Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS PUBLIC MEETING

Tuesday 5th March 2019 commencing at 09:45

Venue: Large Meeting Room, Institute in the Park

AGENDA

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action	Preparation
SAFEGUARD TRAINING led by Julie Knowles (09:45 – 10:15)						
INFORMATION GOVERNANCE TRAINING, led by Joanne Fitzpatrick (IG) Manager (10:15 – 10:30)						
PATIENT STORY (1030 – 1045)						
1	**18/19/321**	**1045**	**Apologies**	Chair	To note apologies.	For noting
2	**18/19/322**	**1045**	**Declarations of Interest**	All	Board Members to declare an interest in particular agenda items, if appropriate.	For noting
3	**18/19/323**	**1045**	**Minutes of the Previous Meeting**	Chair	To consider the minutes of the previous meeting to check for amendments and approve held on: **Tuesday 5th February 2019**	Read Minutes
4	**18/19/324**	**1048**	**Matters Arising and Action Log:**	Chair	To discuss any matters arising from previous meetings and provide updates and review where appropriate.	Verbal
5	**18/19/325**	**1050**	**Key Issues/Reflections**	All	Board to reflect on key issues.	Verbal
Strategy						
6	**18/19/326**	**1105**	**Progress against Strategic Plan 2018- 2021**	D Jones	To receive update report	Read report
Delivery of Outstanding Care						
7.	**18/19/327**	**1120**	**Department for Infection Prevention and Control Quarter 3 report**	V Weston	To receive the Quarter 3 report	Read report
8.	**18/19/328**	**1130**	**Complaints Quarter 3 report**	A Hyson	To receive the Quarter 3 report	Read report
9.	**18/19/329**	**1140**	**Serious Incidents Report**	C Umbers	To inform the Board of the recent serious incidents at the Trust in the last calendar month.	Read report

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action	Preparation
10.	**18/19/340**	**1145**	**Global Digital Exemplar (GDE) update**	P Young/ C Fox	To update the Board on the programme.	Read report
11.	**18/19/341**	**1200**	**Alder Hey in the Park Site Development update** - **Update included on North East plot**	D Powell	To receive an update on key outstanding issues / risks and plans for mitigation.	Read report
12.	**18/19/342**	**1210**	**Clinical Quality Assurance Committee: Chair's update:** - **Chair's verbal update from the meeting that took place on the 20.02.19** - **Minutes from the last meeting held on 11.12.18 and 16.01.19.**	A Marsland	To receive a verbal update from the February meeting and the approved minutes held in December 2018 and January 2019.	Read minutes
The Best People Doing Their Best Work						
13.	**18/19/343**	**1215**	**People Strategy:** - **Staff Survey Report** - **Update on actions on Medical Appraisals** - **Gender Pay Gap Report** - **Workforce and Organisational Development Committee minutes from the meeting held on 23rd October 2018**	M Swindell C Dove	To provide an update.	Read report
Lunch (12:30-13:00)						
14.	**18/19/344**	**1305**	**Freedom to Speak up Guardian**	E Saunders/ Chair	To approve proposed actions.	Read report
Sustainability Through External Partnerships						

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action	Preparation
15.	**18/19/345**	**1310**	**Joint Neonatal Partnership – Alder Hey and Liverpool Women's Hospital.**	A Bateman	To update the Board on progress.	Verbal
Strong Foundations						
16.	**18/19/346**	**1315**	**Kark Report**	E Saunders	Findings and recommendations of the Kark review on the Fit and Proper Person Test	Read report
17.	**18/19/347**	**1325**	**Recruitment of Non-Executive Director:** - **Appointment of Senior Independent Director**	Chair	To review and agree the Job Description	Read report To follow
18.	**18/19/348**	**1340**	**Business Continuity Plan – Brexit**	J Grinnell/ L Stark	To update the Board as to preparations for a 'no deal' exit from the EU.	Presentation
19.	**18/19/349**	**1350**	**2019/20 Control Total**	J Grinnell	To receive the budget setting process for 2019/20.	Presentation
20.	**18/19/350**	**1400**	**Programme Assurance update:** - **Deliver Outstanding Care.** - **Growing External Partnerships.** - **Solid Foundations.** - **Park Community Estates and Facilities.**	N Deakin	To receive an update on programme assurance including the 2018/19 change programme.	Read Report
21.	**18/19/351**	**1405**	**Resources & Business Development Committee:** - **Chair's verbal update from the meeting held on 27th February 2019** - **Approved minutes from the meeting held on 23rd January 2019**	I Quinlan	To receive the approved minutes and a verbal update from the last meeting.	Read report

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action	Preparation
22.	**18/19/352**	**1410**	**Audit Committee:** - **Chair's verbal update from the meeting held on 24th January 2019** - **Approved minutes from the meeting held on 22nd November 2018**	K Byrne	To receive the approved minutes and a verbal update from the last meeting.	Read report
23.	**18/19/353**	**1415**	**Corporate Report** - **Monthly update by Executive Leads.**	J Grinnell/ C Umbers/ M Swindell	To note delivery against financial, operational, HR metrics and quality metrics and mandatory targets within the Corporate Report.	Read report
24.	**18/19/354**	**1425**	**Board Assurance Framework**	Executive leads	To receive an update.	Read report
25.	**18/19/355**	**1430**	**Trust Board Work plan**	ALL	To approve the 2019/20 Trust Board work plan	Read plan
Any Other Business						
26.	**18/19/356**	**1430**	**Any Other Business.**	All	To discuss any further business before the close of the meeting.	Verbal
Date And Time Of Next Meeting: Tuesday 2nd April 2019 at 10:00am, Large Meeting Room, Institute in the Park.						

REGISTER OF TRUST SEAL
The Trust Seal was not used during the month of **February 2019.**

PUBLIC MEETING OF THE BOARD OF DIRECTORS

Minutes of the meeting held on **Tuesday 5th February 2019 at 10:00am,**
Large Meeting Room, Institute in the Park

Present:	Sir D Henshaw	Chairman	(SDH)
	Mr. A. Bateman	Chief Operating Officer	(AB)
	Ms K Byrne	Non-Executive Director	(KB)
	Mrs C Dove	Non-Executive Director	(CD)
	Mrs J France-Hayhurst	Non-Executive Director	(JFH)
	Mr J Grinnell	Director of Finance	(JG)
	Mrs H Gwilliams	Chief Nurse	(HG)
	Mrs A Marsland	Non-Executive Director	(AM)
	Dr N Murdock	Medical Director	(NM)
	Mr I Quinlan	Vice Chair	(IQ)
	Mrs L Shepherd	Chief Executive	(LS)
	Mrs M Swindell	Director of HR & OD	(MS)
	Dame J Williams	Non-Executive Director	(JW)
In Attendance:	Prof M Beresford	Assoc. Director of the Board	(PMB)
	Ms L Cooper	Director of Community Services	(LC)
	Mr M Flannagan	Director of Communications	(MF)
	Dr A Hughes	Director of Medicine	(AH)
	Mrs D Jones	Director of Strategy	(DJ)
	Mrs S Owen	Deputy Director of HR & OD	(SO)
	Miss A Parsons	Governor, Volunteers	
	Ms J Minford	Director of Clinical Effectiveness and Service Transformation	(JM)
	Ms E Saunders	Director of Corporate Affairs	(ES)
	Mrs J Tsao	Committee Administrator (minutes)	(JT)
Apologies:	Mr C Duncan	Director of Surgery	(ChrD)
	Prof L Kenny	Executive Pro Vice Chancellor	(PLK)
	Mr D Powell	Development Director	(DP)
Agenda item: 299	Sue Brown	Associate Director for Development	
298	Cathy Fox	Associate Director IM&T	
301	Professor Matthew Peak	Director of Research	
302	Gavin Clearly	Acting Director of Medical Education	
	Lachlan Stark	Head of Performance and Planning	
	Natalie Deakin	Programme Assurance Manager	

Patient Story

The Board welcomed the parents of Joey to the Board. Joey had initially been taken to Whiston Hospital in November 2018 with stroke like symptoms and was transferred to Alder Hey later that day. A head scan showed tangled blood vessels in his brain, one had burst and had caused the symptoms. A decision was made to carry out life-saving surgery to remove the blood clot. The family were full of praise for the consultant and the clinical teams.

Following the successful surgery, Joey is re-learning to walk and speak. Mum spoke highly of the physio, speech and language therapists and the artistic workshops that had been set up to support Joey.

Mum had recorded a video of her story in support of Alder Hey.

On behalf of the Board the Chair thanked Joey's mum and dad for sharing their experiences with the Board.

18/19/293 Declarations of Interest

There were none to declare.

18/19/294 Minutes of the previous meetings held on 8th January 2019

The Board APPROVED the minutes from the meeting held on 8th January 2019.

18/19/295 Matters Arising and Action Log

The Chair welcomed Professor Nicki Murdock, Medical Director to her first Board meeting and congratulated Dame Jo Williams on her appointment as Chair, which had been approved by the Trust's Council of Governors on 31st January.

The Board noted all actions had either been added to the agenda for a further update or had been completed.

18/19/296 Key Issues/Reflections

Lisa Cooper highlighted it was national Mental Health week with events taking place across the Trust.

A discussion was held on the key strategic themes from the Provider Alliance, which are frail elderly and complex needs. It was agreed a letter would be sent to the Alliance Chair Joe Rafferty, CEO of Merseycare, to include focus on the Starting Well theme.

18/19/297 Serious Incident Report

The Board received and noted the contents of the Serious Incidents report for December 2018. During this reporting period there was one new serious incident in relation to the death of a 24 week gestation baby with co-morbidities. The baby had died following the transfer from Liverpool Women's NHS Foundation Trust. A number of lessons had been learnt on night transfers.

Hilda Gwilliams reported on the good engagement with colleagues at the Women's Hospital to produce the Serious Incident report.

Resolved:

The Board received the Serious Incident report for December 2018.

18/19/298 Global Digital Exemplar

The assurance review meeting with NHS Digital for funding milestone 5 was held on 9 January 2019. A letter confirming the funding was due to be received this week. Once confirmed the funding would be received in this financial year.

Cathy Fox reported that 32 of the 36 speciality packages are live. NHS Digital has signed off this position.

Standard documentation has been live since February 2018. Since their release the GDE team have undertaken a number of surveys and reviews of the documents to improve their ease of use and the new update is due to be released on 18th February 2019. There are 17 new standard forms, five of these are considered mandatory in documenting the corresponding clinical task.

Resolved:

The Board received the GDE update and congratulated the team on progress.

18/19/299 Alder Hey in the Park Site Development Update

Sue Brown provided a regular update to the Board with regard to the key components of the site as they currently stand.

Park

Engagement continues with the Friends of Springfield Park to develop the design of the Park, in particular whether activities are to be provided or whether there is a preference for more space.

Temporary Car Park

Planners are currently reviewing and have requested additional plans on the phasing of the car park, plus a review of the Trust's 2013 Travel Plan; this has been submitted along with the Community Cluster planning application. A decision is expected 23rd April.

A weekly meeting is taking place to ensure we can open the car park as soon as possible, with appropriate lighting and routes in and out of the site clearly communicated to staff and visitors.

The Chair asked if there was any further development in relation to leasing the Thomas Lane playing fields for use as a car park. Sue Brown said the project team are currently looking into an accessible footpath.

Institute in the Park Phase II

The project team are working through the defects in relation to the Phase II building. The spare part for the front door has been ordered and the work is due to be completed by the end of the month.

Professor Michael Beresford raised concerns with security in the new build and asked what was being put in place to improve the position. Sue Brown said security personnel are in the building until late and a second reception desk was to be placed next to the rear doors. Sue Brown agreed to provide an update to universities who are leasing space in the building.

Resolved:

The Board:

- Received the Park Site Development update.

18/19/300 Clinical Quality Assurance Committee

The Board received Anita Marsland's verbal update from the Clinical Quality Assurance Committee that took place on 16th January 2019. An update had been received on Models of Care and Transition. The Board discussed the approach required to progress work across the system on transition for young people to adult services.

The Board noted the following areas of action:

- To agree approach and protocols
- Liaise with Director for Adult Services at the local authority
- Dani Jones agreed to lead on a strategic piece
- It was agreed that assurance would be monitored through CQAC.

Resolved:

The Board received and noted:

- The verbal update from the Clinical Quality Assurance Committee meeting that took place on 16th January 2019.
- Actions agree to progress the work on Transition for young people.

18/19/301 Approve Terms of Reference for new Research Management Board

The Board received the above Terms of Reference.

Professor Matthew Peak noted the RMB had been set up in response to the Trust's Well Led review, as well as anticipating the CQC's inspection approach to research which will focus on how embedded research activity is within an organisation's activities. The RMB will provide a forum in which the clinical Divisions can take forward their research plans, aligned to the research strategy; it will report into the Clinical Quality and Assurance Committee.

Resolved:

The Board APPROVED the Research Management Board Terms of Reference.

18/19/302 People Strategy Update

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

- The Trust's Annual Star Awards are to take place on Friday 8th February 2019 at the Titanic Hotel. 240 nominations had been received.
- Following the statement from NHS Employers to phase out band 1's a working group has been set up to review and amend job descriptions as well as providing support to staff.
- A number of trusts are working in partnership to develop resolution guidelines to reduce the number of cases going to Tribunal.

Health Education England Report

Dr Gavin Clearly presented the quality review outcome report and action plan from the last HEE assessment visit. The priority areas outlined in the report are:

- On call working, patient tracking, incident reporting, responsibility for patients and handover
- Improving the educational component of handover
- Induction of Junior Doctors
- Educational governance structures

The Board discussed the need for a focused approach to supporting junior medical staff. Nicki Murdock agreed to develop a strategy on education (including research) for junior doctors to be presented at the May Board.
Action: NM

A response on the report would be submitted to HEE no later than the 20th February 2019.

Resolved:

The Board received and noted:

- People Strategy update for December 2018
- Noted actions in place in response to HEE report.

18/19/303 Register of Company Shareholder Interests

The Board received the above register.

John Grinnell reported on an action from the Audit Committee for KPMG to review governance arrangements relating to the Trust's partnership with Acorn Ltd. A workshop on this would be held the first week in March. All Board members were

invited. Both Dame Jo Williams and Ian Quinlan agreed to attend. Ian Quinlan highlighted risks with shareholdings over 30% with no lead Director. John Grinnell advised this would be picked up with KPMG.

Resolved:
The Board received the register of company shareholder interests and the update regarding KPMG's work on governance arrangements with Acorn Ltd.

18/19/304 Joint Neonatal Partnership – Alder Hey and Liverpool Women's Hospital
Adam Bateman reported that Specialised Commissioners had confirmed final approval of the business case for a 22 cot unit to be opened in 2021.

Jo Minford reported on a joint workshop with Liverpool Women's Hospital colleagues to agree the estate requirements for the service. Sue Brown said the estate was currently being reviewed to agree if the unit would be included in the building or whether a new build would be required.

One of the last phases was the transition of ventilated patients. As these patients are the highest risk group, the phasing of the programme would need to be re-visited. Adam Bateman agreed to inform the working group of this consideration.

Resolved:
The Board received the update on the Joint Neonatal Partnership and the successful allocation of 22 cots.

18/19/305 Business Continuity Plan – Brexit
Lachlan Stark presented the Brexit continuity plans in preparation for 29th March 2019.

Operational guidance was published on 21st December with a number of technical notices identifying areas of concern. This formed the basis of the risk assessed approach to developing business continuity plans. Further correspondence has been received today from Professor Keith Willett, EU Exit Strategic Commander.

The DHSC is establishing a national Operational Response Centre (ORC) which includes NHS England, NHS Improvement and Public Health England. This entity will lead on responding to any disruption to the delivery of health and care services in England that may be caused or affected by the EU exit.

Lachlan Stark noted that the Trust's continuity plans would be tested by the end of the month.

Resolved:
The Board received the business continuity plan in relation to Brexit noting that monthly updates would be received.

18/19/306 2019/20 Draft Control Total and Budget Setting
John Grinnell presented the draft control total for 2019/20 highlighting:

- Control total set at £2.8m. This is lower than last years' due to the children's tariff revenue reduction.
- Children's tariff reduction £3m (cash downside) – Trust continuing to raise the negative impact with the centre.
- £1.1m efficiency stretch requirement as underlying deficit
- Trust Assessment concluded there is a control total calculation issue of £2.3m and cash downside of £3.7m.

In planning for the 2019/20 budget it was assumed that the control total was accepted with no change to contract setting with commissioners. This would impact as follows:

- Remain in underlying deficit
- Challenging budget with cash downside (circa £4m subject to children's tariff)
- Level of cost pressure/development request exceeds available pot (potential £6m risk)
- Efficiency at 3% requires a radical set of schemes required
- Commissioner position is still under development – could pose a further risk.

Resolved:
Due to the potential £6m risk the Board agreed it would not be able to accept the control total in its current guise. John Grinnell and the Chair agreed to draft a letter to Baroness Dido Harding, NHS Chair highlighting the risks to the Trust and agreeing away forward.

18/19/307 Programme Assurance Update

Natalie Deakin presented the Programme Assurance report for December 2018 highlighting the slide with a line showing projects that hadn't started. One of the projects E-Rostering had been on hold while it was agreed whether it was beneficial to run this project. The outcome was to go ahead with the project and this was due to start in the next couple of weeks.

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

18/19/308 Resource and Business Development Committee

Ian Quinlan gave a verbal update from the meeting held on 23rd January 2019 noting the focus to meet the 2018/19 Control Total.

Resolved:
The Board received and noted the approved minutes from the Resource and Business Development Committee held on 18th December 2018.

18/19/277 Corporate Report

Performance
Adam Bateman noted the strong performance against national standards for the month of December with delivery of Emergency Department, access and cancer standards.

Finance
December was a strong month financially. The Control Total was over achieved by £0.6m thus achieving the Q3 plan which was critical for attaining the associated PSF payment. Year to date we now stand at a £12.5m surplus against a £12.4m plan.

Quality
Hilda Gwilliams updated the Board on the two areas below:
Safe – The Board noted the clinical incident resulting in an unexpected death and the update received under the Serious Incident Item.

Due to the review of a number of medication errors a report had been submitted to CQAC requesting increased support for Medication Safety Officers and a workforce review to implement pharmacy technicians in each inpatient area.

Caring – ED performance improved by 10% in month following a challenging year and a focused work stream addressing concerns identified in the survey findings.

Resolved:
The Board received and noted the contents of the Corporate Report for month 9.

18/19/278 Board Assurance Framework (BAF)

The Board received the BAF update for January 2019. Erica Saunders reported that the majority of strategic risks had been picked up through substantive agenda items, other than the building risks, although an updated position with regard to mitigations had recently been reported via RBD and IGC.

Erica Saunders and John Grinnell agreed to include a specific risk linked to the business continuity plans for Brexit.
Action: ES & JG

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

18/19/249 Any Other Business

Sir David Henshaw's retirement
On behalf of the Board Ian Quinlan thanked the Sir David for his leadership over the last eight years and wished him well for the future.

Date and Time of next meeting: Tuesday 5th March 2019, 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 4.9.18

Alder Hey Children's NHS Foundation Trust

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
Actions for March 2019							
4.9.18.	18/19/154.1	2018 Annual Report for the Framework of Quality Assurance for Responsible Officers and Revalidation	Liaise with Melissa Swindell, Medical HR and the Medical Education Team to look at resolving the issue around the management/inputting of data relating to new recruits.	Gavin Clearly	5.3.19.		27.9.18 - An update will be provided during March's Trust Board meeting on the 5.3.19 under People Strategy.
4.9.18.	18/19/154.2	2018 Annual Report for the Framework of Quality Assurance for Responsible Officers and Revalidation	Discuss the possibility of accessing/triangulating information relating to complaints, incidents and PALS concerns to enable doctors to use this data as part of the reflective element of the appraisal process.	Gavin Clearly	5.3.19.		27.9.18 - An update will be provided during March's Trust Board meeting on the 5.3.19 under People Strategy.
Actions for April 2019							
23.01.19	18/19/143.3	PFI	To update the Board on progress against pipes	Graeme Dixon/David Powell	4.4.19		As this item was being presented to the March IGC this item was deffered until April 2019
Actions for May 2019							
5.2.19	18/19/302	People Strategy Update	To develop a strategy on education including research for Junior Doctors	Nicki Murdock	7.5.19		

Status	
Overdue	
On Track	
Closed	

Alder Hey Children's NHS
NHS Foundation Trust

Strategic Plan 2018-21 – Update as at March 2018

	Strategic Objective	Progress March 2019
Delivering Outstanding Care	Alder Hey will be inspired by Quality which is led from the front line.	Inspiring Quality Delivery Plan in development, including formation of clinical cabinet, appointment of programme manager, work stream leads agreed. Collateral materials commissioned including video, IQ hub and huddle boards.
	Introduce digital pathways to improve patient care across all specialities	32 out of 52 speciality packages implemented to date; next milestone of 52 to be achieved by November (on track).
	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	Brilliant Booking & Scheduling; - Implementing bi-directional texting (rolled out in a number of services and more to follow) which allows families to confirm they can attend their appointment or request a cancellation. - A new booking and scheduling model (Hybrid Booking) being rolled out (May 19) which supports patients being booked in priority / chronological date order with regular review. Patient Flow; - The SAFER care bundle has been implemented on six wards; the percentage of children discharged by 12.00pm increase by 4.7% over each ward. - Standard documentation now in use which requires mandatory completion of an Estimated Date of Discharge. 'Hospital Manager of the Week' has been implemented to ensure timely decision making and a point of contact for escalation. - Working towards a full Trust SAFER launch for September 19. Best in Acute Care; - Created a new team to manage complex patients and an investment plan for an Acute Care Team approved. - Task and finish group established by COO – three 3 phases of delivery underway; diagnostics and project scoping, design new model of care, and make recommendations. Business case scheduled for Operational Delivery Board (28/3/19)

		Comprehensive Mental Health; - Capital secured for Tier 4 plans approved - Trailblazer (schools Liverpool) awarded) Best in Outpatient Care; - Improving patient satisfaction with and experience; through improved play and distraction, flow and booking have resulted in better patient experience (FFT score increased from 89% in March 18, 92% in Dec 18) - Improving clinician experience by 15% (6 monthly survey – Baseline 45 % satisfied in March 18; 60% satisfied at re-survey in Sept 18. Next survey due March 19.
	Achieve outstanding performance in all CQC domains at every level	100% of Must Do actions have been completed, as outlined in Trust, Community and OPD action plans. Action plans monitored through monthly CQAC and Divisional Integrated Governance Meetings. Good progress with remaining actions, with 80% due to be completed due by the end of Q4. Some original timescales amended appropriately. One action relates to 3 year programme of GDE and one action is continually ongoing related to reporting SIRIs.
	Deliver the new Alder Centre	Project delayed due to cost creep. Budget re-set with new target start date 1st week March.
	Develop our Health Park vision	Paper discussed at December Board new Park design being taken to planning in April with public involvement.

	Strategic Objective	Progress March 2019
Supporting the Best people to do their best work	Our workforce must reflect the diversity of the communities we serve, and we will improve the experience of our staff from Diverse backgrounds	Chairs returned to present progress to Board in January 2019 -LGBTQI+ Network now established -Staff Survey results demonstrate improvements in staff reporting discrimination due to their ethnic background – 15.9 % in 2017 to 10% in 2018 -Trust has engaged in the process to attain the Navajo Merseyside & Cheshire (LGBTIQ) Charter Mark
	We will have identified supply pipelines for all key staffing groups, working in partnership with our local HEI's	-Nurse associate roles being supported -Nurse student placements being explored with Keele university
	Deliver at least 50 apprenticeship starts through the Academy each year	-There are now 61 learners enrolled on an apprenticeship. -Alder Hey chosen as Employer/ Apprentice Ambassadors for the Liverpool City Region -Southport College have nominated the Trust for an Employer Award due to successful partnership working
	Implement the Wellbeing Strategy, supporting staff to improve all aspects of their health and wellbeing – with a focus on a reduction in sickness absence	-Wellbeing Strategy roll-out continues -'Time to Change' mental health awareness programme underway -January 2019 sickness rate 5.5%, down from 6% in December 2018 -Bid for central funds to support staff weight loss initiative -Successfully hosted the annual Star Awards
	Build line, clinical and system leadership capability; focused on supporting quality improvement	Cohort 1 of the Mary Seacole Leadership Programme launched in –house. This is a national programme delivered via licence in-house. Cohort 1 at capacity, with Cohort 2 already full. -Leadership apprenticeships continue -Strong Foundations Programme in development to be launched in April 2018 -Leadership Strategy presentation delivered to all divisional awaydays

	Strategic Objective	Progress March 2019
Sustainability through external partnerships	Deliver single neonatal service in partnership with Liverpool Women's Hospital	7 day service for the Neonatal Unit established and running. Business Case submitted to specialist commissioners agreed in principle for 22 cots; work to further evidence the need for the additional 2 cots underway.
	Deliver all-age Coronary Heart Disease Services in partnership with Liverpool Heart and Chest, Royal Liverpool University and Liverpool Women's Hospital	Level 1 adult congenital heart disease underway in Liverpool. Partnership bid for broadened all-age CHD network arrangements submitted to NHSE in January 19
	Deliver Liverpool Children's Integrated Transformation Plan	- Children's Transformation Plan progressing - Action plan and deliverables in place with clear leads. - Development of 2 x pilot 'community hubs' for Children in Speke and Aintree underway (workshops Feb 19) - Development of the model for Paediatric Urgent Care (within all-age model) underway; presented to Liverpool Provider Alliance January 2019.
	Increase specialist child health services regionally, nationally and internationally	- Partnership with Manchester Children's progressing; Partnership Board in March will receive proposed strategies for Neurosciences and Cardiology, and MOU. - Partnership work with Southport and Ormskirk progressing. - Ongoing discussions with NHS England regarding increase Tier 4 beds to 9 for 2019/20
	Lead the co-creation of new models of care for paediatric mental health with Mental Health and LD Programme as part of the Cheshire and Merseyside Sustainability and Transformation Partnership	- STP focusing on new models of care for Tier 4. Presentation delivered to execs in December 2018 outlining strategy.
	Develop regional paediatric / neonatal services as part of Women's and Children's Partnership (STP)	- CEO's of Alder Hey and LWH take up as joint SRO's of the C&M W&C programme and the cross-cutting theme in April; planning next stage of programme underway (plan on a page complete).

	Strategic Objective	Progress March 2019
Game changing research and innovation	Establish a 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 opportunities	Some elements of October Trust Board activated/implemented, notably: - Agreement of Associate Divisional Research Directors (Clinical) [ADRD} - Support for UoL honorary chairs - Senior Research Nurse post submitted to IRG - Workshop on integrated plan for research facilitated by Director of Research and COO - Research Management Board ToR approved by Trust Board - Winner at UoL Staff Awards
	Strengthen our position to attract and appoint internationally renowned leaders and new talent in paediatric research	Update on chairs offered by UoL: - Epilepsy - Job description developed and UK candidate visited Liverpool to meet senior personnel - Cardiac – discussions ongoing with Prof Lip (UoL) and cardiac surgeons (not cardiologists) - Infection – needs to be linked to BRC plans - Public Health – no progress to report - Other – Prof Iain Buchan has affiliated his NHS honorary contract and NIHR Senior Investigator award with Alder Hey - Meeting between representatives of Alder Hey Charity and Trust held in Jan 2019. Director of Research and Brough Chair have proposed an investment plan for research based on £600k p.a. from Charity.
	Contribute to specialist paediatric education through Alder Hey Academy	Award winners in the Great China awards North West 2019, held by the Department for International Trade for the Observership programme. -Academy visit to Shanghai planned for May 2019
	Co-create with staff a new set of innovation products whilst Alder Play is rolled out	Health Innovation Exchange Project continuing to progress against agreed KPIs and on track with majority of outputs, including collaborations with Knowledge Base. Lone Worker App currently being trialled in Community and Mental Health Division with good engagement from staff.
	Integrate front line and research activity through an increasing number of clinicians involved in research	3 x honorary Profs and 1 x honorary Associate Prof appointed. Meeting of these 4 + Research Director and Brough Chair held in Feb 2019 – agreeing roles and responsibilities and development of leadership capabilities. Each to check within host division options for protected research time.

		No new mechanisms yet for increasing institutional capacity for healthcare professionals to contribute to research compared to current status. Will be key role for ADRDs
	Contribute to Liverpool Health Partner themes relevant to 'Starting Well'	Prof Beresford appointed as LHP Starting Well Programme Lead with Carrie Hunt as Programme Manager. Series of meetings underway between Starting Well Lead/Manager and key Trust personnel, other LHP Theme Leads etc. Key year one objective for Starting Well Theme being finalised (with input from Director of Research).

Alder Hey Children's NHS
NHS Foundation Trust

IPC REPORT
Q3 2018-19
(1st April 2018 – 31st December 2018)

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

The work plan for 2018-19 consists of 14 objectives and a total of 118 deliverables. To date ***75%*** (88/118) of the total of deliverables have been completed. ***19%*** (23/118) of the total deliverables are in progress (amber). ***0%*** are classified as red. 6% (7/118) are classified as grey as these are new objectives that have not yet been progressed. Please see table 1 below for RAG rating.

Reporting Period	No of objectives	No. of deliverables	Red	Amber	Green	Grey *New
Q1	14	118	0% (0)	25% (30)	59% (70)	16% (18)
Q2	14	118	0% (0)	21% (25)	72% (85)	7% (8)
Q3	14	118	0% (0)	19% (23)	75% (88)	6% (7)

Table 1: Deliverables RAG rating

Tables 2, 3 and 4 below show the total number of hospital acquired bacteraemia each quarter for 2018-19 compared to 2017-18. Table 4 shows the cumulative total for Q1/Q2/Q3 2017-18 compared to 2018-19.

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

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

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

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

Bacteraemia	Q3 17-18	Q3 18-19
MRSA	2	↓ 0
MSSA	4	↓ 3
E.coli	2	↑ 4
Klebsiella	4	↓ 2
Pseudomonas	1	↓ 0
Infections		
Cdiff	0	⟷ 0
Outbreaks	3	↓ 0

Table 4: Hospital acquired bacteraemia Q3 2017-18 and 2018-19

Bacteraemia	Cumulative 17-18	Cumulative 18-19
MRSA	2	↓ 0
MSSA	11	↓ 5
E.coli	4	↑ 7
Klebsiella	5	↓ 4
Pseudomonas	2	↓ 1
Infections		
Cdiff	0	↔ 0
Outbreaks	3	↓ 0

Table 5: Hospital acquired bacteraemia Q1, Q2, Q3 2017-18 and 2018-19

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

Metric	Target 2018-19	Target Figure	Actual Figure	Current Status
HA - MRSA (BSI)	*Zero Tolerance*	***0***	***0***	✓
C.difficile	*Zero Tolerance*	***0***	***0***	✓
MSSA	*25% Reduction from 17-18*	***10***	***5***	✓
CLABSI (ICU Only)	*10% Reduction from 17-18*	***18***	***14***	✓
Gram-Negative BSI	*10% Reduction from 17-18*	***14***	***12***	✓

Table 6: 2018-19 Targets

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

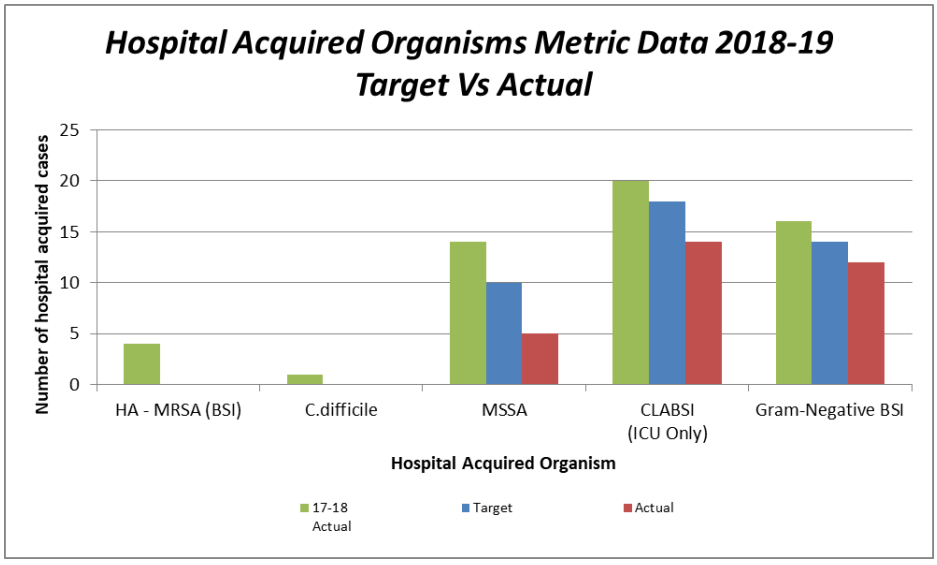

Table 7: Metric Data Actual VS Target.

Infection Prevention & Control Annual Work Plan 2018-2019

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

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

Alder Hey Children's NHS
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Infection Prevention & Control Annual Work Plan 2018/19

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

IPC Code & Trust Values	Plan & Priority Activities 2018-19	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
	PA/Admin assistant - shared with the Sepsis Team(band 4)	Romi Eden (RE)						
	Infection Prevention & Control Committee (IPCC) The IPC reports to the Board via the IPCC. The IPCC meets 6 times per year and is chaired by the DIPC. The Terms of Reference were reviewed and amended in February 2018.	DIPC and Associate DIPC						
2. *Surveillance*								
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 monitored.					

IPC Code & Trust Values	Plan & Priority Activities 2018-19	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
	CPE	Microbiology and IPC Team	To instigate an incident meeting with clinical team for all hospital acquired cases. Disseminate lessons learned for the process and actions required and monitored.					
			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.					***Q1*** *- Business case submitted. Further data required for review July meeting.* ***Q2*** *– Business case successful August 2018.*
	Surgical Site Infection (SSI) for Orthopaedics (spinal, elective implants and k wires), Cardiac Surgery, Neurosurgery and plastics.	Microbiology, LM, Theatre safety board & clinical Review Panel	To assist in the collection and submitting of data for SSIs. To disseminate reports to the relevant clinical staff. To include data and reporting in the DIPC IPC report on a quarterly basis.					
			To support the clinical teams to take more ownership of their SSI data – through attendance at the SSI teaching sessions at Colindale London. To support the investigation and presentation of incidences of SSI through the RCA process at the Review Panel meetings and to support the dissemination of lessons learned to the relevant staff and actions required and monitored.					***Q1****-Review panels to be progressed once IPC Doctor is in post. New SSI reporting template (Shared by Royal Wolverhampton Hospital) – work to be progressed so that reporting can be available across the surgical division.* ***Q2*** *– To progress with introduction of review panels with significant infections. IPC Lead Theatres and ADIPC to attend December SSI training. Two places booked for 6th Dec.* ***Q3*** *– SSI MDT validation meetings to commence Jan 2019. ADIPC and IPC Lead in Theatre attended SSI teaching in Collindale 6th Dec 18.*

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

IPC Code & Trust Values	Plan & Priority Activities 2018-19	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
								Trust in Infection Control Week (15th October 2018). *Update: Due to Industry partner reorganisation plans have halted associate DIPC to seek alternative Industry Partner.* ***Q3** – Initial company has now pulled out of this initiative. IPC team are currently exploring other parties to progress this work.* *Update: New industry partner sourced. Initial meeting to be commenced in January.*
			Present finding of the pilot study to the Trust, and at the Infection Prevention Society Conference – October 2018.					***Q1** – Awaiting commencement of pilot study.* ***Q2** – As above to be progressed once alternative industry partner has been found.* ***Q3** – To be progressed once alternative industry partner has been found.*
			Write up study for publication.					***Q1** – Awaiting commencement of pilot study.* ***Q2** – As above to be progressed once alternative industry partner has been found.* ***Q3** – To be progressed once alternative industry partner has been found.*
			If pilot successful – to introduce scheme across the Trust.					***Q1** – Awaiting commencement of pilot study.* ***Q2** – As above to be progressed once alternative industry partner has been found.* ***Q3** – To be progressed once alternative industry partner has been found.*
	To scope and implement new and innovative hand hygiene signage across the Trust.	IPC Team	To explore the feasibility of introducing new and innovative hand hygiene signage across the Trust.					***Q1** – ADIPC to approach hand hygiene industry partner to scope feasibility of developing new signage.* *Q2 – Roll out of new hand hygiene products across the Trust now completed, including increased signage in public areas.* ***Q3** – Plans to look at this with Communications team. New and*

IPC Code & Trust Values	Plan & Priority Activities 2018-19	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
								innovative ways to promote hand hygiene for staff, patients and visitors.
	To explore new hand hygiene audits tools and technology incorporating the use of Protective Personal Equipment (PPE)	Hand Hygiene audit tools – IPC Team	IPC team to source, trial and decide on new hand hygiene tool.					***Q1*** *– IPC to discuss new hand hygiene alternatives. IPC hand hygiene summit to be organised.* ***Q2*** *– Industry partner in process of setting up system to fit Trust requirements. Training sessions organised for users in Sept and Oct 2018 with launch to follow.*
		New Technology – IPC Team and data analyst (CQ)	IPC team and CQ – to investigate how new tool can be recorded and results disseminated across the Trust.					***Q1*** *– IPC to discuss new hand hygiene alternatives. IPC hand hygiene summit to be organised.* *Q2 – Summit has taken place. Industry partner in process of setting up system to fit Trust requirements. Training sessions organised for users in Sept and Oct 2018 with launch to follow.* ***Q3*** *– New hand hygiene app rolled out across the Trust.*
	To ensure that the non-compliance with hand hygiene proforma is utilised throughout the Trust.	DIPC, Associate DIPC and IPC Team	IPC team to scope how non-compliance can be reported across the Trust.					***Q1*** *– IPC to discuss new hand hygiene alternatives. IPC hand hygiene summit to be organised.* ***Q2*** *– Discussions have taken place to scope out new non-compliance proforma. To be trialled on a medical ward.* ***Q3*** *– Proforma to be introduced on medical ward and evaluated.*
			IPC team to communicate the process via the Link Nurse/Representatives and the governance structures					***Q1*** *– IPC to discuss new hand hygiene alternatives. IPC hand hygiene summit to be organised.* ***Q2*** *– To be progressed following proforma. Lead IPC Nurse to liaise with identified link nurses in the medical division.* ***Q3*** *– Proforma to be introduced on medical ward and evaluated.*
	Introduction of new	Lead Infection	Dissemination of new hand hygiene					***Q1*** *– To be scheduled into Link Nurse Programme.*

IPC Code & Trust Values	Plan & Priority Activities 2018-19	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
	hand hygiene audit technology as part of monthly audit indicators	Prevention & Control Nurse, IPC Team& link nurses	audit technology to link personnel through meetings and training					***Q2*** *– Summit has taken place. Industry partner in process of setting up system to fit Trust requirements. Training sessions organised for users in Sept and Oct 2018 with launch to follow.* *Update: Now completed.*
	To ensure that hand hygiene technique assessments are recorded as a mandatory field on an annual basis for all clinical staff and reflected in ESR.	Associate DIPC and Learning and Development.	To explore the feasibility of putting hand hygiene compliance on the ESR system for all clinical staff on an annual basis.					***Q1*** *– Meeting arranged with Head of Learning and Development 5th July 2018.* ***Q2*** *– Awaiting feedback from L&D. Reminder sent to L&D awaiting reply.* ***Q3*** *– Further discussions have taken place with L&D. Awaiting decision.* *Update: Now agreed. Awaiting implementation via ESR.*
			Once hand hygiene assessments are recorded on ESR. To develop a monitoring system across the Trust.					***Q1*** *– Awaiting meeting with L&D.* ***Q2*** *– Awaiting feedback from L&D. Reminder sent to L&D awaiting reply.* ***Q3*** *– Awaiting feedback from L&D.*
			Include compliance in IPC Dashboards to provide assurance.					***Q1*** *– Awaiting meeting with L&D.* ***Q2*** *– Awaiting feedback from L&D. Reminder sent to L&D awaiting reply.* ***Q3*** *– Awaiting feedback from L&D.*
4. Policies								
IPC code 1,2,3,4,5,6,7,8,9 & 10 **Trust Values** Respect Excellence Innovation Togetherness Openness	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					
5. ANTT								

IPC Code & Trust Values	Plan & Priority Activities 2018-19	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
IPC Code: 1,2,3,4,5,6 & 9 **Trust Values:** Excellence Openness Respect Together Innovation	Monitor Trust wide compliance and increase compliance.	ANTT Specialist Nurse	Provide updated compliance figures to the relevant care groups and for IPCC.					
			ANTT compliance scores to be communicated in IV Newsletter and IPCC Report.					
			ANTT compliance scores communicated in ward and department dashboards.					
	To ensure that ANTT assessments are recorded as a mandatory field on an annual basis for all clinical staff and reflected in ESR.	Associate DIPC, ANTT Specialist and Learning and Development	To explore the feasibility of putting ANTT annual assessments on the ESR system as a mandatory field for all clinical staff.					***Q1*** *– ADIPC to meet with L&D Lead. Meeting scheduled for 5th July 2018.* ***Q2*** *– Meeting has taken place. Awaiting discussion from L&D. Reminder sent to L&D awaiting reply.* ***Q3*** *– Further discussions have taken place with L&D. Awaiting decisions.*
	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.					
	Liaise with St Helens and Knowsley Trust regarding standardising ANTT rotational staff assessments	Associate DIPC/SM	To develop a SOP to standardise ANTT assessments for rotational staff recognising from other Trusts within the last 12 months.					***Q1*** *– SOP discussions have taken place to be progressed.* ***Q2*** *– Meetings have taken place across the North West with regard to standardising ANTT training. Permission has been granted by National ANTT authors to progress standardisation across the whole of the North West.*

IPC Code & Trust Values	Plan & Priority Activities 2018-19	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
								***Q3** – Work continues with IV Forum Group. ADIPC to attend meeting at Whiston February 2019.*
	Plan to expand this process to cover other Trusts in the North West	Associate DIPC/SM	To progress the work started with Whiston to other Trusts in the region through the North West IV Forum.					***Q1** – ADIPC progressing this work through NW IV Forum group.* ***Q2** – Meetings have taken place across the North West with regard to standardising ANTT training. Permission has been granted by National ANTT authors to progress standardisation across the whole of the North West.* ***Q3** – Work continues with IV Forum Group*
	Liaise with ANTT experts to review and refine existing processes.	Associate DIPC/SM	Attend annual ANTT conference and to attend North West IV Forum meetings.					***Q1** – ANTT Lead to attend conference in November 2018.* ***Q2** – ANTT place booked on Conference. New ANTT lead Nurse to attend conference on 2nd Nov 2018.* ***Q3** – Conference attended.*
6. Vascular Access								
IPC Code: **Trust Values:**	Improving patient flow for vascular access.	Lead Nurse IV	Initiation of GDE project – the use of digital technology to implement evidence based practice to improve patient care delivery.					***Q1** – GDE work complete and will be launched at the beginning of September 2018.* ***Q2** – GDE work now live.*
			Implementation of IV access team assessment from receipt of Meditech referral					***Q1** – GDE work complete and will be launched at the beginning of September 2018.* ***Q2** – GDE work now live.*
	Implementation of vessel health and preservation.	Lead Nurse IV	Initiation of GDE project incorporating VHP decision tool.					***Q1** – GDE work complete and will be launched at the beginning of September 2018.* ***Q2** – GDE work now live.*
	Improve workload awareness in vascular access team.	Lead Nurse IV ANS IV	Introduction of daily workload planner.					
	Widen accessibility of	IV Team and	Introduction of ward based					***Q1** – Dates to be scheduled workshop content completed.*

IPC Code & Trust Values	Plan & Priority Activities 2018-19	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
	teaching and training for MDT	Learning and Development	workshop/training updates to keep staff educated in the best evidence based vascular access practice.					***Q2***- *Completed*
			Training drop in sessions in clinical skills room accessible to MDT.					***Q1*** *– To be reviewed following workshop implementation.* ***Q2*** *– Drop in sessions commenced but did not work. Therefore piloting targeted training sessions organised through PDNs.* ***Q3*** *– Meeting with L&D in January 2019.*
			Records to kept by IV team and sent to L&D for recording on ESR.					***Q1*** *– Attendance records kept by IV Team for all training. Meeting to be scheduled with ESR Lead to discuss process.* ***Q2*** *– Awaiting meeting with L&D.* ***Q3*** *– Meeting with L&D in January 2019.*
	Review of Sharps safety and vascular access	IV Team ADIPC	Review of butterfly needles and clinical trials.					***Q1*** *– This will be reviewed following the cannula review. IV Team have started to obtain butterfly needles for review.* ***Q2*** *– Reviewed. Awaiting decision and feedback from IV Forum for trial. Table top review session organised for safety products in December 2018.* ***Q3*** *– Review completed. Trial of safety butterfly needles to commence January 2019.*
			Review of cannula and clinical trials.					***Q1*** *– Review underway. Workshop taking place July 2018 to discuss. Plan to take to table top exercise open to the Trust for evaluation.* ***Q2*** *– Reviewed. Awaiting decision and feedback from IV Forum for trial. Table top review session organised for safety products in December 2018.* ***Q3*** *– Review completed. Trial of safety cannula to commence early 2019.*
			Revisit innovative sharps disposal					***Q1*** *– Delay due to workload of IV Team and IPC Team. Meeting to be scheduled with company.* ***Q2*** *– Discussed at Sharps Safety Group. Product not suitable for entire Trust. A targeted trial introduction to be*

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

IPC Code & Trust Values	Plan & Priority Activities 2018-19	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
	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 for clinical staff.					***Q1*** *– IPC Team to be training in setting up e-learning packages.* ***Q2*** *– Team meetings have commenced to progress. Update: New innovative E-Learning package has been developed by an Industry partner. Alder Hey have been asked to be one of the first to trial specific e-learning packages for staff.* ***Q3*** *– Awaiting company experts to visit the Trust.*
			Non-clinical 3 yearly – work book					
			To develop a new E- Learning package to replace the work book. Following the same principles developed from the Clinical E-Learning package.					***Q1*** *– To be progressed once clinical staff package is developed.* ***Q2*** *– Team meetings have commenced to progress. Update: New innovative E-Learning package has been developed by an Industry partner. Alder Hey have been asked to be one of the first to trial specific e-learning packages for staff.* ***Q3*** *– Awaiting company experts to visit the Trust.*
	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					***Q1*** *– Training sessions continue. However update from wards and departments*

IPC Code & Trust Values	Plan & Priority Activities 2018-19	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
			training reported through IPC Dashboards					*remains sporadic.* ***Q2*** *– Fit testing compliance now forms part of the monthly dashboard.*
	Flu vaccinator Training	Lead Nurse IPC	Annual (4 sessions per year)					***Q1*** *– Training sessions arranged prior to flu season.* ***Q2*** *– Completed*
	Ad hoc training	IPCT	As required					
8. Audit								
IPC Code: 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								
	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
	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.					***Q1** – Initial discussions have taken place with Learning and Development. **Q2** – Induction programme agenda discussed and to be progressed. Q3 – Work continues to progress. Plan in place to deliver sessions by the end of financial year.*
			To introduce AMS training into mandatory training					***Q1** – Initial discussions have taken place with Learning and Development. **Q2** – Awaiting feedback from L&D **Q3** – Further meetings have taken place awaiting decisions from L&D.*
10.Communication								
IPC Code: 1,2,3,4,5,6,7,8,9 & 10 **Trust Values:** Excellence Openness Respect Together Innovation	IPC bi-monthly report	Lead Nurse IPC	IPC bi-monthly report reported through the IPCC.					
	IPC Dashboard	IPC Data Analyst	Monthly dashboard distributed Trust wide reported through Divisional Governance meetings and IPCC.					
	Communication with the Whole Health Economy	ADIPC	To attend HCAI/IPC meetings across the local area.					
	Communication with other Trusts and agencies such as Public Health England (PHE) and NHS England	IPCT	To attend local meetings. Communication and information gathering with other Trusts and agencies to assist in IPC investigations.					
	To keep Infection Prevention and Control	IPC Administrator	Ensure that the IPC intranet pages are kept up to date on a monthly basis or					

IPC Code & Trust Values	Plan & Priority Activities 2018-19	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
	Intranet page up to date with relevant information		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:** Excellence Openness	To continue to enhance the use of Meditech to assist the IPC team in monitoring HCAI	IPC Team, IT team and Pathology IT Manager.	Set up regular meetings to explore how the Meditech system can assist IPC.					***Q1*** *– Ad hoc meetings have taken place. Diary of regular meetings to be developed.* ***Q2*** *– Meetings convened and ongoing.*
	To develop opportunities to enhance	Consultant Infectious Diseases/ADIPC/	To instigate a working group to explore possibilities to enhance the surveillance systems and reporting					***Q1*** *– ADIPC to organise initial meeting.* ***Q2*** *– Awaiting arrival of IPC Doctor.* *Update: Meeting organised for 29th Oct to progress.*

IPC Code & Trust Values	Plan & Priority Activities 2018-19	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
Innovation Together	epidemiological surveillance systems and monitoring opportunities within the Trust	Data Analyst	across the Trust.					***Q3*** *– Meeting has taken place with ADIPC, IPC Dr and ID Dr ongoing meetings arranged for New Year.*
			To develop a business case to develop the enhanced surveillance system agreed.					***Q1*** *– To be progressed through working group.* ***Q2*** *– To be progressed through working group.* ***Q3*** *– To be progressed through working group.*
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					***Q1*** *– IPC review equipment as requested. However IPC not always involved in the process.* ***Q2*** *– ADIPC to highlight process through Divisional meetings.*
	To review new equipment /environmental utilisation	IPCT	Ad hoc meetings as required.					
	Decontamination	Lead Nurse IPC Associate DIPC to attend as required.	To attend scheduled meetings. To provide expert advice and support as required.					
	Water Safety	Associate DIPC	To attend scheduled meetings. To provide expert advice and support as required.					
	Health & Safety/IPC/Interserve & Building services	Associate DIPC/Lead Nurse IPC	To attend scheduled meetings. To provide expert advice and support as required.					

IPC Code & Trust Values	Plan & Priority Activities 2018-19	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
	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 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.					

IPC Code & Trust Values	Plan & Priority Activities 2018-19	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
		Associate DIPC/ LM/CO	To assist in the introduction of the OneTogether programme.					***Q1*** *– OneTogether programme instigated and progressing.* ***Q2*** *– IPC Lead for Theatre to progress and feedback to Surgical Division Board.* ***Q3*** *– IPC Lead for Theatre to progress and feedback to Surgical Division Board.*
	Trust Board	DIPC/ Associate DIPC	To attend scheduled meetings. To provide expert advice and support as required.					
13. Gram Negative Bacteraemia								
IPC Code: 1,3,4,5,6,7,8 & 9 **Trust Values:** Excellence Innovation Respect Together Openness	Adherence with regards to Gram Negative Blood Stream Infections (GNBSIs) targets	DIPC/ Associate DIPC	To attend whole health economy meetings to develop robust action plans to tackle gram negative bacteraemia reduction targets.					
		IPC Data Analyst	Ecoli, Klebsella spp, Pseudomonas aeruginosa bacteraemia data to be recorded on the MESS system.					
		DIPC/ Associate DIPC	PIR reviews to be commenced for all named gram negative bacteraemia.					
		Associate DIPC/IPC Data Analyst	Trust wide situation reports to be developed to share lessons learnt.					***Q1****-Situation reports for 2017-18 completed and to be disseminated. Monthly sit reps to be shared going forward.* ***Q2*** *- Completed*
		Associate DIPC	PIR reviews to be shared across the whole health economy and NHSI.					***Q1****-Situation reports for 2017-18 completed and to be disseminated. Monthly sit reps to be shared going forward.* ***Q2*** *- Completed*
14. Community								

IPC Code & Trust Values	Plan & Priority Activities 2018-19	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
IPC Code 1, 2, 3, 4, 5, 6, 8, 9. 10 **Trust Values** Respect Excellence Innovation Together Openness	To ensure that a high quality Infection Prevention Service (IPC, Tissue Viability and IV services) is delivered to Community Services	Sarah Stephenson (SS) – Quality Lead for Community, Associate DIPC, Lisa Cooper (LC) Director of Children & Young People Community & Mental Health Division	To scope out the provision and requirements for Infection Prevention Services for Community Services. To include an audit programme, specific training – mandatory and ad hoc, advisory services and Link personnel updates and requirements. To include what is achievable able with the existing team resources.					***Q1**-Work has begun to scope out requirements for community.* ***Q2** – Meetings have commenced. Areas for immediate consideration addressed. Training to commence once personnel is organised.* ***Q3** – Meetings continue to scope out provision needed.*
			Impact assessment on the existing Infection Prevention Services in delivering the required service to the Community.					***Q1** - To be progressed once scoping exercise is completed.* ***Q2** – Process commenced.* *Q3 – Progress continues.*
			Development of a Business case to deliver the appropriate identified service across Community services.					***Q1** - To be progressed once scoping exercise is completed.* ***Q2** – Awaiting results of impact assessment.*

Alder Hey Children's NHS
NHS Foundation Trust

Trust Wide Infection Prevention and Control Action Plans

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

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

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

Alder Hey Children's NHS Foundation Trust

Report of	Chief Nurse
Paper prepared by	Head of Quality – Corporate Services Trust Complaints and PALS Lead
Subject/Title	Quarter 3 2018 – 2019 Complaints & PALS report
Background papers	n/a
Purpose of Paper	To receive the Current Complaints Performance report and update regarding previous concerns.
Action/Decision required	The Group are asked to note the report.
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Deliver **Clinical Excellence** in all of our services
Resource Impact	None

Alder Hey Children's NHS Foundation Trust

Quarter 3:- October 2018 – December 2018

Complaints summary

The Trust received 26 formal complaints during this period. One complaint from this quarter was subsequently withdrawn from the process at Mums request as it was not the right time for her to proceed with this process.

In 2017/18 Q3 the Trust received 27 formal complaints – this is therefore a very slight reduction of 1 formal complaint, it is however the first time this year there has been a reduction of complaints compared to last year's timeframe.

The category of complaints received in this quarter are:-

Treatment/Procedure	12
Consent, Communication, Confidentiality	7
Medical Device/Equipment	1
Access, Admission, Transfer, Discharge	4
Environmental/Structural Issue	1
Physical/Verbal Abuse	1

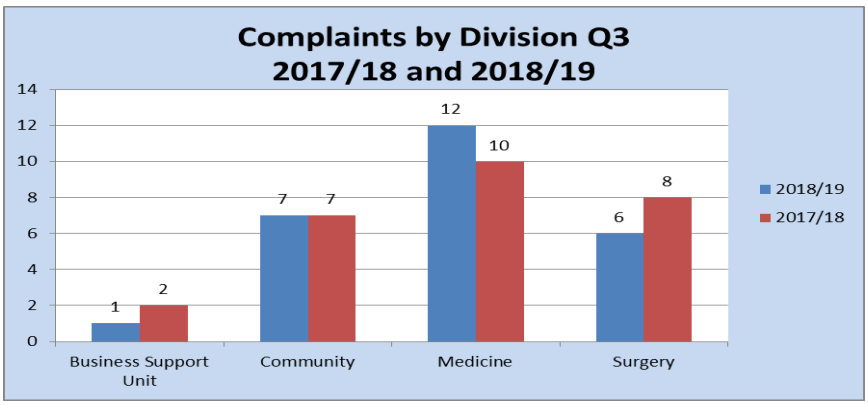
One of the complaints received in this quarter is classed as an "Out of time" complaint – this was 5 years out of time, however was responded to and response sent out in January 2019.

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

Alleged Failure In Medical Care	7
Appointment - Delay (OP)	3
Communication Failure - Medical	3
Alleged Failure In Care - AHP	2
Attitude Of Staff - Nursing	2
Alleged Failure In Nursing Care	1
Attitude Of Staff - Medical	1
ar Parking	1
Diagnosis Delayed	1
Diagnosis Not Made/failure	1
Equipment Inadequate	1
Privacy/Dignity	1
Security Issues	1

Complaints by Division in Quarter 3

The following graph demonstrates the amount of complaints received within each Division during Quarter 3 2018 – 19 and includes a comparison from the same time period in 2017/18.



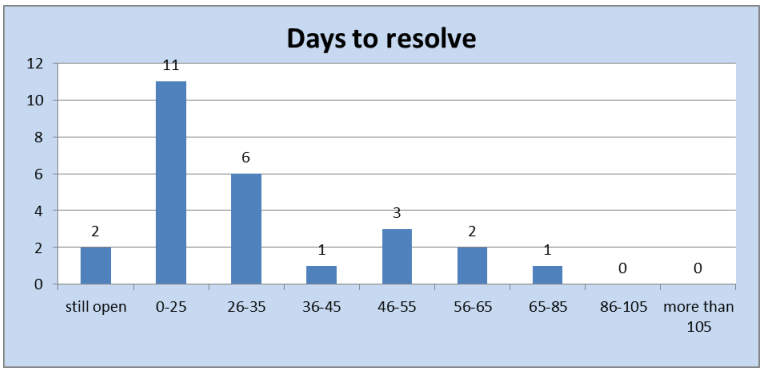
Report against three day acknowledgement

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

In Q3 25 out of 26 complaints were acknowledged within 3 days - 61% on the same day. One complaint was not acknowledged for 38 days. This was an oversight by the Division and sincere apologies was given directly to the Mum who accepted the explanation and apology.

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

The graph below now shows the timeframes the Trust has responded to a formal complaint within Q3 .



It should be noted that 5 of the complaints above missed the 25 day timeframe by one day. All of the complaints where delayed in the Divisions but where very quickly quality checked and approved by the Chief Nurse and Chief Executive to avoid delaying them any further.

Withdrawn complaints

One complaint was withdrawn this quarter**.** The reason given was that Mums personal circumstances had change very soon after she had raised her complaint; she had suffered a very close personal bereavement and her daughter had been readmitted., She therefore felt it was not the most appropriate time for her to raise her concerns and commit to liaising with staff to get these resolved. Mum was advised her complaint is recorded on the system and provided with contact details when she feels able to get in touch and reopen her complaint.

Complaint outcome

17 complaints where upheld within this quarter and 7 where not upheld. 2 complaints are still ongoing

All complainants are fully up dated regarding any delays in response timeframes.

Referrals to Parliamentary & Health Service Ombudsman

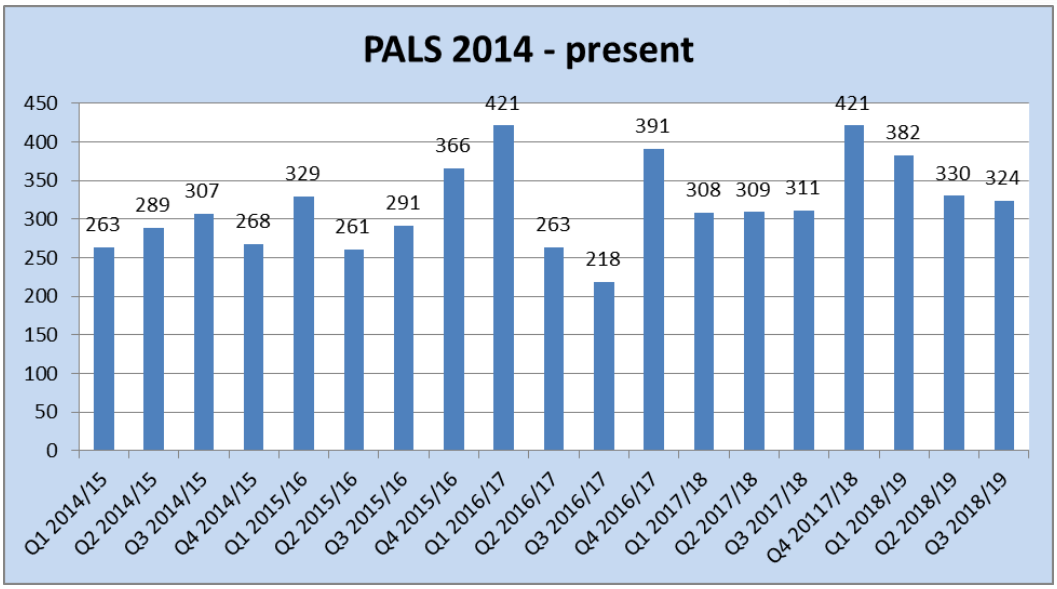
One case from quarter 2 is still being assessed by the PHSO as to whether they plan to investigate or not.

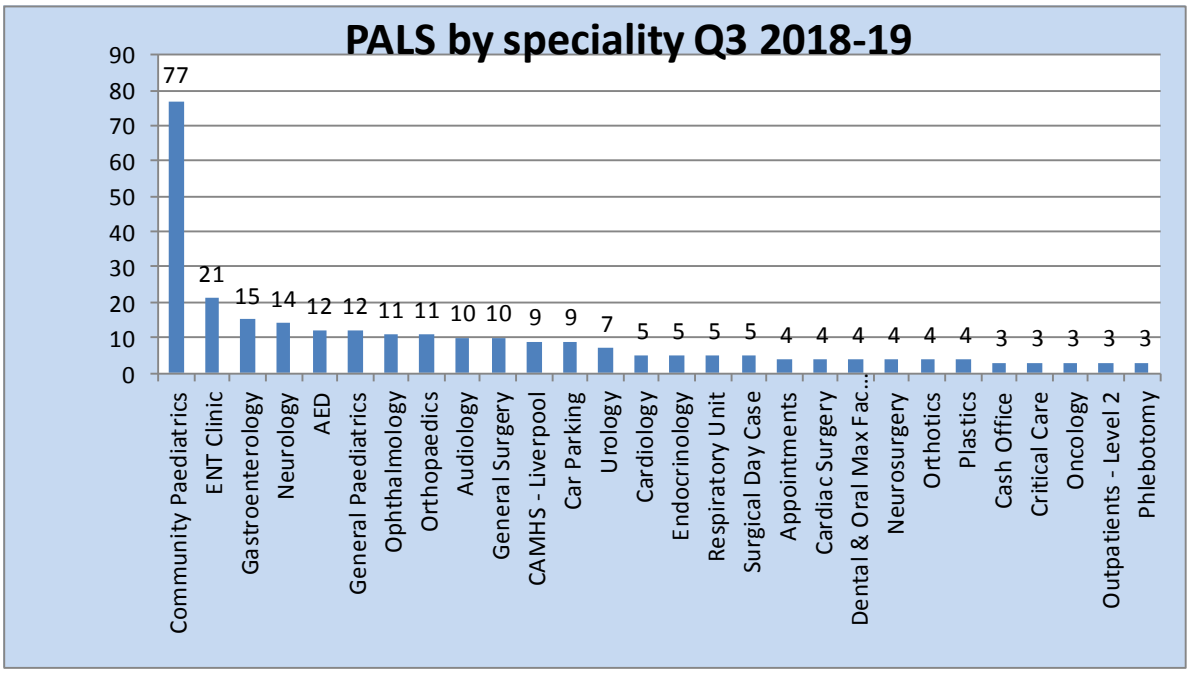
PALS summary

In Q3 2018 -2019 PALS contacts received total 324, in comparison to the same quarter in 2017/18 this is a very slight increase of 13 .

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

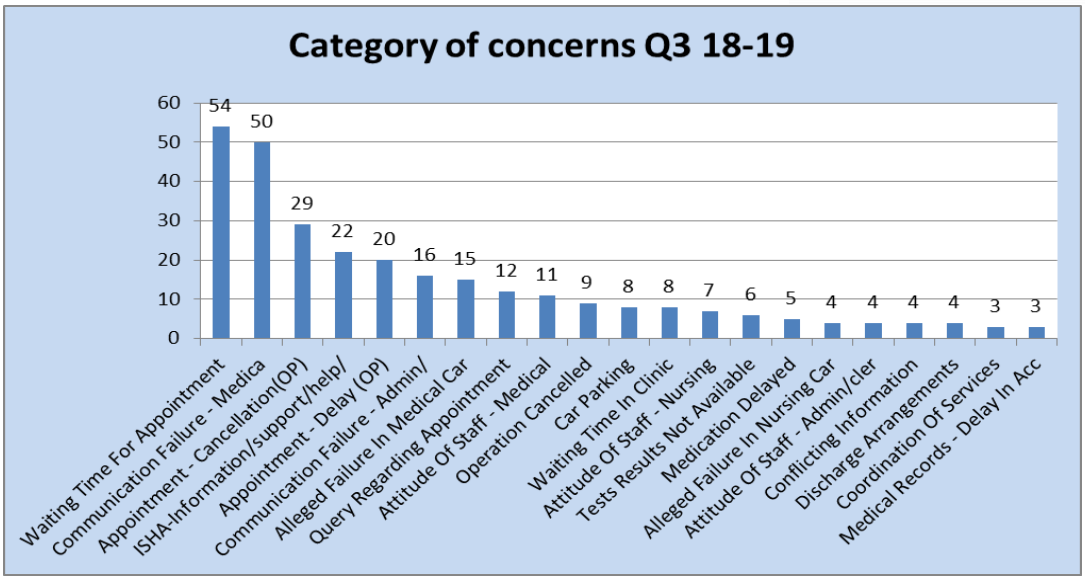
Fig 3- PALS contacts from 2014/15 – Q2 2018/19
The table shows a slight downward trend of contacts into the PALS team in the last 2 quarters.





The table above clearly demonstrates the amount of PALS contacts received by specialities - Community Paediatrics remains the highest area and this quarter has seen a significant increase.

The table below shows the categories in more details – the highest area of concern relates to waiting time for appointments, with communication failure (medical) being the second highest and third cancellation of appointment. This category has not been seen in this volume for a number of months.
Looking at this more closely the three specialities this category relates to in Q3 are:- Community Paediatrics, ENT and Gastroenterology.



Key actions & lessons learnt from PALS during Quarter 3

The main issues identified within Q3 relates to appointments management –waiting times.

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

Waiting time for apt
Community Paeds
Ophthalmology
Audiology
CAMHS - Liverpool

This is the first quarter since Q1 that we have seen this volume of concerns about appointment cancellation.

PALS and complaints are communicated and fed back to senior staff at the three Divisional Integrated Governance meetings to ensure appreciation of current trends are fully disseminated and actions can be taken to look at specific areas of concern. Updates are shared by the Divisions at the Clinical Quality steering Group (CQSG) each month

Compliments

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

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

Mum called into PALS office
Mum provided positive feedback following a visit to the Phlebotomy service today. She mentioned they were seen quickly and the phlebotomist was really nice and explained everything that she was doing to her daughter.

Overall Mum and her daughter received a good service.

Compliment - Patients grandmother into PALS office.

Joshua has been a patient for over 3 years, he was one of the first patients to transfer from the old hospital into the new. He has been under the care of the oncology team, orthopaedics, physio / hydro.

Grandmother says she has nothing but praise for all of the staff who have been involved in her grandson's care over the years. She says everyone they have had contact with has been amazing and she cannot thank the staff enough.

She is also very impressed with the atmosphere of the hospital, she particularly likes that there always activities in the Atrium and that we now have M&S!

Email from Parent:

Please would you pass on our sincere thanks and gratitude to Dave. During our longer than expected stay at Alder Hey, our son Charlie had to go on an MCT (low fat) diet. Dave's (Ward Chef) care, creativity and attentiveness to the individual needs of our son was far and above the call of duty. He made Charlie's meals inviting, appealing and exciting. Charlie looked forward to the special snacks and in particular his tomato soup! He also assisted us in our return home giving advice and help to make it
easy. Charlie always wants to see Dave on return to clinic and this is testament to the impact that he had on his stay in hospital. Thank you for your help in this matter.

Staff support

Within Quarter 3, the PALS team have valued the continued support provided by the LIA team. These sessions have taken place away from the office and provided a safe environment to discuss any issue relating to cases that the staff find difficult, challenging or emotional and how they have dealt with them, the opportunity to reflect has been invaluable.

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

END

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Tuesday 5th March 2019

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

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1. Background:

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

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

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

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

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

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

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

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

Current position

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

During this reporting period, there was one serious incident reported. There were no safeguarding incidents reported and no never events.

Table 2 shows the cumulative position; there is one open serious incident investigation.

Table 3 shows the Trust had one moderate harm incident during this reporting period; which complies with external requirements, including the regulatory requirement for duty of candour.

Table 4 shows there were no closed SIRI'S during this reporting period.

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

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

Table 2 Ongoing serious incidents requiring investigation (cumulative):

On-going SIRI incident investigations							
Reference Number	**Date investigation started**	**Division**	**Incident Description**	**RCA Lead Investigator**	**Progress**	**60 working day compliance (or within agreed extension)**	**Duty of Candour applied**
StEIS 2019/1967	24/01/2019	Surgery	**Never Event Wrong Site Surgery - Wrong site anaesthetic block:** A wrong site block was performed on a patient. Full checks were completed and the 'stop	Paula Clements, Theatre Matron	Investigation gathering underway, panel meeting scheduled for 22/02/2019.	Yes – Report due out 18/04/2019.	Completed.

			before you block' undertaken, however this was before the local anaesthetic was drawn up. Markings were noted as part of the check; however the operator position changed for ergonomics with the ultrasound scan. The error was identified and immediate action was taken, including the declaration of the incident as a 'never event' and a discussion held with the family.				
StEIS 2019/1718	22/01/2019	Medicine	**Unexpected death:** Four month old baby was admitted to Alder Hey via ED on 15.01.19 with a bronchiolitis type illness, admitted to Ward 4C. The patient was managed with Airvo and nasal cannula oxygen plus a mixture of bottle and NGT feeds. Respiratory PCR positive for coronavirus, human metapneumovirus and rhino/enterovirus. The baby previously had multiple attendances to the Trust.	Nursing lead: Amanda Turton, Head of Acute Care Medical lead: Theo Anbu, Consultant	Information gathering in progress, panel meeting scheduled for 07/03/2019.	Yes – Report due out 16/04/2019.	Completed.

			Just over 12 hours pre acute collapse, the baby became tachycardic and had episodes of fever for which she was given paracetamol and ibuprofen on the ward. At 12:00 on 19.01.19, a cardiac arrest call was issued because the baby had been found moribund and peri-arrest on the ward by her mother. The cardiac arrest team resuscitated her with assisted ventilation, dextrose and fluid boluses, IM and IV antibiotics. The baby was intubated on the ward, a high dose adrenaline infusion started and quickly transferred to PICU. Shortly after arriving in PICU, she went into PEA and CPR was commenced at 12:55hrs. Sadly, the baby did not respond to resuscitation and this was discontinued at 13:20 hours				
StEIS 2018/30070	19/12/2018	Surgery	**Unexpected death:** 24 week gestation baby, transferred from Liverpool Women's Hospital for central line insertion. The baby had undergone previous surgery for NED and had previous line	Stefan Verstraelen, Head of Quality, Surgery **Nursing lead:** Joanna McBride, Head of Nursing,	Information gathering ongoing; panel meeting scheduled for 04/03/2019.	Yes – Report due out 18/03/2019.	Completed.

			insertion problems. The baby had many known co-morbidities. The baby died following transfer to the Intensive Care Unit at Alder Hey Children's Hospital.	Cardiac and Critical Care Services **Medical lead:** Peter Murphy, Consultant			

Table 3 Moderate harm incidents:

	Duty of Candour (excluding SIRIs)							
Reference Number	**Date investigation started**	**Type of investigation**	**Division**	**Incident Description**	**Lead Investigator**	**Progress**	**60 working day compliance (or within agreed extension)**	**Duty of Candour applied**
33440	25/01/2019	RCA Level 1	Surgery	A baby attended due to a wound infection and breakdown. The wound was documented subsequently to be open in several places with a cavity at one end. The wound was drained; cultures sent and oral amoxicillin prescribed. The following day the baby re-attended due to ongoing discharge requiring multiple dressing changes. The wound was debrided and oral therapy continued. The baby was discharged. The baby subsequently re-presented to ED that night septic.	Joanna McBride, Head of Nursing, Cardiac and Critical Care Services	Information gathering ongoing.	Yes	Completed.

Table 4 Closed SIRIs:

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**
Nil							

END

Alder Hey Children's NHS
NHS Foundation Trust

Trust Board
5 March 2019

Subject/Title	Global Digital Excellence (GDE) Programme Update
Paper prepared by	Peter Young, Chief Information Officer Cathy Fox, Programme Director for Digital Kerry Morgan, GDE Programme Manager
Action/Decision required	The Board is asked to note the updated progress of the Trusts GDE Programme the achievement of Milestone 5 and the commencement of Milestone 6
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 Committee with an update on the progress of the Trusts Global Digital Exemplar (GDE) Programme; the achievement of Milestone 5 and the commencement of Milestone 6.

2.0 Update of Progress

Since the previous update to the Board on 5 February 2019 the Trust has received assurance from NHS Digital that milestone five was successfully met and funding will be made available. The Trust was commended on the continuing progress against the GDE Programme of work. The Trust continues to ensure phase six milestones are achieved; primary areas of work include:

Standard Documentation

Standardised forms have been live since February 2018. Since their release the GDE team have undertaken a number of surveys and reviews of the documents to improve their ease of use and the new update was released on 18th February 2019. There are 17 new forms, 5 of these are considered mandatory in documenting the corresponding clinical task. Usage of these documents will be monitored by the Weekly Performance Meeting.

Specialty Packages

We are now live within 32 specialties with an additional 2 due to go-live in March; Cardiology and Cardiac Surgery. We are required to deliver 52 specialties by 30 November 2019 for milestone 6. The additional 18 specialty packages have been broken down into tranches to support staggered go-lives with the aim to deliver 3 in April, 10 in July and 5 in October. Work has commenced on these packages; initial meetings have been arranged or undertaken and task and finish groups established.

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

Share2Care – Regional Interoperability

All 7 sites are connected to the platform; three sites are operational and three other sites are to go operational by the end of February, two sites are publishing clinic letters to the live platform from December and three other sites are working toward publishing clinic letter by the end of February 2019. The team has progressed with the migration of the central servers to the data centre and anticipate completing the technical readiness by end of February. The team have also successfully tested query, retrieve and display of documents between the two systems across Cheshire & Merseyside STP (e-Xchange) and Lancashire & South Cumbria (L&SC) STP (LPRES). These systems are now

federated in test environment and proved that L&SC team can see C&M records against patients.

An engagement session with 11 other NHS organisations (Acute, Community and Mental health) was held to prepare these new sites to on board on to the platform. Further sessions are scheduled with various stakeholder groups.

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.

Testing of the system has been successfully completed.

The icon for the system has been deployed to all PCs across the Trust and has been profiled on Single Sign On. This means on clinicians launching the system, they are automatically logged into the system. This negates the need for the clinicians to keep entering their username and password.

The pilot went live on Wednesday 20th February 2019.

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

Voice Recognition

The Project Manager for VR is still in the process of visiting all specialities team meetings to update clinicians on VR and to identify clinicians that need additional 1:1 support as well as clinicians who have never used VR before and would like to give it a try.

An updated version of Fluency Direct has been deployed to all clinicians across the Trust. Positive feedback has been received from the clinicians at the speciality team meetings to confirm that they have seen an improvement in the recognition quality since this update has been applied. This update included improvements to the speech recognisers i.e. the back-end dictionaries by way of uploading the 23,000 legacy Alder Hey letters into the system to improve the language models. This update was due to be released in February 2019 but was brought forward in the January 2019 update.

The ability to dictate using a microphone app on a mobile phone has been successfully tested and is currently being piloted by a small subset of clinicians. This includes clinicians who work out in the community. This allows users to dictate using their personal mobile phone instead of a tethered dictation device. It offers more flexibility and gives the user the ability to be more mobile. Only clinicians, who have enrolled on the Trust's BYOD program and so are connected to the relevant WiFi that allows them to do this, can use this feature.

M*Modal and members of IM&T are scheduled to complete further floor-walking in all clinics and clinicians offices for the whole of w/c 08/04/19 to inform clinicians of the system updates referenced above and support them further in using VR. By this date, it is anticipated that all PCs as per the PC replacement program being led by the Associate Director of Operational IT will have been replaced.

During the month of March 2019, the Project Manager will revisit the specialities team meetings to provide further updates on VR and inform them of the floor-walking plan for April 2019.

Benefits baseline: 54% positive response rate to 'Digital dictation is useful and helps with my clinical practice'.

3.0 Summary of Key Benefits

Project	Aim	Measurement	Baseline Position	Improvement Target	Actual Progress to Target (current)
TCI to theatre	Increased income from backfilling cancelled elective theatre procedures - bi-directional texting	Income received from backfilling theatre slots	£0	Increase in income	£66,342 Dec-18
Booking & Scheduling Project	Improve efficiency in transcription of rejection letters	Time taken to transcribe a rejection letter	£1,579 time per quarter	Eliminate time	£1,579 time saved Dec-18
Booking & Scheduling Project	Improve efficiency in dictating rejection letters	Time taken to dictate a rejection letter	£3,412 time per quarter	Eliminate time	£3,412 time saved Dec-18

4.0 Milestone Assurance

The assurance for milestone 5 has been completed; work on milestone 6 has commenced.

5.0 Next deliverables

Work on milestone 6 has commenced, by November 2019 we will deliver:

- **HIMSS level 6 -** The Trust underwent a formal gap analysis assessment for HIMSS Stage 6 EMRAM assessment in December 2018. Feedback has now been

received and an action plan developed to ensure achievement of level 6 is completed by April 2019. In terms of HIMSS level 7, a parallel piece of work is being carried out to identify the gaps to be addressed for HIMSS level 7 along with an action plan to address these with a view to a full assessment taking place in early January 2020.

- **Bedside medication verification:** A pilot was undertaken in January 2019; an action plan will be developed to ensure this can be rolled out across the Trust.
- **Complete a total of 52 Speciality Package deployments:** 32 specialties are live, 2 are due to go live in March, and a further 18 by November 2019.
- **Patient Portal –** Develop a secure online web portal that gives patients and their responsible guardian view-only access to patients own health records.
- **Share2Care –** Integration of the E-Xchange platform with EMIS.
- **Pilot clinical decision support (Zynx)**
- **Nordinet (Endocrinology) PC Pal**
- **API/FHIR interfacing –** Wirral or Royal – dependent on third party

6.0 Recommendations

The Board are asked note the progress of the Trusts GDE Programme; the achievement of milestone 5 and the on-going progress towards Milestone 6.

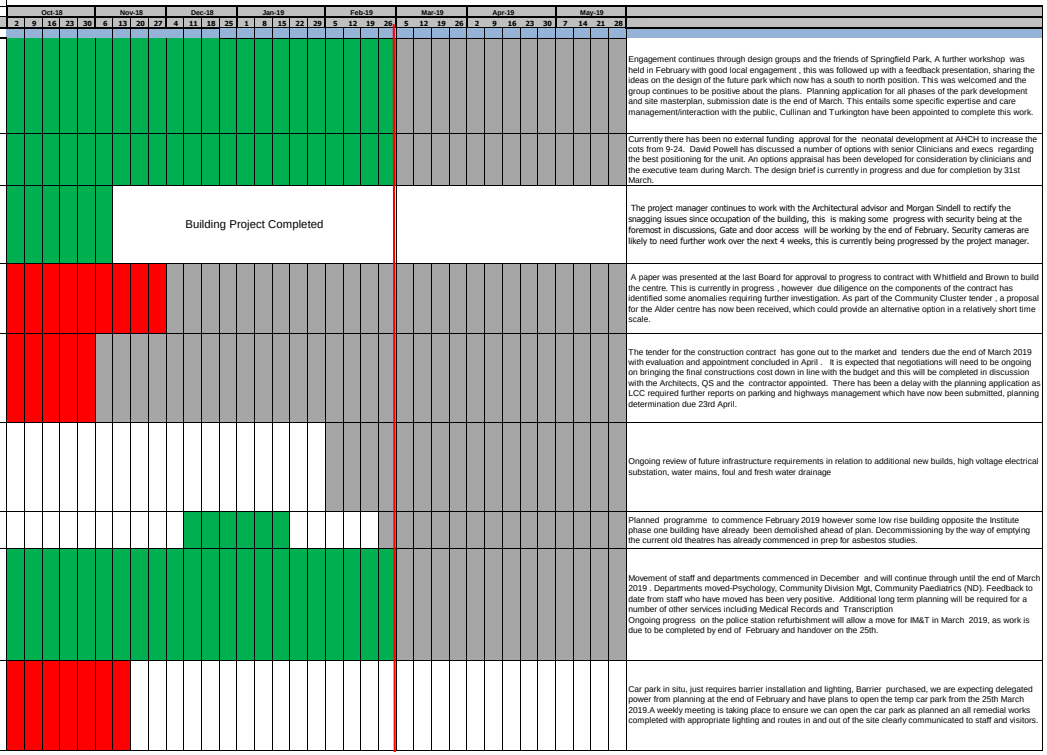
Peter Young
Chief Information Officer 20 February 2019

HIGHLIGHT REPORT Site & Park Development February 2019

SRO: David Powell
Author: Sue Brown

Key

	Planned project timeline
	On track
	up to 3 months delay
	Over 3 months delay



The Park	Engagement continues through design groups and the friends of Springfield Park. A further workshop was held in February with good local engagement , this was followed up with a feedback presentation, sharing the ideas on the design of the future park which now has a south to north position. This was welcomed and the group continues to be positive about the plans. Planning application for all phases of the park development and site masterplan, submission date is the end of March. This entails some specific expertise and care management/interaction with the public, Cullinan and Turkington have been appointed to complete this work.
Future Site Development	Currently there has been no external funding approval for the neonatal development at AHCH to increase the cots from 9-24. David Powell has discussed a number of options with senior Clinicians and execs regarding the best positioning for the unit. An options appraisal has been developed for consideration by clinicians and the executive team during March. The design brief is currently in progress and due for completion by 31st March.
New Schemes: Institute Phase II	The project manager continues to work with the Architectural advisor and Morgan Sindell to rectify the snagging issues since occupation of the building, this is making some progress with security being at the foremost in discussions, Gate and door access will be working by the end of February. Security cameras are likely to need further work over the next 4 weeks, this is currently being progressed by the project manager.
New Schemes: The Alder Centre	A paper was presented at the last Board for approval to progress to contract with Whitfield and Brown to build the centre. This is currently in progress , however due diligence on the components of the contract has identified some anomalies requiring further investigation. As part of the Community Cluster tender , a proposal for the Alder centre has now been received, which could provide an alternative option in a relatively short time scale.
New Schemes: Community Cluster	The tender for the construction contract has gone out to the market and tenders due the end of March 2019 with evaluation and appointment concluded in April . It is expected that negotiations will need to be ongoing on bringing the final constructions cost down in line with the budget and this will be completed in discussion with the Architects, QS and the contractor appointed. There has been a delay with the planning application as LCC required further reports on parking and highways management which have now been submitted, planning determination due 23rd April.
Supporting scheme. Infrastructure	Ongoing review of future infrastructure requirements in relation to additional new builds, high voltage electrical substation, water mains, foul and fresh water drainage
Site Clearance-Demolition and decommission Phase 2	Planned programme to commence February 2019 however some low rise building opposite the Institute phase one building have already been demolished ahead of plan. Decommissioning by the way of emptying the current old theatres has already commenced in prep for asbestos studies.
Site Clearance-relocation of on-site services/corporate teams	Movement of staff and departments commenced in December and will continue through until the end of March 2019 . Departments moved-Psychology, Community Division Mgt, Community Paediatrics (ND). Feedback to date from staff who have moved has been very positive. Additional long term planning will be required for a number of other services including Medical Records and Transcription Ongoing progress on the police station refurbishment will allow a move for IM&T in March 2019, as work is due to be completed by end of February and handover on the 25th.
Site Clearance: Temporary car park	Car park in situ, just requires barrier installation and lighting, Barrier purchased, we are expecting delegated power from planning at the end of February and have plans to open the temp car park from the 25th March 2019.A weekly meeting is taking place to ensure we can open the car park as planned an all remedial works completed with appropriate lighting and routes in and out of the site clearly communicated to staff and visitors.

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Alder Hey/Springfield Park Site Development

1. Overview

Alder Hey has been considering how to complete the lay-out/allocation and purposing of the whole Alder Hey and neighbouring Springfield Park site. The objective of this exercise is to develop a whole campus that:

- Has coherence;
- Returns a high quality park to the neighbourhood;
- Facilitates the work and sustainability of the hospital;
- Furthers the City drive to become a UNICEF Child Friendly City and integrate/enhance the health and care offerings to children and families.

The key parts of this exercise are:

- The creation of the park;
- The development of a zone on Eaton Road within which Alder Hey can continue to place new services;
- The incorporation of neighbouring sites to facilitate the expansion of the hospital in the long term;
- The creation of a complementary site in the North East of the campus to further the objectives of Alder Hey and the City.

2. Themes

The development of the campus allows the progression of 2 strategic themes:

- Science and Knowledge-building on the development of the Innovation Hub, the Alder Hey Academy and the existing Research core;

- Health and Wellbeing including Mental Health-using the Park to bring a focus and opportunity for developing programmes that support the city wide campaign to become a child friendly city and improve the health and wellbeing of children.

3. Scale

The overall site is c20Hectares or c50 acres split into:

- New Hospital: 15 Acres/6 Hectares
- The Park: 24 Acres/9.4 Hectares
- Eaton Road zone for NHS use: 5 Acres/2.01 Hectares
- North east plot: 6 Acres/2.44 Hectares

The neighbouring police, job shop and vet sites total c2 Acres/0.8Hectares.

The latest plans are shown below:

4. History

Alder Hey launched a procurement exercise in 2015/2016 to develop the Alder Road site as principally residential.

This development was strongly resisted by neighbours and was put on pause to allow Alder Hey and the City to engage and explore issues with the local community/children and young people and their families.

5. The 6 Acre North East Plot

There is a requirement to release/develop the North East plot of 6 acres by the end of the financial year (31/03/19).

Alder Hey is working to secure a deal with a developer to achieve this.

As part of this process, Alder Hey is looking to secure a developer with experience of mixed use development (i.e. not a pure housebuilder) in order to create opportunities to develop out the site in a manner that is complementary to the rest of the campus (including the neighbouring Park).

The developer will explore the opportunities for the site and this exploration is likely to include houses/apartments; key worker housing; extra care supported living; housing for children with special needs; science and technology buildings; crèche and Alder Hey support facilities.

Alder Hey is looking to secure a collaboration agreement with the developer to ensure consultation with Alder Hey, local people and Alder Hey partners prior to development.

6. The Strategic Themes

Science and Knowledge

Strategic Fit

Alder Hey has developed an Innovation Hub network with public and private sector partners working on a series of themes to improve children's health and healthcare including:

- Artificial Intelligence with the Hartree Centre;
- Enhanced Medical Visualisation with the University of Liverpool;
- Sensors applied to healthcare with LJMU;
- Apps and digital with private sector software and investment partners.

This has allowed the hub to grow exponentially over the past 2 years to build a portfolio of partners with over 200 products. The team has grown rapidly from a small team of 5 to 20. The first products are now moving out of early exploration/seed funding stage into deployment.

Content

One opportunity with the North East plot is to expand this agenda by linking into the Liverpool knowledge quarter and creating a new facility to facilitate the growth of the Alder Hey Innovation Hub/Network.

This could include:

- Expansion of the core hub to include for example the new £1m seed funding enterprise being planned;

- House spin-off companies from the hub (17 newly created companies have been created over the past 2 years with 2 recently securing EIS funding to grow to next stage) ;
- House partners concerned with the hub activities including Hartree/Universities;
- Provide co-creation space for partners/SMEs, crucially with access to the staff/patients/families and operations at the Alder Hey campus.

Benefits

Alder Hey is targeting 10 in 10 growth (£10m annual operating revenues in 10 years) and this comes with associated jobs/research projects etc. The core team is projected to grow from 20 to 50 over the next 3 years but needs expansion space. The spin off activity is intended to double over the same period. There is an objective to secure substantial research grants with the local HEIs to support this activity; increasing recruitment of white collar workers around the Alder Hey diaspora. In addition, the Alder Hey Academy has secured its first overseas contracts bringing clinicians from abroad to Alder Hey for educational opportunities. Part of this initiative is the application of science and technology to the provision of healthcare.

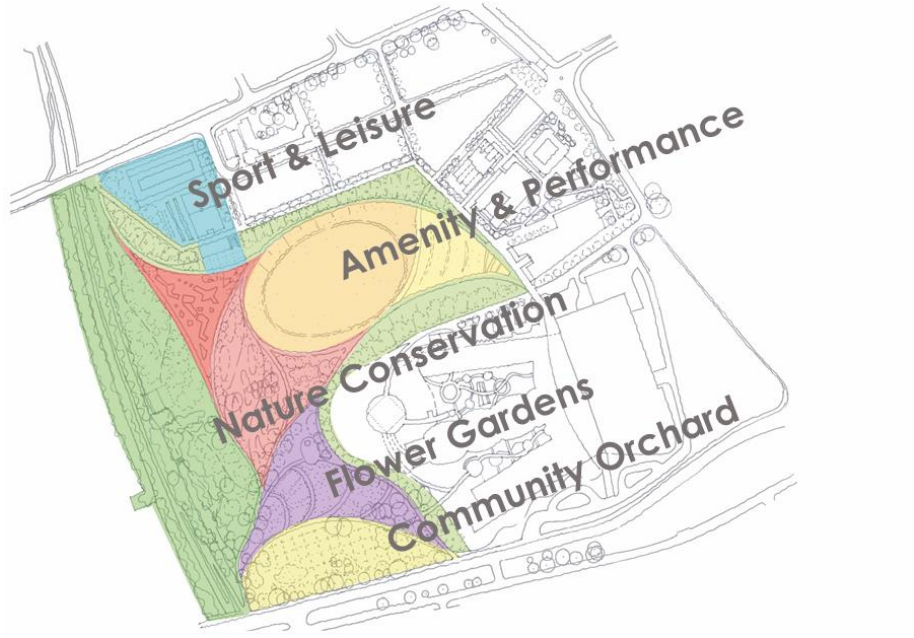
Health and Wellbeing

Strategic Fit

The intention is to develop the Alder Hey campus/Springfield Park to become an innovative, vibrant and safe community asset. In particular, the co-location with Alder Hey allows the opportunity to create a child-friendly environment that provides a beacon with which to lead the campaign to improve child health in Liverpool.

The Park design is being themed to support programmes growing produce/promoting healthy eating; sport for all, play; and generally providing a secure and appealing place for children and young people in Liverpool.

A plan of the new proposed Park is shown below:



As part of this initiative Alder Hey is developing specialist community services for children with Mental Health problems and with neuro-disabilities.

Content

The campus could facilitate complementary social care developments including:

- The proposed Sandfield Park specialist support service for children excluded from school;
- Specialist housing to allow repatriation to Liverpool of children/young adults with autism etc. currently in expensive placements around the country away from their families;
- A base for social care prescribing into the Park wellbeing activities.

Benefits

The co-location of specialist school services with health assessment services plus the Park could provide opportunities to accelerate progress towards mainstream schooling and integration into mainstream services.

The repatriation of children and young adults into the area could bring both quality and financial benefits to the city.

The exploitation of the Park opportunity could provide a focus for the campaign to change lifestyle for young people in Liverpool and improve their health.

Other Opportunities

The development on the campus could link up and augment the above 2 themes for example:

- Deployment of technology from the science development into the supported housing etc.;
- Using this development for researching impact of this technology/the creation of a themed campus etc.
- Building apprentice schemes through the Alder Hey Academy to support the developments;
- Creating a community ownership model and providing support funding linked to the above initiatives (as part of the City drive to build resilient communities and citizens);
- Including complementary facilities into the development such as keyworker apartments/Extra Care housing.

Alder Hey Children's NHS
NHS Foundation Trust

Clinical Quality Assurance Committee
Minutes of the last meeting held on Tuesday 11th December 2018
10.00 am, Large Lecture Theatre, Institute in the Park

Present:	Anita Marsland	(Chair) Non-Executive Director
	Louise Shepherd	Chief Executive
	Hilda Gwilliams	Chief Nurse
	Dame Jo Williams	Non-Executive Director
	Lisa Cooper	Director of Children & Young People Community & Mental Health Division
	Denise Boyle	Associate Chief Nurse (Surgery)
	Tony Rigby	Deputy Director of Risk & Governance
	Erica Saunders	Director of Corporate Affairs
	Jeannie France-Hayhurst	Non-Executive Director
	Adrian Hughes	Acting Joint Medical Director & Director, Medicine Division
	Rachel Greer	Chief Operating Officer, Community Division
	Christian Duncan	Acting Joint Medical Director & Director, Surgical Division
	Pauline Brown	Director of Nursing
	Mark Flannagan	Director of Communications and Marketing
	Cathy Umbers	Associate Director of Nursing and Governance
	Anne Hyson	Head of Quality – Corporate Services
	Adam Bateman	Chief Operating Officer
	John Grinnell	Deputy Chief Executive/Director of Finance
	Melissa Swindell	Director of HR & OD
	Sarah Stephenson	Head of Quality – Community
	Lesley Robinson	Quality Assurance & Compliance Manager
	Stefan Verstraelen	Head of Quality – Surgery

In Attendance:

Natalie Deakin	Change Programme Manager
Joe Gibson	External Programme Assurance
Val Shannon	Patient Experience/Quality Lead
Julie Creevy	Executive Assistant (Minutes)

18/19/114 Apologies:

Matthew Peak	Director of Research
Jacqui Ruddick	Head of Quality – Medicine Division
Dani Jones	Director of Strategy

18/19/115 Declaration of Interest
None declared

18/19/116 Minutes of the previous meeting held on 21st November 2018
Resolved:
CQAC approved the minutes of the previous meeting held on 21st November 2018.

18/19/117 Matters Arising and Action Log

Action Log

18/19/01 – DETECT Study update - HG confirmed that she had undertaken a follow up meeting with Gerri Sefton regarding the lead for NHS Digital requirements, and that a further meeting had been scheduled for January 2019.

HG confirmed that a meeting with appropriate colleagues regarding information integration is scheduled for mid-January 2019.

18/19/104 – Healthwatch report - meeting had been arranged for Robert Benn and Lisa Cooper – this action is now complete and to be removed from the action log.

CQC Action plan – HG stated that she would be meeting with the Associate Chief Nurses in mid January 2019.

18/19/118 Sepsis Update

CQAC noted the Sepsis update report.

18/19/119 PLACE Survey Results

Val Shannon presented findings from the 2018 Patient Led Assessment, (PLACE) which provides a snapshot of how the organisation is performing against a range of non clinical activities, including cleanliness, assessing food and hydration, privacy, dignity and wellbeing, condition, appearance and maintenance of premises and disability. Key issues as follows:-

Areas assessed were 1C, Critical Care, 3A, 3B, 3C, 4A, 4B, 4C, AED, retained estate clinical areas, Radiology, Outpatients Department, corridors and public areas, external areas, the Dewi Jones Unit and EDU.

Specific findings were as follows:-

Cleanliness

- Windows and internal glazing demonstrated poor levels of cleanliness
- Dust in many areas especially high surfaces/areas
- Cleaning schedules not consistent
- External areas need regular cleaning and extra bins at rear of hospital
- Inappropriate uses of patients rooms for storage on wards

Food & hydration

- Assess limited to cold water dispensers on wards
- Stoma food menu should be available in Treetops
- More facilities for parents to use down in the restaurant
- Food prices to be re-considered as perceived to be rather expensive
- Pureed foods to be an option in Treetops
- More vegetarian options

Privacy, dignity and wellbeing

Having looked into the lower than expected privacy, dignity and wellbeing results further, it is believed that some of the assessments had been inputted incorrectly with questions being answered as ‘N’, rather than ‘NA’, resulting in

errorenously negative scores. Discussions had ensued with PLACE, however PLACE are unable to change the results; the importance of an accurate completion process is therefore a key lesson for future assessments.

Although the results for the wards are believed to be incorrect, there are places in the outpatient department that would benefit from improvements. The report does not identify the particular location, however the issues raised related to having sufficient space at a reception desk in order that conversations between staff and patients are not overheard and a question relating to whether patients/family, etc leave consultation/counselling rooms without having to return through the general waiting area – these questions were answered as 'no'.

Condition, appearance and maintenance

- Dull walls around clinics and wards – more colour and images needed
- Poor signage
- M1 needs to be better maintained – poor lighting, dusty chairs. Some chairs unable to be cleaned properly due to their material
- Cigarette butts and chewing gum near A&E entrance
- Additional bins required outside entrances to try and encourage people not to litter
- Some areas of pavements/kerbing too steep for wheelchair users
- Internal glass appearance dirty
- Corridors are a bit too "clinical."

Disability

Increase for the Trust of 14.57% in this area.

- Toilets not designated for single sex use
- Gel dispensers too high
- Access not good - uneven surface/curbs - on the retained estate.

Recommendations

- 2018 Action Plan to be completed by 31st November 2018
- Training to be delivered prior to PLACE assessment
- Department staff to accompany assessors on the day
- Patient experience/quality lead to ensure questions have been answered correctly before inputted to NHS Digital
- Challenge PLACE around single sex accommodation, with a view to changing the questions

CQAC noted the PLACE report and noted the action plan to address issues.

AM thanked VS for her update.

18/19/120 Medication Safety Update

Catrin Barker presented the Medication Safety Business Case update. Key issues were as follows:

- 270,000 children seen per year
- The average inpatient is prescribed 8 medicines during their stay (range 0-35)
- The average inpatient is administered 8 doses of medicines every day (range 0- 47)

- Over 2500 doses of medicines are administered across the Trust each day
- 1209 medication incidents were reported in 2017/18, with a calculated error rate of ~1in 750 doses
- Prescribing and administration medication errors are the largest error theme
- Nationally the Trust is in the top 25% for reporting of errors, but in the bottom 25% for harms due to errors
- Ongoing work is taking place to review error themes and learning and develop guidelines and standardised protocols
- The current team consist of a 0.5 WTE Band 7 Nurse and a 0.5 Band 7 Pharmacist
- The business case proposes a number of options to improve the capacity of the team to support the safety agenda
- The proposed uplift to the team team is as follows:-
  - 1 WTE Band 7 Nurse and 1 WTE Band 7 Pharmacist (Permanent)
  - 2 x 0.5 WTE Band 6/7 Nurse/Pharmacist/Technician (Rotational Secondment)
  - Ward Based Medicines Administration Pharmacy Technicians.

Benefits

- Sustain or increase the current level of medication incident reporting
- Improve completion and turnaround time for investigation of medication related incidents
- Further reduction in medication errors causing harm to patients
- Support reduction in prescribing errors by providing increased teaching and support for junior doctors
- Implement safety changes on Meditech EPMA more quickly
- Introduce into the medicines process a staff group (pharmacy technicians) whose only focus is medicines related activities, who can perform the role of second checker in the medicines administration process, thus releasing nursing time to other duties.

CQAC expressed its support of the proposed model in its entirety. HG stated that there is a need to review the financial model, with regard to hours released from a nursing perspective, if the pharmacy technician option is to be pursued. HG stated that she would work with Associate Chief Nurses to review this further.

Action: HG/PB to review Workforce model in January 2019

The Committee agreed that the Business Case should be presented at Investment Review Group for further discussion.

AM thanked CB for her update.

18/19/121 Programme Assurance Update

Joe Gibson and Natalie Deakin presented the Programme Assurance Update, key issues as follows:

Models of Care – ongoing work had taken place, however progress had been slow to date. There is a draft PID which would require the support of the Executive Sponsor and wider team to complete. Clear metrics for success

are also required. Detailed/tracked milestone planning evidence is required to incorporate into a high level plan.
Sepsis – the PID required updating to reflect changes to new targets; any new targets need to be signed off at Programme Board; insufficient evidence had been uploaded onto SharePoint relating to nine actions. HG stated that she would meet with Glenna Smith to address these issues; she reported that the administrative support for Sepsis had been stepped down, impacting on appropriate supporting evidence being uploaded onto SharePoint.

The Committee noted that there was a detailed Sepsis 'deep dive' paper being presented at Trust Board on 8th January 2019.

Action: HG to meet with GS.

AM thanked JG & ND for the update.

18/19/122 CQC Action plan update

HG stated that at the last CQAC meeting attention was placed upon the movement of action/dates, with no further movement regarding dates. The quarterly engagement meeting with the Trust's local CQC inspectors had taken place on Monday 10th December, with CQC content with the progress made to date. CQC are reviewing their own methodology in terms of frequency of follow up inspections for trusts rated as good or outstanding. HG confirmed that CQC colleagues had stated that the Trust is a low risk organisation. ES emphasised the importance of ensuring previous actions are followed up and that leads are regularly overseeing progress. CQAC noted the importance of submitting timely evidence in order to incorporate with the current CQC action plan.

The Committee particularly thanked Cathy Umbers and team for continued support in relation to CQC action plan.

Discussion took place regarding Transition, which remained the one outstanding action from the 2015 inspection, given the solution required was system-wide. LS stated that a strategic meeting with Liverpool City Council had been scheduled for 23rd January 2019.

AM thanked HG, ES and supporting teams for the update.

18/19/123 Corporate Report – Quality Metrics

HG provided an update by exception as follows:

Safe

- Focus had been placed on high level harms and the Trust had seen a sustained improvement.
- Minor harms were now being targeted with the ultimate aim to move minor harm into near miss category.
- Themes continued around complaints relating to communication/ appointments/clinical care and treatment, with the team continuing to work with Divisions to address this further within the next quarter.

- Medication errors – the Medicine Group had re-established, with group reviewing themes and previous actions.

Caring

Family & Friends Test – CQAC noted the previous challenges in ED regarding patient flow, with the appropriate group reviewing the action plan to address issues.

Following Healthwatch's recent review of A&E departments, together with the PLACE assessment, the Trust is triangulating themes in order to reach 90% compliance; themes relate to waits, professionalism/how families are communicated with, play, distraction and food.

JFH asked for clarification of the term 'professionalism' in this context; HG confirmed that this was referring to the triaging process for patients, and how staff reassure parents.

Discussion took place regarding customer care training which had previously been provided at the Trust. HG stated that there is an issue regarding the lack of any volunteer support during the early evening, as this is generally a busy period for ED.

Complaints & compliments – AH stated that compliments are now being recorded. LS stated that it would be helpful to capture numbers. CU confirmed that the Ulysses compliments module is due to be launched during the week commencing 17th December 2018, with an easy to follow step by step guide for staff. CU requested that colleagues promote the use of the compliments module within their teams going forward.

Discussion took place regarding feedback received via /intranet/internet and how the Trust captures compliments. AH & SS agreed to establish an appropriate flow chart to support this feedback.

LS sought clarity regarding issues for the Community Division in some of the smaller therapy services in Sefton; RG stated that vacancies had been approved on 10th December 2018 with three additional posts funded. LS confirmed that the Trust had made a request for a Board to Board meeting with Sefton CCG to seek agreement of a coherent approach. The Trust is currently awaiting progress/further information from Sefton CCG with regard to a proposed date for a Children's Summit.

Effectiveness

Sepsis – the Sepsis Team is due to present an assurance update to Trust Board on 8th January 2019. HG stated that there will be a mini quality summit/after action review of sepsis patient cases.

Responsive

Discharge - HG confirmed that the appropriate team need to work with Divisions with regard to planned date of discharge, given the need to clearly define this.

Safer bundle - AB stated that standard documentation will be launched in January 2019 as part of GDE and that he is just waiting on review by AH &

CD; he stated that using standard documentation will have clear benefits. HG stated that she is happy to work with teams should this be required.

John Grinnell stated that expectations need to be agreed and set at the pre-op stage.

AM made a plea for appropriate group members to review and define further, in order to bring back a schedule at the end of Quarter 4.

Action: Report/update to be shared at CQAC at end of Quarter 4.

HG stated that she was disappointed with the responses relating to the availability of play activities for patients and that an appropriate group would be established in order to undertake a focussed deep dive, with an update to be provided to CQAC for Quarter 4.

RG queried whether this covered children accessing in school offering, and stated that school access and provision required attention.

Action: HG/PoC discussion required regarding analysis fo Family and Friends, PLACE and Healthwatch reports

Action: Update report on play to be shared with CQAC in Quarter 4

AM thanked HG for the update.

18/19/124 Board Assurance Framework

ES confirmed that continued focus remained on the CQC action plan. She also suggested that quality governance needed to be triangulated and linked to the Inspiring Quality agenda. LS stated clarity is required regarding how Inspiring Quality is launched in terms of culture change.

Action: Inspiring Quality update to be received at the end of Quarter 4

Dame JW stated that the BAF is well embedded within the Trust and all actions are fully owned and understood as appropriate.

Dame JW requested a position statement/update regarding pipework and Interserve.

JG responded that a proposed solution, including a set of remedial actions had been received with regard to the pipework. The proposal states that the replacement of any pipe that has deteriorated assumes the replacement of the same pipework. Deterioration of the pipes did not relate to the standard of the pipes. The Trust had requested an external company to provide findings. Further clarity is required regarding assurance at the January 2019 Trust Board. A meeting is scheduled with Louise Shepherd, David Powell and Adam Bateman to discuss further. The next Liaison Committee meeting is scheduled for 12th December 2018 to discuss contract and performance with Project Co.

CQAC noted that AB is the lead for business continuity relating to Interserve, with a tactical group currently in the process of being established, (expected

to be established week commencing 17th December 2018), in order to ensure continuity of services. CQAC noted that the Trust have a clear continuity plan in place.

AM thanked ES for update.

18/19/125 Clinical Quality Steering Group – Key Issues Report

DB presented the Clinical Quality Steering Group Key issues report, key issues as follows:

- Contractual quality standards - all measures are on track to achieve agreed targets, apart from the medication incidents leading to harm which are above target. Narrative is required around actions/lessons learned etc. A report will be presented to Commissioners in February 2019.
- Infection Prevention & Control quarterly report - IPC work place compliance stands at 72% . Flu compliance target is 75% this year with plans in place to exceed that target. A hand hygiene initiative is to be implemented on pilot wards 4A and 4B to review hand hygiene techniques in children. The pilot will last one week with the report being presented to IPC Committee.
- Performance management report for incident reporting - the report covered incidents in Q2. Duty of candour, STEIS reporting, 72 hour review were all 100% compliant. Reporting on NRLS within 30 days remained at 90% and reporting of near misses to NRLS within 30 days had improved to 91%. Incidents reported within expected standards is at 80% and near misses reported within 1 day is at 82%. There were two never events reported and they related to wrong site surgery, i.e. removal of wrong tooth and insertion of wrong orthopaedic implant.
- SUI Assurance Framework – a presentation was delivered to CQSG and a draft framework presented to prompt a look back 6-12 months after a serious incident in order to provide assurance of action plans being fully completed, and lessons learned are embedded. A 6 monthly assurance report would be presented to CQSG, demonstrating the Trust's position in relation to lessons learned from RCA's and evidence to support lessons learned are being embedded.

AM stated that CQAC intend to periodically have a joint meeting with CQSG during 2019 – date to be agreed.

Action: Joint meeting date to be agreed for 2019 meeting

AM thanked DB for his update.

18/19/126 Any Other Business

None.

18/19/131 Date and Time of Next meeting -

10.00 am – Wednesday 16th January 2019, Large meeting room, Institute in the Park.

Clinical Quality Assurance Committee
Minutes of the last meeting held on Wednesday 16th January 2019
10.00 am, Large Lecture Theatre, Institute in the Park

Present:	Anita Marsland	(Chair) Non-Executive Director
	Hilda Gwilliams	Chief Nurse
	Dame Jo Williams	Non-Executive Director
	Lisa Cooper	Director of Children & Young People Community & Mental Health
	Erica Saunders	Director of Corporate Affairs
	Jeannie France-Hayhurst	Non-Executive Director
	Adrian Hughes	Acting Joint Medical Director & Director, Medicine Division
	Christian Duncan	Acting Joint Medical Director & Director, Surgical Division
	Pauline Brown	Director of Nursing
	Mark Flannagan	Director of Communications and Marketing
	Anne Hyson	Head of Quality – Corporate Services
	Adam Bateman	Chief Operating Officer
	John Grinnell	Deputy Chief Executive/Director of Finance
	Melissa Swindell	Director of HR & OD
	Sarah Stephenson	Head of Quality – Community
	Stefan Verstraelen	Head of Quality – Surgery

In Attendance:

Jacqui Rogers	Transition Lead
Glenna Smith	General Manager – Medicine Division
Natalie Deakin	Change Programme Manager
Joe Gibson	Programme Assurance Director
Liz Edwards	Head of Clinical Audit & NICE guidance
Julie Creevy	Executive Assistant (Minutes)

18/19/132 Apologies:

Louise Shepherd	Chief Executive
Cathy Umbers	Associate Director of Nursing & Governance
Dani Jones	Director of Strategy
Tony Rigby	Deputy Director of Risk & Governance

18/19/133 Declaration of Interest
None declared

18/19/134 Minutes of the previous meeting held on 11th December 2018
Resolved:
CQAC approved the minutes of the previous meeting held on 11th December 2018.

18/19/135 Matters Arising and Action Log

Action Log

18/19/01 – Detect Update - HG reported that unfortunately the meeting scheduled for January 2019 would need to be rescheduled as key personnel were now unable to make the original date, further date being arranged.

18/19/104 – LC reported that a meeting is scheduled with Healthwatch on 25th January 2019 – this item to be closed from the action log.

18//19/106 – CQC Action Plan - HG reported that there is a strategy day scheduled with her team on 1st February 2019.

18/19/122 Programme Assurance Update- meeting regarding slippage with regards to Sepsis supporting documentation being uploaded onto Sharepoint – HG confirmed that G Smith & N Deakin are meeting to address this issue

18/19/125 – Joint CQAC & CQSG meeting to be agreed as appropriate – HG & ES to agree most appropriate date for joint meeting.

18/19/136 Sepsis Update

CQAC noted the Sepsis update agenda and notes from the Sepsis Steering Group meeting held on 19th December 2018, which focussed on antibiotic administration time, MIAA, Board presentation on 8th January 2019, Meditech Standard documentation, DETECT/VitalPac, E-learning/ESR, PID.

GS stated that discussion at the meeting held on 19th December heavily focussed on the 60 minute AB Administration time/target and whether this was correct. GS confirmed that there were strong clinical voices at the meeting, however clinicians were struggling to identify answers, with discussion regarding the over categorising number of patients in the Sepsis cohort.
GS reported that J Ashton had established a working group which is due to meet on 17th January 2019.

AM stated that the process for Sepsis reporting into CQAC is being finalised, and stated that the trialling of using the CQSG template for exception reporting had been agreed. GS confirmed that she had received the appropriate template for future monthly reporting to CQAC.

AM thanked GS for her update.

18/19/137 Transition Update

J Rogers presented the Transition update, key issues as follows:-

- Transition proposal is due to be presented at CQSG at its March 2019 meeting. JR highlighted the importance of receiving divisional and management division support.
- CQAC noted a different approach to delivering/implementing transition across the organisation which had been discussed with the community divisional senior management team. The approach would not deliver anything different in terms of the current practice and adherence to the 10 steps transition pathway, transition preparation and best practice guidance; however, it is hoped to support a more rapid implementation of transition across the Trust.

- The proposed plan is due to be presented to the Transition Steering Group on 29th March 2019 to ensure further ownership and responsibility for transition implementation to be devolved to divisional level across the Trust. This would result in Divisions being responsible for ensuring that all of their services undertake a benchmarking exercise against best practice guidance and National standards, access transition training, and implement the transition process within speciality services.
- The Trust transition service lead nurse would be a source of expert advice, support and guidance.
- The Transition lead nurse had moved to the Community division, and senior team support is now in place.
- Non clinical transition preparation is being delivered for all of the 14 year old patients (from the original identified cohort) with complex neuro-disabilities, and all these patients have dates for appointments in this year in diaries.
- There are 19 patients over 16 years old (from the original identified cohort) who require a first appointment for non-clinical transition preparation, as 12 of these patients had had appointments sent to them but have cancelled (DNA'd). The remaining patients will all have been allocated their 1st appointment date by the end of Quarter 4.
- This new approach which would commence early 2019 following discussion/agreement at the next transition steering group meeting.
- The complex neuro-disabilities case load is currently 56 patients (from the original cohort). This is anticipated to rise to approximately 100 patients, when all of the current 14-17 year old patients are identified and validated.
- There are now 30 young people on the Transition Exception Register (TER), who are stuck in paediatric services – as a result of there being 'no reciprocal adult service' availability to enable transition to take place.
- All other complex patient CQUIN milestones are expected to be achieved; however transition implementation across the organisation remained a challenge from both a clinical and non-clinical perspective.

Discussion took place regarding the most appropriate forum for discussion/agreement to take place, given that the CQSG meeting does not have significant medical engagement. AB stated that he would advocate outreach model, whilst ensuring that there had to be divisional representation, with the need to link into departments.

Action: To ensure prompt further discussion at Cross Divisional Triumvirate Tuesday morning meeting.

JR stated that support would be required with regards to embedding transition information into meditech, to ensure that the training element is embedded.

Dame Jo W queried how the Trust intended to create an alliance with adult services with regards to 30 young people that currently have no service provision. JR provided the background to the 1 year CQUIN monies which supported the Business Case at Aintree to enable Aintree to address the

transition cohort of patients, however Liverpool CCG could not support given the significant financial risk. This issue had previously been escalated to NHSE.

JR stated that a meeting with Whiston Hospital was scheduled for Monday 14th January 2019, however JR stated that she had since received notification that the meeting will now be rearranged for March 2019. JR stated that the meetings scheduled with Aintree had also been cancelled and rearranged a number of times by Aintree. CQAC noted that this issue had already been escalated to NHSE, and that the Trust previously sought assistance from CQC, who had now included transition process within their assessment process. JR stated that unless the adult services received appropriate CQUIN monies that this Trust would not receive any engagement from adult services.

Discussion took place regarding the importance of external collaboration with children's alliance/provider alliance.

J Grinnell stated that it would be beneficial for an Executive Discussion to take place, and that this would be discussed at the next Exec Strategy meeting scheduled on 24th January 2019.

Action: Discussion to take place regarding next steps at the Executive Strategy Session scheduled for 24th January 2019.

JR stated that the 10 Steps Transition Pathway: Improving Transition for Children in Hospital Settings" had been published in the December 2018 edition of the International Journal of Nursing and that the link for the article would be forwarded to J Creevy for circulation to CQAC members.

Action: JC to circulate link on receipt to CQAC members

JR expressed thanks to L Cooper, R Greer & Rose Douglas for continued support to date.

AM thanked JR for her informative update.

18/19/138 Quarter 3 Update: Children & Young People with Medical Complexity

LC provided a Quarter 3 update, key issues as follows:-

- LC shared data regarding occupied bed days above trim which highlighted for 2016/17 – Quarter 3 – 11,325, 2017/18, Quarter 3 – 6,828, 2018/19 Quarter 3 – 7,221.
- LC confirmed that the Trust is currently reporting 25/26 patients who have a significant length of stay.
- Number of delayed discharges – Quarter 1 – 9 patients, Quarter 2 – 7 patients and Quarter 3 – 4 patients. LC stated that there are a number of complexities with regards to these patients.
- 45% of delayed discharges was noted as a result of care packages which included carer training and quality of carers. Other delayed discharges were as a result of equipment, social care (including safeguarding),

housing, rehabilitation, parental engagement, discharge planning and repatriation.
- The Trust had achieved a discharge of a young person with 581 days length of stay
- Appointment of Operational Support Manager
- Recruitment of additional OT resource
- Profile of the team had increased
- Issues with medical palliative care cover had been identified, and a review is currently underway – which related to a single handed consultant.

Discussion took place regarding single handed consultant, with HG highlighting the importance of staff wellbeing and supporting staff. AH stated that there would be opportunities to develop further, with regards to developing models of care and that this would be discussed further during Job Planning discussions.

Quarter 4 plans
- Implementation of 21 Day MDT's.
- New Head of Complex Care & Community Nursing Carol Rowlands is due to commence in post in February 2019.
- Commencement of Social worker in post who commenced in January 2019
- Development of step-down to local hospices.
- SAFER implementation and support.
- Building on links made with Evelina - host event for the Children's Hospital Alliance to agree a shared data set for Children with Medical Complexities 'stranded' in hospital'.

JFH stated that it was clear that there is a gap in step down process and highlighted the importance of establishing whether there are opportunities to apply for charitable support with regards to appropriate provision for patients with medical complexities.

J Grinnell stated it was extremely positive to see the improvements to date and queried whether there was anything the Trust could do differently, in order to discharge those long stay complex patients home, whilst awaiting a care package. LC stated that she planned to provide an annual report, once the Trust has 2 years of data.

AM stated that it was evident that relationships had significantly improved with social care, and that improvements could only further expand in the future, which was welcomed by CQAC.

AM thanked LC for her update.

18/19/139 Models of Care Update

AH & AB presented the General Paediatrics and high dependency care update, key issues as follows:-

AH highlighted that this is a most challenging change programme with significant challenges experienced to date, which included relationship issues, lack of clarity, complexity of patients, resulting in patients in between numerous teams. Discussion had commenced amongst teams which are

ongoing, with progress been made in order to fully understand current issues and gaps, together with complex multiple morbidity. Flow issues had been addressed. Difficult discussions had taken place highlighting the importance of respect, trust and highlighting acceptable behaviours.

'What the Trust is trying to achieve':-

- To provide safe and effective care for acute emergency medical admissions, including enhanced consultant paediatric cover in the evening, to match the arrival time of emergency admissions.
- To reduce preventable deterioration in children, and to provide a rapid response when a child deteriorates.
- To meet national medical staffing standards for PICU and HDU across 7 Days.
- To provide holistic paediatric care to surgical patients who require it

CQAC noted the principles, together with the meeting structure.

Timescales:-

Monday 15th January – Friday 25th January 2019– Diagnostics and project scoping.
Monday 28th January – Friday 15th March 2019– Design new model of care.
Monday 18th March – Thursday 28th March 2019– Recommend and ratify – Report to be shared at Executive Team meeting on Thursday 21st March 2019, with Business Case shared at Operational Delivery Board on Thursday 28th March 2019.

Dame Jo Williams queried whether there would be any opportunity to fully engage with families, children and young people, AB confirmed that families, children and young people would be fully included at future workshops.

CQAC noted that this project had been challenging and that there would opportunity to integrate workforce, with further work required in order to support, which would require Human Resources Support due to organisation change issues. HG stated that investment had been provided with regards to the ART business case. CD stated the importance of holding specialists' to account to provide clarity and support for the sick child.

AH highlighted that a whole change process is required, whilst supporting teams with the ambition regarding primary care work/virtual delivery/GP network and highlighted that discussions needed to commence.

AM thanked AH & AB for informative update and confirmed that CQAC would receive monthly updates going forward.

18/19/140 Programme Assurance Update

N Deakin, Delivery Management Office Lead presented the Programme Assurance Update**,** key issues as follows:-

- The governance rating for the 'Delivering Outstanding Care' programme had improved once again this month, with 6 out of the 7 projects now rated green for governance. Models of Care remained the only project red rated for governance, however the presentation made at CQAC earlier addressed issues.
- Sepsis project – now that the governance issues are being resolved, ratings

for overall delivery should be addressed. Agreement of the new target thresholds and a detailed plan for 'year 2' is now required.

HG stated the importance of the correct level of support required for each project, with regards to alignment of the team, and the support required for each project. J Grinnell stated that the Trust is planning on reflecting on the next stage of the change programme, and outpatients/safe/ flow would all be captured and reviewed when reviewing the change programme in its entirety.

J Gibson stated that it may be beneficial to liaise with Arrowe Park Innovation team with regards to any shared learning regarding virtual clinics etc.

AM thanked ND for her update.

18/19/141 CQC Action Plan update

ES presented the CQC action plan, key issues as follows:-

- ES stated the importance of all services having appropriate up to date Strategy/improvement plans in place prior to the next engagement meeting which was scheduled in March 2019, and highlighted the importance of divisions ensuring all evidence is shared in order to develop appropriate operational plan, which is required within the next month. ES requested divisions to review urgently in order to present a solution.
- ES stated that with regards to the item to ensure "all risks across services are managed in a timely way and any controls and actions identified are recorded as outlined in the risk management strategy" – this item is progressing well and is being presented at the next Audit Committee meeting.
- "Consider the recording of discussion and challenge of executive led meetings" – ES stated that PA's are attending a refresher minute taking course scheduled on 31st January 2019 provided by NHS Providers which is a bespoke minute training course for 25 Executive PA and Divisional Support staff.
- "Consider how all groups feed into executive led committees – ES stated that there is an upcoming review scoped by using two external sources (Robert Forster, Finance Director at Wrightington Wigan & Leigh NHS Trust and Karen Wheatcroft, Operational Director at Mersey Internal Audit Agency in order to provide independent review and recommendations. Meetings would be diarised imminently with the external reviewers and appropriate personnel. ES stated that this review would commence rapidly.
- "Ensure that the Trust is fully compliant with the Lampard recommendations" – Business Case is nearing completion, MS currently working with HR team to progress.

  ES invited comments from divisions regarding whether they foresee any upcoming blockages and queried whether any support is required with regards to evidence gathering. LC stated that within the Community Division there had been some timescales that had slipped, which was as a result of SOP sign off. LC confirmed that she had challenged elements regarding safeguarding and access to training nationally which had been shared with Julie Knowles. LC stated that Liverpool Women's had capacity to provide MCA training.

SS stated that issues relating to IT/connectivity remained problematic regarding obtaining training figures for community. Duncan McCahill regularly attends the Community Divisional Board meetings in order to provide further support.

It was agreed that a training report detailing appropriate figures would be provided at next CQAC meeting it was agreed that MS would obtain further clarity from ES/HG & PB, however it was noted that it would be helpful for divisions to review as soon as possible.

Action: ES/HG & PB to feedback to MS regarding the report requirements, to enable MS/HR team to compile appropriate report for further scrutiny for next CQAC meeting

Dame Jo W requested a position statement with regards to leaflets within the Trust.

AH confirmed that an extensive initiative is progressing well, with 65 revised leaflets being uploaded on 16th January 2019, with team progressing whilst taking a practical approach and ensuring leaflets are child friendly.

ES requested AH to review those red actions within the Radiology action plan, in order to further understand the issues.

Action: AH to review Radiology issues in order to address issues

CQAC noted the importance of having sufficient time to review CQC action plan at future meetings.

AM thanked ES for the update.

18/19/142 **Corporate Report – Quality Metrics**

HG stated that the 2 main challenges related to the 'Friends and Family A&E % recommending the Trust', - which reflected (80.6%), and the '% of patients involved in play and learning' – which equated to 72.5%. HG reported that she had met with the wider group, together with C Wardell and P O'Connor, with P O'Connor leading on this initiative. Plan for action plan to be presented at March CQAC meeting in order to ensure that the plan is robust.

Action: - Action plan to be presented to March CQAC meeting.

- Incident management is improving with divisions review near misses.
- There had been 5 medication errors listed as having caused minor, non Permanent harm.

AM thanked HG for her update.

18/19/143 **Board Assurance Framework**

ES presented the Board Assurance Framework, and confirmed that the Trust continued to receive substantial reports to ensure that the control gap is

addressed and ensuring final actions are closed, in order to review 2019/2020.

Committee noted existing control measures which are in place.

AB stated that the Trust had achieved the required standard with regards to waiting times in AED and as a result the Trust had been recognised nationally by NHSI and had received appropriate payment.

AM thanked ES for her update.

18/19/144 **Clinical Audit and Effectiveness Report & NICE Compliance Report:**

LE presented the Clinical Audit & Effectiveness Report & NICE Compliance Report, key issues as follows:-

- The Trust Clinical Audit plan was formally published in July 2018 and illustrated activity around mandatory National Audits, confidential enquiries and Trust wide audits which would be undertaken to fulfil requirements of the CCG Quality contract and NHS England.
- The Trust audit plan is progressing well with 85% compliance at the end of Quarter 3. There are a number of annual audits that would be undertaken to meet full compliance by end of Quarter 4.
- CQAC noted the update on actions previously identified which ranged from update on quarterly updates to Divisional Integrated Governance Committee, development of standardised approach to divisional reporting, review of longstanding audits which remained incomplete, discussions with divisional teams remain ongoing. Divisional Triumvirate for Medicine had completed a review, and currently activity is progressing to plan.
- The Divisional Triumvirate for Surgery had reported that 20% (previously 23.5%) of audits within the local plan require an update. This would be discussed in detail at Divisional Board and Divisional Integrated Governance meetings with an expectation that all audit activity will progress as planned by end of Quarter 4.
- The Divisional Triumvirate for Community had agreed the Divisional audit plan, which included 89 audits. The update of progress is ongoing and Introduction of Ulysses electronic database to manage Clinical Audit programme as a means to strengthen communication and maintain a central repository for all clinical audit activity.
- The Clinical Audit team are meeting (on the 30 January 2019) with colleagues at Manchester University NHS Foundation Trust (NHSFT) who are established users of the Ulysses Clinical Audit module. This meeting was prompted by a meeting with the team at SNAP (electronic system currently used at Alder Hey to manage the Clinical Audit process) who presented recent developments and newly developed resources within the system, with advanced functions.

  Following the meeting at Manchester, the Head of Clinical Audit and NICE Guidance would provide a report and recommendations to the

Associate Director of Nursing & Governance regarding the preferred system in terms of efficiency, effectiveness and suitability for Alder Hey.

Review of Trust Clinical Audit policy

- The Trust Clinical Audit policy review had been completed and an updated version published on the Trust intranet.

NICE guidance - Since the previous reporting period 7 NICE clinical guidelines had been published. Therefore at present, there are 85 guidelines, of which, 4 (previously 8) required a baseline assessment, 15 require further information regarding appropriateness and action plan development / completion.

Therefore currently the Divisional teams have completed a baseline assessment for 95% of NICE guidelines registered and have provided updates for 76% of clinical guidelines registered (previously 62%).
Dame J W queried what audits had not been completed and queried the reasoning behind non completion. HG stated that she would discuss this issue offline with L Cooper/A Hughes and C Duncan to review methodology.
Of the 47 Quality standards, 1 required an initial assessment (same as previous reporting period), 8 require further information – previously 10 indicating compliance of 83% (previously 77%).

Action: HG to meet with LC/AH & CD, LE re NICE at Triumvirate meeting with completion methodology.

Regionally, discussion had suggested a shift from reporting compliance to demonstrating actions taken in response to the publication of NICE guidance and Quality Standards and identifying actions required by specialities.
This report indicated some improvement in terms of demonstrating the Divisions' management of NICE publications. However there is a need for continuous improvement to provide assurance. The Divisional Integrated Governance committees will receive monthly updates regarding progress and gaps in providing assurance.

The Divisional Triumvirate for medicine is expected to agree a timescale for completion of the reviews and actions required to demonstrate expected compliance by the end of Quarter 4.

National Clinical Audit awareness week - In line with National Clinical Audit awareness week (19 – 23 November 2018), the Clinical Audit team undertook activities to raise the profile and function of Clinical Audit within the Trust.

- CQAC noted actions taken relating to Local Audit plans, RCA action plan audits.
- Clinical Audit Training programme for the Trust is currently under development. This would incorporate training for the use of Ulysses to encompass all stages of the audit process to ensure completeness.
- Dissemination of clinical audit findings, lessons learnt and actions taken as a result of clinical audit is predominantly delivered within specialty
  The Clinical Audit team would organise regular sessions to facilitate Trust wide dissemination and learning, accessible to staff from all areas. This

would take place initially on a monthly basis

AM thanked LE for her update.

18/19/145 Clinical Quality Steering Group key issues report

POC presented the Clinical Quality Steering Group key issues report, key issues as follows:-

- 15 Steps Challenge: - a review had been undertaken by Parents and Children's Forums. 3 wards were visited and OPD. Learning points including findings were similar with the ward accreditation teams. A further 15 step challenge is scheduled to take place in February 2019. This would provide triangulation of data and ensuring best practice.
- Interpretation report – Policy due to be updated early 2019. Trust uses several suppliers regarding Interpreting services. Intranet paged updated. Ulysses updated to include interpreter as a cause group which would enable easier extraction of data. Costs in some areas are high, however patient experience is significantly improved.
- 10xErros Group – originally set up in the Division of Surgery, however the team may look to expand across the Trust reviewing 10xerrors and implementing and monitoring actions.
- Learning Disability: NHSI LD benchmark standards for September 18 included 3 standards - Respecting and protection rights, including & engagement, and workforce. A presentation provided by J Knowles, Director of Safeguarding highlighted that month on month children accessing the service are increasing. HG had undertaken previous discussions with Joann Kiernan, regarding standards, and the Trust is complaint, currently have 4 wte 2 days per week, with a growing service.
- Drugs & Therapeutics – 8 submissions received from CDEG. 7 urgent drug requests. 9 new guidelines approved. Non-medical prescribing policy updated and 6 new NMP's had been added to the register. 10xerrors working group set up in order to provide the Trust with a level of further assurance.

Divisional Quality Dashboards

- **Community –** New performance template developed by CQAC by Heads of Quality. 1 new RCA wrong route medication CCNT. 2 new complaints.
- **Surgery –** Surgery had introduced a staff engagement plan and the progress of this would be monitored and reported. Weekly complaints huddle had been introduced.
- **Medicine –** Exceptions included 1 RCA Level 1 investigation for a grade 2 pressure ulcer. 57% did not know their date of discharge.

AM thanked POC for CQSG key issues report.

18/19/46 Any Other Business

CD stated that the Division are on plan to meet the 400 coronary cases, whilst recognising that this is the first time that the Trust had been on plan to reach this target, CQAC agreed that this is extremely positive for the Division.

18/19/147 Date and Time of Next meeting

10.00 am – Wednesday 20th February 2019, Large meeting room, Institute in the Park.

Alder Hey Children's NHS
NHS Foundation Trust

Board of Directors

5th March 2019

Report of:	Director of Human Resources & Organisational Development
Paper Prepared by:	Director of Human Resources & Organisational Development
Subject/Title:	People Strategy Update for March 2018
Background Papers:	Staff Survey 2018
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 Trust celebrated the 2018 Annual Star Awards Celebration on 8th February 2019. Initial staff feedback from those who attended the awards evening was extremely positive and staff have reported that this was “the best event we have ever had”. Plans are underway in preparation for next year’s event.

The Reward and & Recognition group continue to meet monthly, and have integrated with the Social committee to discuss and establish the best benefits for staff.

Staff Survey

Following the excellent response rates to the staff survey (60%) and the initial results being presented to Trust Board, we have now received the national Staff Survey report.

These reports have now been published nationally, and are included within this Board paper. The highlights from the 2018 survey show significant improvements across the majority of areas from the 2017 survey. The survey is in a new format this year, themed into 10 different headings, and we have improved across all themes, with statistically significant improvements in 4 of these areas; immediate managers, quality of appraisals, safety culture and staff engagement. The report shows that the progress we have made over the last 2-3 years now places our results in a comparable position to our comparators, ‘acute specialist trusts’. This is a great position to be in, however we will continue to focus on improving, with our aim to be in the ‘best’ category in the next 1-2 years.

This year, there are a number of specific areas of focus for us:

- Improving the experience of staff from BAME backgrounds and staff with a disability remains a key priority, as does improving adjustments for staff who need them for their work
- Identifying why staff feel that they can’t deliver the care they aspire to and working on removing these barriers
- Despite big improvements, there is still work to do around improving staff perception of us caring about and taking positive action on their health and well-being, in particular improving how we can support staff who are unwell due to stress caused by work
- Focusing on the quality of appraisals and ensuring they are useful to improve staff output and objectives

We have been granted access to the reporting tool which will allow us to break down the results further. The HR team are currently analysing the data sets into meaningful reports for the Trust, divisions and departments in order to allow them to hold effective conversations about key areas of focus for the year ahead in order to once again improve on our results year on year.

Improving Staff Wellbeing

The Trust is commitment to changing and challenging attitudes towards mental Health and currently in the process of signing up to the Employer Time to Change Pledge, which is run by mental health charity, Mind. The HR team are working with communications on how to most effectively launch and implement the Trusts wellbeing strategy throughout the organisation.

The Trust is continuing to work with NHSI on the national programme of improving employee health and wellbeing and have been working in conjunction with the Economic Evaluation team in conducting research on the impact of local deprivation on sickness absence and the role of occupational health support services.

Brexit- EU Settlement Scheme

For the right to work in the UK after 31/12/2020, EU citizens must apply for UK immigration status under the EU Settlement Scheme. On 29/11/18 the Home Office launched a pilot of the scheme for individuals working in the health and social care sectors.

To date **17** individuals (27%) have confirmed either UK Citizenship or Settled/ Pre-settled status.

The HR department continue to be contact with individuals through specific communications on-going with on a 1:1 basis with EU colleagues. The HRBP's are supporting the divisions in offering wrap round support to staff including signposting and guidance.

2. Workforce Sustainability and Capability

Agenda for Change New Pay Deal – Transition of Band 1 to band 2 staff

Staff side and management met in February 2019, to agree the communications documentation that would be issued to the band 1 staff affected by the transition from band 1 to band 2;

- Domestic Assistants
- Catering Assistants
- Linen Assistants

This communication clearly articulates the transition from band 1 to Band 2 in accordance with the refreshed national Terms and Conditions of Service. This will be imminently circulated and those staff will have 1 month to decide whether they wish to transition across to band 2 or remain on a spot salary. All staff will be offered 1;1 meetings to discuss and understand the impact of the changes.

Education, Learning and Development

Apprenticeships- The Apprenticeship Team have exceeded the annual target of 50 Apprentices by the end of March 2019. Currently there are 56 'live' Apprentices a further 4 have signed their Apprenticeship agreements, making a total of 60.

The Register of Apprenticeship Training Providers (RoATP) has opened and the Trust will have to reapply to remain on the register of Employer Providers.

The Apprenticeship Team have been nominated for an Apprenticeship Employer award by Southport College for building excellent relationships and our contribution to support Alder Hey Staff with Apprenticeship opportunities; the event takes place 19th March.

Liverpool City Region (LCR) Combined Authority has invited the Apprenticeship Team to give a presentation to other Levy payers in the region who are not currently using their Levy. This is to highlight the benefits of Apprenticeships and how Apprenticeships can play an integral part of Workforce Planning, 'plugging the gaps' and 'growing our own'. The Metro Mayor, Steve Rotherham, is also speaking at the event to highlight the loss of Levy funds that will leave Employers Digital Accounts from April 2019 onwards. The Metro Mayor wants Levy payers from across the region to lobby Government to agree to reallocate unused Levy (millions) to the City Region rather than it going to a central pot. The 'Building our Futures' Strategy clearly sets out current and future skills gaps within the region – the Health Sector being one of them, and how these unused funds would help support this. The event is at Anfield FC on 15th March 2019.

Mandatory Training- Mandatory training figures have increased slightly to 89.58% for Core Mandatory Training (from 89.02% in Dec) and decreased slightly (from 88.43% in Dec) to 88.14 in January for Overall Mandatory Training.

The key outlier in terms of low compliance continues to be Information Governance, despite the additional sessions being offered by the Information Governance Lead and additional communication prompts to encourage staff to update their training records it continues to struggle.

This is largely down to the uniqueness of this topic; it is the only topic on a 1 year refresher period that is required by all Alder Hey staff – plus it has a requirement for staff to complete a marked assessment to be deemed as compliant limiting how the

training is completed. We will continue to work closely with the Information Governance lead and managers to push compliance.

The team will also continue to ensure that staff and managers are aware of outstanding requirements and providing communication directly to individual's outstanding mandatory training.

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

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

3. Employee Relations

Employee Consultations

Organisational Change

Portering

Following a meeting with trade unions, arrangements are being made to meet with key affected individuals during February /early March 2019 with a view to progressing along the basis of the alternative proposals.

Emergency Department Reception team

An organisational change consultation is currently in progress, due to conclude at end of February 2019, to review the shift rotas within the reception team, as the present rota results in difficulty in providing cover on some shifts, and potential impact on patient care and additional cost in sourcing extra cover. The consultation is progressing well at the moment with good engagement from the reception team with a number of suggestions for alternative arrangements being actively review by management.

Home Care

Due to continued decreases of packages within the Home Care team and as a result of no expansion in the service since November 2016 a further 5.5 WTE, 7 in total, band 3 HCA's roles are at risk. Management have commenced formal consultation on 4th February and are currently undertaking one to ones with staff affected. Consultation is due to end 13th March.

Day Case Theatres

The Surgical Day Case (SDC) Surgical Admissions Lounge unit currently have separate staffing models and a format of working which have previously enabled the departments to provide continuity of care to patients and families whilst also meeting the flexible working requirements of the staff. As part of service development from November 2018 the department will be introducing a process of staggered admissions. Batched admissions will help the service to manage activity times and staffing requirements and also enable the service to provide a safe and high quality admission route for patients.

In order to support these changes the SDC and SAL services will need to review the current shift patterns across both teams. The current arrangements are not currently conducive to supporting a batched admission process and a dynamic nursing model is required that enables the service to provide safe, effective quality care and enhance patient experience.

Employee Relations Activity

The Trust's ER activity is currently is detailed below:

Department & Case type	No.
Corporate	**1**
Bullying and Harassment	1
Community	**2**
Disciplinary	2
Medicine	**7**
Capability	1
Disciplinary	6
Surgery	**5**
Disciplinary	2
Grievance	1
Bullying and Harassment	2
Grand Total	**15**

Employment Tribunal Cases

The Trust has received the judgement outcome of the ET Claim relating to disability discrimination and protected disclosure which was held at the Liverpool Employment Tribunal on 12th November 2018, concluding on 23rd November. The ET found in favour of the Trust and dismissed all claims by the claimant. The ET Appeal date is due around March 2019.

There will be a de-brief to identify both Trust wide and Divisional learning lessons.

The Trust has been notified of an Appeal to an Employment Tribunal claim that was resolved in favour of the Trust in December 2017. An update is awaited from the Trust solicitors.

The Trust has received a notification of an ET case relating to a member of staff who feels they have suffered detrimental treatment, following their request for set days, through a flexible working request. The Trust is currently working with our Solicitors to progress.

4. Corporate Report

The HR KPIs in the December Corporate Report are:

- Sickness rates have decreased this month from **6.09%** in December to 5.6% in January 2019.
- The Rolling 12 month sickness figure has also decreased to **5.52%**
- Core Mandatory training compliance increased to **90%**
- PDR compliance is at **90%**

Survey Coordination Centre

NHS England

Alder Hey Children's NHS Foundation Trust

2018 NHS Staff Survey

Benchmark Report

Contents

Survey Coordination Centre

Introduction

NHS England

This benchmark report for Alder Hey Children's NHS Foundation Trust contains results for themes and questions from the 2018 NHS Staff Survey, and historical results back to 2014 where possible. These results are presented in the context of the best, average and worst results for similar organisations where appropriate. Data in this report is weighted to allow for fair comparisons between organisations.

Please note: q1, q10a, q19f, q23d-q28a and q29-q31b are not weighted or benchmarked because these questions ask for demographic or factual information.

Full details of how the data is calculated and weighted are included in the Technical Document, available to download from our results website.

The structure of this report

Introduction

- Introduction
- Using the report
- Organisation details

Provides a brief introduction to the report, including the graphs used throughout.

The '**Organisation details**' page contains key information about the organisation's survey and its benchmarking group.

Theme results

- Overview
- Trends
- Detailed information

The ten themes provide a high level overview of the results for an organisation.

The '**Detailed information**' sub-section contains the question results that feed into each theme.

Question results

- Your job
- Your managers
- Your health, well-being and safety at work
- Your personal development
- Your organisation
- Background details

Results from all questions, structured by the questionnaire sections.

Appendices

- Response rate trends
- Significance testing of themes
- Tips on action planning and interpreting results

'**Significance testing of themes**' contains comparisons for the 2018 and 2017 theme scores.

Survey Coordination Centre

Using the report

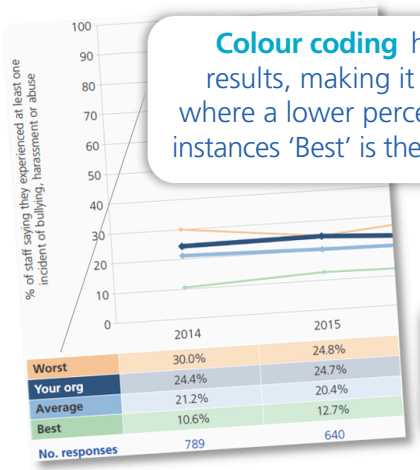
NHS England

Key features

Question number and text (or the theme) specified at the top of each slide

Slide headers are **hyperlinked** throughout the document. '2018 NHS Staff Survey Results' takes you back to the contents page (which is also hyperlinked to each section), while the rest of the text highlighted in bold can be used to navigate to sections and sub-sections

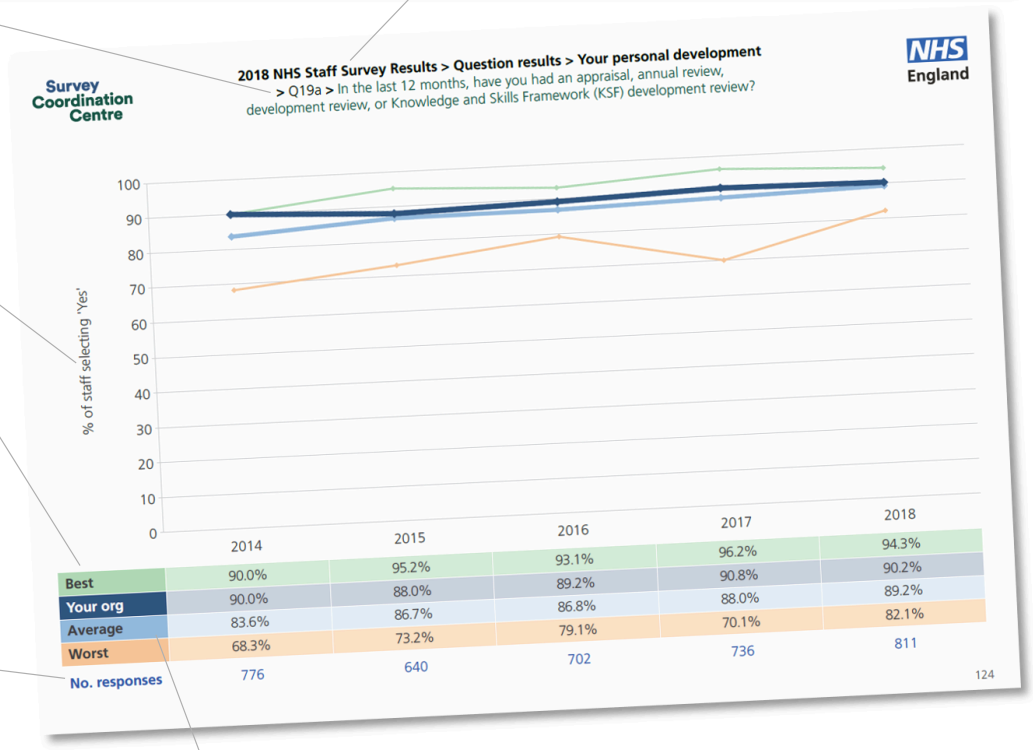
Question-level results are always reported as percentages; the **meaning of the value** is outlined along the axis. Themes are always on a 0-10pt scale where 10 is the best score attainable



Colour coding highlights best / worst results, making it easy to spot questions where a lower percentage is better – in such instances 'Best' is the bottom line in the table

Keep an eye out!

Number of responses for the organisation for the given question



Tips on how to read, interpret and use the data are included in the Appendices

'Best', 'Average', and 'Worst' refer to the **benchmarking group's** best, average and worst **results**

Survey Coordination Centre

Organisation details

NHS England

Alder Hey Children's NHS Foundation Trust

2018 NHS Staff Survey

Organisation details

Completed questionnaires	2,001
2018 response rate	60%

See response rate trend for the last 5 years

Survey details

Survey mode	Mixed
Sample type	Census

This organisation is benchmarked against:

Acute Specialist Trusts

2018 benchmarking group details

Organisations in group: **16**

Average response rate: **53%**

No. of completed questionnaires: **17,643**

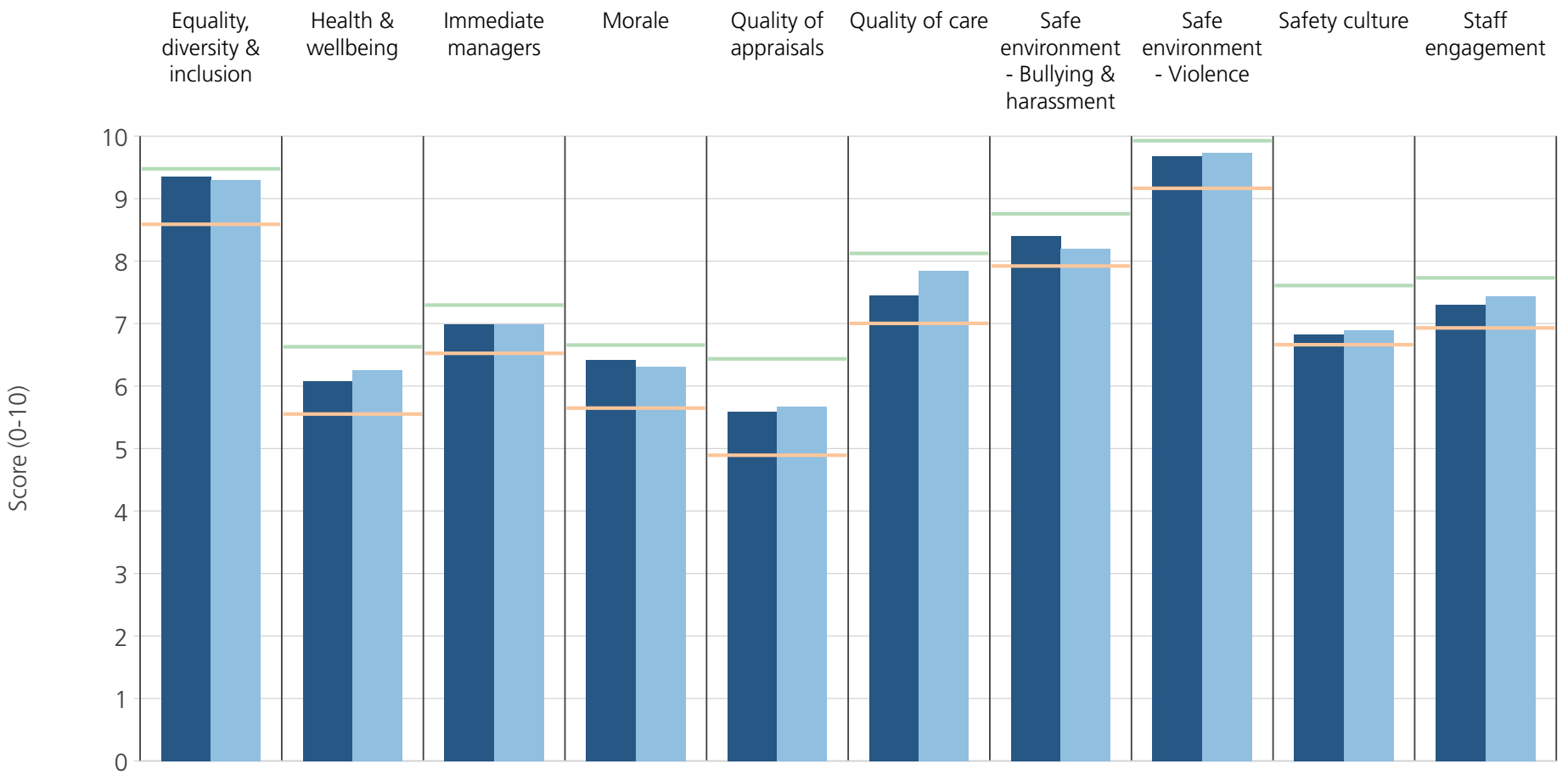
Survey Coordination Centre

NHS England

Theme results

Alder Hey Children's NHS Foundation Trust

2018 NHS Staff Survey Results



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement
Best	9.5	6.6	7.3	6.7	6.4	8.1	8.8	9.9	7.6	7.7
Your org	9.4	6.1	7.0	6.4	5.6	7.4	8.4	9.7	6.8	7.3
Average	9.3	6.3	7.0	6.3	5.7	7.8	8.2	9.7	6.9	7.4
Worst	8.6	5.6	6.5	5.6	4.9	7.0	7.9	9.2	6.7	6.9
No. responses	1,971	1,979	1,985	1,969	1,778	1,745	1,966	1,947	1,971	1,996

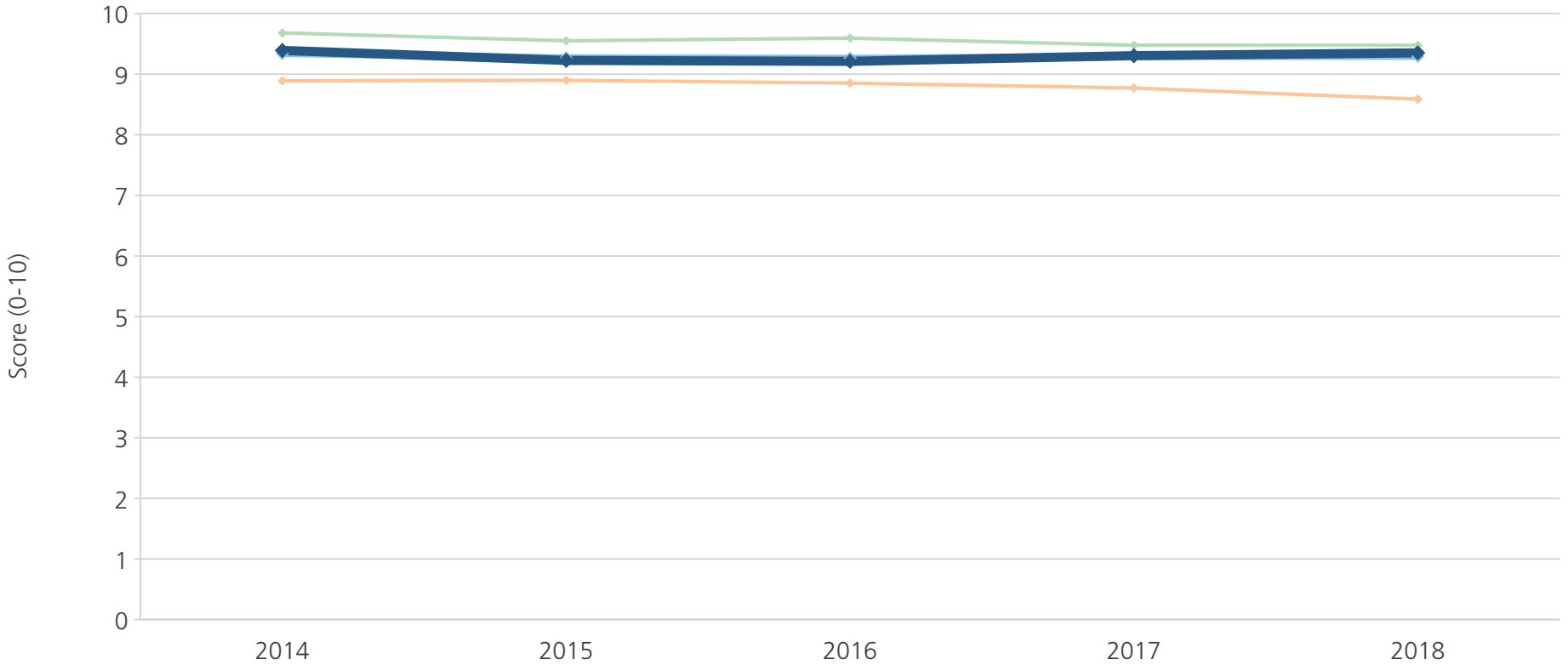
Survey Coordination Centre

NHS England

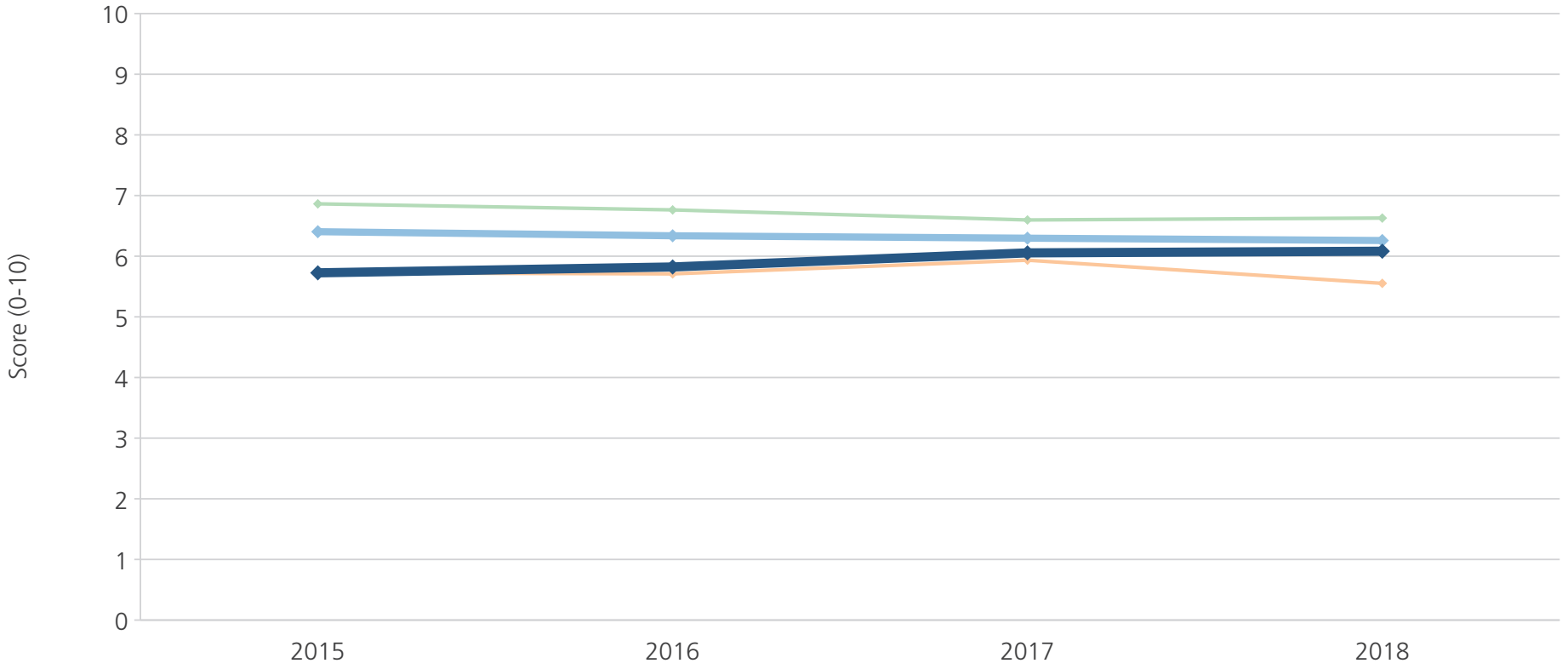
Theme results – Trends

Alder Hey Children's NHS Foundation Trust

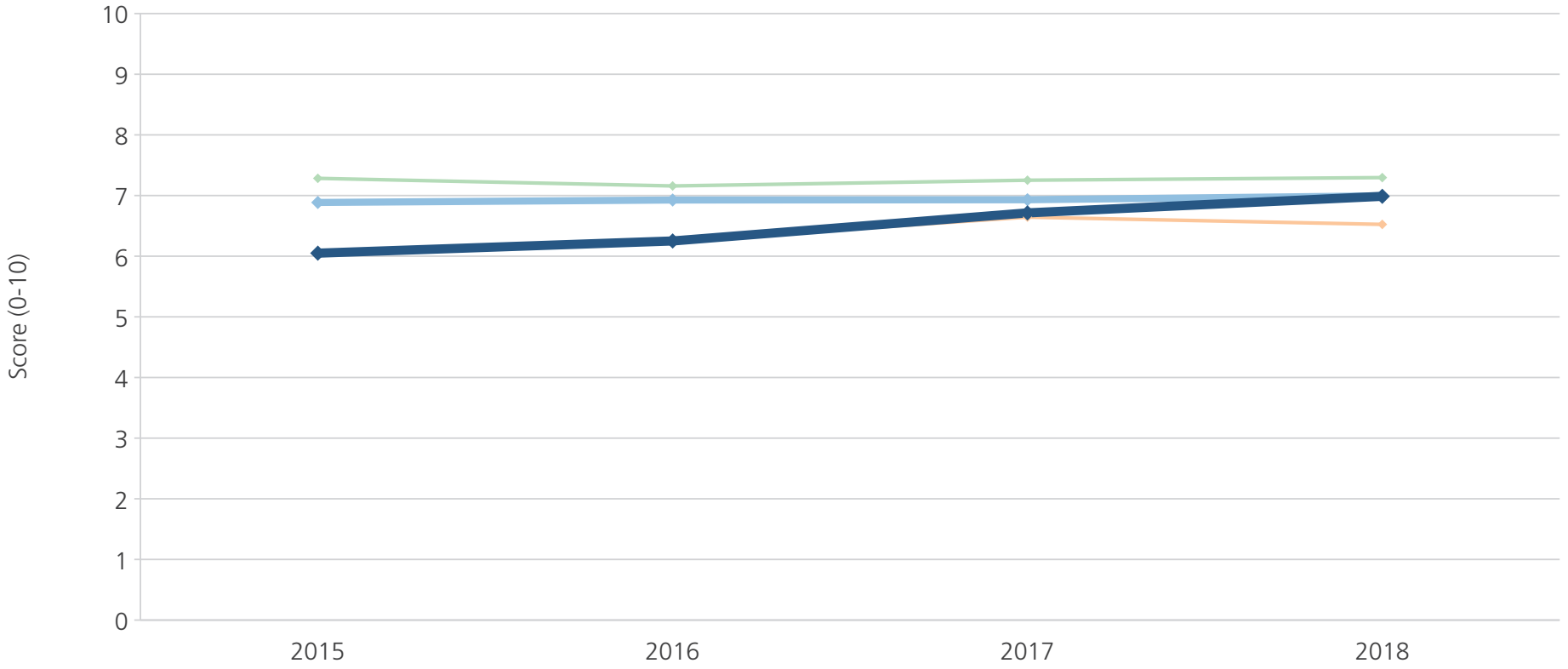
2018 NHS Staff Survey Results



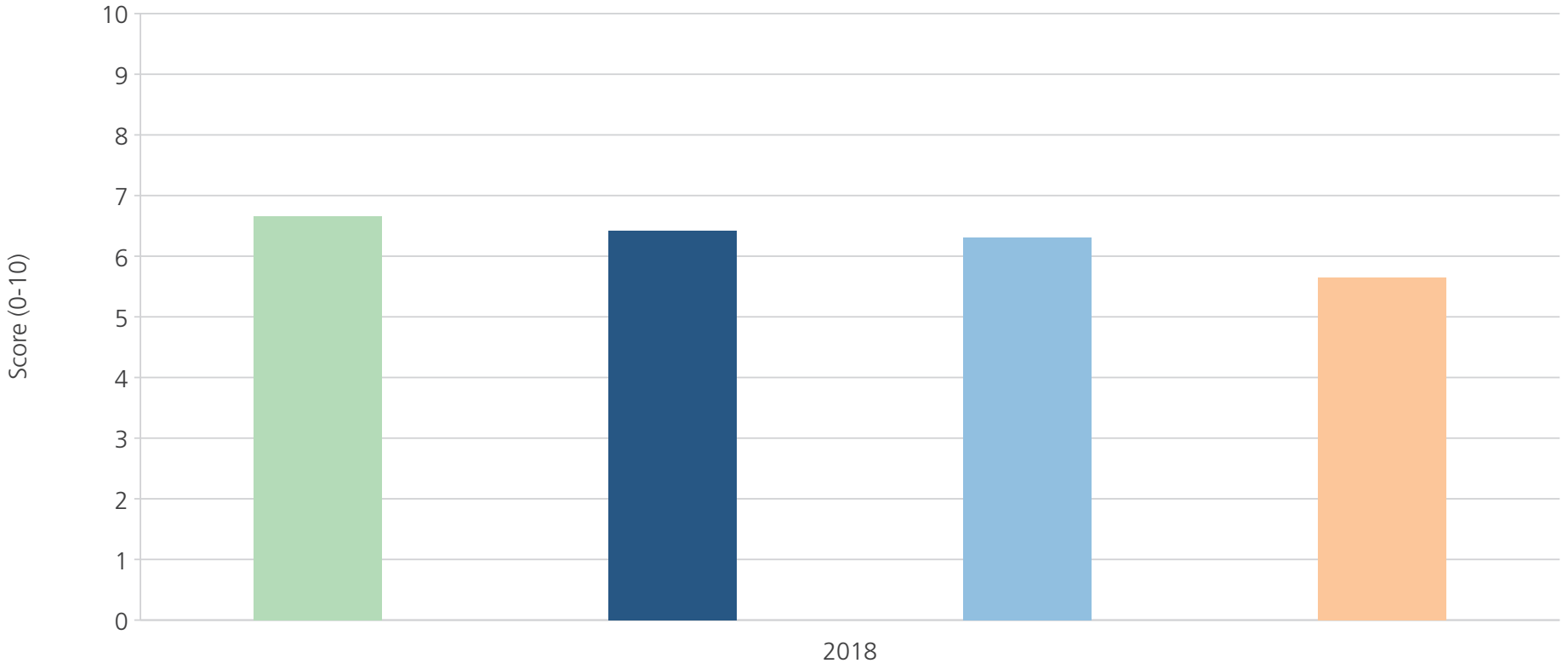
	2014	2015	2016	2017	2018
Best	9.7	9.6	9.6	9.5	9.5
Your org	9.4	9.2	9.2	9.3	9.4
Average	9.3	9.3	9.3	9.3	9.3
Worst	8.9	8.9	8.9	8.8	8.6
No. responses	1,113	926	1,117	1,725	1,971



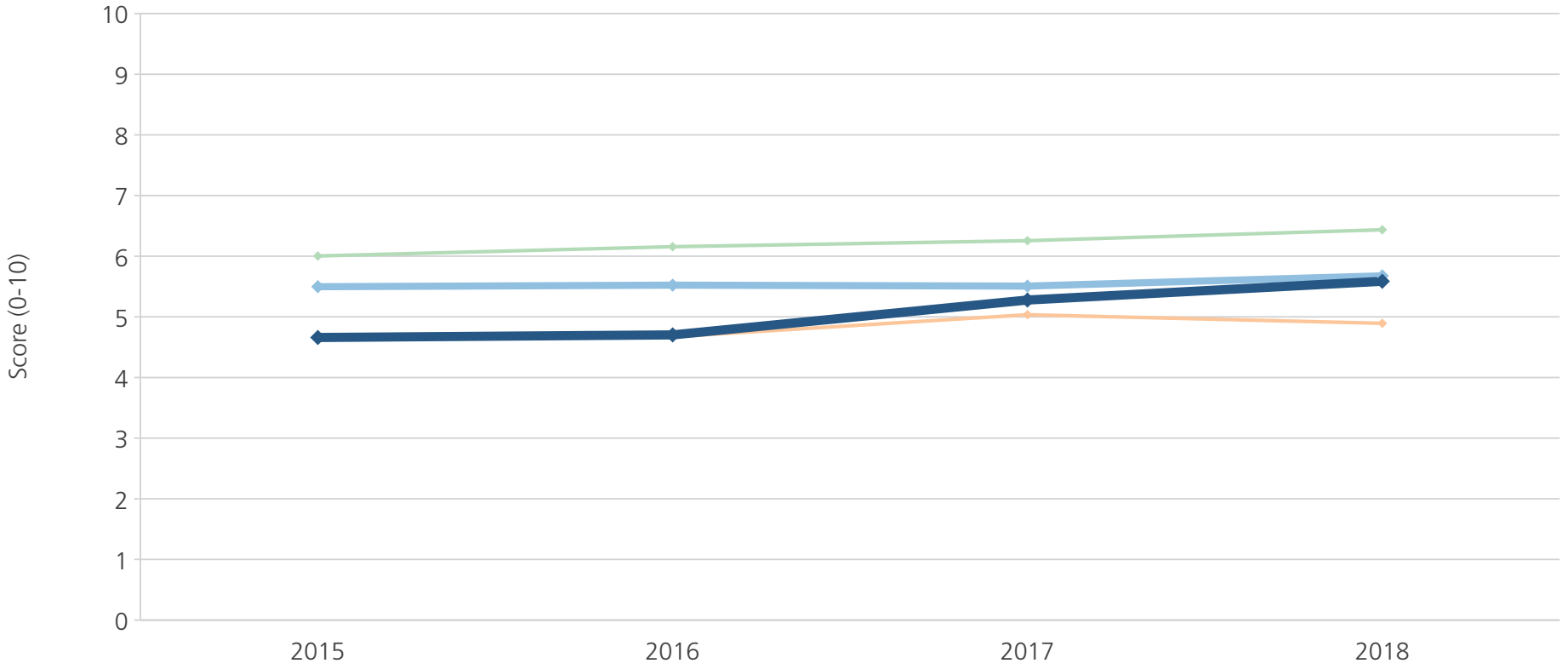
	2015	2016	2017	2018
Best	6.9	6.8	6.6	6.6
Your org	5.7	5.8	6.1	6.1
Average	6.4	6.3	6.3	6.3
Worst	5.7	5.7	5.9	5.6
No. responses	929	1,131	1,743	1,979



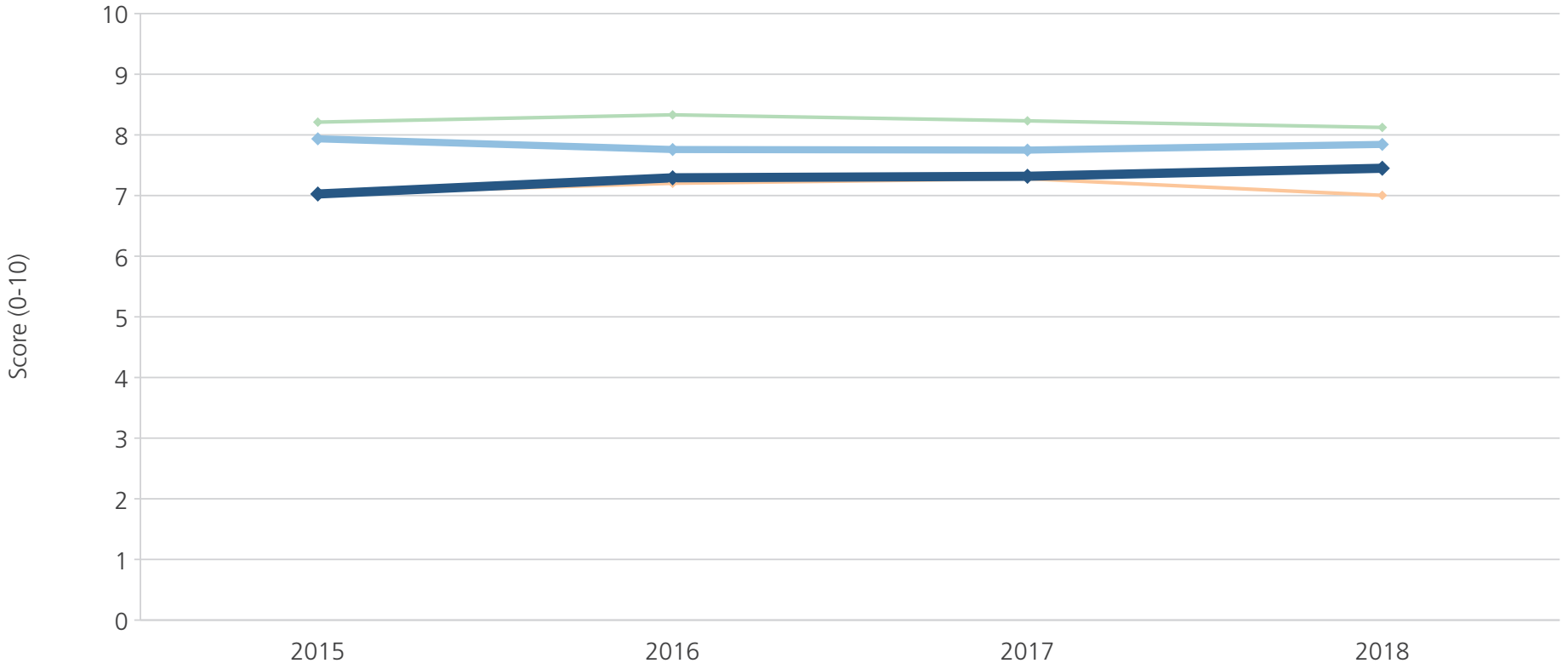
	2015	2016	2017	2018
Best	7.3	7.2	7.3	7.3
Your org	6.0	6.3	6.7	7.0
Average	6.9	6.9	6.9	7.0
Worst	6.0	6.3	6.6	6.5
No. responses	928	1,130	1,737	1,985



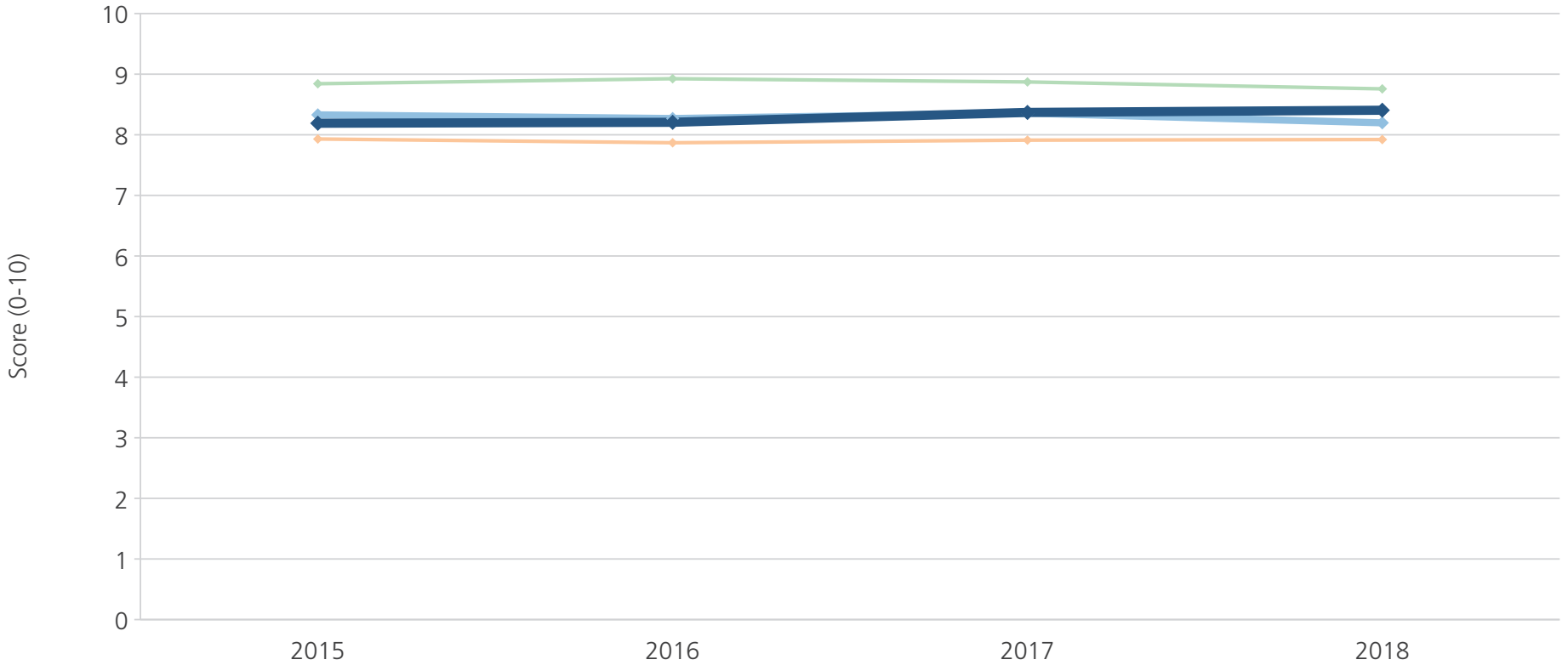
Best	6.7
Your org	6.4
Average	6.3
Worst	5.6
No. responses	1,969



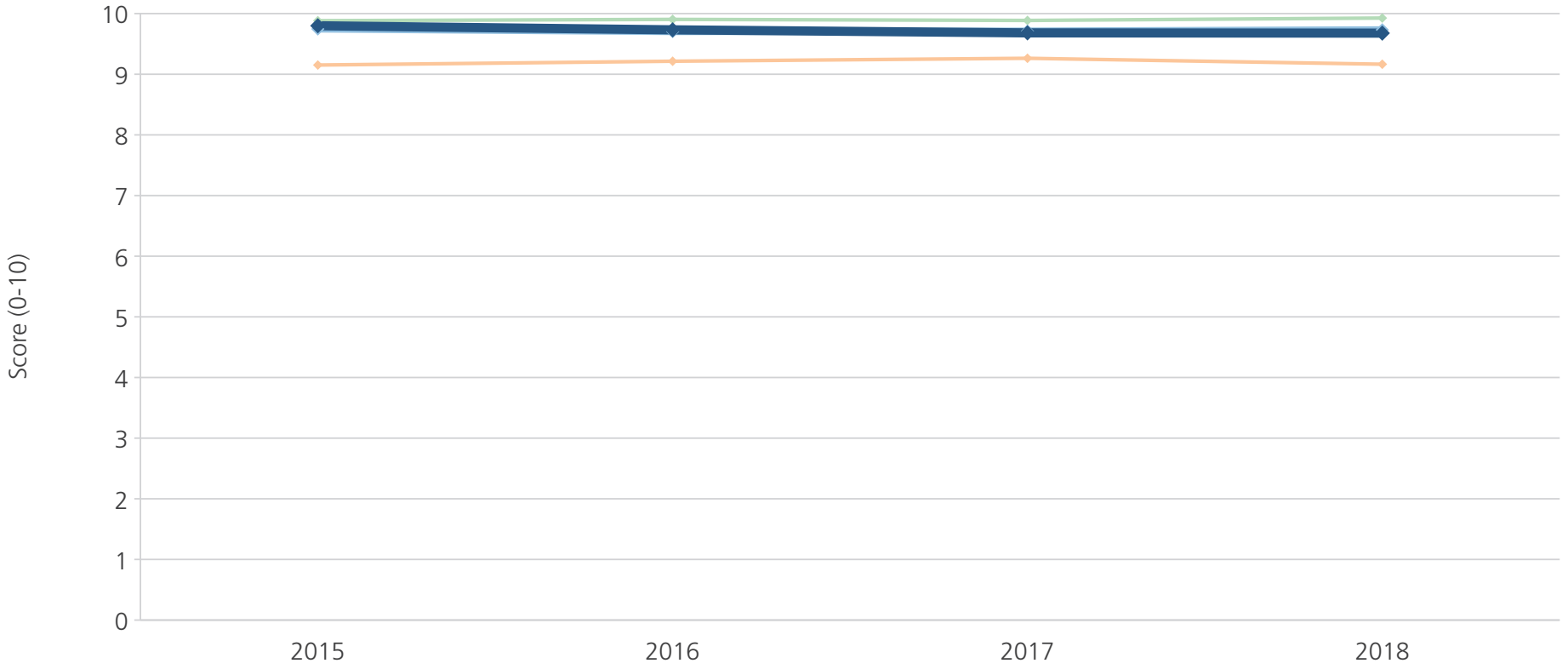
	2015	2016	2017	2018
Best	6.0	6.2	6.3	6.4
Your org	4.7	4.7	5.3	5.6
Average	5.5	5.5	5.5	5.7
Worst	4.7	4.7	5.0	4.9
No. responses	694	899	1,459	1,778



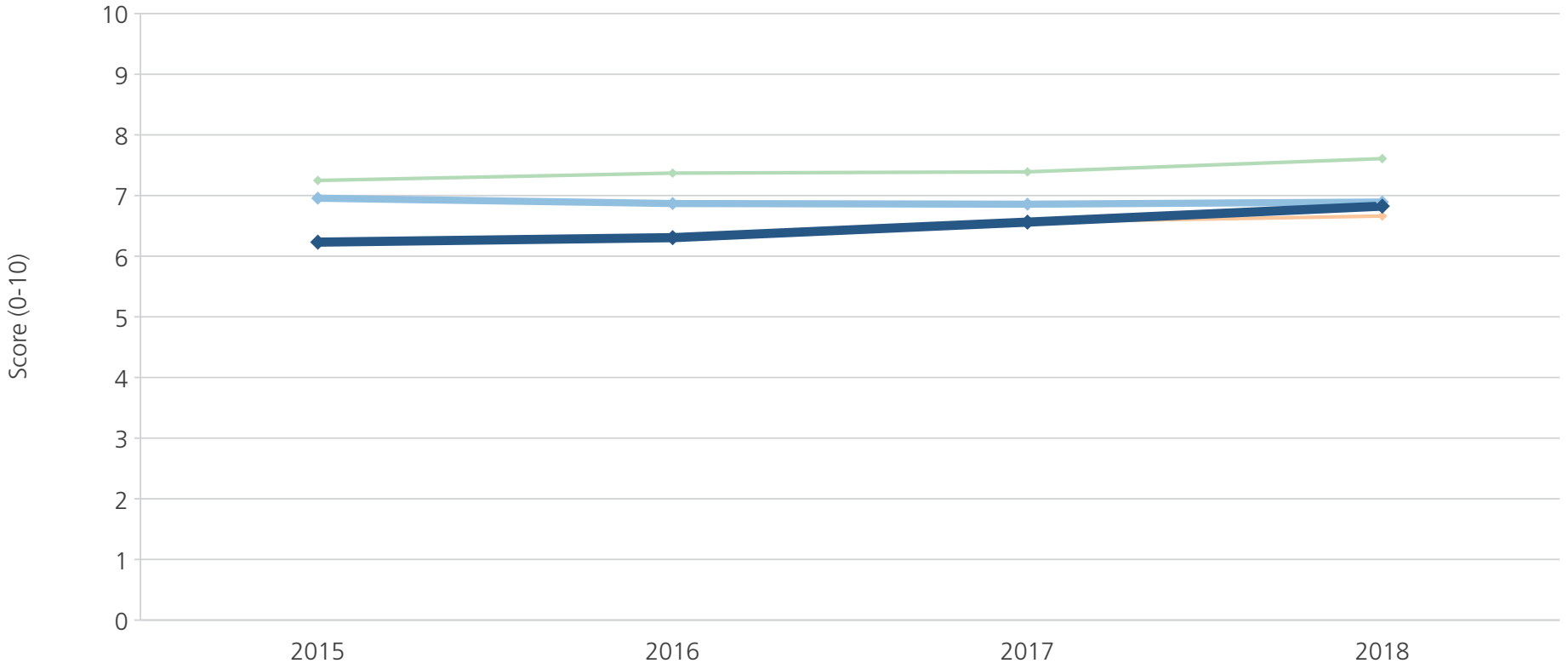
	2015	2016	2017	2018
Best	8.2	8.3	8.2	8.1
Your org	7.0	7.3	7.3	7.4
Average	7.9	7.8	7.7	7.8
Worst	7.0	7.2	7.3	7.0
No. responses	805	966	1,523	1,745



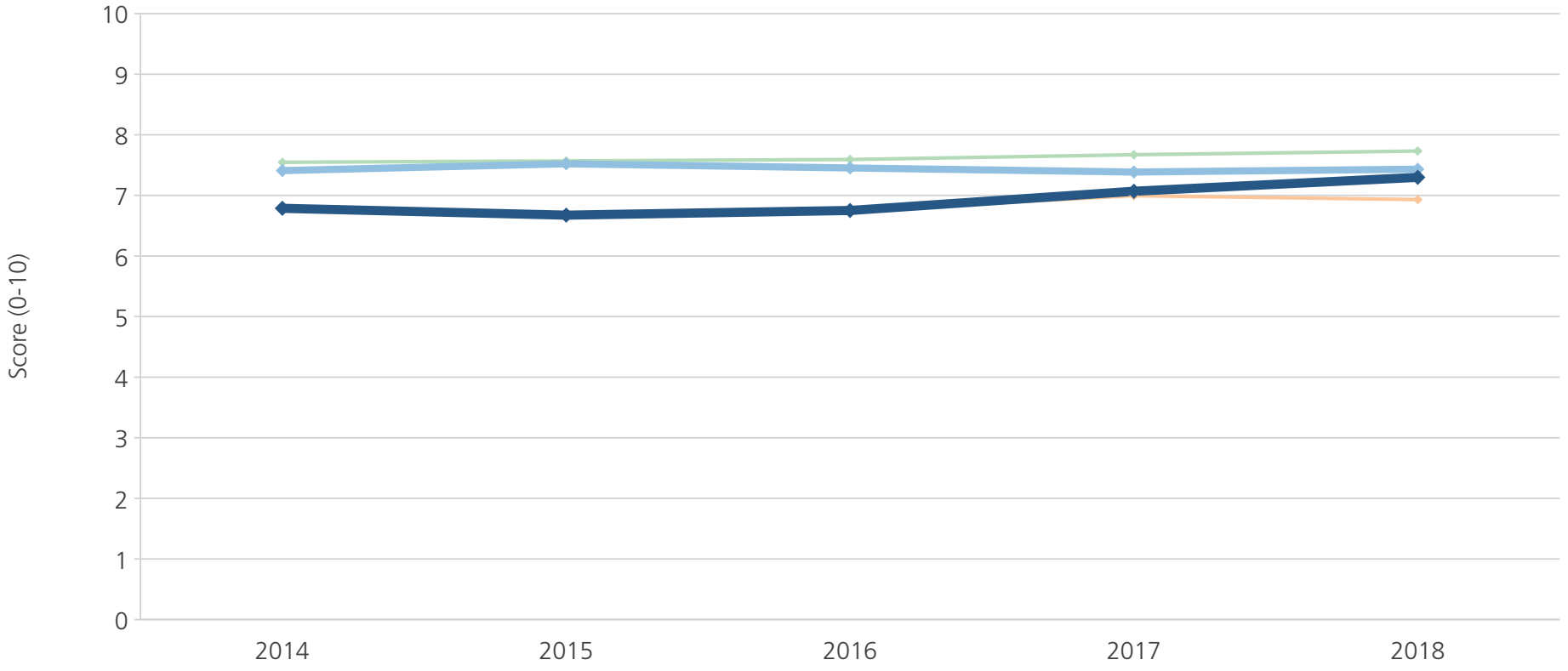
	2015	2016	2017	2018
Best	8.8	8.9	8.9	8.8
Your org	8.2	8.2	8.4	8.4
Average	8.3	8.3	8.4	8.2
Worst	7.9	7.9	7.9	7.9
No. responses	911	1,101	1,713	1,966



	2015	2016	2017	2018
Best	9.9	9.9	9.9	9.9
Your org	9.8	9.7	9.7	9.7
Average	9.7	9.7	9.7	9.7
Worst	9.2	9.2	9.3	9.2
No. responses	923	1,111	1,727	1,947



	2015	2016	2017	2018
Best	7.2	7.4	7.4	7.6
Your org	6.2	6.3	6.6	6.8
Average	7.0	6.9	6.9	6.9
Worst	6.2	6.3	6.6	6.7
No. responses	925	1,123	1,735	1,971



	2014	2015	2016	2017	2018
Best	7.5	7.6	7.6	7.7	7.7
Your org	6.8	6.7	6.8	7.1	7.3
Average	7.4	7.5	7.5	7.4	7.4
Worst	6.8	6.7	6.8	7.0	6.9
No. responses	1,120	929	1,135	1,748	1,996

Survey Coordination Centre

NHS England

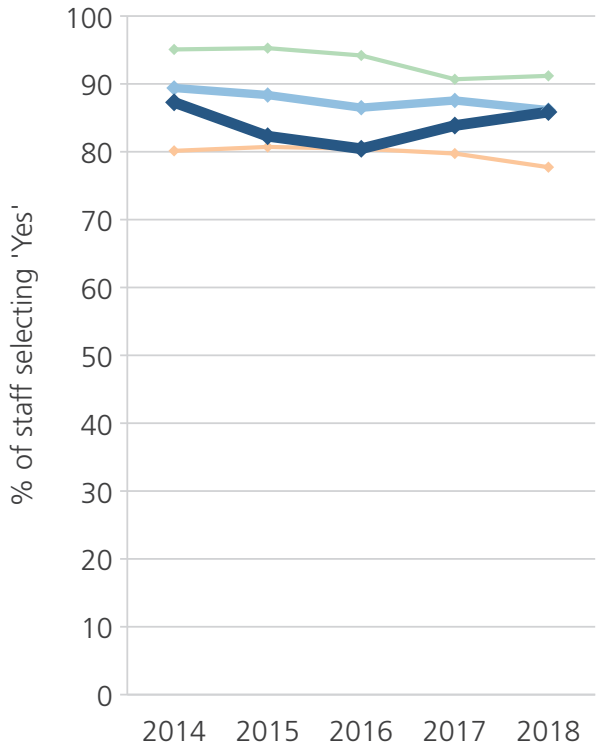
Theme results – Detailed information

Alder Hey Children's NHS Foundation Trust

2018 NHS Staff Survey Results

Q14

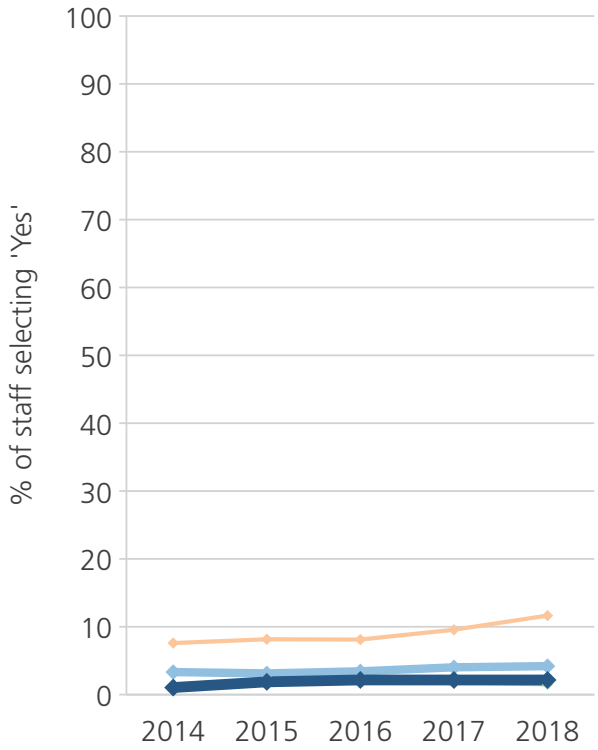
Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?



	2014	2015	2016	2017	2018
Best	95.1%	95.3%	94.2%	90.7%	91.2%
Your org	87.3%	82.3%	80.4%	83.9%	85.9%
Average	89.4%	88.4%	86.5%	87.6%	86.1%
Worst	80.1%	80.7%	80.4%	79.7%	77.7%

Q15a

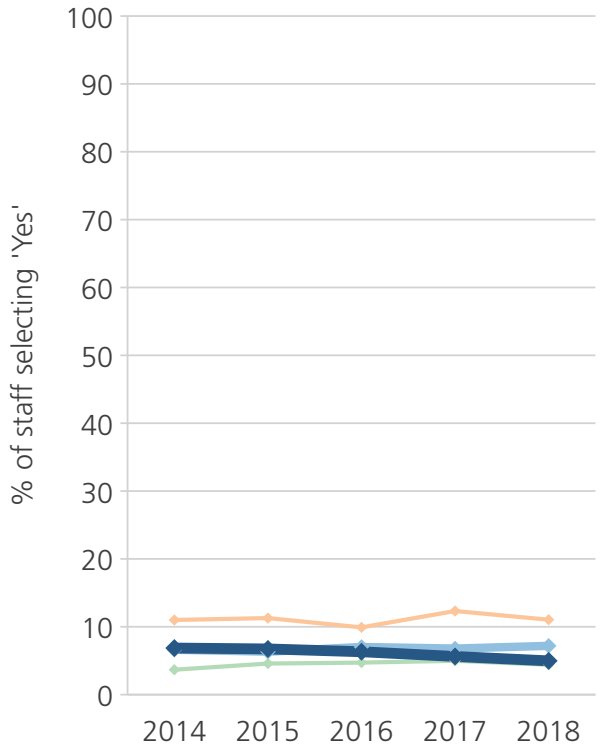
In the last 12 months have you personally experienced discrimination at work from patients / service users, their relatives or other members of the public?



	2014	2015	2016	2017	2018
Worst	7.6%	8.2%	8.1%	9.6%	11.6%
Your org	1.0%	1.9%	2.2%	2.2%	2.2%
Average	3.3%	3.1%	3.4%	4.0%	4.2%
Best	0.9%	1.9%	1.9%	1.8%	1.5%

Q15b

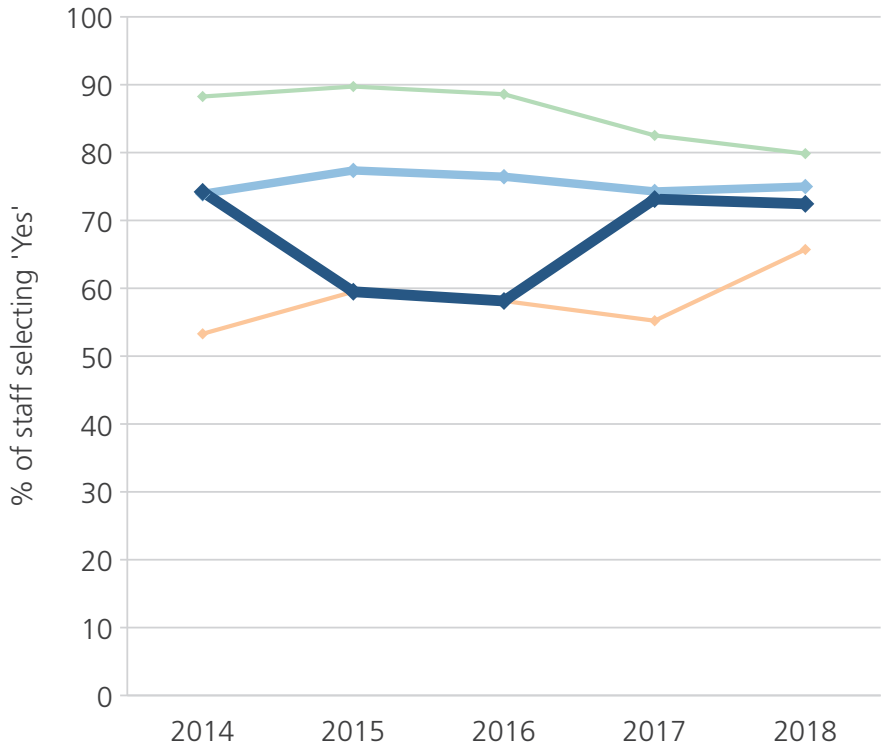
In the last 12 months have you personally experienced discrimination at work from manager / team leader or other colleagues?



	2014	2015	2016	2017	2018
Worst	11.0%	11.3%	9.9%	12.3%	11.0%
Your org	6.9%	6.7%	6.3%	5.6%	5.0%
Average	6.6%	6.3%	7.0%	6.8%	7.2%
Best	3.7%	4.6%	4.7%	5.0%	4.4%

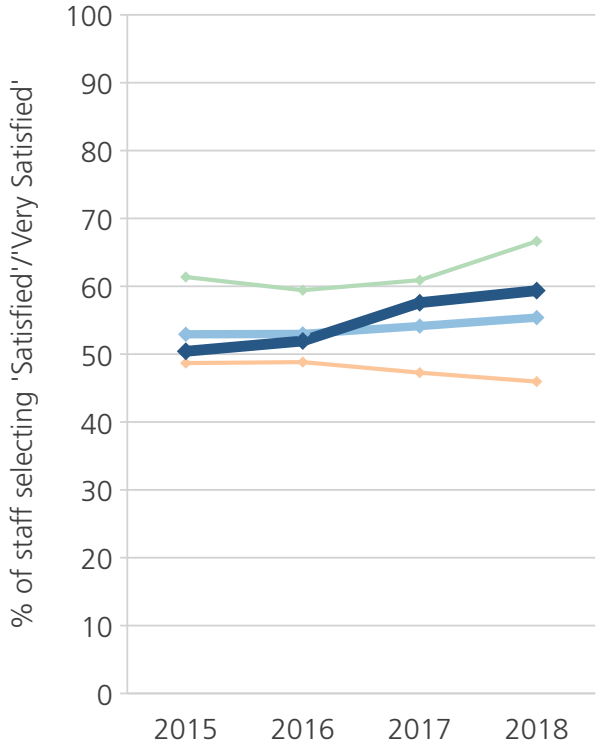
Q28b

Has your employer made adequate adjustment(s) to enable you to carry out your work?



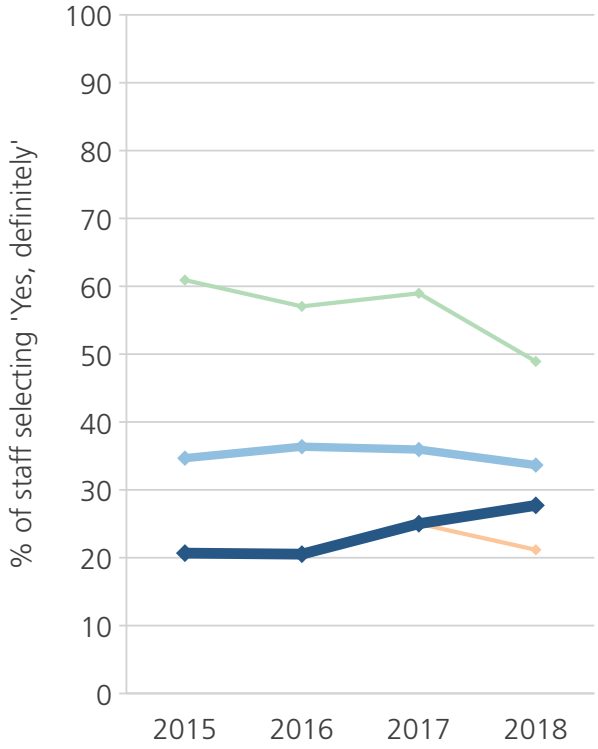
	2014	2015	2016	2017	2018
Best	88.3%	89.7%	88.6%	82.5%	79.8%
Your org	74.2%	59.5%	58.1%	73.1%	72.4%
Average	73.9%	77.4%	76.4%	74.3%	75.0%
Worst	53.3%	59.5%	58.1%	55.2%	65.7%

Q5h
The opportunities for flexible working patterns



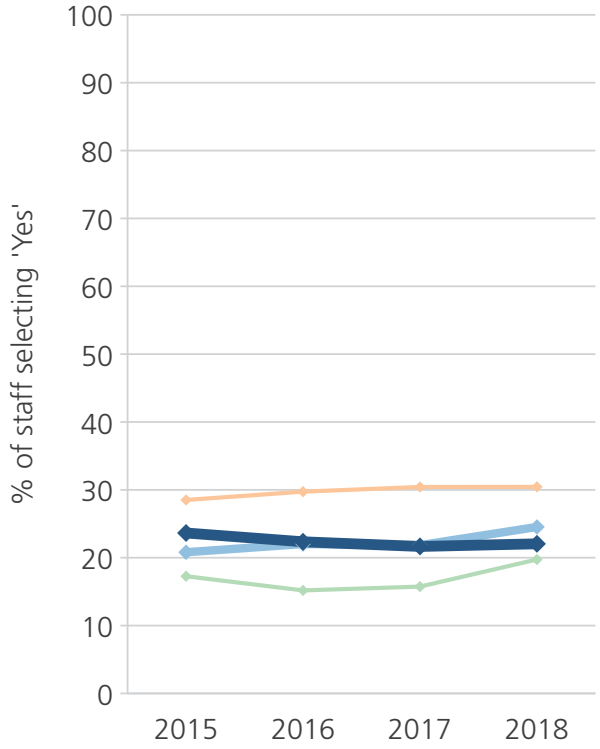
	2015	2016	2017	2018
Best	61.4%	59.4%	60.9%	66.6%
Your org	50.4%	51.9%	57.6%	59.4%
Average	52.9%	53.0%	54.1%	55.4%
Worst	48.7%	48.8%	47.3%	46.0%

Q11a
Does your organisation take positive action on health and well-being?



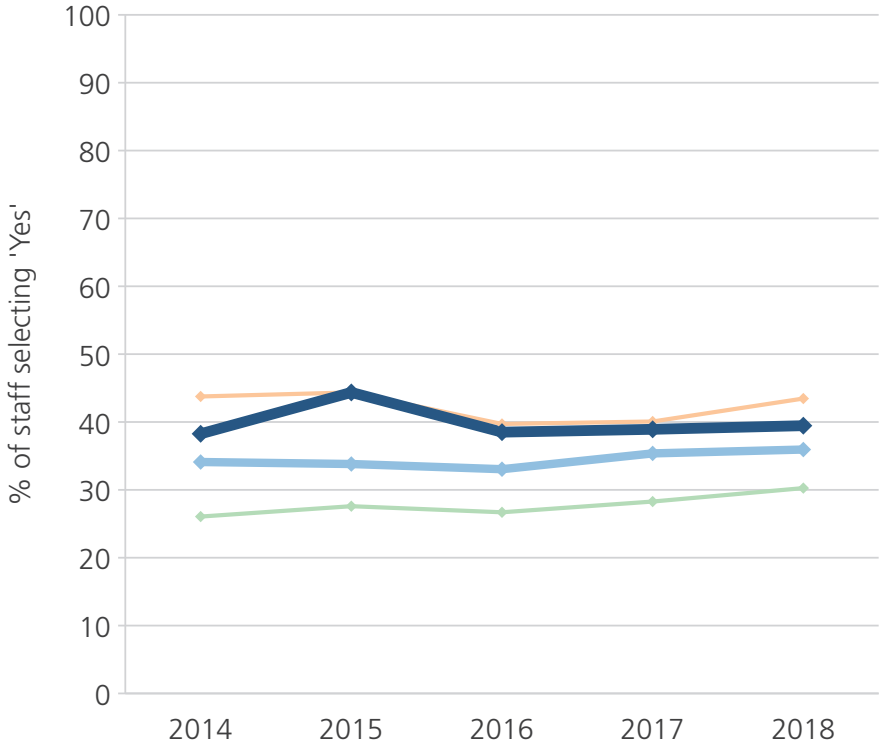
	2015	2016	2017	2018
Best	60.9%	57.0%	59.0%	48.9%
Your org	20.7%	20.5%	25.0%	27.7%
Average	34.7%	36.4%	35.9%	33.6%
Worst	20.7%	20.5%	25.0%	21.2%

Q11b
In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities?



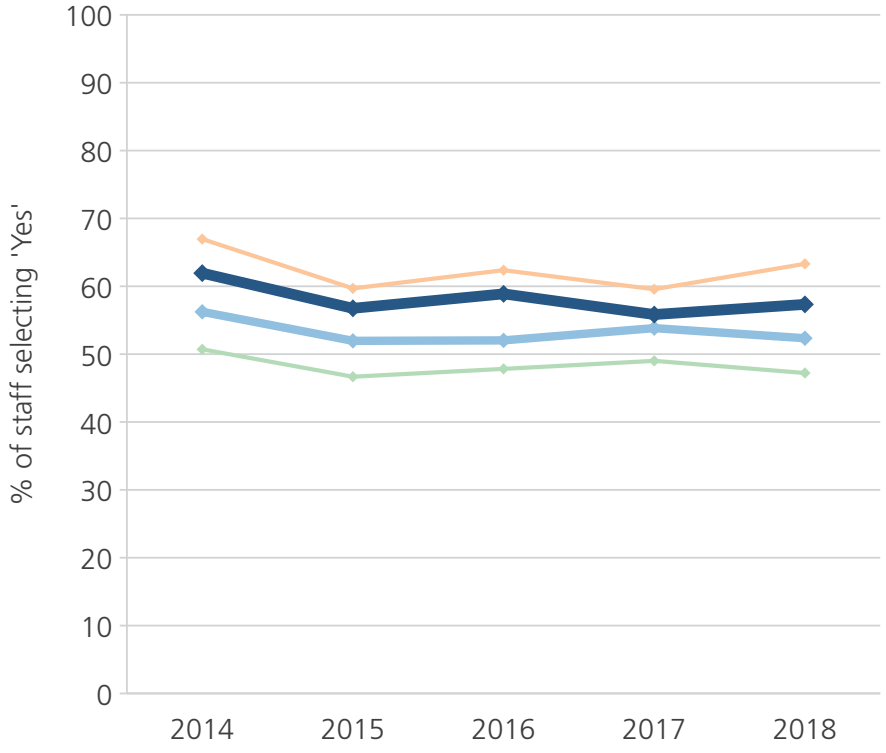
	2015	2016	2017	2018
Worst	28.5%	29.7%	30.4%	30.4%
Your org	23.6%	22.3%	21.7%	22.0%
Average	20.8%	22.0%	21.8%	24.5%
Best	17.3%	15.2%	15.7%	19.7%

Q11c
During the last 12 months have you felt unwell as a result of work related stress?



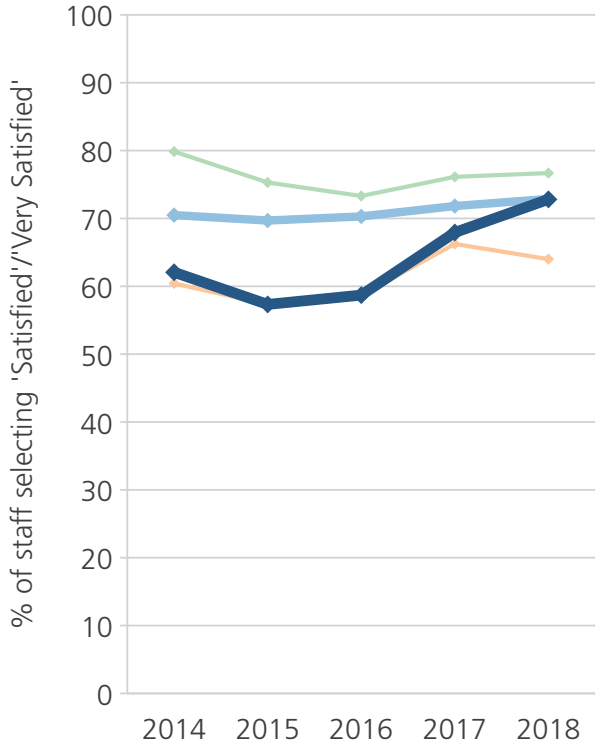
	2014	2015	2016	2017	2018
Worst	43.8%	44.4%	39.7%	40.1%	43.5%
Your org	38.3%	44.4%	38.5%	38.9%	39.5%
Average	34.1%	33.8%	33.0%	35.4%	35.9%
Best	26.1%	27.6%	26.7%	28.3%	30.3%

Q11d
In the last three months have you ever come to work despite not feeling well enough to perform your duties?



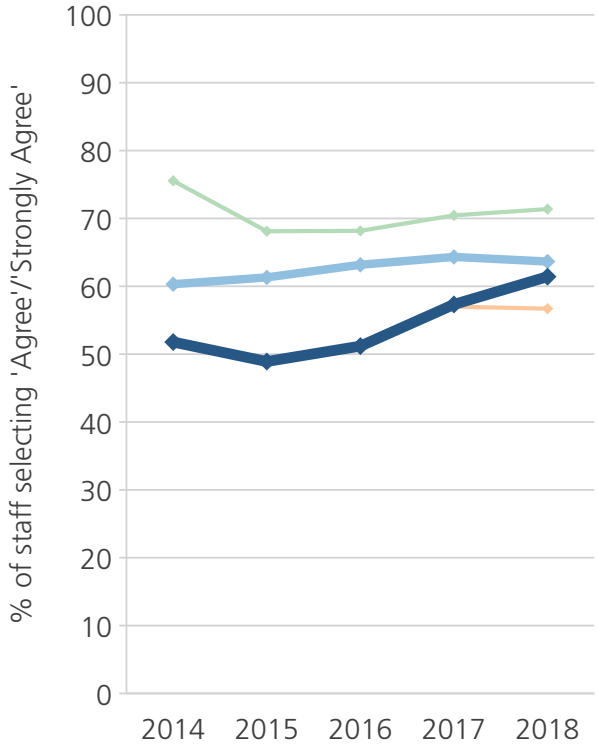
	2014	2015	2016	2017	2018
Worst	67.0%	59.7%	62.4%	59.6%	63.3%
Your org	61.9%	56.8%	58.9%	55.8%	57.3%
Average	56.2%	52.0%	52.0%	53.8%	52.3%
Best	50.7%	46.7%	47.8%	49.0%	47.2%

Q5b
The support I get from my immediate manager



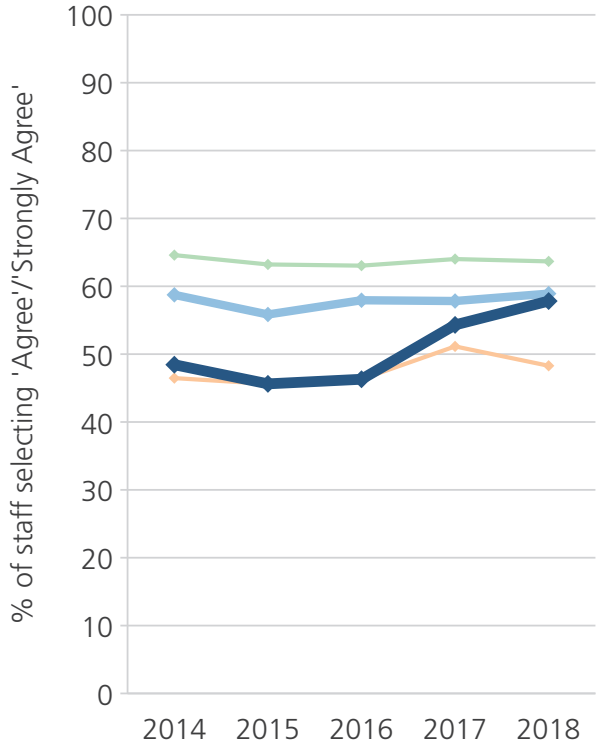
	2014	2015	2016	2017	2018
Best	79.9%	75.3%	73.3%	76.1%	76.7%
Your org	62.1%	57.3%	58.7%	67.9%	72.8%
Average	70.5%	69.7%	70.3%	71.8%	72.9%
Worst	60.4%	57.3%	58.7%	66.2%	64.0%

Q8c
My immediate manager gives me clear feedback on my work



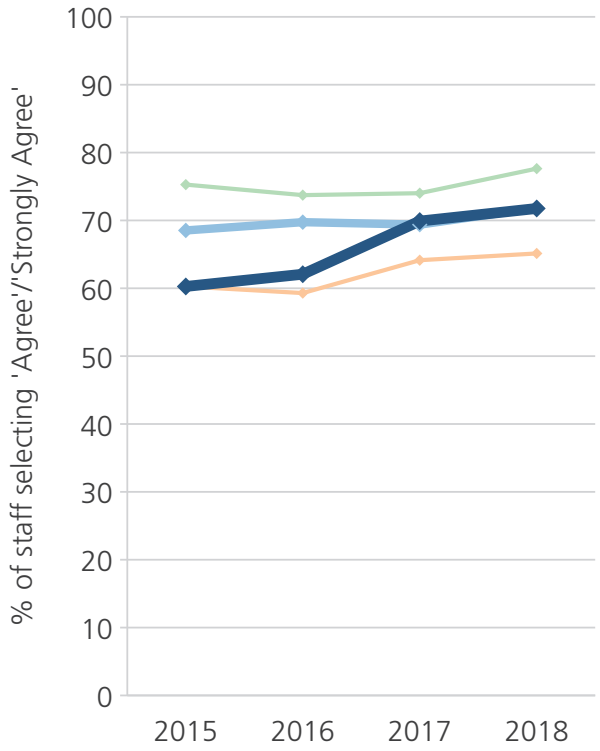
	2014	2015	2016	2017	2018
Best	75.5%	68.1%	68.2%	70.5%	71.4%
Your org	51.8%	48.9%	51.2%	57.3%	61.4%
Average	60.3%	61.3%	63.2%	64.3%	63.6%
Worst	51.8%	48.9%	51.2%	57.0%	56.7%

Q8d
My immediate manager asks for my opinion before making decisions that affect my work



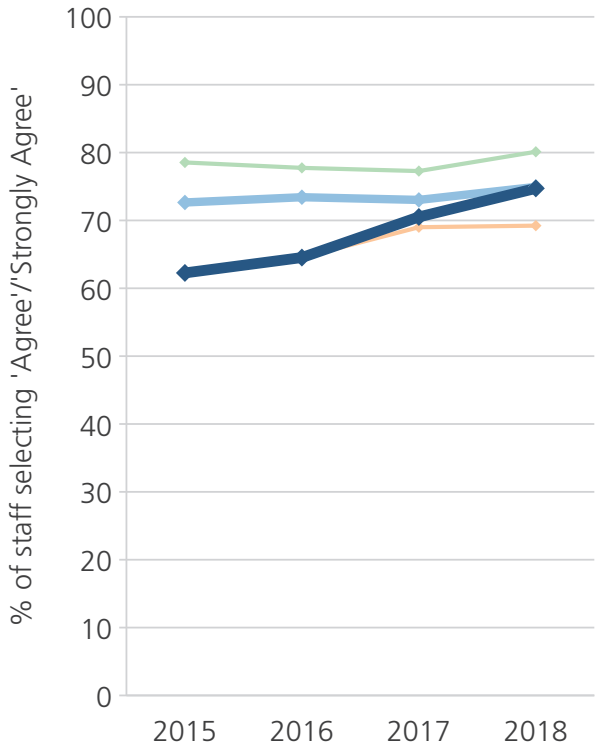
	2014	2015	2016	2017	2018
Best	64.6%	63.2%	63.0%	64.0%	63.7%
Your org	48.4%	45.6%	46.3%	54.3%	57.8%
Average	58.7%	55.8%	57.9%	57.8%	58.9%
Worst	46.5%	45.6%	46.3%	51.1%	48.3%

Q8f
My immediate manager takes a positive interest in my health and well-being



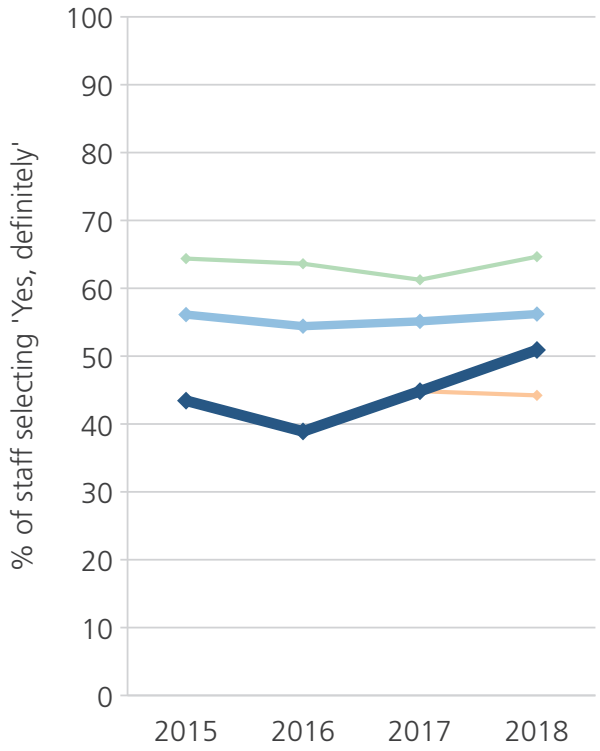
	2015	2016	2017	2018
Best	75.3%	73.7%	74.0%	77.6%
Your org	60.3%	62.1%	69.9%	71.8%
Average	68.5%	69.7%	69.4%	71.9%
Worst	60.3%	59.3%	64.1%	65.1%

Q8g
My immediate manager values my work



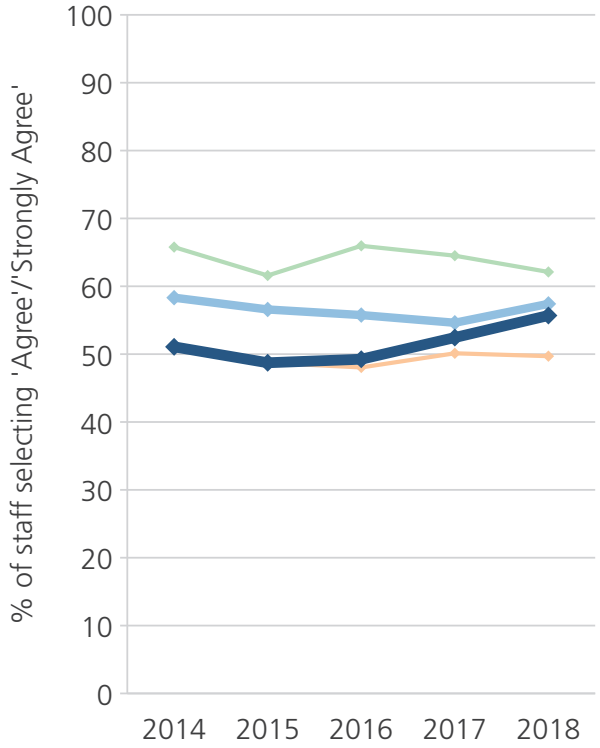
	2015	2016	2017	2018
Best	78.5%	77.7%	77.3%	80.1%
Your org	62.3%	64.5%	70.5%	74.7%
Average	72.6%	73.4%	73.0%	74.9%
Worst	62.3%	64.5%	69.0%	69.2%

Q19g
My manager supported me to receive this training, learning or development



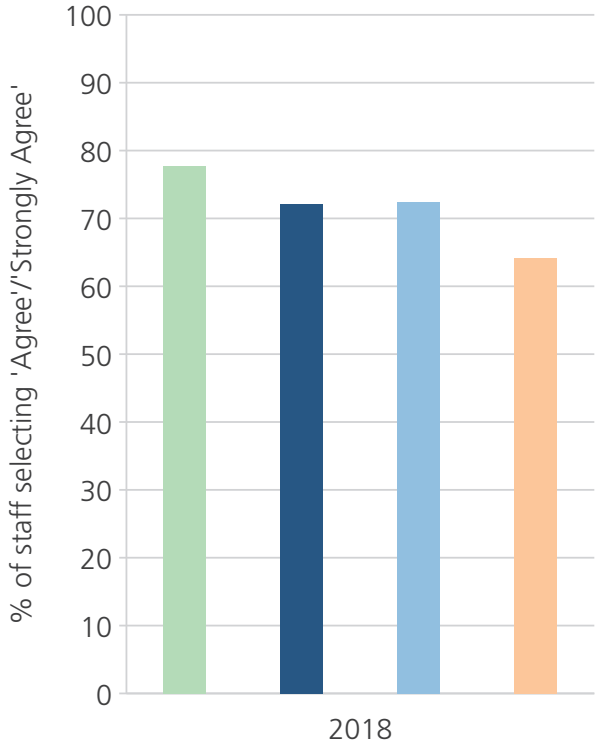
	2015	2016	2017	2018
Best	64.4%	63.6%	61.3%	64.7%
Your org	43.4%	38.9%	44.8%	50.9%
Average	56.1%	54.4%	55.1%	56.2%
Worst	43.4%	38.9%	44.8%	44.2%

Q4c
I am involved in deciding on changes introduced that affect my work area / team / department



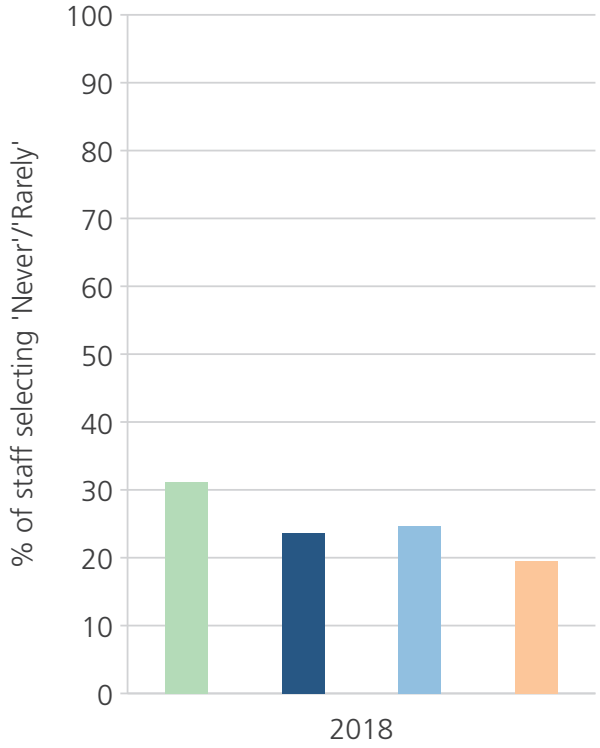
	2014	2015	2016	2017	2018
Best	65.8%	61.6%	66.0%	64.5%	62.1%
Your org	51.1%	48.7%	49.2%	52.4%	55.7%
Average	58.3%	56.6%	55.8%	54.6%	57.4%
Worst	51.1%	48.7%	48.0%	50.1%	49.7%

Q4j
I receive the respect I deserve from my colleagues at work



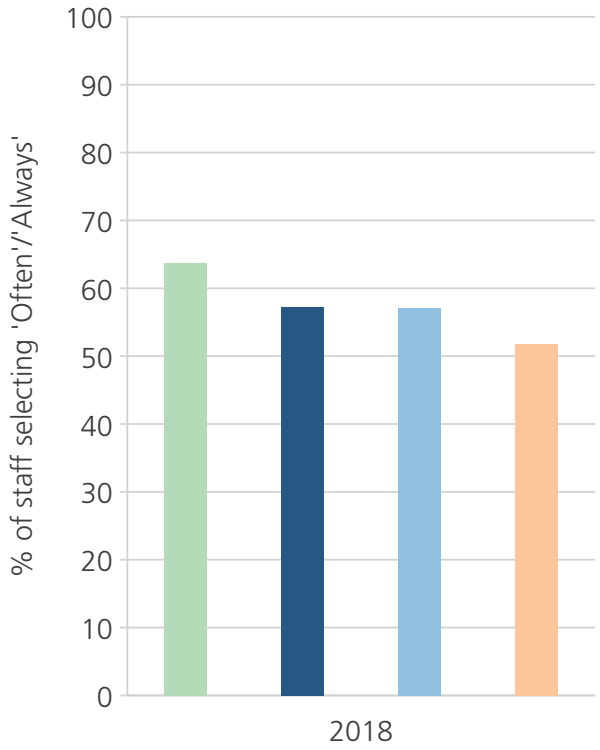
	2018
Best	77.7%
Your org	72.1%
Average	72.4%
Worst	64.1%

Q6a
I have unrealistic time pressures



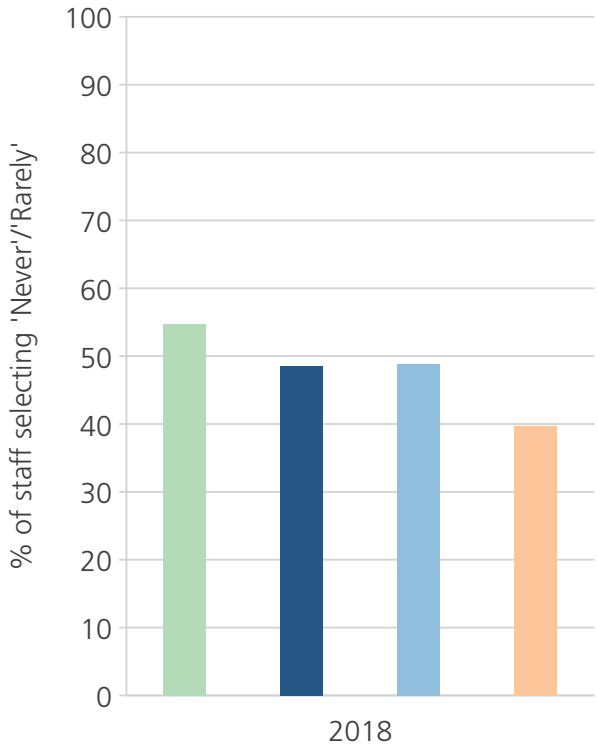
	2018
Best	31.2%
Your org	23.6%
Average	24.6%
Worst	19.5%

Q6b
I have a choice in deciding how to do my work



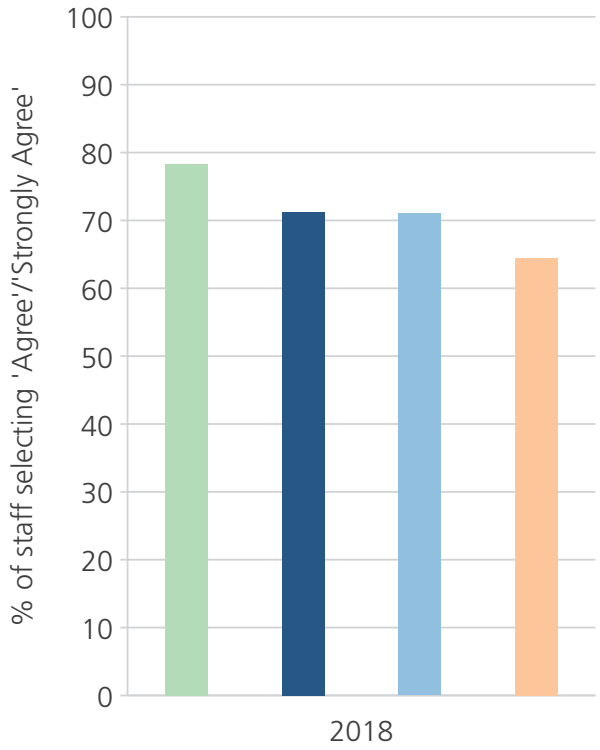
Best	63.7%
Your org	57.2%
Average	57.1%
Worst	51.8%

Q6c
Relationships at work are strained



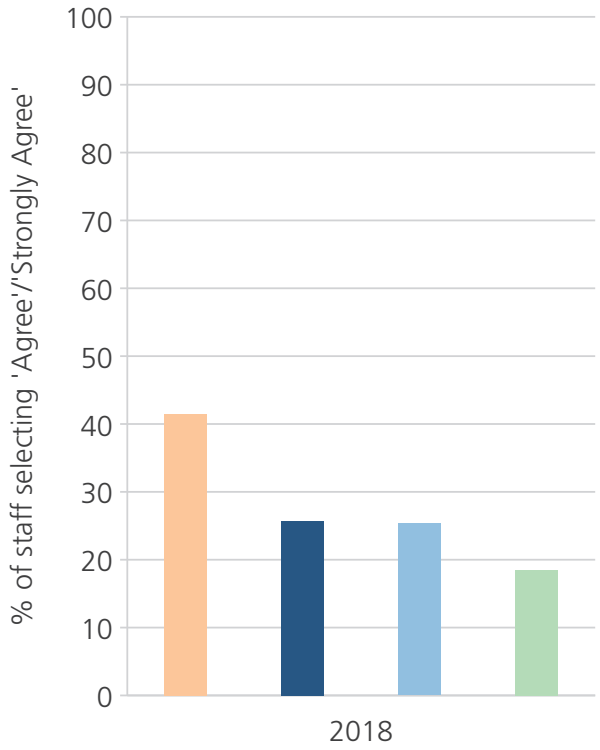
Best	54.8%
Your org	48.6%
Average	48.8%
Worst	39.7%

Q8a
My immediate manager encourages me at work



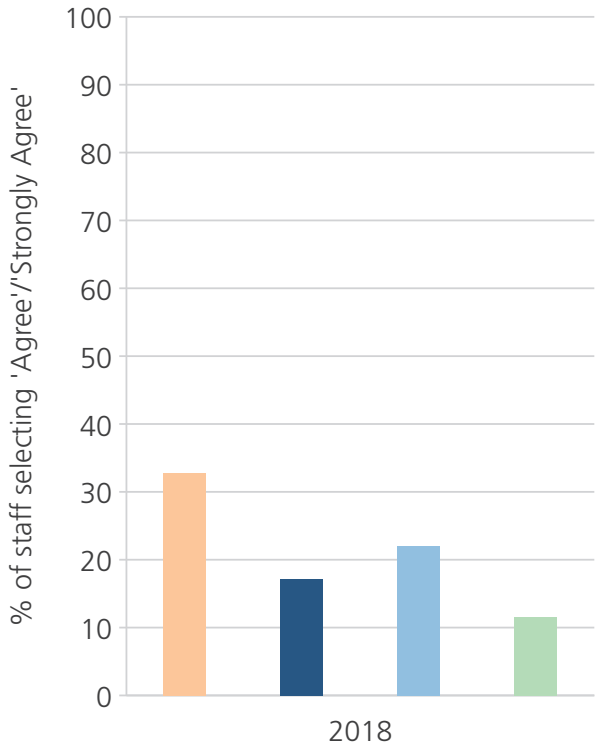
Best	78.4%
Your org	71.2%
Average	71.0%
Worst	64.4%

Q23a
I often think about leaving this organisation



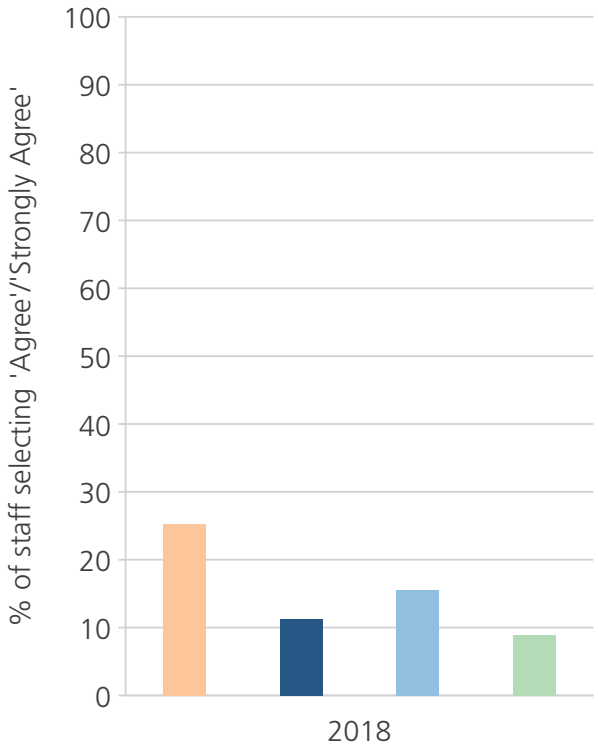
Worst	41.5%
Your org	25.7%
Average	25.3%
Best	18.5%

Q23b
I will probably look for a job at a new organisation in the next 12 months



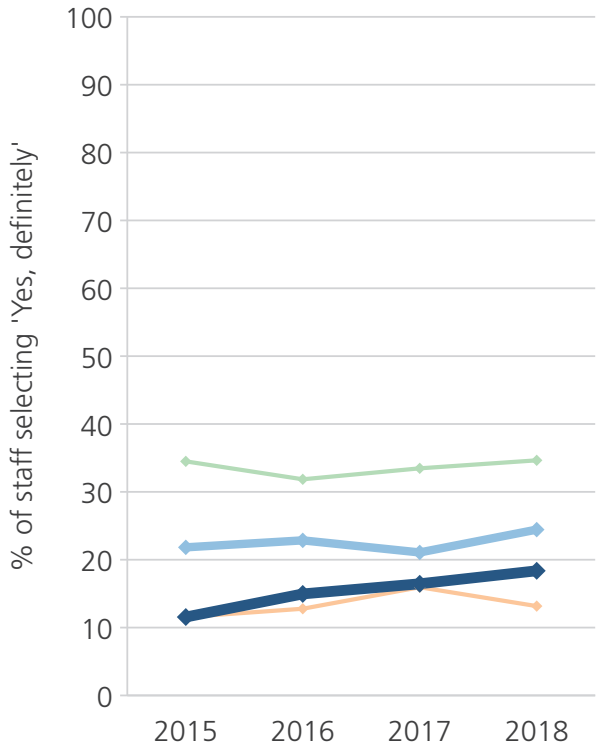
Worst	32.8%
Your org	17.1%
Average	22.1%
Best	11.6%

Q23c
As soon as I can find another job, I will leave this organisation



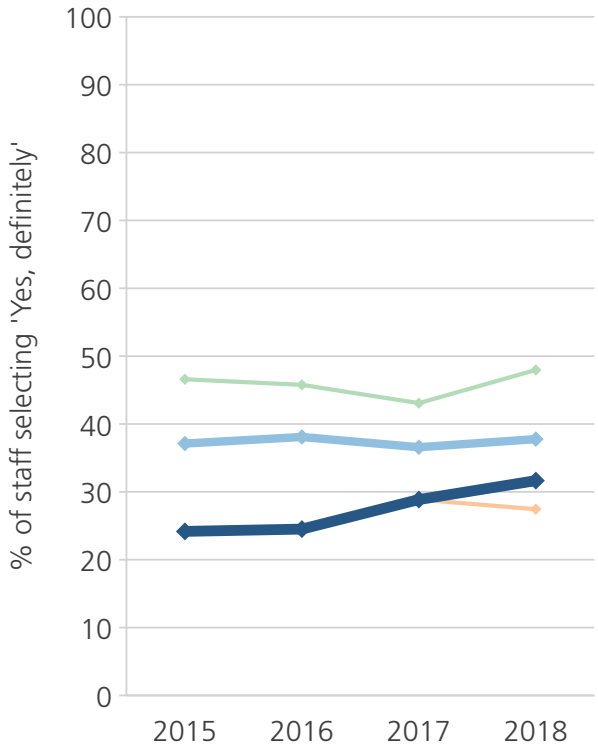
Worst	25.3%
Your org	11.3%
Average	15.6%
Best	8.9%

Q19b
It helped me to improve how I do my job



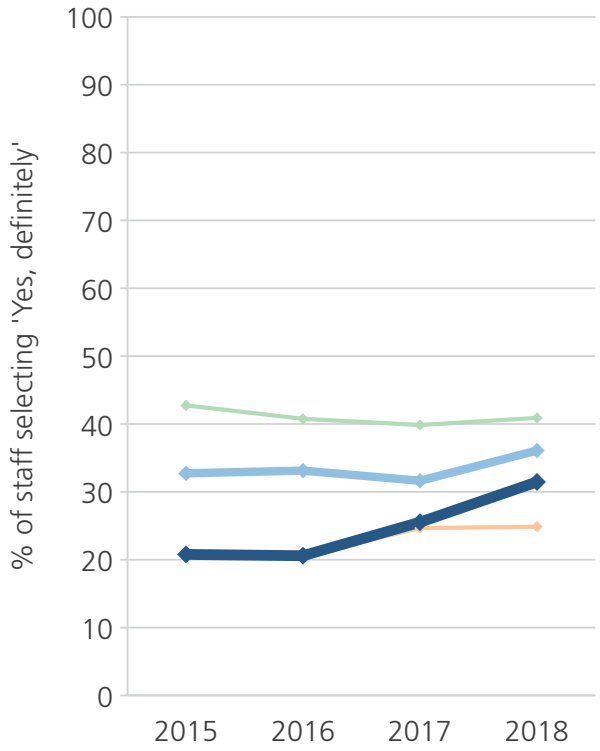
Best	34.5%	31.9%	33.5%	34.6%
Your org	11.6%	15.0%	16.5%	18.4%
Average	21.8%	22.9%	21.1%	24.4%
Worst	11.6%	12.8%	15.9%	13.2%

Q19c
It helped me agree clear objectives for my work



Best	46.6%	45.8%	43.1%	48.0%
Your org	24.2%	24.5%	28.9%	31.7%
Average	37.1%	38.1%	36.6%	37.8%
Worst	24.2%	24.5%	28.9%	27.4%

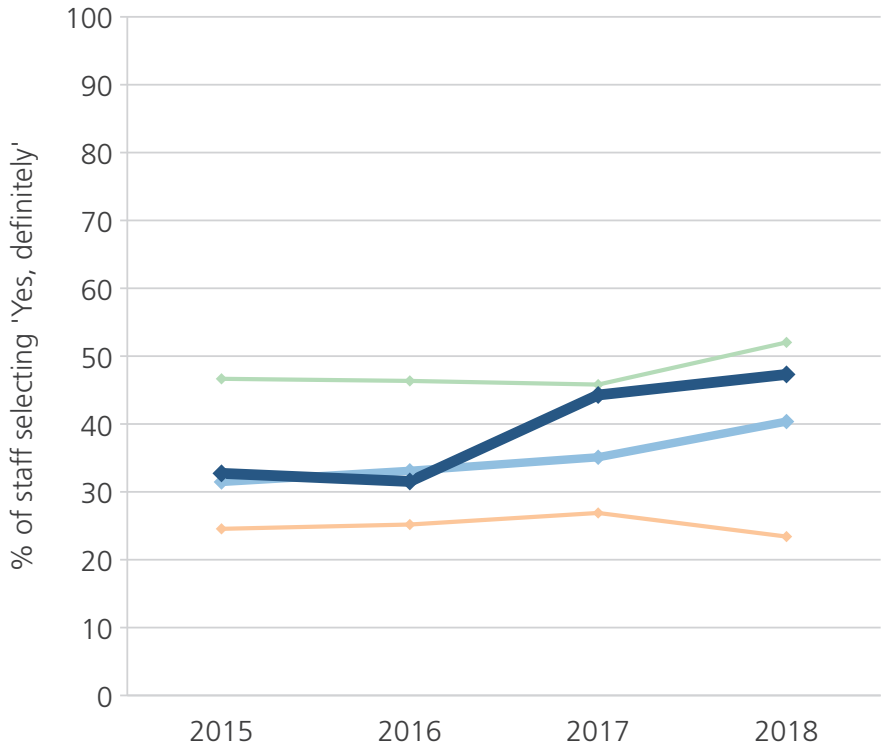
Q19d
It left me feeling that my work is valued by my organisation



Best	42.7%	40.8%	39.9%	40.9%
Your org	20.8%	20.6%	25.5%	31.5%
Average	32.7%	33.1%	31.6%	36.1%
Worst	20.8%	20.6%	24.7%	24.9%

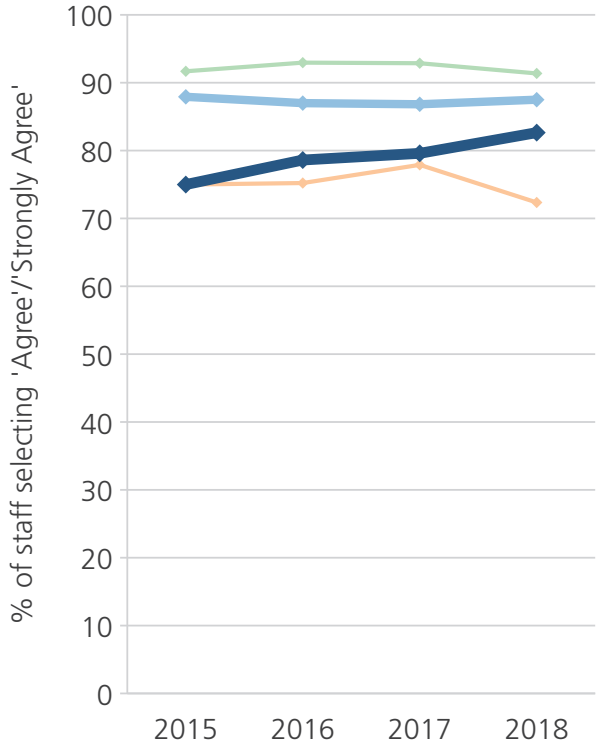
Q19e

The values of my organisation were discussed as part of the appraisal process



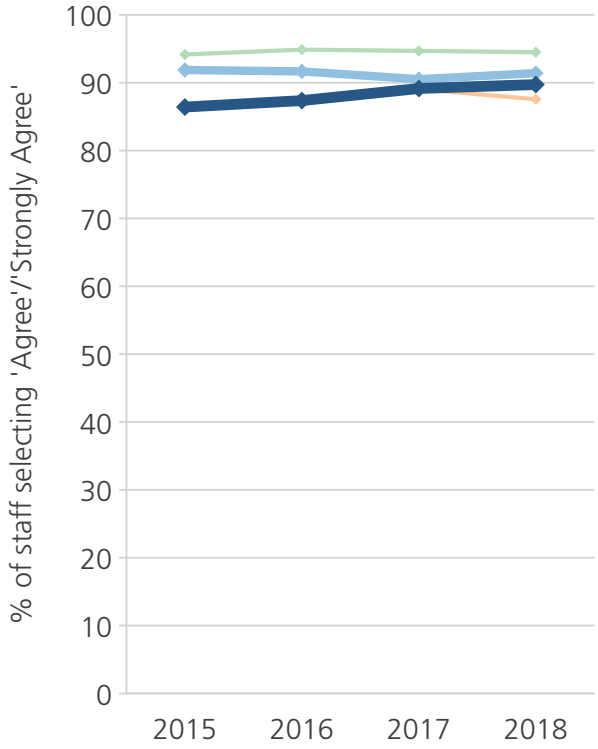
	2015	2016	2017	2018
Best	46.7%	46.3%	45.8%	52.0%
Your org	32.7%	31.5%	44.3%	47.3%
Average	31.5%	33.1%	35.1%	40.4%
Worst	24.6%	25.2%	26.9%	23.4%

Q7a
I am satisfied with the quality of care I give to patients / service users



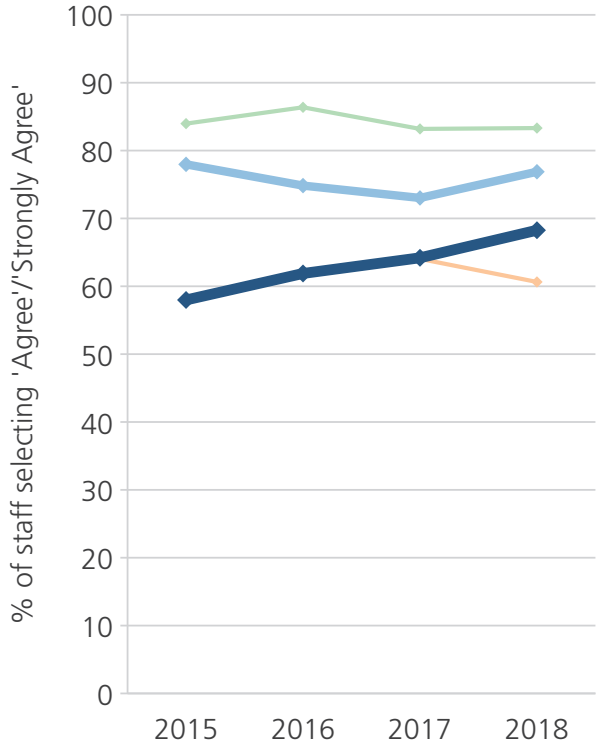
	2015	2016	2017	2018
Best	91.7%	93.0%	92.9%	91.4%
Your org	75.0%	78.6%	79.6%	82.6%
Average	87.9%	87.0%	86.8%	87.5%
Worst	75.0%	75.2%	77.9%	72.4%

Q7b
I feel that my role makes a difference to patients / service users



	2015	2016	2017	2018
Best	94.2%	94.9%	94.7%	94.5%
Your org	86.4%	87.4%	89.1%	89.7%
Average	91.9%	91.7%	90.5%	91.4%
Worst	86.4%	87.4%	89.1%	87.6%

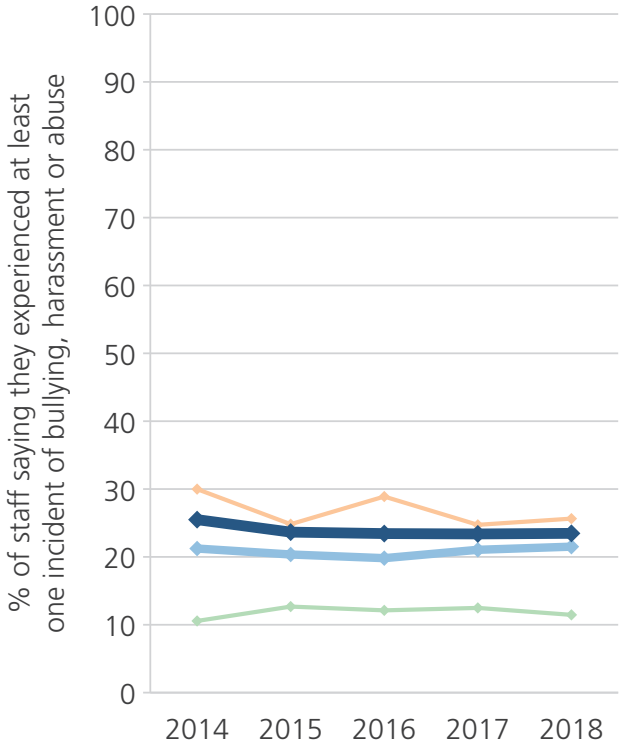
Q7c
I am able to deliver the care I aspire to



	2015	2016	2017	2018
Best	84.0%	86.4%	83.2%	83.3%
Your org	58.0%	61.9%	64.2%	68.3%
Average	78.0%	74.8%	73.0%	76.9%
Worst	58.0%	61.8%	64.0%	60.6%

Q13a

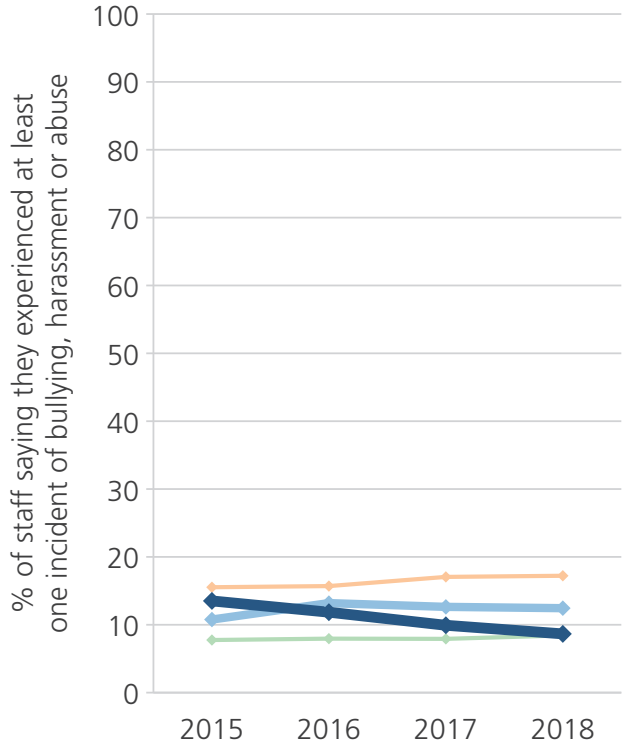
In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from patients / service users, their relatives or other members of the public?



	2014	2015	2016	2017	2018
Worst	30.0%	24.8%	28.9%	24.7%	25.6%
Your org	25.5%	23.7%	23.4%	23.4%	23.5%
Average	21.2%	20.4%	19.8%	21.0%	21.5%
Best	10.6%	12.7%	12.1%	12.5%	11.5%

Q13b

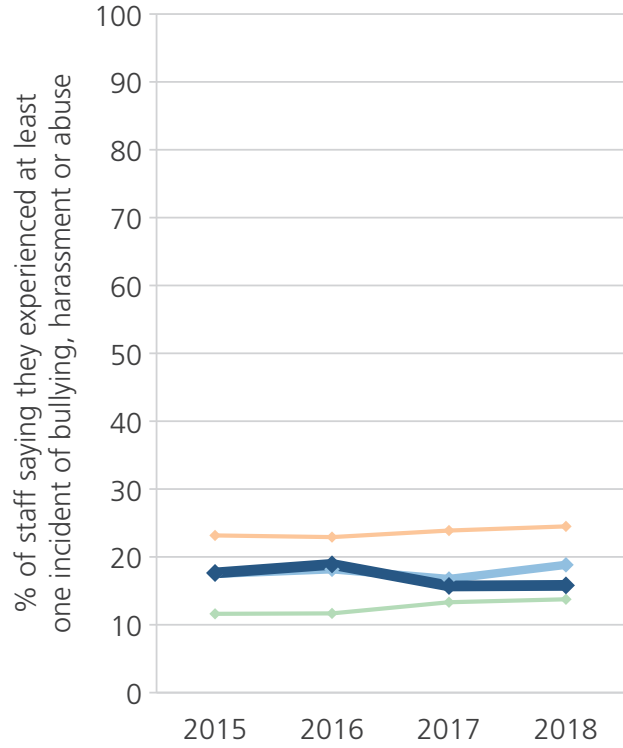
In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from managers?



	2015	2016	2017	2018
Worst	15.5%	15.7%	17.1%	17.2%
Your org	13.5%	11.9%	9.9%	8.7%
Average	10.8%	13.2%	12.6%	12.4%
Best	7.8%	8.0%	7.9%	8.4%

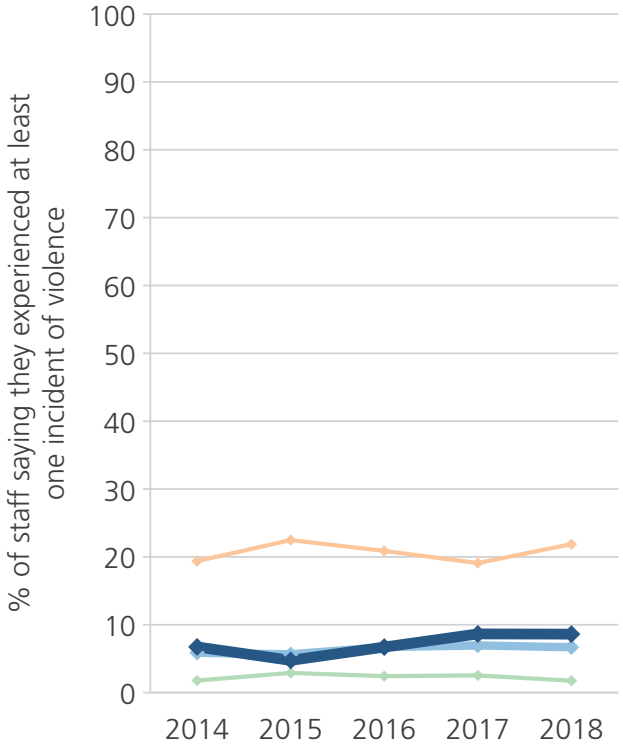
Q13c

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



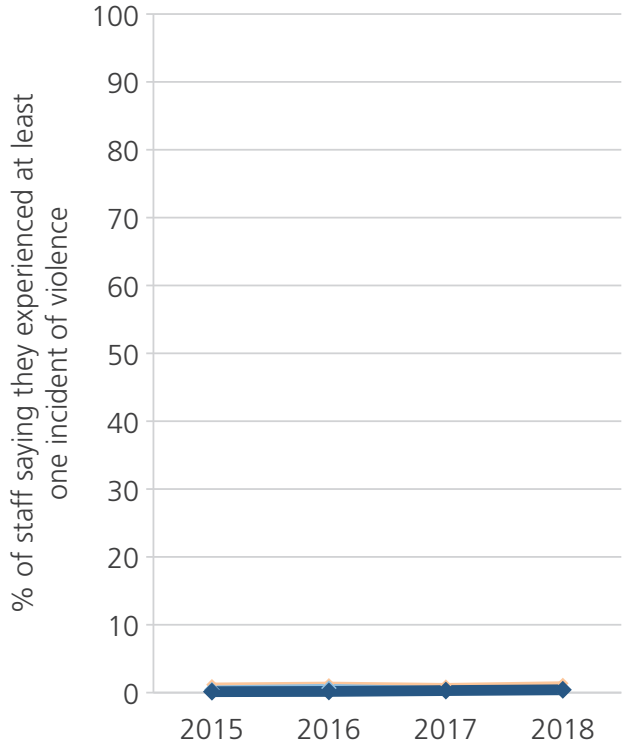
	2015	2016	2017	2018
Worst	23.2%	22.9%	23.9%	24.5%
Your org	17.6%	18.9%	15.7%	15.8%
Average	17.5%	18.2%	16.7%	18.8%
Best	11.6%	11.7%	13.3%	13.8%

Q12a
In the last 12 months how many times have you personally experienced physical violence at work from patients / service users, their relatives or other members of the public?



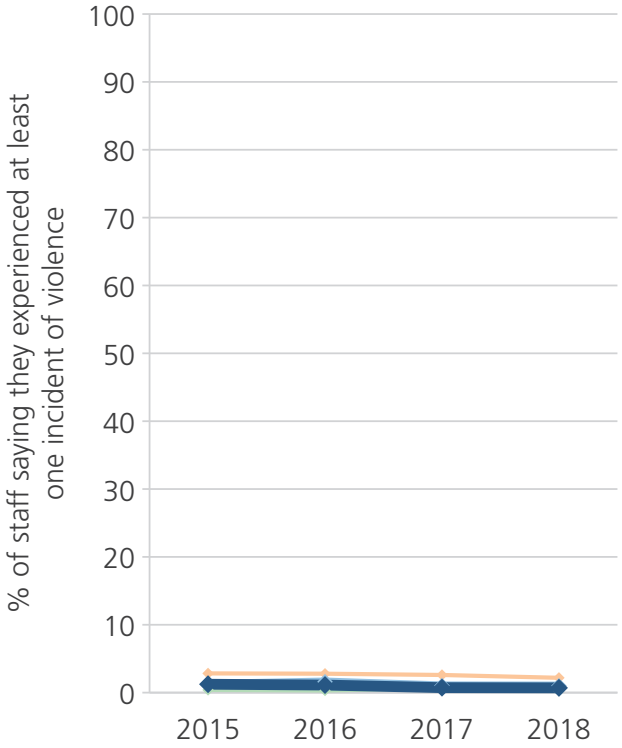
	2014	2015	2016	2017	2018
Worst	19.4%	22.5%	20.9%	19.1%	21.9%
Your org	6.7%	4.8%	6.7%	8.7%	8.6%
Average	5.9%	5.6%	6.7%	6.9%	6.7%
Best	1.8%	2.9%	2.4%	2.5%	1.8%

Q12b
In the last 12 months how many times have you personally experienced physical violence at work from managers?



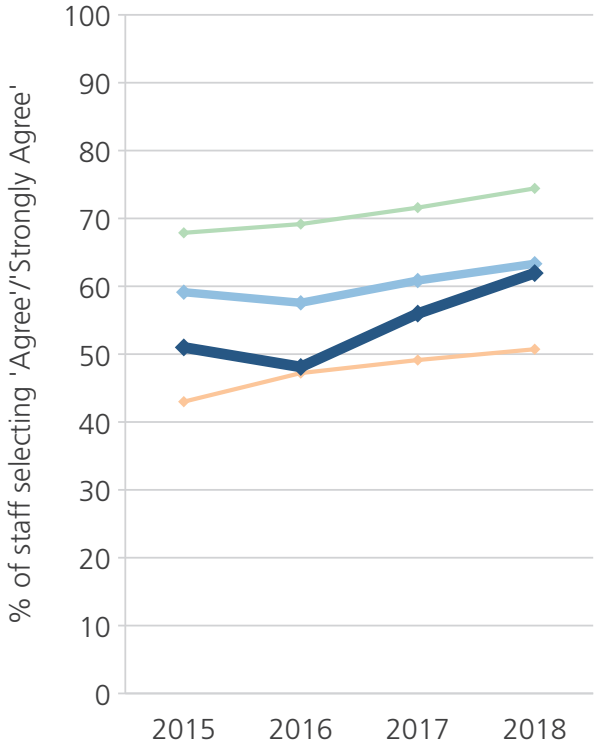
	2015	2016	2017	2018
Worst	1.2%	1.3%	1.1%	1.4%
Your org	0.1%	0.2%	0.3%	0.4%
Average	0.4%	0.7%	0.3%	0.5%
Best	0.0%	0.2%	0.1%	0.0%

Q12c
In the last 12 months how many times have you personally experienced physical violence at work from other colleagues?



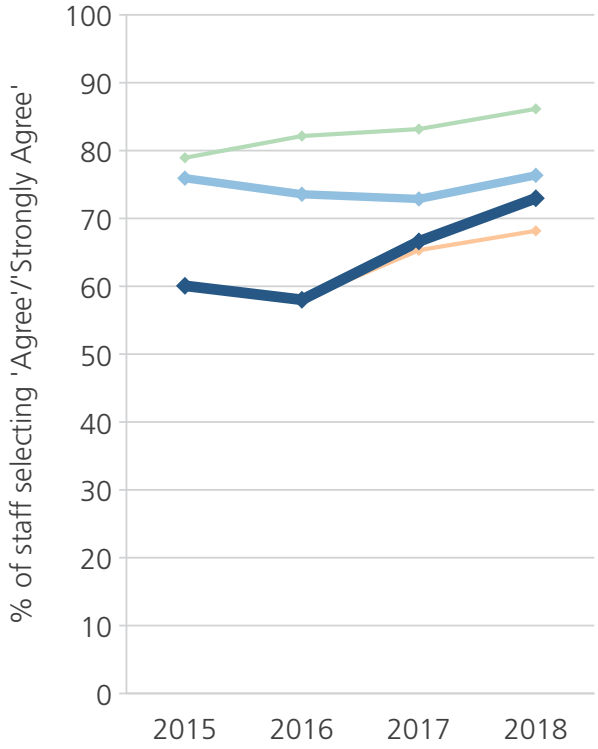
	2015	2016	2017	2018
Worst	2.8%	2.8%	2.6%	2.2%
Your org	1.2%	1.1%	0.7%	0.7%
Average	1.3%	1.6%	1.0%	1.0%
Best	0.4%	0.3%	0.6%	0.3%

Q17a
My organisation treats staff who are involved in an error, near miss or incident fairly



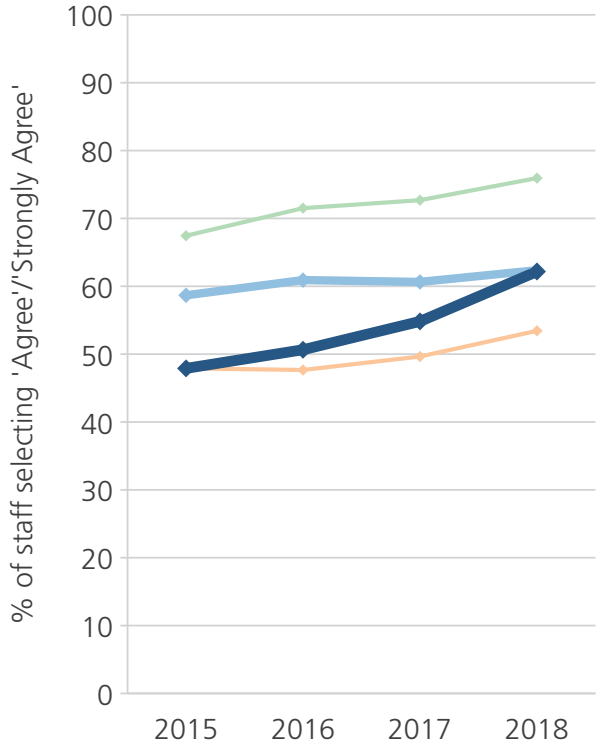
	2015	2016	2017	2018
Best	67.9%	69.2%	71.6%	74.4%
Your org	51.0%	48.1%	56.0%	61.9%
Average	59.1%	57.6%	60.8%	63.3%
Worst	43.0%	47.2%	49.1%	50.7%

Q17c
When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again



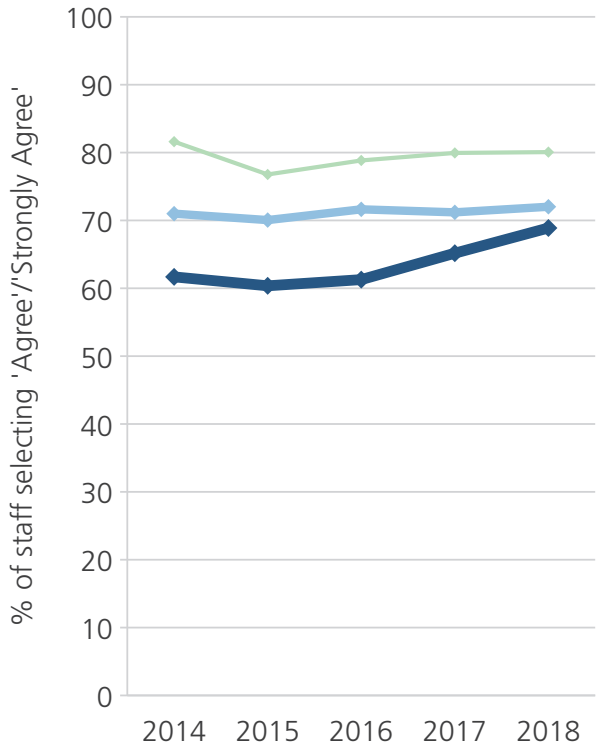
	2015	2016	2017	2018
Best	78.9%	82.1%	83.2%	86.1%
Your org	60.1%	58.0%	66.6%	73.0%
Average	75.9%	73.6%	72.9%	76.4%
Worst	60.1%	58.0%	65.3%	68.2%

Q17d
We are given feedback about changes made in response to reported errors, near misses and incidents



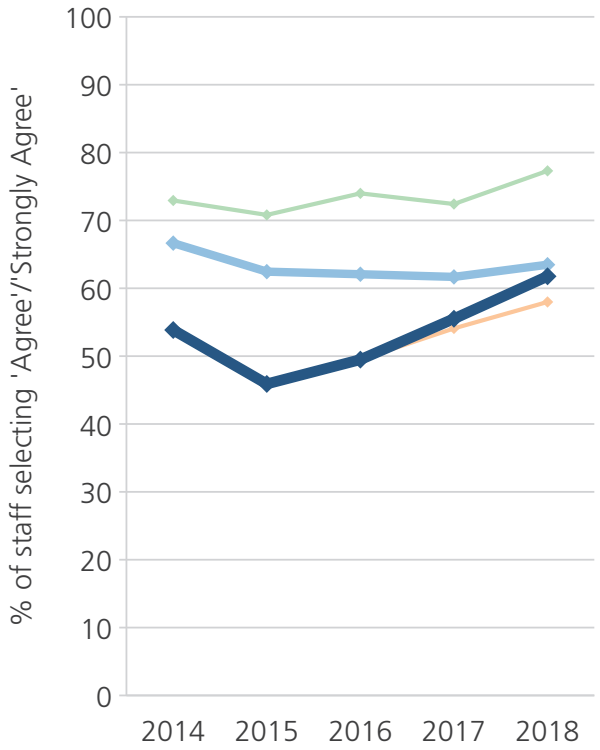
	2015	2016	2017	2018
Best	67.5%	71.5%	72.7%	75.9%
Your org	47.9%	50.6%	54.8%	62.2%
Average	58.7%	60.9%	60.6%	62.4%
Worst	47.9%	47.7%	49.6%	53.4%

Q18b
I would feel secure raising concerns about unsafe clinical practice



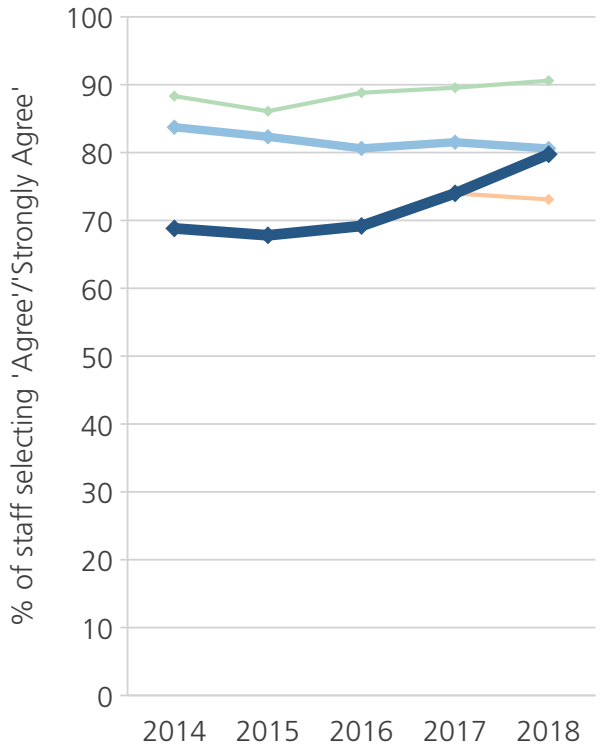
	2014	2015	2016	2017	2018
Best	81.6%	76.8%	78.8%	79.9%	80.1%
Your org	61.7%	60.4%	61.3%	65.2%	68.9%
Average	71.0%	70.1%	71.6%	71.2%	72.0%
Worst	61.7%	60.4%	61.3%	65.2%	68.9%

Q18c
I am confident that my organisation would address my concern



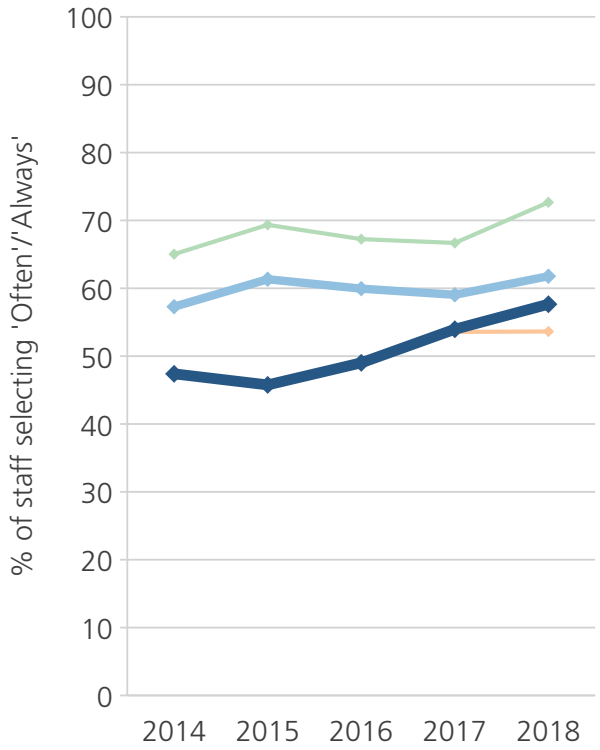
	2014	2015	2016	2017	2018
Best	72.9%	70.8%	74.0%	72.4%	77.3%
Your org	53.9%	45.9%	49.5%	55.5%	61.8%
Average	66.7%	62.5%	62.1%	61.7%	63.5%
Worst	53.9%	45.9%	49.5%	54.1%	58.0%

Q21b
My organisation acts on concerns raised by patients / service users



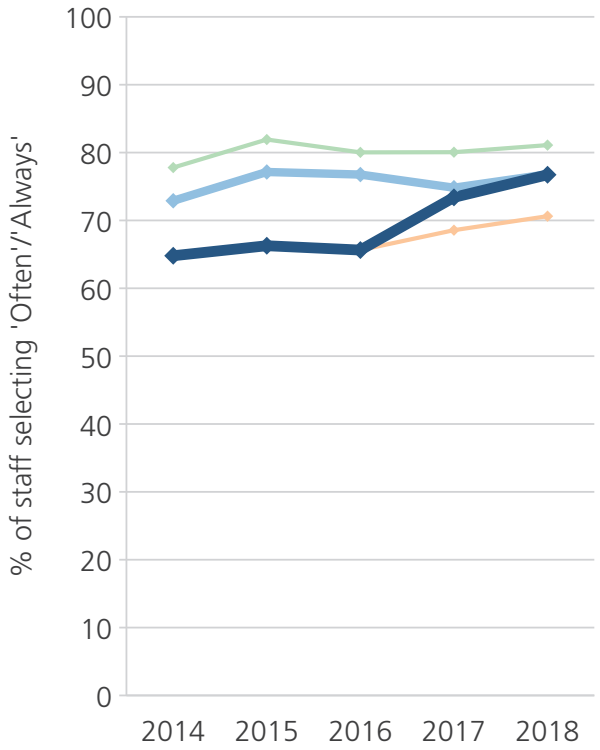
	2014	2015	2016	2017	2018
Best	88.3%	86.1%	88.8%	89.6%	90.6%
Your org	68.8%	67.8%	69.2%	74.0%	79.7%
Average	83.7%	82.3%	80.6%	81.5%	80.6%
Worst	68.8%	67.8%	69.2%	74.0%	73.1%

Q2a
I look forward to going to work



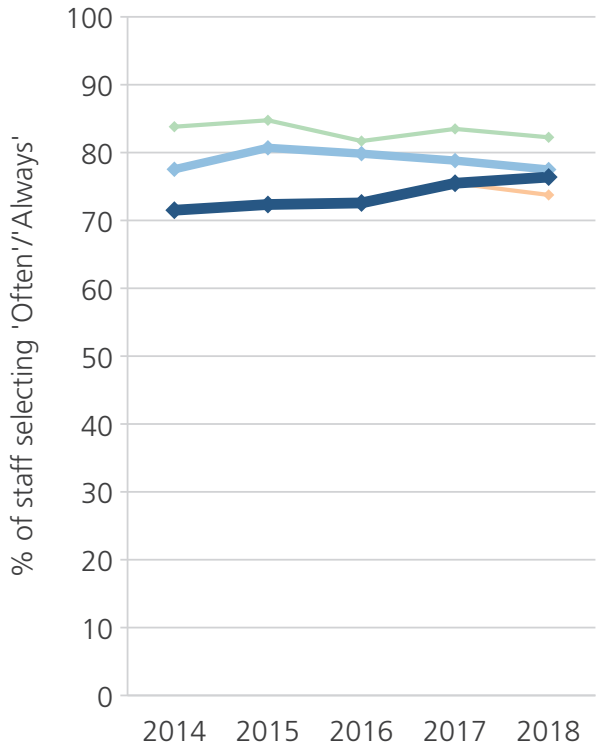
	2014	2015	2016	2017	2018
Best	65.0%	69.4%	67.2%	66.7%	72.7%
Your org	47.4%	45.8%	49.0%	54.0%	57.7%
Average	57.3%	61.3%	59.9%	59.0%	61.8%
Worst	47.4%	45.8%	49.0%	53.6%	53.6%

Q2b
I am enthusiastic about my job



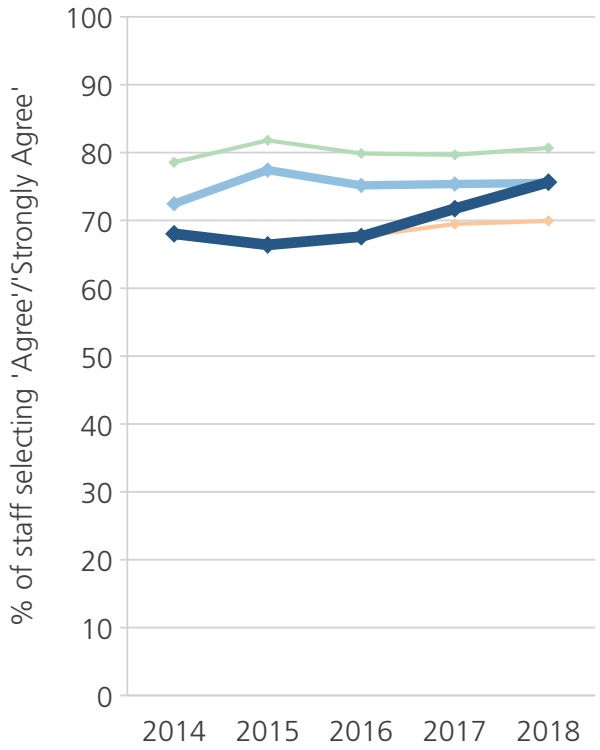
	2014	2015	2016	2017	2018
Best	77.8%	81.9%	80.0%	80.1%	81.1%
Your org	64.8%	66.3%	65.6%	73.4%	76.7%
Average	72.9%	77.1%	76.8%	74.8%	76.8%
Worst	64.8%	66.3%	65.6%	68.6%	70.6%

Q2c
Time passes quickly when I am working



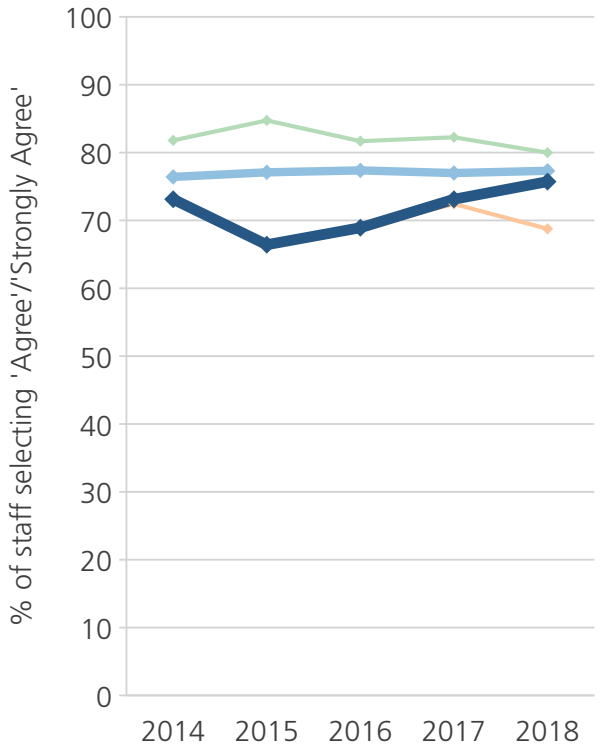
	2014	2015	2016	2017	2018
Best	83.8%	84.8%	81.7%	83.5%	82.2%
Your org	71.5%	72.3%	72.6%	75.5%	76.4%
Average	77.5%	80.7%	79.8%	78.8%	77.5%
Worst	71.5%	72.2%	72.6%	75.5%	73.8%

Q4a
There are frequent opportunities for me to show initiative in my role



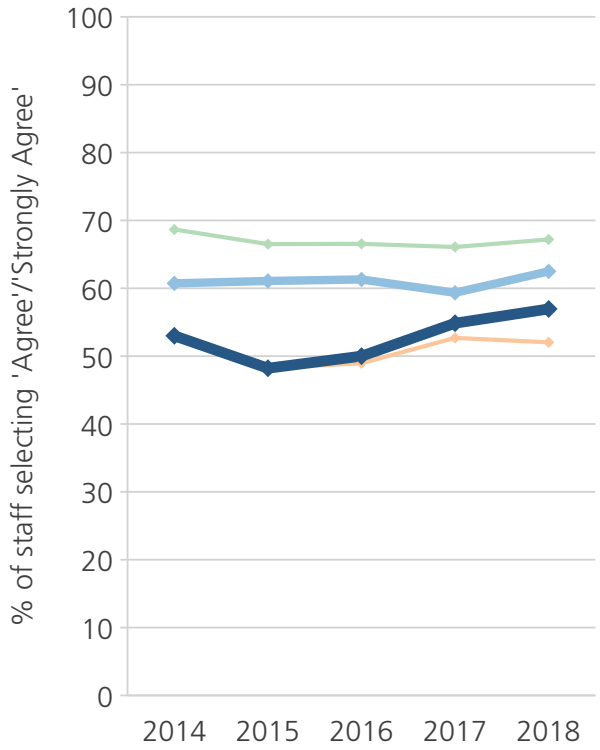
	2014	2015	2016	2017	2018
Best	78.6%	81.8%	79.9%	79.7%	80.7%
Your org	68.0%	66.4%	67.6%	71.7%	75.6%
Average	72.5%	77.4%	75.2%	75.4%	75.5%
Worst	68.0%	66.4%	67.6%	69.5%	69.9%

Q4b
I am able to make suggestions to improve the work of my team / department



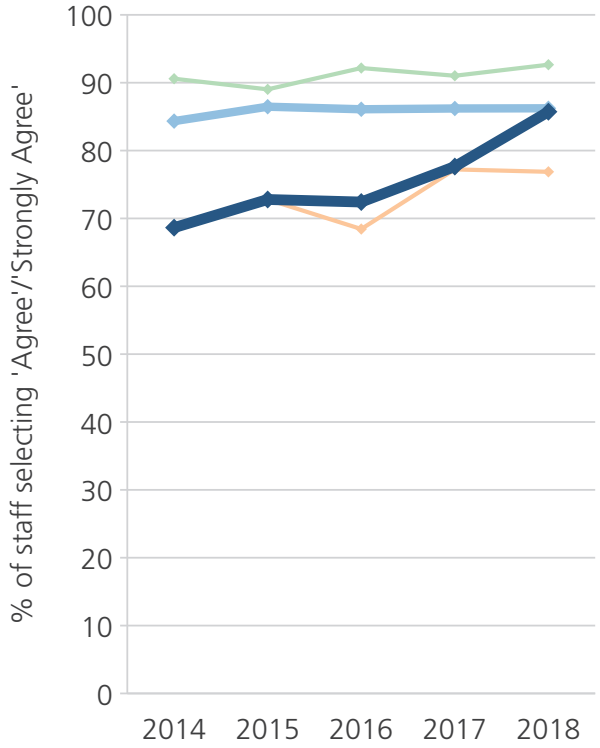
	2014	2015	2016	2017	2018
Best	81.8%	84.7%	81.7%	82.3%	80.0%
Your org	73.1%	66.4%	68.9%	73.1%	75.7%
Average	76.4%	77.1%	77.4%	77.0%	77.3%
Worst	72.9%	66.4%	68.9%	72.4%	68.8%

Q4d
I am able to make improvements happen in my area of work



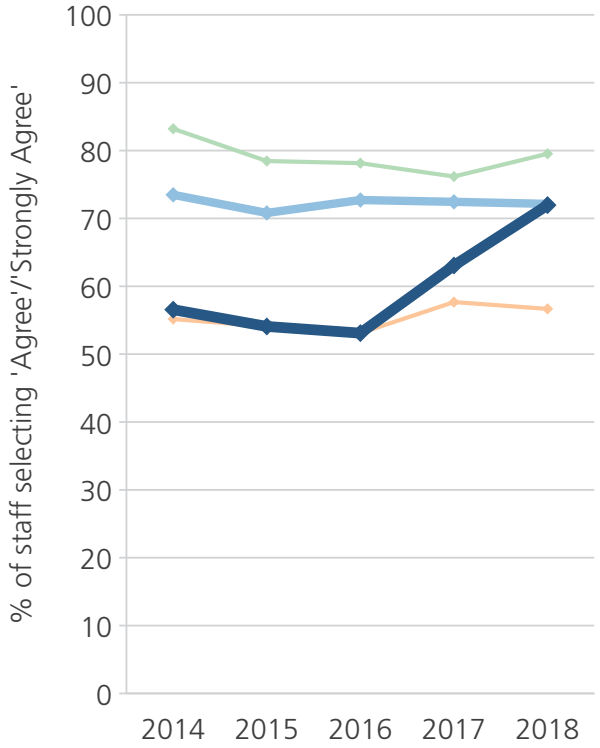
	2014	2015	2016	2017	2018
Best	68.7%	66.5%	66.5%	66.1%	67.2%
Your org	53.0%	48.2%	50.0%	54.9%	57.0%
Average	60.7%	61.1%	61.3%	59.3%	62.5%
Worst	53.0%	48.2%	49.0%	52.7%	52.0%

Q21a
Care of patients / service users is my organisation's top priority



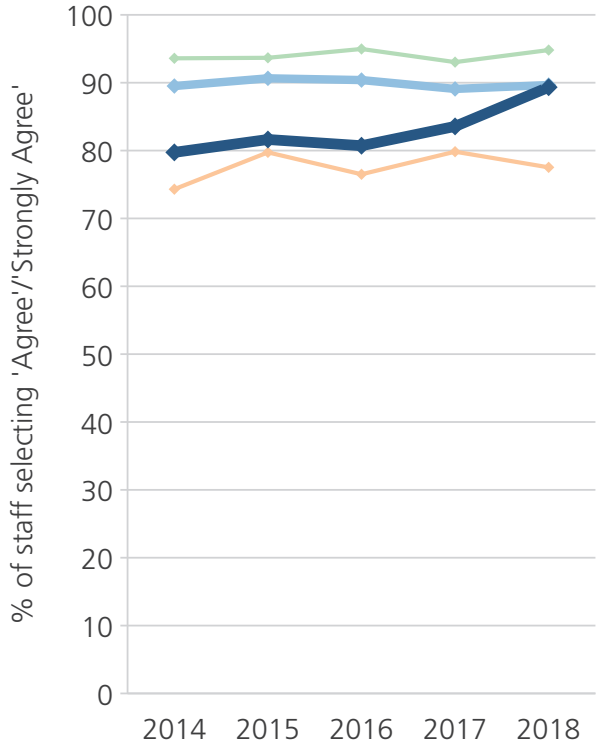
	2014	2015	2016	2017	2018
Best	90.6%	89.0%	92.2%	91.0%	92.7%
Your org	68.6%	72.8%	72.4%	77.6%	85.7%
Average	84.3%	86.5%	86.1%	86.2%	86.2%
Worst	68.5%	72.8%	68.4%	77.2%	76.9%

Q21c
I would recommend my organisation as a place to work



	2014	2015	2016	2017	2018
Best	83.2%	78.5%	78.1%	76.2%	79.5%
Your org	56.6%	54.1%	53.1%	63.1%	72.0%
Average	73.5%	70.8%	72.7%	72.4%	72.1%
Worst	55.2%	54.1%	53.1%	57.7%	56.7%

Q21d
If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation



	2014	2015	2016	2017	2018
Best	93.6%	93.7%	95.0%	93.0%	94.8%
Your org	79.7%	81.6%	80.7%	83.6%	89.3%
Average	89.5%	90.6%	90.4%	89.1%	89.7%
Worst	74.3%	79.7%	76.5%	79.8%	77.5%

Survey Coordination Centre

NHS England

Question results

Alder Hey Children's NHS Foundation Trust

2018 NHS Staff Survey Results

Survey Coordination Centre

NHS England

Question results – Your job

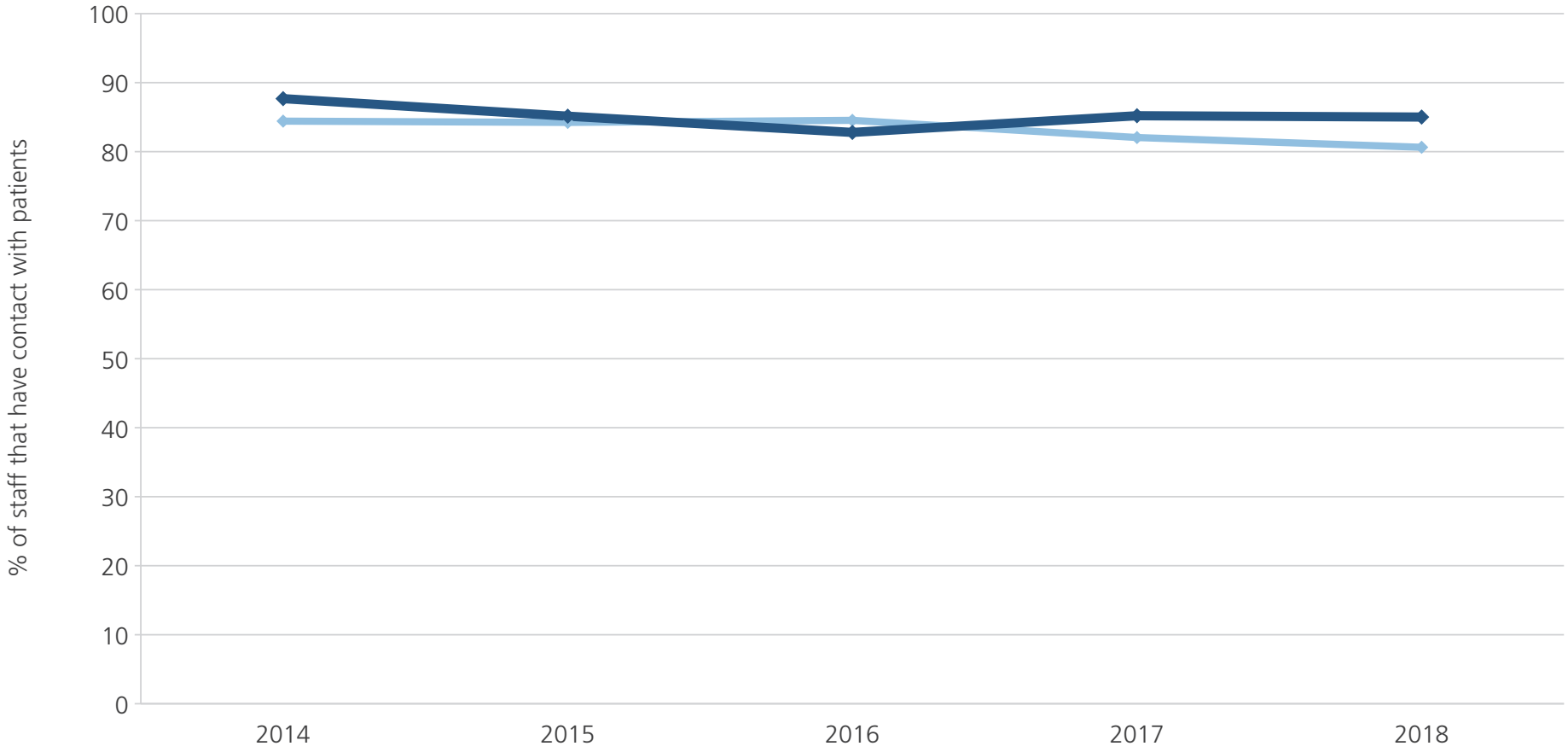
Alder Hey Children's NHS Foundation Trust

2018 NHS Staff Survey Results

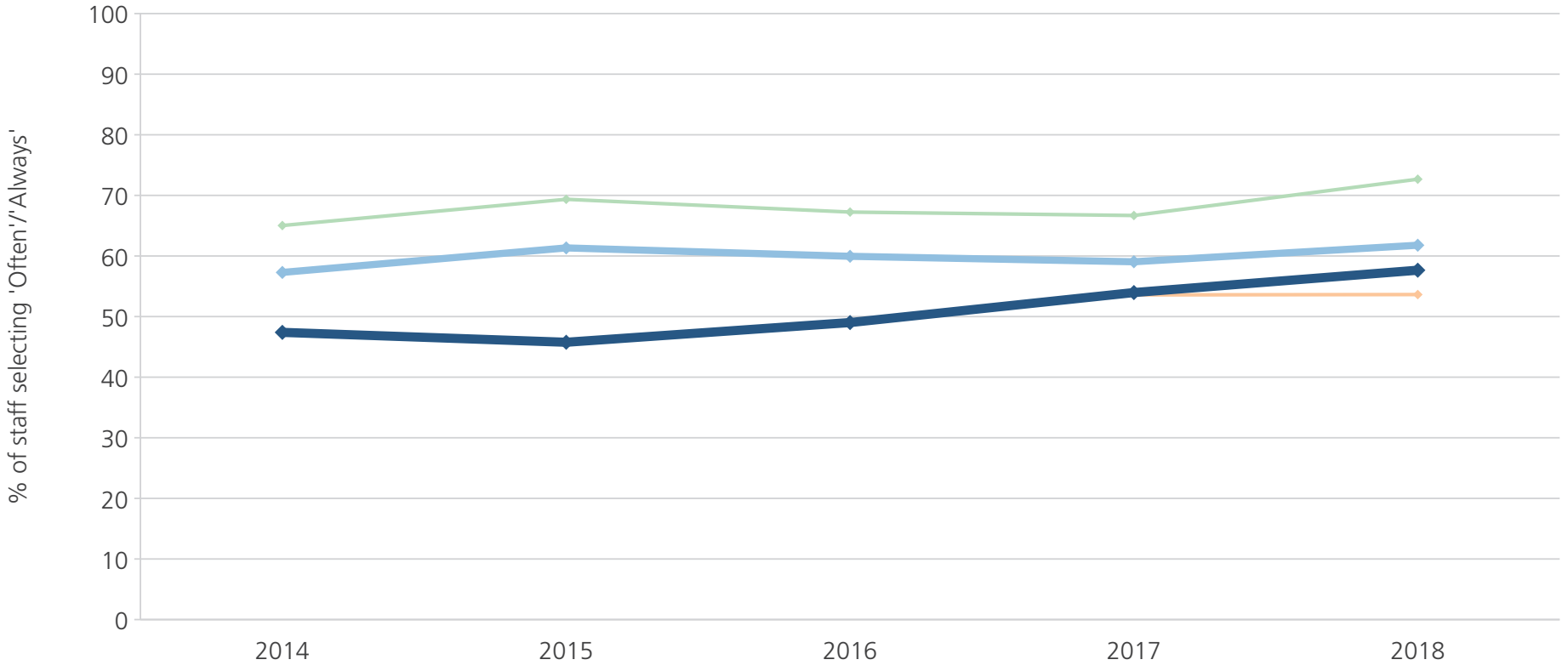
Survey Coordination Centre

2018 NHS Staff Survey Results > Question results > Your job > Q1 > Do you have face-to-face contact with patients / service users as part of your job?

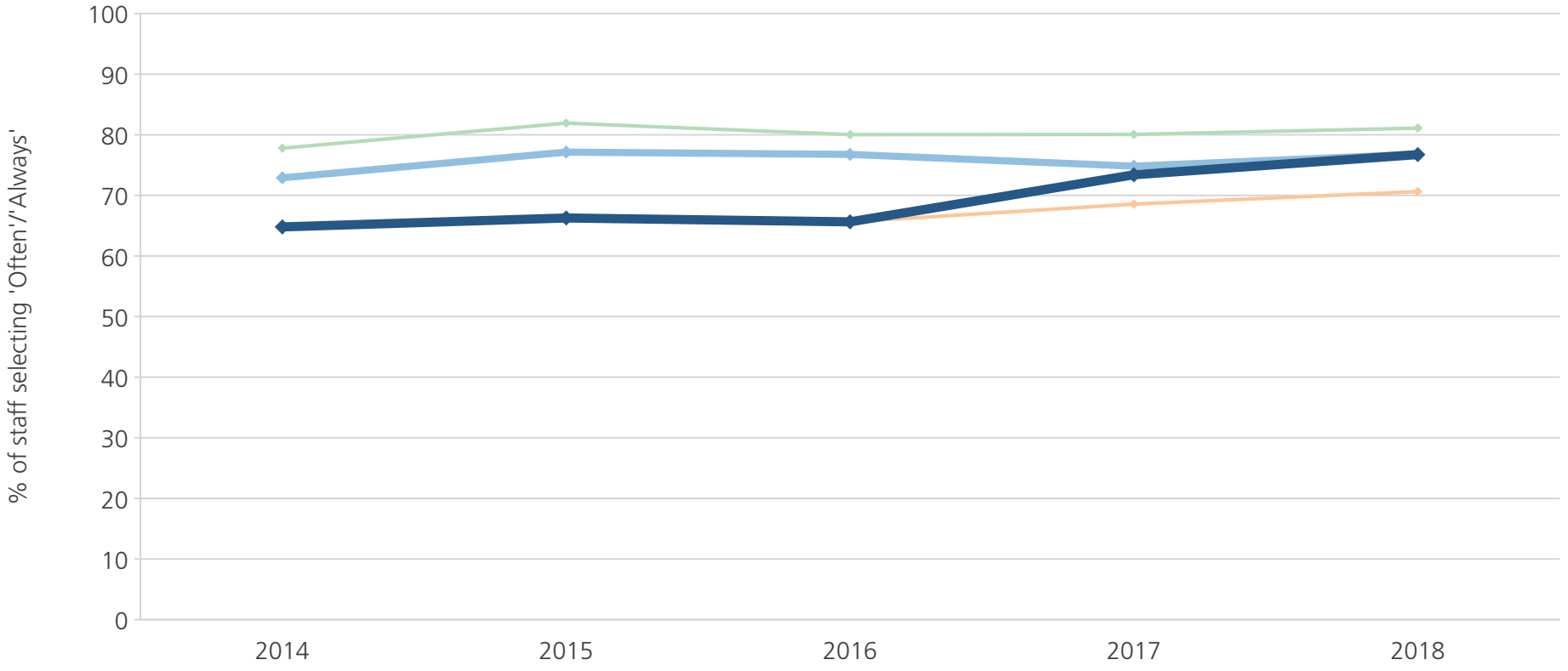
NHS England



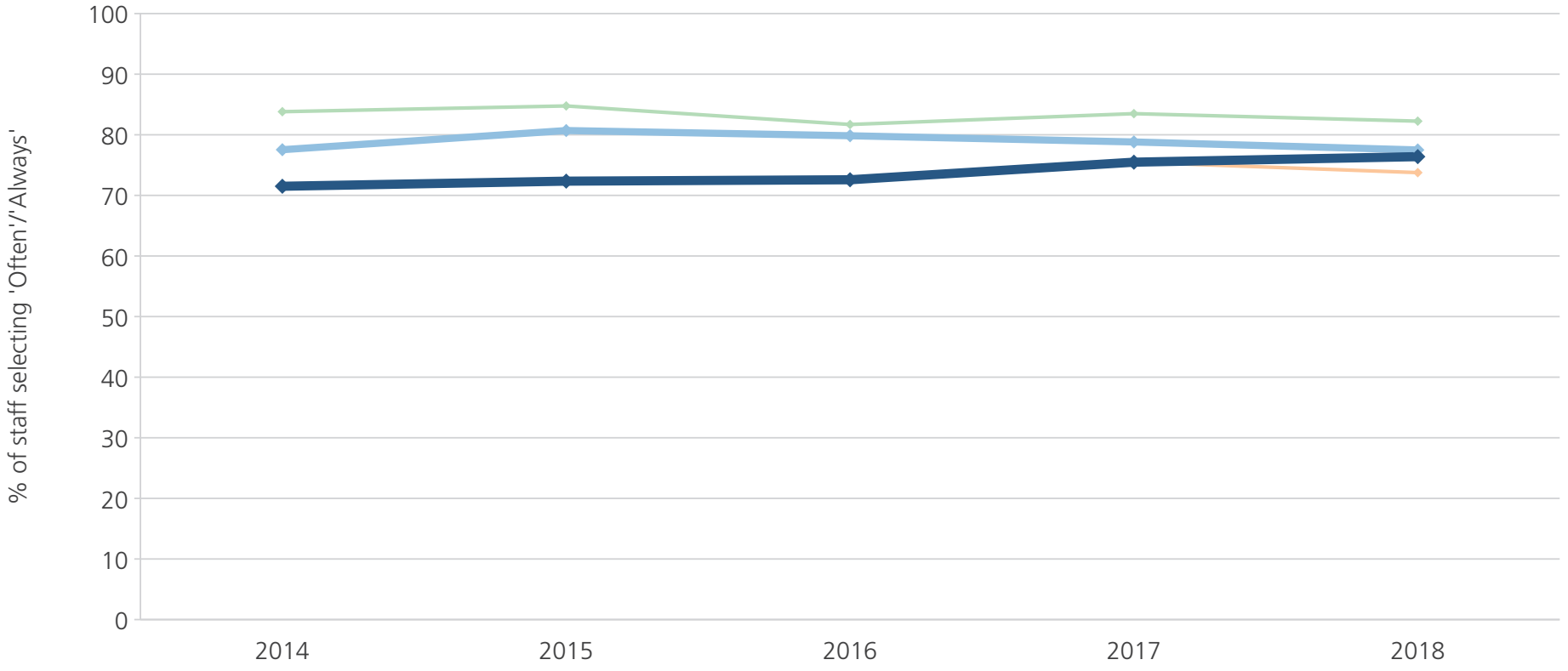
	2014	2015	2016	2017	2018
Your org	87.7%	85.1%	82.8%	85.2%	85.0%
Average	84.4%	84.2%	84.5%	82.0%	80.6%
No. responses	1,112	922	1,127	1,730	1,975



	2014	2015	2016	2017	2018
Best	65.0%	69.4%	67.2%	66.7%	72.7%
Your org	47.4%	45.8%	49.0%	54.0%	57.7%
Average	57.3%	61.3%	59.9%	59.0%	61.8%
Worst	47.4%	45.8%	49.0%	53.6%	53.6%
No. responses	1,119	928	1,129	1,739	1,983



	2014	2015	2016	2017	2018
Best	77.8%	81.9%	80.0%	80.1%	81.1%
Your org	64.8%	66.3%	65.6%	73.4%	76.7%
Average	72.9%	77.1%	76.8%	74.8%	76.8%
Worst	64.8%	66.3%	65.6%	68.6%	70.6%
No. responses	1,115	919	1,122	1,732	1,978

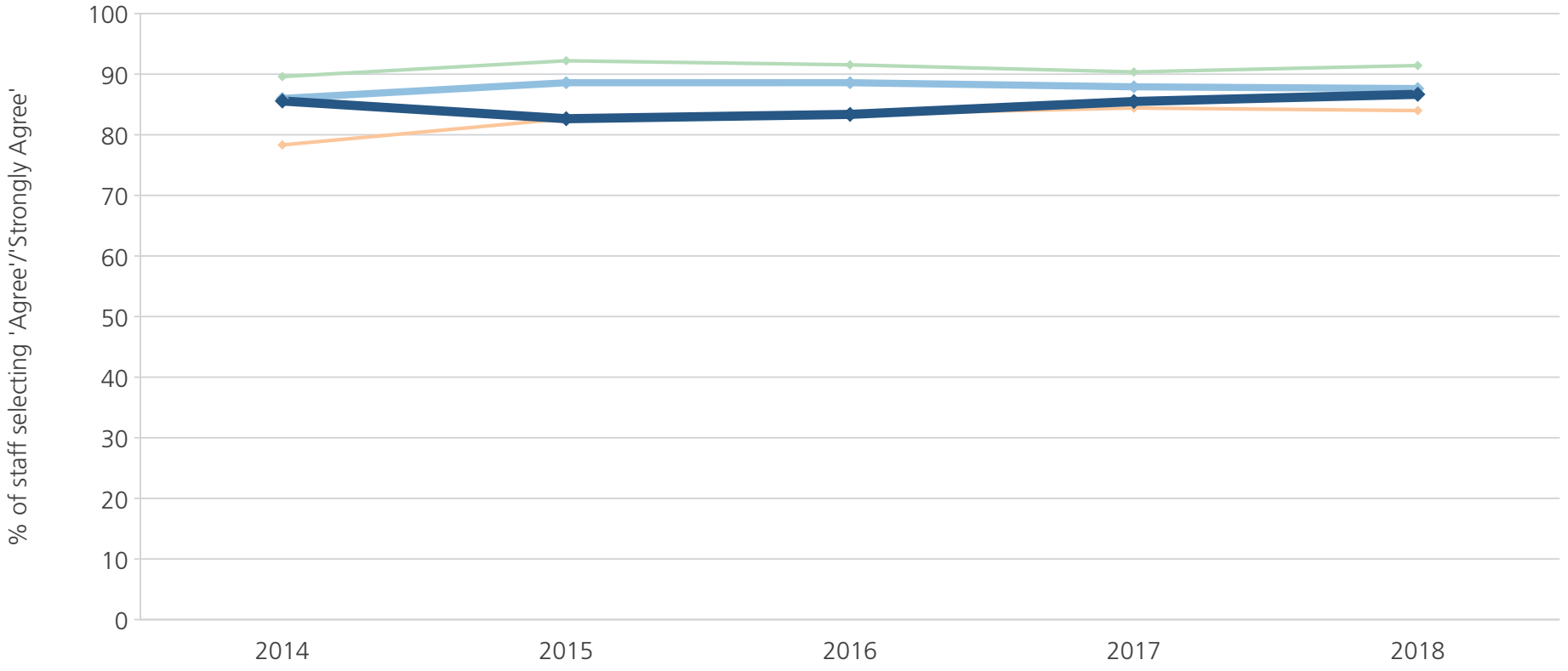


	2014	2015	2016	2017	2018
Best	83.8%	84.8%	81.7%	83.5%	82.2%
Your org	71.5%	72.3%	72.6%	75.5%	76.4%
Average	77.5%	80.7%	79.8%	78.8%	77.5%
Worst	71.5%	72.2%	72.6%	75.5%	73.8%
No. responses	1,113	920	1,120	1,723	1,977

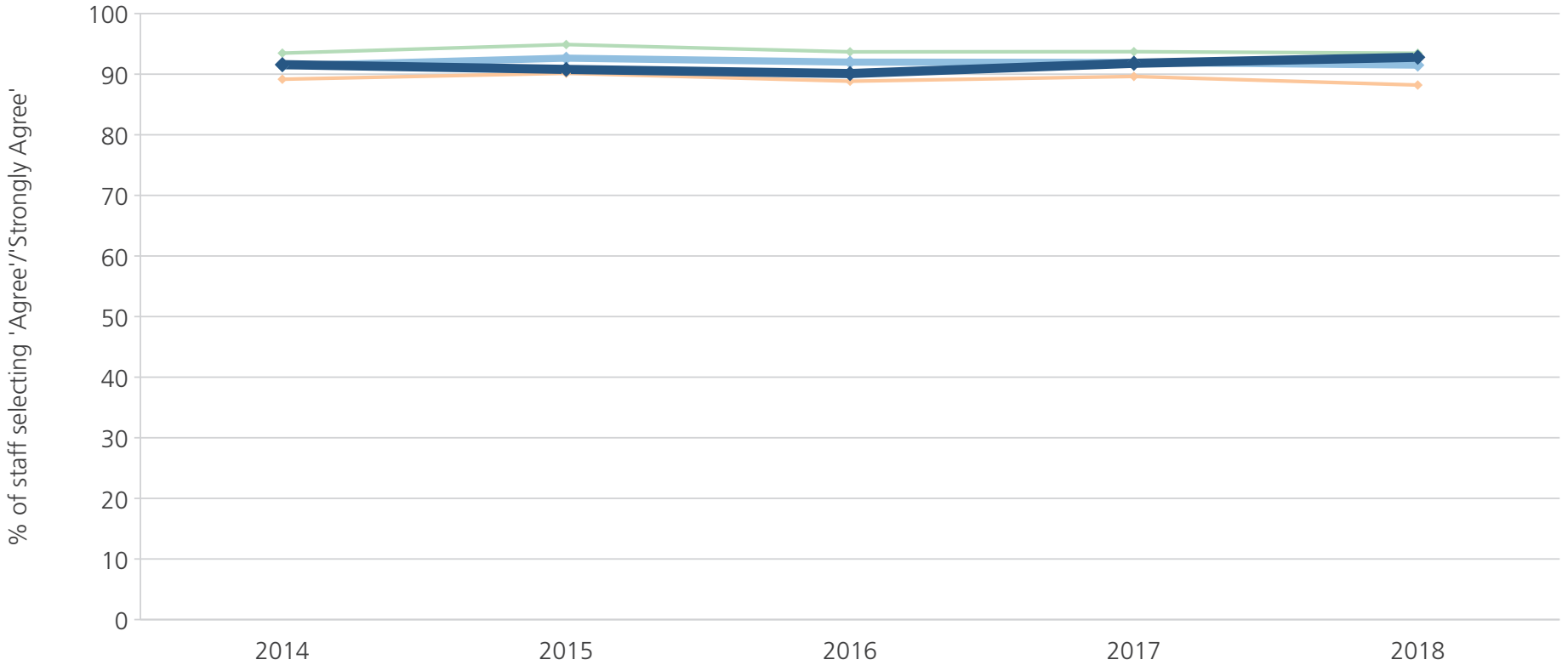
Survey Coordination Centre

2018 NHS Staff Survey Results > Question results > Your job > Q3a **>** I always know what my work responsibilities are

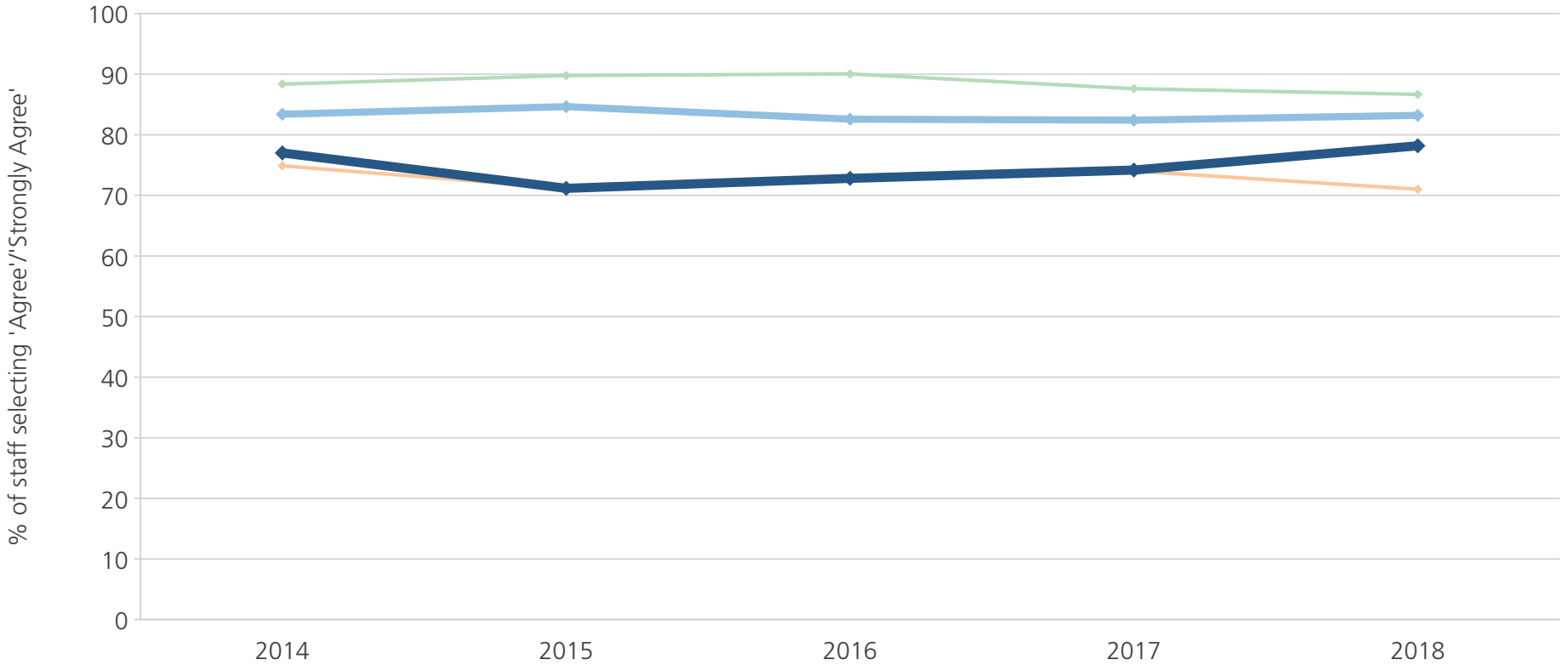
NHS England



	2014	2015	2016	2017	2018
Best	89.6%	92.2%	91.5%	90.4%	91.4%
Your org	85.6%	82.6%	83.4%	85.5%	86.7%
Average	86.0%	88.6%	88.6%	87.9%	87.6%
Worst	78.3%	82.6%	83.4%	84.4%	84.0%
No. responses	1,120	917	1,127	1,707	1,947



	2014	2015	2016	2017	2018
Best	93.5%	94.9%	93.7%	93.7%	93.5%
Your org	91.6%	90.8%	90.1%	91.8%	92.8%
Average	91.4%	92.6%	92.0%	91.9%	91.5%
Worst	89.2%	90.1%	88.8%	89.6%	88.2%
No. responses	1,119	912	1,122	1,699	1,925

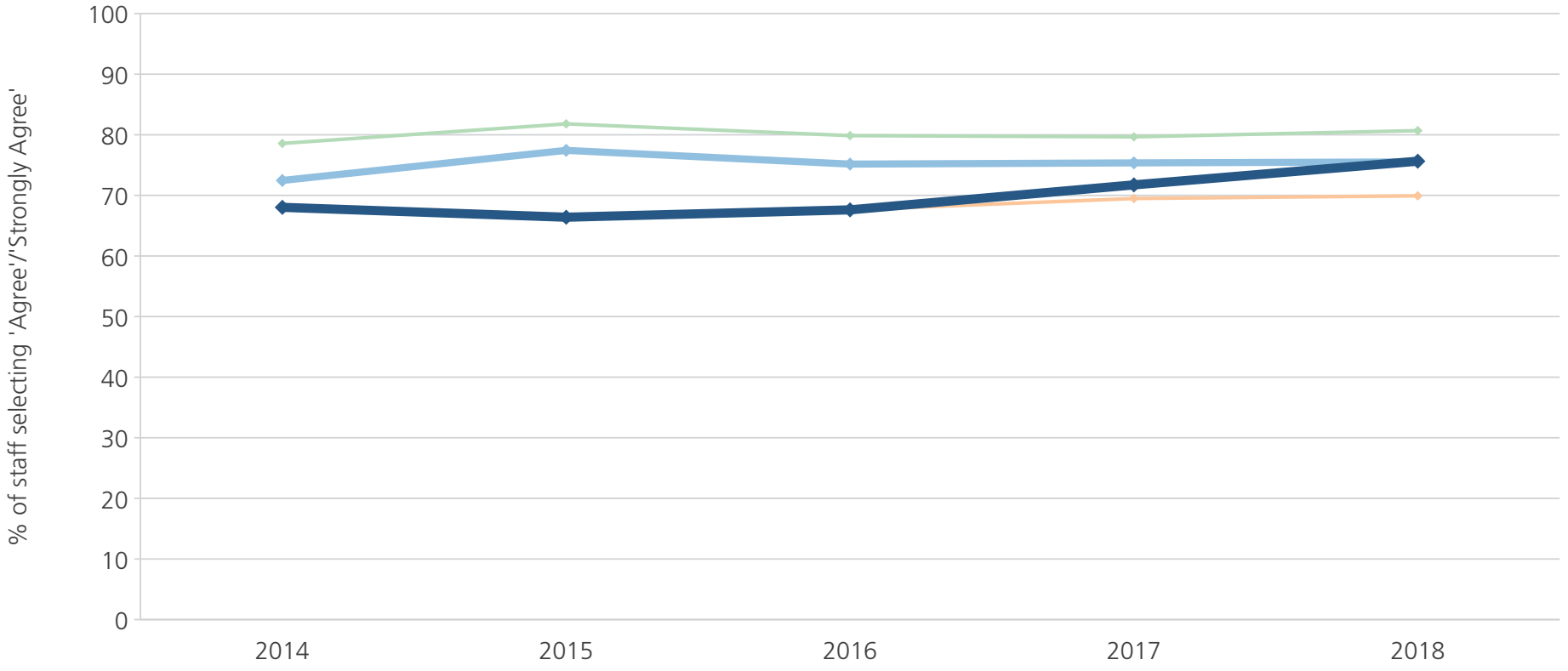


	2014	2015	2016	2017	2018
Best	88.4%	89.8%	90.0%	87.6%	86.7%
Your org	77.0%	71.2%	72.8%	74.2%	78.2%
Average	83.4%	84.6%	82.6%	82.4%	83.2%
Worst	74.9%	71.2%	72.8%	74.0%	71.0%
No. responses	1,120	916	1,121	1,698	1,929

Survey Coordination Centre

2018 NHS Staff Survey Results > Question results > Your job > Q4a
> There are frequent opportunities for me to show initiative in my role

NHS England

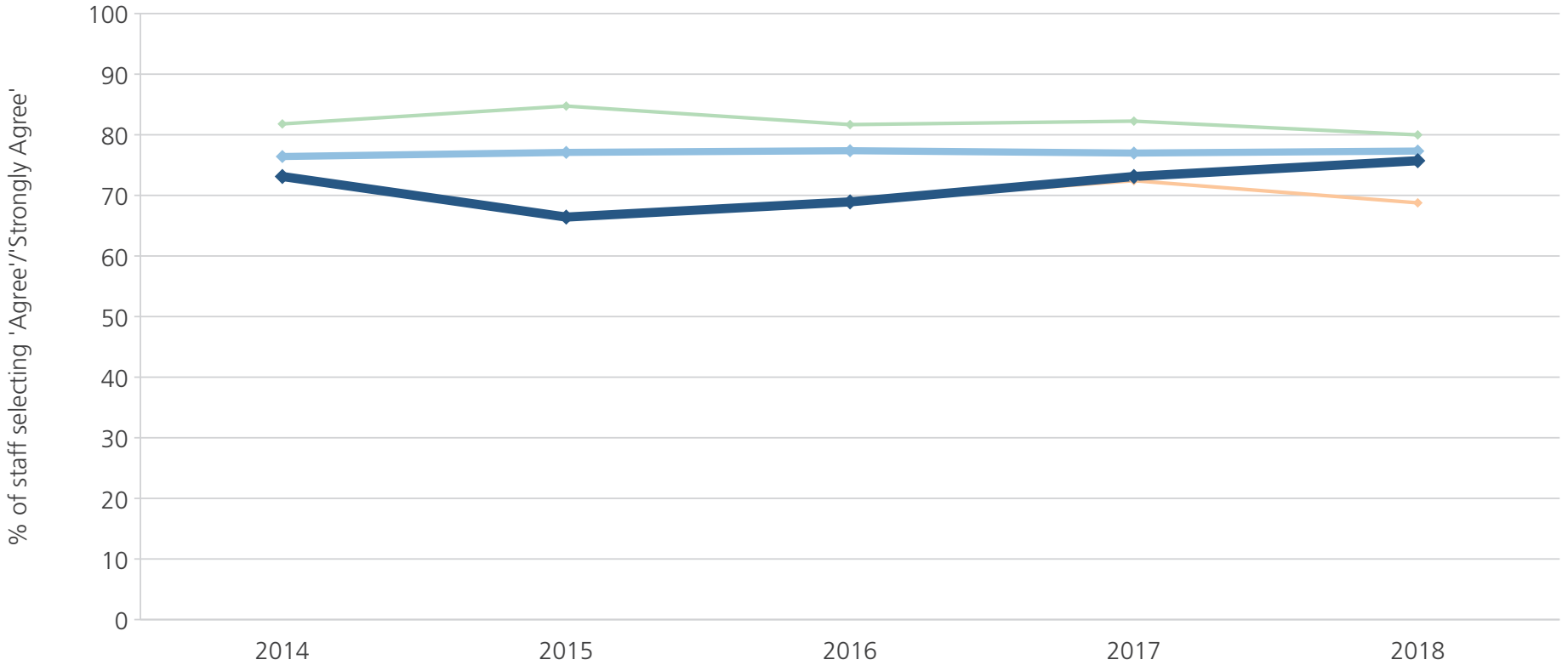


	2014	2015	2016	2017	2018
Best	78.6%	81.8%	79.9%	79.7%	80.7%
Your org	68.0%	66.4%	67.6%	71.7%	75.6%
Average	72.5%	77.4%	75.2%	75.4%	75.5%
Worst	68.0%	66.4%	67.6%	69.5%	69.9%
No. responses	1,118	921	1,135	1,746	1,986

Survey Coordination Centre

2018 NHS Staff Survey Results > Question results > Your job > Q4b **>** I am able to make suggestions to improve the work of my team / department

NHS England

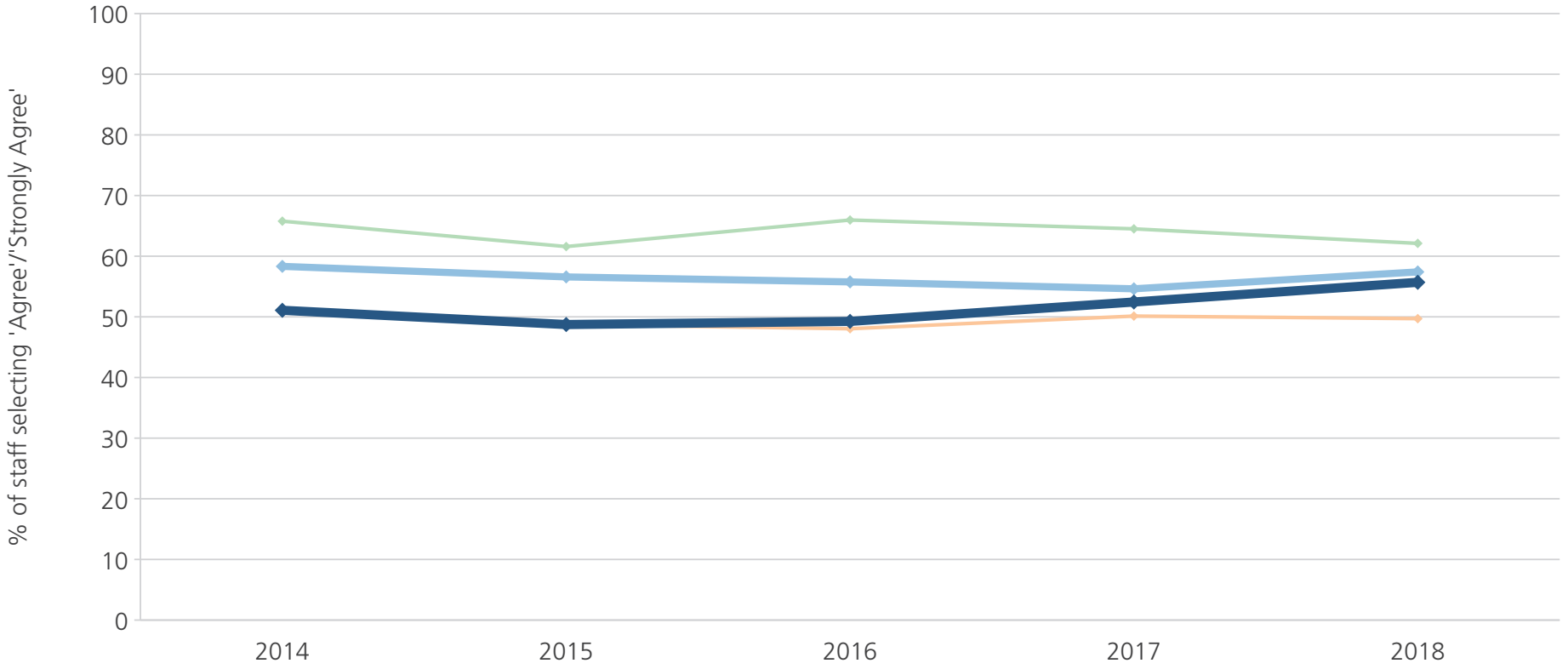


	2014	2015	2016	2017	2018
Best	81.8%	84.7%	81.7%	82.3%	80.0%
Your org	73.1%	66.4%	68.9%	73.1%	75.7%
Average	76.4%	77.1%	77.4%	77.0%	77.3%
Worst	72.9%	66.4%	68.9%	72.4%	68.8%
No. responses	1,120	923	1,134	1,737	1,979

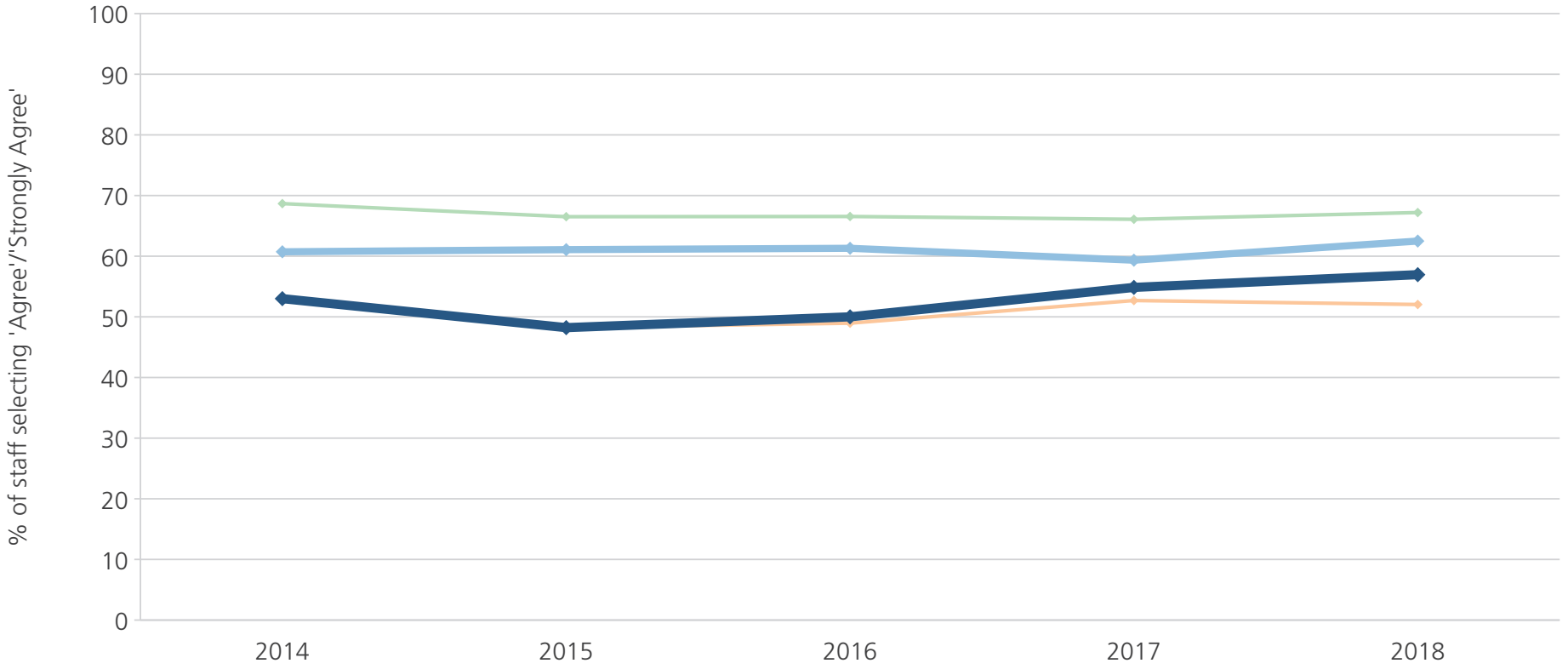
Survey Coordination Centre

2018 NHS Staff Survey Results > Question results > Your job > Q4c **>** I am involved in deciding on changes introduced that affect my work area / team / department

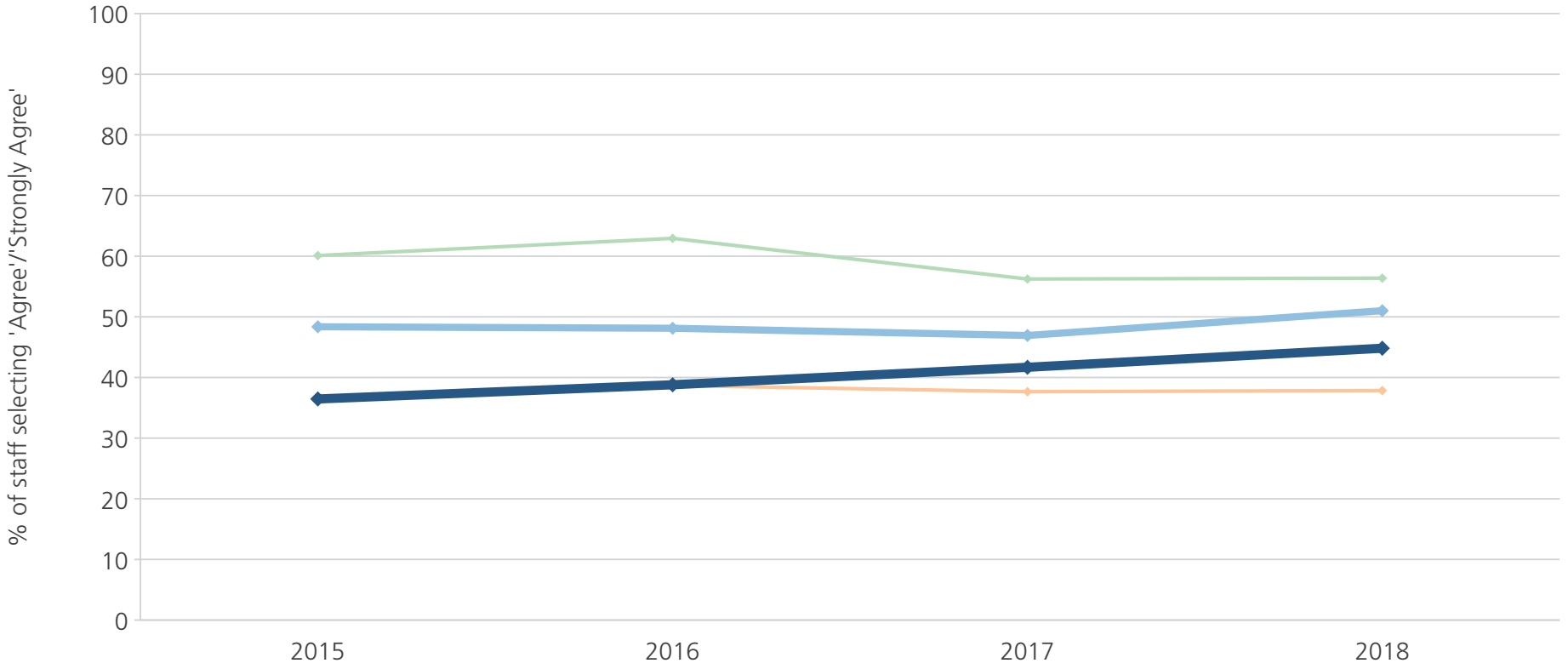
NHS England



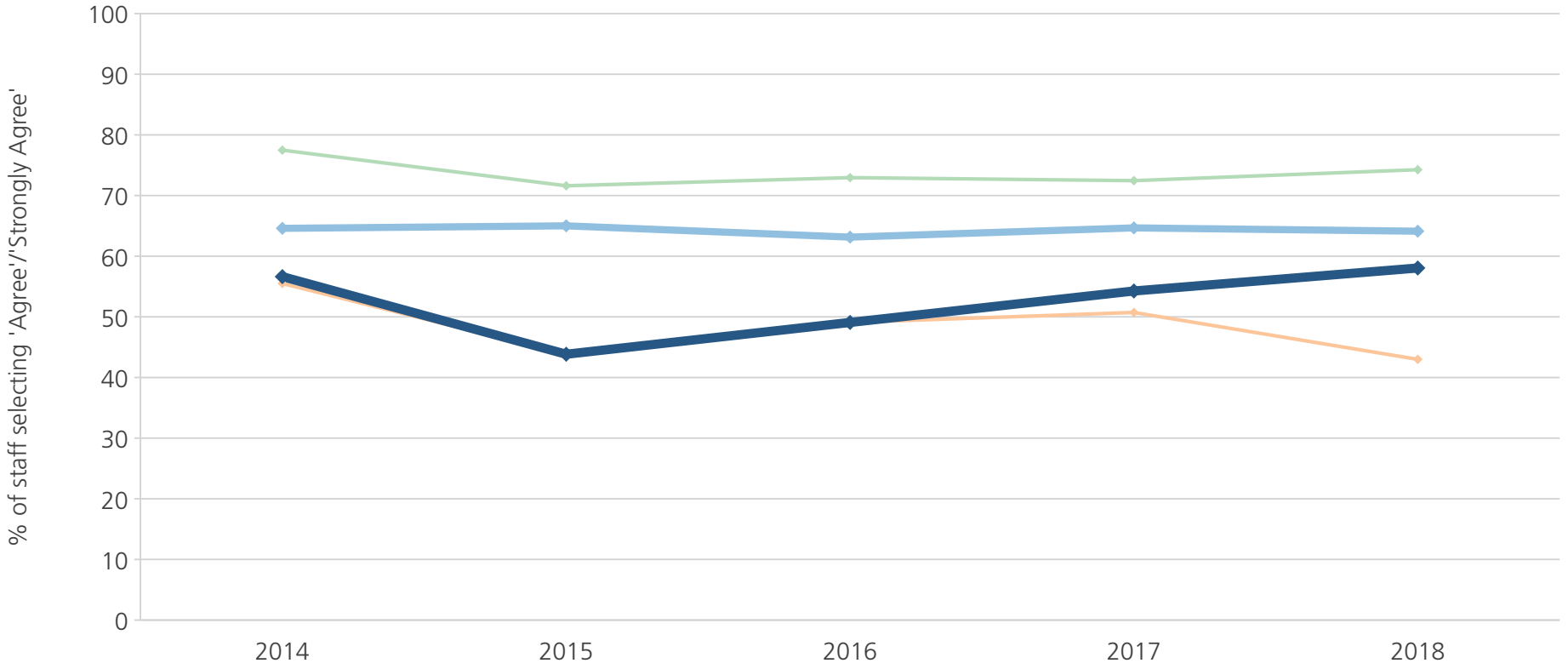
	2014	2015	2016	2017	2018
Best	65.8%	61.6%	66.0%	64.5%	62.1%
Your org	51.1%	48.7%	49.2%	52.4%	55.7%
Average	58.3%	56.6%	55.8%	54.6%	57.4%
Worst	51.1%	48.7%	48.0%	50.1%	49.7%
No. responses	1,116	923	1,130	1,745	1,981



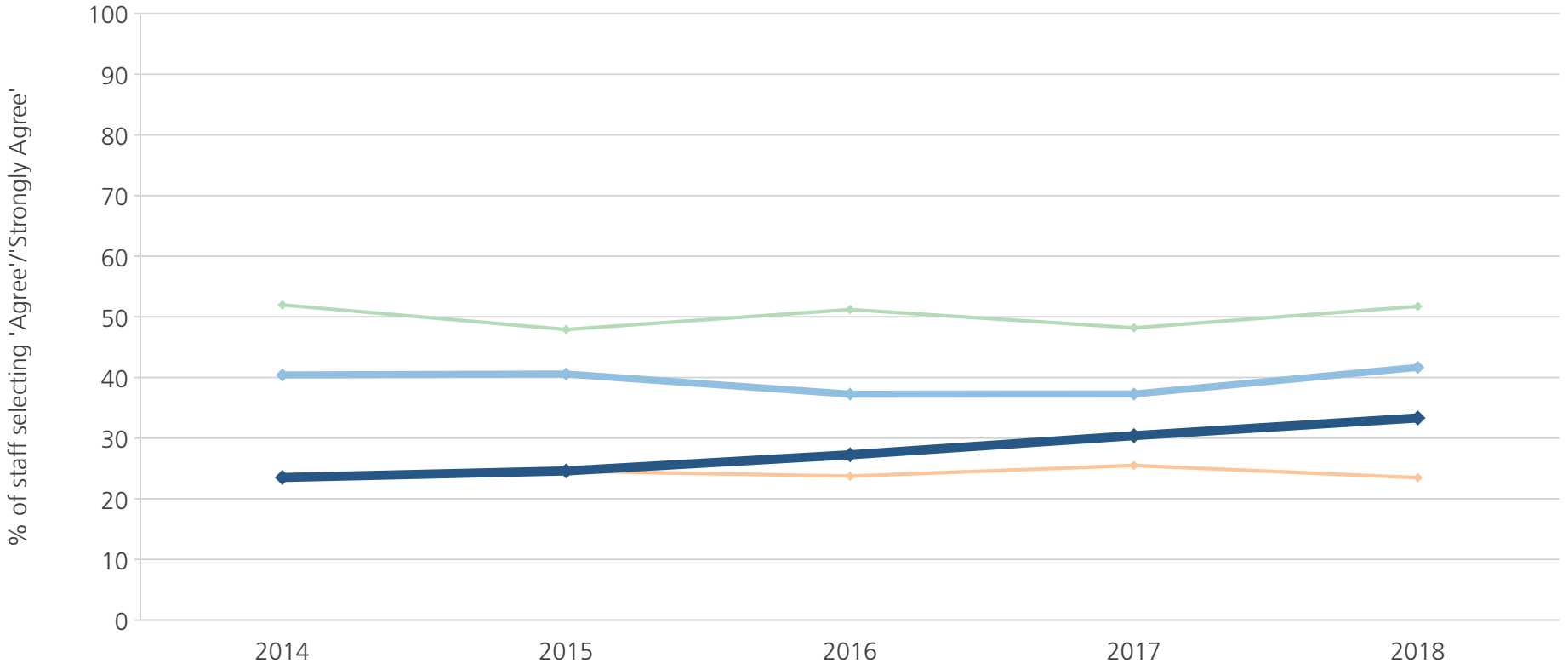
	2014	2015	2016	2017	2018
Best	68.7%	66.5%	66.5%	66.1%	67.2%
Your org	53.0%	48.2%	50.0%	54.9%	57.0%
Average	60.7%	61.1%	61.3%	59.3%	62.5%
Worst	53.0%	48.2%	49.0%	52.7%	52.0%
No. responses	1,114	925	1,131	1,735	1,977



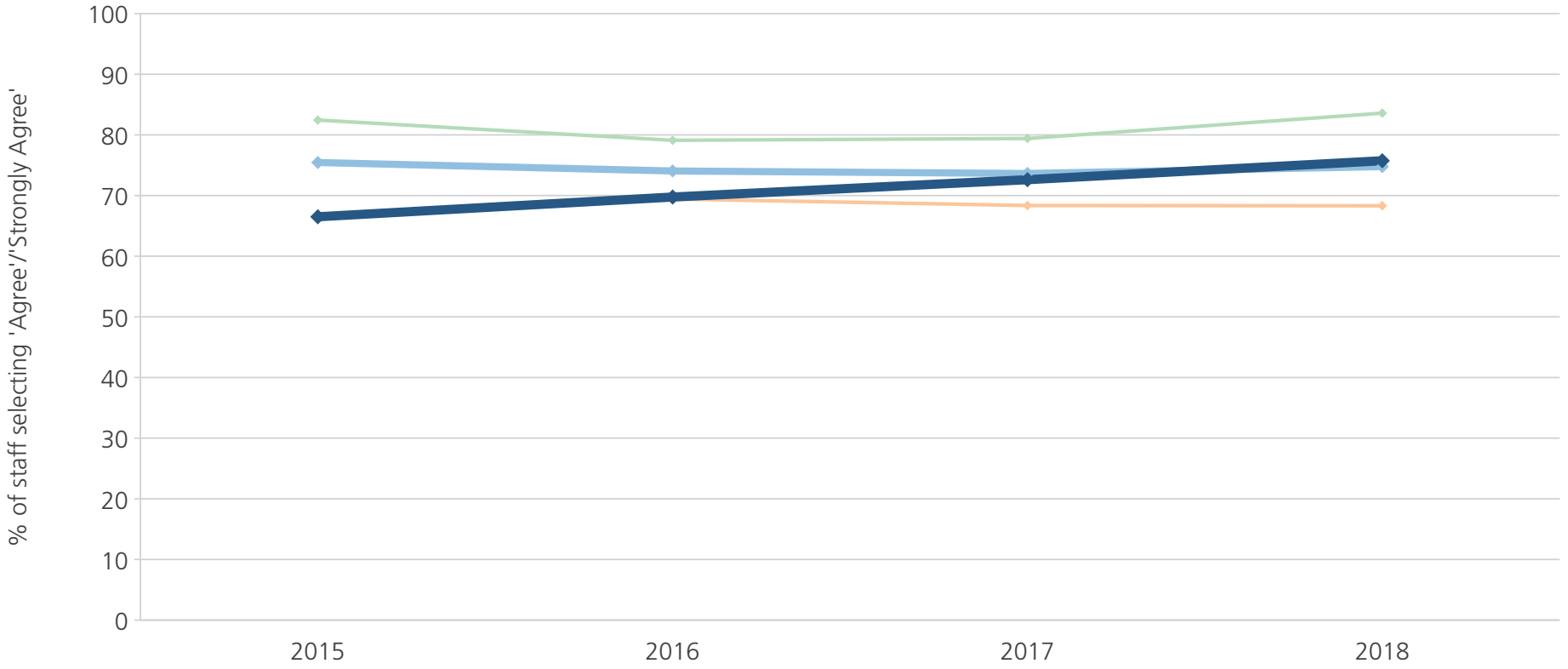
	2015	2016	2017	2018
Best	60.1%	62.9%	56.2%	56.4%
Your org	36.5%	38.8%	41.7%	44.8%
Average	48.4%	48.1%	46.9%	51.0%
Worst	36.5%	38.7%	37.7%	37.8%
No. responses	923	1,127	1,736	1,979



	2014	2015	2016	2017	2018
Best	77.5%	71.6%	73.0%	72.5%	74.3%
Your org	56.6%	43.8%	49.1%	54.3%	58.1%
Average	64.6%	65.0%	63.1%	64.7%	64.1%
Worst	55.5%	43.8%	49.1%	50.7%	43.0%
No. responses	1,110	924	1,131	1,741	1,980



	2014	2015	2016	2017	2018
Best	52.0%	47.9%	51.2%	48.2%	51.7%
Your org	23.5%	24.6%	27.3%	30.4%	33.3%
Average	40.4%	40.6%	37.3%	37.3%	41.7%
Worst	23.5%	24.6%	23.7%	25.5%	23.5%
No. responses	1,113	922	1,130	1,740	1,981

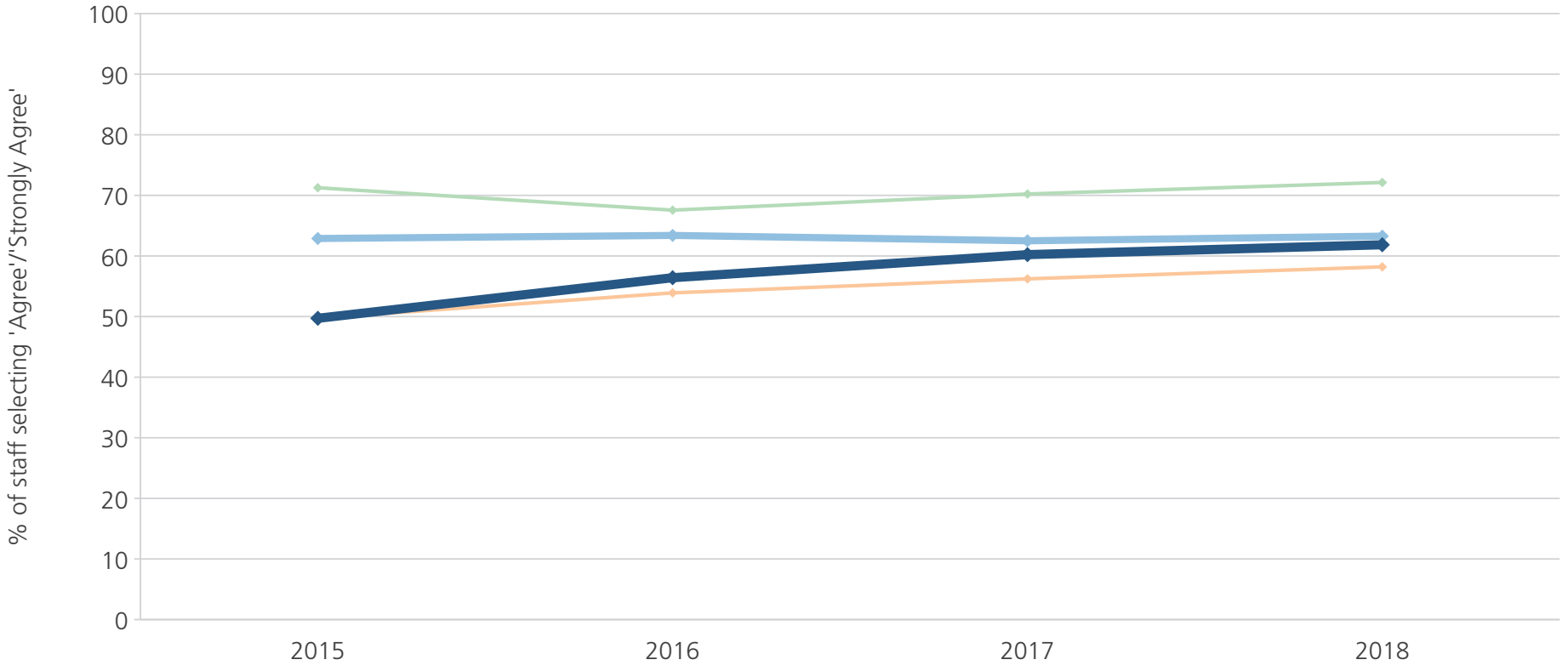


	2015	2016	2017	2018
Best	82.4%	79.1%	79.4%	83.6%
Your org	66.5%	69.8%	72.6%	75.7%
Average	75.4%	74.0%	73.6%	74.8%
Worst	66.5%	69.4%	68.4%	68.3%
No. responses	921	1,127	1,730	1,962

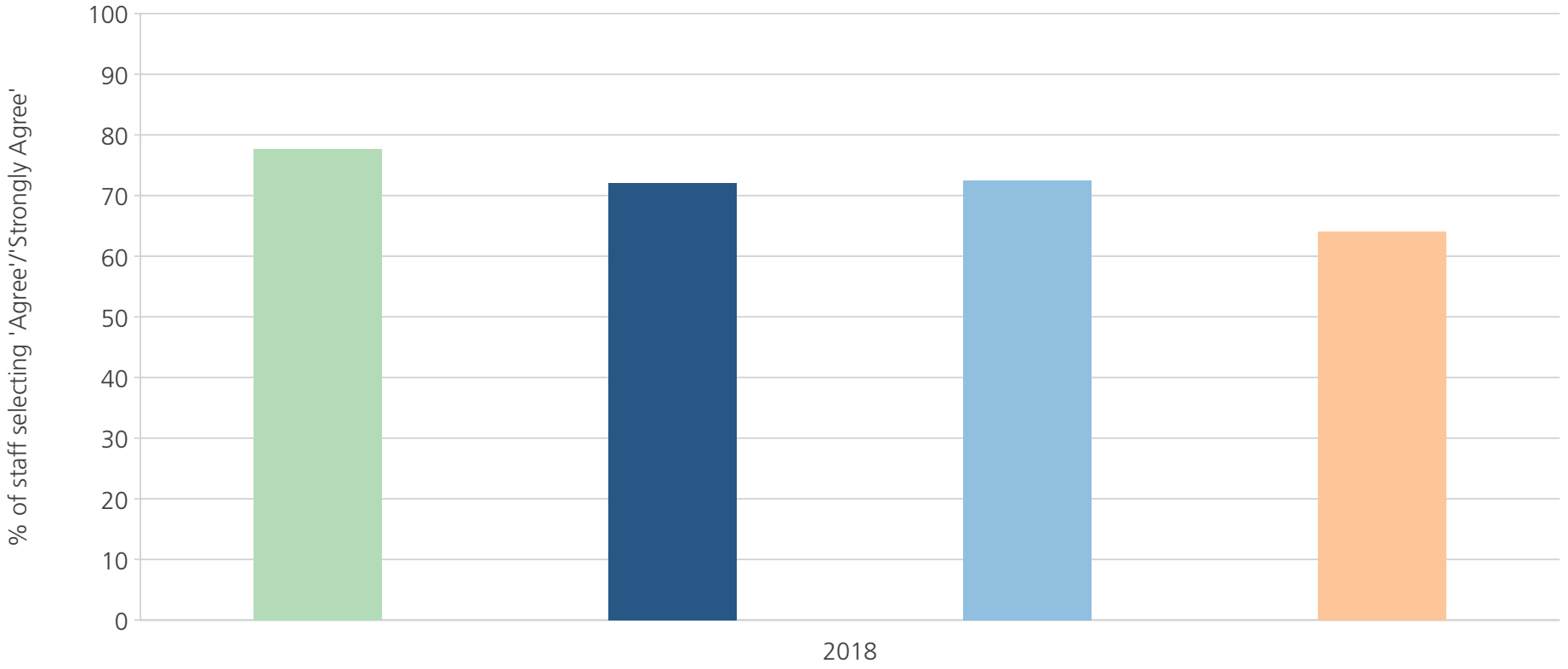
Survey Coordination Centre

2018 NHS Staff Survey Results > Question results > Your job > Q4i
> The team I work in often meets to discuss the team's effectiveness

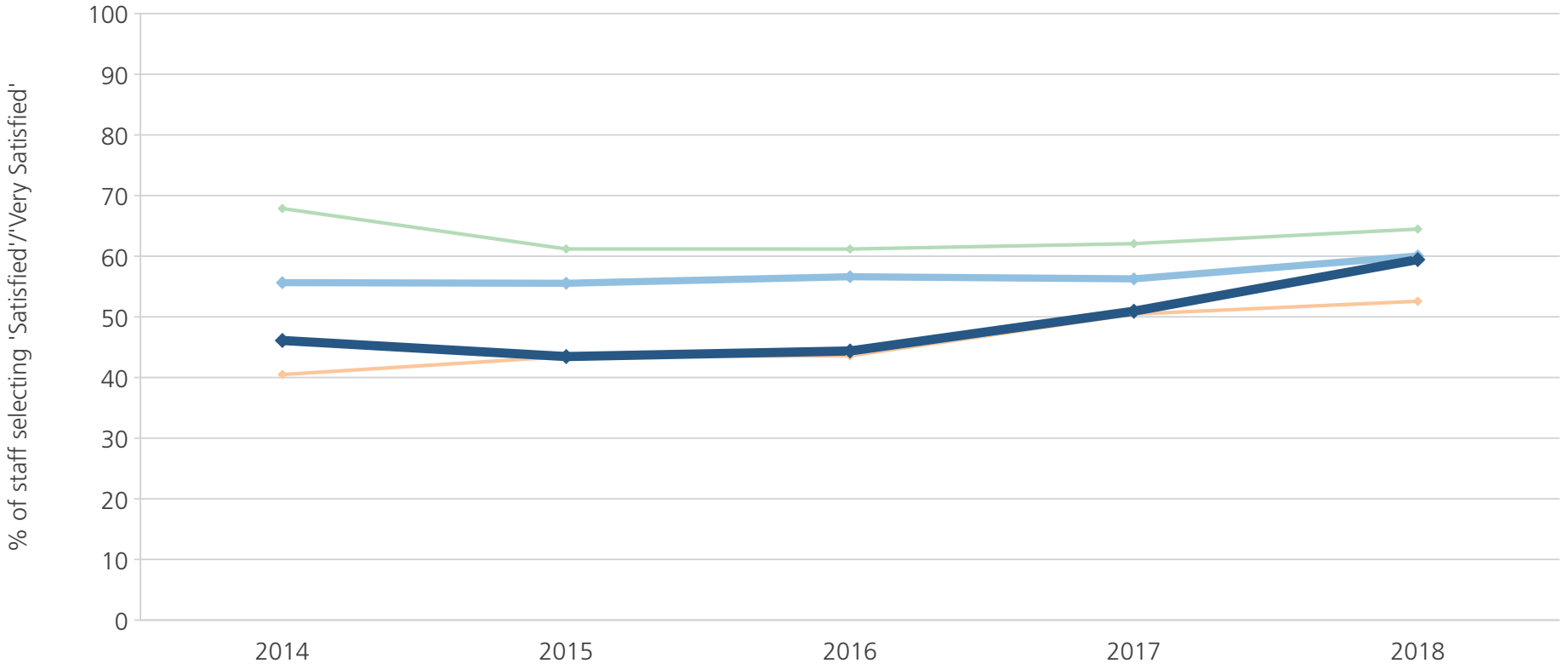
NHS England



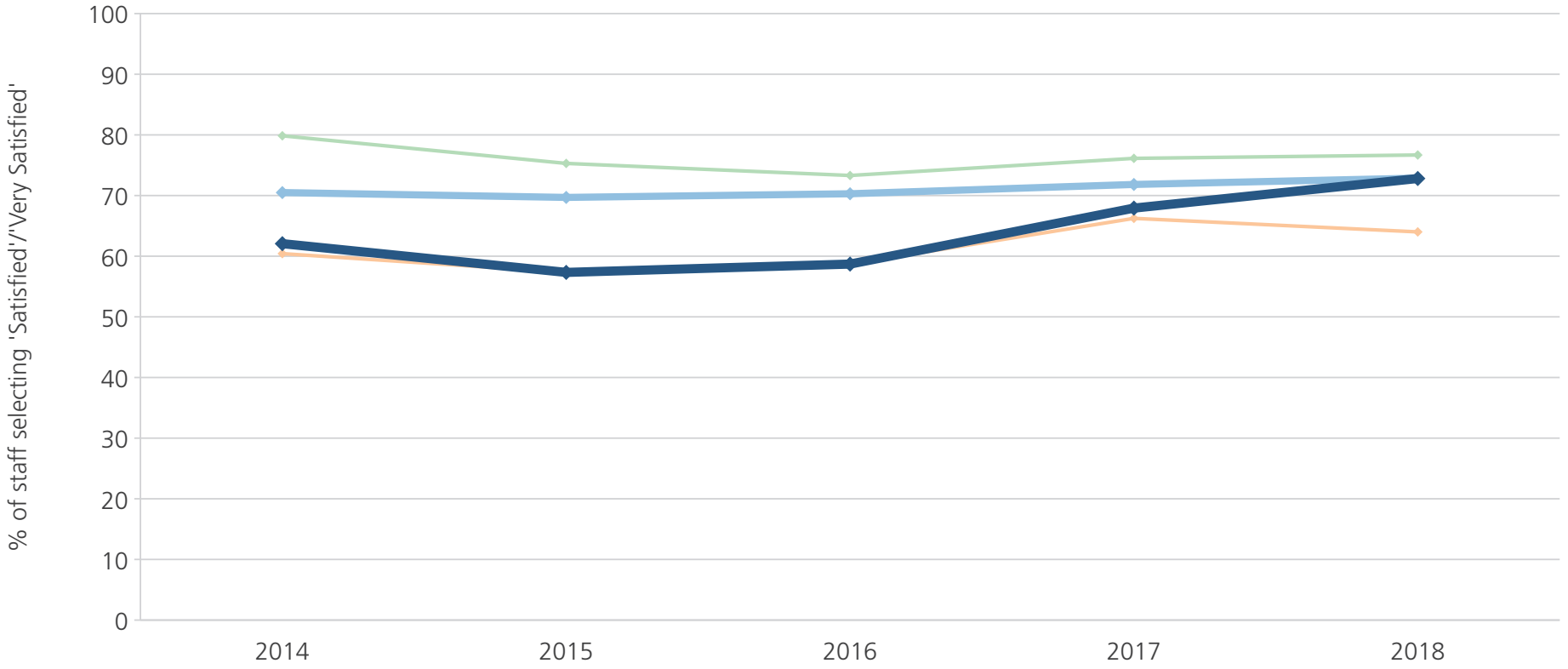
	2015	2016	2017	2018
Best	71.3%	67.6%	70.2%	72.1%
Your org	49.7%	56.4%	60.2%	61.8%
Average	62.9%	63.4%	62.5%	63.3%
Worst	49.7%	53.9%	56.2%	58.2%
No. responses	920	1,133	1,738	1,976



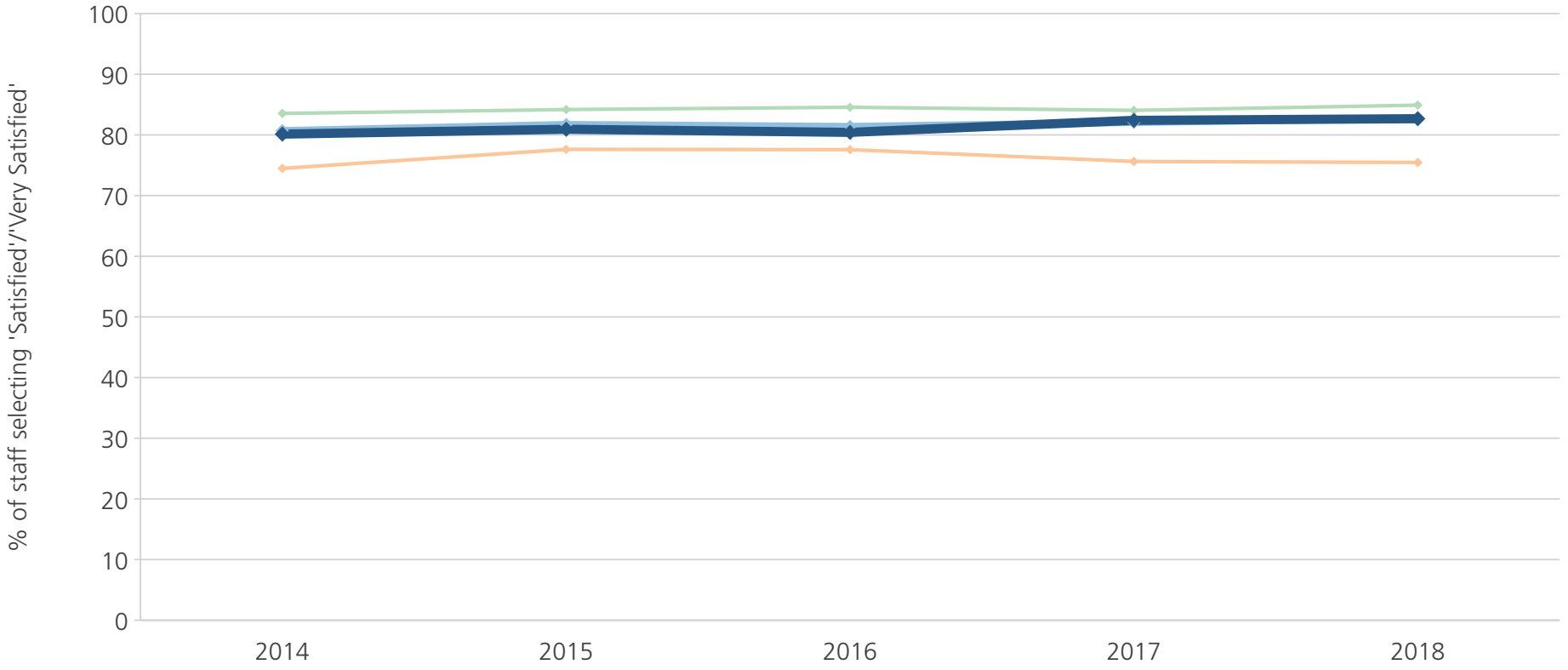
Best	77.7%
Your org	72.1%
Average	72.4%
Worst	64.1%
No. responses	1,979



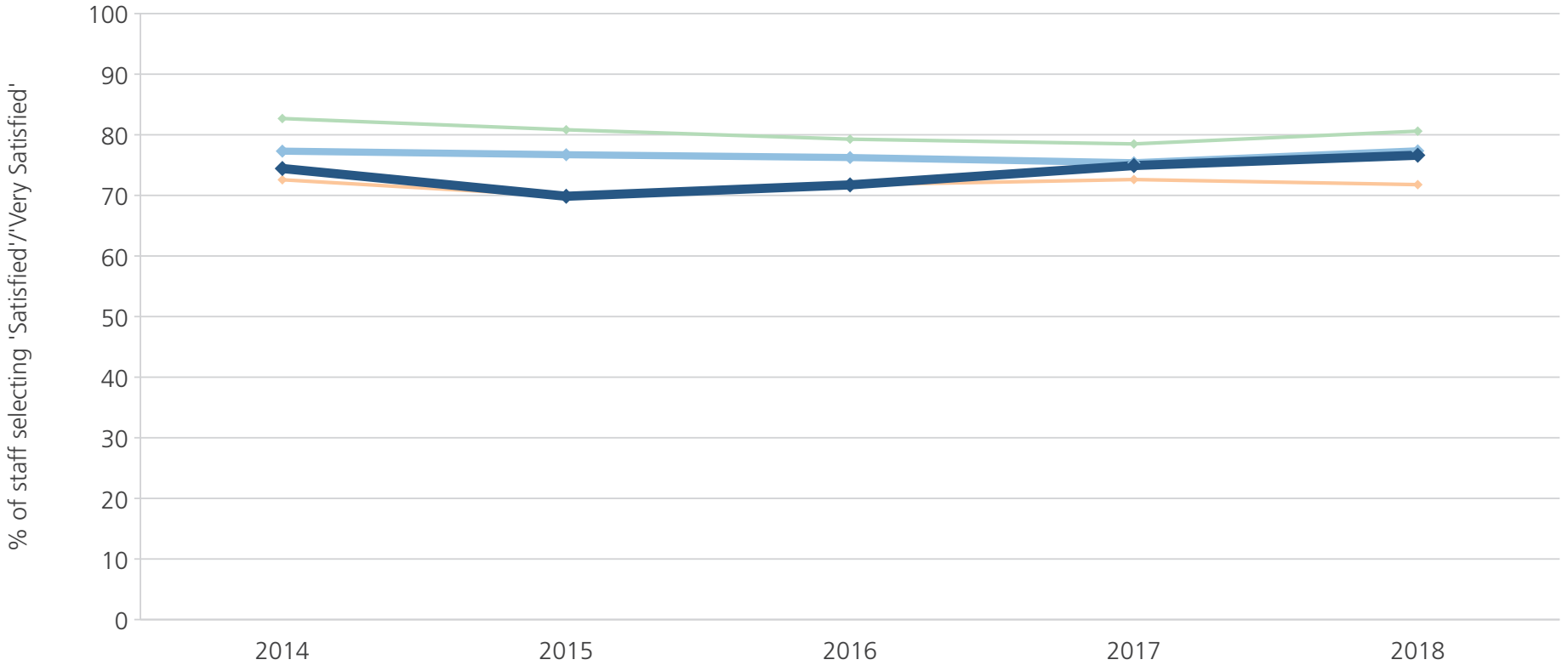
	2014	2015	2016	2017	2018
Best	67.9%	61.2%	61.2%	62.1%	64.5%
Your org	46.1%	43.5%	44.4%	50.9%	59.4%
Average	55.6%	55.5%	56.6%	56.3%	60.0%
Worst	40.5%	43.5%	43.6%	50.5%	52.6%
No. responses	1,116	927	1,124	1,728	1,970



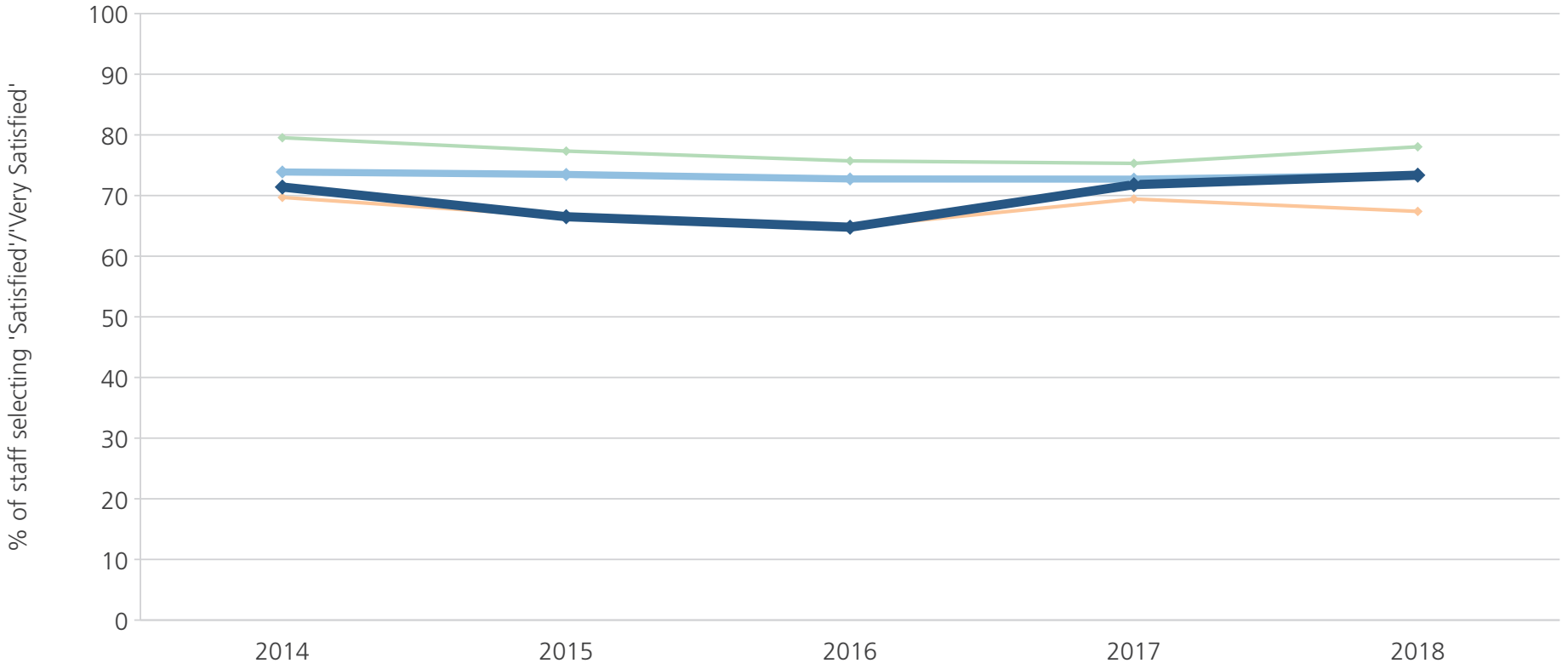
	2014	2015	2016	2017	2018
Best	79.9%	75.3%	73.3%	76.1%	76.7%
Your org	62.1%	57.3%	58.7%	67.9%	72.8%
Average	70.5%	69.7%	70.3%	71.8%	72.9%
Worst	60.4%	57.3%	58.7%	66.2%	64.0%
No. responses	1,114	926	1,125	1,723	1,966



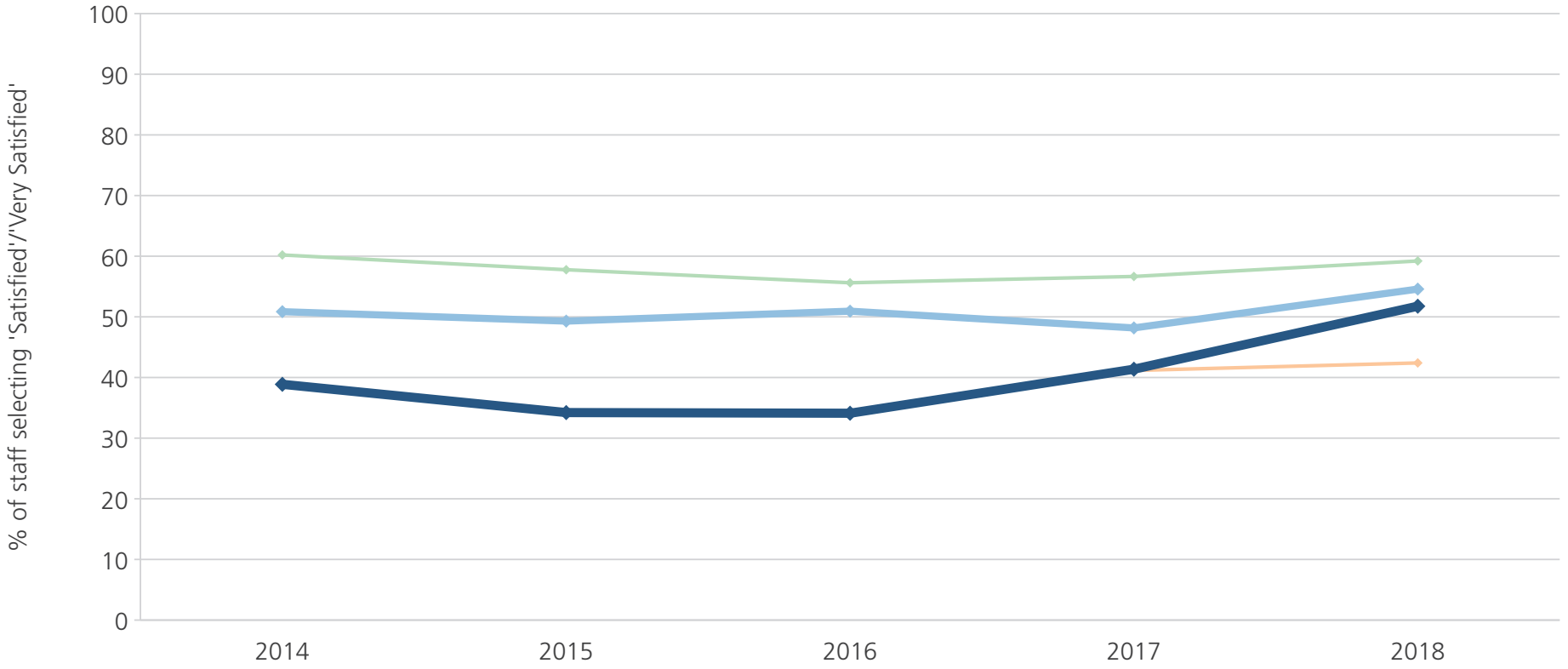
	2014	2015	2016	2017	2018
Best	83.5%	84.2%	84.6%	84.1%	84.9%
Your org	80.1%	80.9%	80.4%	82.4%	82.7%
Average	80.7%	81.7%	81.4%	82.1%	82.7%
Worst	74.5%	77.6%	77.6%	75.6%	75.5%
No. responses	1,120	925	1,128	1,727	1,969



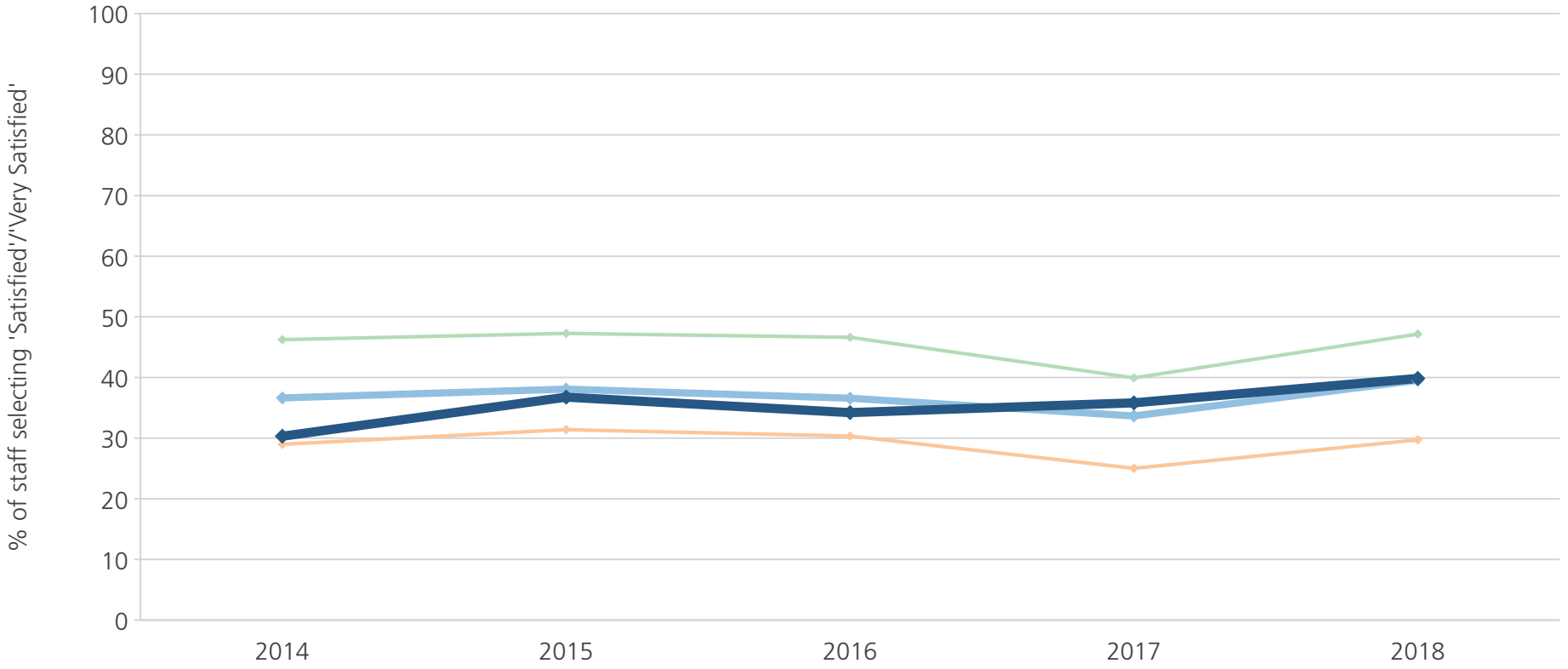
	2014	2015	2016	2017	2018
Best	82.7%	80.8%	79.3%	78.5%	80.6%
Your org	74.4%	69.9%	71.7%	74.9%	76.6%
Average	77.3%	76.7%	76.2%	75.4%	77.4%
Worst	72.6%	69.9%	71.7%	72.6%	71.8%
No. responses	1,118	925	1,124	1,725	1,961



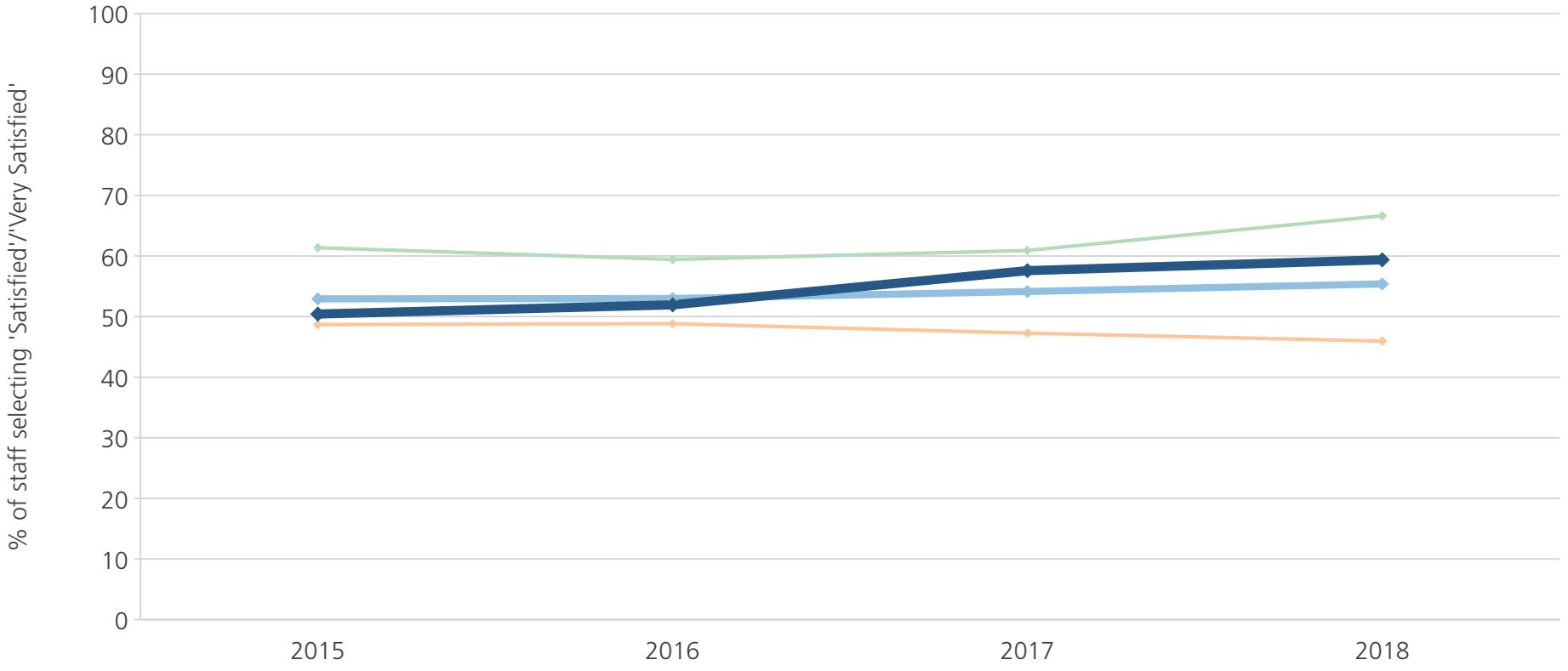
	2014	2015	2016	2017	2018
Best	79.5%	77.3%	75.7%	75.3%	78.0%
Your org	71.4%	66.5%	64.8%	71.8%	73.4%
Average	73.9%	73.5%	72.7%	72.7%	73.3%
Worst	69.7%	66.5%	64.8%	69.4%	67.4%
No. responses	1,118	923	1,126	1,721	1,961



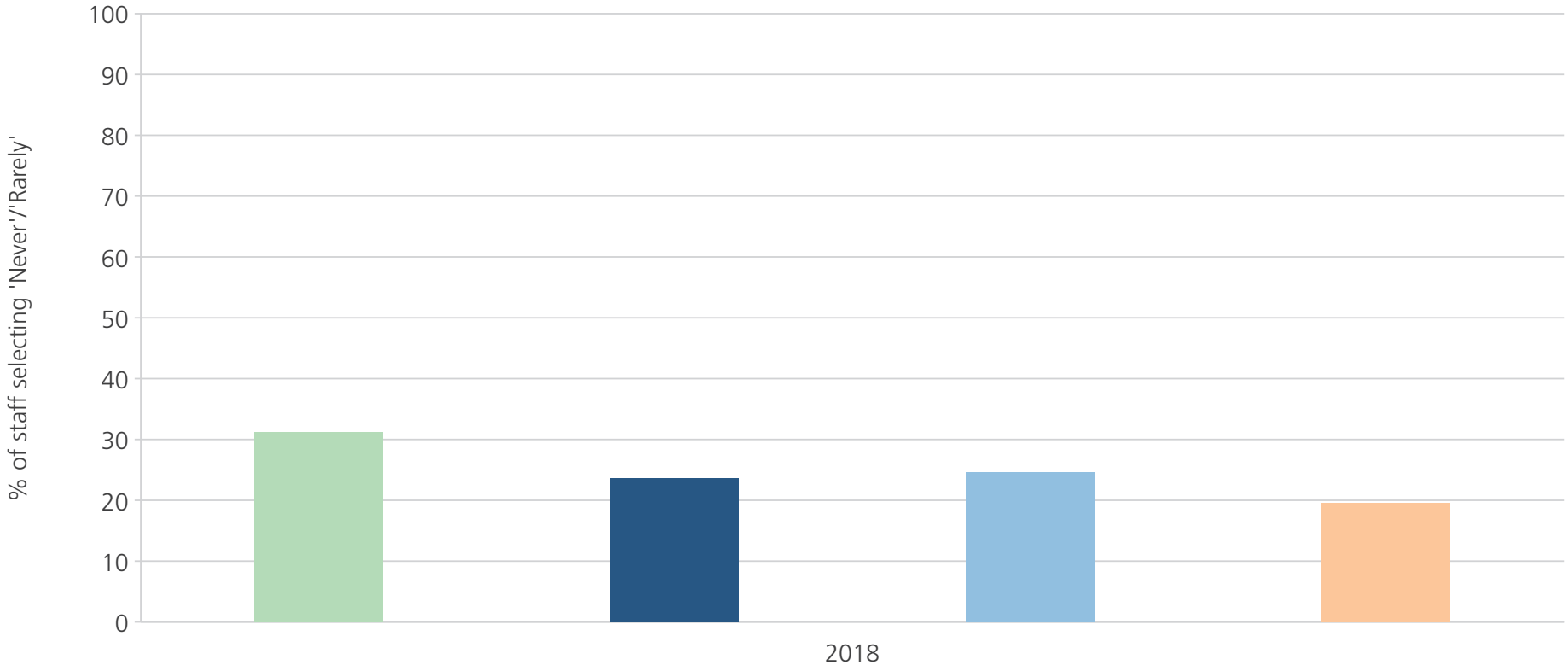
	2014	2015	2016	2017	2018
Best	60.2%	57.8%	55.6%	56.7%	59.2%
Your org	38.9%	34.2%	34.1%	41.4%	51.8%
Average	50.9%	49.3%	50.9%	48.2%	54.6%
Worst	38.9%	34.2%	34.1%	41.2%	42.4%
No. responses	1,116	923	1,125	1,719	1,963



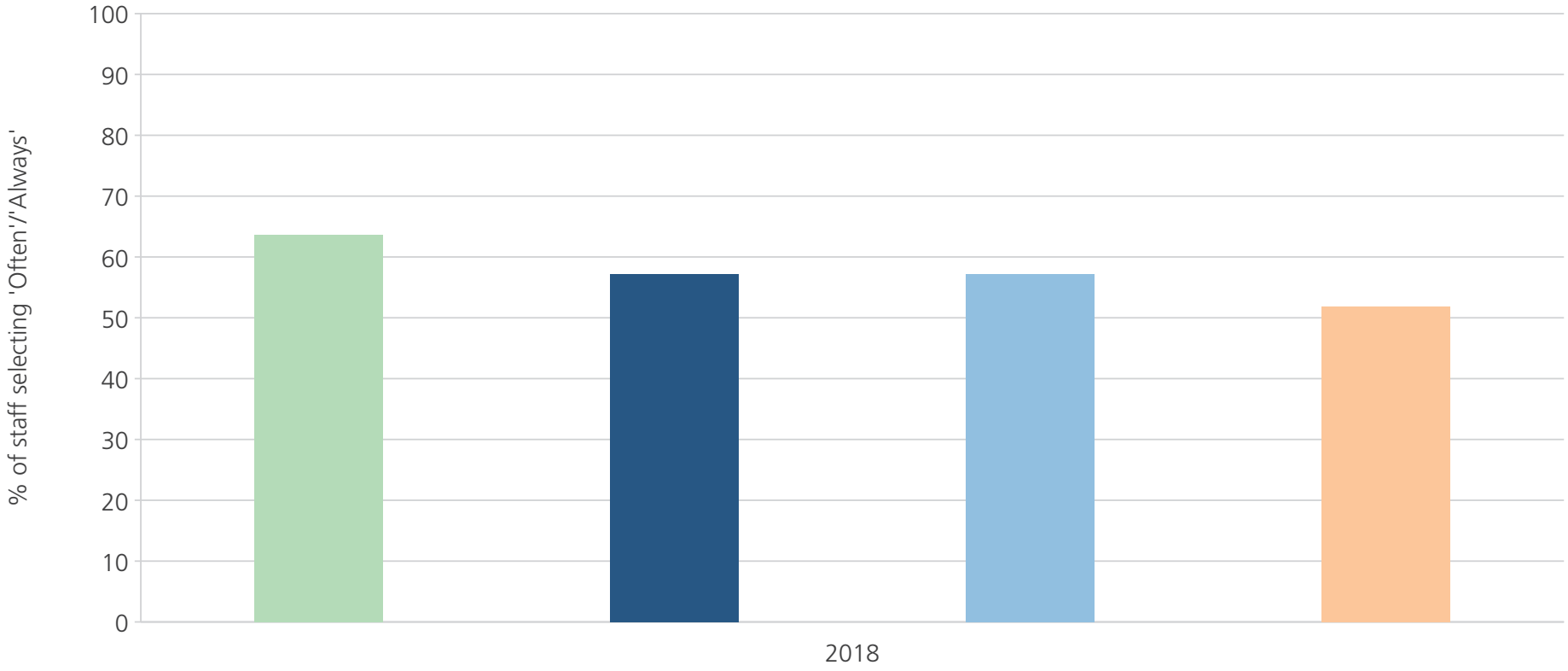
Best	46.2%	47.3%	46.6%	39.9%	47.2%
Your org	30.3%	36.8%	34.2%	35.8%	39.8%
Average	36.6%	38.1%	36.6%	33.7%	39.5%
Worst	29.0%	31.4%	30.3%	25.0%	29.7%
No. responses	1,119	927	1,126	1,726	1,965



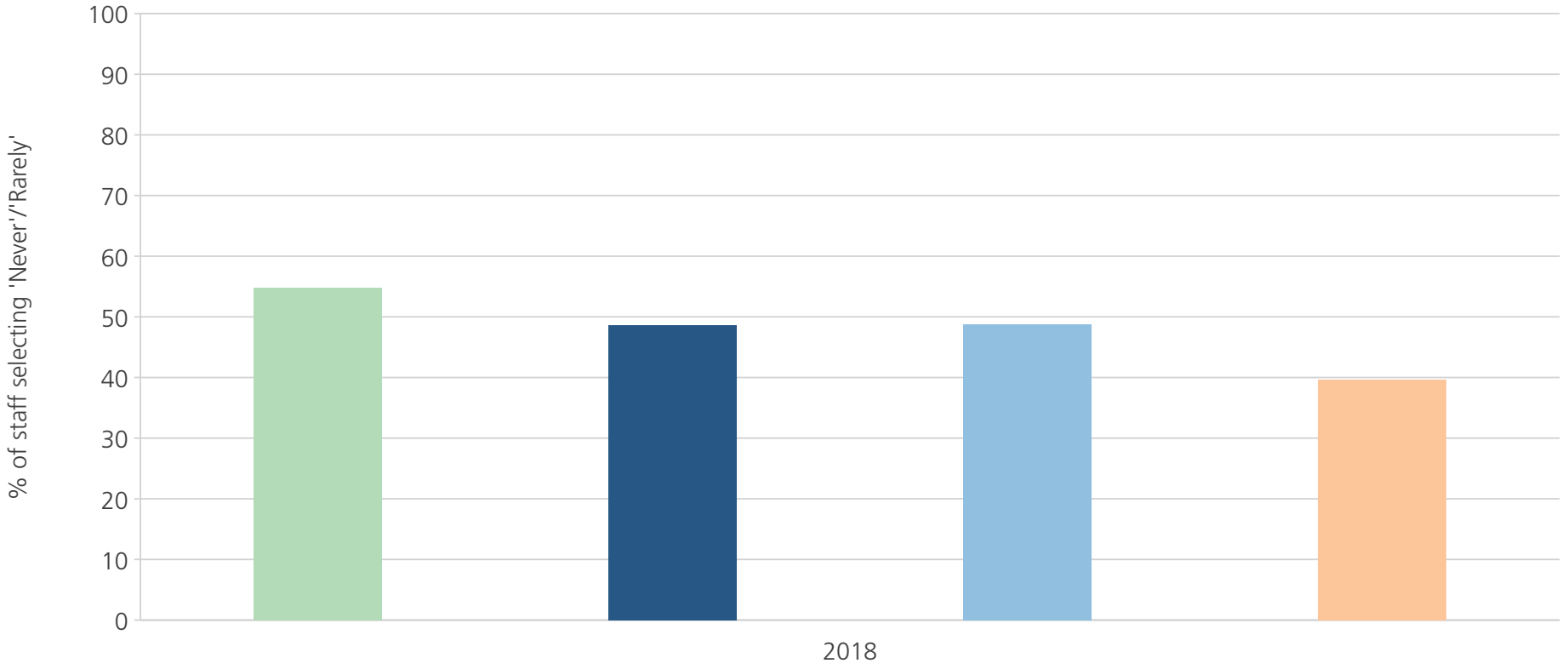
	2015	2016	2017	2018
Best	61.4%	59.4%	60.9%	66.6%
Your org	50.4%	51.9%	57.6%	59.4%
Average	52.9%	53.0%	54.1%	55.4%
Worst	48.7%	48.8%	47.3%	46.0%
No. responses	922	1,124	1,719	1,959



Best	31.2%
Your org	23.6%
Average	24.6%
Worst	19.5%
No. responses	1,924



Best	63.7%
Your org	57.2%
Average	57.1%
Worst	51.8%
No. responses	1,916

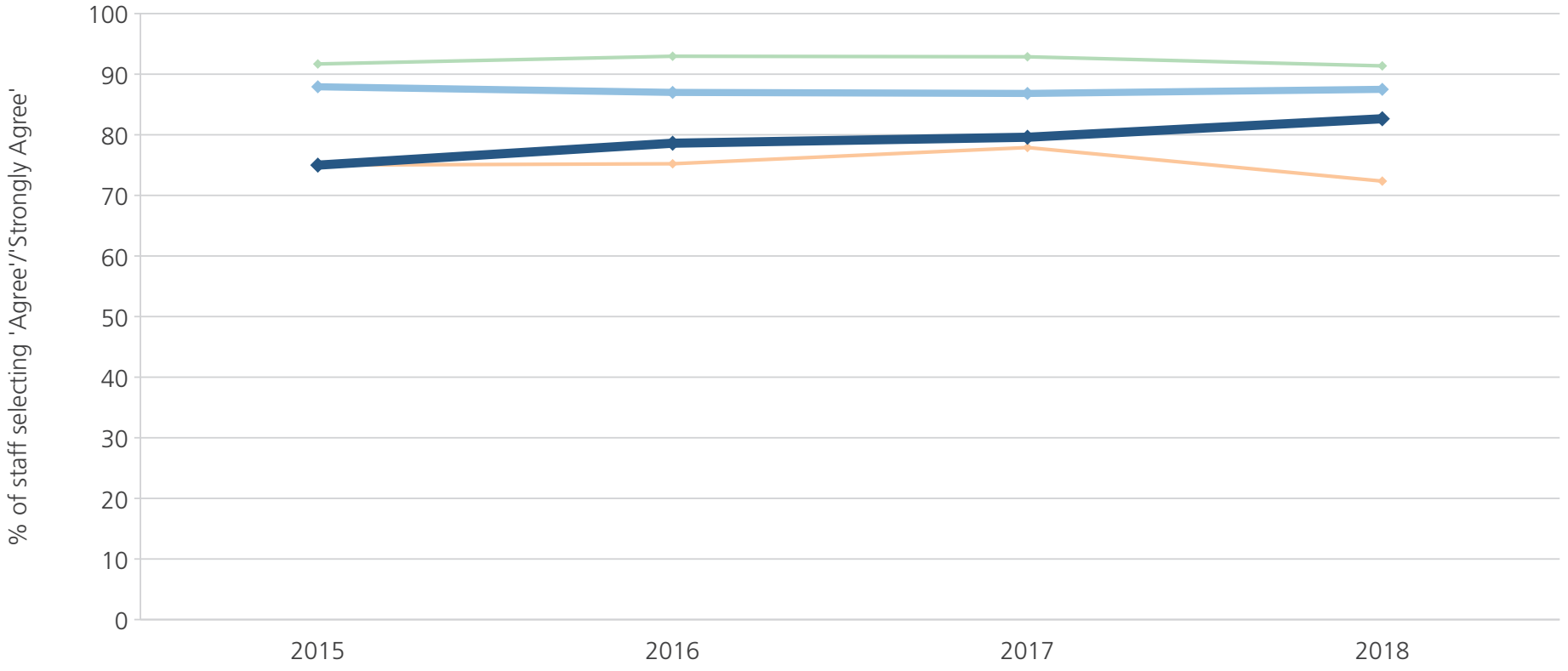


Best	54.8%
Your org	48.6%
Average	48.8%
Worst	39.7%
No. responses	1,920

Survey Coordination Centre

2018 NHS Staff Survey Results > Question results > Your job > Q7a
> I am satisfied with the quality of care I give to patients / service users

NHS England

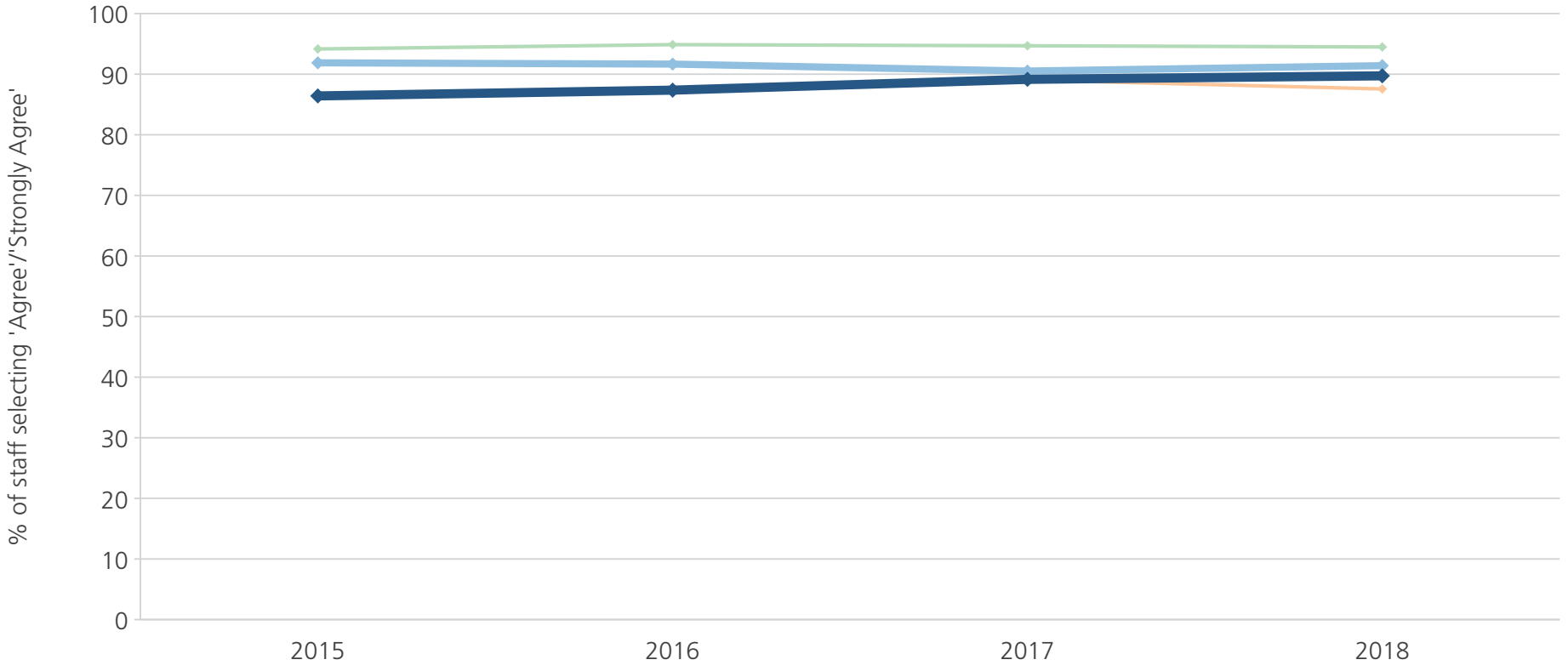


	2015	2016	2017	2018
Best	91.7%	93.0%	92.9%	91.4%
Your org	75.0%	78.6%	79.6%	82.6%
Average	87.9%	87.0%	86.8%	87.5%
Worst	75.0%	75.2%	77.9%	72.4%
No. responses	800	950	1,493	1,720

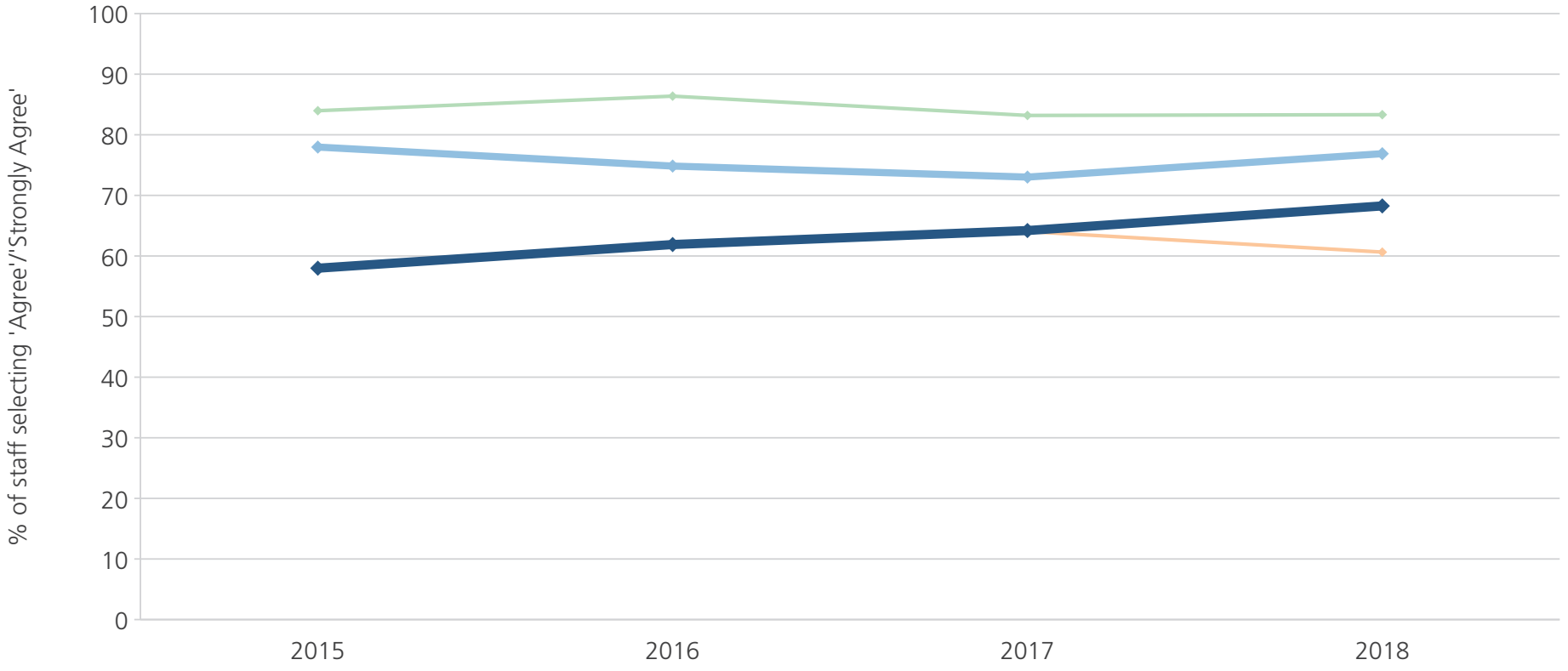
Survey Coordination Centre

2018 NHS Staff Survey Results > Question results > Your job >
Q7b > I feel that my role makes a difference to patients / service users

NHS England



	2015	2016	2017	2018
Best	94.2%	94.9%	94.7%	94.5%
Your org	86.4%	87.4%	89.1%	89.7%
Average	91.9%	91.7%	90.5%	91.4%
Worst	86.4%	87.4%	89.1%	87.6%
No. responses	861	1,042	1,625	1,858



	2015	2016	2017	2018
Best	84.0%	86.4%	83.2%	83.3%
Your org	58.0%	61.9%	64.2%	68.3%
Average	78.0%	74.8%	73.0%	76.9%
Worst	58.0%	61.8%	64.0%	60.6%
No. responses	777	945	1,498	1,705

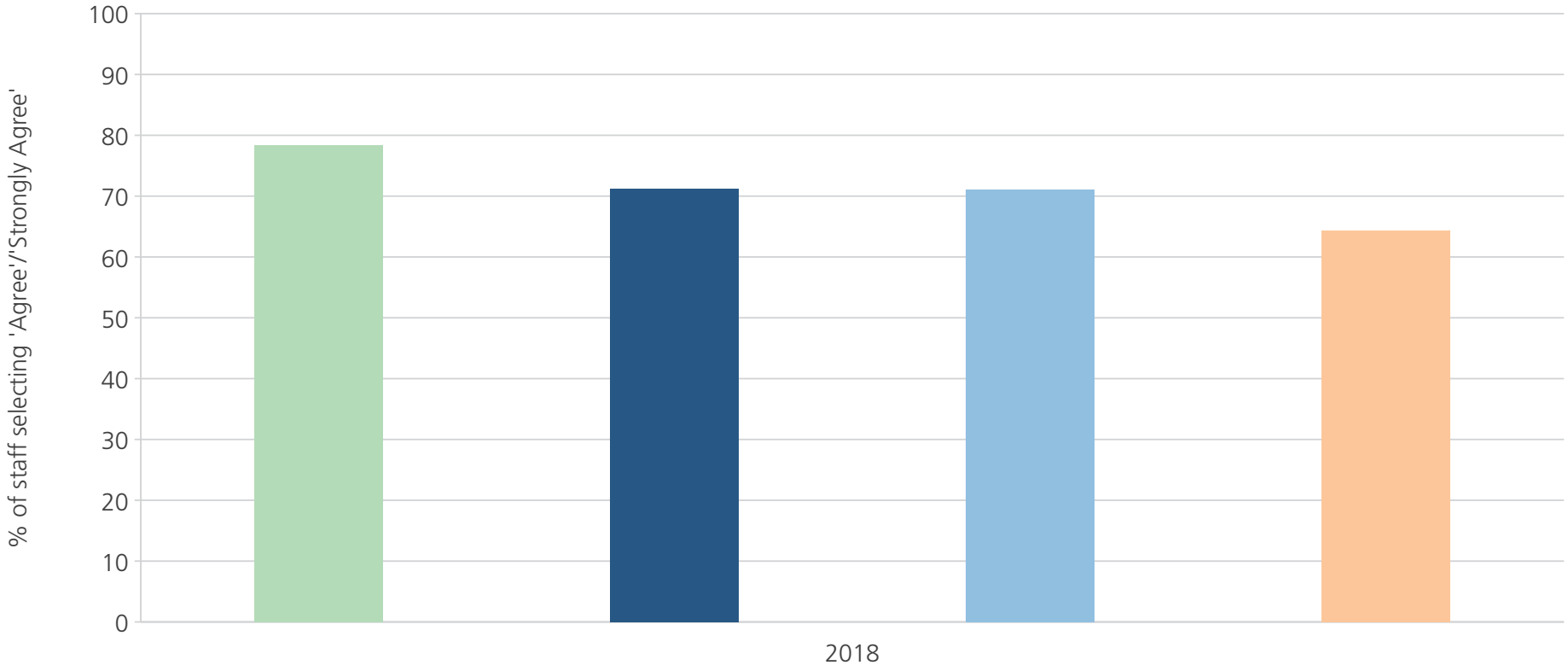
Survey Coordination Centre

NHS England

Question results – Your managers

Alder Hey Children's NHS Foundation Trust

2018 NHS Staff Survey Results

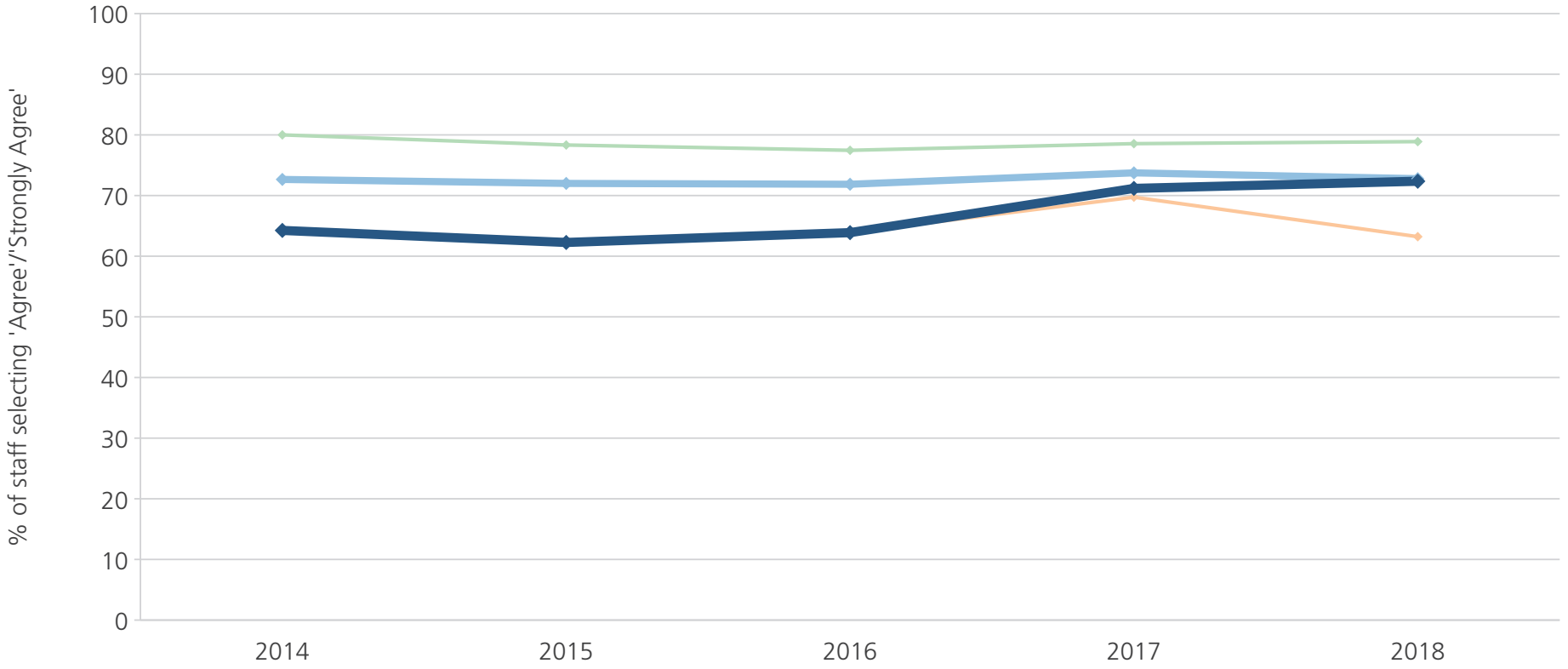


Best	78.4%
Your org	71.2%
Average	71.0%
Worst	64.4%
No. responses	1,985

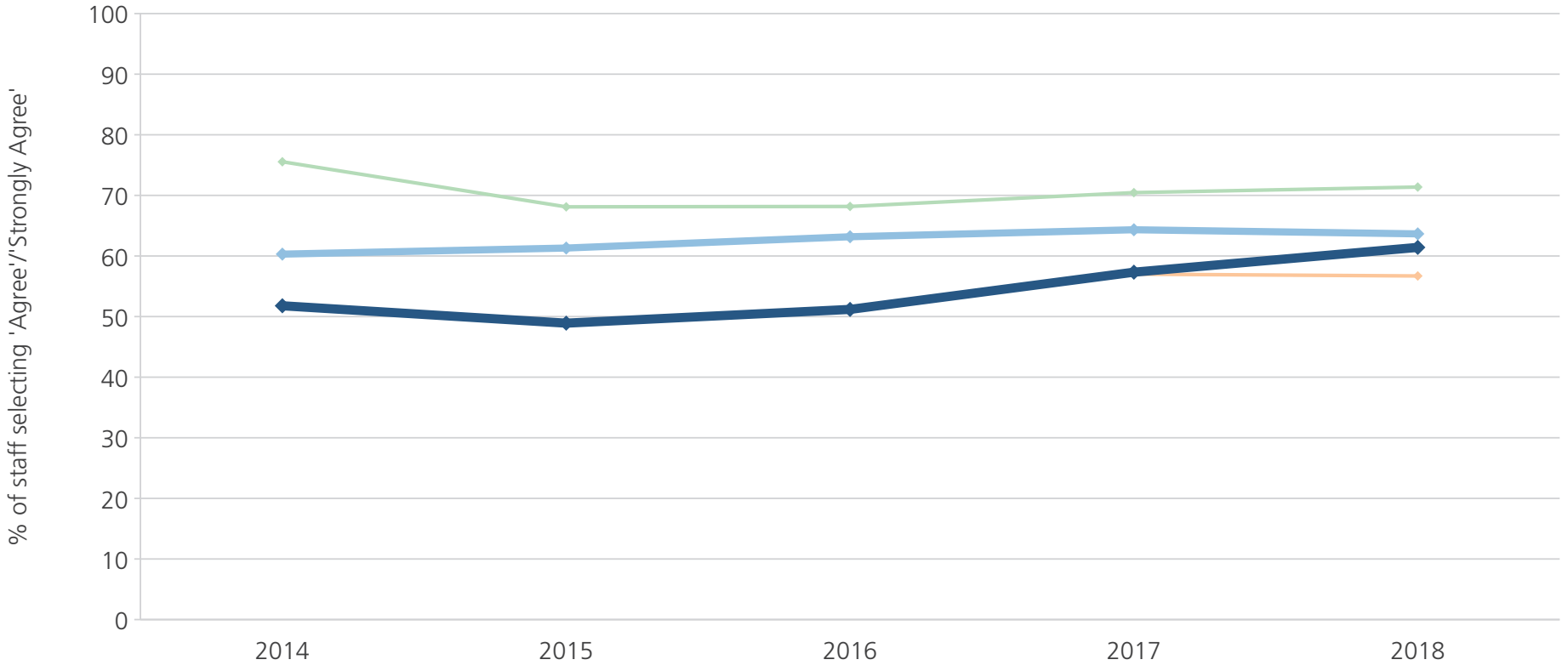
Survey Coordination Centre

2018 NHS Staff Survey Results > Question results > Your managers > Q8b **>**
My immediate manager can be counted on to help me with a difficult task at work

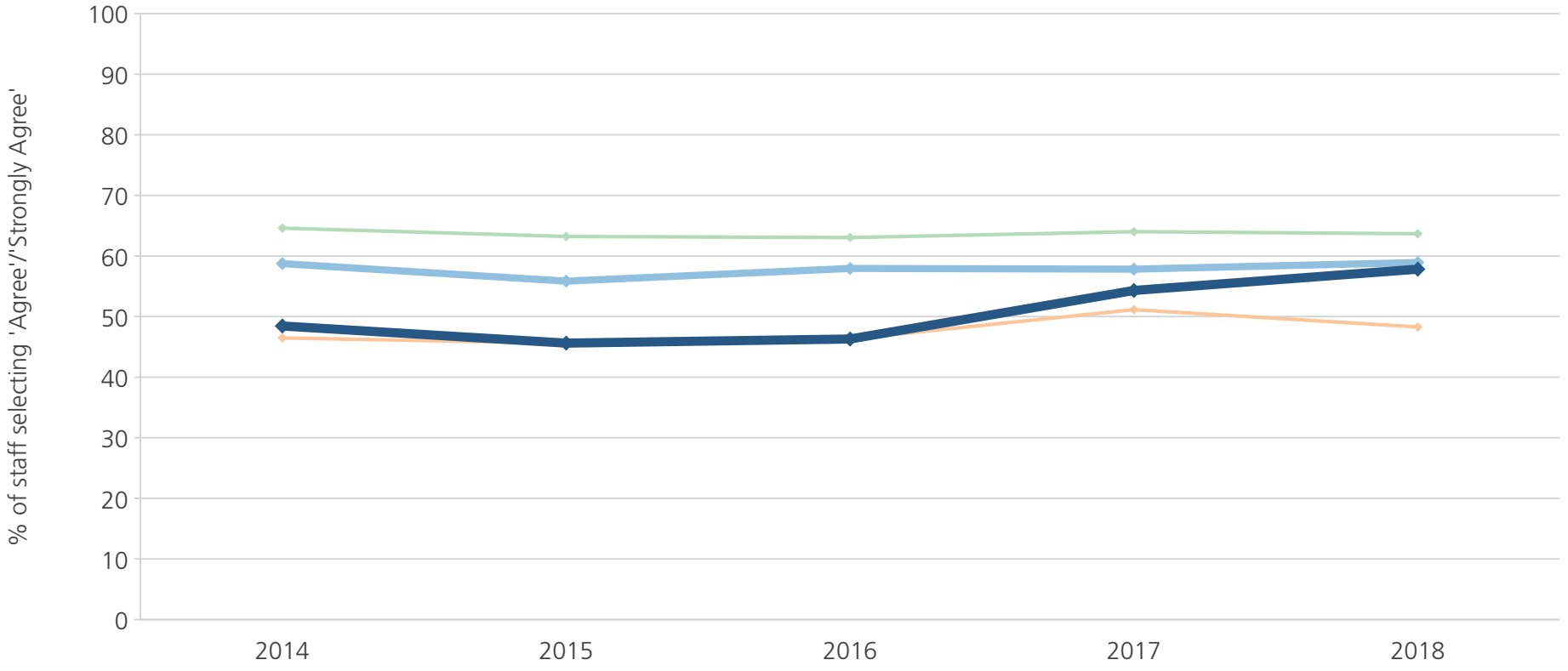
NHS England



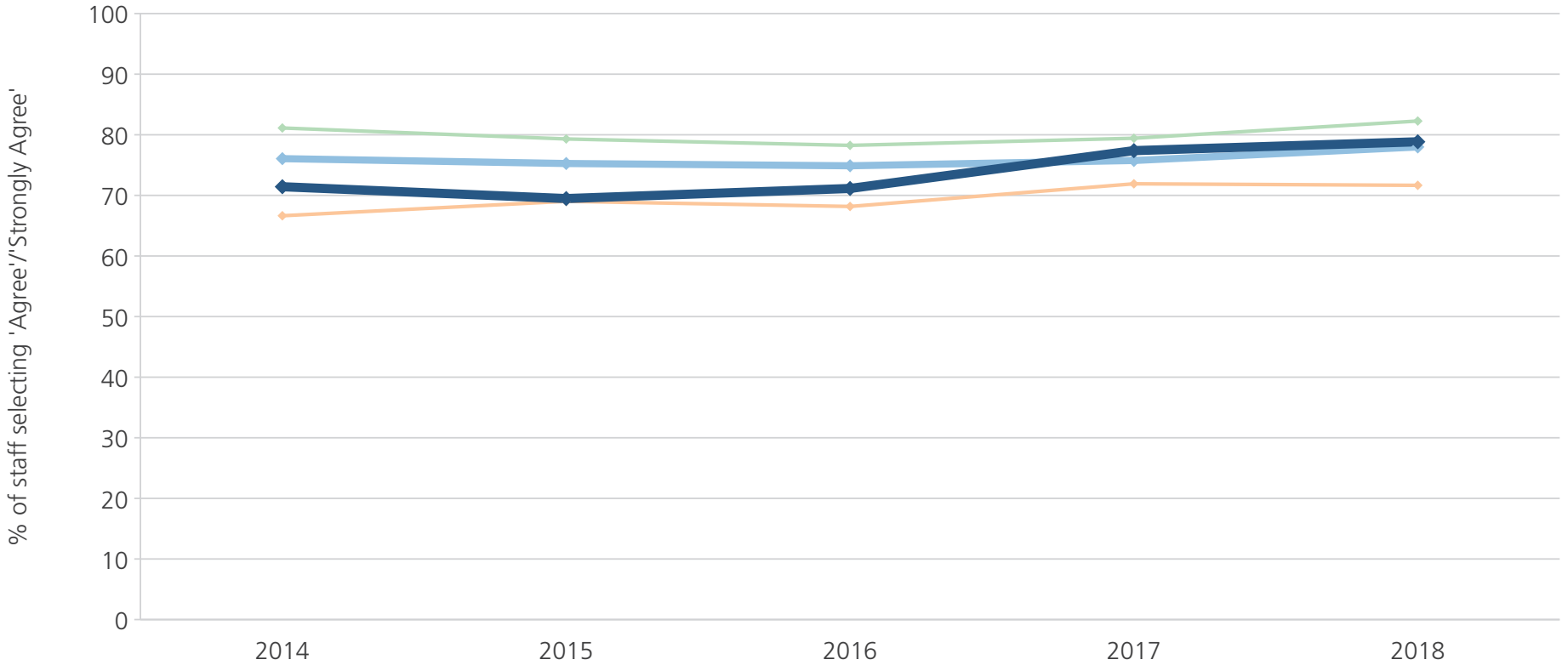
	2014	2015	2016	2017	2018
Best	80.0%	78.3%	77.5%	78.6%	78.9%
Your org	64.2%	62.3%	63.9%	71.2%	72.4%
Average	72.7%	72.0%	71.9%	73.7%	72.8%
Worst	64.2%	62.3%	63.9%	69.7%	63.2%
No. responses	1,109	926	1,130	1,736	1,978



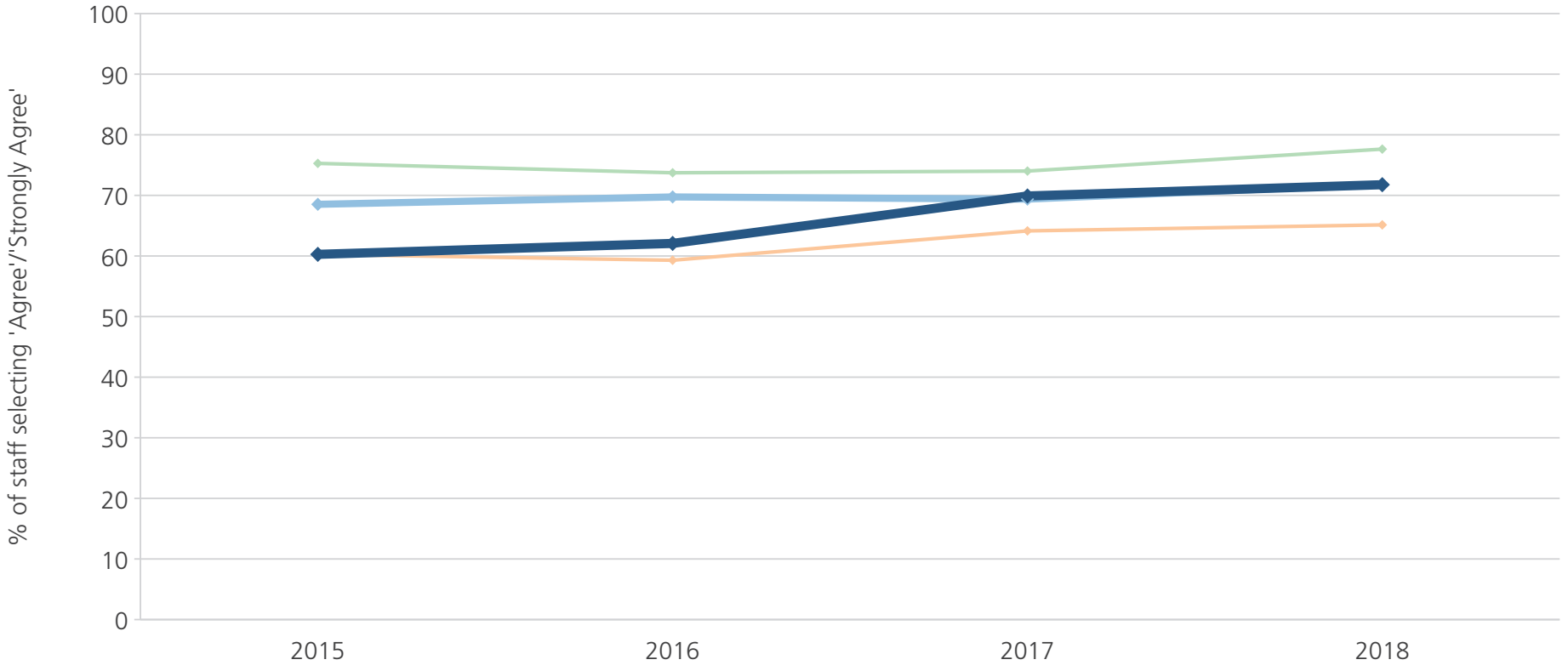
	2014	2015	2016	2017	2018
Best	75.5%	68.1%	68.2%	70.5%	71.4%
Your org	51.8%	48.9%	51.2%	57.3%	61.4%
Average	60.3%	61.3%	63.2%	64.3%	63.6%
Worst	51.8%	48.9%	51.2%	57.0%	56.7%
No. responses	1,110	926	1,128	1,732	1,972



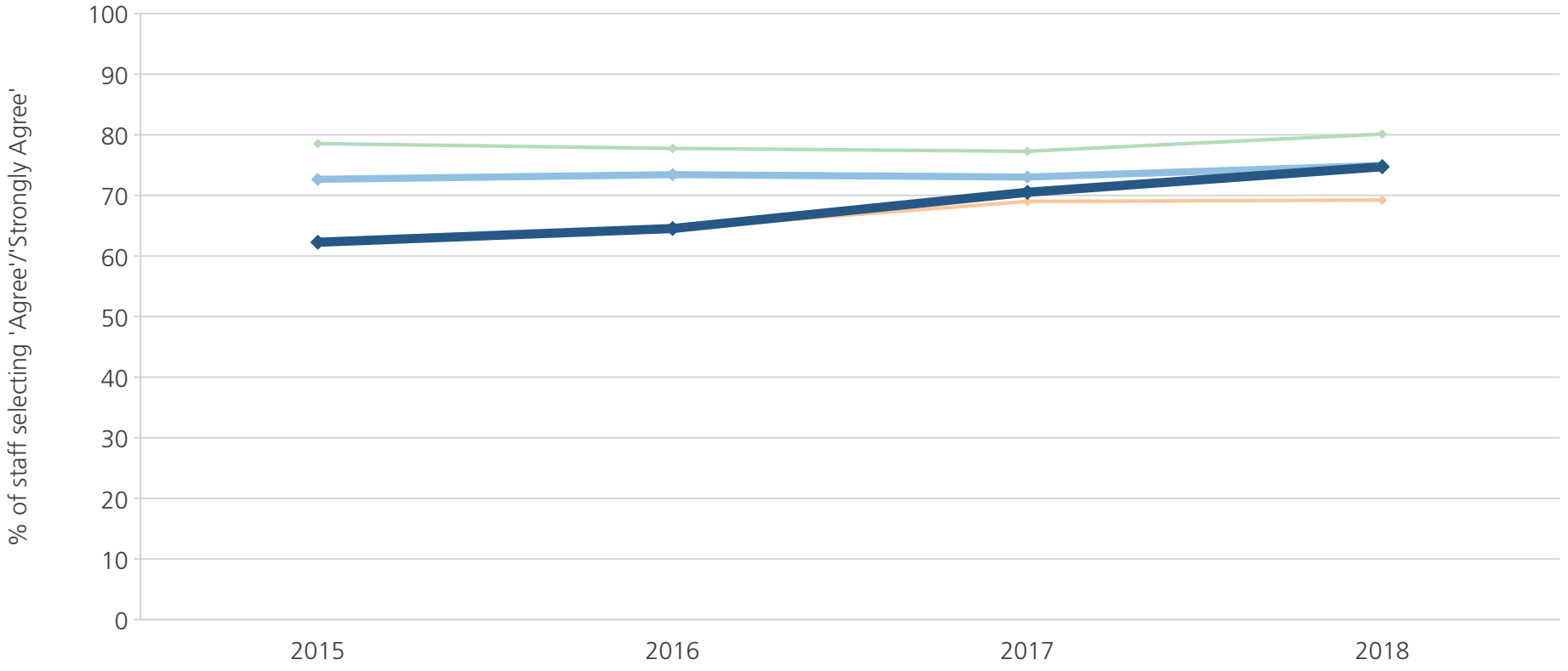
	2014	2015	2016	2017	2018
Best	64.6%	63.2%	63.0%	64.0%	63.7%
Your org	48.4%	45.6%	46.3%	54.3%	57.8%
Average	58.7%	55.8%	57.9%	57.8%	58.9%
Worst	46.5%	45.6%	46.3%	51.1%	48.3%
No. responses	1,107	923	1,125	1,735	1,978



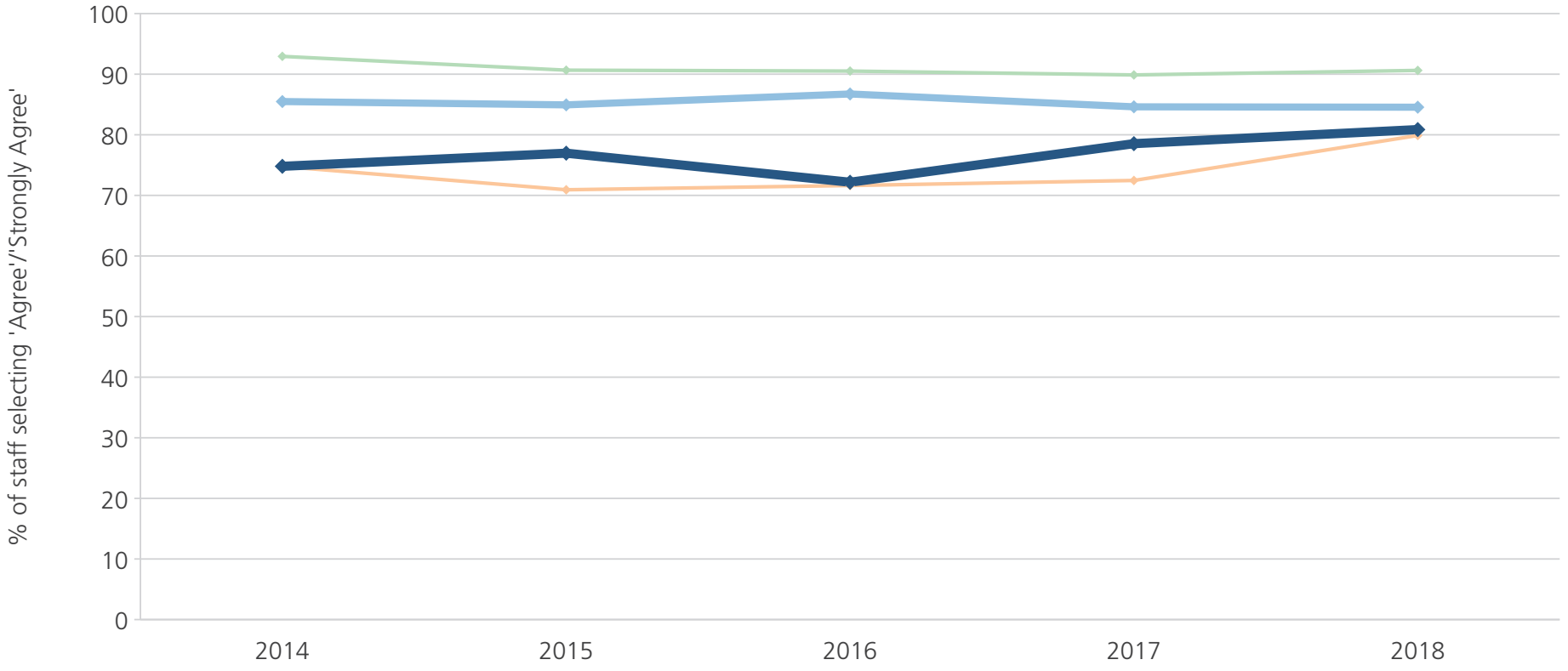
	2014	2015	2016	2017	2018
Best	81.1%	79.3%	78.3%	79.4%	82.3%
Your org	71.4%	69.5%	71.1%	77.4%	78.8%
Average	76.1%	75.3%	74.9%	75.8%	78.0%
Worst	66.6%	69.0%	68.2%	71.9%	71.7%
No. responses	1,106	925	1,129	1,729	1,974



	2015	2016	2017	2018
Best	75.3%	73.7%	74.0%	77.6%
Your org	60.3%	62.1%	69.9%	71.8%
Average	68.5%	69.7%	69.4%	71.9%
Worst	60.3%	59.3%	64.1%	65.1%
No. responses	925	1,128	1,730	1,974



	2015	2016	2017	2018
Best	78.5%	77.7%	77.3%	80.1%
Your org	62.3%	64.5%	70.5%	74.7%
Average	72.6%	73.4%	73.0%	74.9%
Worst	62.3%	64.5%	69.0%	69.2%
No. responses	927	1,126	1,734	1,975

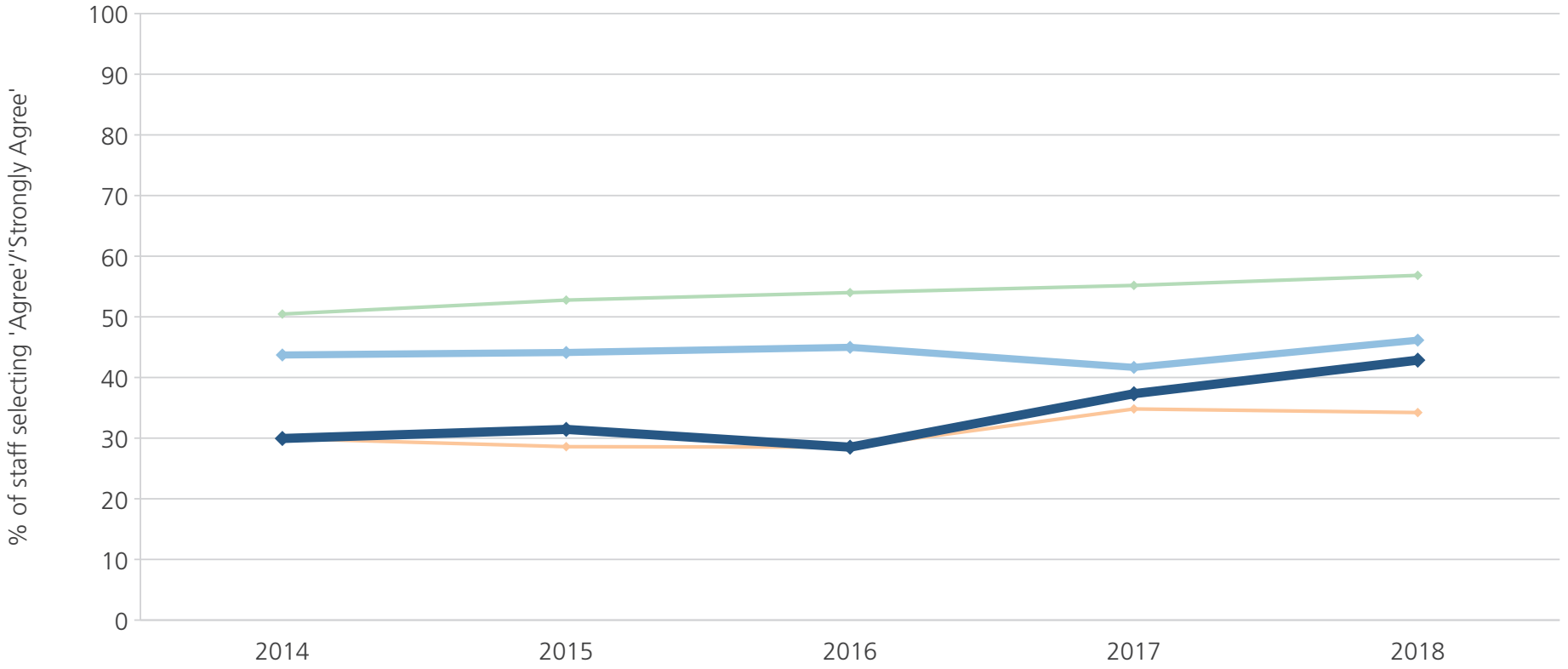


	2014	2015	2016	2017	2018
Best	92.9%	90.7%	90.5%	89.9%	90.6%
Your org	74.8%	77.0%	72.2%	78.5%	80.9%
Average	85.5%	84.9%	86.7%	84.6%	84.6%
Worst	74.8%	70.9%	71.6%	72.5%	79.9%
No. responses	1,110	927	1,127	1,741	1,987

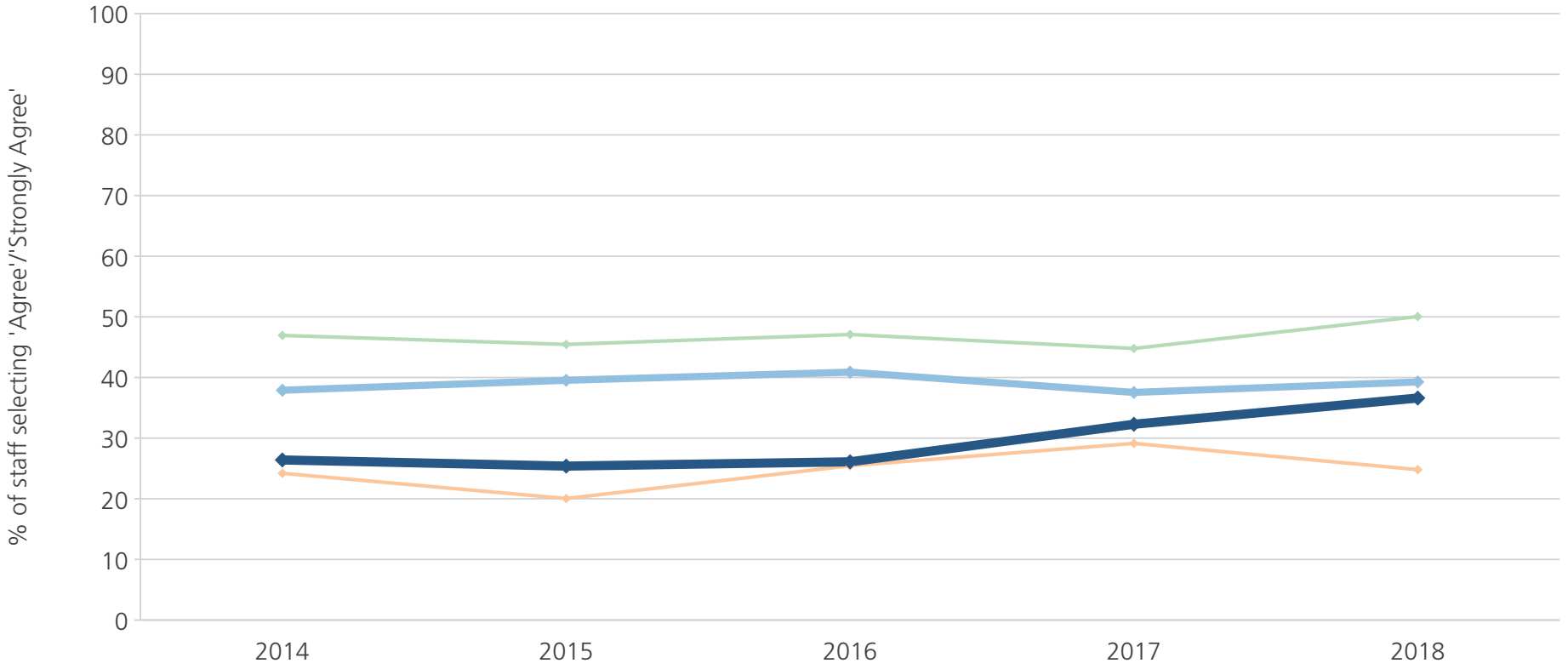
Survey Coordination Centre

2018 NHS Staff Survey Results > Question results > Your managers >
Q9b > Communication between senior management and staff is effective

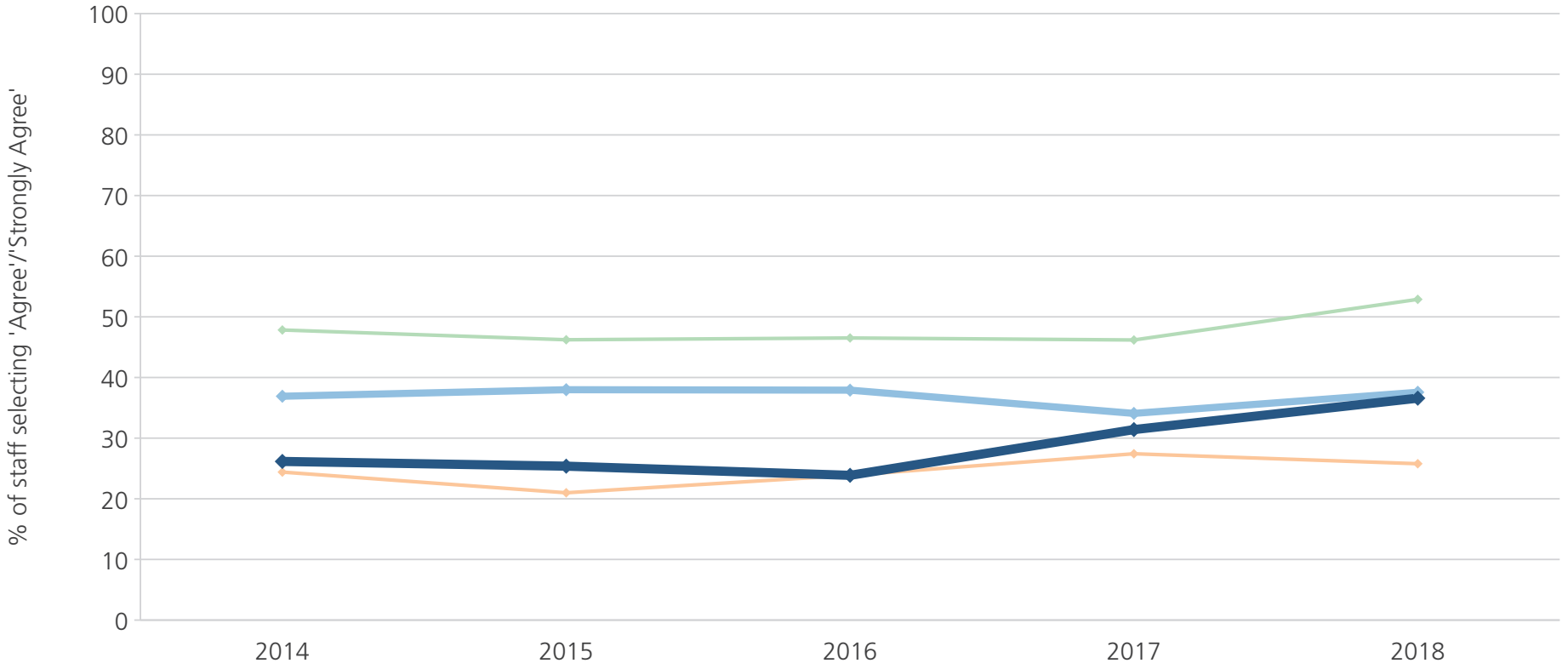
NHS England



	2014	2015	2016	2017	2018
Best	50.5%	52.8%	54.0%	55.2%	56.8%
Your org	29.9%	31.4%	28.5%	37.3%	42.9%
Average	43.7%	44.1%	45.0%	41.7%	46.2%
Worst	29.9%	28.6%	28.5%	34.8%	34.2%
No. responses	1,105	929	1,130	1,735	1,984



	2014	2015	2016	2017	2018
Best	46.9%	45.5%	47.1%	44.8%	50.0%
Your org	26.4%	25.4%	26.1%	32.3%	36.6%
Average	37.9%	39.5%	40.9%	37.5%	39.3%
Worst	24.2%	20.0%	25.4%	29.1%	24.8%
No. responses	1,108	928	1,127	1,735	1,980



	2014	2015	2016	2017	2018
Best	47.8%	46.2%	46.5%	46.2%	52.9%
Your org	26.2%	25.4%	23.9%	31.4%	36.6%
Average	36.9%	38.0%	37.9%	34.1%	37.6%
Worst	24.4%	21.0%	23.9%	27.4%	25.8%
No. responses	1,106	926	1,126	1,731	1,973

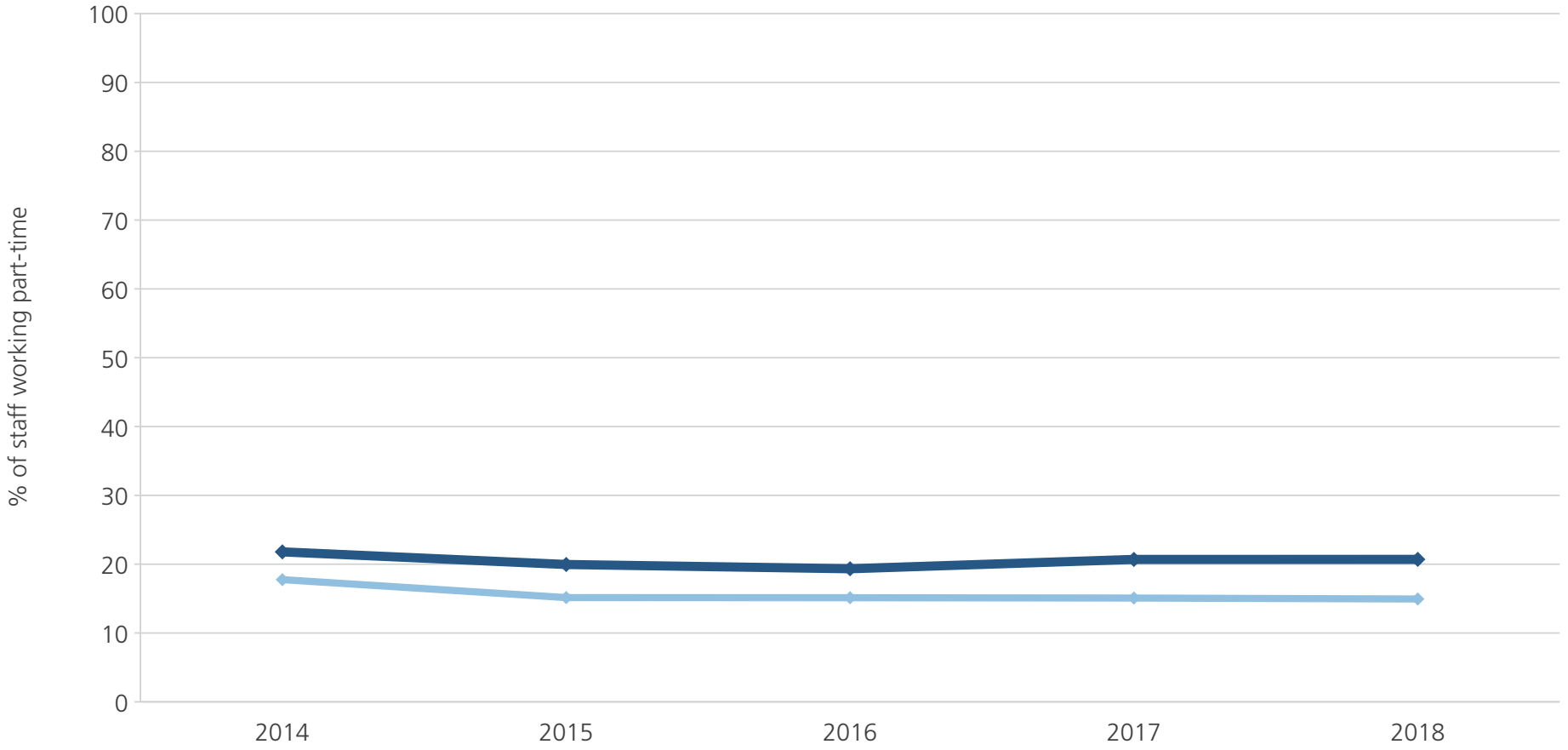
Survey Coordination Centre

NHS England

Question results – Your health, well-being and safety at work

Alder Hey Children's NHS Foundation Trust

2018 NHS Staff Survey Results

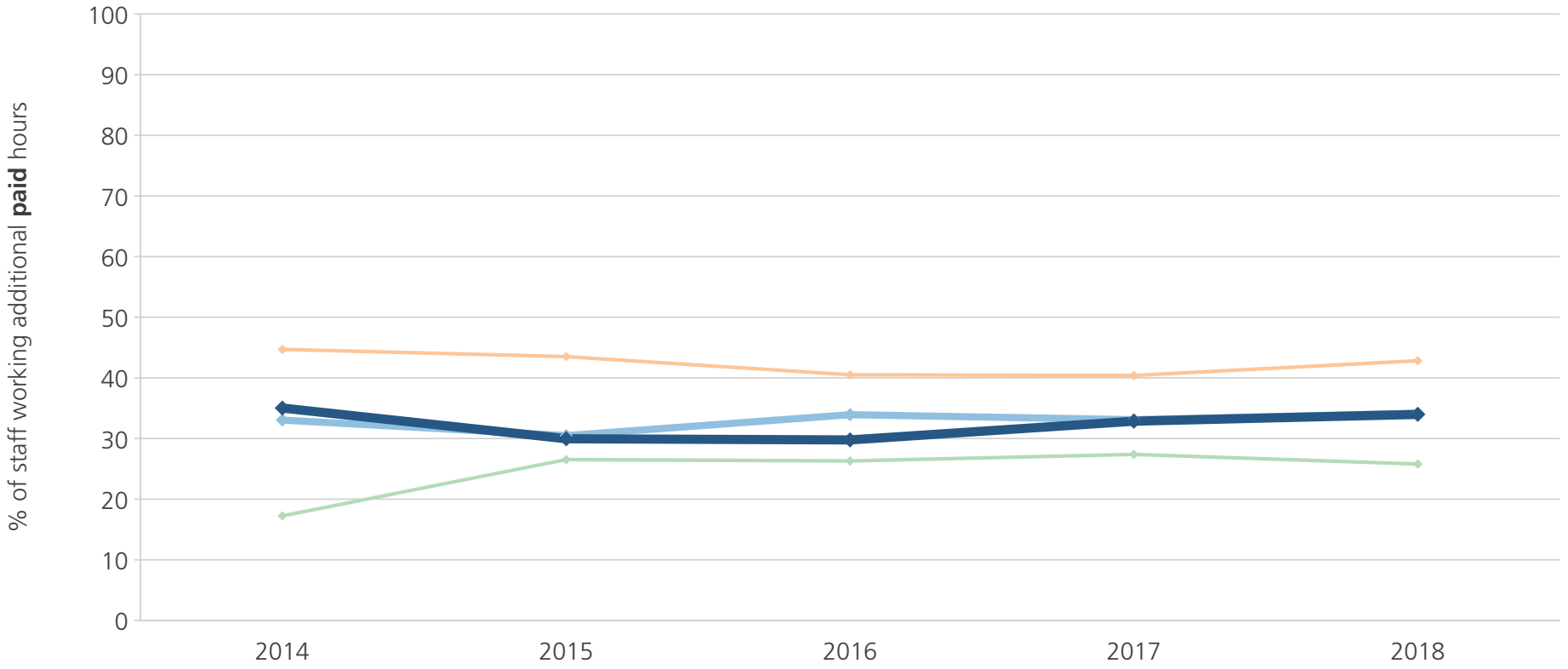


	2014	2015	2016	2017	2018
Your org	21.8%	20.0%	19.3%	20.7%	20.7%
Average	17.8%	15.1%	15.1%	15.1%	14.9%
No. responses	1,106	927	1,117	1,701	1,855

Survey Coordination Centre

2018 NHS Staff Survey Results > Question results > Your health, well-being and safety at work > Q10b **>** On average, how many additional PAID hours do you work per week for this organisation, over and above your contracted hours?

NHS England

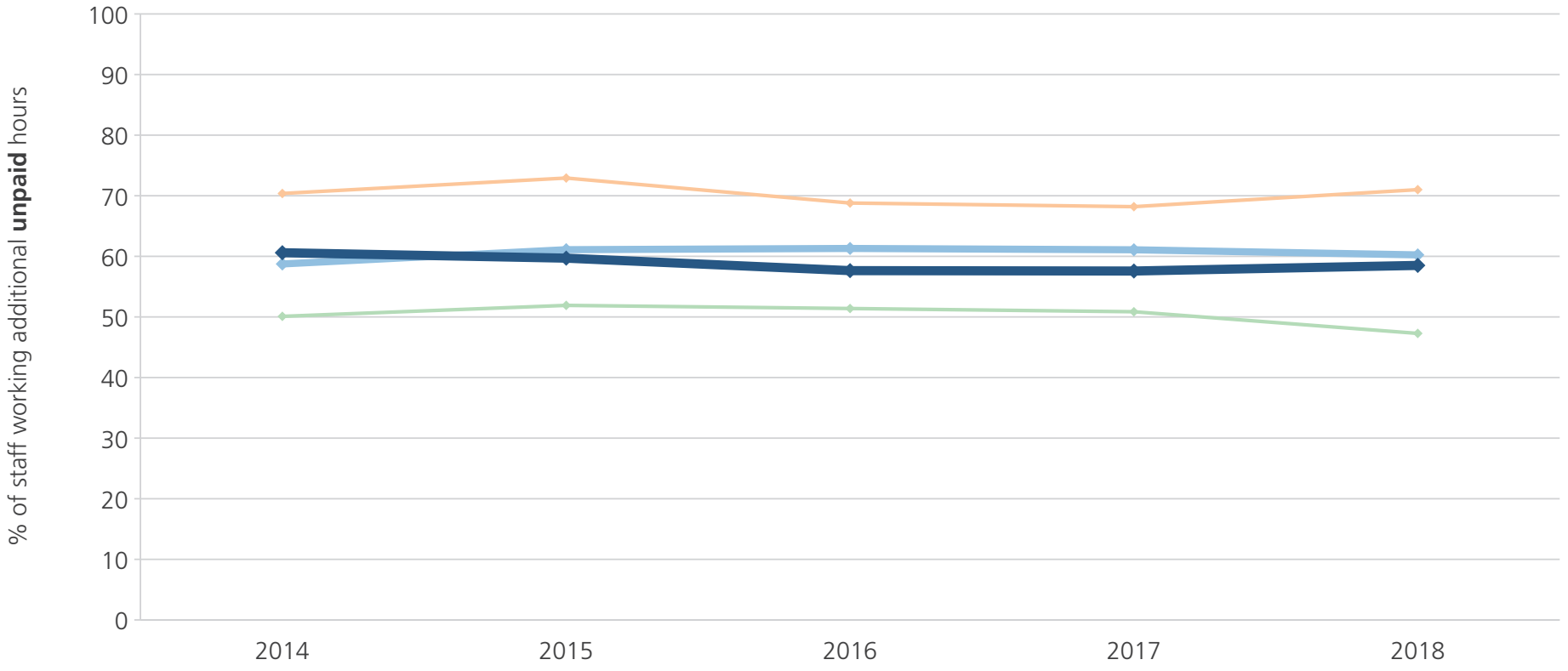


	2014	2015	2016	2017	2018
Worst	44.7%	43.5%	40.5%	40.4%	42.8%
Your org	35.0%	30.0%	29.8%	32.8%	34.0%
Average	33.0%	30.5%	33.9%	33.1%	34.2%
Best	17.2%	26.5%	26.3%	27.4%	25.8%
No. responses	1,080	881	1,079	1,663	1,904

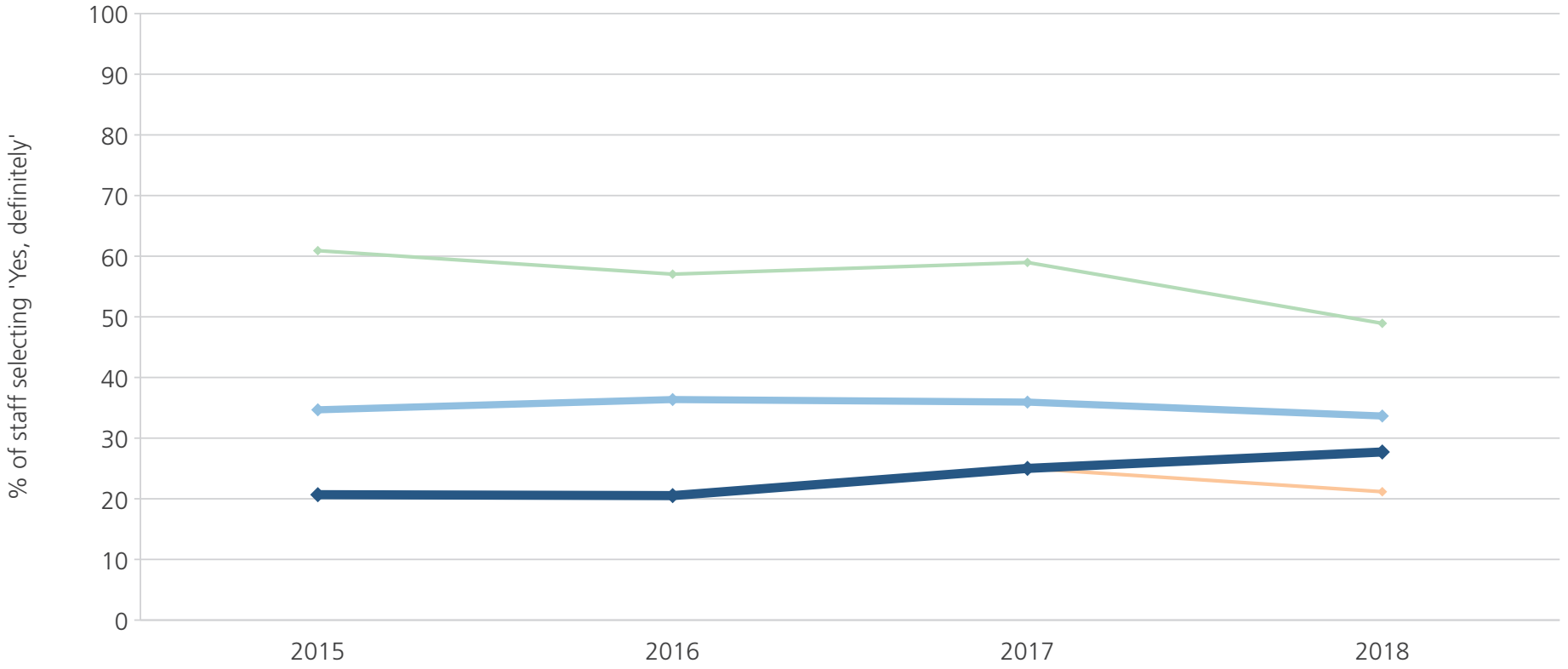
Survey Coordination Centre

2018 NHS Staff Survey Results > Question results > Your health, well-being and safety at work > Q10c **>** On average, how many additional UNPAID hours do you work per week for this organisation, over and above your contracted hours?

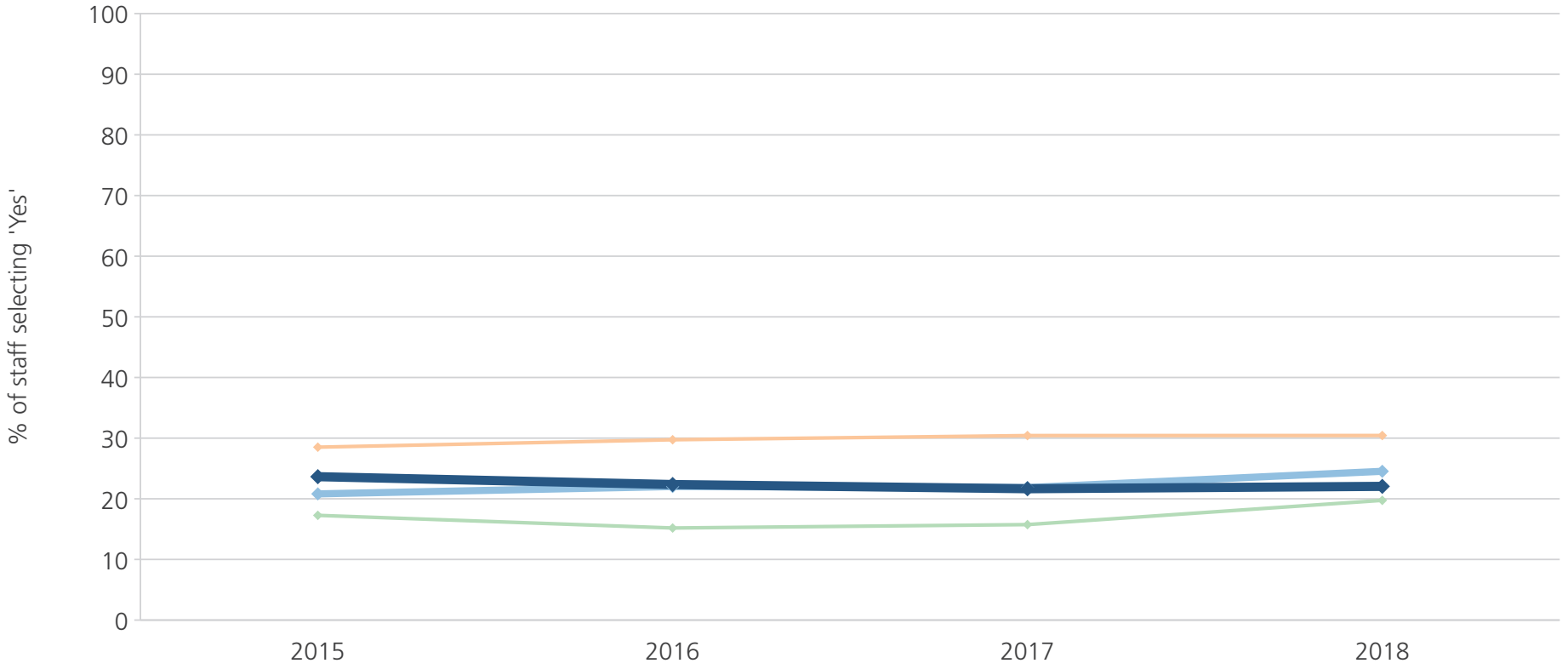
NHS England



	2014	2015	2016	2017	2018
Worst	70.4%	72.9%	68.8%	68.2%	71.0%
Your org	60.6%	59.7%	57.6%	57.6%	58.5%
Average	58.7%	61.1%	61.3%	61.1%	60.2%
Best	50.1%	51.9%	51.4%	50.9%	47.3%
No. responses	1,061	897	1,077	1,662	1,909



	2015	2016	2017	2018
Best	60.9%	57.0%	59.0%	48.9%
Your org	20.7%	20.5%	25.0%	27.7%
Average	34.7%	36.4%	35.9%	33.6%
Worst	20.7%	20.5%	25.0%	21.2%
No. responses	923	1,121	1,726	1,949

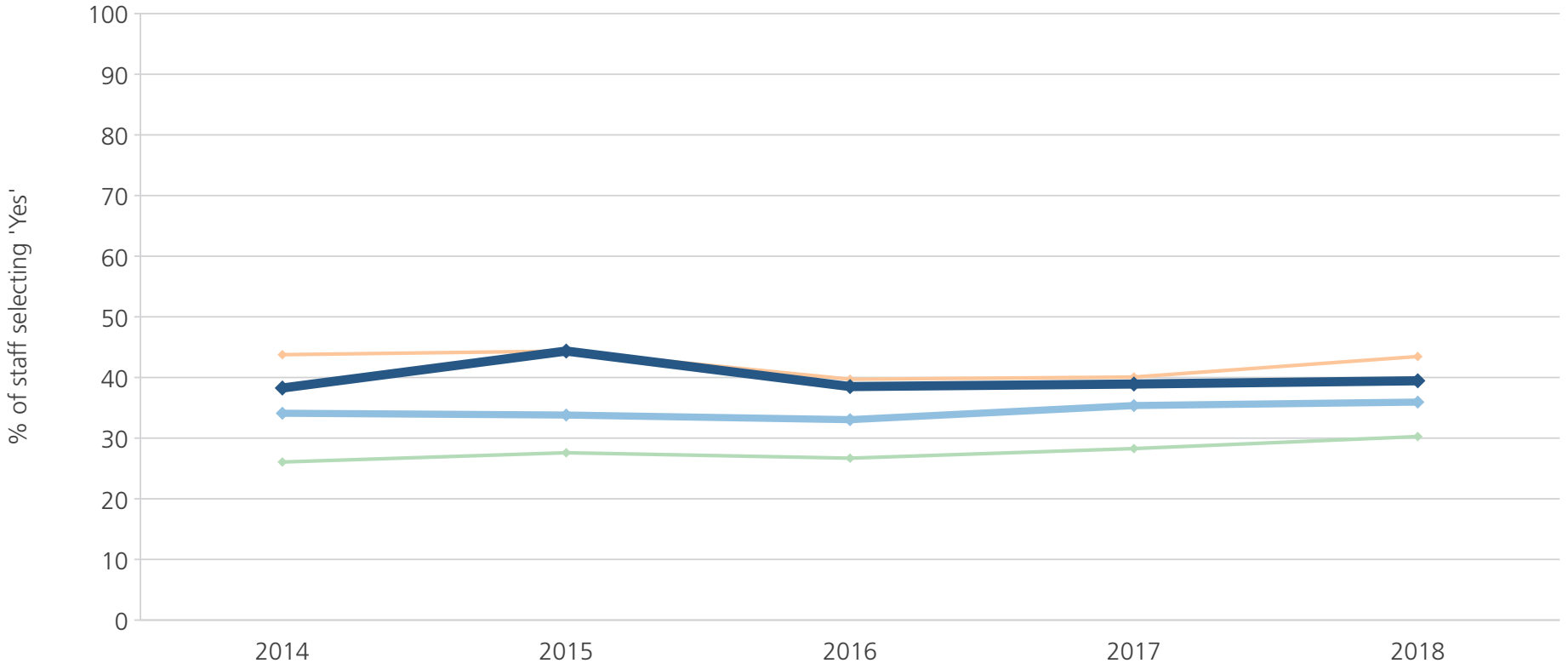


	2015	2016	2017	2018
Worst	28.5%	29.7%	30.4%	30.4%
Your org	23.6%	22.3%	21.7%	22.0%
Average	20.8%	22.0%	21.8%	24.5%
Best	17.3%	15.2%	15.7%	19.7%
No. responses	925	1,124	1,732	1,969

Survey Coordination Centre

2018 NHS Staff Survey Results > Question results > Your health, well-being and safety at work > Q11c **>** During the last 12 months have you felt unwell as a result of work related stress?

NHS England

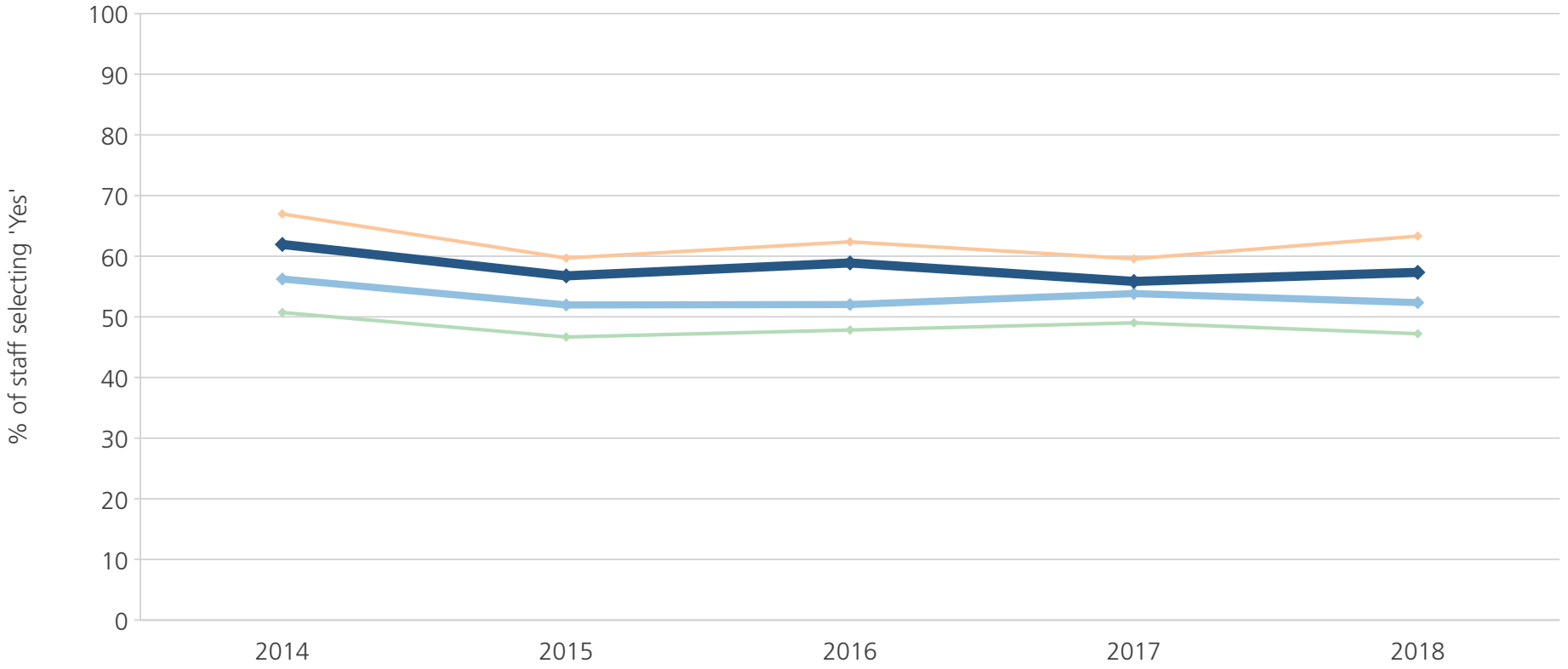


	2014	2015	2016	2017	2018
Worst	43.8%	44.4%	39.7%	40.1%	43.5%
Your org	38.3%	44.4%	38.5%	38.9%	39.5%
Average	34.1%	33.8%	33.0%	35.4%	35.9%
Best	26.1%	27.6%	26.7%	28.3%	30.3%
No. responses	1,089	927	1,128	1,738	1,966

Survey Coordination Centre

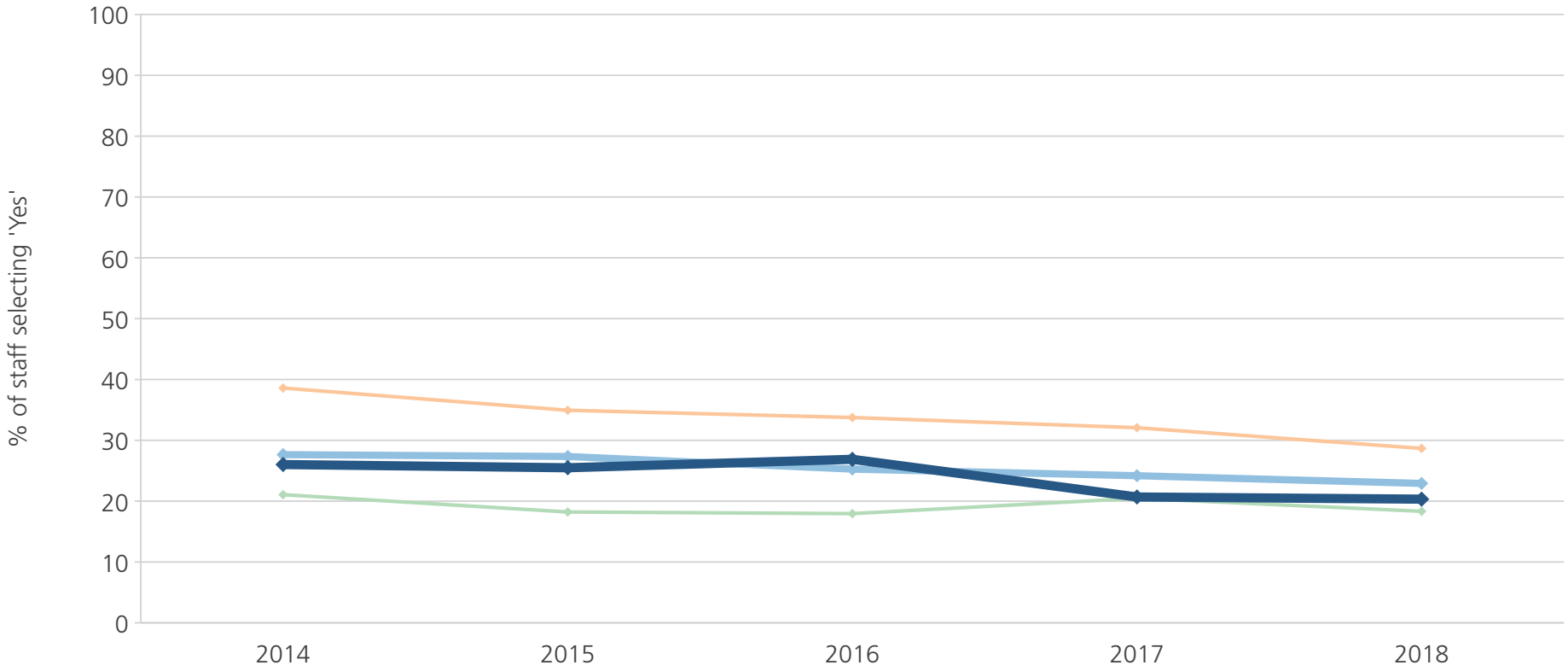
2018 NHS Staff Survey Results > Question results > Your health, well-being and safety at work > Q11d
> In the last three months have you ever come to work despite not feeling well enough to perform your duties?

NHS England



	2014	2015	2016	2017	2018
Worst	67.0%	59.7%	62.4%	59.6%	63.3%
Your org	61.9%	56.8%	58.9%	55.8%	57.3%
Average	56.2%	52.0%	52.0%	53.8%	52.3%
Best	50.7%	46.7%	47.8%	49.0%	47.2%
No. responses	1,060	923	1,125	1,737	1,971

Note: This question was only answered by staff who selected 'Yes' on q11d.



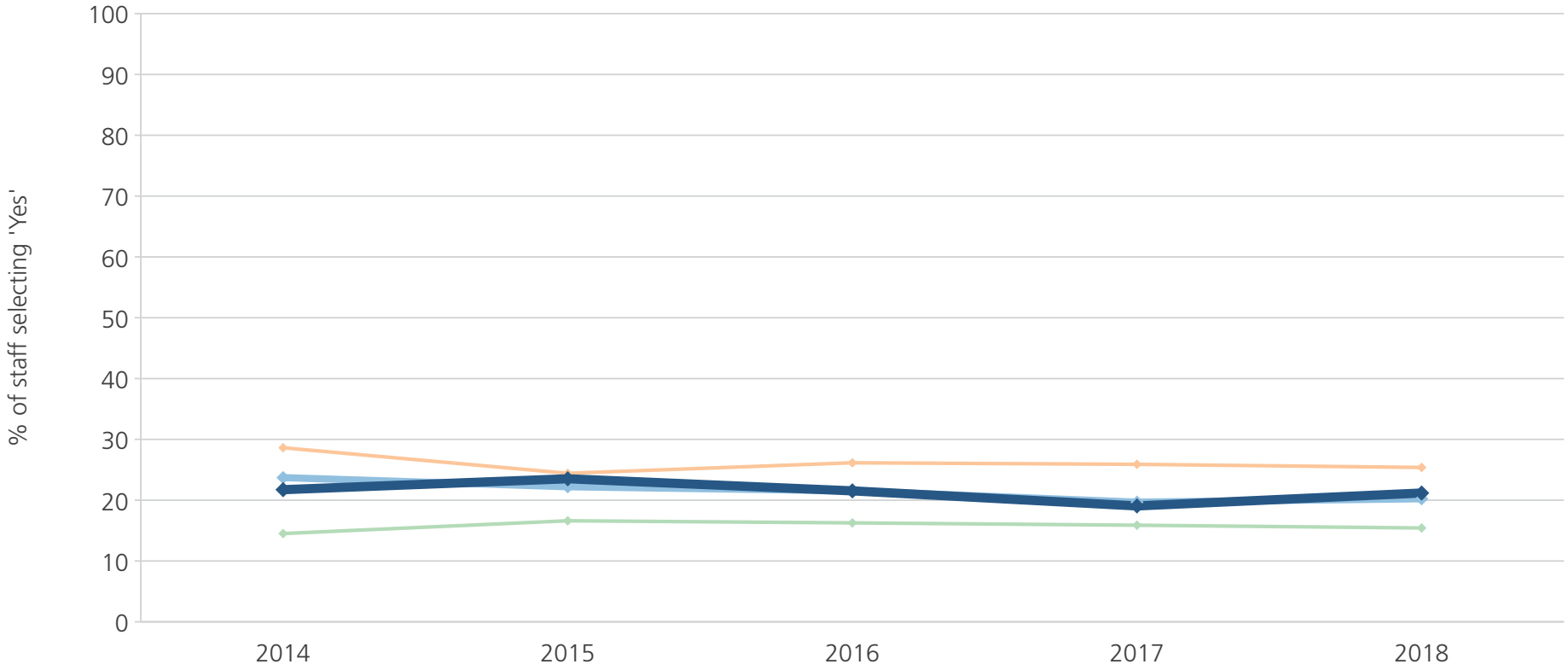
	2014	2015	2016	2017	2018
Worst	38.6%	34.9%	33.7%	32.1%	28.7%
Your org	26.0%	25.5%	26.9%	20.7%	20.3%
Average	27.6%	27.3%	25.3%	24.2%	22.9%
Best	21.1%	18.2%	17.9%	20.5%	18.3%
No. responses	646	512	650	946	1,098

Survey Coordination Centre

2018 NHS Staff Survey Results > Question results > Your health, well-being and safety at work > Q11f **>** Have you felt pressure from colleagues to come to work?

NHS England

Note: This question was only answered by staff who selected 'Yes' on q11d.



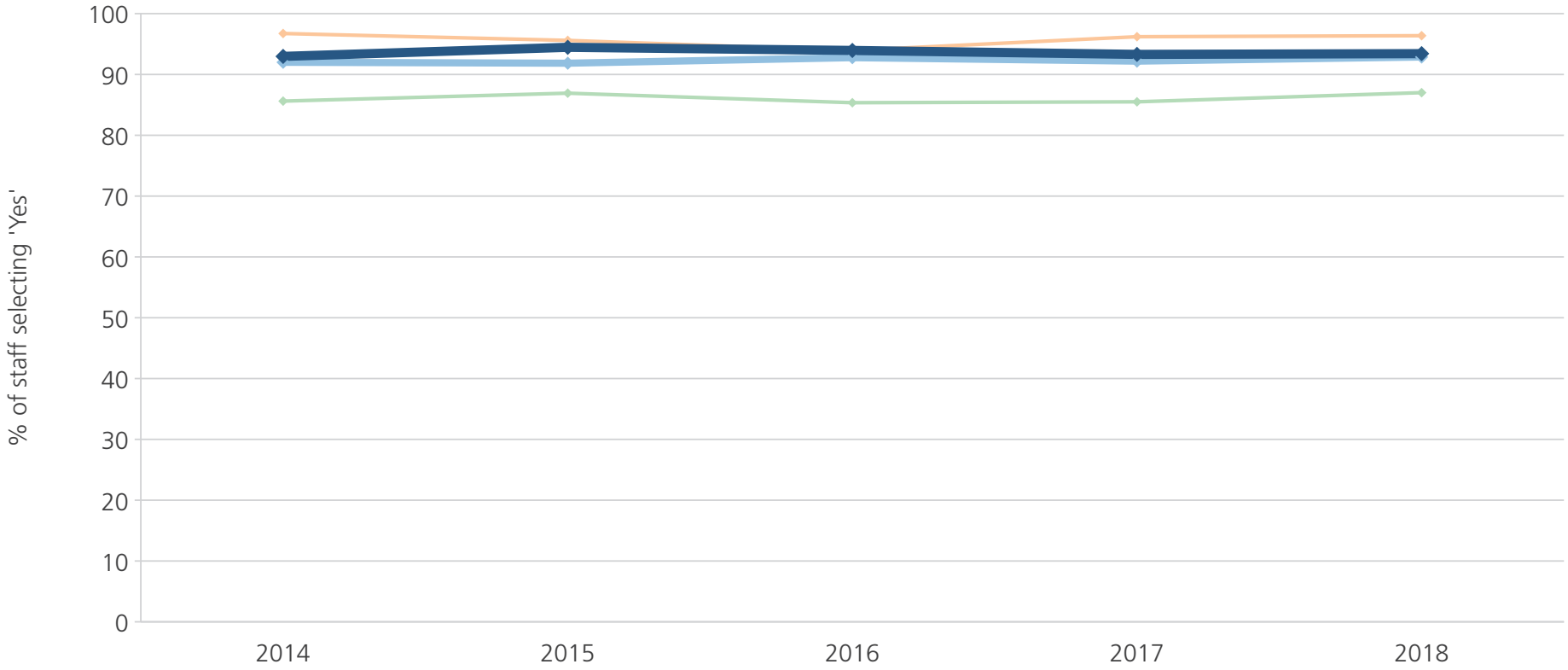
	2014	2015	2016	2017	2018
Worst	28.6%	24.4%	26.1%	25.9%	25.4%
Your org	21.7%	23.5%	21.5%	19.1%	21.2%
Average	23.7%	22.2%	21.5%	19.7%	20.2%
Best	14.5%	16.6%	16.3%	15.9%	15.4%
No. responses	646	512	649	943	1,094

Survey Coordination Centre

2018 NHS Staff Survey Results > Question results > Your health, well-being and safety at work > Q11g **>** Have you put yourself under pressure to come to work?

NHS England

Note: This question was only answered by staff who selected 'Yes' on q11d.

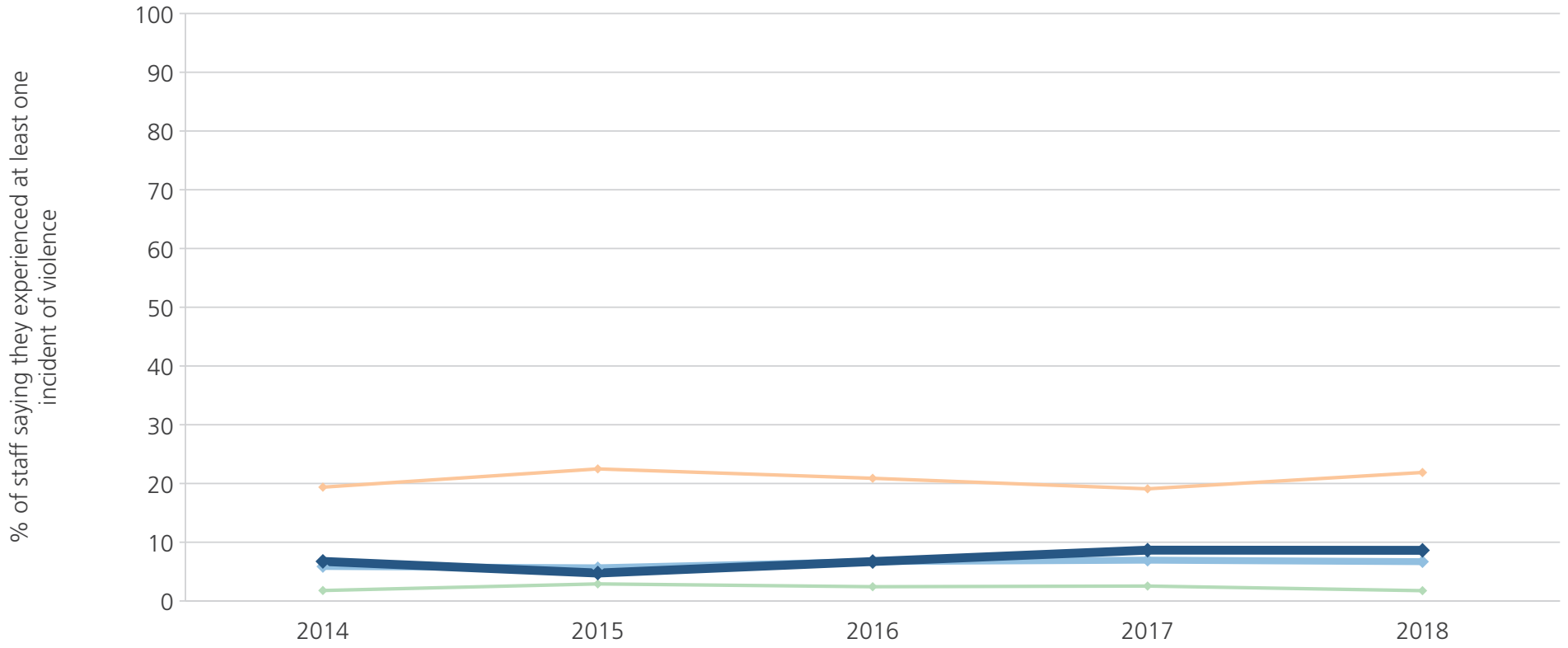


	2014	2015	2016	2017	2018
Worst	96.7%	95.6%	93.9%	96.2%	96.4%
Your org	93.0%	94.5%	93.9%	93.3%	93.4%
Average	92.0%	91.9%	92.8%	92.2%	92.9%
Best	85.6%	86.9%	85.4%	85.5%	87.0%
No. responses	652	516	656	955	1,097

Survey Coordination Centre

2018 NHS Staff Survey Results > Question results > Your health, well-being and safety at work > Q12a **>** In the last 12 months how many times have you personally experienced physical violence at work from patients / service users, their relatives or other members of the public?

NHS England

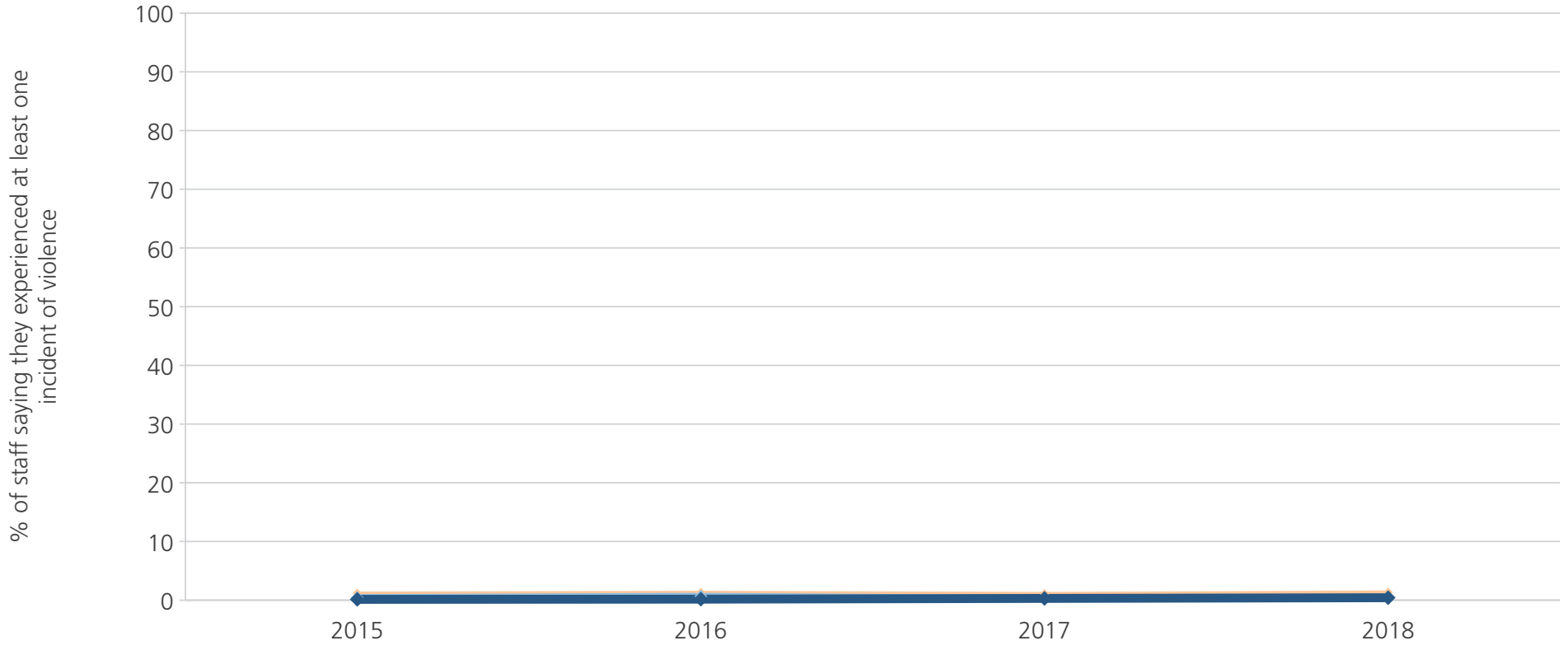


	2014	2015	2016	2017	2018
Worst	19.4%	22.5%	20.9%	19.1%	21.9%
Your org	6.7%	4.8%	6.7%	8.7%	8.6%
Average	5.9%	5.6%	6.7%	6.9%	6.7%
Best	1.8%	2.9%	2.4%	2.5%	1.8%
No. responses	1,110	928	1,115	1,731	1,952

Survey Coordination Centre

2018 NHS Staff Survey Results > Question results > Your health, well-being and safety at work > Q12b **>**
In the last 12 months how many times have you personally experienced physical violence at work from managers?

NHS England

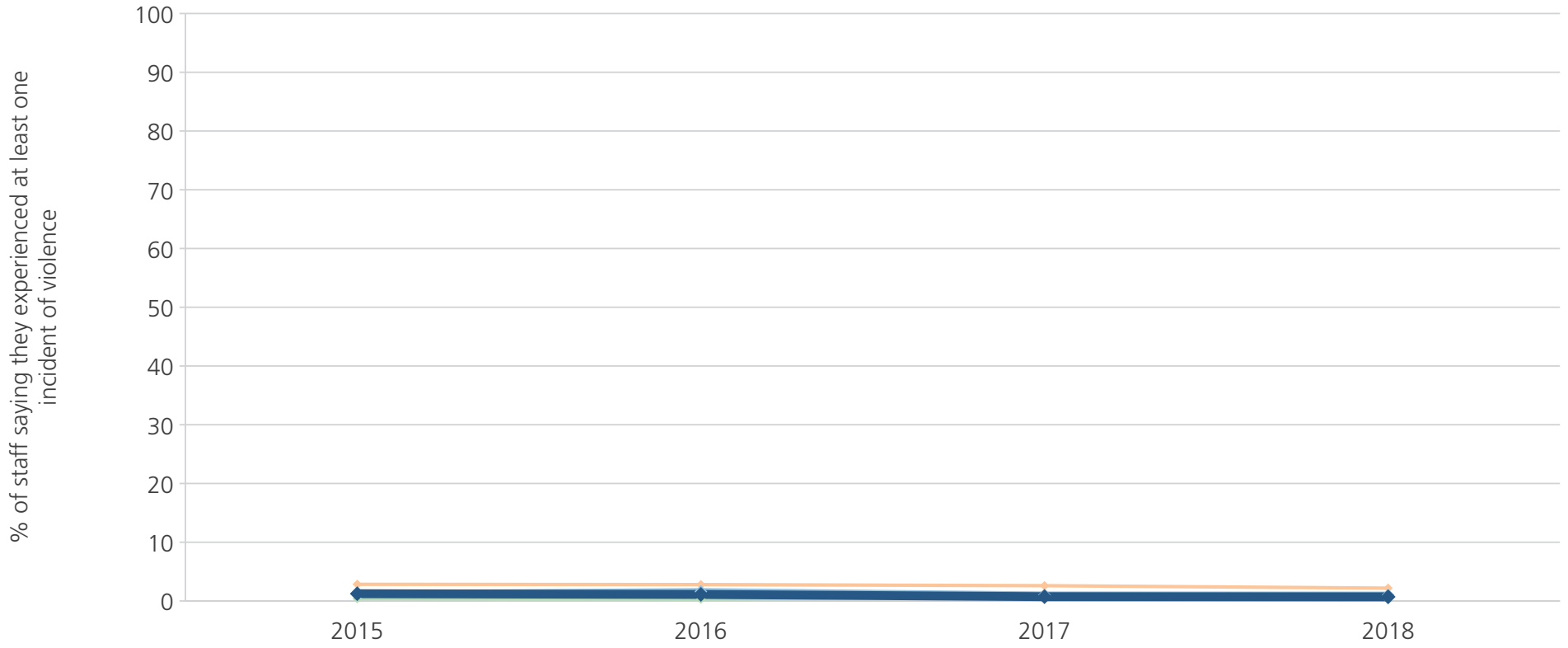


	2015	2016	2017	2018
Worst	1.2%	1.3%	1.1%	1.4%
Your org	0.1%	0.2%	0.3%	0.4%
Average	0.4%	0.7%	0.3%	0.5%
Best	0.0%	0.2%	0.1%	0.0%
No. responses	923	1,106	1,723	1,937

Survey Coordination Centre

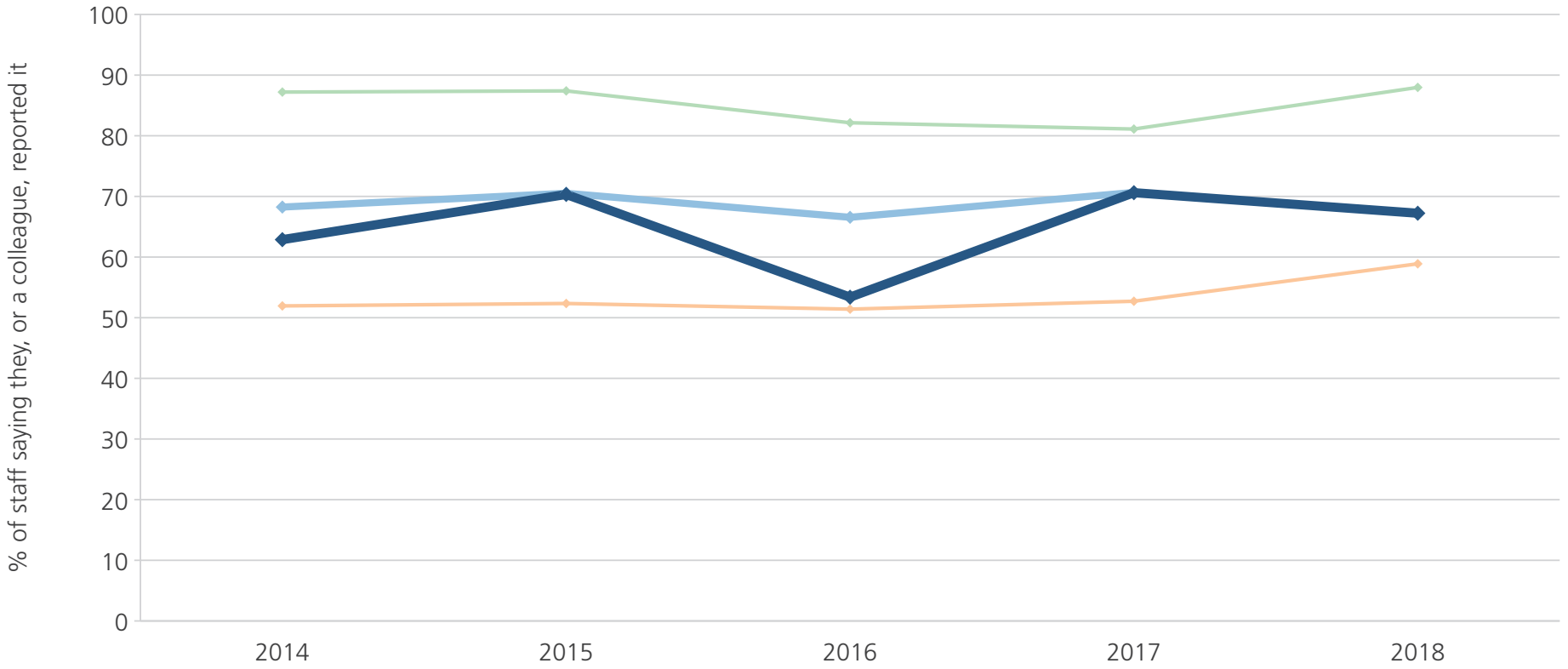
2018 NHS Staff Survey Results > Question results > Your health, well-being and safety at work > Q12c **>** In the last 12 months how many times have you personally experienced physical violence at work from other colleagues?

NHS England



	2015	2016	2017	2018
Worst	2.8%	2.8%	2.6%	2.2%
Your org	1.2%	1.1%	0.7%	0.7%
Average	1.3%	1.6%	1.0%	1.0%
Best	0.4%	0.3%	0.6%	0.3%
No. responses	922	1,107	1,706	1,918

Note: This question was only answered by staff who reported experiencing at least one incident of violence in the last 12 months.

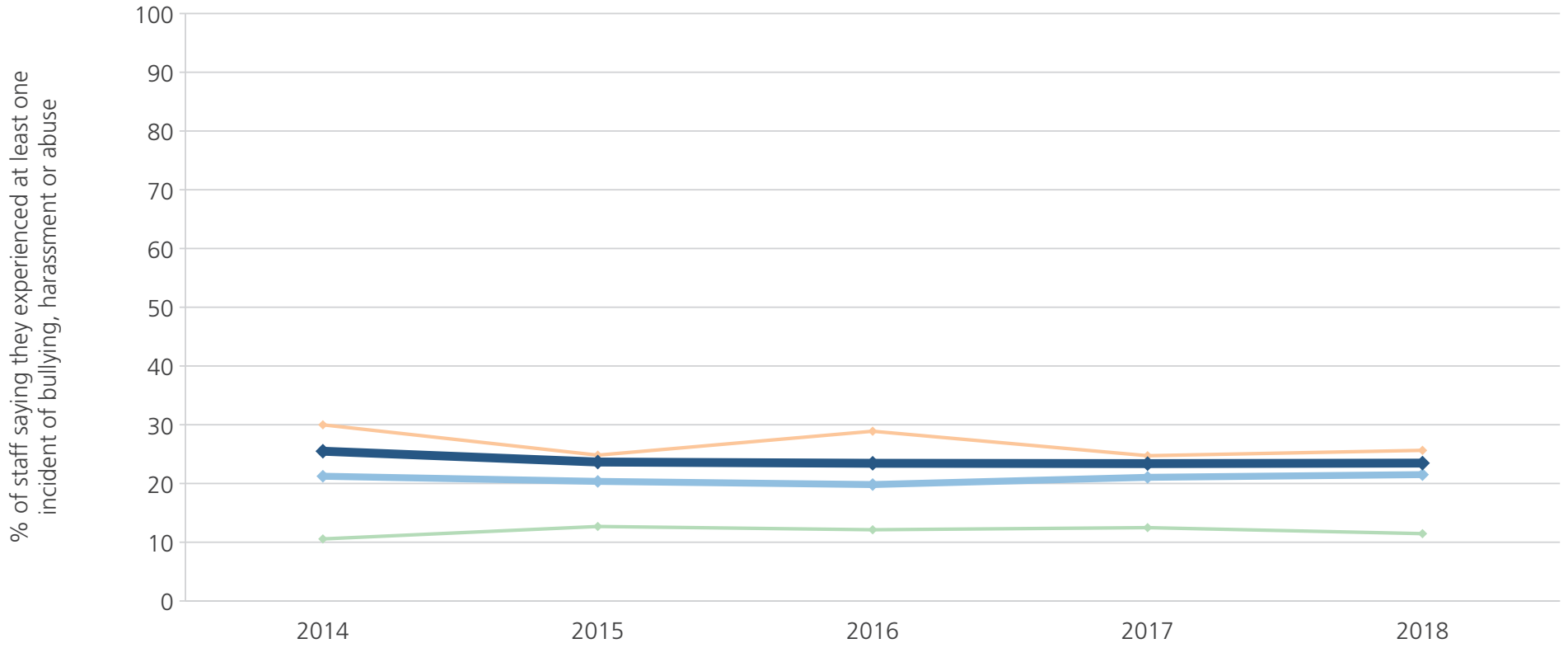


	2014	2015	2016	2017	2018
Best	87.2%	87.4%	82.1%	81.1%	88.0%
Your org	62.9%	70.3%	53.4%	70.6%	67.2%
Average	68.2%	70.5%	66.6%	70.7%	67.2%
Worst	51.9%	52.3%	51.4%	52.7%	58.9%
No. responses	72	48	69	135	141

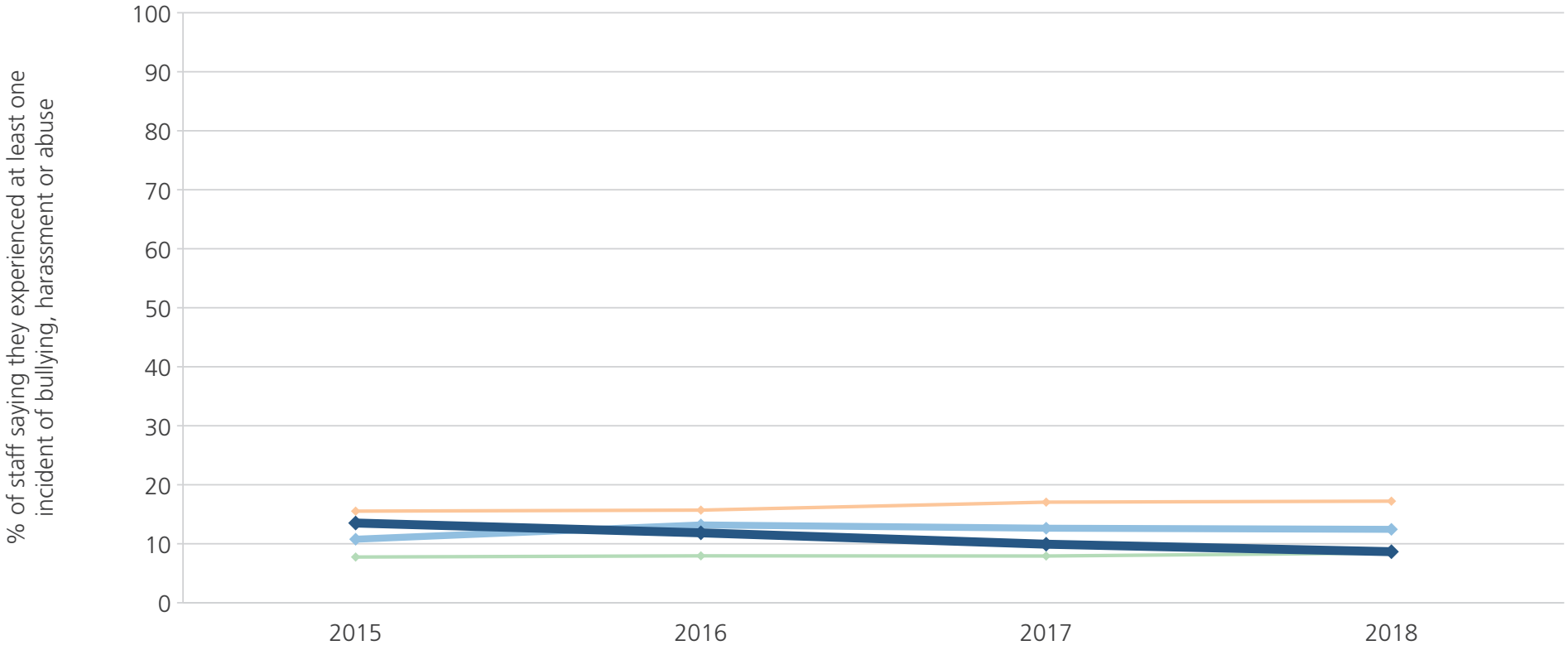
Survey Coordination Centre

2018 NHS Staff Survey Results > Question results > Your health, well-being and safety at work > Q13a **>** In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from patients / service users, their relatives or other members of the public?

NHS England



	2014	2015	2016	2017	2018
Worst	30.0%	24.8%	28.9%	24.7%	25.6%
Your org	25.5%	23.7%	23.4%	23.4%	23.5%
Average	21.2%	20.4%	19.8%	21.0%	21.5%
Best	10.6%	12.7%	12.1%	12.5%	11.5%
No. responses	1,100	919	1,107	1,717	1,966

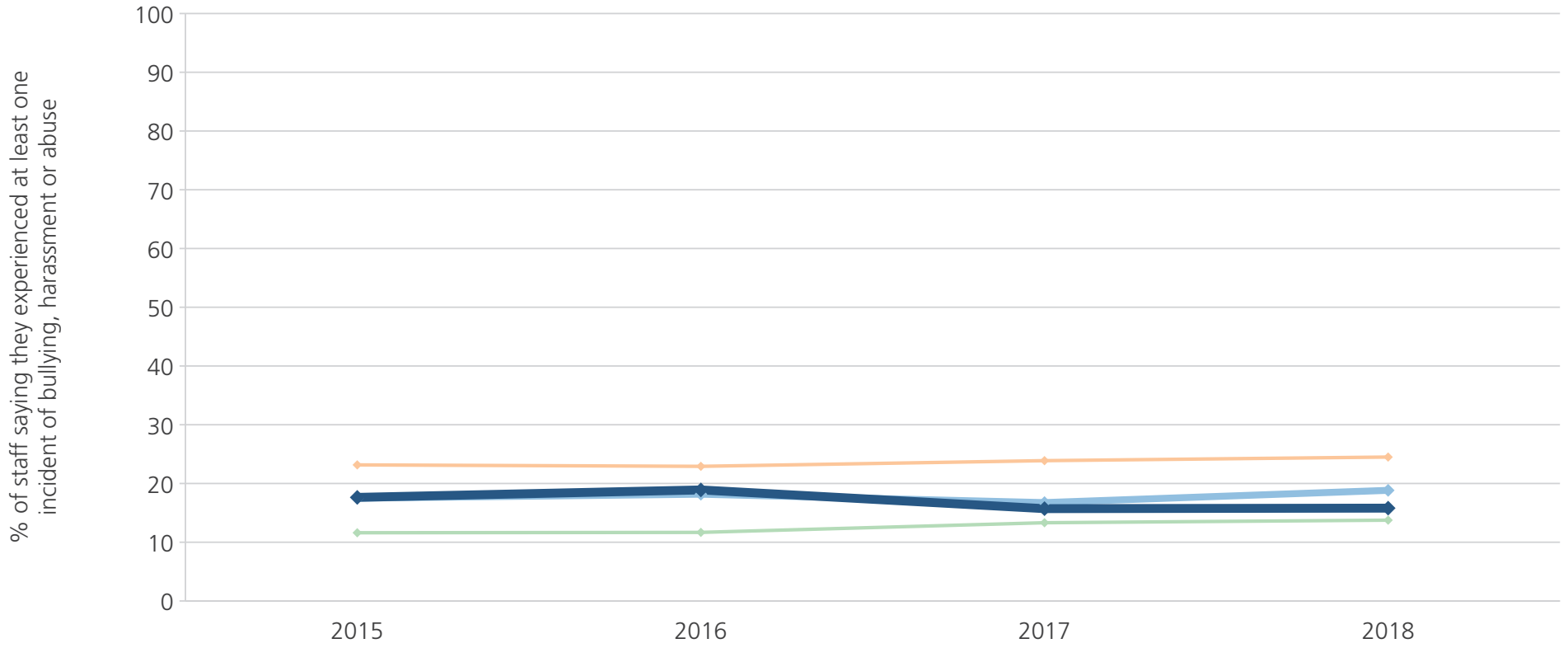


	2015	2016	2017	2018
Worst	15.5%	15.7%	17.1%	17.2%
Your org	13.5%	11.9%	9.9%	8.7%
Average	10.8%	13.2%	12.6%	12.4%
Best	7.8%	8.0%	7.9%	8.4%
No. responses	912	1,089	1,701	1,955

Survey Coordination Centre

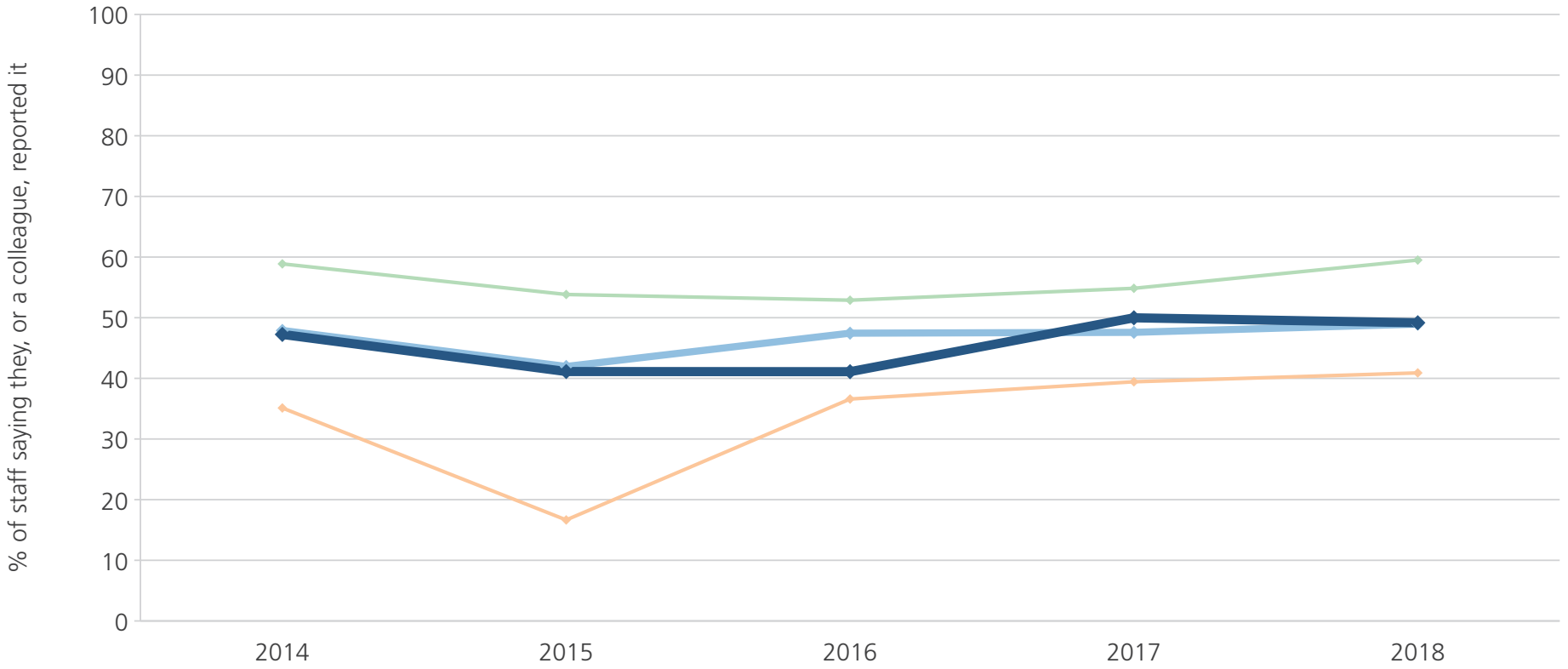
2018 NHS Staff Survey Results > Question results > Your health, well-being and safety at work > Q13c **>** In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from other colleagues?

NHS England



	2015	2016	2017	2018
Worst	23.2%	22.9%	23.9%	24.5%
Your org	17.6%	18.9%	15.7%	15.8%
Average	17.5%	18.2%	16.7%	18.8%
Best	11.6%	11.7%	13.3%	13.8%
No. responses	909	1,095	1,691	1,938

Note: This question was only answered by staff who reported experiencing at least one incident of harassment, bullying or abuse in the last 12 months.

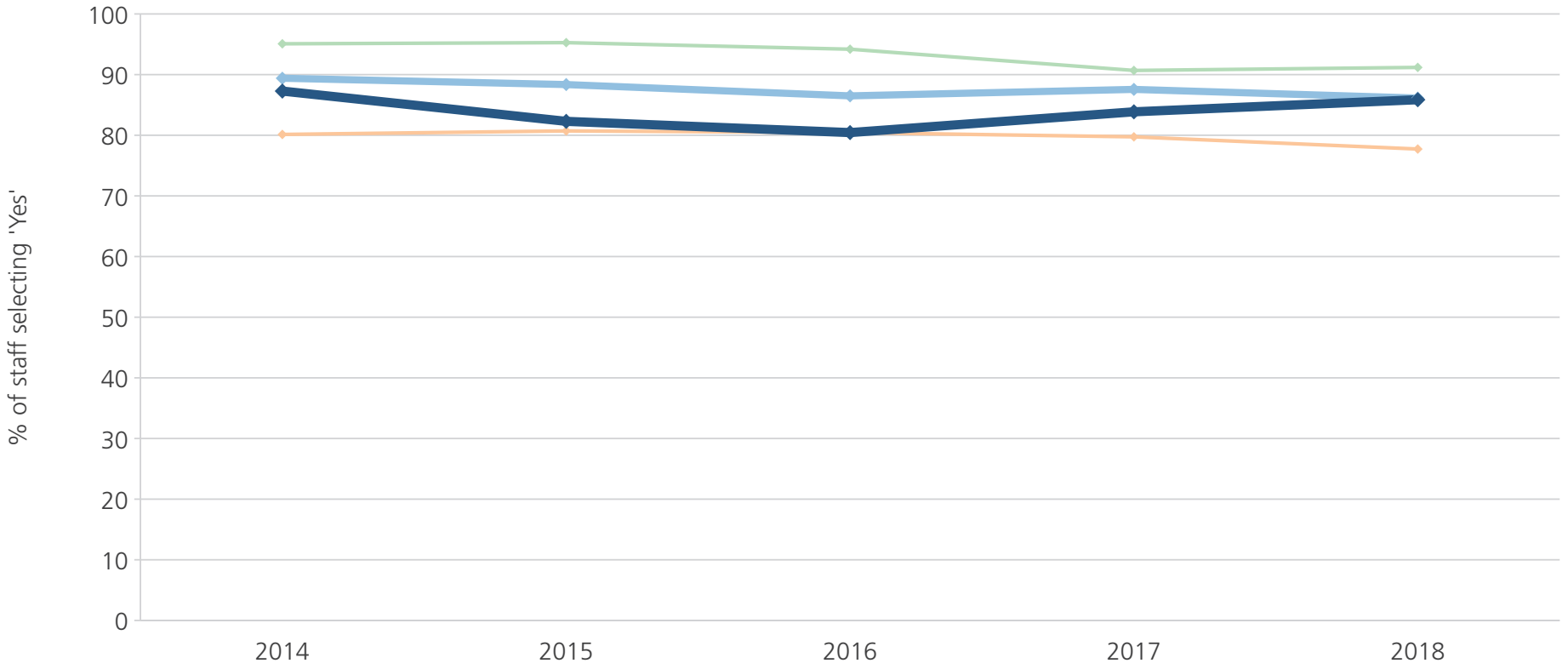


	2014	2015	2016	2017	2018
Best	58.9%	53.8%	52.9%	54.8%	59.5%
Your org	47.2%	41.1%	41.1%	50.0%	49.2%
Average	47.9%	42.0%	47.4%	47.6%	48.9%
Worst	35.1%	16.7%	36.6%	39.4%	40.9%
No. responses	259	325	370	547	553

Survey Coordination Centre

2018 NHS Staff Survey Results > Question results > Your health, well-being and safety at work > Q14 **>** Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?

NHS England

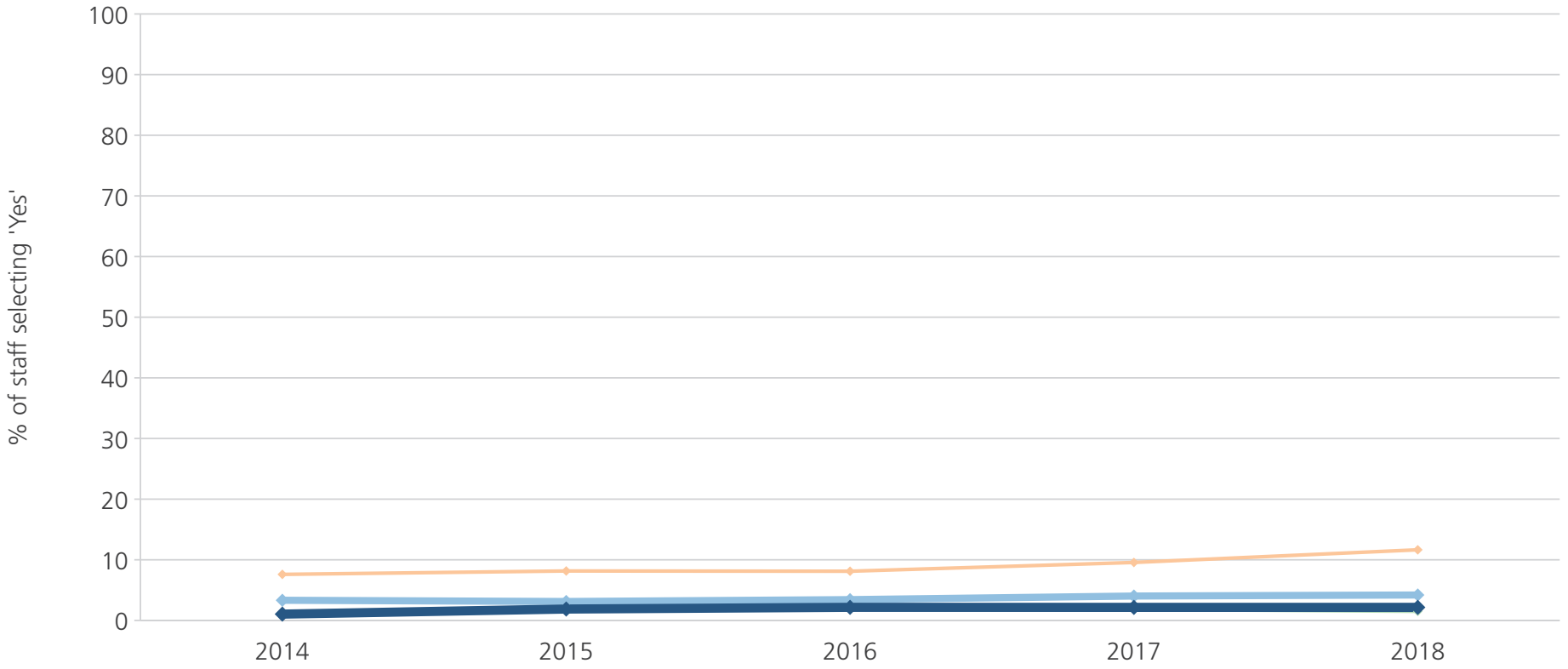


	2014	2015	2016	2017	2018
Best	95.1%	95.3%	94.2%	90.7%	91.2%
Your org	87.3%	82.3%	80.4%	83.9%	85.9%
Average	89.4%	88.4%	86.5%	87.6%	86.1%
Worst	80.1%	80.7%	80.4%	79.7%	77.7%
No. responses	723	599	707	1,137	1,364

Survey Coordination Centre

2018 NHS Staff Survey Results > Question results > Your health, well-being and safety at work > Q15a **>** In the last 12 months have you personally experienced discrimination at work from patients / service users, their relatives or other members of the public?

NHS England

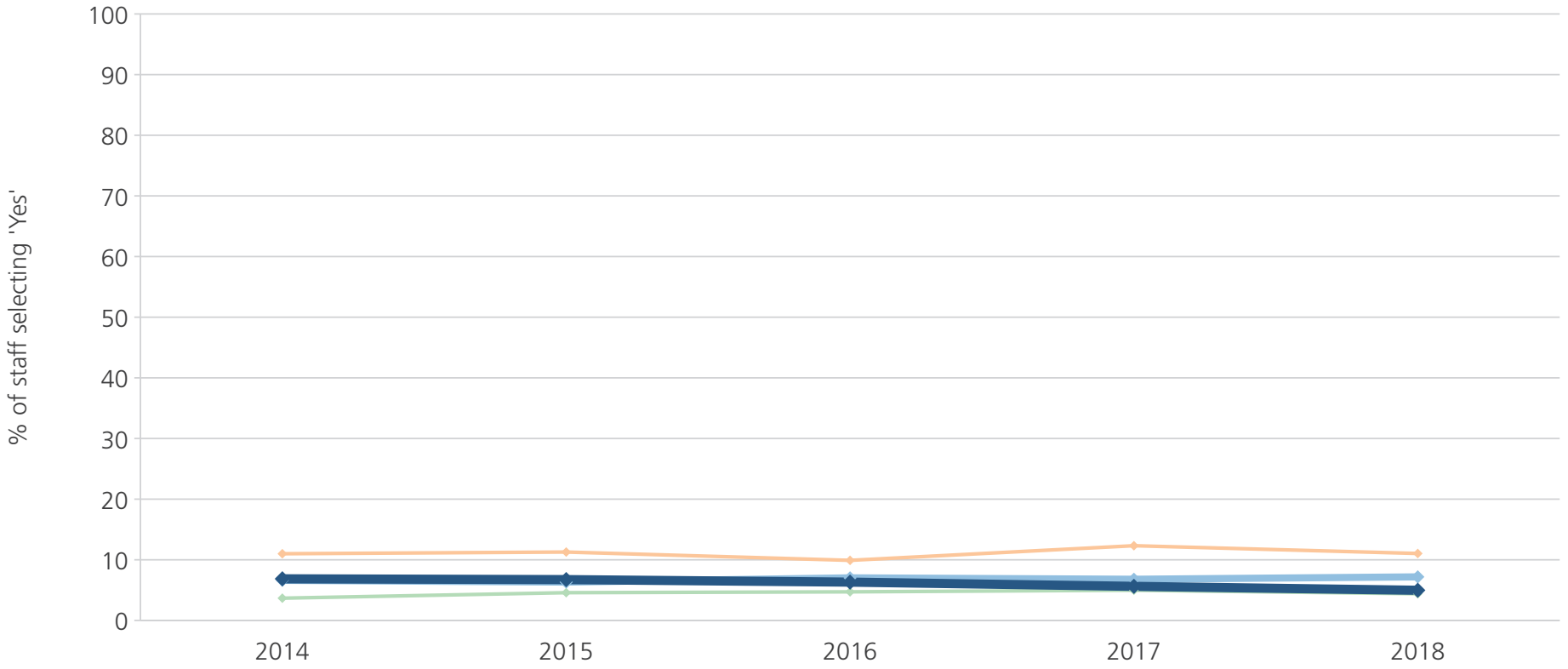


	2014	2015	2016	2017	2018
Worst	7.6%	8.2%	8.1%	9.6%	11.6%
Your org	1.0%	1.9%	2.2%	2.2%	2.2%
Average	3.3%	3.1%	3.4%	4.0%	4.2%
Best	0.9%	1.9%	1.9%	1.8%	1.5%
No. responses	1,110	925	1,118	1,722	1,975

Survey Coordination Centre

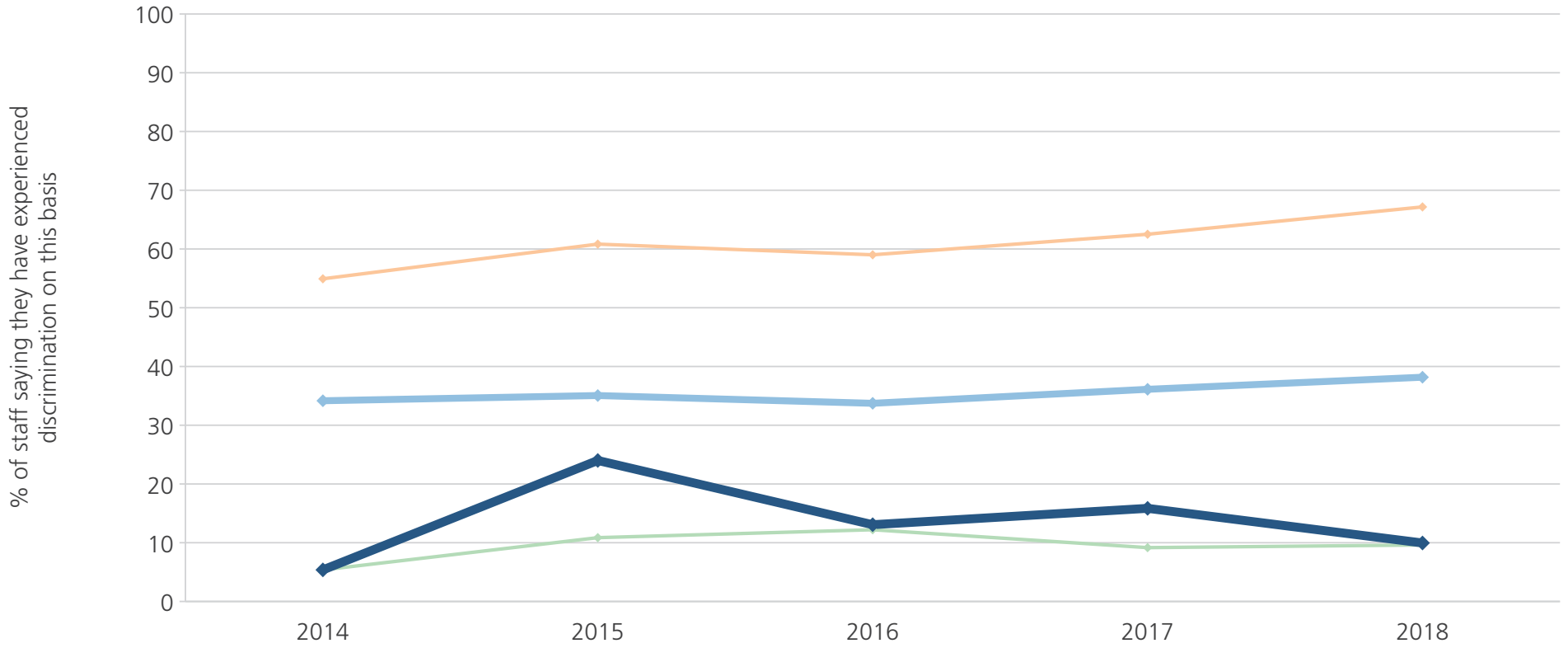
2018 NHS Staff Survey Results > Question results > Your health, well-being and safety at work > Q15b **>** In the last 12 months have you personally experienced discrimination at work from manager / team leader or other colleagues?

NHS England



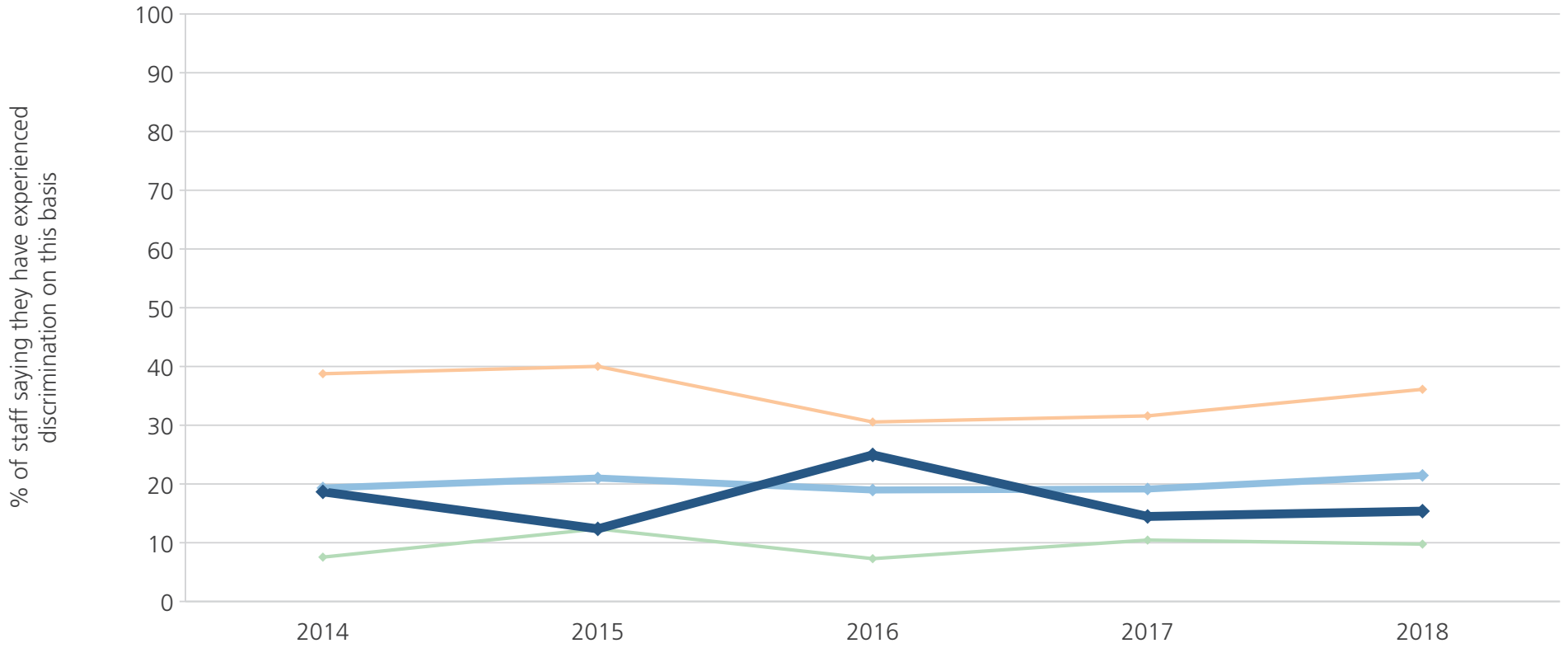
	2014	2015	2016	2017	2018
Worst	11.0%	11.3%	9.9%	12.3%	11.0%
Your org	6.9%	6.7%	6.3%	5.6%	5.0%
Average	6.6%	6.3%	7.0%	6.8%	7.2%
Best	3.7%	4.6%	4.7%	5.0%	4.4%
No. responses	1,112	926	1,115	1,723	1,945

Note: This question was only answered by staff who reported experiencing at least one incident of discrimination in the last 12 months.



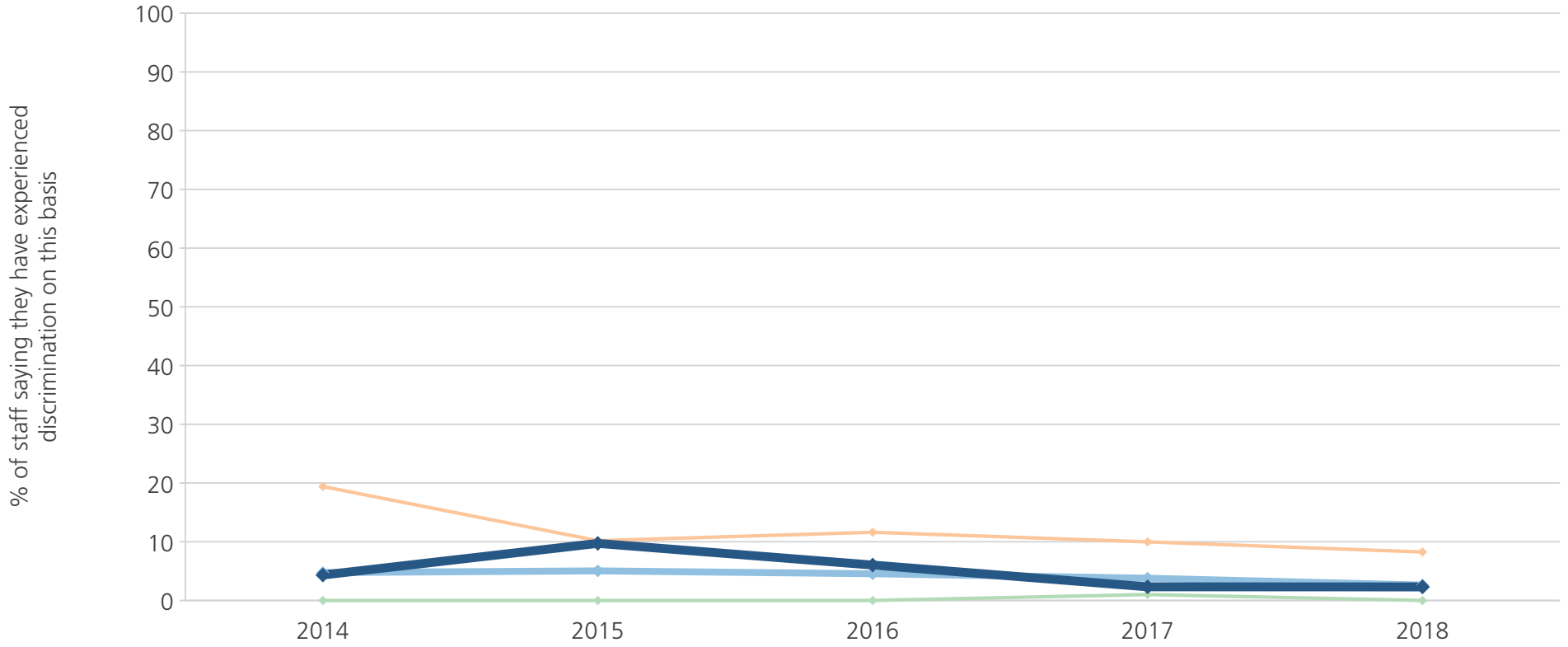
	2014	2015	2016	2017	2018
Worst	54.9%	60.8%	59.0%	62.5%	67.2%
Your org	5.4%	24.0%	13.1%	15.9%	10.0%
Average	34.2%	35.1%	33.7%	36.1%	38.2%
Best	5.4%	10.9%	12.2%	9.2%	9.6%
No. responses	78	65	78	112	111

Note: This question was only answered by staff who reported experiencing at least one incident of discrimination in the last 12 months.



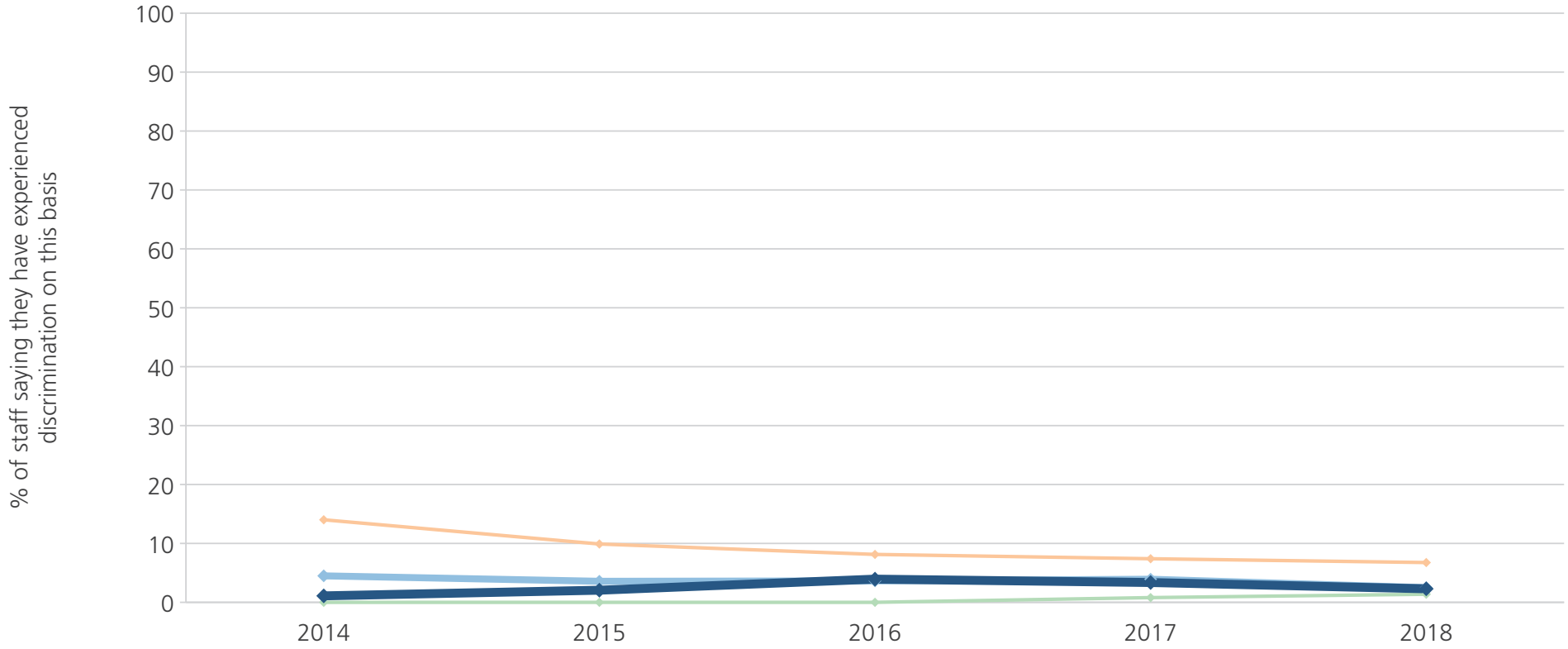
	2014	2015	2016	2017	2018
Worst	38.8%	40.0%	30.5%	31.6%	36.1%
Your org	18.7%	12.4%	24.9%	14.5%	15.4%
Average	19.3%	21.0%	19.0%	19.1%	21.5%
Best	7.5%	12.4%	7.3%	10.4%	9.8%
No. responses	78	65	78	112	111

Note: This question was only answered by staff who reported experiencing at least one incident of discrimination in the last 12 months.



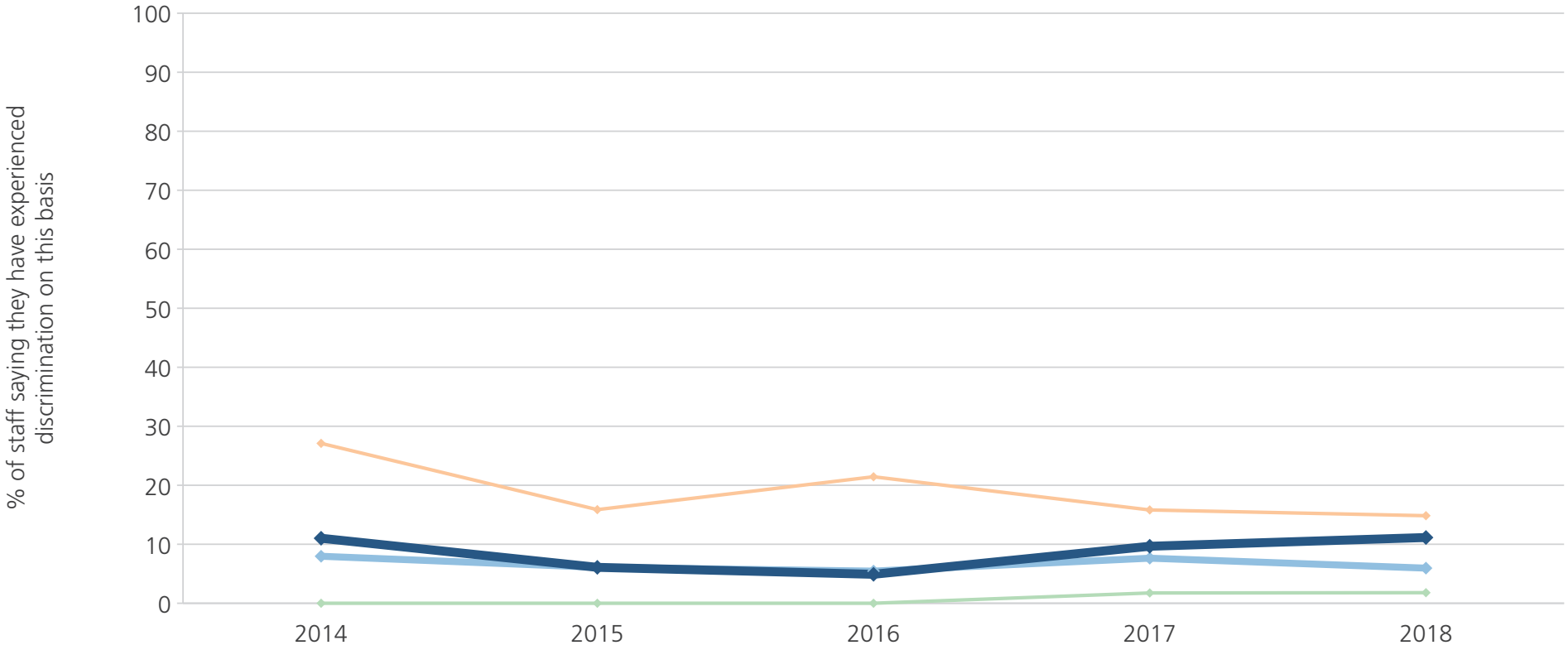
	2014	2015	2016	2017	2018
Worst	19.4%	10.2%	11.6%	10.0%	8.3%
Your org	4.3%	9.7%	6.0%	2.3%	2.3%
Average	4.8%	5.0%	4.6%	3.8%	2.6%
Best	0.0%	0.0%	0.0%	1.0%	0.0%
No. responses	78	65	78	112	111

Note: This question was only answered by staff who reported experiencing at least one incident of discrimination in the last 12 months.



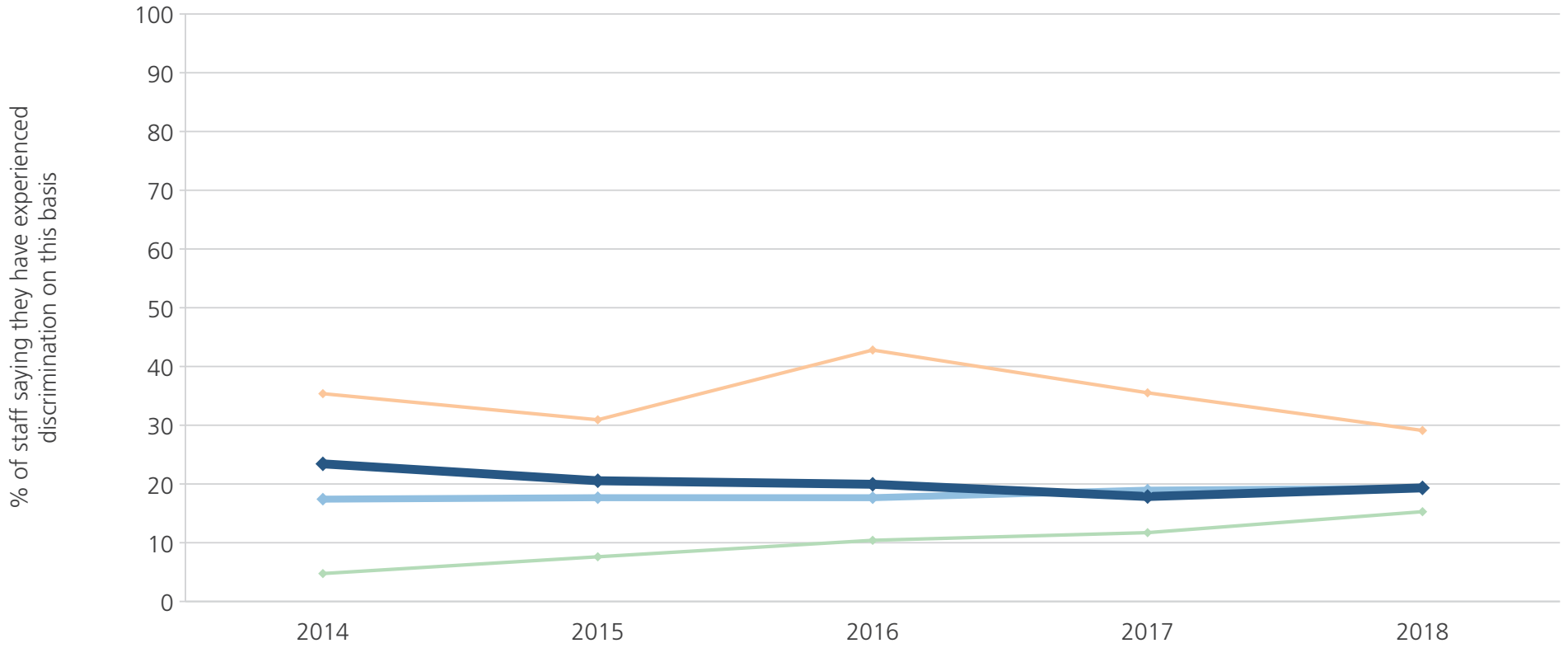
	2014	2015	2016	2017	2018
Worst	14.0%	9.9%	8.1%	7.4%	6.8%
Your org	1.1%	2.1%	3.9%	3.4%	2.3%
Average	4.5%	3.6%	3.6%	3.9%	2.5%
Best	0.0%	0.0%	0.0%	0.8%	1.4%
No. responses	78	65	78	112	111

Note: This question was only answered by staff who reported experiencing at least one incident of discrimination in the last 12 months.



	2014	2015	2016	2017	2018
Worst	27.1%	15.9%	21.4%	15.8%	14.8%
Your org	11.0%	6.1%	4.9%	9.7%	11.1%
Average	8.0%	6.1%	5.4%	7.6%	6.0%
Best	0.0%	0.0%	0.0%	1.7%	1.8%
No. responses	78	65	78	112	111

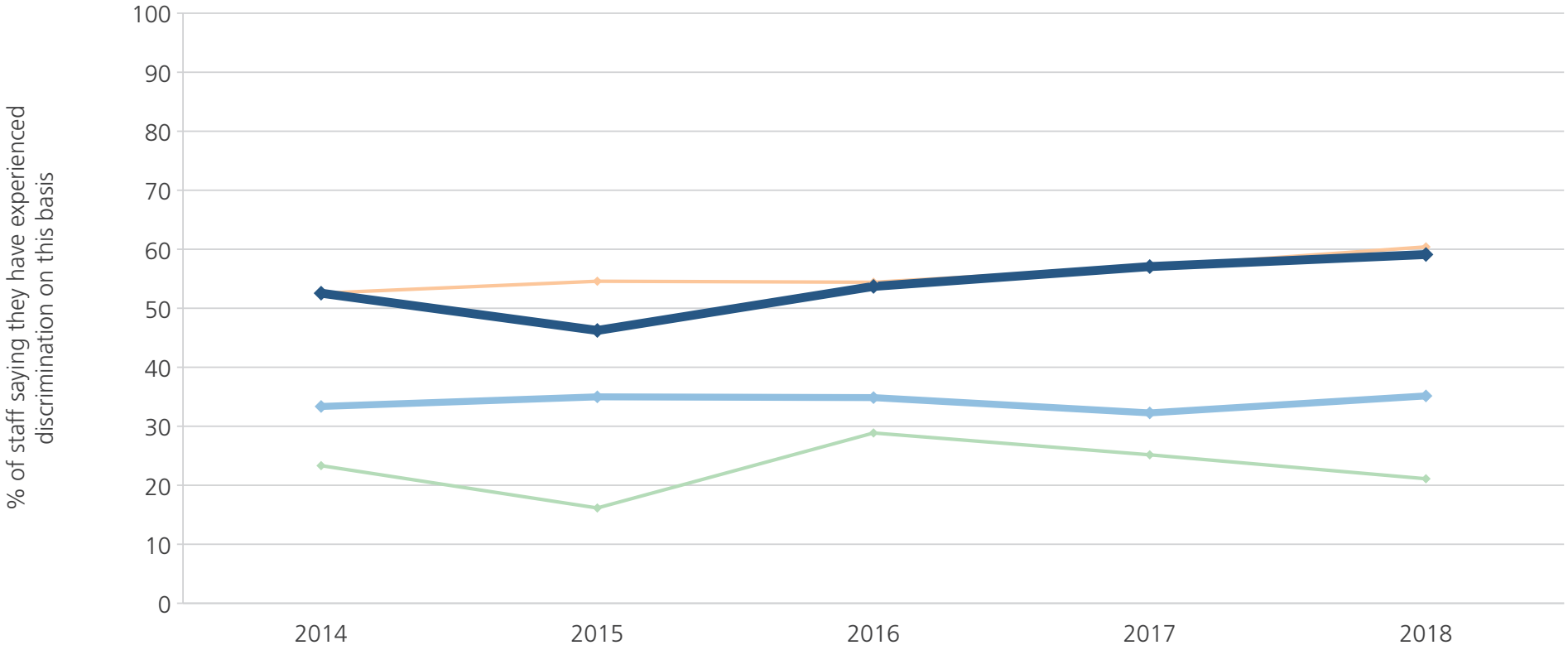
Note: This question was only answered by staff who reported experiencing at least one incident of discrimination in the last 12 months.



	2014	2015	2016	2017	2018
Worst	35.4%	30.9%	42.8%	35.5%	29.1%
Your org	23.4%	20.5%	19.9%	17.9%	19.3%
Average	17.4%	17.7%	17.7%	18.9%	19.3%
Best	4.8%	7.6%	10.4%	11.7%	15.3%
No. responses	78	65	78	112	111

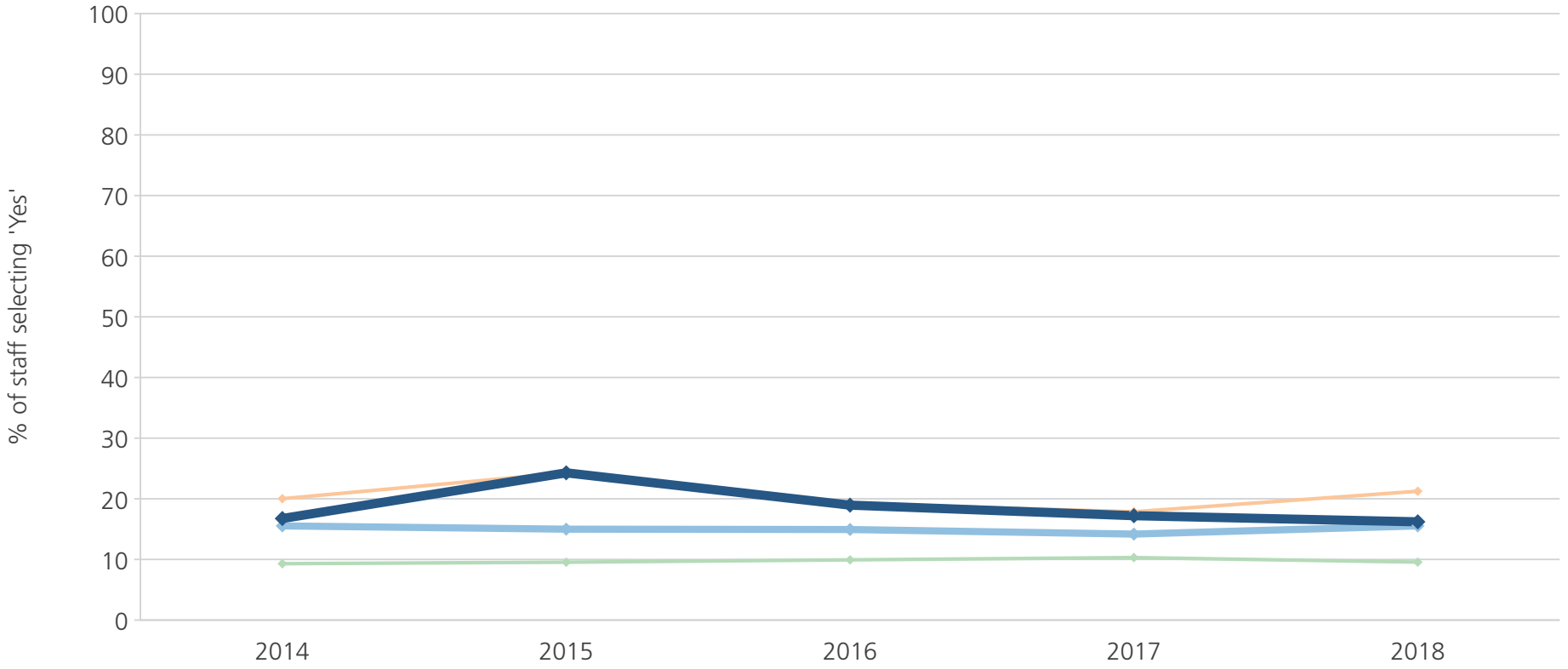
111

Note: This question was only answered by staff who reported experiencing at least one incident of discrimination in the last 12 months.

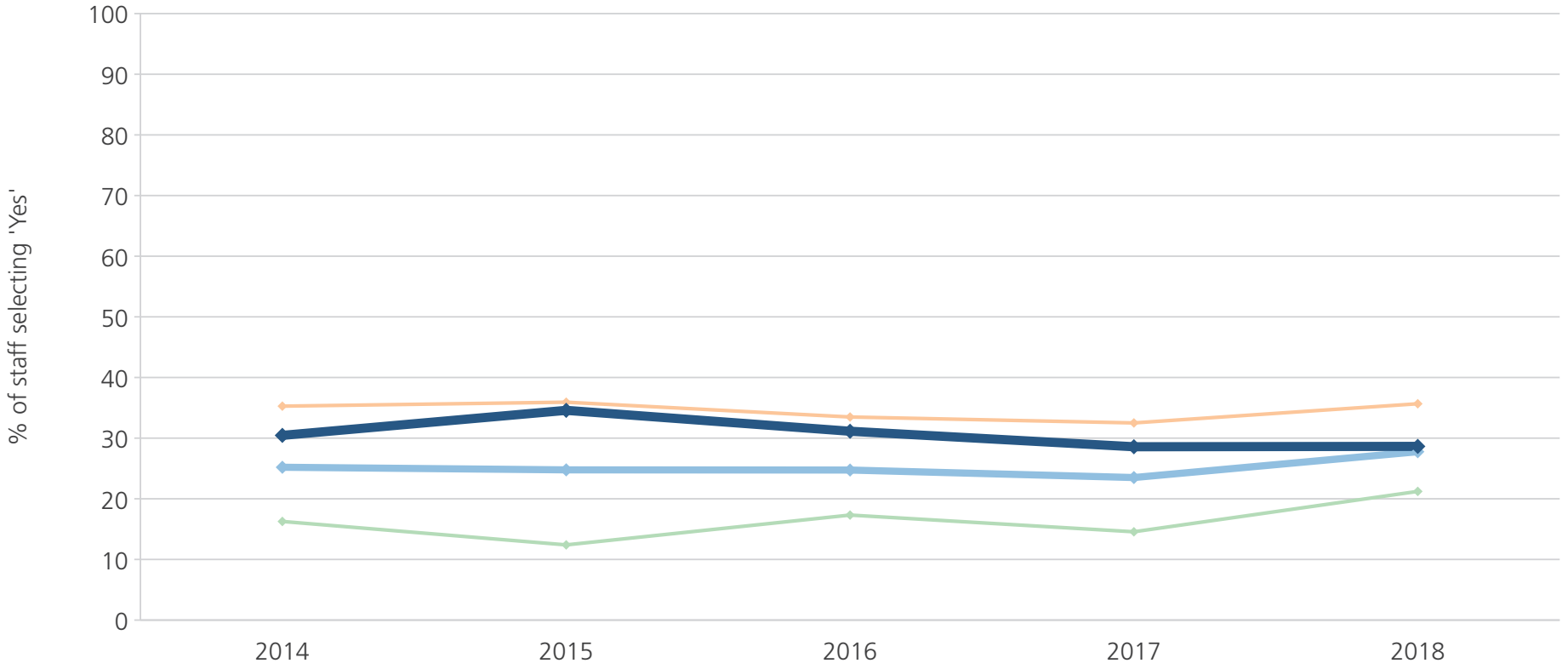


	2014	2015	2016	2017	2018
Worst	52.6%	54.6%	54.4%	57.1%	60.4%
Your org	52.6%	46.2%	53.7%	57.1%	59.1%
Average	33.4%	35.0%	34.9%	32.3%	35.1%
Best	23.3%	16.1%	28.9%	25.2%	21.1%
No. responses	78	65	78	112	111

112



	2014	2015	2016	2017	2018
Worst	20.0%	24.3%	19.2%	17.9%	21.2%
Your org	16.7%	24.3%	19.0%	17.2%	16.2%
Average	15.5%	15.0%	14.9%	14.2%	15.5%
Best	9.3%	9.5%	9.9%	10.3%	9.6%
No. responses	1,085	914	1,117	1,703	1,964



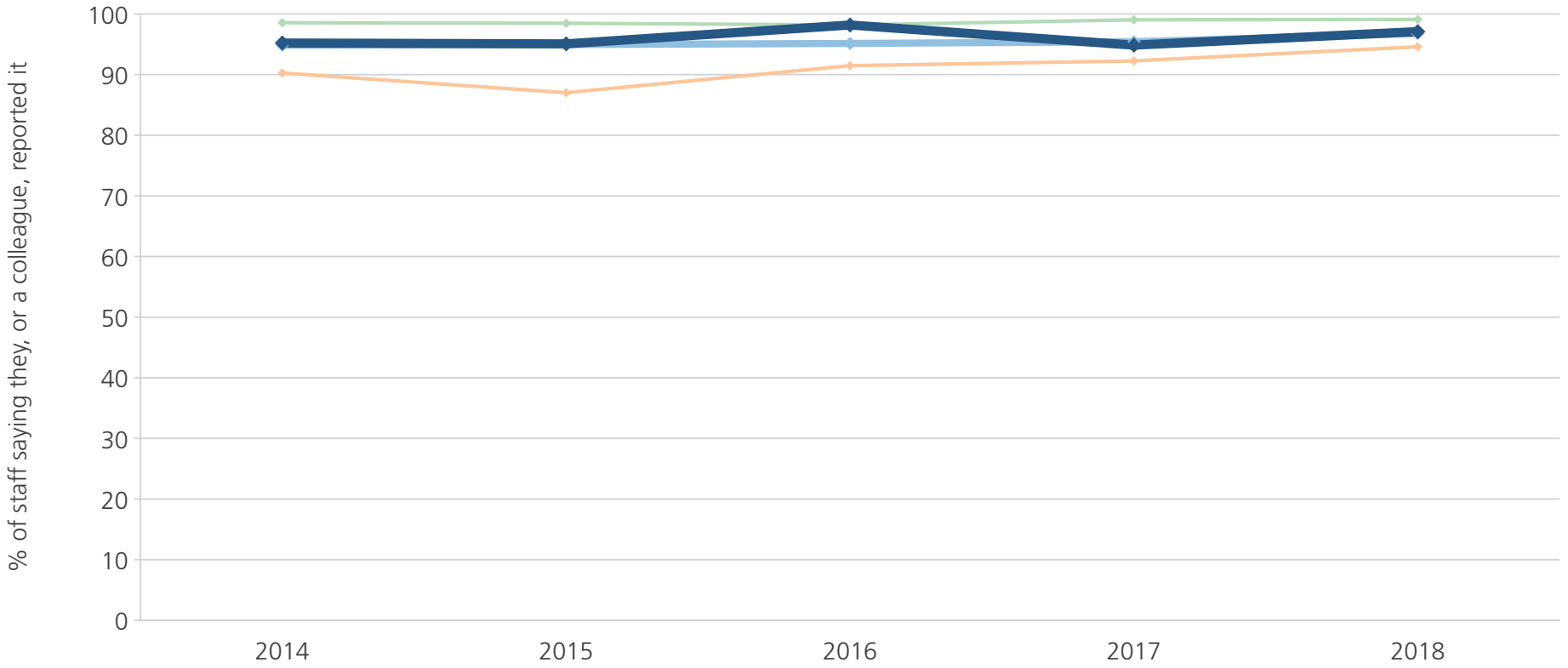
	2014	2015	2016	2017	2018
Worst	35.3%	35.9%	33.5%	32.5%	35.7%
Your org	30.5%	34.6%	31.1%	28.6%	28.6%
Average	25.2%	24.8%	24.7%	23.5%	27.8%
Best	16.3%	12.4%	17.3%	14.6%	21.2%
No. responses	1,085	900	1,104	1,681	1,948

Survey Coordination Centre

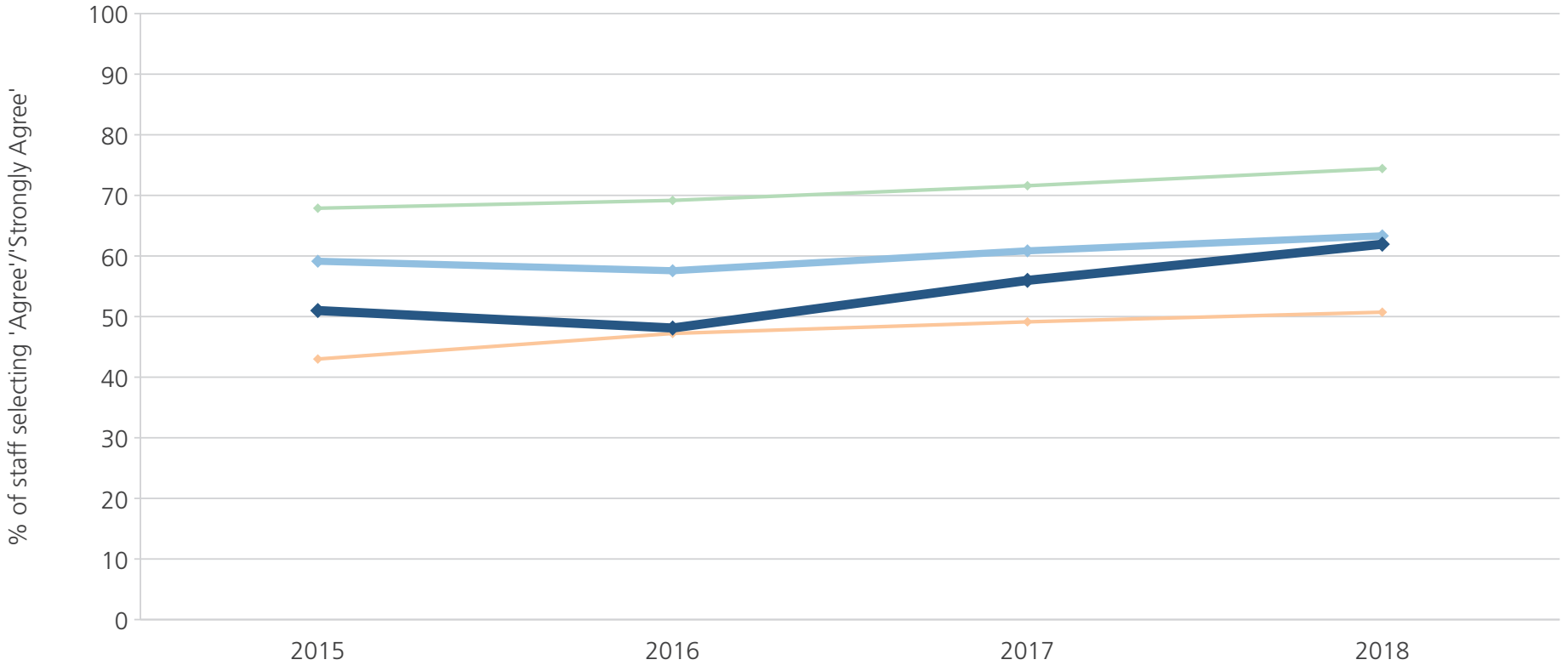
2018 NHS Staff Survey Results > Question results > Your health, well-being and safety at work > Q16c **>** The last time you saw an error, near miss or incident that could have hurt staff or patients / service users, did you or a colleague report it?

NHS England

Note: This question was only answered by staff who reported observing at least one error, near miss or incident in the last month.



	2014	2015	2016	2017	2018
Best	98.6%	98.5%	98.2%	99.0%	99.1%
Your org	95.2%	95.1%	98.2%	94.9%	97.1%
Average	94.8%	94.9%	95.1%	95.4%	96.8%
Worst	90.3%	87.0%	91.5%	92.3%	94.6%
No. responses	381	377	395	539	553

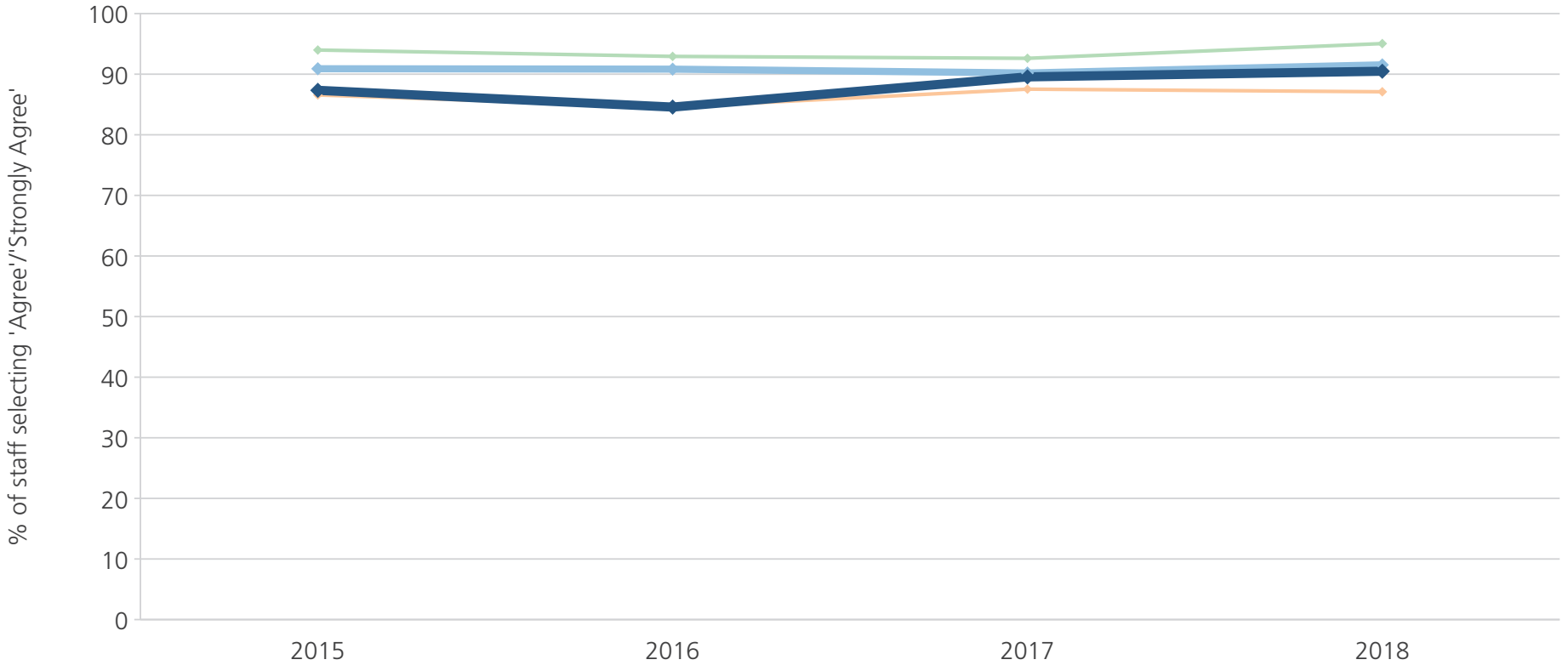


	2015	2016	2017	2018
Best	67.9%	69.2%	71.6%	74.4%
Your org	51.0%	48.1%	56.0%	61.9%
Average	59.1%	57.6%	60.8%	63.3%
Worst	43.0%	47.2%	49.1%	50.7%
No. responses	766	915	1,374	1,518

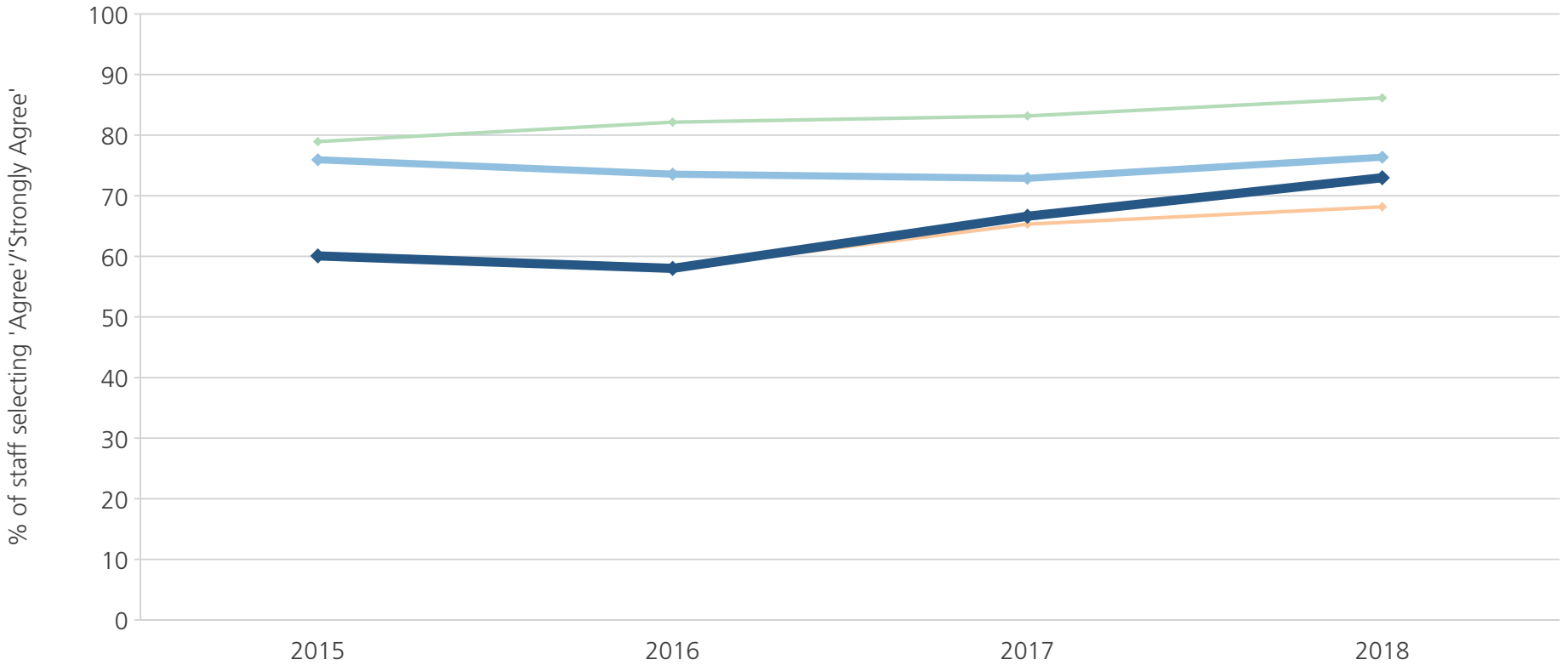
Survey Coordination Centre

2018 NHS Staff Survey Results > Question results > Your health, well-being and safety at work > Q17b **>** My organisation encourages us to report errors, near misses or incidents

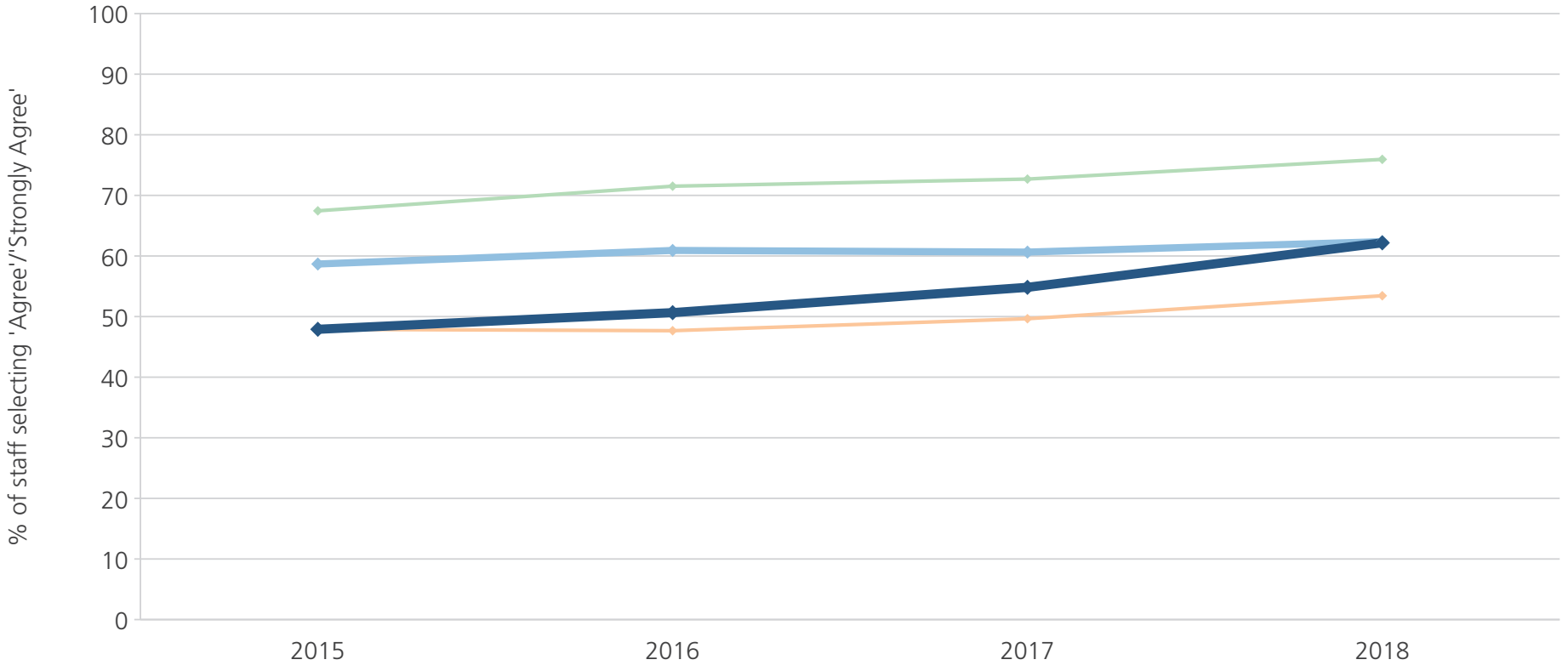
NHS England



	2015	2016	2017	2018
Best	94.0%	92.9%	92.6%	95.0%
Your org	87.3%	84.6%	89.6%	90.5%
Average	90.9%	90.8%	90.2%	91.5%
Worst	86.6%	84.6%	87.5%	87.1%
No. responses	899	1,074	1,663	1,893



	2015	2016	2017	2018
Best	78.9%	82.1%	83.2%	86.1%
Your org	60.1%	58.0%	66.6%	73.0%
Average	75.9%	73.6%	72.9%	76.4%
Worst	60.1%	58.0%	65.3%	68.2%
No. responses	829	1,004	1,528	1,758

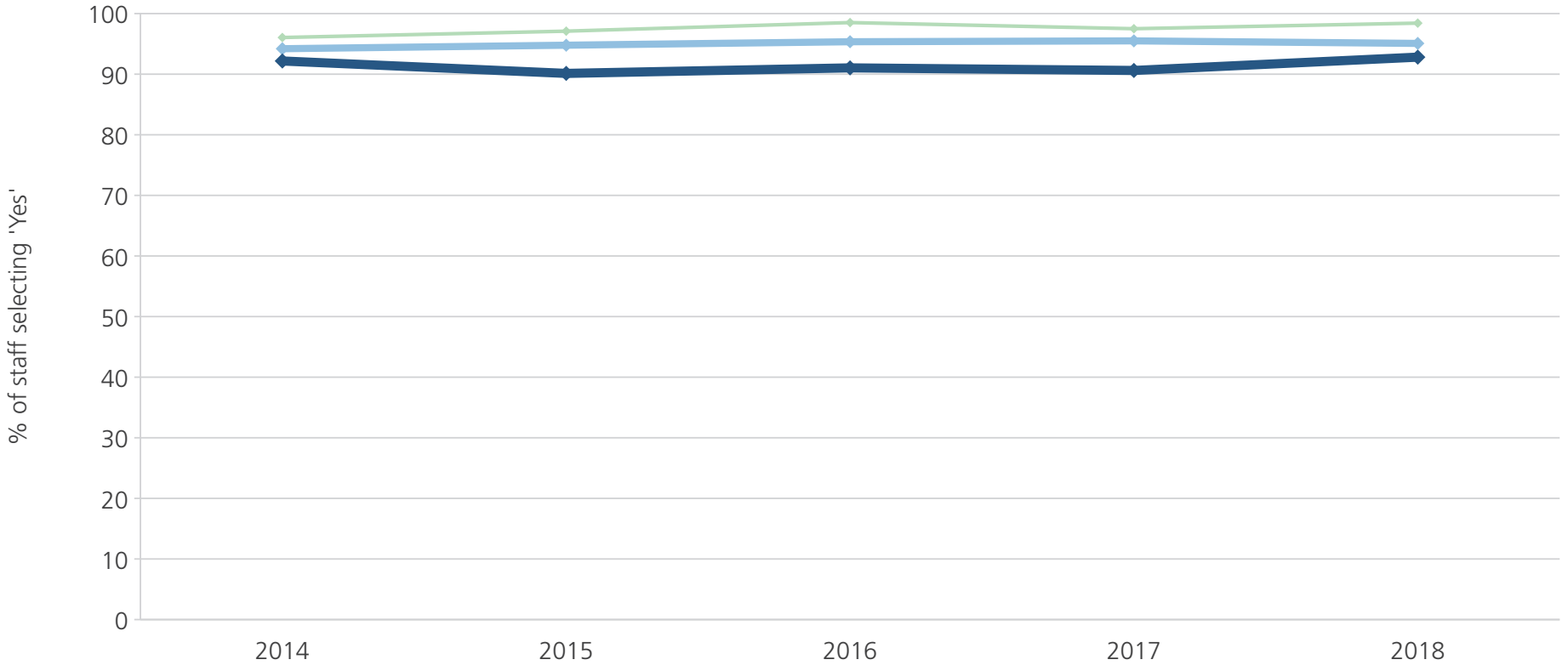


	2015	2016	2017	2018
Best	67.5%	71.5%	72.7%	75.9%
Your org	47.9%	50.6%	54.8%	62.2%
Average	58.7%	60.9%	60.6%	62.4%
Worst	47.9%	47.7%	49.6%	53.4%
No. responses	840	1,027	1,545	1,764

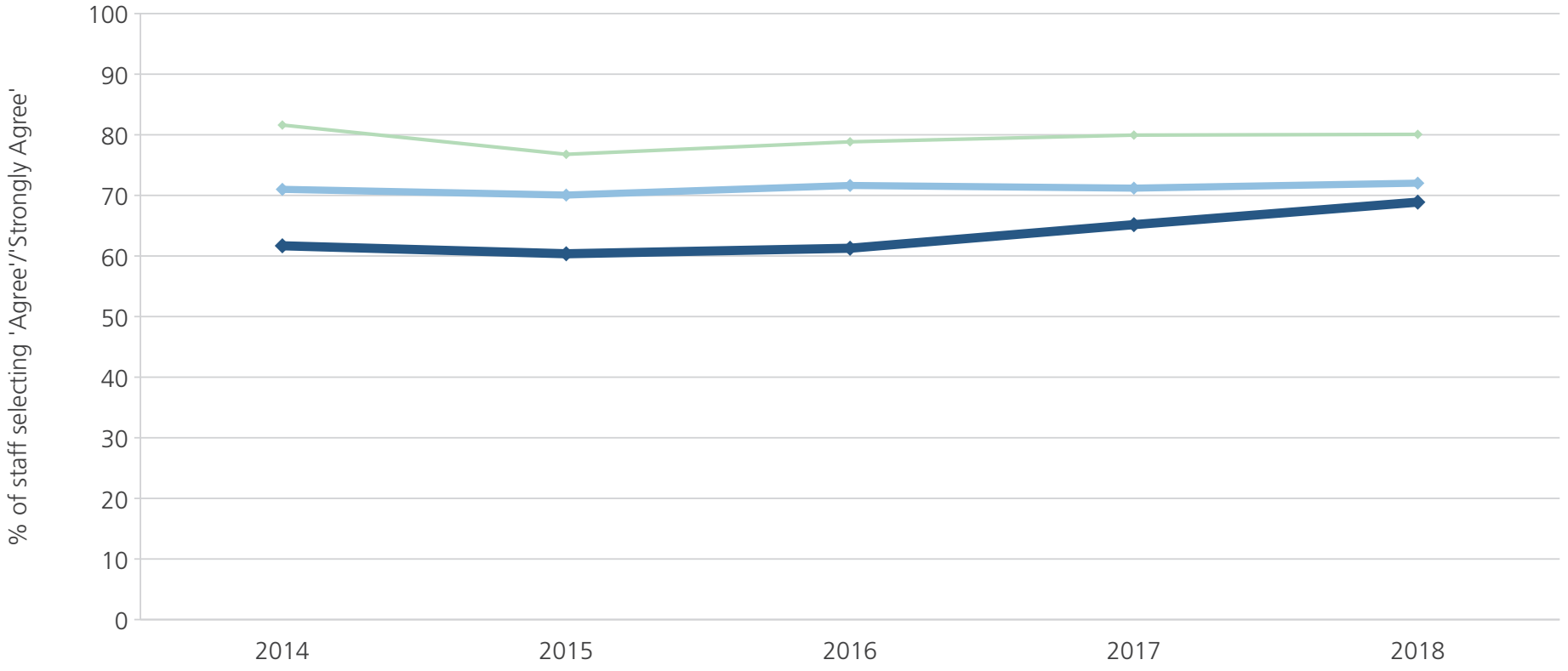
Survey Coordination Centre

2018 NHS Staff Survey Results > Question results > Your health, well-being and safety at work
> Q18a > If you were concerned about unsafe clinical practice, would you know how to report it?

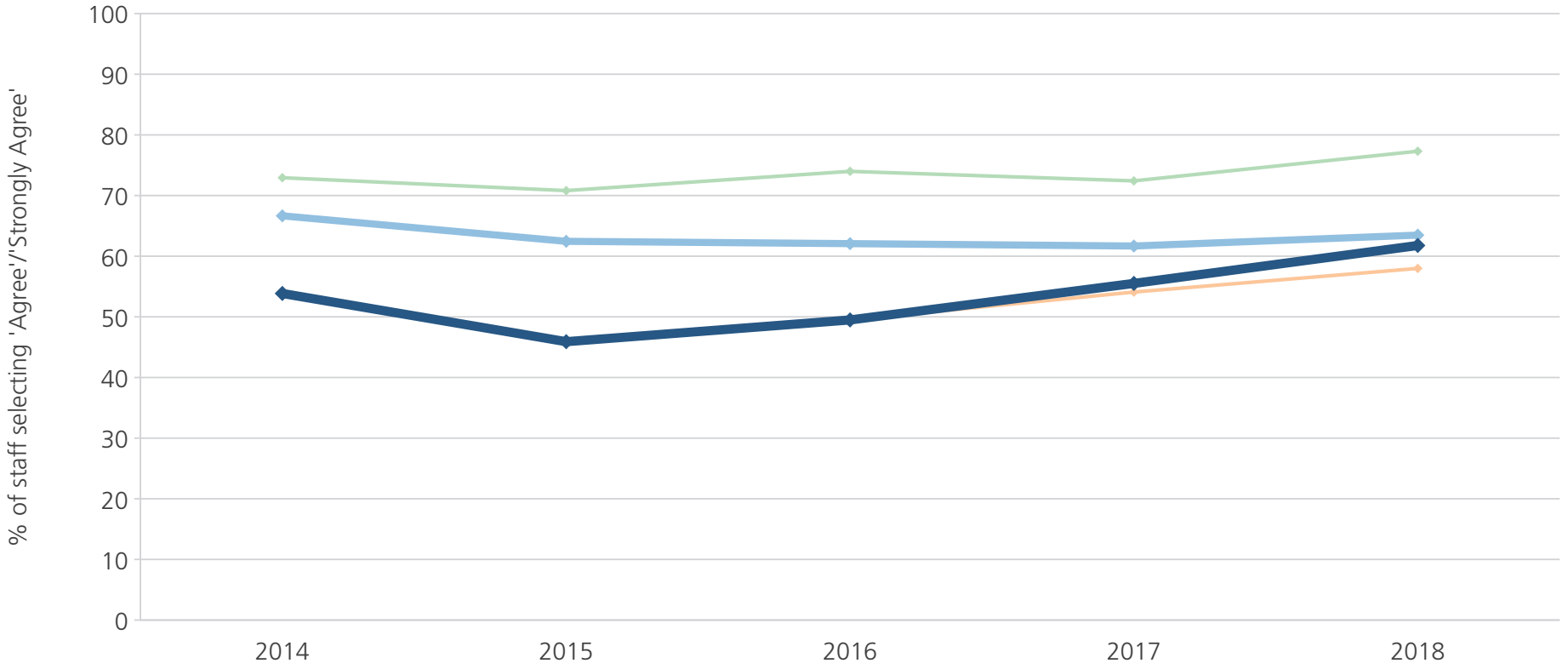
NHS England



	2014	2015	2016	2017	2018
Best	96.1%	97.1%	98.5%	97.5%	98.4%
Your org	92.2%	90.1%	91.0%	90.6%	92.8%
Average	94.2%	94.8%	95.4%	95.5%	95.1%
Worst	91.9%	90.1%	91.0%	90.6%	92.8%
No. responses	990	821	987	1,558	1,742



	2014	2015	2016	2017	2018
Best	81.6%	76.8%	78.8%	79.9%	80.1%
Your org	61.7%	60.4%	61.3%	65.2%	68.9%
Average	71.0%	70.1%	71.6%	71.2%	72.0%
Worst	61.7%	60.4%	61.3%	65.2%	68.9%
No. responses	1,104	916	1,116	1,722	1,965



	2014	2015	2016	2017	2018
Best	72.9%	70.8%	74.0%	72.4%	77.3%
Your org	53.9%	45.9%	49.5%	55.5%	61.8%
Average	66.7%	62.5%	62.1%	61.7%	63.5%
Worst	53.9%	45.9%	49.5%	54.1%	58.0%
No. responses	1,102	914	1,115	1,721	1,955

Survey Coordination Centre

NHS England

Question results – Your personal development

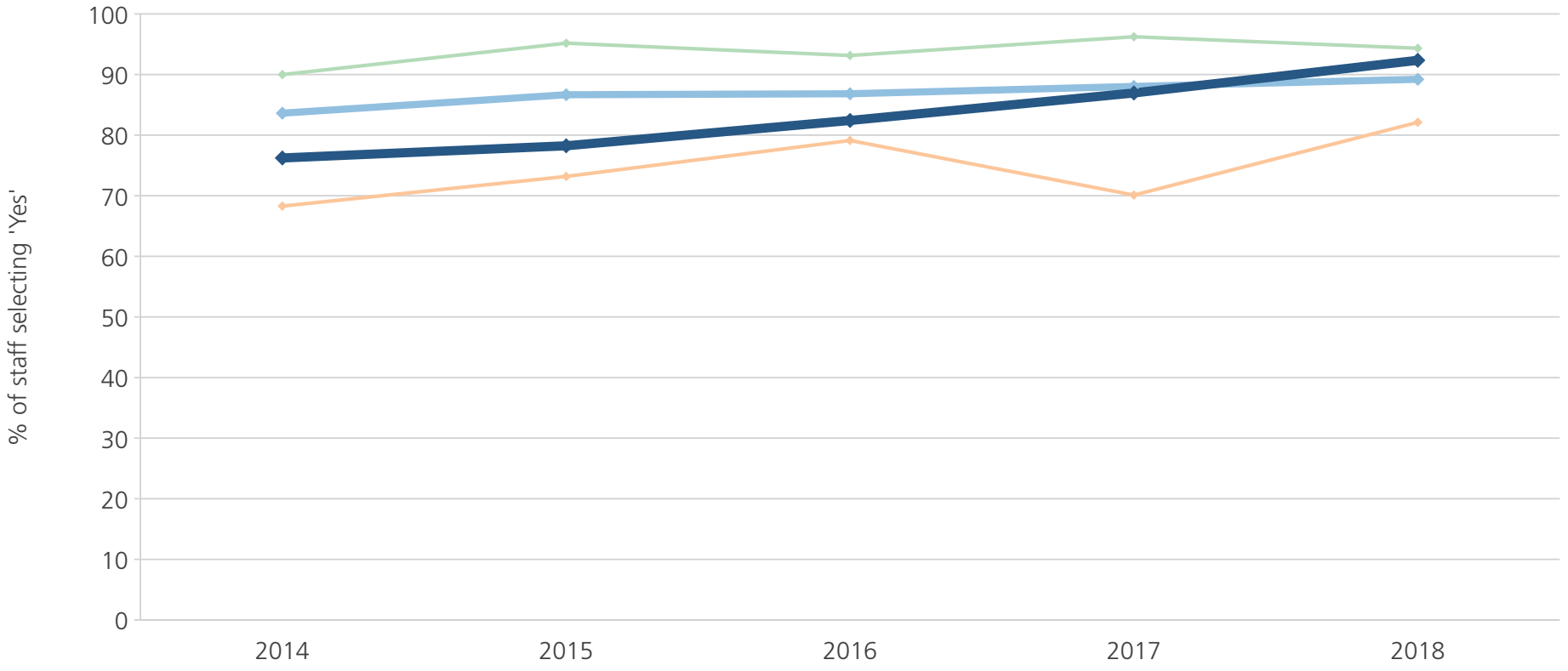
Alder Hey Children's NHS Foundation Trust

2018 NHS Staff Survey Results

Survey Coordination Centre

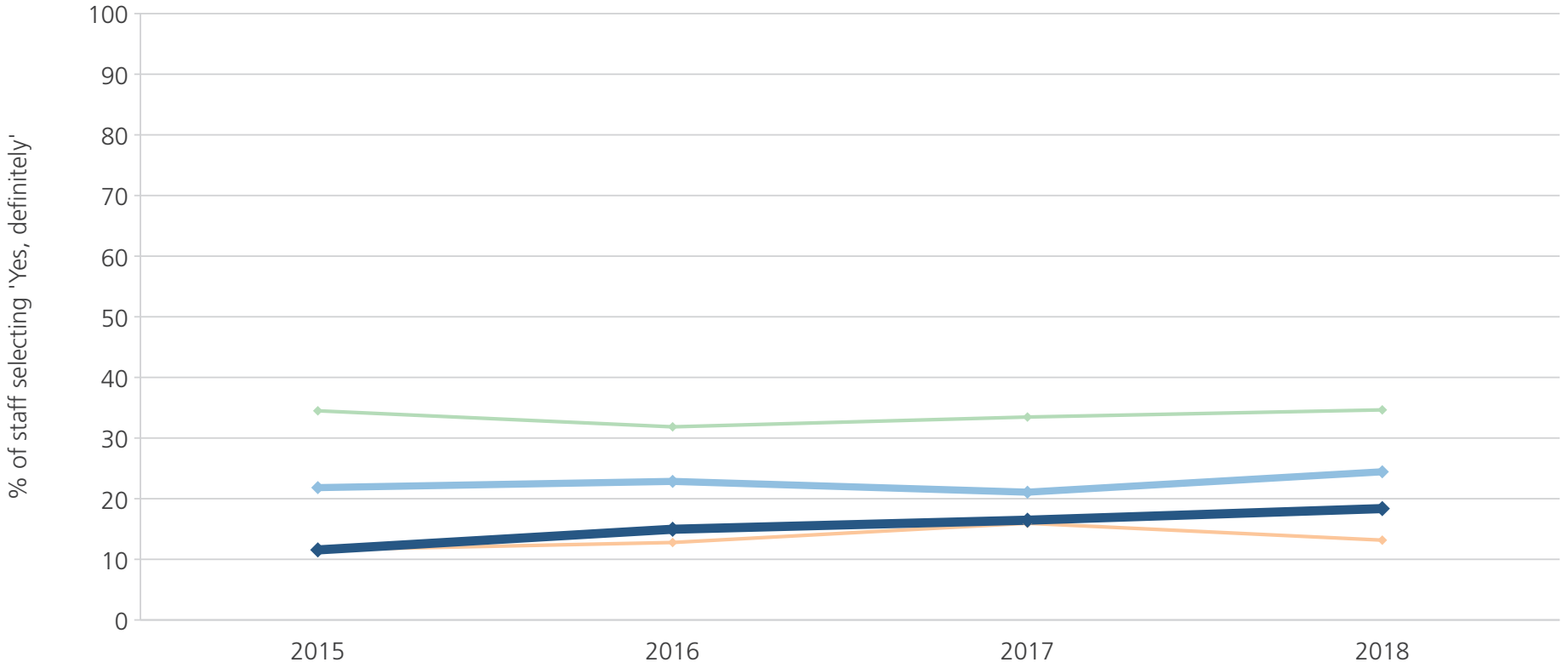
2018 NHS Staff Survey Results > Question results > Your personal development
> Q19a > In the last 12 months, have you had an appraisal, annual review, development review, or Knowledge and Skills Framework (KSF) development review?

NHS England



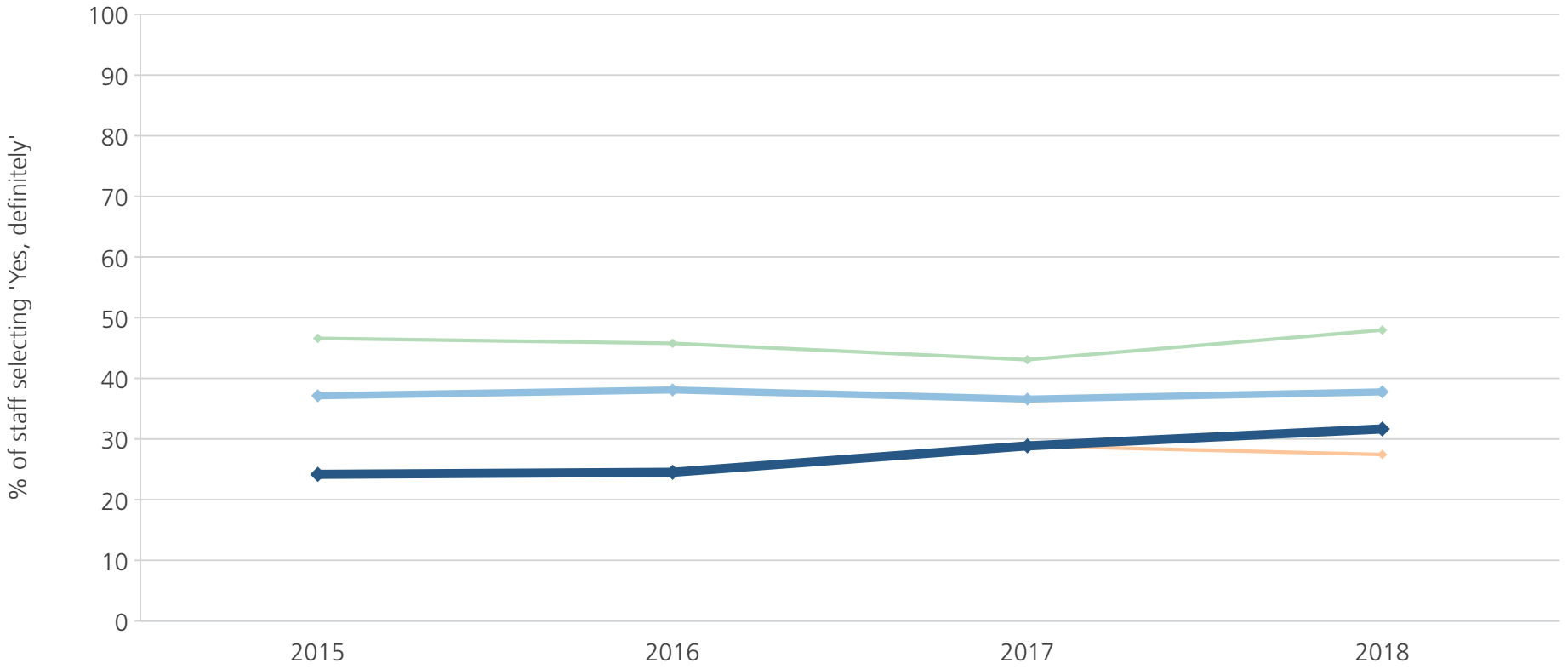
	2014	2015	2016	2017	2018
Best	90.0%	95.2%	93.1%	96.2%	94.3%
Your org	76.2%	78.2%	82.4%	87.0%	92.3%
Average	83.6%	86.7%	86.8%	88.0%	89.2%
Worst	68.3%	73.2%	79.1%	70.1%	82.1%
No. responses	1,078	877	1,089	1,679	1,924

Note: This question was only answered by staff who selected 'Yes' on q19a.



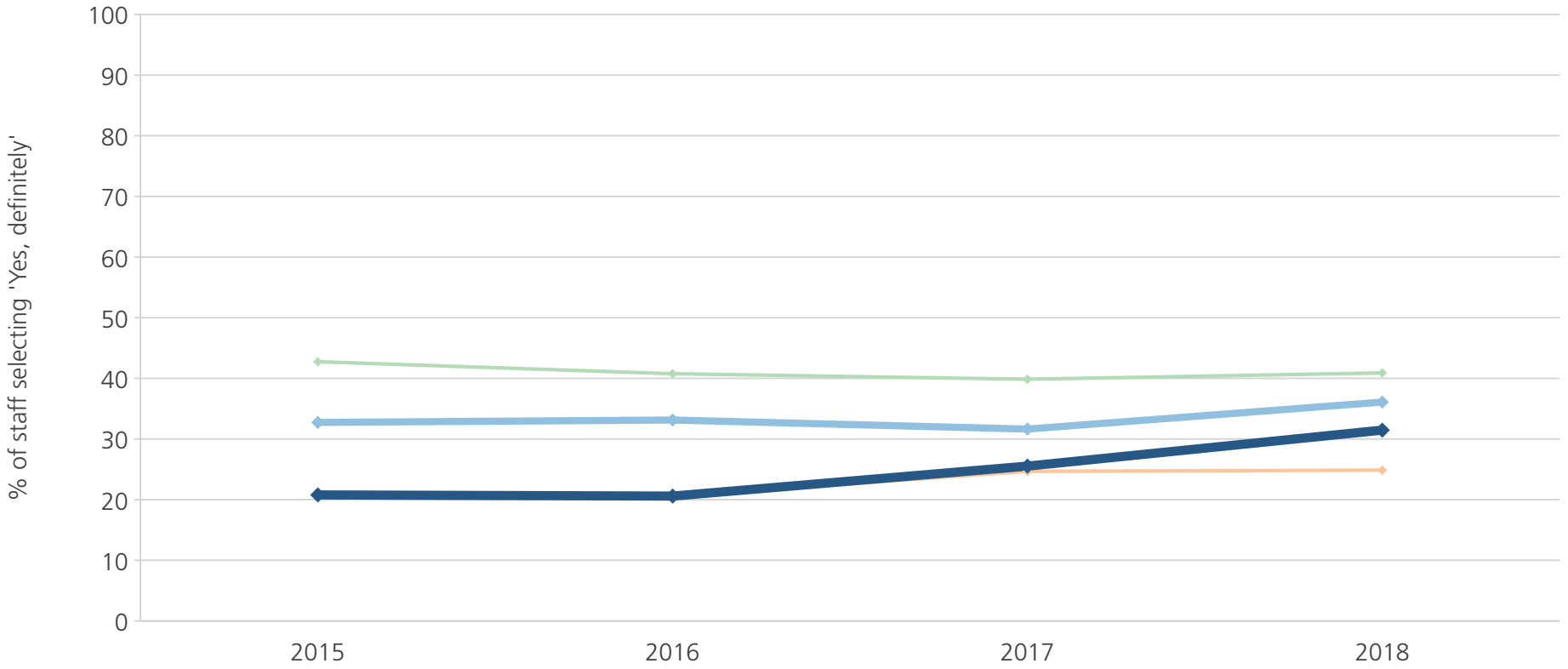
	2015	2016	2017	2018
Best	34.5%	31.9%	33.5%	34.6%
Your org	11.6%	15.0%	16.5%	18.4%
Average	21.8%	22.9%	21.1%	24.4%
Worst	11.6%	12.8%	15.9%	13.2%
No. responses	694	900	1,456	1,772

Note: This question was only answered by staff who selected 'Yes' on q19a.



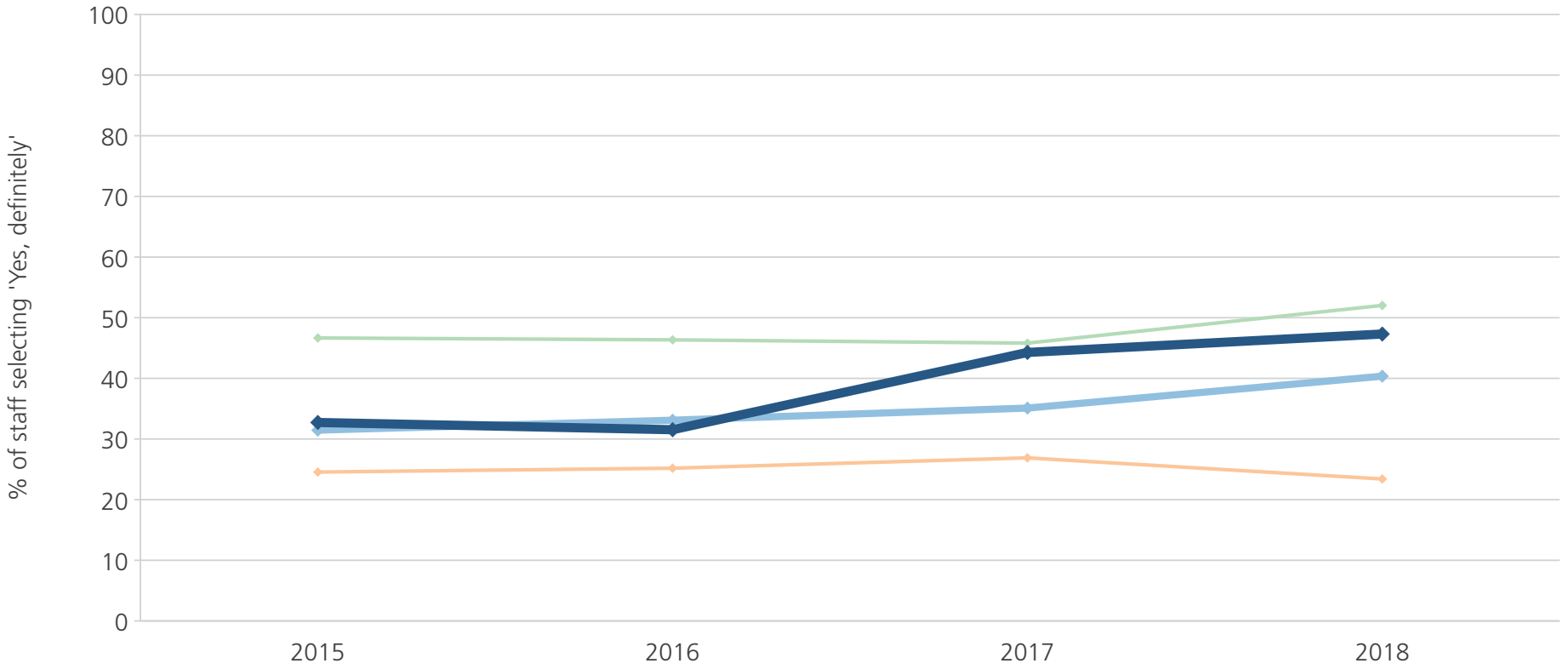
	2015	2016	2017	2018
Best	46.6%	45.8%	43.1%	48.0%
Your org	24.2%	24.5%	28.9%	31.7%
Average	37.1%	38.1%	36.6%	37.8%
Worst	24.2%	24.5%	28.9%	27.4%
No. responses	694	896	1,453	1,762

Note: This question was only answered by staff who selected 'Yes' on q19a.



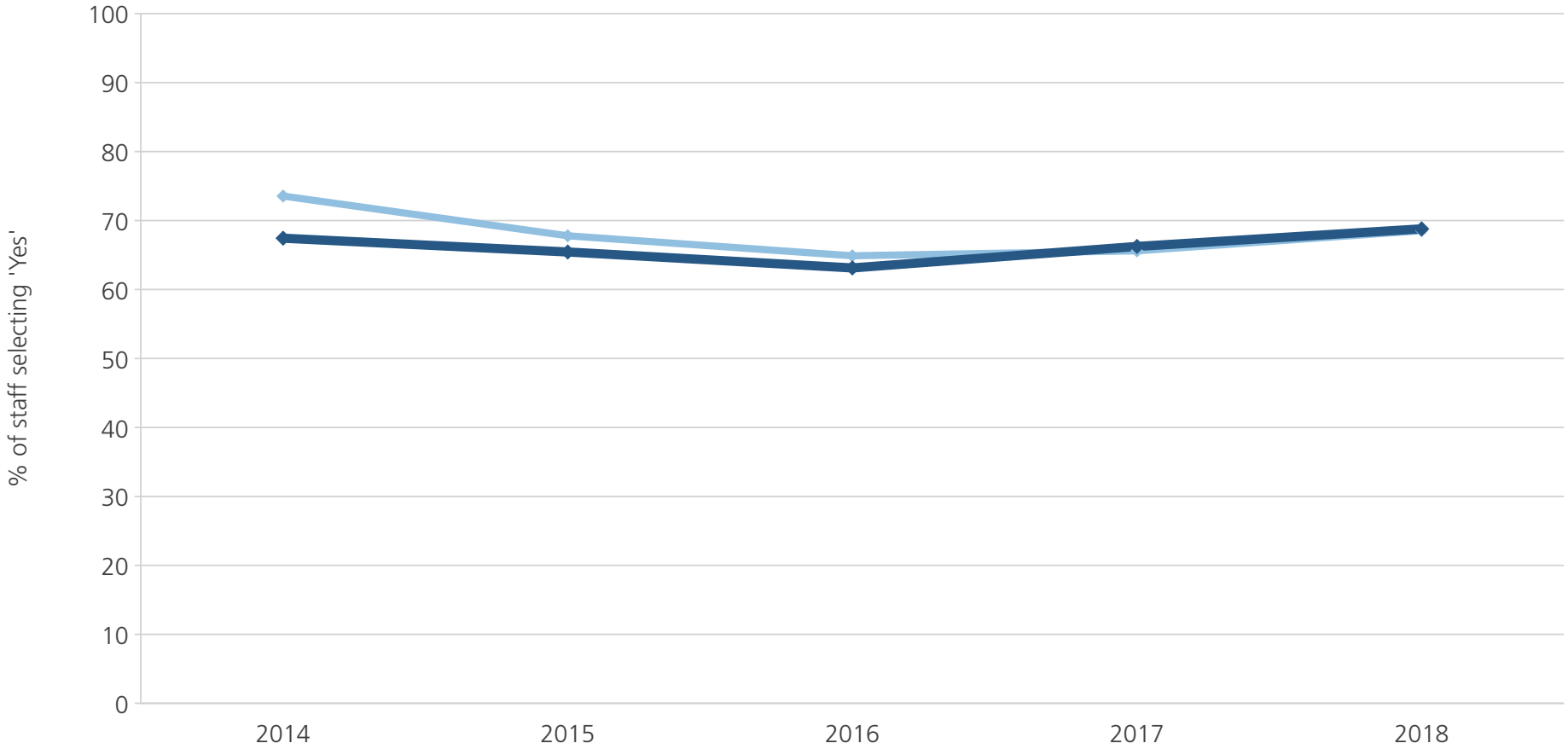
	2015	2016	2017	2018
Best	42.7%	40.8%	39.9%	40.9%
Your org	20.8%	20.6%	25.5%	31.5%
Average	32.7%	33.1%	31.6%	36.1%
Worst	20.8%	20.6%	24.7%	24.9%
No. responses	692	890	1,448	1,755

Note: This question was only answered by staff who selected 'Yes' on q19a.



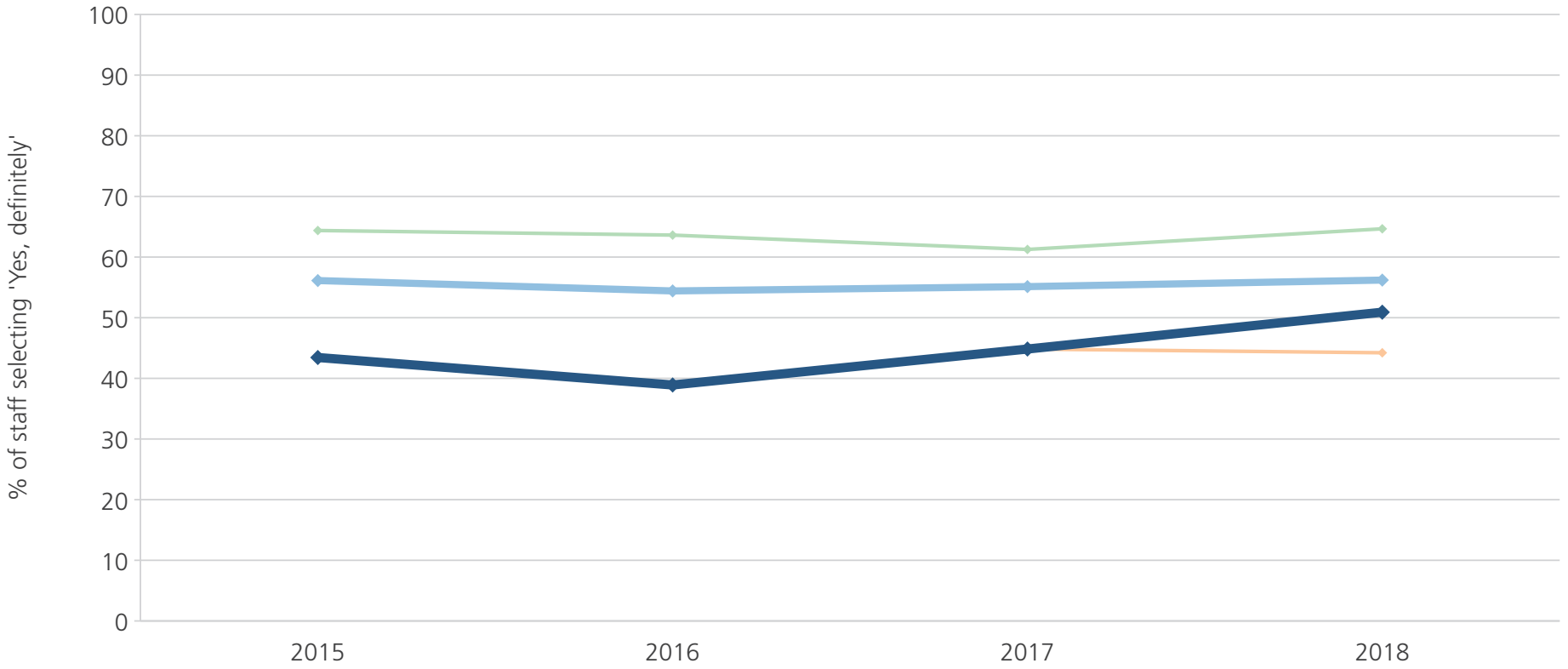
	2015	2016	2017	2018
Best	46.7%	46.3%	45.8%	52.0%
Your org	32.7%	31.5%	44.3%	47.3%
Average	31.5%	33.1%	35.1%	40.4%
Worst	24.6%	25.2%	26.9%	23.4%
No. responses	686	888	1,435	1,750

Note: This question was only answered by staff who selected 'Yes' on q19a.



	2014	2015	2016	2017	2018
Your org	67.4%	65.4%	63.1%	66.2%	68.8%
Average	73.5%	67.8%	64.9%	65.6%	68.5%
No. responses	820	680	876	1,425	1,753

Note: This question was only answered by staff who selected 'Yes' on q19f.

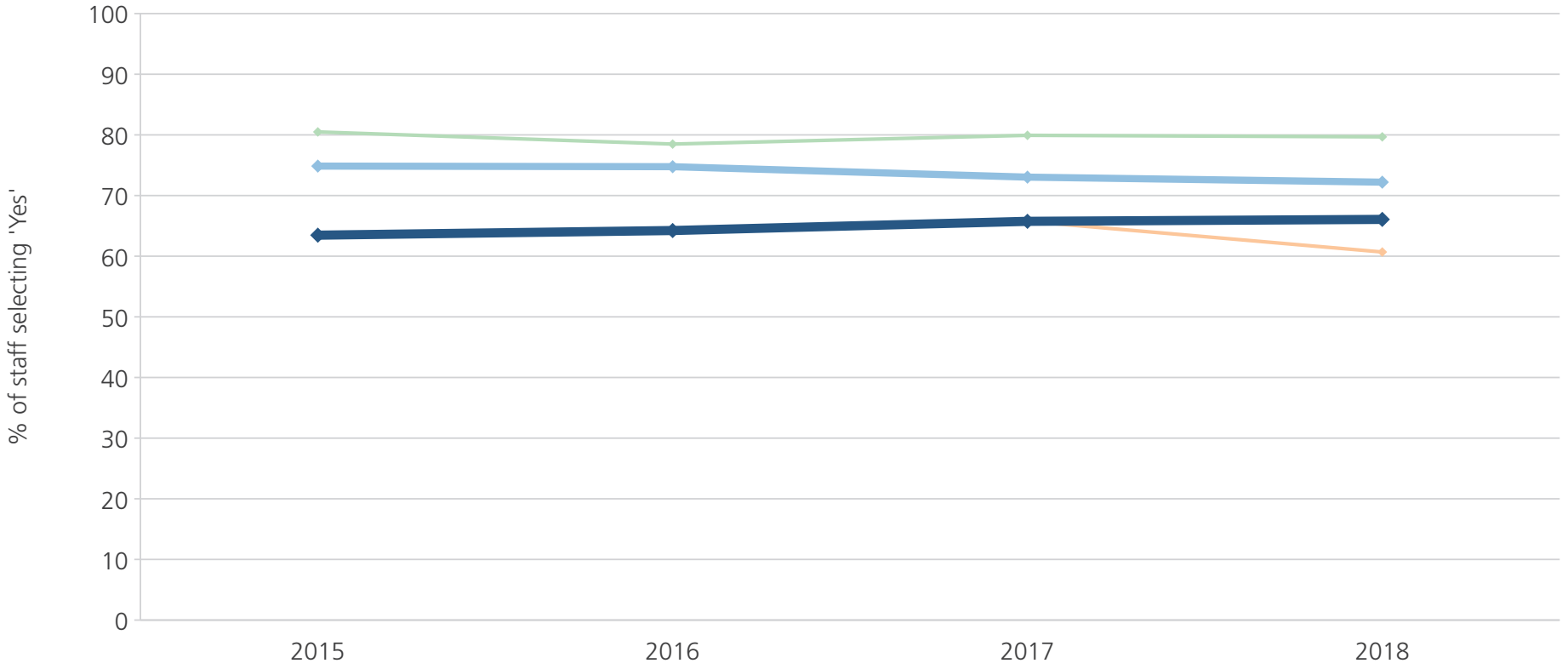


	2015	2016	2017	2018
Best	64.4%	63.6%	61.3%	64.7%
Your org	43.4%	38.9%	44.8%	50.9%
Average	56.1%	54.4%	55.1%	56.2%
Worst	43.4%	38.9%	44.8%	44.2%
No. responses	444	542	933	1,185

Survey Coordination Centre

2018 NHS Staff Survey Results > Question results > Your personal development > Q20
> Have you had any (non-mandatory) training, learning or development in the last 12 months?

NHS England



	2015	2016	2017	2018
Best	80.5%	78.5%	79.9%	79.7%
Your org	63.5%	64.2%	65.7%	66.1%
Average	74.9%	74.8%	73.0%	72.2%
Worst	63.5%	64.2%	65.7%	60.7%
No. responses	902	1,097	1,691	1,929

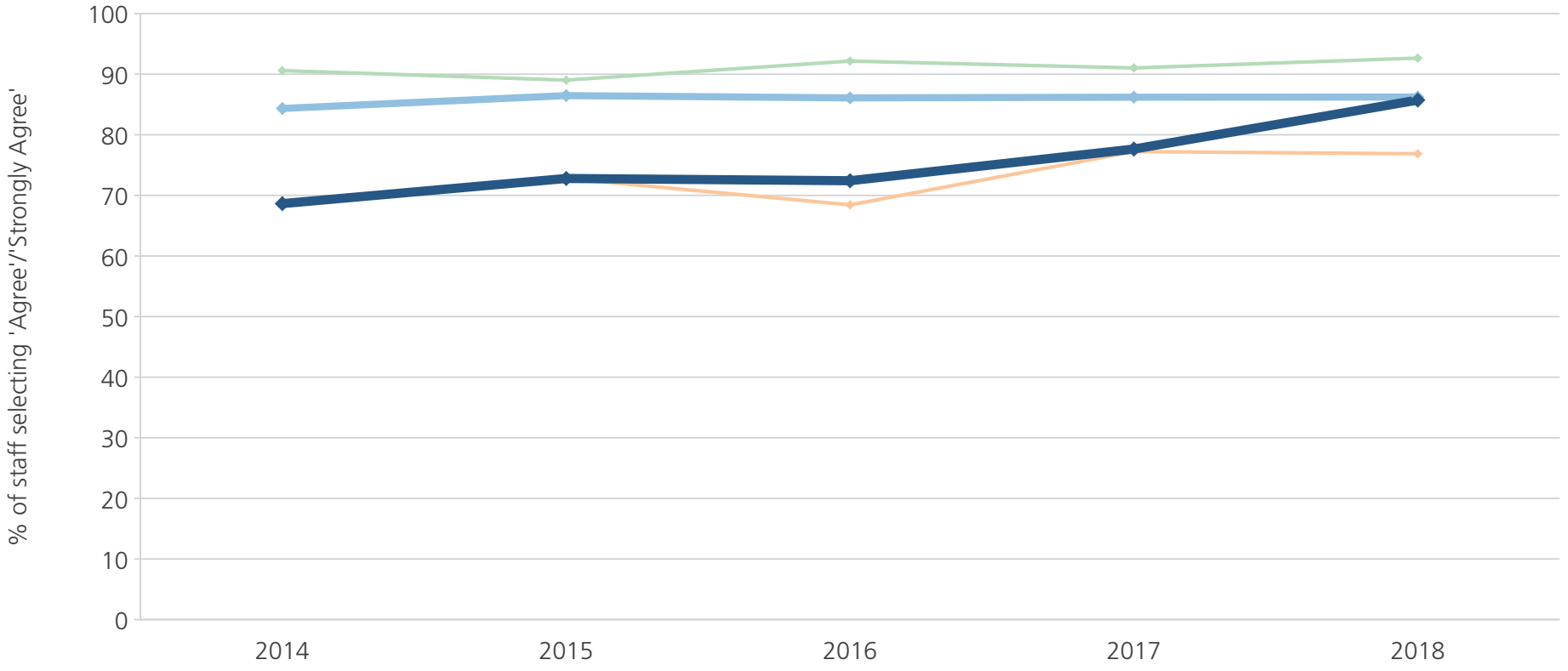
Survey Coordination Centre

NHS England

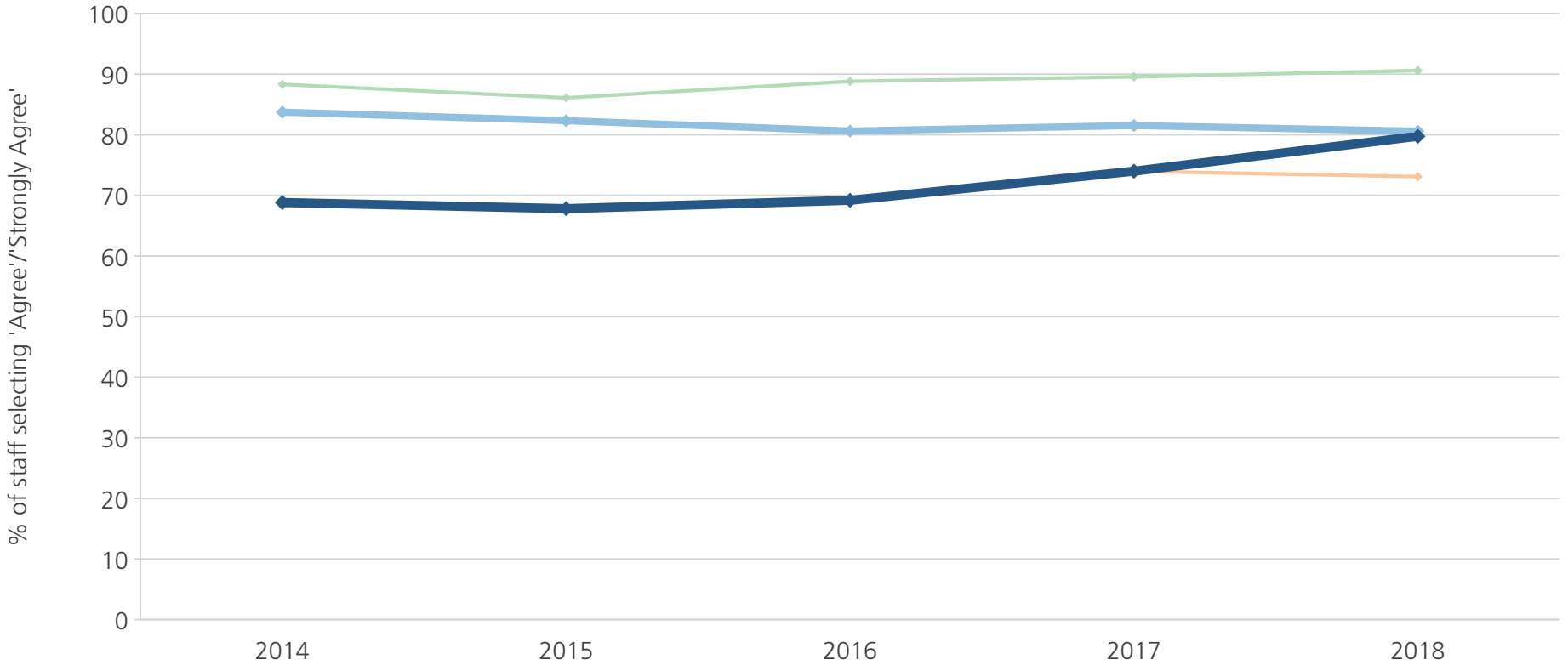
Question results – Your organisation

Alder Hey Children's NHS Foundation Trust

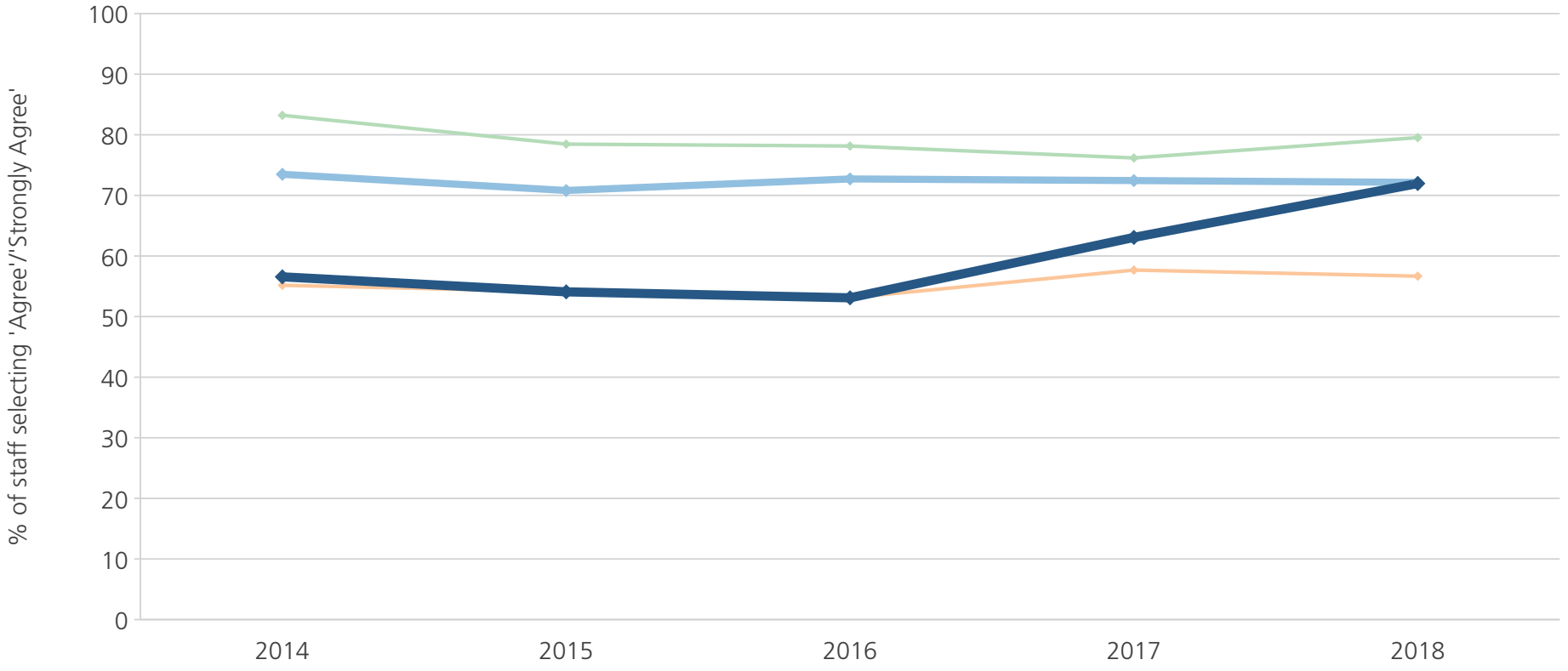
2018 NHS Staff Survey Results



	2014	2015	2016	2017	2018
Best	90.6%	89.0%	92.2%	91.0%	92.7%
Your org	68.6%	72.8%	72.4%	77.6%	85.7%
Average	84.3%	86.5%	86.1%	86.2%	86.2%
Worst	68.5%	72.8%	68.4%	77.2%	76.9%
No. responses	1,107	908	1,108	1,715	1,972



	2014	2015	2016	2017	2018
Best	88.3%	86.1%	88.8%	89.6%	90.6%
Your org	68.8%	67.8%	69.2%	74.0%	79.7%
Average	83.7%	82.3%	80.6%	81.5%	80.6%
Worst	68.8%	67.8%	69.2%	74.0%	73.1%
No. responses	1,105	906	1,107	1,708	1,967

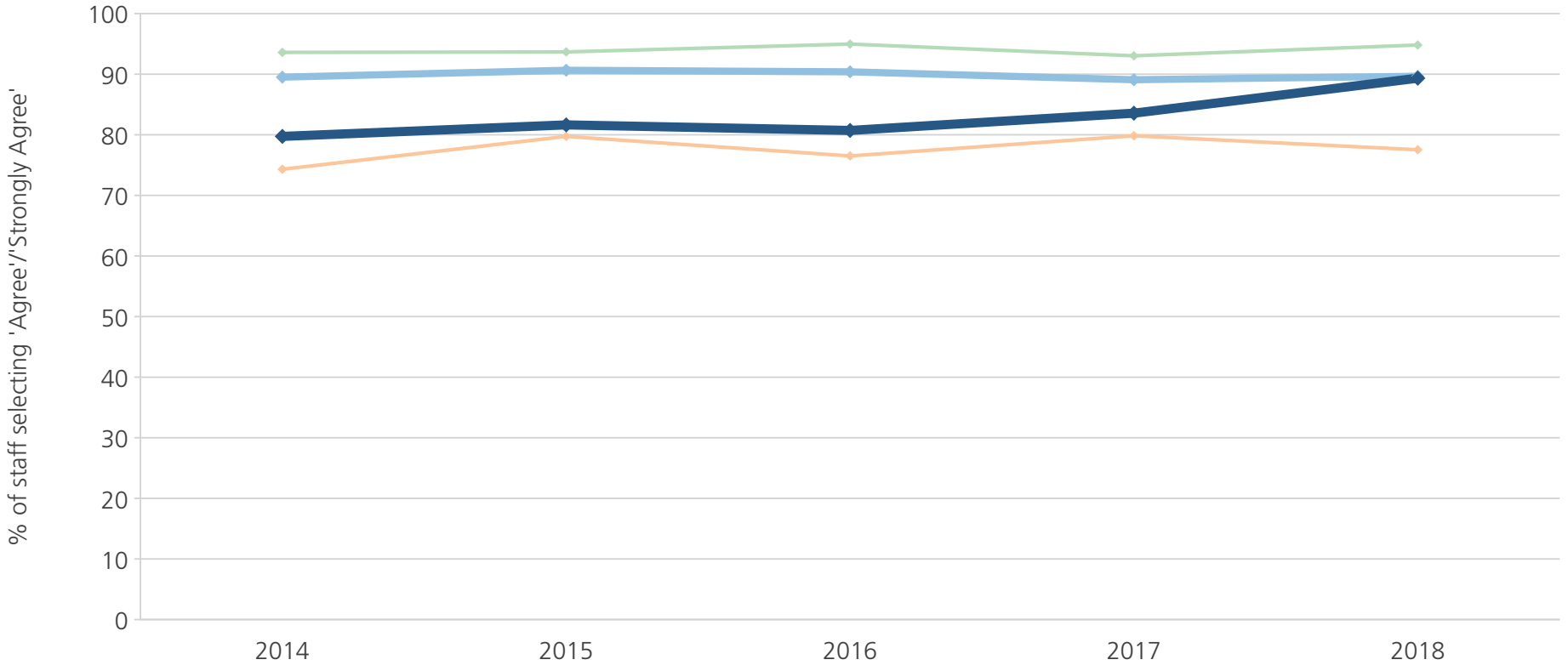


	2014	2015	2016	2017	2018
Best	83.2%	78.5%	78.1%	76.2%	79.5%
Your org	56.6%	54.1%	53.1%	63.1%	72.0%
Average	73.5%	70.8%	72.7%	72.4%	72.1%
Worst	55.2%	54.1%	53.1%	57.7%	56.7%
No. responses	1,107	910	1,104	1,711	1,972

Survey Coordination Centre

2018 NHS Staff Survey Results > Question results > Your organisation > Q21d **>** If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation

NHS England

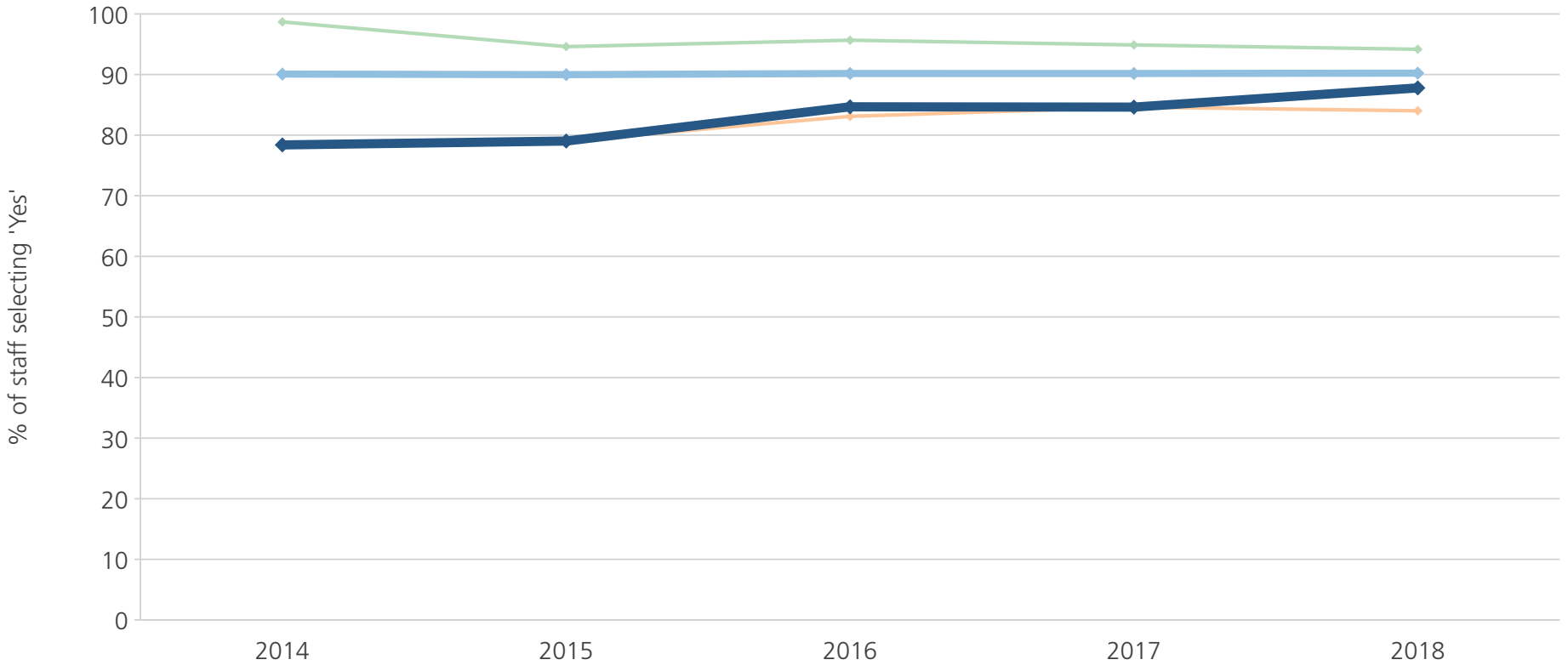


	2014	2015	2016	2017	2018
Best	93.6%	93.7%	95.0%	93.0%	94.8%
Your org	79.7%	81.6%	80.7%	83.6%	89.3%
Average	89.5%	90.6%	90.4%	89.1%	89.7%
Worst	74.3%	79.7%	76.5%	79.8%	77.5%
No. responses	1,104	907	1,105	1,704	1,962

Survey Coordination Centre

2018 NHS Staff Survey Results > Question results > Your organisation > Q22a > Is patient / service user experience feedback collected within your directorate / department? (e.g. Friends and Family Test, patient surveys etc.)

NHS England



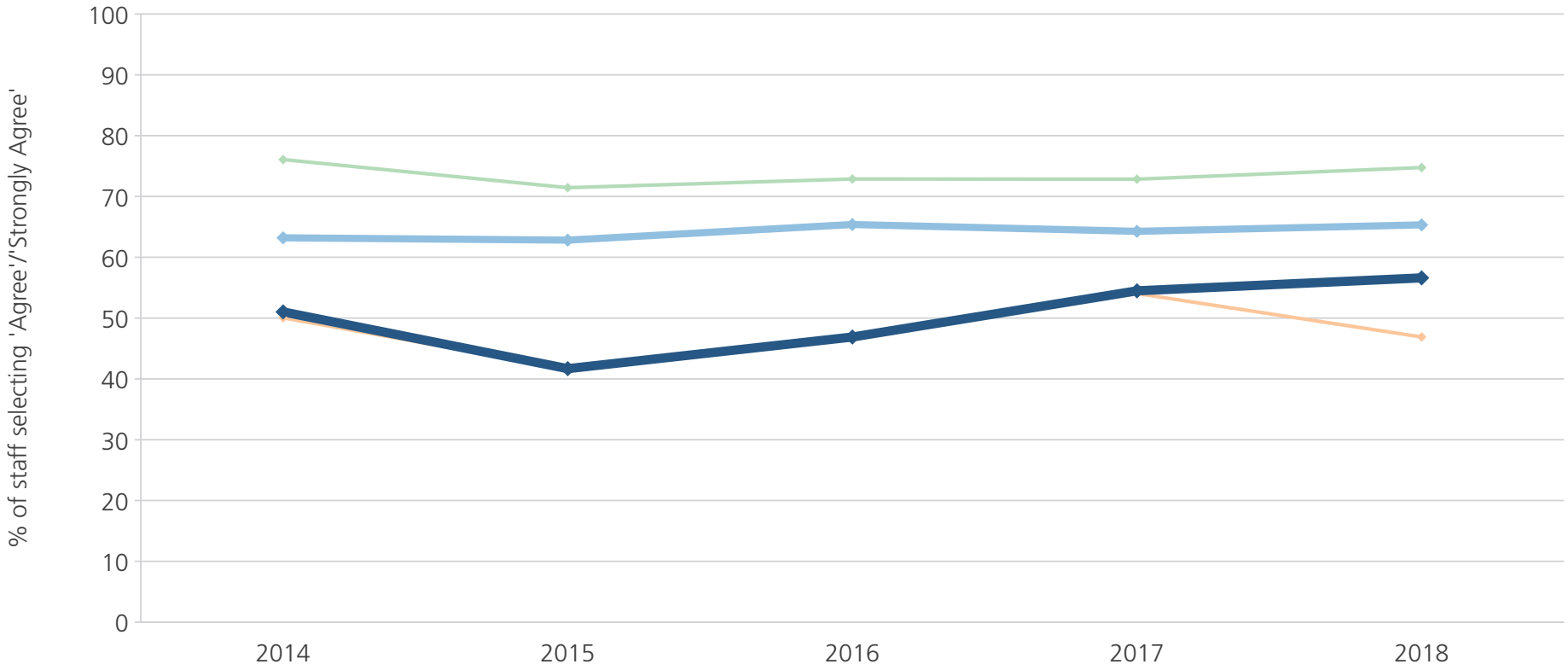
	2014	2015	2016	2017	2018
Best	98.7%	94.6%	95.7%	94.9%	94.2%
Your org	78.4%	79.0%	84.7%	84.6%	87.8%
Average	90.1%	90.0%	90.2%	90.2%	90.2%
Worst	78.4%	79.0%	83.1%	84.6%	84.0%
No. responses	635	529	666	1,100	1,279

Survey Coordination Centre

2018 NHS Staff Survey Results > Question results > Your organisation >
Q22b > I receive regular updates on patient / service user experience feedback in my directorate / department (e.g. via line managers or communications teams)

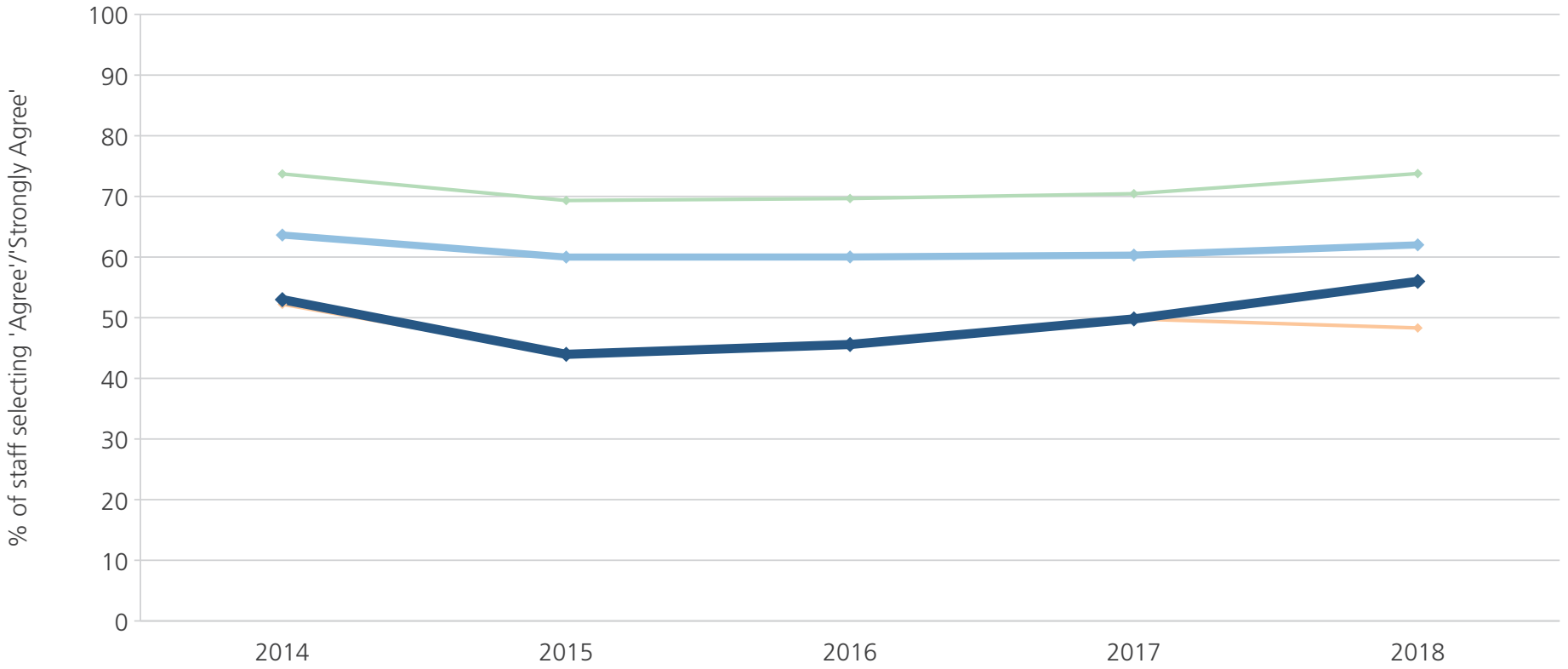
NHS England

Note: This question was only answered by staff who selected 'Yes' on q22a.

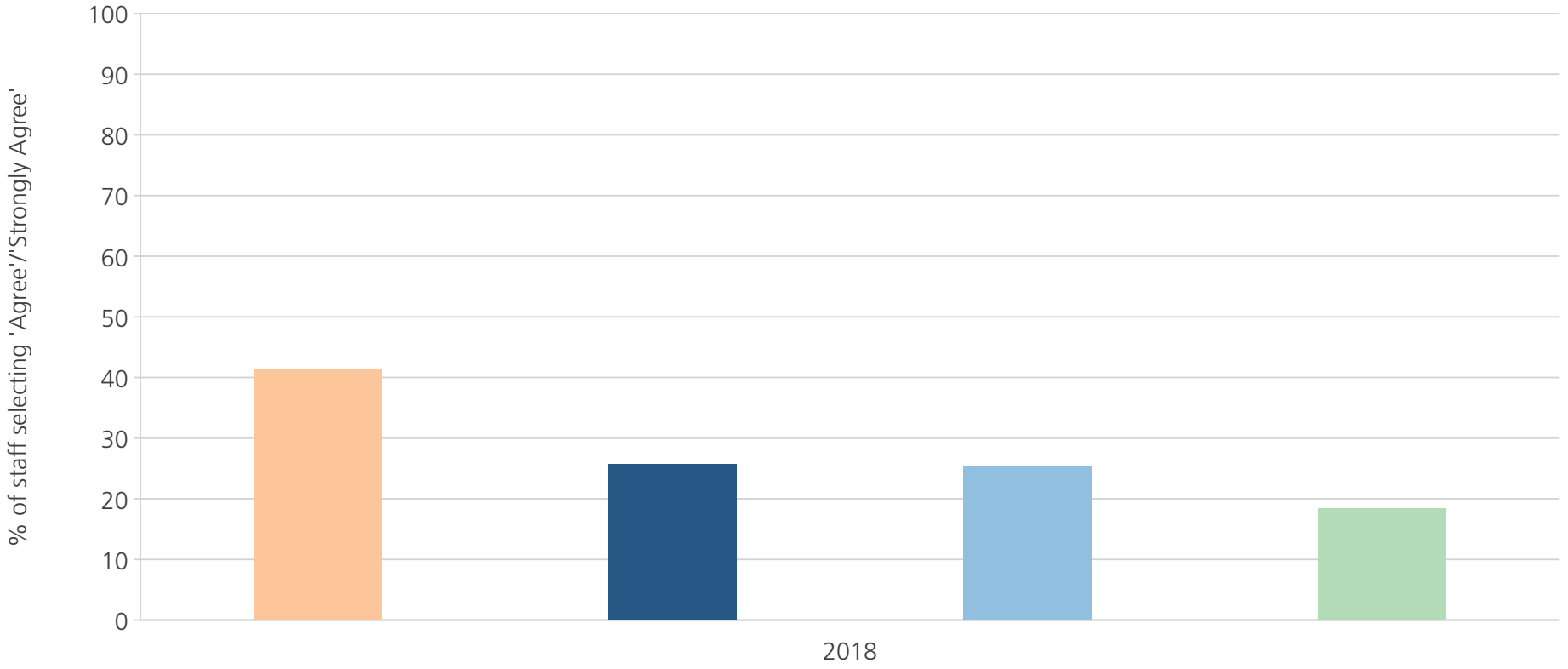


	2014	2015	2016	2017	2018
Best	76.1%	71.4%	72.9%	72.8%	74.8%
Your org	51.0%	41.7%	46.9%	54.5%	56.6%
Average	63.2%	62.8%	65.4%	64.3%	65.3%
Worst	50.0%	41.7%	46.9%	54.0%	46.9%
No. responses	493	411	543	891	1,081

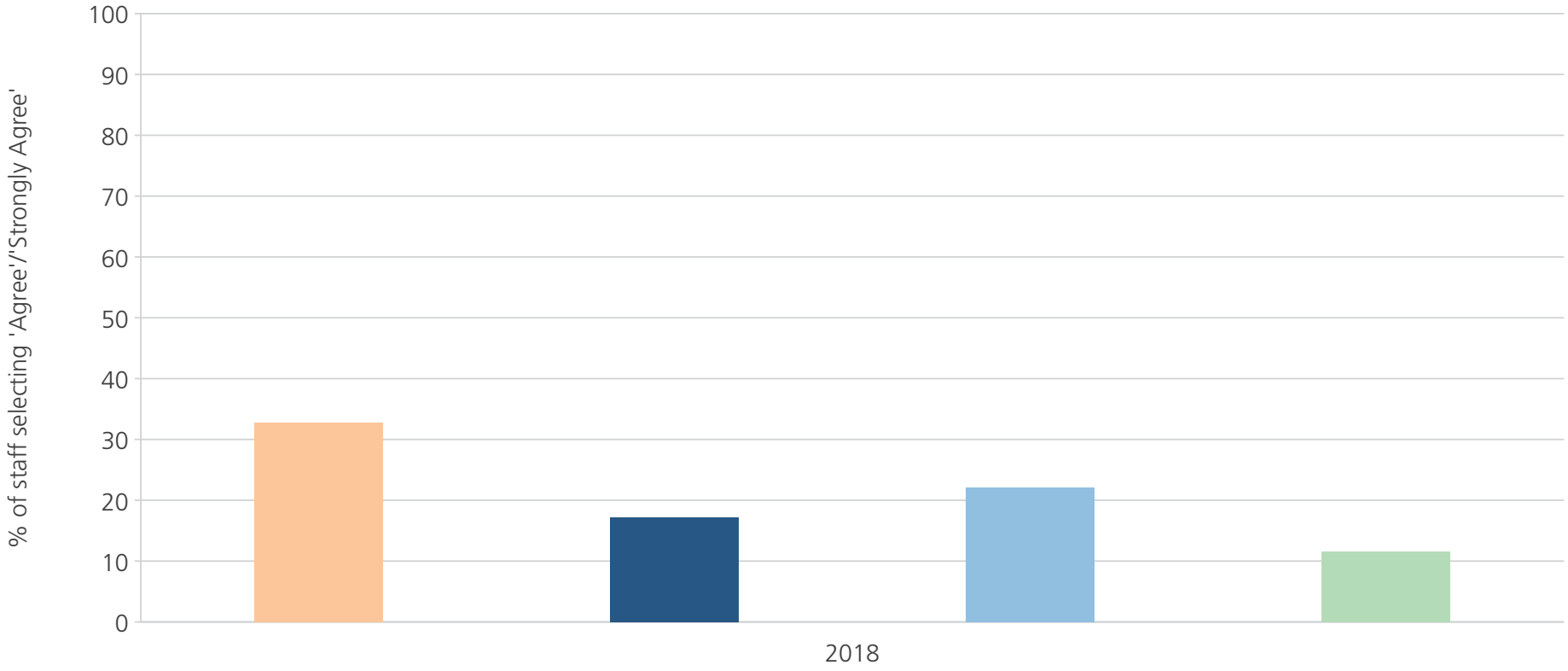
Note: This question was only answered by staff who selected 'Yes' on q22a.



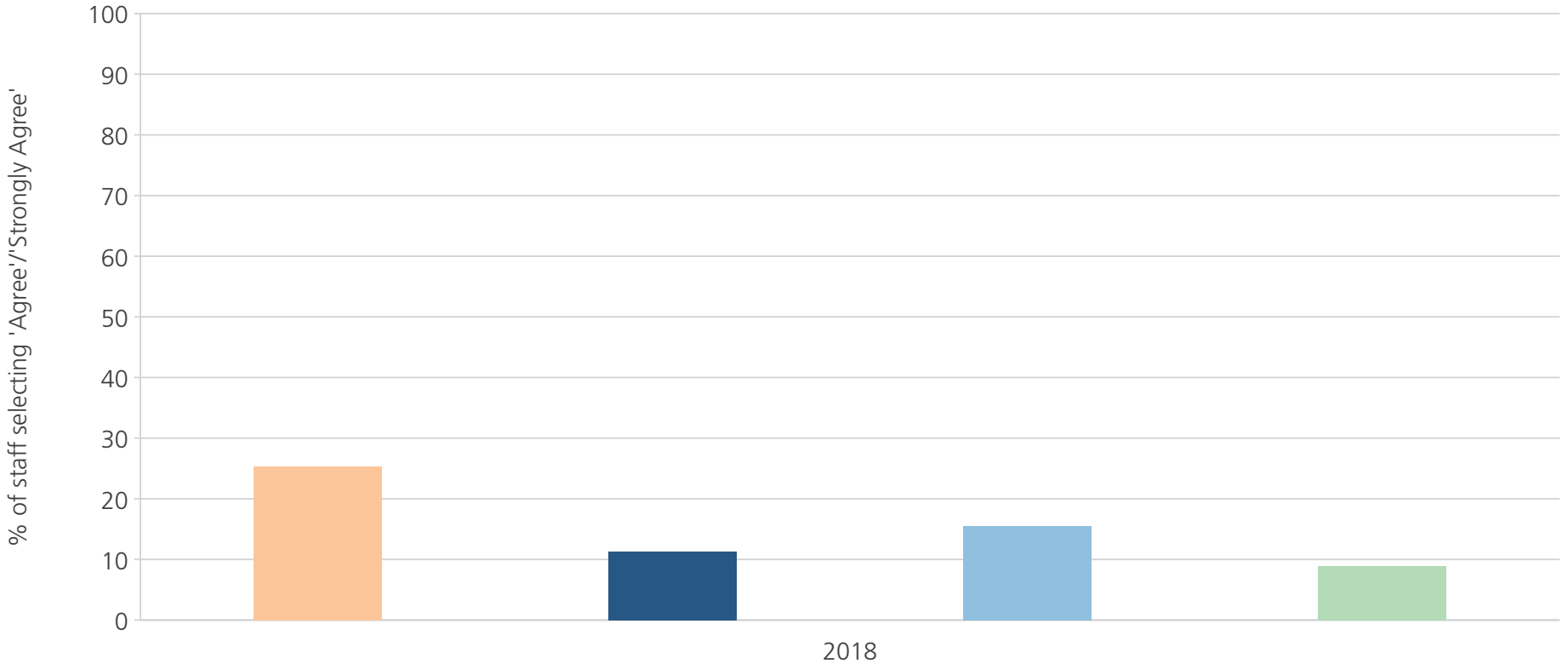
	2014	2015	2016	2017	2018
Best	73.7%	69.3%	69.7%	70.4%	73.8%
Your org	53.0%	44.0%	45.6%	49.8%	56.0%
Average	63.6%	60.0%	60.0%	60.3%	62.0%
Worst	52.2%	44.0%	45.6%	49.8%	48.3%
No. responses	469	393	503	837	983



Worst	41.5%
Your org	25.7%
Average	25.3%
Best	18.5%
No. responses	1,975



Worst	32.8%
Your org	17.1%
Average	22.1%
Best	11.6%
No. responses	1,969

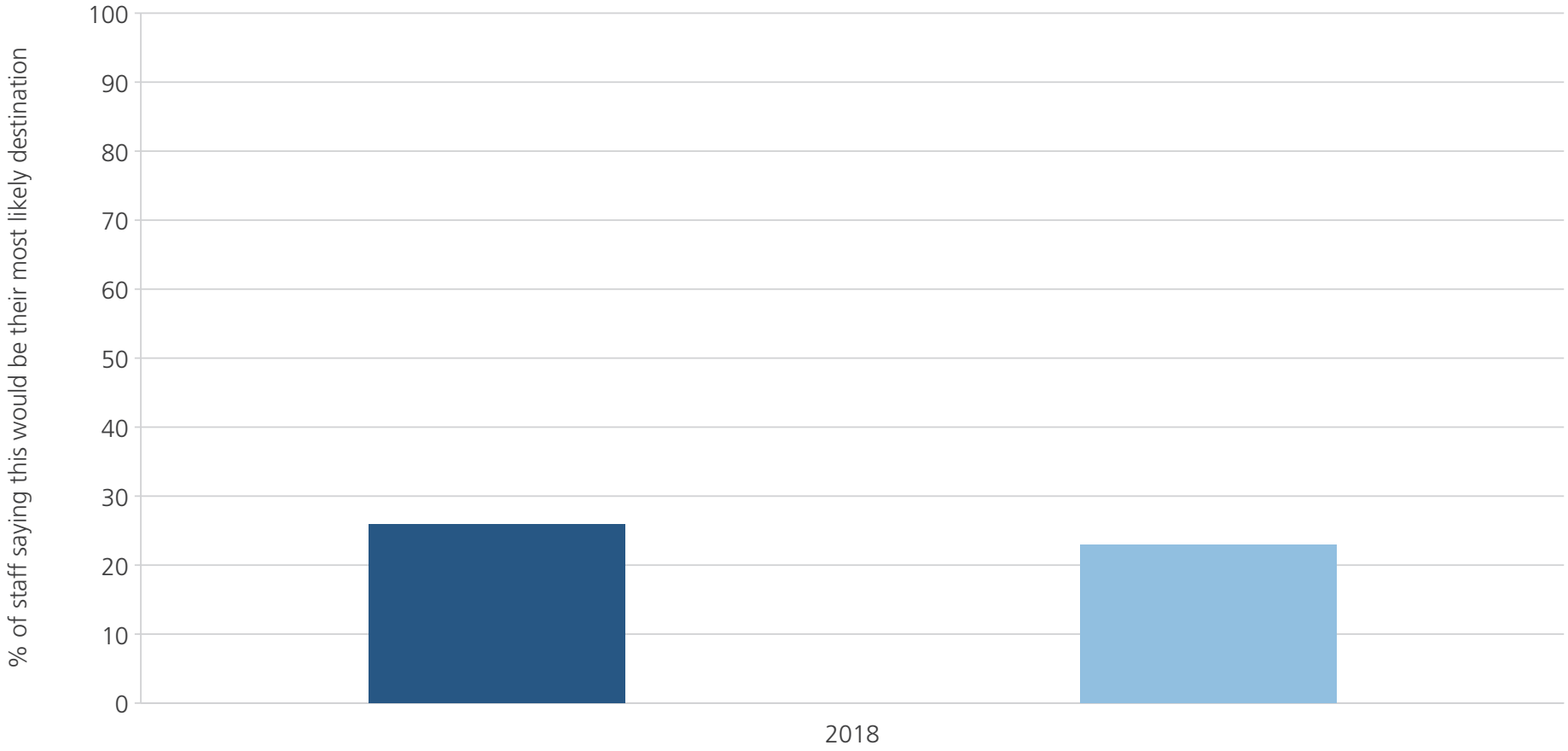


Worst	25.3%
Your org	11.3%
Average	15.6%
Best	8.9%
No. responses	1,957

Survey Coordination Centre

2018 NHS Staff Survey Results > Question results > Your organisation >
Q23d.1 > If you are considering leaving your current job, what would be your most likely destination? - I would want to move to another job within this organisation

NHS England

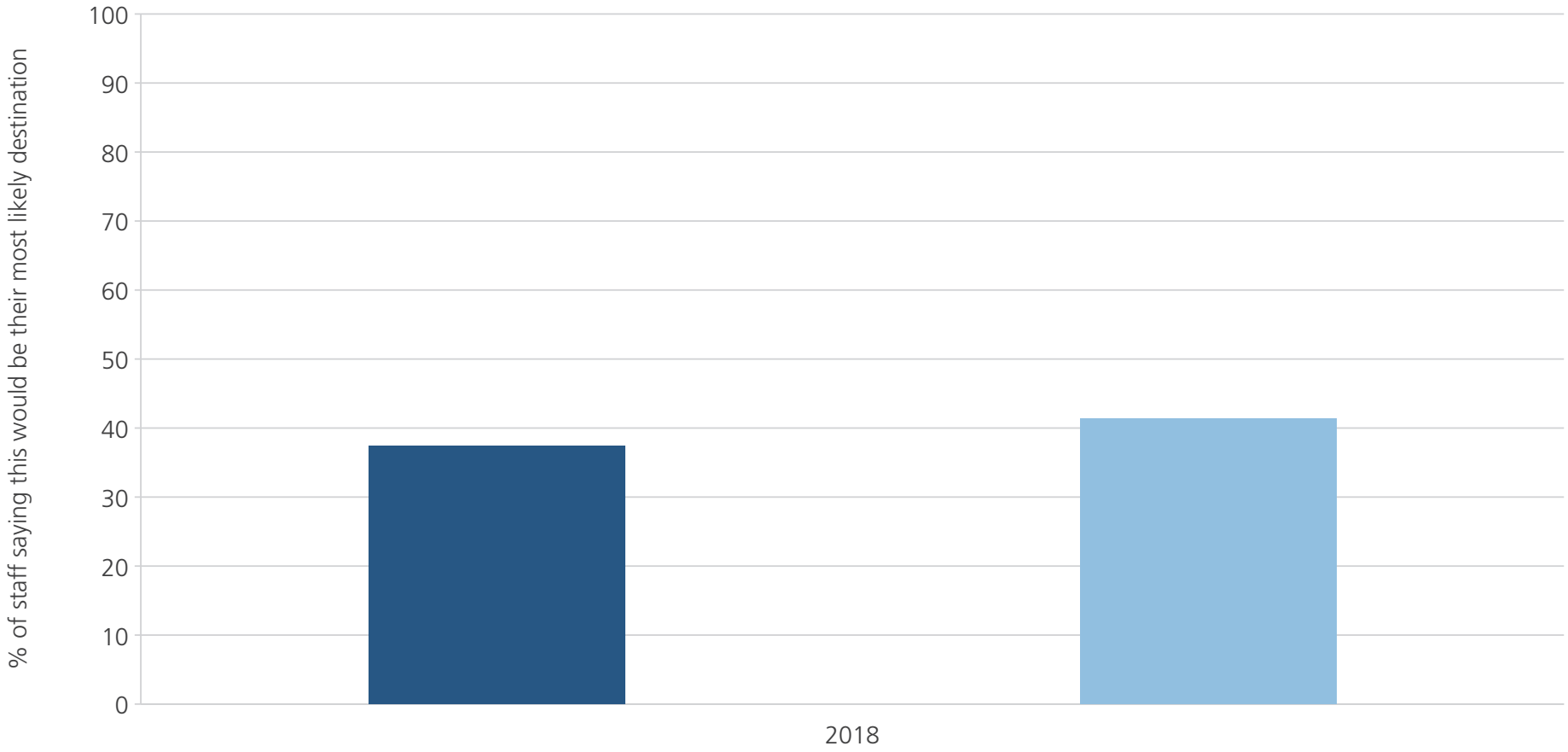


	2018
Your org	25.9%
Average	23.0%
No. responses	752

Survey Coordination Centre

2018 NHS Staff Survey Results > Question results > Your organisation > Q23d.2 > If you are considering leaving your current job, what would be your most likely destination? - I would want to move to a job in a different NHS trust/organisation

NHS England

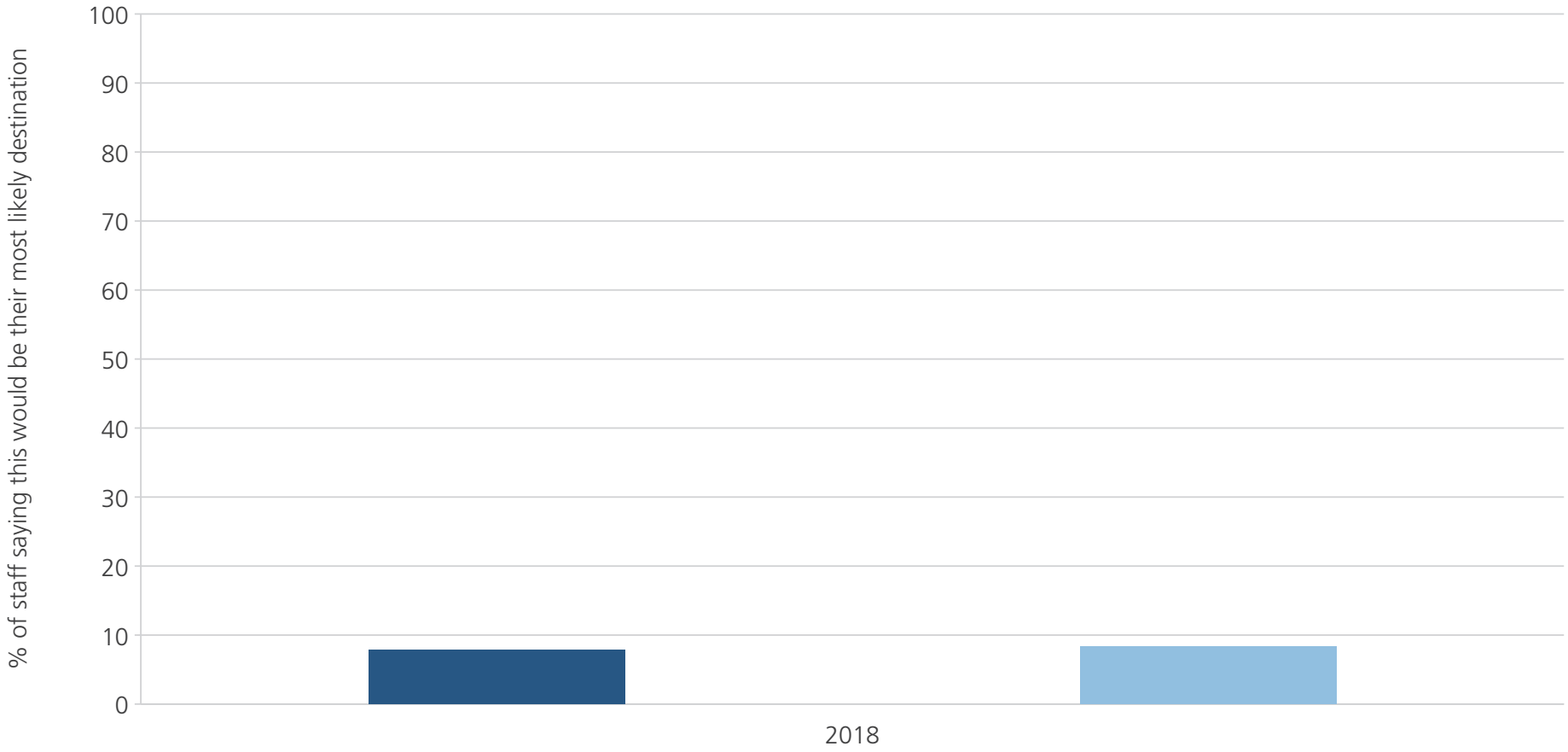


	2018
Your org	37.4%
Average	41.4%
No. responses	752

Survey Coordination Centre

2018 NHS Staff Survey Results > Question results > Your organisation > Q23d.3 > If you are considering leaving your current job, what would be your most likely destination? - I would want to move to a job in healthcare, but outside the NHS

NHS England

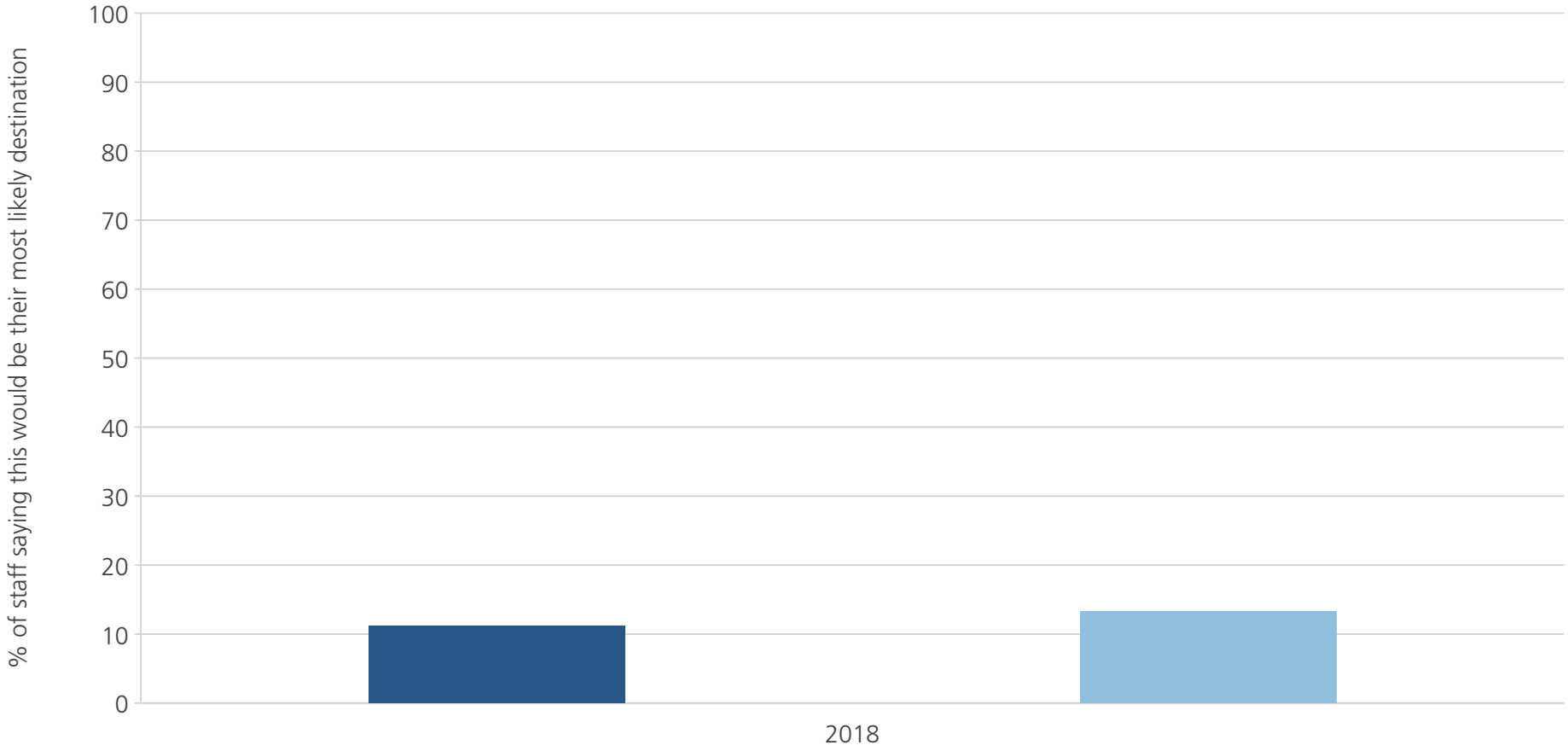


	2018
Your org	7.8%
Average	8.3%
No. responses	752

Survey Coordination Centre

2018 NHS Staff Survey Results > Question results > Your organisation >
Q23d.4 > If you are considering leaving your current job, what would be your most likely destination? - I would want to move to a job outside healthcare

NHS England

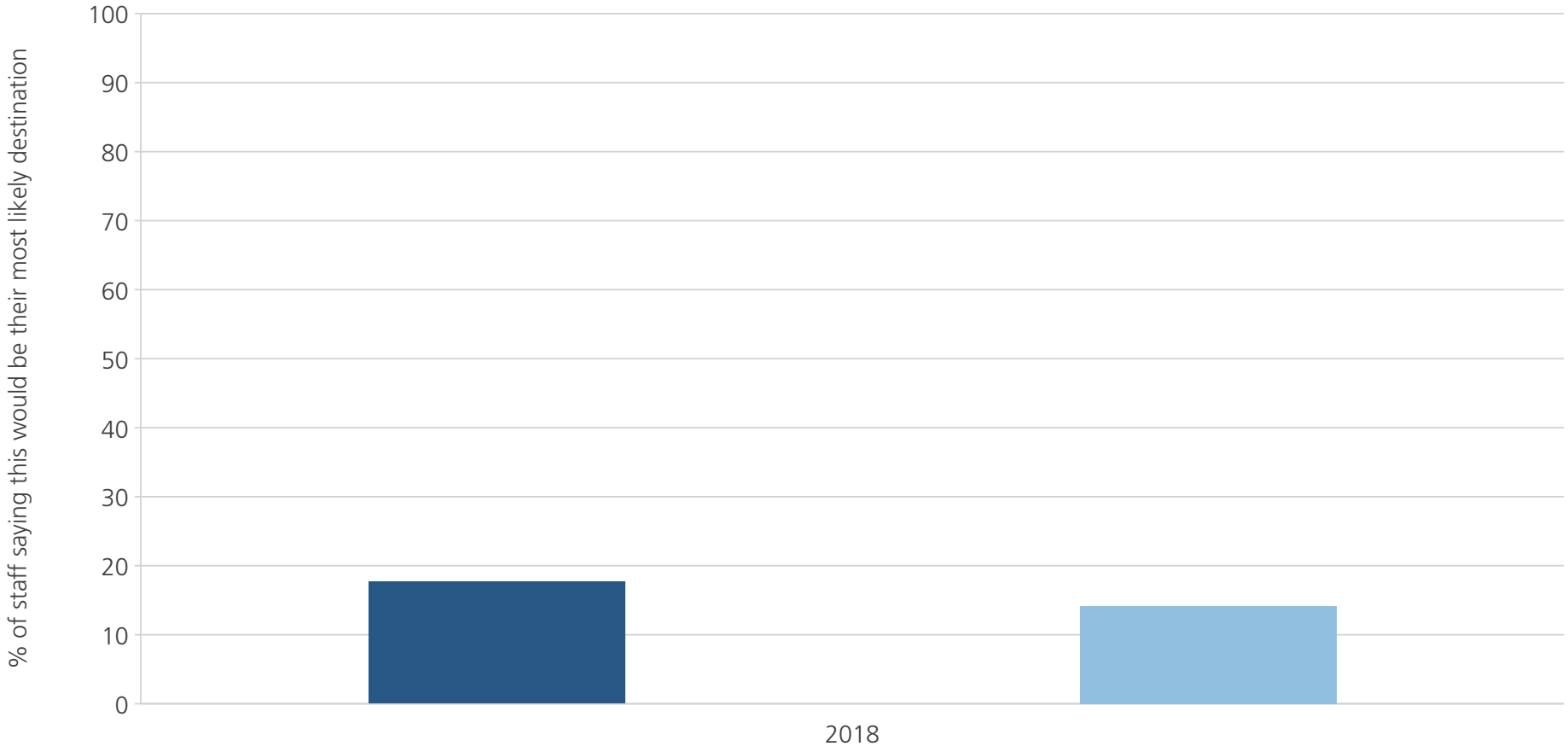


	2018
Your org	11.2%
Average	13.3%
No. responses	752

Survey Coordination Centre

2018 NHS Staff Survey Results > Question results > Your organisation > Q23d.5 **>** If you are considering leaving your current job, what would be your most likely destination? - I would retire or take a career break

NHS England



	2018
Your org	17.7%
Average	14.1%
No. responses	752

Survey Coordination Centre

NHS England

Question results – Background details

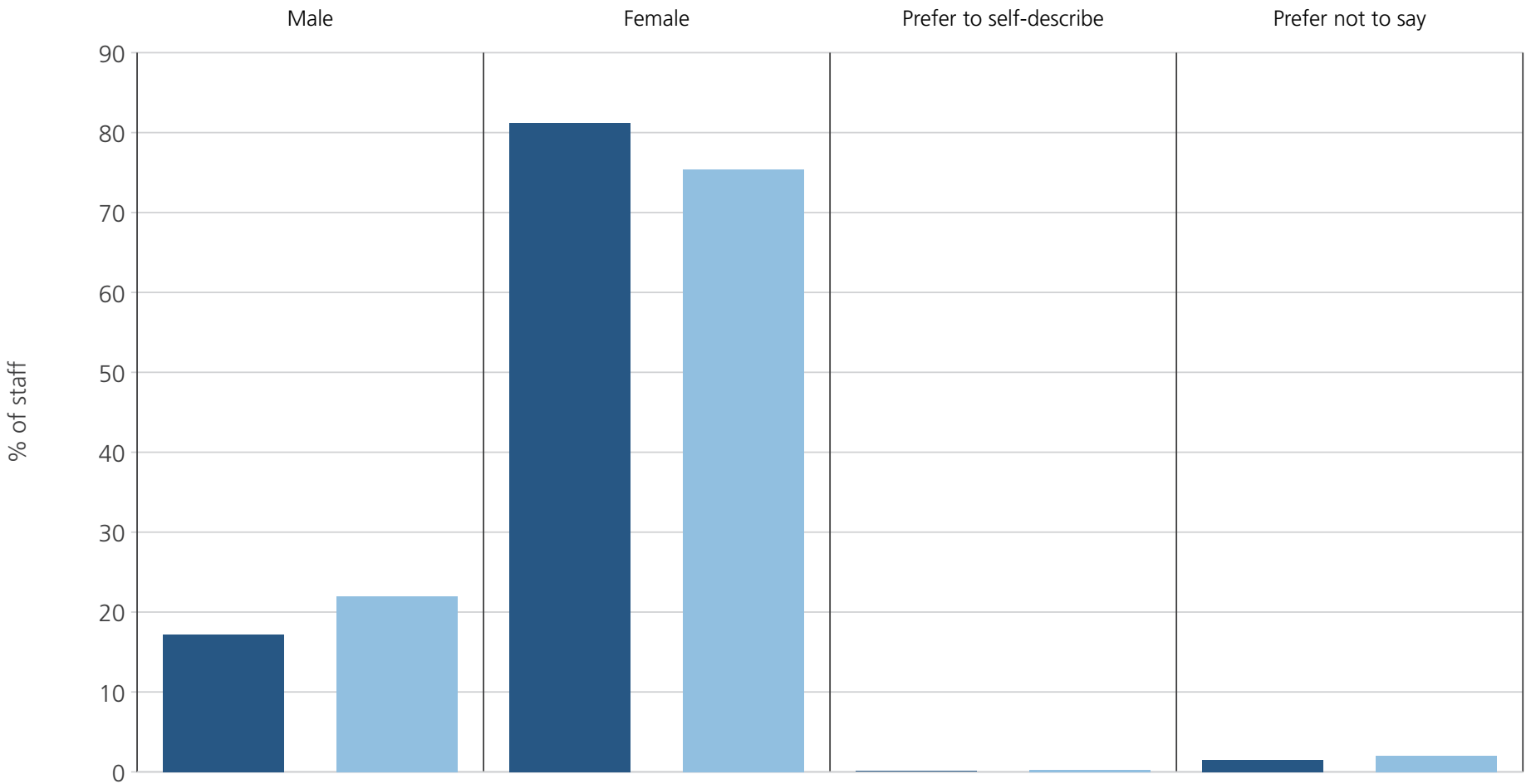
Alder Hey Children's NHS Foundation Trust

2018 NHS Staff Survey Results

Survey Coordination Centre

2018 NHS Staff Survey Results > Question results > Background details > Gender

NHS England

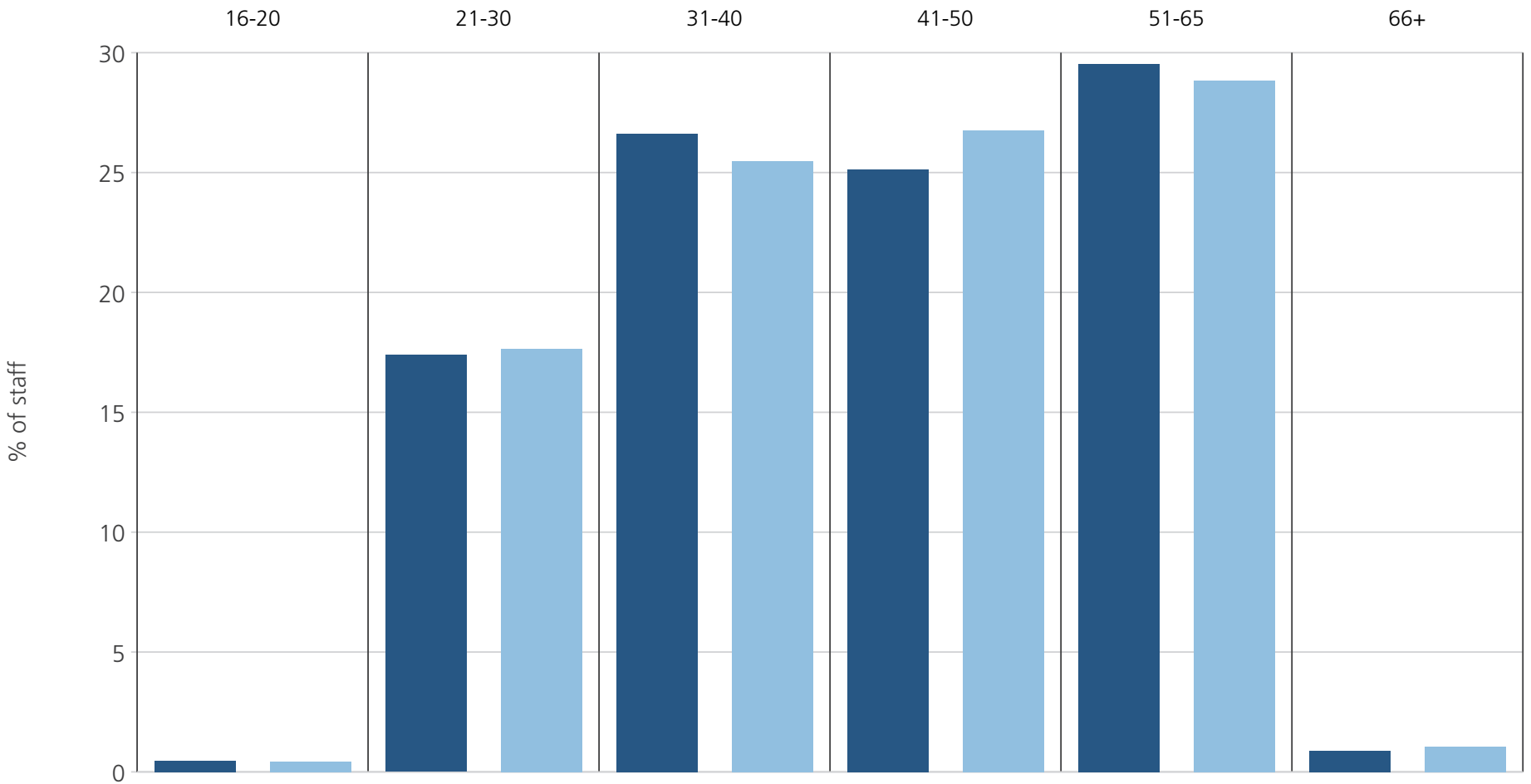


	Male	Female	Prefer to self-describe	Prefer not to say
Your org	17.2%	81.2%	0.1%	1.5%
Average	22.0%	75.4%	0.2%	2.0%
No. responses	1,959	1,959	1,959	1,959

Survey Coordination Centre

2018 NHS Staff Survey Results > Question results > Background details > Age

NHS England

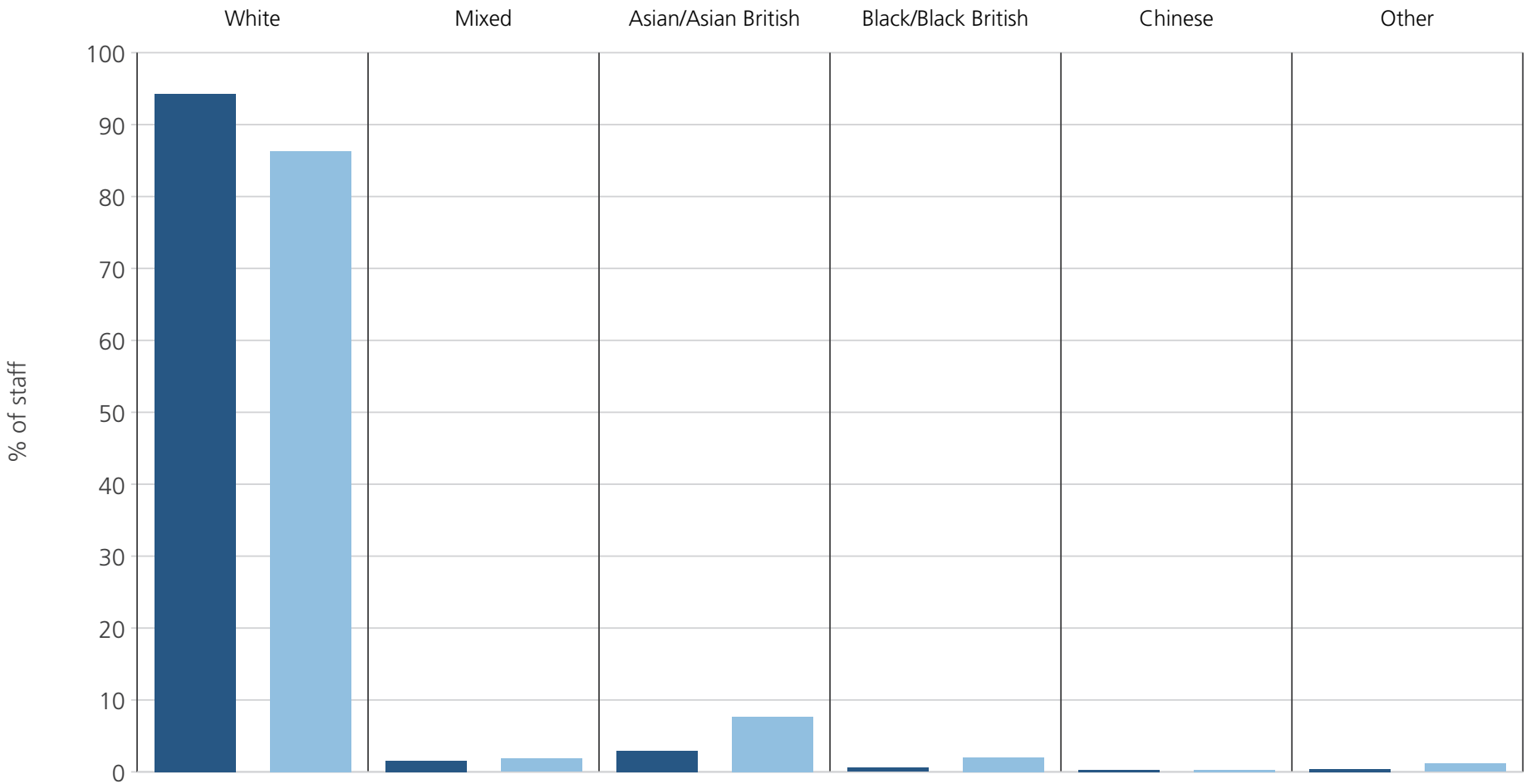


	16-20	21-30	31-40	41-50	51-65	66+
Your org	0.5%	17.4%	26.6%	25.1%	29.5%	0.9%
Average	0.4%	17.6%	25.5%	26.8%	28.8%	1.1%
No. responses	1,961	1,961	1,961	1,961	1,961	1,961

Survey Coordination Centre

2018 NHS Staff Survey Results > Question results > Background details > Ethnicity

NHS England

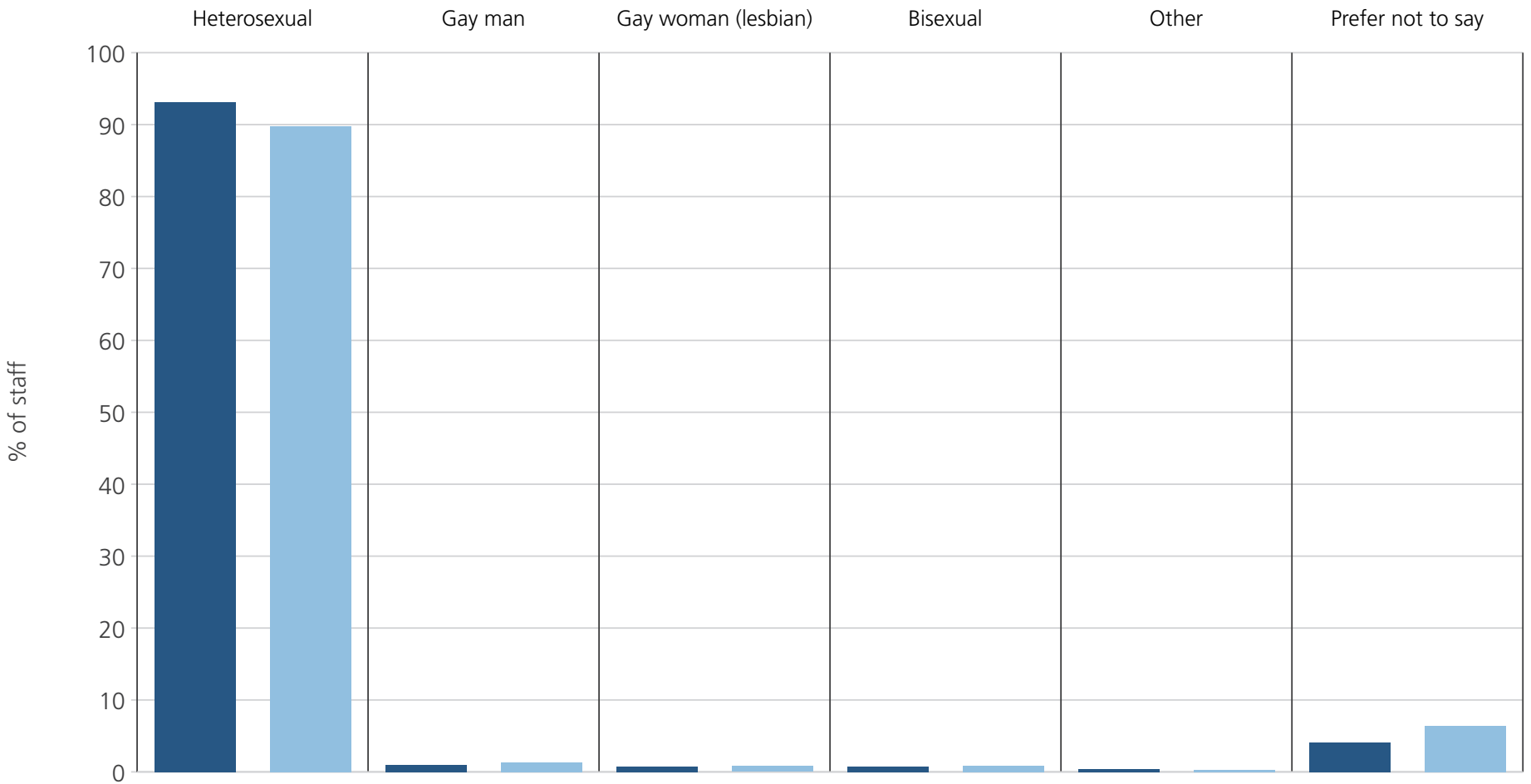


	White	Mixed	Asian/Asian British	Black/Black British	Chinese	Other
Your org	94.3%	1.5%	2.9%	0.6%	0.3%	0.4%
Average	86.3%	1.8%	7.6%	2.1%	0.3%	1.1%
No. responses	1,953	1,953	1,953	1,953	1,953	1,953

Survey Coordination Centre

2018 NHS Staff Survey Results > Question results > Background details > Sexuality

NHS England

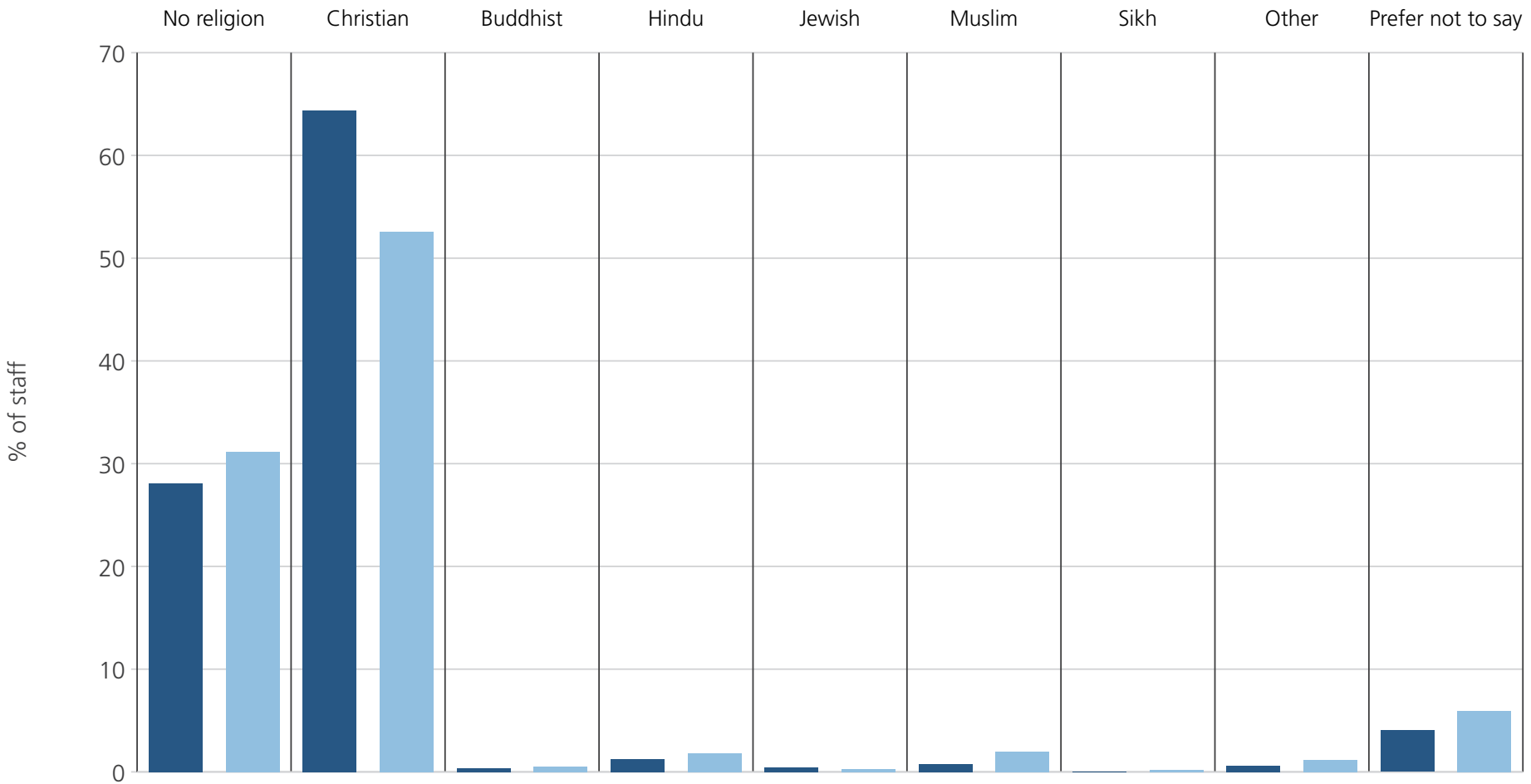


	Heterosexual	Gay man	Gay woman (lesbian)	Bisexual	Other	Prefer not to say
Your org	93.1%	1.0%	0.7%	0.8%	0.4%	4.1%
Average	89.7%	1.3%	0.8%	0.8%	0.2%	6.4%
No. responses	1,960	1,960	1,960	1,960	1,960	1,960

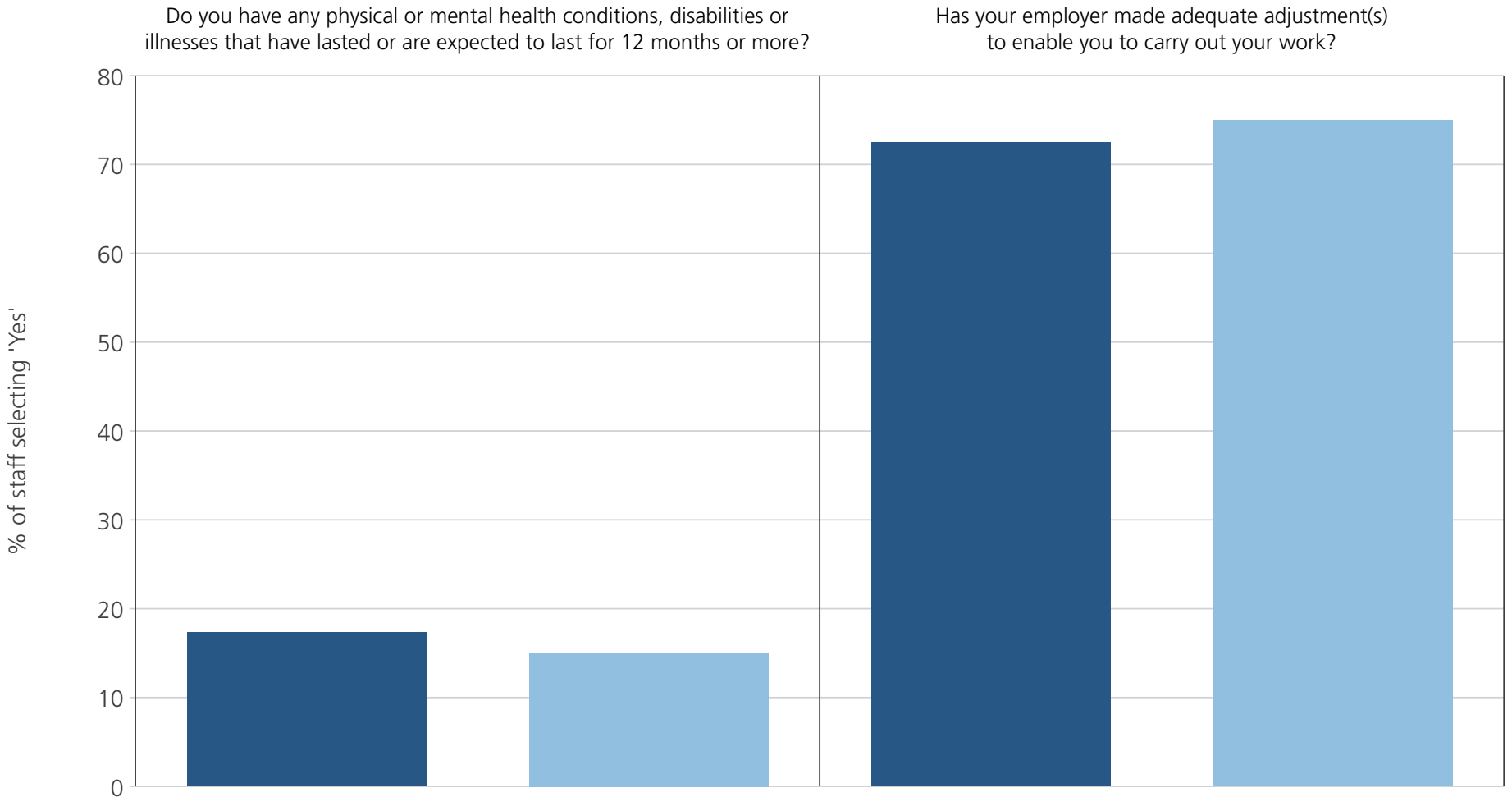
Survey Coordination Centre

2018 NHS Staff Survey Results > Question results > Background details > Religion

NHS England



	No religion	Christian	Buddhist	Hindu	Jewish	Muslim	Sikh	Other	Prefer not to say
Your org	28.1%	64.4%	0.4%	1.3%	0.4%	0.8%	0.1%	0.6%	4.0%
Average	31.2%	52.6%	0.5%	1.8%	0.3%	2.0%	0.2%	1.1%	5.9%
No. responses	1,955	1,955	1,955	1,955	1,955	1,955	1,955	1,955	1,955

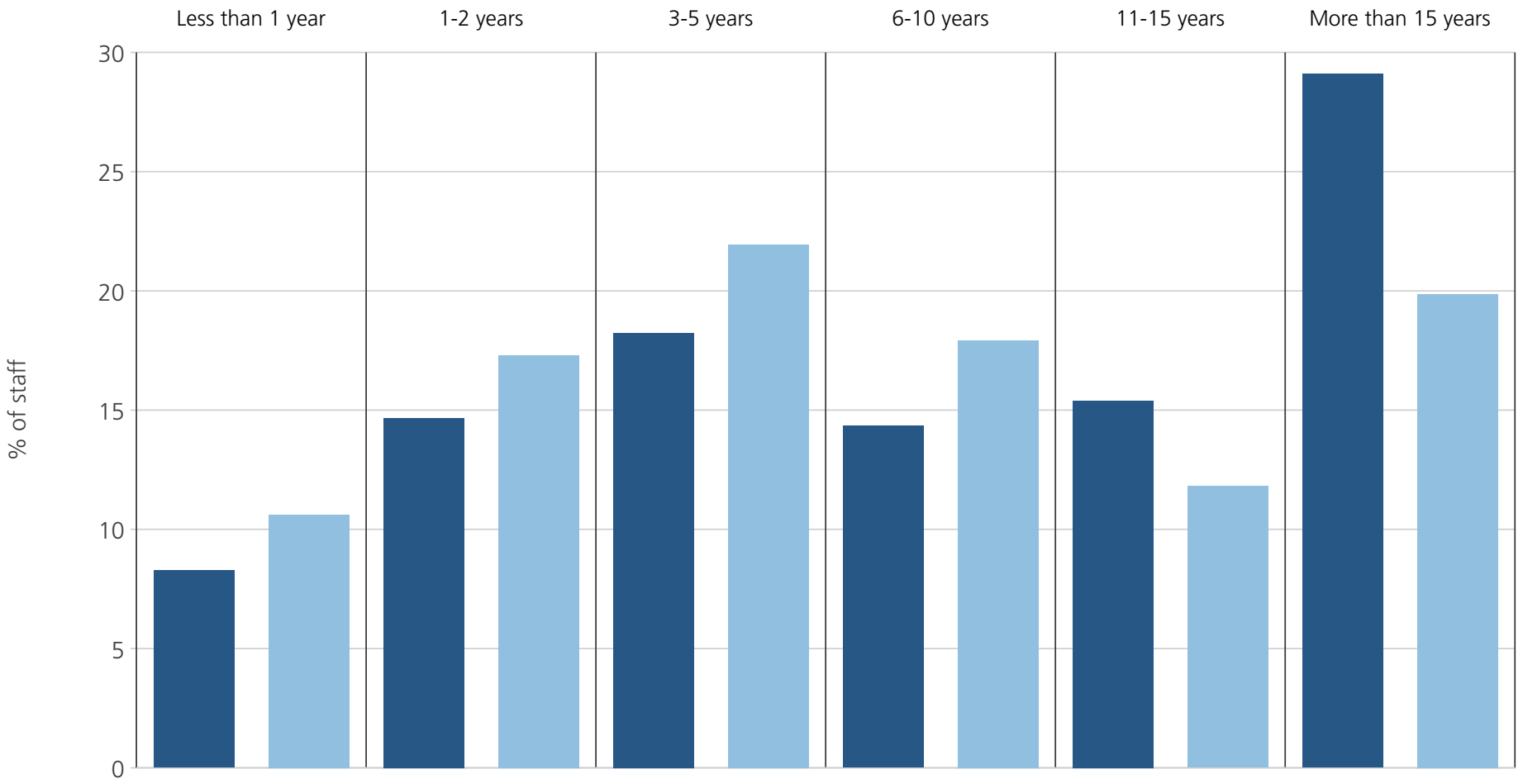


	Do you have any physical or mental health conditions, disabilities or illnesses that have lasted or are expected to last for 12 months or more?	Has your employer made adequate adjustment(s) to enable you to carry out your work?
Your org	17.4%	72.4%
Average	15.0%	75.0%
No. responses	1,964	198

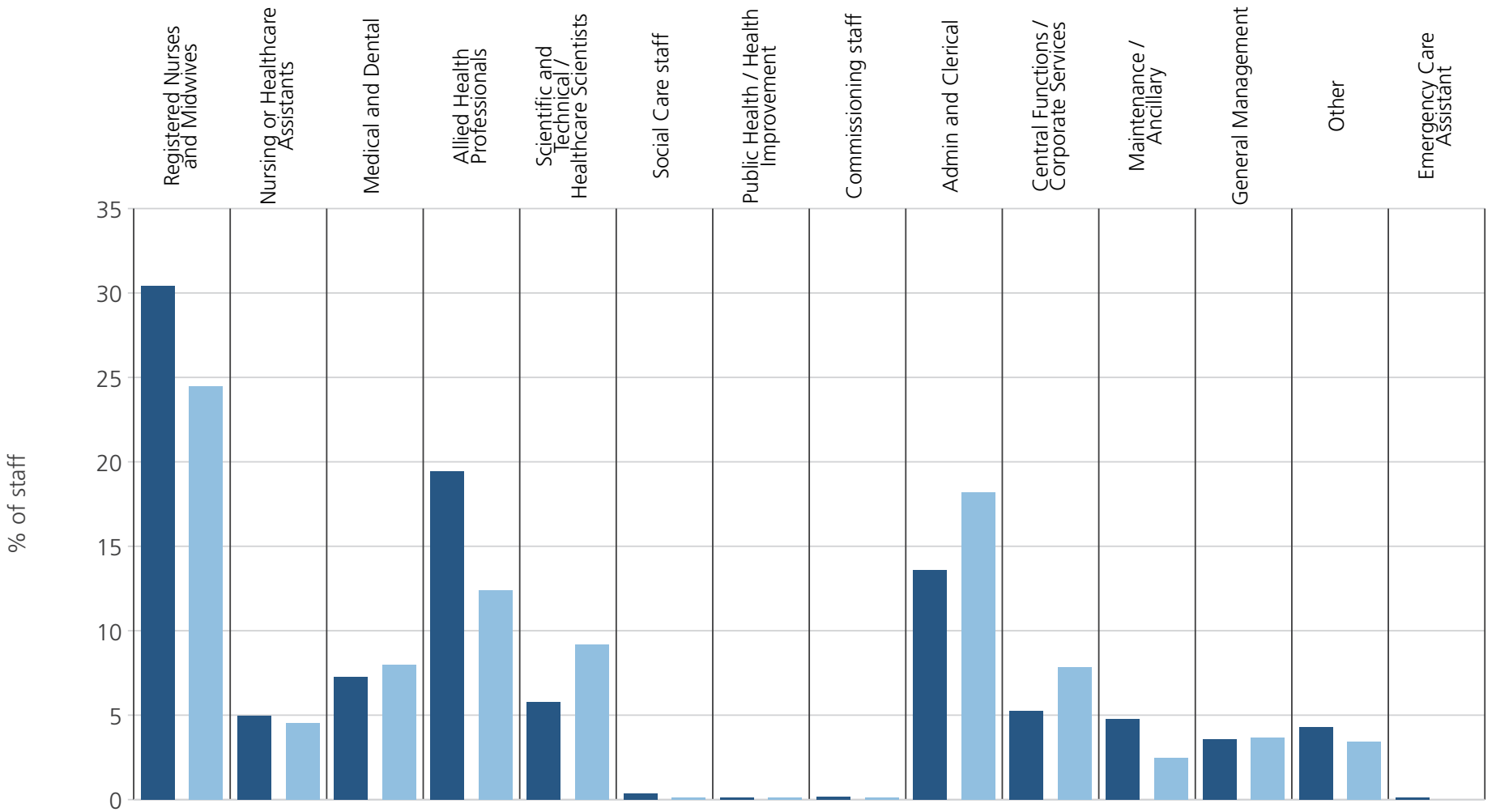
Survey Coordination Centre

2018 NHS Staff Survey Results > Question results > Background details > Length of service

NHS England

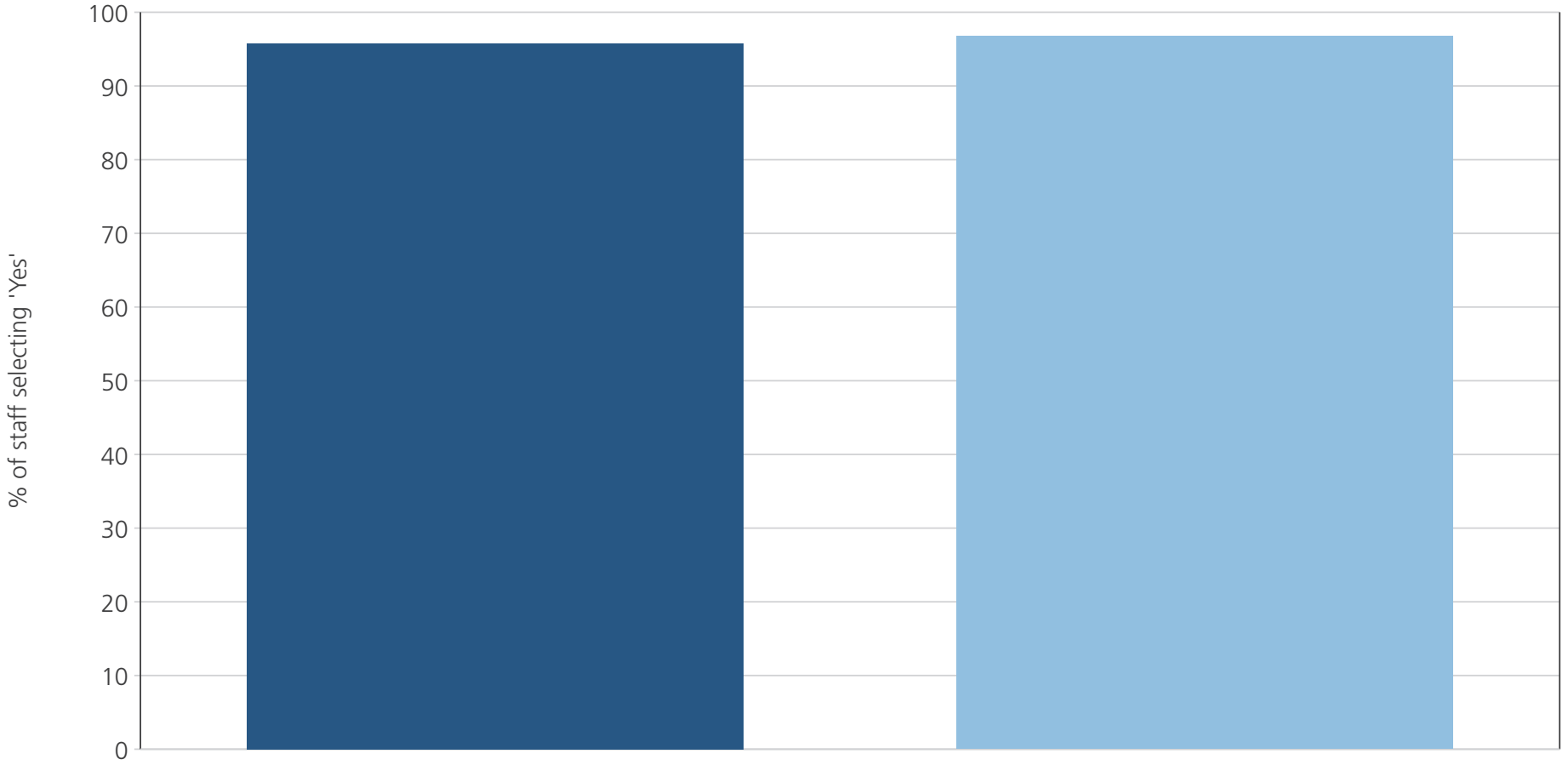


	Less than 1 year	1-2 years	3-5 years	6-10 years	11-15 years	More than 15 years
Your org	8.3%	14.7%	18.2%	14.3%	15.4%	29.1%
Average	10.6%	17.3%	22.0%	17.9%	11.8%	19.9%
No. responses	1,897	1,897	1,897	1,897	1,897	1,897

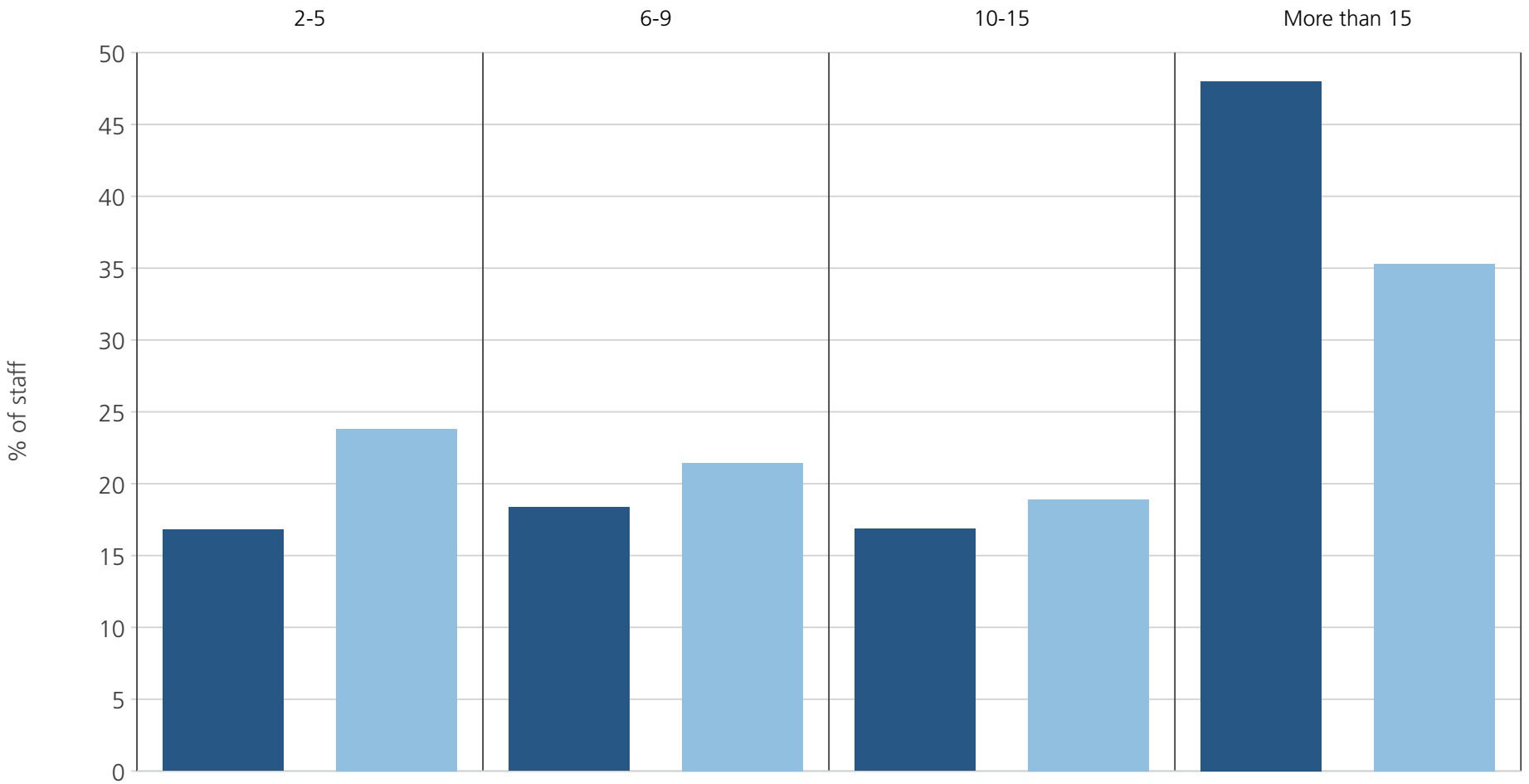


	Registered Nurses and Midwives	Nursing or Healthcare Assistants	Medical and Dental	Allied Health Professionals	Scientific and Technical / Healthcare Scientists	Social Care staff	Public Health / Health Improvement	Commissioning staff	Admin and Clerical	Central Functions / Corporate Services	Maintenance / Ancillary	General Management	Other	Emergency Care Assistant
Your org	30.4%	5.0%	7.3%	19.4%	5.8%	0.4%	0.1%	0.2%	13.6%	5.2%	4.8%	3.6%	4.3%	0.1%
Average	24.5%	4.5%	8.0%	12.4%	9.2%	0.1%	0.1%	0.1%	18.2%	7.8%	2.5%	3.7%	3.4%	0.0%
No. responses	1,931	1,931	1,931	1,931	1,931	1,931	1,931	1,931	1,931	1,931	1,931	1,931	1,931	1,931

Do you work in a team?



Your org	95.8%
Average	96.8%
No. responses	1,958



	2-5	6-9	10-15	More than 15
Your org	16.8%	18.4%	16.9%	48.0%
Average	23.8%	21.4%	18.9%	35.3%
No. responses	1,863	1,863	1,863	1,863

Survey Coordination Centre

NHS England

Appendices

Alder Hey Children's NHS Foundation Trust

2018 NHS Staff Survey Results

Survey Coordination Centre

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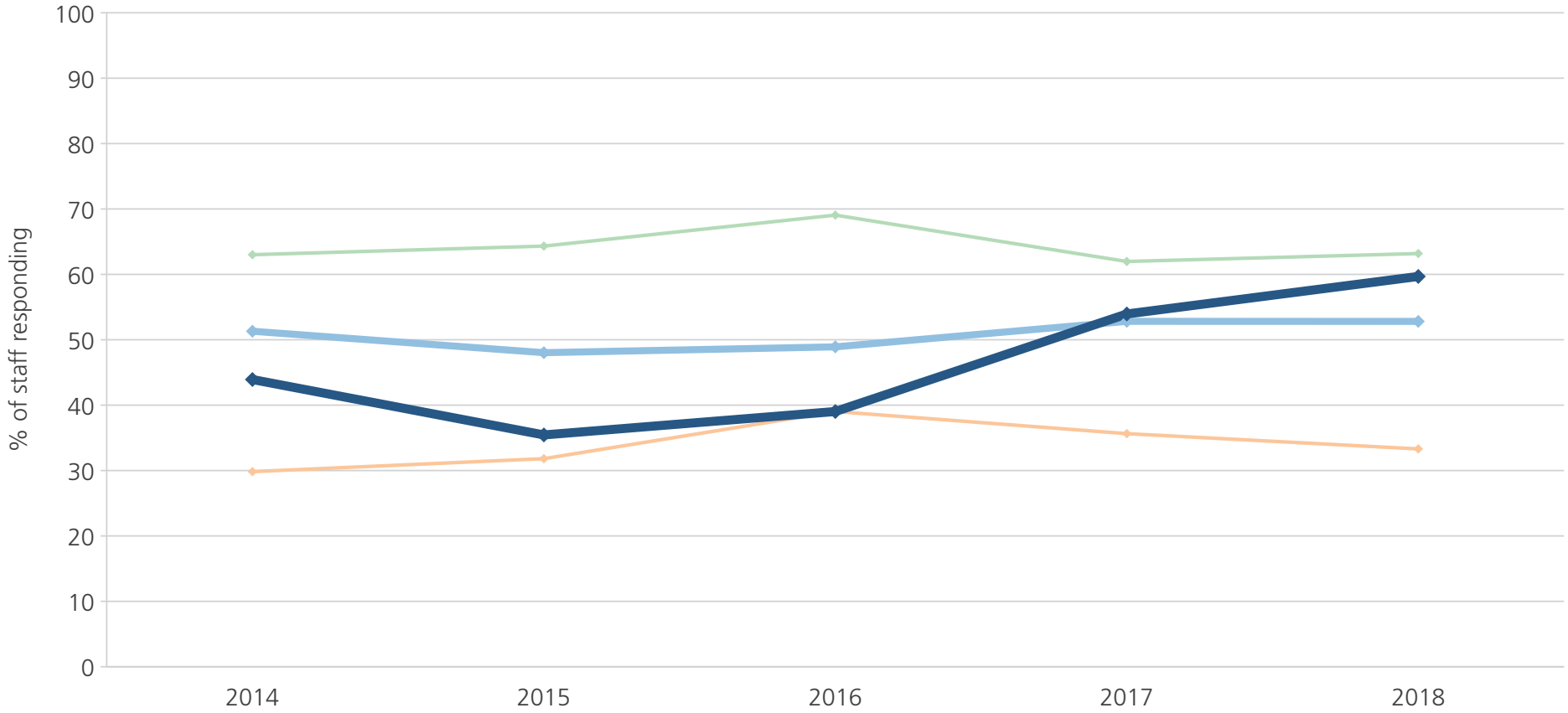
Appendix A: Response rate

Alder Hey Children's NHS Foundation Trust

2018 NHS Staff Survey Results



	2014	2015	2016	2017	2018
Best	63.0%	64.3%	69.1%	62.0%	63.2%
Your org	43.9%	35.4%	39.0%	53.9%	59.7%
Average	51.3%	48.0%	48.9%	52.8%	52.8%
Worst	29.8%	31.8%	39.0%	35.6%	33.3%

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NHS England

Appendix B: Significance testing - 2017 v 2018 theme results

Alder Hey Children's NHS Foundation Trust

2018 NHS Staff Survey Results

The table below presents the results of significance testing conducted on this year's theme scores and those from last year*. It details the organisation's theme scores for both years and the number of responses each of these are based on.

The final column contains the outcome of the significance testing: ↑ indicates that the 2018 score is significantly higher than last year's, whereas ↓ indicates that the 2018 score is significantly lower. If there is no statistically significant difference, you will see 'Not significant'. When there is no comparable data from the past survey year, you will see 'N/A'.

Theme	2017 score	2017 respondents	2018 score	2018 respondents	Statistically significant change?
Equality, diversity & inclusion	**9.3**	1725	**9.4**	1971	Not significant
Health & wellbeing	**6.1**	1743	**6.1**	1979	Not significant
Immediate managers	**6.7**	1737	**7.0**	1985	↑
Morale		0	**6.4**	1969	N/A
Quality of appraisals	**5.3**	1459	**5.6**	1778	↑
Quality of care	**7.3**	1523	**7.4**	1745	Not significant
Safe environment - Bullying & harassment	**8.4**	1713	**8.4**	1966	Not significant
Safe environment - Violence	**9.7**	1727	**9.7**	1947	Not significant
Safety culture	**6.6**	1735	**6.8**	1971	↑
Staff engagement	**7.1**	1748	**7.3**	1996	↑

* Statistical significance is tested using a two-tailed t-test with a 95% level of confidence.

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NHS England

Appendix C: Tips on using your benchmark report

Alder Hey Children's NHS Foundation Trust

2018 NHS Staff Survey Results

Survey Coordination Centre

Data in the new benchmark reports

NHS England

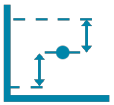
The following pages include tips on how to read, interpret and use the data in this report. The **suggestions are aimed at users who would like some guidance on how to understand the data** in this report. These suggestions are by no means the only way to analyse or use the data, but have been included to aid users transitioning from the previous version of the benchmark report and those who are new to the Staff Survey.

Key changes to note

There are a number of differences in this benchmark report compared to the old style of benchmark reports, that was used prior to the 2018 survey, which are worth noting

- Key Findings have been replaced by themes. The themes cover ten areas of staff experience and present results in these areas in a clear and consistent way. All of the ten themes are scored on a 0-10 scale, where a higher score is more positive than a lower score. These theme scores are created by scoring question results and grouping these results together. **Please note that you cannot directly compare Key Finding results to theme results.**

- A key feature of the new reports is that they **provide organisations with up to 5 years of trend data** across theme **and** question results. Trend data provides a much **more reliable indication of whether the most recent results represent a change from the norm** for an organisation than comparing the most recent results to those from the previous year. Taking a longer term view will help organisations to identify trends over several years that may have been missed when comparisons were drawn solely between the current and previous year.



- **Question results are now benchmarked** so that organisations can make comparisons to their peers on specific areas of staff experience. Question results provide organisations with more granular data that will help them to identify particular areas of concern. This benchmarking has been extended to the trend data that is available so that organisations can identify how results on each question have changed for themselves and their peers over time by looking at a single graph.

Survey Coordination Centre

1. Reviewing theme results

NHS England

When analysing theme results, it is easiest to start with the **theme overview** page to quickly identify areas which are doing better or worse in comparison to other organisations in the given benchmarking group.

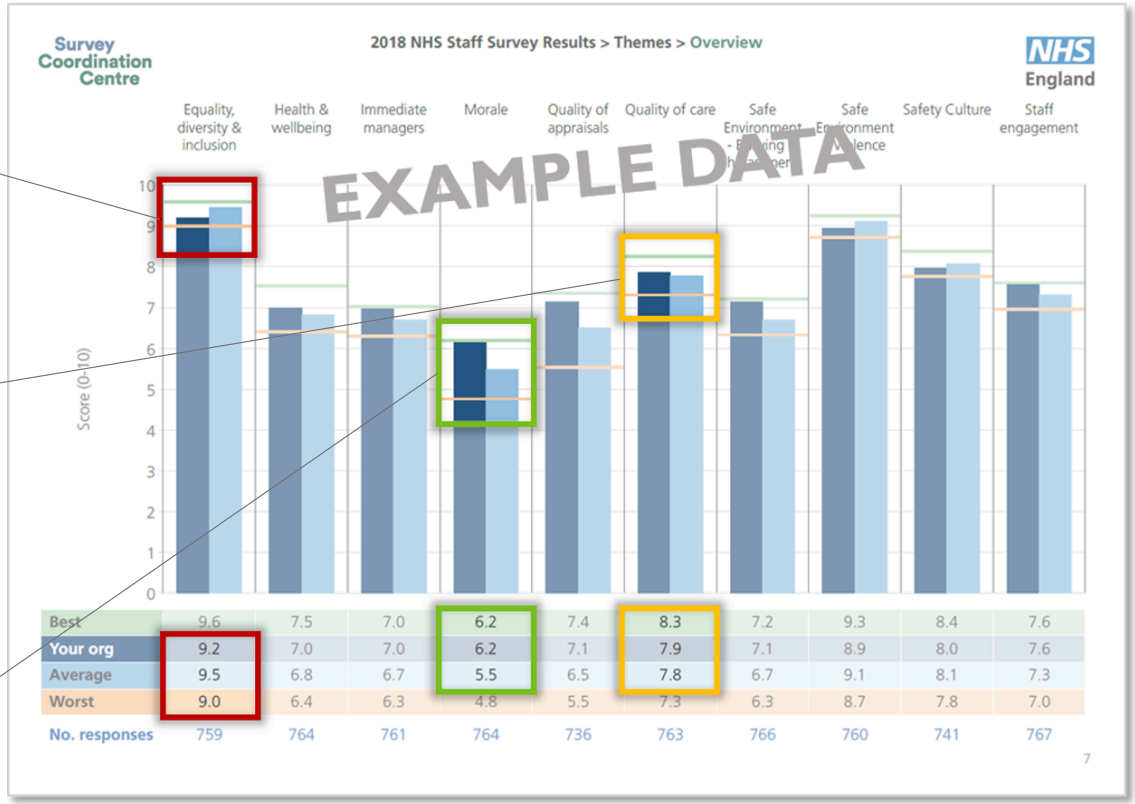
It is important to **consider each theme result within the range of its benchmarking group 'Best' and 'Worst' scores**, rather than comparing theme scores to one another. Comparing organisation scores to the benchmarking group average is another important point of reference.

Areas to improve

- By checking where the 'Your org' column/value is lower than the benchmarking group 'Average' you can quickly identify areas for improvement.
- It is worth looking at the difference between the 'Your org' result and the benchmarking group 'Worst' score. The closer your organisation's result is to the worst score, the more concerning the result.
- Results where your organisation's score is only marginally better than the 'Average', but still lags behind the best result by a notable margin, could also be considered as areas for further improvement.

Positive outcomes

- Similarly, using the overview page it is easy to identify themes which show a positive outcome for your organisation, where 'Your org' scores are distinctly higher than the benchmarking group 'Average' score.



Only one example is highlighted for each point

- Positive stories to report could be ones where your organisation approaches or matches the benchmarking group's 'Best' score.

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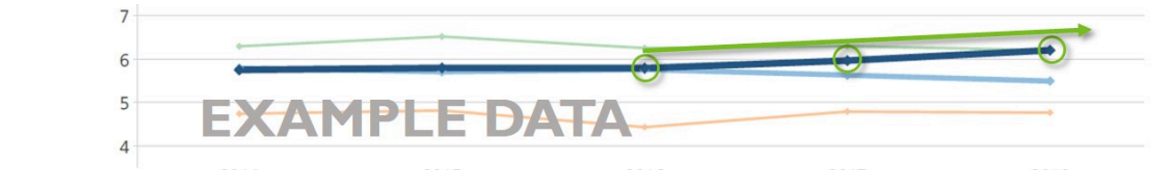
2. Reviewing theme results in more detail

NHS England

Review trend data

Trend data can be used to identify measures which have been consistently improving for your organisation (i.e. showing an upward trend) over the past years and ones which have been declining over time. These charts can **help establish if there is genuine change in the results** (if the results are consistently improving or declining over time), or whether a change between years is just a minor **year-on-year** fluctuation.



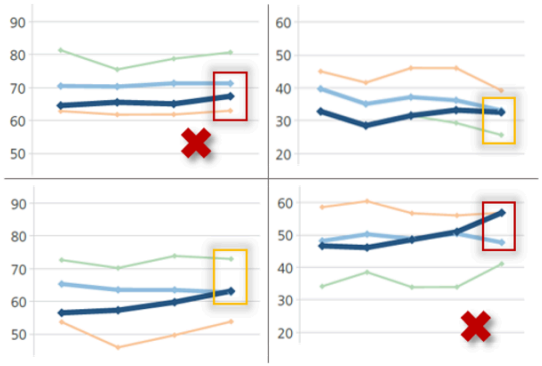
	2014	2015	2016	2017	2018
Best	6.3	6.5	6.3	6.3	6.2
Your org	5.7	5.8	5.8	6.0	6.2
Average	5.8	5.7	5.8	5.6	5.5
Worst	4.7	4.8	4.4	4.8	4.8
No. responses	344	803	668	738	764

Benchmarked trend data also allows you to review local changes and benchmark comparisons at the same time, allowing for various types of questions to be considered: e.g. how have the results for my organisation changed over time? Is my organisation improving faster than our peers?

Review questions feeding into the themes

In order to understand exactly which factors are driving your organisation's theme score, you should review the questions feeding into the theme. The **'Detailed information'** section contains the questions contributing to each theme, grouped together, thus they can be reviewed easily without the need to search through the 'Question results' section. By comparing 'Your org' scores to the benchmarking group 'Average', 'Best' and 'Worst' scores for each question, the **questions which are driving your organisation's theme results can be identified**.

For themes where results need improvement, action plans can be formulated to **focus on the areas where the organisation's results fall between the benchmarking group average and worst results**. Remember to keep an eye out for questions where a lower percentage is a better outcome – such as questions on violence or harassment, bullying and abuse.



✖ = Negative driver, org result falls between average & worst benchmarking group result for question

Survey Coordination Centre

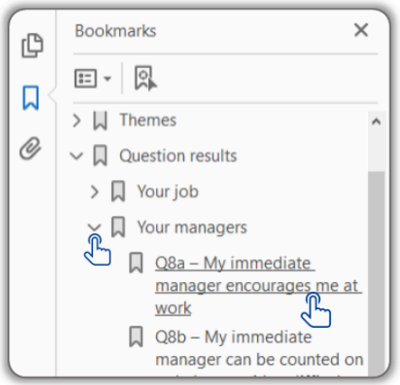
3. Reviewing question results

NHS England

This benchmark report displays results for all questions in the questionnaire, including benchmarked trend data wherever available. While this a key feature of the report, at first glance the amount of information contained on more than 110 pages might appear daunting. The below suggestions aim to provide some guidance on how to get started with navigating through this set of data.

Identifying questions of interest

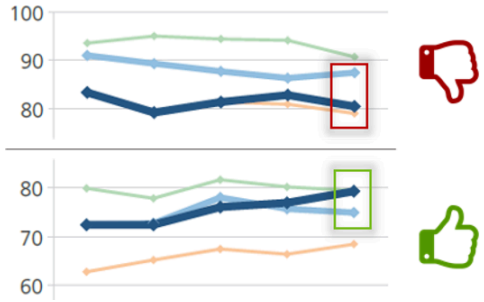
Use the bookmarks bar to navigate directly to questions of interest



- **Pre-defined questions of interest – key questions for your organisation**
  - Most organisations will have questions which have traditionally been a focus for them. Questions which have been targeted with internal policies or programmes, or whose results are of heightened importance due to organisation values or because they are considered a proxy for key issues. Outcomes for these questions can now be assessed on the backdrop of benchmark and historical trend data.
  - **Note:** The bookmarks bar allows for easy navigation through the report, allowing subsections of the report to be folded, for quick access to questions through hyperlinks.

- **Identifying questions of interest based on the results in this report**

  The methods recommended to review your theme results can also be applied to pick out question level results of interest. However, **unlike themes where a higher score always indicates a better result, it is important to keep an eye out for questions where a lower percentage relates to a better outcome** (see details on the 'Using the report' page in the 'Introduction' section).



- To identify areas of concern: look for questions where the organisation value falls between the benchmarking group average and the worst score, particularly questions where your organisation result is very close to the worst score. Review changes in the trend data to establish if there has been a decline or stagnation in results across multiple years, but consider the context of how the trust has performed in comparison to its benchmarking group over this period. A positive trend for a question that is still below the average result can be seen as good progress to build on further in the future.
- When looking for positive outcomes: search for results where your organisation is closest to the benchmarking group best result (but remember to consider results for previous years), or ones where there is a clear trend of continued improvement over multiple years.

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NHS England

Appendix D: Additional reporting outputs

Alder Hey Children's NHS Foundation Trust

2018 NHS Staff Survey Results

Survey Coordination Centre

Additional reporting outputs

NHS England

Below are links to other key reporting outputs which complement this report. A full list and more detailed explanation of the reporting outputs is included in the Technical Document.

Supporting documents

Basic Guide: Provides a brief overview of the NHS Staff Survey data and details on what is contained in each of the reporting outputs.

Technical Document: Contains technical details about the NHS Staff Survey data, including: data cleaning, weighting, benchmarking, theme/KF calculations, historical comparability of organisations and questions in the survey.

Other local results

Key Finding results spreadsheet: Response rate & KF results for every organisation (2017 & 2018). The results are compared and the difference between years is tested for statistical significance.

Local Breakdowns: Dashboards containing results for each organisation broken down by demographic characteristics. Data is available for up to five years where possible.

Directorate Reports: Reports containing theme results split by directorate (locality) for Alder Hey Children's NHS Foundation Trust.

National results

National Trend Data and National Breakdowns: Dashboards containing national results – data available for five years where possible.

Survey Coordination Centre

NHS England

Alder Hey Children's NHS Foundation Trust

2018 NHS Staff Survey

Directorate Report

Contents

Survey Coordination Centre

Introduction

NHS England

This directorate report for Alder Hey Children's NHS Foundation Trust contains results by directorate for themes from the 2018 NHS Staff Survey. These results are compared to the unweighted average for your organisation.

Please note: It is possible that there are differences between the 'Your org' scores reported in this directorate report and those in the benchmark report. This is because the results in the benchmark report are weighted to allow for fair comparisons between organisations of a similar type. However, in this report comparisons are made within your organisation so the unweighted organisation result is a more appropriate point of comparison.

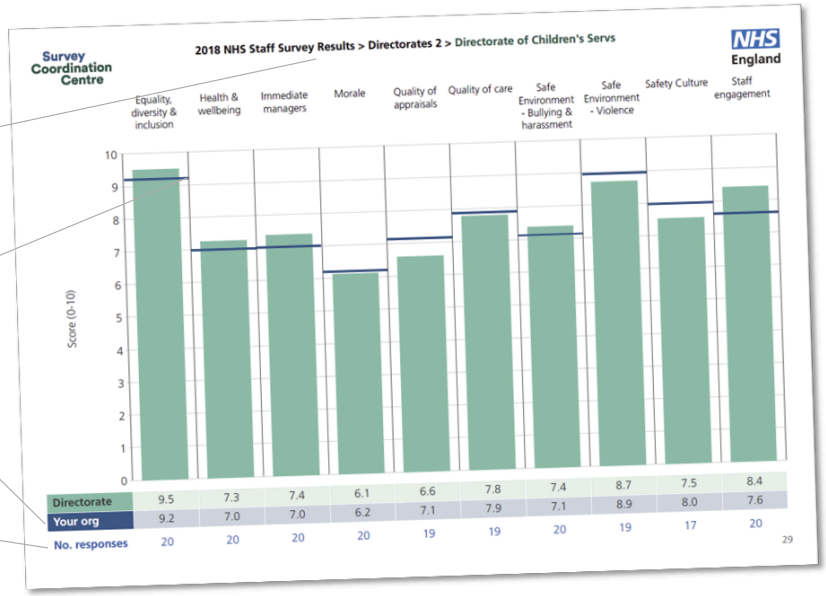
The directorate breakdowns used in this report were provided and defined by Alder Hey Children's NHS Foundation Trust. Details of how the theme scores were calculated are included in the Technical Document, available to download from our results website.

Key features

Breakdown type and **directorate name** are specified in the header. Black text in the header is hyperlinked: clicking on '2018 NHS Staff Survey Results' navigates back to the contents page.

Directorate results are presented in the context of the (unweighted) **organisation average ('Your org')**, so it is easy to tell if a directorate is performing better or worse than the organisation average. For all themes, a higher score is a better result than a lower score.

The **number of responses** feeding into each theme score **for the given directorate** is specified below the table containing the directorate and trust scores.



! **Note:** when there are less than 11 responses in a group, results are suppressed to protect staff confidentiality

Survey Coordination Centre

NHS England

Directorates 1

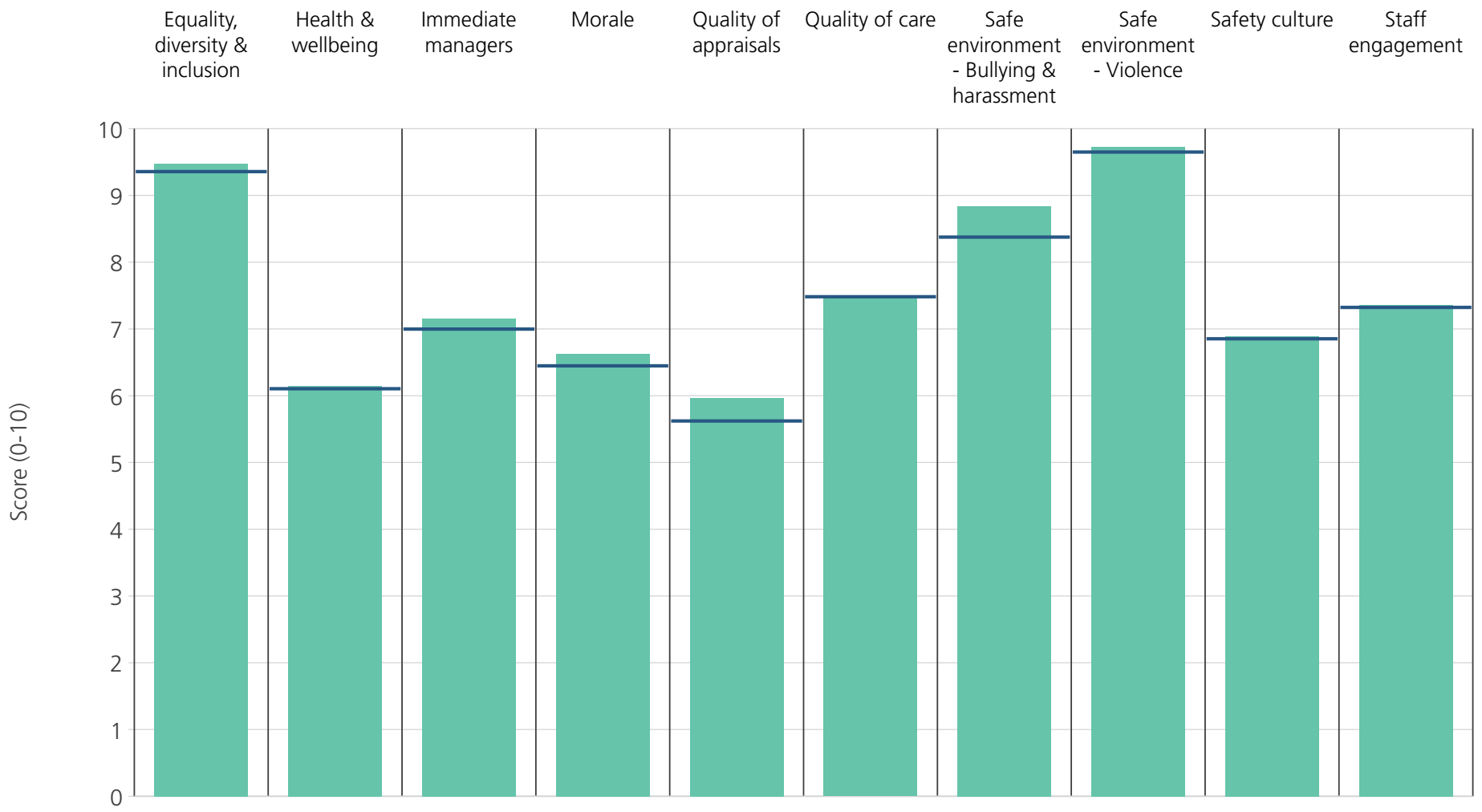
Alder Hey Children's NHS Foundation Trust

2018 NHS Staff Survey Results

Survey Coordination Centre

2018 NHS Staff Survey Results > Directorates 1 > Add Prof Scientific and Technic

NHS England

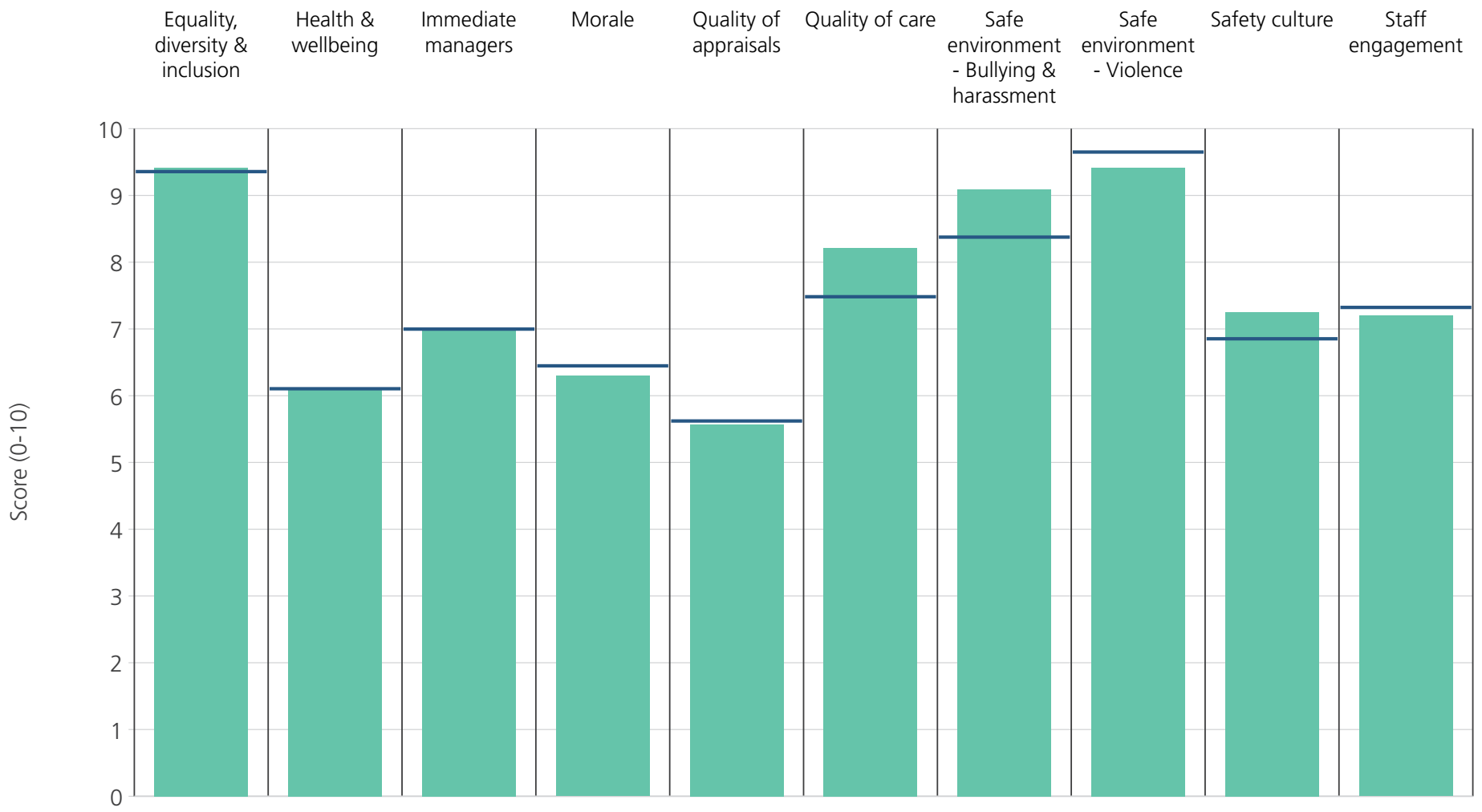


	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement
Directorate	9.5	6.1	7.2	6.6	6.0	7.5	8.8	9.7	6.9	7.4
Your org	9.4	6.1	7.0	6.4	5.6	7.5	8.4	9.6	6.9	7.3
No. responses	148	149	149	149	141	151	149	149	150	150

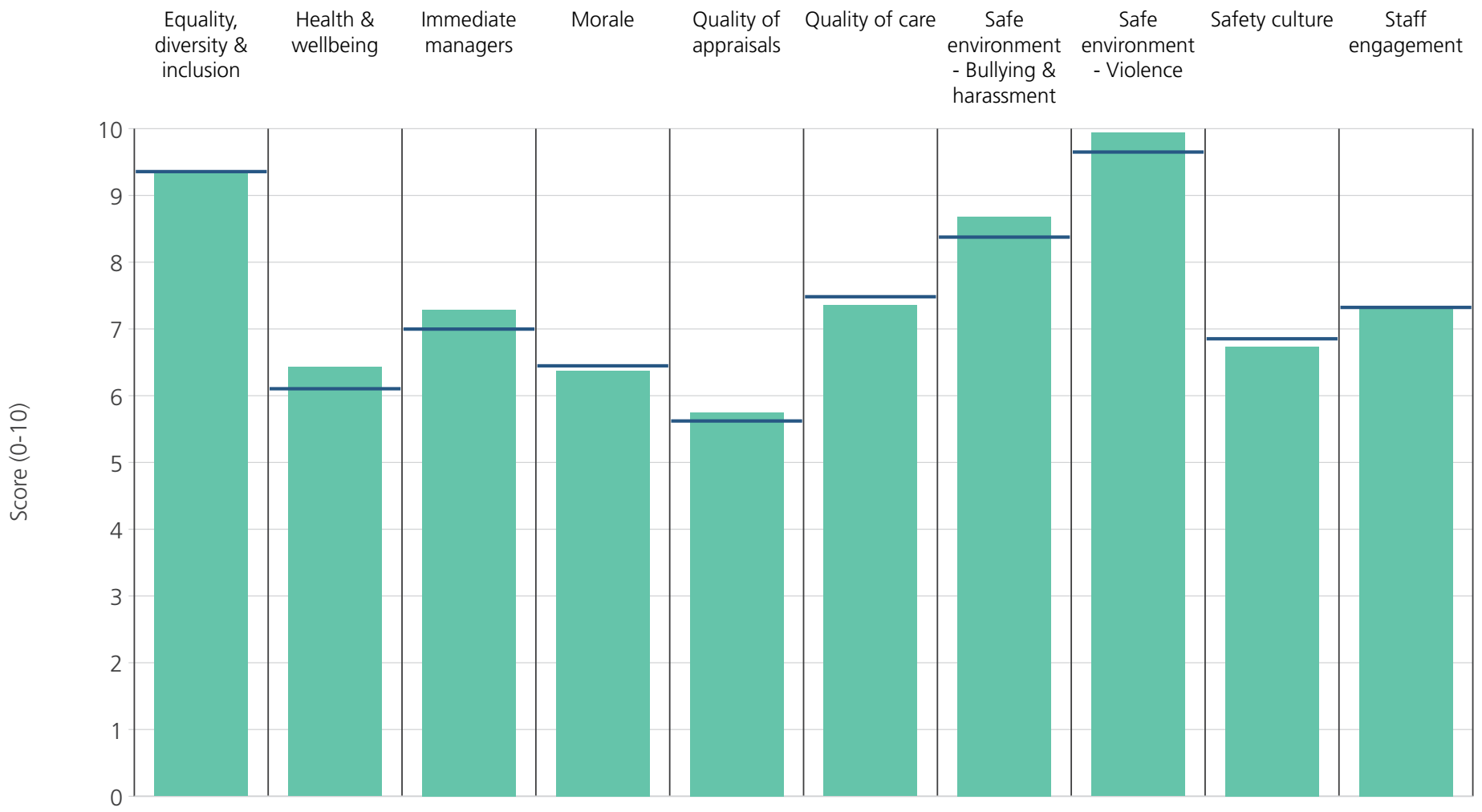
Survey Coordination Centre

2018 NHS Staff Survey Results > Directorates 1 > Additional Clinical Services

NHS England



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement
Directorate	9.4	6.1	7.0	6.3	5.6	8.2	9.1	9.4	7.3	7.2
Your org	9.4	6.1	7.0	6.4	5.6	7.5	8.4	9.6	6.9	7.3
No. responses	232	233	235	230	200	228	232	227	232	234

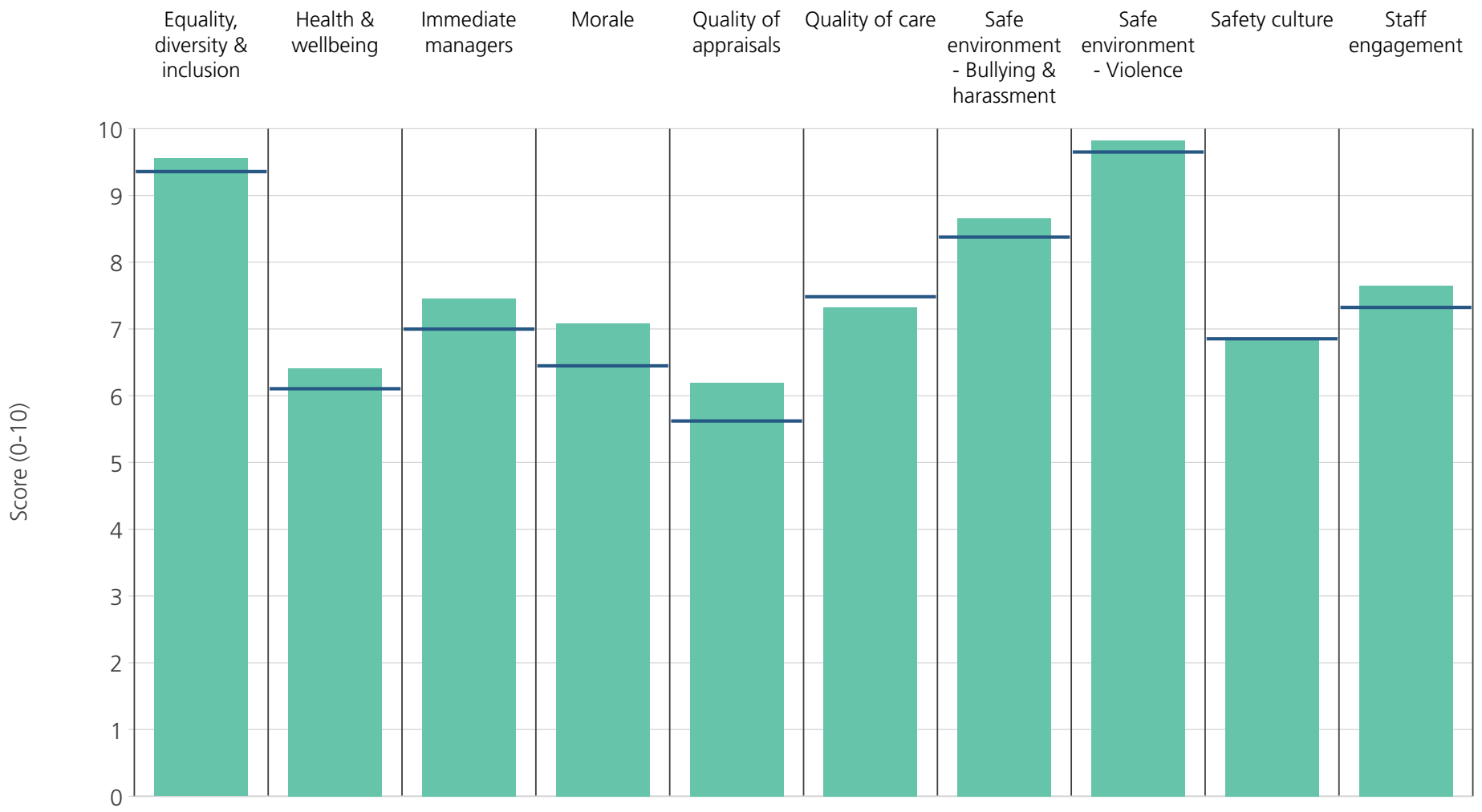


	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement
Directorate	9.3	6.4	7.3	6.4	5.7	7.4	8.7	9.9	6.7	7.3
Your org	9.4	6.1	7.0	6.4	5.6	7.5	8.4	9.6	6.9	7.3
No. responses	544	544	544	543	488	337	534	533	538	551

Survey Coordination Centre

2018 NHS Staff Survey Results > Directorates 1 > Allied Health Professionals

NHS England

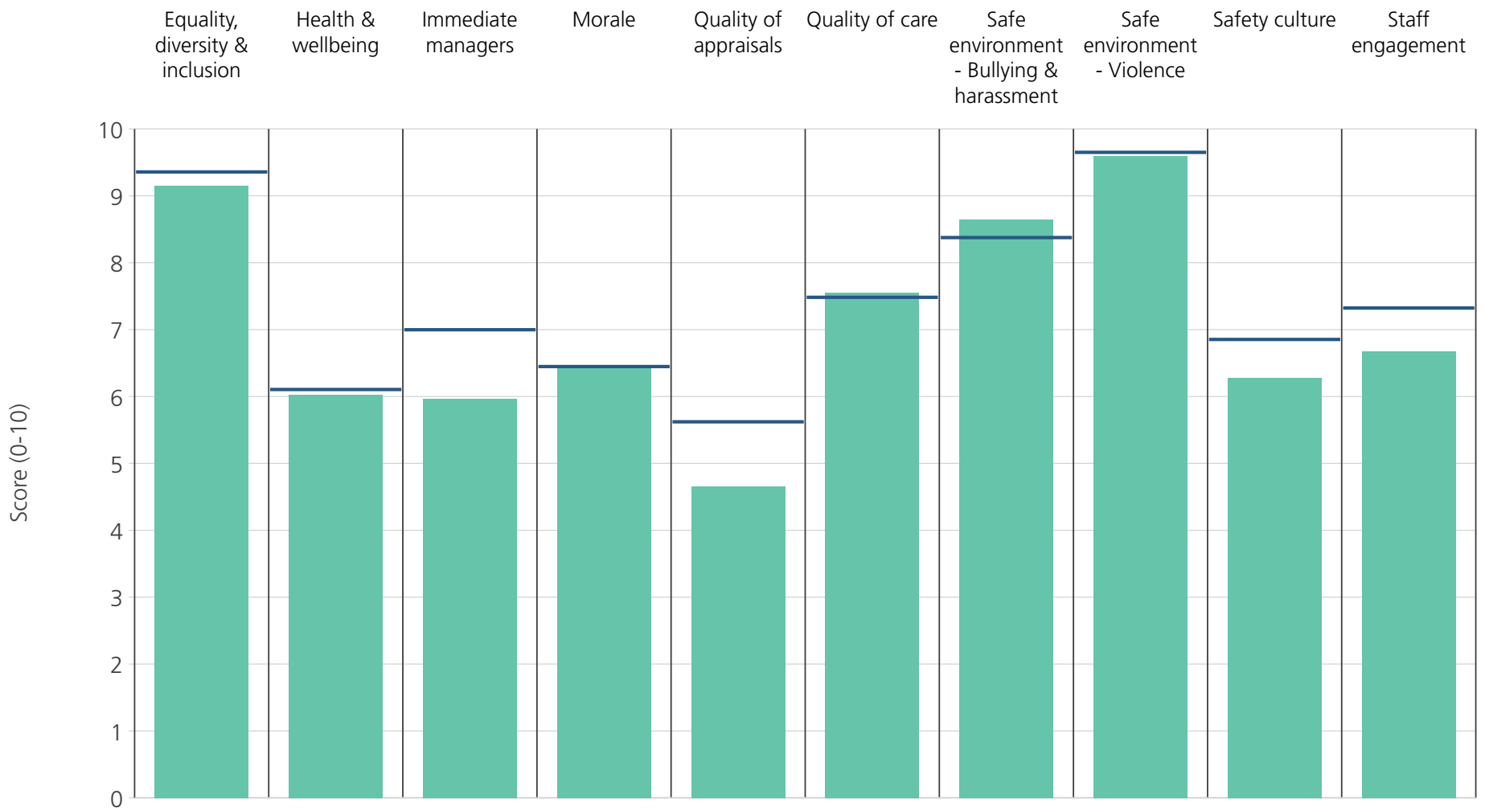


	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement
Directorate	9.6	6.4	7.5	7.1	6.2	7.3	8.7	9.8	6.9	7.7
Your org	9.4	6.1	7.0	6.4	5.6	7.5	8.4	9.6	6.9	7.3
No. responses	196	200	199	199	187	199	198	193	200	201

Survey Coordination Centre

2018 NHS Staff Survey Results > Directorates 1 > Estates and Ancillary

NHS England

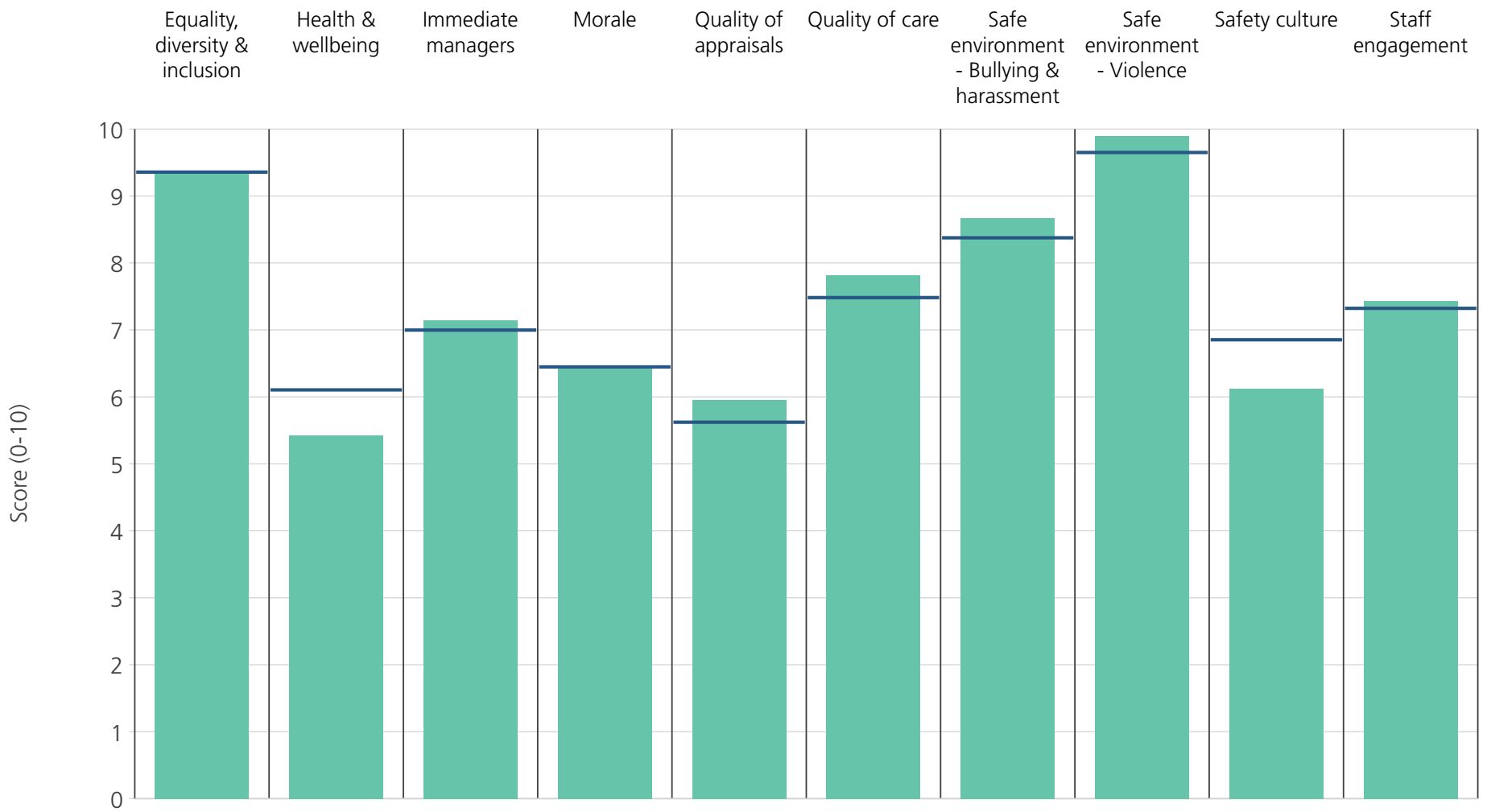


	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement
Directorate	9.1	6.0	6.0	6.4	4.7	7.6	8.6	9.6	6.3	6.7
Your org	9.4	6.1	7.0	6.4	5.6	7.5	8.4	9.6	6.9	7.3
No. responses	90	89	91	87	72	66	90	90	84	90

Survey Coordination Centre

2018 NHS Staff Survey Results > Directorates 1 > Healthcare Scientists

NHS England

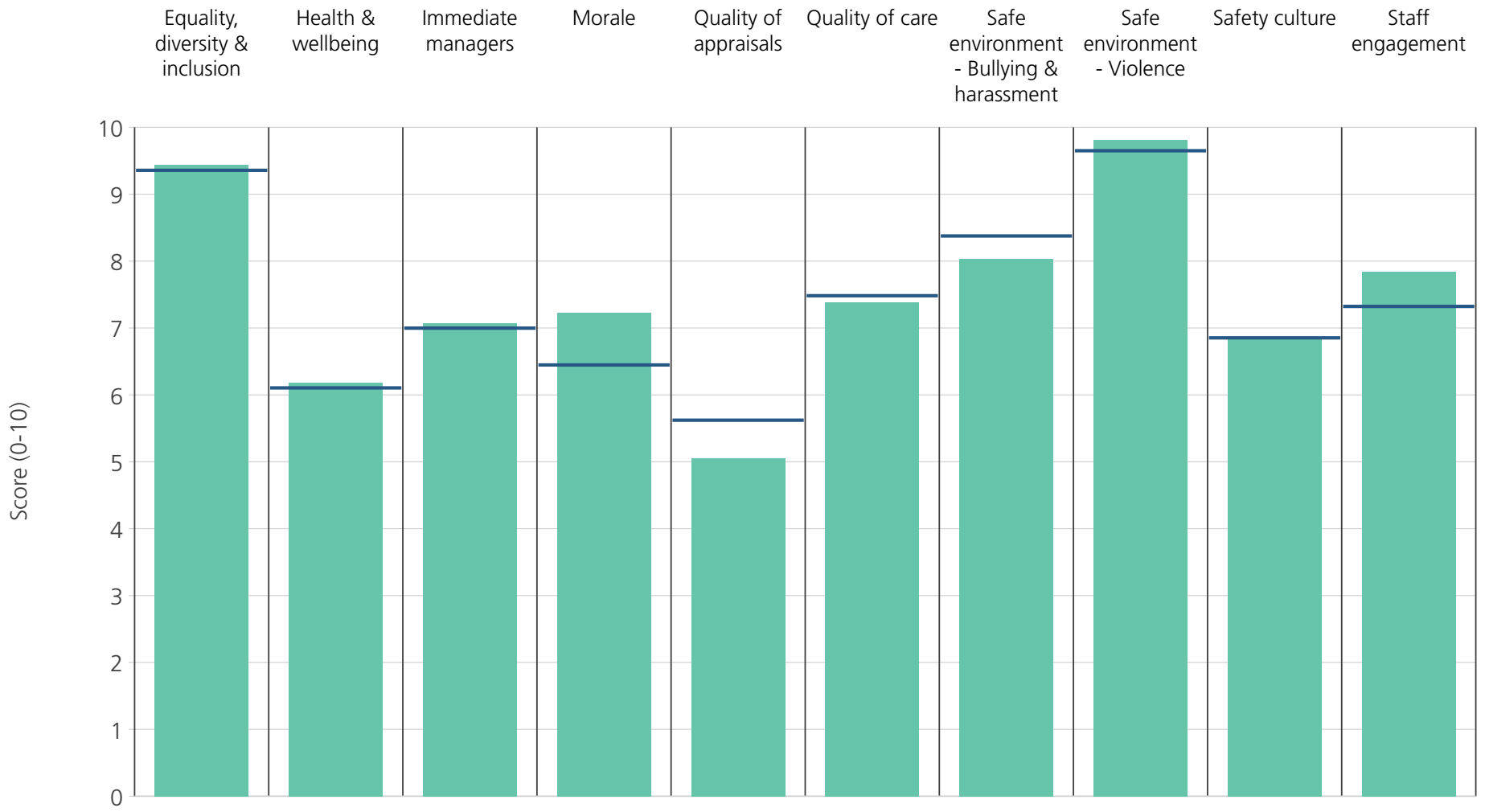


	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement
Directorate	9.3	5.4	7.1	6.5	6.0	7.8	8.7	9.9	6.1	7.4
Your org	9.4	6.1	7.0	6.4	5.6	7.5	8.4	9.6	6.9	7.3
No. responses	65	66	65	66	63	65	65	66	66	66

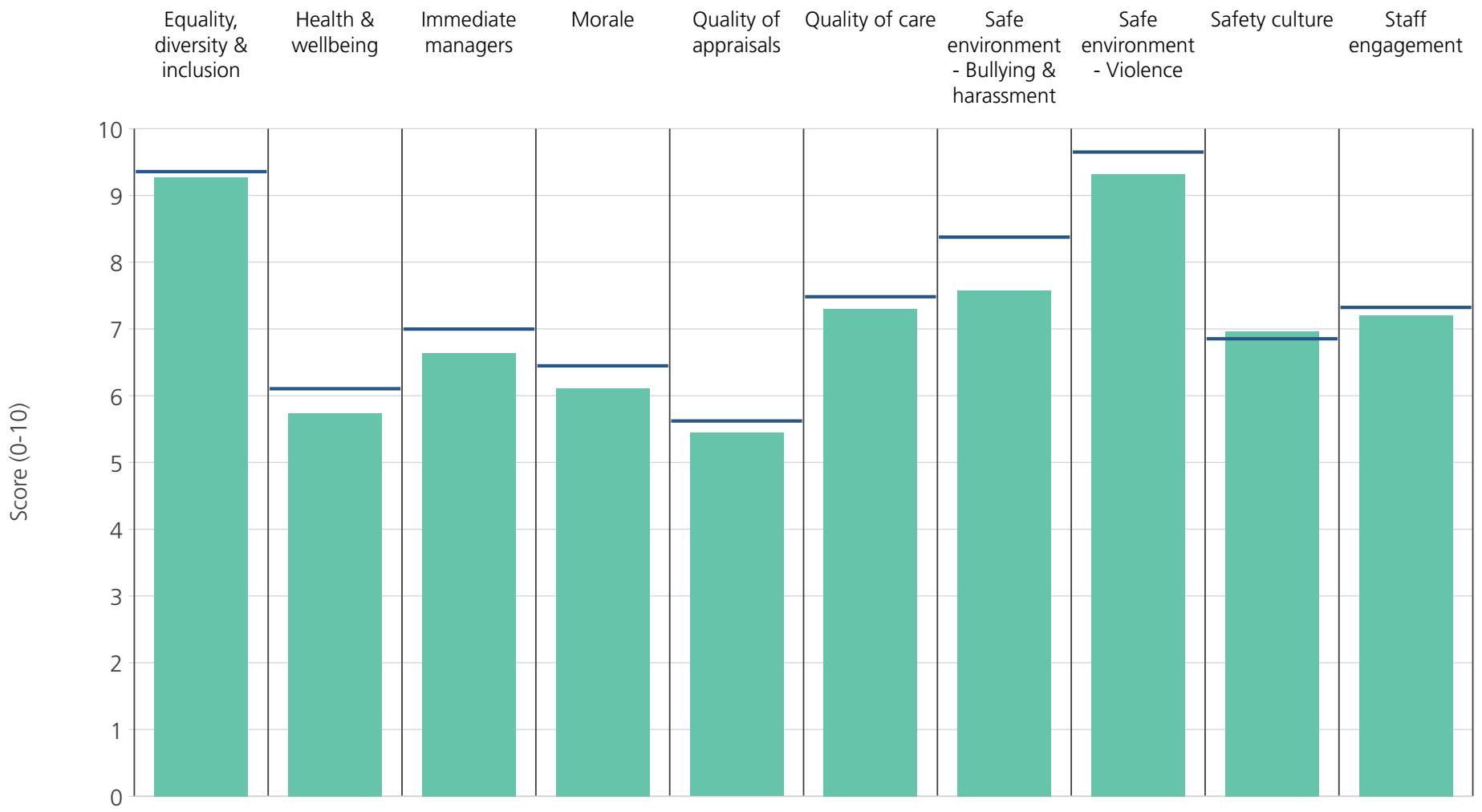
Survey Coordination Centre

2018 NHS Staff Survey Results > Directorates 1 > Medical and Dental

NHS England



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement
Directorate	9.4	6.2	7.1	7.2	5.1	7.4	8.0	9.8	6.8	7.8
Your org	9.4	6.1	7.0	6.4	5.6	7.5	8.4	9.6	6.9	7.3
No. responses	139	140	140	138	123	139	139	140	139	140



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement
Directorate	9.3	5.7	6.6	6.1	5.4	7.3	7.6	9.3	7.0	7.2
Your org	9.4	6.1	7.0	6.4	5.6	7.5	8.4	9.6	6.9	7.3
No. responses	557	558	562	557	504	560	559	549	562	564

Survey Coordination Centre

NHS England

Directorates 2

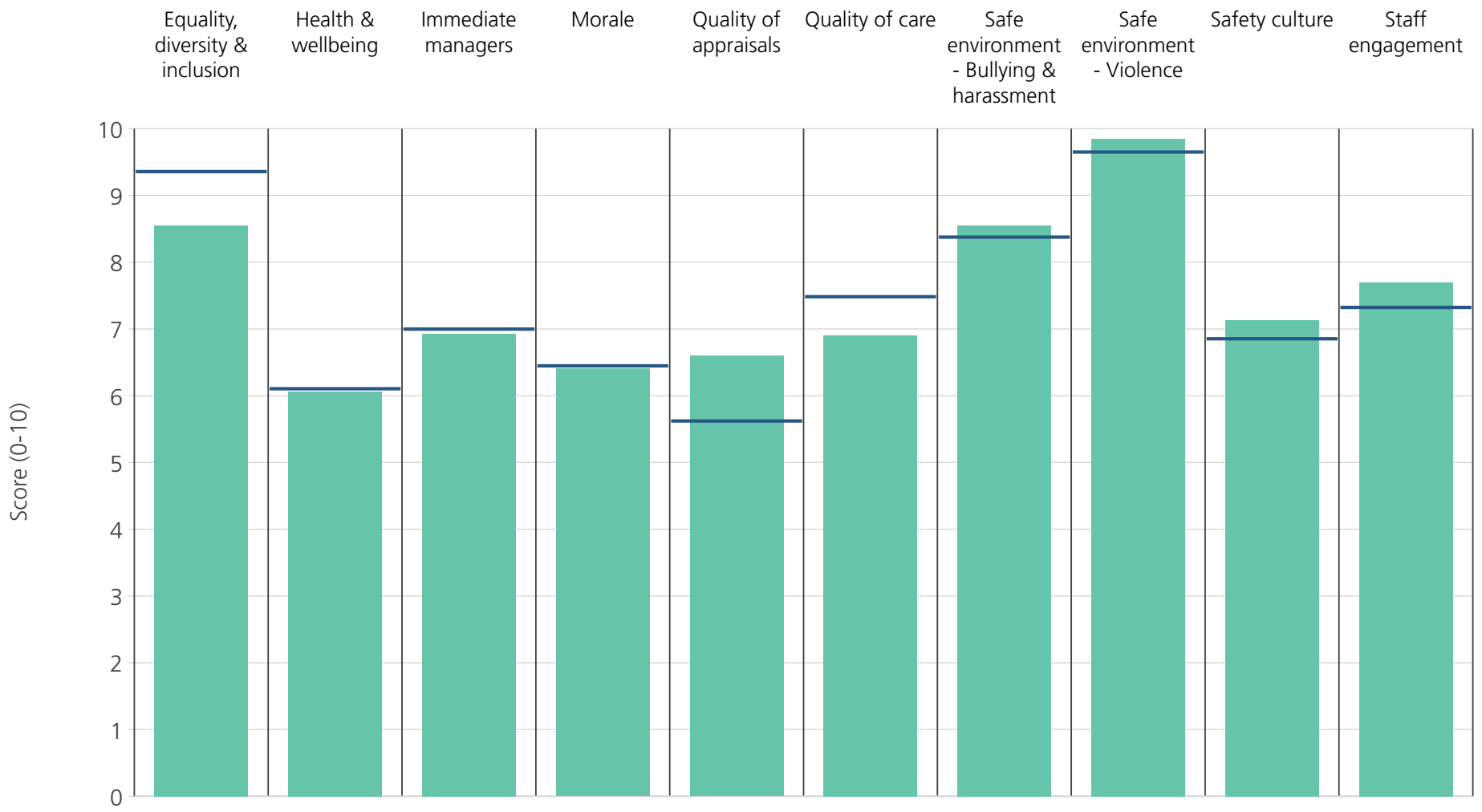
Alder Hey Children's NHS Foundation Trust

2018 NHS Staff Survey Results

Survey Coordination Centre

2018 NHS Staff Survey Results > Directorates 2 > Alder Hey in the Park

NHS England

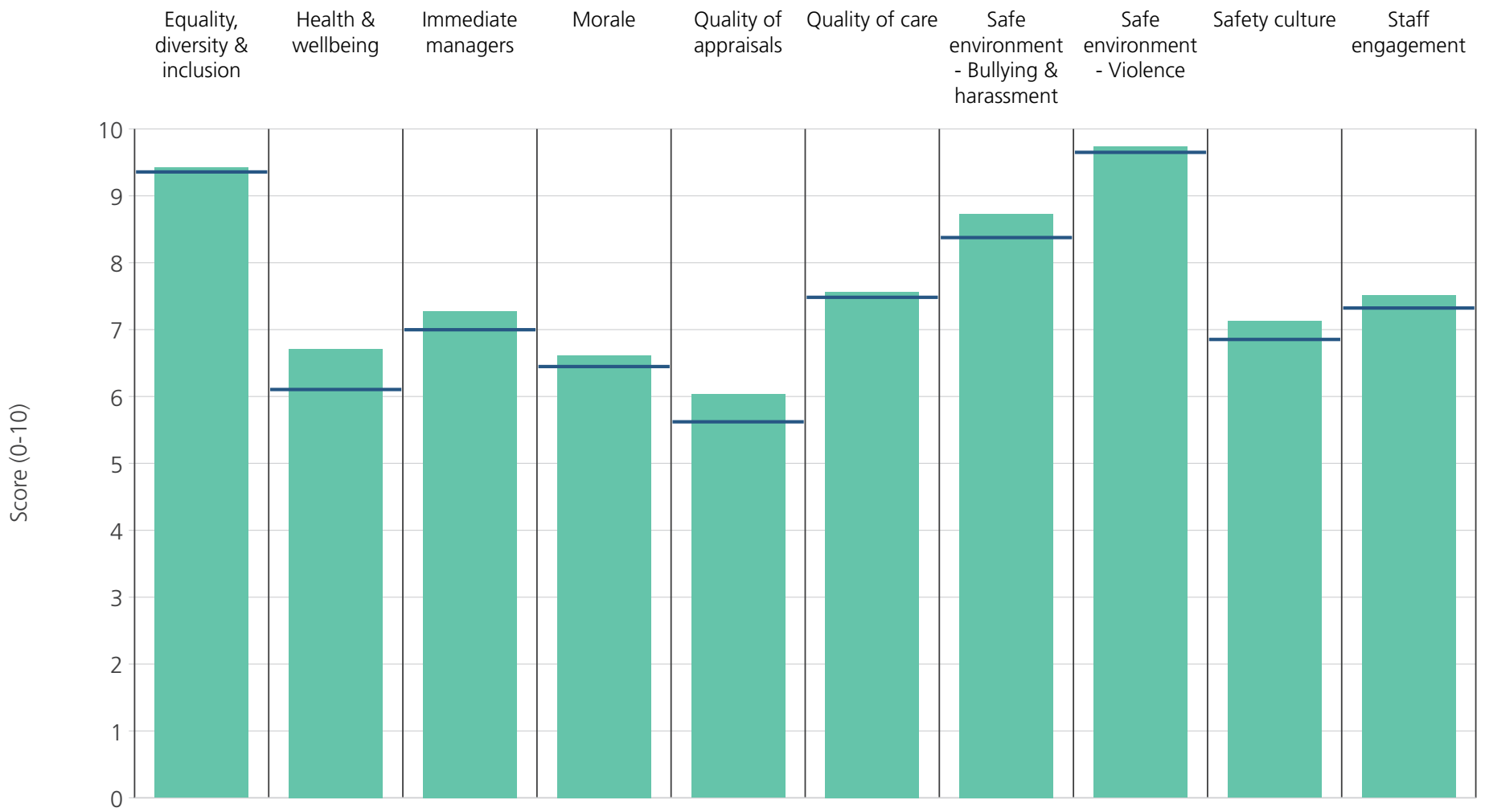


	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement
Directorate	8.6	6.1	6.9	6.4	6.6	6.9	8.6	9.8	7.1	7.7
Your org	9.4	6.1	7.0	6.4	5.6	7.5	8.4	9.6	6.9	7.3
No. responses	23	23	23	23	18	14	23	22	22	23

Survey Coordination Centre

2018 NHS Staff Survey Results > Directorates 2 > Community

NHS England

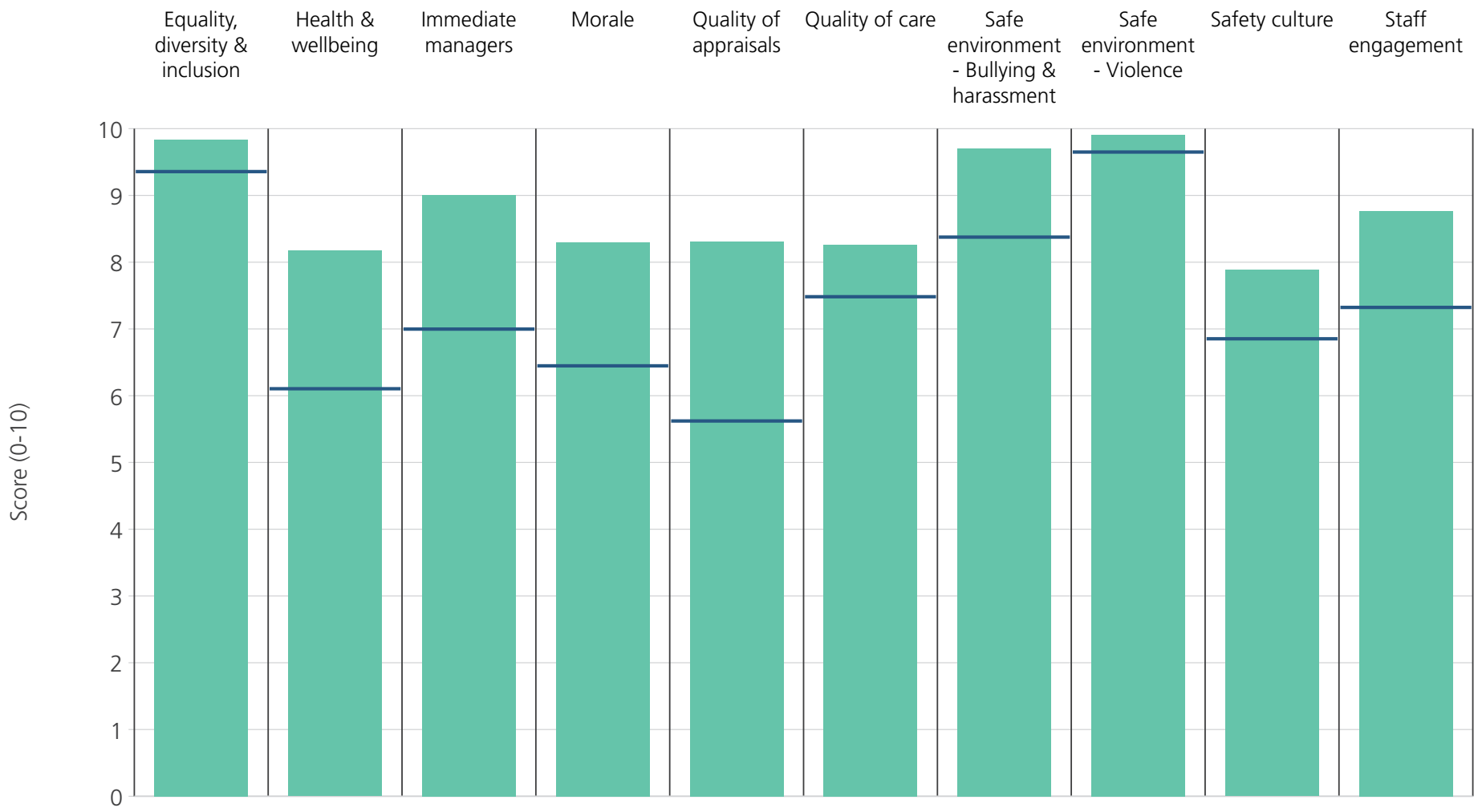


	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement
Directorate	9.4	6.7	7.3	6.6	6.0	7.6	8.7	9.7	7.1	7.5
Your org	9.4	6.1	7.0	6.4	5.6	7.5	8.4	9.6	6.9	7.3
No. responses	329	331	331	328	315	310	329	326	332	332

Survey Coordination Centre

2018 NHS Staff Survey Results > Directorates 2 > Corporate Other Department

NHS England

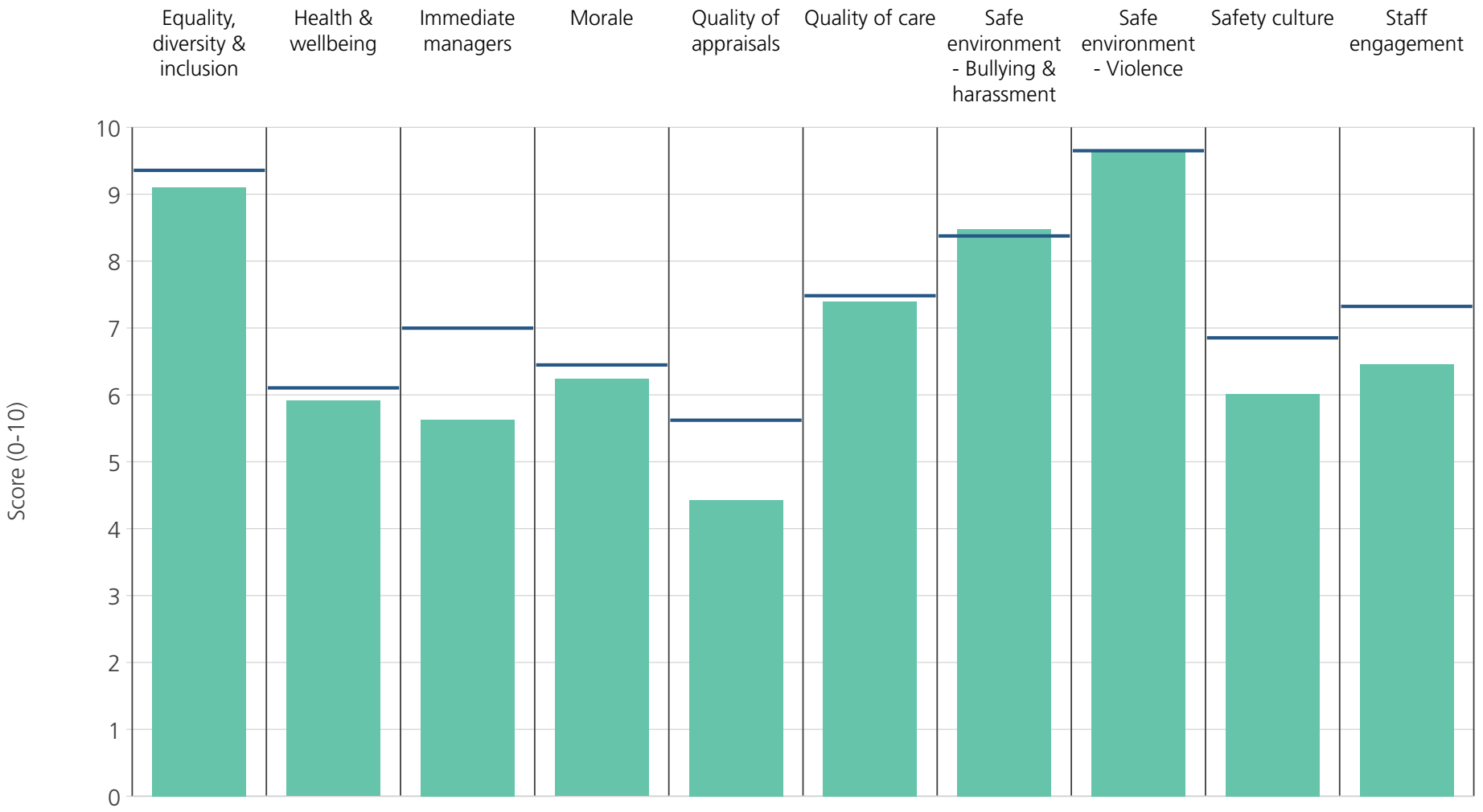


	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement
Directorate	9.8	8.2	9.0	8.3	8.3	8.3	9.7	9.9	7.9	8.8
Your org	9.4	6.1	7.0	6.4	5.6	7.5	8.4	9.6	6.9	7.3
No. responses	35	35	35	35	31	11	34	35	35	35

Survey Coordination Centre

2018 NHS Staff Survey Results > Directorates 2 > Facilities

NHS England

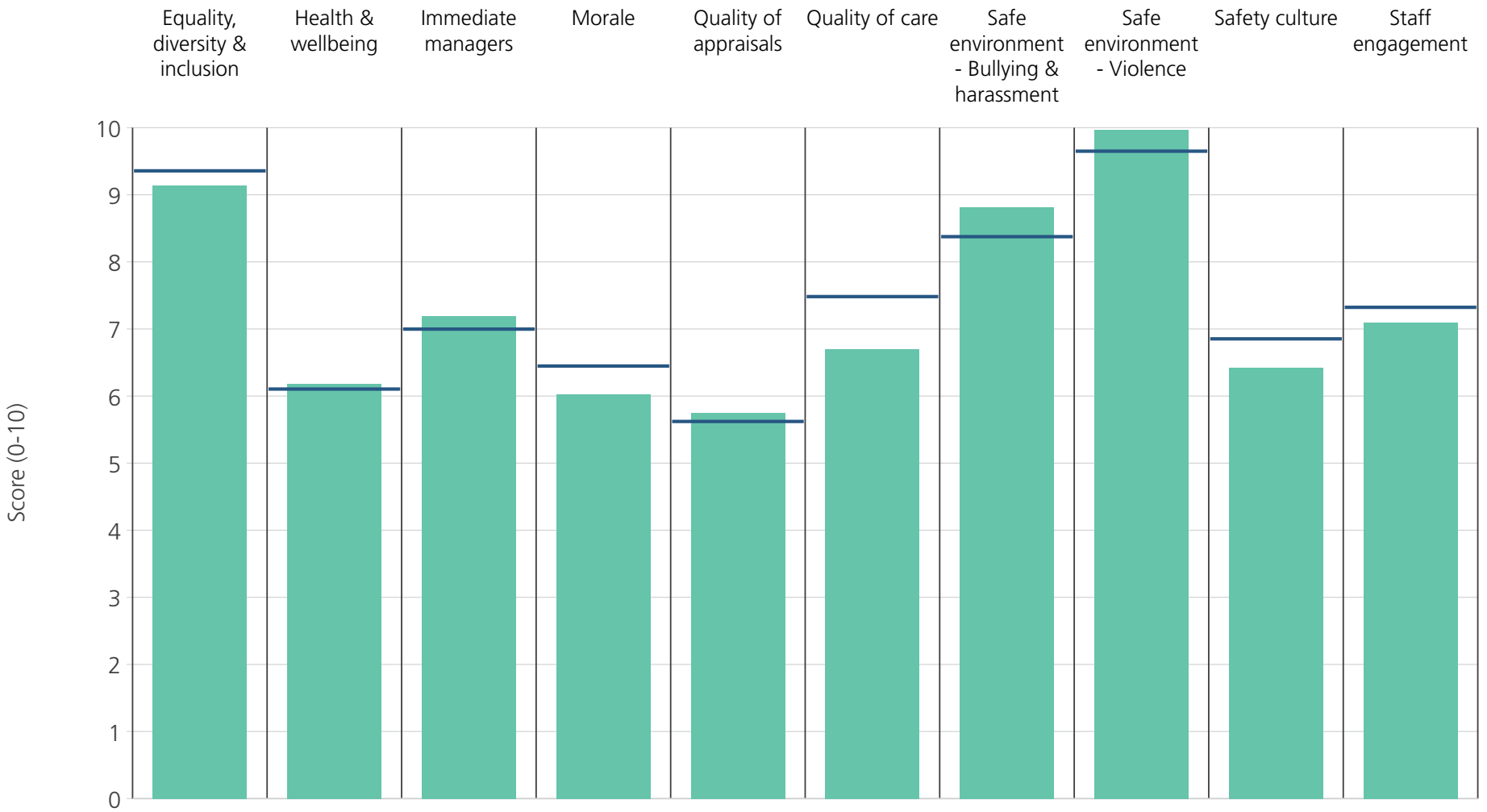


	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement
Directorate	9.1	5.9	5.6	6.2	4.4	7.4	8.5	9.6	6.0	6.5
Your org	9.4	6.1	7.0	6.4	5.6	7.5	8.4	9.6	6.9	7.3
No. responses	82	82	83	79	66	58	82	82	76	82

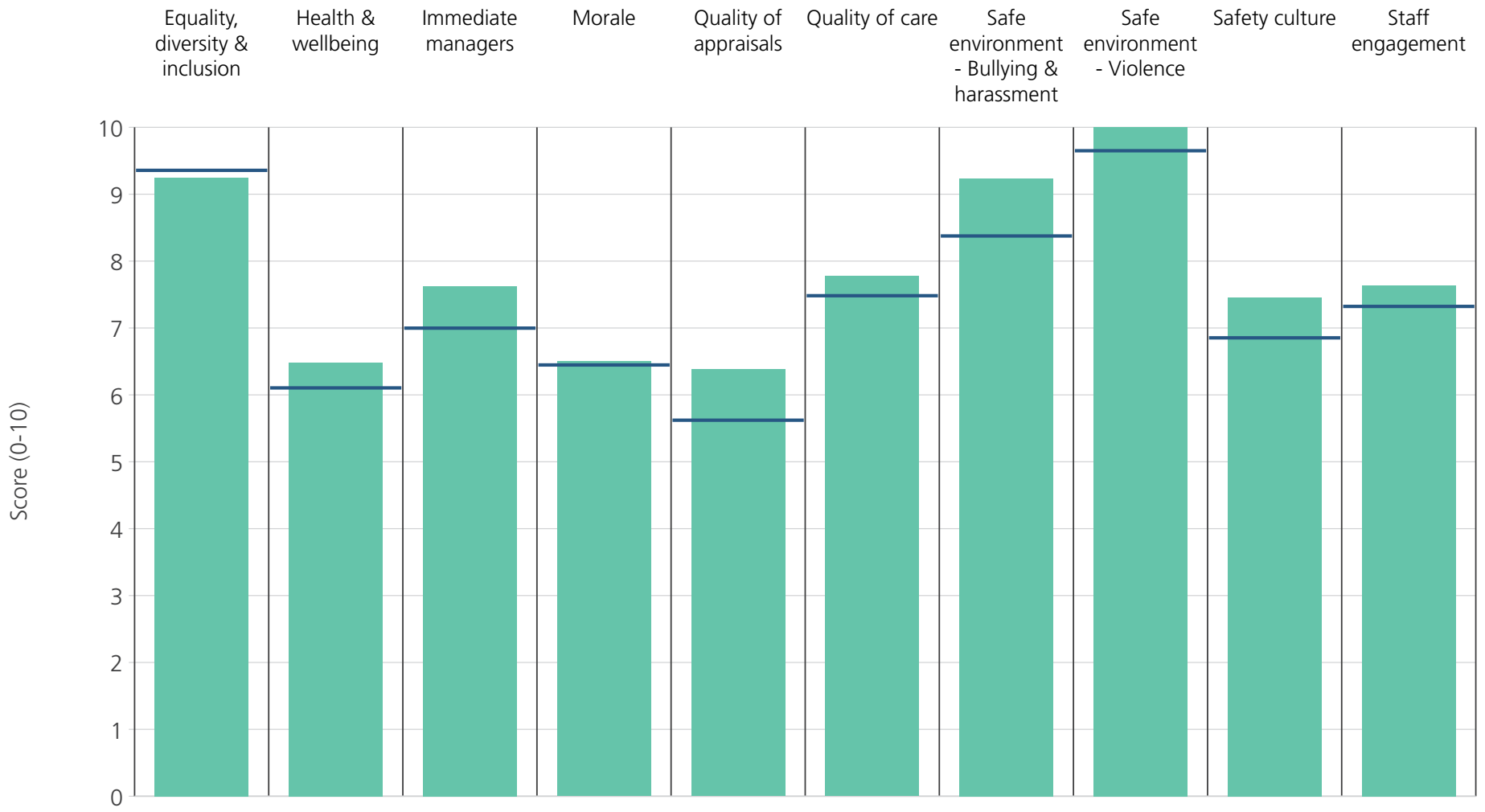
Survey Coordination Centre

2018 NHS Staff Survey Results > Directorates 2 > Finance & IMT

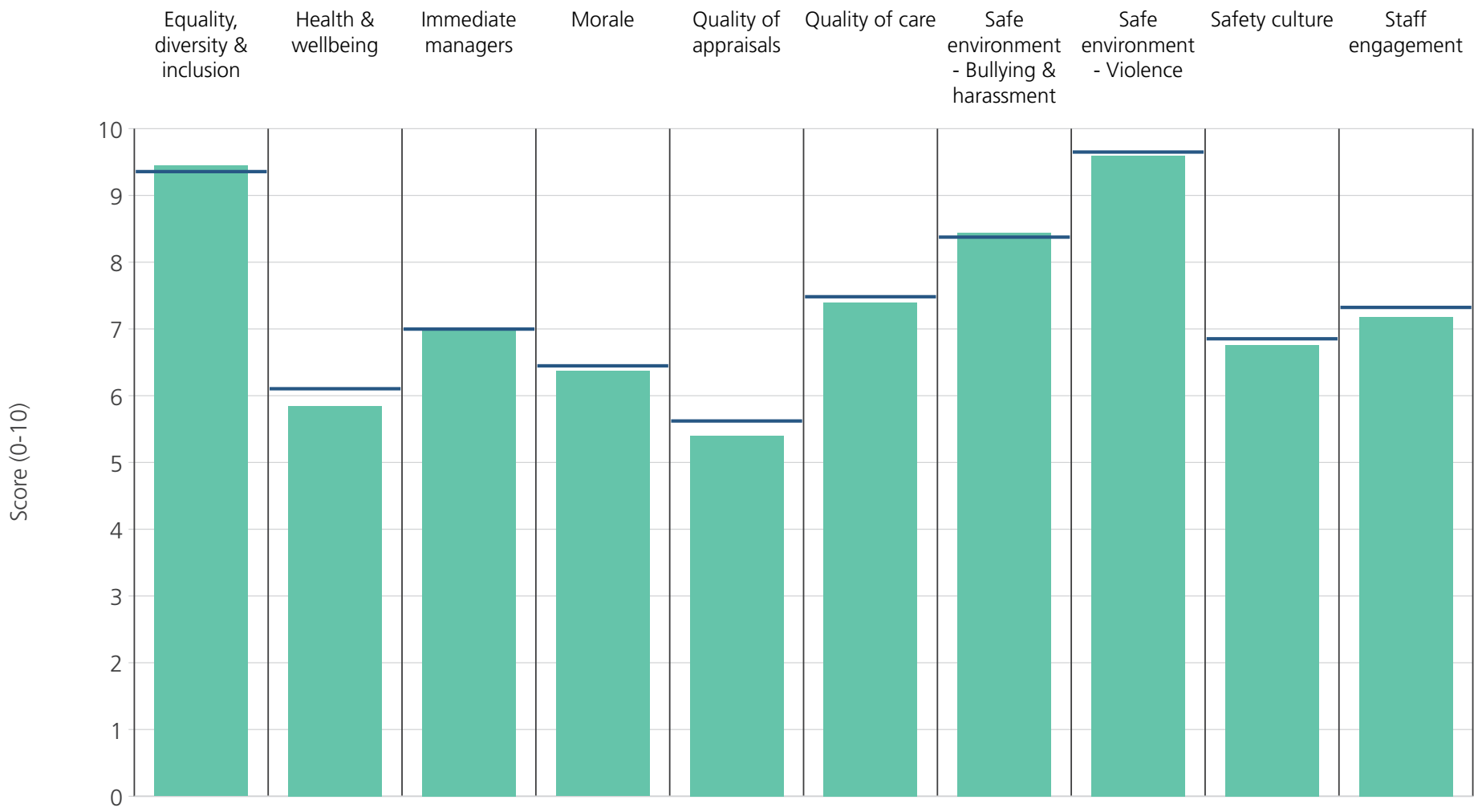
NHS England



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement
Directorate	9.1	6.2	7.2	6.0	5.7	6.7	8.8	10.0	6.4	7.1
Your org	9.4	6.1	7.0	6.4	5.6	7.5	8.4	9.6	6.9	7.3
No. responses	98	100	99	99	92	48	97	97	96	100



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement
Directorate	9.2	6.5	7.6	6.5	6.4	7.8	9.2	10.0	7.5	7.6
Your org	9.4	6.1	7.0	6.4	5.6	7.5	8.4	9.6	6.9	7.3
No. responses	54	54	54	54	45	35	52	50	53	54

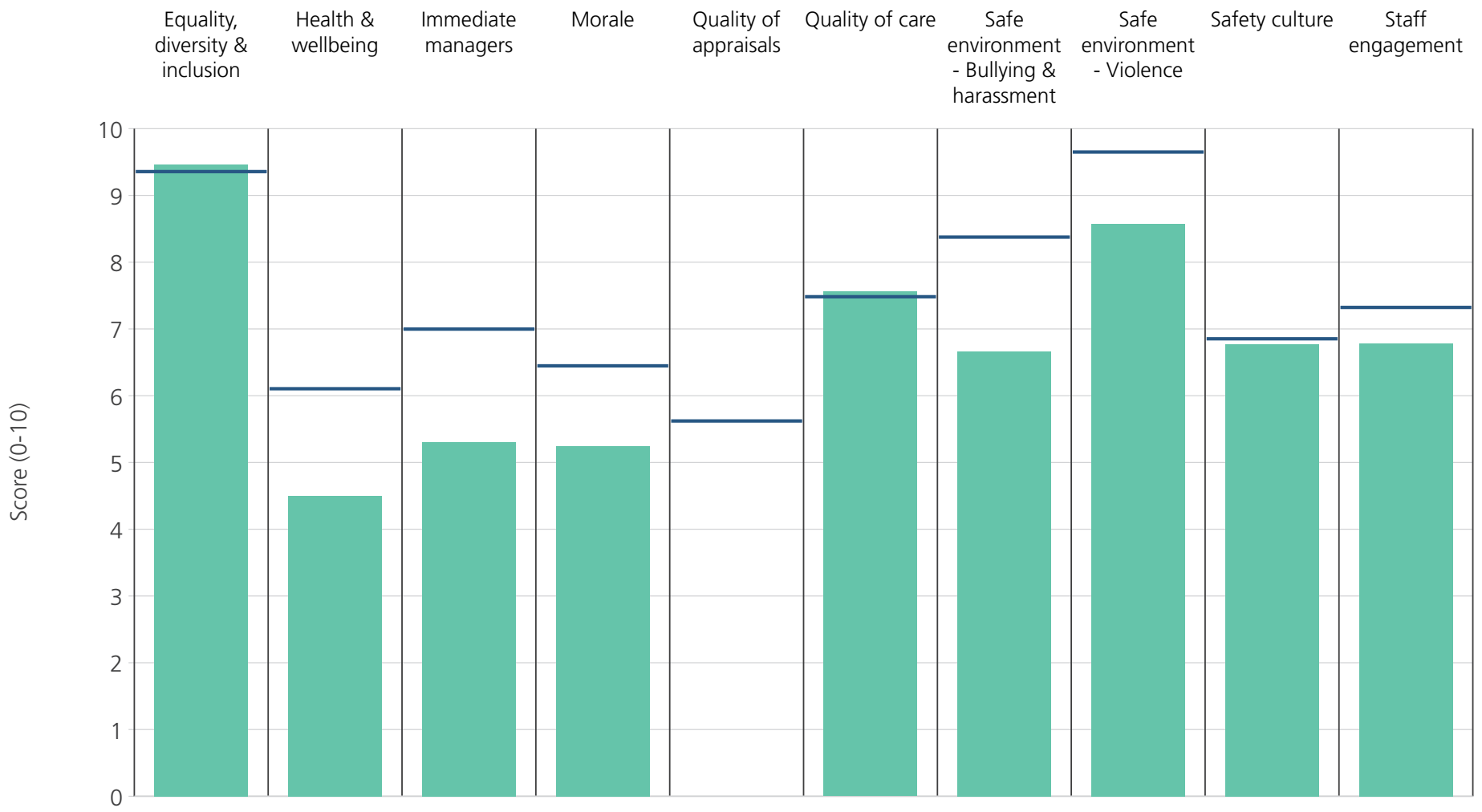


	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement
Directorate	9.4	5.8	7.0	6.4	5.4	7.4	8.4	9.6	6.8	7.2
Your org	9.4	6.1	7.0	6.4	5.6	7.5	8.4	9.6	6.9	7.3
No. responses	664	661	665	661	589	609	662	651	664	673

Survey Coordination Centre

2018 NHS Staff Survey Results > Directorates 2 > Nurse Pool

NHS England

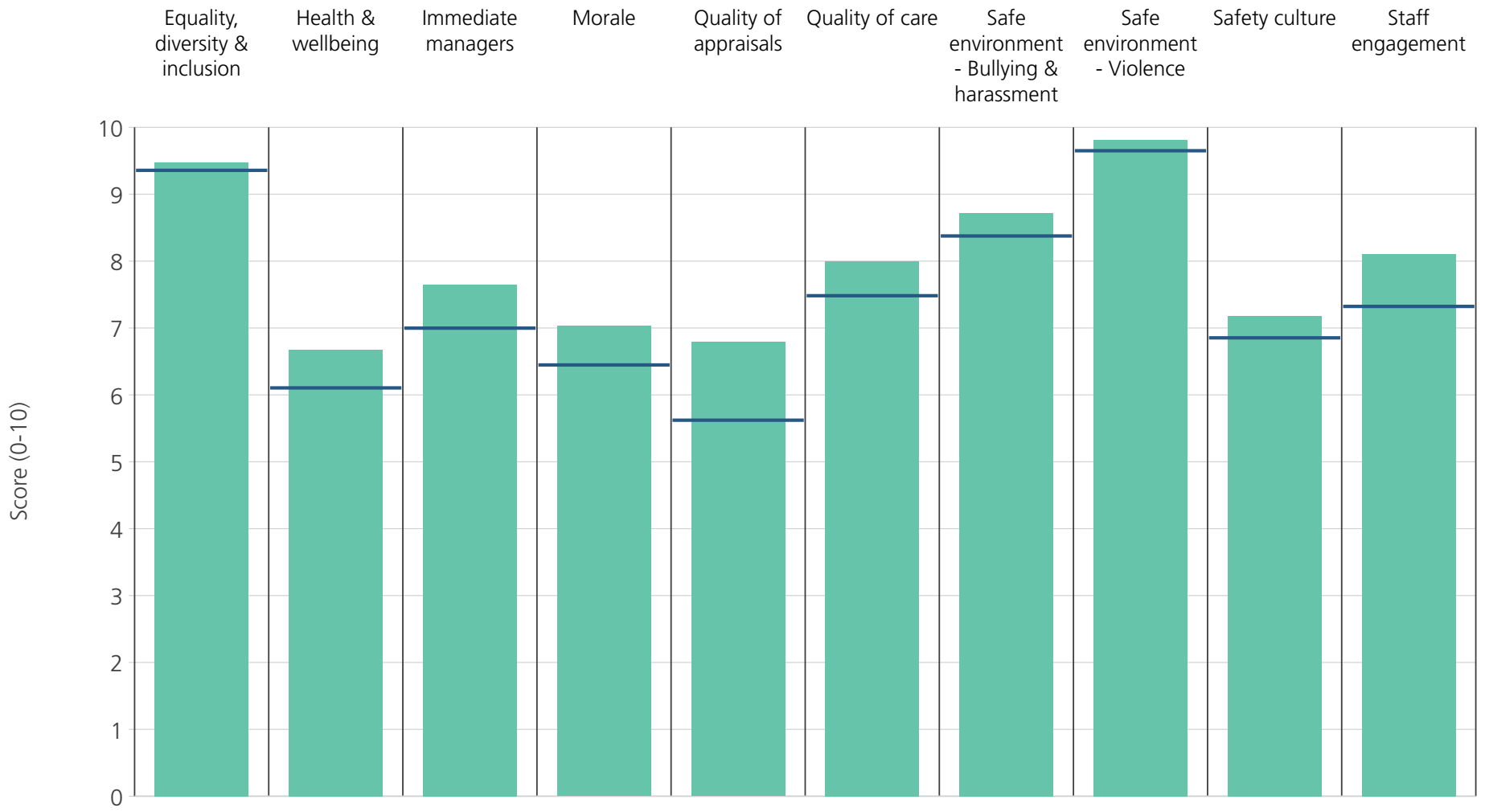


	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement
Directorate	9.5	4.5	5.3	5.2		7.6	6.7	8.6	6.8	6.8
Your org	9.4	6.1	7.0	6.4	5.6	7.5	8.4	9.6	6.9	7.3
No. responses	14	14	14	14	10	14	14	14	14	14

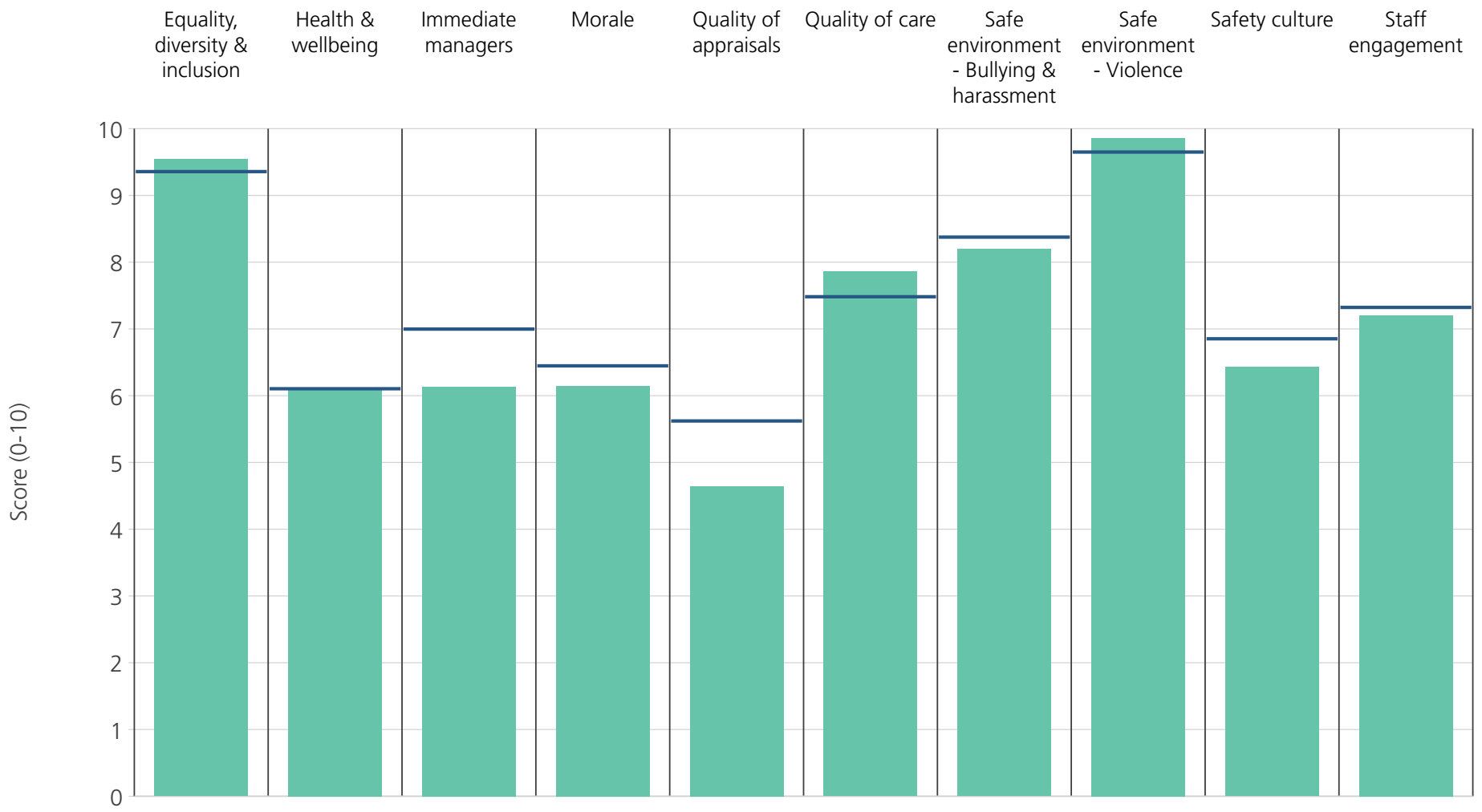
Survey Coordination Centre

2018 NHS Staff Survey Results > Directorates 2 > Nursing & Quality

NHS England



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement
Directorate	9.5	6.7	7.6	7.0	6.8	8.0	8.7	9.8	7.2	8.1
Your org	9.4	6.1	7.0	6.4	5.6	7.5	8.4	9.6	6.9	7.3
No. responses	52	53	53	53	51	40	52	52	53	53

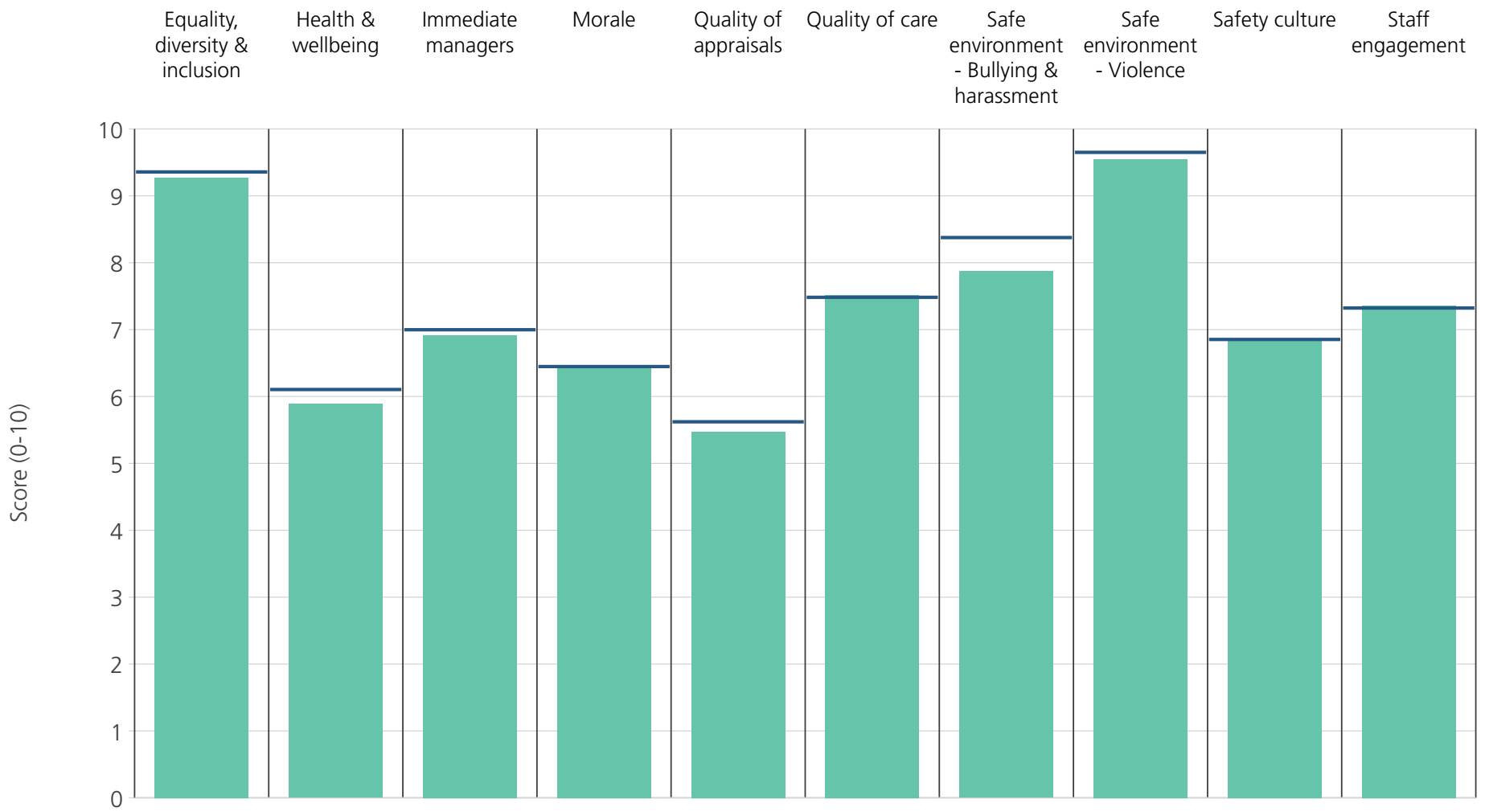


	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement
Directorate	9.5	6.1	6.1	6.1	4.6	7.9	8.2	9.9	6.4	7.2
Your org	9.4	6.1	7.0	6.4	5.6	7.5	8.4	9.6	6.9	7.3
No. responses	49	50	50	50	46	43	48	48	49	50

Survey Coordination Centre

2018 NHS Staff Survey Results > Directorates 2 > Surgery

NHS England



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement
Directorate	9.3	5.9	6.9	6.4	5.5	7.5	7.9	9.5	6.9	7.4
Your org	9.4	6.1	7.0	6.4	5.6	7.5	8.4	9.6	6.9	7.3
No. responses	571	576	578	573	515	563	573	570	577	580

Trust Board Update Paper

Progress on the 2018 Annual Report for the Framework of Quality Assurance for Responsible Officers and Revalidation

Introduction

Further to the presentation of the above report at Trust Board in September 2018, two specific actions were identified with regards to medical appraisals, and it was agreed to provide a progress report of these specific actions to the Board at the March 2019 meeting. These actions were:

1. Liaison with Medical HR and the Medical Education Team to look at resolving the issue around the management/inputting of appraisal data relating to new recruits.
2. Discuss the possibility of accessing/triangulating information relating to complaints, incidents and PALS concerns to enable doctors to use this data as part of the reflective element of the appraisal process.

This briefing will outline to the Board progress to date.

Progress

Action 1

A robust process is now in place between Medical HR and Medical Education to ensure all new medical recruits are registered and included in the appraisal system. This action can now be closed.

Action 2

Information from complaints and PALS concerns are incorporated into the appraisal process. A number of changes have been made to the way how complaints can become a point of learning and reflection:

- Trust Appraisal Lead, Education and Revalidation Manager meets with Trust Complaints and PALS lead to discuss complaints and PALS concern.
- A process is in place where the Appraisal Lead will contact Appraiser to discuss complaint and look at how reflection can incorporate Trust values.
- Complaint available for review in the appraisal document.
- Appraisee will complete reflective note and identify points of learning and reflect on Trust value.
- Reflective note will be available as a tool for future learning.

The appraisal lead will continue to monitor this process to ensure effective learning and reflection for all doctors involved in complaints and PALS concerns.

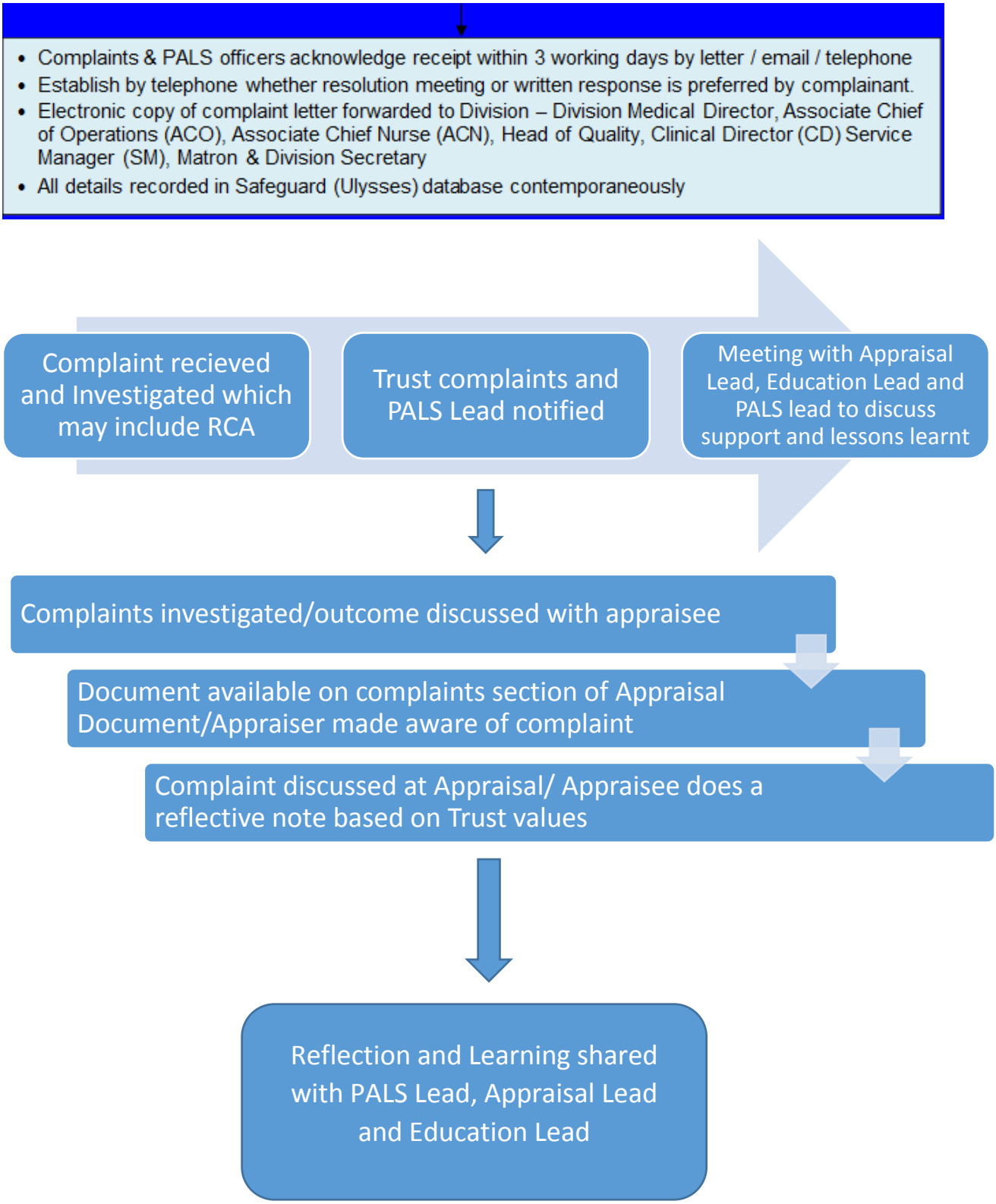
Conclusion

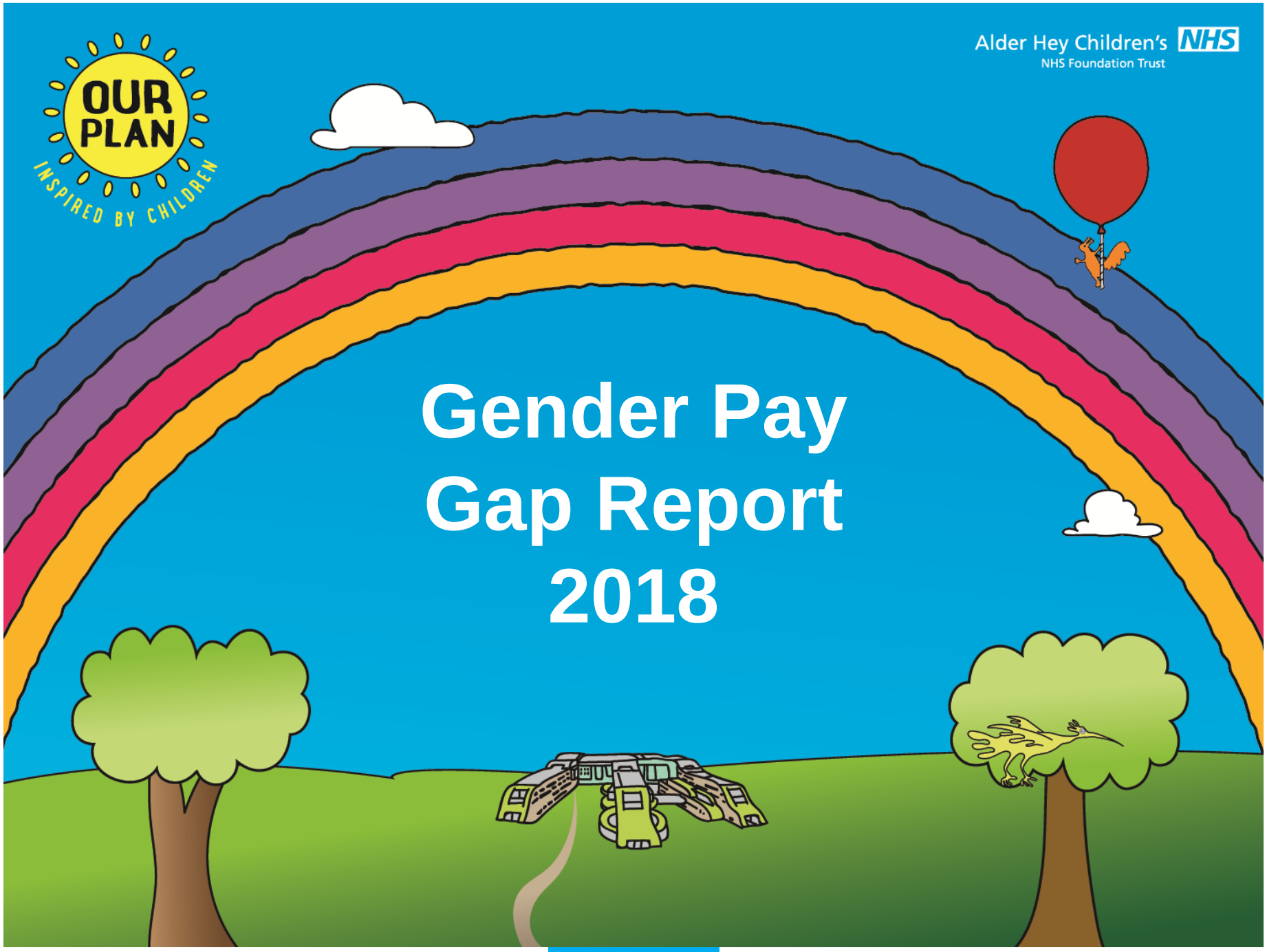
The appraisal lead continues to work closely with the Director of Medical Education and the L&OD teams to ensure the ongoing quality of appraisals. This will include exploring the inclusion of values-based appraisals during 2019.

Urmi Das,

Acting Appraisal/Revalidation Lead

Appendix 1 - Accessing/Triangulating Information related to complaints, incidents and PALS concerns (Medical Staff) for Appraisal/Revalidation

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Alder Hey Children's NHS
NHS Foundation Trust
Gender Pay Gap Report 2018

Alder Hey Children's NHS Foundation Trust

INTRODUCTION

This is the second Trust Gender Pay Gap report produced to meet the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 which came into force on the 31st March 2017.

Gender Pay Gap legislation requires all employers of 250 or more employees to publish their gender pay gap as at 31st March 2018. Alder Hey Children's NHS Foundation Trust employs over 3,000 staff in a range of clinical and non-clinical roles.

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

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

The Trust uses the national job evaluation framework, Agenda for Change, for most levels of staff (except medical) to determine appropriate pay bandings; this provides a clear process of paying employees equally for the same or equivalent work. The Electronic Record System (ESR) has been used to generate the information. In common with most healthcare organisations, women make up the majority of the Trust workforce, with 83% female and 17% male employees as reported in 2017.

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NHS Foundation Trust

Timescales

- The figures must be calculated using a specific reference date – 'the snapshot date'. The snapshot date for public sector organisations is 31 March 2018. The information will demonstrate the pay gap between male and female employees as at 31 March in the previous year. For example, 31 March 2018 data must be published by 30 March 2019 and on an annual basis thereafter.

Mandatory Calculations

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

Salary:

- the mean (average) pay gap
- the median pay gap
- the proportion of male and female staff in each salary quartile band

Bonus:

- the mean bonus pay gap
- the median bonus pay gap
- the proportion of male and female employees receiving a bonus payment

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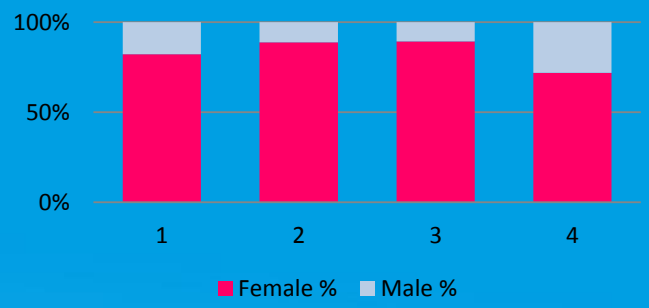
Gender Pay Gap Summary

Alder Hey Children's NHS
NHS Foundation Trust

Salary Information

	2016/17	2017/18
Average Pay Gap	33.17%	29.53%
Median Pay Gap	12.38%	12.17%

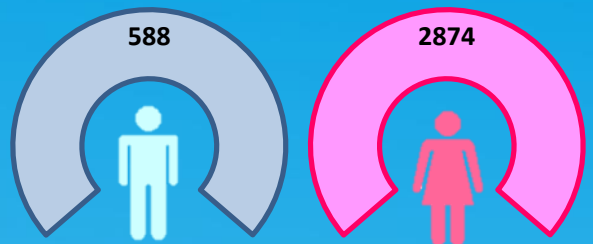
Proportion of Men & Women in Each Salary Quartile Band



Bonus Information

	2016/17	2017/18
Average Bonus Pay Gap	36.78%	37.24%
Median Bonus Pay Gap	49.99%	28.14%

Total Staff numbers vs Total Staff Paid Bonus*



* Only a small proportion of staff are eligible

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Gender Pay Gap – Mean and Median

Alder Hey Children's NHS
NHS Foundation Trust

Mean Gender Pay Gap

The **mean** pay gap is the difference between the average hourly earnings of men and women.
The data tells us that, on average, female employees earn 29.5% less than male employees. This has improved since last year by 3.5%.

Median Gender Pay Gap

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

The median data tells us that female employees continue to earn 12% less than male staff. (The basic pay data includes Clinical Excellence Awards payments that are paid to eligible medical staff)

The mean gender pay gap for the whole of the Public Sector economy (according to the October 2017 Office for National Statistics (ONS) Annual Survey of Hours and Earnings (ASHE) figures) is 17.5%. At 30% the Trust's mean gender pay gap is therefore above that of the wider public sector. This is reflective of the pattern from the wider UK healthcare economy; traditionally the NHS has had a higher proportion of females in the workforce which tend to be in the lower bandings, and a predominantly male workforce in the higher banded Medical & Dental professions, although at Alder Hey this is a section of the workforce with a higher proportion of females this year with 49% males (53% last year) compared to 51% females (47% last year).

	2016/17	2017/18
Average	33.17%	29.53%
Median	12.38%	12.17%

Difference in hourly rate in favour of males:
+£6.90 Avg. Hourly Pay
+£2.04 Median Hourly Pay

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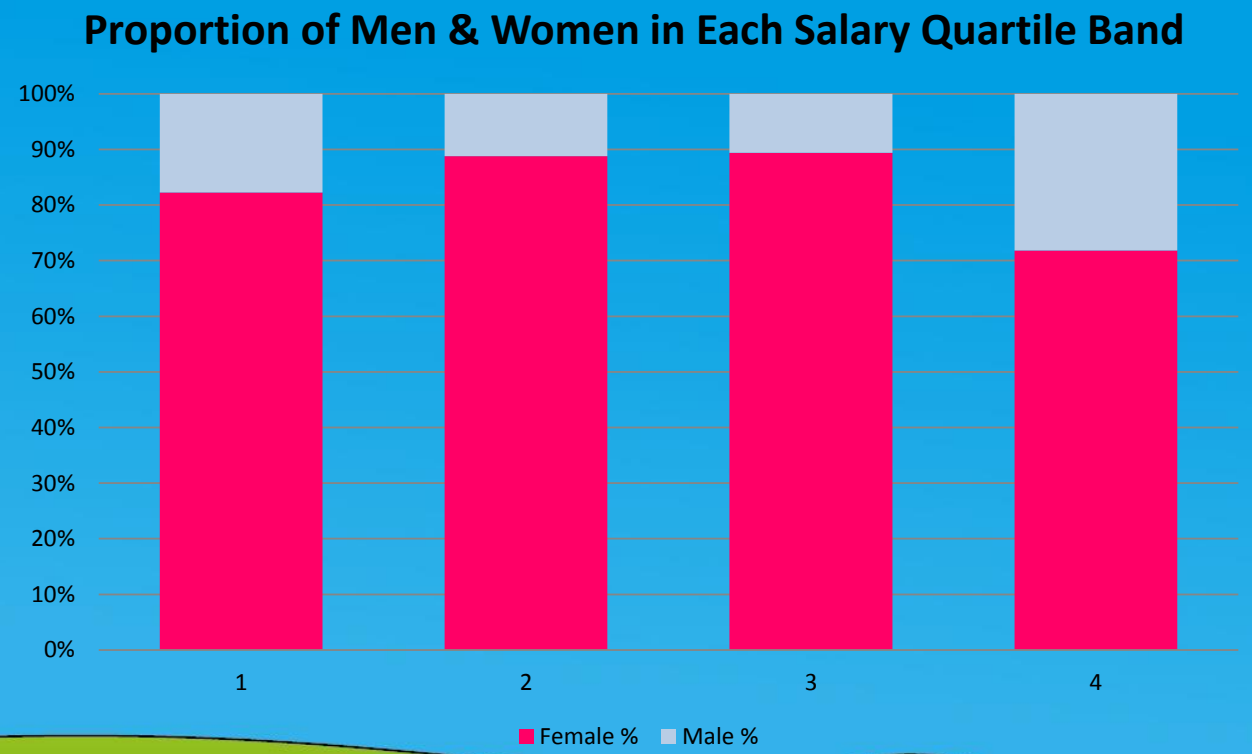
Gender Pay Gap – salary quartiles

Alder Hey Children's NHS
NHS Foundation Trust

Proportion of Men and Women in each Salary Quartile Band

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

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



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Gender Pay Gap Bonus

Alder Hey Children's NHS
NHS Foundation Trust

Bonus Pay, whilst also forming part of basic pay for the purposes of calculating the mean and median average gender pay gap, is only paid to eligible consultant medical staff in the form of Clinical Excellence Awards. These awards recognise and reward individuals who demonstrate achievements in developing and delivering high quality patient care over and above the standard expected of their role, with a commitment to the continuous improvement of the NHS. The CEA's are administered within the Trust on an annual basis. In 2018, this data also includes a one-off discretionary ad-hoc payment to a small number of Executives linked to additional workload and responsibility for a 6 month period.

The Mean Bonus Gender Pay Gap

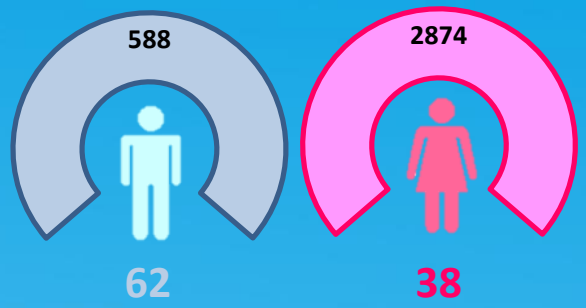
The data tells us that on average bonus pay, female employees earn 37% less than male employees.

The Median Bonus Gender Pay Gap

The data tells us that on median bonus pay, female employees earn 28% less than male staff, this has significantly decreased from last year when this figure was 50%.

	2016/17	2017/18
Ave	36.78%	37.24%
Median	49.99%	28.14%

Total Staff numbers vs Total Staff Paid Bonus



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Gender Pay Gap Bonus (Medical & Dental staff)

Alder Hey Children's NHS
NHS Foundation Trust

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

The Mean Bonus Gender Pay Gap

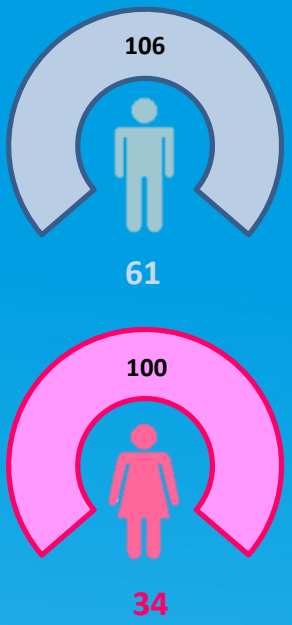
The data tells us that on average bonus pay, female employees earn 32% less than male employees.

The Median Bonus Gender Pay Gap

The data tells us that on median bonus pay, female employees earn the same as male staff, this has significantly decreased from last year when this figure was 50%.

	2016/17	2017/18
Average	36.78%	32.32%
Median	49.99%	0.00%

Total Eligible Medical Staff vs Total Medical Staff Paid Bonus



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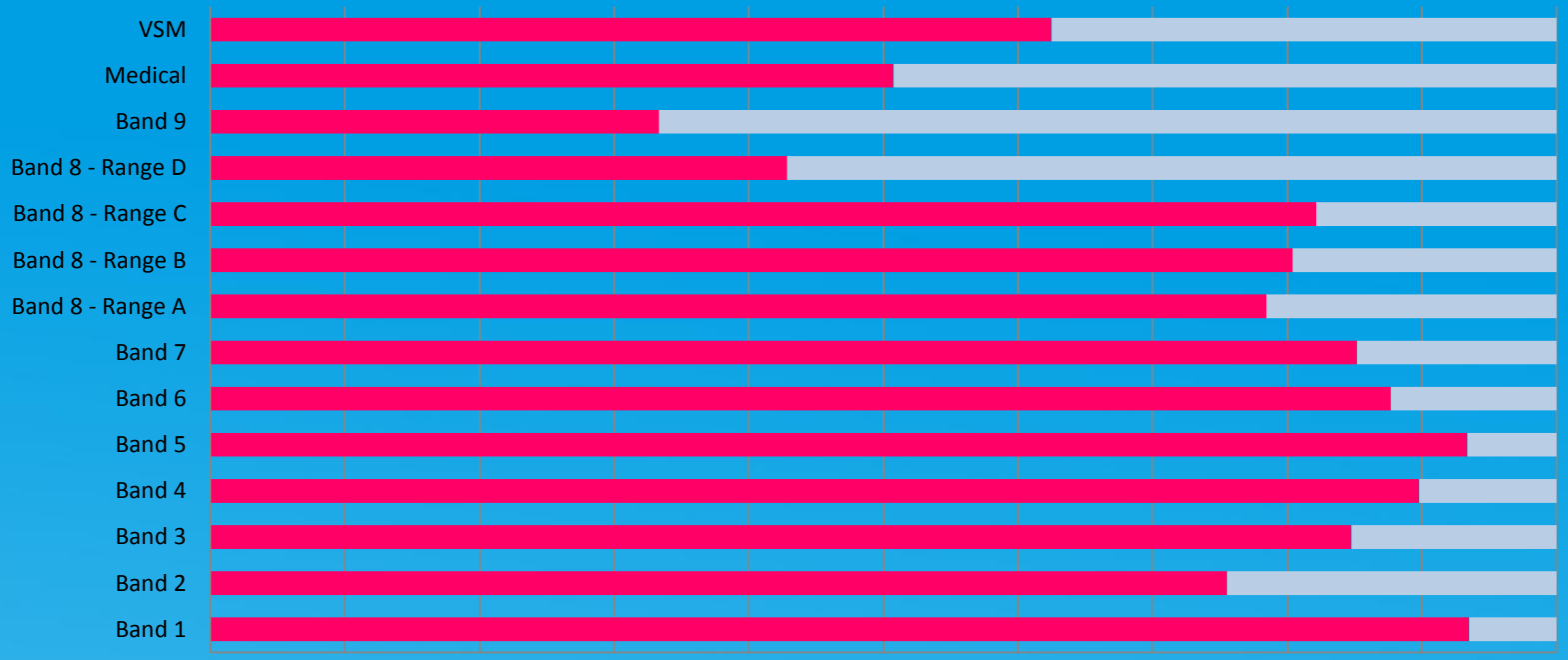
Understanding our Results

Alder Hey Children's NHS Foundation Trust

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



	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8 - Range A	Band 8 - Range B	Band 8 - Range C	Band 8 - Range D	Band 9	Medical	VSM
Female	93.53%	75.54%	84.76%	89.79%	93.38%	87.70%	85.18%	78.44%	80.39%	82.14%	42.86%	33.33%	50.76%	62.50%
Male	6.47%	24.46%	15.24%	10.21%	6.63%	12.30%	14.82%	21.56%	19.61%	17.86%	57.14%	66.67%	49.24%	37.50%

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Alder Hey Children's NHS
NHS Foundation Trust

Understanding our Results

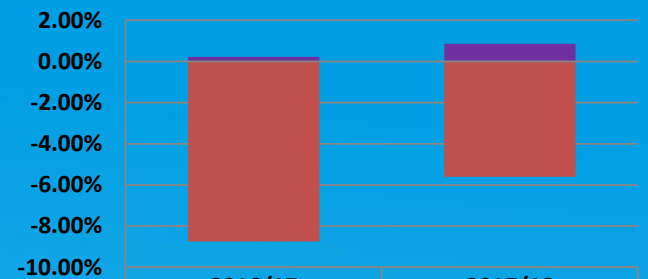
AfC Breakdown

The majority of our employees are on national Agenda for Change Terms and Conditions. An analysis of salary within AfC staff only reveals that there is no mean pay gender gap, and that there is actually a small median gender pay gap for males of 5.61%, an improvement from 2017 data.

Average Pay Males paid more:
+£0.13 Avg. Hourly Pay
Median Pay Females paid more:
-£0.77 Median Hourly Pay

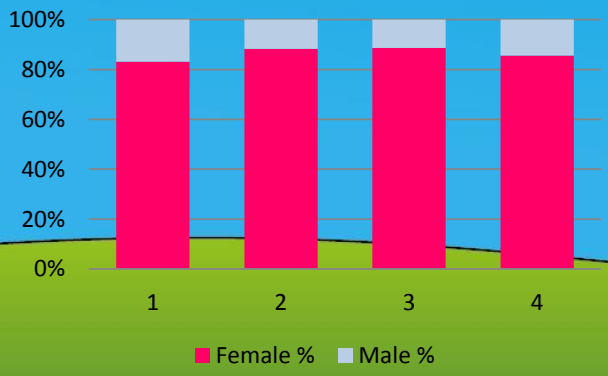
The majority of our employees are on national Agenda for Change Terms and Conditions. An analysis of salary within AfC staff only, above, reveals that there is no mean pay gender gap, and that there is actually a small median gender pay gap for males of 5.61%.

% Pay Gap



	2016/17	2017/18
Median	-8.74%	-5.61%
Avg.	0.23%	0.86%

Proportion of Men & Women in Each Salary Quartile Band



Alder Hey Children's NHS
NHS Foundation Trust

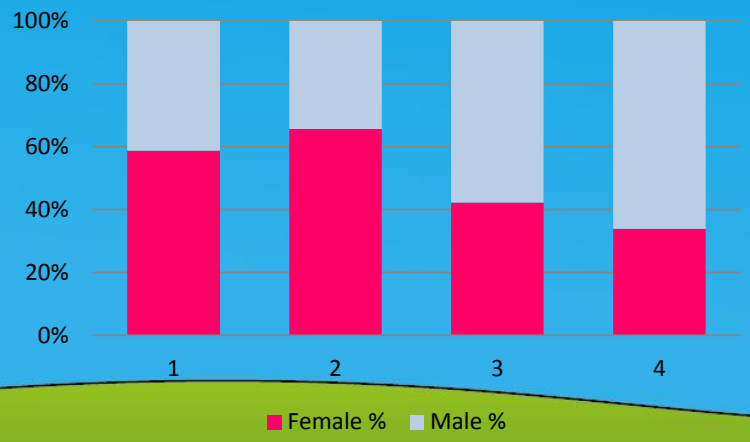
Understanding our Results

Medical & Dental Breakdown

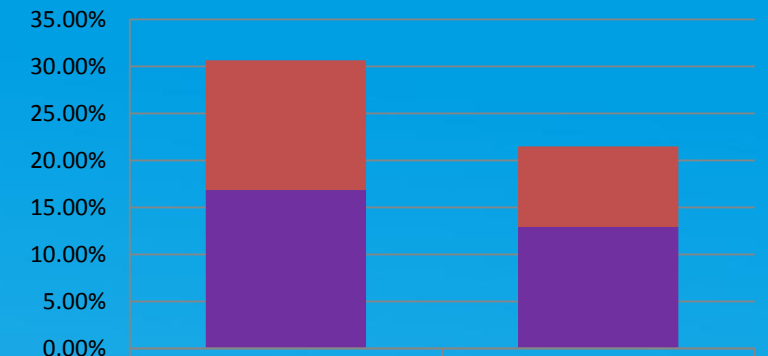
Whilst there is a more even gender split within this staff group, 49% males (last year 53%) to 51% females (last year 47%), there remains a mean gender pay gap of 12.90%, and a median gap of 8.59% although these figures suggest an improvement from last year's data. We do know that, at Alder Hey, more male medical staff have a longer length of service than female medical staff, which impacts upon salary.

Males paid more:
+£5.93 Avg. Hourly Pay
+£3.86 Median Hourly Pay

Proportion of Men & Women in Each Salary Quartile Band



% Pay Gap



	2017	2018
Median	13.80%	8.59%
Avg.	16.83%	12.90%

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Conclusion

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NHS Foundation Trust

The Trust has calculated the gender pay gap data in line with the government's gender pay gap reporting regulations ahead of submission of 30th March 2019. The mean gender pay gap is 30%, and the median is 12%.

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

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

We recognised in 2017 that a key reason for the gender pay gap was less female medical staff holding clinical excellence awards than male; in response during 2018 we undertook a range of actions, including workshops and additional support to encourage more female and 'less than full time' female medical and dental staff to apply for Clinical Excellence Awards.

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Alder Hey Children's NHS
NHS Foundation Trust

Recommendations

The Trust Board are asked to approve the report in readiness for publication on the Trust and government website by the deadline of 30th March 2019.

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

The specific objective for 2019 will be to 'Support all female, including part-time female medical and dental staff, to apply for Clinical Excellence Awards'. This will be achieved by:

1. Understanding why fewer female and part time female medical and dental staff apply and as far as possible take steps to address this
2. Improve the support, advice and guidance provided to female and part-time female medical and dental staff in relation to applications for Clinical Excellence Awards

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NHS Foundation Trust

ANNEX A

WORKFORCE & OD COMMITTEE
MINUTES FROM MEETING
23rd October 2018

Present:	Ms C Dove	Non-Executive Director (Chair) (Part attendance)	(CD)
	Mrs M Swindell	Director of HR & OD	(MKS)
	Mr M Flannagan	Director of Communications & Marketing	(MF)
	Mrs J France-Hayhurst	Non-Executive Director	(JFH)
In Attendance:	Ms J Potier	Consultant Clinical Psychologist	(JP)
	Ms G Thomas	Apprenticeship Delivery Manager	(GT)
	Ms P Brown	Director of Nursing	(PB)
	Ms R Greer	Associate COO – Community Division	(RG)
	Ms E White	Care Pathways, Policies & Guidance Manager	(EW)
	Mr N Davies	HR Business Partner	(ND)
	Ms A Chew	Associate FD – Operational Finance	(AC)
	Mr G Lamont	Director of Education (Part Attendance)	(GL)
Apologies:	Mrs S Owen	Acting Deputy Director of HR&OD	(SO)
	Mr I Quinlan	Non-Executive Director	(IQ)
	Mr A Bateman	Chief Operating Officer	(AB)
	Mr A McColl	Associate COO	(AMc)
	Ms H Ainsworth	Equality & Diversity Manager	(HA)
	Mrs D Brannigan	Patient Governor (Parent & Carer)	(DB)
	Mrs H Gwilliams	Chief Nurse	(HG)
	Mr J Gibson	Programme Assurance Manager	(JG)
	Ms G Smith	Medicine Division	(GS)
	Mrs K Turner	Trust LiA Lead	(KT)
	Ms L Cooper	Director of Children & Young People	(LC)
	Mr P O'Connor	Deputy Director Nursery	(POC)
	Mr A Hughes	Interim Medical Director	(AJ)
	Mr T Johnson	Staff Side Chair	(TJ)

Agenda Item	Key Discussion Points	Action	Owner	Timescale
18/62 **Minutes of the Previous Meeting & Meeting Protocol**	The Committee considered the minutes of the meeting held on 3rd September 2018 and they were **approved** as an accurate record. Introductions were made.			
18/63 **Matters Arising, Actions**	The Committee considered the following under matters arising: **Programme Assurance 'Developing our Workforce'** **17/21** - Update on identified resource for Projects AHP, Temporary Staffing and E-			

Agenda Item	Key Discussion Points	Action	Owner	Timescale
	rostering.- MKS informed the Committee that an identified resource for AHP project has been identified – Rob Griffiths. Temporary staffing spend for junior doctors has seen a recent spike in usage, this has been discussed at the recent Financial Sustainability meeting. MKS added that rotas are complicated and advised that she will lead to group to get under the E-rostering issues.			TBC
	Corporate Induction **18/05 –** 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 informed the Committee that this item will be presented to February 2019 meeting.	Update on Corporate Induction	DS/MKS	February 2019
	Equality & Diversity **15/03 –** Align E&D deliverables with people strategy – Noted as **complete** on action log.			
	Legislation, Terms & Conditions, Employment Policies/EIA's **18/43 –** Ratified First Aid Policy enquire with Resuscitation what implementation and resource plan is in place. – Noted as **complete** on action log.			
	18/51 – share EDS report with Committee members. – Noted as **complete** on action log			
	Staff Survey **18/54 –** Make available comparison data to Corporate/Divisional leads. Noted as **complete** on action log.			
	Board Assurance Framework **18/58 –** Review the exit interview process and make more visible the proforma – MKS to formally update at December's meeting.	Update on Exit Interview Process	MKS	TBC
18/64 **Programme Assurance 'The Best People Doing Their Best Work'**	**Programme Assurance Framework – September 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 the External Programme Assurance representative, the Director of HR & OD advised that the current dashboard shows that the Apprenticeship project is being maintained to a particularly high standard of project management, with evidence posted on the SharePoint site. The 'Improve Portering Services' project has now been re-profiled to accommodate a working trial of the new model, with the aim of implementing the new practices by end of April 2019, the Committee acknowledged that negotiations can impact the time taken to implement projects. The Committee **noted** the comments made.			

Agenda Item	Key Discussion Points	Action	Owner	Timescale
18/65 **Progress against the People Strategy**	**Leadership Strategy 2018-2021** The Committee received a presentation delivered by Consultant Clinical Psychologist. The purpose of the presentation was to share a new approach to leadership development and seek support/ratification from the Committee. The Committee noted the leadership model has been presented to the weekly Executive Meeting and endorsed. As outlined in the presentation, JP advised it has been identified, following feedback, that management and leadership development is key to improving support for staff and patient services. MKS referenced the 2016 NHSI document - developing people, improving care and indicated that the AH Strategy is aligned to the national framework for leadership. The presentation articulated the Trusts framework with proposed actions, to support 'continuous improvement in care. MKS advised that the leadership strategy will work hand in hand with the quality strategy that will be presented at Trust Board in December. JP advised that time had been spent defining what makes a good Alder Hey leader and the presentation outlined the qualities required. The committee discussed the merits of the leadership qualities whilst ensuring staff are on board with developments. JP alluded to the new proposed framework in the presentation, looking at leadership through a slightly different lens, using the vision we already have in place. The premise is to establish a faculty, whose job is leadership training and part of a new way of working will be for the faculty to deliver training processes and mentoring/coaching processes. The first task of the faculty will be to develop in house training to support 'strong foundations' - all leaders will be required to complete this and it will cover the following: self-management, self-awareness and resilience; culturally competent; basic improvement methods; responsible for own wellbeing and wellbeing of others; everyday coaching conversations; person in the policy. The Committee agreed that the Trust Values are intrinsic and part of our strategic aims. JP outlined the processes around how all the above will work in practice for the four different groups of leadership staff. The different groups will, as appropriate, be referred to the faculty for self-assessment; leadership conversations; group supervision and mentoring/coaching peer supervision/reflective practice. The appropriate level of development will be offered and the impact of the interventions will be measured. JP referenced the future growth plans with particular attention brought to the faculty			

Agenda Item	Key Discussion Points	Action	Owner	Timescale
	becoming a regional centre of excellence and the development of in-house offer of specific areas e.g. Influencing skills/compassionate leadership. The Committee reflected on areas such as different work experiences in relation to: your gender; best tools available for training purposes (i.e. webinar; e-learning – making it fun); look at how we fast track staff; look at the age profile of nurses and plan requirements; evaluate the process and do not be afraid to change it; review the name faculty. MKS advised the Leadership Strategy will be presented to the next Board. The Committee **ratified** the approach.			
18/66 **Wellbeing**	**Health & Wellbeing – 'Time to Change'** The Committee received a presentation delivered by the HR&OD Director. The purpose of the presentation is to outline the principles and key actions to support a re-think about mental health. MKS advised that a programme is running across the UK to change public attitudes about mental health, run by Mind, over 450 employers including NHS organisations have signed up to the employer pledge. We would like to adopt this programme at Alder Hey. Zoe Connor, HRBP has produced an Employer Pledge Action Plan outlining the principles of the action plan to support 'time to change' in relation to ending mental health discrimination. This action plan has been presented to the Health and Wellbeing Committee and actions agreed. The Committee discussed in-depth what the trust has in place already to support staff wellbeing and the impact on resources/staff available to support training 100 wellbeing champions. The Committee acknowledged the requirement to 'dovetail' not duplicate support for staff. CD suggested a further discussion is needed to tailor the action plan to the Trust's requirements, particularly in relation to 'champions/counsellors. MKS to pick this up with the Health and Wellbeing Committee and suggested a key staff (Jo & Mark) meet to tailor requirements. The Committee **noted** the progress made.			
18/67	**Health & Wellbeing Update October 2018** The Committee received a report prepared by Zoe Connor HRBP for Surgery, the purpose of the report is to outline the developments to support the Trust focus on health and wellbeing, reflecting the priorities in the Trusts Strategy and feedback from the staff survey with focus on the CQUIN and NICE guidelines. The report provided for information was noted as read.			

Agenda Item	Key Discussion Points	Action	Owner	Timescale
	The Committee **noted** the progress made.			
18/68	**Sickness Update – 'Hot Spots'** The Committee received a report prepared by the HR Business Partner - Medicine. In May 2018 the Trust was invited to take part in a Health and Wellbeing Improvement programme led by NHS Improvement. The focus of this programme is to improve the health and wellbeing of our workforce and to reduce sickness absence rates. The purpose of the report is brief the Committee on the latest developments of the review put in place to establish trends and identify the strategic actions being taken to support staff and managers. The aim of the review is to minimise the impact of sickness absence of individuals and the service and to support and improve staff health and wellbeing. The report was noted as read. MKS outlined the Trusts position with sickness absence rates for the Trust at 5.5% for September with a rolling 12 month figure of 5.31%. Over a rolling 12 months, analysis of data indicates that long term sickness is the highest contributing factor to absence at 3.76% in comparison to 1.56% due to short term sickness. MKS drew attention to interventions and support put in place to manage absence, with HR team providing coaching and advice to managers to enable them to have effective conversations. The HR team are working with areas with the highest levels of sickness by utilising absence data to establish causes and trends and ensure local interventions are in place to provide the necessary support. A dedicated Corporate HR manager role has been put in place to provide HR advisory support across the corporate functions. Newly appointed HR advisers are working with the divisions to establish sickness workshops that will focus on providing localised training and guidance, in addition to developing action plans and support programmes for on-going sickness cases. MKS advised that now the HR Dept. has a full complement of staff in place, they are in a better position to support managers. The Committee **noted** the progress made.			
18/69	**Education Governance Update - 2018 Education & Training Self-Assessment Report (Reporting period 1st August 2017 to 31st July 2018)** The Committee received a draft report prepared by the Director of Education. The purpose of the report is to inform Health Education England how the HEE Quality Domains are being met at the Trust. The report documents the top three successes and top three challenges the Trust has faced in the reporting period. The report is noted as read. The Committee discussed the robust budget setting and quality improvement plans to support the process and it was recognised that this document underpins that work. GL acknowledged there was still some work to do to complete the Assessment and sought the Committee's endorsement of the reports content to			

Agenda Item	Key Discussion Points	Action	Owner	Timescale
	date. The Committee noted the deadline for submission is 31st October 2018 and the completed document will be brought to the Trust Board for information. The Committee **approved** the progress of the draft 2018 Education & Training Self-Assessment Report.			
18/68	**Apprenticeship Update** The Committee received a presentation prepared by the Apprenticeship Delivery Manager. The purpose of the presentation is to update the Committee on the latest developments to support the 18/19 Objectives to utilise the levy. GT advised that with all divisions being supported to consider apprenticeships as part of their workforce plan, the apprenticeship programme has been embraced at the Trust. Attention was drawn to the public sector duty head count 2.3% from April 2017-March 2021 and GT advised that initial projections raised by the contract manager have been revisited with the outcome being that the Trust has nearly reached the 3 year contract for apprenticeships at the Trust. Particular reference was made to the Medicine Division who have reached their target. As outlined in the presentation GT listed the differing apprenticeship's put in place in the Divisions/Corporate with the overall total of 49 members of staff signed up to an apprenticeship. Statistics were shared with the Committee of what had been received/drawn from the levy account to support the internal delivery. GT advised that looking forward a programme of events has commenced to encourage external candidates to embrace apprenticeships with a particular aim to encourage BME/Diversity interest i.e. met with Equality & Diversity Manager to discuss following the implementation of Equality Delivery System 9 steps guidance; working with the Recruitment & Employment Services Manager to deliver apprenticeships via Job Centre Plus, look at the National 10 week recruitment programme, tap into the Council. CD suggested that to support diversity at the Trust we should look to develop more partnerships within communities and in the future she would like to see a breakdown of developments. GT informed the Committee that a work handbook has been produced to enable apprenticeships to self-evaluate progress. The work handbook includes lots of information to support apprenticeship's (i.e. access to counselling) and goes back to the Alder Hey Values and will also enable Ofsted to track individuals progress. The Committee **noted** the progress made.			
18/69	**Staff Survey 2018 Update** The Committee received a Staff Survey update prepared by the Learning &			

Agenda Item	Key Discussion Points	Action	Owner	Timescale
	Development Manager. The purpose of the report is to update on the developments put in place to increase completion rates for this year, with the target of 60%. MKS outlined comparisons to previous year's completion rates and noted that at this current time we are much further head and we still have 7 more weeks to go. The update was noted as read. The Committee **noted** the progress made.			
18/70	**Mandatory Training Update** The Committee received the mandatory training report prepared by the Learning & Development Manager. The purpose of the report is to outline the Trusts commitment to address low levels of compliance with a target of 90% compliance for all recognised mandatory training subjects. MKS advised that since July's report, there have been large volumes of competencies expiring throughout August and September. This is due to it being 3 years since the big move to the new hospital building when all staff were given the 'Big Move Workbook' for completion. This has meant that despite the work in supporting staff to update their mandatory training there has been some dips in training which the Trust is currently working hard with departments and individual staff to get back to the target of 90%. MKS advised that the next area of focus will be improving the quality and accessibility of mandatory training. This is to ensure that learning is taking place, it is as enjoyable as possible, as accessible as possible and we are fully assured that staff have the knowledge required by the Trust. The Committee **noted** the progress made.			
18/71	**18-19 Pay Progression for Non Agenda for Change Staff** The Committee received a report prepared by the HR Business Partner, Surgery. Following the implementation of the refreshed NHS Terms and Conditions of Service (Agenda for Change) a piece of work has been undertaken to review spot salaries, ACOO (General Manager) local scales and historic Trust (Whitley Terms and Conditions) contracts to determine future pay awards outside of AfC. Historically individuals on a non-AfC contract have been awarded 1% pay uplift in line with the national cost of living increase for AfC. Following the implementation of the new pay deal this is no longer applicable. The purpose of the report is to set out proposals for consideration by the Committee in regards to the future remuneration of individuals on non-AfC contracts. The Committee were asked to note the information provided in this paper and to make recommendations on the preferred options. MKS outlined the recommended options to the Committee's. Consideration has been taken to avoid proposed changes			

Agenda Item	Key Discussion Points	Action	Owner	Timescale
	having a detrimental impact on individual's earnings. MKS acknowledge that only a small number of staff were affected by this proposal and the Committee noted that this proposal had been discussed with the unions and agreement reached. The committee **approved** the recommendations.			
18/72 **Key Workforce Risks – Review of top Workforce Risks action planning against most significant risks**	**Board Assurance Framework – September 2018** The Committee received the (BAF) report under the Strategic Objective 'The Best People Doing Their Best Work' for September 2018. The report is noted as read, with no questions raised. The Committee **noted** the content of the Board Assurance Framework.			
18/73	**Key Workforce Risks KPIs – August 2018** The Committee received a regular report prepared by the Acting Deputy Director of HR concerning the key risks relating to workforce monitoring for August 2018. The purpose of the report is to update on key targets/measures and advise of actions to support improvement. The report is noted as read. Key headlines are: PDR's are on target to reach 90%. The Committee **noted** the content of the report.			
18/74 **Legislation, terms & conditions, employment policies/EIA's – review & ratification/approval**	The Committee considered the following Policies and Equality Impact Assessments for formal ratification and approval. As agreed at the last meeting in September, the following policies were issued virtually to Non-Executive's JFH & IQ and ratification received. The Committee received and discussed the EIA's at today's meeting and the documents were approved. **Consultant and SAS Doctors Procedure for Leave** **Consultant and SAS Doctor Job Planning** **Special Leave** The Committee **ratified** the above policies and **approved** the EIA's. Noted as **complete** on action log. **Medical Staff Covering Absent colleagues Procedure Policy & EIA** The Committee **ratified** the policy and **approved** the EIA			

Agenda Item	Key Discussion Points	Action	Owner	Timescale
	Pension Contribution Alternative Award Policy (approve pending consultation) The Committee received a draft policy for approval pending final comments from both LNC & JCNC. The policy outlines arrangements and options for employees who are members of the NHS Pension Scheme (the NHS Scheme) who may be affected by the annual or lifetime allowances in respect of their pension savings in registered pension schemes in the UK. The policy has been introduced to address operational risks that have been identified as a result of the changes introduced to the pension tax regime. MKS noted that this draft policy has been issued to LNC/JCNC Committees and sought ratification of WOD pending feedback from these Committees. MKS advised that it will also be taken to the Remuneration Committee. As an aside from this a number of Pension Education Sessions have been arranged to support staff. MKS acknowledged a number of individuals are opting out of the pension without fully understanding the implications. It was agreed to EW reformat the document once completed. The Committee **ratified** the policy			
18/74	**Sub Committee Minutes** None			
18/75 AOB	**Volunteer Policy - & EIA** EW advised that the Volunteer Policy was approved by CQSG last week – and asked for a view on whether WOD is happy to accept the policy for ratification given that it is not directly an Employment Policy. Following progression by the Policy Review Group, the Committee agreed to receive the Volunteer Policy for review at the next Committee.			
Date of Next Meeting	**Wednesday 23rd January 2019, 1.30pm-3.30pm, Large Meeting Room, Institute in the Park.** **(Please note this meeting was originally due to take place on 12th December 2018)**			

Action List

Minute Reference	Action	Who	When	Status
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. Noted on 23/10/2018 – Rob Griffiths has been identified as resource for AHP. Temp staffing has seen a recent spike and it was advised that MKS will lead a group to get under the E-rostering issues.	JG MKS		Ongoing Ongoing
People Strategy Overview & Progress Against Strategic Aims				
	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 – The Committee noted 23rd October that this item is complete and the action list will be updated to reflect this.	HA	Ongoing	Complete
17/13	• Equality Objectives Plan for 218-2021 – Quarterly Update required & Objectives to be reviewed every 6 months • Equality Metrics Report to be brought back to next Committee	HA HA/SM	1/4ly Update 6 monthly Review	Ongoing 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. Noted on 23/10/2018 - MKS advised that this item will be presented at February 2019 meeting.	MKS/DS/JF	February 2019	Ongoing
18/21	• Following discussion about the annual workforce profile – invite the BME Chair and Apprenticeship to next meeting to update the Committee. Noted on 26th June 2018 that the BME Chair will be updating on development at the Trust Board on 3rd July 2018.	HA/CAO	December 2018	• Apprenticeship Complete • Invite BME to meeting
18/51	• Share EDS report with Committee Members	HA	October 2018	Complete
	Education Governance Update			
18/38	• To be a regular item on the Committee Agenda.	HB	October 2018	Ongoing
	Wellbeing			
18/49	NHSI Health & Wellbeing Improvement Programme Update • Pick up with Sarah Smith sickness data availability for CommCell	MKS	ASAP	

	Staff Survey			
18/54	• Make available comparison date to Corporate/Divisional leads.	MKS	September 2018	Complete
Key Workforce Risks				
	Board Assurance Framework			
18/58	Review the exit interview process and make more visible the proforma. Noted on 23/10/2018 that an update will be brought to December's meeting.	MKS	TBC	Ongoing
Legislation, Terms & Conditions, Employment policies/EIA's				
18/43	• Ratified First Aid Policy enquire with Resuscitation what implementation and resource plan is in place.	MKS	October 2018	Complete
18/53	• The following policies to be ratified virtually by NED's and the supporting EIA's to be brought to October meeting: Consultant and SAS Doctors Procedure for Leave Policy Consultant and SAS Doctor Job Planning Policy Special Leave Policy	 Kate Bayley Kate Bayley Zoe Connor	October 2018	Complete

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Tuesday 5th March 2019

Report of:	Trust Chair Director of Corporate Affairs
Paper Prepared by:	Erica Saunders
Subject/Title:	Freedom to Speak Up – Update
Background Papers:	FTSU Board reports from September 2016 onwards
Purpose of Paper:	To brief the Board as to actions taken to resolve the remaining matters identified in the January stock-take and to seek its support for the actions proposed.
Action/Decision Required:	The Board is asked The Board is asked to approve the proposed actions as set out.
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Best people doing their Best Work
Resource Impact:	To be identified

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

FREEDOM TO SPEAK UP – BOARD UPDATE

1. Purpose

The purpose of this paper is to brief the Board as to actions taken to resolve the remaining matters identified in the January stock-take and to seek its support for the actions proposed.

2. Recommendation

The Board is asked to approve the proposed actions as set out.

3. Outstanding issues from January stock-take and proposed way forward

Board members will recall that there were two key areas that remained outstanding for the Trust in terms of full compliance with the recommendations coming from the National Guardian's Office annual report and the National Guardian's visit to the Trust last autumn:

3.1 Review of current arrangements following feedback from the National Guardian Dr Henrietta Hughes during her visit last October.

Way forward: Having reflected on the view put forward at the visit that the role of Guardian was actually being undertaken by Kerry Turner on a practical level, it is proposed that the Board approves this appointment formally and that the Non-Executive lead role reverts to that described under the 'Raising Concerns' policy.

3.2 Provision of ring-fenced time for the FTSU team.

Way forward: In consultation with Kerry Turner, it is proposed that an average one day per week is allocated for the role of Guardian in the first instance, but that this is reviewed in three months' time. In turn Kerry will assess the time required for the team of advocates and make a recommendation to the Board at the next update.

4. Next Steps

As the Freedom to Speak Up Guardian, Kerry Turner will continue to focus on the actions agreed by the Board in January, in particular the communications plan and increase visibility of the FTSU function through the following mechanisms:

- Corporate induction
- Junior Doctors' forum
- Team Brief/Alder Hey Life
- Communications 'collateral' to improve visual impact
- Leadership training
- Devise quarterly temperature check
- Participation in Patient Safety meeting.

Dame Jo Williams
Chair

Erica Saunders
Director of Corporate Affairs

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Tuesday 5th March 2019

Report of:	Director of Corporate Affairs
Paper Prepared by:	NHS Providers Tom Kark QC
Subject/Title:	*A Review of the Fit and Proper Person Test* – Commissioned by the Minister of State for Health
Background Papers:	CQC regulations Kirkup Review into Liverpool Community Health
Purpose of Paper:	To brief the Board as to the content of the review
Action/Decision Required:	To note the content of the review and receive further updates as the recommendations are consulted upon nationally
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	**The Best People doing their Best Work**
Resource Impact:	None identified

6 February 2019

on the day BRIEFING

NHS Providers

NHS Providers On The Day Briefing: The Kark review of the Fit and Proper Person Test

Background

In July 2018, the former Minister of State for Health, Stephen Barclay MP, commissioned Tom Kark QC to review the scope, operation and purpose of the Fit and Proper Person Test (FPPT). The review has looked in particular at how effective the FPPT is in preventing unsuitable staff from being redeployed or re-employed in the NHS. The review was recommended by Dr Bill Kirkup in his report into Liverpool Community Health NHS Trust, in February 2018.

This briefing sets out the key recommendations and findings of the review, which are significant and potentially far reaching. Members will also want to familiarise themselves with the details in the review report. Should you have any comments or questions about the review or this briefing, please get in touch with Ella Jackson, policy advisor, via Ella.Jackson@nhsproviders.org.

The Fit and Proper Person Test

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 requires all trusts to ensure that all executive and non-executive director posts (or anyone performing similar or equivalent functions) are filled by people that meet the requirements of the Fit and Proper Person Regulations (FPPR). The definition of directors includes those in permanent, interim or associate roles, irrespective of their voting rights at board meetings. These regulations were introduced in November 2014 and the fundamental standards came into force in April 2015.

The regulations (Section 1, Paragraph 5, or 'Regulation 5' as CQC refers to them in its guidance) place a duty on trusts to ensure that their directors, as defined above, are compliant with the FPPR. The regulations stipulate that trusts must not appoint or have in place an executive or a non-executive director unless they meet certain standards. While it is the trust's duty to ensure that they have fit and proper directors in post, CQC has the power to take enforcement action against the trust if it considers that the trust has not complied with the requirements of the FPPR.

Effectiveness of the FPPT

The Kark review has identified a range of issues with the test and the way it is currently interpreted and applied. The review concludes that the FPPT does not do everything that it holds itself out to do and is

regarded by some as a distraction or a tick box exercise, with no real effect on patient care or safety. It does not ensure directors are fit and proper for the post they hold, and it does not stop people who are unfit from moving around the system.

The review identifies a range of problems with the FPPT, including:

- The test only applies to providers. The universal view among those who gave evidence was that it should apply to all areas of the NHS including commissioners and NHS arms length bodies (ALBs).
- The test is applied fairly vigorously on issues such as bankruptcy, Disclosure and Barring Service (DBS) and convictions, but considerably less vigorously (or not at all) on other important aspects such as whether the director has the competence, experience and qualifications to perform the role.
- The quality of information retained by each trust about each director and in support of its decision on the FPPT is of very varying quality and is sometimes non-existent.
- In some cases, the test is being used as a vehicle for trusts to remove individuals on the ground that they were not compliant with the FPPR, after disciplinary proceedings had been concluded with only a warning or suspension.
- There is a lack of clarity as to who is regarded as covered by the test. The responsibility for deciding, beyond those on the board, to whom the test should be applied sits with the trust. This leads to disparity between different trusts as to whom the test is applied.
- The FPPT requires that individuals have the qualifications, competence, skills and experience necessary, but there are no set criteria or standards; the test is much more fluid and will vary for different roles and vary over time.
- Currently, someone is not fit and proper if they have been 'privy to' serious misconduct or mismanagement. The review suggests that anyone on a board is privy to the issues raised before the board or which come to light and are revealed to the board; therefore this regulation would apply to the most junior member of a board which many years ago was responsible for serious mismanagement. It argues this does not seem to allow for insight, reparation, reskilling, rehabilitation, remorse or understanding. The review recommends the words 'privy to' are removed.
- There is confusion about the checks that should be made on directors. The review concludes all directors (clinical and non-clinical) should have a DBS check.
- There is confusion and dissatisfaction regarding CQC's role in relation to the FPPT. The CQC inspects organisations and cannot regulate individual directors, therefore it assesses whether trusts have the systems and processes in place to ensure that all new and existing directors are, and continue to be, fit and proper. A trust could have all the correct processes in place but these may not elicit all the relevant information about a director. This could result in the appointment of potentially unfit director which would not be picked up by the CQC. The review suggests that, as a result, the assurances given by the CQC via their 'Well-Led' rating, may be optimistic and not well-founded.
- There are difficulties for trusts trying to investigate a director's historical conduct in previous employments.

The review suggests it would be relatively easy to reinforce the FPPT by prescribing further tests by which a director can more easily be excluded or barred from appointments. However, it warns that a higher bar might make these jobs even less attractive, recognising that there is a dearth of suitable, qualified people willing to apply for senior executive jobs in NHS trusts.

The review suggests that while progress has been made to improve the culture of providing care within the NHS, the reality is that steps taken to deal specifically with failures in management have been less effective than they should have been. There are cases where directors commit serious acts of misconduct or mismanagement and yet are able to move to other roles within trusts or another part of the NHS. The use of settlement agreements and pay-outs, together with a bland agreed reference and confidentiality clauses has facilitated this.

Recommendations

The review concludes that a system has to be devised to ensure that those who take on the role of senior management at board level in the NHS are equipped with the skills necessary to undertake that important function; that they can be critically assessed to ensure they have those skills; that such assessment is continuous throughout their career; that they can be supported where appropriate to improve their skills; that they are supported and receive further training if things go wrong or if they are found not to have all the skills necessary.

It recommends that this system include the following (set out in more detail below):

1. All directors should meet specified standards of competence to sit on the board of any health providing organisation.
2. A central database should be created, holding relevant information about qualifications and history about each director (including NEDs).
3. Full, honest and accurate mandatory employment references should be required from any relevant employer where an employee is moving from a post covered by Regulation 5 to a post covered by Regulation 5.
4. The FPPT should be extended to all commissioners and other appropriate ALBs (including NHS Improvement (NHSI) and NHS England (NHSE)).
5. An organisation should be set up with the power to suspend and to disbar directors who are found to have committed Serious Misconduct.
6. In relation to the FPPR, the words 'been privy to' are removed (as described above).
7. Further work is done to examine how the test works in the context of the provision of social care. The review team concluded that the question of how the FPPT works in social care was too big and complex to be dealt with in this short review.

Recommendations 1 and 2 were accepted by the Secretary of State for Health and Social Care upon publication of the report. Baroness Dido Haring (Chair, NHSI) has been asked by the Health Secretary to consider the remaining recommendations and how they can be implemented.

There was very strong resistance from the majority of those the review team spoke to, to imposing more formal regulation than was absolutely necessary. Consequently, the review team has not gone so far as to recommend a new, director-focused regulator to oversee and regulate the appointment and continued employment of trust directors. In their view, the effect of doing so would risk creating a new problem of devolving or diminishing responsibility from trust boards for their own appointments. However, they recommend this position should be kept under review.

The review team also make clear that it is crucially important to distinguish the treatment of those directors who are not currently very good at the job (i.e. their competence is poor or the task too great) and who could, with support and/or training, become competent, from those who have been involved in serious misconduct.

The review team also acknowledge that the great majority of trust "Boards and Chief Executives, Chairs and Directors perform an outstanding job, with determination, insight, self-reflection, with a careful view as to the effectiveness of the Board's function, and often, if not always, in challenging financial circumstances". They point out that none of the recommendations should remove from the trust board the overarching responsibility for good corporate governance and the overall responsibility of trust boards to protecting staff and patients.

Recommendation 1: Standards of competence

This recommendation was accepted by the Secretary of State for Health upon publication of the report.

The report concludes that there is a lack of required, adequate, quality training as to what the function of a board is, how a good board operates and how to be an effective board member in the NHS.

The review recommends that:

- In order to assist the effectiveness of boards and board directors and to encourage people within the service to consider board posts, NHSI should, in consultation with other bodies such as the NHS Leadership Academy and the Academy of Medical Royal Colleges, define, design and set high level core competencies which must be met by any person holding or aspiring to a directorship post (including Interim directors and NEDs. Whether or not a director meets the FPPR should be assessed against the identified competencies.
- The high-level core competencies should be embodied in a schedule to the Regulations and that further guidance should be issued when appropriate by NHSI to set out in detail the competencies to be met by every health trust board director and equivalent post.
- The required high-level core competencies relevant to directors should include knowledge and a general understanding of a number of core issues, no matter what role is undertaken: Board governance; Clinical governance; Financial governance; Patient safety and medical management; Recognising the importance of information on clinical outcomes; Responding to serious clinical incidents and learning from errors; The importance of learning from whistleblowing and 'speaking up'; Empowering staff to make autonomous decisions and to raise concerns; Ethical duties towards patients,

relatives and staff; Complying and encouraging compliance with the duty of candour; The protection, security and use of data; Current information systems relevant for health services; The importance of issues of equality and diversity both within the hospital in workforce issues and in relation to appointments to the Board; and the importance of complying on a personal basis with the Nolan principles.

- As part of trusts' ongoing responsibility to assess the competency of each member of the board or those applying for a directorship post, trusts should ensure any necessary training is undertaken by board members where gaps in competency have been identified.
- During the 'Well-Led' inspection, CQC should review the evidence, including sampling appraisals in respect of the directors, to ensure that they are currently able to meet the core competencies, have regular appraisals and are up to date with personal development plans.
- This approach should be kept under review with consideration to be given in due course as to whether a more formalised gateway, registration and validation system is necessary to ensure all directors have acquired and demonstrate the necessary core competencies.

Recommendation 2: A central database of directors

This recommendation was accepted by the Secretary of State for Health upon publication of the report.

The review team believe there is a 'startling' lack of information about the people who manage health trusts at director level'. For example, there is no background information held in relation to board members, no compulsory or comprehensive training at CEO or board level, no accreditation, continuous development scheme or 360-degree appraisal.

The review recommends that:

- A body (such as NHSI) (referred to as the 'Central Database Holder') creates and retains a database which will hold information about each director (including NEDs) to be accessible to potential employers, the NHSI and CQC and where necessary the Health Directors Standards Council (see below). This could be held in any part of the NHSI system and stored in a 'NHSI Directors' Database'. Until this can be placed on a statutory footing the consent of each director about whom information is held will be required.
- The database will hold a list of directors and information about each director such as the following: Name; Current employer; Job description of current employment; A full employment history and explanation of gaps (any gaps that are because of any protected characteristic as defined in the Equality Act 2010 would not need to be explained); History of training and development undertaken; Available references from previous employers; All relevant appraisals and 360 reviews; Any upheld disciplinary findings; Any upheld grievance findings; Any upheld whistleblowing complaint; Any upheld finding pursuant to any Trust policies or procedures concerning employee behaviour; Any Employment Tribunal judgment relevant to the director's history; Any settlement agreements relating to work in any health-related service; Criminal convictions; and Whether the director is or has ever been disqualified or disbarred as a director.

- Consideration should be given to ensuring that the information required to be held by trusts for provision to the CQC by reason of the FPPR should mirror the information to be held by the Central Database Holder so as not unnecessarily to add a burden to trusts. The CQC should be given access to the Central Database when appropriate to assist CQC to carry out its function.
- All relevant employers should be required within a reasonable time to provide to the Central Database Holder the information listed above in relation to each person identified as a director (or those holding equivalent positions) and trusts should keep the information provided to the Central Database Holder regularly updated and current
- The CQC should review whether or not trusts have complied with this duty during their 'Well-Led' reviews. We recommend that all relevant employers be required within a reasonable time to identify all those in 'equivalent' directorial positions whom it considers fall within the FPPR test to the Central Database Holder and to the CQC.

Recommendation 3: Mandatory references

The review recommends that:

- Full, honest and accurate mandatory employment references should be required from any relevant employer where an employee is moving from a post covered by Regulation 5 to a post covered by Regulation 5. Such references must not be subjected to any limitation by the terms of a compromise or settlement agreement and any such attempted limitation shall be regarded as of no effect. The 'old' employer must provide such a reference and the 'new' employer must require one.
- Where an applicant for a role covered by Regulation 5 is being promoted from a non-board director position or is moving from a directorship role in an organisation not covered by Regulation 5, the 'new' employer must make every reasonable attempt to obtain a reference meeting the requirements of the mandatory reference form and to acquire any missing information from the 'old' employer and from the incoming employee.
- The precise nature and requirements of the mandatory reference form is to be devised by NHSI in conjunction with the CQC, NHSE, NHSLA and other relevant organisations
- Each mandatory reference form written for an outgoing director must be signed off by a board director or other director covered by regulation.
- Each employee concerned should have the right to see and note a challenge to the accuracy and fairness of the mandatory reference and provide such explanation as he or she wishes to in writing.
- Any relevant employer employing a director must require to be furnished with such a reference as is specified and should retain it on its records as well as supplying a copy to the Central Database Holder. The Regulations should be amended so as to incorporate reference to a mandatory reference form.
- The CQC should review employment references provided by trusts including forward references as part of their 'Well-Led' review. This assessment should review whether they have met the mandatory reference criteria both for current employees (as directors) and the references written by the employer for onward transmission to future employers.
- A failure to comply with the mandatory reference requirement should be considered by the CQC as part of their 'Well-Led' reviews and should lead to the referral of the director signing-off the reference to

the Trust or the HDSC for Serious Misconduct where there is evidence of deliberate concealment of relevant information or dishonesty. CQC should provide further guidance on this aspect of the Trust's duties.

Recommendation 4: Extending FPPT to all commissioners and ALBs

The review recommends that:

- The FPPT should be extended to apply to all commissioners although because of the current lack of an appropriate regulator of non-providers, the review recommends that, as a first step, that the test is extended by means of voluntary adoption.
- A scoping exercise be undertaken with a view to the test being extended by statute to apply to CCGs and appropriate ALBs but that in the meantime the Senior Appointments Guidance be updated and the principle components of the FPPT be adopted.

Recommendation 5: The power to disbar directors

The review recommends that:

- An organisation is set up which will have the power to suspend and to disbar directors covered by Regulation 5, who are found to have committed Serious Misconduct (see below). In order to affect this, legislation is likely to be required. Such an organisation could be housed within NHSI, and could be known as the 'Health Directors' Standards Council' (HDSC).
- Serious Misconduct should be defined, but the review offers a view on the behaviours that should be included. This definition should be incorporated into the FPPR.
- Consideration should be given to ensuring that the FPPT incorporates as Serious Misconduct the same issues as described above by listing these factors as a separate schedule to the Regulations.
- In considering allegations of misconduct the following process should be adopted: All Serious Misconduct where an employee is still employed by the Trust (the relevant Trust) at which the Serious Misconduct is said to have occurred would first have to be investigated by that Trust. Any Serious Misconduct alleged to have occurred at a previous Trust would be investigated by the HDSC; and If following an investigation by the relevant Trust, Serious Misconduct was found to have occurred, the director concerned would require referral to the HDSC. Such a referral would be mandatory.
- There should be separate routes of referral and or escalation or appeal, to the HDSC from Trusts, other institutions (such as the CQC and professional regulators such as the General Medical Council and Nursing and Midwifery Council) or individuals (which would have to pass a reasonable prospects test).
- The HDSC should have the power permanently to disbar a director although the HDSC's powers should also include shorter periods of disbarment.
- The HDSC should have the power to impose an interim (paid) suspension while an investigation takes place, of no longer than six months, where the safety of the public or other public interest requires it.
- A director who is currently disbarred by the HDSC may not be regarded as a fit and proper person under Regulation
- The Department of Health and Social Care should take steps to ensure that employment contracts for board level directors and their equivalents reflect that a finding of Serious Misconduct by the HDSC is to

be regarded as gross misconduct for the purposes of the employment contract and would normally operate so as to prevent an individual from receiving notice period monies and any 'golden goodbye'.

- The CQC and all appropriate ALBs should amend their appointment rules to prevent them employing someone who has been disbarred by the HDSC for Serious Misconduct.
- All NHS commissioners, commissioning services from the independent sector, should be prohibited from commissioning services from any provider where a disbarred or suspended director sits on the board of the provider or who holds an equivalent director's post.
- If necessary the HDSC be provided with the same powers as the CQC to require Trusts to supply information relevant to the exercise of its powers.
- There should be a statutory time limitation period of five years in relation to historic complaints about Serious Misconduct, unless there are exceptional circumstances and the public interest requires action to be taken.
- All other misconduct (not falling to be categorised as serious) ought to continue be dealt with within the employing Trust as a disciplinary issue.

NHS Providers view

NHS foundation trusts and trusts have a duty to ensure patient safety and the provision of high quality care. In the words of the Kark report itself, "the great majority of Trusts [have] Boards and Chief Executives, Chairs and Directors perform[ing] an outstanding job". We also need to recognise, however, that a very small number of boards and directors have failed in their duties.

The fundamental principle which lies at the heart of foundation trust and trust governance is that the unitary trust board is responsible for everything that happens within the trust. This brings vital clarity in an environment which contains a significant amount of risk – for example safety risk, clinical risk and financial risk. The ability of trust boards to appoint their own directors and oversee their conduct is a key part of that responsibility. We therefore need to consider anything that cuts across this with real care and attention.

Striking the right balance between ensuring the vast majority of trust boards and directors have appropriate autonomy to do their job effectively and intervening to prevent serious failure is difficult but vital.

The proposals in today's Kark Review are significant and potentially far reaching. These recommendations would normally be the subject of a full consultation with opportunity for trusts who will be most affected, and will have to implement the proposals, to give their views.

It is therefore regrettable for the Government to have announced today that they will accept some of the recommendations without such consultation. We will seek to ensure that the views of trusts are fully and properly heard as those recommendations are implemented.

We note the Government's decision to remit consideration of some of the recommendations to Baroness Harding, the Chair of NHS Improvement, as part of her work on workforce issues. We will be writing to

Baroness Harding shortly to seek her assurance that she will create a full and proper consultation process that, in our view, should follow well established Government/NHS best practice on consultation. We also note that the report itself attributes views to NHSI on the issues covered by the report which we believe trusts will disagree with. So we will also be seeking assurances on how NHSI will treat any feedback from the provider sector and how NHSI will formulate its final views.

We have engaged extensively with our membership and the review team on these issues, giving evidence to the review twice, including involving member chief executives and a company secretary on the second occasion. We will want to talk to our members in detail about the proposals but already have a series of questions where we know trusts will have concerns. These include:

- How the operation of any central database of directors will work in practice to ensure the burden of compliance is proportional and reasonable, particularly given the vast majority of directors perform an outstanding job
- How to create a meaningful and proportionate set of core competences and accompanying assessment process to ensure individuals' fitness to be directors. Assessing the effectiveness of an NHS board director is not simply about checking whether a director has the right basic knowledge of NHS finances and clinical safety processes. Judgement, behaviour and cultural approach – issues that are not amenable to a tick box assessment of knowledge - are often more important. That's precisely why trusts need appropriate autonomy to judge the fitness of their directors and decide who to appoint.
- How possible it will be to create a robust, universally applicable, definition of "serious misconduct" given that this has been notoriously difficult to define in the past and that many of the areas the Kark review suggests it covers are not amenable to black and white judgements.
- Whether a Health Directors' Standards Council is required, and if one is created, how it would work in practice. This will include exploring issues such as rights of appeal and the interactions with both employment law and the trust's duties and responsibilities as the director's employer.

Trust board directors have a complicated and difficult set of responsibilities to undertake. We owe it to them to listen to their views and carefully think through any changes to the environment in which they operate. There's a danger of failing to do that here.

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Tuesday 5th March 2019

Report of:	Trust Chair Director of Corporate Affairs
Paper Prepared by:	Erica Saunders, Director of Corporate Affairs
Subject/Title:	Non- Executive Director Job Description and Person Specification
Background Papers:	Trust constitution, paragraph 24.
Purpose of Paper:	To elicit the views of the Board as to the job description and person specification for the role of Non-Executive Director prior to embarking on a recruitment process in March 2019
Action/Decision Required:	The Board is asked to consider the documentation so that any amendments can be conveyed to the Nominations Committee of the Council of Governors, who will be responsible for the recruitment and selection process in accordance with the Trust's constitution
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	**Strong Foundations**
Resource Impact:	None additional

Alder Hey Children's NHS
NHS Foundation Trust

JOB DESCRIPTION

POST:	Non Executive Director
REPORTING ARRANGEMENTS:	Non Executive Directors are responsible to the Chair
KEY RELATIONSHIPS:	Non-Executive Directors, Executive Directors, Council of Governors
JOB SUMMARY:	As a member of a unitary Board, the Non Executive Director will bring external skills and challenge to developing the Trust's strategy, holding the Executive Directors to account for its delivery and ensuring that the Board acts in the best interests of children, young people and their families and the wider community.
TIME COMMITMENT:	A minimum of three days per month
REMUNERATION:	£13,000 per annum
LENGTH OF APPOINTMENT:	Three years

PRINCIPAL DUTIES AND RESPONSIBILITIES

Strategy Development

- To provide independent judgement, expertise and challenge in the development of the Trust's strategy, vision and values as a member of a unitary Board, taking into account the views of the Council of Governors. To hold the Executive Directors to account for the delivery of the agreed strategy, including the organisation's performance against both financial and clinical quality metrics.

- To participate with fellow directors in providing entrepreneurial leadership to the Trust within a framework of prudent and effective controls, which enable risk to be assessed and managed.

- To chair a designated Committee as required and take an active part in other committees established by the Board of Directors to exercise delegated responsibility.

Human Resources

- As a member of the Board's Nominations and Remuneration Committees to appoint, remove, support, encourage and where appropriate 'mentor' Executive Directors.

- To contribute to the determination of appropriate levels of remuneration for Executive Directors.

- To take responsibility, in conjunction with the Board, for his/her own personal development and ensure that this remains a priority.

- To actively support and promote a positive organisational culture and reflects this in her/his own behaviour.

Operations

- To maintain the highest standards of conduct and integrity within the Trust and ensure compliance with the Trust's Values, best practice and statutory and regulatory requirements in all matters, including financial, governance, legal and clinical quality issues.

- To assist fellow directors in setting the Trust's strategic aims, ensuring that the necessary financial and human resources are in place for the Trust to meet its objectives, and that performance is effectively monitored and reviewed.

- In accordance with agreed Board procedures, to monitor the performance and conduct of management in meeting agreed goals, objectives and statutory responsibilities, including the preparation of annual reports and annual accounts.

- To obtain assurance that financial information is accurate and that financial controls and risk management systems are robust and defensible.

- To ensure the provision of accurate, timely and clear information to Directors and Governors, so that within the boundaries of probity, good governance and risk, the Trust meets all its statutory objectives and remains compliant with its Provider Licence.

- To use general management and leadership ability and personal knowledge of the community to guide and advise on the work of the Board of Directors and Governors of the Trust.

- To encourage the best use of resources including the development of effective risk and performance management processes.

- To be aware of and understand relevant regulatory and Central Government policies; and comply at all times with the Trust's published health and safety policies, in particular, by following agreed safe working procedures and reporting incidents, using the Trust's risk reporting systems.

Communication and relationships

- To engage positively and collaboratively in Board discussions.

- To ensure effective and constructive dialogue and productive relationships are promoted with the following bodies as relevant:
  - Board of Directors;
  - Council of Governors;
  - all stakeholders in the Trust's community;
  - national healthcare stakeholders; and
  - regulators such as NHS Improvement and the Care Quality Commission

- To participate fully in the work of the Board of Directors and of Governors and maintain appropriate links with the Chief Executive and individual Executive Directors, as well as with the wider local and national health and social care community.

- To represent the Trust's views with national, regional or local bodies or individuals and ensure that the views of a wide range of stakeholders are considered.

- To uphold the values of the Trust, to be an appropriate role model and to ensure that the Board promotes equality and diversity for all its patients, staff and other stakeholders.

- To be an ambassador for the Trust in engagement with stakeholders including the local community, dealing with the media in accordance with Trust policy.

- To be knowledgeable and aware of local issues.

- To set an example on all policies and procedures designed to ensure equality of employment. Staff, patients and visitors must be treated equally irrespective of gender, ethnic origin, age, disability, sexual orientation, religion, etc.

- To promote public understanding of the Trust's values, objectives, policies and services.

- To adhere to the core standards of conduct expected of all NHS managers in accordance with the *Code of Conduct for NHS Managers.*

This job description is indicative of the range of duties for the postholder. It is not intended to be exhaustive and changes will be discussed with the post holder.

The Chair will agree specific objectives with the post holder on an annual basis.

Trust Policies

It is a requirement for all staff to comply with all infection control policies and procedures as set out in the Trust Infection Control manual.

Working towards equal opportunities

The Trust is no smoking site

All posts are open to job share unless indicated otherwise

The Trust is committed to carefully screening all job applicants to ensure the safeguarding of children

Candidates will be required to meet the Fit and Proper Persons Requirement regulations (the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014)

Alder Hey Children's NHS Foundation Trust is committed to supporting all staff to balance work and other life needs. This is the responsibility of all employees and will be achieved by consultation, open communication and involvement of all team members. The Trust operates a Flexible Working Policy that is available to all staff.

Alder Hey Children's NHS Foundation Trust is committed to achieving equal opportunities in employment. All employees are expected to observe this policy in their behaviour to the public and fellow employees.

All individuals will have some risk management responsibilities with which you are required to comply, for details of your responsibilities please refer to the current Risk Management Strategy which is available on the intranet and in the local strategies folder.

It is the responsibility of all staff to recognize their role in maintaining a safe environment for patients, visitors and staff; to minimize the risk of healthcare associated infection. Employees are responsible for ensuring that they are fully aware of the Trust's infection prevention and control policies, the post holder will undertake infection control training as required by the position.

The Trust is committed to developing an environment that embraces diversity and promotes equality of opportunity.

Alder Hey Children's NHS
NHS Foundation Trust

Person Specification

Non-Executive Director

Summary

Non-Executive Directors must demonstrate a high level of understanding of, and interest in, healthcare issues, and a commitment to the NHS and the aims of NHS foundation Trusts, in particular. Board level experience of the public or private sector, is a requirement together with evidence of a successful track record of delivery. Business acumen, a strong sense of accountability and strategic thinking are essential attributes together with strong interpersonal and leadership skills. Candidates must have sufficient time to fulfil the requirements of the post.

Specific Requirements Essential to the Role

Personal Qualities
Commitment to NHS values and principles and the aims of NHS Foundation Trusts
Good interpersonal skills. Able to work as a team to meet common goals and willingness to utilise skills and experience for the good of the organisation
Good communication skills
Astute, able to grasp relevant issues and understand the relationships between interested parties.
Able to assess strategies and plans of action to achieve objectives.
Independent in judgement and a creative thinker
Experience and Knowledge
Understand and accept the legal duties, liabilities and responsibilities of NHS Non Executive Directors
Understanding of and interest in healthcare issues for children and young people
Well respected with a reputation for commercial expertise in the private or public sector. Accustomed to a high level of accountability
Board level experience in a large organisation
A sound knowledge of, and commitment to, good corporate governance.
Experience of leading or managing significant cultural change

In addition it is essential for all candidates to:

Be eligible to be a member of the NHS Foundation Trust.

Meet the independence criteria for Non-Executive Directors*
Meet the Fit and Proper Person Requirement
Have sufficient time to fulfil the requirements of the post

*Compliance with the NHS Foundation Trust Code of Governance

Non-Executive Directors must meet the independence criteria as set out in the NHS Foundation Trust Code of Governance i.e. must not:-

- have been an employee of the Trust within the last five years;
- have had within the last three years, a material business relationship with the Trust either directly, or as a partner, shareholder, director or senior employee of a body that has such a relationship with the NHS foundation trust;
- have received additional remuneration from the Trust apart from a director's fee, participated in the Trust's performance-related pay scheme, or be a member of the Trust's pension scheme;
- have close family ties with any of the Trust's advisers, directors or senior employees;
- hold cross-directorships or have significant links with other directors through involvement in other companies or bodies;
- have served on the Board for more than nine years from the date of their first election;
- be an appointed representative of the Trust's university medical or dental school.

In addition, all other significant commitments must be declared prior to appointment, e.g. other executive or non-executive directorships. The Non Executive Director's other significant commitments should be disclosed to the Board of Governors before appointment and included in the annual report.

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Tuesday 5th March 2019

Report of:	Trust Chair
Paper Prepared by:	Erica Saunders, Director of Corporate Affairs
Subject/Title:	Non-Executive Director/Senior Independent Director
Background Papers:	NHS Foundation Trust Code of Governance
Purpose of Paper:	To seek to appoint one of the Trust's Non-Executive Directors as the Senior Independent Director
Action/Decision Required:	The Board is asked to approve that the appointment of Anita Marsland as Senior Independent Director
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	**The Best People doing their Best Work** **Strong Foundations**
Resource Impact:	None additional

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

PROPOSAL FOR APPOINTMENT OF A SENIOR INDEPENDENT DIRECTOR

1. Purpose

The purpose of this paper is to propose the appointment of one of the Non-Executive Directors as the Trust's Senior Independent Director.

2. Recommendation

The Board is asked to support and approve the appointment of Anita Marsland to the additional role as Senior Independent Director of the Trust.

3. Foundation Trust Constitution and Code of Governance

Under the Trust's constitution all Non-Executive Director appointments are within the gift of the Council of Governors, including the Senior Independent Director. Provision is made within the NHS FT Code of Governance for a Senior Independent Director as follows: 'In consultation with the council of governors, the board should appoint one of the independent non-executive directors to be the senior independent director to provide a sounding board for the chairperson and to serve as an intermediary for the other directors when necessary. The senior independent director should be available to governors if they have concerns that contact through the normal channels of chairperson, chief executive, finance director or trust secretary has failed to resolve, or for which such contact is inappropriate. The senior independent director could be the deputy chairperson.'

The proposal to appoint Anita Marsland to this additional role was discussed with members of the Council of Governors at an informal meeting on 28th February 2019. A paper will be submitted to the Council on 12th March at its next formal meeting subject to the agreement of the Board.

4. Job Role

The job description for the SID is attached for reference. In addition to the general duties set out for all Non-Executives, the SID is assigned the following:

- To act as the point of contact with the Board of Directors should Governors have concerns which normal channels have been unable to resolve or for which normal channels would be inappropriate.
- To facilitate and oversee the performance evaluation of the Chairman and to report on the outcome of this to the Council of Governors.
- To act as the senior officer for dealing with the formal stage of a whistle blowing allegation under the Trust's Whistleblowing policy; the SID may be approached where a member of staff feels it is inappropriate to raise a matter informally or is dissatisfied with the outcome of the informal process.
- To work alongside Executive Director colleagues to advise upon and support best practice governance arrangements.

Anita Marsland is a highly experience Non-Executive with the requisite skills to carry out this role on behalf of the Board.

Dame Jo Williams
Chair

Change Programme 19/20

Trust Board

Alder Hey Children's NHS
NHS Foundation Trust

Programme Assurance Framework, DMO & Delivery Board

R&BD

Growing Through External Partnerships

Dani

1. Aseptics

Imminent Pipeline

- Neonatal Services

WOD

The Best People Doing Their Best Work

Melissa/Hilda

SG

1. Portering
2. Apprenticeships
3. Catering

Imminent Pipeline

- E-Rostering
- AHP 2023 & Beyond

CQAC

Deliver Outstanding Care

Hilda / Adam

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

Park, Community Estate & Facilities

David

SG

R&BD

1. R&E2
2. Alder Centre
3. Park
4. Hospital Moves
5. Community Cluster
6. Energy
7. Residential Development

Game Changing Research & Innovation

David

RE&I

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

Global Digital Exemplar

John/Steve

R&BD

PB

1. Speciality Packages
2. Voice Recognition

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

Alder Hey Children's NHS
NHS Foundation Trust

Programme Assurance Summary
Change Programme

Programme Summary (to be completed by **Head of Programme Management**)

1. This Board report comprises of extracts from the assurance dashboard covering 5 of the 6 themes of the change programme as reporting to the Board sub-Committees: CQAC 20 February, R&BD 27 February and WOD 1 March.
2. Of the 20 projects rated in this report, for the **overall delivery** assessment: 10% are green rated with 45% amber and 45% red rated. These percentage summary assessments show deterioration from the previous month albeit this may be due to the removal of Strong Foundations from the Change Programme. However, considerable work is required to meet the Alder Hey standards of programme management. Executive Sponsors should support their project teams to attain greater confidence in delivery.
3. Of the projects being rated for the **overall governance** position, over 50% are green rated for governance with just one project red rated in this domain.
4. The attention of Exec Sponsors is still required to initiate the pipeline projects which have remained in the pipeline for numerous months.

N Deakin 27 Feb 19

CIP Summary (to be completed by **Finance Department**)

CIP Position as at 12th February 2019 by work stream

		In Year Forecast			Recurrent Savings			Risk Rating (In Year)					
Workstream	Exec Sponsor	Target £000's	Forecast £000's	Gap £000's	Target £000's	Forecast £000's	Gap £000's	Implemented (Posted) £000's	Fully Developed £000's	Plans in Progress £000's	Opportunity £000's	Gap £000's	Total £000's
Deliver Outstanding Care	Adam B/Hilda G	2,500	980	-1,520	2,500	1,392	-1,108	969	0	11	150	1,370	2,500
Growing Through External Partners	Dani Jones	800	0	-800	800	0	-800	0	0	0	0	800	800
The Best People Doing Their Best V	Melissa Swindell	1,000	1,033	33	1,000	82	-918	1,003	0	30	30	-63	1,000
Game Changing Research and Inno	David Powell	500	0	-500	500	0	-500	0	0	0	0	500	500
Strong Foundations	John G/Claire L	2,200	1,646	-554	2,200	1,819	-381	1,644	0	2	186	368	2,200
Park, Community Estate & Facilitie	David Powell	0	18	18	0	18	18	18	0	0	0	-18	0
Global Digital Exemplar (GDE)	Peter Young	1,000	255	-745	1,000	255	-745	255	0	0	0	745	1,000
Subtotal: Strategic Workstreams		8,000	3,933	-4,067	8,000	3,566	-4,434	3,890	0	43	366	3,701	8,000
Divisional Business		-1,043	2,517	3,561	-1,043	2,469	3,512	2,517	0	0	259	-3,820	-1,043
Unidentified		0	0	0	0	0	0	0	0	0	0	0	0
Grand Total		6,957	6,450	-507	6,957	6,035	-922	6,408	0	43	625	-118	6,957

Alder Hey Children's NHS
NHS Foundation Trust

Programme Assurance Summary
Delivering Outstanding Care

Work Stream Summary (completed by Independent Programme Assurance)

Overall, for the 'Delivery of Outstanding Care' programme, project governance is good with 6 out of the 7 projects rated green and only one amber rated project. However, delivery ratings still require improvement.

For the Sepsis project, now that the governance issues are being resolved, the ratings for overall delivery should be addressed and agreement of the new target thresholds and a detailed plan for 'year 2' is now required.

Focus should now also be given to the benefits within this programme of work that cannot be tracked easily and investigate possible solutions for tracking so that improvement can be measured.

Natalie Deakin, Head of Programme Management and Independent Programme Assurance – 12 Feb 19

Programme Assurance Framework

Alder Hey Children's NHS Foundation Trust

Delivering Outstanding Care (completed by independent Programme Assurance)

Sub-Committee	CQAC	Report Date	12 Feb 19
Workstream Name	Delivering Outstanding Care	Executive Sponsor	Gwilliams/Bateman/Cooper

Current Dashboard Rating (sheet 1 of 2):

Project Title	Project Description	Executive Sponsor Assures the project	OVERALL PROJECT	An effective project team is in place	Scope and Approach is	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	OVERALL PROJECT	Targets / benefits defined/on track	Milestone plan is defined/on track	Comments for attention of the Project Team, Steering Group and sub-Committee
1.0 Delivering Outstanding Care													
Best in Outpatient Care	The Best in Outpatients Project aims to deliver an outstanding experience of outpatient services for children, families and professionals as well as safely increase the number of patients we see in clinic	Hilda Gwilliams											The project team is now fully in place and evidence of Steering Group meetings available (to 24 Jan 2019).PID is detailed and clear. Benefits are being tracked and positive trends are seen in 3 out of the 5 metrics however none have yet reached their targets. There is a comprehensive milestone plan being tracked. Risks are managed via Ulysees and are all within review date. There is a planned approach to stakeholder engagement with some tracking of completion of engagement activities required. A comprehensive newsletter has been recently distributed across the organisation. EA/QIA signed and uploaded. **Last updated 5 Feb 19.**
Brilliant Booking and Scheduling	To provide a booking system that puts patients and families first and meet the needs of clinicians that use it.	Adam Bateman											Project team meetings are scheduled and documented up to 8 Jan 19. A comprehensive PID is available. Benefits tracking plans are comprehensive and some metrics are tracked weekly but too early to ascertain whether positive trends will be maintained. Specialty plans for 10 specialities are available and are being closely tracked, but with several milestones delayed. There is a comprehensive suite of stakeholder engagement updated to 31 Jan 19 with presentations available to all specialities who are about to go live with Hybrid Booking. Risks are detailed and are within their review period. EA/QIA signed off and uploaded. **Last updated 12 Feb 19.**
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	Lisa Cooper											Comprehensive Mental Health project team meetings: the Steering Group (evidence to 6 Dec 18) forms part of the CAMHS board agenda on first Thursday of each month while meetings to discuss each work stream and the milestones happen on a fortnightly basis (evidence to 17 Dec 18). There is a comprehensive PID available. 3 out of the 5 benefits are able to be measured with none of the three showing positive trends. A good milestone plan is in place and being tracked. A stakeholder analysis has been completed but further evidence required of wider stakeholder engagement. Risks are on Ulysses and are within their review period. A signed EA/QIA has been uploaded. **Last updated 12 Feb 19.**
Patient Flow	Improve our processes to enable timely implementation of clinical decisions, and support patients through their pathway efficiently: minimising delays and reducing time spent in hospital. This project consists of 3 workstreams; Expanding Day Surgery, Expanding Pre-Op Assessment and SAFER Bundle.	Adam Bateman											Evidence of SAFER Task Force evidence, for 3A & 4C and 3C & Burns up to 17 January 2019. The PID refinement of benefits and high level milestones is now complete. A comprehensive benefits tracker is available with many trajectories now positive. There is a detailed milestone plan which is being tracked and has milestones up to January 2020. Evidence of wider stakeholder engagement is now required. All risks on Ulysees and within review date. An EA/QIA has been signed. **Last updated 12 Feb 19.**

Programme Assurance Framework

Delivering Outstanding Care (completed by independent Programme Assurance)

Alder Hey Children's NHS Foundation Trust

Sub-Committee	CQAC	Report Date	12 Feb 19
Workstream Name	Delivering Outstanding Care	Executive Sponsor	Hughes/Gwilliams

Current Dashboard Rating (sheet 2 of 2):

Project Title	Project Description	Executive Sponsor Assures the project	OVERALL PROJECT	An effective project team is in place	Scope and Approach is	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	OVERALL PROJECT	Targets / benefits defined/on track	Milestone plan is defined/on track	Comments for attention of the Project Team, Steering Group and sub-Committee
Models of Care	**What:** Consultant led delivery of patient pathways is currently suboptimal for some patients. Care is not always organised around needs of the following patient cohorts: 1) Complex patients (Surgery & Medicine) 2) HDU 3) Specialities 4) General Paediatrics 5) Medical Management of Non-Complex Surgery Patients **Why:** To improve consistency of the management of deteriorating and high dependency patients (in terms of consultant lead, patient pathway and time of day / day of week)	Adrian Hughes											Evidence of project team meetings are available up to 4 Jan 19 for the Models of Care Design Group. Pathway threshold documents are available for eight specialities. A draft PID has been started but now requires completion There are some analyses in the benefits folder but no clear metrics for success. A high level milestone plan is available for the Models of Care work stream and a detailed plan available for the implementation of the ACT Team. Limited evidence of stakeholder engagement and communications. There is a detailed risk register for both Models of Care and ACT Team but last updated in but risks not reviewed since 19 Jan 18 . Risks now required on Ulysees. No signed EA/QIA. **Last updated 11 Feb 19.**
Sepsis	To improve working within and across clinical teams.	Hilda Gwilliams											Sepsis Steering Group minutes to 19 Dec 18 with agendas and minutes. 'Year 2 PID' now uploaded but still in draft form. New benefits / targets now need to be signed off at Programme Board. Milestone Plan for 'year 2' PID now needs to be developed as current milestone plan on Sharepoint is not being tracked and needs further meaningful milestones beyond March 2019. The communications plan 2018-20 gives a high level list of activities but there is no tracked (for completion) milestone plan. All risks are within review date on Ulysses system. EA/QIA complete. **Last updated 11 Feb 19.**
DETECT Study	Using smart technology to reduce critical deterioration	Hilda Gwilliams											Evidence of project team meetings has been uploaded to SharePoint up to 5 Feb 19. A high level description of the scope is available in a 7 slide pack and a detailed PID has now been completed. Benefit metrics are outlined however not being tracked. A detailed Gantt Chart is available (uploaded 3 Dec 18) and will now need tracking on SharePoint. There are materials uploaded which indicate stakeholder engagement, including a presentation to Grand Round 5 Oct 18, but there is no communications plan in evidence. Risk register is in place and risks were last reviewed on 6 Dec 18. Risks now need to be uploaded to Ulysees. EA/QIA signed and uploaded. **Last updated 7 Feb 19.**

Alder Hey Children's NHS
NHS Foundation Trust

Programme Assurance Summary
Growing Through External Partnerships

Work Stream Summary (to be completed by Independent Programme Assurance)

The governance of the 'Aseptics' project is maintained to a good standard. Efforts should now be made to address gaps in measurements of benefits as well as ensuring that milestones are adhered to wherever possible.

A review at Programme Board of pipeline projects is scheduled for the end of February where pipeline projects will be reviewed including the 'Neonatal Services' project.

Natalie Deakin, Head of Programme Management and Independent Programme Assurance – 19 Feb 19

Alder Hey Children's NHS
NHS Foundation Trust

Programme Assurance Framework
Growing Through External Partnerships

Sub-Committee	R&BD	Report Date	19 Feb 2019
Workstream Name	Growing Through External Partnerships	Executive Sponsor	Dani Jones

Current Dashboard Rating:

Project Title	Project Description	Executive Sponsor Assures the project	OVERALL PROJECT	An effective project team is in place	Scope and Approach is	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	OVERALL PROJECT	Targets / benefits defined/on track	Milestone plan is defined/on track	Comments for attention of the Project Team, Steering Group and sub-Committee
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.	Dani Jones											Minutes of the Quality Management Meeting of the Aseptics Services Department are available up to 10 Jan 19. Scope is described by the 'Proposal for commissioning, validation and licensing of the Pharmacy Aseptic Services Unit' dated 16 March 2018' together with a 'Project Overview Document' dated 14 Jun 2018. Some of the targets and benefits are being closely tracked, others need to identify a sustainable way of measuring improvement. Benefits tracker last updated on 7 Feb, with none of the measures yet reaching aspired thresholds. A 'Project Milestone Plan' is in place and being tracked up to 15 Feb 2019. The 'External Audit Action Plan' needs to be updated. Project risks are now out of review date on Ulysees. EA/QIA signed off. **Last updated 15 Feb 19.**

Alder Hey Children's NHS
NHS Foundation Trust

Programme Assurance Summary
Park, Community Estate and Facilities

Work Stream Summary (to be completed by Independent Programme Assurance)

The re-structure of this programme of work now needs to be agreed with the executive sponsor and endorsed by the Programme Board.

Overall the governance of this programme has deteriorated this month with only one project within the programme rated green for governance. Focus is now required to ensure that documentation is kept up to date and maintained to a good standard.

Natalie Deakin, Head of Programme Management and Independent Programme Assurance – 20 Feb 19

Alder Hey Children's NHS
NHS Foundation Trust

Programme Assurance Framework

Park, Community Estate and Facilities

Sub-Committee	R&BD	Report Date	20 Feb 2019
Workstream Name	Park, Community Estate and Facilities.	Executive Sponsor	David Powell

Current Dashboard Rating:

Project Title	Project Description	Executive Sponsor Assures the project	OVERALL PROJECT	An effective project team is in place	Scope and Approach is	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	OVERALL PROJECT	Targets / benefits defined/on track	Milestone plan is defined/on track	Comments for attention of the Project Team, Steering Group and sub-Committee
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		🔴	🟡	🔴	🔴	🟢	🟢		🔴	🔴	There is no evidence of any meetings for over 3 months. The R&E Commissioning Plans and Mobilisation Plans are available to 9 Oct 2018. PID available, benefits still to be confirmed. Milestone Plan continues to show some significant delays with key milestones running late but is being tracked up until 9 Oct 18. Risks are still to be entered on Ulysses however there is an risk register albeit some sections are incomplete. There is a comprehensive issues log uploaded to SharePoint. EA/QIA completed and signed off. Evidence of closure report submitted to Programme Board on 31 Jan 19 but was not signed off. **Last updated 20 February 2019.**
Alder Centre	To plan, develop and construct the new Alder Centre within the park setting	David Powell		🟡	🟢	🟡	🟢	🟢	🟢		🟡	🟡	Steering Group agenda for 21 Nov 18 but no minutes on SharePoint. Scope/approach defined in PID. Benefits defined in PID but no evidence of the tracking of benefits. Milestone Plan has been revised recently but shows the commencement of building work has slipped significantly from original planned date. No recent evidence of Comms/ Engagement activities. Risks are on Ulysses and are within date. EA/QIA complete. **Last updated 20 Feb 2019.**
Park	To set up a JV with LCC & the local community to create a world class Springfield Park that complements & adds value to the New Alder Hey in the Park & the local area	David Powell		🟡	🟢	🟢	🟡	🟢	🟢		🟡	🟡	Steering Group reports available to 21 November 2018.Evidence of reports suggest a planned steering group for January but no evidence whether or not this took place. Updated PID on SharePoint showing comprehensive suite of benefits and high level milestones through to end of project life cycle. An indication of progress against benefits targets (RAG rating or % confidence level achieved would be useful). There is detailed Milestone Plan which is being tracked with a handful of missed milestones. There is a suite of evidence of stakeholder engagement. Risks are on Ulysees with one risk requiring further attention as past review date. EA/QIA complete. **Last updated 13 Feb 2019.**

Alder Hey Children's NHS
NHS Foundation Trust

Programme Assurance Framework
Park, Community Estate and Facilities

Sub-Committee	R&BD	Report Date	20 Feb 2019
Workstream Name	Park, Community Estate and Facilities.	Executive Sponsor	David Powell

Current Dashboard Rating:

Project Title	Project Description	Executive Sponsor Assures the project	OVERALL PROJECT	An effective project team is in place	Scope and Approach is	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	OVERALL PROJECT	Targets / benefits defined/on track	Milestone plan is defined/on track	Comments for attention of the Project Team, Steering Group and sub-Committee
Hospital Moves	To re-provide a high standard of working accommodation for those teams and services currently lodged in interim facilities on the retained estate	David Powell											Minutes of the 'Hospital Moves Steering Group' are available to 14 Aug 2018 and there is an agenda for the meeting planned for 16 Oct 2018; there are notes of the 'Records and Transcriptions meeting' up to 17 Sep 18. The PID dated 9 Jan 18 is available on SharePoint and provides a comprehensive summary of scope and approach. There is a lack of any recent information regarding communications and engagement. There is a comprehensive plan for hospital moves with dates of when these moves are planned to take place within the larger programme plan however; this would benefit from being tracked. Risks are being managed on Ulysses and are within review date. EA/QIA signed, important to review during the project as different accommodation options are decided upon. **Last updated 20 Feb 19.**
Community Cluster	This project is currently at the exploratory and feasability stage and will be rated once fully launched	David Powell											Draft PID uploaded 1 Feb 2018, 'Initiation' Slides uploaded 27 Mar 2018, Design Spec uploaded 27 Sep 18. All other project documentation yet to be developed. No risks available on Ulysses. EA / QIA complete but not signed by Exec Sponsor. **Last updated 27 Sep 2018.**
Energy	To bring down energy cost and ensure budget forecast matches contractual target. Forecast budget for next 12 months for all fuels in line with contractual usage.Once the contractual target of 46.7 G has been achieved look at ways of reducing further by means of energy awareness for staff.	David Powell	N/A										Monthly energy committee minutes available until 13 Nov 18. The POD available on SharePoint gives no details of financial benefits expected for 2018/19. The project plan for 18/19 contains only 6 actions and was last updated July 2018 (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). QIA signed off for the 18/19 programme. **Last updated 17 Dec 18.**

Alder Hey Children's NHS
NHS Foundation Trust

Programme Assurance Summary
Global Digital Exemplar

Work Stream Summary (completed by Independent Programme Assurance)

The GDE 'Statement of Projected Benefits' continues to estimate £2.08m cash realising benefits for 2018/19. The Trust CIP tracker is now forecasting the first contribution of £255k from the GDE initiatives; clearly there needs to be a continued focus on closing this gap between expectation and delivery.

For Speciality Packages focus should remain on the completion of tranche 1 for delivery in April 2019.

The 'Voice Recognition' project is 'red' rated for delivery, due to the difficulty in realising the planned benefits, albeit there continues to be a high standard of project management.

Natalie Deakin, Head of Programme Management and Independent Programme Assurance – 20 Feb 19

Alder Hey Children's NHS
NHS Foundation Trust

Programme Assurance Framework

Global Digital Exemplar (Completed by Assurance Team)

Sub-Committee	R&BD	Report Date	20 Feb 2019
Workstream Name	Global Digital Exemplar	Executive Sponsors	John Grinnell

Current Dashboard Rating:

Project Title	Project Description	Executive Sponsor Assures the project	OVERALL PROJECT	An effective project team is in place	Scope and Approach is	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	OVERALL PROJECT	Targets / benefits defined/on track	Milestone plan is defined/on track	Comments for attention of the Project Team, Steering Group and sub-Committee
GDE	Create exemplars that can inspire others by really showing how information technology can deliver both improved patient outcomes and enhanced business effectiveness	John Grinnell											GDE Delivery Group action log in evidence to 12 Feb 19 with Programme Board Minutes and Agenda in evidence up to 22 Jan 2019. Overall benefits profile and schedule has now been finalised. Internal CIP Tracker shows just £255k posted against a target of £1m, while the SoPB proposes £2.08m cash realising benefits in 2018/19 (VfM Tracker). Milestone Plan 'GDE Programme Workbook v8.1' would benefit from exact dates for milestone to be completed and the project team tab requires updating. Stakeholder evidence has been uploaded with all risks within review date on Ulysses. **Last updated 6 Feb 19.**
Speciality Packages	Delivery of electronic clinical documentation workflow designed to reflect best practice protocols and pathways	John Grinnell						N/A	N/A				Effective project team document has been updated. PID is available. Overall benefits profile and schedule is shown on the SoPB tracker; however a more updated version is now required as the version on SharePoint was last updated in March 18. Project Plan was last updated on 15 Feb 2019 and indicate overall confidence that the tranche 1 deadline of April ios likely to be met. Stakeholder engagements entered to 16 Oct 18. Comprehensive risk log last updated on 3 Jan 19. QIA/EA will be assured and assessed at project level. **Last updated 4 Feb 19.**
Voice Recognition	Deploy voice recognition solution in Medisec and Meditech	John Grinnell											PID and detailed project workbook on SharePoint. Details of financial benefits on separate document, these have not been realised as planned. Project Plan is being kept up to date and the overall standard of the workbook is excellent. Comms/engagement activities are detailed in workbook but evidence required where possible. Risks register is held and up to date in workbook as of 16 Jan. EA/QIA has been signed and uploaded. **Last updated 15 Feb 19.**

Alder Hey Children's NHS
NHS Foundation Trust

Programme Assurance Summary

The Best People doing their Best Work

Work Stream Summary (completed by Independent Programme Assurance)

The 'Apprenticeships' project continues to be managed to a particularly high standard of project management with consistently strong evidence available on the SharePoint site.

The 'Improving Portering Services' project now requires a thorough review which should include charting the course of the project through this year and to its eventual closure.

The 'Catering' project has recently moved under 'The Best People doing their Best Work' programme and with this comes a full assurance review of all project management standards. Overall, the project displays a good standard of assurance evidence.

Natalie Deakin, Head of Programme Management and Independent Programme Assurance – 25 Feb 19

Programme Assurance Framework

The Best People doing their Best Work (completed by independent Programme Assurance)

Alder Hey Children's NHS Foundation Trust

Sub-Committee	WOD	Report Date	25 Feb 19
Workstream Name	The Best People doing their Best Work	Executive Sponsor	Swindell/Gwilliams

Current Dashboard Rating (sheet 1 of 2):

Project Title	Project Description	Executive Sponsor Assures the project	OVERALL PROJECT	An effective project team is in place	Scope and Approach is	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	OVERALL PROJECT	Targets / benefits defined/on track	Milestone plan is defined/on track	Comments for attention of the Project Team, Steering Group and sub-Committee
Apprenticeships	To operationalise the Apprenticeship Strategy and realise the benefits of apprentisehip qualitifcations following introduction of the Apprenticeship Levy.	Melissa Swindell											Project leads meeting notes are available on SharePoint to 14 December 2018 and Steering Group to 28 January 2019. A PID is available at v6 dated 28 May 18. The benefits tracker is in place and being tracked through Jan 19 with metrics on track. A detailed Milestone Plan is available and is being closely tracked; although some milestones have slipped, this is not having an adverse impact of the outcomes/benefits and therefore the rating is green. Comms/Engagement activities detailed in PID and a comms plan is in place with extensive stakeholder engagement material in evidence. Risks are up-to-date on Ulysses. EA/QIA complete. **Last updated 20 Feb 19.**
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											Project team meeting notes available but no evidence of recent meetings. PID available which contains benefits and metrics. The Milestone Plan show significant slippage of all remaining milestones. No recent evidence of stakeholder engagement. There are a number of risks which now require review via Ulysses.EA/QIA complete. **Last updated 15 Jan 19.**
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											Evidence is available for the project 'Steering Group' meetings up to 4 Jan 19.The extensive and detailed 'Review of Catering Services – Final Version' dated January 2018 is serving as a detailed PID. There is a detailed 'Catering Project Benefit Tracker 2019/20' with all benefits tracked to Dec 18. A comprehensive Gantt chart plan has been prepared arising from the review which has been monitored up to 17 Feb 19 and is largely on track. Evidence of stakeholder engagement is available on SharePoint. All risks are within review date on Ulysses. **Last updated 21 Feb 19.**

Alder Hey Children's NHS
NHS Foundation Trust

Resources and Business Development Committee
Draft Minutes of the meeting held on: Wednesday 23rd January 2019 at 9:30am in Large Meeting Room, Institute in the Park

Present	Ian Quinlan (Chair)	Non-Executive Director	(IQ)
	Adam Bateman	Interim Chief Operating Officer	(AB)
	John Grinnell	Director of Finance	(JG)
	Claire Liddy	Director of Operational Finance	(CL)
	Claire Dove	Non- Executive Director	(CD)
In attendance	Sue Brown	Associate Director for Development	(SB)
	Mark Flannagan	Director of Communications	(MF)
	Dani Jones	Director of Strategy	(DJ)
	Erica Saunders	Director of Corporate Affairs	(ES)
	Julie Tsao	Committee Administrator (*minutes*)	(JT)
Apologies	Phil O'Connor	Deputy Director of Nursing.	(POC)
Agenda Item: **143**	Graeme Dixon	Head of Building Services	(GD)
143	Andy McColl	Associate Chief Operating Officer – Surgery	(AMc)
143	Will Weston	Associate Chief Operating Officer – Medicine	(WW)
146	Natalie Deakin	Programme Assurance Manager	(ND)
147	Catrin Barker	Chief Pharmacist	(CB)
147	Clare Langdon	Lead Pharmacist, Aspectic Services	(CLa)
152	Jason Dean	Service Improvement and Costing Accountant	
153	Jason Dean	Service Improvement and Costing Accountant	

18/19/140 **Apologies**
The Chair noted the apologies above.

18/19/141 **Minutes from the meeting held on 18th December 2018**
Resolved:
Graeme Dixion noted the wording under the water safety item wasn't correct and agreed to email the correct wording to Julie Tsao.
Action: JT – Completed

Subject to the above amendment RABD approved the December Minutes.

18/19/142 **Matters Arising and Action log**
As an action from the last meeting Sue Brown provided an update on the Alder Centre Project.

The Alder Centre build was due to start this month however the contractors (W&B) have increased costs which had previously been agreed via the design team. Due to this an urgent meeting is to take place week commencing 28th January with the design Team from AHMM to confirm total cost, followed up with a meeting with the construction contractor where all construction related costs are discussed and agreed before any contract awarded. The option exists to include within the Community Cluster construction which may have some economic benefit and would slightly delay the build and delivery date.

Sue Brown agreed to provider a further update next month.
Action: SB

18/19/143 **Top 5 Risks/Key Priority Areas for 2018/19.**
RABD received the latest slides on the three areas below:
CIPs
The forecast outturn as at 8th January 2019 is £5.8m or 84% delivery.

A further £0.200m of CIP will be realised in quarter 4 to achieve the forecasted CIP delivery of £6.0m by end of the financial year.

The recurrent CIP delivery for 18/19 CIP totals £5.3m a shortfall of £1.7m. The shortfall will carry forward into 19/20.

Capital Programme
Month 9 saw an in month underspend against the submitted NHS Improvement plan of £1,032k due to profiling of schemes and slippage, with the programme currently underspent for the year by £4,218k.

PFI
Graeme Dixon updated RABD on progress since the last meeting. Interseve had commenced work on pipes. An update would be presented at the March Board.
Action: GD

ICU ventilation for isolated room is being considered for feasibility study.

400 tiles have been replaced since December 2018. GD said the issue was in relation to air pressure.

Progress in relation to correcting the hot and cold water temperatures has been made with completion due to be reached by the end of March 2019. Adam Bateman advised completion of all issues relating to water temperature would be around 12 months.

Elective Programme
RABD received a paper on the significant staffing shortfall of 6 Consultant Anaesthetist. This was due to maternity leave, sickness and relocation. Interviews took place in August 2018 however the number of vacancies was not appointed to. This means that the department cannot consistently provide cover for the planned target of 130 theatre sessions per week. Due to this the department is now working to a revised total of 120 theatre sessions per week.

RABD noted the action to maximise capacity in both the short and medium term.

Andy McColl and Will Weston presented elective activity against plan from April - December 2018. Scheduled inpatient/day case activity per working day has reduced in recent months as expected due to winter profile.

RABD received the action plans for Surgery and Medicine to increase activity.

18/19/144 **PFI Monitoring Contract**
RABD received the report and the update above.
Resolved:
The Committee noted the Building Services report for month 9.

18/19/145 **Finance Report**
The Trust is reporting a trading surplus for the month of £2.1m which is ahead of plan by £0.6m. Income is ahead of plan by £0.2m and expenditure is

underspent by £0.4m in the month. The Use of Resources risk rating is 1 in line with plan and cash in the bank of £23.1m.

Claire Liddy reported on the over performance with the NHSE contract. Discussions were being held to agree away forward.

The Welsh contract is still yet to be agreed. Wales have stated that they will not pay for impact of new grouper (value £1.0m) on the basis that they have not been funded centrally. There is also an outstanding dispute in terms of marginal rates for under and over performance. It was hoped this would be resolved by the end of the financial year.

An update was received against meeting the revised Control Total of a surplus of £32.2m and securing a bonus of £18.6m. RABD received the divisional progress to date and actions in place.

The Trust is seeking to dispose circa 6acres of land from the site as per the Trust estates strategy. The sale of the land was required to be finalised by the end of the financial year to contribute to control total.

Resolved:
The Committee noted the contents of the Finance report for month 9.

18/19/146 **Programme Assurance**

Natalie Deakin had taken over the management of Programme Assurance in January and presented the report.

There are currently 8 projects that are to be launched; an update was received on progress to date. RABD noted the decision to be made on whether the projects under Strong Foundations would continue to be included.

Resolved:
RABD received the latest assurance report.

18/19/147 **Programme Assurance: Deep Dive External Partnships – Aspetics Project**

As agreed at a previous RABD Catrin Barker and Clare Langdon had been invited to share progress against the Aspetics project.

- April 2016 – Aseptic Unit Opens
- July 2016 – Audit - Significant Risk
  Clare and Catrin noted reasons for the outcome included moving into the build before it was fit for purpose as the building they had been working in was being demolished.
- September 2017 – Audit – High Risk
- March 2018 – Audit – High Risk
- September 2018 – Audit – Significant Risk
  External audit: risk rating reduced from High to Significant
    - Findings: technical preparation demonstrated as Safe
    - Findings: further development of Quality System and Leadership

Going forward a further Audit is taking place this year. The following processes are in place to achieve the lowest risk rating:

- Risk regards the quality management system
- Managed via the audit action plan
- Monthly development reviews at Quality Meetings

- Cleaning Validation – This action was to be completed by February 2019.

Resolved:
RABD:
- Noted progress and reduced audit risk
- Noted timescale for re-audit (to take place in 2019, date to be agreed)
- Recommend separating the ASU plan into 2 parts.
  Part A 2019/20 Achieve low audit outcome to proceed with license.
  Developing business case to be presented at February Operational Board.
  Part B 2019/20+ Income Generation opportunities

18/19/148 Marketing and Communications Activity Report

Mark Flannagan presented the report noting the first episode of Hospital a BBC2 documentary on 6 hospitals in Liverpool had been aired. Episode 4 would focus on Critical Care and Cardiac Unit in Alder Hey.

Resolved:
RABD received and noted the contents of the Marketing and Communications Activity report.

18/19/149 Board Assurance Framework (BAF)

Erica Saunders presented the report. An update on development of building risks would be presented at the February Board.

Resolved:
RABD received and noted the BAF cover report for month 9.

18/19/150 NHS Improvement Quarter 3

RABD noted the report was no longer a requirement however as NHSI found the report useful it was still produced. The Control Total risk would be amended before the report was submitted.

Resolved:
RABD received NHS Improvement Quarter 3 report.

18/19/151 Budget Setting 2019/20

The Control Total for 2019/20 has been set at £2.8m. The following summary was provided:

1. Complex analysis that is linked to Tariff debate. Need to complete tariff exercise.
2. Too early to fully assess if this Control Total is realistic and acceptable
3. Assess cash impact to 10 year capital affordability
4. Risks i.e CiP drivers requires a process to mitigate

Resolved:
RABD agreed with the recommendation to:
- Present the current position to Board and agree if the CT is acceptable
- Present the final plans at March RABD
  Action: JG/CL

18/19/152 Reference Costs Report

RABD noted:
- Alder Hey's RCI is below the average for the four specialist children's trusts. Prior to the hospital move in 2015/16 it had remained static for three years on 103; it has now returned to that level.

- The 2017/18 return will not be audited. In the previous three audits, which looked at the 2013/14, 2015/16 and 2016/17 returns, Alder Hey was the only trust audited to get the highest possible rating in all costing metrics.
- NHS Improvement once again rated Alder Hey's costing information, methodologies and governance number one in England in 2018.

Resolved:
RABD thanked Jason Dean and the team for receiving number one rating by NHS Improvement.

18/19/153 **Service Line Reporting**

Jason Dean presented the SLR report noting joint working with Programme Assurance and GDE. Below are the priorities/actions for completion by March 2019.

Deficit reducing opportunity – Medicine

- Concentrate on small number of areas
- Gastroenterology

Dani Jones agreed to provide an update at the March RABD on progress to date. **Action: DJ**

- Surplus increasing Opportunity – Daycase
- Medical Daycase Unit

Shaping national/regional policy & showcasing Alder Hey

- Role of costing in STP – Chair of regional costing forum
- Role of costing nationally – Provider lead on NHS Improvement group and Deputy Chair HFMA group
- Conference Speaking - whole team involved
- Future Focussed Finance Accreditation

RABD noted the good national progress above.

Resolved:
RABD received and noted the actions being progressed.

18/19/154 **Corporate Report**

Finance

The Trust is reporting a trading surplus for the month of £2.1m which is ahead of plan by £0.6m. Income is ahead of plan by £0.2m and expenditure is underspent by £0.4m in the month. The Use of Resources risk rating is 1 in line with plan and cash in the bank of £23.1m.

The year to date trading position is 12.5m surplus which is ahead of plan £0.1m.

Performance

Performance against national standards remains strong with delivery of Emergency Department, access and cancer standards.

Operational teams are particularly focused on improving the use of resources in clinics. There are 223 clinics, of 663 in total, with a utilisation of less than 80%. In December 170 of these clinics have agreed an improvement plan to deliver at least 90% utilisation.

Resolved:
The Committee received and noted the Corporate Report for month 9.

18/19/155 **Global Digital Exemplar**
Resolved:
RABD noted the progress of the Trusts GDE Programme and the on-going progress towards Milestone 5.

18/19/156 **Any Other Business**
No other business was reported.

Date and Time of Next Meeting: Wednesday 27th February 2019, 9:30am – 12:30pm, Large Meeting Room, Institute in the park.

Audit Committee

Draft Minutes of the meeting held on **Thursday 22nd November 2018**

Room 7, Mezzanine

Present:	Mrs K Byrne (Chair)	Non-Executive Director	(KB)
	Mrs. A. Marsland	Non-Executive Director	(AM)
In Attendance:	Mrs L Cobain	Assistant Director, MIAA	(LC)
	Mrs C Davies	Senior Manager, Ernst and Young	(CD)
	Mr J Grinnell	Director of Finance	(JG)
	Mrs C Liddy	Deputy Director of Finance	(CL)
	Ms M McMahon-Joseph	Senior Audit Manager, MIAA	(MMc)
	Mr H Rohimun	Executive Director, Ernst and Young	(HR)
	Ms E Saunders	Director of Corporate Affairs	(ES)
	Mrs J Tsao	Committee Administrator *(minutes)*	(SS)
Agenda item:			
18/19/53	Ms L Fearnehough	Head of Technical IT Services	(LF)
Apologies:	Mrs. J. France-Hayhurst	Non-Executive Director	(JFH)

18/19/51 Minutes of the previous meeting held on 20th September 2018

Resolved:

Audit Committee received the minutes from the meeting held on the 20th September 2018. As there were a number of changes to be made for accuracy the Chair agreed to amend and circulate the final version for approval.

18/19/51.1Action: KB/JT

18/19/52 Matters Arising and Action List

All actions had either been closed or had been included on the agenda.

19/19/53 Cyber Baseline Assessment

Leanne Fearnehough presented the findings from the Cyber Security Baseline Assessment undertaken by MIAA, noting the objective was to provide an opinion on the design and the maturity of the technical elements of the Trust's cyber defence framework.

Six domains were scored using a 5 point system:
0 – Control not implemented.
1 – Control partially implemented.
2 – Control fully implemented.
3 – Control fully implemented and monitored
4 – Control fully implemented, monitored tested and assured.

The domains listed below were scored as:

Parameter Controls	2
Malware Protection	3
Data Recovery	2

Leanne Fearnehough provided background and assurance on the following domains that scored 1:

Secure Configuration
An action to upgrade the Firewall had been superseded by the agreement to implement Windows 10 by January 2020.

User Access Control
As the previous Lead for this had now left the Trust Sharon Owen, Deputy Director of HR would be responsible for the management of actions and report to the Integrated Governance Committee.

Patch Management
One of the recommendations had been to schedule Meditech downtime to undertake this work; this had now been completed. One of the 63 servers would be tested annually to ensure information is backed up. The Committee requested for complex servers to be annually tested. This had been added to the risk register and would be reported through the Integrated Governance Committee.

MIAA agreed to add the Cyber Baseline Assessment to the follow up reporting process.

Resolved:
Audit Committee received the Cyber Baseline Assessment.

18/19/54 Progress Report, MIAA
Maria McMahon-Joseph presented the Internal Audit Progress Report noting the five core financial system audits that had been completed since the last Audit Committee meeting. Four of the audits been rated with High Assurance: General Ledger, Accounts Receivable, Treasury Management and Budgetary Control.

The Accounts Payable Audit outcome was Substantial Assurance. Claire Liddy advised the outcome was around enhancing the system rather than there being any underlying issues.

18/19/54.1 The Chair noted the timeframe for audits and asked for awareness around the number of audits being presented at each meeting so there isn't an overload towards the year end. Louise Cobain responded advising that the MIAA team liaise regularly with the teams at Alder Hey to avoid this. A request was made to include days for each audit on the Audit Plan when it is presented in April 2019.
Action: MMc, MIAA

18/19/54.2 Maria McMahon-Joseph agreed to include in the Internal Audit Plan an ad hoc review of the control of contractors processes at the request of the Executive Team following some instances of contractors coming onto site without following the correct notification procedures. It was suggested that this could be achieved without the need for additional audit days in the Plan by adjusting the scope of the work on the Fit and Proper Persons requirement.
Action: MMc, MIAA

18/19/54.3 A discussion was held on full audit reports being made available to the Committee, it was agreed the logistics of this would be agreed outside of the meeting.
Action: MMc, MIAA

18/19/54.4 Louise Cobain agreed to extend the current number of contingency days for the

next financial years Internal Audit Plan to enable flexibility.

Action: LC, MIAA

Resolved:

Audit Committee received the current Progress Report and noted the actions above.

18/19/55 Follow-up Audits, MIAA

Maria McMahon-Joseph presented the above report, a summary of the current position is below:

Reviews	Total actions	Actions not yet due for follow up	Actions previously reported as implemented / superseded	Actions implemented since last Audit Committee	Actions partially implemented	Actions no longer applicable / superseded	Actions not implemented
14	92	4	52	8	9	3	16

Maria McMahon-Joseph advised that MIAA now ensure the description of what is required to demonstrate implementation is clear for Trust Leads. A number of action review dates had lapsed; revised timescales would be agreed with the Lead.

A request was made for context on why agreed actions were outstanding to be included in future reports.

The Chair noted the good position and asked that actions from prior to 2016 are reviewed to ensure that they remain relevant. Any actions that are updated or closed should be reported to Audit Committee.

18/19/55.1Action: MMc/MIAA

Resolved:

Audit Committee noted good progress against agreed actions.

18/19/56 MIAA Insight

Resolved:

Audit Committee received the MIAA Insight Paper which included upcoming events and conferences for MIAA customers.

18/19/57 Ernst and Young Update

18/19/57.External Audit Planning Report – 31st March 2019

Hassan Rohimun gave an overview of the External Audit Planning Report, highlighting the 2019 strategy, proposed response to significant risks and areas of focus.

Reference was made to the impact of Brexit and future service provision under the value for money section. John Grinnell made reference to a paper on Brexit that had been circulated to the Board and agreed to circulate to the Audit Committee.

18/19/57.2Action: JG/JT

A discussion was held on the timeline and assurance was sought (and received) regarding discussions of areas subject to risk and subjectively to minimise delays and challenges to the audit delivery.

Audit Committee noted this would be Caroline Davies' last meeting as she was leaving E&Y. Caroline agreed to have a thorough handover with the incoming Audit Manager. The Chair wished Caroline well on behalf of the Audit Committee.

Resolved:
Audit Committee noted:
- The External Audit Planning Report for the next financial year
- The changes in process for the External Audit Lead for the Trust.
- The position paper on Brexit to be circulated to the Audit Committee

18/19/57.3Data Analytics: Supporting the Audit and Providing Client Insight

The report covered:
- Journal Entry Testing
- Payroll: Trends and Insights
- Other opportunities for use of Data Analytics

Data collected during the audit process is used to provide this report. The data is analysed to highlight areas of interest / outliers / potential areas of concern which can be useful for management to look at.

Claire Liddy thanked Hassan and the team for this piece of work noting it would support the work being carried out by the Finance team.

Resolved:
Audit Committee received and noted the Data Analytics report.

18/19/58 Acorn Partnership Ltd Workshop

Following an action at the last Audit Committee a workshop had been held to discuss and review the innovation partnership with Acorn Partners Ltd.

Claire Liddy highlighted the themes from the workshop noting the recommendation for the Audit Committee to approve the appointment of a specialist advisor (from KPMG) to produce an internal audit assurance review into this partnership.

Themes from workshop included:
- More transparency needed around the accounting of funds and cash fund flow position
- More understanding needed around the EIS and SEIS schemes and the reputational issues if companies are made insolvent by NHS
- More clarity around taxation benefits needed and implications for NHS
- Unclear how the Product Co are managed e.g. name changes etc
- Unclear what the parties / company relationships are and other holding companies e.g. Galactic

The Committee were asked to approve the appointment of a specialist advisor to produce an internal audit assurance review into this partnership. It is suggested that KPMG are requested to provide a proposal and terms of reference. Indicative scope of the internal audit was presented and agreed.

The Chair asked for details on why KPMG had been suggested and why no other quotes had been sought. Claire Liddy advised that KPMG provided some initial support during the early stages of this partnership and therefore have existing knowledge and this was the reason for putting them forward. The Chair also

highlighted the need to ensure that the need for assurance is identified whenever new ventures are considered to ensure that it is sought at the right time. John Grinnell advised that, going forward, the process for external partnerships had been reviewed.

Resolved:
Audit Committee:
- **APROVED** the recommendation to appoint a specialist advisor from KPMG to produce an internal audit assurance review into the ACORN Partnership.

18/19/59 Register of Shareholder Interests
Resolved:
Claire Liddy presented the company shareholdings register as it stands on 31st October 2018.

17/18/60 NHS Improvement Quarterly Submission, Q2
Resolved:
Audit Committee:
- Received and noted the contents of the NHSI Improvement quarterly submission for Q2.
- Noted RABD's approval.

18/19/61 Board Assurance Framework (BAF)
Resolved:
The Committee received and noted the contents of the Board Assurance Framework for October 2018, including the ongoing scrutiny of all strategic risks by the relevant assurance committee.

18/19/62 Any Other Business
There was none to discuss.

18/19/63 Meeting Review
Audit Committee had agreed earlier in the meeting that under this item any audit matters that should be circulated to other committees would be identified. Audit Committee agreed there was no requirement for any matters to be forwarded on.

Date and Time of next meeting: Thursday 24th January 2019, at 14:00, Room 7 on the Mezzanine.

NHS
Alder Hey Children's
NHS Foundation Trust

Corporate Report January 2019

How Did We Do?

Executive Summary **Month: January** **Year: 2019**

Alder Hey Children's NHS
NHS Foundation Trust

Delivery of Outstanding Care

Safe

- The safe domain reports a Never Event in January 2019. NHS Serious Incident Framework and Never Event framework followed to assure standard of investigation and lessons learned are implemented. Duty of Candour has been completed in line with regulation 20. The 72 hour review report has been completed in line with National Standards and Trust policy and submitted to the CQC and CCG. Incident reported to StEIS and NRLS. Level 2 comprehensive investigation is underway.
- Clinical Incidents resulting in Unexpected Death; this incident is currently under investigation. Duty of Candour has been completed in line with regulation 20. The 72 hour review report has been completed in line with National Standards and Trust policy and submitted to the CQC and CCG. This update was provided in the December executive summary for this patient

Highlight

- Strong culture of reporting near miss incidents and clinical incident reporting continues. Continued strong performance in preventing pressure ulcers category 3 and over

Challenges

- The target set for incidents resulting in minor harm remains a challenge thus requiring further consideration when agreeing the harm reduction plan for 2019/20.

The Best People Doing their Best Work

Caring

- Continued increase in the number of CYP who would recommend the Trust
- Decrease in formal complaints however significant increase in informal concerns.

Highlight

- Kiosk stand to further improve collection of feedback from CYP to be installed in April

Challenges

- Fall in positive responses in mental health to be reviewed at the next Divisional Integrated Governance meeting
- Increase in informal concerns. Deep dive to commence in Medical Division to understand and address any themes

Delivery of Outstanding Care

Effective

- Performance against national standards remains strong with delivery of access and cancer standards. ED performance was 92.1% despite significant operational challenges. Cancelled operations and 28 day breaches within tolerance.

Highlight

- Cancer & Diagnostic standards achieved
- Cancelled Ops and 28 breaches reduced despite winter pressures

Challenges

- Theatre utilisation below 90% threshold

Delivery of Outstanding Care

Responsive

- Winter Plan remains active with red week management deployed. Despite this RTT achieved, no patients waiting >52 weeks and waiting list size maintained.

Highlight

- Delivery of core NHSI standards

Challenges

- Super stranded patients (>21days) increased

The Best People Doing their Best Work

Well Led

- The Trust delivered an in month surplus of £5m which was aligned to plan (including PSF incentive). Cumulatively we have delivered a surplus of £17.5m which is marginally ahead of plan (including PSF). This is enabling delivery of our Use of Resources rating of 1. Cash balances were £20m which is £8m behind plan however this is due to PSF incentive money now being transacted at the end of the year which is a change on the original guidance.
- Non elective activity continued to overperform which was largely casemix driven. Elective performance met the financial plan for the month with an underperformance in outpatients. NHSE contract continues to overperform and we are close to agreeing a year end settlement. There remains risks associated with Welsh commissioners agreeing to pay HRG4+ which is being negotiated by NHSi centrally.
- Temporary staffing costs remain high which has driven a £0.5m overspend in month. This is being partly driven by high sickness levels. Non-pay levels were underspent which is an improvement on recent run rates.
- Forecast CIP now stands at £5.9m. We continue to focus on improving by the year end with at least a £6m delivery.
- Capital spend is £5m lower than our original plan which is driven by delays in the Estates programme (Alder Centre and Community Cluster). A revised forecast has been submitted to NHSi.
- Sickness rates remain above our target levels and particularly long term sickness remains a concern. A revised focus on our wider health & wellbeing of our staff remains a priority.

Highlight

- Delivery of in month control total
- Elective performance
- Safe staffing levels

Challenges

- In month CIP delivery
- Progress on capital schemes
- Sickness rates
- Temporary staffing costs

Game Changing Research and Innovation

Research and Development

- Progress against implementing the MHRA inspection findings CAPA has been good.
- The development of a joint research service is well underway.
- The Business/financial model for the CRD has not moved on significantly and a financial gap is anticipated this year.
- Fewer numbers of commercial contracts than anticipated have come to the Trust
- A higher than usual level of rejections of expressions of interest to run studies has resulted in fewer new studies opening.
- Fluctuations and inertia in the research nurse workforce has resulted in a dip in performance.

Highlight

- Leading the development of a joint research service for Liverpool
- Implementing the MHRA inspection CAPA plan is going well
- New CRF manager and Industry manager have been appointed and 4 research fellows are in post.
- A review of structure has concluded with a business case for investment in workforce ready for consideration.

Challenges

- Closing the financial gap
- Organisational change relating to nurse leadership
- Performance against targets is not good this year

Contents

Contents

Contents

Contents

Delivery of Outstanding Care

SAFE

Alder Hey Children's NHS
NHS Foundation Trust

	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Last 12 Months	RAG			Comments Available
Total no of incidents reported Near Miss & Above	450	456	513	413	446	490	432	447	452	478	460	347	423		>=455	>=409	<409	✔
Clinical Incidents resulting in minor harm & above	84	82	93	83	76	90	84	80	92	95	95	71	81		<=76	<=84	>84	✔
Clinical Incidents resulting in moderate, semi permanent harm	2	0	1	0	1	1	1	1	2	0	1	1	2		<=1	N/A	>1	✔
Clinical Incidents resulting in severe, permanent harm	0	0	0	0	0	0	0	0	0	0	0	0	0		0	N/A	>0	✔
Clinical Incidents resulting in catastrophic, death	0	0	0	0	0	0	0	0	0	0	0	0	1		0	N/A	>0	✔
Pressure Ulcers (Category 3)	2	0	0	0	1	0	0	0	0	0	0	0	0		0	N/A	>0	✔
Pressure Ulcers (Category 4)	0	0	0	0	0	0	0	0	0	0	0	0	0		0	N/A	>0	✔
Medication errors resulting in harm	2	5	6	4	3	4	3	4	4	2	5	2	2		<=2	N/A	>2	✔
Never Events	0	0	0	0	0	0	0	2	0	0	0	0	1		0	N/A	>0	✔

The Best People doing their best Work

CARING

Alder Hey Children's NHS
NHS Foundation Trust

	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Last 12 Months	RAG	Comments Available
Friends & Family A&E - % Recommend the Trust	89.8%	85.6%	86.4%	85.4%	82.6%	83.9%	86.3%	88.2%	85.5%	80.0%	80.6%	90.1%	90.5%		>=95 % >=90 % <90 %	✔
Friends & Family Community - % Recommend the Trust	87.5%	100.0%	97.7%	100.0%	96.8%	96.4%	92.2%	100.0%	100.0%	93.2%	100.0%	100.0%	98.5%		>=95 % >=90 % <90 %	✔
Friends & Family Inpatients - % Recommend the Trust	97.3%	96.6%	96.8%	93.7%	95.5%	94.9%	97.0%	97.0%	98.3%	98.2%	97.9%	98.2%	97.0%		>=95 % >=90 % <90 %	✔
Friends & Family Mental Health - % Recommend the Trust	77.8%	82.8%	100.0%	87.5%	82.6%	88.9%	100.0%	89.9%	89.4%	84.7%	97.5%	100.0%	88.9%		>=95 % >=90 % <90 %	✔
Friends & Family Outpatients - % Recommend the Trust	96.1%	91.8%	89.3%	90.3%	88.6%	86.9%	85.5%	89.7%	90.0%	90.3%	91.4%	91.7%	87.4%		>=95 % >=90 % <90 %	✔
Complaints	12	13	5	8	11	11	13	14	11	13	5	7	6		<=9 <=12 >12	✔
PALS	147	145	129	151	126	99	100	100	125	132	115	71	137		<=131 <=145 >145	✔

Delivery of Outstanding Care

EFFECTIVE

Alder Hey Children's NHS
NHS Foundation Trust

	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Last 12 Months	RAG			Comments Available
Sepsis: Patients treated for Sepsis - A&E	60.0%	42.3%	60.9%	66.7%	55.6%	57.1%	65.5%	68.2%	54.5%	65.4%	57.6%	51.9%	77.4%		>=90 %	N/A	<90 %	✔
Sepsis: Patients treated for Sepsis - Inpatients	74.1%	86.4%	79.2%	76.0%	72.7%	78.9%	71.4%	72.5%	75.7%	70.2%	76.2%	73.3%	70.2%		>=90 %	N/A	<90 %	✔
No of children that have suffered avoidable death - Internal	0	0	0	0	0	0	0	0	0	0	0	0	0		0	N/A	>0	✔
% Readmissions to PICU within 48 hrs	2.4%	1.5%	4.1%	3.6%	2.5%	2.7%	6.5%	0.0%	2.7%	1.0%	1.1%	2.4%	1.4%		<=3 %	N/A	>3 %	✔
Hospital Acquired Organisms - MRSA (BSI)	2	0	0	0	0	0	0	0	0	0	0	0	0		0	N/A	>0	✔
Hospital Acquired Organisms - C.difficile	0	0	1	0	0	0	0	0	0	0	0	0	0		0	N/A	>0	✔
Hospital Acquired Organisms - MSSA	0	3	0	0	1	0	0	0	1	2	0	1	1		<=1	N/A	>1	✔
Hospital Acquired Organisms - CLABSI - ICU Only	2	4	2	2	2	2	0	1	0	2	1	3	0		<=1	N/A	>1	✔
Hospital Acquired Organisms - Gram Negative BSI	1	1	3	2	0	1	0	1	2	2	2	2	1		<=1	N/A	>1	✔
Bed Occupancy (Accessible Funded Beds)	88.2%	89.3%	89.6%	90.3%	84.9%	88.5%	83.9%	76.2%	79.9%	85.8%	85.3%	73.7%	72.9%		<=89 %	<=93 %	>93 %	✔
ED: 95% Treated within 4 Hours	93.6%	92.6%	97.2%	95.3%	95.0%	95.6%	96.5%	98.4%	93.7%	90.9%	93.8%	95.3%	92.1%		>=95 %	N/A	<95 %	✔
Average LoS - Elective (Days)	2.94	2.98	3.21	2.79	2.87	2.89	3.13	2.80	2.79	3.05	2.90	3.58	2.35		<=3.0	N/A	>3.0	✔
Average LoS - Non-Elective (Days)	2.10	1.99	2.10	1.96	2.01	2.01	1.85	2.03	1.73	2.05	1.98	1.92	1.81		<=2.1	N/A	>2.1	✔
Theatre Utilisation - % of Session Utilised	87.2%	85.6%	86.2%	88.2%	88.6%	87.9%	89.3%	87.0%	86.6%	86.4%	87.3%	85.7%	88.4%		>=90 %	>=80 %	<80 %	✔
On the day Elective Cancelled Operations for Non Clinical Reasons	24	25	37	26	33	44	35	18	12	28	38	21	1		<=22	N/A	>22	✔
28 Day Breaches	0	3	8	10	5	6	6	7	1	0	6	5	1		0	N/A	>0	✔
Clinic Session Utilisation	85.3%	83.8%	84.0%	83.6%	83.9%	84.9%	82.3%	83.0%	84.2%	83.0%	84.5%	82.2%	82.9%		>=90 %	>=85 %	<85 %	✔
Did Not Attend Rate	10.5%	10.7%	11.3%	10.6%	11.5%	12.1%	12.4%	13.6%	11.4%	11.8%	11.1%	12.6%	11.7%		<=12 %	<=14 %	>14 %	✔
Transcription Turnaround (days)	23.00	26.00	28.50	15.00	6.00	4.50	4.00	1.00	4.00	1.50	2.00	2.50	1.25		<=3	<=5	>5	✔

Delivery of Outstanding Care

RESPONSIVE

Alder Hey Children's NHS
NHS Foundation Trust

	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Last 12 Months	RAG	Comments Available
IP Survey: % Received information enabling choices about their care	94.4%	94.7%	93.1%	94.8%	91.6%	96.2%	94.7%	94.7%	96.3%	96.4%	95.1%	96.7%	88.7%		>=95 % >=90 % <90 %	✔
IP Survey: % Treated with respect	100.0%	99.4%	99.8%	97.7%	98.8%	99.7%	99.7%	99.6%	99.5%	99.6%	100.0%	99.6%	92.4%		100 % >=95 % <95 %	✔
IP Survey: % Know their planned date of discharge	52.1%	59.0%	60.1%	60.5%	76.1%	63.7%	65.7%	60.6%	55.3%	60.2%	69.0%	59.4%	70.7%		>=90 % >=85 % <85 %	✔
IP Survey: % Know who is in charge of their care	93.6%	90.9%	91.6%	91.3%	90.9%	92.7%	94.7%	91.6%	94.9%	92.2%	92.2%	92.5%	89.0%		>=95 % >=90 % <90 %	✔
IP Survey: % Patients involved in play and learning	78.3%	79.6%	75.0%	74.9%	77.8%	74.4%	73.1%	74.8%	73.7%	74.3%	72.5%	68.2%	72.5%		>=90 % >=85 % <85 %	✔
RTT: Open Pathway: % Waiting within 18 Weeks	92.2%	92.1%	92.1%	92.1%	92.0%	92.1%	92.0%	92.0%	92.1%	92.1%	92.1%	92.0%	92.0%		>=92 % >=90 % <90 %	✔
Waiting List Size				13,235	13,238	12,879	12,962	12,925	12,884	12,961	12,934	12,859	12,872		<=12905 N/A >12905	✔
Waiting Greater than 52 weeks	1	2	1	0	0	0	0	0	0	0	0	0	0		0 N/A >0	✔
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.7%	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%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100 % N/A <100 %	✔
All Cancers: 31 day wait until subsequent treatments	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100 % N/A <100 %	✔
Diagnostics: % Completed Within 6 Weeks	100.0%	99.3%	99.8%	99.8%	99.8%	99.2%	99.3%	99.0%	99.8%	99.8%	99.3%	100.0%	99.7%		>=99 % N/A <99 %	✔
Number of Super Stranded Patients (21+ Days)	35	26	32	34	27	32	29	32	29	32	28	24	35		<=32 N/A >32	✔
PFI: PPM%	98.0%	100.0%	98.0%	98.6%	99.0%	99.0%	96.0%	98.0%	100.0%	98.0%	99.0%	100.0%	100.0%		>=98 % N/A <98 %	✔

The Best People doing their best Work

WELL LED

Alder Hey Children's NHS
NHS Foundation Trust

	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Last 12 Months	RAG	Comments Available
CIP In Month Variance (£'000s)	54	-410	864	-248	104	153	-238	-137	175	-174	-285	151	-199		>=0% >=-20% <-20%	✔
Control Total In Month Variance (£'000s)	243	17		-426	154	285	29	-396	359	-463	-48	564	-21		>=0% >=-20% <-20%	✔
Capital Expenditure In Month Variance (£'000s)	1,184	3,161	-887	1,090	-333	1,701	-462	-129	2,907	-751	1,041	1,032	1,032		>=-5% >=-10% <-10%	✔
Cash in Bank (£'000s)	6,712	10,201	12,244	12,406	10,455	9,455	23,910	21,519	20,023	20,315	17,580	23,136	19,983		>=0% >=-20% <-20%	✔
Income In Month Variance (£'000s)	1,893	1,080	19,658	218	591	425	998	741	263	624	684	142	456		>=0% >=-20% <-20%	✔
Pay In Month Variance (£'000s)	-538	-605	546	-17	-7	-38	-111	-311	51	-372	-74	-267	-510		>=-1% >=-20% <-20%	✔
Non Pay In Month Variance (£'000s)	-1,111	-458	1,368	-627	-431	-102	-858	-825	95	-715	-659	689	41		>=0% >=-20% <-20%	✔
NHSI Use of Resources	3	3	1	3	3	3	3	3	2	2	1	1	1		<=2 N/A >2	✔
AvP: IP - Non-Elective				5	5	5	20	9	-1	50	62	111	-14		>=0 N/A <0	✔
AvP: IP Elective vs Forecast				7	13	16	10	18	10	33	-5	-14	3		>=0 N/A <0	✔
AvP: Daycase Activity vs Forecast				-22	-3	6	-11	-2	20	-86	-67	-162	-26		>=0 N/A <0	✔
AvP: Outpatient Activity vs Forecast				974	566	483	496	524	1,049	1,897	1,968	287	1,421		>=0 N/A <0	✔
PDR	79.7%	76.1%	76.4%	1.3%	11.3%	31.1%	64.7%	82.3%	88.8%	90.1%	90.1%	90.1%	90.1%		>=90 % >=85 % <85 %	✔
Medical Appraisal	24.0%	52.1%	67.6%	69.0%	69.0%	2.0%	4.0%	6.3%	100.0%	100.0%	100.0%	100.0%	100.0%		>=95 % >=90 % <90 %	✔
Mandatory Training	88.9%	94.1%	92.9%	92.1%	92.0%	92.1%	91.6%	88.6%	88.1%	89.7%	89.7%	89.0%	89.4%		>=90 % >=80 % <80 %	✔
Sickness	6.3%	5.6%	4.7%	4.5%	4.6%	4.9%	5.3%	5.2%	5.4%	5.6%	5.6%	6.0%	5.7%		<=4.5 % <=5 % >5 %	✔
Short Term Sickness	2.1%	1.7%	1.5%	1.3%	1.2%	1.4%	1.5%	1.3%	1.4%	1.5%	1.6%	1.6%	1.8%		<=1.5 % N/A >1.5 %	✔
Long Term Sickness	4.3%	3.9%	3.2%	3.1%	3.4%	3.5%	3.8%	4.0%	4.0%	4.0%	3.9%	4.4%	3.8%		<=3 % N/A >3 %	✔
Temporary Spend ('000s)	833	926	1,067	977	973	947	901	1,082	820	998	971	883	937		<=800 <=960 >960	✔
% of Correct Pay Achieved	99.6%	99.3%	98.9%	99.8%	99.4%	99.5%	99.5%	99.5%	99.4%	99.4%	99.5%	99.5%	99.5%		>=99.5 % >=99 % <99 %	✔
Staff Turnover	11.5%	11.2%	10.9%	10.6%	10.9%	10.6%	11.5%	10.4%	10.9%	11.2%	10.6%	9.5%	9.8%		<=10 % <=11 % >11 %	✔
Safer Staffing (Shift Fill Rate)	95.9%	94.2%	95.0%	96.4%	96.5%	94.8%	95.0%	93.9%	93.1%	93.2%	95.3%	94.2%	94.5%		>=90 % N/A <90 %	✔
Domestic Cleaning Audit Compliance	75.0%	85.0%	90.0%	90.0%	85.0%	65.5%	97.5%	85.0%	93.8%	60.0%	90.0%	90.0%	92.0%		>=85 % N/A <85 %	✔
Performance Against Single Oversight Framework Themes	0	0	0	0	0	0	0	0	0	0	0	0	0		0 <=1 >1	✔

Game Changing Research & Innovation

R&D

Alder Hey Children's NHS
NHS Foundation Trust

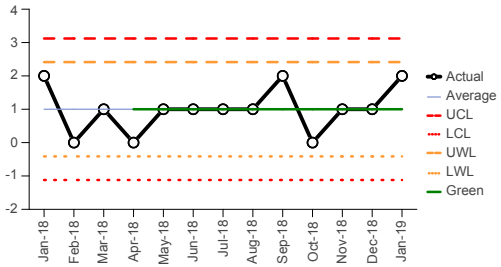
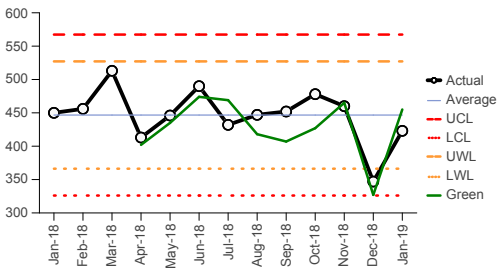
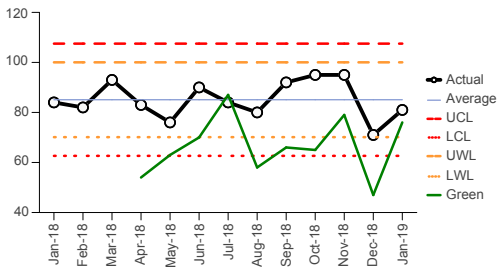
GROW THE FUTURE

	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Last 12 Months	RAG	Comments Available
Number of Open Studies - Academic	0	0	0	148	153	159	159	156	115	143	136	123	121		>=50 N/A <50	✔
Number of Open Studies - Commercial	0	0	0	34	33	34	34	37	27	31	28	27	29		>=5 N/A <5	✔
Number of New Studies Opened - Academic	0	0	0	5	2	5	7	2	3	6	8	2	6		>=4 N/A <4	✔
Number of New Studies Opened - Commercial	0	0	0	3	0	0	1	2	3	2	0	0	1		No Threshold	
Number of patients recruited	0	0	0	272	308	245	288	249	238	195	296	158	238		>=417 N/A <417	✔

Delivery of Outstanding Care

7.1 - QUALITY - SAFE

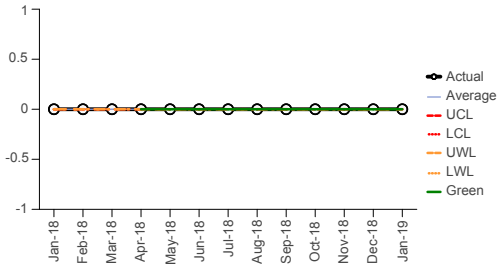
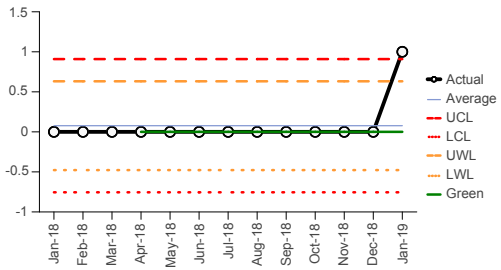
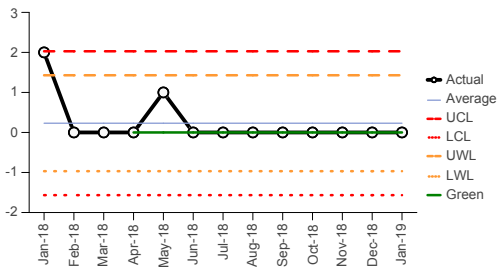
Alder Hey Children's NHS Foundation Trust

	Description	Performance	Threshold	Trend	Management Action (SMART)
Incidents: Reducing Harm	**Clinical Incidents resulting in moderate, semi permanent harm** Incidents reported resulting in moderate harm. The threshold is based on achieving a 10% reduction on the period Apr 17 - Mar 18 (16). 18/19 aim is 12 or less, annually. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	2	R >1 A N/A G <=1		There have been 2 moderate incidents reported however both relate to the same incident for the same patient – a second moderate harm incident form was submitted to consolidate the initial moderate and 2 additional minor harm reports. Level 1 RCA investigation underway. Duty of Candour has been completed in line with regulation 20. The 72 hour review report has been completed in line with National Standards and Trust policy. Incident submitted to NRLS
Incidents: Increasing Reporting	**Total no of incidents reported Near Miss & Above** Total number of Incidents reported. The threshold is based on increasing on last year for the period Apr 17 - Mar 18 (4,241) 18/19 aim is more than last year for the same month to demonstrate a learning culture. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	423	R <409 A >=409 G >=455		Weekly Patient Safety Meeting (PSM) review and monitoring progress with actions. PSM continues to identify a Good Catch each week to share how practitioners have prevented incidents occurring. Monthly Head of Quality analysis reports including lessons learned presented to Divisional Governance Assurance Committee and Clinical Quality Steering Group.
Incidents: Reducing Harm	**Clinical Incidents resulting in minor harm & above** Incidents reported resulting in minor, moderate, major or catastrpohic (death) harm. The threshold is based on achieving a 10% reduction on the period Apr 17 - Mar 18 (913). 18/19 aim is 10% less than last year for the same month. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	81	R >84 A <=84 G <=76		Weekly Patient Safety Meeting review and monitoring progress with actions. Monthly Head of Quality analysis reports including lessons learned presented to Divisional Governance Assurance Committee and Clinical Quality Steering Group. In addition actions for improvement monitored via Divisional governance processes including Divisional Integrated Governance and Quality Improvement Committees

Delivery of Outstanding Care

7.2 - QUALITY - SAFE

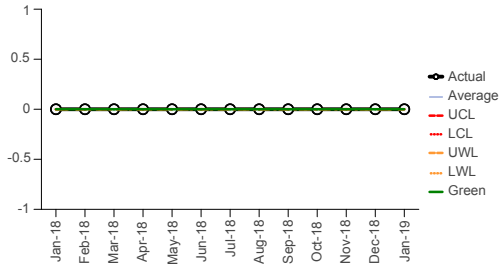
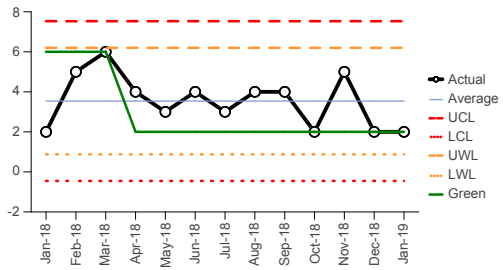
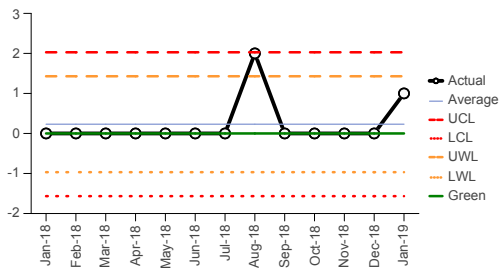
Alder Hey Children's NHS Foundation Trust

	Description	Performance	Threshold	Trend	Management Action (SMART)
Incidents: Reducing Harm	**Clinical Incidents resulting in severe, permanent harm** Incidents reported resulting in severe harm. The threshold is based on this event never occuring. 18/19 aim is zero annually. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	0	R >0 A N/A G 0		No Action Required
Incidents: Reducing Harm	**Clinical Incidents resulting in catastrophic, death** Incidents reported resulting in severe harm. The threshold is based on this event never occuring. 18/19 aim is zero annually. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	1	R >0 A N/A G 0		The death of this patient is currently under investigation. Duty of Candour has been completed in line with regulation 20. The 72 hour review report has been completed in line with National Standards and Trust policy and submitted to the CQC and CCG. Incident reported to StEIS and NRLS and SUDiC notification. Level 2 comprehensive investigation is underway.
Reducing Pressure Ulcers	**Pressure Ulcers (Category 3)** Pressure Ulcers of Category 3. The threshold is based on this event never occuring. 18/19 Aim is zero annually. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	0	R >0 A N/A G 0		No Action Required

Delivery of Outstanding Care

7.3 - QUALITY - SAFE

Alder Hey Children's NHS Foundation Trust

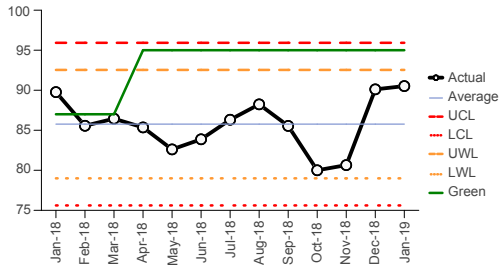
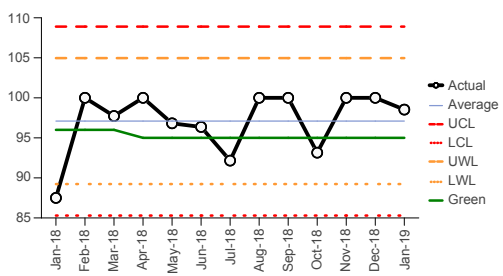
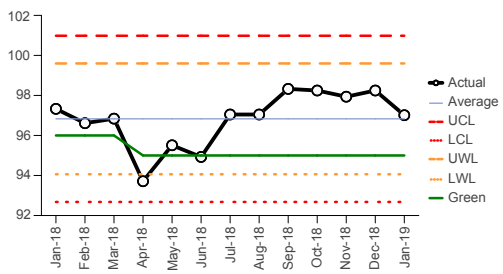
	Description	Performance	Threshold	Trend	Management Action (SMART)
Reducing Pressure Ulcers	**Pressure Ulcers (Category 4)** Pressure Ulcers of Category 4. The threshold is based on this event never occuring. 18/19 Aim is zero annually. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	0	R >0 A N/A G 0		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/Adrian Hughes/Christian Duncan **Committee:** CQAC	2	R >2 A N/A G <=2		No Action Required
Never Events	**Never Events** Never Events. The threshold is based on this event never occuring. 18/19 aim is zero annually. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	1	R >0 A N/A G 0		NHS Serious Incident Framework and Never Event framework followed to assure standard of investigation's and lessons learned are implemented. Duty of Candour has been completed in line with regulation 20. The 72 hour review report has been completed in line with National Standards and Trust policy and submitted to the CQC and CCG. Incident reported to StEIS and NRLS. Level 2 comprehensive investigation is underway.

The Best People doing their best Work

8.1 - QUALITY - CARING

Alder Hey Children's NHS Foundation Trust

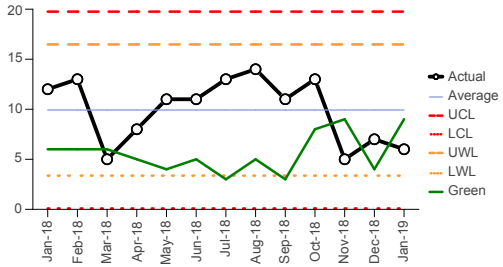
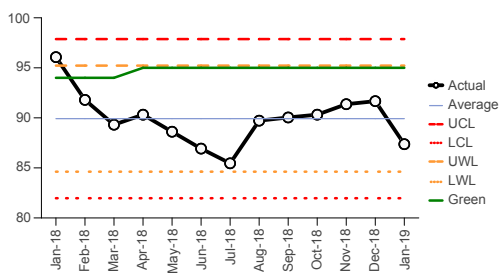
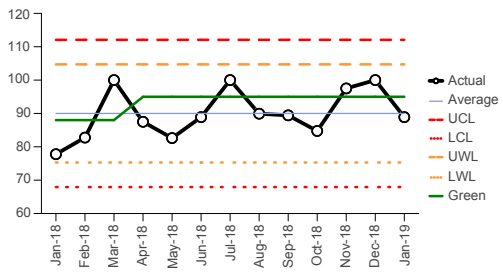
BRILLIANT BASICS

	Description	Performance	Threshold	Trend	Management Action (SMART)
Friends & Family	**Friends & Family A&E - % Recommend the Trust** Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on exceeding the National average in Nov 17. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	90.52 %	R <90 % A >=90 % G >=95 %		The % continues to increase, work is continuing around communication on waiting time using the wobble board, also having volunteers within the department and a patient experience staff member. The introduction of the kiosk stand enabling collection of feedback will be installed in April as will the option to use text messaging to gain vital feedback from our families.
Friends & Family	**Friends & Family Community - % Recommend the Trust** Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	98.53 %	R <90 % A >=90 % G >=95 %		No Action Required
Friends & Family	**Friends & Family Inpatients - % Recommend the Trust** Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	97.01 %	R <90 % A >=90 % G >=95 %		No Action Required

The Best People doing their best Work

8.2 - QUALITY - CARING

Alder Hey Children's NHS Foundation Trust

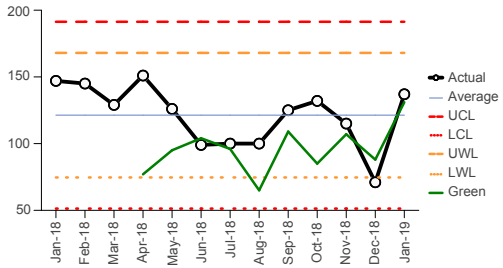
	Description	Performance	Threshold	Trend	Management Action (SMART)
Complaints	**Complaints** Total complaints received. The threshold is based on achieving a 25% reduction on the period Apr 17 - Mar 18 (90). 18/19 aim is to reduce by 25% or more for the same month last year. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	6	R >12 A <=12 G <=9		No Action Required
Friends & Family	**Friends & Family Outpatients - % Recommend the Trust** Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	87.37 %	R <90 % A >=90 % G >=95 %		The Best in Outpatient Care Project (2018-2019) have been working hard to improve experience in Outpatients, for the children and families who visit the department. Areas of focus were defined by using the Family and Friends Test data as a baseline for how are families are feeling and understanding what improvements they want to see Improved. The areas of focus are Play and Distraction in the waiting areas which we have seen an improvement on, Improved Play and Distraction for Phlebotomy, Improved patients flow, improved booking process, improved communication and access to check in machines
Friends & Family	**Friends & Family Mental Health - % Recommend the Trust** Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	88.89 %	R <90 % A >=90 % G >=95 %		This is a significant fall in positive responses. This will be discussed at the next Divisional Integrated Governance meeting and further information will follow. There has been a decrease in the number of feedback collected. This issue will be resolved once the new meridian solution is in place at the beginning of April. This will enable the Trust to identify we are engaging with patients and other stakeholders, identify the drivers of satisfaction, Assess the quality of care provided.

The Best People doing their best Work

8.3 - QUALITY - CARING

Alder Hey Children's NHS Foundation Trust

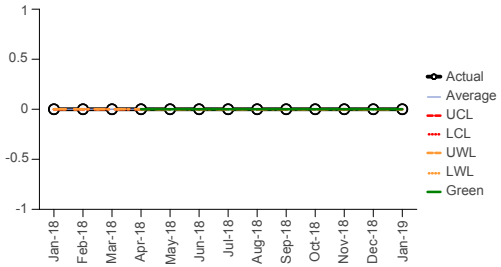
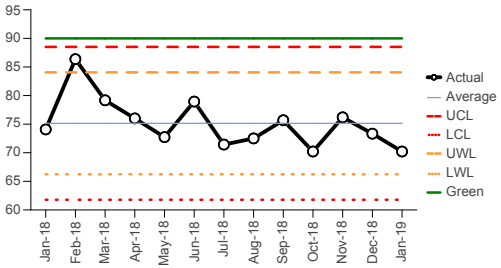
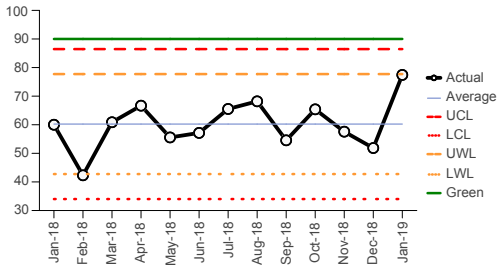
BRILLIANT BASICS

	Description	Performance	Threshold	Trend	Management Action (SMART)
PALS	**PALS** Total number of PALS contacts. Threshold is based on a 10% Reduction on 17/18 (1336). 18/19 aim is to reduce by 10% or more for the same month last year. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	137	R >145 A <=145 G <=131		As the formal complaints this month have markedly reduced we can see the very sharp increase in informal concerns. This is the highest in month total since April 18. Medicine have received the most concerns, with Gastroenterology and General Paeds receiving the most. There have been a number of concerns raised about car parking - by parents of complex needs children - in relation specifically to disabled parking access

Delivery of Outstanding Care

9.1 - QUALITY - EFFECTIVE

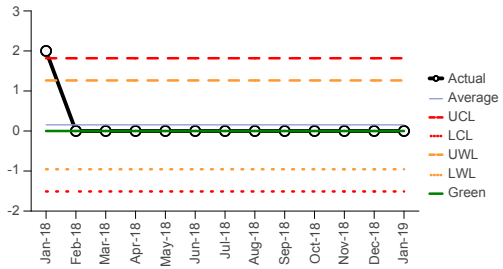
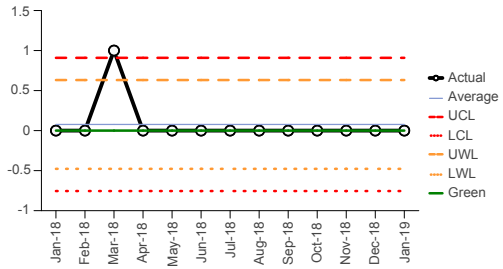
Alder Hey Children's NHS Foundation Trust

	Description	Performance	Threshold	Trend	Management Action (SMART)
Mortality	**No of children that have suffered avoidable death - Internal** Total number of children that have suffered avoidable death with issues relating to care provided in Alderhey. Figures provided by HMRG group. The threshold for 18/19 is zero. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	0	R >0 A N/A G 0		No Action Required
Sepsis	**Sepsis: Patients treated for Sepsis - Inpatients** Percentage of Sepis Patients receiving antibiotic within 60 mins for Inpatients. 18/19 aim is 90%. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	70.21 %	R <90 % A N/A G >=90 %		Number of patients identified approx the same as December but an increase in what look to be delays. Documenation times difficult to ascertain in a number of cases therefore some times have been taken from other sources prior to clinician review. Also a number of clinical deteriorations who have required varying degrees of resuscitation as well as IVAB. As nurses and clinicians we need to ensure documentation supports the timeline of events to be sure of the quality of the data. New ward based metrics have commenced to feedback cases.
Sepsis	**Sepsis: Patients treated for Sepsis - A&E** Percentage of Sepis Patients receiving antibiotic within 60 mins for ED. 18/19 aim is 90%. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	77.42 %	R <90 % A N/A G >=90 %		Number of patients approximately the same as December but much higher number receiving IVAB between 30-59 minutes. This has therefore greatly increased the overall %. Regular feedback given to staff by ED Sepsis Nurse and constant awareness of the potential of sepsis. Number of patients also high acuity/clinically concerns raised early with escalation of treatment. Still a degree of variability in documentation regarding times. Using this months figures to provide feedback to the ED department in showing an improvement and use this as a way to encourage the use of the pathway.

Delivery of Outstanding Care

9.2 - QUALITY - EFFECTIVE

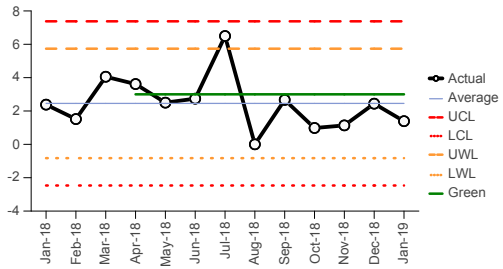
Alder Hey Children's NHS Foundation Trust

	Description	Performance	Threshold	Trend	Management Action (SMART)
Reducing Infections	**Hospital Acquired Organisms - MRSA (BSI)** The threshold is based on this event never occuring. 18/19 Aim is zero annually. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	0	R >0 A N/A G 0		No Action Required
Reducing Infections	**Hospital Acquired Organisms - C.difficile** The threshold is based on this event never occuring. 18/19 Aim is zero annually. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	0	R >0 A N/A G 0		No Action Required

Delivery of Outstanding Care

9.2 - QUALITY - EFFECTIVE

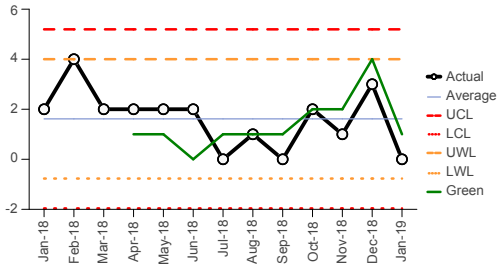
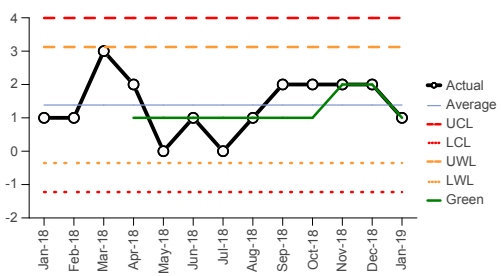
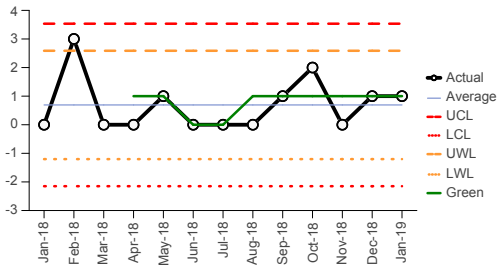
Alder Hey Children's NHS Foundation Trust

	Description	Performance	Threshold	Trend	Management Action (SMART)
PICU Re-admissions	**% Readmissions to PICU within 48 hrs** % of discharges readmitted to PICU within 48hrs sourced from PICANet [Paediatric Intensive Care Audit Network]. Threshold agreed with PICU is based on the reported range nationally from all UK PICUs, most recent published range (16/17) was 0-3% averaged over a calendar year. Data is presented as monthly incidence for the purpose of this report. Annual average for this site was 2.4% **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	1.39 %	R >3 % A N/A G <=3 %		No Action Required

Delivery of Outstanding Care

9.3 - QUALITY - EFFECTIVE

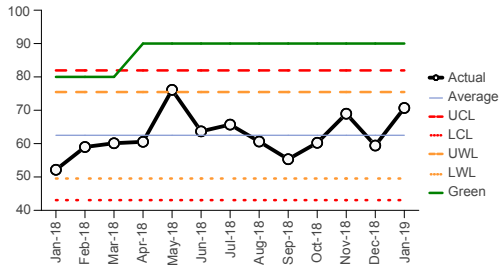
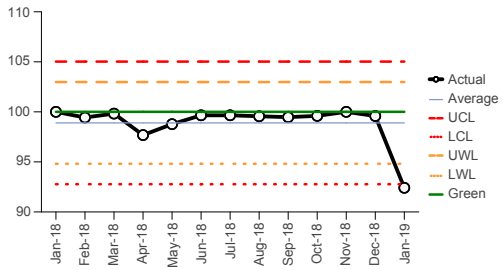
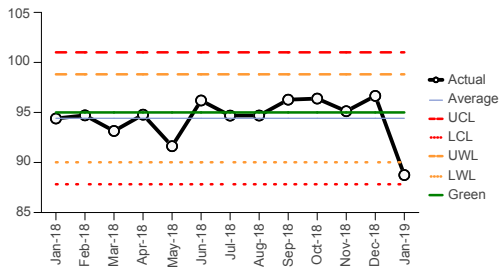
Alder Hey Children's NHS Foundation Trust

	Description	Performance	Threshold	Trend	Management Action (SMART)
Reducing Infections	**Hospital Acquired Organisms - CLABSI - ICU Only** Hospital Acquired Organisms - CLABSI on ICU Ward Only. 18/19 aim is to reduce by 10% or more. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	0	R >1 A N/A G <=1		No Action Required
Reducing Infections	**Hospital Acquired Organisms - Gram Negative BSI** Gram - Negative BSI to include E Coli, Klebsiella and Pseudomonas . 18/19 aim is to reduce by 10% or more. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	1	R >1 A N/A G <=1		No Action Required
Reducing Infections	**Hospital Acquired Organisms - MSSA** Hospital Acquired Organisms - MSSA . 18/19 aim is to reduce by 25% or more. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	1	R >1 A N/A G <=1		No Action Required

Delivery of Outstanding Care

10.1 - QUALITY - RESPONSIVE

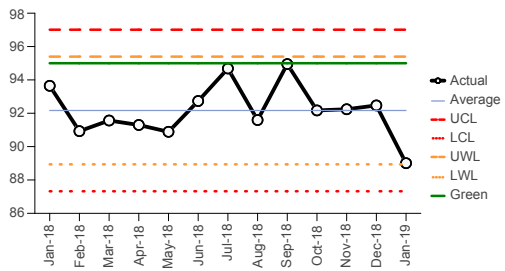
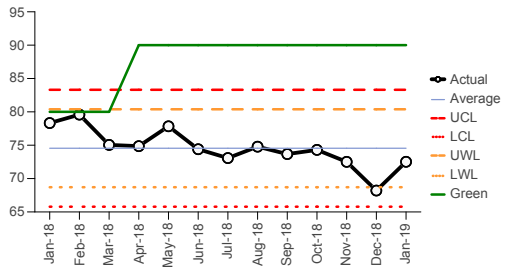
Alder Hey Children's NHS Foundation Trust

	Description	Performance	Threshold	Trend	Management Action (SMART)
Inpatient Survey: Date of Discharge	**IP Survey: % Know their planned date of discharge** Percentage of children / families that report knowing their planned date of discharge. Thresholds are based on previously defined local targets. The 18/19 aim is 90% or above. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	70.68 %	R <85 % A >=85 % G >=90 %		The SAFER programmes have implemented 'My Pads' on each ward. This is a daily plan for each patient 'I am to go home on _____ at _____' and also 'Before I go home I will need to _____'. This is filled out daily by the nurse looking after the patient this will be implemented on all wards by Sep 2019. This is showing a great improvement.
Inpatient Survey: Respect	**IP Survey: % Treated with respect** Percentage of children / families that report being treated with respect. Thresholds are based on previously defined local targets. The 18/19 is 100%. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	92.41 %	R <95 % A >=95 % G 100 %		This is a massive decrease this will be discussed at the next Divisional Integrated Governance meetings and areas to be identified by drilling into ward specific feedback further information will follow.
Inpatient Survey: Choices	**IP Survey: % Received information enabling choices about their care** Percentage of patients / families that report receiving information to enable them to make choices. Thresholds are based on previously defined local targets. The 18/19 aim is 95% or above. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	88.74 %	R <90 % A >=90 % G >=95 %		This is a huge drop from 96.65% this will be discussed at the next Divisional Integrated Governance meetings and areas to be identified by drilling into ward specific feedback further information will follow

Delivery of Outstanding Care

10.2 - QUALITY - RESPONSIVE

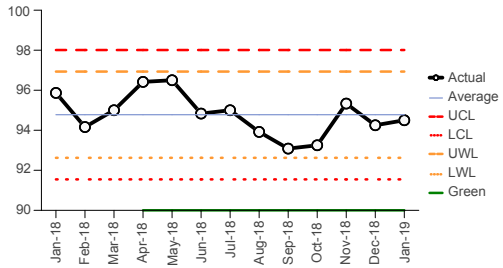
Alder Hey Children's NHS Foundation Trust

	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/Adrian Hughes/Christian Duncan **Committee:** CQAC	89.01 %	R <90 % A >=90 % G >=95 %		This is a disappointing drop in %. Ward staff continue to introduce themselves further detail will be reported as to what wards are not giving this information this will be reported in March.
Inpatient Survey: Play and Learning	**IP Survey: % Patients involved in play and learning** % of children / families that report engaging in play / learning. Thresholds are based on previously defined local targets. The 18/19 aim is 90% or above. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	72.51 %	R <85 % A >=85 % G >=90 %		This is reassuring that there is improvement with play. An action plan has been created to identify areas of concern. The involvement of play staff, volunteers, and junior doctors plus the Trust school are working together for continuous improvemet.. A calendar of activities/entertainment and involvement will be distributed weekly across the inpatient and outpatient departments.

The Best People doing their best Work

11.1 - QUALITY - WELL LED

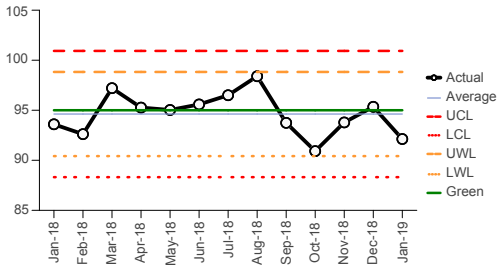
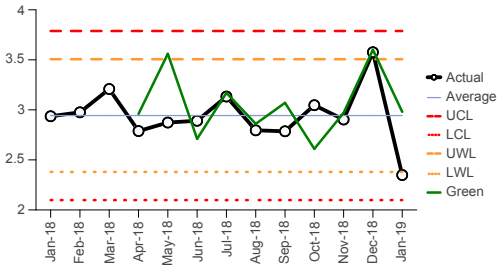
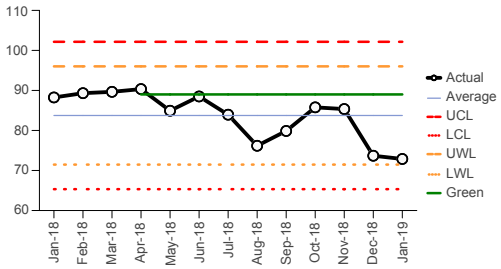
Alder Hey Children's NHS Foundation Trust

	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	94.50 %	R <90 % A N/A G >=90 %		No Action Required

Delivery of Outstanding Care

12.1 - PERFORMANCE - EFFECTIVE

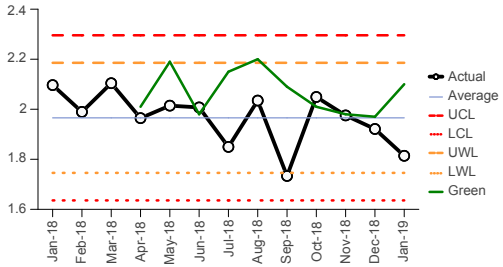
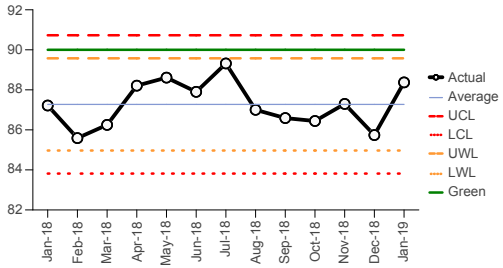
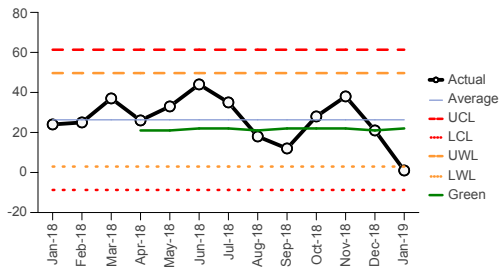
Alder Hey Children's NHS Foundation Trust

	Description	Performance	Threshold	Trend	Management Action (SMART)
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	92.12 %	R <95 % A N/A G >=95 %		Jan attendances were above plan and > the same period last year. Attendance profiles also showed some unusual trends with increased attendances earlier in the day and increased volume of minor stream patients. There were 7 days with attendances >190 compared to same period last year, and admissions breached predictor on 6 days in month. Flu increased week on week. There were staffing pressures across all staff groups due to short term sickness. Core staffing maintained but unable to deliver additional winter plan actions at some times during the month. GP provision reduced in Jan with an ave
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	2.35	R >3.0 A N/A G <=3.0		No Action Required
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 occupnacy readings measured throughout the day. Threshold is based on National NHS Guidance on safe staffing and occupancy levels. **Exec Lead:** Adam Bateman **Committee:** RABD	72.87 %	R >93 % A <=93 % G <=89 %		No Action Required

Delivery of Outstanding Care

12.2 - PERFORMANCE - EFFECTIVE

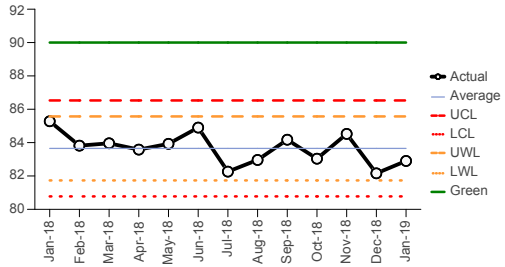
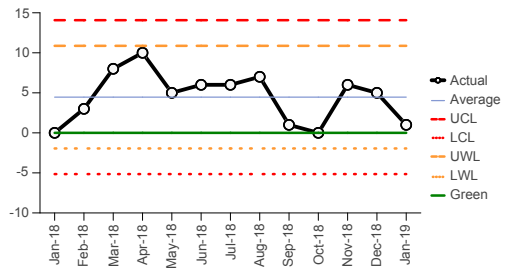
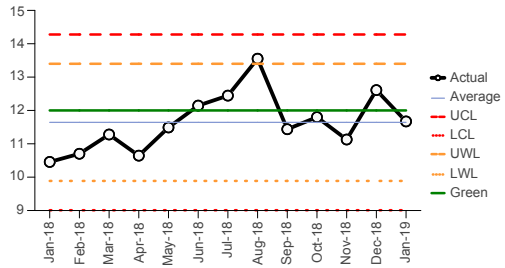
Alder Hey Children's NHS
NHS Foundation Trust

	Description	Performance	Threshold	Trend	Management Action (SMART)
LoS: Non-Elective	**Average LoS - Non-Elective (Days)** Average Non Elective Length of Stay (days). 18/19 aim is to not increase Length of Stay for the same month last year. **Exec Lead:** Adam Bateman **Committee:** RABD	1.81	R >2.1 A N/A G <=2.1		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	88.37 %	R <80 % A >=80 % G >=90 %		3% improvement in month - highest utilisation since July 2018. Only two specialties with utilisation <80% which are both specialties who list patients on a semi-urgent basis (oncology and rheumatology). List utilisation continues to be prospectively reviewed every week by the theatre scheduling team.
Cancelled Operations	**On the day Elective Cancelled Operations for Non Clinical Reasons** Performance is measured for on the day cancelled elective operations for non clinical reasons. This based on National Guidance. Threshold aims to reduce cancellations by 25% based on 17/18 overall performance. **Exec Lead:** Adam Bateman **Committee:** RABD	1	R >22 A N/A G <=22		No Action Required

Delivery of Outstanding Care

12.3 - PERFORMANCE - EFFECTIVE

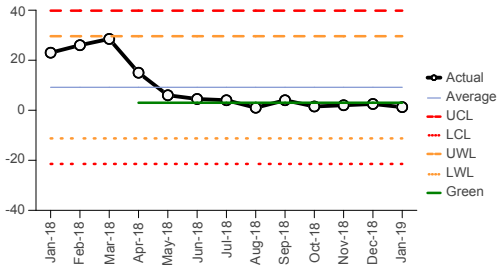
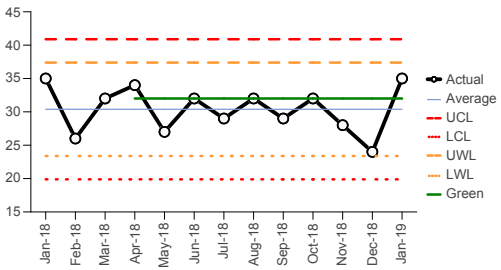
Alder Hey Children's NHS Foundation Trust

	Description	Performance	Threshold	Trend	Management Action (SMART)
Clinic Utilisation	**Clinic Session Utilisation** Threshold is based on a resonable expectation utilising clinics at 90% or greater to take into account short notice cancellations and DNAs. **Exec Lead:** Adam Bateman **Committee:** RABD	82.90 %	R <85 % A >=85 % G >=90 %		Clinic utilisation has improved. Brilliant Booking backfilling has continued across all specialties currently covered. Challenge with filling short notice cancellations (<3days) and notice which is being reviewed within work stream. Utilisation however is understated due to DNA/DQ issues so utilisation will improve. Divisions have shared bespoke ides/actions to improve this metric separately and are currently being developed.
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	1	R >0 A N/A G 0		One urology patient cancelled and unable to be relisted within 28 days as other patients took clinical priority. There have been a reduced number of the on the day cancellations in January which reduce the likelihood of 28 day breaches in February. Potential breaches are reviewed weekly by the division.
DNAs	**Did Not Attend Rate** The target of 12% is a local target aligned to outpatient improvement workstreams (Hybrid Booking, Patient Demogrpahic Checking and bidirectional automate text reminders). **Exec Lead:** Adam Bateman **Committee:** RABD	11.67 %	R >14 % A <=14 % G <=12 %		DNA's have reduced and are just below the threshold. DNA management is currently being reviewed by MIAA; outcome from the audit will be available within the next 4 weeks. A small number of specialties have deteriorated in January with underlying DQ issues negatively impacting upon performance. Validation is currently underway which will improve our DNA performance when complete. Brilliant Booking continues to validate and cleanse the long waiting patients in the approach to delivering Hybrid Booking which is also contributing to DNA volumes.

Delivery of Outstanding Care

12.4 - PERFORMANCE - EFFECTIVE

Alder Hey Children's NHS Foundation Trust

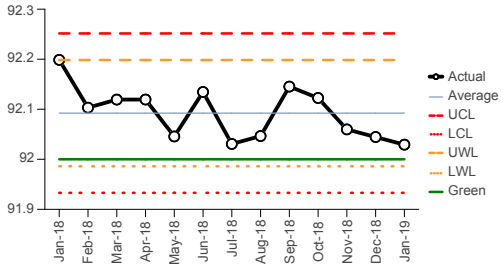
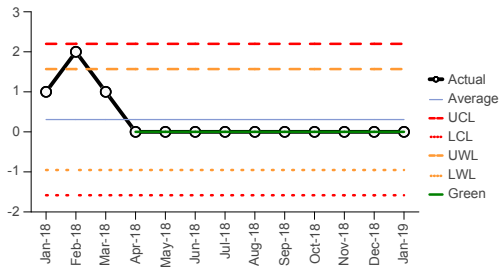
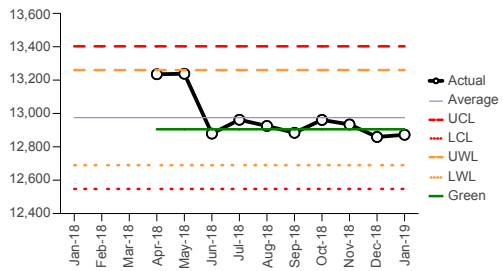
	Description	Performance	Threshold	Trend	Management Action (SMART)
Transcriptions	**Transcription Turnaround (days)** Days from dictation to typing clinic letters for services transcribed by Transcription service. Based on working day average. This is also monitored externally by our local commissioners. **Exec Lead:** Adam Bateman **Committee:** RABD	1.25	R >5 A <=5 G <=3		No Action Required
Stranded Patients	**Number of Super Stranded Patients (21+ Days)** National measure as part of the 18/19 NHSI plan. The target is to reduce the number of stranded patients 21 or more days from March 2018. This excludes patients on ICU/HDU/NEO and Cardiac HDU. **Exec Lead:** Adam Bateman **Committee:** RABD	35	R >32 A N/A G <=32		The recommendations from the earlier approved Business Case are now being embedded.A new Head of Complex Care has now been in post for 2 weeks and a full review of the Complex Discharge process in line with the SAFER principals is currently being undertaken. From the current cohort with LOS is 21+ days, 8 are medically fit for discharge. 5 of those have discharge dates within Feb 2018. All have plans in place but delays are attributable to Housing issues, carers being employed for packages of care (outside agencies) and in one instance training issues with a local DGH (repatriation delay).

Delivery of Outstanding Care

13.1 - PERFORMANCE - RESPONSIVE

BRILLIANT BASICS

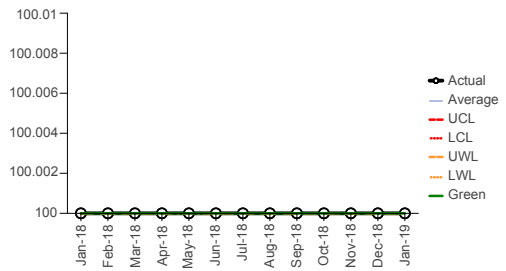
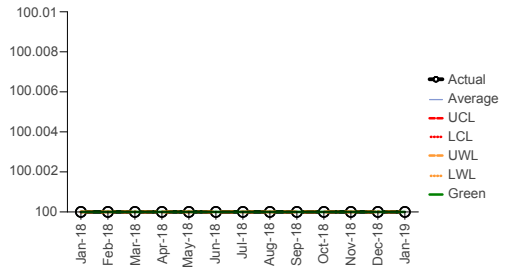
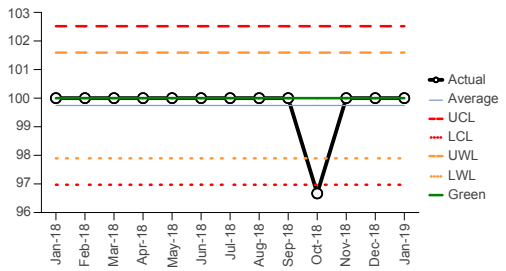
Alder Hey Children's NHS
NHS Foundation Trust

	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	92.03 %	R <90 % A >=90 % G >=92 %		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 >0 A N/A G 0		No Action Required
Waiting Times	**Waiting List Size** National threshold as part of the 18/19 NHSI plan. The target is to reduced the total waitlist size from March 2018. **Exec Lead:** Adam Bateman **Committee:** RABD	12872	R >12905 A N/A G <=12905		No Action Required

Delivery of Outstanding Care

13.2 - PERFORMANCE - RESPONSIVE

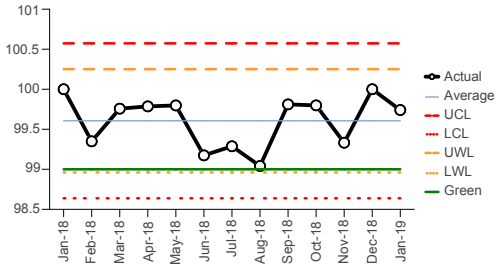
Alder Hey Children's NHS Foundation Trust

	Description	Performance	Threshold	Trend	Management Action (SMART)
Cancer RTT	**All Cancers: 31 day wait until subsequent treatments** Threshold is set at 100% which a stretch target set higher than national performance. **Exec Lead:** Adam Bateman **Committee:** RABD	100 %	R <100 % A N/A G 100 %		No Action Required
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	**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 <100 % A N/A G 100 %		No Action Required

Delivery of Outstanding Care

13.3 - PERFORMANCE - RESPONSIVE

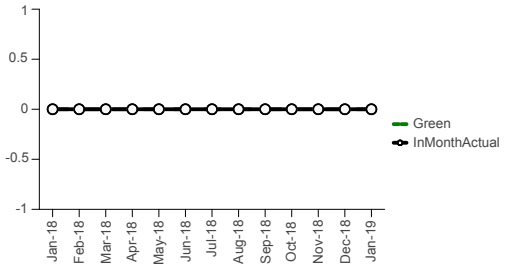
Alder Hey Children's NHS
NHS Foundation Trust

	Description	Performance	Threshold	Trend	Management Action (SMART)
Diagnostics	**Diagnostics: % Completed Within 6 Weeks** Threshold is based on National Guidance set by NHS England at 99%. **Exec Lead:** Adam Bateman **Committee:** RABD	99.74 %	R <99 % A N/A G >=99 %		No Action Required

The Best People doing their best Work

14.1 - PERFORMANCE - WELL LED

Alder Hey Children's NHS Foundation Trust

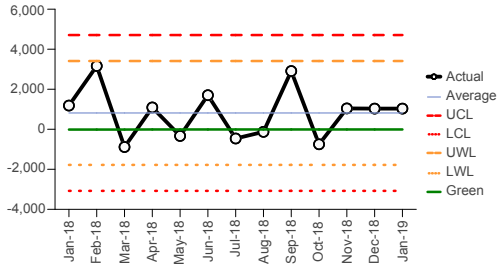
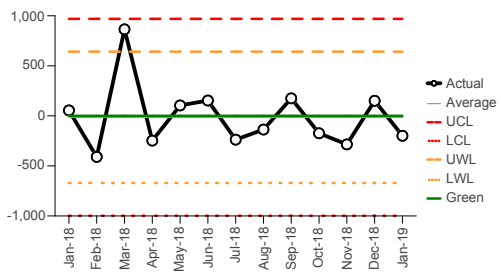
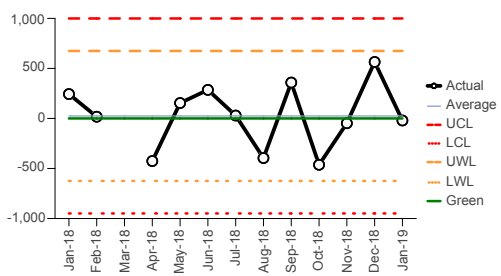
	Description	Performance	Threshold	Trend	Management Action (SMART)
Governance	**Performance Against Single Oversight Framework Themes** Five themes against which trusts' performance is assessed and the indicators that trigger consideration of a potential support need: Quality, Finance and UOR, Operational performance, strategic change and Leadership and improvement capability (well led). **Exec Lead:** Erica Saunders **Committee:** CQAC	0	R >1 A <=1 G 0		No Action Required

The Best People doing their best Work

15.1 - FINANCE - WELL LED

BRILLIANT BASICS

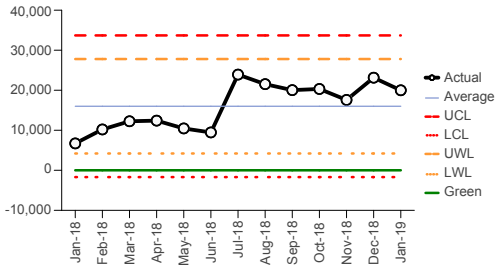
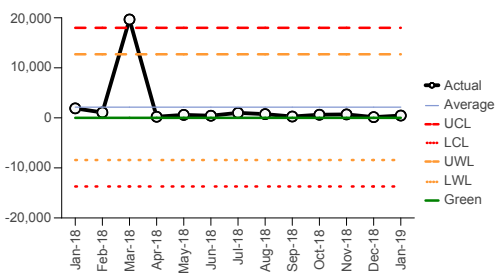
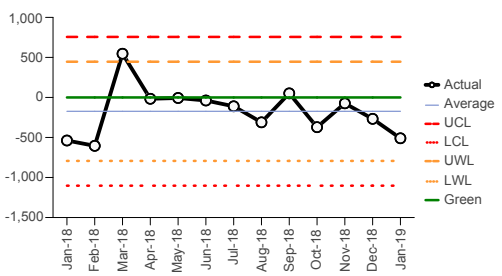
Alder Hey Children's NHS
NHS Foundation Trust

	Description	Performance	Threshold	Trend	Management Action (SMART)
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	1,032	R <-10% A >=-10% G >=-5%		No Action Required
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	-199	R <-20% A >=-20% G >=0%		In January the CIP achieved was behind plan by £0.2m. This took the year to date CIP performance to £0.5m behind plan. The Trust is forecasting to achieve a CIP of £5.9m by the end of the financial year compared to a plan of £6.9m
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	-21	R <-20% A >=-20% G >=0%		The Trust achieved a £5m surplus in January which was in line with the plan. For the year to date the Trust is £0.1m ahead of its Control Total plan.

The Best People doing their best Work

15.2 - FINANCE - WELL LED

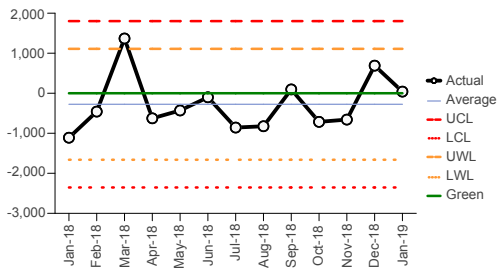
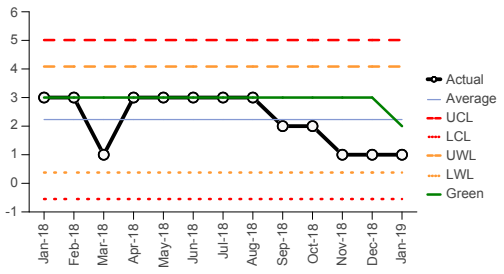
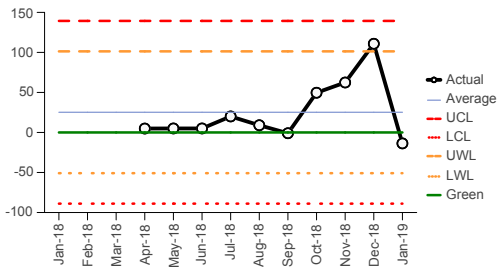
Alder Hey Children's NHS Foundation Trust

	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	19,983	R <-20% A >=-20% G >=0%		At the end of January, cash balance was £20m which is lower than plan of £28.2m. The plan included payment of PSF incentive cash quarterly in arrears but this will not be paid until the new financial year. Also the lease premium from a University remains unpaid.
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	456	R <-20% A >=-20% G >=0%		No Action Required
Finance	**Pay In Month Variance (£'000s)** Variance from pay plan. Variation between months is usual and the threshold of + or - 20% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	-510	R <-20% A >=-20% G >=-1%		In January expenditure on staff costs was £0.5m higher than plan due to costs of temporary staffing.

The Best People doing their best Work

15.3 - FINANCE - WELL LED

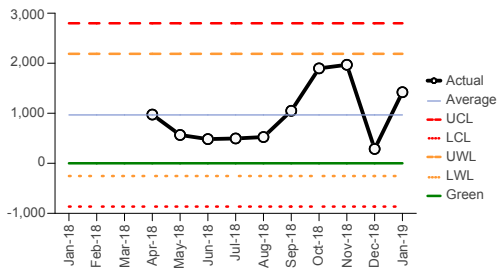
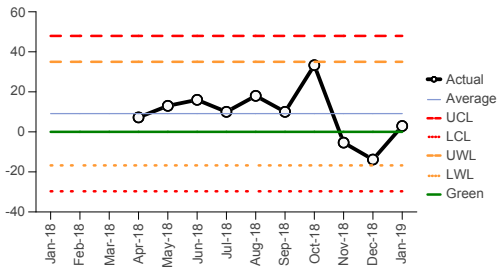
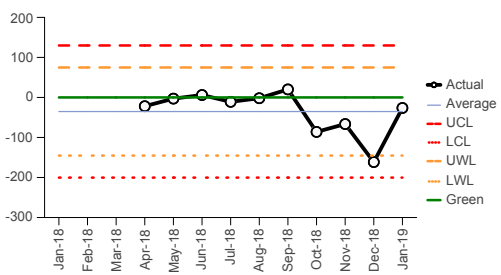
Alder Hey Children's NHS Foundation Trust

	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	41	R <-20% A >=-20% G >=0%		No Action Required
Finance	**NHSI Use of Resources** NHSI Use of Resources Metric indicates financial sustainability of the Trust. This varies from 1 to 4 with 1 being the highest score possible and 4 being the lowest **Exec Lead:** John Grinnell **Committee:** RABD	1	R >2 A N/A G <=2		No Action Required
Finance	**AvP: IP - Non-Elective** Actvity vs Forecast for Inpatient Non-Elective Activity. The threshold is based on achieving forecast or higher. **Exec Lead:** John Grinnell **Committee:** RABD	-13.69	R <0 A N/A G >=0		The most significant adverse activity variance was in respiratory medicine (down 148 spells)

The Best People doing their best Work

15.4 - FINANCE - WELL LED

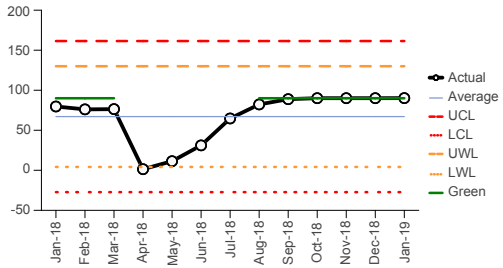
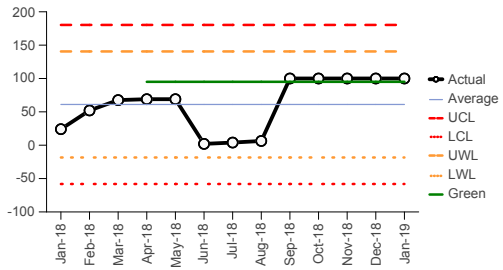
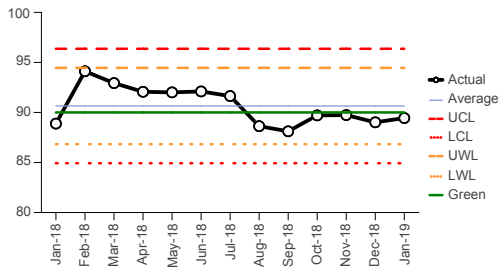
Alder Hey Children's NHS Foundation Trust

	Description	Performance	Threshold	Trend	Management Action (SMART)
Finance	**AvP: Outpatient Activity vs Forecast** Actvity vs Forecast for Outpatient activity. The threshold is based on achieving forecast or higher. **Exec Lead:** John Grinnell **Committee:** RABD	1420.69	R <0 A N/A G >=0		No Action Required
Finance	**AvP: IP Elective vs Forecast** Actvity vs Forecast for Inpatient Elective activity. The threshold is based on achieving forecast or higher. **Exec Lead:** John Grinnell **Committee:** RABD	2.92	R <0 A N/A G >=0		No Action Required
Finance	**AvP: Daycase Activity vs Forecast** Actvity vs Forecast for Daycase activity. The threshold is based on achieving forecast or higher. **Exec Lead:** John Grinnell **Committee:** RABD	-26.37	R <0 A N/A G >=0		The most significant in-month activity variance was in dentistry (down 69 spells)

The Best People doing their best Work

16.1 - HR - WELL LED

Alder Hey Children's NHS Foundation Trust

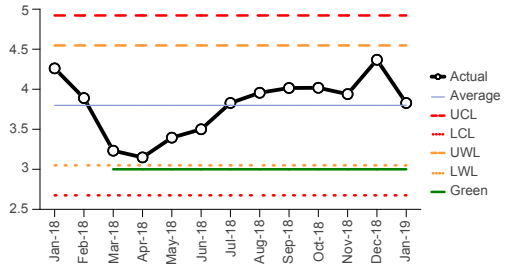
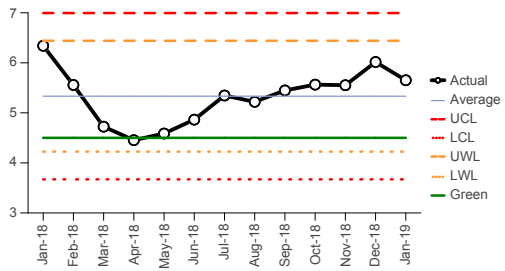
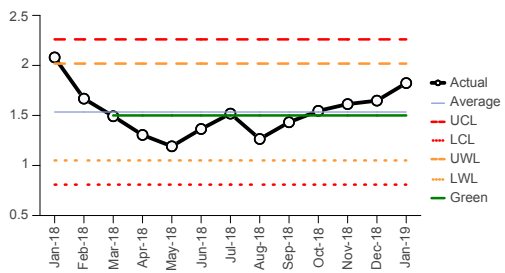
	Description	Performance	Threshold	Trend	Management Action (SMART)
Personal Development	**PDR** Trust target, measuring compliance of staff Personal Development Reviews (Non medical). The Trust compliance period is set to be achieved in the first 4 months of each year (April -July). **Exec Lead:** Melissa Swindell **Committee:** WOD	90.15 %	R <85 % A >=85 % G >=90 %		No Action Required
Appraisal	**Medical Appraisal** Trust Target for compliance for medical staff, which is on a rolling 12mth period. **Exec Lead:** Melissa Swindell **Committee:** WOD	100 %	R <90 % A >=90 % G >=95 %		No Action Required
Training	**Mandatory Training** This is a Trust target that measures the 6 core mandatory training modules that are required of all staff (Safeguarding L1, Moving and Handling, Information Governance, Equality and Diversity, Fire Safety and Health and Safety) **Exec Lead:** Melissa Swindell **Committee:** WOD	89.44 %	R <80 % A >=80 % G >=90 %		The biggest challenge continues to be with Information Governance as a topic, although we have also seen a drop in Safeguarding Level 3 compliance. The Information Governance lead is continuing to offer additional face to face sessions and provide regular reminders to staff and managers to complete their training. Learning and Development are continuing to support this with regular reports to divisional and departmental managers as well as direct emails to staff who are outstanding any mandatory training, highlighting what is outstanding and how to complete.

The Best People doing their best Work

16.2 - HR - WELL LED

Alder Hey Children's NHS Foundation Trust

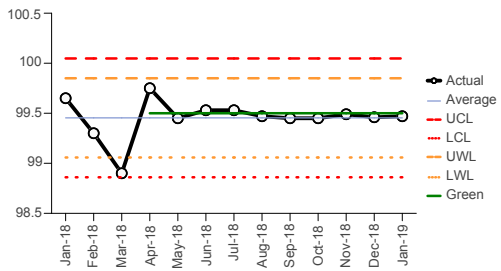
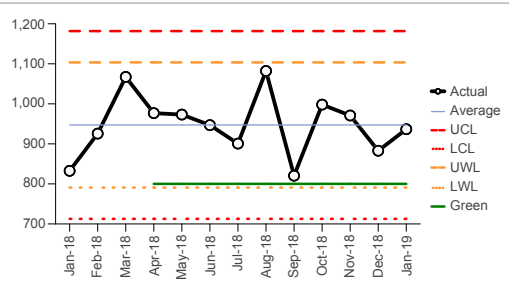
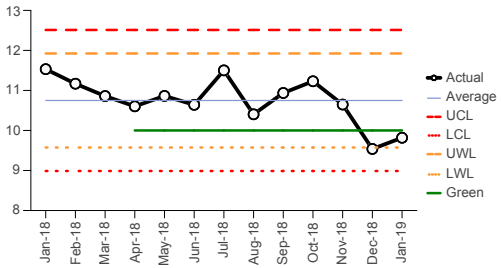
BRILLIANT BASICS

	Description	Performance	Threshold	Trend	Management Action (SMART)
Sickness	**Long Term Sickness** % of Trust staff who have been absent from work due to sickness lasting 28 days or more **Exec Lead:** Melissa Swindell **Committee:** WOD	3.83 %	R >3 % A N/A G <=3 %		See comment for sickness
Sickness	**Sickness** % of staff who have been absent from work due to sickness, this is broken down into LTS & STS in further metrics **Exec Lead:** Melissa Swindell **Committee:** WOD	5.65 %	R >5 % A <=5 % G <=4.5 %		Overall, sickness has reduced from December but there has been a slight increase in short term sicknesses. This can be attributed to the Winter season and is reflected in the increase in Cough, Cold & Flu absences. bsences relating to Anxiety, Stress & Depression account for 36% of all absences in January, this is followed by Cough, Cold, Flu (9.7%) and Gatrointestinal problems (7.3%). Action plans are in place for areas with significant absence. In addition a full review of all absences has been undertaken with individual action plans in place.
Sickness	**Short Term Sickness** % of Trust staff who have been absent from work due to sickness lasting less than 28 days **Exec Lead:** Melissa Swindell **Committee:** WOD	1.82 %	R >1.5 % A N/A G <=1.5 %		See comment for sickness

The Best People doing their best Work

16.3 - HR - WELL LED

Alder Hey Children's NHS Foundation Trust

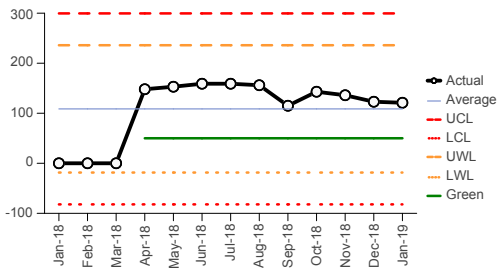
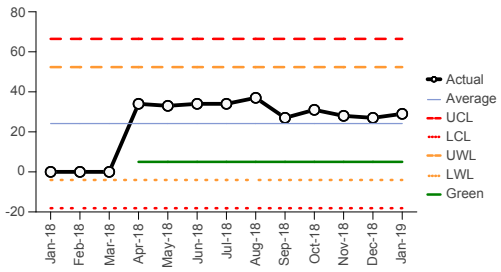
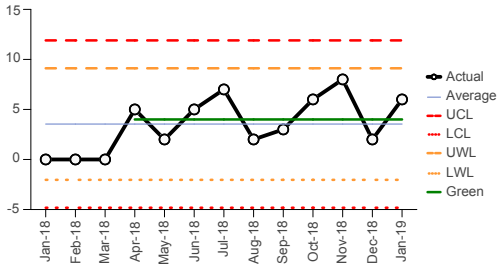
	Description	Performance	Threshold	Trend	Management Action (SMART)
Payroll	**% of Correct Pay Achieved** An agreed service Level target with the Trust payroll provider. **Exec Lead:** Melissa Swindell **Committee:** WOD	99.47 %	R <99 % A >=99 % G >=99.5 %		Pay accuracy is sitting just below our threshoild of 99.5%, Bi-monthly meetings have been arranged for the new financial year between HR, Finance and ELFS so any issues can be discussed.
Temporary Spend	**Temporary Spend ('000s)** Indicates the expenditure on premium temporary pay spend and monitors the reduction. **Exec Lead:** Melissa Swindell **Committee:** WOD	936.60	R >960 A <=960 G <=800		Business Partners together with Finance Accountants and Ass COOs regularly review status in Divisions and advise on actions as appropriate. Monthly temporary staffing reviews also take place with the Director & Deputy Directors of HR & Finance
Staff Turnover	**Staff Turnover** Trust Target which is based on a rolling 12mth period **Exec Lead:** Melissa Swindell **Committee:** WOD	9.82 %	R >11 % A <=11 % G <=10 %		No Action Required

Game Changing Research & Innovation

17.1 - RESEARCH & DEVELOPMENT - WELL LED

Alder Hey Children's NHS Foundation Trust

GROW THE FUTURE

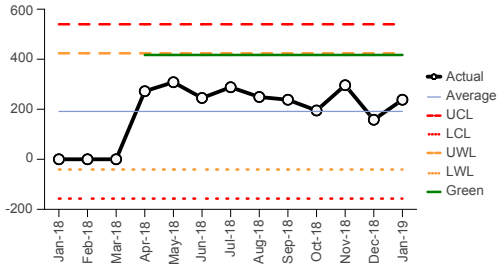
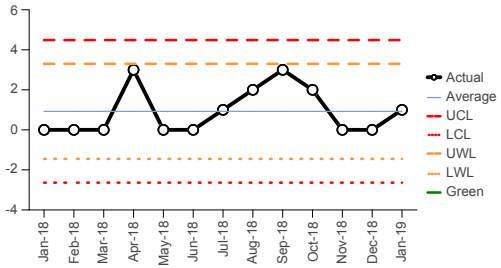
	Description	Performance	Threshold	Trend	Management Action (SMART)
Clinical Research	**Number of Open Studies - Academic** Number of academic studies currently open. **Exec Lead:** Matthew Peak **Committee:** REIC	121	R <50 A N/A G >=50		No Action Required
Clinical Research	**Number of Open Studies - Commercial** Number of commercial studies currently open. **Exec Lead:** Matthew Peak **Committee:** REIC	29	R <5 A N/A G >=5		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	6	R <4 A N/A G >=4		No Action Required

Game Changing Research & Innovation

17.2 - RESEARCH & DEVELOPMENT - WELL LED

GROW THE FUTURE

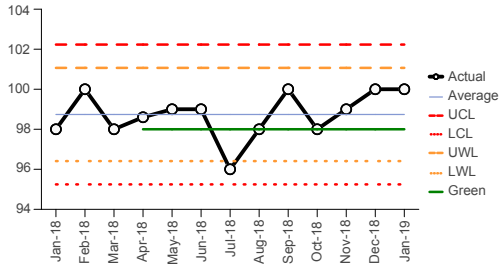
Alder Hey Children's NHS
NHS Foundation Trust

	Description	Performance	Threshold	Trend	Management Action (SMART)
Clinical Research	**Number of patients recruited** Number of patients recruited in month. **Exec Lead:** Matthew Peak **Committee:** REIC	238	R <417 A N/A G >=417		Patient recruitment is low this year and a large study is yet to open (DETECT). Without a large, high recruiting study open that target will not be met. A full portfolio review has taken place and red-amber rated studies looked at. Some potential solutions have been identified and some studies are to close. The performance will be shared with research nurses in a team meeting for them to pick up on amber or red rated studies and pro-actively try to improve the recruitment rate. The portfolio will be looked at on a monthly basis.
Clinical Research	**Number of New Studies Opened - Commercial** Number of new commercial studies opened in month. **Exec Lead:** Matthew Peak **Committee:** REIC	1	No Threshold		

Delivery of Outstanding Care

18.1 - FACILITIES - RESPONSIVE

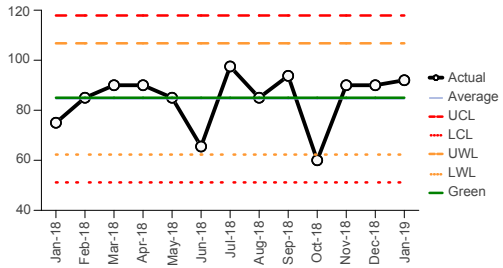
Alder Hey Children's NHS Foundation Trust

	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	100 %	R <98 % A N/A G >=98 %		No Action Required

The Best People doing their best Work

19.1 - FACILITIES - WELL LED

Alder Hey Children's NHS Foundation Trust

	Description	Performance	Threshold	Trend	Management Action (SMART)
Facilities	**Domestic Cleaning Audit Compliance** Auditing for Domestic Services, esnure is to National Cleaning Standards. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** RABD	92 %	R <85 % A N/A G >=85 %		No Action Required

All Divisions

SAFE

	COMMUNITY	MEDICINE	SURGERY	RAG
Total no of incidents reported Near Miss & Above	38	131	216	No Threshold
Clinical Incidents resulting in minor harm & above	1	27	42	No Threshold
Clinical Incidents resulting in moderate, semi permanent harm	0	0	2	No Threshold
Clinical Incidents resulting in severe, permanent harm	0	0	0	0 N/A >0
Clinical Incidents resulting in catastrophic, death	0	1	0	0 N/A >0
Pressure Ulcers (Category 3)	0	0	0	0 N/A >0
Pressure Ulcers (Category 4)	0	0	0	0 N/A >0
Medication errors resulting in harm	0	0	2	No Threshold
Medication errors resulting in moderate, sever harm or death	0	0	1	0 N/A >0
Never Events	0	0	0	0 N/A >0
Acute readmissions of patients with long term conditions within 28 days	0	1	0	No Threshold

CARING

	COMMUNITY	MEDICINE	SURGERY	RAG
Complaints	1	3	1	No Threshold
PALS	35	41	27	No Threshold

EFFECTIVE

	COMMUNITY	MEDICINE	SURGERY	RAG
Readmissions to PICU within 48 hrs	0	0	0	No Threshold
% of acute readmissions within 48 hrs of discharge (exc Oncology)	0.0%	1.3%	1.2%	<=1.3 % N/A >1.3 %
Readmissions within 48 hrs	0	29	18	No Threshold
Outbreak Acquired Organisms - Other	0	0	0	0 N/A >0
Hospital Acquired Organisms - MRSA (BSI)	0	0	0	0 N/A >0
Hospital Acquired Organisms - C.difficile	0	0	0	0 N/A >0
Hospital Acquired Organisms - MSSA	0	0	1	No Threshold

All Divisions

	COMMUNITY	MEDICINE	SURGERY	RAG
Hospital Acquired Organisms - RSV	0	1	1	No Threshold
Hospital Acquired Organisms - CLABSI - ICU Only			0	No Threshold
Outbreak Infections	0	0	0	No Threshold
Referrals Received (Total)	887	1,957	3,592	No Threshold
ED: 95% Treated within 4 Hours		92.1%		>=95 % N/A <95 %
Average LoS - Elective (Days)		2.88	2.10	No Threshold
Average LoS - Non-Elective (Days)		1.39	2.65	No Threshold
Theatre Utilisation - % of Session Utilised		84.5%	89.0%	>=90 % >=85 % <80 %
Cancelled Operations - Non Clinical - On Same Day (%)	0.0%	0.0%	0.1%	<=0.8 % N/A >0.8 %
On the day Elective Cancelled Operations for Non Clinical Reasons	0	0	1	No Threshold
28 Day Breaches	0	0	1	0 N/A >0
Clinic Session Utilisation	79.2%	81.6%	84.3%	>=90 % >=85 % <85 %
OP Appointments Cancelled by Hospital %	18.6%	15.3%	14.3%	<=5 % <=10 % >10 %
Did Not Attend Rate	12.7%	11.7%	11.3%	<=12 % <=14 % >14 %
Incomplete Pathway Forms in Outpatients	987	5,484	9,631	No Threshold
Referral Turnaround (days to log)	5.59	2.91	4.77	No Threshold
Referral Turnaround (Consultant to Action)	11.99	6.96	6.96	No Threshold
Coding average comorbidities	2.00	3.66	3.84	No Threshold
CAMHS: DNA Rate - New	12.7%			<=6 % <=8 % >8 %
CAMHS: DNA Rate - Follow Up	14.8%			<=10 % <=16 % >16 %

RESPONSIVE

	COMMUNITY	MEDICINE	SURGERY	RAG
IP Survey: % Received information enabling choices about their care		93.3%	86.3%	>=95 % >=90 % <90 %
IP Survey: % Treated with respect		100.0%	88.3%	100 % >=95 % <95 %
IP Survey: % Know their planned date of discharge		68.7%	71.8%	>=90 % >=85 % <85 %
IP Survey: % Know who is in charge of their care		98.5%	83.9%	>=95 % >=90 % <90 %

All Divisions

	COMMUNITY	MEDICINE	SURGERY	RAG
IP Survey: % Patients involved in play and learning		73.1%	72.2%	>=90 % >=85 % <85 %
RTT: Open Pathway: % Waiting within 18 Weeks	82.7%	92.9%	93.1%	>=92 % >=90 % <90 %
Waiting List Size	1,263	3,686	7,923	No Threshold
Waiting Greater than 52 weeks	0	0	0	0 N/A >0
Diagnostics: % Completed Within 6 Weeks		99.7%	100.0%	>=99 % N/A <99 %
Number of Stranded Patients (7+ Days)		37	21	No Threshold
Number of Super Stranded Patients (21+ Days)		21	14	No Threshold
CAMHS: 2 Appointments within 6 weeks	0			No Threshold
Urgent EDYS Pathway Average Wait in Weeks	0	0	0	No Threshold
Routine EDYS Pathway Average Wait in Weeks	0	0	0	No Threshold
Routine Eating Disorders (EDYS) Pathway Average Wait in Days	22.00			No Threshold
Urgent Eating Disorders (EDYS) Pathway Average Wait in Days	3.00			No Threshold
CAMHS: Avg Wait from referral to Partnership Appt (Weeks)- Liverpool Specialist	16.00	0.00	0.00	No Threshold
CAMHS: Avg Wait from referral to Partnership Appt (Weeks)- Sefton Specialist	35.00	0.00	0.00	No Threshold

WELL LED

	COMMUNITY	MEDICINE	SURGERY	RAG
Control Total In Month Variance (£'000s)	-23	-444	-228	>=0% >=-20% <-20%
Income In Month Variance (£'000s)	87	50	-49	>=0% >=-20% <-20%
Pay In Month Variance (£'000s)	-144	-219	-26	No Threshold
Non Pay In Month Variance (£'000s)	34	-269	-153	>=0% >=-20% <-20%
AvP: IP - Non-Elective		-9	-5	>=0 N/A <0
AvP: IP Elective vs Forecast	0	-30	33	>=0 N/A <0
AvP: OP New	-83.16	102.38	-114.74	>=0 N/A <0
AvP: OP FollowUp	213.63	300.59	546.98	>=0 N/A <0
AvP: Daycase Activity vs Forecast		17	-48	>=0 N/A <0
AvP: Outpatient Activity vs Forecast	130	403	432	>=0 N/A <0

All Divisions

	COMMUNITY	MEDICINE	SURGERY	RAG
PDR	93.7%	89.2%	90.0%	>=90 % >=80 % <85 %
Mandatory Training	88.3%	91.0%	90.0%	>=90 % >=80 % <80 %
Actual vs Planned Establishment (%)	86.8%	91.3%	97.9%	No Threshold
Sickness	5.3%	5.7%	6.3%	<=4.5 % <=5 % >5 %
Attendance (HR)	94.7%	94.3%	93.7%	>=95.5 % >=90 % <90 %
Short Term Sickness	1.6%	1.9%	2.0%	<=1.5 % N/A >1.5 %
Long Term Sickness	3.7%	3.8%	4.3%	<=3 % N/A >3 %
Temporary Spend ('000s)	151	247	474	No Threshold
Staff Turnover	13.4%	8.6%	10.1%	<=10 % <=11 % >11 %
Safer Staffing (Shift Fill Rate)	97.0%	96.0%	93.3%	>=90 % >=80 % <90 %

Medicine

SAFE

	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Last 12 Months	RAG
Acute readmissions of patients with long term conditions within 28 days	3	3	0	1	1	4	0	3	2	4	6	3	1	No Data Available	No Threshold

CARING

	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Last 12 Months	RAG
Complaints	3	4	3	0	7	4	3	3	5	6	1	4	3		No Threshold
PALS	37	30	39	51	31	27	28	23	21	34	19	21	41		No Threshold

EFFECTIVE

	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Last 12 Months	RAG
Hospital Acquired Organisms - MRSA (BSI)	2	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Hospital Acquired Organisms - C.difficile	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Referrals Received (Total)	1,904	1,855	1,961	1,840	1,947	2,009	1,903	1,567	1,671	2,073	1,970	1,718	1,957	No Data Available	No Threshold
ED: 95% Treated within 4 Hours	93.6%	92.6%	97.2%	95.3%	95.0%	95.6%	96.5%	98.4%	93.7%	90.9%	93.8%	95.3%	92.1%		>=95 % N/A <95 %
Average LoS - Elective (Days)	3.54	3.22	3.17	3.23	2.66	4.01	3.84	2.85	3.18	2.89	3.08	3.54	2.88		No Threshold
Average LoS - Non-Elective (Days)	1.75	1.57	1.50	1.52	1.55	1.59	1.28	1.45	1.35	1.54	1.64	1.45	1.39		No Threshold
Theatre Utilisation - % of Session Utilised	79.9%	80.6%	83.5%	75.4%	75.6%	78.6%	83.0%	77.8%	84.8%	80.4%	80.9%	86.7%	84.5%		>=90 % >=80 % <80 %
Clinic Session Utilisation	85.9%	87.6%	85.6%	84.9%	83.4%	84.8%	81.9%	81.8%	85.2%	83.7%	85.6%	82.1%	81.6%		>=90 % >=80 % <85 %
OP Appointments Cancelled by Hospital %	15.2%	17.6%	17.5%	13.5%	14.1%	12.8%	16.3%	15.6%	13.8%	14.4%	14.2%	15.6%	15.3%	No Data Available	<=5 % <=10 % >10 %
Did Not Attend Rate	9.6%	9.6%	11.1%	10.0%	11.0%	12.6%	12.3%	13.6%	12.3%	12.4%	10.8%	13.2%	11.7%		<=12 % <=14 % >14 %
Coding average comorbidities	3.86	3.49	3.34	3.52	3.35	3.54	3.40	3.52	3.54	3.57	3.57	3.84	3.66	No Data Available	No Threshold

RESPONSIVE

	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Last 12 Months	RAG
RTT: Open Pathway: % Waiting within 18 Weeks	92.9%	93.0%	89.8%	90.0%	90.2%	89.5%	89.7%	90.2%	91.1%	89.9%	91.5%	92.7%	92.9%		>=92 % >=90 % <90 %
Diagnostics: % Completed Within 6 Weeks	100.0%	99.8%	100.0%	99.8%	99.8%	99.1%	99.3%	99.0%	99.8%	99.8%	99.3%	100.0%	99.7%		>=99 % N/A <99 %

WELL LED

	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Last 12 Months	RAG
Control Total In Month Variance (£'000s)	611	461		127	122	408	223	75	178	-115	15	69	-444		>=0% >=-20% <-20%
AvP: IP - Non-Elective				-5	0	2	8	-3	-9	75	69	43	-9		>=0 N/A <0
AvP: IP Elective vs Forecast				-8	1	-2	-8	-5	-2	-19	-22	-29	-30		>=0 N/A <0
AvP: OP New				355.00	-19.08	6.48	-45.36	86.30	122.27	59.41	126.17	90.49	102.38	No Data Available	>=0 N/A <0
AvP: OP FollowUp				67.00	61.48	33.85	-3.40	72.82	99.78	208.62	264.28	-124.55	300.59	No Data Available	>=0 N/A <0
AvP: Daycase Activity vs Forecast				-1	-3	-1	-14	-5	10	-56	-79	-73	17		>=0 N/A <0
AvP: Outpatient Activity vs Forecast				422	42	40	-49	159	222	268	390	-34	403		>=0 N/A <0
PDR	84.0%	81.5%	81.5%	2.2%	13.4%	35.5%	67.2%	85.5%	88.6%	89.2%	89.2%	89.2%	89.2%		>=90 % >=85 % <85 %
Mandatory Training	88.9%	94.7%	93.8%	92.7%	92.8%	92.4%	91.3%	87.9%	87.6%	89.4%	90.4%	90.0%	91.0%		>=90 % >=85 % <80 %
Sickness	5.6%	4.9%	4.3%	3.8%	4.0%	4.4%	5.8%	5.1%	5.3%	5.2%	5.3%	6.0%	5.7%		<=4.5 % <=5 % >5 %
Temporary Spend ('000s)	211	276	316	246	276	196	227	261	212	217	261	197	247		No Threshold

Surgery

SAFE

	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Last 12 Months	RAG
Acute readmissions of patients with long term conditions within 28 days	0	0	0	0	0	0	0	0	0	0	0	0	0	No Data Available	No Threshold

CARING

	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Last 12 Months	RAG
Complaints	2	3	2	1	2	1	5	3	1	1	1	0	1		No Threshold
PALS	26	24	20	25	36	28	20	22	27	27	27	16	27		No Threshold

EFFECTIVE

	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Last 12 Months	RAG
Hospital Acquired Organisms - MRSA (BSI)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Hospital Acquired Organisms - C.difficile	0	0	1	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Referrals Received (Total)	3,344	3,493	3,680	3,770	4,090	3,832	4,248	3,376	3,231	3,641	3,755	2,804	3,592	No Data Available	No Threshold
Average LoS - Elective (Days)	2.62	2.88	3.14	2.40	2.94	2.55	2.68	2.72	2.66	2.97	2.72	3.38	2.10		No Threshold
Average LoS - Non-Elective (Days)	2.67	2.89	3.31	2.63	2.78	2.63	2.61	2.72	2.49	3.15	2.69	2.91	2.65		No Threshold
Theatre Utilisation - % of Session Utilised	88.3%	86.4%	86.8%	90.5%	90.6%	89.5%	90.4%	88.7%	86.9%	87.4%	88.3%	85.6%	89.0%		>=90 % >=80 % <80 %
Clinic Session Utilisation	86.1%	83.5%	85.0%	84.2%	84.9%	85.9%	82.8%	83.8%	84.1%	82.8%	84.6%	83.0%	84.3%		>=90 % >=80 % <85 %
OP Appointments Cancelled by Hospital %	13.0%	14.0%	12.7%	11.2%	12.2%	12.2%	12.3%	12.6%	14.3%	13.5%	12.7%	13.4%	14.3%	No Data Available	<=5 % <=10 % >10 %
Did Not Attend Rate	10.2%	10.1%	10.3%	9.6%	10.6%	11.1%	12.0%	12.9%	10.6%	11.7%	11.0%	12.8%	11.3%		<=12 % <=14 % >14 %
Coding average comorbidities	2.99	3.18	3.24	3.11	3.31	3.50	3.63	3.65	3.66	3.60	3.59	3.92	3.84	No Data Available	No Threshold

RESPONSIVE

	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Last 12 Months	RAG
RTT: Open Pathway: % Waiting within 18 Weeks	91.4%	91.3%	92.6%	92.3%	92.5%	93.1%	92.9%	92.7%	93.1%	93.6%	94.1%	93.7%	93.1%		>=92 % >=90 % <90 %
Diagnostics: % Completed Within 6 Weeks	100.0%	92.6%	94.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		>=99 % N/A <99 %

WELL LED

	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Last 12 Months	RAG
Control Total In Month Variance (£'000s)	-634	-715		-167	32	-23	81	-63	-308	0	-211	-255	-228		>=0% >=-20% <-20%
AvP: IP - Non-Elective				10	4	2	12	12	8	-25	-7	68	-5		>=0 N/A <0
AvP: IP Elective vs Forecast				15	10	16	16	22	12	50	17	14	33		>=0 N/A <0
AvP: OP New				140.79	-86.48	-22.69	-79.39	-47.33	121.38	-162.10	61.67	-490.94	-114.74	No Data Available	>=0 N/A <0
AvP: OP FollowUp				105.22	247.98	44.98	40.98	37.98	237.98	1,126.03	783.98	345.60	546.98	No Data Available	>=0 N/A <0
AvP: Daycase Activity vs Forecast				-23	-2	3	2	3	8	-30	10	-89	-48		>=0 N/A <0
AvP: Outpatient Activity vs Forecast				246	161	22	-38	-9	359	964	846	-145	432		>=0 N/A <0
PDR	89.5%	83.3%	83.3%	1.1%	10.0%	33.5%	64.4%	83.6%	90.7%	90.0%	90.0%	90.0%	90.0%		>=90 % >=85 % <85 %
Mandatory Training	89.3%	93.5%	91.5%	90.2%	89.9%	90.9%	90.3%	87.2%	87.8%	88.6%	87.8%	88.0%	90.0%		>=90 % >=85 % <80 %
Sickness	6.3%	4.9%	4.0%	4.3%	4.7%	5.5%	5.4%	5.6%	6.0%	6.5%	5.9%	6.4%	6.3%		<=4.5 % <=5 % >5 %
Temporary Spend ('000s)	408	434	514	468	420	480	445	509	373	529	485	484	474		No Threshold

Community

SAFE

	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Last 12 Months	RAG
Acute readmissions of patients with long term conditions within 28 days	0	0	0	0	0	0	0	0	0	0	0	0	0	No Data Available	No Threshold

CARING

	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Last 12 Months	RAG
Complaints	3	2	0	2	2	3	5	5	3	2	2	1	1		No Threshold
PALS	34	50	33	32	28	20	21	26	43	36	40	11	35		No Threshold

EFFECTIVE

	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Last 12 Months	RAG
Hospital Acquired Organisms - MRSA (BSI)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Hospital Acquired Organisms - C.difficile	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Referrals Received (Total)	1,153	1,033	1,005	859	1,091	849	1,078	662	689	971	1,059	762	887	No Data Available	No Threshold
Average LoS - Elective (Days)											1.00	3.00			No Threshold
Clinic Session Utilisation	78.0%	75.7%	72.6%	75.3%	79.2%	78.7%	79.8%	80.7%	80.2%	82.7%	81.3%	77.6%	79.2%		>=90 % >=85 % <85 %
OP Appointments Cancelled by Hospital %	12.3%	13.5%	17.2%	16.1%	10.8%	16.8%	16.2%	23.3%	22.3%	17.7%	22.4%	24.1%	18.6%	No Data Available	<=5 % <=10 % >10 %
Did Not Attend Rate	12.6%	14.2%	14.4%	14.5%	14.6%	14.2%	13.8%	15.7%	12.5%	11.0%	11.9%	11.1%	12.7%		<=12 % <=14 % >14 %
Coding average comorbidities	5.00		3.33	5.00	2.33		2.33	8.00	4.00	2.00	2.67		2.00	No Data Available	No Threshold

RESPONSIVE

	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Last 12 Months	RAG
RTT: Open Pathway: % Waiting within 18 Weeks	97.3%	96.5%	96.7%	97.1%	96.1%	95.3%	92.2%	92.7%	87.3%	87.1%	78.8%	78.3%	82.7%		>=92 % >=90 % <90 %

WELL LED

	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Last 12 Months	RAG
Control Total In Month Variance (£'000s)	-161	43		-108	-70	30	62	-144	87	54	-61	118	-23		>=0% >=-20% <-20%
AvP: IP Elective vs Forecast				0	0	0	0	0	0	0	0	0	0		>=0 N/A <0
AvP: OP New				-25.37	-27.35	-34.17	-76.43	-83.03	-73.35	37.51	51.41	-12.24	-83.16	No Data Available	>=0 N/A <0
AvP: OP FollowUp				275.02	350.12	350.57	241.44	8.42	72.01	202.38	248.88	149.39	213.63	No Data Available	>=0 N/A <0
AvP: Outpatient Activity vs Forecast				250	323	316	165	-75	-1	240	300	137	130		>=0 N/A <0
PDR	90.4%	83.9%	83.9%	0.4%	9.3%	31.9%	58.8%	78.7%	87.9%	93.0%	93.0%	93.0%	93.7%		>=90 % >=85 % <85 %
Mandatory Training	89.8%	96.8%	95.7%	95.4%	95.0%	94.1%	94.2%	92.7%	91.2%	92.5%	91.4%	90.9%	88.3%		>=90 % >=85 % <80 %
Sickness	6.2%	6.0%	6.0%	4.8%	5.2%	3.9%	3.5%	3.4%	4.1%	4.0%	5.2%	5.3%	5.3%		<=4.5 % <=5 % >5 %
Temporary Spend ('000s)	146	136	202	166	180	142	131	154	125	131	150	121	151		No Threshold

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Tuesday, 12 March 2019

Report of	Director of Corporate Affairs
Paper prepared by	Executive Team, Clinical Risk Manager
Subject/Title	2018/19 Board Assurance Framework Update (February 2019)
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 – August 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.

Alder Hey Children's NHS
NHS Foundation Trust

Board Assurance Framework 2018/19

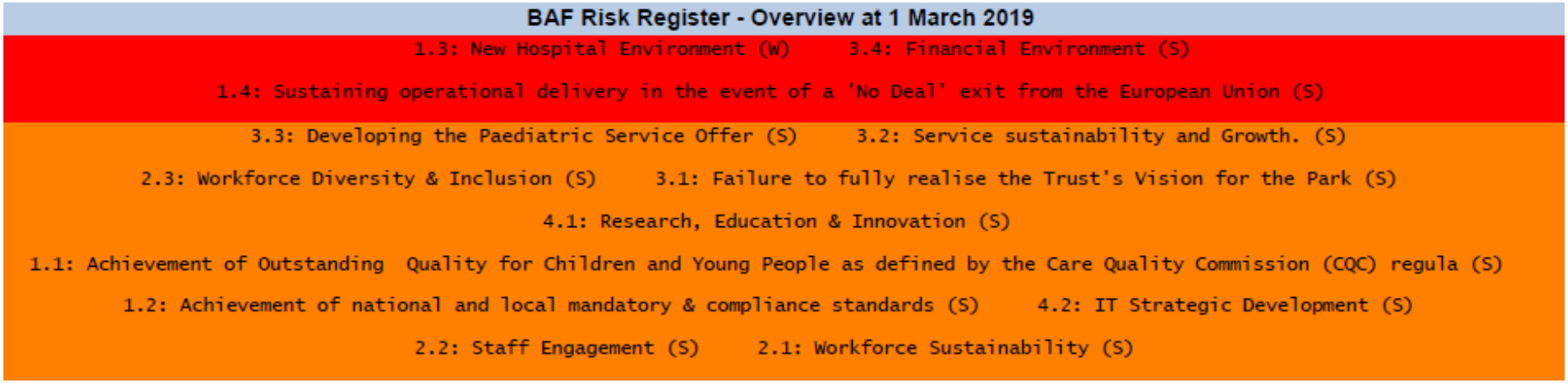
1. Purpose

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 26th February 2019



Trend of risk rating indicated by: NEW, B- Better, S - Static, W - Worse, C - Closed

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	STATIC
1.3 DP	**New Hospital Environment**		4-4	4-2	WORSE	WORSE
1.4 JG	**'No Deal' exit from the European Union**		4-4	3-3	STATIC	STATIC
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**		3-4	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 DJ	**Business Development & Growth**		4-3	4-2	STATIC	STATIC
3.3 DJ	**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**		3-3	3-3	STATIC	STATIC

Changes since February 2019 Board meeting

The diagram above shows that the majority of the risks on the BAF remained static.

External risks

- ***Business development and growth (DJ)***
  MOU, TOR, Cardio and Neuro strategies drafted in preparation for AH : Manchester Partnership Board March 19. Growth and sustainability through partnerships included as key theme in both the Draft Strategic Plan for 19/20-23/24 (under development through Executives - scheduled for Trust Board April 19) and the submitted draft 19/20 Operational Plan. Preferred provider selected for Private Patients project.

- ***Mandatory and compliance standards (ES)***
  ED performance has again been challenged by high volumes of patients with high acuity although bed availability has been good. The change programme project on patient flow has impacted positively on capacity in the last month with only one cancelled operation at time of reporting. A plan to rectify the ED position in March has been developed by the team.

- ***Developing the Paediatric Service Offer (DJ)***
  ACHD partnership network bid submitted to NHSE - awaiting feedback. HCP W&C programme 'plan on a page' submitted to HCP. Inspiring Quality and 'getting it right first time' approach to reducing variation are included as key themes in 19/20 operational plan and draft 19/20-23/24 strategic plan.

- **'No Deal' exit from the European Union – New Risk**
  Failure to implement national and local measures in the event of a 'no deal' exit from the EU to safeguard the organisation's ability to deliver services safely and maintain business continuity. National NHS EU coordination centre established to oversee planning and provide support to local teams to resolve escalating issues. Internal assurance team meeting weekly to implement operational guidance with a focus on eight key areas and to assess level of risk and update plans based on national information. Assurance Team responds to national guidance as it is published and is planning for operational readiness. Information provided by the centre with regards to provision being made for vital clinical supplies to continue to flow to the UK post 29th March 2019. National coordination centre overseeing three functions: central control, logistics and EPRR. SRO identified, risks kept under review. EPRR plans being tested, communications plan in development. Staff awareness/clarity about actions required for each service. Communications plan required to address this and inform staff in real time.

Internal risks:

- ***New Hospital Environment (DP)***
  Liaison meeting with Project Co. to review outstanding risk items.

- ***Achievement of Outstanding Quality for Children and Young People as defined by the CQC regulations (HG)***
  Commenced weekly Quality Performance Planning meeting (QiPP) Chaired by Chief Nurse and attended by Associate Chief Nurses to monitor progress with regulatory requirements (Duty of Candour; complaint responses; RCA timeframes, etc). Devised clear schedule for ward based annual risk assessments.

- ***Financial Environment (JG)***
  Divisions remains stable with £1.6m forecast gap. Year-end commissioner agreements progressing. Specific transactions to support the PSF match are continuing and are forecast at this stage to deliver in full however carry the risk of completion by end March.

- ***Failure to fully realise the Trust's Vision for the Park (DP)***
  Series of meetings with community, planning application for Park launched.

- ***IT Strategic Development (JG)***
  The Go Live of Standard Documents in February has gone very well which digitally standardises a number of processes. Digital Pathway trajectory achieved per agreement with NHS Digital. Process underway to appoint to Clinical GDE leads for each Division.

- ***Workforce Sustainability & Capability (MS)***
  Apprenticeships continue to progress; 61 learners enrolled to date. Successful school careers event hosted in February, with over 30 Yr 10 students in attendance.

- ***Staff Engagement (MS)***
  Publication of Staff Survey results. Significant improvements seen in a number of areas including immediate managers, safety culture, quality of appraisals and staff engagement.

- ***Workforce Diversity & Inclusion (MS)***
  Reciprocal mentorship programme progresses. Gender Pay Gap report completed.

- ***Research, Education & Innovation (DP)***
- Funding strategy review.

Erica Saunders
Director of Corporate Affairs
26th February 2019

Board Assurance Framework 2018-19

Alder Hey Children's NHS Foundation Trust

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. Patient Safety Meeting monitors incidents, including lessons learned, immediate actions for improvement and sharing Trust wide.	• 6. Programme of quality assurance rounds, developed and implemented across all services, aligned to Care Quality Commission, Key lines of enquiry (KLOE).
• 7. Annual clinical workforce assurance report presented to Board, aligned to Relevant Professional Standards.	•
• 8. Quality Strategy 2016/2021, Quality Improvement Change Programme established - associated workstreams subject to sub-committee assurance reporting.	• 9. Governance including risk processes from Ward to Board, linked to NHSI Single Oversight Framework
•	• 10. Acute Provider Infection Prevention and Control framework and associated dashboards and action plans for improvement.
• 11. Internal Nursing pool established and funded	• 12. Nursing leadership in alignment with Royal College of Nursing and Midwifery Standards.
• 13. Annual Patient Survey reports and associated action plans	• 14. Trust policies underpinning expected standards
• 15. CQC regulation compliance	

Assurance Evidence	Gaps in Controls/Assurance
1. Annual QIA assurance report and change programme assurance report 2. Risk assessments etc and associated risks monitored via the Integrated Governance Committee. Trust Board informed via Integrated Governance Committee minutes. Divisional Integrated Governance Committee minutes. 3. Clinical Quality Assurance Committee, Trust Board and Divisional Governance minutes 4. Corporate report/quality section, Trust Board and Divisional Quality Board minutes. 5. Minutes from Trust Board, Clinical Quality Assurance Committee, Executive Committee, Weekly patient safety group, Clinical Quality Steering Group, Divisional Integrated Governance Committees. Also MIAA audit report. 6. Reports and minutes from Clinical Quality Assurance Committee and Divisional Integrated Governance Committees. 7. Annual Medical Appraisal Report and Nurse staffing report to Trust Board biannually and associated minutes. 8. Board and sub-board committees minutes and associated reports. 9. Minutes from NHSI Quarterly engagement meetings, CQC engagement meetings, Trust Board, Clinical Quality Assurance Committee, Executive Committee, Weekly patient safety group, Clinical Quality Steering Group, Divisional Integrated Governance Committees. Patient survey reports and associated action plans, 10. IPC action plan and Trust Board, Clinical Quality Assurance Committee, Integrated Governance Committee, Divisional Quality Board minutes. 11. Nursing Workforce report and associated Board minutes. 12. Nursing Workforce report and associated Board minutes. 13. Patient survey reports and associated action plans, Trust Board, Clinical Quality Steering Group, Workforce and Organisational Development Committee, Divisional Quality Board minutes. 14. Audit committee reports and minutes. 15. CQC action plan monitoring via Board and sub board committees	15. CQC regulation breaches.

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Robust action plan to be developed, implemented and monitored via the Trust Board, Board subcommittees and individual services.	Continued monthly monitoring of progression of Trust and Divisional actions through CQAC with good progress made and any escalation made as required (refer to CQAC minutes). Next CQC Engagement meeting scheduled for 12th March 2019

Executive Lead's Assessment

Nov 2018: CQC action plan continues to address the areas for improvement and is monitored via Trust Board and CQAC, good progress.
DEC 2018: 4: Review of divisional quality metrics underway.
8: E-rostering Change Programme remains as a pipeline project for 2019.
10: Continued improved performance by quarter in relation to IPC workplan.
11: Continued recruitment drive to achieve 40 WTE in nurse pool.
12: Further progress against RCN core standards following successful business case for ACT.
13: Triangulation of patient surveys Healthwatch and PLACE; to collate robust action plan, monitored via CQAC.
JAN 2019: Re-instated annual Children and Young People Survey via PICKER Institute; awaiting a date for the next survey to be undertaken. Open recruitment day securing 25 WTE registered nurses and building on the opportunity of the successful 'Hospital' programme showcasing the Trust as a place to work.

FEB 2019: Commenced weekly Quality Performance Planning meeting (QiPP) Chaired by Chief Nurse and attended by Associate Chief Nurses to monitor progress with regulatory requirements (Duty of Candour; complaint responses; RCA timeframes, etc). Devised clear schedule for ward based annual risk assessments

Board Assurance Framework 2018-19

Alder Hey Children's NHS Foundation Trust

BAF 1.2	**Strategic Objective:** Delivery Of Outstanding Care	Risk Title: Achievement of national and local mandatory & compliance standards		
Related CQC Themes: Safe, Caring, Responsive, Well Led, Effective				
Exec Lead: Erica Saunders	**Type:** Internal, Known	Current IxL: 3-3	Target IxL: 4-1	Trend: STATIC

Risk Description

Failure to meet targets and internal performance metrics due to poor flow and lack of capacity to fulfil activity plans and respond to increasing demand

Existing Control Measures

• Operational Delivery Board taking action to resolve performance issues as they emerge	• Emergency Planning & Resilience meetings in pace
• Divisional Executive Review Meetings taking place monthly with 'three at the top'	• Regulatory status with: NHSI, CQC,NHSLA, ICO, HSE, CPA, HTA,MHRA etc.
• Compliance tracked through the corporate report and Divisional Dashboards.	• Risks to delivery addressed through Operational Board, RBD, CQAC, WOD, IGC & CQSG and then through to Board
• Early Warning indicators now in place	• Weekly performance meetings in place to track progress
• 6 weekly meetings with commissioners (CQPG)	• Divisional leadership structure to implement and embed clinically led services
• Weekly Exec Comm Cell overseeing key operational issues and blockages.	• Refresh of Corporate Report undertaken for 2018/19

Assurance Evidence	Gaps in Controls/Assurance
Regular reporting of delivery against compliance targets through assurance committees & Board. Monthly reporting to the Board via the Corporate Report. NHSI quality concern rating Operational effectiveness measures (key risks with early warning measures) to RABD Compliance assessment against NHSI Provider Licence to Board Divisional/Executive performance reviews Exceptions discussed / resolved at Ops Board Quarterly review meeting and report to NHSI	Critical Care bed capacity Some areas remain fragile e.g. ED 4 hour target. Assurance required to underpin Divisional reporting on CQC standards Work with CCG to manage demand & develop / fully utilise existing capacity across PC Proactive management of patient flow making better use of trend analysis data

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Monitor the use of surgical beds to ensure full activity plan delivered; review activity profile through winter months.	Elective programme being monitored on a weekly basis however significant pressure from NEL orthopaedic cases experienced during June has proved challenging.
Plans to ensure performance sustained across the year need to be embedded and maintained	New Models of Care review findings presented and agree at Ops Board September; action plan agreed.

Executive Lead's Assessment

JANUARY 2019: ED performance remains fragile, slipping below the 95% threshold at the end of the month, having sustained well in the post Christmas period. All Winter Plan measures remain in place and other access targets were achieved in month. The POCU model now fully operational for suitable cases.
FEBRUARY 2019: ED performance has again been challenged by high volumes of patients with high acuity although bed availability has been good. The change programme project on patient flow has impacted positively on capacity in the last month with only one cancelled operation at time of reporting. A plan to rectify the ED position in March has been developed by the team.

Board Assurance Framework 2018-19

Alder Hey Children's NHS Foundation Trust

BAF 1.3	**Strategic Objective:** Delivery Of Outstanding Care		Risk Title: New Hospital Environment		
Related CQC Themes: Safe					
Exec Lead: David Powell	**Type:** Internal, New		Current IxL: 4-4	Target IxL: 4-2	Trend: WORSE

Risk Description	
Sale of PFI Project co. whilst a number of commissioning risks are still present could lead to lack of focus and problems in maintaining safe environment	
Existing Control Measures	
• Monthly issue meetings	• Monthly liaison meetings
• Regular reports to IGC	• Liaison minutes reported to Trust Board monthly
• Building Management Services Risk Register	
Assurance Evidence	**Gaps in Controls/Assurance**
Maintenance of Issues List Issues Review Meeting Escalation to Liaison meeting Red Button escalation mechanism Help Desk monitoring reports	Some repeat/overlap reporting Some lack of clarity over risk ownership/H&S role
Actions Required to Reduce Risk to Target Rating	**Latest Progress on Actions**
Replacement programme for pipe work to be agreed with builder	Report received from Project Co. Agreed to present at October Board
COO updating Action Plan to address key water safety issues	
Interserve developing water safety action plan	Project Co. agreement to scope out water cross-over test. Exercise planned for sept 2018
Whole Hospital review of fire stopping	
Review of various risk elements and consolidation into single report with external validation.	
Complete Fire Notice action plan	
Create action Plan for addressing ceiling tile falls	Proposed plan submitted to Project co. for consolidation
Complete fire stopping work	
Prepare recommendation to Board on proposed pipework replacement strategy	

Executive Lead's Assessment

APRIL 2018: Clutch of commissioning issues still to be resolved including pipework corrosion, water temperatures, delay in achieving operating theatre temperature control. Are currently under review with some attendant action plans still requiring completion.
Next steps-complete reviews and agree all action plans for outstanding issues.
MAY 2018: Interim report on Pipework received. Commercial plan meeting in diary for June. Fire-stopping review under way
JUNE 2018: Consolidated report in production; review meeting with Project Co and refresh of action plan. Outcome to be reported 24/07/2018
AUG 2018: review of consolidated report with sub plans for fire and ceilings
Sept 2018: completion of fire action plan and 90% of fire-stopping works
Oct 2018 Project Co presentation to Trust Board on pipework review
Nov 2018 Fire stopping work complete; pipework action plan tbc
Dec 2018: Preparing a report on the pipework for February's Integrated Governance Committee.
January 2019: Final set of water surveys received
February 2019: Liaison meeting with Project Co. to review outstanding risk items

Board Assurance Framework 2018-19

Alder Hey Children's NHS Foundation Trust

BAF 1.4	**Strategic Objective:** Delivery Of Outstanding Care	Risk Title: Sustaining operational delivery in the event of a 'No Deal' exit from the European Union		
Related CQC Themes: Safe, Effective, Responsive				
Exec Lead: John Grinnell	**Type:** External,	Current IxL: 4-4	Target IxL: 3-3	Trend: STATIC

Risk Description

Failure of measures put in place nationally and locally in the event of a 'no deal' exit from the EU to safeguard the organisation's ability to deliver services safely and maintain business continuity.

Existing Control Measures

• National NHS EU coordination centre established to oversee planning and provide support to local teams to resolve escalating issues. Internal team in place to implement operational guidance.	• Internal command team structure focusing on eight key areas each week to assess level of risk and update plans based on national information. Group responds to national guidance as it is published.
Assurance Evidence	**Gaps in Controls/Assurance**
Information provided by the centre with regard to provision being made for vital clinical supplies to continue to flow to the UK post 29th March. National coordination centre overseeing three functions: central control, logistics and EPRR. Trust command team planning for operational readiness: SRO identified, risks kept under review, EPRR plans being tested, communications plan in development.	Staff awareness/clarity about actions required for each service. Communications plan required to address this and inform staff in real time.
Actions Required to Reduce Risk to Target Rating	**Latest Progress on Actions**
This risk has no actions in place.	

Executive Lead's Assessment

New risk

Board Assurance Framework 2018-19

Alder Hey Children's NHS Foundation Trust

BAF 2.1	**Strategic Objective:** The Best People Doing Their Best Work	Risk Title: Workforce Sustainability		
Related CQC Themes: Safe, Effective, Responsive, Well Led, Well Led, Well				
Exec Lead: Melissa Swindell	**Type:** Internal, Known	Current IxL: 3-3	Target IxL: 3-2	Trend: STATIC

Risk Description	
Failure to deliver consistent, high quality patient centred services due to not having the right people, with the right skills and knowledge, in the right place, at the right time.	
Existing Control Measures	
• Workforce KPIs tracked through the corporate report and divisional dashboards	• Bi-monthly Divisional Performance Meetings.
• Mandatory training fully reviewed in 2017, with a new system of reporting linked to competencies on ESR; enabling better quality reporting.	• Mandatory training mapped to Core Skills Framework. Online portal enables all staff to see their compliance on their chosen IT device.
• Permanent nurse staffing pool	• HR Workforce Policies
• Attendance management process to reduce short & long term absence	• Wellbeing Steering Group established
• Large-scale nurse recruitment event 4 times per year	• Training Needs Analysis linked to CPD requirements
• Apprenticeship Strategy implemented	• Engaged in pre-employment programmes with local job centres to support supply routes
• Engagement with HEENW in support of new role development	• People Strategy
Assurance Evidence	**Gaps in Controls/Assurance**
Regular reporting of delivery against compliance targets via corporate & divisional reports Monthly reporting to the Board via the Corporate Report Reporting at ward level which supports Ward to Board Reporting to HEE People Strategy report monthly to Board Programme Board reporting	Not meeting compliance target in relation to mandatory training in some areas Sickness Absence levels higher than target. Lack of standard methodology to workforce planning across the organisation
Actions Required to Reduce Risk to Target Rating	**Latest Progress on Actions**
ensure a minimum of 50 learners enrolled on apprenticeship pathways.	
Executive Lead's Assessment	
FEB 2019: Apprenticeships continue to progress; 61 learners enrolled to date. Successful school careers event hosted in February, with over 30 Yr 10 students in attendance.	

Board Assurance Framework 2018-19

Alder Hey Children's NHS Foundation Trust

BAF 2.2	**Strategic Objective:** The Best People Doing Their Best Work	Risk Title: Staff Engagement		
Related CQC Themes: Safe, Effective, Responsive, Well Led				
Exec Lead: Melissa Swindell	**Type:** Internal, Known	Current IxL: 3-3	Target IxL: 3-1	Trend: STATIC

Risk Description

Failure to improve workforce engagement which impacts upon operational performance and achievement of strategic aims.

Existing Control Measures

• People Strategy	• Wellbeing Strategy implementation
• Action Plans for Staff Survey	• Values and Behaviours Framework
• Staff Temperature Check Reports to Board (quarterly)	• Values based PDR process
• People Strategy Reports to Board (monthly)	• Listening into Action Guidance and Programme of work
• Staff surveys analysed and followed up (shows improvement)	• Reward and recognition schemes in place: Annual Awards, Star of the Month and quarterly Long Service Recognition Event, Annual Fab Staff Change Week.
•	• BME and Disability Staff Networks

Assurance Evidence	**Gaps in Controls/Assurance**
Monthly People Strategy Report to Board Outcomes from Annual Staff Survey reported to the Board. Staff Survey local departmental conversations PDR completion rates Values and Behaviours Framework Quarterly Engagement Temperature Check reported to the Board. Quarterly Engagement Temperature Check local data sent to Divisions on a quarterly basis to enable them to analyse data locally. Ongoing consultation and information sharing with staff side and LNC Progress reports from LiA to Board Wellbeing Strategy progress reported to WOD Board/sub-Board Committee minutes Minutes of Staff Networks Engagement through Editorial Board leadership for Alder Hey Life	Internal Communications Strategy and Plan Refreshed Leadership Strategy

Actions Required to Reduce Risk to Target Rating	**Latest Progress on Actions**
Framework now completed awating sign off	
L&D manager to undertake a review of the methodology, with a view to launching new system in June 18	Staff Survey will be used for Q3 data. Currently speaking with other local organisations to see how they complete this requirement to see if there is a 'norm' or best practice. Plan to launch revised process for Q4 (Jan-March-19)

Executive Lead's Assessment

FEB 2019: Publication of Staff Survey results. Significant improvements seen in a number of areas including immediate managers, safety culture, quality of appraisals and staff engagement.

Board Assurance Framework 2018-19

Alder Hey Children's NHS Foundation Trust

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	• LGBTQ+ Network established
•	•

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	None recorded.

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

FEB 2019: Reciprocal mentorship programme progresses. Gender Pay Gap report completed

Board Assurance Framework 2018-19

Alder Hey Children's NHS Foundation Trust

BAF 3.1	**Strategic Objective:** Sustainability Through External Partnerships	Risk Title: Failure to fully realise the Trust's Vision for the Park		
Related CQC Themes: Responsive, Well Led				
Exec Lead: David Powell	**Type:** Internal, Known	Current IxL: 3-3	Target IxL: 3-2	Trend: STATIC

Risk Description	
Failure to fully realise the Trust's vision for the Park and campus, in partnership with the local community and other key stakeholders as a legacy for future generations	
Existing Control Measures	
• Business Cases developed for various elements of the Park & Campus	• Monitoring reports on progress
• Heads of Terms agreed with LCC for joint venture approved	• Redevelopment Steering Group
• Monthly reports to Board & RABD	
Assurance Evidence	**Gaps in Controls/Assurance**
Approved Business Cases for various elements of the Park & Campus approved Every Project has a dedicated Project Manager assigned to it End user consultation events held Highlight reports to relevant assurance committees and through to Board Stakeholder events held/reported back to Trust Board Representation at Friends of Springfield Park Group Monthly Board report	Fully reconciled budget with Plan. Risk quantification around the development projects.
Actions Required to Reduce Risk to Target Rating	**Latest Progress on Actions**
Secure approval for plans to increase Park footprint	Planning for Park extension submitted 31/07/2018
Approval of Business Case at LCC / Discuss park Heads of Terms with LCC	On hold-Dependent upon residential scheme (revised target date no April 2018)
Create plan for demolition and phasing	
Organise Park design session with Friends of Springfield Park	
Prepare and submit planning application	

Executive Lead's Assessment
APRIL 2018: New Park manager appointed MAY 2018: Meeting arranged with Friends of Springfield Park to agree 1st park extension. JUNE 2018: 2nd round of user meetings on Community Cluster. Commissioning Programme for Institute under way. Implemented bi-weekly control group meetings on the Institute commissioning Aug 2018: Planning application for park extension. Handover of Institute Phase 2 Sept 2018: Plan agreed for retraction of site following opening of Institute Nov 2018: Agreement to secure design input into new park with community groups Dec 2018: Session held with community groups on park design. Jan & Feb 2019: Series of meetings with community, planning application for Park launched.

Board Assurance Framework 2018-19

Alder Hey Children's NHS Foundation Trust

BAF 3.2	**Strategic Objective:** Sustainability Through External Partnerships	Risk Title: Service sustainability and Growth.		
Related CQC Themes: Caring, Effective, Responsive, Safe, Well Led				
Exec Lead: Dani Jones	**Type:** External, Known	Current IxL: 4-3	Target IxL: 4-2	Trend: STATIC

Risk Description

Risk to service sustainability development/growth; due to NHS financial environment and constraints on internal infrastructure to deliver business as usual as well as maximise growth opportunities. External opportunities for partnership may not be fully optimised.

Existing Control Measures

• Divisional Performance Management Framework.	• Clear trajectories for challenged specialities to deliver.
• Business Development Plan	• Change Programme Projects (Strategic Partnerships & International Clinical Business and non NHS Patient Services)
• Five year plan agreed by Board and Governors in 2014	• Capacity Plan identifies beds and theatres required to deliver BD Plan.
• Service development strategy including Private / International patient proposal approved by Council of Governors as part of strategic plan sign off (March 18, September 18)	• 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	• Growth and sustainability through external partnerships is a key theme in the Change Programme.

Assurance Evidence	Gaps in Controls/Assurance
Marketing and Business Development Committee has been refreshed as a Growth Through Sustainable Partnerships Group. First meeting planned July 2018. Business Development Plan reviewed monthly by RBDC via Contract Monitoring Report. Daily activity tracker and forecast monitoring performance for all activity. CIPs in new Change Programme subject to assurance and sub-committee performance management. Clinical Network Partnership development with Manchester Children's Hospital.	Ability to respond swiftly to potential problems. Workforce constraints in specialised services. Early warning indicators for leading indicators. Growth through Partnerships to be included in Strategic Business planning - both annual operational plan and long term plan through next planning cycle.
Actions Required to Reduce Risk to Target Rating	**Latest Progress on Actions**
Development of the international agenda	Private Patients Project -Preferred Provider Selected - February 2019 Alder Hey Marketing Packs - Deployed from April 2019 Healthcare UK Export Catalyst Workshop - August 2018 Healthcare UK Export Catalyst Project -Planned for Apr-Jul 19 Business Development being pursued in China - Xi'an contract letters being prepared. Qingdao strategy in development. Shanghai exploratory meetings - April 2019 Business Development strategy for India - Internal Discussions being scheduled.

Executive Lead's Assessment

NOV 2018: Clinical Network event with Manchester Children's Hospital. Single service model for neurosciences supported. Refreshed Network Partnership Board to be held in February 2019.
DEC 2018: Network Partnership Agreement with Manchester Children's Hospital under development and quarterly Partnership Board dates scheduled (beginning February 18). Monthly network meetings to progress Neurosciences and Cardiac networks underway.
JAN 2019: Strategic planning process underway, in light of NHS Long Term Plan; system submission of 5yr plan Autumn 19. BAF risk review planned for April 19 in line with this.
Partnership Board with Manchester scheduled for March; MOU, network review, Cardio and Neurosciences prioritised.
FEB 2019: MOU, TOR, Cardio and Neuro strategies drafted in preparation for AH : Manchester Partnership Board March 19. Growth and sustainability through partnerships included as key theme in both the Draft Strategic Plan for 19/20-23/24 (under development through Executives - scheduled for Trust Board April 19) and the submitted draft 19/20 Operational Plan. Preferred provider selected for Private Patients project.

Board Assurance Framework 2018-19

Alder Hey Children's NHS Foundation Trust

BAF 3.3	**Strategic Objective:** Sustainability Through External Partnerships	Risk Title: Developing the Paediatric Service Offer		
Related CQC Themes: Safe, Caring, Effective, Responsive, Well Led,				
Exec Lead: Dani Jones	**Type:** External, Known	Current IxL: 4-3	Target IxL: 4-2	Trend: STATIC

Risk Description

Failure to maximise opportunities for working with key partners to develop children's services and reduce variation across the City region and beyond

Existing Control Measures

• Internal review of service specifications as part of Specialist Commissioning review.	• Analysis of compliance and actions agreed where not fully met.
• Gap/risk analysis against all draft national service specification undertaken and action plans developed.	• Accreditations confirmed through national review processes.
• Compliance with Neonatal Standards	• Compliance with All Age ACHD Standard
• Post implementation review of Trauma Business Case.	• Current derogations secured in relation to specialist service specs.
• Growing Through External Partnerships - Change Programme Workstream (All Projects)	• Change Programme - 7 Day Working Project
• Alder Hey leading the partnership development of the future model of Paediatric Urgent Care in Liverpool.	

Assurance Evidence	Gaps in Controls/Assurance
Key developments monitored through Divisions Monitored at refreshed 'Sustainability Through External Partnerships Steering Group' (proposal to develop this during Mar/April into Strategy and Ops Delivery Board - to maximise alignment the strategy and delivery agendas). Monthly to Board via RABD & Board. Compliance with final national specifications. Single Neonatal Services Business Case approved by NHS England.	Inability to recruit to highly specialist roles due to skill shortages nationally. Trust has sought derogation in a number of service areas where it does not meet certain standards and is progressing actions to ensure compliance by due date. Potential elective underperformance due to cancelled sessions. Awaiting final results re. CHD service at national level. Working with partners including CMFT to progress transfer of adult CHD services and to support partners during transition. Go live due beginning of September 2018.

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
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.
Key partnerships for sustainability 2018/19 - review underway in line with Strategic Planning Process; update planned to Board Q1 2019/20. Existing and new Partnerships need to be strengthened and grown	

Executive Lead's Assessment

OCT 2018: Plan to review this risk assessment prior to the next Board meeting. The neonatal business case for 24 cots not fully approved, 19 cots approved. Aim to have full approval of 24 cots by March 2019.
DEC 2018: Neonatal case for final approval of 24 cots to be considered by commissioners in January - on track for approval by March 2019. Alder Hey & Liverpool Women's CEO's to jointly chair Cheshire & Merseyside Women's and Children's Network from 2019.
JAN 2019: Business case for 22 neonatal cots approved in principle. C&M W&C Partnership refresh with emphasis on paediatric workforce as well as maternity. Paediatric Urgent Care presentation to Liverpool Provider Alliance delivered 18.1.19. Partnership bid for Cardiac ODN underway through CHIG.
FEB 19: ACHD partnership network bid submitted to NHSE - awaiting feedback. HCP W&C programme 'plan on a page' submitted to HCP. Inspiring Quality and 'getting it right first time' approach to reducing variation are included as key themes in 19/20 operational plan and draft 19/20-23/24 strategic plan.

Board Assurance Framework 2018-19

Alder Hey Children's NHS Foundation Trust

BAF 3.4	**Strategic Objective:** Sustainability Through External Partnerships	Risk Title: Financial Environment		
Related CQC Themes: Safe, Effective, Responsive, Well Led				
Exec Lead: John Grinnell	**Type:** Internal, Known	Current IxL: 4-4	Target IxL: 4-3	Trend: STATIC

Risk Description

Failure to deliver Trust control total and financial risk rating

Existing Control Measures

• Organisation-wide financial plan.	• Monitor financial regime and financial risk ratings.
• Financial systems, budgetary control and financial reporting processes.	• Capital Planning Review Group
• Monthly performance review meetings with Divisional Clinical/Management Team and the Executive	• Financial Position (subject to regular monitoring).
• Weekly meeting with divisions to review forward look bookings for elective and day case procedures to ensure activity booked meets contract and recovery plans. Also review of status of outpatient slot utilisation	• Financial Recovery Board in place
• CIP subject to programme assessment and sub-committee performance management	

Assurance Evidence	Gaps in Controls/Assurance
Monthly Corporate Performance Report presented to both Board and the RABD. Specific Reports (i.e. NHSI Plan Review by RABD) Monthly Performance Management Reporting with General Managers. Internal and External Audit reporting through Audit Committee. Daily activity tracker to support divisional performance management of activity delivery Pay cost control 10 point plan introduced aimed at forecasting and tracking actions to reduce pay cost overspend run rate - updates to Execs, R&BD. Full electronic access to budgets & specialty performance results Weekly Financial Sustainability delivery meeting papers Board 2 Board with Spec comm	Divisions improved financial control and effective recovery required in identified where slippage against agreed recovery trajectories occurring Ongoing cost of temporary staff Divisional recovery plans to hit yearend financial control targets to ensure delivery of overall Trust financial plan. 'Grip' on CIP CIP Position improved however Divisional forecasts still showing a potential £1.6m gap

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Tracking actions from Financial Recovery Board	on target
Develop fully worked up CIP programme - Progress has been made however still forecasting £1.2m under target	Reviewed at financial sustainability group 2.7.18 Further work to take place as part of Q1 review and in July. Review again at expected completion date

Executive Lead's Assessment

JUNE 2018: Key risks highlighted as delivery of CiP (£2.5m gap), elective run rates/winter plan delivery and other emerging cost pressures. Total Divisional risk equates to c£8m and will be through divisional recovery supported by an effective winter plan and identification of non-recurrent measures. Mitigation plan to be tracked through RABD
AUG 2018: CIP identified has plateau at £5m against £6.8m plan. Efforts continue with £6m looking deliverable. Main concerns now relate to Divisional forecast gap of £6.8m and level of Spec Comm over performance which is now subject to a formal activity notice.
SEPT: CIP identified increased identified to £5.5m with £6m a key next phase we aim to get to by end of Sept. Divisions have reduced forecast gap which now stands at £3.5m. Work on-going to further reduce this deficit. Key risks remains commissioner over performance which is material. A new risk related to estates capital spend overspends (unmitigated estimate £6m-£9m). Work has started to prepare a capital recovery plan and reduce value of risk.
October: CIP gap remains at £1.5m with focus on closing the gap to £1m. Divisions forecasting £2.8m shortfall against original control total. Financial Recovery being overseen by Monday Sustainability Group. Board to Board with spec comm agreed next steps on this financial year however remains a risk. Still to finalise payment terms with Welsh commissioners - meeting with Senior representatives of NHSi to progress.
Nov: Underperformance in November. Current Divisional forecast gap at £1.9m with recovery plans being finalised to bridge. Continued risk relating to commissioner overperformance - discussions underway regarding year end forecast. PSF match opportunities being progressed.
DEC: Met plan in December. Current Divisional forecast gap at £1.8m with recovery plans being finalised to bridge. Continued risk relating to commissioner overperformance - discussions underway regarding year end forecast. PSF match opportunities being progressed.
JAN 19. Divisions have made progress with the forecast gap now at £1.6m from their control totals. Discussions progressing with commissioners to close year end agreements. The main risk lies with spec comm where there is a £1.8m difference which we are working on. Specific transactions to support the PSF match are continuing and are forecast at thi stage to deliver in gull however carry the risk of completion by end March.
FEB 19: Divisions remains stable with £1.6m forecast gap. Year-end commissioner agreements progressing.Specific transactions to support the PSF match are continuing and are forecast at this stage to deliver in full however carry the risk of completion by end March.

Board Assurance Framework 2018-19

Alder Hey Children's NHS Foundation Trust

BAF 4.1	**Strategic Objective:** Game-Changing Research And Innovation	Risk Title: Research, Education & Innovation		
Related CQC Themes: Responsive, Well Led				
Exec Lead: David Powell	**Type:** Internal, Known	Current IxL: 3-3	Target IxL: 3-2	Trend: STATIC

Risk Description

Failure to exploit new opportunities in research, innovation & education due to incomplete management systems.

Existing Control Measures

• Establishment of RIE Board Sub-committee	• Steering Board reporting through to Trust Board
• RABD review of contractual arrangements	• Programme assurance via regular Programme Board scrutiny
• Digital Exemplar budget completed and reconciled	• Innovation Co budget in place

Assurance Evidence	Gaps in Controls/Assurance
Research Strategy Committee set up as a new Board Assurance Committee Research, Education and Innovation Committee established Secured ERDF funding for Innovation Team Innovation Board established	Sporadic meetings of RIE committee Governance structure for Innovation Board to be agreed Re-energise Research governance processes Reporting frameworks and standards for all services to be agreed/harmonised

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Develop a robust Academy Business Model	Framework refresh
Establish pipeline structure for work-streams (Acorn and Crucible)	Legal work complete on Crucible Contract
Execute contract for RIE with back to back arrangements with the Charity and HEIs	Final Documentation with solicitors prior to completion before move in to Institute Phase 2
Agree incentivisation framework for staff and teams	
Create new vision for integrated themes	
Agree Funding Strategy for Innovation	

Executive Lead's Assessment

APRIL 2018: REI committee refreshed and re-launched
MAY 2018: Revised plan for 2017/18 innovation activity
JUNE 2018: Innovation Refresh 2nd session
AUG 2018: Innovation prioritisation exercise
Sept 2018: presentation of innovation re-set to Innovation Board
Oct 2018: Review of Acorn Launch of crucible Launch of Alder Play
Nov 2018: Execs review of RIE arrangements
Dec 2018: Execs review of RIE arrangements completed. Discussions held with the Knowledge Quarter regarding incorporating Alder Hey.
Jan 2019: Draft paper circulated on management arrangements for RIE
Feb 2019: Funding strategy review

Board Assurance Framework 2018-19

Alder Hey Children's NHS Foundation Trust

BAF 4.2	**Strategic Objective:** Game-Changing Research And Innovation	Risk Title: IT Strategic Development		
Related CQC Themes: Safe, Caring, Effective, Responsive, Well Led				
Exec Lead: John Grinnell	**Type:** Internal, Known	Current IxL: 3-3	Target IxL: 3-3	Trend: STATIC

Risk Description

Failure to deliver an IM&T Strategy which will place Alder Hey at the forefront of technological advancement in paediatric healthcare

Existing Control Measures

• Key projects and progress tracked through the Clinical Systems Informatics Steering Group and RABD Committee	• Clinical Systems Informatics Project Group leading on stakeholder engagement - ad hoc groups on specific key topics as needed
• Forward Communications plan agreed and tracked at steering group.	• Board approval "Asset Owner" process in place to ensure organisational ownership of systems and system development
• Improvement scheduled training provision including refresher training and workshops to address data quality issues	• Formal change control processes now in place
• Executive level CIO in place	• Monthly update to Trust Board on GDE Programme
• GDE Programme Board in place & fully resourced - Chaired by Medical Director	• Clinical Engagement in IT Roadmap
• NHSE external oversight of GDE programme	• Resilience of underlying infrastructure
• A plan is now in place to develop new strategy and roadmap to present to board in Autumn 2018 including plan for user engagement. Plan will include the current GDE programme and beyond, as well as review of Meditech offerings beyond current contract.	• Operational & Clinical oversight of the programme needs enhancing

Assurance Evidence	Gaps in Controls/Assurance
Regular progress reports presented to RABD and Operational Board & Trust Board MIAA providing assurance role Board agreed change process Participate in Digital Alder Hey programme Internal Audit Reviews NHSE tracking of GDE Programme GDE Programme Board tracking delivery - Chaired by MD Plan presented to Ops Board June 18 Implementation of weekly Oversight group	IM&T Strategy out of date - update work in progress to produce Roadmap for March 2019 Resilience of underlying infrastructure - replacement being installed

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Replacement equipment procured - equipment is now installed however delay in ensuring appropriate electrical back up in place which is being rectified. Awaiting final solution on electrical supply.	
IT Roadmap to be concluded	Meeting held with Meditech to agree how we work more effectively going forward and have more onsite presence

Executive Lead's Assessment

APRIL 2018: ImageNow and bed management module key next phases of the programme. Clinical Advisory Group in place supporting these developments. Real progress being made on STP wide intra-operability platform
MAY 2018: No material changes to report in-month
JUNE 2018: Replacement underlying infrastructure ordered; Excellent feedback from NHSE on benefits realisation
AUG 2018: Replacement infrastructure in situ. Continued positive feedback from NHSE. Programme on track with revised approached for VR in place.
SEPT 18: Progress with NHSE milestones remains positive with full funding schedule in place. Recent positives include the roll of out of a sepsis module in standard documentation and interoperability piece. Gap in Programme Manager a concern with plans in place to mitigate.
OCT18: Programme Manager now in place. Risks relating to January go live of standard Docs and number of pathways to be completed discussed at Execs. Enhanced support given to GDE to include weekly oversight Group with Executive presence.
Nov 18: Progress made on delivering Jan milestones although there remains a level of risk given the number of pathways still to go live. Revised GDE operational structure agreed that will bolster delivery in this next phase of the programme.
Dec18: Jan milestones on track although there remains a level of risk given the number of pathways still to go live. Revised GDE operational structure and live that will bolster delivery in this next phase of the programme.
Jan 19: January milestones delivered and signed off by NHS Digital which releases next tranche of funds. Key next phase is got live of Standards Documentation in February which has a significant roll out programme. Discussions taking place with Clinical teams as to how we maximise the opportunity of the next phase of Digital Pathways. Revised operational structure in place and paying dividends.
Feb 19 - The Go Live of Standard Documents in February has gone very well which digitally standardises a number of processes. Digital Pathway trajectory achieved per agreement with NHS Digital. Process underway to appoint to Clinical GDE leads for each Division.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS
2019/20 ANNUAL AGENDA TIMETABLE
Papers to be with Julie Tsao 7 working days prior to the meeting

Agenda Item	2 Apr	7 May	28 May	2 July	3 Sept	1 Oct	5 Nov	3 Dec	7 JAN	4 FEB	3 MAR
	PATIENT STORY										
Finance & Activity											
Integrated Business Plan & 2018/19 Budget	✓										
Corporate Report Karl Edwardson	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Recognition of the Trust as a Going Concern	✓										
Annual Report & Accounts 2018/19 Erica Saunders			✓								
Alder Hey in the Park											
AHP Updates David Powell	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Governance & Risk											
NHSI Operational Plan			✓								
Committee Annual Reports		✓									
Quality Account			✓				✓				
Election results Julie Tsao/Erica Saunders					✓						
Board Assurance Framework Jill Preece	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Quality and Risk Profile Report Jill Preece		✓			✓		✓				
DIPC Report Valya Weston/Jo Keward/Julie		**Q4**			**Q1**			**Q2**			**Q3**

Agenda Item	2 Apr	7 May	28 May	2 July	3 Sept	1 Oct	5 Nov	3 Dec	7 JAN	4 FEB	3 MAR
	PATIENT STORY										
Roberts/Carly Quirk											
Change Programme Update Natalie Deakin	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Quality Report – included as part of Corporate Report	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Serious Incident reports Jo Gwilliams	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Complaints Anne Hyson		✓			✓			✓			✓
Infection Control Annual Report Jo Keward/Richard Cooke/Julie Roberts				✓							
Quarterly Mortality Report Julie Grice / Karl Edwardson	**Q3**			**Q4**		**Q1**			**Q2**		
Winter Preparedeness Mags Barnaby						✓					
Operational Plan											
Delivery of the Corporate Plan (& Divisional Presentations)	✓										
Half year review of the Corporate Plan (& Divisional Presentations) / Operational Plan and Update							✓				
Operational Plan/update							✓				✓
Quality Strategy & Plans				✓							
IM&T Progress Reports	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Review Annual Plan to NHSI											✓
Human Resources											
Workforce Briefing	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Staff Survey	✓										

Agenda Item	2 Apr	7 May	28 May	2 July	3 Sept	1 Oct	5 Nov	3 Dec	7 JAN	4 FEB	3 MAR
	PATIENT STORY										
Equality Act	✓										
Medical Revalidation Update					✓						✓
Listening into Action Kerry Turner	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓
Minutes and Key Issues											
Clinical Quality Assurance Committee Julie Creevy	**March**	**April**	**May**	-	**June/ July/ Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**
RBD Committee	**March**	**April**	**May**	-	**June/ July/ Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**
Audit Committee	**Jan**				**April**	**May**			**Nov**		
Workforce, Organisational Development Committee Jackie Friday		**Feb**			**April**	**June**	**Sept**		**Oct**		**Dec**
Integrated Governance Committee Lesley Calder	**Jan**				**March**	**July**		**Sept**		**Nov**	
Liaison Committee	**March**	**April**	**May**	-	**June/ July/ Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**