and others to enable them to escalate patient safety issues rapidly, preserving confidence as appropriate.		None identified	Access to seniors leads fully available when needed

Leaders receive assurance in a variety of forms			
Workers in all areas know, understand and support the FTSU vision, are aware of the policy and have confidence in the speaking up process.		Learning and Development Programme to include sessions on FTSU	NHS Survey Results Promoted through the Induction Programme FTSU on staff intranet, including tools i.e. behavioural framework
Steps are taken to identify and remove barriers to speaking up for those in more vulnerable groups, such as Black, Asian or minority ethnic (BAME), workers and agency workers		Recruitment of FTSU advocate from BME/Disability network	Inclusion on the BME/Disability Network agendas
Speak up issues that raise immediate patient safety concerns are quickly escalated		Reiterate this process with advocates	One Patient Safety issue raised through FTSU route, Medical Director immediately contacted and issue being dealt with
Action is taken to address evidence that workers have been victimised as a result of speaking up, regardless of seniority		Ensure clarity in existing policy framework	No concerns raised to date One current case on the FTSU database has suggested that their

			suspension was related to speaking up but this has been clearly documented and evidenced as not being the reason
Lessons learnt are shared widely both within relevant service areas and across the trust		Consider ways to share themes whilst maintaining confidentiality of individuals	Programme to be established
The handling of speaking up issues is routinely audited to ensure that the FTSU policy is being implemented		Audit to be established	
FTSU policies and procedures are reviewed and improved using feedback from workers		Feedback to be used (No relevant feedback currently)	Staff side involved in the review of the Whistleblowing policy through PRG
The board receives a report, at least every six months, from the FTSU Guardian.		Maintain reporting cycle and keep under review	Established
Leaders engage with all relevant stakeholders			
A diverse range of workers' views are sought, heard and acted upon to shape the culture of the organisation		Work towards establishing a LGBTQ	WRES Data Established

in relation to speaking up; these are reflected in the FTSU vision and plan.		network	BME/Disability Network
Issues raised via speaking up are part of the performance data discussed openly with commissioners, CQC and NHS Improvement.		Link to development of measures	FTSU Role and issues raised discussed during recent CQC visit, however there is further clarity required by the regulators as there appears to be a lack of understanding by the regulators into the FTSU position within organisations
Discussion of FTSU matters regularly takes place in the public section of the board meetings (while respecting the confidentiality of individuals).			Established
The trust's annual report contains high level, anonymised data relating to speaking up as well as information on actions the trust is taking to support a positive speaking up culture.		Develop appropriate reporting of data for 2018/19 report	No data re cases documented, however there is information describing FTSU within the report. Raise it, Change it Ward Accreditation

			programme
Reviews and audits are shared externally to support improvement elsewhere.		Continue to support local and national networks	FTSU Advocates attend North West Regional FTSU meeting where lessons are shared, recently created a shared database through this group which is accessible to all members
Senior leaders work openly and positively with regional FTSU Guardians and the National Guardian to continually improve the trust's speaking up culture		National Guardian scheduled to visit Trust in October 2018 and will meet the Trust's Guardian, the CEO and Executive Directors	FTSU Advocates do this on behalf of the senior Leaders
Senior leaders encourage their FTSU Guardians to develop bilateral relationships with regulators, inspectors and other local FTSU Guardians		Additional opportunities identified and actioned as appropriate	Active engagement ongoing via various forums
Senior leaders request external improvement support when required.		Consider this aspect as part of QI development work	Link with AQuA Human Factors training

Leaders are focused on learning and continual improvement			
Senior leaders use speaking up as an opportunity for learning that can be embedded in future practice to deliver better quality care and improve workers' experience.		Consider themes from Board reports as they arise	LiA Behavioural Framework Raise it, Change it
Senior leaders and the FTSU Guardian engage with other trusts to identify best practice.		None identified	Through the FTSU network National Guardians Conference
Executive and non-executive leads, and the FTSU Guardian, review all guidance and case review reports from the National Guardian to identify improvement possibilities.		Continue to include in Board reports	All NGO case reviews, reviewed to identify any missed learning
Senior leaders regularly reflect on how they respond to feedback, learn and continually improve and encourage the same throughout the organisation.		Consider this aspect as part of QI development work	Weekly meeting of harm LiA events People Strategy reports Staff Survey
The executive lead responsible for FTSU reviews the FTSU strategy annually, using a range of qualitative and quantitative measures, to assess what has been		Incorporate into Quality and People strategies	

achieved and what hasn't; what the barriers have been and how they can be overcome; and whether the right indicators are being used to measure success.			
The FTSU policy and process is reviewed annually to check they are fit for purpose and realistic; up to date; and takes account of feedback from workers who have used them.		Policy review cycle is currently three years – consider annual review	Reviewed through PRG Review date October 2019
A sample of cases is quality assured to ensure: • the investigation process is of high quality; that outcomes and recommendations are reasonable and that the impact of change is being measured • workers are thanked for speaking up, are kept up to date though out the investigation and are told of the outcome • Investigations are independent, fair and objective; recommendations are designed to promote patient safety and learning; and change will be monitored		Quality assurance process to be established	
Positive outcomes from speaking up cases are promoted and as a result workers are more confident to speak up.		To be considered on a case by case basis by Guardian and advocates	Theatre review promoted the positive outcomes of speaking

			that led to the creation of the Behavioural framework and Raise it, Change it
Individual responsibilities			
Chief executive and chair			
The chief executive is responsible for appointing the FTSU Guardian.		Review when existing Guardian steps down	Board nominated Guardian in accordance with national guidance as at October 2016
The chief executive is accountable for ensuring that FTSU arrangements meet the needs of the workers in their trust.		None identified	Supports and is fully sighted
The chief executive and chair are responsible for ensuring the annual report contains information about FTSU.		Report to be expanded to include FTSU case review information as appropriate	Annual Report meets NHSI guidance
The chief executive and chair are responsible for ensuring the trust is engaged with both the regional Guardian network and the National Guardian's Office.		None identified	FTSU Advocates established strong links with Regional Networks and National office

Both the chief executive and chair are key sources of advice and support for their FTSU Guardian and meet with them regularly.		None identified	Regular meetings established with CEO and as required with Chair
Executive lead for FTSU			
Ensuring they are aware of latest guidance from National Guardian's Office.		Ensure guidance is sent to executive lead	Board papers sponsored by Exec Lead
Overseeing the creation of the FTSU vision and strategy.		Ensure FTSU is referenced in Trust strategies as appropriate	Works with senior FTSU advocate to ensure vision is communicated
Ensuring the FTSU Guardian role has been implemented, using a fair recruitment process in accordance with the example job description and other guidance published by the National Guardian.		Review process when existing Guardian steps down	Nomination process adopted to select as per original guidance
Ensuring that the FTSU Guardian has a suitable amount of ring fenced time and other resources and there is cover for planned and unplanned absence.		Review of time required and cover	Guardian has ensured sufficient number of advocates recruited to provide coverage at local level across the Trust

Ensuring that a sample of speaking up cases have been quality assured.		Quality Assurance process to be established	
Conducting an annual review of the strategy, policy and process.		Review to be established	Policy launched October 2016
Operationalising the learning derived from speaking up issues.		Will be shared when appropriate	
Ensuring allegations of detriment are promptly and fairly investigated and acted on.		To be dealt with on a case by case basis with HR/legal advice as appropriate	None raised to date
Providing the board with a variety of assurance about the effectiveness of the trust's strategy, policy and process.		Development of annual FTSU report	
Non-executive lead for FTSU			
Ensuring they are aware of latest guidance from National Guardian's Office.		Ensure latest guidance is sent to NED	Board papers
Holding the chief executive, executive FTSU lead and the board to account for implementing the speaking up strategy.		Regular review/report/discussion at Board	Board papers

Robustly challenge the board to reflect on whether it could do more to create a culture responsive to feedback and focused on learning and continual improvement.		Regular review/report/discussion at Board	Board papers including People Strategy updates, SIRI reports, staff survey. Quality Assurance Round report to CQAC.
Role-modelling high standards of conduct around FTSU.		None identified	Example case currently in system
Acting as an alternative source of advice and support for the FTSU Guardian.	N/A		
Overseeing speaking up concerns regarding board members.		None identified	Would happen if concerns raised
Human resource and organisational development directors			
Ensuring that the FTSU Guardian has the support of HR staff and appropriate access to information to enable them to triangulate intelligence from speaking up issues with other information that may be used as measures of FTSU culture or indicators of barriers to speaking up.		None identified	Meetings with Deputy Director of HR Review of exit interview
Ensuring that HR culture and practice encourage and support speaking up and that learning in relation to			

workers' experience is disseminated across the trust.			
Ensuring that workers have the right knowledge, skills and capability to speak up and that managers listen well and respond to issues raised effectively.		Repeat FTSU comms on a regular basis	Well established policy framework tested via staff survey
Medical director and director of nursing			
Ensuring that the FTSU Guardian has appropriate support and advice on patient safety and safeguarding issues.		None identified	Ready access to advice and support from professional leads
Ensuring that effective and, as appropriate, immediate action is taken when potential patient safety issues are highlighted by speaking up.		Reiterate the existing process with advocates	Evidence available from cases as appropriate
Ensuring learning is operationalised within the teams and departments that they oversee.		Keep under review	Currently limited learning from cases raised to date

Kerry Turner
Erica Saunders
Melissa Swindell

Memorandum of Understanding

Between Alder Hey Children's NHS Foundation Trust and Liverpool Women's NHS Foundation Trust for a Single Neonatal Service for Liverpool and the wider region

Introduction

The following Memorandum of Understanding (MoU) sets out the framework for collaborative partnership working between Alder Hey Children's NHS Foundation Trust (AHCH) and Liverpool Women's NHS Foundation Trust (LWH) (the Parties) to support the delivery of a three year implementation plan for the proposed new model of care for surgical neonates across a two site single service model which will significantly improve the quality of care outcomes and safety of the service as per the joint business case.

The model of care will see the establishment of a new NICU facility with 24 cots at AHCH which will be staffed by nurses with neonatal specialty training, Advanced Neonatal Nurse Practitioners, Consultant Neonatologists, Consultant Paediatric Surgeons and therapists. In accordance with the aspirations of the Parties, staffing levels are to be fully compliant with BAPM standards although both Parties recognise that this will require investment by commissioners, which is reflected in the phased approach set out in the joint business case.

1. Shared Purpose

The Parties share a commitment to the provision of the best possible care for the neonatal population of Liverpool and the north west region and will act with one voice as part of the Neonatal network and wider health economy.

All neonatal surgery will continue to be performed on AHCH site; and in collaboration with LWH AHCH will the establish a new model of care with a designated Neonatal Intensive Care provision and enhanced post-natal support at AHCH (a two site single service model) and will include enhanced surgical support at LWH.

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

- Providing dedicated neonatal intensive care provision at 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 and which optimises neonatal and surgical care provision on each site
- Developing the clinical research capability across both trusts and their academic partners
- Supporting outstanding educational opportunities to build the right workforce for the future.

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2. Partnership Principles

The parties will:

- ensure that a Partnership Board (PB) and associated governance structure is established set out in paragraph 4 below. The Terms of Reference of the PB and associated are set out in Appendix 1;
- ensure the commitment to safeguarding services and safety of patients will be an unbroken thread through the collaboration work between the parties;
- uphold the principle of fairness to ensure there will be similar benefits for both parties and the populations they serve;
- ensure mutual transparency of data in areas of collaboration;
- be consistently transparent about strengths, weaknesses opportunities and challenges;
- mutually sustain any project management or implementation resources as required;
- recognise that collaboration is intrinsically demanding on time and resources and therefore ensure the benefits outweigh the investment of time and resource;
- commit individuals/teams to a joint workshop designed to work through the key aims, objectives and challenges;
- establish appropriate contractual arrangements, including honorary contracts, in order to further enhance mutual understanding of the collective commitment to the service;
- appropriately reflect the content and spirit of the MoU in each other's business plans and strategies; and
- operate in accordance with the stated values of both organisations and in an environment of 'no surprises.'

3. Partnership Decision making

The PB will acknowledge an agreed a set of reserved matters for the Parties respective Board of Director. With the exception of those items reserved, all actions and work programmes in support of the purpose and principles set out in this MoU will fall within the remit of the PB to progress and make decisions when they arise.

4. Partnership Governance

The existence of the PB will not impinge upon the legal sovereignty of the Parties, each of whom will retain responsibility for meeting all expected quality and service standards, including performance to the relevant regulatory standards including the Care Quality Commission's *Fundamental Standards* and the requirements set out in NHSI's *Single Oversight Framework*. The Board of Directors of each organisation will continue to be accountable for its own service provision in accordance with its constitution, provider licence and statute. Formal minutes of the PB will be made available to each of the Parties Board of Directors and any matters of concern escalated through their existing governance structures.

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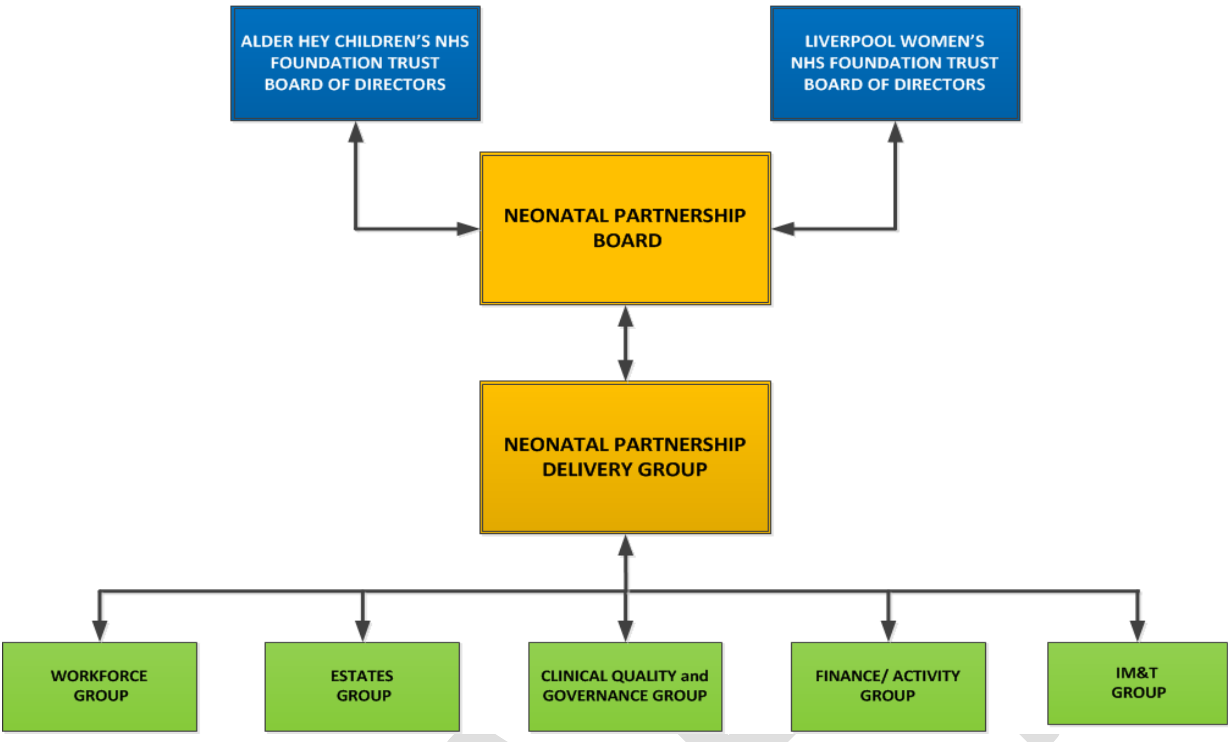

4. Duration of the MoU

This MoU, including the terms of reference of the PB, will be kept in place until it is replaced by [define end point]. Both parties agree that the MoU will be reviewed each year on the anniversary of the date this MoU was signed.

5. Variation and Escalation

Variations may be made at any time to the Memorandum with the express agreement of both organisations.

The MoU will be reviewed annually or earlier if required. Any changes will be mutually agreed and signed by the parties.

Any issues or disputes which cannot be immediately resolved by Partnership Board to all parties' satisfaction should be escalated to the CEOs of both Trusts. In the event that the CEOs cannot resolve issues or disputes, the issues should be escalated to Trust Boards.

The MoU is not intended to be legally binding, or to give rise to any liability of any kind whatsoever.

6. Confidentiality

Both parties will adhere to all the statutory requirements relating to confidentiality, information governance and data protection (GDPR) and for the avoidance of doubt, will apply to all consultants, professional advisers and contractors employed and/or engaged by the Parties.

Information shared between the Parties will be treated in the strictest confidence and not shared with another organisation unless explicit permission is given.

I accept the terms of the MoU for and on behalf of Liverpool Women's NHS Foundation Trust:

Signed

…………………………………………………
Chair

…………………………………………………
Chief Executive

Date

I accept the terms of the MoU for and on behalf of Alder Hey Children's NHS Foundation Trust:

Signed

…………………………………………………
Chair

…………………………………………………
Chief Executive

Date

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Appendix 1

Neonatal Partnership Board
TERMS OF REFERENCE

Constitution:	The Neonatal Partnership Board is established by the Trust boards of Alder Hey and the Liverpool Women's Trust Boards and will be known as the Partnership Board.
Duties:	The Partnership Board is responsible for: **The delivery of the implementation plan for a single Neonatal Service on two sites.** The Partnership Board will:- • Overseeing the delivery of the implementation plan for a single Neonatal Service on two sites • Overseeing the current partnership service delivery of Neonatal Care – managing risks and incidents jointly. • Monitoring progress against the implementation plan via reports from the Partnership Delivery Group • Identifying and monitoring the strategic risks of the programme, together with reports of any clinical incidents and the learning from them • Establishing a communications strategy • Ensuring the programme stays within the scope of the original business case and financial envelope and ensure benefits are realised. • Reporting progress to both organisation's Boards. • Ensuring alignment with the strategic and commissioning environment • Resolving any escalation of issues from the Partnership Delivery Group
Membership:	The Partnership Board is a decision making forum which will provide the strategic direction necessary to deliver the new model of care; it will be jointly chaired by the trusts' Medical Directors and will consist of the following members for each organisation: • Medical Director (joint chair – each on a rotating six monthly basis) • Chief Nurse • Chief Operating Officer • Clinical lead for Neonatal service • Lead Nurse • Divisional Manager • Finance representative In attendance

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	• NHSE Specialist Commissioning representative • Neonatal Network • Communication Lead Members can participate in meetings by two-way audio link including telephone, video or computer link (excepting email communication). Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum The Trust Boards will appoint a member of the Neonatal Partnership Partnership Board as Chair and another member to be Vice Chair from the outset. The Vice Chair will automatically assume the authority of the Chair should the latter be absent.
Quorum:	A quorum shall be [4] members including: • A Clinical Representative • The Chair or Vice Chair • Director of Operations or Chief Operating Officer
Voting:	Each member will have one vote with the Chair having a second and casting vote, if required. Should a vote be necessary a decision will be determined by a simple majority.
Attendance:	**a. Members** Members will be required to attend a minimum of 75% of all meetings. **b. Officers** Other officers and staff of the Trust will be invited to attend the meeting as appropriate when an issue relating to their area of operation or responsibility is being discussed. Representatives from partner organisations or other external bodies may be invited to attend as appropriate. Such representatives will not have voting rights.
Frequency:	Meetings shall be held a minimum of 5 times per year. Additional meetings may be arranged from time to time, if required, to support the effective functioning of the Programme. The meeting will routinely be held at XX on the first xxday of each month.
Authority:	The Partnership Board is authorised by the Trust Boards to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Programme Board.
Accountability and reporting arrangements:	The Partnership Board will be accountable to the Trust Boards of both Trusts The minutes of Partnership Board will be formally recorded. A Chair's report will be submitted to the Trust Boards. The Chair of

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	the Partnership Board shall draw to the attention of the Trust Boards any issues that require disclosure to it, or require executive action. The Partnership Board will report to the Trust Boards on its work and performance in the preceding year. Trust standing orders and standing financial instructions apply to the operation of the Partnership Board.
Reporting Committees/Groups	The sub-committees/groups listed below are required to submit the following information to the Trust Boards a) Chair's Report [and/or] minutes of meetings; and b) An Annual Report setting out the progress they have made and future developments.
Monitoring effectiveness:	The Partnership Board will undertake an annual review of its performance against its duties in order to evaluate its achievements.
Review:	These terms of reference will be reviewed at least annually by the Trust Board
Reviewed by Committee:	2018
Approved by Finance, Performance and Business Development :	2018
Review date:	June 2019
Document owner:	Medical Director AH Email: Steve.Ryan@alderhey.nhs.uk Medical Director LWH Email: andrew.loughney@lwh.nhs.uk

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Neonatal Partnership Delivery Group
TERMS OF REFERENCE

Constitution:	The Neonatal Partnership Board – Operations and Management is established by the Neonatal Partnership Programme Board and will be known as the Delivery Group.
Duties:	The Delivery Group is responsible for: **The delivery of the implementation plan for a single Neonatal Service on two sites.** The Partnership Delivery Group will: • Manage the implementation plan for a single Neonatal Service on two sites, using the recognised programme management methodology • Manage any risks or incidents in the delivery of the current Neonatal Service. • Ensure delivery to programme budget and ensure prudent and appropriate use of resources • Maintain an effective and auditable project administration process, including the development and monitoring of an agreed robust QIA/EIA • Monitor and operationally manage progress against the implementation plan from the agreed workstreams – Workforce, Finance/Activity, Clinical Quality and Governance, Estates • Work with recognised experts to ensure delivery of a high quality fit for future unit and the safe migration of patients both during decant and into the new unit. • Provide oversight for the management of services and activities of site specific project sub groups. • Identify, record and manage project risk with appropriate escalation • Review and approve output specification designs • Review and approve joint operating policies covering key areas eg infection prevention and control, consent, incident management, investigations, complaints, claims, information management (Badger system) and information governance • Identify benefits criteria and manage benefits realisation • Report progress to Neonatal Partnership Board.
Membership:	The Partnership Delivery Group is the operational and managerial arm of the Single Neonatal Service project; it will oversee delivery across both sites and is accountable to the Partnership Board. It will be jointly chaired by the COO of each organisation and will consist of the following members:

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	• COO • Lead Nurse • Service Manager • Quality Lead • PICU representative • Estates representative • Infection control lead • Project manager • IT lead • Finance representative • HR representative In attendance/advisory • Senior Network representative (clinical). • Communication Lead Members can participate in meetings by two-way audio link including telephone, video or computer link (excepting email communication). Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum The Partnership board will appoint a member of the Delivery Group as Chair and another member to be Vice Chair from the outset. The Vice Chair will automatically assume the authority of the Chair should the latter be absent.
Quorum:	A quorum shall be [4] members including: • A Clinical Representative from both Trusts • The Chair or Vice Chair • Director of Operations or Chief Operating Officer
Voting:	Each member will have one vote with the Chair having a second and casting vote, if required. Should a vote be necessary a decision will be determined by a simple majority.
Attendance:	**c. Members** Members will be required to attend a minimum of 75% of all meetings. **d. Officers** Other officers and staff of the Trust will be invited to attend the meeting as appropriate when an issue relating to their area of operation or responsibility is being discussed. Representatives from partner organisations or other external bodies may be invited to attend as appropriate. Such representatives will not have voting rights.
Frequency:	Meetings shall be held a minimum of 10 times per year. Additional meetings may be arranged from time to time, if required, to support the effective functioning of the Programme. The meeting will

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	routinely be held at XX on the first xxday of each month.
Authority:	The Delivery Group is authorised by the Partnership Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Partnership Board.
Accountability and reporting arrangements:	The Delivery Group will be accountable to the Partnership Board. The minutes of Delivery Group will be formally recorded. A Chair's report will be submitted to the Partnership Board. The Chair of the Delivery Group shall draw to the attention of the PartnershipBoard any issues that require disclosure to it, or require executive action. The Delivery Group will report to the Partnership Board on its work and performance in the preceding year. Trust standing orders and standing financial instructions apply to the operation of the Delivery Group.
Reporting Committees/Groups	The sub-committees/groups listed below are required to submit the following information to the Programme Boards c) Chairs Report [and/or] minutes of meetings; and d) An Annual Report setting out the progress they have made and future developments.
Monitoring effectiveness:	The Delivery Group will undertake an annual review of its performance against its duties in order to evaluate its achievements.
Review:	These terms of reference will be reviewed at least annually by the Partnership Board
Reviewed by Committee:	2018
Approved by Finance, Performance and Business Development :	2018
Review date:	June 2019
Document owner:	Director of Operations LWH Email: jeff.johnston@lwh.nhs.uk Chief Operating Officer Email: Adam Bateman adam.bateman@lwh.nhs.uk

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LIVERPOOL PROVIDER ALLIANCE PLAN 2018-19

Executive Summary

This document sets out the priorities and delivery plans that will be taken forward by the Liverpool Provider Alliance in 2018/19.

The Provider Alliance vision is to work together as one team to provide the best possible services for our communities. From cradle to grave, we will look to improve health and wellbeing and promote greater independence.

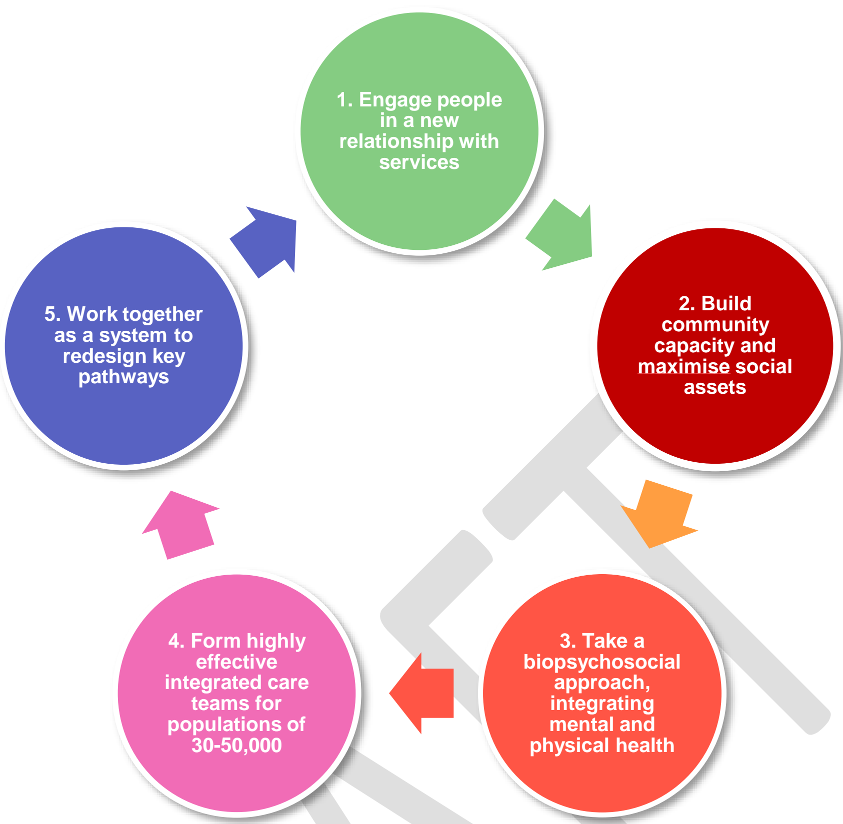
There has been a range of national policy initiatives over recent years designed to strengthen the provision and integration of community-based health and care services (e.g., *Shifting the Balance of Care*, Better Care Fund). Despite these, and without denying the developments accruing from such, acute hospital services have continued to increase their proportionate share of NHS funding. Over the past five years, primary and community services have struggled to secure real terms growth whilst social care provision has been severely affected by financial constraints and real term cuts.

The increase in expenditure in hospital services has itself struggled to match rising demand, fuelled by demographic, societal, behavioural and technological factors. However, this demand is in part comprised of needs, which could be better met within community settings and primary care, subject to the availability, and accessibility of appropriately integrated and resourced care, supported by public awareness and behavioural change.

The sustainability of the current model of health and social care is now being fundamentally questioned, prompting unprecedented ambitions of productivity aligned to the development of transformational, whole-system plans designed to create a sustainable health and care system.

Central to these plans is a commitment and need to radically enhance to provision of care closer to home, enabling a stepped change in levels of self-care linked to behavioural change, earlier intervention supported by risk stratification and population segmentation and enhanced access to integrated services, particularly for the frail, those with long term conditions and those with mental ill-health. The 'Five Year Forward View' (NHS England, 2014) and GP Forward View (NHS England, 2016) set out a clear direction for the NHS, showing why change is needed and what it will look like.

This plan sets out how the Liverpool provider alliance will work together using it's collective resources to deliver this change in the community, from prevention through to recovery, encompassing all-ages and delivering parity of esteem for mental health with physical health.



Through integrated care teams we will provide a biopsychosocial model of health care that will address the holistic needs of service users ensuring they receive the most appropriate, cost effective interventions in the right location at the time whilst reducing duplication. The biopsychosocial model will promote parity of esteem and address the wider determinants of health that impact on service utilisation. We will also create a new behaviourist role to work with people with complex needs and give them the knowledge, skills and support to change their behaviour.

We will bring some of the more specialist roles out of traditional hospital settings to deliver care closer to home and to work closely with integrated care teams sharing knowledge and expertise and providing seamless pathways of care.

A single point of access will deliver rapid and consistent response and the development of an interoperable care record will ensure information sharing is accurate, timely and efficient.

We will collaboratively with both statutory and non-statutory organisations to maximise the extensive resources within the borough to create cohesive communities, supporting people within their 'place'. With a clear focus on prevention and supportive self-managed care, we will offer alternatives to more traditional health and social care services.

Through new relationships with communities we will facilitate a culture of change that will provide a new deal for local people, creating a resilient 'place' that will have a positive impact on the health and well-being of residents.

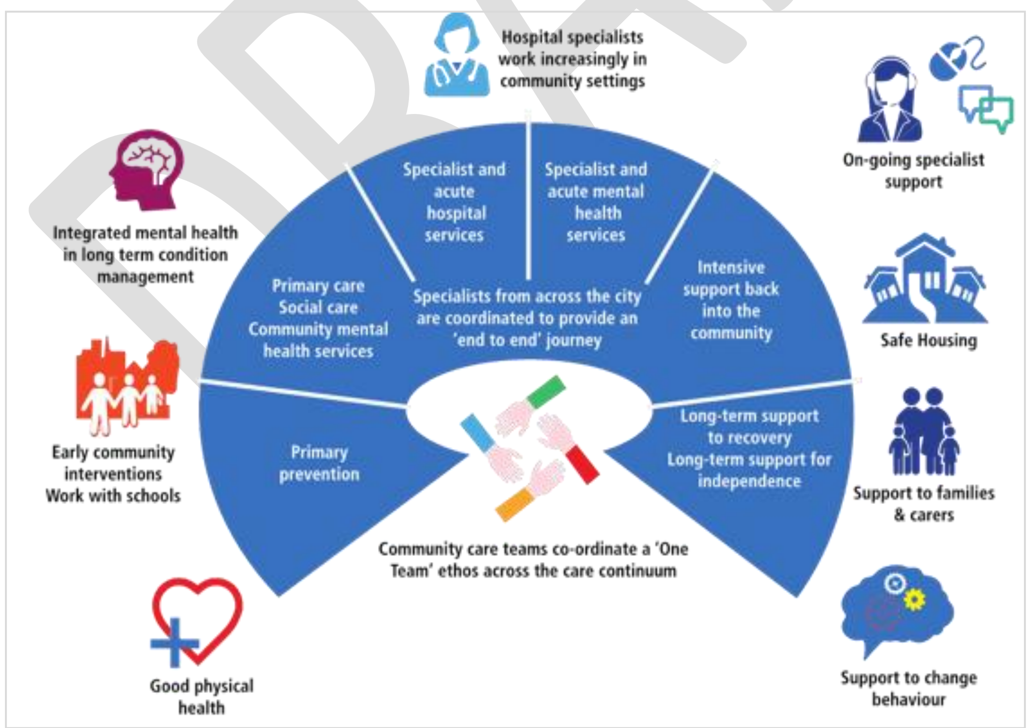
This plan will address the fragmented approach to service delivery, improve quality, address health inequalities, deliver better experience for service users and support sustainability of the wider healthcare system.

Liverpool Provider Alliance

Improving health outcomes is a complex challenge which is bigger than any single organisation and therefore requires effective partnership working. We have the potential to be more impactful we pull in the same direction, work in similar ways and collaborate to provide more holistic support to people in our communities.

Liverpool has a diverse and complex health and care system, with eight NHS provider trusts including two large adult acute hospitals within five miles of each other, a children's acute trust, a women's acute trust and four specialist trusts, located in the city but serving the wider region. In addition to these statutory organisations, there are believed to be over 1,300 registered voluntary sector organisations serving the Liverpool the majority of which work in the fields of health, education and life-long learning, leisure and community development. In 2019/20, over £1.1bn will be spent by Liverpool City Council and Liverpool CCG on services for local people.

The Provider Alliance is up of those organisations who are involved in joint community service delivery (GPs, social care and the voluntary sector) and pathway partners (acute trusts, UC24 and care homes) who are linked to or impacted by community services.



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Our place-based model of care is based upon a series of principles, informed by the evidence base from integrated care internationally and in England through the NHS England New Care Models programme:

- We will empower those with long term conditions to take more control of their own health.
- We will provide whole-person care through a bio psychosocial approach.
- We will break down existing barriers between primary, community, hospital, mental health and social care, to create a streamlined experience for patients and avoid duplication.
- We will maximise community assets.
- We will make the health care system simpler, particularly for those with complex needs.
- We will pull specialist services out of hospital settings to be delivered as close to the patient/community as possible.

The implementation of our integrated community care model will be based on the neighbourhood approach adopted within Liverpool for a number of years. The basic building blocks of this model are integrated community care teams aligned to neighbourhoods and GP practices. There are 12 established neighbourhoods across Liverpool, each covering populations of 30-50,000.

This provider alliance reports to the Integrated Care Partnership Group established by Liverpool City Council, and the Joint Commissioning committee that reports to the Health and Wellbeing Board.

This plan sets out how the Liverpool Provider Alliance will use the collective resources of the NHS, the Council, housing, the voluntary sector and other partners in 2018/19 to deliver the One Liverpool Plan.

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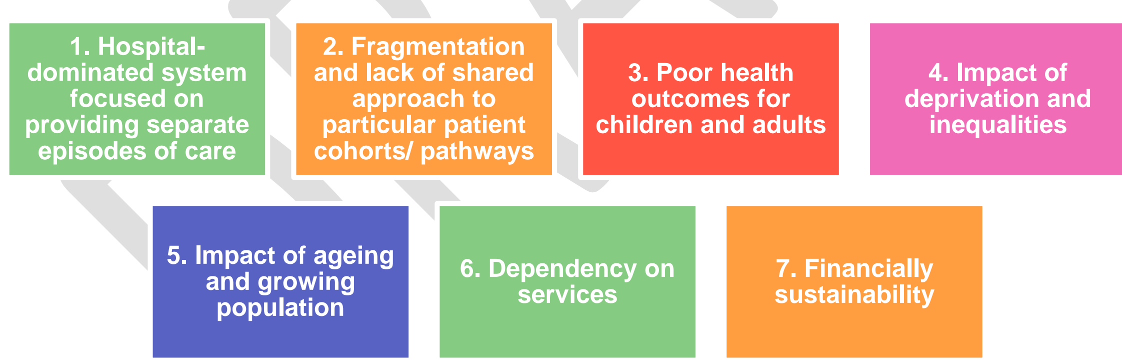
A. The problems - why we need change in the city

Integrated care only works when local service commissioners and providers have a shared view of the problems and solutions in their local health system.

Public services play a critical role in helping and protecting people, but we know something is not working. Despite having a number of excellent hospitals, a thriving voluntary and third sector and good quality social services, local services are not solving the most intractable health challenges, with huge variation in health outcomes even within neighbourhoods of Liverpool. We know that individuals and families with the most complex needs experience multiple interventions from different services and agencies and yet all too often remain trapped in repeating cycles of intervention. People's lives and associated health problems are increasingly complex and require services to work together in order to be effective, but all too often individual organisations offer services in isolation. Driven by clinical complexity, older and sicker patients with more co-morbidities, administrative complexity caused by multiple commissioners and multiple providers we have a care system that is very difficult to navigate, particularly at a time of crisis. As is set out in the Five Year Forward View and the Cheshire and Merseyside Sustainability and Transformation Plan, the NHS part of this system is not financially or clinically sustainable in its current form.

The Provider Alliance must tackle a number of systemic problems if it is to deliver the One Liverpool Plan.

The problems:



[DN review and add local evidence for statements made below]

1. Hospital dominated system focused on providing separate episodes of care

The health and care system in England was designed in 1948 to episodes of care to normally healthy people. Despite massive social, economic, technological and demographic change since then, the health system of 2018 is still based on this premise, with separate organisations (including eight NHS provider trusts in Liverpool) treating patients as a series of separate episodes of care.

2. Fragmentation and lack of shared approach to particular patient cohorts/ pathways

As a system we are not geared to caring for the most frequent users of the NHS - those with more than one long term condition. Our health system has become one of the most complicated systems in the world, with multiple commissioners, providers and regulators. Providers tend to focus on providing separate episodes of care rather than working together to manage the end to end patient journey.

A recurring theme from our patient engagement is frustration at being assessed numerous times by different health and social care professionals who are not able to share information and are delivering care in silos.

"**I have to tell my story over and over, don't you people listen**?" Patient with long term physical health condition

"I want to see the same person who knows me, not just my condition." Patient with long term physical health condition

"I ended up having to stay in hospital far longer because information about how to manage my symptoms when in crisis wasn't shared with the ambulance staff who transferred me to hospital." Patient with lung disease

"I am grateful for the support I now get from the people who know me, but has taken years to get support from the same people." Patient with long term mental health condition

"Where I am now is because of me not because of the support I got from doctors." Patient with mental health and physical health long term conditions

3. Poor health outcomes for children and adults

In 2016, 1,800 Liverpudlians died young (under 75) and over 1,000 of these deaths were considered preventable. The number of people with long term conditions in Liverpool is above national levels, with many people undiagnosed. The biggest killers are cancer (30%), CVD (20%) and respiratory disease (15%). On average, men born in Liverpool can expect to live to 76.3 years while women born in Liverpool can expect to live to 80.4 years, both significantly below the England average. Life expectancy in the city has plateaued in recent years

The level of infant deaths per 1,000 live births in 2014-2016 was statistically significantly higher than the England rate. Children in the city have the lowest rates of 'school readiness' in the country and only 6 out of 10 Liverpool children have a good level of development at the end of their school reception year, compared with 7 out of 10 nationally. There are 115 looked after children per 10,000, compared with an England average of 60 per 10,000. Liverpool has a high rate of A&E attendances for children aged 0-4 years, 60% higher than England.

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4. Impact of deprivation and inequalities

Liverpool is persistently one of the most deprived areas of the country. The biggest cause of illness and poor wellbeing in the city is poor mental health and in Liverpool, if you have a serious mental illness, you are three-times as likely to die before the age of 75 years, on average dying 15-20 years earlier than other people.

This level of complex need is reflected in rising demand for mental and physical health services in Liverpool. Hospital admissions for alcohol-specific conditions in the city are almost three times the national average, and Liverpool's premature mortality rate for liver disease is more than twice the national rate. Drug misuse is a significant cause of premature mortality in the UK. Around 40 people die from drug misuse each year in the city. The Liverpool rate of 9 per 100,000 is more than twice the national rate.

5. Impact of an ageing and growing population

Liverpool has a growing and ageing population. Over the next ten years plus, the largest population increase is predicted in people aged 65 and over. A 17% increase in over 60s is forecast in the next decade along with a substantial increase in children. Liverpool has the highest level of emergency admissions due to falls in the over 75s in the country (with around 2,365 admissions each year) and there has been a 5% increase in the mortality rate for 85+ year olds over the last 3 years.

6. Dependency on services

[DN add detail regarding hospital utilisation benchmarking]

We know that most care is delivered outside the formal health system, but there is little recognition of this by services. Personal behaviour, social relationships, homes and income are more powerful drivers of good health than doctors, hospitals or GP surgeries. But all too often medical or care interventions are provided in isolation to people's social circumstances, without addressing how people's behaviour and choices might need to change and without addressing the root causes of poor health that lie outside the treatment room or clinic.

7. Financially unsustainable

We face these challenges within a greatly constrained financial environment. Liverpool has been particularly affected by changes in central government funding affecting the council as a whole but in particular, in this context, adult social care and public health. Liverpool City Council central government funding will have reduced from £523.7m in 2010/11 to £246m in 2019/20[1]. This represents a real terms reduction in government funding of £444m or 64%. Over the same period Adult Social Care (ASC) has delivered savings of £79.4m.

[1] Indicative figures released by the Government as part of the 2018/19 Provisional Finance Settlement

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NHS Liverpool Clinical Commissioning Group begins 2018/19 in accordance with NHS England Business Rules with a brought forward cumulative surplus of £16.4m (equivalent of 2%). This is based on a current forecast 'in-year' break even position in 2017/18. It has been difficult 18 months for the CCG which has required a significant increase in level of cash releasing savings and expenditure reductions (£13m and £26m, in 2016/17 and 2017/18 financial years respectively) in order to achieve these financial requirements. The CCG's begin the financial year 2018/19 with a total 'resource' allocation of £880.4 million which we expect to rise to £923.6 million by 2020/21 (although resource allocation beyond 2018/19 financial year is not yet confirmed).

The NHS and local government have sought to mitigate the funding pressures by providing certainty through the NHS acting as one contracts for 2017 to 2019 and through the pooled budgets within the Better Care Fund.

B. The solutions – offered by providers working together

Community services play an invaluable, but often overlooked, role in people's lives. NHS community health services cover an extensive and diverse range of activities. Beyond the narrow definition of NHS community health services there is a much wider range of sectors and services that deliver care and support in the community. Patients receiving care in community settings often have multiple, complex health needs and depend on many health and social care services to meet these needs. These services have evolved in diverse ways and have been often formed from a coalescence of what local hospitals are not doing rather than their own strategy and purpose. We need a more ambitious and proactive approach to community services because they are important in themselves, to meet people's long term health needs more effectively and to support people's long term physical and mental health more holistically.

Shared principles for developing care closer to home in a Memorandum of Understanding

Integrated care only works when individuals and organisation share the same vision, purpose and goal. Integration therefore closes the gaps in care by enabling aspects of care to fit together. In addition communication, collaboration and coordination of care create a much more responsive and efficient service. The Provider Alliance will agree a Memorandum of Understanding which reflects the following shared principles and goals.

- **We will empower those with long term conditions to take more control of their own health.** 80% of people using health services are now cared for in low acuity setting, where the overwhelming control is with the person/child/family. We will enable people to do more for themselves, helped along by people who are sensitive to the strengths and circumstances of that individual and through relationships developed over time that are based on behaviour change.

- **We will provide whole-person care through a biopsychosocial approach.** Psychological needs and social circumstances are a strong but often overlooked driver of a person's health needs and their use of public services. There is overwhelming evidence that developing an integrated response to people with both mental and physical health problems, in particular supporting people with common mental health problems (such as, depression or anxiety) alongside a physical long-term condition could dramatically improve outcomes and reduce cost. Addressing people's psychological needs can enhance their motivation to make healthier choices and take more control over their own health, particularly for long term conditions.

- **We will break down existing barriers between primary, community, hospital, mental health and social care, to create a streamlined experience for patients and avoid duplication.** The integrated model of care being developed in Liverpool is not about the 'bolt-on' of other services to providers existing service portfolio, but a genuine integration

of functions and services in order to deliver significant benefits for patients, neighbourhoods and commissioners. This will require aligned infrastructure, clinical governance and resources. We believe that such an approach will enable providers and commissioners to achieve significant allocative efficiencies by deploying existing staff and teams differently, shifting resources to more preventative interventions, and stopping ineffective interventions.

- **We will maximise community assets.** We are clear that to improve health and wellbeing we will need to deliver much more of a 'social model of health' that addresses the broader influences on health, social, cultural, environmental and economic factors. Liverpool CCG commissions a range of non-medical programmes and the provider alliance will build on this, developing the existing neighbourhood structure to actively engage health and social care teams with their local communities, involving other agencies to actively work together to improve the health and wellbeing of local communities.

- **We will make the health care system simpler, particularly for those with complex needs.** We will stop the practice of different specialists visiting patients to assess for particular needs, co-ordinating care through designated Care Co-ordinators operating within the neighbourhood integrated care team. Innovative approaches will be implemented to provide more specialist and targeted support where it is clear that the universal care offer is not delivering positive outcomes.

- **We will pull specialist services out of hospital settings to be delivered as close to the patient/community as possible.** We will work with CCG and clinicians from local acute and specialist trusts to redesign stroke, cardiology and respiratory pathways. Hospital specialists will work with integrated care teams to ensure people are getting timely specialist access and assessment.

Actions:

- **We will agree a Memorandum of understanding for the Provider Alliance by the end of June 2018 to confirm commitment and resources to the integrated care team model.**

Developing a new operational model for care closer to home

Rather than continue to run separate mental health, social care or physical community services, local providers will operate within a 'One Team' ethos for out of hospital care, uniting primary care, social care, community physical and mental health services and the voluntary sector, delivering the following solutions to the system-wide problems set out. This means that different professionals, teams and organisations will link together and work alongside each other in a seamless way to wrap care around the patient.

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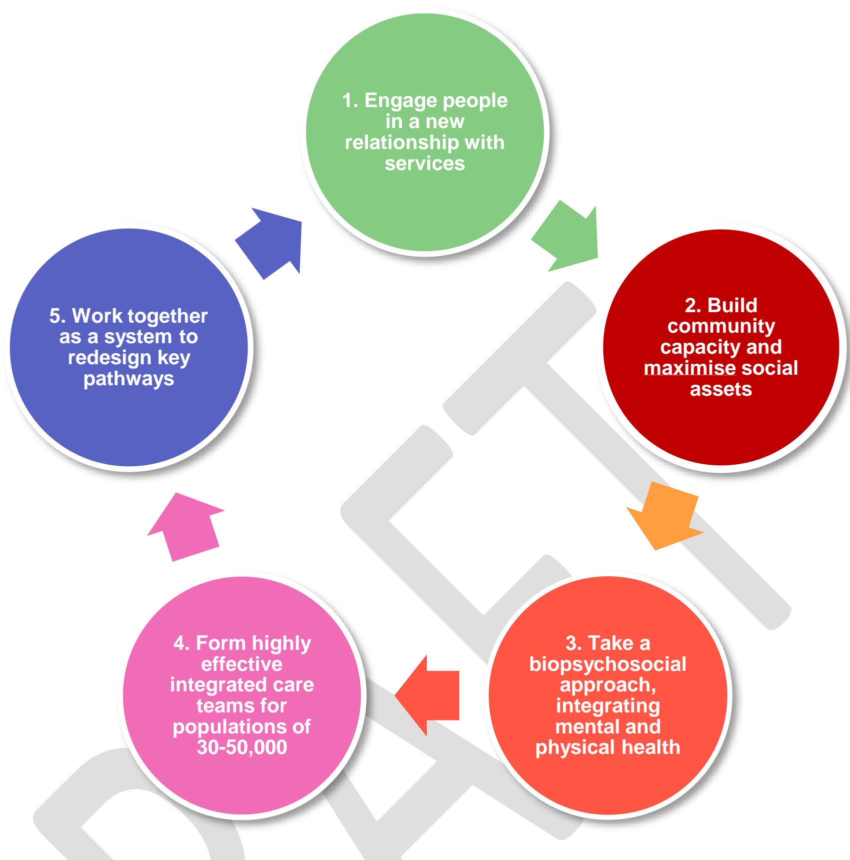
The key components of our new shared operational model for community services are set out in the diagram overleaf.



The model is based on the theory that we must address people's dependency on hospital services by changing their passive relationship to services, maximising social support in the community and taking a biopsychosocial approach that addresses people's needs holistically. This approach will be operationalised through the development of highly effective integrated care teams for populations of 30-50,000, and reflected in the whole-system redesign of key pathways such as urgent care, the frailty pathway to reduce hospital dependency.

The components of our model are further explained below.

1. Engage people/ communities in a new relationship with services

An essential first step in developing effective care closer to home will be to engage with local people to understand what is important to them and to change their relationship to NHS services from the current dependent/passive relationship, to a more independent and active relationship. We want to engage local people for a purpose and not for the sake of doing so.

We will gain insight by understanding how services are used differently by different social groups and segments, and understanding what service users prefer, expect and value. We also hope to gain insight how we can support self-care more effectively.

We will give information about the full range of services available and make it easy for local communities to use the services that are available in their neighbourhood.

We will engage in difficult conversations to manage expectations and to encourage them to use services differently. We will engage local people in conversations to encourage them to take responsibility for how local services are utilised, and to build support for service change in line with a more preventative model.

Actions:

- **We will engage with local people together about self care and a 'new deal' in health and care.**
- **We will increase the use of Mersey Care's Life Rooms and other wellbeing centres to support self care and recovery from illness.**
- **We will enhance self care and control with the Behaviourist role in integrated care teams**

Goals:

- **We will increase the proportion of people reporting that they are in control of their condition by ( ).**

2. Build community capacity for health and maximise social assets

We believe that public services need to become more accountable to the people and communities they serve, but also develop greater insight into what makes those communities 'tick' and find ways to enable these things to support wellbeing. We believe that public sector organisations must learn how to connect more effectively to community assets such as employers, housing providers, the police, education and voluntary and faith organisations. For example, loneliness and social isolation are as great a killer as smoking and relationships are a key protective factor for good mental health, but the health service does not factor social isolation into its treatment and care. A collaborative platform is needed to bring together business, housing, the NHS and the voluntary sector to work together to support wellbeing in each neighbourhood. Neighbourhood teams will develop a valued network of local voluntary sector organisations an through new forms of partnership working, community services such as housing, mental health specialists, the police and the voluntary sector work can together help to reduce loneliness and social isolation.

We have already undertaken a number of design thinking events with local residents, statutory and voluntary sector organisations that have informed our model of care. We will continue to develop a neighbourhood-centred collaborative model based on the social model of health which builds on the resources available across Liverpool. We will work with both voluntary and statutory sector organisations to create a network that will ensure community assets are maximised and targeted on building resilience. This will encompass the wider

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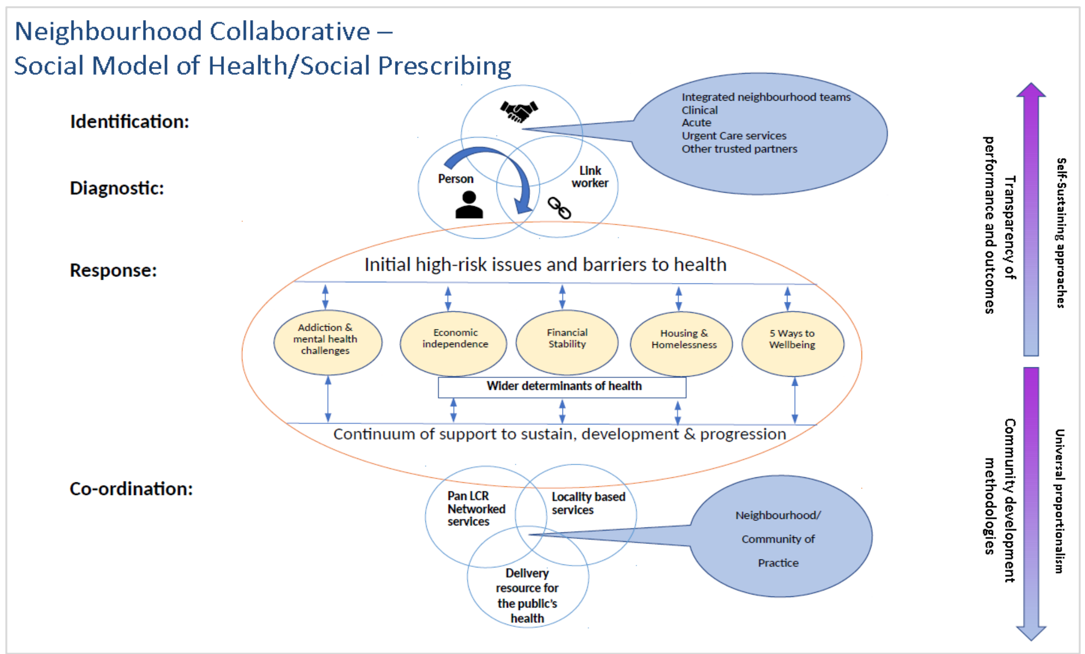
influences on health and well-being such as social, cultural, environmental and economic factors.

We will take the following approaches were to building community capacity for health:

- Identifying and supporting key individuals in the community
- Supporting social prescribing in general practice
- Developing innovative community schemes and supporting volunteering
- Using digital media to promote social connections (e.g. internet support groups)
- Promoting community governance and levels of control (e.g. community budgets)
- Enhancing environmental assets (e.g. good housing and green spaces)
- Developing asset based mapping and other measures relating to community resilience
- Developing workforce skills in promoting community resilience (e.g. training public health staff in asset mapping and community development).

We will establish a collaborative of community organisations linked to each integrated care team. A collaborative platform is needed to bring together business, housing, the NHS and the voluntary sector to work together to support wellbeing in each neighbourhood. Through new forms of partnership working, could community services such as housing, mental health specialists, the police and the voluntary sector work together to reduce loneliness and social isolation. This is summarised in the diagram below.



Actions: [DN dates required]

- **Showcase wellbeing offering at neighbourhood level, linked to Life Rooms.**
- **Develop a neighbourhood forum/citizens panel for health and care knowledge to be shared, e.g. dementia awareness, suicide prevention, practical support to carers relating to common mental health issues.**
- **Connect voluntary sector assets to integrated care neighbourhood team**
- **Themed events for local agencies/activists with NHS and social care professionals**

on mental health, suicide prevention, dealing with crisis or conflict, personality disorder etc

- **Conduct a communication and information audit for health and care services at neighbourhood level.**

Goals:

- **We will increase the proportion of people reporting that they have as much social contact as they would like by ( ) [DN data currently only includes people in contact with social care, so may not capture widely, but is a robust measure].**

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3. Take a biopsychosocial approach, integrating physical and mental health

The Marmot review in 2010 highlighted the need for action on social determinants of health to improve and reduce health inequalities. Personal behaviour, social relationships, physical environments and income are more powerful drivers of good health than medical systems. It is estimated that around 20% of patients consult their GP for what is primarily a social problem (Low Commission 2015). We also know that patients with medically unexplained symptoms can create pressure across the health system, often with poor experiences and outcomes.

In a period of severe pressure on the public pound the NHS must become more adept at influencing people to use services responsibly and take more control over their own health. Working with local commissioners, the provider alliance will help re-write the script that defines the relationship between its services and patients, to enable people to play a more active role in looking after their own health. The alliance will offer patients opportunities to co-produce better health through the creation of the proactive care in neighbourhoods, through the redesign of local pathways and through working with local voluntary sector organisations.

Behaviourists will encourage behaviour change through motivational tools and techniques. We will provide assistive technology and innovative digital Apps where our patients prefer this approach. Through “neighbourhood collaboratives” we will work with local organisations who can add specific expertise, e.g. the voluntary sector, housing associations, charities. Life Rooms and Recovery College offer life opportunities, encouraging independence and health and wellbeing. We plan to expand on these models in view of the resounding success they have achieved in terms of outcomes.

The bio-psycho-social model of health encourages health care professionals to think beyond physical health and consider how the mind, body and social circumstances affect the health and well-being of the patient This is a fundamental shift from a disease focused approach to one that provides a holistic view, taking account numerous factors and how these impact on behaviours and service utilisation. It also creates opportunities to provide education in prevention and deliver lifestyle changes to improve quality of life.

The integration of physical and mental health staff, alongside social care staff in ICTs, will allow for education and knowledge sharing that will support the bio-psycho-social model of care. In addition, we will create a new 'behaviourist' role to work with people with complex needs, forming close relationships and building their confidence to change their behaviour. The behaviourists will be based in GP practices, forming strong relationships with the primary care team and other services and being a 'first port of call' for advice on patients with mental health problems.

Information and motivation are powerful drivers of behavior change and the behaviourist role will work with individuals providing a consistency of approach to both generate and sustain behavioural change. This will encompass lifestyle choices, health education and prevention and service utilisation. Through getting to know the local area the behaviourist role will connect people to both formal and informal care available to them.

A standardised referral and assessment framework will ensure that bio-psycho-social needs are identified at the outset and people receive the correct interventions to holistically address their needs.

With closer working between mental health specialists and other professionals, and more integrated information across health and social care settings, we will provide a holistic mental health and wellbeing service in community settings. This has the potential to significantly reduce the demand on secondary care services. The service will enhance clinical collaboration across primary and secondary care through consultants aligned to practices and a new link worker role based in primary care, but will also use community assets and expertise of previous and current service users to co-produce interventions.

Actions:

- **We will implement collaborative care between Mersey Care community mental health teams and GP practices in Liverpool.**
- **We will establish a network of 'behaviourists' linked to GP practices in Liverpool.**
- **We will increase the use of Mersey Care Life Rooms for patients in primary care.**
- **We will integrate Talk Liverpool IAPT (talking therapies) and long term conditions services for people experiencing common mental health problems**

Goals:

- **We will increase Mersey Care Life Rooms activity by ()%**
- **We will increase the proportion of people with mental health problems who have received physical health checks by ( )**
- **We will increase the number of people with long term conditions accessing IAPT (talking therapies) by ( ).**

- **We will increase the number of patients with common mental health problems (clusters 1-3) being cared for in primary care, reducing those on the caseloads of community mental health teams to 250 by December 2018.**

4. Form highly effective integrated care teams (ICTs) at 30,000 population level

Central to the delivery of integrated care is the development of effective working relationships with primary and secondary care clinicians and other professions and the development of relational coordination between staff within the **12 established neighbourhoods across Liverpool, each covering populations of 25-30,000**.

Each neighbourhood will be served by a multi-disciplinary integrated care team (ICT)**. A memorandum of understanding will confirm the commitment of staff and resources to the ICT** operational model. Any core member of the ICT will be able to undertake core responsibilities as set out in the operational model, supporting efficient use of staff time and continuity of care. The key elements of the integrated care team model are set out in the diagram overleaf.

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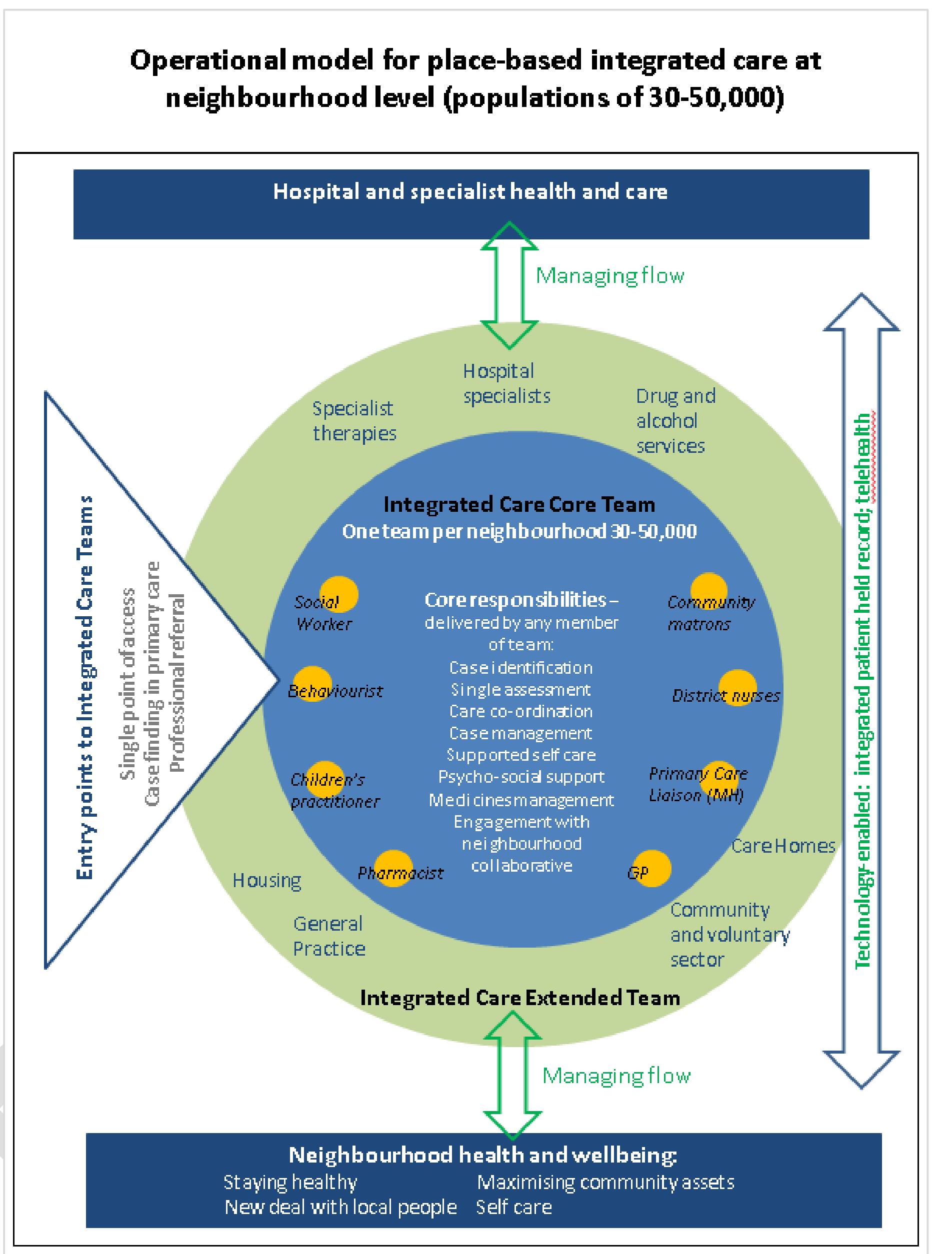


Each integrated care team will:

- Act proactively to identify and support people at risk of hospital admissions.
- Respond to referrals via a single point of access (operating Monday to Friday, 8am-8pm, with calls diverted to a named individual outside these hours)
- Ensure a co-ordinated response to the planning and delivery of care.
- Support self care and also engagement with neighbourhood assets (social prescribing)

A new 'behaviourist' role, will form part of the core ICT. They will to work with people with complex needs forming close relationships and building skills and confidence to change

people's behaviour. Working closely with primary care, they will act as a 'first port of call' for advice on patients with mental health problems.

Speciality community staff and hospital consultants will form part of the extended ICT, providing advice and guidance, training and education or direct clinical consultation. The specialist staff will be co-located with these local teams so they can build relationships and discuss cases easily without the need for referral forms. This will reduce delays in accessing a specialist opinion and result in better outcomes for patients as it will facilitate earlier commencement of treatment. In the year ahead, clinicians from primary and secondary care, social care staff, and voluntary sector and housing partners will **work together to redesign 'priority pathways'** –frailty, urgent care, children and maternity, planned care, complex needs (including co-morbid mental health problems, alcohol and/or drug addiction).

[DN priority pathways to be agreed by Alliance partners]

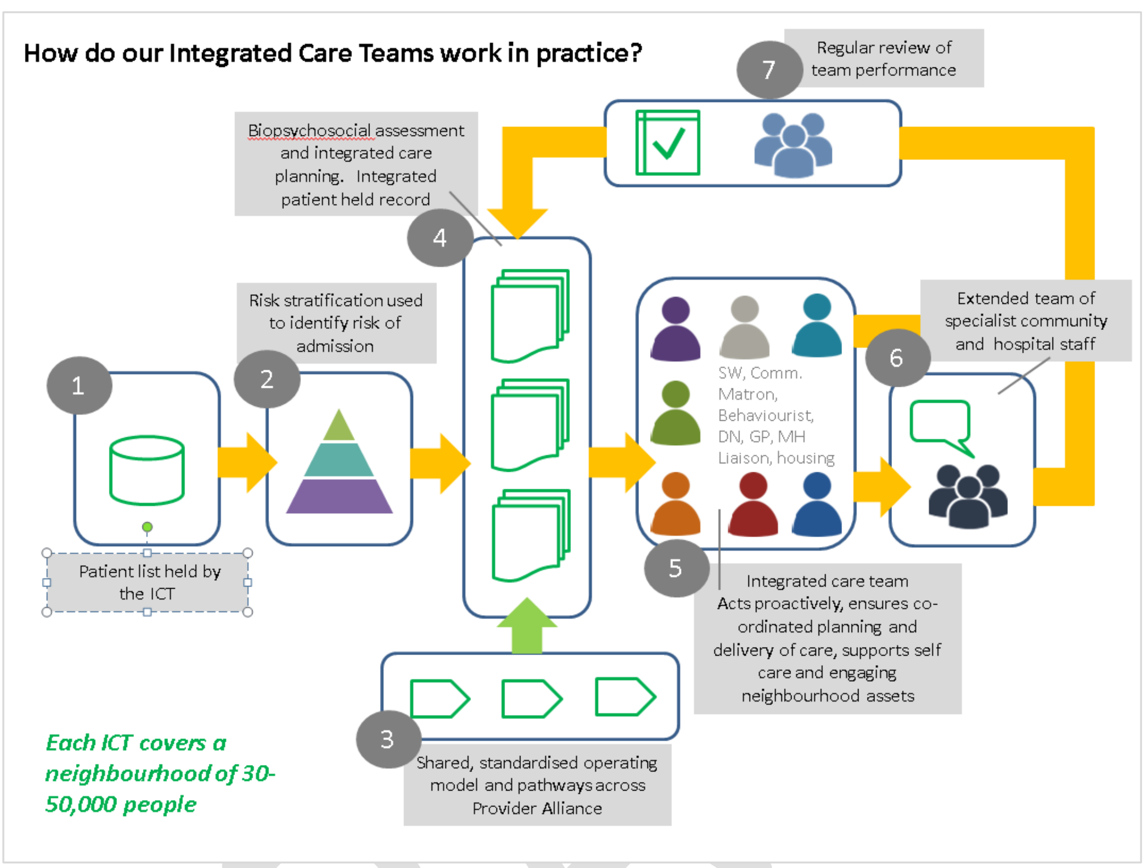
At neighbourhood level, the integration of physical and mental health staff, alongside social care staff in ICTs, will allow for education and knowledge sharing supporting a **bio-psycho-social model of care and support parity of esteem**. Extending the ICT to encompass housing, voluntary sector and other partners, ensures that the holistic social care needs of people are addressed.

This core and extended ICT will **manage the flow in and out of hospital and specialist health and care, and greatly enhance the management of long term conditions in primary care**. Furthermore, a memorandum of understanding will set out how loaclity GP practices will work together to address the health outcomes that are priorities for the population and the benefits that will be achieved by the practices working together at scale with the other providers.

ICTs will **work closely with the care home sector to implement quality improvement** and develop the skills of care home staff with the aim of the care home sector being aligned to our '**One Team'** ethos.

Care interventions are often provided in isolation to peoples social circumstances, without addressing how peoples behaviour and choices might need to change and without addressing the root causes of poor health that lie outside the treatment room or clinic. Our Integrated Care Teams will **make better connections to people and communities tapping into the strengths that are already there via clearly articulated neighbourhood collaborative arrangements**. Our social model of health/social prescribing builds on the work that has previously been undertaken in Liverpool to ensure the communities we serve are provided with asset based community approaches that focus on strengths and build resilience. The **model will also address the broader influences on health (social, cultural, environment and economic factors that can have an impact on health and well being)**. The Provider Alliance is working with a range of third sector partners to develop a collaborative neighbourhood model.

The diagram below sets out how our Integrated Care Teams will work in practice:



Technology is a significant enabler of our place based model of care:

Integrated patient held record - Mersey Care will maximise its Global Digital Exemplar status and resources to implement an **integrated patient held record providing access to current care plans from all providers and giving patients their own health and well-being record** including diary; mood; self scored diagnostics; appointments. In 2018, we will implement our plan to develop the technology system to integrate care records from EMIS Web community and RiO community; co-design with service users / patients the look and feel of their record and pilot the record in one Integrated Care Team in October 2018. We will work with other providers (social care and GPs) to include them in next phases of development and work with the STP Digital group towards a fully interoperable care record.

The Telehealth programme will provide remote telemitry, education and monitoring for people living with COPD, heart failure and diabetes and form part of the hospital discharge package. We will also pilot the use of telehealth with other conditions/treatments.

We are currently using apps and/or online services to view part of our medical records, book appointments, order repeat prsecriptons, monitor long term condiitons, access health information and monitor our activity, diet and lifestyle. Digital No Wrong Door will be a recognised mobile app/online offering that brings together the current fragmented and

compex digital initiatives that across our and social care economy. This will support patient held record system enabling online idenity verification.

Actions:

- **We will build on the neighbourhood model to develop integrated care teams and develop a revised model of integrated care through engaging stakeholders**
- **We will roll-out a new model of integrated care teams from June 2018.**
- **We will specify the role of hospital specialists in integrated care teams.**

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5. Working together as a whole-system to redesign key pathways

In 2018/19, the Provider Alliance will lead the development and implementation of key pathways in relation to frailty, standard approaches to assessment and discharge, urgent care and people with complex needs. The scope and metrics for measurement will be agreed with the Alliance.

Provider alliance partners will work together to create shared care pathways, developing our capability to plan care pathways prospectively as a system rather than reactively as individual providers. Alliance partners will be articulate with clarity what they do for each patient group, how they do it, why they do it in that way, to what effect and how it fits, cost effectively, into everything else the health economy is endeavouring to achieve.

We have a strong foundation to build upon in the extensive clinical development work that has already been done to in relation to pathways for cancers, chest pain, syncope, heart failure, respiratory conditions muskulo-skeletal conditions, gastroenterological conditions, amongst others. Many of these are ready for implementation.

6. Develop enablers of integration – shared financial model, estates, workforce and IM&T plans

Financial model

[DN detailed financial modeling work in progress – reliant on information from partners]

Workforce

In the short-term, we will continue to build the capacity and resilience of our skilled workforce pool. All members of the provider alliance have robust contingency arrangements in place – E-rostering, use of our internal bank and ensuring all our staff are trained to be able to cover

key duties**.** For other planned contingencies, for example to support winter planning, providers are able to flex capacity between teams and provide cover through the use of our internal staff pools and clinical staff bank.

Our long-term workforce plan (currently being developed) will include actions to take account of anticipated skills gaps to future proof the out-of-hospital workforce. Key aspects of our plan are:

- the development of Advanced Clinical Practitioner roles, e.g. IV therapy, mobile diagnostics and advanced care management;
- reciprocal training and up-skilling between mental health and physical healthcare professionals;
- up-skilling our assessment staff so that they can play a greater role in supporting patients, e.g. by proactive telephoning/SMS of patients to provide advice, co-ordinating and monitoring assistive technology;
- technology solutions to support workforce efficiency and effectiveness – apart from the shared care record and digital care plan developments, we would examine opportunities for remote consultations and further improving uptake of assistive technology.

Estates

Estates is a critical enabler of the development of effective out of hospital services in Liverpool. The health and social care estate varies significantly in terms of quality, condition and suitability. Some of the estate is in excellent condition providing state of the art facilities, whilst at the other end of the scale there are a lot of properties that are in very poor condition and no-longer fit for purpose. Working with commissioners, the provider alliance will develop a shared estates strategy to enable the community care teams to be embedded and to enable the implementation of new clinical care pathways for frailty, long-term respiratory and cardio-vascular disease, and urgent care.

IM&T

The provider alliance will produce a shared digital plan for out of hospital services, building on the local iLINKS programme and the Local Digital Roadmap (LDR). All alliance members have been involved in the work of iLINKS since its inception as members of the Clinical Informatics Advisory group (CIAG) Mersey Care has been a key contributor to the development of the Local Digital Roadmap. The integration objectives of the local digital roadmap are:

- Data – a single repository for all information and data assets, with self-serve reporting and dashboards;
- Clinical Information Systems – clinical systems are replaced or enhanced; integrated and interoperable with other organisations; with a patient health record portal;

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- IT Estate – refresh of PCs, laptops and mobile devices to support fully enabled mobile working; and
- Infrastructure – a faster underlying network and a move towards cloud storage.

Enabler milestones	Timeframe
Co-design workforce model with the involvement of staff in all partner organisations.	June/July 2018
Undertake Place based Estates review in collaboration with partners.	May – June 2018
Develop an Estates Place based Delivery Plan to ensure maximisation of estates assets and co-location of MDT's, sharing system wide buildings.	July 2018
Develop an integrated Communications Strategy which enables delivery of shared vision items such as 'Big Neighbourhood Debate' to enable continuation of community insight work.	June 2018
Develop an integrated care record which works towards interoperability.	October 2018
Develop an integrated Communications Strategy which enables delivery of shared vision items such as 'Big Neighbourhood Debate' to enable continuation of community insight work.	June 2018
Agree an Evaluation framework and identify who will undertake the evaluation.	May 2018

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C. Outcomes and benefits

[DN The detail provided in this section is taken from CCG assessment impact of the One Liverpool plan in relation to integrated care team implementation and priority pathway redesign. The exact impact will be refined based upon the final pathways prioritised for 2018/19 with agreement from Provider Alliance members.]

Our Provider Alliance Plan targets outcomes in the following areas:

Demand management

- A reduction in hospital admissions of 2,850 over three years, at an indicative value of £4.8m
- The equates to a reduction in beds over three years of 45 across the Liverpool system

(see Return on Investment Section for more detail)

Improvement in ability to self-care

- An increase in telehealth installations from 1750 to 3300 in 18/19 and a further 3300 in 2019/20
- An improvement in the % of people reporting they are in control of their condition from 67.5% to 68.6%
- An improvement in the quality of life for people with Long Terms conditions from 0.67 to 0.70 achieving the right Care Peer average by 2019/20
- An improvement in patient activation, as measured by the PAM (Patient Activation Measure).

Improved chronic disease identification and management

- An increase in the number of people at risk of hospital admission with a proactive care plan from 520 in 17/18 to 1000 per year in 19/20
- Improvement in the expected to reported prevalence of a set of Long Term Conditions including hypertension, diabetes, COPD through review of 15,000 undiagnosed, at risk patients at practice and neighbourhood level.

Parity of esteem

- An increase of people with mental health conditions receiving a 12 month physical review of health from 37.7% to 60% by 2019/20.

Impact: Activity

The expected impact is predominantly on non-elective admissions. Growth in non-electives is expected at 2.7% per year based on national IHAM models. This is a 3 year increase against the 17/18 FOT of 8.4% (5,761 admissions). The schemes will have cumulative impact of 2,850, netting off 49% of this growth. The waterfall chart below illustrates this picture.

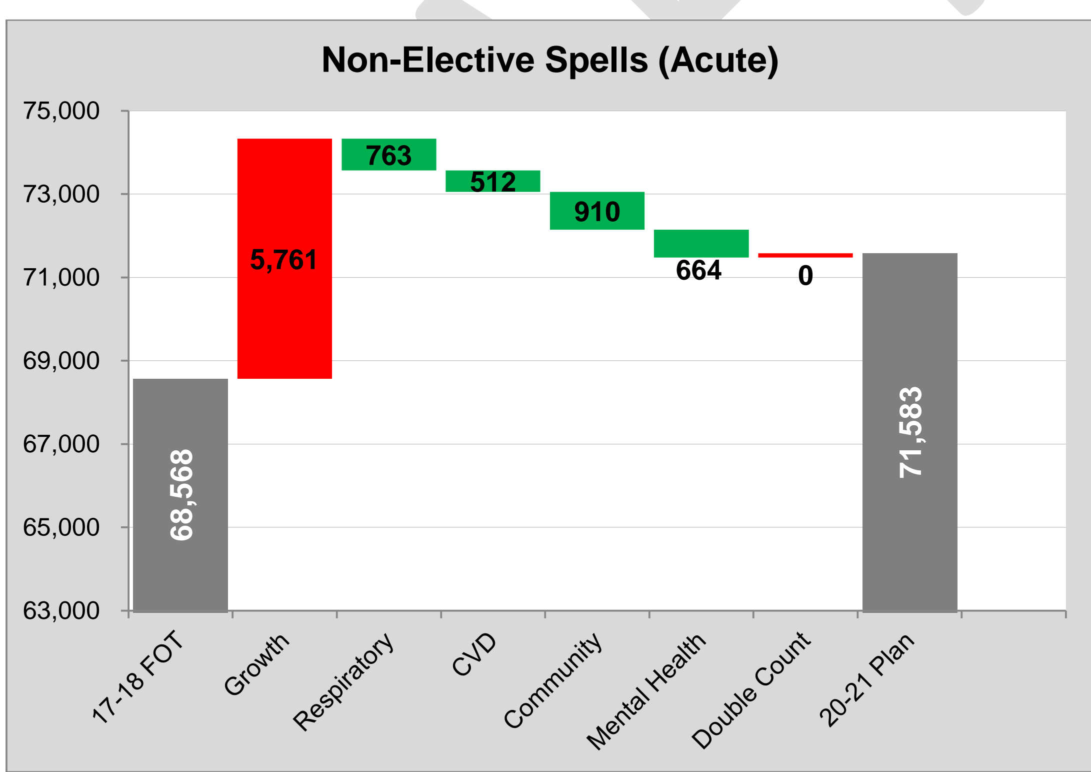
Impact: Finance

Schemes have been indicatively priced at average tariff for the baseline period or in some cases adjusted for the lighter end of the case mix. This equates to a three year cumulative impact of £4.8m. Acting as one contracts have been agreed for 18/19, the release of cash therefore will be incumbent upon future contract negotiations in 19/20 and 20/21.

Further impacts to associated AED attendances, length of stay and outpatient attendances will be modelled as the schemes progresses.

Impact: Beds

Beds impact has been calculated by using average length of stay for each scheme cohort and a 90% occupancy rate. This equates to a cumulative bed reduction of 46 for the system.



		Three year cumulative Impact non-elective admissions								
		18/19			19/20			20/21		
		Activity	Finance (£)	Beds	No.	Finance (£)	Beds	No.	Finance (£)	Beds
Growth		1,869			3,815			5,761		
Community Teams	Care Homes	86	206,837	2	86	206,837	2	86	206,837	2
	CCTs	381	381,000	5	545	545,000	8	545	545,000	8
	Telehealth	279	580,259	5	279	580,259	5	279	580,259	5
Priority Pathway Redesign	Enhanced CRT	16	33,080	0	69	140,591	1	122	248,102	2
	Pul Rehab	54	108,115	1	274	558,533	4	494	1,008,951	7
	Adult Asthma	37	23,399	0	147	90,594	1	147	90,594	1
	AF (Stroke Adm)	5	22,039	0	10	44,078	0	15	66,117	1
	Cardiac Rehab	2	4,975	0	7	17,413	0	12	29,852	0
	Diabetes	69	117,551	1	156	266,278	2	262	446,896	3
	Heart Failure	113	419,210	3	225	838,421	7	225	838,421	7
	EIP	102	71,000	2	102	71,000	2	102	71,000	2
	Core 24	99	128,008	2	200	256,016	3	562	727,683	9
Double Count		-103	-324,488	-2			0			0
TOTAL Impact		1,139	1,770,985	19	2,100	3,615,020	35	2,850	4,859,712	46

Assumptions:

For each scheme an evidence review has been undertaken to understand possible impact on activity. Where possible assumptions have been applied from this evidence base to the Liverpool population. Different scenarios have been tested with clinical and service leads and a most likely scenario has been assumed. Evidence has been graded against the below hierarchy to give an idea of robustness of the modelling and full detail is available on request.

Source of Evidence	Grading
Meta-Analysis and Systematic Review	A
Randomised Controlled Trials	B
Case control study: More robust	C
Case control studies: Less Robust	D
Case-series study	E
Ideas/opinion	F

D. Delivery plan

[DN include here:

- **Details of SROs, if known**
- **Programme resourcing**
- **Monitoring and reporting arrangements]**

CHILDREN'S TRANSFORMATION PROGRAMME

A PLAN FOR THE DELIVERY OF A NEW MODEL OF INTEGRATED COMMUNITY CHILD & FAMILY SERVICES ACROSS LIVERPOOL

2018 – 2021

'Together we make a difference'

29 MAY 2018

Name	Role	Organisation	Signed
Louise Shepherd	Chief Executive and Programme Board Chair	NHS Alder Hey Children's Foundation Trust	
Jan Ledward	Chief Officer	NHS Liverpool Clinical Commissioning Group	
Steve Reddy	Director of Children and Young Peoples Services	Liverpool City Council	
Barry Kushner	Cabinet Lead for Children's Services	Liverpool City Council	
Sandra Davies	Director of Public Health	Liverpool City Council	
Kathryn Thomson	Chief Executive	NHS Liverpool Women's Foundation Trust	
Joe Rafferty	Chief Executive	Mersey Care NHS Foundation Trust	
Jim Cuthbert	Chair	Liverpool GP Federation	
David Taylor-Robinson	Professor of Public Health and Policy and Honorary Consultant in Child Public Health	University of Liverpool	

EXECUTIVE SUMMARY

Children living in poverty and experiencing disadvantage in the UK are more likely to die in the first year of life; be born small, be bottle fed; breathe second hand smoke; become over weight; perform poorly in school; die in an accident and become a young parent. As adults, they are more likely to die earlier, be out of work, live in poor housing, to receive inadequate wages and experience poor health[1].

Early disadvantage tracks forward to influence health and development in later life. Children who start behind stay behind. Interventions that aim to support and improve early years experiences are therefore not just critical for children's health and wellbeing; they are essential in terms of influencing the excess burden of adult ill health in Liverpool. The economic costs of health inequalities, which have their origins in childhood, are immense; reinforcing the need for a concerted effort around early intervention.

The Children's Transformation Programme has produced this plan for the delivery of a new model of care and support for children and families in Liverpool based on our vision:

To improve outcomes and reduce inequalities for children, young people and families through an integrated, community focused model of care and support.

To achieve this vision the Children's Transformation Programme intends to drive the reorganisation of services and resources based on clear evidence that community focused care and support can best address modifiable risk factors to mediate their impact on our population. We aim to strengthen collaborative working between primary and secondary care to unify clinical delivery, while promoting working in an integrated way with local authority colleagues to sharpen the focus on the child's learning and development needs, and support for carers. The system will work together to provide outcome-focused, child and family-centred services.

Our new model will have a primary goal of laying down the foundations for good health and wellbeing in children and young people, tackling the social determinants of illness, and building resilience in families. The central building block will be comprehensive locality-based Children and Families Health and Wellbeing Hub(s), located across Liverpool and each supported by skilled workers operating in an aligned, coordinated or integrated way. The model proposes building on the success of integrated approaches developed by children's centres, enhancing the community-based offer by extending the range and scope of integrated services, particularly health and specialist services.

A number of underpinning design principles have been applied to support the development of the model; one of the most important being the concept of 'no wrong door', a short-hand for saying that access to services needs to be simple and straightforward and that services should feel timely and joined-up for families and professionals alike.

The model is based on aligning, coordinating and/or co-locating services. The Children's Transformation Board will support 'collapsing boundaries' between organisations and sectors to enable collaboration for the collective 'good', driving the pooling or delegation of resources (in whatever way makes the most sense) in order to realise the benefits and efficiencies of an integrated system. The model will be supported by enabling processes such as improved information–sharing and consistent needs assessment to help professionals work together.

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[1] See evidence summary 'Liverpool CCG Investment Proposal for the Children and Maternity Programme' 25.05.16.

The new model of care and support aligns well with the neighbourhood model of community provision developed for adult services. Whilst children's hubs may be centred around different physical estate, the similar approaches to integrated working and teams based in communities plus a commitment to better, more effective transitions will be a support to Liverpool's ambitions for a seamless 'all age' approach to health and social care.

The leadership from health, social care and education will 'act as one' at a locality level, sharing management approaches that support timely delivery of preventative and early help services, aligning demand for services with improved use of child health resources for more effective service utilisation. The system will demonstrate that outcomes for children improve when the new model of care and support is enabled to work well.

This delivery plan will be championed by the Children's Transformation Programme Board which has membership from all key delivery partners. The focus in 18/19 will be the implementation of the new model of care and support through existing resources, testing application of the approach in key sites and realising the expected benefits. Should the model require additional investment to operate effectively at scale then the Board will make the case for investment to shift from expenditure on adults to children and the expectation will be on commissioners and providers alike to ensure there is a shared mission across organisations to support required expansion/improvements.

The Children's Transformation Board will ensure that an effective workplan, supported by six strategic workstreams (plus enablers), revised governance and reporting all serves to facilitate the successful delivery of the new model in 18/19 in key sites. This delivery plan will be reported on to relevant oversight and assurance groups (see Board Terms of Reference May 2018) and delivery milestones will be refreshed annually.

The new model of care and support proposed in this plan is derived from a clear and well documented evidence-base, (which is not repeated here) as well as 'bottom up' dialogue with practitioners and clinicians, all with expert knowledge of local services. A wide range of policies and strategies have also informed the development of this plan including the latest Liverpool Clinical Commissioning Group 'One Liverpool Plan 2018-2021', the City of Liverpool 'Children, Young People and Families Plan' 2018-2021. The plan is also underpinned by Liverpool's current ambitions to be a designated UNICEF 'Child Friendly City'.

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2. Case for Action: Why Change is Needed?
3. The Vision
4. The New Model
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6. Making it Happen
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APPENDIX 1: High Level Mobilisation Plan

1. INTRODUCTION

This plan describes a new model of care and support for community child and family services across Liverpool that will better meet needs and ensure sustainable and productive services for the future. It summarises challenges faced by the current system and describes a better approach for tackling the key factors that impact on outcomes for children and families.

Integrated care is the principal mechanism for the delivery of our new model. It will support achievement of a collaborative and coordinated child and family system. Local delivery partners have committed to working together to provide integrated care across the spectrum of health and social need, in the context of a place-based approach with the power to bridge organisational and service boundaries. Underpinned by a growing body of bespoke intelligence, the new model will use asset-based approaches, aiming to build resilience and strengthen families as well as providing more joined up health and social care.

The new model of care and support proposed in this plan is derived from a clear and well documented evidence-base[2], (which is not repeated here) as well as 'bottom up' dialogue with practitioners and clinicians, all with expert knowledge of local services. A wide range of policies and strategies have also informed the development of this plan including the latest Liverpool Clinical Commissioning Group 'One Liverpool Plan 2018-2021', the City of Liverpool 'Children, Young People and Families Plan' 2018-2021. The plan is also underpinned by Liverpool's current ambitions to be a designated UNICEF 'Child Friendly City'.

2. CASE FOR ACTION: WHY CHANGE IS NEEDED

The main driver of change in child health services is the **epidemiological shift** that has taken place over the last 40 years. There has been an increase in childhood lifestyle risk factors particularly obesity, mental distress and malnutrition, and also chronic health conditions, principally asthma, diabetes, cystic fibrosis, cerebral palsy, developmental disabilities and preterm birth complications such as lung disease, retinopathy of prematurity and delay. Many of these risk factors and health conditions have social origins and are mostly preventable, while the treatment of rare conditions requires better access to specialist services and expertise. These changing needs pose significant challenges to the current child health system, not least in respect of how it prioritises the allocation of resource.

Our new model of care and support must find ways to **address the broader determinants of health**. Across Liverpool, children and young people experience higher levels of poor health and inequalities compared to the rest of the country. Poor health outcomes and life chances result from poverty and reduced quality of life including living conditions. These risk factors impact on health outcomes and life chances from birth and accumulate throughout childhood, generating poorer health and life outcomes in adulthood. There is a large body of evidence demonstrating that early disadvantage tracks forward to generate excess morbidity in adult life, reinforcing the need for **a focus on the Early Years**. The economic costs of health inequalities, which have their origins in childhood, are immense. This is crucial to the development of sustainable health services – for example, more than half of Alder Hey activity is used by children under five.

Children are not 'little adults', they have a dynamic developmental physiology, and their needs are constantly changing. **Timely delivery of children's services is essential**. While the importance of an immediate response is well understood for acute presentations, there is no equivalent sense of urgency for children with developmental or psychological conditions. Delays mean that the child will almost certainly fall behind in their development and have lower school readiness levels. Missing these milestones will significantly diminish their life chances.

[2] https://cles.org.uk/news/inquiry-publishes-due-north-report-on-health-equity/

Long waits for essential services can be exacerbated by fragmentation and disjointed care pathways. The provider landscape for children and families in Liverpool, across public and voluntary sectors is particularly complex. **'Integrated care'** is advocated as a means to overcome fragmentation of care within and between organisations that provide health care and associated services. Standardised and integrated approaches are needed across key service domains, and **the workforce needs to be supported** in applying these approaches.

When a child is ill, significant demands are placed on their parents/carers, and this can cause stress as well as impact adversely on income levels, creating a cycle of hardship and disadvantage which is difficult for the family to manage. It is therefore essential to **consider the needs of the whole family**. The evidence tells us that supporting positive interventions with a family will have more impact on a child's wellbeing than any other single factor. Stable and secure home circumstances and confident parenting will help ensure that the child flourishes and achieves, developing social and self-care skills, self-esteem and health literacy.

The case for change is clear and can be summarised by five principle arguments:

1. **A disadvantaged childhood leads to worse health and social outcomes in childhood and as an adult.**

Child and adult health outcomes in Liverpool are some of the worst in the country. These poor health outcomes and the health inequalities we see within Liverpool have their origins in early childhood and are intimately related to social disadvantage. Early years risk factors, and a lack of supportive factors are significantly reducing life expectancies for both sexes in Liverpool compared to the North West region and England. The early onset of disease and dependency of healthcare is statistically significantly greater in Liverpool; the age of healthy life expectancy is significantly lower in Liverpool. These life expectancy and health inequalities stem from childhood. Children who have grown up in adverse conditions are more likely to face recurring disadvantage that is harmful to their health as adults.

We know that children from less advantaged backgrounds have a higher risk of death in adulthood across almost all conditions that have been studied, including many of the key outcomes highlighted in the 'One Liverpool Plan': mortality from stomach cancer, lung cancer, haemorrhagic stroke, coronary heart disease, and respiratory-related deaths, accidents, and alcohol-related causes of death.

2. **Primary prevention and early help in a child's early years can significantly improve mental and physical health, educational attainment and employment opportunities.**

The first years of life are crucial for brain development and provide the foundations for children's capacities to learn. Brain development is on-going process that begins before birth and continues into adulthood. As it emerges, the quality of early brain development provides either a sturdy or a fragile foundation for all the skills and behaviours that follow.

In Liverpool, around 62% of children are deemed to have achieved a good level of development by the time they arrive in school (4-5years), suggesting that many children are being left behind at an early stage. Furthermore, only around 50% of Liverpool children achieve 5 GCSEs grades A-C (including Maths and English) at 15/16years, suggesting half of

children are still behind in later childhood. Alongside this, around one in 12 of Liverpool's children are not in education, employment or training.

Over the last 10 years numerous reviews of evidence and policy have repeatedly emphasised the need to provide better support early in children's lives if there is to be any chance of significantly reducing the inequalities in life chances experienced by people in the UK. The Commission on the Social Determinants of Health's overarching recommendation, for instance, relates to improving daily living conditions for all and mandates a renewed focus on child health, with a major emphasis on early child development. This focus on the early years is echoed in the UK Marmot review of health inequalities, which remains the blueprint for action on inequalities in child health in the UK:

"Central to the Review is a life course perspective. Disadvantage starts before birth and accumulates throughout life. Action to reduce health inequalities must start before birth and be followed through the life of the child. Only then can the close links between early disadvantage and poor outcomes throughout life be broken. For this reason, giving every child the best start in life is our highest priority recommendation." (Fair Society, Healthy Lives)

3. Closing the gap on inequitable health and social care funding supports improving outcomes.

Children in Liverpool have amongst the worse health outcomes across the Country. This stems, in part, from the lack of investments in their early years and existing services straining under current levels of demand. In 2016 Liverpool CCG spent c5% of its total budget on children's services and 95.5% on adult services. According to 2015 Public Health England Spend and Outcome Tool (SPOT) data Liverpool City Council is an outlier on spend per head of resident population, spending more on adults as measured against every other comparator group (Core City, ONS Cluster etc.). Liverpool City Council also spends less on children compared to equally deprived areas.

Maintenance of this disproportionate spend will further exacerbate the challenges that exist in tackling the crisis of child health and the long-term avoidable impact on adult health will remain. The CCG (alongside all Children's Transformation programme partners) are committed to supporting delivery of a new model of care and have prioritised the implementation of the new model in the 18/19 CCG Operating Plan and Provider Alliance work programme. The Liverpool health and social care system are supportive of Liverpool's application to Unicef to become a Child Friendly City. Awarding of this status requires demonstration of an 'appropriate children's budget'.

4. Integrated care delivers improved outcomes and creates efficiencies.

National legislation and policies are driving local service integration. The NHS Five Year Forward View (NHSE 2014) emphasises the need for commissioners to focus on prevention, working collaboratively with colleagues in the local authority to agree joint plans for health improvement and addressing health inequalities. The underlying assumption is that integrating care optimises health outcomes, improves patient experience and reduces overall costs.

Qualitative studies on integration show a number of positive effects including enhanced communication between services leading to better co-operation and implementation. Integrated services are more responsive with greater accessibility and user engagement. Integration reduces duplication and is more cost effective. There is also evidence that

integration improves outcomes for children in terms of increased cognitive development, better physical health and behaviour and improvement in parenting and family relations.

5. Intervening later is costlier and the rate of return on remedial, rehabilitative and reactive treatments declines as children get older and entrenched behaviours become harder to correct.

There is increasing and overwhelming evidence that intervening early is more cost effective. For example, each child with an untreated behavioural problem costs an average of £70,000 by the time they reach 28 years old – 10 times the cost of children without behaviour problems.

More often than not, delayed interventions result in expensive palliative measures that fail to address problems at their source. The prevailing culture of late intervention is expensive and ineffective. Over half of mental health problems in adult life (excluding dementia) start by the age of 14 and seventy-five percent by 18. As a consequence of not getting the help they need as quickly as they should, young people go onto develop mental health difficulties such as anxiety, low mood, depression, conduct disorders develop. A key theme of Future in Mind (2015) is early intervention, prevention and the promotion of resilience.

In 2014-15, in numerical terms, the annual spend (£m) on child injury admissions was 140; child mental health admissions: 440; children in specialist substance misuse services: 440. Health care costs of domestic violence constituted £3 billion spend by the NHS. These costs underline the importance of adopting a social and child focused model of health, alongside an adults model, to deliver a financially sustainable 'all age' approach.

3. THE VISION

The Children's Transformation Programme has produced this plan for the delivery of a new model of care and support for children and families in Liverpool, based on our vision:

To improve outcomes and reduce inequalities for children, young people and families through an integrated, community focused model of care and support.

We aim to develop new ways of working that address the challenges the evidence bares as well as responding to parent's ambitions.

"I want my family's health to have a positive start with a strong network of local support until my child attends school. My midwife and health visitor need to work together and with my GP and other early years services, so that I can access services quickly if my child needs help or is sick, without having to visit the ED"

"My child's … learning and health needs must be spotted early and addressed early with the support of skilled professionals. I want my child to learn and reach her potential. She needs to grow up healthy, happy and safe from harm. Should she need support from services as she grows, then services need to work well."

Our vision enables us to drive towards a better system that will support the delivery of good health and wellbeing. Our commitment to a new model of care and support aligns to wider system goals across Liverpool for improved outcomes for children and families.

4. EXPECTED OUTCOMES

We expect the benefits of the new model of care and support for children and families to be cross-cutting, both at a population and individual level as well as at a services and intervention level. The Children's Transformation Programme is aware that there are potentially many ways to measure the impact of the model on improving outcomes for children and their families. We believe there is value in choosing a small number of indicative measures that are consistent with existing standards, targets and reporting. Our new model will aim to support achievement of these outcome measures.

The following leading indicators, linked to improving outcomes and reducing inequalities have been identified as relevant to this plan. Baseline measures, targets to be achieved and reporting arrangements associated with those leading indicators are outlined below.

Delivery of the new model of care and support for children and families across Liverpool aims to have a positive impact on these health outcomes. Our six strategic workstreams (explained later in this plan), that will enable us to deliver the new model, will ensure that their actions serve to support delivery of these outcomes measures, as aligned with their work.

No.	Outcome	Indicator	Baseline (16/17)*[3]	UK**[4] Average
1.	All children have the best start in life and the percentage of children achieving a good level of development improves (ready to learn age 2.5, ready for school age 5).	Percentage of children achieving a good level of development at the end of Reception	62.1%	70.7%
2.	Increased numbers of mothers breast-feeding for 6 – 8 weeks	Breast feeding prevalence at 6 - 8 weeks	33.5%	44.4%
3.	A reduction in women smoking during pregnancy and at the time of delivery	Maternal smoking at delivery	14.3%	10.7%
4.	An increase in ante-natal assessments	Antenatal assessments within 13 weeks	84%	84.3%
5.	A reduction in hospital admissions and shorter lengths of stay for children with conditions such as respiratory conditions, diabetes and epilepsy	Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s[5]	81.6	303.7

[3] Unless otherwise stated
[4] Unless otherwise stated
[5] Rate per 100,000

6.	A reduction in waits for neurological development, CAMHS and SALT services.	Waiting times assessment to treatment in Neurological Development[6] Waiting times assessment to treatment in CAMHS[7] Number of weeks waiting (92 Percentile) Paediatric SLT - local data[8]	52[9] 10.7[10] 12[11]	18[12] 18[13] 18[14]
7.	An increase in the number of children who are a healthy weight.	Over weight (including obese) in 4-5 year olds Over weight (including obese) in 10-11 year olds	26.8% 37.9%	22.6% 34.2%
8.	Increased educational attainment	Learning & Achieving - Young people achieving 5A*-C inc. English & Maths at GCSE (provisional)	56.6%[15]	63.3%
9.	Reduction in the number of children and young people not in education or employment.	16-18 year olds not in education, employment or training (NEET)	11.7%	6%
10.	Safely reduce the number of Looked After Children per 10k (of the child population).	Children in care - number of looked after children[16]	122	62
11.	Reduction in persistent absence from school.	Pupil Persistent Absenteeism (15% Threshold)	14.1%	10.8%
12.	Increase the number of children who achieve good immunisation status.	MMR2 uptake - 2 doses (5 year olds) Seasonal Flu Vaccine Uptake - Children aged 2-4 years School Nursing: Girls aged 12-13 who have received all 3 doses of the HPV vaccine	87.9% 30% 82.7%	87.6% 38.1% 87.2%

[6] Weeks waiting
[7] Weeks waiting
[8] Weeks waiting
[9] 17/18
[10] 17/18
[11] 17/18
[12] National weeks waiting target
[13] National weeks waiting target
[14] National weeks waiting target
[15] 15/16
[16] Rate per 100,000

13.	Annual reduction in the number of under 18 conceptions.	Teen Conceptions Rate Per 1,000 (3 Year Pooled)	27.6[17]	18.8[18]
14.	Reduction in the number of referrals to Children's Social Care and a reduction in the number of re-referrals per 10k (of the child population)	Number of referrals per 10K pop < 18 The % of referrals that are repeat referrals within 12 months	731.4[19] 27.6%[20]	548[21] 22%[22]
15.	Increase in the number of child beneficiaries of a completed early help assessment per 10k of the child population)	Number of children subject to a completed early help assessment.	328[23]	10%[24]
16.	Reduction in the number of low birth weight babies	Low birth weight full-term babies	3.4%	2.8%
17.	Reduction in the infant mortality rate		5.2[25]	3.9[26]

The Children's Transformation Board understands the importance of outcome measures centred on patient experience. There are currently no PROMS (Patient Reported Outcome Measures) for Children, though lots of providers use their own qualitative approaches to measure quality of experience. The Board will dedicate effort during 18/19 to co-producing consistent experience-based outcomes measures for children. These will be tested and implemented as part of supporting our commitment to ensuring that the new model of care and support actually makes a positive difference.

5. UNDERPINNING DESIGN PRINCIPLES

The Children's Transformation Board has applied a number of design and delivery principles to the development of the new model. These are:

- **A 'whole family approach'.** Working with the family as a unit rather than addressing a child's needs in isolation; helping parents to develop social and self-care skills, self-esteem and health literacy.

- **Early years focus**: Investing resources in early childhood development to tackle the 'tracking forward' of inequality and ill health and providing access to co-ordinated early help in accordance with need as soon as difficulties are identified.

- **Child and family centred**: A family centred approach with pathways, which clearly identify the routes in and out of services and ensure a seamless experience for families ('no wrong door').

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[17] Rate per 100,000
[18] Rate per 100,000
[19] National average
[20] National average
[21] National average
[22] National average
[23] Rate per 10,000
[24] Increase
[25] Per 1000 live births
[26] Per 1000 live births

- **Universal and targeted services**: Care and support is based on the principle of proportional universalism, with additional activity and resources targeted at the most disadvantaged areas and group(s).

- **"Being proactive" approach**. Identifying and supporting families in need of early help, preventing the escalation of problems, enabling them to become more resilient and to develop the capabilities to prevent and resolve problems themselves.

- **Focused on integration**: Existing integrated initiatives are identified and built upon. For example, the successful integrated approaches delivered by children's centre services and by the use of the multi-agency common assessment tool (EHAT).

- **Community perspective**: Families and community as key participants and programmes and activities that are culturally inclusive, sensitive, and appropriate.

- **Engaging stakeholders**: Stakeholders across multiple service domains (education, health, care and the voluntary sector) developing strong integrated partnerships. Service providers working together take responsibility for children and families not only within their own service but also across the whole service system.

- **Evidence based**: Interventions based on a sound methodology where activities are systematically reviewed to ensure all decisions are based on the best available evidence of what really works.

- **Knowledge & sharing**: A shared learning approach to inform future planning through active collaboration, communication and sharing of information and experience.

- **Utilisation of existing resources**: Making effective and creative use of community assets across the local economy in order to be affordable and sustainable.

- **Providing clear points of access to services within the community** and a more streamlined response, co-ordinated by a lead practitioner utilising a single-family assessment approach.

- **Adding social value** by supporting non-medical, resilience-based solutions, positively influencing social determinants of health, increasing 'upstream' prevention activity, and increasing integration of services so families are better and more easily supported.

- **Improving skills** so that staff are empowered, skilled and connected; support for clinicians and practitioners to provide them with the tools to innovate and develop leadership capability.

- **Focus on outcomes** and staying alert to the difference that an intervention will make the child's life and measuring outcomes to assess improvement.

- **Adopting a rights-based approach**, aligned with the Child Friendly City agenda, which can lead to improvements in children's life chances by ensuring public services are designed and delivered with a focus on children, in closer collaboration with children.

These principles provide our 'litmus test' for moving forward. They will help guide us as we implement our new model, ensuring that our mobilisation plans stay true to what we are aiming to achieve.

6. THE NEW MODEL

The new model of care and support proposed in this plan is based on evidence that a more integrated, co-located, community-facing way of working is better for families and better for outcomes. This assumption is not just ascertained from literature and research. It is also reinforced by feedback from local families who have used existing services that have aligned together more closely (examples below).

"It was brilliant being able to visit the GP and then attend the Nurturing Programme at the same place"

I attended for one thing but I was able to receive support for other things at the same time instead of going to different places which was great, plus I made friends.

Now we come to everything, even though we have moved because we are familiar with the staff that work there. If it wasn't for us attending the children's centre classes, I don't think they would have let us keep [Child A]"

This kind of feedback represents our local 'proof of concept' as attested to by the Liverpool based experience of families and 'front line' professionals. We intend to build on positive experiences to provide better services and offers of care and support to children and their families through further integration and community-based service development.

Our new model is premised on delivering an enhanced, integrated health and social care service offer to children and families from various physical locations based across the City. We have developed the model around a number of 'building blocks'. These are described below:

- **Services will be centred around Children and Family Health and Wellbeing Hubs based in localities.**[27] In this context a Children and Families Health and Wellbeing Hub is defined as:

'A physical location in which children and families from the local area will access a broad range of health and social care services, either provided directly and routinely on site by staff located in the building, provided sessionally on site through an outreach approach by services located elsewhere or provided off site but accessed through and with the hub and its key relationships with other services'.

There are multiple opportunities for the hub model to be provided in partnership with existing sites (e.g. Children's Centres, Early Help, Primary Care Centres, Integrated Community Care Neighbourhood Teams, Neighbourhood Collaboratives etc.). There is no intention to set up separate Children and Family Health and Wellbeing Hubs on separate sites to those already in existence or planned. A map of existing facilities across Liverpool is provided below.

[27] The number of hubs in each locality will be determined following a mapping exercise of viable locations.

- **Hubs will aim to support a population of 30,000-50,000** either at a locality level or within localities, depending on need, evidence and opportunity.

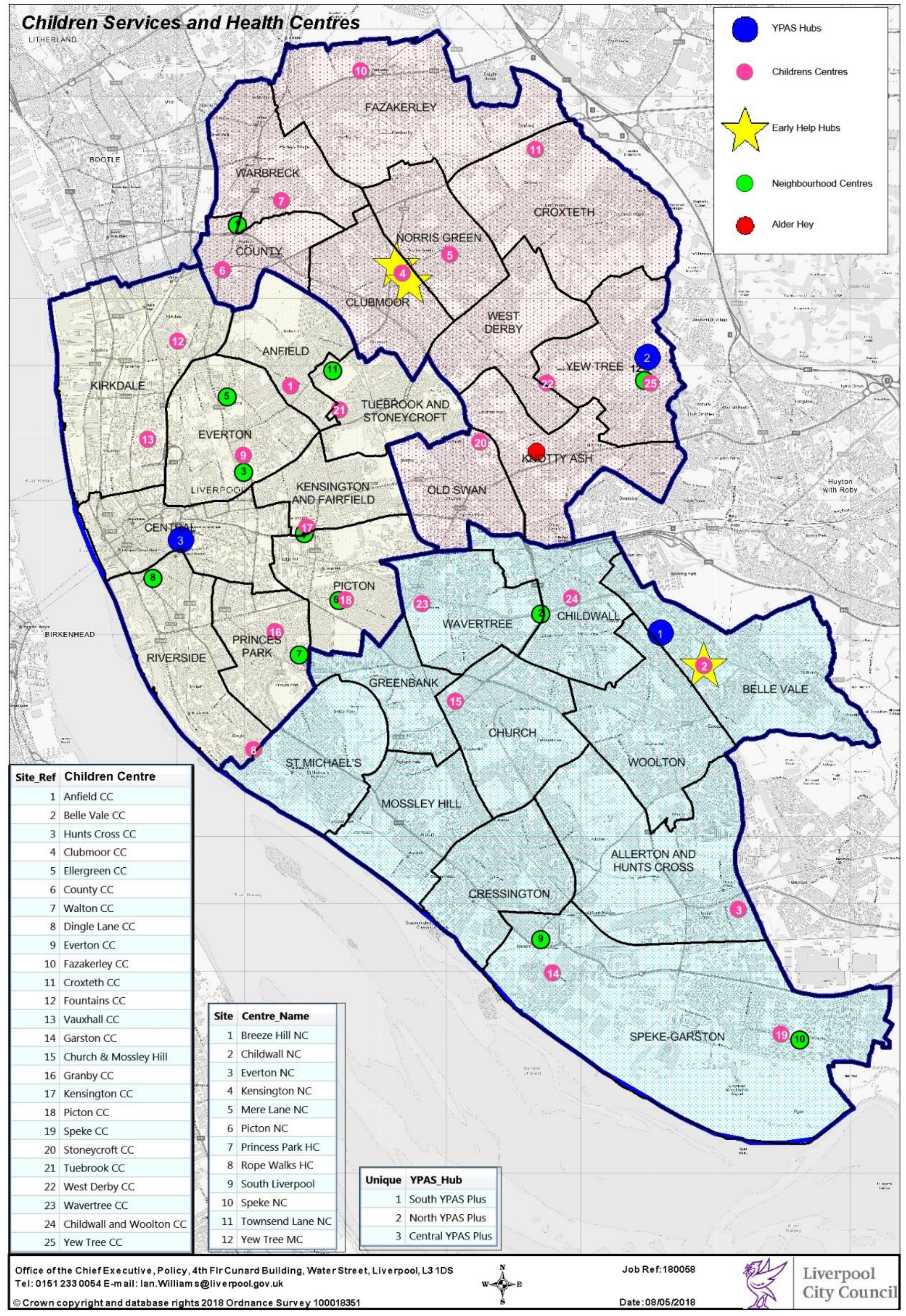
- **Hubs will build on and expand the success of integrated approaches already developed** and our new model will seek to enhance rather than re-invent the existing community-based offer. We will extend the range and scope of integrated services, by ensuring that health and specialist services become part of the offer.

- **Hubs will deliver different ways of working depending on what makes the most sense** and what the evidence suggests will work best. It is important to note that the Children's Transformation Board sees the enhancement of Children's Centres as a principal opportunity for the delivery of the new model. However, we do not expect every hub to be delivered in the same way across the City. Estates constraints, varying population needs, different evidence of what works best for different communities will inform agreements about which existing site is identified as the best positioned for the delivery of the new model and which services fit best on and/or with that site.

  A key priority in mobilisation of this plan is to identify the right site for the right service configuration. 18/19 will be a year of 'early adopter' work to identify a small number of sites and services that can move forward at a quicker pace than others. More information is provided about this in the Mobilisation Plan (Appendix 1).

- **Hubs will focus on delivering coordinated, co-located and/or integrated care and support** as well as ensuring a continued emphasis on building resilience and community assets.

- **Hubs will link to other work in the city that aims to support the broader determinants of child health** such as initiatives and services aimed at reducing poverty and improving welfare; increasing access to suitable housing; regeneration; domestic violence prevention; connecting people into employment; improving parental mental health.



Site_Ref	Children Centre
1	Anfield CC
2	Belle Vale CC
3	Hunts Cross CC
4	Clubmoor CC
5	Ellergreen CC
6	County CC
7	Walton CC
8	Dingle Lane CC
9	Everton CC
10	Fazakerley CC
11	Croxteth CC
12	Fountains CC
13	Vauxhall CC
14	Garston CC
15	Church & Mossley Hill
16	Granby CC
17	Kensington CC
18	Picton CC
19	Speke CC
20	Stoneycroft CC
21	Tuebrook CC
22	West Derby CC
23	Wavertree CC
24	Childwall and Woolton CC
25	Yew Tree CC

Site	Centre_Name
1	Breeze Hill NC
2	Childwall NC
3	Everton NC
4	Kensington NC
5	Mere Lane NC
6	Picton NC
7	Princess Park HC
8	Rope Walks HC
9	South Liverpool
10	Speke NC
11	Townsend Lane NC
12	Yew Tree MC

Unique	YPAS_Hub
1	South YPAS Plus
2	North YPAS Plus
3	Central YPAS Plus

A visual representation of our new model is provided below.

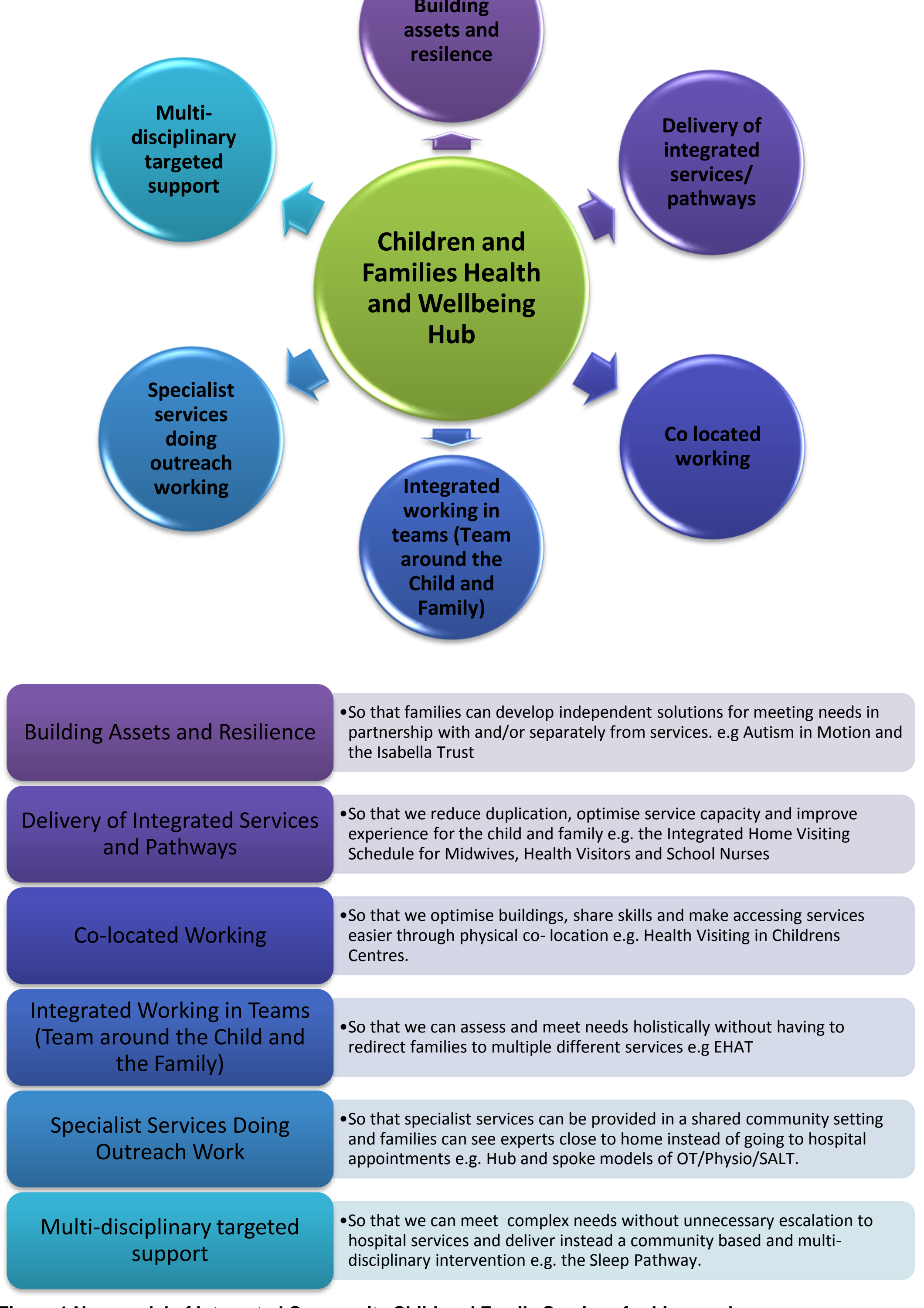


Figure 1 New model of Integrated Community Child and Family Services for Liverpool

- **Hubs will be the 'go to' place for child and family services**. Every family will be able to access a core programme of services and supports that includes maternity care, the Healthy Child Programme, community learning, parenting support, advice, health interventions and access to some specialist health care services.

- **An emphasis on Early Help will support early intervention**. Families whose children have additional needs will have timely access to co-ordinated early help and care. The offer will be integrated, evidence-based and personalised, embedded within a whole-family approach. Collaboration will help services improve support to children and families, preventing the escalation of problems, promoting resilience and self-care.

- **There will be clear points of access to services** with a streamlined response co-ordinated at a neighbourhood level by a lead practitioner. There will be a shared approach to assessment and intervention.

- **Hubs will make effective and creative use of every available asset across the local economy**. Enhanced partnerships with voluntary and community sector organisations as well as health services will provide a wide range additional activities and support, enhancing the core offer. Hubs will support public health improvement and health services to increase 'upstream' prevention activity. They will continue to connect systematically with initiatives that help lift families out of poverty and promote a culture of empowerment and learning: training, volunteering, employment, jobs and social enterprise; basic skills in literacy, numeracy and IT; access to apprenticeships; support for debt, housing, domestic abuse, English as a second language (ESOL).

- **Hubs will work with all levels of need** and staff will continue to grow their skills in working with children and families secure in the knowledge that they have the support of experts where needed.

- **All services will be in scope for the development of the hub model** (whether that be as better coordinated, co-located or fully integrated) i.e.

    - Maternity and Ante Natal
    - Neonatal and Perinatal
    - Postnatal
    - Health Visiting and School Nursing
    - Early Help Teams
    - Secondary Care (Paediatrics, Planned Care, CCNT, Matrons)
    - Disabled Children's Social Work Teams and Children's Social Work Teams
    - Specialist Nurses (out-patient, in-patient and community)

The footprint of localities accords with those established by Clinical Commissioning Groups and Councils, as well as with local GP neighbourhoods and Education Consortia.

7. FUTURE OPPORTUNITIES

As we build on existing opportunities to enhance services and deliver new ways of working we know that there are future possibilities to expand the approach even further. The development of the 'community cluster' at Alder Hey As will build on existing opportunities to enhance services and deliver new ways of working. The development of the 'community cluster' at Alder Hey will provide a centralised office base for community services as well as a place where specialised services can be delivered.

The 'community cluster' development will support:

- Rapid and early access to co-ordinated specialist multi-disciplinary care
- Key clinicians working in one place, up to date facilities for assessment and diagnosis of conditions providing 'one-stop' multi-disciplinary team resource for families
- Expert provision of specialised pathways of care for neuro developmental paediatrics and CAMHS
- Ability to link with specialised paediatric services for care for children with long term conditions specifically, neurology, cardiology, infectious diseases
- Delivery of statutory services from the community cluster will enable more responsive, coordinated health assessments for most vulnerable children and families

The 'community cluster' development will act as a bridge from hospital to home, supporting the development of personalised, family centred care through the network of teams working in localities and neighbourhoods. It will add an additional layer of community focused delivery supporting the Children and Families Health and Wellbeing hubs with a more integrated, specialist service offer.

8. MAKING IT HAPPEN

Implementation of our new care and support model will be practitioner and clinician-led, and organised around six strategic workstreams, these are*:*

- ***Giving Children the Best Start in Life,***
- ***Supporting Children with Mental Health Conditions,***
- ***Supporting Sick Children at Home,***
- ***Supporting Children with Disabilities,***
- ***Supporting Children and Young People with Long-Term Conditions,***
- ***Effective Use of Unplanned and Urgent Care,***

These workstreams have been identified based on evidence of opportunity to find new ways of working and a need for change/improvement. The workstreams will seek to deliver the new model by mobilising activities that support implementation of workstream specific responsibilities, as well as ones that cut across each and all i.e.

- Supporting a resilience-based approach for families
- Ensuring that services are health promoting
- Making every contact count

A visual representation of workstreams is provided below.

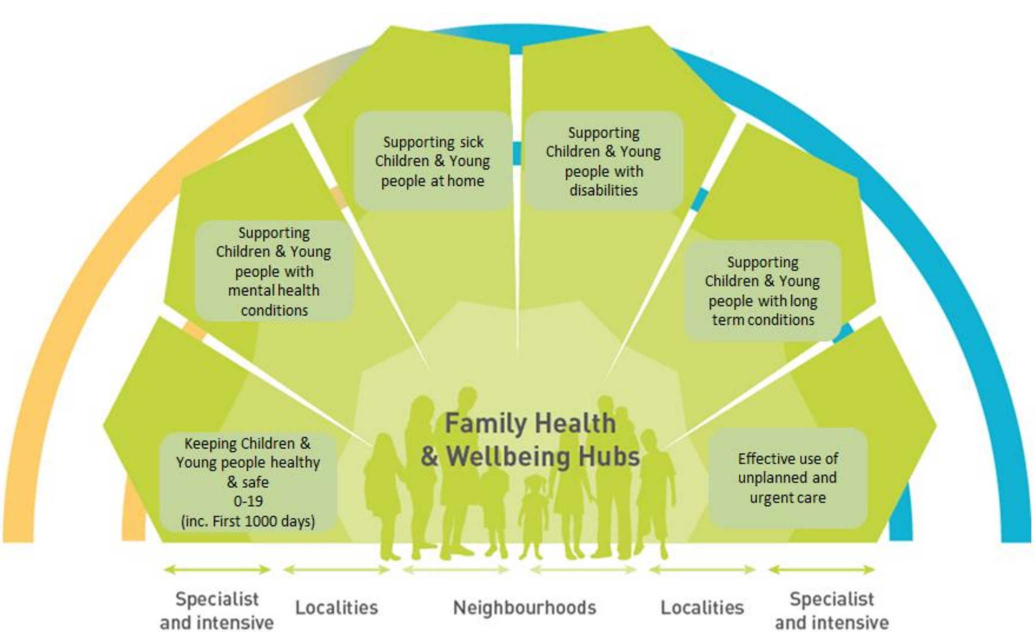


Figure 2 Strategic Workstreams

Each workstream has been assigned a leader/co leader. Leads have developed/are developing detailed action plans for their specific workstream. A high-level summary of workstreams, key objectives, outcome measures and leads is provided in Appendix 1 as part of an outline Mobilisation Plan. Reporting on progress to deliver workstream action plans (and thus implement the new care and support model) will be managed through a Programme Delivery Group which is accountable to the Children and Families Programme Board. Revised governance arrangements have been established to support and direct all mobilisation and delivery activity.

Our strategic workstreams have been aligned to the Liverpool system Operating Priorities for 18/19, overseen by the Provider Alliance. Those schemes relevant both to the children's agenda and the new model of care and support have been assigned to our workstreams (where relevant) to ensure connectivity. The connections are highlighted in the Mobilisation Plan. It should be noted that there are a small number of children's Operating Priorities that will be delivered in 18/19 without need for connection to this Plan at this stage; these include:

- Dietetics
- Autism Spectrum Disorder
- Palliative care

Maternity service reconfiguration is an Operating Priority for 2019/20.

Commissioning leads at Liverpool Clinical Commissioning Group will ensure delivery and accountability for these specific schemes.

As well as the six strategic workstreams identified to support this Plan, there are a number of other enabling workstreams that will be initiated to enable implementation. This includes work around:

- Data

- Communication
- Engagement
- Finance
- Estates

The Board acknowledges that system leadership will need to adopt a stepped approach to implementation, remaining flexible and adaptive. Lead partners will need to involve stakeholders and children and families in improvements, producing iterative action plans with good ownership at local and strategic levels. It is essential to harness the effort of the collective in order to be effective in delivering our desired outcomes.

9. CONCLUSION

The new model is based on enhancing proven ways of working, joining-up and co-locating services, especially health and social care services in response to evidence that integrated working is the best way to tackle child ill health and to improve outcomes for children and families. It is informed by a clear understanding of the needs of local children and families, combined with local intelligence about service utilization and pressures.

The new model will serve a primary goal of laying down the foundations for good health and wellbeing in children and young people, tackling the social determinants of illness, and building resilience in families. The central building block will be comprehensive locality-based Children and Families Health and Wellbeing Hub(s), located across Liverpool and each supported by skilled workers operating in an aligned, coordinated or integrated way. The model proposes building on the success of integrated approaches developed by children's centres, enhancing the community-based offer by extending the range and scope of integrated services, particularly health and specialist services.

A whole-system culture change is required to make delivery of the model successful, collapsing boundaries between organisations and sectors to enable collaboration for the collective 'good', pooling resources in order to realise the benefits and efficiencies of a fully integrated system. The capability of new technologies will need to be harnessed to improve information–sharing and needs assessment.

Oversight and adaptive system leadership will need to be provided by the Children's Transformation Board with membership from all key delivery partners. As the model becomes a shared mission across commissioners and agencies, so the improvements it will realise will become a reality for children and families.

Appendix 1: High Level Mobilisation Plan

A PLAN FOR THE DELIVERY OF A NEW MODEL OF INTEGRATED COMMUNITY CHILD & FAMILY SERVICES ACROSS LIVERPOOL 2018 – 2021 High Level Mobilisation Plan 2018/19	
Workstream: Keeping children and young people healthy and safe (Pre-birth - 19 and First 1001 Critical Days)	
Lead: Martin Smith and Deputy Lead: Suzanne Metcalfe	
Outcome Measures: 1,2,3,4,7,12,13,16.	
Operating Plan/Provider Alliance Scheme: None	
Key Deliverables	**Target Date**
1. Implementation of the Pre Birth-19 action plan focusing on needs assessment, clinical engagement, design of the best fit hub model for increasingly integrated, community focused delivery going forward and for successful implementation of that model.	Summer 2018
2. Implementation of the First 1001 Critical Days action plan focusing on expanding the early help offer in the community, improving infant health outcomes and establishing a foundation for school readiness; increasing targeted support in the community, improving data flows and ensuring outcome measurement.	Summer 2018
Workstream: Supporting children and young people with mental health conditions	
Lead: Andrew Williams and Deputy Lead: Monique Collier	
Outcome Measures: 6,11	
Operating Plan/Provider Alliance Scheme: 1. To increase the capacity of the CAHMS service to meet extra demand and achieve 18 weeks referral to treatment times 2. To enhance the IT Infrastructure so all services are reporting waiting times (currently 3 aren't) 3. To sustain the current MH crisis service which provides a) a telephone line, b) weekday and enhanced weekend cover and c) follow up following AED attendance AND	

To improve services for children and young people with a learning disability or autism by:1. Reducing hospitalisation 2. Improved access to health care 3. Increased investment 4. Improved Care, Education and Treatment Review (CETR) 18/19 Targets are to implement a dynamic support database to improve monitoring of people and to improve uptake of CETR assessments	
Key Deliverables	**Target Date**
1. Review of the CAMHS pathway across all providers to identify the best alignment of services (based on need and evidence) to/with the hub model.	Summer 2018
2. Make recommendations for service re-alignment as appropriate.	Autumn 2018
3. Maintain and sustain access and drive forward initiatives that reduce waiting times and increase access (e.g. 12 weeks referral to treatment time and 0-25yrs) while implementing opportunities for more effective means of delivery.	Spring 2019
4. Implement the recommendations of the CQC thematic review.	Spring 2019
5. Implement the 0-25 service specification with and across the CAMHS partnership (once developed and approved by commissioners).	Spring 2019
Workstream: Supporting sick children and young people at home	
Lead: Cath McLaughlin	
Outcome Measures: 8,9,11,15,14,10	
Operating Plan/Provider Alliance Scheme: SEND: Ensuring that sick children and young people at home have particular support needs identified and EHCPs completed.	
Key Deliverables	**Target Date**
1. Agree the best configuration of children's nursing services to deliver improved access to community-based care in/with hubs, more effective referral to treatment pathways and more integrated working.	Summer 2018
2. Support mobilisation of the new specification for children's nursing services (introducing better arrangements for response rates, assessments, caseload working, care planning and hospital discharge support).	Autumn 2018
Workstream: Supporting children and young people with disabilities	
Lead: Martin Lawton and Deputy Lead Suzanne Metcalfe	
Outcome Measures: (Note: Transition plan specific outcomes measures will be developed to support this workstream)	
Operating Plan/Provider Alliance Scheme: None	
Key Deliverables	**Target Date**
1. Identify improved transition points for children including within children's community and specialist services and between children's services and adults services.	Autumn 2018
2. Maximise opportunities for reduced transition points in/with the hub model.	Autumn 2018

Workstream: Supporting children and young people with long-term conditions	
Lead: Jim Cuthbert	
Outcome Measures: 5, 11	
Operating Plan/Provider Alliance Scheme: Transforming the asthma pathway.	
Key Deliverables	**Target Date**
1. Identify priority long-term conditions and mobilise pathway re-design; maximising opportunities created from the hub model and focusing on early diagnosis and keeping children out of hospital, at home and at school.	Spring 2018
2. Ensure provision of effective community services that are integrated with GPs and primary care.	Summer 2018
3. Mobilise integrated pathways with secondary care.	Autumn 2018
Workstream: Effective use of unplanned and urgent care	
Lead: Jim Cuthbert and Deputy Lead: (c/o Trish Mattinson)	
Outcome Measures: 5	
Operating Plan/Provider Alliance Scheme: None (but links to the adult programme of Urgent Treatment Centres)	
Key Deliverables	**Target Date**
1. Actively participate in the consultation work to agree the best future model of walk in centres in alignment with opportunities for increased service access in hubs.	Summer 2018
2. Inform the all age urgent treatment centre model, ensuring links to the children's hub model.	Summer 2018
Workstream: Data	
Lead(s): Alison Williams	
Key Deliverables	**Target Date**
1. Ensure that data flows and outcomes reporting align to and support any developments agreed around the hubs.	Summer 2018
2. Influence wider work around electronic health records, information sharing and inter-operability between IT systems to ensure that support for hubs is considered.	Summer 2018
Workstream: Communication	
Lead(s): Julie Haywood/Programme Director	
Key Deliverables	**Target Date**
1. Initiate a comms plan for the Children's Transformation Board to ensure that the children's hub model is appropriately socialized and shared across the wider system.	Summer 2018
2. Ensure communication of key messages from work to mobilise the hub model through 18/19.	Summer 2018
Workstream: Engagement	

Lead(s): Julie Haywood/Programme Director	
Key Deliverables	**Target Date**
1. Initiate service user representation into/alongside the Childrens Transformation Board to ensure that the mobilisation of the childrens hub model happens with expert inputs from families.	Summer 2018
2. Maintain engagement with families and communities through the work streams.	Summer 2018
Workstream: Finance.	
Lead(s): Julie Haywood/Programme Director	
Key Deliverables	**Target Date**
1. Ensure 'costing' of the hub model occurs in terms of savings or costs associated with the use of existing resources in different ways and any capital/physical needs for infrastructure etc.	Autumn 2018
2. Use costings established for 'early adopters' to informs plans/investment needs for roll out at scale.	Spring 2019
Workstream: Estates	
Lead(s): Julie Haywood/Programme Director	
Key Deliverables	**Target Date**
1. Identify four 'early adopter' hubs in Liverpool.	Summer 2018
2. Map work stream service models and pathways to the identified hubs.	Summer 2018
3. Implement new service models and report on impacts.	Spring 2019

CONSTITUTION

Version 9

July 2018

FOREWORD

The Alder Hey Children's NHS Foundation Trust ("the Trust") is a public benefit corporation established in accordance with the provisions of the National Health Service Act 2006 ("the 2006 Act").

As a body corporate, the Trust has specific powers to contract in its own name. The Trust also has a common law duty as a bailee for patients' property held on behalf of patients.

The principal place of business of the Trust is Alder Hey Children's Hospital.

This Constitution is for the regulation of the Trust's governance and the proceedings of its Council of Governors and Board of Directors.

The Trust provides care on more than 200,000 occasions each year to children, young people and their families. The Trust is proud to be a family-centered organisation. Our values reflect the fact that we see the children, young people and families we serve at the centre of the services we provide and we recognise that we can learn much from them, which helps us to improve what we do continuously.

Directors and Governors are expected to observe the Nolan principles of selflessness, integrity, objectivity, accountability, openness, honesty and leadership, and adhere to the "children values".

The Council of Governors and Board of Directors shall at all times seek to comply with the Trust's Codes of Conduct for Governors and Directors.

There should be sufficient transparency about the Trust's activities to promote confidence between the Trust and its staff, patients and the public.

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1. Interpretation and definitions

1.1 Unless the contrary intention appears or the context otherwise requires, words or expressions contained in this Constitution bear the same meaning as in the 2006 Act, as amended by the 2012 Act.

1.2 References in this Constitution to legislation include all amendments, replacements, or re-enactments of such legislation.

1.3 Headings are for ease of reference only and are not to affect interpretation.

1.4 In this Constitution:

"the 2006 Act"	means the National Health Service Act 2006;
"the 1977 Act"	means the National Health Service Act 1977;
the 2012 Act	**means** the Health and Social Care Act 2012.
"appointed Governors"	means those Governors appointed by the appointing organisations;
"appointing organisations"	means those organisations named in this Constitution who are entitled to appoint Governors;
"areas of the Trust"	means the areas specified in Annex 1;
"authorisation"	means an authorisation given by the Regulator;
"Board of Directors"	means the Board of Directors as constituted in accordance with this Constitution;
"carer"	means a person who provides regular and substantial care and support to an individual who: requires such care because of age, vulnerability, disability or illness; and is under the age of 20 years or, in the case of a deceased individual, who would be under the age of 20 years had s/he survived; and has at any time attended at any of the Trust's hospitals as a patient provided that such person is not providing care in pursuance of a contract (including a contract of employment) or as a volunteer for a voluntary organisation (being a body, other than a public or local authority, the activities of which are not carried on for profit) and provided that such person has attended at any of the Trust's hospitals as the carer of that individual within the period of twenty years immediately preceding the date of his/her application to become a member of

	the Trust;
"Council of Governors"	means the Council of Governors as constituted in accordance with this Constitution (which shall have the same meaning as the 'Council of Governors' in the 2006 Act);
"Director"	means a member of the Board of Directors;
"elected Governors"	means those Governors elected by the Public Constituency, the classes of the Staff Constituency and the classes of the Patients' Constituency;
"external auditor"	means any external auditor, other than the financial auditor, appointed under this Constitution to review and report upon aspects of the Trust's performance;
"financial auditor"	means the person appointed to audit the accounts of the Trust (referred to as the auditor in the 2006 Act);
"financial year"	means (a) the period beginning with the date on which the Trust is authorised and ending with the next 31st March; and (b) each successive period of twelve months beginning with 1st April;
"Local Authority Governor"	means a Governor appointed by one or more local authorities whose area includes the whole or part of one of the areas of the Trust;
"member"	means a member of the Trust;
"the NHS Trust"	means the Alder Hey Children's NHS Trust which made the application to become an NHS foundation trust;
"Other clinical staff" (for the purpose of Class 3 of the Staff Constituency)	means an individual who is eligible to be a member of the Staff Constituency who does not fall within Class 1 or 2 of the Staff Constituency, but who is registered with and/or a member of one or more of the following professional bodies: the Health Professions Council the British Psychological Society the Association for Family Therapy The Association of Child Psychotherapists The United Kingdom Council for Psychotherapy The British Confederation of Psychotherapists the Royal Pharmaceutical Society of Great Britain;
"Other staff" (for the purpose of Class 4 of the Staff Constituency)	means an individual who is eligible to be a member of the Staff Constituency, but who does not fall within Classes 1, 2 or 3 of the Staff Constituency;
"partner"	means, in relation to another person, a member of the same household living together as a family unit;

“Partnership Governor”	means a Governor appointed by a partnership organisation;
“Patients’ Constituency”	means collectively those members comprising the three classes of the Patients’ Constituency;
“Patient Governor”	means a Governor elected by the members of one of the classes of the Patients’ Constituency;
“Public Constituency”	means collectively those members living in one of the areas of the Trust;
“Public Governor”	means a Governor elected by the members of one of the Public Constituencies;
Senior Governor	means the governor elected by the Council of Governors as the main link between the governors and the Chair of the Trust, and in exceptional circumstances , the link to Monitor
Senior Independent Director	means an independent Non Executive Director with the responsibility to work with the governors to understand their issues and act on their behalf at Board level
“Staff Constituency”	means collectively those members of the classes comprising the Staff Constituency;
“Staff Governor”	means a Governor elected by the members of one of the classes of the Staff Constituency;
“registered dentist”	means a registered dentist within the meaning of the Dentists Act 1984;
“registered medical practitioner”	means a fully registered person within the meaning of the Medical Act 1983 who holds a licence to practice under that Act;
“registered nurse”	means a person who is registered to practice as a nurse with the Nursing and Midwifery Council;
“the Regulator”	Monitor is the body corporate known as Monitor, as provided by Section 61 of the 2012 Act.
“the Trust”	means the Alder Hey Children’s NHS Foundation Trust;
“Trust volunteers” (for the purpose of Class 4 of the Staff Constituency)	means individuals who are eligible to become a member of the Staff Constituency by virtue of paragraph 8.3 of this Constitution.

2. <u>Name and status</u>

The name of the Trust is the **Alder Hey** Children’s NHS Foundation Trust. The Trust is a public benefit corporation authorised under the provisions of the 2006 Act.

3. <u>Principal purpose</u>

3.1 The principal purpose of the trust is the provision of goods and services for the purposes of the health service in England[1].

3.2 The trust does not fulfil its principal purpose unless, in each financial year, its total income from the provision of goods and services for the purposes of the health service in England is greater than its total income from the provision of goods and services for any other purposes.

3.3 The trust may provide goods and services for any purposes related to—

3.3.1. the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and

3.3.2. the promotion and protection of public health.

3.4 The trust may also carry on activities other than those mentioned in the above paragraph for the purpose of making additional income available in order better to carry on its principal purpose.

4. Powers

4.1 The Trust may do those things, which appear to it to be necessary or desirable for the purposes of or in connection with its functions, subject to the provisions of the 2006 Act and any restrictions set out in the Trust's authorisation.

4.2 The powers of the Trust shall be exercised by the Board of Directors on behalf of the Trust.

4.3 Any of these powers may be delegated to a committee of Directors or to an Executive Director.

5. Membership and constituencies

5.1 The Trust shall have members, each of whom shall be a member of one of the following constituencies:

5.1.1. The Public Constituency;

5.1.2. The Staff Constituency;

5.1.3. The Patients' Constituency.

5.2 The names of members shall be entered in the register of members.

5.3 Members may attend and participate in members meetings, vote in elections to, and stand for election to, the Council of Governors, and take such other part in the affairs of the Trust as is provided for in this Constitution.

Eligibility for membership

5.4 Members shall:

5.4.1. be seven years of age or over; and

5.4.2. meet the criteria for membership of one or more of the Trust's Constituencies.

5.5 Individuals who meet the criteria for membership of the Public Constituency and also for membership of one of the classes of the Patients' Constituency shall choose which Constituency s/he would like to apply for membership of.

Representative membership

5.6 The Trust shall take reasonable steps to ensure that its membership is representative of those eligible for membership. To this end, the Trust shall comply with its Membership Strategy.

5.7 The Membership Strategy shall be reviewed from time to time by the Council of Governors, and at least every three years.

5.8 The Council of Governors shall present to each Annual Members Meeting:

5.8.1. a report on steps taken to ensure that the Trust's membership is representative of those eligible for membership;

5.8.2. any changes to the Membership Strategy.

Conditions of membership

5.9 Members:

5.9.1. will not receive payment or any fees associated with becoming or remaining a member of the Trust;

5.9.2. will not receive any preferential care or treatment as a consequence of being a member;

5.9.3. can resign their membership at any time;

5.9.4. can be members of more than one Trust.

6. Application for Membership

6.1 An individual who is eligible to become a member of the Trust may do so on application to the Trust.

7. Public Constituency

7.1 An individual who lives in an area specified in Annex 1 as an area for a public constituency may become or continue as a member of the Trust.

7.2 Those individuals who live in an area specified in Annex 1 as an area for any public constituency are referred to collectively as the Public Constituency.

7.3 The minimum number of members in each area for the Public Constituency is specified in Annex 1.

8. Staff Constituency

8.1 An individual who is employed by the Trust under a contract of employment with the Trust may become or continue as a member of the Trust provided:

8.1.1. s/he is employed by the Trust under a contract of employment which has no fixed term or has a fixed term of at least 12 months; or

8.1.2. s/he has been continuously employed by the Trust under a contract of employment for at least 12 months.

8.2 An individual who exercises functions for the purposes of the Trust, otherwise than under a contract of employment with the Trust, may become or continue as a member of the Trust provided s/he has exercised those functions continuously for a period of at least 12 months. Such individuals may include, but shall not be limited to, locum and bank staff, staff who have a joint contract with either Liverpool University, John Moores University or Edge Hill University and the Trust, and University employees who have honorary contracts with the Trust.

8.3 An individual who provides services and exercises functions for the purposes of the Trust under a Trust Volunteer Agreement is eligible to become or continue as a member of the Trust provided s/he has provided such services continuously under that Agreement for a period of at least 12 months.

8.4 Those individuals who are eligible for membership of the Trust by reason of the previous provisions are referred to collectively as the Staff Constituency.

8.5 The Staff Constituency shall be divided into four classes of individuals who are eligible for membership of the Constituency, each class of individuals being specified within Annex 2.

8.6 The minimum number of members in each class of the Staff Constituency is specified in Annex 2.

8.7 An individual who is:

8.7.1. eligible to become a member of the Staff constituency; and

8.7.2. invited by the Trust to become a member of the Staff Constituency and a member of the appropriate class within the Staff Constituency, shall become a member of the Trust as a member of the Staff Constituency and appropriate class within the Staff Constituency without an application being made, unless s/he informs the Trust that s/he does not wish to do so within 14 days of being so invited.

9. Patients' Constituency

9.1 An individual who is under the age of 20 years and has at any time during the preceding 20 years immediately preceding the date of their application attended at any of the Trust's hospitals as a patient may become or continue as a member of the Trust.

9.2 The natural parents of, or any person with parental responsibility for, an individual who is under the age of 20 years or, in the case of a deceased individual, who would be under the age of 20 years had s/he survived and who has at any time attended at any of the Trust's hospitals as a patient, may become or continue as a member of the Trust, provided that such persons have attended at any of the Trust's hospitals as the carer of that individual within the period of twenty years immediately preceding the date of their application to become a member of the Trust.

9.3 A carer of an individual who is under the age of 20 years or, in the case of a deceased individual, who would be under the age of 20 years had s/he survived and who has at any time attended at any of the Trust's hospitals as a patient, may become or continue as a member of the Trust, provided that such person is not providing care in pursuance of a contract (including a contract of employment) or as a volunteer for a voluntary organisation (being a body, other than a public or local authority, the activities of which are not carried on for profit), and provided that such person has attended at any of the Trust's hospitals as the carer of that individual within the period of twenty years immediately preceding the date of his/her application to become a member of the Trust.

9.4 Those individuals who are eligible for membership of the Trust by reason of the previous provisions are referred to collectively as the Patients' Constituency.

9.5 An individual providing care in pursuance of a contract (including a contract of employment) with a voluntary organisation, or as a volunteer for a voluntary organisation, does not come within the category of those who qualify for membership of the Patients' Constituency, but may qualify as a member of the Public Constituency if s/he lives within one of the areas of the Trust.

9.6 When an individual no longer meets the criteria for membership of the patients' classes of the Patients' Constituency, s/he will be given the opportunity to transfer their membership to the parents and carers class of the Constituency, if s/he meets the criteria for membership of that class, or to the Public Constituency, if s/he meets the criteria for membership of that Constituency.

9.7 When an individual no longer meets the criteria for membership of the parents and carers class of the Patients' Constituency, s/he will be given the opportunity to transfer their membership to the Public Constituency, if s/he meets the criteria for membership of that Constituency.

9.8 The Patients' Constituency shall be divided into three classes of individuals who are eligible for membership of the Constituency, each class of individuals being specified within Annex 3.

9.9 The minimum number of members in each class of the Patients' Constituency is specified in Annex 3.

10. Restriction on membership

10.1 An individual who is a member of a Constituency, or of a class within a Constituency, may not while membership of that Constituency or class continues, be a member of any other Constituency or class.

10.2 An individual who satisfies the criteria for membership of the Staff Constituency may not become or continue as a member of any Constituency other than the Staff Constituency.

10.3 Further provisions as to the circumstances in which an individual may not become or continue as a member of the Trust are set out in Annex 9.

11. Members meetings

11.1 The Trust is to hold a members meeting (called the Annual Members Meeting) within 9 months of the end of each financial year and additional members meetings may be held as and when considered necessary.

11.2 Members meetings are open to all members of the Trust, Governors and Directors, representatives of the financial auditor and any external auditors,and members of the public . The Council of Governors may invite representatives of the media and any experts or advisors whose attendance they consider to be in the best interests of the Trust to attend a members meeting.

11.3 All members' meetings are to be convened by the Secretary by order of the Council of Governors.

11.4 The Council of Governors may decide whether a members meeting is to be held and may also for the benefit of members arrange for the Annual Members Meeting to be held in different venues each year.

11.5 At the Annual Members Meeting: -

11.5.1 At least one member of the board of directors of the corporation must attend the meeting and present the following documents to the members at the meeting: -

the annual accounts;

any report of the financial auditor;

any report of any other external auditor of the Trust's affairs;

the forward planning information provided to the Regulator for that financial year in accordance with paragraph 37 of this Constitution;

the Annual Report prepared in accordance with paragraph 40.1 of this Constitution.

11.5.2 the Council of Governors shall present to the members: -

any proposed changes to the composition of the Council of Governors;

the results of any election, the appointment of Governors and the appointment of Non-Executive Directors;

the matters set out in paragraph 5.8 of this Constitution.

11.6 Notice of a members meeting is to be given: -

by notice to all members;

by notice prominently displayed at the Trust's Head Office; and

by notice on the Trust's website,

at least 14 clear days before the date of the meeting. The notice must:

be given to the Council of Governors and to the Board of Directors, and to the financial auditor and any external auditors;

state whether the meeting is an Annual Members Meeting;

give the time, date and place of the meeting; and

indicate the business to be dealt with at the meeting.

11.7 Before a members' meeting can undertake business there must be a quorum present. Except where this Constitution says otherwise, a quorum is one member present from each of the Trust's Constituencies. In the case of the Annual Members Meeting, a quorum shall be one member present from each of the Trust's Constituencies, one Governor elected from each of the Trust's Constituencies, one appointed Governor, one Executive Director, the Chair (or, in his/her absence, the Vice Chair, or, in his/her absence, a Non-Executive Director appointed by the Council of Governors to fulfil the role of Chair) and one other Non-Executive Director.

11.8 The Trust may make arrangements for members to vote by post, or by using electronic communications.

11.9 It is the responsibility of the Chair of the meeting to ensure that at any members meeting: -

the issues to be decided are clearly explained;

sufficient information is provided to members to enable rational discussion to take place.

11.10 The Chair of the Trust or, in their absence, the Vice Chair, or, in their absence, one of the Non-Executive Directors shall act as Chair at all members' meetings of the Trust.

11.11 If no quorum is present within half an hour of the time fixed for the start of the meeting, the meeting shall stand adjourned to the same day in the next week at the same time and place or to such time and place as the Council of Governors determine. If a quorum is not present within half an hour of the time fixed for the start of the adjourned meeting, the number of members present during the meeting is to be a quorum.

11.12 A resolution put to the vote at a members meeting shall be decided upon by a poll.

11.13 Every member present and every member who has voted by post or using electronic communications is to have one vote. In the case of an equality of votes, the Chair of the meeting is to have a second or casting vote.

11.14 The result of any vote will be declared by the Chair and entered in the minutes. The minutes will be conclusive evidence of the result of the vote.

12. Council of Governors – composition

12.1 The Trust is to have a Council of Governors, which shall comprise both elected and appointed Governors.

12.2 The composition of the Council of Governors is specified in Annex 4.

12.3 The members of the Council of Governors, other than the appointed members, shall be chosen by election by their Constituency or, where there are classes within a Constituency, by their class within that Constituency. The number of Governors to be elected by each Constituency, or, where appropriate, by each class of each Constituency, is specified in Annex 4.

12.4 A Senior Governor will be elected by the Council of Governors as the main link between the Governors and the Chair of the Trust and, in exceptional circumstances, the link to Monitor.

13. Council of Governors – election of Governors

13.1 Elections for elected members of the Council of Governors shall be conducted on a 'First Past the Post' basis and in accordance with the Model Rules for Elections, as may be varied from time to time.

13.2 The Model Rules for Elections, as may be varied from time to time, form part of this Constitution and are attached at Annex 5.

13.3 A variation of the Model Rules, other than a unilateral variation by the Trust, shall not constitute a variation of the terms of this Constitution.

13.4 Elections for the Council of Governors shall be conducted in accordance with any regulations, which may be made under Section 59 of the 2006 Act.

13.5 An election, if contested, shall be by secret ballot.

14. Council of Governors – appointment of Governors

14.1 The Board of Directors has approved a process for agreeing the appointment of Local Authority Governors, and Partnership Governors. The approved process has been adopted by the Secretary so as to confirm the appointments.

15. Council of Governors – tenure

15.1 A Governor may hold office for a period of up to three years, subject to paragraph 15.4.

15.2 An elected Governor shall cease to hold office if s/he ceases to be a member of the Constituency or class by which s/he was elected.

15.3 A Governor shall be eligible for re-election or re-appointment at the end of his/her three year term, but may not hold office for more than nine consecutive years.

15.4 Not less than one half of the initial Public Governors, Patient Governors and Staff Governors (comprising those who polled the highest number of votes if elections took place, and otherwise to be chosen by lot) will serve a term of office of three years. The remaining

initial Public Governors, Patient Governors and Staff Governors will serve a term of office of two years.

15.5 Subject to paragraph 15.6, those initial Governors serving a term of office of two years shall be eligible for re-election at the end of the two year term and such re-election shall be for a period of up to three years. Such Governors may not hold office for more than five consecutive years.

15.6 Those Governors elected from the patients' classes of the Patients' Constituency shall be eligible for re-election provided that he/she continues to meet the eligibility criteria within this class. Governors reaching age twenty will be given the opportunity to apply for membership of the appropriate Constituency for which s/he meets the criteria for membership and will be eligible for election in that constituency when a vacancy occurs.

16. Council of Governors – disqualification and removal

16.1 The following may not become or continue as a member of the Council of Governors:

16.1.1. a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;

16.1.2. a person who has made a composition or arrangement with, or granted a trust deed for, his/her creditors and has not been discharged in respect of it;

16.1.3. a person who within the preceding five years has been convicted in the British Isles or elsewhere of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him/her.

16.2 Further provisions as to the circumstances in which an individual may not become or continue as a member of the Council of Governors are set out in Annex 6.

16.3 The Constitution is to make provision for the removal of Governors. Such provision is set out in Annex 6.

17. Council of Governors – meetings of Governors

17.1 The Chair of the Trust or, in his/her absence the Vice Chair, shall preside at meetings of the Council of Governors or if the Council of Governors is meeting to appoint or remove the Chair of the Trust or decide his/her remuneration and allowances and other terms and conditions of office, the Senior Governor shall preside. Otherwise, another Non Executive Director shall preside.

17.2 Meetings of the Council of Governors shall be open to members of the public. Members of the public may be excluded from all or part of any meeting by resolution of the Council of Governors on the grounds that the Council considers that publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of the business or the proceedings. The Chair may exclude any member of the public from a meeting of the Council of Governors if s/he considers that they are interfering with or preventing the proper conduct of the meeting.

17.3 For the purpose of obtaining information about the Trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the corporation's or directors' performance), the council of governors may require one or more of the directors to attend a meeting.

17.4 Further provisions as to meetings of the Council of Governors are set out in the Council of Governors' Standing Orders at Annex 7.

18. Council of Governors – Standing Orders

The Standing Orders for the practice and procedure of the Council of Governors, as may be varied from time to time, are attached at Annex 7.

19. Council of Governors – conflicts of interest of Governors

If a Governor has an interest, which is relevant and material to a matter to be discussed or considered by the Council of Governors, whether that interest is actual or potential and whether that interest is direct or indirect, the Governor shall disclose that interest to the members of the Council of Governors as soon as s/he becomes aware of it. The Standing Orders for the Council of Governors shall make provision for the disclosure of interests and arrangements for the exclusion of a Governor declaring any interest from any discussion or consideration of the matter in respect of which an interest has been disclosed.

20. Council of Governors – travel and other expenses

20.1 The Trust may reimburse members of the Council of Governors travel and other expenses reasonably and necessarily incurred in carrying out their duties, subject to the provisions of the Trust's policy on the reimbursement of such expenses, which shall be approved by the Board of Directors and reviewed by the Board from time to time as considered necessary.

20.2 Governors shall not receive remuneration in respect of carrying out their role as a Governor.

21. Council of Governors – further provisions

Further provisions with respect to the Council of Governors are set out in Annex 6.

22. Board of Directors – composition

22.1 The Trust is to have a Board of Directors.

22.2 The Board of Directors shall be composed of not less than:

22.2.1. a Non-Executive Chair;

22.2.2. five-seven other Non-Executive Directors; and

22.2.3. five-seven Executive Directors.

22.3 One of the Executive Directors shall be the Chief Executive.

22.4 The Chief Executive shall be the Accounting Officer.

22.5 One of the Executive Directors shall be the Finance Director.

22.6 One of the Executive Directors is to be a registered medical practitioner or a registered dentist.

22.7 One of the Executive Directors is to be a registered nurse.

22.8 The number of Directors on the Board of Directors may be increased to seven, provided always that at least half of the Board, excluding the Chair, comprises Non-Executive Directors.

23. Board of Directors – qualification for appointment as a Non-Executive Director

A person may be appointed as a Non-Executive Director only if –

23.1 S/he is a member of the Public Constituency; or

23.2 S/he is a member of the parent and carer class of the Patients' Constituency; or

23.3 Where any of the Trust's hospitals includes a medical or dental school provided by a university, s/he exercises functions for the purposes of that university; and

23.4 S/he is not disqualified by virtue of paragraph 27 below.

24. Board of Directors – appointment and removal of Chair and other Non-Executive Directors

24.1 The Council of Governors shall approve by a majority vote the recommendations of the Nominations Committee to appoint the Chair of the Trust and the other Non-Executive Directors, including the Senior Independent Director.

24.2 Removal of the Chair or another Non-Executive Director/Senior Independent Director shall require the approval of two thirds of the Council of Governors.

24.3 Membership of the Nominations Committee will consist of: -

The Chair of the Trust (or Vice Chair when the appointment of the Chair and his/her remuneration and allowances and other terms and conditions of office are being discussed);

The Chief Executive of the Trust;

One Appointed Governor;

Two Elected Governors (one of whom to be a staff Governor)

An external assessor, with the appropriate skills and experience, will be appointed by the Committee to advise the Committee as and when required.

Members of the Committee may be required to undertake training and development commensurate with their responsibilities.

A quorum shall be at least two Governors.

24.4 Responsibilities of the Committee

To prepare job descriptions and/or person specifications detailing the skills, knowledge and experience required for the posts of Non-Executive Directors, taking into account the views of the Board of Directors.

To determine and undertake the recruitment and selection process for Non-Executive Directors.

To make recommendations to the Council of Governors as to suitable candidates for approval by the Council of Governors. The Council of Governors shall either appoint the recommended individual(s) or invite the Committee to make an alternative recommendation.

To consider whether to recommend to the Council of Governors the reappointment of the retiring Non-Executive Director.

To make recommendations to the Council of Governors as to the remuneration and allowances and other terms and conditions of office of Non-Executive Directors.

25. Board of Directors – appointment of Vice Chair

The Nominations Committee shall advise the Council of Governors re the appointment of one of the Non-Executive Directors as Vice Chair of the Trust.

26. Board of Directors – appointment and removal of the Chief Executive and other Executive Directors

26.1 The Appointments and Remuneration Committee of the Board of Directors (excluding the Chief Executive) shall appoint or remove the Chief Executive.

26.2 The appointment of the Chief Executive shall require the approval of the Council of Governors.

26.3 The Appointments and Remuneration Committee of the Board of Directors (inclusive of the Chief Executive) shall appoint or remove the other Executive Directors.

27. Board of Directors – disqualification

A person may not become or continue as a member of the Board of Directors if:

27.1 S/he has been removed from office as a Governor of the Trust; in accordance with the provisions set out in Annex 6 paragraph 8 of the section titled "Termination of office and removal of Governors".

27.2 S/he is a spouse, partner, parent or child of a member of the Council of Governors or Board of Directors;

27.3 S/he is a member of a local authority's scrutiny committee covering health matters;

27.4 S/he has been adjudged bankrupt or his/her estate has been sequestrated and (in either case) has not been discharged;

27.5 S/he has made a composition or arrangement with, or granted a trust deed for, his/her creditors and has not been discharged in respect of it;

27.6 S/he has, within the preceding five years, been convicted in the British Isles or elsewhere of any offence and a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him/her;

27.7 On the basis of disclosures obtained through an application to the Criminal Records Bureau, s/he is not considered suitable by the Trust's Director responsible for Human Resources;

27.8 S/he is or has been the subject of a sex offender order;

27.9 S/he is the subject of a disqualification order made under the Company Directors Disqualification Act 1986;

27.10 S/he is incapable by reason of mental disorder, illness or injury of managing or administering his/her property and affairs;

27.11 In the case of a Non-Executive Director, s/he is no longer a member of the Public Constituency or the parent and carer class of the Patients' Constituency;

27.12 S/he has within the preceding two years been dismissed, otherwise than by reason of redundancy, from any paid employment with a health service body;

27.13 S/he is a person whose tenure of office as the Chair or as a member or Director of a health service body has been terminated on the grounds that his/her appointment is not in the interests of the health service, for non-attendance at meetings, or for non-disclosure of a pecuniary interest;

27.14 S/he has had his/her name removed from any list prepared under Part II of the NHS Act 1977 and, due to the reason(s) for such removal, s/he is not considered suitable by the Trust's Director responsible for Human Resources;

27.15 In the case of a Non-Executive Director, s/he has refused without reasonable cause to fulfil any training requirements established by the Board of Directors;

27.16 S/he has refused to sign and deliver to the Secretary a statement in the form specified by the Board of Directors confirming acceptance of the Trusts' Code of Conduct for Directors.

28. Board of Directors – Standing Orders

The Standing Orders for the practice and procedure of the Board of Directors, as may be varied from time to time, are attached at Annex 8.

29. Board of Directors – conflicts of interest of Directors

29.1 If a Director has an interest, which is relevant and material to a matter to be discussed or considered by the Board of Directors, whether that interest is actual or potential and whether that interest is direct or indirect, the Director shall disclose that interest to the members of the Board of Directors as soon as s/he becomes aware of it. The Standing Orders for the Board of Directors shall make provision for the disclosure of interests and arrangements for the exclusion of a Director declaring any interest from any discussion or consideration of the matter in respect of which an interest has been disclosed.

29.2 The duties that a director of a public benefit corporation has by virtue of being a director include in particular—

(a)a duty to avoid a situation in which the director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the corporation;

(b)a duty not to accept a benefit from a third party by reason of being a director or doing (or not doing) anything in that capacity.

30. Board of Directors – remuneration and terms of office

30.1 The Council of Governors at a general meeting of the Council of Governors shall decide the remuneration and allowances, and the other terms and conditions of office, of the Chair and the other Non-Executive Directors following recommendations from the Nominations Committee.

30.2 The Appointments and Remuneration Committee of the Board of Directors shall decide the remuneration and allowances, and the other

terms and conditions of office, of the Chief Executive and other Executive Directors (save that the Committee shall not include the Chief Executive when his/her remuneration and allowances and other terms and conditions of office are being considered).

31. Secretary

31.1 The Trust shall have a Secretary who may be an employee. The Secretary may not be a Governor, or the Chief Executive or the Finance Director.

31.2 The Secretary's functions shall include, but shall not be limited to:

31.2.1. Acting as Secretary to the Council of Governors and the Board of Directors, and any committees;

31.2.2. Attending all members meetings, meetings of the Council of Governors and the Board of Directors and ensure that accurate minutes are taken at those meetings;

31.2.3. Maintaining and keeping up to date the register of members and other registers and books required by this Constitution;

31.2.4. Taking charge of the Trust's seal;

31.2.5. Publishing to members in an appropriate form relevant information about the Trust's affairs;

31.2.6. Preparing and sending to the Regulator and any other statutory body all returns which are required to be made.

31.3 The Secretary shall be appointed and removed by the Board of Directors in consultation with the Council of Governors.

32. Registers

The Trust shall have:

32.1 A register of members showing, in respect of each member, the Constituency to which s/he belongs and, where there are classes within it, the class to which s/he belongs;

32.2 A register of members of the Council of Governors;

32.3 A register of interests of Governors;

32.4 A register of Directors; and

32.5 A register of interests of the Directors.

The registers may be kept in either paper or electronic form.

Registers – inspection and copies

32.6 The Trust shall make the registers specified in paragraph 32 above available for inspection by members of the public, except in the circumstances set out below or as otherwise prescribed by regulations.

32.7 The Trust shall not make any part of its registers available for inspection by members of the public which shows details of –

32.7.1. any member of the Patients' Constituency; or

32.7.2. any other member of the Trust, if s/he so requests.

32.8 So far as the registers are required to be made available:

32.8.1. they are to be available for inspection free of charge at all reasonable times; and

32.8.2. a person who requests a copy of or extract from the registers is to be provided with a copy or extract.

32.9 If the person requesting a copy or extract is not a member of the Trust, the Trust may impose a reasonable charge for doing so.

33. Documents available for public inspection

33.1 The Trust shall make the following documents available for inspection by members of the public free of charge at all reasonable times:

33.1.1. a copy of the current Constitution;

33.1.2. a copy of the current authorisation;

33.1.3. a copy of the latest annual accounts and of any report of the financial auditor on them;

33.1.4. a copy of the report of any other external auditor of the Trust's affairs appointed by the Council of Governors;

33.1.5. a copy of the latest annual report;

33.1.6. a copy of the latest information as to its forward planning; and

33.1.7. a copy of any notice given under Section 52 of the 2006 Act.

33.2 Any person who requests a copy of or extract from any of the above documents is to be provided with a copy.

33.3 If the person requesting a copy or extract is not a member of the Trust, the Trust may impose a reasonable charge for doing so.

34. Auditors

34.1 The Trust shall have a financial auditor and shall provide the financial auditor with every facility and all information, which s/he may reasonably require for the purpose of fulfilling his/her functions under the 2006 Act.

34.2 A person may only be appointed as the financial auditor if s/he (or in the case of a firm each of its members) are a member of one or more of the bodies referred to in paragraph 23(4) of Schedule 7 to the 2006 Act.

34.3 The Council of Governors shall appoint or remove the financial auditor at a general meeting of the Council of Governors.

34.4 An officer of the Audit Commission may be appointed as the financial auditor with the agreement of the Audit Commission.

34.5 The financial auditor is to carry out his/her duties in accordance with Schedule 10 to the 2006 Act and in accordance with any directions given by the Secretary of State on standards, procedures and techniques to be adopted.

34.6 The Board of Directors may resolve that external auditors be appointed to review and publish a report on any other aspect of the Trust's performance. Any such auditors are to be appointed by the Council of Governors.

35. Audit committee

35.1 The Trust shall establish a committee of Non-Executive Directors as an audit committee to perform such monitoring, reviewing and other functions as are appropriate.

36. Annual accounts

36.1 The Trust must keep proper accounts and proper records in relation to the accounts.2

36.2 Monitor may with the approval of the Secretary of State3 give directions to the Trust as to the content and form of its accounts.

36.3 The Accounting Officer of the Trust shall cause to be prepared in respect of each financial year annual accounts in such form as the Regulator may, with the approval of the Secretary of State direct[4].

36.4 The annual accounts shall be audited by the Trust's financial auditor.

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Annual report and forward plans and non-NHS work

37.

37.1 The Trust shall prepare an Annual Report, including the Quality Report and send it to the Regulator.

37.2 The Trust shall give information as to its forward planning in respect of each financial year to the Regulator.

37.3 The document containing the information with respect to forward planning (referred to above) shall be prepared by the Directors.

37.4 In preparing the document, the Directors shall have regard to the views of the Council of Governors.

37.5 Each forward plan must include information about –

37.5.1. the activities other than the provision of goods and services for the purposes of the health service in England that the trust proposes to carry on, and

37.5.2. the income it expects to receive from doing so.

37.6 Where a forward plan contains a proposal that the trust carry on an activity of a kind mentioned in sub-paragraph 37.5.1 the Council of Governors must –

37.6.1. determine whether it is satisfied that the carrying on of the activity will not to any significant extent interfere with the fulfillment by the trust of its principal purpose or the performance of its other functions, and

37.6.2. notify the directors of the trust of its determination.

37.7 A trust which proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of the health service in England may implement the proposal only if more than half of the members of the council of governors of the trust voting approve its implementation.

38. <u>Meeting of Council of Governors to consider annual accounts and reports</u>

The following documents are to be presented to the Council of Governors at a general meeting of the Council of Governors:

38.1 The annual accounts;

38.2 Any report of the financial auditor on them;

38.3 The annual report.

39. Instruments

39.1 The Trust shall have a seal

39.2 The seal shall not be affixed except under the authority of the Board of Directors.

40. Dispute resolution procedures

40.1 Every unresolved dispute which arises out of this Constitution between the Trust and:

40.1.1. a member;

40.1.2. any person aggrieved who has ceased to be a member within the six months prior to the date of the dispute; or

40.1.3. any person bringing a claim under this Constitution;

is to be submitted to an arbitrator agreed by the parties or, in the absence of agreement, to be nominated by the relevant Strategic Health Authority. The arbitrator's decision will be binding and conclusive on all parties.

40.2 Any person bringing a dispute must, if required to do so, deposit with the Trust a reasonable sum (not exceeding £250) to be determined by the Council of Governors and approved by the Secretary. The arbitrator will decide how the costs of the arbitration will be paid and what should be done with the deposit.

41. Amendment of the Constitution

41.1 No amendment shall be made to this Constitution unless:

41.1.1. it has been approved by a majority of those Directors present and eligible to vote at a meeting of the Board of Directors; and

41.1.2. it has been approved by a majority of governors present and eligible to vote at a meeting of the Council of Governors

41.1.3. .

41.2 Where an amendment is made to the constitution in relation to the powers or duties of the Council of Governors of a public benefit corporation (or otherwise with respect to the role that the council has as part of the corporation)—

(a) at least one member of the Council of Governors must attend the next meeting to be held under this paragraph and present the amendment, and

(b) the corporation must give the members an opportunity to vote on whether they approve the amendment.

41.3 If more than half of the members voting approve the amendment, the amendment continues to have effect; otherwise, it ceases to have effect and the corporation must take such steps as are necessary as a result.

41.4 The Trust must inform the regulator of amendments made in accordance with the provisions set out above.

42. Mergers

42.1 The Trust may, in accordance with Section 56 of the 2006 Act, apply to the Regulator jointly with another NHS Foundation Trust or another NHS Trust for authorisation of the dissolution of the Trust and the transfer of some or all of its property and liabilities to a new NHS Foundation Trust established under that Section. Such application shall only be made if a majority of those Directors present and voting at a meeting of the Board of Directors shall have approved the making of such an application.

43. Significant Transactions

43.1 The Trust may enter into a significant transaction only if more than half of the members of the Council of Governors of the Trust present and eligible to vote approve entering into the transaction. The governors have agreed a definition of ‘significant transaction’ consistent with the thresholds used by Monitor in its Compliance Framework and REID (Risk Evaluation for Investment Decisions by NHS Foundation Trusts) guidance, ie.

- >25% of gross assets subject to the transaction divided by the gross assets of the trust; or
- >25% of the income attributable to the assets or the contract associated with the transaction, divided by the income of the trust, or
- >25% of the company or business being acquired or divested, divided by the total capital of the trust following completion or the effects on the total capital of the foundation trust resulting from a transaction.

44. Head Office

The Trust's Head Office will be at Alder Hey Children's Hospital or such other place as the Board of Directors shall decide.

45. Notices

45.1 Any notice required by this Constitution to be given shall be given in writing to an address for the time being notified for that purpose.

45.2 A notice shall be treated as delivered 48 hours after the envelope containing it was posted or in the case of a notice contained in an electronic communication, 48 hours after it was sent.

ANNEX 1 – THE PUBLIC CONSTITUENCY

The Public Constituency consists of the Local Government electoral wards specified in the table below.

The electoral wards are grouped into 5 areas as shown below, together with the minimum membership of each area. Members in each area shall elect Governors in accordance with Annex 4 to represent them on the Council of Governors.

Area 1 Merseyside	Area 2 Cheshire	Area 3 Wider North West		Area 4 – Rest of England	Area5 – North Wales
Liverpool	Warrington	Carlisle		Any electoral area in England not already specified	Conwy
Wirral	Halton	Allerdale			Denbighshire
Sefton		Eden			Flintshire
Knowsley	Cheshire West and Chester	Copeland			Gwynedd
St Helens		South Lakeland			Isle of Anglesey
		Lancaster			Wrexham
		Ribble Valley			
		Wyre			
	Cheshire East	Fleetwood			
		Blackpool			
		Fylde			
		Preston			
		South Ribble			
		West Lancashire			
		Chorley			
		Pendle			
		Burnley			
		Hyndburn			
		Blackburn			
		Rossendale			
		Wigan			
		Bolton			
		Bury			
		Rochdale			
		Oldham			

		Tameside			
		Manchester			
		Salford			
		Trafford			
		Stockport			

Minimum membership

20	**10**	**10**		**5**	**5**

ANNEX 2 – THE STAFF CONSTITUENCY

The Staff Constituency is to be divided into four classes, as shown below, together with the minimum membership of each class.

Class	Minimum number of members
Class 1 - Registered medical practitioners and registered dentists*	20
Class 2 - Registered nurses*	20
Class 3 - Other clinical staff *	20
Class 4 - Other staff and Trust volunteers* **	20
Total	**80**

*Including individuals who exercise functions for the purpose of the Trust otherwise than under a contract of employment with the Trust, to include individuals who exercise such functions under a joint contract with the Trust and Liverpool University, John Moores University or Edge Hill University, or under an honorary contract with the Trust.

**Trust volunteers shall come within Class 4 of the Staff Constituency regardless of whether or not they also satisfy the criteria for membership of any other Class of the Constituency.

ANNEX 3 – THE PATIENTS' CONSTITUENCY

The Patients Constituency will be divided into three classes, as shown below, together with the minimum membership of each class.

Class	Minimum membership
Class 1 – Patients in Merseyside*	10
Class 2 – Patients in the Rest of England and North Wales*	8
Class 3 – Parents and carers	20
Total	**38**

*Those patients (past and current) ordinarily resident in Area 1 as specified in Annex 1 will come within Class 1 of the Patients' Constituency. Those patients (past and current) ordinarily resident in Areas 2-6 as specified in Annex 1, will come within Class 2 of the Patients' Constituency.

ANNEX 4 – COMPOSITION OF COUNCIL OF GOVERNORS

The Council of Governors consists of:

(1) Governors appointed by:

(a) Primary Care Trusts for which the Trust provides goods or services;
(b) Local Authorities for an area which includes the whole or part of an area of a public constituency;
(c) Partnership organisations, including local Universities and voluntary organisations;.

(2) Governors elected by;

(a) Members of the public or patients, parents and carers in each of the Constituencies defined in Annexes 1 and 3 of this Constitution;
(b) Individuals within each class of the Staff Constituency defined in Annex 2 of this Constitution.

More than half of the members of the Council of Governors shall be elected by those in (2)(a) above.

Composition

Appointed Governors

Organisation appointing	Number to be appointed	Role
North Wales authorities	1	
Local Councils:		
Liverpool City Council	2	To represent key local non-NHS health economy partners, one of whom should be the senior officer with responsibility for children's services
Any local authority within the Alder Hey catchment	1	To provide public health expertise to the Council of Governors, preferably at director level
Partnership Organisations:		
Local Universities:		
Liverpool University	1	To ensure a strong teaching and research partnership to ensure that the Trust continues to provide training for children's specialist clinicians and continues to undertake research into childhood illnesses.
John Moores University and Edge Hill University	1 (can be appointed on a rotational basis)	As above.
Voluntary organisations:		

Voluntary organisations Representatives chosen from the list attached at Annex 4A	2	To ensure the representation of a wide range oforganisations with an interest in children's services.
Commissioners	2	To represent the Trust's main commissioners
Total Appointed Governors	**10**	

Elected Governors

Constituency/class electing	Number to be elected	Role
Staff Constituency		
Class 1 – Registered medical practitioners and registered dentists	1	To assist the Trust in developing the services it provides and ensure active representation from those who deliver those services.
Class 2 – Registered nurses	2	As above.
Class 3 – Other clinical staff	1	As above.
Class 4 – Other staff and Trust volunteers	2	As above.
	6	
Public Constituency		
Area 1 – Merseyside	4	To represent the public and patients living in areas served by the Trust.
Area 2 – Cheshire	1	As above.
Area 3 – Wider North West	2	As above.
Area 4 - Rest of England	1	As above.
Area 5 – North Wales	1	As above.
Patients' Constituency		
Class 1 – Merseyside patients	3	To represent the views and interests of current and past patients of the Trust.
Class 2 – Rest of England and North Wales patients	1	As above.
Class 3 – Parents and carers	6	To represent the views and interests of parents and carers of and those with parental responsibility for, current and past patients of the Trust.

	19	
Total Elected Governors	**25**	
Total membership of Council of Governors		
Appointed Governors	**10**	
Elected Governors	**25**	
Total	**35**	

ANNEX 4A

VOLUNTARY ORGANISATIONS WORKING WITH ALDER HEY CHILDREN'S NHS FOUNDATION TRUST

CLIC Sargent (children & young people with cancer)
McMillan Cancer Support
Alder Hey League of Friends
Wrong Trousers
British Heart Foundation
Liverpool Children's Deaf Society
Henshaw's Society for Deaf People
ERIC (enuresis)
Alder Hey Kidney Fund
SCOPE (cerebral palsy)
Contact a Family
Cystic Fibrosis Trust
Family Fund
Ronald McDonald House
Zoe's Place
Claire House
Addactions
WRVS (Woman's Royal Voluntary Service)
Barnardos
ASBAH (Association for Spina Bifida and Hydrocephalus)
Merseyside Regional Epilepsy Association
Back Up Trust
CHICKS (Children's Cancer Support Group)
Winston's Wish
The Children's Heart Association

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Part 1 – Interpretation

1. Interpretation

In these rules, unless the context otherwise requires -

“the Corporation” means the public benefit corporation subject to this Constitution;

“election” means an election by a Constituency, or by a class within a Constituency, to fill a vacancy among one or more posts on the Council of Governors;

“the Regulator” means the independent regulator for NHS foundation trusts;

“the 2006 Act” means the National Health Service Act 2006.

Other expressions used in these rules and in Schedule 1 to the National Health Service Act 2006 shall have the same meaning in these rules as in that Schedule.

Part 2 – Timetable for election

2. Timetable

The proceedings at an election shall be conducted in accordance with the following timetable.

Proceeding	**Time**
Publication of notice of election	Not later than the fortieth day before the day of the close of the poll.
Final day for delivery of nomination papers to returning officer	Not later than the twenty eighth day before the day of the close of the poll.
Publication of statement of nominated candidates	Not later than the twenty seventh day before the day of the close of the poll.
Final day for delivery of notices of withdrawals by candidates from election	Not later than twenty fifth day before the day of the close of the poll.
Notice of the poll	Not later than the fifteenth day before the day of the close of the poll.
Close of the poll	By 5.00pm on the final day of the election

3. Computation of time

(1) In computing any period of time for the purposes of the timetable -

(a) a Saturday or Sunday;
(b) Christmas day, Good Friday, or a bank holiday, or
(c) a day appointed for public thanksgiving or mourning,

shall be disregarded, and any such day shall not be treated as a day for the purpose of any proceedings up to the completion of the poll, nor shall the returning officer be obliged to proceed with the counting of votes on such a day.

(2) In this rule, “bank holiday” means a day which is a bank holiday under the Banking and Financial Dealings Act 1971 in England and Wales.

Part 3 – Returning officer

4. Returning officer

(1) Subject to rule 64, the returning officer for an election is to be appointed by the Corporation.

(2) Where two or more elections are to be held concurrently, the same returning officer may be appointed for all those elections.

5. Staff

Subject to rule 64, the returning officer may appoint and pay such staff, including such technical advisers, as s/he considers necessary for the purposes of the election.

6. Expenditure

The Corporation is to pay the returning officer –

(a) any expenses incurred by that officer in the exercise of his or her functions under these rules,

(b) such remuneration and other expenses as the Corporation may determine.

7. Duty of co-operation

The Corporation is to co-operate with the returning officer in the exercise of his or her functions under these rules.

Part 4 - Stages Common to Contested and Uncontested Elections

8. Notice of election

The returning officer is to publish a notice of the election stating –

(a) the Constituency, or class within a Constituency, for which the election is being held,

(b) the number of members of the Council of Governors to be elected from that Constituency, or class within that Constituency,

(c) the details of any nomination committee that has been established by the Corporation,

(d) the address and times at which nomination papers may be obtained;

(e) the address for return of nomination papers and the date and time by which they must be received by the returning officer,

(f) the date and time by which any notice of withdrawal must be received by the returning officer;

(g) the contact details of the returning officer; and

(h) the date and time of the close of the poll in the event of a contest.

9. Nomination of candidates

(1) Each candidate must nominate themselves on a single nomination paper.

(2) The returning officer-

(a) is to supply any member of the Corporation with a nomination paper, and

(b) is to prepare a nomination paper for signature at the request of any member of the Corporation,

but it is not necessary for a nomination to be on a form supplied by the returning officer.

10. Candidate's particulars

(1) The nomination paper must state the candidate's –

(a) full name,

(b) contact address in full, and

(c) Constituency, or class within a Constituency, of which the candidate is a member.

11. Declaration of interests

The nomination paper must state –

(a) any financial interest that the candidate has in the Corporation, and

(b) whether the candidate is a member of a political party, and if so, which party,

and if the candidate has no such interests, the paper must include a statement to that effect.

12. Declaration of eligibility

The nomination paper must include a declaration made by the candidate –

(a) that s/he is not prevented from being a member of the Council of Governors by paragraph 8 of Schedule 7 of the 2006 Act or by any provision of the Constitution; and

(b) for a member of the Public or Patients' Constituency, of the particulars of his or her qualification to vote as a member of that Constituency, or class within that Constituency, for which the election is being held.

13. Signature of candidate

The nomination paper must be signed and dated by the candidate, indicating that –

(a) they wish to stand as a candidate,

(b) their declaration of interests as required under rule 11, is true and correct, and

(c) their declaration of eligibility, as required under rule 12, is true and correct.

14. Decisions as to the validity of nomination

(1) Where a nomination paper is received by the returning officer in accordance with these rules, the candidate is deemed to stand for election unless and until the returning officer –

(a) decides that the candidate is not eligible to stand,

(b) decides that the nomination paper is invalid,

(c) receives satisfactory proof that the candidate has died, or

(d) receives a written request by the candidate of their withdrawal from candidacy.

(2) The returning officer is entitled to decide that a nomination paper is invalid only on one of the following grounds –

(a) that the paper is not received on or before the final time and date for return of nomination papers, as specified in the notice of the election,

(b) that the paper does not contain the candidate's particulars, as required by rule 10;

(c) that the paper does not contain a declaration of the interests of the candidate, as required by rule 11,

(d) that the paper does not include a declaration of eligibility as required by rule 12, or

(e) that the paper is not signed and dated by the candidate, as required by rule 13.

(3) The returning officer is to examine each nomination paper as soon as is practicable after s/he has received it, and decide whether the candidate has been validly nominated.

(4) Where the returning officer decides that a nomination is invalid, the returning officer must endorse this on the nomination paper, stating the reasons for their decision.

(5) The returning officer is to send notice of the decision as to whether a nomination is valid or invalid to the candidate at the contact address given in the candidate's nomination paper.

15. Publication of statement of candidates

(1) The returning officer is to prepare and publish a statement showing the candidates who are standing for election.

(2) The statement must show –

(a) the name, contact address, and Constituency or class within a Constituency of each candidate standing, and

(b) the declared interests of each candidate standing, as given in their nomination paper.

(3) The statement must list the candidates standing for election in alphabetical order by surname.

(4) The returning officer must send a copy of the statement of candidates and copies of the nomination papers to the Corporation as soon as is practicable after publishing the statement.

16. Inspection of statement of nominated candidates and nomination papers

(1) The Corporation is to make the statements of the candidates and the nomination papers supplied by the returning officer under rule 15(4) available for inspection by members of the public free of charge at all reasonable times.

(2) If a person requests a copy or extract of the statements of candidates or their nomination papers, the Corporation is to provide that person with the copy or extract free of charge.

17. Withdrawal of candidates

A candidate may withdraw from election on or before the date and time for withdrawal by candidates, by providing to the returning officer a written notice of withdrawal, which is signed by the candidate and attested by a witness.

18. Method of election

(1) If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is greater than the number of members to be elected to the Council of Governors, a poll is to be taken in accordance with Parts 5 and 6 of these rules.

(2) If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is equal to the number of members to be elected to the Council of Governors, those candidates are to be declared elected in accordance with Part 7 of these rules.

(3) If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is less than the number of members to be elected to the Council of Governors, then –

(a) the candidates who remain validly nominated are to be declared elected in accordance with Part 7 of these rules, and

(b) the returning officer is to order a new election to fill any vacancy which remains unfilled, on a day appointed by him or her in consultation with the Corporation.

Part 5 – Contested elections

19. Poll to be taken by ballot

(1) The votes at the poll must be given by secret ballot.

(2) The votes are to be counted and the result of the poll determined in accordance with Part 6 of these rules.

20. The ballot paper

(1) The ballot of each voter is to consist of a ballot paper with the persons remaining validly nominated for an election after any withdrawals under these rules, and no others, inserted in the paper.

(2) Every ballot paper must specify –

(a) the name of the Corporation,

(b) the Constituency, or class within a Constituency, for which the election is being held,

(c) the number of members of the Council of Governors to be elected from that Constituency, or class within that Constituency,

(d) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(e) instructions on how to vote,

(f) if the ballot paper is to be returned by post, the address for its return and the date and time of the close of the poll, and

(g) the contact details of the returning officer.

(3) Each ballot paper must have a unique identifier.

(4) Each ballot paper must have features incorporated into it to prevent it from being reproduced.

21. The declaration of identity (Public and Patients' Constituencies)

(1) In respect of an election for a Public or Patients' Constituency a declaration of identity must be issued with each ballot paper.

(2) The declaration of identity is to include a declaration –

(a) that the voter is the person to whom the ballot paper was addressed,

(b) that the voter has not marked or returned any other voting paper in the election, and

(c) for a member of the Public or Patients' Constituency, of the particulars of that member's qualification to vote as a member of the Constituency or class within a Constituency for which the election is being held.

(3) The declaration of identity is to include space for –

(a) the name of the voter,

(b) the address of the voter,

(c) the voter's signature, and

(d) the date that the declaration was made by the voter.

(4) The voter must be required to return the declaration of identity together with the ballot paper.

(5) The declaration of identity must caution the voter that, if it is not returned with the ballot paper, or if it is returned without being correctly completed, the voter's ballot paper may be declared invalid.

Action to be taken before the poll

22. List of eligible voters

(1) The Corporation is to provide the returning officer with a list of the members of the Constituency or class within a Constituency for which the election is being held who are eligible to vote by virtue of rule 26 as soon as is reasonably practicable after the final date for the delivery of notices of withdrawals by candidates from an election.

(2) The list is to include, for each member, a mailing address where his or her ballot paper is to be sent.

23. Notice of poll

The returning officer is to publish a notice of the poll stating–

(a) the name of the Corporation,

(b) the Constituency, or class within a Constituency, for which the election is being held,

(c) the number of members of the Council of Governors to be elected from that Constituency, or class with that Constituency,

(d) the names, contact addresses, and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(e) that the ballot papers for the election are to be issued and returned, if appropriate, by post,

(f) the address for return of the ballot papers, and the date and time of the close of the poll,

(g) the address and final dates for applications for replacement ballot papers, and

(h) the contact details of the returning officer.

24. Issue of voting documents by returning officer

(1) As soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following documents to each member of the Corporation named in the list of eligible voters –

(a) a ballot paper and ballot paper envelope,

(b) a declaration of identity (if required),

(c) information about each candidate standing for election, pursuant to rule 59 of these rules, and

(d) a covering envelope.

(2) The documents are to be sent to the mailing address for each member, as specified in the list of eligible voters.

25. Ballot paper envelope and covering envelope

(1) The ballot paper envelope must have clear instructions to the voter printed on it, instructing the voter to seal the ballot paper inside the envelope once the ballot paper has been marked.

(2) The covering envelope is to have –

(a) the address for return of the ballot paper printed on it, and

(b) pre-paid postage for return to that address.

(3) There should be clear instructions, either printed on the covering envelope or elsewhere, instructing the voter to seal the following documents inside the covering envelope and return it to the returning officer –

(a) the completed declaration of identity if required, and

(b) the ballot paper envelope, with the ballot paper sealed inside it.

The poll

26. Eligibility to vote

An individual who becomes a member of the Corporation on or before the closing date for the receipt of nominations by candidates for the election, is eligible to vote in that election.

27. Voting by persons who require assistance

(1) The returning officer is to put in place arrangements to enable requests for assistance to vote to be made.

(2) Where the returning officer receives a request from a voter who requires assistance to vote, the returning officer is to make such arrangements as s/he considers necessary to enable that voter to vote.

28. Spoilt ballot papers

(1) If a voter has dealt with his or her ballot paper in such a manner that it cannot be accepted as a ballot paper (referred to a "spoilt ballot paper"), that voter may apply to the returning officer for a replacement ballot paper.

(2) On receiving an application, the returning officer is to obtain the details of the unique identifier on the spoilt ballot paper, if s/he can obtain it.

(3) The returning officer may not issue a replacement ballot paper for a spoilt ballot paper unless s/he –

(a) is satisfied as to the voter's identity, and

(b) has ensured that the declaration of identity, if required, has not been returned.

(4) After issuing a replacement ballot paper for a spoilt ballot paper, the returning officer shall enter in a list ("the list of spoilt ballot papers") –

(a) the name of the voter, and

(b) the details of the unique identifier of the spoilt ballot paper (if that officer was able to obtain it), and

(c) the details of the unique identifier of the replacement ballot paper.

29. Lost ballot papers

(1) Where a voter has not received his or her ballot paper by the fourth day before the close of the poll, that voter may apply to the returning officer for a replacement ballot paper.

(2) The returning officer may not issue a replacement ballot paper for a lost ballot paper unless s/he –

(a) is satisfied as to the voter's identity,

(b) has no reason to doubt that the voter did not receive the original ballot paper, and

(c) has ensured that the declaration of identity if required has not been returned.

(3) After issuing a replacement ballot paper for a lost ballot paper, the returning officer shall enter in a list ("the list of lost ballot papers") –

(a) the name of the voter, and

(b) the details of the unique identifier of the replacement ballot paper.

30. Issue of replacement ballot paper

(1) If a person applies for a replacement ballot paper under rule 28 or 29 and a declaration of identity has already been received by the returning officer in the name of that voter, the returning officer may not issue a replacement ballot paper unless, in addition to the requirements imposed rule 28(3) or 29(2), s/he is also satisfied that that person has not already voted in the election, notwithstanding the fact that a declaration of identity if required has already been received by the returning officer in the name of that voter.

(2) After issuing a replacement ballot paper under this rule, the returning officer shall enter in a list ("the list of tendered ballot papers") –

(a) the name of the voter, and

(b) the details of the unique identifier of the replacement ballot paper issued under this rule.

31. Declaration of identity for replacement ballot papers (Public and Patients' Constituencies)

(1) In respect of an election for a Public or Patients' Constituency a declaration of identity must be issued with each replacement ballot paper.

(2) The declaration of identity is to include a declaration –

(a) that the voter has not voted in the election with any ballot paper other than the ballot paper being returned with the declaration, and

(b) of the particulars of that member's qualification to vote as a member of the Public or Patients' Constituency, or class within a Constituency, for which the election is being held.

(3) The declaration of identity is to include space for –

(a) the name of the voter,

(b) the address of the voter,

(c) the voter's signature, and

(d) the date that the declaration was made by the voter.

(4) The voter must be required to return the declaration of identity together with the ballot paper.

(5) The declaration of identity must caution the voter that if it is not returned with the ballot paper, or if it is returned without being correctly completed, the replacement ballot paper may be declared invalid.

Procedure for receipt of envelopes

32. Receipt of voting documents

(1) Where the returning officer receives a –

(a) covering envelope, or

(b) any other envelope containing a declaration of identity if required, a ballot paper envelope, or a ballot paper,

before the close of the poll, that officer is to open it as soon as is practicable; and rules 33 and 34 are to apply.

(2) The returning officer may open any ballot paper envelope for the purposes of rules 33 and 34, but must make arrangements to ensure that no person obtains or communicates information as to –

(a) the candidate for whom a voter has voted, or

(b) the unique identifier on a ballot paper.

(3) The returning officer must make arrangements to ensure the safety and security of the ballot papers and other documents.

33. Validity of ballot paper

(1) A ballot paper shall not be taken to be duly returned unless the returning officer is satisfied that it has been received by the returning officer before the close of the poll, with a declaration of identity if required that has been correctly completed, signed, and dated.

(2) Where the returning officer is satisfied that paragraph (1) has been fulfilled, s/he is to –

(a) put the declaration of identity if required in a separate packet, and

(b) put the ballot paper aside for counting after the close of the poll.

(3) Where the returning officer is not satisfied that paragraph (1) has been fulfilled, s/he is to –

(a) mark the ballot paper "disqualified",

(b) if there is a declaration of identity accompanying the ballot paper, mark it as "disqualified" and attach it the ballot paper,

(c) record the unique identifier on the ballot paper in a list (the "list of disqualified documents"); and

(d) place the document or documents in a separate packet.

34. Declaration of identity but no ballot paper (Public and Patients' Constituency)

Where the returning officer receives a declaration of identity if required but no ballot paper, the returning officer is to –

(a) mark the declaration of identity "disqualified",

(b) record the name of the voter in the list of disqualified documents, indicating that a declaration of identity was received from the voter without a ballot paper; and

(c) place the declaration of identity in a separate packet.

35. Sealing of packets

As soon as is possible after the close of the poll and after the completion of the procedure under rules 33 and 34, the returning officer is to seal the packets containing –

(a) the disqualified documents, together with the list of disqualified documents inside it,

(b) the declarations of identity if required,

(c) the list of spoilt ballot papers,

(d) the list of lost ballot papers,

(e) the list of eligible voters, and

(f) the list of tendered ballot papers.

Part 6 - Counting the votes

36. Arrangements for counting of the votes

The returning officer is to make arrangements for counting the votes as soon as is practicable after the close of the poll.

37. The count

(1) The returning officer is to –

(a) count and record the number of ballot papers that have been returned, and

(b) count the votes according to the provisions in this Part of the rules.

(2) The returning officer, while counting and recording the number of ballot papers and counting the votes, must make arrangements to ensure that no person obtains or communicates information as to the unique identifier on a ballot paper.

(3) The returning officer is to proceed continuously with counting the votes as far as is practicable.

38. Rejected ballot papers

(1) Any ballot paper –

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,

(b) on which votes are given for more candidates than the voter is entitled to vote,

(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(d) which is unmarked or rejected because of uncertainty,

shall, subject to paragraphs (2) and (3) below, be rejected and not counted.

(2) Where the voter is entitled to vote for more than one candidate, a ballot paper is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

(3) A ballot paper on which a vote is marked –

(a) elsewhere than in the proper place,

(b) otherwise than by means of a clear mark,

(c) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the paper is marked does not itself identify the voter and it is not shown that s/he can be identified by it.

(4) The returning officer is to –

(a) endorse the word “rejected” on any ballot paper which under this rule is not to be counted, and

(b) in the case of a ballot paper on which any vote is counted under paragraph (2) or (3) above, endorse the words “rejected in part” on the ballot paper and indicate which vote or votes have been counted.

(5) The returning officer is to draw up a statement showing the number of rejected ballot papers under the following headings –

(a) does not bear proper features that have been incorporated into the ballot paper,

(b) voting for more candidates than the voter is entitled to,

(c) writing or mark by which voter could be identified, and

(d) unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of ballot papers rejected in part.

40. Equality of votes

Where, after the counting of votes is completed, an equality of votes is found to exist between any candidates and the addition of a vote would entitle any of those candidates to be declared elected, the returning officer is to decide between those candidates by a lot, and proceed as if the candidate on whom the lot falls had received an additional vote.

Part 7 – Final proceedings in contested and uncontested elections

41. Declaration of result for contested elections

(1) In a contested election, when the result of the poll has been ascertained, the returning officer is to –

(a) declare the candidate or candidates whom more votes have been given than for the other candidates, up to the number of vacancies to be filled on the Council of Governors from the Constituency, or class within a Constituency, for which the election is being held to be elected,

(b) give notice of the name of each candidate who he or she has declared elected–

(i). where the election is held under a proposed constitution pursuant to powers conferred on the NHS Trust by section 33(4) of the 2006 Act, to the Chair of the NHS Trust, or

(ii). in any other case, to the Chair of the Corporation; and

(c) give public notice of the name of each candidate whom s/he has declared elected.

(2) The returning officer is to make –

(a) the total number of votes given for each candidate (whether elected or not), and

(b) the number of rejected ballot papers under each of the headings in rule fpp39(5),

available on request.

42. Declaration of result for uncontested elections

In an uncontested election, the returning officer is to as soon as is practicable after final day for the delivery of notices of withdrawals by candidates from the election –

(a) declare the candidate or candidates remaining validly nominated to be elected,

(b) give notice of the name of each candidate who s/he has declared elected to the Chair of the Corporation, and

(c) give public notice of the name of each candidate who s/he has declared elected.

Part 8 – Disposal of documents

43. Sealing up of documents relating to the poll

(1) On completion of the counting at a contested election, the returning officer is to seal up the following documents in separate packets –

(a) the counted ballot papers,

(b) the ballot papers endorsed with “rejected in part”,

(c) the rejected ballot papers, and

(d) the statement of rejected ballot papers.

(2) The returning officer must not open the sealed packets of –

(a) the disqualified documents, with the list of disqualified documents inside it,

(b) the declarations of identity,

(c) the list of spoilt ballot papers,

(d) the list of lost ballot papers,

(e) the list of eligible voters, and

(f) the list of tendered ballot papers.

(3) The returning officer must endorse on each packet a description of –

(a) its contents,

(b) the date of the publication of notice of the election,

(c) the name of the Corporation to which the election relates, and

(d) the Constituency, or class within a Constituency, to which the election relates.

44. Delivery of documents

Once the documents relating to the poll have been sealed up and endorsed pursuant to rule 49, the returning officer is to forward them to the Chair of the Corporation.

45. Forwarding of documents received after close of the poll

Where –

(a) any voting documents are received by the returning officer after the close of the poll, or

(b) any envelopes addressed to eligible voters are returned as undelivered too late to be resent, or

(c) any applications for replacement ballot papers are made too late to enable new ballot papers to be issued, the returning officer is to put them in a separate packet, seal it up, and endorse and forward it to the Chair of the Corporation.

46. Retention and public inspection of documents

(1) The Corporation is to retain the documents relating to an election that are forwarded to the Chair by the returning officer under these rules for one year, and then, unless otherwise directed by the Regulator, cause them to be destroyed.

(2) With the exception of the documents listed in rule 53(1), the documents relating to an election that are held by the Corporation shall be available for inspection by members of the public at all reasonable times.

(3) A person may request a copy or extract from the documents relating to an election that are held by the Corporation, and the Corporation is to provide it, and may impose a reasonable charge for doing so.

47. Application for inspection of certain documents relating to an election

(1) The Corporation may not allow the inspection of, or the opening of any sealed packet containing –

(a) any rejected ballot papers, including ballot papers rejected in part,

(b) any disqualified documents, or the list of disqualified documents,

(c) any counted ballot papers,

(d) any declarations of identity, or

(e) the list of eligible voters,

by any person without the consent of the Regulator.

(2) A person may apply to the Regulator to inspect any of the documents listed in (1), and the Regulator may only consent to such inspection if it is satisfied that it is necessary for the purpose of questioning an election pursuant to Part 11.

(3) The Regulator's consent may be on any terms or conditions that it thinks necessary, including conditions as to –

(a) persons,

(b) time,

(c) place and mode of inspection,

(d) production or opening,

and the Corporation must only make the documents available for inspection in accordance with those terms and conditions.

(4) On an application to inspect any of the documents listed in paragraph (1), –

(a) in giving its consent, the Regulator, and

(b) and making the documents available for inspection, the Corporation, must ensure that the way in which the vote of any particular member has been given shall not be disclosed, until it has been established –

(i). that his or her vote was given, and

(ii). that the Regulator has declared that the vote was invalid.

Part 9 – Death of a candidate during a contested election

48. Countermand or abandonment of poll on death of candidate

(1) If, at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to

(a) countermand notice of the poll, or, if ballot papers have been issued, direct that the poll be abandoned within that Constituency or class, and

(b) order a new election, on a date to be appointed by him or her in consultation with the Corporation, within the period of 40 days, computed in accordance with rule 3 of these rules, beginning with the day that the poll was countermanded or abandoned.

(2) Where a new election is ordered under paragraph (1), no fresh nomination is necessary for any candidate who was validly nominated for the election where the poll was countermanded or abandoned but further candidates shall be invited for that Constituency or class.

(3) Where a poll is abandoned under paragraph (1)(a), paragraphs (4) to (7) are to apply.

(4) The returning officer shall not take any step or further step to open envelopes or deal with their contents in accordance with rules 33 and 34, and is to make up separate sealed packets in accordance with rule 35.

(5) The returning officer is to –

(a) count and record the number of ballot papers that have been received, and

(b) seal up the ballot papers into packets, along with the records of the number of ballot papers.

(6) The returning officer is to endorse on each packet a description of -

(a) its contents,

(b) the date of the publication of notice of the election,

(c) the name of the Corporation to which the election relates, and

(d) the Constituency, or class within a Constituency, to which the election relates.

(7) Once the documents relating to the poll have been sealed up and endorsed pursuant to paragraphs (4) to (6), the returning officer is to deliver them to the Chair of the Corporation, and rules 52 and 53 are to apply.

Part 10 – Election expenses and publicity

Election expenses

49. Election expenses

Any expenses incurred, or payments made, for the purposes of an election which contravene this Part are an electoral irregularity, which may only be questioned in an application to the Regulator under Part 11 of these rules.

50. Expenses and payments by candidates

A candidate may not incur any expenses or make a payment (of whatever nature) for the purposes of an election, other than expenses or payments that relate to –

(a) personal expenses,

(b) travelling expenses, and expenses incurred while living away from home, and

(c) expenses for stationery, postage, telephone, internet (or any similar means of communication) and other petty expenses, to a limit of £25.

51. Election expenses incurred by other persons

(1) No person may –

(a) incur any expenses or make a payment (of whatever nature) for the purposes of a candidate's election, whether on that candidate's behalf or otherwise, or

(b) give a candidate or his or her family any money or property (whether as a gift, donation, loan, or otherwise) to meet or contribute to expenses incurred by or on behalf of the candidate for the purposes of an election.

(2) Nothing in this rule is to prevent the Corporation from incurring such expenses, and making such payments, as it considers necessary pursuant to rules 58 and 59.

Publicity

52. Publicity about election by the Corporation

(1) The Corporation may –

(a) compile and distribute such information about the candidates, and

(b) organise and hold such meetings to enable the candidates to speak and respond to questions, as it considers necessary.

(2) Any information provided by the Corporation about the candidates, including information compiled by the Corporation under rule 59, must be –

(a) objective, balanced and fair,

(b) equivalent in size and content for all candidates,

(c) compiled and distributed in consultation with all of the candidates standing for election, and

(d) must not seek to promote or procure the election of a specific candidate or candidates, at the expense of the electoral prospects of one or more other candidates.

(3) Where the Corporation proposes to hold a meeting to enable the candidates to speak, the Corporation must ensure that all of the candidates are invited to attend, and in organising and holding such a meeting, the Corporation must not seek to promote or procure the election of a specific candidate or candidates at the expense of the electoral prospects of one or more other candidates.

53. Information about candidates for inclusion with voting documents

(1) The Corporation must compile information about the candidates standing for election, to be distributed by the returning officer pursuant to rule 24 of these rules.

(2) The information must consist of –

(a) a statement submitted by the candidate of no more than 250 words, and

(b) a photograph of the candidate.

54. Meaning of "for the purposes of an election"

(1) In this Part, the phrase "for the purposes of an election" means with a view to, or otherwise in connection with, promoting or procuring a candidate's election, including the prejudicing of another candidate's electoral prospects; and the phrase "for the purposes of a candidate's election" is to be construed accordingly.

(2) The provision by any individual of his or her own services voluntarily, on his or her own time, and free of charge is not to be considered an expense for the purposes of this Part.

Part 11 – Questioning elections and the consequence of irregularities

55. Application to question an election

(1) An application alleging a breach of these rules, including an electoral irregularity under Part 10, may be made to the Regulator.

(2) An application may only be made once the outcome of the election has been declared by the returning officer.

(3) An application may only be made to the Regulator by –

(a) a person who voted at the election or who claimed to have had the right to vote, or

(b) a candidate, or a person claiming to have had a right to be elected at the election.

(4) The application must –

(a) describe the alleged breach of the rules or electoral irregularity, and

(b) be in such a form as the Regulator may require.

(5) The application must be presented in writing within 21 days of the declaration of the result of the election.

(6) If the Regulator requests further information from the applicant, then that person must provide it as soon as is reasonably practicable.

(a) The Regulator shall delegate the determination of an application to a person or persons to be nominated for the purpose of the Regulator.

(b) The determination by the person or persons nominated in accordance with Rule 61(7) shall be binding on and shall be given effect by the Corporation, the applicant and the members of the Constituency (or class within a Constituency) including all the candidates for the election to which the application relates.

(c) The Regulator may prescribe rules of procedure for the determination of an application including costs.

Part 12 – Miscellaneous

56. Secrecy

(1) The following persons –

(a) the returning officer,

(b) the returning officer's staff,

must maintain and aid in maintaining the secrecy of the voting and the counting of the votes, and must not, except for some purpose authorised by law, communicate to any person any information as to –

(i). the name of any member of the Corporation who has or has not been given a ballot paper or who has or has not voted,

(ii). the unique identifier on any ballot paper,

(iii). the candidate(s) for whom any member has voted.

(2) No person may obtain or attempt to obtain information as to the candidate(s) for whom a voter is about to vote or has voted, or communicate such information to

any person at any time, including the unique identifier on a ballot paper given to a voter.

(3) The returning officer is to make such arrangements as s/he thinks fit to ensure that the individuals who are affected by this provision are aware of the duties it imposes.

57. Prohibition of disclosure of vote

No person who has voted at an election shall, in any legal or other proceedings to question the election, be required to state for whom s/he has voted.

58. Disqualification

A person may not be appointed as a returning officer, or as staff of the returning officer pursuant to these rules, if that person is –

(a) a member of the Corporation,

(b) an employee of the Corporation,

(c) a Director of the Corporation, or

(d) employed by or on behalf of a person who has been nominated for election.

59. Delay in postal service through industrial action or unforeseen event

If industrial action, or some other unforeseen event, results in a delay in –

(a) the delivery of the documents in rule 24, or

(b) the return of the ballot papers and declarations of identity, the returning officer may extend the time between the publication of the notice of the poll and the close of the poll, with the agreement of the Regulator.

ANNEX 6 – ADDITIONAL PROVISIONS – COUNCIL OF GOVERNORS

Compliance with Code of Conduct

Governors shall comply with the Trust's Code of Conduct for Governors, as may be varied from time to time.

Training

The Membership Strategy outlines the details of the training programme for Governors. Governors shall comply in so far as is possible with any training requirements identified by the Trust. The training programme set out in the Membership Strategy shall be reviewed from time to time and amended as required.

Eligibility to be a Governor

A person may not become a Governor of the Trust, and if already holding such office will immediately cease to do so if:

1. S/he is a Director of the Trust, or a Governor or Director of another NHS Foundation Trust or any other NHS body, unless such Foundation Trust or NHS body is an appointing organisation which is appointing him/her under this Constitution;

2. S/he is the spouse, partner, parent or child of a member of the Council of Governors or Board of Directors of the Trust;

3. S/he is under sixteen years of age at the time s/he is nominated for election or appointment;

4. S/he is a member of a local authority's scrutiny committee covering health matters;

5. Being a member of one of the public constituencies or one of the classes of the Patients' Constituency, s/he fails to sign a declaration in the form specified by the Council of Governors of the particulars of his/her qualification to vote as a member of the Trust, and that s/he is not prevented from being a member of the Council of Governors;

6. S/he fails to agree to comply with the Trust's Code of Conduct for Governors;

7. S/he is or has been subject to a sex offender order;

8. On the basis of disclosures obtained through an application to the Criminal Records Bureau, s/he is not considered suitable by the Trust's Executive Director responsible for Human Resources;

9. S/he is incapable by reason of mental disorder, illness or injury of managing or administering his/her property and affairs;

10. S/he has within the preceding two years been dismissed, otherwise than by reason of redundancy, from any paid employment with a health service body;

11. S/he is a person whose tenure of office as the Chair or as a member or Director of a health service body has been terminated on the grounds that his/her

appointment is not in the interests of the health service, for non-attendance at meetings, or for non-disclosure of a pecuniary interest;

12. S/he has had his/her name removed from any list prepared under Part II of the NHS Act 1977 and, due to the reason(s) for such removal, s/he is not considered suitable by the Trust's Executive Director responsible for Human Resources;

13. S/he has previously been removed from office as a Governor of the Trust in accordance with the provisions of paragraph 8 below under the section titled 'Termination of office and removal of Governors'.

Requirement of Governor to notify Trust

Where a person has been elected or appointed to be a Governor and s/he becomes disqualified from office under the provisions of this Constitution, s/he shall notify the Secretary in writing of such disqualification.

Termination of office and removal of Governors

A person holding office as a Governor shall immediately cease to do so if:

1. S/he resigns by notice in writing to the Secretary;

2. It otherwise comes to the notice of the Secretary at the time the Governor takes office or later that the Governor is disqualified;

3. S/he fails to attend two meetings in any financial year, unless the other Governors are satisfied that:
   a. the absences were due to reasonable causes; and
   b. s/he will be able to start attending meetings of the Trust again within such a period as they consider reasonable;

4. In the case of an elected Governor, s/he ceases to be a member of the Trust;

5. In the case of an appointed Governor, the appointing organisation terminates the appointment;

6. S/he has refused without reasonable cause to undertake any training, which the Council of Governors requires all Governors to undertake;

7. S/he has failed to sign and deliver to the Secretary a statement in the form required by the Council of Governors confirming acceptance of the Trust's Code of Conduct for Governors;

8. S/he is removed from the Council of Governors by a resolution approved by a majority of the remaining Governors present and voting at a general meeting on the grounds that:

   a. s/he has committed a serious breach of the Trust's Code of Conduct; or
   b. s/he has failed to declare a relevant and material interest in accordance with the Council of Governor's Standing Orders; or
   c. s/he has acted in a manner detrimental to the interests of the Trust; or
   d. the Council of Governors consider that it is not in the best interests of the Trust for him/her to continue as a Governor.

Vacancies amongst Governors

1. Where a vacancy arises on the Council of Governors for any reason other than expiry of term of office, the following provisions will apply.

2. Where the vacancy arises amongst the appointed Governors, the Secretary shall request that the appointing organisation appoints a replacement to hold office for the remainder of the term of office.

3. Where the vacancy arises amongst the elected Governors, the Council of Governors shall be at liberty either:

   - to call an election within three months to fill the seat for the remainder of that term of office, or

   - to invite the next highest polling candidate for that seat at the most recent election, who is willing to take office, to fill the seat for any unexpired period of the term of office; or

   - to leave the vacancy outstanding until the next annual election, providing that the vacancy shall not be for more than nine months.

Roles and Responsibilities

The Governors have three general roles:

- Advisory – to communicate to the Board the views and interests of members and the wider community;
- Guardianship – to ensure that the Trust is operating in accordance with its authorisation;
- Strategic – to advise on the Trust's strategy and deliverance of that strategy.

The Governors shall carry out their roles and responsibilities in accordance with this Constitution and the Trust's authorisation.

The roles and responsibilities of the Governors shall include to:

1. Appoint or remove the Chair and the other Non-Executive Directors. The removal of a Non-Executive Director requires the approval of two thirds of the Council of Governors ;

2. Decide the remuneration and allowances, and the other terms and conditions of office, of the Non-Executive Directors;

3. Appoint or remove any external auditor and the Trust's financial auditor;

4. Approve (by a majority of the Council of Governors voting) an appointment (by the Appointments and Remuneration Committee of the Board of Directors, excluding the Chief Executive) of the Chief Executive;

5. Give the views of the Council of Governors to the Board of Directors for the purposes of the preparation (by the Directors) of the document containing information as to the Trust's forward planning in respect of each financial year to be given to the Regulator;

6. Consider the annual accounts, any report of the financial auditor on them, and the annual report;

7. Consult with the Board of Directors on future plans for the services provided by the Trust;

8. Work with the Board of Directors to ensure the Trust operates within its terms of authorisation;

9. Respond to any matter as appropriate when consulted by the Directors;

10. Review the Trust's Membership Strategy from time to time and at least once every three years to develop the membership of the Trust and represent the interests of members, and to review from time to time the Trust's policy for the composition of the Council of Governors;

11. Establish mechanisms for consulting with the members and partnership organisations they may represent, particularly on developments and significant changes to services provided by the Trust;

12. Act as a source of ideas about how the Trust can provide services which reflect the needs of patients and the wider community;

13. Ensure that the Trust follows its values, as set out in the Trust's Membership Strategy;

14. Monitor the success of the Trust in meeting its planned service objectives;

15. Undertake such functions as the Board of Directors shall from time to time request.

Appointment of Non-Executive Directors (including Chair, Vice Chair, Senior Independent Director and Chair of Audit)

1. The Board of Directors will identify the skills and experience required for Non-Executive Director posts, including the Chair, Vice Chair, Chair of Audit and Senior Independent Director of the Trust, and will prepare a suitable job description(s), which may be revised by the Board from time to time as required.

2. The Council of Governors shall establish a Nominations Committee to prepare job descriptions (taking into account the views of the Board regarding skills and experience) and identify suitable candidates to assist with the process of selection of Non-Executive Directors by the Council of Governors.

ANNEX 7 – COUNCIL OF GOVERNORS STANDING ORDERS

FOREWORD

The Alder Hey Children's NHS Foundation Trust ("the Trust") is a public benefit corporation established in accordance with the provisions of the National Health Service Act 2006 ("the 2006 Act").

As a body corporate, the Trust has specific powers to contract in its own name and to act as a corporate trustee. In its latter role, the Trust is accountable to the Charity Commission for those funds deemed to be charitable. The Trust also has a common law duty as a bailee for patients' property held on behalf of patients.

The principal place of business of the Trust is Alder Hey Children's Hospital.

These Standing Orders are for the regulation of the proceedings of the Council of Governors.

The Trust provides care on more than 200,000 occasions each year to children, young people and their families. The Trust is proud to be a family-centered organisation. Our values reflect the fact that we see the children, young people and families we serve at the centre of the services we provide and we recognise that we can learn much from them, which helps us to improve what we do continuously. Directors and Governors are expected to observe the Nolan principles of selflessness, integrity, objectivity, accountability, openness, honesty and leadership.

The Council of Governors and Board of Directors shall at all times seek to comply with the Trust's Codes of Conduct for Governors and Directors.

There should be sufficient transparency about the Trust's activities to promote confidence between the Trust and its staff, patients and the public.

Alder Hey Children's NHS Foundation Trust

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Alder Hey Children's NHS Foundation Trust

1. Interpretation

1.1. Save as permitted by law, the Chair of the Trust shall be the final authority on the interpretation of Standing Orders (on which s/he shall be advised by the Chief Executive and Director of Finance).

1.2. Any expression to which a meaning is given in the 2006 Act shall have the same meaning in this interpretation and in addition:

"ACCOUNTING OFFICER" shall be the Officer responsible and accountable for funds entrusted to the Trust. S/he shall be responsible for ensuring the proper stewardship of public funds and assets. For this Trust it shall be the Chief Executive.

"BOARD" shall mean the Chair and Non-Executive Directors, appointed by the Council of Governors, and the Executive Directors appointed by the Appointments and Remuneration Committee of the Board.

"BUDGET" shall mean a resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust.

"CHAIR" is the person appointed by the Council of Governors in accordance with paragraphs 24 and 25 of this Constitution. The expression "the Chair of the Trust" shall be deemed to include the Non-Executive Director appointed by the Council of Governors to take on the Chair's duties if the Chair is absent or is otherwise unavailable (the Vice Chair).

"CHIEF EXECUTIVE" shall mean the chief officer of the Trust.

"COMMITTEE" shall mean a committee appointed by the Council of Governors.

"COMMITTEE MEMBERS" shall be persons formally appointed by the Council of Governors to sit on or to chair specific committees.

"DIRECTOR" shall mean a person appointed to the Board of Directors in accordance with the Trust's Constitution and includes the Chair.

"MOTION" means a formal proposition to be discussed and voted on during the course of a meeting.

"NOMINATED OFFICER" means an Officer charged with the responsibility for discharging specific tasks within Standing Orders.

"OFFICER" means an employee of the Trust.

"SENIOR INDEPENDENT DIRECTOR" means an independent Non Executive Director with the responsibility to work with the Governors to understand their issues and act on their behalf at Board level

"SOs" mean Standing Orders.

"TRUST" means the Alder Hey Children's NHS Foundation Trust.

2. General Information

2.1. The purpose of the Council of Governors Standing Orders is to ensure that the highest standards of corporate governance and conduct are applied to all Council meetings and associated deliberations. The Council shall at all times seek to comply with the Trust's Code of Conduct for Governors.

2.2. All business shall be conducted in the name of the Trust.

2.3. The Board of Directors shall appoint trustees to administer separately charitable funds received by the Trust and for which they are accountable to the Charity Commission.

2.4. A Governor who has acted honestly and in good faith will not have to meet out of his or her own personal resources any personal civil liability which is incurred in the execution or purported execution of his or her functions as a Governor save where the Governor has acted recklessly. On behalf of the Council of Governors, and as part of the Trust's overall insurance arrangements, the Board of Directors shall put in place appropriate insurance provision to cover such indemnity.

3. Composition of the Council of Governors

3.1. The composition of the Council of Governors shall be in accordance with paragraph 12 of the Trust's Constitution.

3.2. **Appointment and Removal of the Chair and Vice Chair of the Council of Governors -** These appointments shall be made by the Governors in accordance with paragraph 24 of the Trust's Constitution.

3.3. **Duties of Vice Chair** - Where the Chair of the Trust has died or has otherwise ceased to hold office or where s/he has been unable to perform his/her duties as Chair owing to illness, absence from England and Wales or any other cause, references to the Chair shall, so long as there is no Chair able to perform his/her duties, be taken to include references to the Vice Chair or the Non-Executive Director nominated by the Council of Governors to take on the duties of the

Chair or Vice Chair should both be absent from a meeting or otherwise unavailable or unable to perform his/her duties.

4. Meetings of the Council of Governors

4.1. Meetings held in Public

4.1.1 Meetings of the Council of Governors must be open to the public, subject to paragraphs 4.1.2 and 4.1.3 below.

4.1.2 The Council of Governors may resolve to exclude members of the public from any meeting or part of a meeting on the grounds that it considers that:

publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted; or

there are special reasons stated in the resolution and arising from the nature of the business of the proceedings.

4.1.3 The Chair may exclude any member of the public from the meeting of the Council if s/he considers that s/he is interfering with or preventing any conduct of the meeting.

4.1.4 Meetings of the Council of Governors shall be held at least three times each year at times and places that the Council of Governors may determine.

4.1.5 The Council may invite the Chief Executive, and other appropriate Directors, to attend any meeting of the Council to enable Governors to raise questions about the Trust's affairs.

4.2 Calling Meetings

Notwithstanding paragraph 4.1.4 above, the Chair may call a meeting of the Council of Governors at any time. If the Chair refuses to call a meeting after a requisition for that purpose, signed by a majority of the Governors, or if without so refusing the Chair does not call a meeting within fourteen days after requisition to do so, then the Governors may forthwith call a meeting provided they have been requisitioned to do so by more than 50% of their members.

4.3 Notice of Meetings

4.3.1 Before each meeting of the Council of Governors, a notice of the meeting, specifying the business proposed to be transacted at it, and signed by the Chair or by an Officer of the Trust authorised by the Chair to sign on his/her behalf [subject to paragraphs 4.3.2 and 4.3.3 below] shall be delivered to every Governor, or sent by post to the usual place of residence of such Governor, so as to be available to him/her at least twenty-one clear days before the meeting. Lack of service of

the notice on any Governor shall not affect the validity of a meeting, subject to paragraph 4.3.4 below.

4.3.2 Notwithstanding the above requirement for notice, the Chair may waive notice in the case of emergencies or in the case of the need to conduct urgent business.

4.3.3 In the case of a meeting called by Governors in default of the Chair, the notice shall be signed by those Governors calling the meeting and no business shall be transacted at the meeting other than that specified in the notice.

4.3.4 Subject to paragraph 4.3.2, failure to serve notice on more than three quarters of Governors will invalidate any meeting. A notice will be presumed to have been served 48 hours after the envelope containing it was posted or, in the case of a notice contained in an electronic communication, 48 hours after it was sent.

4.4 **Setting the Agenda**

4.4.1 The Council of Governors may determine that certain matters shall appear on every agenda for a meeting of the Council and shall be addressed prior to any other business being conducted.

4.4.2 In the case of a meeting called by the Chair, a Governor desiring a matter to be included on an agenda shall make his/her request in writing to the Chair at least ten clear days before the meeting. Requests made less than ten days before a meeting may be included on the agenda at the discretion of the Chair.

4.4.3 The Chair shall make arrangements to ensure that the final agenda and any supporting papers for the meeting, following the receipt of any requests in accordance with 4.4.2 above, are delivered to every Governor, or sent by post to the usual place of residence of such Governor, so as to be available to him/her at least five clear days before the meeting.

4.5 **Chair of Meeting**

At any meeting of the Council of Governors, the Chair, if present, shall preside. If the Chair is absent from the meeting or the Council of Governors is meeting to appoint or remove the Chair or decide his/her remuneration and allowances and other terms and conditions of office, the sSenior Governor shall preside. Otherwise, another Non-Executive Director shall preside.

4.6 **Notices of Motions**

4.6.1 A Governor of the Trust desiring to move or amend a motion shall send a written notice thereof at least ten clear days before the meeting to the Chair, who shall insert this in the agenda for the meeting. All notices so received are subject to the notice given being permissible under the appropriate regulations. This

paragraph shall not prevent any motion being moved during the meeting, without notice, on any business mentioned on the agenda subject to section 4.3.3 of these Standing Orders.

4.6.2 A motion or amendment, once moved and seconded, may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair.

4.6.3 Notice of motion to amend or rescind any resolution (or the general substance of any resolution), which has been passed within the preceding six calendar months, shall bear the signature of the Governors who gave it and also the signature of four other Governors. When any such motion has been disposed of by the Council it shall not be competent for any Governor, other than the Chair, to propose a motion to the same effect within six months; however the Chair may do so if s/he considers it appropriate.

4.6.4 The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

4.6.5 When a motion is under discussion or immediately prior to discussion it shall be open to a Governor to move:

(a) An amendment to the motion.

(b) The adjournment of the discussion or the meeting.

(c) The appointment of an ad hoc committee to deal with a specific item of business.

(d) That the meeting proceed to the next business.

(e) That the motion be now put.

Such a motion, if seconded, shall be disposed of before the motion, which was originally under discussion or about to be discussed. No amendment to the motion shall be admitted if, in the opinion of the Chair of the meeting, the amendment negates the substance of the motion.

In the case of motions under (d) and (e), to ensure objectivity, motions may only be put by a Governor who has not previously taken part in the debate.

4.7 **Chair's Ruling**

Statements of Governors made at meetings of the Council shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting on questions of order, relevancy, regularity and any other matters shall be observed at the meeting.

4.8 **Voting**

4.8.1 Decisions at meetings shall be determined by a majority of the votes of the Governors present and voting. In the case of any

equality of votes, the person presiding shall have a second or casting vote.

4.8.2 All decisions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the Governors present so request.

4.8.3 If at least one-third of the Governors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each Governor present voted or abstained.

4.8.4 If a Governor so requests, his/her vote shall be recorded by name upon any vote (other than by paper ballot).

4.8.5 In no circumstances may an absent Governor vote by proxy. Absence is defined as being absent at the time of the vote.

4.8.6 A Governor who is a member of the Public Constituency or one of the classes of the Patients' Constituency may not vote at a meeting of the Council of Governors unless, before attending the meeting, they have made a declaration in the form specified by the Secretary of the particulars of their qualification to vote as a member of the Trust and that they are not prevented from being a member of the Trust. A Governor shall be deemed to have confirmed the declaration upon attending any subsequent meeting of the Council of Governors and every agenda for meetings of the Council of Governors shall draw this to the attention of the Governors.

4.9 Suspension of Standing Orders (SOs)

4.9.1 Except where this would contravene any statutory provision, any one or more of these Standing Orders may be suspended at any meeting, provided that at least two-thirds of members of the Council are present and that a majority of those present vote in favour of suspension.

4.9.2 A decision to suspend SOs shall be recorded in the minutes of the meeting.

4.9.3 A separate record of matters discussed during the suspension of SOs shall be made and shall be available to the Directors.

4.9.4 No formal business may be transacted while SOs are suspended.

4.9.5 The Trust's Audit Committee shall review every decision to suspend SOs.

4.10 **Variation and Amendment of Standing Orders**

These Standing Orders shall be amended only if:

- a notice of motion has been given; and
- no fewer than two thirds of the total number of Governors approve the variation/amendment; and
- the variation/amendment proposed does not contravene a statutory requirement.

4.11 **Record of Attendance**

The names of the Governors present at the meeting shall be recorded in the minutes.

4.12 **Minutes**

4.12.1 The minutes of the proceedings of the meeting shall be drawn up and maintained as a public record. They will be submitted for agreement at the next meeting where they will be signed by the person presiding at it.

4.12.2 No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

4.12.3 Minutes shall be circulated in accordance with the Governors' wishes. The minutes of the meeting shall be made available to the public except for minutes relating to business conducted when members of the public are excluded under the terms of section 4.1 of these Standing Orders (Code of Practice on Openness in the NHS adopted voluntarily by the Trust).

4.13 **Quorum**

4.13.1 No business shall be transacted at a meeting of the Council of Governors unless at least one-third of all the members of the Council of Governors are present.

4.13.2 If a Governor has been disqualified from participating in the discussion on any matter and from voting on any resolution by reason of the declaration of a conflict of interest s/he shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

5. Arrangements for the Exercise of Functions by Delegation

5.1 **Emergency Powers** - The powers which the Council of Governors has retained to itself within these Standing Orders may in an emergency be exercised by the Chair after having consulted at least five elected Governors. The exercise of such powers by the Chair shall be reported to the next formal meeting of the Council for ratification.

5.2 **Delegation to a Governor** – The Council of Governors may delegate duties to an individual Governor but only under a clear remit approved by the Council.

5.3 The Nominations Committee of the Council of Governors, the Terms of Reference for which are set out in its Terms of Reference on behalf of the Council.

6. Confidentiality

6.1 A member of the Council of Governors shall not disclose a matter dealt with by, or brought before, the Council of Governors without its permission.

6.2 Members of the Nominations Committee shall not disclose any matter dealt with by the Committee, notwithstanding that the matter has been reported or action has been concluded, if the Council of Governors or Committee resolves that it is confidential.

7. Declaration of Interests and Register of Interests

7.1 Declaration of Interests

Governors are required to comply with the Trust's Standards of Business Conduct and to declare interests that are relevant and material to the Council. All Governors should declare such interests on appointment and on any subsequent occasion that a conflict arises.

7.1.1 Interests regarded as "relevant and material" include any of the following, held by a Governor, or the spouse, partner, parent or child of a Governor:

a) Directorships, including non-executive directorships, held in private companies or PLCs (with the exception of those of dormant companies).

b) Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.

c) Employment with any private company, business or consultancy.

d) Significant share holdings (more than 5%) in organisations likely or possibly seeking to do business with the NHS.

e) A position of authority in a charity or voluntary organisation in the field of health and social care.

f) Any connection with a voluntary or other organisation contracting for NHS services.

7.1.2 If a Governor has any doubt about the relevance of an interest, s/he should discuss it with the Chair who shall advise him/her whether or not to disclose the interest.

7.1.3 At the time Governors' interests are declared, they should be recorded in the Council of Governors minutes and entered on a Register of Interests of Governors to be maintained by the Secretary. Any changes in interests should be declared at the next Council meeting following the change occurring.

7.1.4 Governors' directorships of companies likely or possibly seeking to do business with the NHS should be published in the Trust's annual report.

7.1.5 During the course of a Council meeting, if a conflict of interest is established, the Governor concerned shall, unless two thirds of those Governors present agree, otherwise withdraw from the meeting and play no part in the relevant discussion or decision. If the Governor remains present at the meeting on the agreement of two thirds of those Governors present, s/he shall not be entitled to vote on the issue in respect of which the conflict of interest has been established.

7.2 **Register of Interests**

7.2.1 The Trust Secretary, will ensure that a Register of Interests is established to record formally declarations of interests of Governors.

7.2.2 Details of the Register will be kept up to date and reviewed annually.

7.2.3 The Register will be available to the public.

8. Compliance - Other Matters

8.1 All Governors of the Council shall comply with the Standards of Business Conduct set by the Board of Directors for the guidance of all staff employed by the Trust.

8.2 All Governors of the Trust shall comply with Standing Financial Instructions prepared by the Director of Finance and approved by the Board of Directors for the guidance of all staff employed by the Trust.

8.3 All Governors must behave in accordance with the seven Nolan principles of behaviour in Public Life (and the Trust's Code of Conduct for Governors as amended from time to time): -

- Selflessness;
- Integrity;
- Objectivity;
- Accountability;
- Openness;
- Honesty, and
- Leadership.

9. Resolution of Disputes with Board of Directors

9.1 The council has three main roles:

9.1.1 Strategic – to use the breadth of experience of the governors to help determine the trust's future direction and support it in delivering its plans and to hold the non-executive directors individually and collectively to account for the performance of the board of directors

9.1.2 Advisory – to act as a critical friend providing support, feedback and advice.

9.1.3 Representative – to represent the interests of the members of the corporation as a whole and the interests of the public and to use the views of their electorate or organisation to enhance and inform the work of the trust.

9.2 The board has overall responsibility for running the affairs of the trust. Its role is to:

9.2.1 Set a strategic direction.

9.2.2 Set organisational and operational targets.

9.2.3 Minimise risk.

9.2.4 Assess achievement against the above objectives.

9.2.5 Ensure that action is taken to eliminate or minimise, as appropriate, adverse deviations from objectives.

9.2.6 Ensure that the highest standards of corporate governance are applied throughout the organisation.

9.2.7 Act with a view to promoting the success of the corporation so as to maximise the benefits for the members of the corporation as a whole and for the public

9.3 Should a dispute arise between the council and the board then the disputes resolution procedure set out below recognises the different roles of the council and the board as described above.

9.3.1 The chair, or Senior Independent Director (if the dispute involves the chair) shall first endeavour through discussion with appropriate representatives of the governors and the directors to achieve the earliest possible resolution of the matter in dispute to the reasonable satisfaction of both parties.

9.3.2 Failing resolution under council standing order 9.3.1 above then the board or the council, as appropriate, shall at its next formal meeting approve the precise wording of a disputes statement setting out clearly and concisely the issue or issues giving rise to the dispute.

9.3.3 The chair or Senior Independent Director (if the dispute involves the chair) shall ensure that the disputes statement produced in accordance with council standing order 9.3.2 above, without amendment or abbreviation in any way, shall be an agenda item and agenda paper at the next formal meeting of the board or council as appropriate (i.e the body that does not issue the disputes statement). That meeting shall agree the precise wording of a response to the disputes statement.

9.3.4 The chair or Senior Independent Director (if the dispute involves the chair) shall immediately or as soon as is practical, communicate the outcome to the other party and deliver the written response to the disputes statement.

9.3.5 If, in the opinion of the chair or Senior Independent Director (if the dispute involves the chair), and following the further discussions prescribed in council standing order 9.3.4, there is no further prospect of a full resolution or, if at any stage in the whole process, in the opinion of the chair or Senior Independent Director (as the case may be), there is no prospect of a resolution (partial or otherwise) then he or she shall appoint a special committee comprising equal numbers of directors and governors under the chairmanship of the senior independent director to consider the circumstances and to make recommendations to the Council and the board with a view to resolving the dispute.

9.3.6 On the satisfactory completion of this disputes process the board shall implement agreed changes.

9.3.7 If the recommendations (if any) of the special committee are unsuccessful in resolving the dispute, the chair may refer the dispute to an external mediator as he or she considers appropriate.

9.4 Nothing in this procedure shall prevent the council, if it so desires, from informing Monitor that, in the council's opinion, the board has not responded constructively to concerns of the council that the trust is not meeting the terms of its authorisation.

10. Council Performance

The Trust must take steps to secure that the governors are equipped with the skills and knowledge they require in their capacity as such. The Chair shall, at least annually, lead a performance assessment process for the Council to enable the Council to review its roles, structure and composition, and procedures, taking into account emerging best practice.

11. Changes to Standing Orders

For the sake of clarity, future amendments to these Standing Orders by the Council must be regarded as a change to the Trust's Constitution.

ANNEX 8

BOARD STANDING ORDERS

FOREWORD

The Alder Hey Children's NHS Foundation Trust ("the Trust") is a public benefit corporation established in accordance with the provisions of the National Health Service Act 2006 ("the 2006 Act").

As a body corporate, the Trust has specific powers to contract in its own name and to act as a corporate trustee. In its latter role, the Trust is accountable to the Charity Commission for those funds deemed to be charitable. The Trust also has a common law duty as a bailee for patients' property held on behalf of patients.

The principal place of business of the Trust is Alder Hey Children's Hospital.

These Standing Orders are for the regulation of the proceedings of the Board of Directors.

The Trust provides care on more than 200,000 occasions each year to children, young people and their families. The Trust is proud to be a family-centred organisation. Our values reflect the fact that we see the children, young people and families we serve at the centre of the services we provide and we recognise that we can learn much from them, which helps us to improve what we do continuously. Directors and Governors are expected to observe the Nolan principles of selflessness, integrity, objectivity, accountability, openness, honesty and leadership.

The Council of Governors and Board of Directors shall at all times seek to comply with the Trust's Codes of Conduct for Governors and Directors.

There should be sufficient transparency about the Trust's activities to promote confidence between the Trust and its staff, patients and the public.

Alder Hey Children's NHS Foundation Trust

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13. Changes to Board Standing Orders

1. Interpretation

1.1. Save as permitted by law, the Chair of the Trust shall be the final authority on the interpretation of Standing Orders (on which s/he shall be advised by the Chief Executive and Director of Finance).

1.2. Any expression to which a meaning is given in the 2006 Act shall have the same meaning in this interpretation and in addition:

"ACCOUNTING OFFICER" shall be the Officer responsible and accountable for funds entrusted to the Trust. S/he shall be responsible for ensuring the proper stewardship of public funds and assets. For this Trust it shall be the Chief Executive.

"BOARD" shall mean the Chair and Non-Executive Directors, appointed by the Council of Governors, and the Executive Directors appointed by the Appointments and Remuneration Committee of the Board.

"BUDGET" shall mean a resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust.

"CHAIR" is the person appointed by the Council of Governors in accordance with paragraph 24 of this Constitution. The expression "the Chair" shall be deemed to include the Vice Chair or otherwise a Non-Executive Director appointed by the Board to preside for the time being over its meetings.

"CHIEF EXECUTIVE" shall mean the chief officer of the Trust.

"COMMITTEE" shall mean a committee appointed by the Board.

"COMMITTEE MEMBERS" shall be persons formally appointed by the Board of Directors to sit on or to chair specific committees.

"DIRECTOR" shall mean a person appointed to the Board of Directors in accordance with the Trust's Constitution and includes the Chair.

"MOTION" means a formal proposition to be discussed and voted on during the course of a meeting.

"NOMINATED OFFICER" means an Officer charged with the responsibility for discharging specific tasks within Standing Orders.

"OFFICER" means an employee of the Trust.

"SOs" mean Standing Orders.

"TRUST" means the Alder Hey Children's NHS Foundation Trust.

2. General Information

2.1. The purpose of the Board Standing Orders is to ensure that the highest standards of Corporate Governance are achieved in the Board and throughout the organisation. The Board shall at all times seek to comply with the Trust's Code of Conduct for Directors.

2.2. All business shall be conducted in the name of the Trust.

2.3. The Directors shall appoint trustees to administer separately charitable funds received by the Trust and for which they are accountable to the Charity Commission.

2.4. A Director, or Officer of the Trust, who has acted honestly and in good faith will not have to meet out of his or her own personal resources any personal civil liability which is incurred in the execution or purported execution of his or her functions as a Director save where the Director has acted recklessly. On behalf of the Directors, and as part of the Trust's overall insurance arrangements, the Board of Directors shall put in place appropriate insurance provision to cover such indemnity.

3. Composition of the Board

3.1. The composition of the Board shall be as a minimum:

The Chair of the Trust
Five - Seven Non-Executive Directors
Five – Seven Executive Directors

The number of Directors may be increased by the Board, provided always that at least half the Board, excluding the Chair, comprises Non-Executive Directors.

3.2. **Appointment and Removal of the Chair and Non-Executive Directors** - The Chair and Non-Executive Directors are appointed and removed by the Council of Governors in accordance with the Trust's Constitution.

3.3. **Appointment and Removal of the Executive Directors** – The Appointments and Remuneration Committee of the Board of Directors (excluding the Chief Executive) shall appoint the Chief Executive (which appointment shall be approved by the Council of Governors). The Appointments and Remuneration Committee of the Board of Directors (inclusive of the Chief Executive) shall appoint or remove the other Executive Directors.

3.4. **Appointment and Removal of the Vice Chair** – For the purpose of enabling the proceedings of the Trust to be conducted in the absence of

the Chair, the Council of Governors of the Trust will appoint one of the Non-Executive Directors to be the Vice Chair.

3.5. **Powers of Vice Chair** - Where the Chair of the Trust has died or has otherwise ceased to hold office or where s/he has been unable to perform his/her duties as Chair owing to illness, absence from England and Wales or any other cause, references to the Chair shall, so long as there is no Chair able to perform his/her duties, be taken to include references to the Vice Chair or otherwise to the Non-Executive Director appointed by the Board to preside for the time being over its meetings.

3.6. **Joint Directors** - Where more than one person is appointed jointly to a post in the Trust which qualifies the holder for executive directorship or in relation to which an Executive Director is to be appointed, those persons shall become appointed as an Executive Director jointly, and shall count as one person.

3.7. Non-Executive Directors may seek external advice or appoint an external advisor on any material matter of concern provided the decision to do so is a collective one by the majority of Non-Executive Directors.

4. Meetings of the Board

4.1. Meetings held in Public

4.1.1. Meetings of the Board must be open to the public, subject to paragraphs 4.1.2 and 4.1.3 below.

4.1.2. The Board may resolve to exclude members of the public from any meeting or part of a meeting on the grounds that it considers that:

(a) publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted; or

(b) there are special reasons stated in the resolution and arising from the nature of the business of the proceedings.

4.1.3. The Chair may exclude any member of the public from the meeting of the Board if s/he considers that s/he is interfering with or preventing any conduct of the meeting.

4.1.4. Meetings of the Board shall be held at least three times each year at times and places that the Board may determine.

4.1.5. The Board shall arrange for an annual public meeting to be held within 9 months of the end of each financial year. The registers and documents set out in paragraphs 32 and 33 of the Trust's Constitution shall be available for inspection at the meeting.

4.2. Calling Meetings

The Chair may call a meeting of the Board at any time. If the Chair refuses to call a meeting after a requisition for that purpose, signed by at least one-third of the whole number of Directors, has been presented to him/her, or if, without so refusing, the Chair does not call a meeting within seven days after such requisition has been presented to him/her, at the Trust's Head Office, such one third or more Directors may forthwith call a meeting.

4.3. **Notice of Meetings**

4.3.1. Before each meeting of the Board, a notice of the meeting, specifying the business proposed to be transacted at it, and signed by the Chair or by an Officer of the Trust authorised by the Chair to sign on his/her behalf shall be delivered to every Director, or sent by post to the usual place of residence of such Director, so as to be available to him/her at least twenty-one clear days before the meeting. Lack of service of the notice on any Director shall not affect the validity of a meeting, subject to paragraph 4.3.4 below.

4.3.2. Notwithstanding the above requirement for notice, the Chair may waive notice in the case of emergencies or in the case of the need to conduct urgent business or on written receipt of the agreement of at least two-thirds of Directors (Executive and Non-Executive Directors taken together) but to include a minimum of two Executive Directors and two Non-Executive Directors.

4.3.3. In the case of a meeting called by Directors in default of the Chair, the notice shall be signed by those Directors and no business shall be transacted at the meeting other than that specified in the notice.

4.3.4. Subject to paragraph 4.3.2, failure to serve such a notice on more than three Directors will invalidate the meeting. A notice will be presumed to have been served 48 hours after the envelope containing it was posted or, in the case of a notice contained in an electronic communication, 48 hours after it was sent.

4.4. **Setting the Agenda**

4.4.1. The Board may determine that certain matters shall appear on every agenda for a meeting of the Board and shall be addressed prior to any other business being conducted.

4.4.2. In the case of a meeting called by the Chair, a Director desiring a matter to be included on an agenda shall make his/her request in writing to the Chair at least ten clear days before the meeting. Requests made less than ten days before a meeting may be included on the agenda at the discretion of the Chair.

4.4.3. The Chair shall make arrangements to ensure that the final agenda and any supporting papers for the meeting, following the receipt of any requests in accordance with 4.4.2 above, are delivered to every Director, or sent by post to the usual place of residence of such Director, so as to be available to him/her at least five clear days before the meeting.

4.4.4. Before holding a meeting, the board of directors must send a copy of the agenda of the meeting to the council of governors.

4.5. **Chair of Meeting**

At any meeting of the Board, the Chair, if present, shall preside. If the Chair is absent from the meeting the Vice Chair appointed by the Council of Governors to take on the Chair's duties shall preside. Otherwise, such Non-Executive Director as the Directors present shall choose shall preside.

4.6. **Notices of Motions**

4.6.1. A Director of the Trust desiring to move or amend a motion shall send a written notice thereof at least ten clear days before the meeting to the Chair, who shall insert in the agenda for the meeting all notices so received subject to the notice being permissible under the appropriate regulations. This paragraph shall not prevent any motion being moved during the meeting, without notice, on any business mentioned on the agenda subject to paragraph 4.3.3 above.

4.6.2. A motion or amendment, once moved and seconded, may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair.

4.6.3. Notice of motion to amend or rescind any resolution (or the general substance of any resolution), which has been passed within the preceding six calendar months, shall bear the signature of the Directors who gave it and also the signature of four other Directors. When any such motion has been disposed of by the Board it shall not be competent for any Director, other than the Chair, to propose a motion to the same effect within six months; however the Chair may do so if s/he considers it appropriate.

4.6.4. The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

4.6.5. When a motion is under discussion or immediately prior to discussion it shall be open to a Director to move:

(a) An amendment to the motion.

(b) The adjournment of the discussion or the meeting.

(c) The appointment of an ad hoc committee to deal with a specific item of business.

(d) That the meeting proceed to the next business.

(e) That the motion be now put.

Such a motion, if seconded, shall be disposed of before the motion, which was originally under discussion or about to be discussed. No amendment to the motion shall be admitted if, in the opinion of the Chair of the meeting, the amendment negates the substance of the motion.

In the case of motions under (d) and (e), to ensure objectivity, motions may only be put by a Director who has not previously taken part in the debate.

4.7. **Chair's Ruling**

Statements of Directors made at meetings of the Board shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting on questions of order, relevancy, regularity and any other matters shall be observed at the meeting.

4.8. **Voting**

4.8.1. Decisions at meetings shall be determined by a majority of the votes of the Directors present and voting. In the case of any equality of votes, the person presiding shall have a second or casting vote.

4.8.2. All decisions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the Directors present so request.

4.8.3. If at least one-third of the Directors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each Director present voted or abstained.

4.8.4. If a Director so requests, his/her vote shall be recorded by name upon any vote (other than by paper ballot).

4.8.5. In no circumstances may an absent Director vote by proxy. Absence is defined as being absent at the time of the vote.

4.8.6. An officer who has been appointed formally by the Board to act up for an Executive Director during a period of incapacity or temporarily to fill an Executive Director vacancy, shall be entitled to exercise the voting rights of the Executive Director. An Officer attending the Board to represent an Executive Director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Executive Director. An Officer's status when attending a meeting shall be recorded in the minutes.

4.9. **Joint Directors**

Where an Executive Director post is shared by more than one person:

(a) each person shall be entitled to attend meetings of the Board;

(b) in the case of agreement between them, they shall be eligible to have one vote between them;

(c) in the case of disagreement between them, no vote should be cast;

(d) the presence of those persons shall count as one person.

4.10. **Suspension of Standing Orders (SOs)**

4.10.1. Except where this would contravene any statutory provision, any one or more of these Standing Orders may be suspended at any meeting, provided that at least two-thirds of the Board are present, including two Executive Directors and two Non-Executive Directors, and that a majority of those present vote in favour of suspension.

4.10.2. A decision to suspend SOs shall be recorded in the minutes of the meeting.

4.10.3. A separate record of matters discussed during the suspension of SOs shall be made and shall be available to the Directors.

4.10.4. No formal business may be transacted while SOs are suspended.

4.10.5. The Audit Committee shall review every decision to suspend SOs.

4.11. **Variation and Amendment of Standing Orders**

These Standing Orders shall be amended only if:

- a notice of motion has been given; and
- no fewer than two-thirds of the number of members of the Board approve the variation/amendment; and
- the variation/amendment proposed does not contravene a statutory provision.

4.12. **Record of Attendance**

The names of the Directors present at the meeting shall be recorded in the minutes.

4.13. **Minutes**

4.13.1. The minutes of the proceedings of a meeting shall be drawn up and maintained as a permanent record. They will be submitted for agreement at the next meeting where they will be signed by the person presiding at it.

4.13.2. No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

4.13.3. Minutes shall be circulated in accordance with the Directors' wishes. The minutes shall be made available to the public except for minutes relating to business conducted when members of the public are excluded under the terms of section 4.1 of these Standing Orders (required by Code of Practice on Openness in the NHS).

4.13.4. As soon as practicable after holding a meeting, the board of directors must send a copy of the minutes of the meeting to the council of governors

4.14. **Quorum**

4.14.1. No business shall be transacted at a meeting of the Board unless at least one-third of the whole number of the Directors are present including at least one Executive Director and one Non-Executive Director.

4.14.2. An Officer in attendance for an Executive Director but without formal acting up status may not count towards the quorum.

4.14.3. If a Director has been disqualified from participating in the discussion on any matter and from voting on any resolution by reason of the declaration of a conflict of interest s/he shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

5. Arrangements for the Exercise of Functions by Delegation

5.1. The Board may make arrangements for the exercise, on behalf of the Trust, of any of its functions by a committee or sub-committee, or by a Director or an Officer of the Trust in each case subject to such restrictions and conditions as the Board thinks fit.

5.2. **Emergency Powers -** The powers which the Board has retained to itself within these Standing Orders may in emergency be exercised by the Chief Executive and the Chair after having consulted at least two Non-Executive Directors. The exercise of such powers by the Chief

Executive and the Chair shall be reported to the next formal meeting of the Board for ratification.

5.3. **Delegation to Committees** - The Board shall agree from time to time to the delegation of executive powers to be exercised by committees or sub-committees, which it has formally constituted. The constitution and terms of reference of these committees, or sub-committees, and their specific executive powers shall be approved by the Board.

5.4. **Delegation to Officers -** Those functions of the Trust which have not been retained as reserved by the Board or delegated to one of its Committees shall be exercised on behalf of the Board by the Chief Executive. S/he shall determine which functions s/he will perform personally and shall nominate Officers to undertake remaining functions but still retain accountability for these to the Board.

5.5. The Chief Executive shall prepare a Scheme of Delegation identifying his/her proposals that shall be considered and approved by the Board, subject to any amendment agreed during the discussion. The Chief Executive may periodically propose amendment to the Scheme of Delegation, which shall be considered and approved by the Board as indicated above.

5.6. Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of the Executive Directors to provide information and advise the Board in accordance with any statutory requirements.

5.7. The arrangements made by the Board as set out in the "Scheme of Delegation" shall have effect as if incorporated into these Standing Orders.

6. Committees

6.1. Appointment of Committees

6.1.1. The Board may appoint committees of the Board, consisting wholly or partly of Directors of the Trust or wholly of persons who are not Directors of the Trust.

6.1.2. A committee so appointed may appoint sub-committees consisting wholly or partly of members of the committee (whether or not they include Directors of the Trust) or wholly of persons who are not members of the committee (whether or not they include Directors of the Trust).

6.1.3. The Standing Orders of the Board, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees or sub-committees established by the Board.

6.1.4. Each such committee or sub-committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board) as the Board shall decide from time to time following reviews of the terms of reference, powers and

conditions. Such terms of reference shall have effect as if incorporated into these Standing Orders.

6.1.5. Committees may not delegate their executive powers to a sub-committee unless expressly authorised by the Board.

6.1.6. The Board shall approve the appointments to each of the committees that it has formally constituted. Where the Board determines that persons, who are neither Directors nor Officers, shall be appointed to a committee, the terms of such appointment shall be determined by the Board.

6.1.7. Where the Trust is required to appoint persons to a committee, which is to operate independently of the Trust, such appointment shall be approved by the Board.

6.2. Confidentiality

6.2.1. A member of the Board shall not disclose a matter dealt with by, or brought before, the Board without its permission.

6.2.2. A member of a committee of the Board shall not disclose any matter dealt with by, or brought before, the committee, notwithstanding that the matter has been reported or action has been concluded, if the Board or committee shall resolve that it is confidential.

7. Declaration of Interests and Register of Interests

7.1. Declaration of Interests

7.1.1. Directors are required to comply with the Trust's Standards of Business Conduct and to declare interests that are relevant and material to the Board. All Directors should declare such interests on appointment and on any subsequent occasion that a conflict arises.

7.1.2. Interests regarded as "relevant and material" include any of the following, held by a Director, or the spouse, partner, parent or child of a Director:

a) Directorships, including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies).

b) Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.

c) Employment with any private company, business or consultancy.

d) Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS.

e) A position of authority in a charity or voluntary organisation in the field of health and social care.

f) Any connection with a voluntary or other organisation contracting for NHS services.

7.1.3. If Directors have any doubt about the relevance of an interest, this should be discussed with the Chair.

7.1.4. At the time Directors' interests are declared, they should be recorded in the Board minutes. Any changes in interests should be declared at the next Board meeting following the change occurring.

7.1.5. Directors' directorships of companies likely or possibly seeking to do business with the NHS should be published in the Board's annual report. The information should be kept up to date for inclusion in succeeding annual reports.

7.1.6. During the course of a Board meeting, if a conflict of interest is established in accordance with this Standing Order, the Director concerned should, unless two thirds of the Directors present agree (including two Executive and two Non-Executive Directors), withdraw from the meeting and play no part in the relevant discussion or decision. If the Director remains present at the meeting on the agreement of two thirds of those Directors present, s/he shall not be entitled to vote on the issue in respect of which the conflict of interest has been established.

7.2. **Register of Interests**

7.2.1. The Chief Executive will ensure that a Register of Interests is established to record formally declarations of interests of Directors. In particular the Register will include details of all directorships and other relevant and material interests that have been declared by both Executive and Non-Executive Directors.

7.2.2. These details will be kept up to date by means of an annual review of the Register in which any changes to interests declared during the preceding twelve months will be incorporated.

7.2.3. The Register will be available to the public and the Chief Executive will take reasonable steps to bring the existence of the Register to the attention of the local population and to publicise arrangements for viewing it.

8. Disability of Directors in Proceedings on Account of Pecuniary Interest

8.1. Subject to the following provisions of this Standing Order, if the Chair or a Director of the Trust has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Board at which the contract or other matter is the subject of consideration, s/he shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the

consideration or discussion of the contract or other matter or vote on any question with respect to it.

8.2. The Board shall exclude the Chair or a Director from a meeting of the Board while any contract, proposed contract or other matter in which s/he has a pecuniary interest, is under consideration.

8.3. The Board, as it may think fit, may remove any disability imposed by this Standing Order in any case in which it appears to the Board that, in the interests of the National Health Service, the disability shall be removed. Such action shall have the support of at least two-thirds of the Directors present at the meeting (including two Executive and two Non-Executive Directors).

8.4. Any remuneration, compensation or allowances payable to a Director of the Trust by virtue of paragraph 9 of Schedule 2 to the NHS and Community Care Act 1990 shall not be treated as a pecuniary interest for the purpose of this Standing Order.

8.5. For the purpose of this Standing Order the Chair or a Director shall be treated, subject to paragraphs 8.3 and 8.6, as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

(a) s/he, or his/her nominee is a director of a company or other body, not being a public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration; **or**

(b) s/he is a partner of, or is in the employment of a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration; **and**

in the case of persons living together the interest of one partner shall, if known to the other, be deemed for the purposes of this Standing Order to be also an interest of the other.

8.6. The Chair or a Director shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only:

(a) of his/her membership of a company or other body, if s/he has no beneficial interest in any securities of that company or other body;

(b) of an interest in any company, body or person with which s/he is connected as mentioned above which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a Director in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

8.7. Where the Chair or a Director:

(a) has an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body, and

(b) the total nominal value of those securities does not exceed £5,000 or one-hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less, and

(c) if the share capital is of more than one class, the total nominal value of shares of any one class in which s/he has a beneficial interest does not exceed one-hundredth of the total issued share capital of that class,

this Standing Order shall not prohibit him/her from taking part in the consideration or discussion of the contract or other matter or from voting on any question with respect to it without prejudice however to his/her duty to disclose his/her interest.

8.8. This Standing Order applies to a committee or sub-committee of the Board as it applies to the Board and applies to any member of any such committee or sub-committee (whether or not s/he is also a Director of the Trust) as it applies to a Director of the Trust.

9. Compliance - Other Matters

9.1. All Directors of the Trust shall comply with the Standards of Business Conduct set by the Board for the guidance of all staff employed by the Trust.

9.2. All Directors of the Trust shall comply with Standing Financial Instructions prepared by the Director of Finance and approved by the Board.

9.3. All Directors must behave in accordance with the seven Nolan principles of behaviour in Public Life (and the Trust's Code of Conduct for Directors as amended from time to time): -

- Selflessness;
- Integrity;
- Objectivity;
- Accountability;
- Openness;
- Honesty; and
- Leadership.

10. Resolution of Disputes with Council of Governors

10.1 Should a dispute arise between the Board of Directors and the Council of Governors, then the disputes resolution procedure set out below shall be followed.

10.2 The Chair, or Senior Independent Director (if the dispute involves the Chair), shall first endeavour, through discussion with appropriate representatives of the Governors and Directors to achieve the earliest possible resolution of the matter in dispute to the reasonable satisfaction of both parties.

10.3 Failing resolution under 10.2 above, then the Board or the Council, as appropriate, shall at its next formal meeting approve the precise wording of a Disputes Statement setting out clearly and concisely the issue or issues giving rise to the dispute.

10.4 The Chair or Senior Independent Director (if the dispute involves the Chair) shall ensure that the Disputes Statement produced in accordance with 10.3 above, without amendment or abbreviation in any way, shall be an agenda item and agenda paper at the next formal meeting of the Board or Council as appropriate (ie. the body that does not issue the disputes statement). That meeting shall agree the precise wording of a Response to Disputes Statement.

10.5 The Chair or Senior Independent Director (if the dispute involves the Chair) shall immediately or as soon as is practical, communicate the outcome to the other party and deliver the written Response to Disputes Statement.

10.6 If, in the opinion of the Chair or Senior Independent Director (if the dispute involves the Chair) and following the further discussions prescribed in 10.5 above, there is no prospect of a resolution (partial or otherwise) then he or she will appoint a special committee comprising equal numbers of directors and governors under the chairmanship of the senior independent director to consider the circumstances and to make recommendations to the Council and the Board with a view to resolving the dispute.

10.7 On the satisfactory completion of this disputes process, the Board of Directors shall implement agreed changes.

10.8 On the unsatisfactory completion of this disputes process the view of the Board of Directors shall prevail.

10.9 Nothing in this procedure shall prevent the Council, if it so desires, from informing the Regulator that, in the Council's opinion, the Board has not responded constructively to concerns of the Council that the Trust is not meeting the terms of its authorisation.

11. Notification to the Regulator and Council of Governors

The Board shall notify the Regulator and the Council of Governors of any major changes in the circumstances of the Trust, which have made or could lead to a substantial change to its financial well-being, healthcare delivery

performance, or reputation and standing or which might otherwise affect the Trust's compliance with the terms of its authorisation.

12. Board Performance

The Chair shall, at least annually, lead a performance assessment process for the Board. This process should act as the basis for determining individual and collective professional development programmes for Directors.

13. Changes to Board Standing Orders

For the sake of clarity, future amendments to these Standing Orders by the Board must be regarded as a change to the Trust's Constitution.

ANNEX 9 – MEMBERS - FURTHER PROVISIONS

Disqualification from membership

1. A person may not become a member of the Trust if within the last five years;

    a. they have received a Red Card under the Trust's Procedure for Care of Patients who are Violent or Abusive; or

    b. they have been involved as a perpetrator in a serious incident of violence at any of the Trust's hospitals or facilities or against any of the Trust's employees or other persons who exercise functions for the purposes of the Trust, or against volunteers.

2. A person may not become or continue as a member of the Trust if s/he is subject to a sex offender order.

3. A person may not become a member of the Trust if s/he is under 7 years of age.

4. A person may not become or continue as a member of the Trust if s/he does not agree to comply with the Trust's aims and values.

5. Where the Trust is placed on notice that a member may be disqualified from membership, or may no longer be eligible to be a member, the Secretary shall give the member 14 days written notice to show cause why his/her name should not be removed from the register of members. If such information is not supplied by the member within 14 days, the Secretary may, if s/he considers it appropriate, remove the member from the register of members. In the event of any dispute the Secretary shall refer the matter to the Council of Governors to determine.

6. All members of the Trust shall notify the Secretary of any change in their particulars, which may affect their entitlement to be a member.

Termination of membership

A member shall cease to be a member if:

1. S/he dies;

2. S/he resigns by notice to the Secretary;

3. S/he ceases to be entitled under this Constitution to be a member of any of the Trust's Constituencies;

4. S/he is expelled under this Constitution;

5. It appears to the Secretary that s/he no longer wishes to be a member of the Trust, and after enquiries made in accordance with a process approved by the Council of Governors, s/he fails to establish that s/he wishes to continue to be a member of the Trust.

Expulsion

A member may be expelled by a resolution carried by the votes of two-thirds of the members of the Council of Governors present and voting at a meeting of the Council. The following procedure is to be adopted:

1. Any member may complain in writing to the Secretary that another member has acted in a way detrimental to the interests of the Trust.

2. If a complaint is made, the Council of Governors may itself consider the complaint having taken such steps as it considers appropriate to ensure that each member's point of view is heard and may either:

    a. dismiss the complaint and take no further action; or

    b. arrange for a resolution to expel the member complained of to be considered at the next meeting of the Council of Governors.

3. If a resolution to expel a member is to be considered at a meeting of the Council of Governors, details of the complaint must be sent to the member complained of not less than one calendar month before the meeting with an invitation to answer the complaint and attend the meeting.

4. At the meeting the Council of Governors will consider evidence in support of the complaint and such evidence as the member complained of may wish to place before them.

5. If the member complained of fails to attend the meeting without due cause the meeting may proceed in their absence.

A person expelled from membership will cease to be a member upon the declaration by the Chair of the meeting that the resolution to expel them is carried.

No person who has been expelled from membership is to be re-admitted except by a resolution carried by the votes of two-thirds of the members of the Council of Governors present and voting at a meeting of the Council.

Voting at Patient and Public Governor Elections

A person may not vote at a patient or public election for an elected governor unless within the specified period s/he has made a declaration in the specified form setting out the particulars of his/her qualification to vote as a member of the Constituency for which the election is being held. It is an offence to knowingly or recklessly make such a declaration which is false in a material particular.

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 Change Programme for 18/19 (and beyond, as many of the work streams are multi-year initiatives) has taken time to fully mobilise and the assurance ratings were proving stubborn to move; however, June has seen a marked improvement across almost all areas and the efforts of leaders and their teams should be recognised.
2. The areas where ratings remain stuck are now being subject to additional scrutiny to see what further assistance can be afforded to the Executive Sponsors and their teams; however, it also needs to be recognised that a small number of projects are stalled or late (site development being an example) due to reasons outside of the control of project teams.
3. The Programme Board of 28 Jun 18 will have, by the time this report is discussed at Trust Board, addressed some of these shortfalls and ensure that measures are in place to further enhance the assurance picture.

J Grinnell 26 Jun 18

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

1. This Board report contains assurance reports submitted to the following sub-Cttes: **CQAC on 20 Jun 18, WOD on 26 Jun 18 and R&BD on 27 Jun 18.**
2. The weekly 'Financial Sustainability Board' continues to conduct reviews of the forecast and contributions from each work stream comprising the change programme; the overall level of contribution from the change programme is a continuing risk to the overall achievement of CIP.
3. The assurance ratings have improved markedly in the past moth as a result of renewed focus from the executive sponsors, project team efforts and the valuable support provided by the DMO.

J Gibson 26 Jun 18

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

See CIP status at slide 3 of this pack. In sum, the 18/19 change programme contribution to the CIP targets continues well below trajectory. Executive Sponsors are requested to expedite the actions required to improve the prospects of achieving programme CIP benefits.

Change Programme

PROPOSED PROGRAMME 18/19

Trust Board

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

Programme Assurance Framework, DMO & Delivery Board

Growing Through External Partnerships
John

1. CHD Liverpool Partnership
2. Aseptics

Pipeline
- Neonatal Services

The Best People Doing Their Best Work
Melissa/Hilda SG

1. Portering
2. Apprenticeships

Pipeline
- E-Rostering

Deliver Outstanding Care
Hilda / Steve

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

Pipeline
- Models of Care
- Care of Complex Children

Global Digital Exemplar
John/Steve

1. Speciality Packages
2. Voice Recognition

Strong Foundations SG
John

1. Inventory Management
2. Procurement CIP
3. Energy
4. Coding & Capture
5. Medicines Optim'tion
6. Model Hospital
7. Catering

Park, Community Estate & Facilities
David SG

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

RE&I

Game Changing Research & Innovation
David

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

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

Programme Contribution to CIP Status – as at 6 Jun 18

Workstream	Exec Sponsor	Year to Date			In Year Forecast		
		Target £000's	Achieved (Posted) £000's	Gap £000's	Target £000's	Forecast £000's	Gap £000's
Deliver Outstanding Care	Adam B/Hilda G	417	145	-271	2,500	1,225	-1,275
Growing Through External Partnerships	Margaret Barnaby	133	0	-133	800	0	-800
The Best People Doing Their Best Work	Melissa Swindell	167	125	-41	1,000	330	-670
Game Changing Research and Innovation	David Powell	83	0	-83	500	0	-500
Strong Foundations	John G/Claire L	367	56	-311	2,200	1,575	-625
Park, Community Estate & Facilities	David Powell	0	3	3	0	18	18
Global Digital Exemplar (GDE)	Peter Young	167	0	-167	1,000	0	-1,000
Subtotal: Strategic Workstreams		**1,333**	**329**	**-1,004**	**8,000**	**3,148**	**-4,852**
Divisional Business		-581	207	787	-1,043	1,280	2,323
Unidentified		0	0	0	0	0	0
Grand Total		**753**	**536**	**-217**	**6,957**	**4,428**	**-2,529**

Programme Assurance Summary
Growing Through External Partnerships

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

There has been a welcome improvement in the overall assurance ratings this month, Executive Sponsors are requested to take the necessary actions for their respective projects in supporting the project teams to achieve fully green ratings.

The International and Non-NHS project closure report is was submitted to the Programme Board on 31 May 2018 and it was agreed that the project would close.

Estimated contribution to the CIP effort from this work stream needs to be expedited.

Claire Liddy, Director of Operational Finance – 19 Jun 2018

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

The CHD Liverpool Partnership project needs to do more work to clearly define the benefits that the project is intended to deliver and upload this evidence onto the programme SharePoint site.

The exception report for the Aseptics project, to re-baseline the milestone Plan, should be submitted to the Programme Board in June 2018.

Joe Gibson, External Programme Assessment – 19 Jun 2018

Sub-Committee	R&BD	Report Date	19 Jun 2018
Workstream Name	Growing Through External Partnerships	Executive Sponsor	John Grinnell

Programme Assurance Framework

Growing Through External Partnerships (Completed by Assurance Team)

Current Dashboard Rating:

Project Ref	Project Title	Project Description	Executive Sponsor Assures the project	OVERALL PROJECT RAG status	An effective project team is in place	Scope and Approach is defined	Targets / benefits defined/on track	Milestone plan is defined/on track	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	Comments for attention of the Project Team, Steering Group and sub-Committee
2.0 Growing Through External Partnerships 18/19													
R&BD 2.5	CHD Liverpool Partnership	The aim of this project is to deliver the potential Level One centre status for adult congenital heart disease across the NW/North Wales and Isle of Man; bringing together a partnership of 4 Liverpool providers.	Steve Ryan	Green	● green	● green	● amber	● green	● amber	● green	N/A	N/A	Minutes of meetings and governance structure now uploaded to SharePoint. Following NHSE decision on 30 Nov 17, project documentation has been developed to provide a mobilisation plan. Milestone Plan uploaded, with tabs for various work streams, and is green rated. Benefits need to be further refined with evidence on SharePoint. Risk Register uploaded with risks last reviewed on 25 May 18. **Last updated 18 Jun 18.**
RABD 2.6	Aseptics	Validate and commission aseptic unit. To provide internal service which reduces outsourcing to minimal levels. Take unit to licence to offer income generating opportunities.	Mags Barnaby	Amber	● green	● amber	● amber	● amber	● green	● green	● green	● green	Minutes of the Quality Management Meeting of the Aseptics Services Department are available and up to date. Scope is decribed by the 'Proposal for commissioning, validation and licensing of the Pharmacy Aseptic Services Unit' now dated 16 March 2018'. Targets and benefits are being closely tracked but not yet reaching aspired thresholds, full realisation will commence in Apr 19. A Gantt chart is in place and being tracked; however, there are significant delays to milestones, but is being closely tracked. The Programme Board of 31 May 18 invited the project to submit an **exception report** to re-baseline the milestone plan in light of the project history since the new hospital opened and to get a clearer view of current progress to plan. Inceasing levels of evidence of stakeholder engagement now being uploaded. Audit of Aseptic Services has been uploaded to SharePoint. EA/QIA signed off. Evidence of meetings to September 2017. **Last updated 19 Jun 18.**

Sub-Committee	R&BD	Report Date	19 Jun 2018
Workstream Name	Growing Through External Partnerships	Executive Sponsor	John Grinnell

Programme Assurance Framework

Growing Through External Partnerships (Completed by Assurance Team)

Financial Benefits Profile - at 6 Jun 18:

		Year to Date			In Year Forecast		
Workstream	Exec Sponsor	Target £000's	Achieved (Posted) £000's	Gap £000's	Target £000's	Forecast £000's	Gap £000's
Deliver Outstanding Care	Adam B/Hilda G	417	145	-271	2,500	1,225	-1,275
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Strong Foundations	John G/Claire L	367	56	-311	2,200	1,575	-625
Park, Community Estate & Facilities	David Powell	0	3	3	0	18	18
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Divisional Business		-581	207	787	-1,043	1,280	2,323
Unidentified		0	0	0	0	0	0
Grand Total		**753**	**536**	**-217**	**6,957**	**4,428**	**-2,529**

Programme Assurance Summary

Strong Foundations

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

The ratings across this work stream have improved considerably this month and the efforts of the project teams should be commended; the focus should remain on bringing all the SharePoint ratings into the green zone.

The 'Medicine Optimisation' and 'Energy' projects need to be completed in terms of the full suite of project documentation.

We understand that the mobilisation of the 'Catering' is ongoing and it should be launched as soon as practicable.

Claire Liddy, Director of Operational Finance – 19 Jun 2018

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

The project teams have improved the assurance evidence – in terms of working project documents - for several projects and this improvement is reflected in the improved ratings.

The two 'Amber' rated projects should also be the subject of further detailed work to bring them up to the required level of project evidence and 'Green' ratings.

The Catering project is awaiting a specialist advisor to join the project team before work commences in earnest.

Joe Gibson, External Programme Assessment – 19 Jun 2018

Programme Assurance Framework

Strong Foundations (Completed by Assurance Team)

Sub-Committee	R&BD	Report Date	19 Jun 2018
Work stream Name	Strong Foundations	Executive Sponsor	John Grinnell/ David Powell

Project Ref	Project Title	Project Description	Executive Sponsor Assures the project	OVERALL PROJECT RAG status	An effective project team is in place	Scope and Approach is defined	Targets / benefits defined/on track	Milestone plan is defined/on track	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	Comments for attention of the Project Team, Steering Group and sub-Committee
7.0 Strong Foundations 18/19													
RABD 7.1	Inventory Management	The Procurement CIP scheme is an annual project aimed at ensuring that best value is obtained in respect of the supply of all goods and services purchased by the Trust.	John Grinnell										Documentation relevant to this specific type of project now on SharePoint. Detailed POD available with precise metrics. Plan updated, benefits profile also needs to feed into Trust CIP numbers (not yet reflecting procurement benefits as tracked on SharePoint). Evidence of stakeholder engagement uploaded although this appears relatively narrow. EA/QIA now signed off. **Last updated 16 May 2018.**
RABD 7.2	Procurement CIP	The Procurement CIP scheme is an annual project aimed at ensuring that best value is obtained in respect of the supply of all goods and services purchased by the Trust.	John Grinnell										Documentation relevant to this specific type of project now on SharePoint. Plan last updated 9 May 18. Evidence of stakeholder engagement now uploaded but not extensive. EA/QIA signed off. **Last updated 16 May 2018.**
RABD 7.3	Medicine Optimisation	To deliver the trust MO strategy and deliver quality improvements and financial benefits	Steve Ryan										Team structure now complete and minutes of Steering Group available up 26 Apr 18. POD now uploaded, needs to show phasing of savings across the year to allow coherent feed into Trust CIP tracking. Plan uploaded, needs completion; tracking and completion of milestones for actions and benefits needs to be clear. Good stakeholder engagement evidence is emerging. A risk register needs to be uploaded. EA/QIA complete. **Last updated 22 May 2018.**
RABD 7.5	Coding and Capture	To ensure the AH delivers a above average depth of coding and complies with the business rules whilst maximising income	Claire Liddy										Project team structure now complete. Minutes of Steering Group available up 26 Apr 18. POD uploaded and benefits baselines still to be established. Detailed benefits tracker uploaded, with savings starting to flow and forecast to exceed target. Detailed Milestone Plan in evidence, tracked and up to date, with project actions over the full project cycle. Further evidence of stakeholder engagement required. Risk register in place a reviewed on 30 May 18. It has been confrimed that the QIA signed of at end of 2017 applies to the 18/19 programme (and will be reviewed in Dec 18). **Last updated 18 June 2018.**
RABD 7.6	Energy	To bring down energy cost and ensure budget forecast matches contractual target. Forecast budget for next 12 months for all fuels in line with contractual usage.Once the contractual target of 46.7 G has been achieved look at ways of reducing further by means of energy awareness for staff.	David Powell										Evidence of team meetings is available. However, the POD available available on SharePoint but describes no planned benefits for 2018/19; precision is required on benefits sought and delivered. The project plan for 18/19 contains only 6 actions (2 of these relate to usage monitoring and 2 relate to a compensation claim; more detail is required if this is to be considered a project. Evidence provided concerning risks is limited to the single BAF entry. Need assurance that the QIA signed of at end of 2017 applies to the 18/19 programme. **Last updated 22 May 2018.**
RABD 7.7	Catering	To implement the recommendations from the Independent Catering review to improve the overall food service delivery at Alder Hey whilst reducing the financial loss current operating within the Catering Department.	Hilda Gwilliams										No evidence of project team meetings to date. There is a PID template that needs to be completed and a lengthy list of actions arising from the review of catering. There is nothing specific to capture the benefits apart from cross-reference to the review findings. A comprehensive Gantt chart plan has been prepared arising from the review but many milestones need to be completed in terms of entering the dates. There is no evidence uploaded in terms of stakeholders, risks or EA/QIA. **Last updated 4 May 2018.**

Sub-Committee	R&BD	Report Date	19 Jun 2018
Work stream Name	Strong Foundations	Executive Sponsor	John Grinnell

Programme Assurance Framework

Strong Foundations (Completed by Assurance Team)

Financial Benefits Profile - at 6 Jun 18:

		Year to Date			In Year Forecast		
Workstream	Exec Sponsor	Target £000's	Achieved (Posted) £000's	Gap £000's	Target £000's	Forecast £000's	Gap £000's
Deliver Outstanding Care	Adam B/Hilda G	417	145	-271	2,500	1,225	-1,275
Growing Through External Partnerships	Margaret Barnaby	133	0	-133	800	0	-800
The Best People Doing Their Best Work	Melissa Swindell	167	125	-41	1,000	330	-670
Game Changing Research and Innovation	David Powell	83	0	-83	500	0	-500
Strong Foundations	John G/Claire L	367	56	-311	2,200	1,575	-625
Park, Community Estate & Facilities	David Powell	0	3	3	0	18	18
Global Digital Exemplar (GDE)	Peter Young	167	0	-167	1,000	0	-1,000
Subtotal: Strategic Workstreams		1,333	329	-1,004	8,000	3,148	-4,852
Divisional Business		-581	207	787	-1,043	1,280	2,323
Unidentified		0	0	0	0	0	0
Grand Total		753	536	-217	6,957	4,428	-2,529

Programme Assurance Summary
Park, Community Estate and Facilities

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

As previously stated:

- The 'Community Cluster' project needs to be fully mobilised so that ratings of all domains can be conducted.
- It is now critical that this work stream bring the documentation to a standard that will provide assurance to the Trust Board.

Claire Liddy, Director of Operational Finance – 19 Jun 2018

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

The work stream ratings continue to remain below standard and there is no sign of improvement: of the 7 projects with evidence on SharePoint 3 are amber rated and 4 red.

As previously stated, the Executive Sponsor now needs to engage with all project teams as the wider evidence base on SharePoint – for all these projects – is weak. Moreover, the Executive Sponsor is requested to attend R&BD to explain the next steps to improve assurance.

Joe Gibson, External Programme Assessment – 19 Jun 2018

Sub-Committee	**R&BD**	**Report Date**	**19 Jun 2018**
Workstream Name	Park, Community Estate and Facilities.	**Executive Sponsor**	**David Powell**

Programme Assurance Framework

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

Current Dashboard Rating:

Project Ref	Project Title	Project Description	Executive Sponsor Assures the project	OVERALL PROJECT RAG status	An effective project team is in place	Scope and Approach is defined	Targets / benefits defined/on track	Milestone plan is defined/on track	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	Comments for attention of the Project Team, Steering Group and sub-Committee
5.0 Park, Community Estate & Facilities 18/19													
R&BD 5.1	Decommission & Demolition	The aim of the project is to move out from and make safe the old hospital ready for demolition	David Powell										PID available, however details of benefits requires review in line with revised/ updated dates. Milestone plan shows that all planned activities have now completed; confirmation required of the milestones dates for future activity. Details of communication/engagement activities to be confirmed and evidence provided where possible. Risks now on Ulysses, some require review. **Last updated 7 May 2018.**
R&BD 5.2	R&E 2	The aim of the project is to complete Phase 2 of the RI & E building to a world class standard	David Powell										Progress Meeting Notes available to February 2018. The R&E Commissioning Plans and notes of the related 'Agile' meeting are also available. PID available, benefits to be confirmed. Milestone Plan shows some delays (tenancy agreements) now over 10 months from original milestone date and some other key milestones are running late or not identified. There is a key dependency on the 'Agile' working project which remains in 'pipeline' status; however, detailed evidence of the work of the 'Agile' group is now on SharePoint and stakeholders are being engaged. Issues Log uploaded, risks to be entered on Ulysses. Deatils of Catering options are also on SharePoint. EA/QIA completed and signed off. **Last updated 18 June 2018.**
R&BD 5.3	Alder Centre	To plan, develop and construct the new Alder Centre within the park setting	David Powell										Steering Group meeting notes available. Scope/approach defined in PID (revised recently). Benefits defined in PID. Milestone Plan has been revised recently - shows procurement of contrator has now been completed (although some 5 months off track). Finalisation of design has been completed with start of build scheduled 2 months later than showing on the plan. Evidence of Comms/ Engagement activities. Risks to be confirmed on Ulysses. EA/QIA complete. **Last updated 4 Jun 18.**
R&BD 5.4	Park	To set up a JV with LCC & the local community to create a world class Springfield Park that complements & adds value to the New Alder Hey in the Park & the local area	David Powell										Updated PID on SharePoint - confirmation of updates required/approval at Steering Group. Benefits defined in PID, tracking/reporting of delivery required. Milestone plan shows multiple actions that have missed deadlines with extended delays and many with no revised milestones. Risks on Ulysses - need confirmation these are up to date. EA/QIA complete. **Last updated 4 Jun 18.**
R&BD 5.5	Residential Development	To create a high quality residential scheme that co-ordinates with the themes and activities within the wider park site	David Powell										Scope/approach and benefits defined in PID. Plan shows extended delays - now beyond 6 months - with planning permission and public consultation milestones missed; revised milestones are now showing on the plan. Evidence required of comms/engagement activities. Risks on Ulysses and require review (last review May 2017). EA/QIA complete. **Last updated 4 Jun 18.**
R&BD 5.6	International Design & Build Consultancy	To develop business in advising other health organisations - both nationally and internationally - with organisational new builds	David Powell								N/A	N/A	Work stream reports need to be augmented with evidence of notes/minutes of project meetings. Draft/outline PID on SharePoint. All project documentation to be fully developed including risk register. **Last updated 4 Jun 18.**
R&BD 5.7	Reprovision of Retained Estates	To re-provide a high standard of working accommodation for those teams and services currently lodged in interim facilities on the retained estate	David Powell										No evidence of meetings available on SharePoint. A high level critical path has been uploaded as well as an option for external provision of space. Milestone plan shows numerous delays - ranging between 2-9 months. All project documentation to be fully developed. Important to have the 'people' aspects detailed on the plans for all departments (personal move plans, consultation, 'day in the life' etc as per hospital move). **Last updated 4 Jun 18.**
R&BD 5.8	Community Cluster	This project is currently at the exploratory and feasability stage and will be rated once fully launched	David Powell										Draft PID uploaded 1 Feb 2018, 'Initiation' Slides uploaded 27 Mar 2018. All other project documentation yet to be developed. **Last updated 27 Mar 18.**

Sub-Committee	R&BD	Report Date	19 Jun 2018
Work stream Name	Park, Community Estates and Facilities	Executive Sponsor	John Grinnell

Programme Assurance Framework

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

Financial Benefits Profile - at 6 Jun 18:

Workstream	Exec Sponsor	Year to Date: Target £000's	Year to Date: Achieved (Posted) £000's	Year to Date: Gap £000's	In Year Forecast: Target £000's	In Year Forecast: Forecast £000's	In Year Forecast: Gap £000's
Deliver Outstanding Care	Adam B/Hilda G	417	145	-271	2,500	1,225	-1,275
Growing Through External Partnerships	Margaret Barnaby	133	0	-133	800	0	-800
The Best People Doing Their Best Work	Melissa Swindell	167	125	-41	1,000	330	-670
Game Changing Research and Innovation	David Powell	83	0	-83	500	0	-500
Strong Foundations	John G/Claire L	367	56	-311	2,200	1,575	-625
Park, Community Estate & Facilities	David Powell	0	3	3	0	18	18
Global Digital Exemplar (GDE)	Peter Young	167	0	-167	1,000	0	-1,000
Subtotal: Strategic Workstreams		**1,333**	**329**	**-1,004**	**8,000**	**3,148**	**-4,852**
Divisional Business		-581	207	787	-1,043	1,280	2,323
Unidentified		0	0	0	0	0	0
Grand Total		**753**	**536**	**-217**	**6,957**	**4,428**	**-2,529**

Programme Assurance Summary
Global Digital Exemplar

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

As stated at the GDE Programme Board on 19 Jun 18, the discussions with the operational divisions concerning the need for them to take ownership of, and mange through, the 'potential benefits' being reported by the GDE programme, need to come to fruition.

While these efforts need to be governed and facilitated by the GDE Programme Board, the Monday 'Sustainability Delivery Group' will also play a key role in stimulating this action to realise benefits.

Claire Liddy, Director of Operational Finance – 19 Jun 2018

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

While the GDE Programme Board continues to receive reports concerning the detailed identification of 'potential benefits' there is no reporting of the 'benefits realised'.

The lack of realised benefits, against the Statement of Projected Benefits' estimating £2.08m cash realising for 2018/19, has resulted in a red rating for GDE benefits and a subsequent overall rating now at 'amber'; however, other aspects of the programme governance and work remain at a high standard.

Otherwise, the 'Speciality Packages' project remains 'amber' rated due to a lack of recent update to the project plan, while the 'Voice Recognition' project (see previous reports) remains 'amber' rated, albeit there continues to be a high standard of project management – due to the difficulty in realising the planned benefits.

Joe Gibson, External Programme Assessment – 19 Jun 2018

Programme Assurance Framework

Global Digital Exemplar (Completed by Assurance Team)

Sub-Committee	R&BD	Report Date	19 Jun 2018
Workstream Name	Global Digital Exemplar	Executive Sponsors	John Grinnell / Steve Ryan

Current Dashboard Rating:

Project Ref	Project Title	Project Description	Executive Sponsor Assures the project	OVERALL PROJECT RAG status	An effective project team is in place	Scope and Approach is defined	Targets / benefits defined/on track	Milestone plan is defined/on track	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	Comments for attention of the Project Team, Steering Group and sub-Committee
4.0 Global Digital Exemplar 18/19													
R&BD 4.1	**GDE**	Create exemplars that can inspire others by really showing how information technology can deliver both improved patient outcomes and enhanced business effectiveness	Steve Ryan/ John Grinnell	(Amber)	Green	Green	Red	Amber	Green	Green	Green	Green	Programme Board Minutes and Agenda up to April 2018 in evidence as well as GDE Action Log to 8 May 18. PID of 28 Jun 18 v8 available. Overall benefits profile and schedule has now been finalised, 'Strategic Owner' column on SoPB still requires updating to reflect current trust executive appointments; internal CIP Tracker shows no financial benefit yet delivered in 2018 while SoPB proposes £2.08m cash realising benefits in 2018/19 (VfM Tracker). Milestone Plan on Dashboard shows several key delivery dates missed, some by significant amounts of time, as discussed at May GDE Programme Board; several milestones have RAG ratings that do not reflect the delivery dates. Further stakeholder evidence has been uploaded and a register updated to March 2018 with Newslteers to 27 April 2018. Risk protocols vis-à-vis national and Trust sytsems have been harmonised. **Last updated 8 May 2018.**
R&BD 4.1a	**Speciality Packages**	Delivery of electronic clinical documentation workflow designed to reflect best practice protocols and pathways	Steve Ryan/ John Grinnell	(Amber)	Green	Green	Amber	Red	Green	Green	**N/A**	**N/A**	Overall benefits profile and schedule is shown on the SoPB tracker; internally, there are no financial benefits yet reported for 2018. Project Plan last updated 7 weeks ago, 27 March 2018, and many milestones outstanding are unreported. Risk protocols vis-à-vis national and Trust systems are now harmonised and finalised. Risks and issues aggregated at GDE programme level. **Last updated 4 May 18.** QIA/EA will be assured and assessed at project level.
R&BD 4.10	**Voice Recognition**	Deploy voice recognition solution in Medisec and Meditech	Steve Ryan/ John Grinnell	(Amber)	Green	Green	Red	Green	Green	Green	Green	Green	PID and detailed project workbook on SharePoint. Details of financial benefits on separate document, these have not been realised as planned. Project Plan is being kept up to date and the overall standard of the workbook is excellent. Comms/engagement activities detailed in PID, evidence required where possible. Risks detailed in workbook. EA/QIA has been signed and uploaded. **Last updated 1 Jun 18.**

Sub-Committee	R&BD	Report Date	19 Jun 2018
Workstream Name	Global Digital Exemplar	Executive Sponsor	John Grinnell/Steve Ryan

Programme Assurance Framework

Global Digital Exemplar (Completed by Assurance Team)

Financial Benefits Profile - at 6 Jun 18:

		Year to Date			In Year Forecast		
Workstream	Exec Sponsor	Target £000's	Achieved (Posted) £000's	Gap £000's	Target £000's	Forecast £000's	Gap £000's
Deliver Outstanding Care	Adam B/Hilda G	417	145	-271	2,500	1,225	-1,275
Growing Through External Partnerships	Margaret Barnaby	133	0	-133	800	0	-800
The Best People Doing Their Best Work	Melissa Swindell	167	125	-41	1,000	330	-670
Game Changing Research and Innovation	David Powell	83	0	-83	500	0	-500
Strong Foundations	John G/Claire L	367	56	-311	2,200	1,575	-625
Park, Community Estate & Facilities	David Powell	0	3	3	0	18	18
Global Digital Exemplar (GDE)	Peter Young	167	0	-167	1,000	0	-1,000
Subtotal: Strategic Workstreams		**1,333**	**329**	**-1,004**	**8,000**	**3,148**	**-4,852**
Divisional Business		-581	207	787	-1,043	1,280	2,323
Unidentified		0	0	0	0	0	0
Grand Total		**753**	**536**	**-217**	**6,957**	**4,428**	**-2,529**

Programme Assurance Summary
Delivering Outstanding Care

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

While there has been a noteworthy improvement in the dashboard ratings, the ratings for 'benefits identification and delivery' - for both quality and sustainability benefits – need to be improved to reduce the risk (given the assurance ratings overleaf).

There are clearly issues with the Sepsis project being able to evidence the work in progress as it does appear to be visible on the programme SharePoint site; this will need to be remedied.

It is requested that the relevant Executive Sponsors, as named on page 2 of this report, address these issues.

Claire Liddy, Director of Operational Finance – 12 Jun 18

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

The overall ratings from the 'Delivering Outstanding Care' work stream have seen a marked improvement this month, with the May ratings of 4 red rated and 2 amber rated projects now superseded by 2 green rated, 3 amber and just the single red rated. It is clear from the evidence (the working project documents) on SharePoint that a lot of hard work has been put into improving the pace and governance of projects by both the leaders, programme team members and new DMO.

However, the teams should not be satisfied with the remaining amber/red ratings and focus should now be turned to improving all the sub-ratings. For example, with team meetings convened for the wider membership, 'Comprehensive Meeting Health' would attract an overall green rating (this has been discussed with the project manager but needs leadership action). For the Sepsis project, a revised approach is being formulated by the Executive Sponsor that seeks to address the issues with respect to the evidence base on SharePoint.

Joe Gibson, External Programme Assessment – 12 Jun 18

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

Sub-Committee	CQAC	Report Date	12 Jun 18
Workstream Name	Delivering Outstanding Care	Executive Sponsor	Hilda Gwilliams/Steve Ryan

Current Dashboard Rating:

Project Ref	Project Title	Project Description	Executive Sponsor Assures the project	OVERALL PROJECT RAG status	An effective project team is in place	Scope and Approach is defined	Targets / benefits defined/on track	Milestone plan is defined/on track	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	Comments for attention of the Project Team, Steering Group and sub-Committee
1.0 Deliver Outstanding Care 18/19													
CQAC	Best in Outpatient Care	The Best in Outpatients Project aims to deliver an outstanding experience of outpatient services for children, families and professionals as well as safely increase the number of patients we see in clinic	Hilda Gwilliams	Green	Green	Green	Amber	Green	Green	Green	Green	Green	The project team is now fully in place and good minutes of meetings available with action notes tracked; a future schedule of meetings has been planned. The PID is detailed and clear but the targets do need some minor work to meet the assurance stanbdard. There is a comprehaensive milestone plan being tracked. A risk register is held and is up to date. There is an impressive approach to stakeholder engagement. **Last updated 5 Jun 18.**
CQAC	Brilliant Booking and Scheduling	To provide a booking system that puts patients and families first and meet the needs of clinicians that use it.	Adam Bateman	Green	Green	Amber	Amber	Green	Green	Amber	Green	Green	Project team meetings are scheduled, documented and well attended. The PID still requires work to fully define benefits. Benefits tracking plans are comprehensive but with some baselines still to be established. The Gantt Project Plan is now complete and being tracked with milestones being hit. The risk register is detailed but requires some mitigating actions to be completed for the top three risks. EA/QIA signed off and uploaded. **Last updated 23 May 18.**
CQAC	Comprehensive Mental Health	Deliver improvements in mental health services to better meet the needs of children and young people. Be recognised as leading the way for CAMHS services nationally	Cath McLaughlin	Amber	Amber	Green	Green	Green	Red	Amber	Green	Green	There is good evidence of project team meetings; however, these appear to be a meeting of 4 members whereas the project team in the PID names 9 individuals. Therefore, wider project team meetings should be invoked and recorded. There is a comprehensive PID (although the PID high level milestones should project out to the end of the project cycle) and benefits are defined. A good milestone plan is in place and being tracked. Evidence is required of stakeholder engagement (the folder currently holds project team minutes). A risk register has been completed but needs to be to a Trust/DMO standard format. A signed EA/QIA has been uploaded. **Last updated 5 Jun 18.**
CQAC	Patient Flow	Improve our processes to enable timely implementation of clinical decisions, and support patients through their pathway efficiently: minimising delays and reducing time spent in hospital. This project consists of 3 workstreams; Expanding Day Surgery, Expanding Pre-Op Assessment and SAFER Bundle.	Adam Bateman	Amber	Green	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Evidence of team meetings and the start of a draft plan for pre-operative assessment. Incomplete PID that needs further work. A detailed milestone plan has been uploaded for SAFER but milestone need further additions to due dates. Stakeholder engagement evidence is limited to a 'Black Marble' presentation, additional evidence is now required. A rcomprehensive risk register has been prepared but target risk scores are missing and also actions to reduce risk for some entries. An EA/QIA has been drafted for signature. **Last updated 1 Jun 18.**
CQAC	Sepsis	This project will ensure prompt recognition and management of the deteriorating patient and implementation of the Sepsis Pathway	Hilda Gwilliams	Red	Red	Green	Red	Red	Amber	Red	Green	Green	Project implementation meeting notes available to December 2017 but no evidence of meetings in 2018. PID complete. Benefits defined, tracking/reporting of benefits has commenced but last up-dated fiugures are December 2017. From the benefits tracker on SharePoint: Time to Antibiotic Presecription from Diagnosis is against a threshold of 90% was at 63% (ED ONLY) and 73% (Inpatients ONLY) and target was for both to be 90% by March 2018. Training records for nurses were at 91% overall at February 2018. Milestone Plan was last updated February 2018 and expired at the end of April 2018. There needs to be a new plan for 2018/19. Evidence has been provided for certain stakeholder engagement activities but there is no tracked communications plan. No evidence on SharePoint of risks on Ulysses system and the risk register on SharePoint is no longer in use (last update May 2017). EA/QIA complete. **Last updated 23 May 18.**
CQAC	DETECT Study	Using smart technology to reduce critical deterioration	Hilda Gwilliams	Amber	Green	Amber	Amber	Amber	Amber	Red	Red	Red	Evidence of project team meetings has been uploaded to SharePoint. A high level description of the scope is available in a 7 slide pack, a detailed PID is still required. A detailed Gantt Chart is available (revised 4 Apr 18) but is not tracked on SharePoint. There are materials uploaded which indicate stakeholder enagegemtn but ther is no communications plan in evidence. There is no risk register and an EA/QIA is needed. **Last updated 22 May 18.**

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

Sub-Committee	CQAC	Report Date	12 Jun 18
Workstream Name	Delivering Outstanding Care	Executive Sponsor	Hilda Gwilliams/Steve Ryan

Financial Reporting: at 6 Jun 18

		Year to Date			In Year Forecast		
Workstream	Exec Sponsor	Target £000's	Achieved (Posted) £000's	Gap £000's	Target £000's	Forecast £000's	Gap £000's
Deliver Outstanding Care	Adam B/Hilda G	417	145	-271	2,500	1,225	-1,275
Growing Through External Partnerships	Margaret Barnaby	133	0	-133	800	0	-800
The Best People Doing Their Best Work	Melissa Swindell	167	125	-41	1,000	330	-670
Game Changing Research and Innovation	David Powell	83	0	-83	500	0	-500
Strong Foundations	John G/Claire L	367	56	-311	2,200	1,575	-625
Park, Community Estate & Facilities	David Powell	0	3	3	0	18	18
Global Digital Exemplar (GDE)	Peter Young	167	0	-167	1,000	0	-1,000
Subtotal: Strategic Workstreams		**1,333**	**329**	**-1,004**	**8,000**	**3,148**	**-4,852**
Divisional Business		-581	207	787	-1,043	1,280	2,323
Unidentified		0	0	0	0	0	0
Grand Total		**753**	**536**	**-217**	**6,957**	**4,428**	**-2,529**

Programme Assurance Summary

The best people doing their best work

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

The ‘e-Rostering’ project was moved into the imminent pipeline, at the request of the Programme Board, and a date by which it will be fully mobilised should be agreed by the Executive Sponsor as a matter of urgency. The proposals for ‘Engagement and Communication’ and ‘Sickness’ to be run as projects within the programme have been withdrawn and these initiatives will now be run through normal service/business channels.

‘Agile Working’ remains under consideration for adoption into the programme assurance structure and the Programme Board needs to consider whether the project is a fit with the programme architecture.

Work remains to fully define the schemes to deliver the £1m target in 2018/19.

Claire Liddy, Director of Operational Finance 12 Jun 18

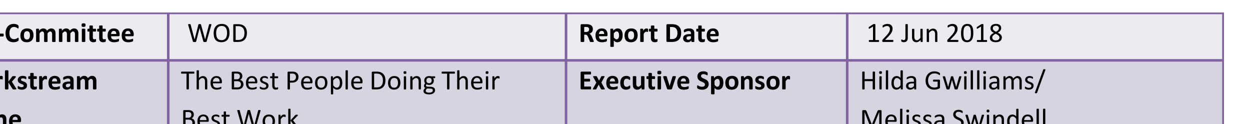
Work Stream Summary (to be completed by External Programme Assessment)

The overall ratings have improved gain this month, albeit only 2 projects are currently being rated as others remain in the pipeline.

The ‘Apprenticeships’ project is being particularly well run and this is testament (with evidence on the SharePoint site) of the hard work of the project team and the diligence of the DMO project management.

The ‘Improve Portering Services’ project remains amber rated and is subject with ongoing discussions with staff side.

Joe Gibson, External Programme Assurance 12 Jun 18



Sub-Committee	WOD	Report Date	12 Jun 2018
Workstream Name	The Best People Doing Their Best Work	Executive Sponsor	Hilda Gwilliams/ Melissa Swindell

Current Dashboard Rating:

Project Ref	Project Title	Project Description	Executive Sponsor Assures the project	OVERALL PROJECT RAG status	An effective project team is in place	Scope and Approach is defined	Targets / benefits defined/on track	Milestone plan is defined/on track	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	Comments for attention of the Project Team, Steering Group and sub-Committee
3.0 The Best People Doing Their Best Work 18/19													
WOD	Apprenticeships	To operationalise the Apprenticeship Strategy and realise the benefits of apprentisehip qualitifcations following introduction of the Apprenticeship Levy.	Melissa Swindell										Project aims to get the steering group in place for 1st week in July; pre-meetings are happening ahead of that date and the membership and roles are defined. Reports to Workstream Steering Group, notes or minutes required on project sharePoint site. PID available, financial benefits to be completed. A detailed Milestone Plan is available and on track with an operational tracking matrix also uploaded. Comms/Engagement activities detailed in PID and a comms plan is in place with extensive stakeholder engagement materail in evidence. Delivery Plan - evidence required where possible. Evidence that risks are up-to-date on Ulysses is required. EA/QIA complete. **Last updated 5 Jun 18**
WOD 3.2c	Improving Portering Services Project	The aim of this project is to deliver an effective portering service which meets all KPIs agreed by the Trust relating to all portering tasks and to ensure that the department has the right resource at the right times throughout the working day and week .	Hilda Gwilliams										Team meetings and briefing notes available. PID available which contains benefits and metrics. Milestone Plan available, shows significant slippage of the overall end date, updated 21 November 2017. The project is now subject to negotiations with Unions following rejection of the proposals by ballot on 20 Apr 18. The Trust will be meeting imminently with the Unions to try to agree a trial period and the project work will await the outcome of those discussions. Evidence available of Comms/ Engagement activities. Risks captured on Risk Log and reviewed 17 Apr 18. EA/QIA complete. **Last updated 23 May 18.**

Programme Assurance Framework
The Best People Doing Their Best Work (Completed by Assurance Team)

Sub-Committee	WOD	Report Date	12 June 2018
Workstream Name	The Best People Doing Their Best Work	Executive Sponsor	Hilda Gwilliams/Melissa Swindell

Financial
Reporting: at 6 Jun 18

Workstream	Exec Sponsor	Year to Date Target £000's	Year to Date Achieved (Posted) £000's	Year to Date Gap £000's	In Year Forecast Target £000's	In Year Forecast Forecast £000's	In Year Forecast Gap £000's
Deliver Outstanding Care	Adam B/Hilda G	417	145	-271	2,500	1,225	-1,275
Growing Through External Partnerships	Margaret Barnaby	133	0	-133	800	0	-800
The Best People Doing Their Best Work	Melissa Swindell	167	125	-41	1,000	330	-670
Game Changing Research and Innovation	David Powell	83	0	-83	500	0	-500
Strong Foundations	John G/Claire L	367	56	-311	2,200	1,575	-625
Park, Community Estate & Facilities	David Powell	0	3	3	0	18	18
Global Digital Exemplar (GDE)	Peter Young	167	0	-167	1,000	0	-1,000
Subtotal: Strategic Workstreams		1,333	329	-1,004	8,000	3,148	-4,852
Divisional Business		-581	207	787	-1,043	1,280	2,323
Unidentified		0	0	0	0	0	0
Grand Total		753	536	-217	6,957	4,428	-2,529

NHS
Alder Hey Children's
NHS Foundation Trust
Corporate Report May 2018
BRILLIANT BASICS
GROW THE FUTURE

Safe

9 of the 11 Safe metrics have been achieved this month. Clinical Incidents resulting in minor harm & above was 27 above threshold, although trend is reducing from a peak in March 18. Divisions committed to monthly monitoring and feedback via Integrated Governance Committee. Pressure Ulcers (Grade 3) resulted from Complex RTA case- currently awaiting results from RCA investigation. Specific pressure ulcer training has been completed by the Tissue Viability Link Nurses. Further session scheduled for August 2018. Training also booked for July 2018 for pressure ulcer recognition and grading.	**Highlight** • Zero Never Events since June 17 **Challenges** • Clinical Incidents resulting in minor harm & above • Pressure Ulcers (Grade 3)

Caring

Friends and Family is amber overall with a declining trend. Threshold of 95% has not been achieved since Jan 18. Contributing to this is A&E at 82.6%. A task and finish group has been established to improve results. A&E is the pilot area for improvement with recent introduction of kiosk for survey collection. Inpatients and Community continue to be above threshold. Complaints and PALs continue to rise. This was subject to a report shared at Trust Board in May and actions from this will be implemented from this in each division.	**Highlight** • Inpatient Friends and Family • Community Friends and Family **Challenges** • A&E Friends and Family • Complaints • PALs

Effective

Sepsis indicators are both below threshold. Review of the Sepsis tool and parameters for A&E is ongoing to ensure appropriateness of use. The biggest issue affecting Inpatients for Sepsis are delays in administering antibiotics. Significant improvements have been made in turnaround times for the typing of clinical letters following outsourcing of the activity. The Trust remained very busy in month with high non elective numbers. This compromised our elective capacity resulting in a higher than average number of cancellations. The 'Patient Flow' group is rolling out the SAFER bundle, and two wards are piloting this in June 2018. There has been a deteriorating trend in the utilisation of our outpatient capacity. The Bes in Outpatient care change programme is taking immediate action to improve this.	**Highlight** • Theatre Utilisation - % of Session Utilised • ED: 95% Treated within 4 Hours **Challenges** • Sepsis – A&E • Sepsis – Inpatients • Cancelled Operations • Outpatient Utilisation

Responsive	
All national targets have been met for the month of May. The new NHSI measure of total list size will be incorporated in the month 3 report. The number of inpatients in bed for over 21 days has reduced against the same position last year. This includes 2 discharges for very long stay patients over 300+ days. Inpatient Survey in relation to planned date of discharge is still improving. Further work on refining this metric to ensure that surveys are requested in relevant areas (to exclude ICU and HDU). IP Survey for % Patients involved in play and learning is continuing to improve. The remaining Inpatient Survey results are below threshold, however action plans are in place and show an improving trend.	**Highlight** • Achieve Core Standards • PPM **Challenges** • Inpatient Survey

Well Led	
From the 20 well led metrics half of these have been achieved. Specific areas of focus have been placed on sickness absence, temporary spend and PDR compliance. The window for PDR's is currently open but will close end of July and there are a significant number of PDR's to be undertaken in the next 5 weeks. The HR &OD team are working closely with divisions to achieve this. Sickness absence is being addressed through a large scale project on improving the Health and Wellbeing of our staff, (inaugural Trust meeting is on 2nd July). The Trust is also being supported through the national NHSI project on improving wellbeing and reducing sickness absence. This large project will also deliver positive impacts on temporary spend, some of which is attributed to absence and some through difficult to fill posts. Month 2 financials were stronger with the Trust achieving a small surplus of £78k which as £154k ahead of plan. Cumulatively we are now showing a deficit of £986k which is £276k behind plan. Cash balances at £10.5m which is ahead if plan with capital spend of £3.6m. Focus now is on delivery of the Q1 position and forecast for the year end which will be further detailed to the Board.	**Highlight** • Mandatory training compliance remains above threshold at 92% **Challenges** • PDR & Medical appraisal compliance is low • Sickness absence rates remain high and higher than comparable Trusts • Temporary spend remains high

Alder Hey Children's
NHS Foundation Trust

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Delivery of Outstanding Care

SAFE

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

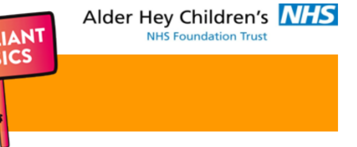
	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Last 12 Months	RAG		
Total no of incidents reported Near Miss & Above	434	473	468	417	406	426	464	326	454	457	514	413	447		>=435	>=391	<391
Pressure Ulcers (Grade 3)	1	0	2	0	0	0	0	1	2	0	0	0	1		0	N/A	>0
Pressure Ulcers (Grade 4)	0	0	0	0	0	0	0	0	0	0	0	0	0		0	N/A	>0
Never Events	0	1	0	0	0	0	0	0	0	0	0	0	0		0	N/A	>0
Medication errors resulting in harm	1	1	4	2	2	1	4	3	2	5	6	4	2		<=2	N/A	>2
Clinical Incidents resulting in minor harm & above	70	78	97	65	73	71	88	51	84	80	95	84	79		<=63	<=70	>70
Clinical Incidents resulting in moderate, semi permanent harm	2	0	3	0	2	0	3	2	2	0	1	0	1		<=1	N/A	>1
Clinical Incidents resulting in severe, permanent harm	0	0	0	0	0	0	0	0	0	0	0	0	0		0	N/A	>0
Clinical Incidents resulting in catastrophic, death	0	0	0	0	1	0	0	0	0	0	0	0	0		0	N/A	>0

The Best People doing their best Work

CARING

	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Last 12 Months	RAG		
Complaints	5	6	4	6	4	10	12	5	12	13	5	9	11		<=4	<=5	>5
PALS	105	115	107	72	121	94	119	98	145	145	129	151	123		<=95	<=105	>105
Friends & Family Inpatients - % Recommend the Trust	82.1%	90.8%	97.6%	94.2%	98.5%	97.9%	97.5%	97.3%	97.3%	96.6%	96.8%	93.7%	95.5%		>=95 %	>=90 %	<90 %
Friends & Family Outpatients - % Recommend the Trust	94.3%	94.8%	92.8%	92.0%	91.4%	95.8%	92.0%	97.7%	96.1%	91.8%	89.3%	90.3%	88.6%		>=95 %	>=90 %	<90 %
Friends & Family A&E - % Recommend the Trust	88.5%	95.7%	100.0%	92.3%	93.2%	95.2%	89.1%	90.9%	89.8%	85.6%	86.4%	85.4%	82.6%		>=95 %	>=90 %	<90 %
Friends & Family Mental Health - % Recommend the Trust	100.0%	82.1%	93.3%	96.7%	96.3%	94.1%	96.0%	100.0%	77.8%	82.8%	100.0%	87.5%	82.6%		>=95 %	>=90 %	<90 %
Friends & Family Community - % Recommend the Trust	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	87.5%	100.0%	97.7%	100.0%	96.8%		>=95 %	>=90 %	<90 %

EFFECTIVE



	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Last 12 Months	RAG		
ED: 95% Treated within 4 Hours	95.6%	96.0%	93.1%	98.3%	95.0%	94.5%	92.8%	94.1%	93.6%	92.6%	97.2%	95.3%	95.0%		>=95 %	N/A	<95 %
Average LoS - Elective (Days)	3.56	2.71	3.17	2.86	3.07	2.61	2.97	3.60	2.98	2.98	3.21	2.79	2.90		<=3.6	N/A	>3.6
Average LoS - Non-Elective (Days)	2.19	1.98	2.15	2.20	2.09	2.01	1.98	1.97	2.10	1.99	2.10	1.96	2.01		<=2.2	N/A	>2.2
Theatre Utilisation - % of Session Utilised	87.3%	88.3%	86.1%	87.5%	86.5%	86.4%	84.4%	86.0%	87.2%	85.6%	86.2%	88.0%	88.6%		>=90 %	>=80 %	<80 %
28 Day Breaches	2	5	1	9	0	8	5	5	0	3	8	10	4		0	N/A	>0
Clinic Session Utilisation	85.9%	85.0%	85.7%	84.8%	83.9%	85.4%	86.7%	83.0%	85.9%	84.3%	84.2%	83.9%	83.9%		>=90 %	>=80 %	<85 %
On the day Elective Cancelled Operations for Non Clinical Reasons	57	19	31	15	48	26	40	15	24	25	37	27	34		No Threshold		
Hospital Acquired Organisms - MRSA (BSI)	0	0	0	0	0	1	1	0	2	0	0	0	0		0	N/A	>0
Hospital Acquired Organisms - C.difficile	0	0	0	0	0	0	0	0	0	0	1	0	0		0	N/A	>0
Hospital Acquired Organisms - MSSA	0	2	0	1	3	2	0	2	0	3	0	0	1		<=1	N/A	>1
Bed Occupancy (Accessible Funded Beds)	83.7%	81.4%	86.5%	74.7%	85.0%	85.1%	88.8%	78.9%	88.2%	89.3%	89.6%	90.3%	84.9%		<=89 %	<=93 %	>93 %
Sepsis: Patients treated for Sepsis - A&E	76.5%	80.8%	59.1%	68.8%	44.4%	54.5%	60.0%	57.1%	60.0%	42.3%	60.9%	66.7%	55.6%		>=90 %	>=80 %	<90 %
Sepsis: Patients treated for Sepsis - Inpatients	57.1%	69.6%	66.7%	82.6%	72.4%	83.7%	85.4%	70.3%	74.1%	86.4%	79.2%	76.0%	72.7%		>=90 %	>=80 %	<90 %
Transcription Turnaround (days)	11.00	8.50	9.25	8.50	8.50	12.50	13.00	18.50	23.00	26.00	28.50	15.00	6.00		<=3	<=5	>5
No of children that have suffered avoidable death	0	0	0	0	0	0	0	0	0	0	0	0	0		0	N/A	>0
Hospital Acquired Organisms - Gram Negative BSI	1	0	1	1	0	2	3	2	1	1	3	2	0		<=1	N/A	>1
Hospital Acquired Organisms - CLABSI - ICU Only	1	1	0	0	1	2	1	6	2	4	2	2	2		<=1	N/A	>1
% Readmissions to PICU within 48 hrs	2.2%	1.1%	0.0%	6.0%	4.5%	2.9%	2.4%	0.0%	2.4%	1.5%	4.1%	3.6%	1.2%		<=3 %	N/A	>3 %

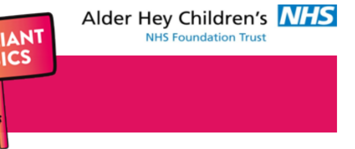
RESPONSIVE

Alder Hey Children's NHS
NHS Foundation Trust

	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Last 12 Months	RAG		
RTT: Open Pathway: % Waiting within 18 Weeks	92.1%	92.1%	92.0%	92.0%	92.1%	92.2%	92.0%	92.0%	92.2%	92.1%	92.1%	92.1%	92.0%		>=92 %	>=90 %	<90 %
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	92.9%	100.0%	100.0%	100.0%	100.0%	100.0%		100 %	N/A	<100 %
All Cancers: 31 day diagnosis to treament	100.0%	100.0%	100.0%	100.0%	100.0%	92.3%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100 %	N/A	<100 %
All Cancers: 31 day wait until subsequent treatments	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100 %	N/A	<100 %
IP Survey: % Received information enabling choices about their care	94.9%	94.7%	95.7%	92.1%	96.5%	96.1%	94.9%	94.7%	94.4%	94.7%	93.1%	94.8%	91.6%		>=95 %	>=90 %	<90 %
IP Survey: % Treated with respect	100.0%	98.8%	99.4%	99.3%	99.5%	99.3%	99.8%	99.4%	100.0%	99.4%	99.8%	97.7%	98.8%		100 %	N/A	<95 %
IP Survey: % Know their planned date of discharge	69.1%	65.5%	64.0%	53.9%	65.0%	57.4%	61.9%	62.5%	52.1%	59.0%	60.1%	60.5%	76.1%		>=90 %	>=85 %	<85 %
IP Survey: % Know who is in charge of their care	96.1%	90.9%	92.9%	91.2%	92.8%	93.8%	94.9%	90.6%	93.6%	90.9%	91.6%	91.3%	90.9%		>=95 %	>=90 %	<90 %
IP Survey: % Patients involved in play and learning	75.8%	71.3%	74.0%	65.7%	73.0%	72.6%	76.7%	76.4%	78.3%	79.6%	75.0%	74.9%	77.8%		>=90 %	>=85 %	<85 %
Diagnostics: % Completed Within 6 Weeks	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.8%	100.0%	99.3%	99.8%	99.8%	99.8%		>=99 %	N/A	<99 %
Number of Super Stranded Patients (21+ Days)	26	22	30	31	27	26	33	29	35	26	32	34	27		<=32	N/A	>32
Waiting Greater than 52 weeks	0	0	0	0	0	0	1	0	1	2	1	0	0		0	N/A	>0
PFI: PPM%	96.0%	89.0%	99.0%	94.0%	88.0%	88.0%	98.0%	100.0%	98.0%	100.0%	98.0%	98.6%	99.0%		>=98 %	N/A	<98 %

The Best People doing their best Work

WELL LED



	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Last 12 Months	RAG		
Domestic Cleaning Audit Compliance	5.0%	5.0%	20.0%	20.0%	25.0%	75.0%	60.0%	65.0%	75.0%	85.0%	90.0%	90.0%	85.0%		>=85 %	N/A	<85 %
PDR	12.0%	43.0%	70.6%	75.9%	77.7%	79.7%	80.1%	79.6%	79.7%	76.1%	76.4%	1.3%	11.3%		No Threshold		
Medical Appraisal	77.7%	33.3%	79.2%	81.0%	8.0%	8.0%	11.6%	13.6%	24.0%	52.1%	67.6%	69.0%	69.0%		>=95 %	>=90 %	<90 %
Sickness	4.6%	4.6%	5.1%	5.0%	4.9%	5.4%	5.3%	5.8%	6.3%	5.5%	4.7%	4.4%	4.6%		<=4.5 %	<=5 %	>5 %
CIP In Month Variance (£'000s)	69	161	-72	37	5	-459	-433	-149	54	-410	864	-248	104		>=0%	>=-20%	<-20%
NHSI Use of Resources	3	3	3	3	3	3	3	3	3	3	1	3	3		<=3	N/A	>3
Staff Turnover	10.3%	10.3%	10.7%	11.0%	10.8%	10.9%	11.0%	11.5%	11.5%	11.5%	11.0%	10.8%	11.2%		<=10 %	<=11 %	>11 %
Performance Against Single Oversight Framework Themes	0	0	0	0	0	0	0	0	0	0	0	0	0		0	<=1	>1
Mandatory Training	73.8%	74.1%	75.7%	74.8%	71.8%	73.6%	80.5%	86.2%	88.9%	94.1%	92.9%	92.1%	92.0%		>=90 %	>=80 %	<80 %
Temporary Spend ('000s)	917	883	1,092	1,166	999	918	938	761	833	926	1,067	977	973		<=800	<=960	>960
Control Total In Month Variance (£'000s)	206	274	-141	100	45	-688	418	218	243	17		-426	154		>=0%	>=-20%	<-20%
Capital Expenditure In Month Variance (£'000s)	2,696	2,027	-292	786	70	1,623	-141	2,329	1,184	3,161	-887	1,090	-333		>=-5%	>=-10%	<-10%
Cash in Bank (£'000s)	5,243	3,738	11,263	10,405	9,116	10,872	6,753	8,171	6,712	10,201	12,244	12,406	10,455		>=0%	>=-20%	<-20%
Income In Month Variance (£'000s)	987	1,062	-407	995	133	-16	3,837	455	1,893	1,080	19,658	218	591		>=0%	>=-20%	<-20%
Non Pay In Month Variance (£'000s)	-600	-706	468	-633	60	-24	-2,703	189	-1,111	-458	1,368	-627	-431		>=0%	>=-20%	<-20%
Pay In Month Variance (£'000s)	-181	-82	-202	-263	-148	-647	-716	-426	-538	-605	546	-17	-7		>=-1%	>=-20%	<-20%
Short Term Sickness	1.3%	1.4%	1.6%	1.3%	1.2%	1.7%	1.5%	1.7%	2.1%	1.7%	1.5%	1.3%	1.1%		<=1.5 %	N/A	>1.5 %
Long Term Sickness	3.2%	3.3%	3.4%	3.6%	3.7%	3.7%	3.8%	4.1%	4.2%	3.8%	3.2%	3.1%	3.5%		<=3 %	N/A	>3 %
% of Correct Pay Achieved	99.7%	99.5%	99.4%	99.6%	99.6%	99.5%	99.6%	98.0%	99.6%	99.3%	98.9%	99.8%	99.4%		>=99.5 %	>=99 %	<99 %
Safer Staffing (Shift Fill Rate)	94.3%	95.8%	94.7%	92.8%	93.9%	93.2%	96.2%	93.9%	95.9%	94.2%	95.0%	96.4%	96.5%		>=90 %	>=80 %	<90 %

Game-changing research and innovation

R&D

	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Last 12 Months	RAG		
Number of Open Studies - Academic												148	153		>=50	N/A	<50
Number of Open Studies - Commercial												34	33		>=5	N/A	<5
Number of New Studies Opened - Academic												5	2		>=4	N/A	<4
Number of New Studies Opened - Commercial												3	0		No Threshold		
Number of patients recruited												272	308		>=417	N/A	<417

Delivery of Outstanding Care

9.1 - QUALITY - SAFE

	Description	Performance	Threshold		Trend	Management Action (SMART)
Incidents: Increasing Reporting	**Total no of incidents reported Near Miss & Above** Total number of Incidents reported. The threshold is based on increasing on last year for the period Apr 17 - Mar 18 (4,241) 18/19 aim is more than last year for the same month to demonstrate a learning culture. **Exec Lead:** Hilda Gwilliams/Steve Ryan **Committee:** CQAC	447	R A G	<391 >=391 >=435	Chart (May-17 to May-18): Actual, Average, UCL, LCL, UWL, LWL, Green	No Action Required
Incidents: Reducing Harm	**Clinical Incidents resulting in minor harm & above** Incidents reported resulting in minor, moderate, major or catastrpohic (death) harm. The threshold is based on achieving a 10% reduction on the period Apr 17 - Mar 18 (913). 18/19 aim is 10% less than last year for the same month. **Exec Lead:** Hilda Gwilliams/Steve Ryan **Committee:** CQAC	79	R A G	>70 <=70 <=63	Chart (May-17 to May-18): Actual, Average, UCL, LCL, UWL, LWL, Green	All incidents classed as 'low harm', SOP in place. All incidents resulting in harm will be reviewed by the Divisions Heads of Quality, who will produce a monthly report summarising the findings of the review and actions in place to improve the accuracy of reporting, ensure lessons are learned to minimise risks and reduce harm incidents including reduction of incidents by theme. This report will be discussed at the Divisions Integrated Governance Committee.
Incidents: Reducing Harm	**Clinical Incidents resulting in moderate, semi permanent harm** Incidents reported resulting in moderate harm. The threshold is based on achieving a 10% reduction on the period Apr 17 - Mar 18 (16). 18/19 aim is 12 or less, annually. **Exec Lead:** Hilda Gwilliams/Steve Ryan **Committee:** CQAC	1	R A G	>1 N/A <=1	Chart (May-17 to May-18): Actual, Average, UCL, LCL, UWL, LWL, Green	No Action Required

Delivery of Outstanding Care

9.2 - QUALITY - SAFE

	Description	Performance	Threshold		Trend	Management Action (SMART)
Incidents: Reducing Harm	**Clinical Incidents resulting in severe, permanent harm** Incidents reported resulting in major harm. The threshold is based on this event never occuring. 18/19 aim is zero annually. **Exec Lead:** Hilda Gwilliams/Steve Ryan **Committee:** CQAC	0	R A G	>0 N/A 0	Chart (May-17 to May-18): Actual, Average, UCL, LCL, UWL, LWL, Green	No Action Required
Incidents: Reducing Harm	**Clinical Incidents resulting in catastrophic, death** Incidents reported resulting in major harm. The threshold is based on this event never occuring. 18/19 aim is zero annually. **Exec Lead:** Hilda Gwilliams/Steve Ryan **Committee:** CQAC	0	R A G	>0 N/A 0	Chart (May-17 to May-18): Actual, Average, UCL, LCL, UWL, LWL, Green	No Action Required
Reducing Pressure Ulcers	**Pressure Ulcers (Grade 3)** Pressure Ulcers of Grade 3. The threshold is based on this event never occuring. 18/19 Aim is zero annually. **Exec Lead:** Hilda Gwilliams/Steve Ryan **Committee:** CQAC	1	R A G	>0 N/A 0	Chart (May-17 to May-18): Actual, Average, UCL, LCL, UWL, LWL, Green	Complex RTA case- awaiting results from RCA investigation. Specific pressure ulcer training has been completed by the Tissue Viability Link Nurses on 29th May 2018. Further session scheduled for 29th August 2018. Training also booked for 25th July 2018 for pressure ulcer recognition and grading.

Delivery of Outstanding Care

9.3 - QUALITY - SAFE

	Description	Performance	Threshold		Trend	Management Action (SMART)
Reducing Pressure Ulcers	**Pressure Ulcers (Grade 4)** Pressure Ulcers of Grade 4. The threshold is based on this event never occuring. 18/19 Aim is zero annually. **Exec Lead:** Hilda Gwilliams/Steve Ryan **Committee:** CQAC	0	R A G	>0 N/A 0	Actual, Average, UCL, LCL, UWL, LWL, Green (May-17 – May-18)	No Action Required
Reducing Medication Errors	**Medication errors resulting in harm** Medication errors reported resulting in minor, moderate, major or catastrpohic (death) harm. The threshold is based on achieving a 25% reduction on the period Apr 17 - Mar 18 (32). 18/19 aim is 2 avg per month, or less, per month (less than 24 annually) **Exec Lead:** Hilda Gwilliams/Steve Ryan **Committee:** CQAC	2	R A G	>2 N/A <=2	Actual, Average, UCL, LCL, UWL, LWL, Green (May-17 – May-18)	11/06/2018 - A. Meikle-Roche (Medication Safety Pharmacist) Reduction on number of errors resulting in harm from April. One incident form related to a known adverse reaction from a combination of medicines. Of remaining two, one was discussed at the Weekly Meeting of Harm. Noted that Trust wide issue with reviewing long term patients' medications. Local learning established and email sent from Medical Director to Consultant leads highlighting needs. To continue linking with wards and medical teams to provide bespoke training. Medication Safety week to be held w/c 25th June.
Never Events	**Never Events** Never Events. The threshold is based on this event never occuring. 18/19 aim is zero annually. **Exec Lead:** Hilda Gwilliams/Steve Ryan **Committee:** CQAC	0	R A G	>0 N/A 0	Actual, Average, UCL, LCL, UWL, LWL, Green (May-17 – May-18)	No Action Required

The Best People doing their best Work

10.1 - QUALITY - CARING

Alder Hey Children's NHS
NHS Foundation Trust

	Description	Performance	Threshold		Trend	Management Action (SMART)
Friends & Family	**Friends & Family A&E - % Recommend the Trust** Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on exceeding the National average in Nov 17. **Exec Lead:** Hilda Gwilliams/Steve Ryan **Committee:** CQAC	82.61 %	R A G	<90 % >=90 % >=95 %		We continue to receive very positive comments about staff also comments regarding staff not being friendly and patients not listened to. More play and activities are required. A FFT kiosk is in A&E on a month's trial to see if quantity and qualitative feedback is increased. The FFT feedback is part of an overall departmental action plan that is monitored and evaluated at their divisional governance meetings. A&E continues to be the pilot for the improvement of FFT task and finish group
Friends & Family	**Friends & Family Community - % Recommend the Trust** Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Hilda Gwilliams/Steve Ryan **Committee:** CQAC	96.82 %	R A G	<90 % >=90 % >=95 %		FFT Task Group has been set up to address improvements to FFT responses and the way in which we collect the data: Text messages, Kiosks, Alder app, Web portal. Interaction with play leaders on the wards using different feedback has been introduced. We are in the process of identifying the best methods of engaging children and teenagers who use our Community, A&E, EDU and clinics to improve the total response.
Friends & Family	**Friends & Family Inpatients - % Recommend the Trust** Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Hilda Gwilliams/Steve Ryan **Committee:** CQAC	95.51 %	R A G	<90 % >=90 % >=95 %		Significant increase in responses from 1B Burns, an overall increase in positive comments for the hospital and staff. Negative - recent situation and police presence has had negative feedback. More communication children that have multiple consultants. A lack of resources for disabled children in regards to bathing aids. Requests could phlebotomy attend wards again. Department managers are responsible for their individual action plans. The FFT feedback is part over an overall departmental action plan that is monitored and evaluated at their divisional governance meetings.

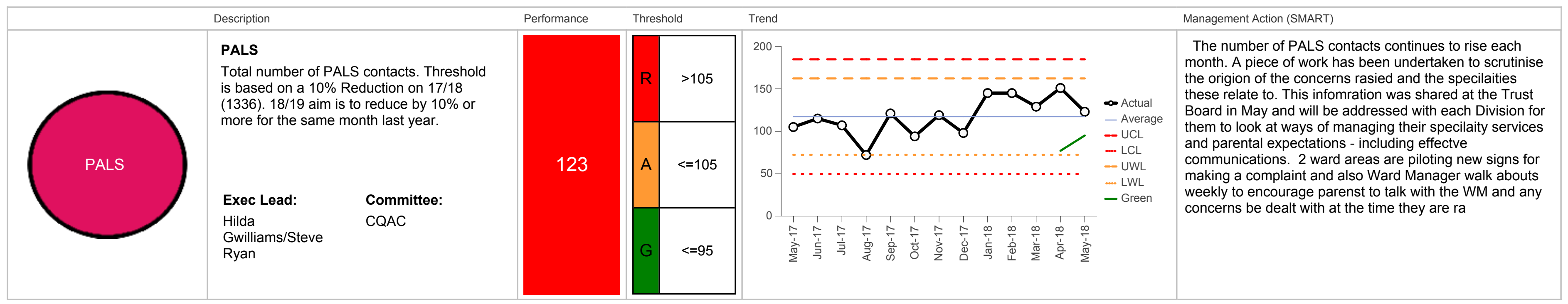
10.2 - QUALITY - CARING

Alder Hey Children's NHS
NHS Foundation Trust

	Description	Performance	Threshold	Trend	Management Action (SMART)
Friends & Family	**Friends & Family Mental Health - % Recommend the Trust** Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Hilda Gwilliams/Steve Ryan **Committee:** CQAC	82.61 %	R <90 % A >=90 % G >=95 %		Excellent feedback from the comments received. Thresholds are now set for the Trust to measure responses Further work is required by the head of quality for community this will be highlighted at the next task and finish meeting in June
Friends & Family	**Friends & Family Outpatients - % Recommend the Trust** Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Hilda Gwilliams/Steve Ryan **Committee:** CQAC	88.61 %	R <90 % A >=90 % G >=95 %		The Best in Outpatient Care Project have identified the top 5/6 suggestions to improve each OPD floor the tasks include reduce waiting times, communicate delays, Increase play and distraction, Improve check in system, Improve signage and cleanliness. Further negative repots to be addressed are: Staffs attitude, car parking, more seating, play, feedback to families... Department managers are responsible for their individual action plans. The FFT feedback is part over an overall departmental action plan that is monitored and evaluated at their divisional governance meetings
Complaints	**Complaints** Total complaints received. The threshold is based on achieving a 25% reduction on the period Apr 17 - Mar 18 (90). 18/19 aim is to reduce by 25% or more for the same month last year. **Exec Lead:** Hilda Gwilliams/Steve Ryan **Committee:** CQAC	11	R >5 A <=5 G <=4		The Trust has identified the need for a Head of Quality for Corporate Service who leads on Complaints & PALS for the Trust. This role will enable closer scrutiny of complaints, appropriate and effective management of the process and ensures the complainant is supported during the process of making a complaint. 8 out of the 11 relates to concerns about treatment/procedure (shared across the 3 Divisions) , 1 relates toaccess/admission (Community Paeds) ,1 relates to staffing concerns (Gastro), 1 relates to Communication failure (Neurology)

10.3 - QUALITY - CARING

Alder Hey Children's NHS
NHS Foundation Trust



	Description	Performance	Threshold		Trend	Management Action (SMART)
PALS	**PALS** Total number of PALS contacts. Threshold is based on a 10% Reduction on 17/18 (1336). 18/19 aim is to reduce by 10% or more for the same month last year. **Exec Lead:** Hilda Gwilliams/Steve Ryan **Committee:** CQAC	123	R	>105		The number of PALS contacts continues to rise each month. A piece of work has been undertaken to scrutinise the origin of the concerns rasied and the specilaities these relate to. This infomration was shared at the Trust Board in May and will be addressed with each Division for them to look at ways of managing their specilaity services and parental expectations - including effectve communications. 2 ward areas are piloting new signs for making a complaint and also Ward Manager walk abouts weekly to encourage parenst to talk with the WM and any concerns be dealt with at the time they are ra
			A	<=105		
			G	<=95		

Delivery of Outstanding Care

11.1 - QUALITY - EFFECTIVE

Alder Hey Children's NHS
NHS Foundation Trust

	Description	Performance	Threshold	Trend	Management Action (SMART)
Sepsis	**Sepsis: Patients treated for Sepsis - A&E** Percentage of Sepis Patients receiving antibiotic within 60 mins for ED. 18/19 aim is 90%. **Exec Lead:** Hilda Gwilliams/Steve Ryan **Committee:** CQAC	55.56 %	R <90 %; A N/A; G >=90 %		ED face an ongoing challenge of the oversensitivity of the sepsis tool, which increases the proportion of possible sepsis patients. This issue is subject to audit and discussion at the next Sepsis Steering Group.
Sepsis	**Sepsis: Patients treated for Sepsis - Inpatients** Percentage of Sepis Patients receiving antibiotic within 60 mins for Inpatients. 18/19 aim is 90%. **Exec Lead:** Hilda Gwilliams/Steve Ryan **Committee:** CQAC	72.73 %	R <90 %; A N/A; G >=90 %		Upon reviewing the reasons for delays in administration of antibiotics, the biggest issue remains the delays in prescribing from clinician review. We are therefore unable to administer the antibiotics quickly. Most of these cases occur outside of normal working hours.
Mortality	**No of children that have suffered avoidable death** Total number of children that have suffered avoidable death. Figures provided by HMRG group. The threshold for 18/19 is zero. **Exec Lead:** Hilda Gwilliams/Steve Ryan **Committee:** CQAC	0	R >0; A N/A; G 0		No Action Required

Delivery of Outstanding Care

11.2 - QUALITY - EFFECTIVE

	Description	Performance	Threshold		Trend	Management Action (SMART)
PICU Re-admissions	**% Readmissions to PICU within 48 hrs** % of discharges readmitted to PICU within 48hrs sourced from PICANet [Paediatric Intensive Care Audit Network]. Threshold agreed with PICU is based on the reported range nationally from all UK PICUs, most recent published range (16/17) was 0-3% averaged over a calendar year. Data is presented as monthly incidence for the purpose of this report. Annual average for this site was 2.4% **Exec Lead:** Hilda Gwilliams/Steve Ryan **Committee:** CQAC	1.25 %	R A G	>3 % N/A <=3 %	Chart (May-17 to May-18): Actual, Average, UCL, LCL, UWL, LWL, Green	No Action Required
Reducing Infections	**Hospital Acquired Organisms - MRSA (BSI)** The threshold is based on this event never occuring. 18/19 Aim is zero annually. **Exec Lead:** Hilda Gwilliams/Steve Ryan **Committee:** CQAC	0	R A G	>0 N/A 0	Chart (May-17 to May-18): Actual, Average, UCL, LCL, UWL, LWL, Green	No Action Required
Reducing Infections	**Hospital Acquired Organisms - C.difficile** The threshold is based on this event never occuring. 18/19 Aim is zero annually. **Exec Lead:** Hilda Gwilliams/Steve Ryan **Committee:** CQAC	0	R A G	>0 N/A 0	Chart (May-17 to May-18): Actual, Average, UCL, LCL, UWL, LWL, Green	No Action Required

Delivery of Outstanding Care

11.3 - QUALITY - EFFECTIVE

Alder Hey Children's NHS
NHS Foundation Trust

	Description	Performance	Threshold		Trend	Management Action (SMART)
Reducing Infections	**Hospital Acquired Organisms - MSSA** Hospital Acquired Organisms - MSSA . 18/19 aim is to reduce by 25% or more. **Exec Lead:** Hilda Gwilliams/Steve Ryan **Committee:** CQAC	1	R A G	>1 N/A <=1		No Action Required
Reducing Infections	**Hospital Acquired Organisms - CLABSI - ICU Only** Hospital Acquired Organisms - CLABSI on ICU Ward Only. 18/19 aim is to reduce by 10% or more. **Exec Lead:** Hilda Gwilliams/Steve Ryan **Committee:** CQAC	2	R A G	>1 N/A <=1		multi-disciplinary CLABSI reduction initiative on PICU. Looking at all aspects of central line care including hand hygiene, central line insertion procedures and central line care bundles (high impact interventions). Progress with this initiative to be fed back through Surgical governance structure and IPCC. Initiative remains in progress.
Reducing Infections	**Hospital Acquired Organisms - Gram Negative BSI** Gram - Negative BSI to include E Coli, Klebsiella and Pseudomonas . 18/19 aim is to reduce by 10% or more. **Exec Lead:** Hilda Gwilliams/Steve Ryan **Committee:** CQAC	0	R A G	>1 N/A <=1		No Action Required

Delivery of Outstanding Care

12.1 - QUALITY - RESPONSIVE

Alder Hey Children's NHS
NHS Foundation Trust

	Description	Performance	Threshold	Trend	Management Action (SMART)
Inpatient Survey: Choices	**IP Survey: % Received information enabling choices about their care** Percentage of patients / families that report receiving information to enable them to make choices. Thresholds are based on previously defined local targets. The 18/19 aim is 95% or above. **Exec Lead:** Hilda Gwilliams/Steve Ryan **Committee:** CQAC	91.63 %	R <90 % A >=90 % G >=95 %		Following the implementation of the FFT action plan further development from managers will be monitored at there divisional governance meetings.
Inpatient Survey: Respect	**IP Survey: % Treated with respect** Percentage of children / families that report being treated with respect. Thresholds are based on previously defined local targets. The 18/19 is 100%. **Exec Lead:** Hilda Gwilliams/Steve Ryan **Committee:** CQAC	98.77 %	R <95 % A >=95 % G 100 %		The implementation of the FFT action plan will identify the departments/areas of concern. Further support /training will be needed to be given by the department managers. Events during April have had an impact on this response, A&E and out patients show particular negative responses
Inpatient Survey: Date of Discharge	**IP Survey: % Know their planned date of discharge** Percentage of children / families that report knowing their planned date of discharge. Thresholds are based on previously defined local targets. The 18/19 aim is 90% or above. **Exec Lead:** Hilda Gwilliams/Steve Ryan **Committee:** CQAC	76.11 %	R <85 % A >=85 % G >=90 %		Having looked at the FFT feedback it is apparent that we are asking this question on wards such as HDU PICCU when it is unrealistic for families to know when they will be discharged. Therefore from July this question will not be asked in this department. This should show an increase in the %.

Trend charts (each): x-axis May-17, Jun-17, Jul-17, Aug-17, Sep-17, Oct-17, Nov-17, Dec-17, Jan-18, Feb-18, Mar-18, Apr-18, May-18; legend: Actual, Average, UCL, LCL, UWL, LWL, Green. Y-axis: Choices 90–100; Respect 97–102; Date of Discharge 40–100.

Delivery of Outstanding Care

12.2 - QUALITY - RESPONSIVE

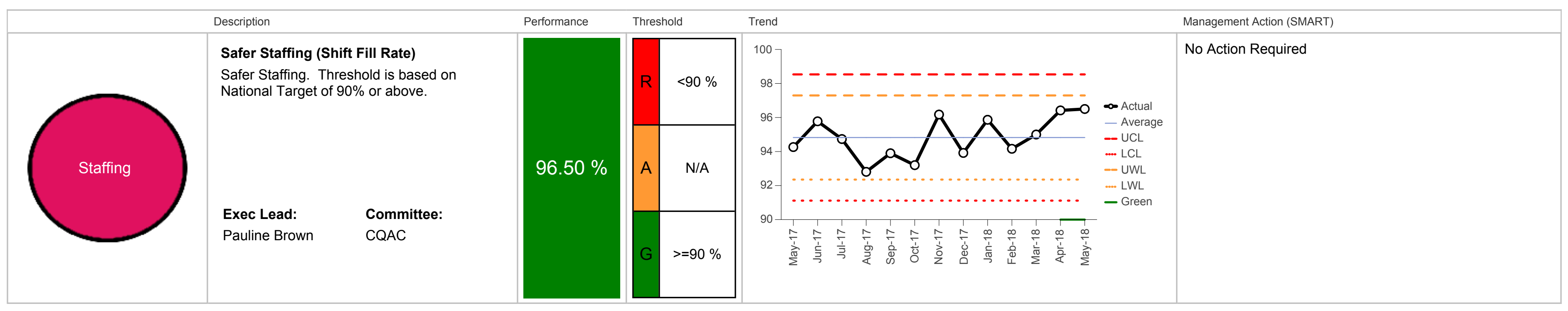
Alder Hey Children's NHS
NHS Foundation Trust

	Description	Performance	Threshold		Trend	Management Action (SMART)
Inpatient Survey: In Charge of Care	**IP Survey: % Know who is in charge of their care** % of children / families that report knowing who is in charge of their care. Thresholds are based on previously defined local targets. The 18/19 aim is 95% or above. **Exec Lead:** Hilda Gwilliams/Steve Ryan **Committee:** CQAC	90.89 %	R A G	<90 % >=90 % >=95 %		Departments have an action plan in place to identify these areas of concern. This will be monitored by the divisional governance meetings.
Inpatient Survey: Play and Learning	**IP Survey: % Patients involved in play and learning** % of children / families that report engaging in play / learning. Thresholds are based on previously defined local targets. The 18/19 aim is 90% or above. **Exec Lead:** Hilda Gwilliams/Steve Ryan **Committee:** CQAC	77.83 %	R A G	<85 % >=85 % >=90 %		The play manager has been in post since January, staff resources have been utilised to effectively cover all ward areas. The introduction to using volunteers in outpatients and A&E is a working progress. Future recorded referrals from play will see an increase in financial benefits and in return will be able to add resources in terms of staff and equipment. The play department have ongoing weekly/monthly meetings to discuss further improvements

Alder Hey Children's NHS
NHS Foundation Trust

The Best People doing their best Work

13.1 - QUALITY - WELL LED



	Description	Performance	Threshold		Trend	Management Action (SMART)
Staffing	**Safer Staffing (Shift Fill Rate)** Safer Staffing. Threshold is based on National Target of 90% or above. **Exec Lead:** Pauline Brown **Committee:** CQAC	96.50 %	R	<90 %		No Action Required
			A	N/A		
			G	>=90 %		

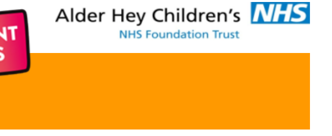
Delivery of Outstanding Care

16.1 - PERFORMANCE - EFFECTIVE

	Description	Performance	Threshold	Trend	Management Action (SMART)
Bed Occupancy	**Bed Occupancy (Accessible Funded Beds)** Percentage of funded beds that are occupied in accessible wards 3A, 4A, 3C and 4C, this is based on 3 occupancy readings measured throughout the day. Threshold is based on National NHS Guidance on safe staffing and occupancy levels. **Exec Lead:** Adam Bateman **Committee:** RABD	84.93 %	R >93 % A <=93 % G <=89 %	Chart (May-17 to May-18; Actual, Average, UCL, LCL, UWL, LWL, Green)	No Action Required
ED 4 Hour Standard	**ED: 95% Treated within 4 Hours** Threshold is based on National Guidance set by NHS England at 95%. **Exec Lead:** Adam Bateman **Committee:** RABD	95.03 %	R <95 % A N/A G >=95 %	Chart (May-17 to May-18; Actual, Average, UCL, LCL, UWL, LWL, Green)	No Action Required
LoS: Elective	**Average LoS - Elective (Days)** Average Elective Length of Stay (days). 18/19 aim is to not increase Length of Stay for the same month last year. **Exec Lead:** Adam Bateman **Committee:** RABD	2.90	R >3.6 A N/A G <=3.6	Chart (May-17 to May-18; Actual, Average, UCL, LCL, UWL, LWL, Green)	No Action Required

Delivery of Outstanding Care

16.2 - PERFORMANCE - EFFECTIVE



	Description	Performance	Threshold	Trend	Management Action (SMART)
LoS: Non-Elective	**Average LoS - Non-Elective (Days)** Average Non Elective Length of Stay (days). 18/19 aim is to not increase Length of Stay for the same month last year. **Exec Lead:** Adam Bateman **Committee:** RABD	2.01	R >2.2 A N/A G <=2.2		No Action Required
Theatre Utilisation	**Theatre Utilisation - % of Session Utilised** Threshold is based on the productive theatre improvement measures at greater than or equal to 90% utilisation of theatres. **Exec Lead:** Adam Bateman **Committee:** RABD	88.61 %	R <80 % A >=80 % G >=90 %		Improvement on previous month - actions to be created and monitored for 6 specialties with utilisation <80%
Cancelled Operations	**On the day Elective Cancelled Operations for Non Clinical Reasons** Performance is measured for on the day cancelled elective operations for non clinical reasons. This based on National Guidance. **Exec Lead:** Adam Bateman **Committee:** RABD	34	No Threshold		Majority of patients cancelled due to no ward bed or high number of emergency cases waiting. Ongoing actions from Patient Flow steering group are being taken to reduced ward bed related cancellations, such as an improved communication process between patient flow and theatres, and implementation of the SAFER model. Additional allocation of emergency/trauma lists on weekdays and weekends is underway to reduce elective cancellations due to emergency cases

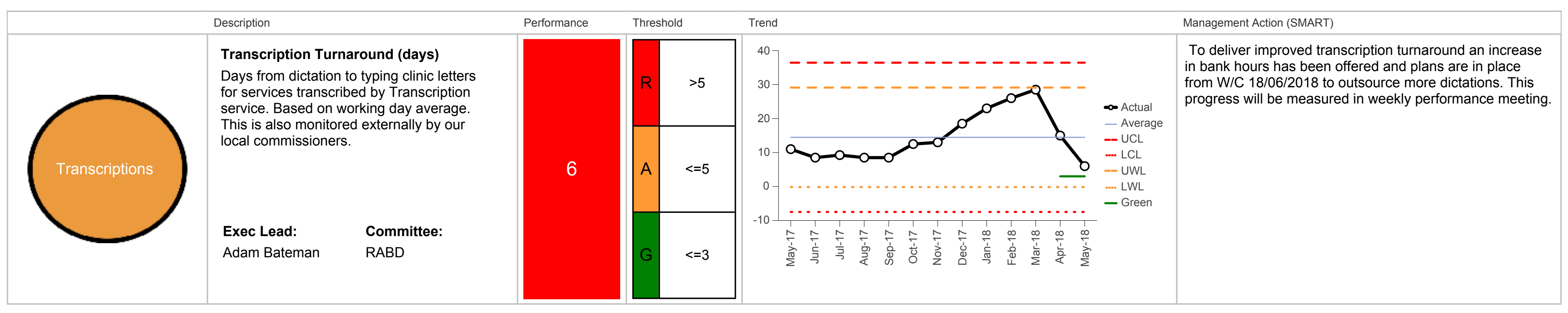
Delivery of Outstanding Care

16.3 - PERFORMANCE - EFFECTIVE

Alder Hey Children's NHS
NHS Foundation Trust

	Description	Performance	Threshold		Trend	Management Action (SMART)
Operation Breaches	**28 Day Breaches** Standard is when a patients operation is cancelled by the hospital last minute for non-clinical reasons, the hospital will have to offer another binding date with 28 days. This is based on national guidance. **Exec Lead:** Adam Bateman **Committee:** RABD	4	R A G	>0 N/A 0		Improvement from April as part of divisional target to have no 28 day breaches. Both patients cancelled due to no beds and breached due to list availability. Due to high number of cancellations in recent month, it has been challenging to accommodate all cancellations within 28 day breach date
Clinic Utilisation	**Clinic Session Utilisation** Threshold is based on a resonable expectation utilising clinics at 90% or greater to take into account short notice cancellations and DNAs. **Exec Lead:** Adam Bateman **Committee:** RABD	83.92 %	R A G	<85 % >=85 % >=90 %		Clinic Utilisation is now being reviewed as part of the Brilliant Booking workstream. Plan is to increase utilisation by 5% through implementing a Hybrid Booking solution. Project team are assembled and now meet weekly. Recruitment plans finalised to support filling of empty slots. Plans are currently being implemented and benefits realisation forecast from Q3. Planned utilisation continues to be reviewed in Weekly performance to support booking to 100%.
Stranded Patients	**Number of Super Stranded Patients (21+ Days)** National measure as part of the 18/19 NHSI plan. The target is to reduce the number of stranded patients 21 or more days from March 2018. **Exec Lead:** Adam Bateman **Committee:** RABD	27	R A G	>32 N/A <=32		Two superstranded children with LOS > 400 and 300 days respectively safely discharged home this month with local services support and substantial care packages. Continue to improve co-ordination of care with multiple speciality involvement. Business case submitted to enable same level of scrutiny and support to be provided for children with 7 – 21 day LOS as highlighted in the stranded patient metrics from the DOH.

16.4 - PERFORMANCE - EFFECTIVE



	Description	Performance	Threshold		Trend	Management Action (SMART)
Transcriptions	**Transcription Turnaround (days)** Days from dictation to typing clinic letters for services transcribed by Transcription service. Based on working day average. This is also monitored externally by our local commissioners. **Exec Lead:** Adam Bateman **Committee:** RABD	6	R	>5		To deliver improved transcription turnaround an increase in bank hours has been offered and plans are in place from W/C 18/06/2018 to outsource more dictations. This progress will be measured in weekly performance meeting.
			A	<=5		
			G	<=3		

17.1 - PERFORMANCE - RESPONSIVE

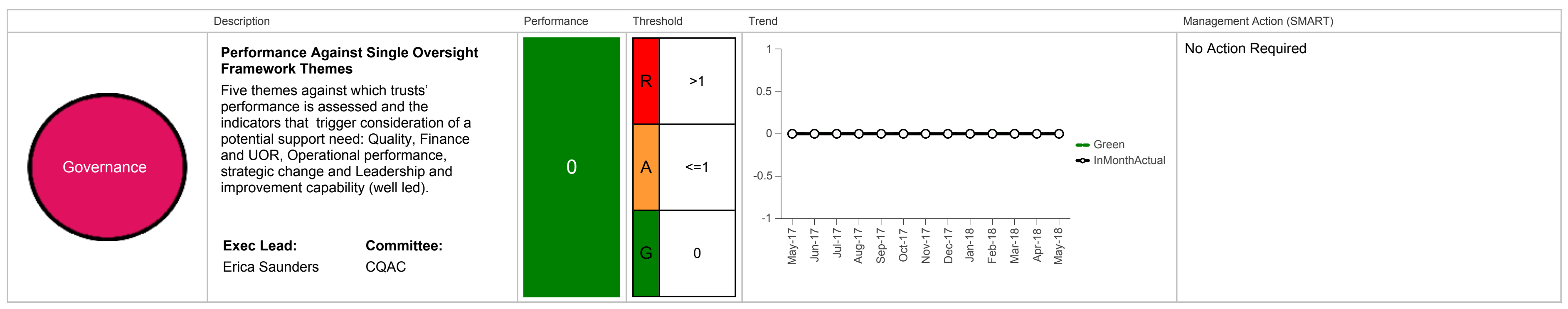
	Description	Performance	Threshold		Trend	Management Action (SMART)
RTT	**RTT: Open Pathway: % Waiting within 18 Weeks** Percentage of patients waiting within 18 weeks. Threshold is based on previous national target of 92%, this is applied in order to maintain monitoring of measure. **Exec Lead:** Adam Bateman **Committee:** RABD	92.05 %	R A G	<90 % >=90 % >=92 %	Chart (May-17 to May-18; legend: Actual, Average, UCL, LCL, UWL, LWL, Green)	No Action Required
Waiting Times	**Waiting Greater than 52 weeks** Total number of more than 52 weeks for first treatment. The threshold is based on this event never occuring. 18/19 aim is zero annually. There is a financial and contractual penalties in the failure to achieve this. **Exec Lead:** Adam Bateman **Committee:** RABD	0	R A G	>0 N/A 0	Chart (May-17 to May-18; legend: Actual, Average, UCL, LCL, UWL, LWL, Green)	No Action Required
Cancer RTT	**Cancer: 2 week wait from referral to date 1st seen - all urgent referrals** Threshold is set at 100% which a stretch target set higher than national performance. **Exec Lead:** Adam Bateman **Committee:** RABD	100 %	R A G	<100 % N/A 100 %	Chart (May-17 to May-18; legend: Actual, Average, UCL, LCL, UWL, LWL, Green)	No Action Required

17.2 - PERFORMANCE - RESPONSIVE

	Description	Performance	Threshold	Trend	Management Action (SMART)
Cancer RTT	**All Cancers: 31 day diagnosis to treament** Threshold is set at 100% which a stretch target set higher than national performance. **Exec Lead:** Adam Bateman **Committee:** RABD	100 %	R <100 % A N/A G 100 %		No Action Required
Cancer RTT	**All Cancers: 31 day wait until subsequent treatments** Threshold is set at 100% which a stretch target set higher than national performance. **Exec Lead:** Adam Bateman **Committee:** RABD	100 %	R <100 % A N/A G 100 %		No Action Required
Diagnostics	**Diagnostics: % Completed Within 6 Weeks** Threshold is based on National Guidance set by NHS England at 99%. **Exec Lead:** Adam Bateman **Committee:** RABD	99.80 %	R <99 % A N/A G >=99 %		No Action Required

The Best People doing their best Work

18.1 - PERFORMANCE - WELL LED



	Description	Performance	Threshold		Trend	Management Action (SMART)
Governance	**Performance Against Single Oversight Framework Themes** Five themes against which trusts' performance is assessed and the indicators that trigger consideration of a potential support need: Quality, Finance and UOR, Operational performance, strategic change and Leadership and improvement capability (well led). **Exec Lead:** Erica Saunders **Committee:** CQAC	0	R	>1		No Action Required
			A	<=1		
			G	0		

21.1 - FINANCE - WELL LED

	Description	Performance	Threshold	Trend	Management Action (SMART)
Finance	**CIP In Month Variance (£'000s)** Variance from Sustainability plan (CIP). Variation between months is usual and the threshold of + or - 20% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	104	R <-20% A >=-20% G >=0%		No Action Required
Finance	**Control Total In Month Variance (£'000s)** Variance from Control Total plan. Variation between months is usual and the threshold of + or - 20% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	154	R <-20% A >=-20% G >=0%		No Action Required
Finance	**Capital Expenditure In Month Variance (£'000s)** Variance from capital plan. Variation between months is usual and the threshold of + or - 5% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	-333	R <-10% A >=-10% G >=-5%		Although the expenditure in May exceeds the budget for the month the year to date expenditure is below the allocated budget and therefore not a cause for concern. This is relating to slippage and timing differences on the capital projects.

21.2 - FINANCE - WELL LED

	Description	Performance	Threshold		Trend	Management Action (SMART)
Finance	**Cash in Bank (£'000s)** Variance from Cash plan. Variation between months is usual and the threshold of + or - 20% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	10,455	R A G	<-20% >=-20% >=0%	Chart: 0–20,000; May-17 to May-18; Actual, Average, UCL, LCL, UWL, LWL, Green	No Action Required
Finance	**Income In Month Variance (£'000s)** Variance from income plan. Variation between months is usual and the threshold of + or - 20% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	591	R A G	<-20% >=-20% >=0%	Chart: -20,000–20,000; May-17 to May-18; Actual, Average, UCL, LCL, UWL, LWL, Green	No Action Required
Finance	**Pay In Month Variance (£'000s)** Variance from pay plan. Variation between months is usual and the threshold of + or - 20% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	-7	R A G	<-20% >=-20% >=-1%	Chart: -1,500–1,000; May-17 to May-18; Actual, Average, UCL, LCL, UWL, LWL, Green	No Action Required

21.3 - FINANCE - WELL LED

	Description	Performance	Threshold	Trend	Management Action (SMART)
Finance	**Non Pay In Month Variance (£'000s)** Variance from non pay plan. Variation between months is usual and the threshold of + or - 20% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	-431	R: <-20% A: >=-20% G: >=0%	Chart: Actual, Average, UCL, LCL, UWL, LWL, Green; May-17 to May-18	Non Pay costs are £0.4m overspent in the month. Of this overspend £0.3m relates to costs which are offset by income. The remaining £0.1m relates to overspend on Utility bills which are under investigation by the Estates team.
Finance	**NHSI Use of Resources** NHSI Use of Resources Metric indicates financial sustainability of the Trust. This varies from 1 to 4 with 1 being the highest score possible and 4 being the lowest **Exec Lead:** John Grinnell **Committee:** RABD	3	R: >3 A: N/A G: <=3	Chart: Actual, Average, UCL, LCL, UWL, LWL, Green; May-17 to May-18	No Action Required

22.1 - HR - WELL LED

	Description	Performance	Threshold	Trend	Management Action (SMART)
Personal Development	**PDR** Trust target, measuring compliance of staff Personal Development Reviews (Non medical). The Trust compliance period is set to be achieved in the first 4 months of each year (April -July). **Exec Lead:** Melissa Swindell **Committee:** WOD	11.34 %	No Threshold		The PDR window remains open until July. Month by month from April there has been an increase, however there will be enhanced communications with Divisional and departmental leads to ensure all PDR's are planned with Staff before end of July when the PDR window closes and compliance is expected to be at 90%.
Appraisal	**Medical Appraisal** Trust Target for compliance for medical staff, which is on a rolling 12mth period. **Exec Lead:** Melissa Swindell **Committee:** WOD	68.97 %	R <90 % A >=90 % G >=95 %		Medical Appraisal has remained the same since April. There are a number of Medical Appraisals booked in June so this figure is expected to increase for July's report.
Training	**Mandatory Training** This is a Trust target that measures the 6 core mandatory training modules that are required of all staff (Safeguarding L1, Moving and Handling, Information Governance, Equality and Diversity, Fire Safety and Health and Safety) **Exec Lead:** Melissa Swindell **Committee:** WOD	92.01 %	R <80 % A >=80 % G >=90 %		No Action Required

The Best People doing their best Work

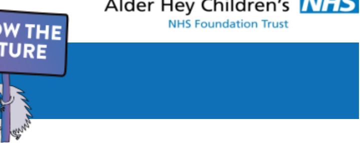
22.2 - HR - WELL LED

	Description	Performance	Threshold	Trend	Management Action (SMART)
Temporary Spend	**Temporary Spend ('000s)** Indicates the expenditure on premium temporary pay spend and monitors the reduction. **Exec Lead:** Melissa Swindell **Committee:** WOD	973.13	R >960 A <=960 G <=800		A slight reduction from April temporary spend
Sickness	**Sickness** **Exec Lead:** Melissa Swindell **Committee:** WOD	4.58 %	R >5 % A <=5 % G <=4.5 %		A detailed review of sickness is underway and the establishment of a wellbeing group set up to address the issue of improving our staff wellbing. The Trust is also workign with NHSI on improving health and wellbeing
Sickness	**Short Term Sickness** Trust target to measure levels of short term sickness absence **Exec Lead:** Melissa Swindell **Committee:** WOD	1.13 %	R >1.5 % A N/A G <=1.5 %		No Action Required

The Best People doing their best Work

22.3 - HR - WELL LED

	Description	Performance	Threshold		Trend	Management Action (SMART)
Sickness	**Long Term Sickness** Trust target to measure levels of long term sickness absence **Exec Lead:** Melissa Swindell **Committee:** WOD	3.46 %	R A G	>3 % N/A <=3 %		Long Term Sickness remains above the Trust threshold with a slight worsening since April 2018, previously having seen a month on month decrease since January 2018. The HR Team continue to provide support to Divisional and Corporate Managers to reduce overall sickness
Staff Turnover	**Staff Turnover** Trust Target which is based on a rolling 12mth period **Exec Lead:** Melissa Swindell **Committee:** WOD	11.22 %	R A G	>11 % <=11 % <=10 %		Staff turnover has increased slightly from April 2018, now highlighted as red, previously having shown continued decreases since January 2018.
Payroll	**% of Correct Pay Achieved** An agreed service Level target with the Trust payroll provider. **Exec Lead:** Melissa Swindell **Committee:** WOD	99.45 %	R A G	<99 % >=99 % >=99.5 %		There has been a very slight decrease in achievement this month, now showing as amber. Whilst at this stage no action is required, the position will be closely monitored next month and any appropriate action taken



Game-changing research and innovation

24.1 - RESEARCH & DEVELOPMENT - WELL LED

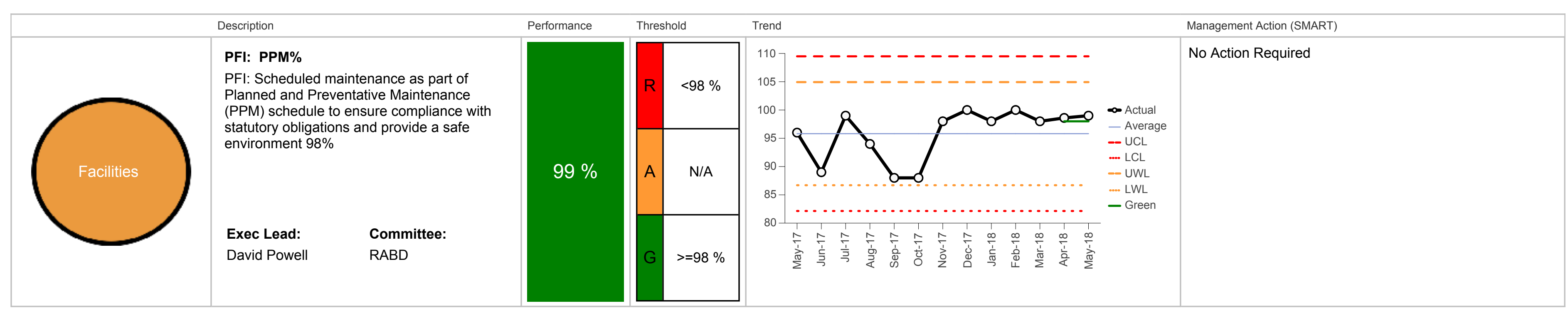
	Description	Performance	Threshold	Trend	Management Action (SMART)
Clinical Research	**Number of Open Studies - Academic** Number of academic studies currently open. **Exec Lead:** Matthew Peak **Committee:** REIC	153	R: <50 A: N/A G: >=50	Actual, Average, UCL, LCL, UWL, LWL, Green (May-17 to May-18)	No Action Required
Clinical Research	**Number of Open Studies - Commercial** Number of commercial studies currently open. **Exec Lead:** Matthew Peak **Committee:** REIC	33	R: <5 A: N/A G: >=5	Actual, Average, UCL, LCL, UWL, LWL, Green (May-17 to May-18)	No Action Required
Clinical Research	**Number of New Studies Opened - Academic** Number of new academic studies opened in month. **Exec Lead:** Matthew Peak **Committee:** REIC	2	R: <4 A: N/A G: >=4	Actual, Average, UCL, LCL, UWL, LWL, Green (May-17 to May-18)	150 in april is the whole year total not in month. however the usual trend is more than 2 per month open. This metric requires monitoring on a quarterly basis.

Game-changing research and innovation

24.2 - RESEARCH & DEVELOPMENT - WELL LED

	Description	Performance	Threshold	Trend	Management Action (SMART)
Clinical Research	**Number of New Studies Opened - Commercial** Number of new commercial studies opened in month. **Exec Lead:** Matthew Peak **Committee:** REIC	0	No Threshold		No action required at present - quarterly monitoring will take place. In addition a comparison of the number of interests we have expressed for studies Vs the number that A H has been selected as a site will determine if drops in performance are a tim related issue rather than a performance issue.
Clinical Research	**Number of patients recruited** Number of patients recruited in month. **Exec Lead:** Matthew Peak **Committee:** REIC	308	R <417 A N/A G >=417		performing well above the required number. NO action.

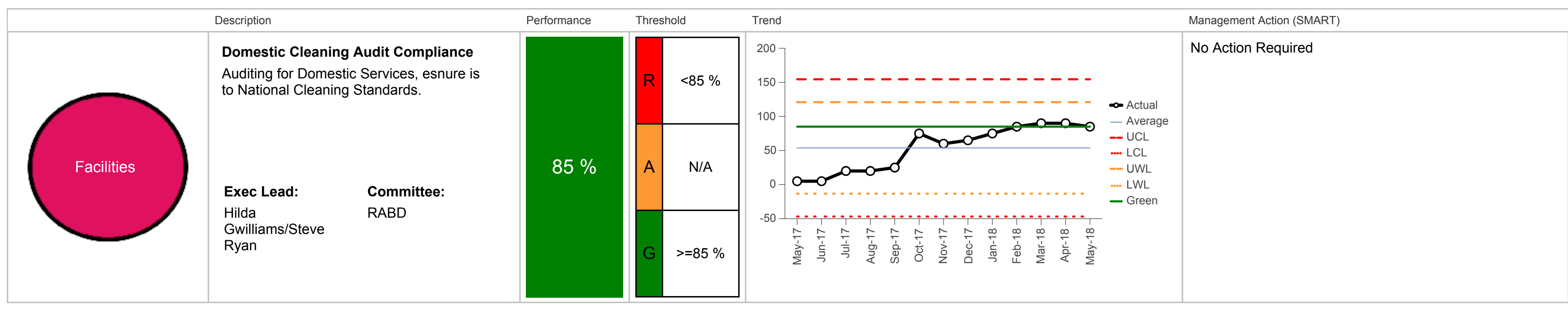
25.1 - FACILITIES - RESPONSIVE



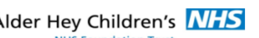
	Description	Performance	Threshold		Trend	Management Action (SMART)
Facilities	**PFI: PPM%** PFI: Scheduled maintenance as part of Planned and Preventative Maintenance (PPM) schedule to ensure compliance with statutory obligations and provide a safe environment 98% **Exec Lead:** David Powell **Committee:** RABD	99 %	R	<98 %		No Action Required
			A	N/A		
			G	>=98 %		

The Best People doing their best Work

26.1 - FACILITIES - WELL LED



	Description	Performance	Threshold		Trend	Management Action (SMART)
Facilities	**Domestic Cleaning Audit Compliance** Auditing for Domestic Services, esnure is to National Cleaning Standards. **Exec Lead:** Hilda Gwilliams/Steve Ryan **Committee:** RABD	85 %	R	<85 %		No Action Required
			A	N/A		
			G	>=85 %		



All Divisions

SAFE

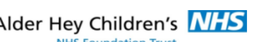
	COMMUNITY	MEDICINE	SURGERY	RAG		
Clinical Incidents resulting in catastrophic, death	0	0	0	0	N/A	>0
Clinical Incidents resulting in severe, permanent harm	0	0	0	0	N/A	>0
Medication errors resulting in moderate, sever harm or death	0	0	0	0	N/A	>0
Never Events	0	0	0	0	N/A	>0
Pressure Ulcers (Grade 3)	0	0	1	0	N/A	>0
Pressure Ulcers (Grade 4)	0	0	0	0	N/A	>0
Acute readmissions of patients with long term conditions within 28 days	0	1	0	No Threshold		
Clinical Incidents resulting in minor harm & above	2	23	53	No Threshold		
Clinical Incidents resulting in moderate, semi permanent harm	0	0	1	No Threshold		
Medication errors resulting in harm	0	1	1	No Threshold		
Total no of incidents reported Near Miss & Above	28	149	249	No Threshold		

CARING

	COMMUNITY	MEDICINE	SURGERY	RAG
Complaints	2	7	2	No Threshold
PALS	28	31	35	No Threshold

EFFECTIVE

	COMMUNITY	MEDICINE	SURGERY	RAG		
Cancelled Operations - Non Clinical - On Same Day (%)	0.0%	0.2%	2.8%	<=0.8 %	N/A	>0.8 %
% of acute readmissions within 48 hrs of discharge (exc Oncology)	0.0%	1.8%	1.3%	<=1.1 %	N/A	>1.1 %
CAMHS: DNA Rate - Follow Up	15.9%			<=10 %	<=16 %	>16 %
Did Not Attend Rate	14.2%	11.0%	10.4%	<=12 %	<=14 %	>14 %
OP Appointments Cancelled by Hospital %	10.9%	15.5%	12.5%	<=5 %	<=10 %	>10 %
CAMHS: DNA Rate - New	10.6%			<=6 %	<=8 %	>8 %
Clinic Session Utilisation	75.1%	85.0%	85.0%	>=90 %	>=85 %	<85 %

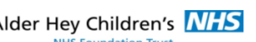


All Divisions

	COMMUNITY	MEDICINE	SURGERY	RAG		
28 Day Breaches	0	1	3	0	N/A	>0
Hospital Acquired Organisms - C.difficile	0	0	0	0	N/A	>0
Hospital Acquired Organisms - MRSA (BSI)	0	0	0	0	N/A	>0
Outbreak Acquired Organisms - Other	0	0	0	0	N/A	>0
Coding average comorbidities	2.33	3.27	3.31	No Threshold		
Hospital Acquired Organisms - MSSA	0	0	1	No Threshold		
Hospital Acquired Organisms - RSV	0	0	0	No Threshold		
Incomplete Pathway Forms in Outpatients	2,837	4,806	9,343	No Threshold		
On the day Elective Cancelled Operations for Non Clinical Reasons	0	2	32	No Threshold		
Outbreak Infections	0	0	0	No Threshold		
Readmissions to PICU within 48 hrs	0	0	0	No Threshold		
Readmissions within 48 hrs	0	37	21	No Threshold		
Referral Turnaround (Consultant to Action)	9.76	7.48	6.36	No Threshold		
Referral Turnaround (days to log)	5.17	3.43	4.21	No Threshold		
Referrals Received (Total)	1,067	1,891	4,022	No Threshold		
Theatre Utilisation - % of Session Utilised		75.7%	90.5%	>=90 %	>=85 %	<80 %
ED: 95% Treated within 4 Hours		95.0%		>=95 %	N/A	<95 %
Average LoS - Elective (Days)		2.50	3.04	No Threshold		
Average LoS - Non-Elective (Days)		1.55	2.76	No Threshold		
Hospital Acquired Organisms - CLABSI - ICU Only			2	No Threshold		

RESPONSIVE

	COMMUNITY	MEDICINE	SURGERY	RAG		
RTT: Open Pathway: % Waiting within 18 Weeks	96.1%	90.2%	92.5%	>=92 %	>=90 %	<90 %
Waiting Greater than 52 weeks	0	0	0	0	N/A	>0
CAMHS: 2 Appointments within 6 weeks	0			No Threshold		
CAMHS: Avg Wait from referral to Partnership Appt (Weeks)- Liverpool Specialist	15.00	0.00	0.00	No Threshold		

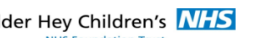


All Divisions

	COMMUNITY	MEDICINE	SURGERY	RAG		
CAMHS: Avg Wait from referral to Partnership Appt (Weeks)- Sefton Specialist	13.00	0.00	0.00	No Threshold		
Routine Eating Disorders (EDYS) Pathway Average Wait in Days	23.00			No Threshold		
Routine EDYS Pathway Average Wait in Weeks	0	0	0	No Threshold		
Urgent Eating Disorders (EDYS) Pathway Average Wait in Days	13.00			No Threshold		
Urgent EDYS Pathway Average Wait in Weeks	0	0	0	No Threshold		
Waiting List Size	801	3,791	8,645	No Threshold		
IP Survey: % Patients involved in play and learning		70.6%	84.0%	>=90 %	>=85 %	<85 %
IP Survey: % Know their planned date of discharge		90.9%	63.5%	>=90 %	>=85 %	<85 %
IP Survey: % Know who is in charge of their care		90.9%	90.9%	>=95 %	>=90 %	<90 %
IP Survey: % Received information enabling choices about their care		86.6%	95.9%	>=95 %	>=90 %	<90 %
Diagnostics: % Completed Within 6 Weeks		99.8%	100.0%	>=99 %	N/A	<99 %
IP Survey: % Treated with respect		98.4%	99.1%	100 %	>=95 %	<95 %
Number of Stranded Patients (7+ Days)		27	10	No Threshold		
Number of Super Stranded Patients (21+ Days)		8	4	No Threshold		

WELL LED

	COMMUNITY	MEDICINE	SURGERY	RAG		
Short Term Sickness	1.0%	1.0%	1.4%	<=1.5 %	N/A	>1.5 %
Staff Turnover	12.7%	12.0%	9.8%	<=10 %	<=11 %	>11 %
Long Term Sickness	4.1%	3.1%	3.3%	<=3 %	N/A	>3 %
Sickness	5.1%	4.1%	4.7%	<=4.5 %	<=5 %	>5 %
Control Total In Month Variance (£'000s)	-70	122	32	>=0%	>=-20%	<-20%
Income In Month Variance (£'000s)	48	423	139	>=0%	>=-20%	<-20%
Non Pay In Month Variance (£'000s)	-76	-362	-101	>=0%	>=-20%	<-20%
Mandatory Training	95.0%	92.8%	89.9%	>=90 %	>=80 %	<80 %
Safer Staffing (Shift Fill Rate)	100.0%	99.2%	94.4%	>=90 %	>=80 %	<90 %
Attendance (HR)	94.9%	95.9%	95.3%	>=95.5 %	>=90 %	<90 %



All Divisions

	COMMUNITY	MEDICINE	SURGERY	RAG
Actual vs Planned Establishment (%)	93.3%	90.8%	96.5%	No Threshold
Pay In Month Variance (£'000s)	-42	61	-5	No Threshold
PDR	9.3%	13.4%	10.0%	No Threshold
Temporary Spend ('000s)	180	276	420	No Threshold

Medicine

SAFE

	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Last 12 Months	RAG
Acute readmissions of patients with long term conditions within 28 days	2	8	5	7	8	4	4	6	3	3	0	1	1		No Threshold

CARING

	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Last 12 Months	RAG
Complaints	2	3	2	3	0	1	5	2	3	4	3	0	7		No Threshold
PALS	31	29	25	21	25	20	27	30	37	30	39	51	31		No Threshold

EFFECTIVE

	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Last 12 Months	RAG
ED: 95% Treated within 4 Hours	95.6%	96.0%	93.1%	98.3%	95.0%	94.5%	92.8%	94.1%	93.6%	92.6%	97.2%	95.3%	95.0%		>=95 % N/A <95 %
Average LoS - Elective (Days)	3.40	2.94	3.05	2.90	3.06	2.89	3.33	4.06	3.54	3.22	3.17	3.23	2.50		No Threshold
Average LoS - Non-Elective (Days)	1.60	1.51	1.65	1.49	1.63	1.39	1.41	1.50	1.75	1.57	1.50	1.52	1.55		No Threshold
Theatre Utilisation - % of Session Utilised	83.6%	84.6%	76.9%	81.8%	82.0%	81.5%	79.6%	82.5%	79.9%	80.6%	83.5%	75.4%	75.7%		>=90 % >=80 % <80 %
Clinic Session Utilisation	87.1%	84.8%	87.1%	87.1%	86.6%	86.9%	88.5%	86.5%	88.0%	89.1%	87.0%	87.0%	85.0%		>=90 % >=80 % <85 %
Referrals Received (Total)	2,030	1,884	1,876	1,599	1,604	1,805	1,880	1,518	1,879	1,834	1,944	1,802	1,891		No Threshold
OP Appointments Cancelled by Hospital %	11.5%	13.7%	14.8%	13.7%	13.6%	14.3%	13.5%	15.3%	15.3%	18.0%	17.9%	14.3%	15.5%		<=5 % <=10 % >10 %
Hospital Acquired Organisms - MRSA (BSI)	0	0	0	0	0	0	1	0	2	0	0	0	0		0 N/A >0
Hospital Acquired Organisms - C.difficile	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Coding average comorbidities	3.15	2.97	3.14	3.05	3.57	3.43	3.42	3.92	3.86	3.49	3.34	3.52	3.27		No Threshold

RESPONSIVE

	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Last 12 Months	RAG
RTT: Open Pathway: % Waiting within 18 Weeks	94.5%	94.0%	93.6%	93.3%	94.2%	92.7%	91.2%	92.6%	92.9%	93.0%	89.8%	90.0%	90.2%		>=92 % >=90 % <90 %
Diagnostics: % Completed Within 6 Weeks	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.8%	100.0%	99.8%	99.8%		>=99 % N/A <99 %

WELL LED

	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Last 12 Months	RAG
PDR	15.4%	41.3%	73.8%	79.7%	82.2%	84.0%	85.0%	84.0%	84.0%	81.5%	81.5%	2.2%	13.4%		No Threshold
Sickness	4.8%	4.3%	4.7%	3.8%	4.1%	5.0%	5.3%	5.1%	5.6%	4.9%	4.3%	3.7%	4.1%		<=4.5 % <=5 % >5 %
Mandatory Training	80.0%	80.5%	79.0%	78.3%	75.7%	77.3%	82.2%	86.6%	88.9%	94.7%	93.8%	92.7%	92.8%		>=90 % >=80 % <80 %
Temporary Spend ('000s)	322	222	323	326	250	186	242	207	211	276	316	246	276		No Threshold
Control Total In Month Variance (£'000s)	-72	-370	-649	155	-21	-464	529	-52	611	461		127	122		>=0% >=-20% <-20%

Surgery

CARING

	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Last 12 Months	RAG
Complaints	2	1	1	2	2	3	0	2	2	3	2	1	2		No Threshold
PALS	18	30	31	14	30	21	25	16	26	24	20	25	35		No Threshold

EFFECTIVE

	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Last 12 Months	RAG
Average LoS - Elective (Days)	3.57	2.57	3.10	2.91	3.03	2.36	2.76	3.30	2.62	2.88	3.14	2.40	3.04		No Threshold
Average LoS - Non-Elective (Days)	3.06	2.57	2.86	2.96	2.74	2.90	3.17	3.18	2.67	2.89	3.31	2.63	2.76		No Threshold
Theatre Utilisation - % of Session Utilised	88.0%	88.9%	87.7%	88.6%	87.3%	87.3%	85.2%	86.6%	88.3%	86.4%	86.8%	90.2%	90.5%		>=90 % >=80 % <80 %
Clinic Session Utilisation	86.0%	85.9%	86.2%	84.8%	83.2%	85.2%	87.0%	82.9%	86.2%	83.6%	85.1%	84.2%	85.0%		>=90 % >=80 % <85 %
Referrals Received (Total)	4,125	4,093	3,522	3,407	3,427	3,515	3,528	2,664	3,338	3,486	3,674	3,754	4,022		No Threshold
OP Appointments Cancelled by Hospital %	11.2%	12.7%	12.0%	12.8%	11.8%	12.3%	13.2%	13.2%	12.9%	14.0%	12.7%	11.1%	12.5%		<=5 % <=10 % >10 %
Hospital Acquired Organisms - MRSA (BSI)	0	0	0	0	0	1	0	0	0	0	0	0	0		0 N/A >0
Hospital Acquired Organisms - C.difficile	0	0	0	0	0	0	0	0	0	0	1	0	0		0 N/A >0
Coding average comorbidities	3.32	3.18	3.18	3.11	3.18	3.13	3.18	3.06	2.99	3.18	3.24	3.11	3.31		No Threshold

RESPONSIVE

	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Last 12 Months	RAG
RTT: Open Pathway: % Waiting within 18 Weeks	90.8%	91.3%	91.2%	91.2%	90.9%	91.6%	92.0%	91.3%	91.4%	91.3%	92.6%	92.3%	92.5%		>=92 % >=90 % <90 %
Diagnostics: % Completed Within 6 Weeks	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	95.0%	100.0%	92.6%	94.7%	100.0%	100.0%		>=99 % N/A <99 %

WELL LED

	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Last 12 Months	RAG
PDR	11.2%	63.0%	87.6%	91.1%	90.1%	89.5%	88.1%	89.5%	89.5%	83.3%	83.3%	1.1%	10.0%		No Threshold
Sickness	4.4%	4.7%	4.7%	4.7%	4.6%	5.1%	4.8%	6.0%	6.3%	4.9%	4.0%	4.3%	4.7%		<=4.5 % <=5 % >5 %
Mandatory Training	80.7%	81.5%	79.1%	77.0%	73.0%	73.8%	80.9%	85.8%	89.3%	93.5%	91.5%	90.2%	89.9%		>=90 % >=80 % <80 %
Temporary Spend ('000s)	402	456	511	554	429	479	383	331	408	434	514	468	420		No Threshold
Control Total In Month Variance (£'000s)	157	650	82	532	-167	-506	-610	-489	-634	-715		-167	32		>=0% >=-20% <-20%

Community

CARING

	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Last 12 Months	RAG
Complaints	1	0	0	0	1	3	1	1	3	2	0	2	2		No Threshold
PALS	23	23	18	13	35	28	28	14	33	50	33	32	28		No Threshold

EFFECTIVE

	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Last 12 Months	RAG
Clinic Session Utilisation	81.8%	79.6%	79.1%	76.9%	79.9%	83.1%	80.4%	73.1%	77.7%	75.9%	71.8%	75.0%	75.1%		>=90 % >=85 % <85 %
Referrals Received (Total)	1,224	1,073	975	807	878	1,228	1,122	972	1,147	1,029	997	851	1,067		No Threshold
OP Appointments Cancelled by Hospital %	14.5%	18.8%	13.3%	17.1%	15.9%	15.1%	16.7%	17.0%	12.3%	13.5%	17.4%	16.4%	10.9%		<=5 % <=10 % >10 %
Coding average comorbidities	6.00			4.50	2.00	3.00	3.50		5.00		3.33	5.00	2.33		No Threshold

RESPONSIVE

	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Last 12 Months	RAG
RTT: Open Pathway: % Waiting within 18 Weeks	97.4%	94.3%	94.6%	96.5%	96.1%	96.3%	96.8%	97.3%	97.3%	96.5%	96.7%	97.1%	96.1%		>=92 % >=90 % <90 %
CAMHS: Avg Wait from referral to Partnership Appt (Weeks)- Liverpool Specialist	13.00	18.00	13.00	18.00	20.00	15.00	19.00	13.00	18.00	13.00	13.00	15.00	15.00		No Threshold
CAMHS: Avg Wait from referral to Partnership Appt (Weeks)- Sefton Specialist	16.00	18.00	18.00	17.00	27.00	26.00	24.00	27.00	25.00	30.00	25.00	19.00	13.00		No Threshold
CAMHS: 2 Appointments within 6 weeks	0	0	0	0	0	0	0	0	0	0	0				No Threshold
Routine Eating Disorders (EDYS) Pathway Average Wait in Days	5.00	15.00	1.00	23.00	14.00	11.00	11.00	13.00	18.00	17.00	28.00	25.20	23.00		No Threshold
Urgent Eating Disorders (EDYS) Pathway Average Wait in Days	0.00	7.00	0.00	0.00	1.00	4.00	5.00	3.00	7.00	5.00	0.00	11.90	13.00		No Threshold

WELL LED

	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Last 12 Months	RAG
PDR	5.7%	26.5%	71.0%	82.8%	87.4%	90.4%	88.8%	90.4%	90.4%	83.9%	83.9%	0.4%	9.3%		No Threshold
Sickness	5.6%	5.7%	6.4%	6.3%	7.0%	5.8%	5.6%	6.7%	6.0%	5.7%	5.9%	4.6%	5.1%		<=4.5 % <=5 % >5 %
Mandatory Training	56.1%	55.2%	74.5%	75.3%	74.6%	75.1%	80.3%	86.7%	89.8%	96.8%	95.7%	95.4%	95.0%		>=90 % >=80 % <80 %
Temporary Spend ('000s)	103	116	146	169	195	141	167	131	146	136	202	166	180		No Threshold
Control Total In Month Variance (£'000s)	95	6	-69	-136	-55	-64	-72	-86	-161	43		-108	-70		>=0% >=-20% <-20%

BOARD OF DIRECTORS

Tuesday, 3 July 2018

Report of	Director of Corporate Affairs
Paper prepared by	Executive Team, Clinical Risk Manager
Subject/Title	2018/19 Board Assurance Framework Update (June 2018)
Background papers	Monthly BAF updates/reports
Purpose of Paper	To provide the Board with the BAF update report
Action/Decision required	The Board is asked to discuss and note the changes to the Board Assurance Framework – June position.
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	➢ Delivery of outstanding care ➢ The best people doing their best work ➢ Sustainability through external partnerships ➢ Game-changing research & innovation
Resource Impact	Non achievement of the Trust's objectives could have a negative impact on the services provided by the Trust.

Board Assurance Framework 2018/19

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.

BAF Risk Register - Overview at 2 July 2018
3.4: Financial Environment (S) 1.3: New Hospital Environment (W)
3.2: Business Development and Growth. (S) 3.3: Developing the Paediatric Service Offer (S)
4.2: IT Strategic Development (S) 2.3: Workforce Diversity & Inclusion (S)
3.1: Failure to fully realise the Trust's Vision for the Park (S) 4.1: Research, Education & Innovation (S)
1.2: Achievement of national and local mandatory & compliance standards (W)
1.1: Achievement of Outstanding Quality for Children and Young People as defined by the Care Quality Commission (CQC) regula (S)
2.2: Staff Engagement (S) 2.1: Workforce Sustainability (S)

Ref, Owner	Risk Title	Risk Rating: I x L		Monthly Trend	
		Current	Target	Last	Now
STRATEGIC PILLAR: Delivery of Outstanding Care					
1.1 HG	**Achievement of outstanding quality for children and young people**	3-3	2-2	STATIC	STATIC
1.2 ES	**Mandatory & Compliance Standards**	3-3	4-1	STATIC	WORSE
1.3 DP	**New Hospital Environment**	4-4	4-2	STATIC	WORSE
STRATEGIC PILLAR: The Best People Doing Their Best Work					
2.1 MS	**Workforce Sustainability & Capability**	3-3	3-2	STATIC	STATIC
2.2 MS	**Staff Engagement**	3-3	3-1	STATIC	STATIC
2.3 MS	**Workforce Diversity & Inclusion**	3-3	3-1	STATIC	STATIC
STRATEGIC PILLAR: Sustainability Through External Partnerships					
3.1 DP	**Failure to fully realise the Trust's Vision for the Park**	3-3	3-2	STATIC	STATIC
3.2 MB	**Business Development & Growth**	4-3	4-2	STATIC	STATIC
3.3 MB	**Developing the Paediatric Service Offer**	4-3	4-2	STATIC	STATIC
3.4 JG	**Financial Environment**	4-4	4-3	STATIC	STATIC
STRATEGIC PILLAR: Game-Changing Research And Innovation					
4.1 DP	**Research, Education & Innovation**	3-3	3-2	STATIC	STATIC
4.2 JG	**IT Strategic Development**	3-4	3-3	STATIC	STATIC

Changes since 22 May 2018 Board meeting

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

External risks

- ***Business development and growth (MB)***
  Clinical sustainability strategy to be finalised at Board meeting on 3rd July.

- ***Mandatory and compliance standards (ES)***
  All external mandatory targets met; focus required to ensure elective programme remains on track given demand pressures.

- ***Developing the Paediatric Service Offer (MB)***
  CEO now chair of Children's Transformation Board; Single Neonatal Service model moving to implementation phase.

Internal risks:

- ***New Hospital Environment (DP)***
  Consolidated report in production; review meeting with Project Co and refresh of action plan. Outcome to be reported 24/07/2018

- ***Achievement of Outstanding Quality for Children and Young People as defined by the CQC regulations (HG).***
  Refresh of risk assessment and revision of actions to reflect current gaps including CQC action plan to address compliance gaps identified in CQC inspection report published June 2018, and inclusion of identified relevant high risks on the agenda for Clinical Quality Assurance Committee.

- ***Financial Environment (JG)***
  Key risks highlighted as delivery of CiP (£2.5m gap), elective run rates/winter plan delivery and other emerging cost pressures. Total Divisional risk equates to c£8m and will be through divisional recovery supported by an effective winter plan and identification of non-recurrent measures. Mitigation plan to be tracked through RABD.

- ***Failure to fully realise the Trust's Vision for the Park (DP)***
  2nd round of user meetings on Community Cluster. Commissioning Programme for Institute under way. Implemented bi-weekly control group meetings on the Institute commissioning.

- ***IT Strategic Development (JG)***
  Replacement underlying infrastructure ordered; excellent feedback from NHSE on benefits realisation.

- ***Workforce Sustainability & Capability (MS)***
  Conversations with Divisions re workforce planning have been completed and actions identified to support. Funding secured from HEENW to support CPD requirements.

- ***Staff Engagement (MS)***
  Review and revision of BAF risk assessment, additional actions added including development of Communication Strategy and Plan and Leadership Strategy.

- ***Workforce Diversity & Inclusion (MS)***
  BAF risk assessment reviewed and revised to reflect current position. Comprehensive diversity and inclusion action plan developed and presented to Board for approval.

- ***Research, Education & Innovation (DP)***
  Innovation Refresh 2nd session.

Erica Saunders
Director of Corporate Affairs
2 July 2018

Board Assurance Framework 2018-19

BAF 1.1	**Strategic Objective:** Delivery Of Outstanding Care		Risk Title: Achievement of Outstanding Quality for Children and Young People as defined by the Care Quality Commission (CQC) regulations.		
Related CQC Themes: Safe, Caring, Effective, Responsive, Well Led					
Exec Lead: Hilda Gwilliams		**Type:** Internal, Known	Current IxL: 3-3	Target IxL: 2-2	Trend: STATIC

Risk Description

Not having sufficiently robust, clear governance systems and processes and people in place supported by the expected culture and values that underpin learning for improvement

Existing Control Measures

• 1. Quality impact assessment completed for all planned changes (NHSe). Change programme assurance reports monthly	• 2. Risk registers including corporate register inform Board assurance.
• 3. Quality section of Corporate Report including incidents, complaints, infection control including sepsis, friends and family test, best in acute care, best in surgical care, performance managed at Clinical Quality Assurance Committee and Trust Board.	• 4. Division and Corporate Quality & Safety Dashboards in place and monitored consistently via performance framework. This includes safety thermometer i.e. infections, falls, pressure ulcers, medication, workforce 'Hard Truths', sickness, appraisals, etc.
• 5. Weekly Meeting of Harm monitors incidents, including lessons learned, immediate actions for improvement and sharing Trust wide.	• 6. Programme of quality assurance rounds, developed and implemented across all services, aligned to Care Quality Commission, Key lines of enquiry (KLOE).
• 7. Annual clinical workforce assurance report presented to Board, aligned to Relevant Professional Standards.	•
• 8. Quality Strategy 2016/2021, Quality Improvement Change Programme established - associated workstreams subject to sub-committee assurance reporting.	• 9. Governance including risk processes from Ward to Board, linked to NHSI Single Oversight Framework
•	• 10. Acute Provider Infection Prevention and Control framework and associated dashboards and action plans for improvement.
• 11. Internal Nursing pool established and funded	• 12. Nursing leadership in alignment with Royal College of Nursing and Midwifery Standards.
• 13. Annual Patient Survey reports and associated action plans	• 14. Trust policies underpinning expected standards
• 15. CQC regulation compliance	

Assurance Evidence	Gaps in Controls/Assurance
1. Annual QIA assurance report and change programme assurance report 2. Risk assessments etc and associated risks monitored via the Integrated Governance Committee. Trust Board informed via Integrated Governance Committee minutes. Divisional Integrated Governance Committee minutes. 3. Clinical Quality Assurance Committee, Trust Board and Divisional Governance minutes 4. Corporate report/quality section, Trust Board and Divisional Quality Board minutes. 5. Minutes from Trust Board, Clinical Quality Assurance Committee, Executive Committee, Weekly meeting of harm group, Clinical Quality Steering Group, Divisional Integrated Governance Committees. Also MIAA audit report. 6. Reports and minutes from Clinical Quality Assurance Committee and Divisional Integrated Governance Committees. 7. Annual Medical Appraisal Report and Nurse staffing report to Trust Board biannually and associated minutes. 8. Board and sub-board committees minutes and associated reports. 9. TO BE ADDED 10. IPC action plan and Trust Board, Clinical Quality Assurance Committee, Integrated Governance Committee, Divisional Quality Board minutes. 11. Nursing Workforce report and associated Board minutes. 12. Nursing Workforce report and associated Board minutes. 13. Patient survey reports and associated action plans, Trust Board, Clinical Quality Steering Group, Workforce and Organisational Development Committee, Divisional Quality Board minutes. 14. Audit committee reports and minutes. 15. CQC action plan monitoring via Board and sub board committees	2. High risks reporting to Clinical Quality Assurance Committee and Divisional Integrated Governance Committee minutes do not provide assurance of monitoring and risk reduction. 15. CQC action plan in development, in response to the findings from the CQC inspection report June 2018.

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Executive lead to agree with Chairperson of committee and Director of Corporate Affairs process for review and challenge at the Clinical Quality Assurance Committee	
Robust action plan to be developed, implemented and monitored via the Trust Board, Board subcommittees and individual services.	

Executive Lead's Assessment
Refresh of risk assessment and revision of actions to reflect current gaps, including CQC action plan to address compliance gaps identified in CQC inspection report published June 2018, and inclusion of identified relevant high risks on the agenda for Clinical Quality Assurance Committee.

Board Assurance Framework 2018-19

BAF 1.2	Strategic Objective: Delivery Of Outstanding Care		Risk Title: Achievement of national and local mandatory & compliance standards		
Related CQC Themes: Safe, Caring, Responsive, Well Led, Effective					
Exec Lead: Erica Saunders		Type: Internal, Known	Current IxL: 3-3	Target IxL: 4-1	Trend: WORSE

Risk Description

Failure to meet targets and internal performance metrics due to poor flow and lack of capacity to fulfil activity plans and respond to increasing demand

Existing Control Measures

• Operational Delivery Board taking action to resolve performance issues as they emerge	• Emergency Planning & Resilience meetings in pace
• Divisional Executive Review Meetings taking place monthly with 'three at the top'	• Regulatory status with: NHSI, CQC,NHSLA, ICO, HSE, CPA, HTA,MHRA etc.
• Compliance tracked through the corporate report and Divisional Dashboards.	• Risks to delivery addressed through Operational Board, RBD, CQAC, WOD, IGC & CQSG and then through to Board
• Early Warning indicators now in place	• Weekly performance meetings in place to track progress
• 6 weekly meetings with commissioners (CQPG)	• Divisional leadership structure to implement and embed clinically led services
• Weekly Exec Comm Cell overseeing key operational issues and blockages.	• Refresh of Corporate Report undertaken for 2018/19

Assurance Evidence	Gaps in Controls/Assurance
Regular reporting of delivery against compliance targets through assurance committees & Board. Monthly reporting to the Board via the Corporate Report. NHSI quality concern rating Operational effectiveness measures (key risks with early warning measures) to RABD Compliance assessment against NHSI Provider Licence to Board Divisional/Executive performance reviews Exceptions discussed / resolved at Ops Board Quarterly review meeting and report to NHSI	Critical Care bed capacity Some areas remain fragile e.g. ED 4 hour target. Assurance required to underpin Divisional reporting on CQC standards Work with CCG to manage demand & develop / fully utilise existing capacity across PC Proactive management of patient flow making better use of trend analysis data

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Monitor the use of surgical beds to ensure full activity plan delivered	Elective programme being monitored on a weekly basis however significant pressure from NEL orthopaedic cases experienced during June has proved challenging.
ED plan for March approved at Operational Board in February based on additional medical shifts in ED, additional specialty doctor cover and to staff the four additional beds in ED.	ED target met for March 2018
Plans to ensure performance sustained across the year need to be embedded and maintained	Review of hospital flow underway
New model to deliver required number of CCAD cases agreed at Board on 22/5/18. COO to lead implementation.	

Executive Lead's Assessment

APRIL 2018: All compliance targets achieved at end of April. Trust is projecting a financial risk rating of 1. No governance concerns
MAY 2018: No compliance concerns at this stage in the month
JUNE 2018: All external mandatory targets met; focus required to ensure elective programme remains on track given demand pressures

Board Assurance Framework 2018-19

BAF 1.3	**Strategic Objective:** Delivery Of Outstanding Care		Risk Title: New Hospital Environment		
Related CQC Themes: Safe					
Exec Lead: David Powell		**Type:** Internal, New	Current IxL: 4-4	Target IxL: 4-2	Trend: WORSE

Risk Description

Sale of PFI Project co. whilst a number of commissioning risks are still present could lead to lack of focus and problems in maintaining safe environment

Existing Control Measures

• Monthly issue meetings	• Monthly liaison meetings
• Regular reports to IGC	• Liaison minutes reported to Trust Board monthly
• Building Management Services Risk Register	

Assurance Evidence	Gaps in Controls/Assurance
Maintenance of Issues List Issues Review Meeting Escalation to Liaison meeting Red Button escalation mechanism Help Desk monitoring reports	Some repeat/overlap reporting Some lack of clarity over risk ownership/H&S role

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Replacement programme for pipe work to be agreed with builder	Cost obtained for replacement programme
COO updating Action Plan to address key water safety issues	
Interserve developing water safety action plan	
Whole Hospital review of fire stopping	
Review of various risk elements and consolidation into single report with external validation.	

Executive Lead's Assessment

APRIL 2018: Clutch of commissioning issues still to be resolved including pipework corrosion, water temperatures, delay in achieving operating theatre temperature control. Are currently under review with some attendant action plans still requiring completion.
Next steps-complete reviews and agree all action plans for outstanding issues.
MAY 2018: Interim report on Pipework received. Commercial plan meeting in diary for June. Fire-stopping review under way
JUNE 2018: Consolidated report in production; review meeting with Project Co and refresh of action plan. Outcome to be reported 24/07/2018

Board Assurance Framework 2018-19

BAF 2.1	**Strategic Objective:** The Best People Doing Their Best Work	Risk Title: Workforce Sustainability		
Related CQC Themes: Safe, Effective, Responsive, Well Led, Well Led, Well				
Exec Lead: Melissa Swindell	**Type:** Internal, Known	Current IxL: 3-3	Target IxL: 3-2	Trend: STATIC

Risk Description
Failure to deliver consistent, high quality patient centred services due to not having the right people, with the right skills and knowledge, in the right place, at the right time.

Existing Control Measures	
• Workforce KPIs tracked through the corporate report and divisional dashboards	• Bi-monthly Divisional Performance Meetings.
• Mandatory training fully reviewed in 2017, with a new system of reporting linked to competencies on ESR; enabling better quality reporting.	• Mandatory training mapped to Core Skills Framework. Online portal enables all staff to see their compliance on their chosen IT device.
• Permanent nurse staffing pool	• HR Workforce Policies
• Attendance management process to reduce short & long term absence	• Wellbeing Steering Group established
• Large-scale nurse recruitment event 4 times per year	• Training Needs Analysis linked to CPD requirements
• Apprenticeship Strategy implemented	• Engaged in pre-employment programmes with local job centres to support supply routes
• Engagement with HEENW in support of new role development	• People Strategy

Assurance Evidence	Gaps in Controls/Assurance
Regular reporting of delivery against compliance targets via corporate & divisional reports Monthly reporting to the Board via the Corporate Report Reporting at ward level which supports Ward to Board Reporting to HEE People Strategy report monthly to Board Programme Board reporting	Not meeting compliance target in relation to mandatory training in some areas Sickness Absence levels higher than target. Lack of standard methodology to workforce planning across the organisation

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Undertake review of recruitment methods to support Community Division in recruiting hard to reach posts	
Undertaking a sickness absence review in 2018Working with Trade Unions to refresh the policy, understand further the drivers for high sickness absence	
ensure a minimum of 50 learners enrolled on apprenticeship pathways.	
Training required for HR Business Partners and Advisers in workforce planning methodologies	
L&D to undertake full review of mandatory training; comms, process and quality. See date for progress update.	

Executive Lead's Assessment
JULY 2018: Full review of BAF risk assessment and update of actions including mandatory training, workforce planning training, sickness absence and recruitment in Community.

Board Assurance Framework 2018-19

BAF 2.2	**Strategic Objective:** The Best People Doing Their Best Work		Risk Title: Staff Engagement		
Related CQC Themes: Safe, Effective, Responsive, Well Led					
Exec Lead: Melissa Swindell		**Type:** Internal, Known	Current IxL: 3-3	Target IxL: 3-1	Trend: STATIC

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

Existing Control Measures	
• People Strategy	• Wellbeing Strategy implementation
• Action Plans for Staff Survey	• Values and Behaviours Framework
• Staff Temperature Check Reports to Board (quarterly)	• Values based PDR process
• People Strategy Reports to Board (monthly)	• Listening into Action Guidance and Programme of work
• Staff surveys analysed and followed up (shows improvement)	• Reward and recognition schemes in place: Annual Awards, Star of the Month and quarterly Long Service Recognition Event, Annual Fab Staff Change Week.
•	• BME and Disability Staff Networks

Assurance Evidence	**Gaps in Controls/Assurance**
Monthly People Strategy Report to Board Outcomes from Annual Staff Survey reported to the Board. Staff Survey local departmental conversations PDR completion rates Values and Behaviours Framework Quarterly Engagement Temperature Check reported to the Board. Quarterly Engagement Temperature Check local data sent to Divisions on a quarterly basis to enable them to analyse data locally. Ongoing consultation and information sharing with staff side and LNC Progress reports from LiA to Board Wellbeing Strategy progress reported to WOD Board/sub-Board Committee minutes Minutes of Staff Networks	Internal Communications Strategy and Plan Refreshed Leadership Strategy

Actions Required to Reduce Risk to Target Rating	**Latest Progress on Actions**
L&D manager to undertake a review of the methodology, with a view to launching new system in June 18	
Group to be established and to roll-out the approach to HWB across the organisation	
Requirement to provide the internal Comms strategy and plan. Please note expected date for completion.	
Further to previous action email, please provide progress update.	
Please prepare outline strategy for discussion at away day on the 9th July 18.	
Further to last action email, complete strategy by end July.	

Executive Lead's Assessment
JUNE 2018: Review and revision of BAF risk assessment, additional actions added including development of Communication Strategy and Plan and Leadership Strategy.

Board Assurance Framework 2018-19

BAF 2.3	**Strategic Objective:** The Best People Doing Their Best Work	Risk Title: Workforce Diversity & Inclusion		
Related CQC Themes: Well Led, Effective				
Exec Lead: Melissa Swindell	**Type:** Internal, Known	Current IxL: 3-4	Target IxL: 3-1	Trend: STATIC

Risk Description

Failure to proactively develop a future workforce that reflects the diversity of the local population, and provide equal opportunities for career development and growth for existing staff.

Existing Control Measures

• Wellbeing Strategy	• WOD Committee ToR includes duties around diversity and inclusion, and requirements for regular reporting.
• Wellbeing Steering Group	• Staff Survey results analysed by protected characteristics and actions taken by E&D Lead.
• HR Workforce Policies	• Equality Analysis Policy
• Equality, Diversity & Human Rights Policy	• BME Network established, sponsored by Director of HR & OD
• Disability Network established, sponsored by Director of HR & OD	• Actions taken in response to the WRES
• Action plan specifically in response to increasing the diversity of the workforce, and improving the experience of BME staff who work at Alder Hey	•
•	•

Assurance Evidence	Gaps in Controls/Assurance
Monthly recruitment reports provided by HR to divisions Diversity and Inclusion Action Plan reported to Board Bi-monthly reporting to Board via WOD on diversity and inclusion issues Monthly Corporate Report (including workforce KPIs) to the Board Taking forward actions for LiA - enabling achievement of a more inclusive culture Equality Impact Assessments undertaken for every policy & project Workforce Race Equality Standards EDS Publication Equality Objectives	LGBTQ Network not yet in place

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Establish LGBTQ network	No progress due to capacity issues. Revised timeline for completion.

Executive Lead's Assessment

JULY 2018: BAF risk assessment reviewed and revised to reflect current position. comprehensive diversity and inclusion action plan developed and presented to Board for approval.

Board Assurance Framework 2018-19

BAF 3.1	**Strategic Objective:** Sustainability Through External Partnerships		Risk Title: Failure to fully realise the Trust's Vision for the Park		
Related CQC Themes: Responsive, Well Led					
Exec Lead: David Powell		**Type:** Internal, Known	Current IxL: 3-3	Target IxL: 3-2	Trend: STATIC

Risk Description

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

Existing Control Measures

• Business Cases developed for various elements of the Park & Campus	• Monitoring reports on progress
• Heads of Terms agreed with LCC for joint venture approved	• Redevelopment Steering Group
• Monthly reports to Board & RABD	

Assurance Evidence	Gaps in Controls/Assurance
Approved Business Cases for various elements of the Park & Campus approved Every Project has a dedicated Project Manager assigned to it End user consultation events held Highlight reports to relevant assurance committees and through to Board Stakeholder events held/reported back to Trust Board Representation at Friends of Springfield Park Group Monthly Board report	Fully reconciled budget with Plan. Risk quantification around the development projects.

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Secure approval for plans to increase Park footprint	Consultation held with local residents regarding plans to expand Park
Approval of Business Case at LCC / Discuss park Heads of Terms with LCC	On hold-Dependent upon residential scheme (revised target date no April 2018)

Executive Lead's Assessment

APRIL 2018: New Park manager appointed
MAY 2018: Meeting arranged with Friends of Springfield Park to agree 1st park extension.
JUNE 2018: 2nd round of user meetings on Community Cluster. Commissioning Programme for Institute under way. Implemented bi-weekly control group meetings on the Institute commissioning

Board Assurance Framework 2018-19

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

Risk Description

Risk to business development/growth due to NHS financial environment and constraints on internal infrastructure to deliver business as usual as well as maximise growth opportunities. External opportunities for partnership may not be fully optimised

Existing Control Measures

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

Assurance Evidence	Gaps in Controls/Assurance
Marketing and Business Development Committee is being refreshed as a Growth Through Sustainable Partnerships Group. First meeting planned July 2018 . Business Development Plan reviewed monthly by RBDC via Contract Monitoring Report. Daily activity tracker and forecast monitoring performance for all activity. CIPs in new Change Programme subject to assurance and sub-committee performance management	Ability to respond swiftly to potential problems. Workforce constraints in specialised services. Early warning indicators for leading indicators. Potential delay to cardiac growth - current gap c. £0.8m forecast against 16/17 CIP target Growth through Partnerships to be included as part of Strategic elements of business planning in the next planning cycle

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Development of the international agenda	
Operational Business Planning underway - to contain forecasts regarding growth opportunities	

Executive Lead's Assessment

APRIL 2018. Final Clinical and Sustainability Strategy to July Board.
MAY 2018: Detailed discussion at Execs (17 May). Further work up of detailed proposals for 18/19 to be completed by end of June and for July Trust Board.
JUNE 2018: Clinical sustainability strategy to be finalised at Board meeting on 3rd July.

Board Assurance Framework 2018-19

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

Risk Description
Failure to maximise opportunities for working with key partners to develop children's services across the City region and beyond

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

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

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Delivery of a refreshed clinical and sustainability strategy	The refreshed Strategy will now be finalised by the Board on 3rd July
Development of a single neonatal service business case across Alder Hey & LWH	Governance model developed and agreed by both trusts and NHS England including delivery model and work streams. MoU drafted and due to be approved by both boards in July 2018.
CHD Liverpool partnership - development of Level 1 status for adult congenital heart disease across North West / NW / Wales and Isle of Man, bringing together a partnership across 4 Liverpool providers. Partnership achieved November 2017.	
Strengthening the paediatric workforce	6 monthly audit of 7-day standards is subject to external scrutiny. Global Digital Excellence has improved measurement capability. Adrian Hughes is now leading as one of the top 5 Operational Priorities known as 'New Models of Care'. In addition, junior doctor numbers were bolstered during the winter which improved cover and consultant arrangements.
Agreement of key partnerships for sustainability 2018/19 achieved on 30th November 2017. Actions now in planning and delivery phase, with Executive Oversight provided by the CEO Oversight Group, and planning delivery through the joint CHIG Group. Delivery will take up to two years.	

Executive Lead's Assessment
APRIL 2018: Trust Board Workshop to be scheduled for June 2018 to consider growth and sustainability scenarios to inform clinical and sustainability strategy. MAY 2018: Workshop held on 17 May and next steps agreed JUNE 2018: CEO now chair of Children's Transformation Board; Single Neonatal Service model moving to implementation phase.

Board Assurance Framework 2018-19

BAF 3.4	**Strategic Objective:** Sustainability Through External Partnerships	Risk Title: Financial Environment	
Related CQC Themes: Safe, Effective, Responsive, Well Led			
Exec Lead: John Grinnell	**Type:** Internal, Known	Current IxL: 4-4	Target IxL: 4-3	Trend: STATIC

Risk Description

Failure to deliver Trust control total and financial risk rating

Existing Control Measures

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

Assurance Evidence	Gaps in Controls/Assurance
Monthly Corporate Performance Report presented to both Board and the RABD. Specific Reports (i.e. NHSI Plan Review by RABD) Monthly Performance Management Reporting with General Managers. Internal and External Audit reporting through Audit Committee. Daily activity tracker to support divisional performance management of activity delivery Pay cost control 10 point plan introduced aimed at forecasting and tracking actions to reduce pay cost overspend run rate - updates to Execs, R&BD. Full electronic access to budgets & specialty performance results Weekly Financial Sustainability delivery meeting papers	Divisions improved financial control and effective recovery required in identified where slippage against agreed recovery trajectories occurring Ongoing cost of temporary staff Divisional recovery plans to hit yearend financial control targets to ensure delivery of overall Trust financial plan. 'Grip' on CIP Recovery Plan still demonstrating £2M gap although mitigating close gap consolidated Conclude commissioner year-end discussions

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Tracking actions from Financial Recovery Board	on target
Conclude Sefton CCG contract negotiaitions	Base contract agreed. Discussions on-going regarding targeted investment in the community / CMAHS services
Develop fully worked up CIP programme	Reviewed at financial sustainability group 2.7.18 Further work to take place as part of Q1 review and in July. Review again at expected completion date

Executive Lead's Assessment

JUNE 2018: Key risks highlighted as delivery of CiP (£2.5m gap), elective run rates/winter plan delivery and other emerging cost pressures. Total Divisional risk equates to c£8m and will be through divisional recovery supported by an effective winter plan and identification of non-recurrent measures. Mitigation plan to be tracked through RABD

Board Assurance Framework 2018-19

BAF 4.1	**Strategic Objective:** Game-Changing Research And Innovation		Risk Title: Research, Education & Innovation		
Related CQC Themes: Responsive, Well Led					
Exec Lead: David Powell		**Type:** Internal, Known	Current IxL: 3-3	Target IxL: 3-2	Trend: STATIC

Risk Description
Failure to exploit new opportunities in research, innovation & education due to incomplete management systems.

Existing Control Measures	
• Establishment of RIE Board Sub-committee	• Steering Board reporting through to Trust Board
• RABD review of contractual arrangements	• Programme assurance via regular Programme Board scrutiny
• Digital Exemplar budget completed and reconciled	• Innovation Co budget in place

Assurance Evidence	Gaps in Controls/Assurance
Research Strategy Committee set up as a new Board Assurance Committee Research, Education and Innovation Committee established Secured ERDF funding for Innovation Team Innovation Board established	Sporadic meetings of RIE committee Governance structure for Innovation Board to be agreed Re-energise Research governance processes Reporting frameworks and standards for all services to be agreed/harmonised

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Develop a robust Academy Business Model	Framework refresh
Establish pipeline structure for work-streams (Acorn and Crucible)	Heads of Terms agreed with Crucible. Acorn paperwork received for authorisation
Execute contract for RIE with back to back arrangements with the Charity and HEIs	LJMU Contract now agreed internally
Agree incentivisation framework for staff and teams	

Executive Lead's Assessment
APRIL 2018: REI committee refreshed and re-launched MAY 2018: Revised plan for 2017/18 innovation activity JUNE 2018: Innovation Refresh 2nd session

Board Assurance Framework 2018-19

BAF 4.2	**Strategic Objective:** Game-Changing Research And Innovation		Risk Title: IT Strategic Development		
Related CQC Themes: Safe, Caring, Effective, Responsive, Well Led					
Exec Lead: John Grinnell		**Type:** Internal, Known	Current IxL: 3-4	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	• Monthly update to Trust Board on GDE Programme
• GDE Programme Board in place & fully resourced - Chaired by Medical Director	• Clinical Engagement in IT Roadmap
• NHSE external oversight of GDE programme	• Resilience of underlying infrastructure

Assurance Evidence	Gaps in Controls/Assurance
Regular progress reports presented to RABD and Operational Board & Trust Board MIAA providing assurance role Board agreed change process Participate in Digital Alder Hey programme Internal Audit Reviews NHSE tracking of GDE Programme GDE Programme Board tracking delivery - Chaired by MD	IM&T Strategy out of date - update work in progress to produce Roadmap for September 19 Resilience of underlying infrastructure - currently awaiting replacement

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Replacement equipment procured - awaiting delivery and installation	
IT Roadmap to be concluded	Meeting held with Meditech to agree how we work more effectively going forward and have more onsite presence

Executive Lead's Assessment
APRIL 2018: ImageNow and bed management module key next phases of the programme. Clinical Advisory Group in place supporting these developments. Real progress being made on STP wide intra-operability platform MAY 2018: No material changes to report in-month JUNE 2018: Replacement underlying infrastructure ordered; Excellent feedback from NHSE on benefits realisation

Board of Directors

Report of	The Director of Infection, Prevention & Control on behalf of the Trust's Infection Prevention & Control Committee
Paper prepared by	Steve Ryan, Medical Director & DIPC Valya Weston ADIPC & IPC Service Lead
Subject/Title	2017/18 Annual Report of the Infection Prevention & Control Committee
Background papers	Code of Practice for Health and Adult Social Care on the Prevention and Control of Infections and Related Guidance. 2009 (revised 2015)
Purpose of Paper	• To provide assurance in respect of all the elements contained in the assurance framework. • To highlight achievements • To highlight areas of non-compliance and provide areas for improvement in 2018-19. • To highlight current pressures
Action/Decision required	• That the Board receives and approves the Annual Report of the Infection Prevention & Control Committee
Link to:	IPC Work plan which is mapped to the IPC code and Trust objectives.
Resource Impact	Healthcare associated infections have a financial resource implication for all Trusts. Implementation of the 2018-19 IPC work plan and associated Trust wide action plans will have resource implications; however the aim of these projects is to have a direct impact on the reduction of Healthcare associated infections.

ANNUAL REPORT TO THE TRUST BOARD

PREPARED BY THE ASSOCIATE DIRECTOR OF INFECTION PREVENTION AND CONTROL ON BEHALF OF THE INFECTION PREVENTION & CONTROL COMMITTEE

April 1st 2017- March 31st 2018

Director of Infection Prevention and Control
Dr Steve Ryan

Contributors

Val Weston, *Associate DIPC & IPC Service Lead*
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EXECUTIVE SUMMARY

Work Plan Performance

At the end of Q4 **86%** (71/83) of the total of deliverables have been completed. **14%** (14/83) of the total deliverables are in progress (amber). 0**%** are classified as red. Please see table 1 below for RAG rating.

Reporting Period	No of objectives	No. of deliverables	Red	Amber	Green
Q1	11	76	8% (6)	39% (30)	53% (40)
Q2	11	76	3% (2)	34% (26)	63% (48)
Q3	12	82	1% (1)	28% (23)	71% (58)
Q4	12	83	0% (0)	14% (12)	86% (71)

Figure 1: Objectives RAG rating Q4

Please click the link below for the full work plan.

Work Plan - 201718 - Update 24042018.do

Achievements

- Successful completion of 2017-18 IPC Work Plan.
- Successful incorporation of the Vascular Access and Tissue Viability Teams within the IPC team to create a new Infection Prevention Service.
- Introduction of monthly IPC audits onto wards and departments to target specific IPC issues to ensure that wards and departments have the support and guidance of the IPC team on a regular basis. These audits now replace the yearly IPC audits.
- Implementation of the new IPC dashboards across the Trust. These dashboards are reported monthly to the divisions and are discussed and actioned through the divisional governance structure. Quality leads feedback on their divisional dashboards to the IPCC.
- Introduction of the yearly ANTT assessments for all clinical staff at the Trust.
- Introduction of the aseptic non-touch technique (ANTT) key trainer programme into the Trust.
- Commencement of an Intravenous Access and Therapy group to facilitate and lead a Trust wide multidisciplinary approach to improvements in IV access and therapy. The aim is to provide a forum for collaboration across Directorates and specialities, monitoring quality indicators and facilitating the development of Trust wide Intravenous guidelines and to provide expertise for service improvement.
- Expansion of the Trust wide post infection reviews (PIR) for significant infection from just MRSA bacteraemia and Clostridium Difficile to incorporate all bacteraemia reported to PHE including MSSA, EColi, Klebsiella and pseudomonas.

- This financial year 1579 bed days were saved by the OPAT team which equates to approximately £720,000 saved through early discharge or admission avoidance.

- Continuation of Hand hygiene awareness in PICU. The unit are now consistently scoring over 85%.

- Commencement of the hand hygiene initiative with one of our industry partners to educate and promote hand hygiene with our patients using novel micro-organism stickers and soft toys.

- Rationalisation and evaluation of all cleaning products across the Trust which has lead to implementation of new cleaning products and cleaning procedures across the Trust.

- Successful implementation of a new cleaning process with patient flow and domestic services.

- The IPCT achieved the NHS England flu vaccination target of 75% for front line staff and met the CQUIN target of 70%. We also increased the percentage of non-front line staff vaccinated to 58.6% in 2017-18.

- K Wire surveillance commenced April –September using PHE methodology and reported internally.

- Successful development of links with the wider health economy including:
  - IPC Lead Nurse Network Meetings
  - North Mersey Gram Negative Blood Stream Infection (GNBSI) meetings to assist in the reduction of GNBSI.
  - Infection Prevention Society (IPS) Paediatric Forum- to share best practice/benchmarking and act as a support for other Paediatric staff.
  - North West IV Forum.

1 Introduction

Alder Hey Children's NHS Foundation Trust recognises the obligation placed upon it by the Health Act 2008, (updated 2015) to comply with the Code of Practice for Health and Social care on the prevention and control of infections and related guidance.

The Trust supports the principle that infections should be prevented wherever possible or, where this is not possible, minimised to an irreducible level and that effective systematic arrangements for the surveillance, prevention and control of infection are provided within the Trust.

1.1 Purpose

The Code of Practice (DH 2008) requires Trust boards to receive an annual report from the Director of Infection Prevention and Control and Associate DIPC. The purpose of the annual report is to inform the Trust Board of progress in delivering the Infection Prevention and Control Agenda and to provide assurance that appropriate measures are being taken to prevent and control healthcare associated infections.

1.2 Scope

This report is in relation to the provision of an effective Infection Prevention and Control (IPC) service for Alder Hey Children's NHS Foundation Trust

2 Performance

2.1 *Work Plan Performance*

At the end of Q4 **86%** (71/83) of the total of deliverables have been completed. **14%** (14/83) of the total deliverables are in progress (amber). 0**%** were classified as red. Please see table 1 below for RAG rating.

Reporting Period	No of objectives	No. of deliverables	Red	Amber	Green
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Q4	12	83	0% (0)	14% (12)	86% (71)

Figure 2; Objectives RAG rating Q4

2.2 *Hospital acquired Infections*

The table below show the number of hospital acquired infections for 2017-18 compared to 2015-16 and 2016-17.

	2015-16	2016-17	2017-18
MRSA BSI	***3***	***2***	***4***
MRSA (Non bloodstream)	***8***	***4***	***9***
Cdiff	***2***	***1***	***1***
MSSA	***6***	***13***	***14***
Gram Negative bacteraemia	***11***	***8***	***16****
RSV	***10***	***11***	***10***
Influenza	***8***	***5***	***8***
Rotavirus	***0***	***0***	***0***

Figure 3; Hospital acquired infections

The Trust is obliged to report infections caused by mandatory reportable organism's i.e. Clostridium difficile toxin (CDT) enteritis, E.coli Bloodstream infection (BSI), MRSA BSI, MSSA BSI and from 2017-18 onwards we now also must report Klebsiella bacteraemia infections and also pseudomonas bacteraemia infections.

In 2017-18 the Trust reported 35 hospital acquired infections due to mandatory reportable organisms. This is a rate of 0.58 per 100 bed days. This compares to 24 hospital acquired infections reported in 2016-17 with a rate of 0.37 per 1000 bed days.

*The increase in the incidence of mandatory reportable HAI in 2017-18 was due largely to an increase of mandatory reportable organisms that we are now obliged to report to PHE.

2.2.1 *MRSA Bacteraemia*

There have been **4** hospital acquired cases of MRSA bacteraemia during 2017/18 compared to **2** cases in 2016/2017, 1 in surgery and 3 on the same patient in medicine.

A post infection review (PIR) was conducted for all cases, action plans were developed and implemented and monitored through the Divisional Governance structures and IPCC. The issues considered to play a causative role in the MRSA bacteraemia were as follows:

Case	Identified Lapses in Care	Actions Taken
Case 1 (Surgery)	1. Possible contaminant, however unable to ascertain due to the process used to obtain the Blood culture. 2. Patient colonised with MRSA prior to admission. Patient possibly not screened prior to admission. 3. Central line site not screened on admission. 4. There were identified omissions in the decolonisation procedure for the patient. 5. Lack of documentation around insertion, maintenance and removal of vascular access lines including ANTT.	1. ANTT specialist Nurse to work with PICU to improve blood culture sampling. 2. To encourage staff to establish infection prevention and control risks prior to admission. 3. MRSA screening policy reviewed to include all vascular access site as soon after admission as possible. 4. Educational sessions for staff undertaken in MRSA decolonisation procedures. 5. ANTT Specialist Nurse to work with staff and IV team to review documentation and suggest improvements to ensure documentation is completed.
Case 2 (Medicine)	1. Portacath – unable to ascertain if this was the focal point for the infection – however the skin over the site was previously colonised with MRSA and was red and excoriated prior to the infection and was being accessed for IV Paracetamol analgesia. 2. Patient previously identified as being colonised with MRSA. MRSA also present in PEG site and wound to the ear. 3. Communication/Safeguarding – between the MDT and the parent/grandparents to discuss and agree the most appropriate and safest clinical approach to managing the care of the patient. 4. Meditech System – when undergoing the investigation for this case it emerged that for long stay patients the Meditech system will only allow a certain amount of interventions to be documented	1. MDT meeting convened to discuss the case and to provide guidance on how the Portacath should be utilised in the future. 2. MDT meeting convened to discuss the case and ensure that prescribed decolonisation is being implemented correctly. 3. MDT meeting convened to discuss the case and to provide guidance on the most appropriate and safest clinical approach to managing the care of the patient. 4. This anomaly is to be investigated and rectified by the Meditech team.
Case 3 (Medicine) Same child	Same issues identified as per case 2	MDT meeting took place on 22.01.2018. Results of the meeting were to explore alternative analgesia options along with

Case	Identified Lapses in Care	Actions Taken
as case 2		discussions to take place between parent and Lead Consultant to discuss the potential serious risks of accessing the Portacath going forward.
Case 4 (Medicine) Same child as case 2 and 3	1. To ask the medical teams involved in the patients care to explore alternative analgesia and routes for the analgesia to be administered.	*1.* This has been reviewed by the multi professional team - options were discussed such as modified release morphine and gabapentin. However the patient remains on IV paracetamol and enteral oromorph as despite much discussion by the multi professional team they were unable to get parent to agree to change pain management.
	2. A meeting would be arranged between mum and Lead Consultant to discuss the potential serious risks posed by accessing the Portacath on a regular basis.	2. The Lead Respiratory Consultant discussed this issue with the family in December after episode no 1 but also other colleagues had discussed the risks of ongoing IV access with the family. However the Respiratory Consultant has also repeated this to the family again following the third episode of MRSA bacteraemia.
	3. For the medical teams to discuss the viability of the Portacath and to explore alternative vascular access routes.	3. The Portacath needs to be removed due to the high risk of re infection. However alternative IV access needed to be available. Portacath removed 2/2/18 and alternative vascular access sourced.

Figure 4; Case breakdown

2.2.2 CDIFF

There has been **1** hospital acquired case of *Clostridium difficile* during 2017/18 which is the same as in 2016/17.

A PIR was conducted and after review with Liverpool and East Cheshire CCGs the case was successfully appealed and it was deemed that there had been no lapses in care on behalf of the Trust.

2.2.3 MSSA

Data collected from 2016/17 demonstrated that there had been a 50% increase in the number of hospital acquired MSSA bacteraemia in the Trust. A multi- disciplinary team was set up to examine the reasons for the increase and to develop a Trust wide Action plan to reduce the avoidable incidences of MSSA bacteraemia across the Trust. Please see link below for action plan.

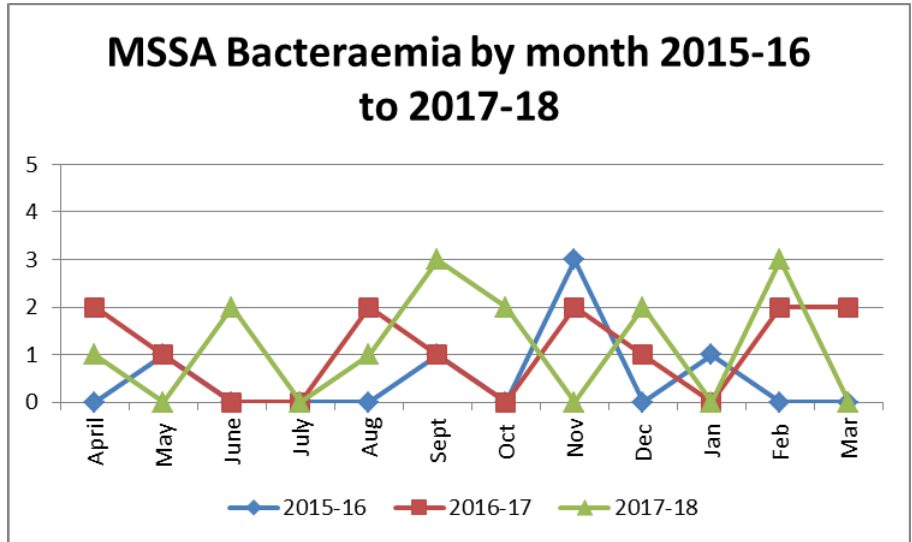


Figure 5; MSSA Bacteraemia Graph

Data collected from 2017/18 has shown 14 hospital acquired MSSA bacteraemia.

2.2.4 Gram Negative Bacteraemia

At the start of April 2017 the mandatory surveillance for Public Health England (PHE) was expanded from just E Coli bacteraemia to include all Klebsiella and Pseudomonas bacteraemia. PIRs have commenced for all these identified Gram Negative bacteraemia and are reviewed via the Post Infection Review panel and will be reported via the Situation Reports through the Divisional Governance structures.

PIR themes are also fed back to the North Mersey Gram Negative Blood Stream Infection Reduction Group as part of the whole Health economy strategy.

2.2.5 Respiratory Syncytial Virus (RSV)

RSV is a highly transmissible seasonal viral respiratory infection predominately seen in the paediatric population. Children require isolation whilst they are symptomatic and high numbers are seen during the winter period. RSV is monitored as part of the Trust local surveillance programme and is a key infection prevention marker for paediatric Trusts.

During 2017/2018 there were **10** cases of hospital acquired RSV compared to **11** in 2016/17.

The table below shows a rate for RSV per 1000 bed days for the Trust, for the winter period 2017/2018. The Trust had a rate of 0.24 per 1000 bed days for hospital acquired RSV for 2017/2018. This has decreased from last year when the Trust rate was 2.7 per 1000 bed days. The rate of 0.24 per 1000 bed days is within limits published in literature but there are no national rates published to be able to benchmark against.

	Total RSV for season	Occupied beds for season	Rate per occupied bed days
14/15 Season	11	38,712	0.28
15/16 Season	10	33,090	0.30
16/17 Season	9	33,092	0.27
17/18 Season	8	33,955	0.24
Season = 1st October - 31st March			

Figure 6; RSV breakdown by year

****Please note the table below shows 8 cases as 2 of the 10 cases for 2017/2018 fell outside the winter period.***

2.2.6 Influenza

During 2017/2018 there have been **8** cases of hospital acquired Influenza compared to **5** in 2016/2017. The table below shows the Trust rate for hospital acquired influenza per 1000 bed days.

The rate for hospital acquired influenza for 2017/2018 was 0.21 per 100 bed days. This has increased from last year when the rate was 0.15. There was an increase in the total number of flu cases from 47 in 2016-17 (Jan-Mar) to 125 cases in 2017-18 (Jan –Mar) and a mismatch between the circulating Flu B virus and the vaccine which may have led to an increase in staff contacting Flu in 2017-18.

	Total Influenza for season	Occupied beds for season	Rate per occupied bed days
14/15 Season	6	38,712	0.15
15/16 Season	8	33,090	0.24
16/17 Season	5	33,092	0.15
17/18 Season	7	33,955	0.21
Season = 1st October - 31st March			

Figure 7; Objectives RAG rating Q4

****Please note the table below shows 7 cases as 1 of the 8 cases for 2017/2018 fell outside the winter period.***

Actions

- A member of the IPC team has undergone the training in Respiratory Protective Equipment Fit Testing/An Introduction at the Health and Safety Executive.
- The uptake of training in FFP3 respiratory face masks for aerosol generating procedures across the Trust needs to be improved. Identification of key trainers for wards/departments should be led by the Divisions and training records should be kept locally and reported to the IPC team.
- Obtaining Quadrivalent Flu vaccine for 2018-19 to provide greater protection for staff from circulating flu strains.

Staff Influenza Vaccination

The campaign ended with the Trust achieving **75.3%** of all frontline staff vaccinated against influenza. These results are consistent with last year’s compliance but the actual numbers of front

line staff vaccinated rose from 1427 in 2016-17 to 1947. There was also an increase in the numbers of non-frontline staff from 31% in 2016-17 to 58.6%.

Group (baseline)	Percentage uptake 2016-17	Baseline	Overall Uptake	Percentage Uptake 2017-18
1-Doctors (ESR)	65%	309	198	64%
1-Junior /Rotation Doctors + medical students	N/A	317	289	81%
2- Nurses(ESR) + student nurses	80%	1271	1030	81%
3- Support to Tech(ESR)	62%	427	257	60.1%
4- Support to clinical(ESR)+trainees	71%	261	173	66%
TOTAL FRONT LINE STAFF UPTAKE	75.4%	2585	1947	75.3%
Other staff vaccinated including volunteers	N/A	1290	760	**58.6%**

Compliance (Green) is indicated by a score >75%

Figure 8; Influenza uptake by staff group

<u>What worked well 2017-2018</u>

- Ward based vaccinators
- Ward walk rounds
- Drop in sessions during the first 6 weeks.

<u>Actions</u>

- A Budget needs to be allocated for the campaign for 2018-19
- Staff resource- vaccinator / OCH resource. There is insufficient capacity within the IPC nursing team to provide sufficient hours to the campaign and deliver the IPC service. An additional full time vaccinator is required for 2018-19.
- Areas with low uptake PICU, theatres –action plan to be developed in the divisions to increase uptake in the staff groups/ areas with uptake below 75%.
- Access to vaccination for Community teams – especially mental health needs to improve.
- NHS England has advised Trusts to provide the quadrivalent vaccine to staff in 2018-19 rather than trivalent vaccines which have been obtained previously. This will be a cost pressure as the quadrivalent vaccines are more expensive.

2.2.7 Rotavirus

Rotavirus is a seasonal infection and cases are usually seen during the spring season.

During 2017/18 there were **0** cases of Hospital Acquired Rotavirus compared to **0** cases during 2016/2017. This reflects the introduction of the Rotavirus vaccine as part of the National Immunisation Schedule in September 2013.

2.3 Outbreaks

There were **3** viral outbreaks during 2017/2018 compared to **0** in 2016/2017. The outbreaks were as follows:

- A measles outbreak November 2017, 11 cases identified all admitted from the community. 1 hospital acquired case (staff member who had received MMR). 3 cases acquired from ED waiting room at Alder Hey.

- Norovirus outbreak in November 2017 on Ward 4A , 19 patients and 11 staff affected (no specimen confirmation due to no specimens being collected, although the pattern of cases reflected Norovirus

- There was 1 Norovirus outbreak on Ward 4B with 13 patients affected and 14 staff members. Ward closed from 13th – 18th December 2017. (2 patients were laboratory confirmed cases).

2.4 Central Line Associated Bacteraemia Infections (CLABSIs)

CLABSIs are one of the most significant hospital-acquired infections with **50 cases** in 2017/2018 compared to **66 cases** in 2016/2017 (These numbers are not validated as currently we are only able to validate PICU cases). ***This is a 24% reduction*** from 2016-17 to 2017-18. The table below shows hospital-acquired lab confirmed CLABSIs during 2017-18 compared to 2016/2017 and 2015/2016.

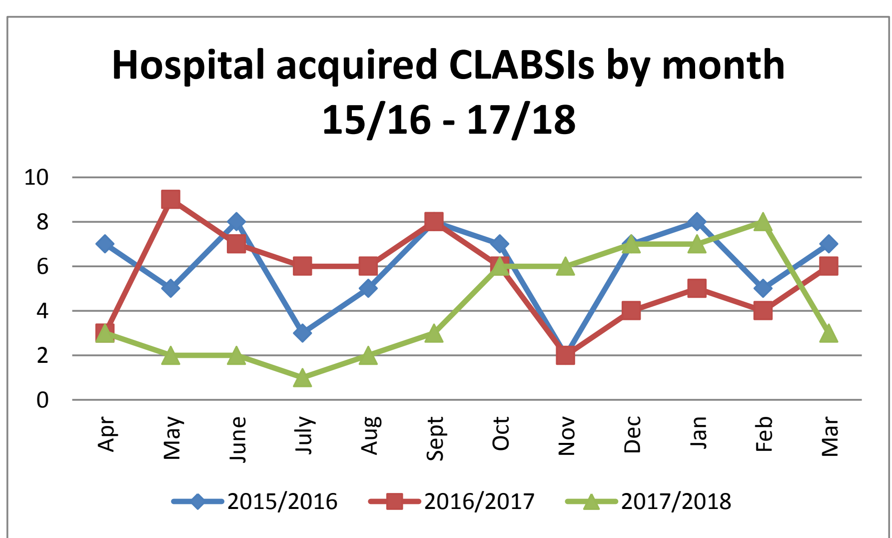


Figure 9; Hospital acquired CLABSI

The graph below shows the PICU CLABSI rate by month.

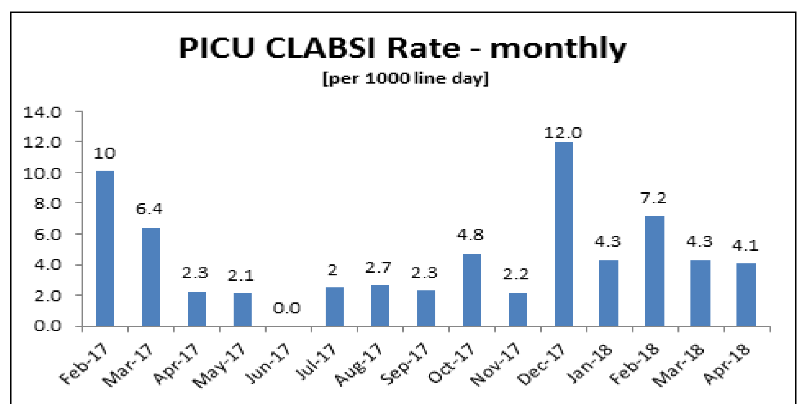


Figure 10; Hospital acquired CLABSI for PICU

Key issues

The validated CLABSI rate per 1000 catheter days for PICU remains at approximately 4 per 1000 catheter days. This rate remains high compared to paediatric published data, however the acuity of the patients treated at the Trust needs to be taken into account when considering these figures.

Currently the Trust is unable to report validated Trust wide CLABSI rates in 1000 line days. However with the commencement of the new Infection Prevention and Control Doctor in September 2018 this can be progressed.

Actions

- Collaborative working across the Trust to prevent CLABSI through the Intravenous Access and Therapy group and the commencement of the CLABSI initiative to heighten the awareness of CLABSI and CLABSI rates on the PICU department.
- Working with the GDE project team to develop a programme in the Meditech system to capture robust vascular access data.

2.3 Multi Drug Resistant (MDR) Organisms

Organism	Cases
• MRSA bacteraemia	**4 cases**
• MRSA (not bacteraemia)	**9 cases**
• CRE (Carbapenemase Resistant Enterobacteriaceae)	**8 cases**
• CPE (Carbapenemase Producing Enterobacteriaceae)	**8 cases**
• VRE (Vancomycin-resistant Enterococcus)	**2 cases**
• ESBL (Extended Spectrum Beta-Lactamases) outbreaks	**0 cases**

Multi-drug resistant organisms pose a significant clinical risk due to the limited range of therapeutic antibiotics that may be available to treat a patient's infection. There continues to be the emergence of extended spectrum β-lactamases (ESBLs) and Carbapenemase Producing Enterobacteriaceae (CPEs) both regionally, nationally and internationally. The main focus for the reduction of ESBLs and CPEs continues to be effective antibiotic stewardship, patient surveillance by rectal screening and implementation of basic infection prevention and control practices.

NHS Trusts across the North West continue to encounter significant cases of CPE. The number of these organisms remain low at Alder Hey. However ongoing surveillance for these organisms is extremely important in view of inter hospital transfers.

Delay in the laboratory confirmation of presumptive CPE results by the reference laboratory is having a significant impact on the period of isolation for suspected cases. A business case has been developed to introduce rapid testing for CPE detection into the Trust. This business case is waiting to be presented at IRG.

2.3.1 MRSA Admission Screening

MRSA admission screening is undertaken to detect colonisation (carrying the bacteria without any infection). In certain individuals, colonisation may predispose to infection and colonised patients have the potential to transmit the bacteria to another patient. An internal tolerance for compliance has been set at 95% following the removal of mandatory reporting to the DH.

The graph below shows the compliance by month for MRSA screening for 2017-18 compared to 2016/2017 and 2015/2016.

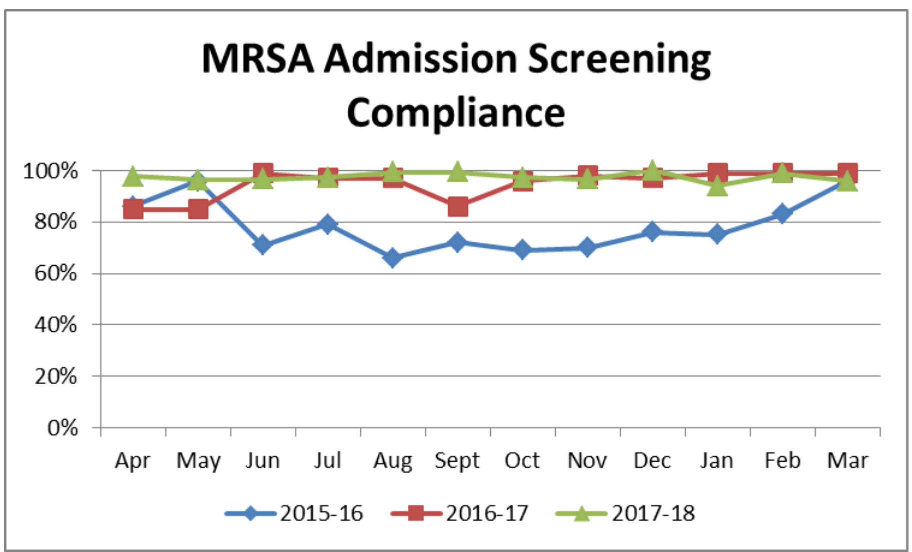


Figure 11; MRSA Admission screening compliance

2.3.4 CPE Screening

The graph below shows CPE screening compliance by month for 2017-18 compared to 2016-17 and 2015-16.

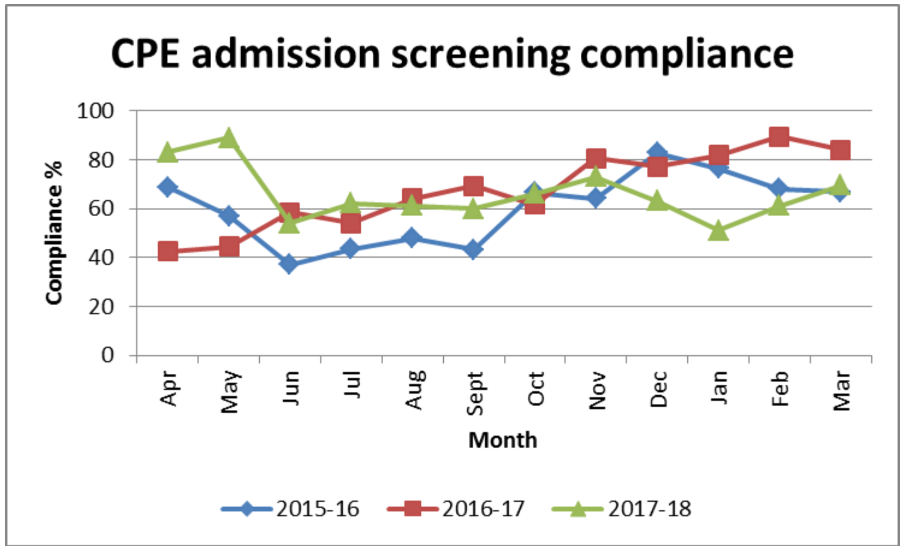


Figure 12; CPE Admission screening compliance

Key Issues

Compliance for CPE admission screening was 66% in 2017-18 compared to 67% in 2016-17. This remains a concerning trend that needs to be reversed due to the increase in cases of CPE especially in the North West region.

Actions

- CPE admission screening sample results that have been rejected due to not enough faecal matter on the sample are now being collected by the IPC team on a daily basis. This is then communicated to the ward and a repeat sample is requested.

- CPE admission screening results are now communicated to the wards on a monthly basis via IPC dashboards. These results are then discussed at Divisional governance meetings and reported to the IPCC.

- CPE admission screening meeting to be convened to identify and examine the barriers to complying with the CPE admission screening policy and to develop an action plan to address the issues and improve compliance.

- A business case is being developed for ultra violet cleaning in the Trust. This process will enhance the already developed system and ensure a robust evidence based cleaning process.

2.3.5 Antibiotic Stewardship

Although we await the processing and publication of our antibiotic consumption data by NHS England, our internal reporting indicates that we have achieved two of our three CQUIN targets.

Our Antimicrobial Consumption CQUIN targets were split into 3 sections (baseline 2016/17):

- Total consumption of antibiotics – reduce by 1%

- Consumption of carbapenems – reduce by 1%
- Consumption of piperacillin/tazobactam – reduce by 1%

We reduced our carbapenem consumption by 12.4% and piperacillin/tazobactam consumption by 18.3%. Unfortunately we saw an increase in total consumption of antibiotics by 10.4% and have therefore missed this target.

It is difficult to fully understand what has caused the rise in total consumption but we can attribute the following:

National shortage of piperacillin/tazobactam
In response to a global shortage which lasted around 4 months the Department of Health advised to replace piperacillin/tazobactam with alternatives. Replacement therapy included combinations of 2 or more antibiotics. This also saw a rise in certain antibiotics which were used as alternate therapy to piperacillin/tazobactam when compared to 2016/17.

Actions

- Continue an Antimicrobial Stewardship ward-round Monday to Friday - consultant-led ward rounds 3 times a week
- Introduce Antimicrobial Stewardship training at induction for clinical staff

2.3.6 Sepsis

Sepsis Pathway

The Sepsis pathway went live across all inpatient wards (excl PICU) and the emergency department by the end of June 2017 after a staged roll out. The pathway is built in to Meditech 6 following the criteria set out in the 'NICE Sepsis – recognition, diagnosis and early management' guideline. The documentation of pre-existing risk factors and a screening question in the clinical observation recording panel so that every time a set of observations are carried out, the nurse has to answer a 'could this be sepsis' question has increased awareness about the possibility of sepsis being a concern in a deteriorating child. As the integration of complete electronic documentation continues, specific sections in clinicians' documentation templates include sepsis impression and sepsis actions. The actions are in accordance to the NICE Sepsis guidelines.

Feedback is given through a number of different channels including CommCell and CQAC. We look at all cases where treatment was given over 60 minutes and use these to look for trends and ways to improve.

To monitor our sepsis pathway we have been submitting the Sepsis CQUIN 2017-2018 and were able to provide data for all four quarters as summarised below.

CQUIN Performance for Inpatients

	Q1	Q2	Q3	Q4
2a) Sepsis screening	100%	100%	100%	100%
2b) Timely treatment of sepsis with IV antibiotics	67%	73%	80.2%	79.5%
2c) Antibiotic Review	98%	100%	100%	94%

Figure 13; CQUIN performance for inpatients 2017-18

CQUIN Performance for ED

	Q1	Q2	Q3	Q4
2a) Sepsis screening	100%	100%	100%	100%
2b) Timely treatment of sepsis with IV antibiotics	79%	57%	57.7%	53.4%

Figure 14; CQUIN performance for ED

Training and Education

There has been a continued emphasis on training and education delivered both by face to face sessions and presentations. By February 2018 we had trained 91% of the nursing workforce. We have implemented our e-learning package in May which can be accessed by staff now with the aim to have Sepsis included in the trusts mandatory training from September 2018. Clinicians have a sepsis presentation at their trust induction and we also have sessions booked for nursing students as they start their placements in the trust, 1st years to final placements.

In June we started our community based training sessions looking to provide knowledge about to the wider workforce. Nine sessions over three months have been arranged with the support of the different community specialities. Feedback will be obtained and summarised to allow us to review and tailor future training.

Actions

- Continued emphasis on the sepsis pathway and awareness about sepsis.
- Monitoring of all patients were nursing concern of sepsis is recorded.
- Monitoring of all patients given IVAB with a clinical indicator of sepsis.
- Continued training and education for both hospital and community staff.

2.3.7 Surgical Site Infections

Current Trust SSI (surgical site infection) rates are:

- Cardiac PHE Rate for quarter 3 was ***0%.*** Data was not submitted for periods 1 &2.
- Orthopaedic spinal surgery PHE rate for quarter 1,2 and 3 was ***0%.***
- Orthopaedic implant surgery for quarter 1 was ***5.7%***, quarter 2 was ***2.5%*** and quarter 3 was ***2.6%.***
- Neurosurgery PHE rate for quarter 1, 2 and 3 is ***0%***.
- K-Wire SSI rate was ***8.1%.***

Data for Q4 has been submitted but rates are not available currently.

Orthopaedic implant surgery SSI rate has reduced over the year from 5.7% to 2.6%. This decrease is due to the implementation of the care bundle with speciality.

K wire surveillance was established in house over the summer period (Apr-Sept) with a rate of 8.1%. As this has not been undertaken before we are unable to comment on the rate however there are plans to monitor this in the future.

Actions

- Database now established to collect the surgical site infection information but currently work is still ongoing to be able to allow direct reporting to PHE.
- SSI officer now in place. 30 day follow up telephone calls to patients will resume.
- Texting patients for follow up has been initiated and will hopefully commence 2018-19.
- New leaflet for surgical site infection has been approved and is now available for patients.

3 Environment

3.1 IPC Spot Audits

This year the IPCT have established a new spot audit which is conducted monthly on each ward area. The audits encompass ward environment, linen/waste/sharps/spillages, patient equipment and clinical practice. The table below shows overall results by month by ward/department.

	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Yearly Average
AED	68	62		68	67	71	74	68
EDU	84	67		72	77	78	74	75
1B PICU	64	64		69			79	69
1B HDU		70		71			77	73
1B Burns	84	80		84	78		84	82
1C	75	88			81	81		81
3A	53	80			59	69		65
3B	70	88		81	83	73	74	78
3C	82	91		90	84	72	85	84
4A		66				75	77	73
4B	79	82		85	69	71	63	75
4C	76	82		91	83	64	75	79
Dialysis	89	83		81	93	90	93	88
CRF						57	78	68
OPD 1st	86							86
OPD 2nd							67	67
Medical Daycase	79	78		73	96	83	79	81
Radiology							74	74
Surgical Daycase Unit							72	72
Total	76	77		79	79	74	77	77

Figure 15; IPC Sport audit compliance by month and department.

*Please note no audits were undertaken in November due to outbreaks and staff shortage within the team.

3.2 Facilities/IPC/Domestics Walk Around

During 2017-18 a multidisciplinary walk around was introduced. Walk arounds are conducted by the IPCT, facilities and domestic supervisors to look at the ward/department environment. The table below shows the overall compliance figures.

	Visable Damage	Sinks	General	Overall
AED	50	50	83	67
1B PICU	50	100	83	75
1C	63	100	73	74
3A	50	100	82	74
3C	63	50	83	71
4A	50	100	82	74

	Visable Damage	Sinks	General	Overall
4C	50	100	91	78
OPD GF	38	50	92	67
OPD 1st	38	25	75	54
OPD 2nd	38	25	75	54
Theatres	50	75	83	71
Pathology	63	50	83	71
Atrium	60	50	100	78
Average Compliance	49	70	82	69

Figure 16; Walk round compliance by department.

3.3 Water quality

Over the course of the last year water safety has increased in its risk rating for the Trust and is monitored through the Water Safety Group (WSG).

- Hot water return legs have shown to be below 55 degrees, which is below the recommendation for set out in the HTM Guidance. Project Co has appointed a specialist company to look at rebalancing the system and as of 25th June 2018 this is being reviewed by the sub group of the WSG. It is expected that work will commence early July and will take approximately eight weeks to complete.

- Low levels of legionella counts have been found in several areas. An action plan is in place that includes closing of the areas, disinfecting the taps and the fitting of filters where required. The action plan has been successful and proactive testing will continue to ensure compliance and remedial works when necessary. The WSG are aware of the issue, actively monitoring these occurrences and managing the identified risks.

- Pseudomonas testing continues in identified augmented care areas. A Standard Operating Procedure (SOP) is in place which consists of fitting a filter, disinfecting the tap over a course of three weeks and then retesting. This has proved effective and a new sink cleaning regime has also been agreed and put into place to further reduce the risk.

- Cold water elevated temperatures still remain an issue and although several causes have been identified and addressed, the issue still remains. Work continues with Project Co and the Trust to ensure compliance.

3.4 Air quality

The Trust continues to undertake monthly surveillance for aspergillus in critical care and on the Oncology unit whilst the demolition and building work continues. Currently aspergillus air levels remain very low.

Air quality in theatres, particularly in the ultra-clean theatres is compliant with HTM guidance for ventilation. This is monitored by the Trusts Theatre Manager and the authorised engineer (AE) in Ventilation.

3.5 Environmental Cleanliness

Working with and alongside the IPC team, Domestic services have been involved in:

- The rationalisation and implementation of new cleaning products across the Trust.
- Collaboration between IPC, Domestic Services and Patient Flow to develop and introduce the 'Traffic Light System' to assist in targeting resources for IPC cleaning leading to improvements in patient flow across the Trust.
- Development and implementation of various Standard Operating Procedures (SOPs) including but not limited to:

  (i) Bed Cleaning
  (ii) Sink Cleaning
  (iii) Cubicle cleaning

- A new cleaning policy will be introduced in 2018-19 which will include all new processes which have been introduced across the trust.

3.6 Decontamination

Interpreting Final Rinse Water Results

All quarterly and annual maintenance has been performed with satisfactory results. Maintenance reports are arriving into the Trust inconsistently and untimely. IFM are working with decontamination and manufacturers contractors in order to ensure consistency i.e. electronic and timely reports are provided.

Environmental Mycobacteria testing in Endoscopy

Water Test	Satisfactory Results	Frequency
Total organic carbon	Less than 1 mg/L	Yearly
Appearance	Clear bright and colourless	Yearly
PH	5.5 - 8.0	Yearly
Electrical conductivity	Less than 40 µs/cm at 25°C	Weekly
Hardness	Less than 50 mg/L $CaCO_3$	Weekly if appropriate
Total Viable Count	Less than 10 cfu m/L acceptable	Weekly
Environmental Mycobacteria	Non detected in 100 m/L samples	Quarterly
Pseudomonas aeruginosa	Non detected in 100 m/L samples	Quarterly

Water Test	Satisfactory Results	Frequency

Figure 17; Environmental Mycobacteria testing in Endoscopy

Achievements within 2017-2018:

- Re-appointment of Authorised Engineer for Decontamination
- Schedule of Decontamination Audits and dates to be presented to Decontamination Committee developed (as below)
- Introduced template for departmental returns in order to improve communication and keep committee updated of current issues (as below)
- Introduces a series of meetings looking at decontamination in the community
- Decontamination Advisor completed Decontamination Lead Course
- Obtained Corporate membership of institute of Decontamination Sciences
- New automatic flushing equipment has been implemented within endoscopy decontamination unit, reducing the risk of human error

Trust Decontamination Audit and Committee Schedule 2018-2019		
APRIL 30 Endoscopy (6 Monthly)	**MAY** 24 Dental (6 Monthly) 31 Special Feeds	**JUNE** 12 Hydrotherapy (6 Monthly) 28 Theatres
Present to Decontamination Committee 10th May	Present to Decontamination Committee 12th July	Present to Decontamination Committee 12th July
JULY Decontamination Annual Report 19 Radiology 23 Ophthalmology 26/27 Communities	**AUGUST** 21 Critical Care 21 Echo/Cardiac/ECG 23 Wards 3a 3b 3c 23 14 4a 4b 4c audit	**SEPTEMBER** 4 Accident Emergency Department 5 Bed Wash Area 6 ENT
Present to Decontamination Committee 11th October	Present to Decontamination Committee 11th October	Present to Decontamination Committee 11th October
OCTOBER 15 Endoscopy (6 Monthly) 30 Dental	**NOVEMBER** 2 Pathology - Autoclave 5 OPD 8 Mortuary	**DECEMBER** 4 Washing Machines 6 Hydrotherapy
Present to Decontamination Committee 17th January	Present to Decontamination Committee 17th January	Present to Decontamination Committee 17th January
JANUARY No Audits winter pressures	**FEBRUARY** No Audits winter pressures	**MARCH** No Audits winter pressures
All areas must devise and update their own departmental audit action plan		
NOTE: All Departments to Complete a Departmental Audit Template, to update the Committee whether in attendance or sending apologies		

Figure 18; Decontamination Audit schedule

Annual and Quarterly Testing during 2017/18 set out below against the requirements

EQUIP	APR 2017	MAY 2017	JUN 2017	JUL 2017	AUG 2017	SEP 2017	OCT 2017	NOV 2017	DEC 2017	JAN 2018	FEB 2018	MAR 2018
AUTOCLAVE				10/07						15/01		
CLOG WASHER	NOT IN USE											
CART/BED WASHER	NOT IN USE											
WASHING MACHINES	11/04											
DENTAL CHAIRS									01/12			
AUTO REPROCESSOR 1			12/06			11/09			12/12			05/03
AUTO REPROCESSOR 2			13/06			12/09			12/12			06/03
AUTO REPROCESSOR 3			12/06			13/09			11/12			05/03
STORAGE CABINET 1		02/05				14/09						17/03
STORAGE CABINET 2		02/05				14/09						17/03
STORAGE CABINET 3		02/05				14/09						17/03
WASHER DISINFECTOR	21/04			04/07			06/10					22/03

Figure 19; Decontamination Equipment Validation Reports – 12 Months April 2017-March 2018

The table above contains the essential bacteria testing in final rinse water in endoscopy, as detailed in HTM 01-06 Part E. The Trust can be assured that all of these tests are performed at the frequency in Decontamination of flexible endoscopes – see extracted table 6.3 below. Training in interpreting water results is currently being sought.

3.7 Building Services

The Building Services Team, (BST) is responsible for the monitoring of the Private Finance Initiative, (PFI), contract including the monitoring of the Hard FM provider Interserve to ensure Planned and Preventative Maintenance, (PPM) is compliant and that routine call logs for various issues is resolved in line with the contractual obligation. The BST are also responsible for working alongside department requests for works outside of the contract, these are known as ad hoc works, small works and Trust Variation Requirements, (TVE's). The category of job is based on the actual cost of the works.

Over the past year the BST have worked in partnership with the Infection & Prevention Control team, (IPC), on several key issues.

These include, but not limited to:

- potential changes to the ventilation specification within several areas of the ICU department to ensure highly infectious patients can be accommodated without risk to other patients
- Water Safety Group collaboration in regards to cold water issues
- changes to dirty utility rooms due to not meeting the contractual air changes specification
- general cleanliness of the environment and improving with weekly walkabouts

The BST will continue to grow the relationship with IPC and support the department in any way which contributes to the overall objective of ensuring a safe environment for patients and staff.

4 Infection Prevention and Control Activity

4.1 Hand Hygiene Trust Compliance

Hand Hygiene Compliance-self reporting by clinical areas

Compliance with hand hygiene is demonstrated by scoring above 95%. Overall hand hygiene Compliance was **90%**. Compliance varied by staff group and opportunity. Overall senior nurses and staff nurses scored the highest with **94%** compliance. Although compliance for volunteers was 50% they were only audited on 3 occasions, domestics 31 opportunities audited and porters 68 opportunities. The total number of opportunities audited was 14,491. The chart below shows the compliance by staff group for 2017-18.

Senior Nurses	Staff Nurses	Students Nurses	HCA	Porter	Domestics	Volunteers	Allied Healthcare	Medical Staff
94%	*94%*	*89%*	*89%*	*71%*	*65%*	*50%*	*89%*	*83%*

Figure 20; Staff groups hand hygiene compliance 2017-18

The chart below shows overall hand hygiene (self-reporting by clinical areas) compliance by month for 2017-18 compared to 2016/2017 Trust –wide.

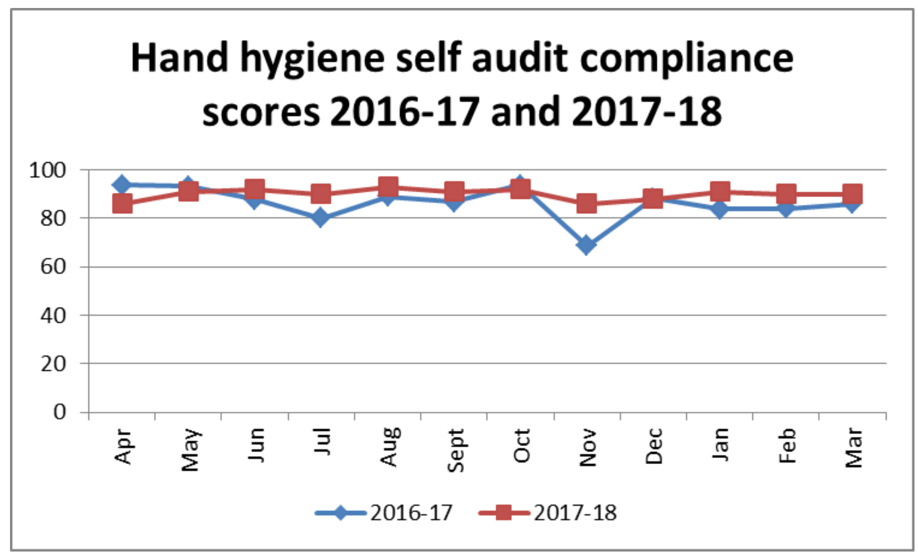


Figure 21; Hand Hygiene compliance score 2016-17 and 2017-18

Actions

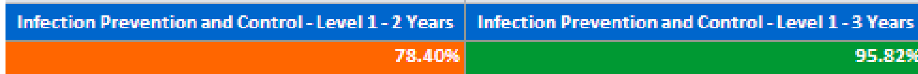
- Monthly audits continue on PICU and results are discussed weekly at doctor's handover.
- PICU nursing staff receive monthly audit results via e mail and results are displayed on the information screens within PICU.
- The hand hygiene app continues to be used on PICU and HDU to enable staff to be able to collect more hand hygiene opportunities.

- IPC training (including hand hygiene) for portering and domestic staff continues and there are plans to roll out specific training for housekeepers in 2018/19.

- Yearly mandatory assessment of hand hygiene technique will be introduced in 2018-19 for all clinical staff within the Trust.

4.2 Infection Prevention and Control Mandatory Training

IPC training is delivered in stand up sessions at Induction and during mandatory training study days and via online work books. Additional training is provided for IPC Link personnel at monthly education sessions and bespoke sessions are provided for Critical care, Bank staff, Medical and Nursing students and Hotel services staff. Ad hoc sessions are provided as required.



Infection Prevention and Control - Level 1 - 2 Years	Infection Prevention and Control - Level 1 - 3 Years
78.40%	95.82%

Figure 22; Mandatory Training compliance Trust wide 2017-18

Compliance data is now being provided on a monthly basis from training and development. Compliance is rag rated with green as compliant.

Key issues

- Compliance <90% for front line staff.

Actions for 2018-19

- Increase requirement for front line staff to attend annual updates
- Provide additional mandatory training sessions for community staff
- Expand Link nurse system to include community teams and off site premises
- Development of e-learning package for Infection prevention & control

4.3 Policies and Procedures

The following policies/guidelines have been written/reviewed/updated in 2017/2018:

Title
Theatre infection control policy
Flu Pandemic Plan
High Consequence Infectious Diseases (HCID) Plan
Data & Surveillance Policy
Control of Aspergillus Policy
Infection Control in the Mortuary Suite Policy
Sharps Management Policy
MRSA and Surveillance Screening Policy
Blood Borne Virus Policy
Measles Policy

5 Infection Prevention & Control Annual Work Plan 2018/19

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

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

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

IPC Code & Trust Values	Plan & Priority Activities 2018-19	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
			monitored.					
	CPE	Microbiology and IPC Team	To instigate an incident meeting with clinical team for all hospital acquired cases. Disseminate lessons learned for the process and actions required and monitored.					
			To develop and submit a business plan for rapid PCR testing to ensure timely screening and isolation of identified at risk and previous positive patients.					
	Surgical Site Infection (SSI) for Orthopaedics (spinal, elective implants and k wires), Cardiac Surgery, Neurosurgery and plastics.	Microbiology, LM, Theatre safety board & clinical Review Panel	To assist in the collection and submitting of data for SSIs. To disseminate reports to the relevant clinical staff. To include data and reporting in the DIPC IPC report on a quarterly basis.					
			To support the clinical teams to take more ownership of their SSI data – through attendance at the SSI teaching sessions at Colindale London. To support the investigation and presentation of incidences of SSI through the RCA process at the Review Panel meetings and to support the dissemination of lessons learned					

IPC Code & Trust Values	Plan & Priority Activities 2018-19	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
			to the relevant staff and actions required and monitored.					
	Viruses	Microbiology & IPC Team	To provide data on HAI Influenza & RSV rates per 1000 bed days.					
			To support investigations into HAI Influenza and RSV cases and investigations into outbreaks with other respiratory viruses.					
			To provide predictions and provide commentary during the winter season on Respiratory viruses (in collaboration with the PHE) to assist in planning elective activity and patient flow.					
	Expert Virology provision and expertise	Medicine General Manager Glenna Smith (GS) and Microbiology.	To secure expert Virology provision and expertise.					
3. Hand Decontamination								
IPC Code: 1,2,4,5,6,7,8 & 9 **Trust Values:**	Children's Hand Hygiene Initiative – in conjunction with PDI	IPC Team and PDI	Complete an initial evaluation of hand hygiene behaviour of children across the areas identified for the pilot.					

IPC Code & Trust Values	Plan & Priority Activities 2018-19	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
Excellence Openness Respect Together Innovation			Introduce the pilot scheme into the identified areas. Pilot study to run over 2 months.					
			Present finding of the pilot study to the Trust, and at the Infection Prevention Society Conference – October 2018.					
			Write up study for publication.					
			If pilot successful – to introduce scheme across the Trust.					
	To scope and implement new and innovative hand hygiene signage across the Trust to ensure	IPC Team	To explore the feasibility of introducing new and innovative hand hygiene signage across the Trust.					
	To explore new hand hygiene audits tools and technology incorporating the use of Protective Personal Equipment (PPE)	Hand Hygiene audit tools – IPC Team	IPC team to source, trial and decide on new hand hygiene tool.					
		New Technology – IPC Team and data analyst (CQ)	IPC team and CQ – to investigate how new tool can be recoded and results disseminated across the Trust.					
	To ensure that the non-compliance with hand hygiene proforma is utilised throughout the	DIPC, Associate DIPC and IPC Team	IPC team to scope how non-compliance can be reported across the Trust.					
			IPC team to communicate the process					

IPC Code & Trust Values	Plan & Priority Activities 2018-19	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
	Trust.		via the Link Nurse/Representatives and the governance structures					
	Introduction of new hand hygiene audit technology as part of monthly audit indicators	Lead Infection Prevention & Control Nurse, IPC Team& link nurses	Dissemination of new hand hygiene audit technology to link personnel through meetings and training					
	To ensure that hand hygiene technique assessments are recorded as a mandatory field on an annual basis for all clinical staff and reflected in ESR.	Associate DIPC and Learning and Development.	To explore the feasibility of putting hand hygiene compliance on the ESR system for all clinical staff on an annual basis.					
			Once hand hygiene assessments are recorded on ESR. To develop a monitoring system across the Trust.					
			Include compliance in IPC Dashboards to provide assurance.					
4. Policies								
IPC code 1,2,3,4,5,6,7,8,9 & 10 **Trust Values** Respect Excellence Innovation Togetherness	Review and update IPC policies as required.	IPC Team	Monitored reviewed and updated as part of the IPCT meetings on a bi-weekly basis.					
	To provide advice and support on IPC policies.	IPC Team						
	Participation in updating where IPC is an integral component of relevant policies.	EW	Provide an update of policy review dates					

IPC Code & Trust Values	Plan & Priority Activities 2018-19	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
Openness								
5. ANTT								
IPC Code: 1,2,3,4,5,6 & 9 **Trust Values:** Excellence Openness Respect Together Innovation	Monitor Trust wide compliance and increase compliance.	ANTT Specialist Nurse	Provide updated compliance figures to the relevant care groups and for IPCC.					
			ANTT compliance scores to be communicated in IV Newsletter and IPCC Report.					
			ANTT compliance scores communicated in ward and department dashboards.					
	To ensure that ANTT assessments are recorded as a mandatory field on an annual basis for all clinical staff and reflected in ESR.	Associate DIPC, ANTT Specialist and Learning and Development	To explore the feasibility of putting ANTT annual assessments on the ESR system as a mandatory field for all clinical staff.					
	Ensure guidelines and ANTT policy remain up to date with latest evidence based practice.	IV Lead Nurse (SM) and ANTT Specialist Nurse	Review all latest evidence based practice and review guidelines and update policy where necessary and appropriate.					
	Provide and update Key Trainer training on an annual basis.	ANTT Specialist Nurse assisted by BBraun.	Key trainer training days are provided 6 times per year.					

IPC Code & Trust Values	Plan & Priority Activities 2018-19	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
	Liaise with St Helens and Knowsley Trust regarding standardising ANTT rotational staff assessments	Associate DIPC/SM	To develop a SOP to standardise ANTT assessments for rotational staff recognising from other Trusts within the last 12 months.					
	Plan to expand this process to cover other Trusts in the North West	Associate DIPC/SM	To progress the work started with Whiston to other Trusts in the region through the North West IV Forum.					
	Liaise with ANTT experts to review and refine existing processes.	Associate DIPC/SM	Attend annual ANTT conference and to attend North West IV Forum meetings.					
6. Vascular Access								
IPC Code: **Trust Values:**	Improving patient flow for vascular access.	Lead Nurse IV	Initiation of GDE project – the use of digital technology to implement evidence based practice to improve patient care delivery.					
			Implementation of IV access team assessment from receipt of Meditech referral					
	Implementation of vessel health and preservation.	Lead Nurse IV	Initiation of GDE project incorporating VHP decision tool.					
	Improve workload awareness in vascular access team.	Lead Nurse IV ANS IV	Introduction of daily workload planner.					
	Widen accessibility of teaching and training for	IV Team and Learning and	Introduction of ward based workshop/training updates to keep					

IPC Code & Trust Values	Plan & Priority Activities 2018-19	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
	MDT	Development	staff educated in the best evidence based vascular access practice.					
			Training drop in sessions in clinical skills room accessible to MDT. Records to kept by IV team and sent to L&D for recording on ESR.					
	Review of Sharps safety and vascular access	IV Team ADIPC	Review of butterfly needles and clinical trials.					
			Review of cannula and clinical trials.					
			Revisit innovative sharps disposal					
			Exploration of possible introduction of pre filled saline syringes.					
	Review of vascular access dressings.	IV Team	Explore dressing options					
			Undertake clinical trial					
			Implementation of new dressing for peripheral vascular access.					
7. Training								
IPC Code: 1,2,3,4,5,6,7,8,9 & 10 **Trust Values:** Excellence Openness Respect	To ensure that IPC staff and kept updated with IPC evidence based practice.	Lead IPC Nurse	To ensure that a member IPC Team attends the North West Infection Prevention Society (IPS) meetings at least once per year.					
		Associate DIPC	To regularly attend local HCAI whole health economy meetings.					
		Associate DIPC/Lead IPC	To attend local and national IPC/relevant conferences as the					

IPC Code & Trust Values	Plan & Priority Activities 2018-19	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
Together Innovation		Nurse	service will allow					
		Lead IPC Nurse	To attend Vaccinator training or undertake on line update					
	To ensure that Trust staff are kept updated with IPC evidence based practice: Please see plan below.							
	Induction	Lead Nurse IPC/CO	At least once per month					
	Mandatory	IPC Team	For all clinical staff yearly (monthly sessions) & work book.					
			To develop a new E-Learning package to replace monthly sessions and workbook.					
			Non-clinical 3 yearly – work book					
			To develop a new E- Learning package to replace the work book. Following the same principles developed from the Clinical E-Learning package.					
	ANTT Key Trainers	SM	Bimonthly					
	Volunteer IPC Training	CO/VL	Quarterly					
	Hotels Services IPC training	VL	At least once per quarter					
	Link Personnel	IPCT	Monthly					
	Fit Testing Key Trainers	CO	Updated Annually – records of staff					

IPC Code & Trust Values	Plan & Priority Activities 2018-19	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
			training reported through IPC Dashboards					
	Flu vaccinator Training	Lead Nurse IPC	Annual (4 sessions per year)					
	Ad hoc training	IPCT	As required					
8. Audit								
IPC Code: 1,2,3,4,5,6,7,8 & 9 **Trust Values:** Excellence Openness Respect Together Innovation	To provide assurance to the board and relevant committees of adherence to high quality IPC practices.	Lead IPC Nurse/ IPC Specialist Nurse/IPC clinical assistant follow the audit plan The Audit programme is revised on a yearly basis. Further audits are undertaken by the IPC Team as set out in the work plan and as the service requires.	All findings are communicated to the relevant clinical staff and reported via the IPC dashboards and discussed at divisional governance meetings and the IPCC. All lessons learnt are disseminated to the relevant staff and other agencies as Appropriate in a timely manner.					
9. Antimicrobial Prescribing								
IPC Code: 1,3,4,5,6,7 & 9	Antimicrobial Stewardship (AMS) ward rounds	Antimicrobial Pharmacist						
			AMS ward rounds (x3/week)					

IPC Code & Trust Values	Plan & Priority Activities 2018-19	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
Trust Values: Excellence Openness Respect Together Innovation	AMS Committee meetings		AMS Committee (meet at least quarterly)					
	Introduction of AMS training to all clinical staff in the Trust.	Antimicrobial Pharmacist (AT) Sepsis Nurse Specialist – James Ashton (JA) OPAT Nurse Specialist – Ruth Cantwell (RC).	AMS training to be introduced across the Trust – currently delivered to junior doctors on induction but not to nurses. To introduce AMS training into induction training. To introduce AMS training into mandatory training.					
10.Communication								
IPC Code: 1,2,3,4,5,6,7,8,9 & 10 **Trust Values:** Excellence Openness Respect Together Innovation	IPC bi-monthly report	Lead Nurse IPC	IPC bi-monthly report reported through the IPCC.					
	IPC Dashboard	IPC Data Analyst	Monthly dashboard distributed Trust wide reported through Divisional Governance meetings and IPCC.					
	Communication with the Whole Health Economy	ADIPC	To attend HCAI/IPC meetings across the local area.					
	Communication with other Trusts and agencies such as Public Health England (PHE) and NHS England	IPCT	To attend local meetings. Communication and information gathering with other Trusts and agencies to assist in IPC investigations.					

IPC Code & Trust Values	Plan & Priority Activities 2018-19	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
	To keep Infection Prevention and Control Intranet page up to date with relevant information	IPC Administrator	Ensure that the IPC intranet pages are kept up to date on a monthly basis or as necessary.					
	To ensure that Paediatric Infection Prevention and Control remains high on the agenda at a national level.	Associate DIPC	Associate DIPC to communicate specific paediatric needs to Infection Prevention Society (IPS) through representation on the IPS Board.					
	Communication with other Paediatric Trusts and other hospitals/healthcare facilities caring for paediatric patients. Scoping Paper for the Paediatric Special	Associate DIPC/CO	Commencement of the national IPS Paediatric Forum to share best evidence based practice, benchmarking and innovative projects. To include meetings face to face and virtual and a national annual conference.					
11. Information Technology								
IPC Code: 1,2,3,4,5,6,7,8,9 & 10 **Trust Values:**	To continue to enhance the use of Meditech to assist the IPC team in monitoring HCAI	IPC Team, IT team and Pathology IT Manager.	Set up regular meetings to explore how the Meditech system can assist IPC.					

IPC Code & Trust Values	Plan & Priority Activities 2018-19	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
Excellence Openness Innovation Together								
	To develop opportunities to enhance epidemiological surveillance systems and monitoring opportunities within the Trust	Consultant Infectious Diseases/ADIPC/ Data Analysts	To instigate a working group to explore possibilities to enhance the surveillance systems and reporting across the Trust. To develop a business case to develop the enhanced surveillance system agreed.					
12. Interface with relevant groups								
IPC Code: 1,2,3,4,5,6,7,8,9 & 10 **Trust Values:** Excellence Openness Respect Together Innovation	IPC to attend and provide expert opinion for topics related to IPC.							
	Escalate issues to DIPC as necessary.	Associate DIPC	Regular meetings with DIPC					
	To review new equipment /environmental utilisation	IPCT	Ad hoc meetings as required.					
	Decontamination	Lead Nurse IPC	To attend scheduled meetings.					

IPC Code & Trust Values	Plan & Priority Activities 2018-19	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
		Associate DIPC to attend as required.	To provide expert advice and support as required.					
	Water Safety	Associate DIPC	To attend scheduled meetings. To provide expert advice and support as required.					
	Health & Safety/IPC/Interserve & Building services	Associate DIPC/Lead Nurse IPC	To attend scheduled meetings. To provide expert advice and support as required.					
	Hotel services	Lead Nurse IPC Associate DIPC to attend when required.	To attend scheduled meetings. To provide expert advice and support as required.					
	Ward managers/matrons	Lead Nurse IPC Associate DIPC or IPCT to attend when required.	To attend scheduled meetings. To provide expert advice and support as required.					
	Health and Safety	Lead Nurse IPC	To attend scheduled meetings. To provide expert advice and support as required.					
	Integrated Governance Committee	DIPC/Associate DIPC/ Lead Nurse IPC	To attend scheduled meetings. To provide expert advice and support as required.					
	Medical Devices Committee	DIPC/ CO	To attend scheduled meetings. To provide expert advice and support					

IPC Code & Trust Values	Plan & Priority Activities 2018-19	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
			as required.					
	Trust Quality meetings • ***CQAC*** • ***CQSG*** • ***CQPG***	Associate DIPC Lead Nurse IPC to deputise. IPCT to attend ad hoc for training purposes.	To attend scheduled meetings. To provide expert advice and support as required.					
	Theatre Safety Board	LM/CO	To attend scheduled meetings. To provide expert advice and support as required.					
		Associate DIPC/ LM/CO	To assist in the introduction of the OneTogether programme.					
	Trust Board	DIPC/ Associate DIPC	To attend scheduled meetings. To provide expert advice and support as required.					
13. Gram Negative Bacteraemia								
IPC Code: 1,3,4,5,6,7,8 & 9 **Trust Values:** Excellence Innovation Respect Together	Adherence with regards to Gram Negative Blood Stream Infections (GNBSIs) targets	DIPC/ Associate DIPC	To attend whole health economy meetings to develop robust action plans to tackle gram negative bacteraemia reduction targets.					
		IPC Data Analyst	Ecoli, Klebsella spp, Pseudomonas aeruginosa bacteraemia data to be recorded on the MESS system.					
		DIPC/ Associate	PIR reviews to be commenced for all					

IPC Code & Trust Values	Plan & Priority Activities 2018-19	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
Openness		DIPC	named gram negative bacteraemia.					
		Associate DIPC/IPC Data Analyst	Trust wide situation reports to be developed to share lessons learnt.					
		Associate DIPC	PIR reviews to be shared across the whole health economy and NHSI.					
14. Community								
IPC Code 1, 2, 3, 4, 5, 6, 8, 9. 10 **Trust Values** Respect Excellence Innovation Together Openness	To ensure that a high quality a Infection Prevention Service (IPC, Tissue Viability and IV services) is delivered to Community Services	Sarah Stephenson (SS) – Quality Lead for Community, Associate DIPC	To scope out the provision and requirements for Infection Prevention Services for Community Services. To include an audit programme, specific training – mandatory and ad hoc, advisory services and Link personnel updates and requirements. To include what is achievable able with the existing team resources.					
			Impact assessment on the existing Infection Prevention Services in delivering the required service to the Community.					
			Development of a Business case to deliver the appropriate identified service across Community services.					

Trust Wide Infection Prevention and Control Action Plans

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

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

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