Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS MEETING

Tuesday 23rd May 2016 commencing at 1000

Venue: Institute in the Park Large Meeting Room, Alder Hey Children's Foundation Trust

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action	Preparation
		1000	**PATIENT STORY**			
Board Business						
1.	**16/17/38**	**1010**	**Apologies**	Chair		--
2.	**16/17/39**	**1011**	**Declarations of Interest**	All	Board Members to declare an interest in particular agenda items, if appropriate	--
3.	**16/17/40**	**1012**	**Minutes of the Previous Meeting**	Chair	To consider the minutes of the previous meeting held on **3 May 2016** and check for amendments and approve	Read Minutes
4.	**16/17/41**	**1014**	**Matters Arising and Board Action List**	Chair	To discuss any matters arising from previous meetings and provide updates and review where appropriate	Verbal
5.	**16/17/42**	**1015**	**Key Issues/Reflections**	All	The Board to reflect on key issues.	Verbal
Excellence in Quality						
6.	**16/17/43**	**1020**	**Quality Summit 18th May 2016**	H Gwilliams	To provide an update on the internal Quality Summit process as part of the Trust's Quality Improvement Culture	Verbal
7.	**16/17/44**	**1025**	**CQC Engagement Meeting**	H Gwilliams	To provide an update on the CQC Engagement meeting held on Monday 25th May 2016	Verbal
8.	**16/17/45**	**1030**	**Serious Incidents Report**	H Gwilliams	To inform the Board of the recent serious incidents at the Trust in the last calendar month	Read Report
9.	**16/17/47**	**1040**	**Clinical Quality Assurance Committee: Chair's update and Annual report**	A Marsland	To receive and review the following :- a) minutes from the meeting held on; 20th April 2016 b) 2015/16 Committee Annual report	Read minutes

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action	Preparation
Great Talented Teams						
10.	**16/17/48**	**1045**	**People Strategy Update** - **Workforce Diversity task and finish group**	M Swindell	To provide an update on the strategy	Read report
Patient Centred Services						
11.	**16/17/49**	**1055**	**Alder Hey in the Park update**	D Powell	• To receive an update on key outstanding issues / risks and plan for mitigation .	Read report
Financial Growth and Safeguarding Core Business						
12.	**16/17/50**	**1100**	**2015/16 Annual Report and Accounts**	E Saunders/ J Stephens/ S Igoe	To approve the Annual report and Accounts	Read report
13.	**16/17/51**	**1120**	**Corporate Governance Statement**	E Saunders	To approve the Corporate Governance statement 2015/16-2016/17.	Read report
14.	**16/17/52**	**1130**	**Board Self – Certification of Compliance with the Provider License**	E Saunders	To approve the declaration in relation to general condition 6 and the corporate governance statement, AHSC's and Governor Training	Read report
15.	**16/17/53**	**1145**	**Corporate Report**	J Stephens/ M Barnaby/ H Gwilliams/ M Swindell/ E Saunders/	To note delivery against financial , operational, HR metrics and mandatory targets within the Corporate Report for the month of March 2016	Read report
16.	**16/17/54**	**1200**	**Programme Assurance update** • **Research Education and Innovation Committee** • **Clinical Quality Assurance Committee**	J Gibson	To receive an update on programme assurance.	Read report

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action	Preparation
			• **Resource Assurance and Business Development**			
17.	**16/17/55**	**1205**	**Integrated Assurance Report** - **Board Assurance Framework 16/17** - **Board Assurance Framework May 2016**	E Saunders	To discuss and agree the principal strategic risks for the next 12 months Monthly BAF update.	Read report
18.	**16/17/56**	**1210**	**Integrated Governance Committee Annual report 2015/16**	E Saunders	To receive and review the 2015/16 Committee Annual report	Read report
19.	**16/17/57**	**1215**	**Resources & Business Development Committee Annual report 2015/16**	I Quinlan	To receive and review the 2015/16 Committee Annual report	Read report
20.	**16/17/58**	**1220**	**Audit Committee Chairs update and Annual report Annual report 2015/16**	S Igoe	To receive and review the 2015/16 Committee Annual report	Read report
Any Other Business						
21.	**16/17/59**	**1225**	**Any Other Business**	All	To discuss any further business before the close of the meeting	Verbal
1230 Date and Time of Next Meeting: Tuesday 5th July 2016 at **10:00am, Institute in the Park Boardroom**						
Lunch						

REGISTER OF TRUST SEAL
The Trust Seal was used during the month of **May 2016** for; • W.H Smiths license to make alterations agreement • Land registry transfer of whole registered title deeds

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Minutes of the last meeting held on **Tuesday 3rd May 2016**
Institute in the Park Large Meeting Room at Alder Hey

Present:	Sir David Henshaw	Chairman	(DH)
	Mrs M Barnaby	Interim Chief Operating Officer	(MB)
	Mrs C Dove	Non-Executive Director	(CD)
	Mrs J France-Hayhurst	Non-Executive Director	(JFH)
	Mr J Stephens	Director of Finance	(JS)
	Mrs M Swindell	Interim Director of HR & OD	(MS)
	Mr R Turnock	Medical Director	(RT)
In Attendance:	Ms L Dunn	Director of Marketing and Communications	(LD)
	Mrs H Gwilliams	Director of Nursing	(HG)
	Ms T Patten	Associate Director of Strategic Development	(TP)
	Mr D Powell	Development Director	(DP)
Apologies:	Prof M Beresford	Assoc. Director of the Board	(MB)
	Mr S Igoe	Non-Executive Director	(SI)
	Mrs A Marsland	Non-Executive Director	(AM)
	Mr I Quinlan	Non-Executive Director	(IQ)
	Ms E Saunders	Director of Corporate Affairs	(ES)
	Mrs L Shepherd	Chief Executive	(LS)
Agenda item: 30	Mr J Gibson	External Programme	(JG)

16/17/18 Patient Story

The Board welcomed patient J with his mum and dad to the meeting.

J had been admitted into to PICU on 25th July 2015 for a period of 4 weeks. After PICU J was moved to Ward 4B, J's dad went through how difficult this time was for the family, noting the support of the staff and the PICU parent area had been really helpful through this hard time.

Dad said the open parent area outside the new PICU is difficult if the family wanted to have some privacy, prepare a meal or discuss J's care.

The family said the move to the new hospital had gone really well.

J's room was much better in the new building and included blinds for the family to close if they wanted to. There were some concerns about what was allowed in the room but they were able to work with this.

Dad went through how helpful the kitchen staff on the wards had been with J including having discussions with the family on the different foods that he likes and making them for him. Dad noted the long period of time J had been in the hospital and advised the food in the canteen got repetitive and was expensive.

Medicines had not always been arriving on time and Dad had asked if the family would be able to administer J's medicines themselves. This was continuing to be looked into.

Dad noted issues with smoking outside the building and in the decking areas. It was noted the Trust had asked for a non-smoking shelter that had been rejected due to plans for having no smoking hospitals. It was noted this would continue to be looked into.

Part of J's recovery included sessions in the Hospital pool. J had now had his tracheostomy removed and was doing remarkably well.

The Chair thanked J, his mum and dad for attending the Board meeting and sharing their experiences.

16/17/19 Declarations of Interest
None Declared.

16/17/20 Minutes of the previous meeting held on 5th April 2016
Resolved:
The Board reviewed and approved the minutes of the last meeting.

16/17/21 Matters Arising and Board Action list
All matters for discussion were listed on the agenda.

16/17/22 Key Issues/Reflections
CAHMS
Therese Patten reported on CAHMS and the recruitment process that had taken place for an external leadership role within the team following agreement at the April 2016 Board. Therese was due to call the shortlisted candidate tomorrow morning to offer them the post.

Mags Barnaby
The Chairman asked Mags Barnaby, new COO, to offer her first impressions of the Trust, since commencing in post in April. Mags advised the board that her early impressions had been very positive, with many clinical, nursing and managerial colleagues working hard to support their patients and provide good quality services. There were some areas of services that demonstrated some difficulties in their organisation and delivery of services (outpatients) and others that were having difficulty delivering levels of activity agreed. Mags advised her focus would be in strengthening ways of working, systems and organisation that focus on delivery of improved patient centred services on time and within budget.

North West Best Scheme Awards
David Powell reported on the following three awards won by the Trust;

RIBA North West-Best scheme
RICS North West Best Scheme
LABC North West-Best public sector scheme

Workforce Diversity Task and Finish Group
Claire Dove reported on an issue raised regarding a filming crew within the Trust asking for black staff to be filmed for a programme they were making. The Board noted this was not acceptable.

Melissa Swindell reported on the ongoing piece of work that had been carried out by a workforce diversity task and finish group. Melissa agreed to present a paper at the next meeting.

Staff Awards 9th June 2016
The judging for the staff awards had taken place recently. Louise Dunn highlighted the positive nominations that had been received.

16/17/23 Question and Answer session with Robin Harrison, Industrial Relations Officer, British Medical Association
The Chair welcomed Robin Harrison, BMA to discuss the dispute implementation of the Junior Doctors new contract and the strikes that had been held.

Robin said he had been to the Trust's last planning meeting prior to the strike action and reported on the high level of detail that had been discussed at the meeting.

No further strike action had been planned. The BMA were holding a meeting with Junior Doctors on Saturday morning to reflect on the recent strike actions and discuss next steps.

Robin thanked the Board for inviting him to the meeting and agreed to stay in contact with Rick Turnock regarding any future developments.

Resolved:
Board received an update on the new Junior Doctors contracts.

16/17/24 Proposed Quality Summit
Hilda Gwilliams went through the proposed Quality Summit process to take place following two or more never events/Serious Incident Requiring Investigation/ a near miss serious incident or a combination that have common elements or demonstrate repeated failure to learn, implement improvement.

The Quality Summit review panel would consist of a Non-Executive Director to the chair the review, Chief Nurse or Medical Director, another Executive Director and clinical leaders not previously involved in the case. If possible the panel would also include an external representative.

The May Clinical Quality and Assurance Committee meeting would be a walkabout in the Surgery, Cardiac, Anaesthesia and Critical Care CBU. Any actions from the walkabout would be monitored through CQAC.

A meeting was in the diary with the CQC on 16th May to discuss the recent never events.

Resolved:
The Board approved the proposed Quality Summit process.

16/17/25 Serious Incident Report

Hilda Gwilliams presented the Serious Incident report for March 2016 noting; 1 new serious incident, 7 ongoing and 2 closed. There had been no new safeguarding cases.

Serious Incident Requiring Investigation (SIRI) - Delay in referral to Paediatric Ophthalmic Unit. Patient underwent cataract surgery, attended Accident & Emergency Department 6 weeks later with red eye, subsequent clinic appointment 5 days later revealed retinal detachment, surgical repair not possible due to delay from onset of symptoms, resulting in permanent loss of vision. Christian Duncan, Clinical Director was leading the review.

From the seven ongoing serious incidents one had not met the 60 working day target due to the complicated nature of the case and an extension had been agreed. There were no concerns with the remaining 6 SIRI meeting the 60 working day deadline.

Resolved:
The Board received the Serious Incident report for March 2016.

16/17/26 Clinical Quality Assurance Committee: Chair's update

Resolved:
The Board received the CQAC minutes from the last meeting held on 16th March 2016.

16/17/27 People Strategy update

Melissa Swindell provided the people strategy progress update report.

The official Trust opening was taking place on Wednesday 22nd June. Invitations were due to be circulated this week.

HR was currently working on new starters having their mandatory training day on their first day of joining the Trust.

The Listening into Action project was being led by Kerry Turner and had been launched on 28th April 2016. The project aims to support a new way of working and embed new ways to engage staff in making improvements in patient care.

Feedback from Listening into action included a reduction in meetings. Executives agreed to consciously reduce meeting burden to release time in their week to be more visible, listening and supportive of staff.

Resolved:

a) The Board received and noted the content of the People Strategy update.

b) Executive team to review reducing the number of meetings to be more visible and supportive for staff.

16/17/28 Alder Hey in the Park

David Powell provided an update on the plans for the development of the residual site. Temporary moves of staff were in progress from the buildings to be demolished which would enable the development to begin.

Resolved:
The Board received an update of Alder Hey in the park.

16/17/29 Corporate Report

At the end of 2015/16 the Trust is reporting a deficit position of £4.4m which is £1.7m behind plan. The Trust is £4m behind the CIP target. Monitor risk rating of 2 for the year.

The average daily attendance, A&E in March was approximate 190 patients with over 50% being green triaged (minor illness or injury and GP). To support this flow; work is underway to divert appropriate patients back to primary care. This piece of work is being support by Liverpool CCG.

Resolved:
The Board received and noted the content of the March 2016 Corporate report.

16/17/30 Programme Assurance Update

Joe Gibson provided an overview of the programme assurance arrangements following approval for the workstreams to report to sub committees of the Trust Board.

The change programme overall is 3 months behind the optimal progress against initial planning assumptions ; 12 of 25 projects are yet t fully complete a Project Initiation Documents (PIDs). It is essential all projects have clearly outlined the scope of the project, the key targets and benefits together with the miles stones for delivery.

Joe Gibson and Mags Barnaby were meeting tomorrow to discuss progressing performance.

Resolved:
The Board noted the importance for the programme to meet the targets set.

16/17/31 Integrated Assurance Report and supporting documents

Resolved:
The Board agreed to defer this item until the next meeting.

16/17/32 Resource and Business Development Committee: Chair's Update

Resolved:
The Board noted the minutes from the meeting held 30th March 2016.

Date and Time of next meeting: - Monday 23rd May 2016 at 10:00am in the Institute in the Park, Large Meeting Room, Alder Hey.

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Monday 23rd May 2016

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

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1. Background:

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

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

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

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

2. SIRI performance data:

SIRI (General)														
2014/15							2015/16							
Month	**Mar**	**Apr**	**May**	**June**	**July**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**
New	4	1	0	5	0	3	2	2	2	1	1	3	1	2
Open	2	5	6	5	7	5	2	3	3	3	5	6	7	6
Closed	2	1	0	1	3	2	4	1	0	2	1	0	2	2
Safeguarding														
Month	**Mar**	**Apr**	**May**	**June**	**July**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**
New	1	2	0	0	0	1	0	0	0	0	1	2	0	0
Open	0	1	3	0	0	0	0	0	0	0	0	0	0	0
Closed	0	0	0	3	0	0	0	0	0	0	0	0	0	0
Total closed	**3**	**0**	**0**	**0**	**3**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

3. Recommendations:

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

New SIRI Incidents reported between the period 01/04/2016 to 30/04/2016:							
Reference Number	**Date investigation started**	**CBU**	**Incident Description**	**RCA Lead Investigator**	**Progress**	**60 working day compliance**	**Duty of Candour/ Being Open policy implemented**
RCA 183 2016/17 StEIS 2016/9552	11/04/2016	SCACC	Never Event – Wrong side chest drain inserted into patient.	Paul Baines, Consultant, Paediatric Intensive Care Unit	Initial fact finding underway (statement gathering, collation of timeline of events).	Yes	Yes
RCA 184 2016/17 StEIS 2016/10039	12/04/2016	SCACC	Grade 3 Pressure Sore to back of patient's head.	Sue Tickle, Sister, Paediatric Intensive Care Unit	Following initial investigation, pressure sore deemed to be unavoidable due to the clinical condition of the patient. RCA not required, to be closed.	N/A	Yes

New Safeguarding investigations reported 01/04/2016 to 30/04/2016:							
Reference Number	**Date investigation started**	**CBU**	**Incident Description**	**RCA Lead Investigator**	**Progress**	**60 working day compliance**	**Being Open policy implemented**
Nil							

On-going SIRI incident investigations (including those above)							
Reference Number	**Date investigation started**	**CBU**	**Incident Description**	**RCA Lead Investigator**	**Progress**	**60 working day compliance (or within agreed extension)**	**Duty of Candour/ Being Open policy implemented**
RCA 180 2015/16 StEIS 2016/8081	21/03/2016	NMSS	Delay in referral to Paediatric Ophthalmic Unit. Patient underwent cataract surgery, attended Accident & Emergency Department 6 weeks later with red eye, subsequent clinic appointment 5 days later revealed retinal detachment, surgical repair not possible due to delay from onset of symptoms, resulting in permanent loss of vision.	Brigid Doyle, Lead Nurse	RCA panel meeting held 04/05/16. RCA report to be written.	Yes	Yes
RCA 173 2015/16 StEIS 2016/4710	15/02/2016	NMSS	Grade 4 pressure sore to patient's heel from plaster cast, identified at OPD.	Keith Rafferty, Quality and Safety Improvement Lead	RCA report in the final stages of quality check.	Yes	Yes
RCA 172 2015/16 StEIS 2016/3088	01/02/2016	SCACC	Never Event. Wrong site surgery. Patient listed and marked for umbilical hernia repair. Surgical incision made at site of marking and not below the umbilicus as planned. Incision closed and new incision made approximately 1 inch lower.	Harriet Corbett, Consultant Surgeon and Maureen Arrowsmith, Ward Manager	Further questions raised during the quality check stage of the report which are required to be addressed; following which report will be written.	Yes	Yes
RCA 162 2015/16 StEIS	14/01/2016	SCACC	Never Event. Wrong site anaesthetic block to patient. During anaesthesia for a right	Kerry Turner, Theatre Risk and	Further questions raised during quality check stage.	Yes	Yes

2016/1409			femoral fixation, left side block performed.	Governance Lead	Observation of practice being undertaken and panel meeting to be held 27/05/2016. RCA report to be written following above panel.		
RCA 155 L2 2015/16 **Internal**	26/11/2015	MS	Patient suffered 10x medication (teicoplanin) error repeated on 3 occasions.	Dave Walker, Medication Safety Officer	RCA report undergoing quality check.	Parents' Decision	Yes
RCA 136 L2 2015/16 StEIS 2015/29703	11/09/2015	CS	Delay in diagnosis of CF in patient.	Paul Newland, Clinical Director	Multi Agency RCA Alder Hey report completed. Super panel meeting held with external agencies 12/05/2016, final report to be completed by June 2016.	Yes	Yes

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

SIRI incidents closed since last report						
Reference Number	**Date investigation started**	**CBU**	**Incident Description**	**RCA Lead Investigator**	**Outcome**	**Duty of Candour/Being open policy Implemented**
RCA 158 L2 2015/16 StEIS 2015/38524	09/11/2015	ICS	Grade 4 extravasation injury to patient.	Cheryl Brindley, Homecare/ CCNT Manager	RCA report completed and sent to family.	Yes
RCA 178 2015/16 StEIS 2016/6230	25/02/2016 04/03/2016 (confirmed Grade 3)	SCACC	Grade 3 pressure sore to patient's sacrum. Patient on ECMO, too clinically unstable to turn, query unavoidable.	Ellen Buckley, Tissue Viability Nurse Specialist	Following investigation, pressure sore deemed to be unavoidable due to patient's clinical status. RCA investigation not required.	Yes

Safeguarding investigations closed since last report
Nil

Clinical Quality Assurance Committee
Minutes of the last meeting held on Wednesday 20th April 2016,
Room 5, Level 1 Mezzanine

Present:	Anita Marsland, (Chair)	Non- Executive Director	AM
	Mags Barnaby	Interim Chief Operating Officer	MB
	Gill Core	Chief Nurse	GC
	Hilda Gwilliams	Director of Chief Nurse	HG
	Jeannie France Hayhurst	Non- Executive Director	JFH
	Erica Saunders	Director of Corporate Affairs	ES
	Jonathan Stephens	Director of Finance	JS
	Melissa Swindell	Interim Director of HR	MS
	Rick Turnock	Medical Director	RT
In Attendance:	Adam Bateman	General Manager Surgery	AB
	Colin Beaver	Interim Internal Coms Manager	CB
	Pauline Brown	Lead Nurse, SCACC	PB
	Sue Brown	Strategic Project Manager	SB
	Christian Duncan	Clinical Director for NMSS	CD
	Dan Grimes	General Manager, Medical Spec	DG
	Jacqui Flynn	Integrated Community Services	JF
	Joe Gibson	External Programme	JG
	Rachel Greer	General Manager NMSS	RG
	Gail Hewitt	Deputy Director of Quality	GH
	Janet Richardson	Programme Manager	JR
	Tony Rigby	General Manager, Quality Strategy	TR
	Lachlan Stark	Head of Planning and Performance	LS
	Julie Tsao	Committee Administrator	JT
Agenda item: 06	Julie Hughes	Associate Director of Infection Prevention & Control	JH

16/17/01 Apologies:

Simon Kenny	Clinical Director SCACC	SK
Paul Newland	Clinical Director for Clinical Support CBU/Consultant Biochemis	PN
Mary Ryan	Clinical Director ICS	MR
Louise Shepherd	Chief Executive	LS

16/17/02 Declarations of Interest
None Declared.

16/17/03 Minutes of the previous meeting held on 16th March 2016
The Committee approved the minutes of the last Clinical Quality Assurance Committee held on 16th March 2016.

16/17/04 Matters Arising and Action list
A number of Clinical Directors had sent their apologies noting this was due to clinical commitments or annual leave.

Jackie Flynn said the new reception area had been approved, a date for it to be fitted was to be confirmed and it was hoped this would be done before the end of May 2016.

All actions from the previous meeting had been completed or was listed as an item on the agenda.

16/17/05 Programme Assurance 'Our Patients at the Centre'
Implementation of the Quality Strategy

An update on the implementation of the Quality Strategy since the last meeting was provided.

Tony Rigby went through the Milestones/Deliverables from the Project Initiation document (PID), advising it was likely the completed date on the milestone for; establish devolved Quality Improvement teams in CBUs may be delayed due to the current CBU review.
A discussion was held on the clinical cabinet that was to be implemented to provide leadership and oversight on quality improvement. To support the implementation of the clinical cabinet Tony Rigby was in discussions with governance to set up a what's App Group.

Tony Rigby reported on the good engagement that had been received from colleagues.

Resolved:
CQAC received and approved Implementation of the Quality Strategy (PID).

Best in Operative Care
An update on the Best in Operative Care project since it was developed, January 2016 was given.

An issue had previously been raised noting the requirement for Botox to be stored on the unit to improve discharge times. This had now been resolved.

An update on the focus for theatre times to start promptly at 8:30am every morning.

The CQAC Committee noted a number of gaps in the benefit and measures table on page 8 of the (PID). Adam Bateman advised the data was now available and this would be updated.

Adam Bateman reported on the good engagement that had been received from colleagues.

Resolved:
CQAC received and approved Best in Operative Care (PID) subject to completion of page 8 of the (PID).

Complex Care made Simple
The project will focus on improving the quality of care delivered to these children, reducing waste and releasing bed capacity by facilitating early discharge or avoiding admissions. It will be underpinned by the POINT principals which have been developed as a best practice model for supporting children with complex needs. This involves;

- Potential – Clear and effective goal setting using SMART objectives
- Organised – Clearly defined roles and responsibilities and clear communication
- Involved – PFCC approach ensuring that the voice of the child and family is listened to at every stage
- Need Based – Working across traditional boundaries to deliver what is needed
- Together – Collaborative approach underpinned by MDT working and interagency co-operation

A meeting had been arranged for the beginning of May to discuss the lack of funding Vanguard had received.

Dan Grimes reported on a team of newly qualified Nurse Social Workers (NSW) who have been in post since September 2015 with the objective of progressing discharge for long-stay patients who tend to have complex health and/or social needs.

The (NSW) identify all (non-Oncology) patients with a length of stay of more than 30 days but patients can be referred earlier by any member of clinical/nursing staff who felt that a patient may benefit from (NSW) Intervention.

Since November 2015 the number of long stay patients had dropped from 45 to 26.

A discussion was held on future funding for the (NSW) team noting the benefits the team provide for local authorities as well as the Trust. Options would be looked into including contacting Liverpool Clinical Commissioning Group for funding.

Resolved:
CQAC noted their support for the Nurse Social Workers team and approved the Complex Care made simple PID.

Joe Gibson went through the three page Programme Assurance progress update that would be presented to provide an update on each of the (PIDs). A total of 6 (PIDs) would be reporting into CQAC. Three had been presented today with the three following (PIDs) to be presented; Improving Outpatients, Improved Flow and Clinical Support Services. As it was early stages for both Improving Outpatients and Clinical Support Services no targets had been set against the (PIDs) yet.

A steering group had been established to support the Improving Flow (PID).

A discussion was held on the difficulty of clinical representation being available to support the (PIDs).

The Programme Assurance Framework is a weekly item on the Executive agenda to ensure actions are completed within time and prior to the next CQAC meeting.

Resolved:
a) CQAC received and approved three PIDs
b) CQAC noted the importance for the PIDs to continue to be progressed
c) To be a standard item on the agenda

16/17/06 Infection Prevention Control Service External Review
Julie Hughes went through the findings of her external review that took place from January – March 2016. The aim and the objectives was to review compliance with practices and procedures.

Findings included;
- The Infection Prevention and Control team (IPCT) identified a proactive, dedicated team however the Lead Nurse is the only practitioner with a qualification in infection prevention and control. The (IPCT) are also a relatively new team and although experienced practitioners in other fields require further specialised training and development in infection prevention which is in progress. The Consultant Microbiologist/DIPC is also to retire. Hilda Gwilliams and Rick Turnock advised they would action a succession plan outside of the meeting.
- Currently the requirements to undertake (IPC) mandatory training is every 3 years and attendance particularly with medical staff was to be improved. The (IPCT) were working closely with the Education team to improve and resolve this.
- In relation to water sampling there was initial ongoing disagreement with responsibility and accountability for funding the process resulting in a lack of legionella sampling from November until March despite high end of line water temperatures with the potential risk to the Trust. This is now resolved with Interserve undertaking

responsibility and no issues have been identified with the results. Lang O'Rouke has agreed responsibility for investigating and resolving the end of line temperatures.
- The dispenser hand hygiene signage issue had now been resolved.
- Review and reintroduce the Ward Decontamination Checklists of which the utilisation is varied across the Trust
- Meetings were being held with the domestic teams to improve the cleanliness of the Trust.

Resolved:
a) The Chair thanked Julie Hughes and the team on behalf of CQAC for their support on resolving concerns.
b) It was agreed Infection, Prevention and Control would continue to be reported on quarterly to CQAC.

16/17/07 Radiology update

Following an agenda item at the previous meeting on the CQC action plan Dan Grimes had agreed to invite the Radiology team to CQAC to report on the progress to date from the CQC action plan. As a lead for the team was currently on sick leave it was agreed this item would be deferred until they returned.

Resolved:
a) Item deferred.
b) Dan Grimes agreed to inform Hilda Gwilliams and Julie Tsao once the member of staff had returned from sick leave.

16/17/08 Quality Accounts 2015/16

Gail Hewitt presented the draft Quality Account with a separate document highlighting the Trust's quality achievements since 2013.

One of the targets for 2014/15 had been to reduce grade 2, 3 and 4 hospital acquired pressure ulcers. Overall pressure ulcers had reduced and implementation of improvement plans would continue.

Melissa Swindell queried the stated budgeted for HR and agreed to discuss this further with Gail Hewitt outside of the meeting.

Jackie Flynn said she would like to include CAMHS in the quality report and agreed to send the information to Gail.

Resolved:
The Chair thanked Gail Hewitt and the teams for developing the 15/16 Quality Accounts.

16/17/09 Self-assessment against Monitors Quality Framework

Resolved:
a) CQAC received and noted the Self-assessment against Monitors Quality Framework position at March 2016.
b) CQAC agreed for position statements to be submitted quarterly.

16/17/10 Corporate report – Quality Metrics February 2016.

The first draft of the corporate report – quality Metrics for the end of February 2016 was presented and discussed.

There were 2 serious incidents requiring investigation in February, one of which was a Never Event. There have been a total of 3 Never Events to date and the annual improvement target is zero.

Pressure ulcers grade 2 and 3 have reached the annual improvement targets of 20 and 1 respectively. Pressure ulcers grade 4 have exceeded the annual improvement target of zero. Medication errors that result in harm, readmissions to PICU within 48 hours and clinical incidents resulting in all levels of harm are below February's improvement goal are on track to achieve the annual improvement target.

The Patient Experience Summary was to be added.

The number of complaints received had increased, this was welcomed by CQAC as issues would then be resolved.

Patients had been calling the Patient Advisor Liaisons office for appointments. Information was to be circulated to patients highlighting the correct process to book appointments.

A discussion was held on the arrow colour and direction within the trend box and how this might be incorrectly interpreted. Hilda Gwilliams asked CQAC to email feedback on improving the metrics.

Resolved:

a) CQAC received and noted the quality metrics ending February 2016.
b) CQAC to email Julie Tsao with feedback on improving the metrics within the Corporate report.

16/17/11 Committee Annual Report

Resolved:

The CQAC Annual report was approved subject to both Jeannie France Hayhurst and Jonathan Stephens being added to the attendance list.

16/17/12 Board Assurance Framework

The 2015-16 Board Assurance Framework for 1.1 Deliver Clinical Excellence in all our services was presented.

Jill Preece, Quality Assurance Officer was currently developing the risks for 2016/17.

A discussion was held on statement outlining the purpose of the committee relating to each BAF to be included.

Resolved:

CQAC received and noted the Board Assurance Framework for 2015-16.

16/17/13 Claims Management Policy

The Claims Management Policy was presented for approval.

Resolved:

Subject to a number of minor amendments CQAC approved the Claims Management policy.

16/17/14 Resuscitation Services Action Plan

Resolved:

An update on the external review of resuscitation services was given. Melissa Swindell agreed to present the action plan at the next meeting.

16/17/15 Any Other Business

Gill Core, last meeting

The Chair thanked Gill Core for all her support over the years and wished her well in the future on behalf of CQAC.

Supporting Papers five days prior to meeting
Joe Gibson noted papers for meetings are due to be circulated 5 days prior to the meeting and asked CQAC to forward any items to Julie Tsao at least 6 days prior to future meeting dates.

Date and Time of next meeting: - Wednesday 18th May at 10am, Large Meeting Room, Institute in the Park.

Alder Hey Children's NHS
NHS Foundation Trust

Draft Clinical Quality Assurance Committee Annual Report 2015/16

The Clinical Quality Assurance Committee

The purpose of the Clinical Quality Assurance Committee is to provide assurance to the Board of Directors that the Trust's systems, processes and culture ensure the highest standards of clinical quality in terms of patient safety, clinical effectiveness and patient/carer experience to our children and young people and their families.

The Committee has delegated powers from the Trust Board to oversee the effectiveness of clinical quality, clinical practice and clinical governance within the Trust, ensuring that all supporting systems and processes enable all staff to adhere to their duty of candour. It does this principally via the Clinical Business Units and Clinical Directors who have the authority to implement the Trust's Quality Strategy and supporting Quality Aims within and across CBUs, supported by the central functions.

The principal devolution of the Board's responsibilities are as follows:

Quality Strategy

- To oversee the development, implementation and evaluation of the Trust's Quality Strategy and its underpinning strategies, in accordance with the Monitor *Quality Governance Framework*.
- To monitor the performance of the Trust against its agreed Quality Aims and all national mandatory/regulatory targets and quality standards.
- To provide assurance to the Board of Directors that the key clinical risks to the organisation are being identified and managed appropriately.

Quality Improvement Culture

- To seek assurance that all staff are fulfilling their **responsibilities** for delivering high quality, child-centred services under the auspices of the Trust's *Quality Improvement Culture* initiative.
- To seek assurance that the right mechanisms, **leadership and culture** are in place to address, monitor and manage the quality of clinical/patient services.
- To monitor the effectiveness of the Trust's framework for raising concerns.

Constitution

The terms of reference are reviewed and revised annually and were last approved by the Committee in July 2015. The Membership comprises four Non-Executive Directors, including the Chair of the Committee, Chair of the Audit Committee and Integrated Governance Committee, Medical Director, Chief Nurse, Chief Executive, HR Director, Director of Finance, Chief Operating Officer, Director of Corporate Affairs and the CBU Clinical Directors. To ensure that CQAC remains strategic and assurance led, it is also supported by the Clinical Quality Steering Group (CQSG) which monitors quality assurance at an operational level and reports in to CQAC.

CQAC meets bi-monthly while Quality walkrounds, which are open to all Board Directors and Governors, are held every other month. A schedule of attendance is shown in Appendix A which shows full compliance with quoracy, however attendance from some CDs has continued to be disappointing at certain times during the year.

From April 2015 to March 2016 seven meetings of CQAC were held and four quality walkarounds undertaken. The quality walkarounds are structured with a presentation beforehand, a debrief afterwards and the creation of an action plan by the relevant CBU which is monitored during the year with good practices also highlighted. Key findings, issues and concerns are fed back at each Board meeting by the Committee Chair.

Achievements in 2015/16

- The Trust was subject to a full inspection by the Care Quality Commission in June 2015 which resulted in an overall rating of 'Good' with 'Outstanding' in the Caring domain; the Committee had been responsible for overseeing the implementation the action plan leading up to the inspection, ensuring that all 'must do' areas were addressed.
- On behalf of the Board, the Committee commissioned KPMG to undertake a follow up review of the Trust's performance against Monitor's Quality Governance Framework, the first one having resulted in an overall score of 4.5; the re-review gave a score of 3 which is below the Monitor threshold for FT applicants and is a piece of robust external assurance from a regulatory perspective.
- Two workshops were held during the year to facilitate discussion of the Quality Strategy and associated initiatives; the outcome was consensus that the strategy and direction remain fundamentally sound, with evidence of the principle of 'quality at the heart of everything we do' becoming more embedded across the organisation through the vehicle of clinical engagement via a newly constituted Clinical Cabinet.
- Following the move to the new Hospital the Committee focused its walkaround activity on key areas, specifically ED which was experiencing some teething problems; the Committee brought the associated actions back until resolution was reached.
- The Committee approved and monitored its annual work programme, regularly reviewed the Quality Report and those risks for which the Committee is responsible for oversight. The Trust's Quality Account and limited assurance work undertaken by External Audit and the reports arising from their review were presented to the Committee. In addition, a number of independent peer reviews and external visits were reported to the Committee including invited reviews undertaken by Medical Royal Colleges.

Assurance Statement

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

Committee Priorities for 2016/17

- The chief priority of the Committee in 2016/17 is to oversee the implementation of the refreshed Quality Strategy
- The revised governance arrangements that underpin the Change Programme and its specific projects will be a key focus as the organisation moves to a position where programme assurance will fall under the auspices of Board committees including CQAC. Progress with implementation of the new arrangements will be reviewed on a regular basis.
- The Committee will continue to hold CBUs to account for quality performance and will seek to drive measurable improvements in key quality indicators linked to the Quality Aims.

- Progress with embedding the Duty of Candour in every day clinical practice will be monitored by the Committee as will compliance with CQC Fundamental Standards.
- The completion of the CQC action plan will remain a priority as part of the drive toward achieving an overall 'Outstanding' rating at the next inspection.
- The focus on using the CQC's KLOEs will continue as the basis for walkarounds.

Anita Marsland
Committee Chair
April 2016

APPENDIX A

CQAC - RECORD OF ATTENDANCE 2015/16

Quorum: Chair or nominated deputy, two Directors (one of whom is a clinical lead)

Member/Date of Meeting	2015									2016		
	22nd April	20th May	17th June	22nd July	19th Aug	23rd Sept	21st Oct	18th Nov	15th Dec	20th Jan	17th Feb	16th Mar
Mrs Anita Marsland (Non-Executive Director)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	C	✓ (Chair)	✓ (Chair)	✓	✓	✓	✓	✓
Mr Steve Igoe (Non-Executive Director)	✓	✓	✓	✗	A	✗	✓	✓	✗	✓	✓	✓
Mr Phil Huggon (Non-Executive Director)	✓	✓	✗	✗	N	✓	✓	✓	✓	✗	✓	✓
Mrs Jeannie France-Hayhurst (Non-Executive Director)	✓	✓	✓	✗	C	✓	✗	✗	✓	✓	✗	✗
Mr R Turnock (Medical Director)	✗	✓	✗	✗	E	✗	✓	✓	✓	✗	✗	✗
Ms Gill Core (Chief Nurse)	✓	✗	✗	✗	L	✓	✗	✓	✗	✓	✓	✓
Mrs Hilda Gwilliams (Director of Nursing)	-	-	✗	✓	E	✓	✓	✓	✓	✓	✓	✓
Mrs Louise Shepherd (Chief Executive)	✓	✓	✓	✓	D	✓	✗	✓	✓	✗	✗	✓
Mr J Stephens (Director of Finance)	✓	✓	✗	✓	-	✓	✗	✓	✗	✓	✓	✓
Ms Erica Saunders (Director of Corporate Affairs)	✓	✓	✓	✓	-	✗	✗	✓	✓	✓	✓	✓
Mr David Alexander (Director of HR & OD)	✓	✓	✓	✓	-	✓	n/a	n/a	n/a	n/a	n/a	n/a
Mrs M Swindell (Interim Director of HR & OD)	n/a	n/a	n/a	n/a	-	n/a	✓	✓	✓	✓	✗	✓
Mrs Jude Adams (Chief Operating Officer)	✓	✓	✓	✓	-	✓	✓	✓	✓	✓	✗	✓

Alder Hey Children's NHS
NHS Foundation Trust

Board of Directors
23rd May 2016

Report of:	Director of Human Resources & Organisational Development
Paper Prepared by:	Interim Director of Human Resources & Organisational Development
Subject/Title:	People Strategy Progress Update April 2016
Background Papers:	Employee Temperature Check for April
Purpose of Paper:	To present to the Board monthly update of activity for noting and/or discussion.
Action/Decision Required:	The Committee is asked to note the contents of the report.
Link to: **Trust's Strategic Direction Strategic Objectives**	Great Talented Teams
Resource Impact:	None

Section 1 - Engagement

That we build on Alder Hey's strengths to further develop a culture that focuses on quality and the continuous improvement of the service that we provide to patients.

People Support and Engagement

The Trust signed up to Listening into Action in April, a methodology which will, over the next 12 months, support improved staff engagement and patient care. Activities taking place in May have included the distribution of the Pulse Check and the Leadership Scorecard, two staff surveys taken at the start of the 12 month journey which provide baseline data from which to compare progress in 12 months time; invitations to the 5 'Big Conversations' in June have been distributed, from which we aim to have 400 staff attending over the 5 events; the launch event for the first ten clinical teams who are going to work the 'LIA way' is taking place on the 18th May 2016.

To supplement this engagement work, the OD team will continue to issue the Temperature Check, the results of which will supplement understanding with LiA processes and it will also serve as an indicator of our progress with our developing Leadership and Management Strategy.

Development of Leaders

The Leadership and Management Development Strategy was ratified in April 2016; this supports the piloting and implementation of interventions to support management and leadership development across the Trust. The team will be supporting the implementation of these programmes with a coaching approach. An introduction to Leadership Values will be trialled from mid June 2016 for existing managers and open to new managers from October, and a Management Induction programme is being finalised and will run from July 2016. The HR & L&D team will also be supplying Essential Skills training sessions supporting the understanding of HR policy and processes, also from July onwards.

Coaching support continues for senior leaders via Fiona Reed Associates.

Improving communication and hearing the employee voice

In the April Temperature Check the Staff Friends and Family scores for place to work and place for treatment were 28% and 79% respectively. CBUs are provided with their own data each month to enable them to identify specific locally raised issues. Both scores are lower than the previous month and so we will use the local data to identify areas of concern.

Section 2 - Availability of key skills

That we always have the right people, with the right skills and knowledge, in the right place, at the right time.

Effective workforce planning

Human resources Business Partners continue to engage closely with Finance colleagues and senior CBU and Corporate Managers to support strategic development and delivery of CIP requirements.

The workforce CIP project continues to focus on reducing the variable pay costs arising from control of agency, bank, overtime, sickness and vacancies. Close engagement with NHSP colleagues is ongoing, who are in the process of increasing both internal and external banks across staff groups in the Trust (excluding medics) and seeking alternative agency routes where there are barriers to meeting Monitor Agency cap requirements. Weekly Monitor submissions are being completed in line with reporting requirements to detail totals of weekly agency shifts undertaken in various staff groups.

Meetings are also taking place to review ongoing use of medical locums and to consider alternative use of STAFFflow to reduce cost of VAT and to enable a more streamlined approach to recruitment of medical locums within Monitor requirements. Recent information indicates an increasing usage of STAFFflow at 42% of locum engagement.

The HR team in support of the Trust's CIP challenge for 2016/17, continue to focus on high variable costs (inc ongoing agency usage) within CBUs/Depts and discussions are ongoing with managers to review existing structures and support and to consider options such as transferring agency staff to either bank positions via NHSP or to recruit to Alder Hey staffing, eg, fixed term contracts, to minimise excess cost. As an example, the Hotel Services Department transferred 30 Agency Domestic staff to Alder Hey employment on 18th April 2016, thus reducing Agency costs. Other individual roles are being reviewed with respective senior management to transfer either to NHSP (bank) or Alder Hey contracts to minimise costs.

Hotel Services – Following the conclusion of the consultation process in relation to staffing structures and working practises/ patterns in the CHP, only one appeal remains outstanding. The appeal hearing chaired by a General Manager took place on 9th May 2016 with decision pending.

Theatres – Consultation processes concluded at the end of March Outside Theatre Care Assistant teams, which encompass a review of management structures, shift patterns and roles and responsibilities. Two staff submitted separate appeals regarding their shifts which have been informally resolved and mutually accepted. Implementation of the new proposal commenced 9th May 2016.

A&E reception – An organisational change document is being finalised to commence consultation on adjustments to shift patterns. The consultation documents are in the process of being circulated for commencement mid May 2016 for 30 days

Ophthalmology - Consultation process concluded at the end of April with no appeals raised. Posts are currently going through the job matching processes with the Head of Services post currently advertised. It is expected that implementation will commence May/June 2016.

Pathology - Discussions are ongoing with senior pathology management as a result of a re-tendering of a contract for pathology services with a local Trust – it is understood that the Department will be submitting an application to continue providing the service. Should the application not be successful this could result in TUPE transfer of up to 4 staff to the successful bidder – informal discussions taking place with staff.

Learning and Development

The PDR window for 2016/17 reopened again in April 2016. The emphasis is on supporting new managers with review skills, recording, as well as mandatory training and nurse revalidation. Individual and group coaching sessions have been accessed by staff and further groups learning sessions have been planned with the leadership development facilitator for the remainder of the window.

There has been renewed focus on improving Corporate Induction attendance. Processes are being developed with recruitment to ensure mandatory attendance of new starters on or around the first day of employment without exception. These processes include aligning payroll sign on to induction. We intend to trial the new processes in July 2016.

Section 3 - Structure & Systems

That we have a best in class HR processes, policies and collective bargaining arrangements that deliver on the things that are important to the Trust

Effective Policies

Concerns continue regarding the lack of staff side involvement in the review of some policies and attending PRG, which have been escalated at JCNC, however work continues and the sub-groups presented the final drafts of the revised “Absence and Attendance Policy” and the “Management of Stress at Work Policy” at March’s PRG. Both policies were approved and subsequently ratified at WOD committee. The next steps are implementation of the new policies which will include bespoke training sessions to managers who have responsibility for managing the policy, managers guides, and drop in Q & A sessions for staff over the June and July.

Employee Relations Activity

There are currently 10 formal cases ongoing with 2 staff suspended. The cases comprise of disciplinary investigations, grievances and bullying and harassment complaints. There has been a steady reduction in the number of formal cases being managed by the HR Team over the last few months, with many cases reaching their conclusion. The team are continuing to work with managers and our staff side partners to ensure that the remaining cases are managed efficiently and within shorter timeframes.

Corporate Report

The April Corporate Report shows all five HR areas under target, three of which are 'red', including PDR compliance, Corporate Induction and sickness absence. These areas remain a key area of focus for the HR Team, and form elements of the priority projects plans going forward for Workforce Capability and Leadership & Management Development.

Section 4 - Health & Wellbeing

That all Trust employees feel valued and respected by the organisation and actively contribute to the organisation's success.

Creating a healthy workforce
A Health and Wellbeing subgroup has been formed as part of the Quality Strategy Steering Group, and is exploring ideas and priorities to support employee health and wellbeing.

Promoting positive attendance
The Trust's absence rate is 5.6% for end of March 2016, which shows no change from last month.

We continue to focus on highlighting the importance of effectively managing sickness in line with the existing policy and putting in place a framework of additional management information and improving the current policy with updated training.

The HR team continue to meet weekly and monthly with General Managers, operational service leads and CBU management teams to review absence statistics/trends/hotspots and trigger information; to review and report on outstanding actions to support improved absence rates, to deliver focussed masterclass absence training and to provide one-to-one coaching in difficult and complex absence case work.

Leading in Equality & Diversity

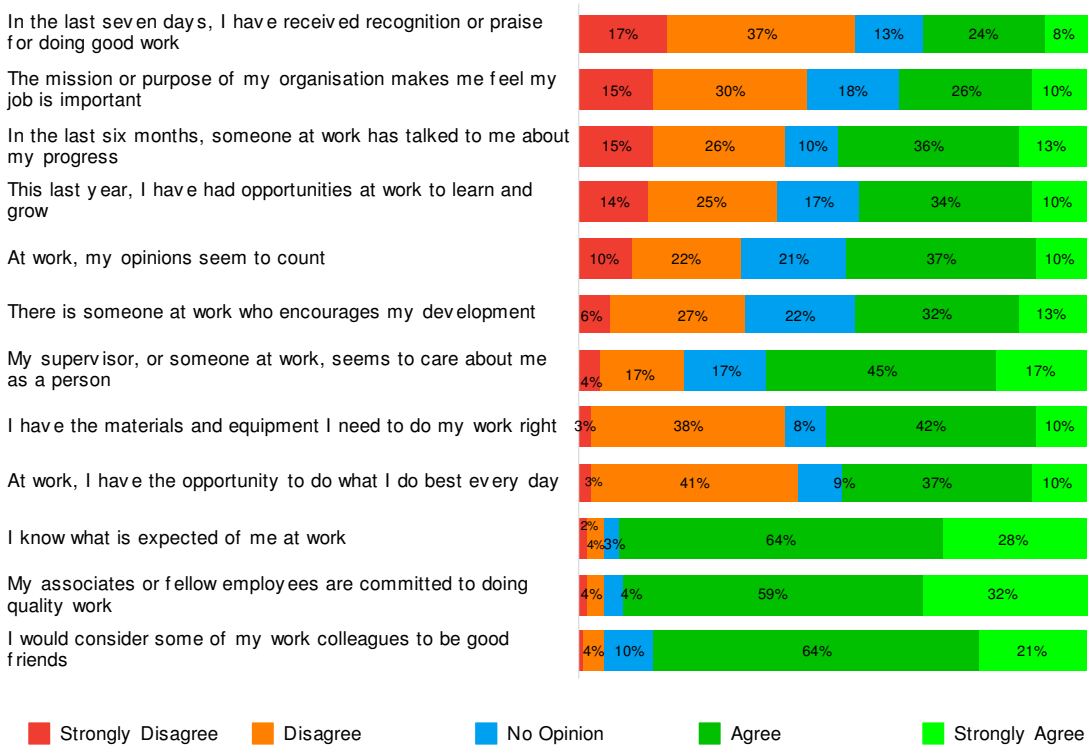
A separate paper attached in Appendix Two details the approach we are taking to address the issues we have identified regarding workforce diversity.

Summary of monthly Employee Temperature Check for: April

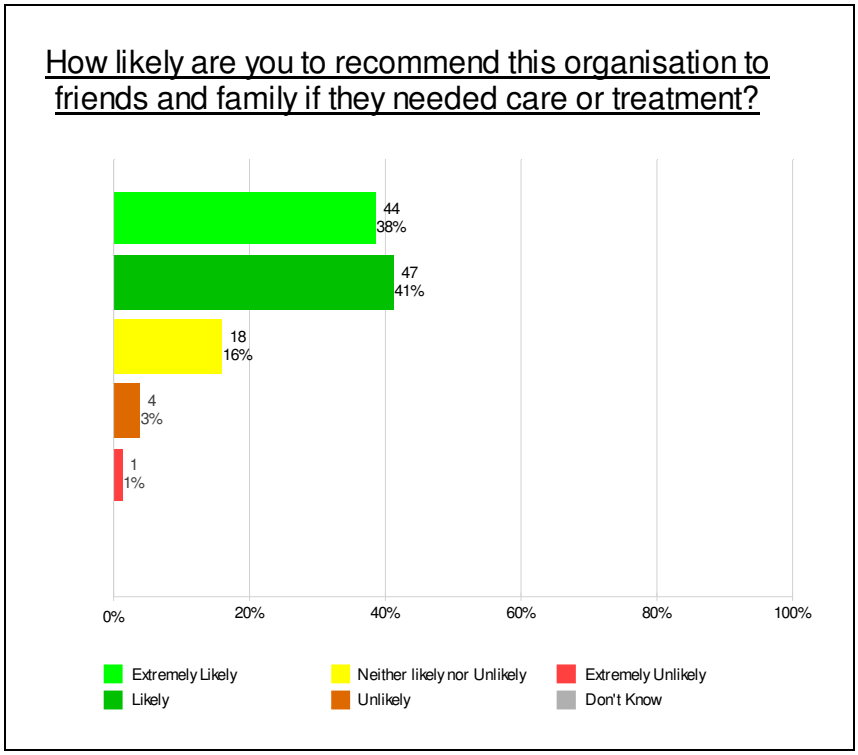
The percentage of staff who were in Overall agreement with the 12 questions for **April** was **57%**.

The area most in need of improvement was **In the last seven days, I have received recognition or praise for doing good work.** This question recorded an overall Disagreement score of **55%**.

Rating Scale for 12 questions



Overall Engagement for 12 questions



What is the main reason for the answers you have chosen?

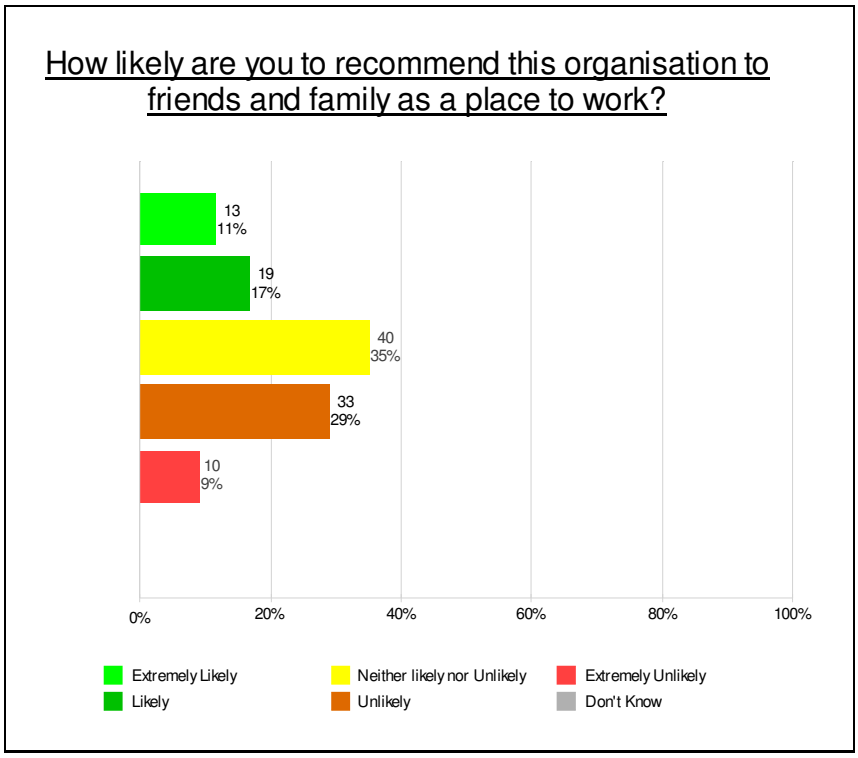
It is a local hospital with dedicated front line staff who do great work
This is an amazing organisation and provides a great service to the patients
We seem to be losing some quality consultants and various staff from across the board as changes have been implemented especially since the new hospital was built
I know the people working here care for the children who come here.
Poor accommodation. It is totally sub-standard and we should not allow our children and families have to put up with such poor conditions.
Excellent care from Doctors and Nurses
The clinicians, doctors, nurses and support staff are the best in the area, committed, dedicated and caring. Unfortunately NHS funding is limited yet they struggle through every day to provide the best care to each and every patient despite this.
The Quality and Dedication of the staff within the trust.
nursing and medical staff dedicated in their work in the provision of care
The commitment and expertise of the staff is excellent but the poor infrastructure results in constant inefficiency and delays, duplications, omissions etc, and there is a real risk that this will result in patient harm
I believe the nursing and medical staff strive to give good care, although often under difficult circumstances.
I am not local to Alder Hey
Fantastic staff who work over and above to provide the best care they can.

What is the main reason for the answers you have chosen?
The staff are fantastic and I am proud to work in this hospital
it's the best place
We have a fantastic facilities and the care shown by staff is excellent.
Likely to recommend, but only because I know that if my friends/ relatives needed treatment I would make sure they got the right input.
Based on personal experience of my children being treated here
Staff on the ground work together well and care
Despite all the problems the staff on the delivery side strive to give good care to families
expertise
Excellent care from caring staff
Frontline staff provide high standard of care for children and families. On the whole nursing/medical staff are caring, committed and compassionate.
Overall Alder Hey offers a good service
Good Clinical care. Staff are still committed to our patients and will do their utmost for the patients despite the lack of facilities.
Staff shortages, staff morale
The commitment and caring attitudes I have seen from medical consultants
It's where you'd come anyway, doesn't need recommending
I trust my colleagues i see the excellent quality of work that goes on here.
There is always staff shortages and some departments are poorly managed that have impacts on the service
the staff who work with the patients are highly skilled professionals
depends on which speciality they need
IT'S A FANTASTIC TRUST WITH AMAZING STAFF
Still a few patchy areas. I would check who they were going to see.
This new hospital does not have the atmosphere nor the warm feeling of a hospital. I know many of the doctors, surgeons and nurses and know they do a great job, but, the atmosphere is not like it was in the old Alder Hey - I miss this :(.
teh organisation only seems to care about money not patients or people
the direct care is first class
I had positive personal experience as a parent
I think the clinicians are skilled the systems leave a lot to be desired on occasions
I have worked in this trust for many years and in my opinion we have some of the best medical professionals and it is very true that the work force makes Alder Hey special.
Wait list
confident that we provide excellent care

What is the main reason for the answers you have chosen?
This organisation provides good quality care, but with financial pressures, the resources are stretched and do not always deliver the best possible services. This is the case across the NHS, so the organisation probably compares well to other providers, but many of the changes over the last year with the new hospital and the new meditech system have caused further stress and I think have impacted on services that can be provided.
high quality care and treatment is given cannot however speak for other departments
generally good care is delivered but that is because of the effort staff put in which is above what would normally be expected of them
Alder Hey has a very good reputation, I would not hesitate in recommending family/friends to be referred her for any sort of treatment, knowing that the treatment they would be get would be of benefit to them and a good patient experience.
Quality of care
best children's hospital
The staff here are dedicated to giving the best service they can.
because despite the daily difficulties and challenges, staff do care about the patients and families safety and experiences whilst in hospital
Consultant led care is excellent. However I have been embarrassed on many occasions when friends and acquaintances have received poor nursing care and have felt that medical decisions have not been made in a timely manner. In addition there is often a poor level of general hygiene in many clinical areas.
We continue to strive to deliver quality services
Concerns regarding appropriate staffing to provide a safe and efficient service (medical and pharmacy).
I feel the staff within my organisation are committed to giving the best that they can, given the stressful surroundings they are under.
Long waiting times for Out-patient appointments
I feel we do what we can to best of our ability
I think the trust is still undergoing a period of extreme change, I think it will take time for everything to settle down and for us to become 'excellent' at what we do again. I feel we are lurching from crisis to crisis, every day seems to be running at crisis point finding beds for everyone to go into.
The staff are extremely caring and do a fantastic job looking after children when they are given the time to do their jobs properly. The problem is that there are just not enough staff to enable everyone to carry out their roles to the best of their abilities, jobs are rushed, corners cut and staff are feeling demoralised which does affect patient care.
reorganisations have made patient experience worse through the theatres and safety issues remain unaddressed / ignored
Majority of staff want to do the best for pateints and families
High quality care.
THAT THE WARD LEVEL STAFF DELIVERING THE CARE ARE EXCEPTIONAL KNOWLEDGABLE PEOPLE THAT WANT TO DO THEIR BEST FOR THEIR PATIENTS DESPITE EVERYTHING ELSE
good quality of care

What is the main reason for the answers you have chosen?

Children's hospital



What is the main reason for the answers you have chosen?

Admin & Clerical staff are under valued nowadays
I have reservations after my working experiences so far
SINCE THE NEW HOSPITAL WE SEEM TO BE BEING OVERLOOKED ESPECIALLY THOSE OF US LEFT BEHIND IN THE OLD BUILDING. FEWER CLEANERS, NO SECURITY LESS PARKING SPACES FOR THOSE OF US WHO ARE STILL PAYING EACH MONTH WHILE THOSE WHO DONT ARE GETTING FREE PARKING
the Trust has made massive changes in the last few years and continues to strive to ensure staff and patients are listened too so that they can provide the best possible care
Don't feel valued, my pay band is low and I have not moved up in 12 years or been given the opportunity to be able to move up.
staff working environment and staff facilities very poor operational and flow systems inadequate unrealistic expectations of staff
No vision, poor leadership, and poor communication
I know that the all members of staff work tirelessly to ensure the optimal care of patients so I would recommend the Trust as a good place of care for children. However I feel staff morale is very low, despite the move to the new hospital (where endless teething troubles are so frustrating) - increased workload with fewer staff and I could not recommend working here at the present time

What is the main reason for the answers you have chosen?
There are worse organisations to work for. This one has its faults but on the whole it is tolerable.
For admin staff there is no career progression/development opportunities
Friendly staff, modern facilities.
nursing moral low at present due to work pressures as staff shortages
See above
staff are undervalued. management don't listen when problems are voiced.
Friends and family are not local to Alder Hey
because we are expected to work long hours often without breaks and leave late in order to give the best care. it is not a safe place to work. you don't feel valued just used. you get no recognition for lack of sickness and reliability.
I do not feel that the move tot he new trust has benefitted staff we are more stressed short staffed and the computers are too time consuming and take away from what we should be doing
Through the current climate I don't think the staff are valued enough. Everyone is under immense pressure and short staffed.
Not enough staff on the wards and departments, there is no longer any flexibility in the system. Not enough listening to staff at grass roots level - when people do 'listen' - it is ignored.
Any organisation can be a good place of work but it depends on the department and team you work with to make it an enjoyable job
The organisation doesn't appear to be concerned about staff wellbeing
Frustrations at HR, Management, lack of support - workload increases despite staff numbers reducing
unstable department
concern about the future especially for AHPs at present
Would be unlikely to recommend NHS as an employer. There is very little recognition from senior management for the dedication and commitment of staff. Senior Management seem to poor knowledge about the everyday issues facing frontline staff. More responsibilities being place on staff .
I have worked for Alder Hey for 23 years. It isn't perfect, but when I compare to other physios in neighbourin Trusts I would reckon that we are fortunate
no support. New IT systems/M6 and lack of back up support from depts. such as medical records make assessing patients very difficult. management make changes to clinics without consulting the Clinicians and therefore make the situation worse. No PDRs therefore no progression etc. My last real PDR was in 2012
I feel we are in a period of significant transition and financial insecurity and I am uncertain of the immediate future in the Trust. I feel there is a great deal if underlying tension in the Trust which makes the Trust a difficult place to function effectively at times. I am not sure any NHS Trust is any different at this time.
staff morale
The work can be rewarding but staff morale is poor. Meditech 6 has caused major problems and makes everybody's job more difficult to do efficiently.
it is a good place to work with many opportunities to develop excellent working conditions.
BIG CHANGES FOR STAFF WITH THE NEW BUILD ---STAFF NOT CONSIDERED

What is the main reason for the answers you have chosen?
Mindset much improved from a few years ago but still a few niggles here and there.
From my point of view, I see the changes in the hospital and I feel uncomfortable sitting at my station. I am constantly having to watch what I am doing and looking over my shoulder for whom is watching me if I make mistakes. I don't feel wanted, as part of a team or valued. So the reason for my answer is - if you don't mind working like a robot or having people watching every movement, then this is your place. Too many people will suck to climb the ladder, rather than earning their right like in the olden days.
honesty
as above
lack of commitment and negative communications from the Trust to MH needs and workplace
because the main aim of the organisation is to cut cost without taking into consideration the impact on patients and staff
I think management raises hope of situations getting better, but it never really happens -it the next change demand -again its about pushing it through very often without consultation-communication -situations become fragmented. My department has improved but that's due to my colleagues and their resilience. There are also too many chiefs this has a detrimental effect
Staff morale in this trust is at an all time low and management need to realise they can't keep blaming it on the new hospital and settling in. Granted it hasn't helped but the problems have been building over many years. I have family and friends who work in other Trusts and they are often shocked by the way staff are treated in this Trust.
lack off support by manager
Because the Service we provide is second to none the staff go above and beyond, many self fund training - as training budget is so small and contributions from the trust is so small - but the ethos towards staff is such that rather than looking after the well-being and development of staff seems to come second to performance and stats and the pressure that staff are put under at times is untenable.
They don't look after staff.
happy in my job
stressful at times as short staffed
Don't feel appreciated, especially in my department where there has been a restructure, there are total extremes in the way some staff have been treated compared to others, no consistency at all. Lines of communication practically non existent at the moment.
This organisation provides good quality care, but with financial pressures, the resources are stretched and do not always deliver the best possible services. This is the case across the NHS, so the organisation probably compares well to other providers, but many of the changes over the last year with the new hospital and the new meditech system have caused further stress and I think have impacted on services that can be provided. This has impacted negatively on staff morale.
I would recommend my area of work as it friendly a high standard of care given and we work as a team
staff are under constant stress since move into new build everything that should have made our job easier has made it twice as hard due to the persistant lack of staff and a feeling that management do not care about it as long as it looks good on paper

What is the main reason for the answers you have chosen?
generally I ma happy with work though I do find the layout of the new hospital terrible for patient safety and staff morale.
All jobs have their up and down days, but if you get one parent/member of the team thanking you for your help then this would certainly cancel out any negativity I have had i.e. via a phone call from an irrate parent.
the lack of clinical staff with the correct skills and the waste of time and money spent fixing problems that have arisen due introduction of schemes that don't work and staff already stated they wouldn't work. Constantly having to educate managers about specialties and patient needs.
Opportunity and comittment
job satisfaction
Stress at work!
I would recommend the majority of our services because they are on a par with others and I do consider that a lot of our consultants are amongst the best. I certainly wouldn't recommend all of our services, as they are better elsewhere and safe staffing levels concern me greatly. I wouldn't recommend as an employer due to the management heavy structure and the very poor opportunities for career progression for nurses. Also non-clinical roles are more highly valued and better paid eg research/ data collection. Where is the appreciation of unsocial hours, working public holidays, arduous physical work, high risk clinical areas with high acuity patients. It is difficult to attract the best nurses into these roles when they can be better rewarded for easier work lives, this then impacts on standards of care.
The funding crisis in the NHS is starting to really bite and the is a less compassionate approach from employers and managers.
I feel that the trust does not value it's staff, make them feel important or provide for them sufficiently. Considering that we have just had a wonderful new building built, some of the staff provisions and workplace provisions are inadequate. We also have many staff leaving this trust for higher band jobs elsewhere because they do not feel valued here and their work goes unappreciated. The trust will not (is not able) to acknowledge their hard work and/or offer them sufficient remuneration.
Concerns regarding appropriate staffing to provide a safe and efficient service (medical and pharmacy).
I feel the trust put staff under a lot of pressure to work in areas they feel are not deemed safe due to the patient / staff ratio
do not feel appreciated
same reasons as above.
CARE IS SECOND TO NONE. THE CARE I GIVE IS ALWAYS 200%. HOWEVER WE AS STAFF ARE NOT TREATED IN THE SAME WAY. WE NEED TO GO HOME TO OUR OWN FAMILIES/CHILDREN. WHEN I AM CONSTANTLY OFF LATE AND THE WHOLE MACHIENE THAT IS ALDER HEY CANNOT FUNCTION WITHOUT ME STAYING IT IS A POO SITUATION TO EXPECT MY SIX YEAR OLD TO DO SO!!!!!!
I have worked at Alder Hey for many years and on the whole enjoy my job. However, whether I would recommend it as a place to work would very much depend on the job in question and the experience of the person concerned. There is little time to train new staff in their roles and support is not always available due to lack of staff.

What is the main reason for the answers you have chosen?
new hospital and working patterns mean people more isolated and difficult to find. makes working life less enjoyable. notes not available . meditech 6 obviously not initially designed for clinicians. daily work more difficult
Support from colleagues who try and provide quality work. sometimes against the odds.
Good facilities. Good multidisciplinary teams.
LACK OF SUPPORT FOR JUNIOR STAFF MEMBERS
patient care is excellent. need to improve training and development as well as support for staff
Because in the main the level of care is of a high standard and I do like my job
Too short staffed

Appendix Two

Improving Workforce Diversity at Alder Hey

1. Introduction:

Through its equality monitoring processes (WRES, EDS2), the Trust has identified that action needs to be taken in relation to the current under-representation of BME staff within the workforce. To support this work, we will establish a Task and Finish Group with specific objectives to identify ways of improving this position and address under representation.

2. Local Context:

The census data suggests that Liverpool has a higher than national and regional average of mixed ethnic groups at **11%**. Of its total workforce, Alder Hey employ **6%** of its staff from this group. Data from a number of sources, including the staff survey and local recruitment data from NHS Jobs shows:

- that white shortlisted applicants are on average 1.74 times more likely to be appointed than are BME shortlisted applicants;
- That BME staff are more likely than white staff to experience harassment, bullying or abuse from other staff;
- that BME staff are more likely to experience discrimination at work from colleagues and their managers;
- BME staff are less likely to believe that their organisation provides equal opportunities for career progression;
- the proportion of NHS board members and senior managers who are of BME origin is significantly smaller than the proportion within the total workforce and the local communities served.

3. The Task and Finish Group:

We propose moving quickly with the formation of a Workforce Diversity task and finish group. We have invited participants to be part of the group with the inaugural meeting to take place on the 15th June 2016 and thereafter to meet fortnightly.

3.1 Group Membership:

- Melissa Swindell, Chair & Executive Lead
- Paula Davies, Learning and Development
- Hannah Ainsworth, Equality Lead
- Maria Salcedo, Equality HR Lead
- Hellie-Patterson Brown, Recruitment & Employment Services Manager
- Sharon Owen, HR Manager Recruitment Lead
- Val Shannon, Volunteers Manager
- Pauline Brown, Deputy Director of Nursing
- Iris Aitken, Staff Side Representative
- Abu Sawaneh, Diversity and Inclusion Champion

3.2 Objectives:

The purpose and objectives of the group will include:

- A review of the recruitment process of Black and Minority Ethnic (BME) staff (all levels)
- A review of the selection process of Black and Minority Ethnic (BME) staff (all levels)
- To ask BME staff about their work place experience
- To review the data we have available and what we need to monitor
- To work with education providers and assess their recruitment processes
- To identify opportunities available for apprentices and volunteers
- To learn from other organisations, for example Bradford Teaching Hospital
- To involve local stakeholders e.g. community leaders, job centres, health watch, higher education providers

3.3 Measures of Success:

The long term target will be to achieve a 1% increase per annum in improvements in numbers of BME staff employed by the Trust over the next 5 years, and a workforce aligned more closely to the local working population.

It is recommended that for assurance, monitoring of task and finish groups actions will be reported to WOD Committee bi-monthly.

3.4 National and Local Drivers for this approach:

- There is considerable evidence strongly suggesting that the less favourable treatment of BME staff in the NHS, through poor treatment and opportunities, has a significant impact on staff well-being, patient outcomes and on the efficient and effective running of the NHS.
- It is morally the right thing to do, we have local people who may not be getting a fair opportunity to obtain employment at Alder Hey
- It is an opportunity to allow local people to apply for job vacancies including in hard to fill areas
- Families need to see and feel that Alder Hey is an inclusive and welcoming environment to all, and the current workforce profile does not indicate this
- Working towards race equality is rooted in the fundamental values, pledges and responsibilities of the NHS Constitution
- The Equality Act 2010 places Public Sector General and Specific Duties on the Trust
- It is an obligation of our Quality Contract/CCG
- The Equality Delivery System (EDS2) goal 3.1 requires evidence showing 'Fair NHS recruitment and selection processes lead to a more representative workforce at all levels'
- We are required to publish and report to NHS England annually the Workforce Equality Standard (WRES) and an action plan to address inequality identified.

4. Recommendations:

The Board is requested to support the approach and proposals outlined in this report.

ALDER HEY IN THE PARK PROJECT

HIGHLIGHT REPORT - Site & Park Development	Date: 20/05/16	Period: May 2016	SRO: David Powell
	Report Number: 1		Author: Chris McCall

Programme 2016/17	Apr-16				May-16					Jun-16				Jul-16				Aug-16					Sep-16				
Week Commencing	4	11	18	25	2	9	16	23	30	6	13	20	27	4	11	18	25	1	8	15	22	29	5	12	19	26	
Temporary Moves																											All on track - will be delivered on programme
Decommissioning & Demolition (Phase 1 & 2)																											2 months behind programme primarily due to lack of funding to fully meet demolition tender pressures, over budget. Exploring options to bring back into budget.
Residential																											Programme on track. 23 expressions of interest received, resulted in 9 PQQ submissions. Project group, consisting of Trust, LCC & external advisors, met and have selected 6 submissions to proceed to enter into dialogue.
Park																											Shadow Board has been established, representatives from Local Councillor, LCC Planning and local residents. A major design event/workshop planned for 10th June to identify the first year events and developments within the existing park. Project Coordinator appointed and will commence mid June.
Corporate Offices/Clinical on-site																											Initial designs presented to staff. Delay due to developing an affordable scheme. Proposal is to take 300sq m out of the scheme to achieve affordability - costs still need to be substantiated. A review of required office accommodation to be conducted over the next 2/3 weeks.
Community																											Project due to commence June 2016 on receipt of service delivery model currently being worked on by Business Development Team/CBU
Reseach & Education Phase II																											Trust has instructed design to be developed up to a stage for pricing and construction ready.
Agile Working																											Project due to commence June 2016. PID is complete. External advisor commissioned from BT on limited funding.
On-site Residual																											Project due to commence July 2016 - programme documentation under development
Alder Centre																											Project due to commence July 2016 - Project Lead and Centre Manager currently visiting other recently built centres.
Commercial																											Trust in discussion with Police regarding occupying space in corporate offices with a view to a deal on acquiring the Eaton Road police station site. Veterinary surgery proposed land swap with Trust, decision to be made by Trust within the next 3 months.

Risk/Cost impacts

No.	Risk	Actions to reduce risj to target rating	Score
2. Decommissioning & Demolition			
2.1	Decommissioning cost pressure - CP of £150K anticipted for the cost of decommissioning and movement of goods across the site	Fortnightly project meetings and weekly discussions with Finance department. Reported to Strategic Project Group, no identified budget but estimate on total costs presented as a baseline to work to	15
2.2	Income shortfall/decommissioning - Shortfall against the expected income from sale of goods/assets from old estate	Continue monitoring and efforts to sell on as much as possible	15
2.3	Demolition and decommisioning on retained estate - process could result in breach of H&S for patients and staff	Ensure all existing controls are monitored and additonal controls undertaken as appropriate	15
2.4	Demolition delay effects overall programme plan	Strategic Project Group to oversee project milestones and take actions to rectify any unmet milestones	12
4. Park			
4.1	Capital funding - Obtaining adequate funding to develop the 3 themes of the development	Developer interest already identified. Sustrans and LFC charity bids being developed	12
4.2	Revenue funding - receiving adequate funding for the park to be sustainable	Sustrans and LFC charity bids being developed. Local interest groups already maintaining areas of park. Local council ward funding providing safe stores and equipment to commence regular local support	12
5. Corporate Offices/Clinical On-site			
5.1	Delay in programme due to procurement delay of design team and builder	Trust has instructed Hopkins to undertake works under OJEU limit. Intention is to appoint Morgan Sindall via direct award if we can demonstrate VFM	12
5.2	Project affordability	Trust has reduced area and will continue to look at Value engineering options. Seeking to bundle project with R&E to generate further savings	12
5.3	New office too small - insufficient desks for corporate staff	Agile Working Project to deliver 34% agile working. Alternative accommodation options in R&E Phase 2, Ex. Histo Building and Main hospital	12
5.4	Demolition programme slips	Risk and mitigation covered in Demolition Project	12
7. Research & Education Phase II			
7.1	Construction costs increasing due to programme delays	Trust developing a shell & core option to start construction to mitigate some of the inflation costs	15
7.2	Funding shortfall – Currently £4m shortfall	Trust and partners actively seeking new sources of funding	15
7.3	New Occupiers of Phase 2 require Design Changes	User Group sessions organised to review design	12

Alder Hey Children's NHS
NHS Foundation Trust

Draft Management Representation Letter

Eaton Road
Liverpool
L12 2AP

Telephone: 0151 282 4692
www.alderhey.com

Amanda Latham
Director
KPMG LLP Audit
1 St Peter's Square
Manchester
M2 3AE
United Kingdom

23 May 2016

Dear Amanda,

This representation letter is provided in connection with KPMG LLP's audit of the financial statements of Alder Hey Children's NHS Foundation Trust ("the Trust"), for the year ended 31 March 2016, for the purpose of expressing an opinion:

- as to whether these financial statements give a true and fair view of the state of the financial position of the Trust as at 31 March 2016 and of the Trust's income and expenditure for the financial year then ended; and
- whether the Trust's financial statements have been prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2015/16.

These financial statements comprise the Trust's Statement of Financial Position, the Statement of Comprehensive Income, the Statement of Cash Flows, the Statement of Changes in Taxpayers Equity and notes, comprising a summary of significant accounting policies and other explanatory notes.

The Board confirms that the representations it makes in this letter are in accordance with the definitions set out in the Appendix to this letter.

The Board confirms that, to the best of its knowledge and belief, having made such inquiries as it considered necessary for the purpose of appropriately informing itself:

Financial statements

1. The Board has fulfilled its responsibilities for the preparation of financial statements that:
   i. give a true and fair view of the financial position of the Trust as at 31 March 2016 and of the Trust's income and expenditure for that financial year; and
   ii. have been prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2015/16.

   The financial statements have been prepared on a going concern basis.

2. Measurement methods and significant assumptions used by the Board in making accounting estimates, including those measured at fair value,are reasonable.

3. All events subsequent to the date of the financial statements and for which IAS 10 Events after the reporting period requires adjustment or disclosure have been adjusted or disclosed.

4. The effects of uncorrected misstatements are immaterial, both individually and in aggregate, to the financial statements as a whole. The effects of uncorrected misstatements are immaterial, both individually and in aggregate, to the financial statements as a whole. There is one uncorrected adjustment above £190k following audit of the 2015/16 financial statements.

Information provided

6. The Board has provided you with:

   - access to all information of which it is aware, that is relevant to the preparation of the financial statements, such as records, documentation and other matters;

   - additional information that you have requested from the Board for the purpose of the audit; and

   - unrestricted access to persons within the Trust from whom you determined it necessary to obtain audit evidence.

7. All transactions have been recorded in the accounting records and are reflected in the financial statements.

8. The Board confirms the following:

   i. The Board has disclosed to you the results of its assessment of the risk that the financial statements may be materially misstated as a result of fraud.

   ii. The Board has disclosed to you all information in relation to:

      a) Fraud or suspected fraud that it is aware of and that affects the Trust and involves:

         - management;

         - employees who have significant roles in internal control; or

         - others where the fraud could have a material effect on the financial statements; and

      b) allegations of fraud, or suspected fraud, affecting the Trust's financial statements communicated by employees, former employees, analysts, regulators or others.

      In respect of the above, the Board acknowledges its responsibility for such internal control as it determines necessary for the preparation of financial statements that are free from material misstatement, whether due to fraud or error. In particular, the Board acknowledges its responsibility for the design, implementation and maintenance of internal control to prevent and detect fraud and error.

9. The Board has disclosed to you all known instances of non-compliance or suspected non-compliance with laws and regulations whose effects should be considered when preparing the financial statements.

10. The Board has disclosed to you and has appropriately accounted for and/or disclosed in the financial statements, in accordance with IAS 37 Provisions, Contingent Liabilities and Contingent Assets, all known actual or possible litigation and claims whose effects should be considered when preparing the financial statements.

11. The Board has disclosed to you the identity of the Trust's related parties and all the related party relationships and transactions of which it is aware. All related party relationships and transactions have been appropriately accounted for and disclosed in accordance with IAS 24 Related Party Disclosures.

12. The Board confirms that all intra-NHS balances included in the Statement of Financial Position (SOFP) at 31 March 2016 in excess of £100,000 have been disclosed to you and that the Trust has complied with the requirements of the Intra NHS Agreement of Balances Exercise. The Board confirms that Intra-NHS balances includes all balances with NHS counterparties, regardless of whether these balances are reported within those SOFP classifications formally deemed to be included within the Agreement of Balances exercise.

13. The Board confirms that:

    a) The financial statements disclose all of the key risk factors, assumptions made and uncertainties surrounding the Trust's ability to continue as a going concern as required to provide a true and fair view.

    b) Any uncertainties disclosed are not considered to be material and therefore do not cast significant doubt on the ability of the Trust to continue as a going concern.

This letter was tabled and agreed at the meeting of the Audit Committee on 19 May 2016.

Yours sincerely

[SIGNATURE]

Jonathan Stephens

Director of Finance

[SIGNATURE]

Louise Shepherd

Chief Executive

For and on behalf of the Board of Alder Hey Children's NHS Foundation Trust

Appendix to the Board Representation Letter: Definitions

Financial Statements

IAS 1.10 states that a complete set of financial statements comprises:

- a statement of financial position as at the end of the period;
- a statement of comprehensive income for the period;
- a statement of changes in equity for the period;
- a statement of cash flows for the period;
- notes, comprising a summary of significant accounting policies and other explanatory information;
- comparative information in respect of the previous period; and
- a statement of financial position as at the beginning of the earliest comparative period when an entity applies an accounting policy retrospectively or makes a retrospective restatement of items in its financial statements, or when it reclassifies items in its financial statements.

Material Matters

Certain representations in this letter are described as being limited to matters that are material.

IAS 1.7 and IAS 8.5 state that:

"Material omissions or misstatements of items are material if they could, individually or collectively, influence the economic decisions that users make on the basis of the financial statements. Materiality depends on the size and nature of the omission or misstatement judged in the surrounding circumstances. The size or nature of the item, or a combination of both, could be the determining factor."

Fraud

Fraudulent financial reporting involves intentional misstatements including omissions of amounts or disclosures in financial statements to deceive financial statement users.

Misappropriation of assets involves the theft of an entity's assets. It is often accompanied by false or misleading records or documents in order to conceal the fact that the assets are missing or have been pledged without proper authorisation.

Error

An error is an unintentional misstatement in financial statements, including the omission of an amount or a disclosure.

Prior period errors are omissions from, and misstatements in, the entity's financial statements for one or more prior periods arising from a failure to use, or misuse of, reliable information that:

a) was available when financial statements for those periods were authorised for issue; and

b) could reasonably be expected to have been obtained and taken into account in the preparation and presentation of those financial statements.

Such errors include the effects of mathematical mistakes, mistakes in applying accounting policies, oversights or misinterpretations of facts, and fraud.

Management

For the purposes of this letter, references to "management" should be read as "management and, where appropriate, those charged with governance".

Related parties

A related party is a person or entity that is related to the entity that is preparing its financial statements (referred to in IAS 24 *Related Party Disclosures* as the "reporting entity").

a) A person or a close member of that person's family is related to a reporting entity if that person:

   i. has control or joint control over the reporting entity;

   ii. has significant influence over the reporting entity; or

   iii. is a member of the key management personnel of the reporting entity or of a parent of the reporting entity.

b) An entity is related to a reporting entity if any of the following conditions applies:

   i. The entity and the reporting entity are members of the same group (which means that each parent, subsidiary and fellow subsidiary is related to the others).

   ii. One entity is an associate or joint venture of the other entity (or an associate or joint venture of a member of a group of which the other entity is a member).

   iii. Both entities are joint ventures of the same third party.

   iv. One entity is a joint venture of a third entity and the other entity is an associate of the third entity.

   v. The entity is a post-employment benefit plan for the benefit of employees of either the reporting entity or an entity related to the reporting entity. If the reporting entity is itself such a plan, the sponsoring employers are also related to the reporting entity.

   vi. The entity is controlled, or jointly controlled by a person identified in (a).

   vii. A person identified in (a)(i) has significant influence over the entity or is a member of the key management personnel of the entity (or of a parent of the entity).

Related party transaction

A transfer of resources, services or obligations between a reporting entity and a related party, regardless of whether a price is charged.

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Private & confidential
The Board
c/o Jonathan Stephens
Finance and Business Development Director
Alder Hey Children's NHS Foundation Trust
Eaton Road
West Derby
Liverpool
L12 2AP

Our ref QAMR – 15/16

17 May 2016

Dear Jonathan

Management Representations for Alder Hey Children's NHS Foundation Trust for the period ended 31 March 2016

We are required by Auditing Standards to obtain appropriate representations from management before our audit report on the Quality Report is issued. In an NHS context we believe it is appropriate for these representations to be discussed and agreed by at a minimum the Audit Committee, however you may also wish for these to be considered by the Board. The actual representation letter from the Board should be signed by an Executive Director on behalf of the Directors, on the same date as the Board approves the Quality Report.

We have attached an example representation letter, which you may find helpful. Please note that this is not the only evidence we obtain in relation to these matters. If you feel that you cannot make the representations suggested in the example letter we will take this into account in determining the level of audit risk and the scope of our work relating to the Quality Report.

Please contact us if you have any queries about the above or foresee any difficulties providing us with the representations sought in this letter.

Yours sincerely

Amanda Latham
Director

Alder Hey Children's NHS
NHS Foundation Trust

KPMG LLP
1 St Peter's Square
Manchester
M2 3AE

[X] May 2016

Dear Sirs

QUALITY REPORT 2015/16 - BOARD REPRESENTATION LETTER

This representation letter is provided in connection with your limited assurance engagement regarding the Quality Report of Alder Hey Children's NHS Foundation Trust ("the Trust") for the year ended 31 March 2016 for the purpose of forming a conclusion, based on limited assurance procedures, on whether anything has come to your attention that causes you to believe that:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual 2015/16;
- the Quality Report is not consistent in all material respects with the sources specified in the Monitor guidance; and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the 'NHS Foundation Trust Annual Reporting Manual' and the six dimensions of data quality set out in the 'Detailed Guidance for External Assurance on Quality Reports 2015/16' (the Guidance').

The Board confirms that:

(a) The Quality Report has been prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2015/16 and supporting guidance;

(b) The content of the Quality Report is not inconsistent with the internal and external sources of information set out in [Section 2.1] of the Guidance;

(c) The Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;

(d) The performance information reported in the Quality Report is reliable and accurate;

(e) There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;

(f) The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and

(g) The Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

This letter was tabled and agreed at the meeting of the Board of Directors on 23rd May 2016 May 2015.

Yours sincerely

Hilda Gwilliams
Chief Nurse

Alder Hey Children's NHS

NHS Foundation Trust

Annual Report & Accounts 2015/16

Presented to Parliament pursuant to
Schedule 7, paragraph 25(4) of the
National Health Service Act 2006

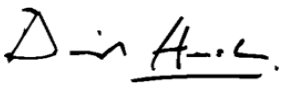
Contents

Chair and Chief Executive's Welcome

We are delighted to bring you our Annual Report for 2015/16, a truly remarkable year in Alder Hey's history. After almost a decade of dreaming and planning, we finally moved into our fantastic state of the art hospital, which together with our plans for Springfield Park and our wider Campus, represents a unique and lasting legacy for the children of Liverpool and beyond for generations to come. In support of this and our aim to provide exceptional care to match our exceptional facilities, we implemented a new Electronic Patient Care System which we intend will provide the basis for a fully technologically enabled hospital environment over the next few years. Our journey of improvement is by no means over, but we now have added impetus and opportunity to continue to strive for excellence for our patients and the community.

Last summer, in the midst of plans for the move and the delivery of a significant programme of change to ensure that our models of care are fully aligned to the new building, we also welcomed back our colleagues from the Care Quality Commission to undertake a re-inspection of our services. This resulted in an overall rating of Good, with the Caring domain considered Outstanding by the inspection team. This is a stunning and thoroughly deserved achievement for our staff who had worked tirelessly to respond to the recommendations made by CQC in 2014. This places Alder Hey in the top 20% of NHS organisations nationally. We are continually awed by the dedication and commitment of our highly professional, hard-working teams for whom going the extra mile is a daily occurrence. We hope that this report does justice to the collective, sustained effort made by everyone at Alder Hey to deliver such an extraordinary performance in 2015/16.

The process of reflecting on past achievements inevitably leads to consideration of what the future holds. Our ambition as an organisation remains steadfastly focused on providing the best possible care to every one of our patients, founded on leading edge, evidence based research and innovative, technologically enabled practice. Thanks to the peerless endeavours of our staff and the unstinting support of our partners, we are optimistic that we will make our vision a reality.



Sir David Henshaw
Chairman

Louise Shepherd
Chief Executive

Performance Report

Overview

About the Trust

Alder Hey Children's NHS Foundation Trust continues to provide care for over 275,000 children and young people each year. In addition to the hospital site at West Derby, Alder Hey has a presence at a number of community outreach sites and in collaboration with other providers, our consultants help deliver care closer to patients' homes by holding local clinics at locations from Cumbria to Shropshire, in Wales and the Isle of Man. We also provide inpatient care for children with complex mental health needs at our Alder Park building in the nearby borough of Sefton.

The Trust employs a workforce of 2,796 staff who work across our community and hospital sites and as a teaching and training hospital we provide education and training to around 540 medical and over 500 nursing and allied health professional students each year.

Our operating turnover is £216m of which £175m directly relates to the clinical services we provide; 33% of our clinical income is non-specialised and 67% is specialised. Our principal contract is with NHS England for tertiary and quaternary care. The Trust also serves a wide population base for secondary care with Liverpool Clinical Commissioning Group (CCG) hosting the £52.3m contract on behalf of 20 associate CCG's in the North West of England. In addition we have a contract with of £12m with commissioners in Wales.

Alder Hey offers a number of specialist services and we are one of only two providers in the North West designated to receive the specialist children's top up to national tariff for this work. We are one of the two accredited major trauma units for children in the North West and are also nationally commissioned as one of four epilepsy surgical centres, a service we provide in partnership with Manchester Children's Hospital. As the regional cardiac surgical centre we continue to lead on developing the cardiac network across the region in order to provide seamless pathways of care for children with congenital heart problems.

Alder Hey continues to be a top performing Trust. We remain registered with the Care Quality Commission (CQC) without conditions. Our ratings from the health sector regulator, Monitor, have been generally among the highest available ('green' for governance and 4 or 5 for financial performance) since authorisation in 2008 and we have consistently achieved the majority of the government's access and quality targets, including those for infection rates. In 2015/16 the Trust planned and achieved a continuity of services risk rating of 2 (financial risk rating). This represents a higher financial risk than previous years and reflected the anticipated impact on the financial position of the implementation of the new electronic patient care system (EPCS) and the move to the new hospital.

Our services are managed through five Clinical Business Units (CBU) each led by a clinical director and general manager who, along with lead nurses, service groups

leads and service line managers are responsible and accountable for the overall clinical, workforce and financial performance of their area.

The Trust has a thriving research portfolio and hosts the UK Medicines for Children Research Network (MCRN) with a Department of Health grant worth £22m; it is also the lead centre for the Cheshire, Merseyside and North Wales MCRN. It leads the field in paediatric pharmacovigilance, and was awarded the only paediatric NHS programme grant (£2m) for work in this area. We continue to be an active member of the Liverpool Academic Health Science System – Liverpool Health Partners Limited - which will enable us to continue to build our research reputation and portfolio whilst ensuring that benefits are brought to patient care.

The Trust is supported by two main registered charities and through the work that they do to support the hospital, we can ensure that Alder Hey's pioneering work continues to make a difference to the lives of children. In addition to the Alder Hey Children's Charity, the Ronald McDonald House charity continues to support 84 families in 'home away from home' accommodation on site whilst their children are being treated in the hospital. We continue to work closely and strengthen our relationship with our charitable partners.

Alder Hey was England's first public health promoting paediatric hospital accredited by the World Health Organisation. With concern for our patients, their parents and carers and our staff in one of the country's most deprived areas, we believe we have a duty of care to provide health awareness, education and support to the communities we serve.

We were authorised as a foundation trust in August 2008 and have an active Council of Governors representing patients, parents, carers, staff, the general public and partner organisations. The Council represents our membership which currently totals 13,500 people across the regions we serve. We have also established our Children and Young Peoples' Forum which meets regularly with Trust staff and has input to the design of the new hospital, as well as supporting the recruitment of key Board level posts.

Our Services

The Trust remains committed to its model of managing services through Clinical Business Units (CBU's), which aims to move decision making about services much closer to patients and put clinicians in the driving seat.

The five Clinical Business Units are comprised as follows:

Medical Specialties	**Integrated Community Services**
• Respiratory medicine • Infectious diseases • Immunology • Metabolic diseases • Nephrology • Rheumatology • Gastroenterology • Endocrinology • Dietetics • Oncology • Haematology • Palliative Care	• Accident and Emergency Department • General paediatrics • Diabetes • Dermatology • Cystic Fibrosis • Myalgic Encephalomyelitis • Community Child Health • Safeguarding services • Neurodisability • Fostering and adoption • Audiology • Child and Adolescent Mental Health Services

Surgery, Anaesthetics, Critical Care and Cardiac Services	**Neurosciences, Musculo-skeletal and specialist surgery**
• Cardiology • Cardiac surgery • Paediatric Intensive Care • High Dependency Unit • Burns Unit • General surgery • Urology • Gynaecology • Neonatal surgery • Theatres • Anaesthesia • Pain control	• Ear nose and throat • Cleft lip and palate • Ophthalmology • Maxillofacial surgery • Dentistry and orthodontics • Neurology • Neurosurgery • Craniofacial surgery • Long term ventilation • Orthopaedics • Plastic surgery

Clinical Support Services
• Radiology • Pathology • Pharmacy • Therapies • EBME • Central admissions • Bed management • Medical records • Outpatients

Our Purpose and Vision

Our Purpose

We are here for children and young people, to improve their health and wellbeing by providing the highest quality, innovative care.

Our Vision

Alder Hey: building a healthier future for children and young people, as one of the recognised world leaders in research and healthcare.

Our Strategic Approach

The Board agreed the Trust's overarching strategy in 2011/12, which set out the four year direction of travel until 2016. The process to refresh the strategy for the next five years commenced in December 2015, following the move to the new hospital and was finalized in April 2016. The Board agreed that the organization's original purpose and vision remain relevant today and will be unchanged to 2020. We will also re-commit to the key strategic pillars illustrated below.

Progress against the Trust's strategic plans has been achieved through the delivery of actions identified within annual operational plans. This has been supported by a performance framework that ensures effective performance improvement alongside continuous development of service line management and reporting.

Delivering on our Strategic Aims: Our Achievements in 2015/16 at a glance

2015/16 was another successful year for Alder Hey. Highlights of progress against each of the strategic pillars during the year include the following:

Excellence in Quality

- *Delivered the nurse recruitment programme, with 250 new nurses joining the Trust*
- *Worked collaboratively with HEI's to embed 'early recruitment programme' enabling 3rd year students to gain employment at an optimal time of their career pathway*
- *Developed further the monthly Quality Report for the Board, measuring progress and outlining improvement actions against the Trust's quality aims*
- *Embedded the* Weekly Meeting of Harm *with increasing attendance. Improved management of incidents reflected both by staff engagement and significant improvement in Trust position in relation to the National Reporting and Learning System (NRLS); the Trust is in the top 25% of its peer group*
- *Remained committed to and enhanced culture of openness embracing the principles of the Duty of Candour*
- *Strengthened 'Ward to Board' governance and risk management processes supported by Trust wide training in 'Principles of Risk Management' to encourage frontline participation*
- *Launched the* Sign up to Safety *campaign linked to achievement of the Quality Aims.*

Patient Centred Services

- *Finalised the development of new clinical models of care in preparation for our new hospital move across the eight key areas identified through the '*How We Will Work in the Future' *project*
- *Continued to develop 'Immerse' model to ensure patient shadowing integrated with medical education to improve patient and family centred care*
- *Implemented the new Electronic Patient Care System (EPCS.*
- *Invested in the creation of an Innovation Hub to enable clinically led innovation to thrive and develop*
- *New hospital development successfully and safely delivered in October 2015.*
- *The hospital has already won a range of awards and prizes to date including:*
    - *Building Design Partnership (BDP) George Greenfall Baines Award (GGB) - Winner BPD Best Building 2015*
    - *Local Authority Building Control (LABC) – Building Excellence Awards 2016 North West - Winner Best Public Service Building*
    - *Royal Institute of British Architects (RIBA) – North West Awards 2016 - Winner Sustainability Award, Regional Winner Best Building Award and Overall North West Winner Best Building Award*
    - *Royal Institute Chartered Surveyors (RICS) – 2016 RICS Awards North West - Design through Innovation, Community Benefit and Project of the Year*.

Great Talented People

- *Embedded our refreshed Trust values based PDR process with improved satisfaction ratings and completion rates*
- *Provided education and training to over 500 medical students and 500 nursing and AHP students*
- *Delivered a comprehensive medical leadership development plan*
- *Continued to provide support for staff raising concerns under the* 'Raise It. Change It' mechanism.

Developing our Business

- *Achieved growth of £1.6m in year from Business Development plans, with expected recurrent full year value of £3.6m revenue*
- *Developed and agreed a new model of Integrated Community Care with Primary Care colleagues, with an initial pilot in Norris Green.*
- *Commenced an implementation process for new investment in the Eating Disorder service.*
- *Expansion of Consultant teams in Gastroenterology and Rheumatology.*
- *Reconfiguration of Critical Care beds, to enable an increase in bed capacity.*
- *Continued to provide "surge capacity" for Respiratory ECMO.*
- *Developed partnership working and joint outpatient clinics in Belfast for Craniofacial and Spasticity services.*
- *Engaged Commissioners (NHS England and local CCGs) with proposals regarding development of a formal pathway for Paediatric Rehabilitation.*

International Research and Education

- *Brough Chair appointed jointly with the University of Liverpool*
- *Phase 1 Institute in the Park Built and accommodated*
- *Ten new commercial research contracts secured*
- *Two Global first patients recruited into international clinical trials*
- *Nearly 2000 (or over 1700) children recruited into clinical research*
- *Four consultants formally recognised by NIHR for outstanding contribution to the life sciences industry in the UK*
- *Award of HTA commissioned call research grant in Cystic Fibrosis*
- *Selected by UK neuromuscular charities as one of three centres of excellence in Duchenne Muscular Dystrophy research in the UK*
- *Successful opening of new CRF with no disruption to service*
- *Collaboration underway with two local small businesses to develop devices due to successful funding from Small Business Research Initiative (SBRI)*
- *Early closure of the SYCAMORE Trial, investigating use of anti-TNF biologic therapy in view of major positive effect, impacting on NHS England's policy on treatment of children with uveitis complicating childhood arthritis, and opening of follow on trial led by the UK Experimental Arthritis Treatment Centre for Children in those failing to respond*

- *Increase in multi-disciplinary training programmes in clinical and translational research and hosting of national trainee meetings championing research*

Quality Achievements since 2013/14

56% increase in incident reporting

120 patients moved safely to new Alder Hey in the Park

Decrease from **23% to 13%** of reported incidents of harm

80% decrease in registered nurse vacancies

119% increase in medication incident reporting

7% increase in the number of registered nurses

Decrease from **20% to 8%** of reported medication incidents of harm

38% decrease of hospital acquired alert organism infections

159% increase in theatre incident reporting

58% decrease in formal complaints

29% decrease in reported theatre incident of harm

93% average for Friends and Family who would recommend Alder Hey

Achievements in 2015/16

For the second time since the last award three years ago, Alder Hey has been awarded “Paediatric Neuromuscular Centre of clinical excellence” status by Muscular Dystrophy UK

Hosted a Hackathon with over 200 clinicians, engineers and innovators

Signed Strategic Partnership with Sony to develop video over data networks in healthcare environments

Secured funding for a PHD student studying innovation in the NHS in conjunction with Liverpool School of Management

Alder Hey as part of Liverpool Health Partners was recognised as one of the top research centres for research into rheumatology by the European League Against Rheumatism (EULAR)

Opened a 1000m^2 Innovation Hub for clinicians and industry in March 2016

Developed partnership with the Virtual Engineering Centre to produce a Virtual Reality imaging platform

Alder Hey is now the hospital in Kidzania in London. Kidzania aims to empower and educate children about medicine and health and reduce fear and unease about hospitals. Children can be a surgeon, paramedic or nurse for the day

Andrea Spyropoulos Project Manager for Alder Hey in the Park and past president of the Royal College of Nursing, was awarded an honorary degree by Liverpool University

Liz Grady awarded Flu Fighter Champion of the year by NHS Employers as Alder Hey achieved 75% compliance target by December 2015

Produced UK’s first 3D sterilisable intra-operative reference model for spinal surgery. This adds an extra level of safety supporting detailed planning and reduced time in theatre.

Developed a secure physically encrypted link for mothers and babies separated by distance

Dr Richard Appleton appointed as Clinical Lead for the Royal College of Paediatrics and Child Health Epilepsy Passport Project launched at the House of Commons in September 2015

Awarded Centre of Excellence Status for ECMO (extra corporeal membrane oxygenation) by the Extracorporeal Life Support Organisation. Alder Hey is one of only a few orgasnisations to achieve this status outside of the USA

Performance Analysis

Alder Hey's approach

Over the past five years, the Trust has developed and agreed a range of Key Performance Indicators linked to regulatory requirements and the achievement of our strategic aims and objectives. The Corporate Performance Report has been developed through the past year, in line with the move to an electronic platform and includes a commentary on each element to highlight areas of good practice, as well as any aspect which falls below standard and the actions being taken to recover the position. The report is supported by an electronic business intelligence system which enables the Clinical Business Units to drill down into key financial, operational and clinical metrics at service line and even individual patient level.

During the latter half of the year, the Trust has reviewed its performance management arrangements to ensure that robust clinical leadership and accountability are in place. From April 2016, the responsibility for the assurance aspects of the next phase of the Trust's change programme will transfer to the Board's key assurance committees, which will be attended by the Clinical Directors and General Managers to enable issues to be resolved in a timely way.

Performance against national priorities

The Trust's performance against national access and other mandated targets for 2015/16 is set out below:

Target or Indicator (per 2013-14 Risk Assessment Framework)	Threshold	National Performance	Qtr1	Qtr2	Qtr3	Qtr4
Summary Hospital level Mortality Indicator (SHMI)[1]			n/a	n/a	n/a	n/a
C. Difficile Numbers – due to lapses in care			0	0	0	0
C. Difficile - Rates per 100,000 Bed days		6.9	0	10.8	0	0
18 Week RTT Target Open Pathways (Patients still waiting for Treatment	92%	92.6%[2]	92.2%	92.1%	92.2%	92.1%
All cancers: two week GP referrals	100%	94.8%[3]	100.0%	100.0%	100.0%	100.0%
All cancers: one month diagnosis (decision to treat) to treatment	100%	97.8%[3]	100.0%	100.0%	100.0%	100.0%
All cancers: 31 day wait until subsequent treatments	100%	97.8%[3]	100.0%	100.0%	100.0%	100.0%

A&E - Total time in A&E (95th Percentile) <4 hours	**95%**	**92.8%**[4]	**96.3%**	**95.3%**	**83.1%**	**84.5%**
Readmission rate within 28 days of Discharge		**0-15 Years:** **16 Years and over:**	**7.0%** **3.6%**	**6.9%** **8.2%**	**8.2%** **5.7%**	**7.4%** **7.4%**
% of Staff who would recommend the trust as a provider of care to their family or friends.			**86%**	**84%**	**Not required**	**88%**
Staff Survey results: % staff experiencing harassment, bullying or abuse from staff in the last 12 months		**23%**	**24%**			
Staff Survey results: % believing that trust provides equal opportunities for career progression or promotion) for the Workforce Race Equality Standard		**88%**	**82%**			
Financial & Service performance Ratings[5]			**4**	**2**	**2**	**2**
Rate of Patient Safety Incidents per 1000 bed days			**54**	**63**	**78**	**82**
Patient Safety Incidents and the Percentage that result in Severe Harm Death			**0%**	**0.1%**	**0.2%**	**0.1%**

[1]Specialist Trusts are excluded from SHMI reporting
[2] National Performance based on most recent published data for April 2015- Jan 2016.
[3] National Performance is based on most recent published Quarter 3 data for 2015/16. Alder Hey had 1 breach of the Children's Cancer standard (1 month from Referral to Treatment) and this was as a result of delay for clinical reasons
[4] A&E National Performance based on most recent published data for April 2015- Jan 2016.
[5] Quarter 1 reported under the old CSR ratio. From Quarter 2 rating have been reported under the new FSRR ratio.

Corporate Objectives 2015/16

Given the unique circumstances which prevailed in 2015/16, the Trust's senior team agreed a clear set of specific and limited objectives for the year appropriate to the key priorities and focus required to deliver on the major projects that lay ahead. These can be summarized as followed with the caveat that the section headed 'Securing the Future' has a longer term element to it.

Quality
- CQC re-inspection
- Quality Strategy and culture
- Customer care
- Develop Electronic Patient Care Systems (EPCS)

Business as Usual
- Delivering our contracts
- Achieving CIP and growth
- Meeting access targets

Safe and Successful Move
- Preparation of buildings and staff
- Implement new models
- Trouble shooting and bedding-in

Research, Innovation & Education
- Secure the BRU
- Develop robust infrastructure including facilities

Securing the Future
- CHP site development plan
- Community services
- Strategic partnerships
- Secure key senior posts

Delivery against Corporate Objectives

- **Quality**

Care Quality Commission Re-inspection

The Trust underwent a focused re-inspection by CQC in June 2015, following its full inspection in May 2014. In addition, our Child and Adolescent Mental Health Service (CAMHS) was inspected for the first time, as were diagnostic and screening procedures as part of the CQC's revised Outpatient inspection regime.

The overall ratings are set out below:

Overall rating for this trust Good

Are services at this trust safe? **Good**

Are services at this trust effective? **Good**

Are services at this trust caring? **Outstanding**

Are services at this trust responsive? **Good**

Are services at this trust well-led? **Good**

The inspection team commented that *'It was evident that the trust had made a very positive response to the findings of our last inspection and improvements had been made in all of the areas we identified. The trust had also improved in a number of areas where we indicated it should make improvements with particular reference to the services for young people transitioning in to adult services and in the engagement and inclusion of staff in the change agenda for the transfer in to a new purpose built hospital in October 2015.'*

Staff across the organisation had worked tirelessly to address the recommendations from the 2014 inspection and we are delighted to have received these ratings as a consequence, placing Alder Hey in the top 20% of trusts nationally.

Our specialist community CAMHS service was rated as 'Requires Improvement' due to some specific issues about waiting times for access to routine appointments which prevailed at the time of the inspection. The inpatient service was rated in the same way as the rest of the Trust. We are currently working through a comprehensive action plan in response to the CQC inspection report with a view to having community CAMHS re-inspected during 2016/17.

The CQC also carried out an inspection of the new hospital building in September 2015 just prior to the move. This inspection did not carry a rating as it was a specific review of the building, environment and process for transfer to the new hospital. The CQC made three recommendations which were implemented prior to the move and were satisfied that the preparations in place for the move were fit for purpose. They also noted the good practice employed by the Trust in terms of its involvement of children and young people in the design and planning for the new facility.

Quality Strategy and Culture

Quality continued to be the Trust's key strategic pillar during the year, with 2015/16 set to see the delivery of two long term goals which will have a significant impact upon Alder Hey's ability to realise its ambitions in this arena – the new hospital and the implementation of the EPR. Alongside the planning process for these developments, the Trust continued to take

forward the work to drive quality improvements begun in 2013, embedding the systems and processes vital to these achievements including the Weekly Meeting of Harm and increased incident reporting. The latter can be seen as one of the year's most notable successes, with the Trust now in the top 25% of its peer organisations in terms of reporting though NRLS.

In the second part of the year, the Chief Nurse led an extensive consultation among staff with regard to the shape of the next phase of the Quality Strategy, which was at the end of its first cycle: 2011 to 2016. The fundamental aims of the new strategy will remain as previously, however the approach is new and is based upon a model which is clinically led.

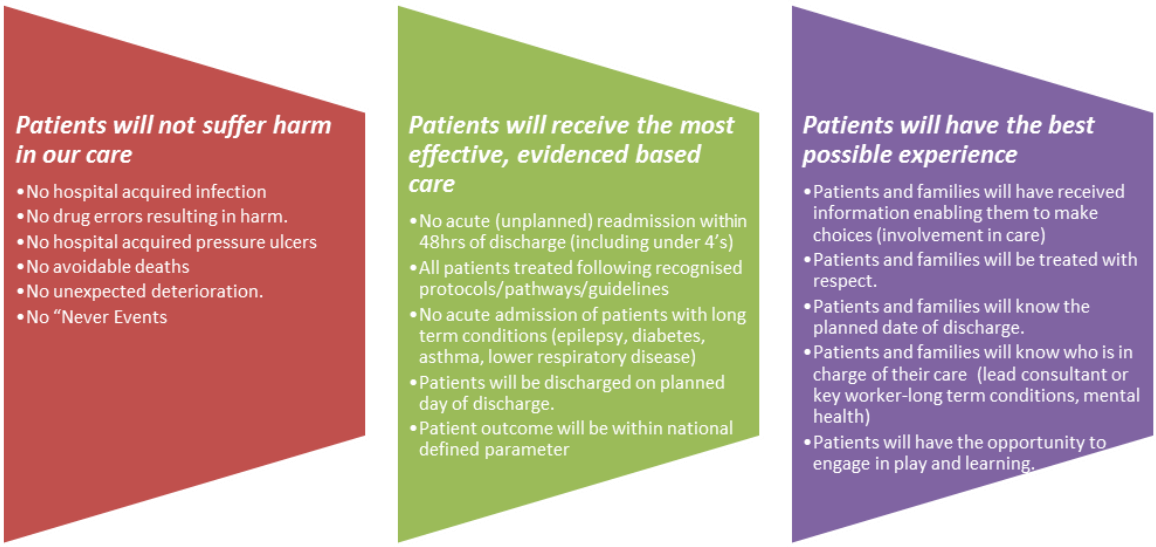
Clinical leadership through 'Clinical Cabinet'

The five year strategy will deliver a culture change across the organisation through wide engagement of the workforce in quality improvement.

After the first 12 months of implementation there will be a fully functioning **clinical cabinet** providing **strong leadership** and oversight to all matters of quality improvement, ensuring effort and resources are appropriately placed to deliver **services that are organised around our children**.

There will be **a system of devolved quality and governance** with local ownership and accountability for risk management systems and processes. Risk registers will be kept up to date, incidents and complaints will be investigated in a timely manner with lessons learned shared widely across the Trust and follow up actions completed and reviewed.

The 16 Quality Aims agreed in 2013 will remain at the heart of the strategy.



Quality Improvement Team

2015/16 saw the successful recruitment of a Quality Improvement Team to support the delivery of the Trust's three year safety plan: *Improved Organisational Safety Culture*. The Trust safety plan incorporates clinical priorities for improvement and has been developed as part of Alder Hey's membership of the national 'Sign Up to Safety' campaign which aims to halve avoidable harm and save an additional 6000 lives over the next three years. As part of the 'Sign Up to Safety' campaign, the Trust has pledged to:

1. Put safety first.
2. Continually learn.
3. Be honest and transparent.
4. Collaborate with others to promote learning.
5. Be supportive and help people understand why things go wrong.

Quality Improvement Programme

The 2015/16 Trust wide Safety Improvement Plan has focused on improvements in the following areas:

- Promoting a culture of safety
- Medication safety
- Infection prevention and control
- Pressure ulcer prevention and management
- Perioperative care

Whilst there have been areas of improvement the Trust recognises that further improvement is required and therefore these areas will remain clinical priorities for improvement in 2016/17.

For a comprehensive analysis of the Trust's performance in relation to its Quality Strategy in 2015/16 please see the Quality Report on page 94 of this document.

Implementing our Electronic Patient Care System

After a significant amount of work from the project team and whole organisation, Phase 1 of the MEDITECH 6 system 'went live' on 20th June 2015. This involved an enormous amount of input and feedback from a variety of staff into the workflows and design of the system. Over 2000 staff were trained prior to 'go live' through a combination of classroom style hands on training and masterclasses.

New functionality included:

- New theatre module
- New nursing module and documentation
- New e-prescribing and Medicines Administration
- New pathology module
- New pharmacy module
- All new order sets
- New Emergency Department module
- New outpatient management
- New inpatient management
- New discharge process

Following 'go live', issues identified were managed via the Electronic Patient Care System Development Committee and supported by input from the MEDITECH team. The system had to be updated to reflect the new locations and configuration prior to the move into the new hospital October 2015.

Work is now underway to prioritise further enhancements and developments for the system during 2016/17.

- **Business as Usual**

Delivering our Contracts

For 2015/2016 the Trust had three main contracts. £99m was received form NHS England for the provision of specialised services including critical care, £54m from Clinical Commissioning Groups for secondary activity including Community and Child Mental Health services and £11m from Health Commission Wales as the preferred provider of specialist paediatric services for North Wales. Total income for the year was £201,509 which represents an underperformance of £1,595k (0.8%) compared to the plan of £203,104k. The majority of the underperformance relates to a small number of specialties, including Nephrology, Cardiac Surgery, Orthopaedic surgery and ENT. The chief components of this were as follows:

- Elective activity: £2945k (7%) underperformance
- Non-elective activity: £1387k (5%) underperformance
- Out-patients activity: £1660k (7%) underperformance

The underperformance largely related to the planned downscaling of activity during the two key change periods in June and October, however plans to recover the position at other times in the year were not quite realized.

Achieving planned activity is one of the key financial strategies in 2016/2017 therefore the weekly forward look, run-rate monitoring meetings will continue with our Clinical Business Units.

Cost Improvement Programme

The Trust achieved a Cost improvement Programme (CiP) amounting to £6.2m in 2015/16. The efficiencies allowed the Trust to improve processes and streamline services to benefit patients. A large part of the efficiencies related to procurement initiatives which totaled £1m and included saving on contracts, standardisation of products and rebates from suppliers.

Access Targets

The Trust met all of its access targets in 2015/16 with the exception of the 4 hour wait in A&E, which we failed in the second half of the year for the first time in the Trust's history. This had been anticipated ahead of the move as the brand of the hospital remains a strong pull for parents across the city and beyond and the Trust had planned for an increase in attendances with the opening of the new hospital facility. Following the move last October, demand on Alder Hey's A&E increased above our initial planning assumptions. We had anticipated increases of 10% for an initial 3 month period based upon other hospital experiences however we have seen demand increase by an initial 16% peaking at 22% above baseline in February. Analysis of the attendances identified that the majority of these patients did not require admission, which remained at a consistent level.

Alder Hey's A&E team continues to proactively manage demand through a Multi-Disciplinary approach. Through liaison with our co-ordinating commissioner (Liverpool CCG) and our local System Resilience Group we are implementing a shared action plan that will mitigate the demand placed upon our A&E team and hospital. The efforts of the team have led to significant improvements already in April and May, with the target met for 2016/17 so far, however the Trust is aware that this needs to be achieved once more on a sustainable basis.

- **Safe and Successful Move**

Alder Hey in the Park – Making an historic move

One of the Trust's major achievements during 2015/16 was delivering a successful move to the new Alder Hey in the Park in October 2015. This was accomplished over a planned five day period commencing on Friday 4th October, making the most of out of hours clinical 'downtime' as far as possible.

The new hospital has a floor area of 60,000m^2 and 270 beds, including 48 critical care beds for patients in ICU, HDU and Burns. There are six standard wards with 32 beds. Each ward has two four bed bays and 24 (75%) single rooms on each ward with ensuite bathrooms, improving patient and family privacy and dignity. The unique design also ensures that the majority of bedrooms have park views and patients have easy access to play areas on and outside their ward. There are also 16 operating theatres, four for day-case surgery and 12 inpatient theatres. The new development also includes a multi-storey car park with 1200 spaces, 200 more than the old site.

The concept, inspired by designs from children, continued to be developed throughout the construction period with children, parents and staff participating in design meetings and presentations both in the Trust and other local venues and schools. Engagement with our key stakeholders on interior designs, colour schemes and way finding was also carried out during the year.

The hospital will also include a range of gardens, play areas and play decks that reach out into the park. In addition we are developing a range of digital technologies that will allow children and parents to check in to the hospital, engage in play in the atrium, bedrooms and waiting areas and will also provide information about the hospital and its services.

Preparation of buildings and staff

The first part of the year was spent finalising design and construction works (including the fit-out of the building and the completion of the roof gardens) and completing plans for the move into the new hospital.

The plans for the move were developed by a team from across the Trust led by Chief Operating Officer Jude Adams, together with lead Healthcare Planner Angela Appleton and Consultant Anaesthetist Dr. Pete Murphy, who was the clinical lead responsible for ensuring a safe transition.

The move itself was conducted over the first week-end of October for inpatients and then throughout the following week for outpatients.

The move was facilitated by a temporary bridge link to the old hospital that allowed patients to be transferred under cover without recourse to ambulances.

Each of the hospital departments developed their own training and operational plan and this ensured that they were safe and appropriate and reflected the working practices of each team.

The hospital is full of the latest medical technology and great care was spent by the equipment committee chaired by Consultant Anaesthetist Dr. Harvey Livingstone and supported by members of the Estates and Bio-Medical Engineering teams, Graeme Dixon and Barry Laithwaite to ensure that all the kit was specified correctly and ready to go. This was an enormously complex exercise that was completed successfully with the time and expertise of the big technical depts. such as imaging, pathology, ICU, pharmacy and theatres playing a big role.

There was a big focus on modernisation of support departments such as catering, portering and supplies with robotic distribution of goods, ward based kitchens and a whole new approach to cleaning the building. Great credit goes to the facilities teams led by Director of Facilities Mark Devereaux and supported by Graeme Dixon to get these new systems off the ground.

The new wards themselves have a new lay-out with 75% single rooms complete with parent accommodation, en-suite bathrooms and a glazed room-front. The ward teams led by Director of Nursing Hilda Gwilliams and supported by all the Ward Managers spent a great deal of

time in the careful planning and transition to the new facilities. There were numerous challenges on the way but these were all successfully overcome.

There were a number of other complex moves including the Outpatient facility with its new call systems and self-check in process as well as all of the new therapy, daycare, medical photography, testing and clinical support departments.

All these services required a massive IM&T planning effort for Director of Informatics Cathy Fox's team who dedicated hours and hours to plugging in all the new systems including a comprehensive Wi-fi network.

Alongside the clinical moves there were a whole range of environmental enhancements including garden areas, artworks and digital capability and the Alder Hey Charity pulled out all the stops to get these wonderful enhancements funded.

Finally, Project Manager Sue Brown and Director of Estates John Williams orchestrated the move of the Trust's administrative and a range of community and clinical services into a temporary home on the Alder Hey site whilst their final homes are developed over the coming 24months. This has prepared the way for the demolition of the old hospital and the creation of a new Park and campus on the Alder Hey site.

- **Research, Education and Innovation**

International Research and Education

In September 2015, the Institute in the Park opened as part of the Alder Hey in the Park campus. This new facility houses the major research teams and facilities which support the Trust's Integrated Research Strategy for Child Health, comprising personnel from within Alder Hey, the University of Liverpool and other higher education institutions. The Institute offers a superb environment to facilitate cross-disciplinary development of research and in partnership with the themes of education and innovation.

The Integrated Research Strategy for Child Health was reviewed and refreshed through the leadership of the Trust's Director of Research and the University of Liverpool Brough Chair in Child Health. The revised research strategy was approved by the Trust Board in September 2015, providing a road map for the Trust's continued ambition to be a sustainable international leader in child health research. The key domains within the revised strategy are:

- Attracting and developing the next generation of leaders of children's health researchers
- Alder Hey as the premier partner for children's research
- Working with children, young people and families to realise our research potential
- Proactive integration of research and innovation by the organisation
- International leadership in children's research
- Demonstrating an improvement in the health and wellbeing of children and young people

The Trust, in collaboration with its key academic partners, continues to develop translational and applied programmes of research in a number of focused areas, including: musculoskeletal disease; respiratory disease; infection; pharmacology/medicines; neurosciences. The research strategy is designed to identify and support new and emerging areas of research strength, ensuring that clinical and research expertise locally and nationally is exploited.

Some examples of key outputs from research programmes in the past year include:

- Dose optimisation regimes for use of legacy antimicrobials in paediatric practice.
- Development of novel formulations of medicines for use in paediatric practice.
- Evaluation of novel technologies for non-invasive measurement of blood biomarkers in babies and children.
- Three further 'global firsts' of first-in-human dosing of medicinal products in children in partnership with colleagues in the pharmaceutical sector.

The sister development to the Institute in the Park is the 'Bat-cave'. This is an underground factory attached to the main hospital where clinicians and industries can come together and create new products and technologies. Innovation at Alder Hey will be driven by a strategy of co creation with large technology companies within the 'Bat-cave'. By leveraging their resources and product delivery mechanisms we will accelerate innovation within the hospital and within industry. The Bat-cave will be the place where SENSORHOSPITAL@ALDERHEY is brought to life.

Securing the Future

Following the move into the new hospital, work has begun on creating new facilities for those teams of staff who are not housed within the main hospital. These will form part of a developed Alder Hey Campus and Park as well as a network of community facilities. Teams included in this development are: the Alder Centre, a wide range of office based corporate services, research, innovation and education services and other clinical services such as CAMHS, psychological services and various community teams. There will be an opportunity for staff and patients, parents and carers to be involved in the design of these facilities. The objective is to open these new facilities in 2017.

In the interim, services are being accommodated in the western part of the old campus in some of the newer modular buildings, to allow demolition of the old hospital to commence. Demolitions will begin in autumn of 2016 and will start with the old A&E block.

The New Park

At the centre of this development is a new Springfield Park. The Trust and Liverpool City Council are working together to establish a new charity to run the Park and create a world class amenity for the children and families of Liverpool.

Park Themes

The Park will be themed to maximise its impact. The proposed themes are: Grow your own produce and healthy living; sport for all; events and festivals and interactive play.

Growing Produce and Healthy Living

This theme would exploit the fact that the hospital is unique within the NHS in that it has individual ward based kitchens, rather than the traditional central production kitchen, that allow the preparation and serving of fresh meals to order for children and parents. The Park will be developed to provide a series of gardens with opportunities for Alder Hey patients and the local community to become involved in the growing of sustainable and healthy food which will be used to service the ward based kitchens. Additional uses for the produce could be markets and festivals and potential food outlets/restaurants based in the Park. The hospital will use its charitable connections with celebrity chefs and local businesses to help promote this initiative and keep it vibrant and active.

Sport for All

The Park will be developed to provide well maintained, state of the art sports facilities designed to be both able-bodied and disability friendly. The facilities will allow for a range of sporting activities and events aimed at encouraging participation in sport and fitness for Alder Hey patients and the wider community. We will utilise our charitable links with local sportspeople, sports associations and football clubs to generate interest and enthusiasm. The emphasis will be on making sport and fitness as accessible as possible, encouraging the participation of children of all interests and abilities. The hire of our facilities for sporting events would provide an income stream for the park.

Events and Festivals

The Park will stage a series of rolling events and festivals aimed at promoting, Alder Hey and bringing life and activity into the Park. The events will aim to complement the overarching Park themes with for example, food markets and festivals, sporting events, art exhibitions and performances such as concerts, children's choirs and orchestras. The main aim of this theme will be to bring as much activity and buzz to the location as possible, putting it on par with equivalent green spaces in the Liverpool area. Managed well, the hire of the park for events and festival would provide a reliable income stream for the park.

Play and Activity

There will be a world-class play installation in the Park that will draw children from the local area and beyond. The play installation will reflect Alder Hey's appetite for innovation, incorporating play with physical exercise and digital interaction. The objective is to have the most notable play installation in the UK.

Key Risks to Delivery in 2015/16

The Trust was very aware that to undertake such a large scale change programme all at once carried a high degree of risk, but the organization was clear that the benefits of securing these improvements were much greater. The challenge therefore was to plan the changes very carefully, ensuring that the risks were managed and mitigated as far as possible. In this process, the Trust's Programme Management Office (PMO) was vital, assisting the various teams charged with delivering the major aspects of the change to remain on track and to understand new risks and issues as they emerged so that they could take timely action. It was as a consequence of this discipline that the implementation date for the new Electronic Patient Record was moved from May to June 2015. In terms of the new models of care developed through the HWWWIF project, each one went through a Critical Design Review, which was a formal and very inclusive process to ensure that those responsible for making the new models work in the new hospital were fully signed up to the changes and how these would operate in the new environment.

The change programme was overseen by a Programme Board from which the Trust Board received a full Programme Assurance Report each month, in addition to regular Integrated Assurance Reports capturing all key strategic and operational risks from the Board Assurance Framework and Corporate Risk Register. In addition, the key assurance committees continued to maintain their work programmes to oversee the delivery of 'business as usual' during the crucial planning and implementation periods.

Financial Performance

The Trust ended the year with a reported deficit of £40.7m after all technical adjustments related to bringing the new Private Finance Initiative (PFI) Hospital into use were accounted for. (For background information on the PFI, see note 30 in the Annual Accounts later in this document). 'Normalising' items are defined as one-off and technical expenditure that are not part of the Trust's normal business activities and financial performance. In 2015/16 the Trust incurred various 'normalising expenditure' that relates to the opening of the new Hospital and Institute in the Park Building. The Trust reported a 'normalised' surplus of £9.9m which included £14.1m of charity and grant donation for capital assets.

The reported surplus has been adjusted to reflect the 'normalised' surplus position in the table below:

	2015/16 £'000	2014/15 £'000
Reported Surplus/(Deficit)	**(40,699)**	**16,257**
Normalising Items:		
MASS	(36)	0
Fixed Asset Impairment	(45,189)	(512)
Gains/losses on asset disposals	(5,403)	(10)
"Normalised" Surplus/Deficit	**9,929**	**16,779**

Capital expenditure for the year is £33.6m; this spend includes the costs of IT and equipping the hospital and payments the Trust made towards the new Hospital Building and Institute Building.

The Trust had a cash balance of £10.5m at the end of March.

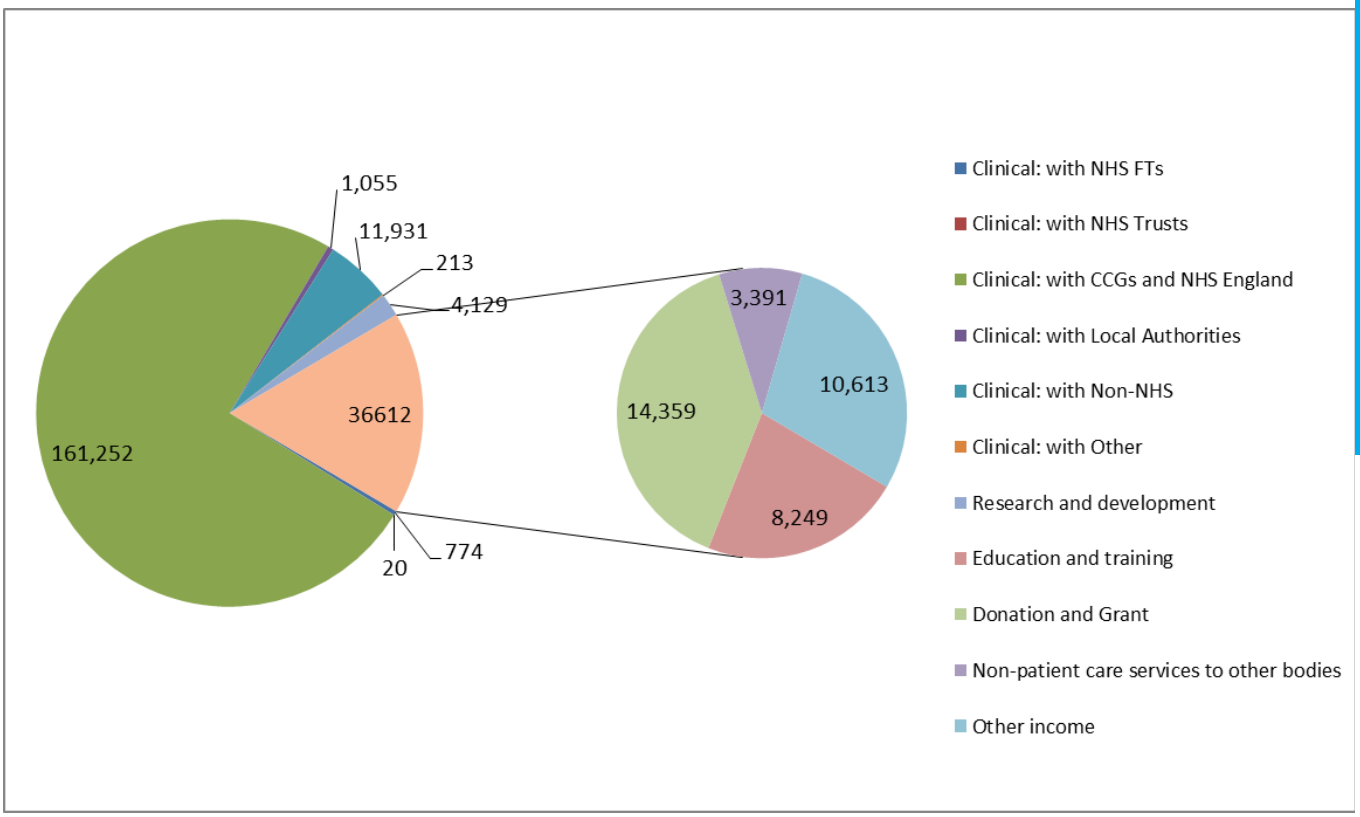
Ratio	Criterion	Measure	Weighting	15/16 Metric	FSRR	14/15 Metric	FSRR
1	Liquidity (days)	Shows ratio of liquid assets to total assets	25%	-19	1	139	4
2	Continuity of Service	Shows revenue available for capital service	25%	0.78	1	7.26	4
3	I&E Margin	Shows underlying performance	25%	4.48%	4	N/A	N/A
4	Variance in I&E performance as a % of Income	Shows performance against plan	25%	-1.58%	2	N/A	N/A
				FSRR	**2**	**CSR**	**4**

Monitor is the sector regulator for health services in England. When assessing Trust performance, Monitor uses a risk rating system for financial performance/continuity of services and governance. The purpose of the Continuity of Services ratios is to assess the level of risk to the ongoing availability of key services and takes into account our liquidity and capital servicing capacity. A scale of 1 – 4 is used with 4 indicating the lowest financial risk and 1 the highest financial risk. In 2015/16 the Trust planned and achieved a continuity of services risk rating of 2 (financial risk rating). This represents a higher financial risk than achieved in 2014/15 and reflected the anticipated in year impact on the financial position of the implementation of the new electronic patient care system (EPCS) and the move to the new hospital.

Income

Total income received by the Trust in the year ended 31st March 2016 was £216m with £175.2m (81%) coming from the delivery of clinical services. The Trust's clinical income comes from three main contracts. Our principal contract is with NHS England to provide tertiary services with a value of £99.1m. The Trust also has a contract hosted by Liverpool CCG to provide secondary services with a value of £54.7. In addition the Trust has a contract with Welsh commissioners to provide secondary and tertiary services with a value of £11.4m. The £40.7m non-clinical income includes donations from charities, education and training levies, research activities, services provided to other organisations and commercial activities such as the provision of catering services. Income was reduced in 2015/16 due to planned reduction related to the hospital move and the implementation of a new electronic patient recording system.

Income by source 2015/16:

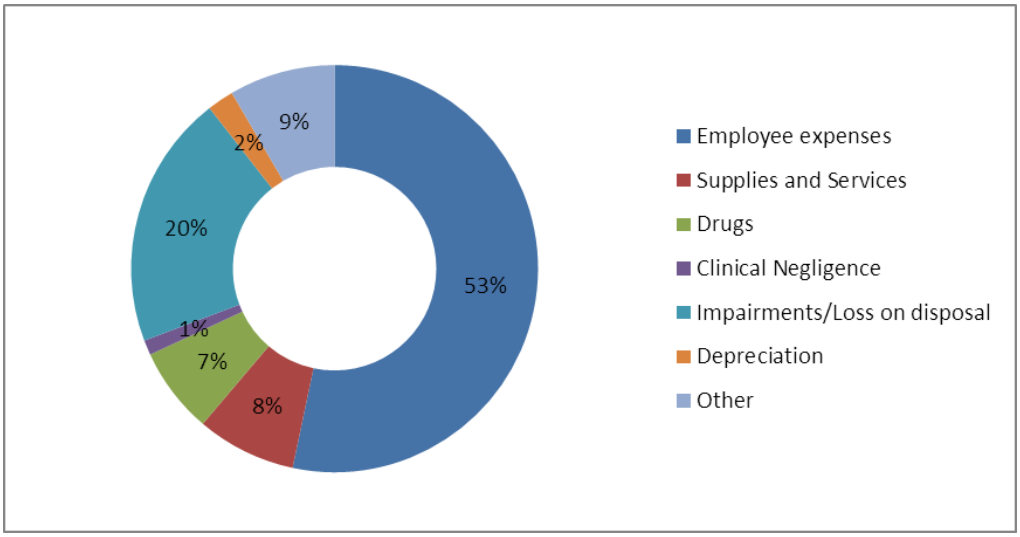


Clinical income by Point of Delivery

	2015/16 £000s	Restated 2014/15 £000s	Adjustment	Original 2014/15 £000s
Elective income	38,739	39,344		39,344
1 Non-elective income	27,202	27,777		27,777
2 Outpatient income	26,281	26,384		26,384
A&E income	4,837	4,791		4,791
3 Private patient income	90	94		94
4 Community and Mental Health	19,570	20,136		20,136
Critical Care	22,025	21,273		21,273
5 Drugs and devices	18,266	16,805		16,805
6 Clinical Services	17,076	19,280		19,280
7 Other	1,159	1,887	-3,291	5,178
	175,245	**177,771**		**181,062**

Expenditure

Operating expenses totalled £250.3m for the year and, as in previous years, staff costs account for the largest use of resources at 53%. An analysis of operating expenses by type is shown in the graph below:



Financial and Operating risk

Total clinical income for the year was £175.2m, which was broadly in line with the plan figure of £175.3m. Total normalised expenditure (excluding technical issues) for the year was £206.1m which was £0.3m higher than the plan of £205.8m. Expenditure on pay exceeded the plan by £4m which included agency staff totalling £5.5m although this is partly offset by vacancies in substantive posts. Drugs expenditure is £1.6m higher than planned although the majority of this is recovered via income for specialist drugs not funded through Payment by Results (PBR). The remaining variances on expenditure resulted from other clinical and non-clinical non pay expenditure which was offset by savings resulting from the delay in the PFI payments following the delayed hand over of the new hospital.

£6.2m of cost improvements (CIP) and efficiency savings were achieved during the year.

Capital Investment Programme

During the year the trust completed £33.6m of capital investments which will significantly improve services for both patients and staff. A summary of capital investment undertaken in the year is provided in the table below:

Capital Investment Scheme	Investment Benefit from activities	Value £'000
Planned Capital Estates	Includes interim & retained estates associated with hospital move and demolition	1,506
Research and Education Building	Construction of phase 1 of the Research and Education building and scoping costs for stage 2	4,697
IM & T capital schemes	Investment in IM&T including Electronic Patient Record costs	9,244

Medical Equipment	Investment in medical equipment inclusive of equipment replacement cycle	6,221
Alder Hey in the Park	New hospital non-medical equipment and site development costs	11,901
Total Capital Investment 2015/16		**33,569**

Accounting Policies

There have been no significant changes to our accounting policies since authorisation as a Foundation Trust.

We have complied with the cost allocated and charging requirements set out in HM Treasury and Office of Public Sector Information guidance and followed the NHS costing manual and best practice guidance published by Monitor. The Finance Department works with all financially significant departments to use the activity information available within the Trust and an established NHS costing package to appropriately allocate expenditure to services and patients.

Going Concern

The financial statements have been prepared on a going concern basis and the Trust is planning to be financially sustainable over the next five year NHS planning horizon. The Trust is however planning a deficit in 2016/17 of £5.9m (excluding fixed assets impairments) which reflects the time needed to bring operational performance back on track over the first part of the year and to allow new ways of working to become embedded following the Trust's move to the new hospital. In addition, the Trust is having to manage cost increases in 2016/17 which are over and above the level funded in national prices. In planning a deficit of £5.9m in 2016/17 the Trust has applied to NHS improvement (NHSi) for interim cash support of £8m which it requires in 2016/17 to underpin the Trusts operational cash flow funding requirements. At the time of preparing these accounts the cash funding has not been confirmed and therefore remains an uncertainty, but the Trust is liaising directly with NHSi to ensure this matter is resolved and its required cash position secured. The Trust is also working with its stakeholders to ensure the overall operational plan for 2016/17 is delivered.

In addition to the matter referred to above, the Trust anticipates the continuation of the provision of services in the foreseeable future as evidenced by the inclusion of financial provision for those services in published documents and contracts for services with commissioners.

Based on these indications, the directors believe that it remains appropriate to prepare the financial statements on a going concern basis. The financial statements do not include any adjustments that would result from the basis of preparation being inappropriate

Post Balance Sheet Events

There are no material contingent liabilities or material litigation as far as the Board is aware; to the extent that if there is potential litigation it is believed that this will be covered by the

NHS Litigation Authority. For these reasons, the Trust continues to adopt the going concern basis in preparing the accounts.

Board Statement

The Board of Directors approved the foregoing Performance Report at its meeting on 23rd May 2016.

Signed on behalf of the Board

Louise Shepherd
Chief Executive
23rd May 2016

Accountability Report

Directors' Report

Composition of the Board of Directors

- **Chair and Chief Executive**

Sir David Henshaw – Chair

Sir David took up post as Chair of Alder Hey in February 2011; he was re-appointed in January 2014 for a second term of three years. Among his many achievements, Sir David was responsible for the review of the child support system in the UK in 2007. He was also involved in the Prime Minister's Delivery Unit Capability Review programme of central government departments. Alongside his valuable experience within the health arena, including as Chair of NHS North West for four years, Sir David has worked extensively in local government. He spent ten years at Knowsley Borough Council before being appointed as Chief Executive of Liverpool City Council, a role which he occupied for seven years. Today, Merseyside residents see and are enjoying the benefits from many of the regeneration initiatives his team brought to the region, including securing the award of European Capital of Culture in 2008. Alongside his role at Alder Hey, Sir David has also been and is also a Chair and Non-Executive Director for a number of other public and private organisations. Sir David has been asked by Monitor to take on the role of Interim Chair at three other NHS organisations over the past four years: between February 2012 and April 213 at University Hospitals of Morecambe Bay NHS Foundation Trust; at Dorset Healthcare NHS Foundation Trust which he undertook from October 2013 to April 2014 and most recently at St Georges NHS Foundation Trust in London commencing in March 2016. This latter role is ongoing.

Louise Shepherd – Chief Executive

Louise joined Alder Hey in March 2008 from Liverpool Women's Hospital where as Chief Executive she led it to foundation trust status in 2005, the first in Merseyside to achieve this. Formerly Deputy Chief Executive and Finance Director at the Countess of Chester NHS Trust for five and a half years, Louise first joined the health service in 1993 as Director of Business Development at Birmingham Heartlands and Solihull NHS Trust. A Cambridge University graduate in 1985, Louise trained as an accountant in local government before spending four years with KPMG as a financial and management consultant to the public sector. Louise is very active in Liverpool outside of the health service; she was previously vice chair of the Royal Liverpool Philharmonic Society and continues to be an active member. In March 2016 Louise was invited to chair the Sustainability and Transformation Planning group for the Cheshire and Merseyside footprint.

- **Executive Directors**

Rick Turnock – Medical Director

Rick was appointed as interim Medical Director in May 2014, the role being made substantive upon Professor Lewis' retirement in April 2015. Having trained as a Paediatric Surgeon at Alder Hey and Great Ormond Street, he was appointed as a Consultant Paediatric Surgeon at

Alder Hey in 1993. Shortly after this appointment, he took on the role as Clinical Director of Surgery for 5 years, moving to his first period as the Trust Executive Medical Director in 2000 for 3 years. He then fulfilled a series of external roles including Honorary Secretary of the British Association of Paediatric Surgeons (BAPS), the first Head of the Cheshire and Merseyside Deanery Postgraduate School of Surgery and latterly as President of BAPS (2012-14), in which role he sat on the Council of the Royal College of Surgeons of England (RCSEng). He was an Examiner for the FRCS in Paediatric Surgery for 10 years and is now an Examiner Assessor. He has been the RCSEng Regional Specialty Adviser for Paediatric Surgery in the North West for the last five years.

Jonathan Stephens – Director of Finance and Deputy Chief Executive

Jonathan took up post in June 2013; he has over twenty years' experience working within the NHS, operating at a senior level in most sectors of the health service, including community care services, specialist teaching hospitals, Strategic Health Authority and acute district hospitals. He has operated at Executive Director level for the past nine years and since 2009 undertaken the role of Deputy Chief Executive. Jonathan has a proven track record of delivering key financial targets year on year and leading and developing financial strategy within challenging health economies. He has led two trusts to foundation status, Tameside Hospital and Warrington and Halton Hospitals, taken a £100m PFI hospital development to financial close and supported all of the organisations he has worked for in delivering improvements to patient care and patient outcomes.

Gill Core – Chief Nurse

Gill joined Alder Hey as Director of Nursing in July 2012. Gill became a nurse in 1981 and spent a number of years in clinical roles in Intensive Care and Surgical specialties. Since her first managerial role as Head of Quality in Norfolk in the 1990's she has gained increasing experience in quality improvement and nursing leadership. She came to Alder Hey following seven years in Director of Nursing roles - at Liverpool Women's NHS Foundation Trust and most recently at St Helens and Knowsley NHS Trust, where she gained experience in leading the nursing workforce in transition from an old Victorian hospital into a brand new facility. Gill has maintained and developed strong educational links and currently participates in delivering the MSc in Leadership Development at Edge Hill University. Along with a variety of clinical qualifications she has an MA and post graduate teaching certificate.

David Alexander – Director of Human Resources and Organisational Development (to September 2015)

David joined Alder Hey as Director of HR and OD in August 2012 from Thomas Cook Airlines where he had been HR Director for 8 years. David graduated from the University of Leeds with a BSc in Applied Zoology in 1985 and gained his postgraduate qualification in HR Management from Bristol Business School in 1987. David started his HR Career with the Cooperative Wholesale Society as a graduate trainee he then moved to P&O Ferrymasters as HR and Training Manager before joining Servisair where he spent 9 years, the last 5 years in the role of UK HR Director. David joined Thomas Cook Airlines in 2004 and managed the merger with MYTravel Airways in 2007/8. David's HR career has put him in organisations where constant change in a unionised, regulated environment has been the norm. David is an experienced HR Director who has operated at Board level for 13 years.

Melissa Swindell – Interim Director of Human Resources and Organisational Development (from October 2015)

Melissa joined Alder Hey in 2009 as the Deputy Director of HR and OD, and has been the Interim Director of HR and OD since October 2015. Following her graduation in Economic and Social History from the University of Liverpool, Melissa started her HR career in the airline industry before joining the NHS. She has worked in HR and OD in a range of NHS organisations both in London and the North West. A Chartered Fellow of the CIPD, Melissa also has postgraduate qualifications in training, coaching and the use of psychometric assessments. During her time at Alder Hey, Melissa has lead the people development agenda; successful projects include a Trust wide review of the organisational values, supporting medical leadership capability and the introduction of a Trust wide values based appraisal process.

Judith Adams – Chief Operating Officer (to end March 2016)

Jude joined Alder Hey as Chief Operating Officer in March 2011 and has over 25 years working in the health service. Jude trained as a nurse and has clinical experience working in specialist and University Teaching trusts both in and outside of London as well as overseas. She moved into healthcare management in 2002 when she applied through the Department of Health for a national advisory role in the Heart Choice programme and worked with the Picker Institute in evaluating patient choice. Jude has held a senior post at the Royal Liverpool and Broadgreen NHS Trust as Divisional Nurse Director for Surgical Services and later becoming Divisional General Manager for this Division. Prior to her role at Alder Hey, Jude was the Director of Operations and Programme Director at Salford Royal NHS Foundation Trust where she led the Trust on a £48m Cost Improvement Plan over three years, as well as leading significant transformation across a number of clinical services. Jude has masters level training in clinical practice and is nearing completion of her MSc in Healthcare Management.

Erica Saunders – Director of Corporate Affairs (non-voting)

Erica joined the Alder Hey team in September 2010 as Director of Corporate Affairs. She began her NHS career in 1991 through its graduate management training scheme. Erica spent over ten years working in primary care and commissioning roles before moving to the acute sector in 2003. Part of her job includes the role of Trust Secretary, advising and supporting the Chair, Board of Directors and Council of Governors on all aspects of regulation and corporate governance. Prior to coming to Alder Hey, Erica was Director of Corporate Affairs at the Liverpool Women's NHS Foundation Trust where she directed the successful application to become the first foundation trust in Merseyside. Erica has an MBA and BA (Hons) and is in the final stages of study to become a chartered company secretary. Erica is a trustee and Company Secretary on the Board of the Fiveways Partnership on behalf of Alder Hey.

David Powell – Development Director (non-voting)

David joined Alder Hey as Development Director in Dec 2012 and has over 30 years' experience working in the NHS. Prior to his role at Alder Hey, David held Development

Director posts in Bristol and London overseeing new hospital programmes. David has a history degree from Manchester University and is a qualified accountant.

Louise Dunn - Director of Communications and Marketing (from October 2015, non-voting)

Louise joined Alder Hey with over 20 years' experience working in the pharmaceutical industry. Most recently she was Vice President of Communications for Research and Development and Global Commercial Franchises at GlaxoSmithKline. In this role, she led internal and external communications around a multi-year transformation of GSK's global research and development and the subsequent commercial launches of a number of new medicines. Prior to this she worked in GSK's International, Global and UK Operations. Louise graduated in biochemistry from Oxford University in 1992 and started her career in consultancy. At Alder Hey, Louise's priorities are to build the reputation of the organisation, enhance the Alder Hey brand and engage employees in the long term business strategy. Louise is responsible for marketing and communications for both the Trust and the Alder Hey Charity.

Hilda Gwilliams – Director of Nursing/Acting Chief Nurse

Hilda joined Alder Hey in February 2013 as Deputy Director of Nursing and recently has been appointed as Chief Nurse. Formerly Hilda was deputy Director of Nursing at St Helens and Knowsley NHS Trust for three years where she gained experience in moving hospital services from an old build to a new purpose built hospital. She qualified as a nurse in 1984 and spent a number of years in a variety of clinical roles in surgical specialties including neurosurgical intensive care. Hilda has maintained strong educational links and continues to provide professional guidance in relation to 'fitness for practice' concerns pertaining to students at local HEI's.

Graham Lamont – Acting Medical Director (June 2015) Associate Medical Director (Education)

Graham graduated as MBChB from Glasgow University in 1980, and pursued a general surgical training in Glasgow, and Nottingham, completing his registrar and research training there. He then trained as a Paediatric Surgeon in Manchester and Edinburgh before being appointed to a consultant position at Alder Hey in 1994. From 2000–14 Graham was Associate, and then Deputy Postgraduate Dean for the Mersey Deanery and undertook a formal qualification in education, graduating with Honours from Edge Hill University in 2012.
In 2015 Graham took up the role of Associate Medical Director for Education, at an exciting time for Alder Hey and Graham's remit, as well as overseeing the provision of the current education offering across the different paediatric specialties, is to work with the Directors of Research, and Innovation in delivering on the Trusts vision for an integrated strategy for Education Research and Innovation, that becomes both nationally and internationally recognised.

- **Non-Executive Directors**

Steve Igoe - Non Executive Director and Chair of the Audit Committee/Senior Independent Director

Steve joined the Alder Hey Board in October 2010 and was re-appointed by the Council of Governors in September 2013 for a further three years. He is the Deputy Vice-Chancellor at Edge Hill University and a Chartered Accountant by training. Prior to working for Edge Hill, he worked for Coopers and Lybrand Deloitte a predecessor firm of Price Waterhouse Coopers as a Senior Manager in their North West offices. In his current role he has Board responsibility for Finance, IT, HR, Infrastructure and Estate Developments, Facilities Management, Learning Services, Strategic planning and the University's international activities. He has previously advised the Government on the regulation of the Higher Education sector and was an adviser to the Higher Education Funding Council for England (HEFCE) Board on leadership, governance and management and costing systems within higher education. Steve has been a Governor of a large acute NHS trust, a trustee of a charity specialising in respiratory education and an executive and founding director of a substantial IT network company. As well as acting as chair of the Trust's Audit Committee Steve also chair's the Integrated Governance Committee.

Ian Quinlan - Non-Executive Director/Vice Chair and Chair of the Resources and Business Development Committee

Ian joined the Alder Hey Board in September 2011 and was re-appointed for a second term of three years in September 2014. He is a Chartered Accountant and joined Ernst and Whinney (now Ernst and Young) in 1974 and in 1982, became a partner. In 1988 he became Group Finance Director of the Albert Fisher Group PLC, a leading global food processor and distributor. From 2003 to 2013, Ian held senior positions with VPS Holdings Limited, which is the largest void property services company in the world. Between 2003 and the beginning of 2011 he was Group Chief Executive, during which time the turnover of the business increased from £3m to £200m. Between January 2011 and October 2013 he was a director of the business responsible for acquisitions. Ian is now a Financial Consultant and assists the owners of private companies to prepare their companies for sale.

Phillip Huggon – Non-Executive Director (to end March 2016)

Philip joined the Alder Hey Board in March 2010; he was re-appointed for a term of two years in March 2014. He has several Non-Executive and trustee roles in the private and public sector, with a particular focus on marketing and business development. His board roles include Seafish, a Non-Departmental Public Body set up to promote the fishing industry, the Business Continuity Institute, Sports Leaders UK, the English Table-Tennis Association and he also chairs RCU, an education consultancy. His background is mostly marketing, strategy and change management gained from 20 years' experience with Shell, MARS and BP, both in the UK and overseas.

Jeannie France-Hayhurst – Non-Executive Director

Jeannie took up her role at Alder Hey in July 2013. She is a highly-regarded family law barrister with wide experience of the voluntary sector, politics and the commercial world. She is known throughout the wider community in the North West as a fearless advocate and is much sought after on the seminar/lecturing circuit. Jeannie has made time in her busy career for voluntary and charitable work and has extensive experience of dealing with vulnerable

adults and the socially disadvantaged. She has significant experience of service on boards and committees at both local and national level.

Claire Dove – Non-Executive Director and chair of the Workforce and Organisational Development Committee

Claire joined the Alder Hey Board in October 2013. She is a high impact leader of social change. She brings a track record of success from a variety of non-executive, executive and community leadership roles – shaping policy and practice in the business, social enterprise and charity worlds. Renowned in Merseyside, known nationally and internationally, Claire's work in education, regeneration, anti-poverty, equality and fairness arenas positions her as an independent thinker, experienced practitioner and trusted adviser to many. She was awarded an OBE for services to education in 2012. Claire's achievements cross many decades, fields and roles. Having built the award winning Blackburne House Group (BHG) over the last 30 years, her attention is now moving towards growing a portfolio of roles to complement her work at BHG.

Anita Marsland – Non-Executive Director and Chair of the Clinical Quality Assurance Committee

Anita began her career in Local Government in 1974 and is a qualified a social worker. She later held a range of senior management posts, rising to Chief Officer. In 2002 Anita became one of the country's first joint appointments between an NHS organisation (Chief Executive level) and a Local Authority. Anita has pioneered integrated working between Local Government and the NHS for many years and the model of partnership working that she has developed has been adopted and implemented successfully in other parts of the country.
She has a strong reputation nationally for promoting and implementing innovative solutions to tackle health inequalities. Her work has been acknowledged through several awards including an MBE for services to health and social care in 2008. In 2010 Anita was seconded to the Department of Health at Director General level to lead the setting up of Public Health England (an executive agency of the DH) as the delivery arm for DH public health policy, in line with changes introduced by the Health and Social Care Act 2012. Anita has recently been awarded an Honorary Membership of the Faculty of Public Health.

Declaration of Interests

A copy of the Register of Interests is available by request from Erica Saunders, Director of Corporate Affairs via the the Membership Office on 0151 252 5128 or by email at membership@alderhey.nhs.uk.

Political Donations

Alder Hey did not make any political donations during 2015/16.

Better Payments Practice Code – Measure of Compliance

In line with other public sector bodies, NHS organisations are required to pay invoices within 30 days or within the agreed payment terms whichever is sooner. This is known as the Better

Payment Practice code. NHS trusts are required to ensure that at least 95% of invoices are dealt with in line with this code. Performance against this code is provided in the table below.

	2015/16	2014/15
% of invoices paid within 30 days	90%	94%

Quality Governance

The Board at Alder Hey continues to review its governance arrangements and underpinning systems and processes on a regular basis. From September 2013, keen to test and challenge itself and the organisation, the Board has shaped its agenda around the five key questions that form the cornerstones of the CQC inspection process introduced at that time, specifically:

- Are we safe?
- Are we effective?
- Are our services caring and compassionate?
- Are our services responsive to patients' needs?
- Are we well led?

This approach has continued throughout 2015/16 and has assisted the Board in its drive to keep quality as its key focus, with substantive reports that aim to provide real assurance and address principal strategic and operational risks.

The Clinical Quality Assurance Committee, whose membership includes all Clinical Directors as well as Board directors, carries out more detailed scrutiny under its delegated authority from the Board for oversight of the Trust's performance against Monitor's Quality Governance Framework, the delivery of the Quality Strategy incorporating measures of clinical effectiveness, patient safety and positive patient experience. The work of the Audit Committee complements this by discharging its responsibility for the maintenance of an effective system of integrated governance, risk management and internal control across the whole of the organisation's activities.

The Clinical Quality Assurance Committee walk round process, which involves extensive visiting of clinical business departments throughout the month preceding the committee meeting, continued during the first half of the year. The aim of this is to provide multiple opportunities for committee members to meet with staff, view service delivery at close quarters and meet with patients and parents to establish first hand feedback of quality of care. The result of this process is a comprehensive action plan agreed with the CBU management team to be achieved in subsequent months and evaluated through the committee. In the period following the move to the new hospital, walkarounds were focused on 'hot spots' such as the Emergency Department which was seeing unprecedented levels of attendance together with a number of snagging and bedding in issues, which often accompany the operational reality of new and innovatively designed facilities. As a consequence of the Committee's involvement, a number of timely improvements were made to the 'front door' of the hospital to address the issues identified, including flow, confidentiality and overall patient comfort.

The monthly Quality Report, as part of the Corporate Performance Report presented to the Board has continued to be developed during the past year, with the aim of providing key performance measures against the Trust's quality aims and highlight the improvement actions required. The report includes information on nurse staffing in order to provide further level of assurance, which was borne out by the conclusions of the CQC re-inspection; it also describes progress against various other quality initiatives undertaken for example Sign up to Safety.

The Board Assurance Framework is scrutinised by the Board at its meeting each month to enable the Board to be fully sighted on key risks to delivery and the controls put in place to manage and mitigate them, as well as enabling all members to have an opportunity to identify key issues, concerns or changes. During 2015/16, work has continued to enhance and embed the Trust's corporate governance and risk management systems and processes under the auspices of the Integrated Governance Committee chaired by the Senior Independent Director. The Committee was established in the previous year to provide an additional assurance mechanism that links together more closely the Board Assurance Framework and Corporate Risk Register, which in turn is informed by individual CBU and departmental risk registers. The Committee provides a structured process to test controls and ensure that strategic and operational risks are being addressed as part of a coherent system from ward to Board. Following each meeting an Integrated Assurance Report is submitted to the Board and is also scrutinised by the Audit Committee. Relevant risks have also continued to be monitored each month by each of the assurance committees throughout the year.

In January 2014 the Trust commissioned its external auditors KPMG to carry out a review of its quality governance arrangements and to independently test out the evidence used in the successive self-assessments undertaken against Monitor's Quality Governance Framework since its publication in 2010. The review resulted in a score of 4.5: the scoring methodology used by Monitor to assess applicants for foundation trust status requires that a score of 4 or lower be achieved in order to progress. Whilst this was considered to be a good score for a foundation trust which has been authorised for a number of years, the Board was keen to make improvements to our quality governance arrangements in response to KPMG's recommendations. A follow up review was therefore conducted in the final quarter of 2014/15, which resulted in a score of 3 which was very encouraging. The Clinical Quality Assurance Committee continues to undertake a quarterly self-assessment against the framework which captures the remaining actions from the second KPMG review. The Trust was also assured by the comments in the CQC's inspection report published in December 2015 that the work undertaken in this area '*indicated positive improvements*.'

Further details about the Trust's approach to quality and quality governance can be found within the Quality Report (page xx) and Annual Governance Statement (page xxx).

Patient Care

Infection Prevention and Control

In 2014/15 the Ttrust appointed a highly experienced Infection Control Doctor as the Director of Infection Prevention and Control (DIPC) and a second Consultant Microbiologist. In 2015/16 the trust has further expanded the Infection Prevention and Control (IP&C) service,

with the appointment of an administrator and data analyst; in addition re-organisation of the team has resulted in the post of IP&C Support Worker.

The expansion of the team has enabled the provision of enhanced infection data for clinical teams, ward based education and additional period prevalence surveys to more accurately capture the incidence of healthcare associated infections (HCAI) at Alder Hey.

The move to the new hospital has brought a major benefit of access to additional single rooms for infected patients during the winter season; the continued benefits of the Film Array were demonstrated during last year's severe influenza season when we were able to quickly identify and treat children admitted with influenza with antivirals, in line with Public Health England guidance. However, the new facility also brought a number of challenges as ward teams merged and staff were required to learn to work differently in a new environment. In recognition of these challenges a key objective for 2015/16 was to avoid any increase in hospital acquired infections.

Close working and engagement with the nursing and medical leads for the new wards and departments, including the production of department specific IP&C guidelines and key performance indicators, the revision of the Trust's IPC dashboard and participation in consultant ward rounds has ensured that the move into the new hospital did not result in an increase in monitored infections.

Whilst overall monitored infections have not increased, the Trust recognises that further improvements must be made in respect of reducing hospital acquired infections. To identify areas for further improvement, the Ttrust commissioned a comprehensive external review, the aim and objectives of which were**:**

- To review compliance with practices and procedures in relation to infection prevention and control
- To undertake a spot-check of wards/departments to gauge:
    - Standards
    - Staff engagement
    - Skills and knowledge
    - General environmental cleanliness
- To advise the organisation on service gaps as evidenced through policies and procedures and interviews with staff
- To advise on skill mix to achieve compliance and develop the service to meet any needs identified.

This report presented the findings of the review undertaken under the following sections:

- IPC Team structure
- Reporting arrangements/assurance frameworks and deliverance on the HCAI agenda
- Key documents review
- Audit processes and compliance with IPC practices
- HCAI monitoring and incident surveillance and reporting
- Training and education

The report made a number of recommendations for improvement and these have been incorporated into the 2016/17 IP&C Improvement Plan. Detailed infection control performance is provided in the Quality Report on page xx.

Patient Information

During 2015-16 staff have received advice and support to enable a 62% increase in the production of quality assured patient information leaflets that meet national standards. A partnership has been developed with two local schools whose pupils have been actively involved in developing a variety of resources to support the patient experience and quality and safety initiatives. Communication cards and easy read materials have been made available to our staff to support and improve communication with our patients and their families with learning disabilities.

Complaints

During 2015/16 the Trust received a total of 87 formal complaints, 13 of which were withdrawn and four where investigated as a serious incident, with a route cause analysis being completed (RCA) following the Trust Being Open policy and applied Duty of Candour if appropriate. These where identified during the initial acknowledgement stage of the complaints process. The reduction of formal complaints seen in this year compared to 2014/15 is 45% and much of this can be attributed to the quick intervention and resolution involving many key professionals to ensure the family's concerns where acted upon as soon as possible. The complainants where all advised if they remained dissatisfied when the investigation process concluded they should contact the complaints team for further advice and support.

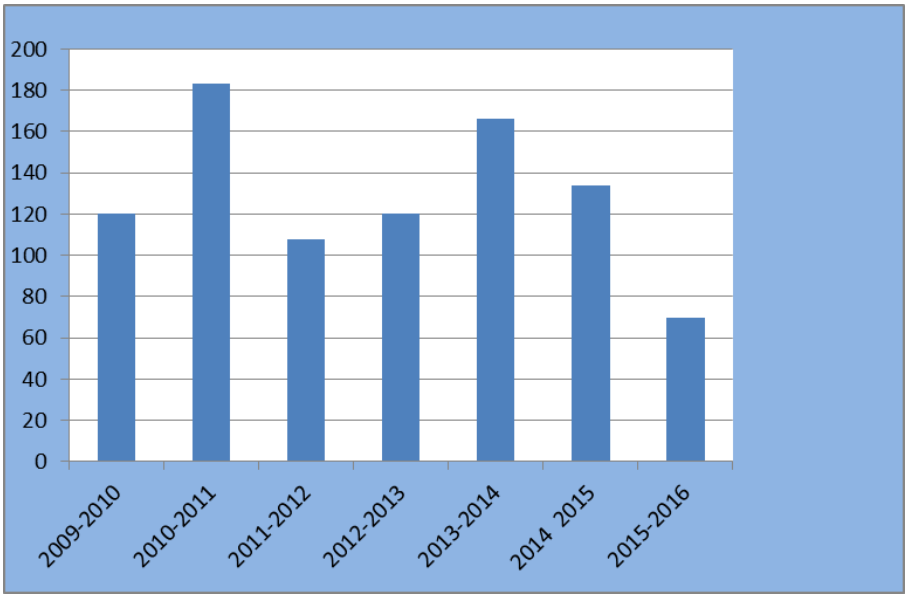


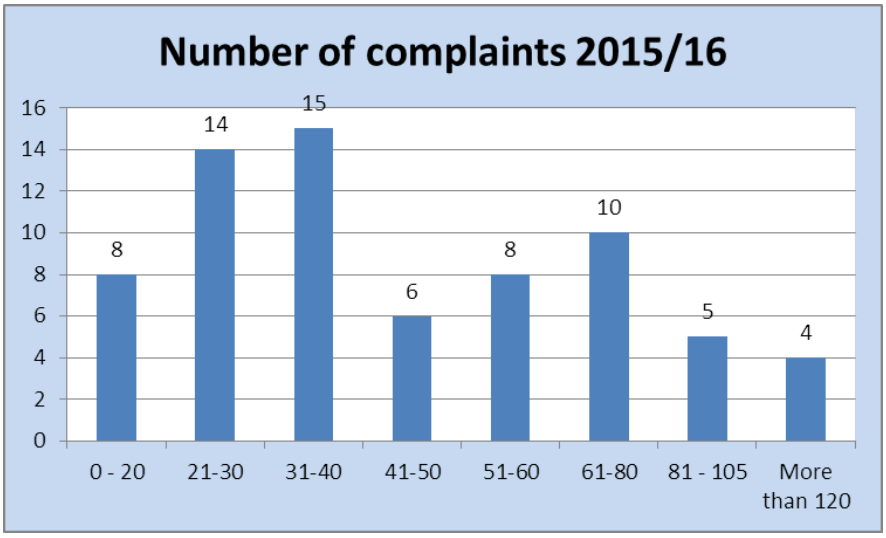
Table 1 – formal complaints received each year.

Due to the significant reduction in formal complaints this means that the content and complexity of the 70 received this year are much more detailed and significant and therefore may take longer to respond to than our initial timeframe of 25 working days. If we anticipate

the timeframe not to be appropriate we will have a telephone conversation with the complainant to agree an extension.

Table 2 - below demonstrates the length of time the formal response has taken.

It should be noted that any complainant who remains dissatisfied can ask that we relook at their complaint. Within Ulysses this case is the reopened and the clock continues to count length of time taken to respond in total from the original date received.



All complainants are offered the opportunity to attend a meeting to resolve their concerns to receive a written response. The complaint meeting is recorded and a copy is provided to the family for their own records. Subsequently a response letter from the Chief Executive is sent to the complainant acknowledging that the meeting has taken place and highlighting the actions that have been agreed in response to issues raised.

Learning from complaints

Actions taken as a result of complaints during this period:

- Issues accessing British sign language interpreters for unplanned / emergency care. Still not resolved but being looked at by procurement team
- Adapted vehicles do not fit into multi-storey car park. PALS team co-ordinate a work around utilising short stay car park near Emergency Department. Families contact the PALS team directly who liaise with the car parking attendants.
- PALS team assist families with Autistic children who have sensory issues in the atrium to use the PALS office as a safe haven and find alternative route to get to Out patients for their appointment that are quieter and protect them from overload of noise, people and other stimuli.
- Parents who are separated cannot both have their addresses on Meditech and both receive information relating to their child when they both have parental responsibility – the Meditech team are aware of this and will be working towards including the ability to enter two different addresses onto Meditech and utilising this function as required.

- Issues within Emergency department waiting area – escalated to relevant CBU and feedback utilised to inform improvement team looking at making enhancements to this area.

Nurse Staffing

Acting on the lessons learned from various reports, strategies and inquiries the Trust has comprehensively reviewed all wards/departments nurse staffing establishments and significantly invested in additional nurses. This recognition of the importance of nursing staffing levels is reflected in our ongoing workforce planning and recruitment. Since March 2014 the Trust has secured a 7% increase in registered nurses with an 80% reduction in registered nurse vacancies.

Patient Safety Champions

The Trust has expanded the number of Patient Safety Champions within the Trust, in addition to nursing staff there is now a broader representation from other staff disciplines, such as, medical staff, pharmacists, counsellors, allied health professionals and volunteers. Their role has been revised and they are instrumental in improving patient safety and supporting their clinical area in achieving Ward Accreditation status.

Ward Accreditation scheme

The Ward Accreditation Scheme has been developed in consultation with Ward Managers, Lead Nurses and Patient Safety Champions and informed by the views of children, young people and their parents/carers. The accreditation scheme has been named as STAR (Safe, Together and Always Right) ‘a journey to the stars’, by the children and young people who will participate in the process of accreditation.

The scheme incorporates the Quality Review programme and the Paediatric Scan, maintaining engagement of both users and providers of service, along with reviewing practice against known service standards. In addition, it strengthens Trust Board assurance and aligns with the Care Quality Commission key lines of enquiry, post Francis enquiry and Essence of Care benchmarks.

National Patient Survey

The national inpatient survey indicated the following areas for improvement:

- Provision of age appropriate toys and play resource
- Quality of hospital food
- Staff not aware of children’s condition
- Staff not always available when required
- Poor overnight facilities for parents and carers

Feedback from children and carers indicates an improvement in satisfaction in these areas since the move to the new hospital. The Trust will continue to review feedback from children, young people and their parents and carers through national and local surveys, inclusive of the

Friends and Family test, to identify areas where further improvements can be made to enhance the patient, carers and visitors experience at Alder Hey.

Patient Information

During 2015/16 staff have received advice and support to enable a 62% increase in the production of quality assured patient information leaflets that meet national standards. A partnership has been developed with two local schools whose pupils have been actively involved in developing a variety of resources to support the patient experience and quality and safety initiatives. Communication cards and easy read materials have been made available to our staff to support and improve communication with our patients and their families with learning disabilities.

Stakeholder Relations

Involvement in the Local Health Economy

In June 2014 Alder Hey submitted a Five Year Strategic Plan for 2014-19 to Monitor. The strategic plan was developed in collaboration with clinicians and seeks to build on the strengths of the Trust while recognising and addressing identified risks and challenges. As part of this work, the Trust completed a comprehensive market assessment which remains current today. The following strategic themes were described:

- Alder Hey as a provider of Integrated Care
- Developing and Formalising Strategic Partnerships
- Increasing provision of care to International and Private Patients
- Becoming a world class leader in children's healthcare Research
- Developing Alder Hey's Education offering

To deliver on these strategic themes Alder Hey continues to work with local, regional and national stakeholders. For community and secondary services Alder Hey works closely with the local CCG within the context of their programme of change the *Healthy Liverpool Programme*. For specialist services the key relationship is with the North Specialised Commissioning team.

We have used the strategic plan as a foundation to begin conversations with health and social care partners about the future of community services for children. This work has been against the backdrop of Liverpool Community Health becoming a distressed Trust and undergoing a transaction into a new organisation. For 18 months the Trust has worked with partners to develop an integrated model for children's community provision which we hope will secure the future of children's services. To support delivery Liverpool CCG has convened a Children's Transformation Board, which Alder Hey co-chairs, to progress a number of workstreams including an integrated community model and unplanned care.

Alder Hey has significant experience of working through clinical networks and has evidence of how robust clinical peer review and clinical standardisation has driven up service quality. We currently utilise a 'service level chain' model to provide a range of high quality paediatric services, under the AlderHey@ brand to more than 30 partner district general hospitals

across a wide geography. We have developed this model further within the Cheshire and Merseyside Women's and Children's Services Partnership, which successfully achieve national Vanguard status. Within this framework we are working closely with Warrington and Halton Hospitals Trust to develop a robust model for sustainable paediatric services at the secondary-tertiary hospital interface.

The Trust has been heavily involved in the work by NHS England to recommission Congenital Heart Disease services against the new set of national standards and service specification. Alder Hey has led work with partners in Liverpool to form a North West CHD Partnership which will work collaboratively to provide a fully compliant, resilient and clinically safe service model for North West of England, North Wales and the Isle of Man. We will begin the phased implementation of this service as soon as NHS England finalises commissioning arrangements.

Liverpool Women's NHS Foundation Trust announced in December 2014 that it was seeking a sustainable future for the organisation which could involve the relocation of the hospital. Alder Hey continues to be actively involved in discussions regarding the development of more collaborative women and children's services in Liverpool building on the real clinical synergies that can be identified from creating an integrated network of care for women, children and families. Liverpool CCG has commissioned an options appraisal to consider future service configurations in which Alder Hey is fully participating.

The Trust has signed a Memorandum of Understanding with the eight Mental Health Trusts in the North West and Central Manchester University Hospitals Trust, to work together under NHS England planning guidance to trial a managed tertiary budget programme for 2016/17. We will work together on the CAHMS Tier 4 workstream to redesign services and strategically redeploy resources to reduce service fragmentation and improve patient outcomes. We wait to hear if our expression of interest has been successful and are keen to move forward with this exciting piece of work. In April CAHMS was pleased to host a visit from the Sefton Overview and Scrutiny Committee which was very constructive.

On 29 January Alder Hey participated in an event to agree our sustainability and transformation plan footprint. All commissioners and providers from the region were represented and the footprint was tentatively agreed as Cheshire and Merseyside. We are pleased that our Chief Executive is leading this piece of work and are working closely to ensure the development of a realistic strategic vision for the region.

The Alder Hey Children's Charity

In a similar move to a number of other NHS Charities, on 1st April 2015 Alder Hey Children's Charity became an independent charity (registration number 1160661) and company limited by guarantee (company no 09389239).

Becoming an independent charity enabled Alder Hey Charity to be more flexible in securing resources and more responsive to opportunities to raise funds. At a time of public debate about the NHS, independence also offered reassurance and absolute transparency to donors about the uses of charitable funds and the impact of their gift.

During the year, the Charity increased its income to £6.8m and supported the hospital with grants totaling £6.38m. This included funding for the new integrated theatre system, EOS machine, patient distraction within the radiology department, parent beds in the new hospital, continued contributions to Phase 1 of the Research Institute, research posts and ongoing support for toys and arts and craft for patients.

Fundraising to support the second phase of the Research Institute continued during the year in partnership with the University of Liverpool and to date a total of £1.9m has been pledged and donated to this build.

The Charity continues to build strategic relationships with its corporate partners. This year Matalan again delivered a cause-related marketing product, raising over £600,000 through their 'Beanies versus Bobbles' campaign. This was again backed by a national multi-million pound advertising campaign across all channels including prime time television. Matalan has raised £1.3 million to date for Alder Hey Charity.

In addition, digital online retailer, Shop Direct, offered fundraising support and expertise in online personalisation to develop the Alder Hey App which will incorporate virtual touring, games and rewards for patients and families.

The Institute of Travel and Tourism continues to offer fundraising support and networking opportunities through its members.

Home Bargains supported the enhancement of 13 operating theatres, enabling live video streaming of surgery as well as the facility to pause and rewind the operation as it happens. In addition the enhancements provide capability to dial out of the operating room to anywhere in the world, in real time, giving Alder Hey the capacity to link to specialists around the globe. These enhancements will make Alder Hey an international reference site

A new partnership was developed with Sixt rent a car which held a spectacular ball and raised £75,000 to equip Alder Hey's performance space in the main Atrium of the new hospital. This area will be a key focal point for the 275,000 children and families who visit Alder Hey each year. This space will be used to host a range of live performances to entertain children in the main Atrium waiting area as well as being streamed into the children's bedrooms on the wards.

The Charity's partnership with Sony Europe Ltd continued during the year with further donations of equipment as well as the development of its strategic partnership with the Hospital Trust around medical devices.

The Charity has established a strong community fundraising base, particularly throughout the North West. Income through sponsored events came in at over £500,000 and our own bespoke events grossed over £200,000. In light of tightened regulation regarding direct marketing, our mass participation events may prove to be a useful tool to help recruit future regular donors.

In 2015/16 income through community businesses increased by 600% on the previous year, donations from educational establishments increased by over 400%, and income from community/voluntary groups increased by 370%.

We now have sixteen young Charity Ambassadors, located in diverse geographic areas throughout the North West, North Wales, Yorkshire and the Isle of Man, who are helping to raise both funds and awareness.

The Charity lottery continues to grow and is now at over 10,000 members.

The Charity continues to broaden its fundraising bases to maximize income and during 2015 opened a trading company, Hardleeys Ltd, with a view of developing the Hardleeys characters used within Alder Hey hospital as a media asset.

Statement as to Disclosure of Information to Auditors

The directors who were in office on the date of approval of these financial statements have confirmed, as far as they are aware, that there is no relevant audit information of which the auditors are unaware. Each of the directors have confirmed that they have taken all the steps that they ought to have taken as directors in order to make themselves aware of any relevant audit information and to establish that it has been communicated to the auditor.

Remuneration Report

The Appointments and Remuneration Committee of the Board of Directors is responsible for determining the remuneration and terms and conditions of the Chief Executive, Executive Directors and non-voting Directors taking into account the results of the annual appraisal process. The Committee is chaired by the Trust Chairman and comprises all Non-Executive directors; it operates in accordance with:

- Legal requirements
- The principles of probity
- Good people management practice
- Proper corporate governance

The Chair undertakes the annual appraisal of the Chief Executive, who in turn is responsible for assessing the performance of the Executive Directors and Associate Directors. The Committee convened twice during the year with all Non-Executives attending; although there was no general uplift applied to Executive Directors salaries during 2015/16 in line with national policy. The Committee's focus was upon succession planning and arrangements for Executive Director vacancies. As appropriate, the Committee receives professional advice from the Director of Human Resources and Organisational Development, who has access to comparative information from the sector. The Trust does not award bonuses over and above the basic remuneration of its Directors. At the time of reporting there is no intention to change the existing remuneration policy.

The Chief Executive and Executive Directors are employed on permanent contracts of employment; they are entitled to receive six months' notice and may give three months' notice. Provision is included within contracts of employment for contracts to be terminated with immediate effect and without compensation in certain circumstances. Rates of pay for all senior managers are based on job size, market intelligence (including published remuneration surveys) and performance. They are set with regard to the remuneration of other Trust employees who hold contracts under terms and conditions agreed nationally, by assessing relative and proportional rates of pay.

Senior officials include five Clinical Directors who are engaged in clinical activities for the majority of their time but are including in the figures as one rather than part time.

The Nominations Committee of the Council of Governors is responsible for setting the remuneration, allowances and other terms and conditions of Non-Executive Directors. It comprises one appointed governor and two elected governors, one of whom must be a staff governor; its other members are the Trust Chair (or Acting Chair in the case of the appointment of a new substantive Chair) and Chief Executive. The Committee's duties are to review the balance of skills, knowledge and expertise required on the Board in the context of the challenges ahead and in this context to agree job roles, person specifications and modes of advertisement, to undertake short-listing and to make a formal appointment.

The Trust Chair is responsible for assessing the performance of the Non-Executive Directors. The Chair's appraisal is undertaken by the Senior Independent Director using an inclusive process across members of the Board and Council of Governors, in accordance with a policy which has been developed to reflect best practice nationally. For Non-Executive Directors' remuneration, comparative data is provided to the Nominations Committee from other

foundation trusts, mutual organisations and the private sector. Remuneration rates for Non-Executive Directors have remained at the level set by the Nominations Committee in 2009/10.

During 2015/16 there was a total of 14 Board Directors in post across the period. Of these, nine individuals claimed £9,891.62 in expenses; for 2014/15 the figures were 12 directors claiming £13,797.22 in expenses. In the year there were 30 governors in office, six of whom received £ 1,552.30 in expenses; whereas in 2014/15 three governors claimed £1,124.00.

The HM Treasury FReM requires disclosure of the median remuneration of the reporting entity's staff and the ratio between this and the mid-point of the banded remuneration of the highest paid director (as defined as a senior manager in paragraph 7.35 and paragraphs 7.51 to 7.55), whether or not this is the Accounting Officer or Chief Executive. The calculation is based on full-time equivalent staff of the reporting entity at the reporting period end date on an annualised basis. Foundation trusts shall disclose information explaining the calculation, including the causes of significant variances, where applicable. Further guidance is provided on the HM Treasury FReM's website (document 'Hutton Review of Fair Pay - Implementation guidance').

The remuneration of the median salary and multiple to the highest paid employee of the Trust for 2015/16 and the prior year comparative is provided below:

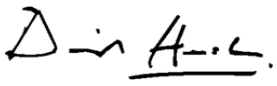
	2015/16	**2014/15**
Band of highest paid director (bands of £5,000)	£145-150	£150-155
Median total remuneration	£27,357	£30,223
Ratio	5.4	5.0

There are two senior managers who during the year were paid more than £142,500 (the sum that equates to the Prime Minister's ministerial and parliamentary salary). One of these was the Chief Executive, the other is the Trust's Development Director. The Trust is satisfied that for both roles the level of remuneration is reasonable for the responsibilities carried and benchmarks favourably with comparable organisations.

The Trust's remuneration policy applies to Executive Directors and senior below Board level posts and is based upon open, transparent and proportionate pay decisions. All pay decisions are based on market intelligence and are designed to be capable of responding flexibly to recruitment imperatives to secure high calibre people. When setting levels of remuneration, the Trust's Nominations and Remuneration Committees also take into account the remuneration policies and practices applicable to our other employees, along with any guidance received from the sector regulator and the Department of Health. The Committee also receives professional independent reports based on objective evidence of pay benchmarking across a range of industry comparators. The conclusion reached in professional independent reports is that 'weightings accredited to the various posts in relation to market comparisons had resulted in remuneration that is in line with current pay practice.' The way in which the Committee operates is subject to audit scrutiny. The work of the Committees is subject to an independent level of scrutiny by the Audit Committee and this scrutiny can be exercised at any time.

The remuneration and retirement benefits of all Directors, together with all other relevant disclosures are set out below.

Signed:



Sir David Henshaw
Chairman
23rd May 2016

Salary and pension entitlements of senior managers

Total Remuneration

Name	Title	2015/2016				2014/2015			
		Salary (bands of £5,000) £000s	Taxable Benefits £	Pension related benefits (bands of £2,500) £000s	Total (bands of £5,000) £000s	Salary (bands of £5,000) £000s	Taxable Benefits £	Pension related benefits (bands of £2,500) £000s	Total (bands of £5,000) £000s
Louise Shepherd	Chief Executive	145-150	8200	10-12.5	165-170	145-150	8200	0	125-130
Jonathan Stephens	Director of Finance	115-120	0	2.5-5	120-125	115-120	0	0	115-120
Gill Core	Director of Nursing	95-100	0	7.5-10	105-110	95-100	0	0	85-90
David Alexander	Director of Human Resources	50-55	0	0-2.5	50-55	100-105	0	17.5-20	120-125
Judith Adams	Chief Operating Officer	100-105	0	20-22.5	120-125	100-105	0	0	100-105
Richard Turnock	Medical Director	85-90	0	0	85-90	110-115	0	0	95-100
Hilda Gwilliams	Acting Director of Nursing	20-25	0	7.5-10	30-35				
Melissa Swindell	Acting Director of Human Resources	40-45	0	32.5-35	70-75				
Graham Lamont	Acting Medical Director	5-10	0	0	5-10				
Professor Ian Lewis	Medical Director	0	0	0	0	150-155	0	0	150-155
Sir David Henshaw	Chair (R)	40-45	0	0	40-45	40-45	0	0	40-45

Claire Dove	Non-Executive Director (R)	10-15	0	0	10-15	15-20	0	0	15-20
Phil Huggon	Non-Executive Director (R) (A)	10-15	0	0	10-15	10-15	0	0	10-15
Steve Igoe	Non-Executive Director (R) (A)	15-20	0	0	15-20	15-20	0	0	15-20
Ian Quinlan	Non-Executive Director (R)	10-15	0	0	10-15	10-15	0	0	10-15
Jean France-Hayhurst	Non-Executive Director (A)	10-15	0	0	10-15	10-15	0	0	10-15
Anita Marsland	Non-Executive Director (A)	10-15	0	0	10-15	5-10	0	0	10-15

(R) Indicates that the individual is a member of the Remuneration Committee

(A) Indicates that the individual is a member of the Audit Committee

- The Trust has disclosed negative movements in pension related benefits as zero in accordance with the Department of Health Group Manual for Accounts 2015/16
- Professor Ian Lewis retired in April 2015
- Richard Turnock was appointed as Interim Medical Director from 1st May 2014 and was substantively appointed as Medical Director in July 2015
- Graham Lamont acted up as Medical Director between 3rd June and 6th July 2015
- David Alexander left the Trust in September 2015
- Melissa Swindell was appointed as Director of Human Resources from 1st October 2015
- Hilda Gwilliams had two periods of acting up in 2015/16 from 8th – 26th May and 1st June to 17th August.

Salary and pension entitlements of senior managers (cont'd)

Pension entitlements

Name and Title	Real increase in pension at age 60 (bands of £2,500) £000s	Real increase in lump sum at aged 60 (bands of £2,500) £000s	Total accrued pension at age 60 at 31 March 2016 (bands of £5,000) £000s	Lump sum at age 60 related to pension at 31 March 2016 (bands of £5,000) £000s	Cash Equivalent Transfer Value at 1 April 2015 £000s	Real Increase in Cash Equivalent Transfer Value £000s	Cash Equivalent Transfer Value at 31 March 2016 £000s	E co s
Louise Shepherd Chief Executive	0-2.5	2.5-5	50-55	150-155	901	34	935	
Jonathan Stephens Director of Finance	0-2.5	2.5-5	45-50	145-150	837	21	858	
Judith Adams Chief Operating Officer	0-2.5	0-(2.5)	25-30	70-75	402	8	410	
Gill Core Director of Nursing	0-2.5	2.5.5	45-50	135-140	870	34	904	
David Alexander Director of Human Resources	0-2.5	0	5-10	0	57	1	58	
Melissa Swindell Acting Director of Human Resources	2.5-5	5-7.5	10-15	35-40	140	46	186	
Hilda Gwilliams Acting Director of Nursing	0-2.5	5-7.5	25-30	75-80	454	53	507	

- As Non-Executive Directors do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive Directors.
- Rick Turnock does not have accrued pension or CETV as at 31 March 2016 his pension is in payment.
- On 16 March 2016, the Chancellor of the Exchequer announced a change in the Superannuation Contributions Adjusted for Past Experience (SCAPE) discount rate from 3.0% to 2.8%. This rate affects the calculation of CETV figures in this report. Due to the lead time required to perform calculations and prepare annual reports, the CETV figures quoted in this report for members of the NHS Pension scheme are based on the previous discount rate and have not been recalculated.

Staff Report

Analysis of Trust staff during the year is set out in the table below, together with a comparison with 2014/15:

Average number of employees (WTE basis)

	Permanent Number	Other Number	2015/16 Total Number	2014/15 Total Number
Medical and dental	371	4	**375**	383
Administration and estates	552	27	**579**	555
Healthcare assistants and other support staff	161	79	**240**	198
Nursing, midwifery and health visiting staff	1,111	10	**1,121**	980
Scientific, therapeutic and technical staff	537	2	**539**	519
Other	0	0	**0**	0
Total average numbers	**2,732**	**122**	**2,854**	**2,635**
Of which:				
Number of employees (WTE) engaged on capital projects	20	-	**20**	18

At the end of the year the gender breakdown of our workforce was as follows:

	Male	Female
Directors	8	7
Senior Managers	8	4
Employees	500	2560

Sickness absence data

The Trust closely monitors its performance against sickness absence targets and the position as at the end of March 2016 was 4.97%.

Staff Policies and Actions

Communications

A dedicated resource was allocated to communicating all aspects of the preparation and execution of the hospital move to staff during 2015. This provided a systematic way of ensuring individuals were provided with information on matters of concern to them in a variety of formats, and supported their personal move planning.

Information Governance

The Trust has ensured that no data breaches occurred during the move to the new site. Moving premises presents a risk to any data held by an organisation and much work was done to ensure all data was reviewed and disposed of or transferred in an appropriate and secure manner.

The Trust completes the national Information Governance Toolkit assessment on an annual basis. This is the Department of health tool which monitors compliance and improvement of Information Governance principles. Although much time was invested in the security of data leading up to and during the move the Trust was able to maintain our score in March 2015 from the 2014 submission of 83%.

We continue to monitor and improve our mechanisms to ensure the information we collect and hold is handled appropriately. We also recognise that with advances in technology and ways of working come potential risks to data. We continue to work to advise and support the use of these technologies and initiatives to ensure secure and appropriate handling. .

Counter Fraud

The Local Counter Fraud Specialist, supported by the Trust, has continued to enhance the overall anti-fraud arrangements at Alder Hey through the conduct of a range of agreed activities specified in the Trust's Anti-Fraud Workplan for 2015/16. The key to the success of these activities is the achievement of outcomes across the defined areas of anti-fraud work.

One of the basic principles of the NHS is the proper use of public funds. It is therefore important that all those individuals or organisations that utilise, or have relationships with, the NHS are aware of the risks of fraud, bribery, corruption, theft, and other illegal acts involving dishonesty.

The ultimate aim of all anti-fraud work is to support improved NHS services and ensure that fraud within the NHS is clearly seen as being unacceptable. Stopping the theft of public money by fraudsters who are committing criminal offences, brings with it the bonus of being able to see NHS funds being deployed for the public good, as the taxpayer intended. During the year the Local Counter Fraud Specialist undertook a range of preventive and investigatory activities in pursuit of this aim.

Staff Survey 2015: Results and Actions

Staff engagement

Improving staff engagement and staff satisfaction remains a key priority for the Board.

Staff have been engaging well with the Trust over the past 12 months, as evidenced by the high levels of involvement in the design, planning and successful move into the new hospital and the highly successful Flu Vaccination Campaign, for which we were the recipients of the national Flu Fighter Award in early 2016.

In addition to the Staff Survey, we continue with a monthly questionnaire to measure staff engagement which includes the 'Staff Friends and Family' questions. Sharing feedback with staff remains a key priority, and the communications plan includes an ongoing feedback campaign throughout the year to ensure staff are kept informed about progress against key actions.

Summary of Performance - Results from the NHS Staff Survey

A summary of performance can be seen in Table 1, where comparisons can be made with both the Trust and national average scores for acute specialist Trusts received in 2014 and 2015.

2015 was a unique year for Alder Hey, and as the hospital move coincided with the Staff Survey distribution window, permission was granted for a later and therefore shorter, distribution of the staff survey. This resulted in a lower response rate than in 2014.

The Trust response rate was 35%, below the overall national response rate for all organisations in England of 45%.

Top ranking scores and progress since 2014

The top ranking scores in 2015 reflect how the Trust has supported staff with improved work life balance, incident reporting and support for 'zero tolerance' with regards physical violence from service users.

The positive actions taken by the Trust regarding dealing with violence and aggression can be demonstrated by the responses for KF 22, which has been identified as one of our top ranking scores (% of staff experiencing physical violence from patients, relatives and public in the last 12 months). KF16 (% of staff working extra hours) has also been identified as one of our top ranking scores.

Two of our top ranking scores (KF 24 and KF 29) are a positive indicator of staff actively reporting incidents and supporting a safety culture.

Bottom ranking scores and action planning

The Trust has been ranked below average, when compared to similar Trusts, on all five of its bottom ranking scores (see Table 1). One of the Key Findings is new for 2015. As in 2014, we surveyed all staff in 2015, so we have been able to break down the results by department. Each department has been provided with their own survey data in order for them to take action locally.

In addition, Trust wide actions have been agreed and supported by the senior leadership team, aiming to address key areas identified as requiring improvement such as:

- Taking action on patient feedback
- Supporting leadership and management development
- Continued focus on staff communication
- Taking steps to improve stress management and resilience

Future priorities and targets

Alder Hey has signed up to be part of the next cohort of Trusts adopting a new way of working, Listening into Action (LiA). LiA has already been implemented by over 60 NHS Trusts, which has improved both patient experience and staff engagement in all of these organisations. We see LiA as a key enabler of engagement for the Trust during 2016. In addition, we remain committed to:

- Continuing to engage the whole workforce in the Staff Survey and further increase the Staff Survey response rate for 2016
- Ensure continued engagement with staff side representatives
- Encourage local ownership for survey outcomes, especially at department level
- Continue with the monthly 'temperature checks' and monitor Trust wide and locally.
- Monitor performance regularly at the Board and the Workforce and Organisational Development Committee.

Table 1- Summary of Performance - Results from the NHS staff survey 2015 and 2014

	2014		2015		Trust Improvement/ Deterioration since 2014
Response Rate	**Trust**	**National Average**	**Trust**	**National Average**	
	44%	42%	35%	45%	Decrease of 10% (2015 also based on a full staff survey)

	2014		2015 %		Trust Improvement/ Deterioration since 2014
Top 5 ranking Scores (2015)	**Trust**	**National Average**	**Trust**	**National Average**	
KF16. Percentage of staff working extra hours	72%	72%	70%	75%	Increase of 2% (improvement)
KF20. Percentage of staff experiencing discrimination at work in last 12 months	7%	9%	8%	8%	Increase of 1% (deterioration)
KF24. Percentage of staff / colleagues reporting most recent experience of violence	50%	-	59%	56%	Increase of 9% (improvement)
KF22. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months	7%	6%	5%	6%	Decrease of 2% (improvement)
KF29. Percentage of staff reporting errors, near misses or incidents witnessed in the last month	93%	92%	93%	92%	No movement

	2014 %		2015 %		Trust Improvement/ Deterioration since 2014
Bottom 5 ranking Scores (2015)	**Trust**	**National Average**	**Trust**	**National Average**	
KF4. Staff motivation at work	3.73	3.90	3.72	3.98	Increase of 0.1 (deterioration)
KF3. Percentage of staff agreeing that their role makes a difference to patients / service users	91%	92%	86%	92%	Decrease of 5% (deterioration)
KF19. Organisation and management interest in and action on health and wellbeing	-	-	3.34	3.72	-
KF10. Support from immediate managers	3.58	3.78	3.49	3.79	Decrease of 0.9 (deterioration)
KF7. Percentage of staff able to contribute towards improvements at work	66%	71%	61%	73%	Decrease of 5% (deterioration)

Expenditure on Consultancy

Expenditure on consultancy in 2015/16 was for specialist advice and support to identify potential opportunities and drive implementation of improvements within the Trust.

Off Payroll Engagements

Details of the Trust's off-payroll engagements during the year are set out in the tables below:

Table 1: Off Payroll engagements as at 31st March 2016, for more than £220 per day and that last longer than 6 months

No.of existing engagements as at 31 March 2016		
of which		
	No. that have existed for less than 1 year at time of reporting	8
	No. that have existed for between 1 and 2 years at time of reporting	16
	No. that have existed for between 2 and 3 years at time of reporting	2
	No. that have existed for between 3 and 4 years at time of reporting	0
	No. that have existed for 4 or more years at time of reporting	2

From the numbers above a total of 11 were engaged to support the Electronic Patient Care System, currently one is still in post. Four staff were engaged to support the move into the new hospital, currently two are still in post.

The Trust can confirm that all existing off-payroll engagements outlined above have at some point been subject to a risk based assessment as to whether assurance is required that the individual is paying the right amount of tax and where necessary, that assurance has been sought.

Table 2: For all new off-payroll engagements, or those that reached 6 months in duration, between 1 April 2015 and 31 March 2016, for more than £220 per day and that last for longer than 6 months

Number of new engagements, or those that reached 6 months in duration between 1 April 2015 and 31 March 2016		8
No. of the above which include contractual clauses giving the Trust the right to request assurance in relation to income tax and National Insurance obligations		8
No. for whom assurance has been requested		8
of which		
	No. for whom assurance has been	8

	received	
	No. for whom assurance has not been received	0
	No. that have been terminated as a result of assurance not being received	0

Table 3: For any off-payroll engagements of board members, and/or, senior officials, with significant financial responsibility, between 1 April 2015 and 31 March 2016

No. of off-payroll engagements of board members, and/or senior officials with significant financial responsibility, during the financial year	0
In relation to the above engagement the exceptional circumstances that led to this was a business need for specialist advice. The duration of the engagement was two years.	
No. of individuals that have been deemed "board members and/or senior officials with significant financial responsibility" during the financial year.	32

Exit Packages

There were two exit packages agreed in 2015/16. One was a redundancy payment, the other was a mutually agreed voluntary severance payment. Both were in relation to changes to estates and facilities personnel as a result of the hospital move.

Reporting of compensation schemes - exit packages 2015/16

	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
	Number	Number	Number
Exit package cost band (including any special payment element)			
<£10,000	1	-	**1**
£10,001 - £25,000	-	-	**-**
£25,001 - 50,000	-	1	**1**
£50,001 - £100,000	-	-	**-**
£100,001 - £150,000	-	-	**-**
£150,001 - £200,000	-	-	**-**
>£200,000	-	-	**-**
Total number of exit packages by type	**1**	**1**	**2**
Total resource cost (£)	£7,125	£29,192	**£36,317**

Reporting of compensation schemes - exit packages 2014/15

	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
	Number	Number	Number
Exit package cost band (including any special payment element)			
<£10,000	-	-	**-**
£10,001 - £25,000	-	-	**-**
£25,001 - 50,000	-	-	**-**
£50,001 - £100,000	-	-	**-**
£100,001 - £150,000	-	-	**-**
£150,001 - £200,000	-	-	**-**
>£200,000	-	-	**-**
Total number of exit packages by type	**-**	**-**	**-**
Total resource cost (£)	£0	£0	**£0**

Exit packages: other (non-compulsory) departure payments

	2015/16		2014/15	
	Payments agreed	Total value of agreements	Payments agreed	Total value of agreements
	Number	£000	Number	£000
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignations (MARS) contractual costs	1	29	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	-	-	-	-
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT approval	-	-	-	-
Total	**1**	**29**	**-**	**-**
Of which:				
Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	-	-	-	-

NHS Foundation Trust Code of Governance

The NHS Foundation Trust Code of Governance, was first published by Monitor in 2006. The purpose of the Code of Governance is to assist NHS foundation trust boards in improving their governance practices by bringing together the best practice of public and private sector corporate governance. The Code is issued by Monitor as best practice advice but imposes some disclosure requirements which are set out in the sections below.

Alder Hey Children's NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a 'comply or explain' basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

The arrangements put in place by the Trust in response to the Code are set out in the sections below and elsewhere in the report as appropriate.

Our Council of Governors

2015/16 saw a number of changes on the Council of Governors following the annual elections. We continued to strengthen the way in which we work together as two governing bodies, regularly reviewing the format of meetings to ensure there is sufficient interactive discussion to enable the Council to properly fulfil its statutory functions, including the holding to account of the Non-Executive Directors for the performance of the Trust.

The Council has continued to work alongside the Board to understand and contribute to the Trust's plans for the future. The governors' extranet provides a rapid and accessible mechanism for the Board to share information with them ensuring that they are kept up to date between formal meetings. It also equips the governors with the information they require to give feedback about the Trust's activities to members and other stakeholders, including the host organisations of appointed governors. The governors use a variety of mechanisms to canvass the view of members and the wider community; some of these are informal and carried out through individuals' networks and others more formal such as inviting comments via the newsletter and direct engagement at the Annual Members' meeting. Such views are fed back to the Board throughout the year at regular formal meetings and topic based workshops, for example the annual session held to discuss the Monitor Plan.

The Council met formally six times during the year, including a briefing and discussion session specifically relating to the development of Trust's Operational Plan for 2016/17, with particular emphasis on the emerging financial context and how this would impact upon projections. Details of individual attendance are set out below. Executive and Non-Executive Directors attend the Council of Governors' meetings and the Chief Executive reports on the Trust's performance and on key strategic and operational issues and developments. This ensures that the agendas of the two bodies remain closely interlinked and appropriate decisions taken by each in accordance with its Standing Orders.

The 2015 Annual Members' Meeting held in December was something of a challenge logistically, given the timing of the move to the new hospital. Unfortunately, the event was not as well attended as previous years, in spite of a delightful keynote speech on the Alder Hey Arts Programme '*Inspired by Children: Bringing Alder Hey in the Park to Life'* delivered by the Trust's Clinical Lead for the Children's Health Park and Chair of Alder Hey Arts, Dr Jane Ratcliffe, Consultant in Paediatric Intensive Care.

Other significant issues considered by the governors during the year focused upon two key areas: the Trust's preparations for the CQC's re- inspection in June and progress with plans for moving to the new hospital in October and the associated change programme.

The governors have also continued to input into a fully inclusive process for the Chair's appraisal and agreement of annual objectives, led by the Senior Independent Director.

In terms of the assessment of its own performance, the Council used the survey work undertaken during 2014/15 to focus on key areas such as understanding accountability in the context of holding the Non-Executive Directors to account. The Lead Governor and Senior Independent Director devised a joint plan to bring the Governors and NEDs closer together; this included the NEDs presenting on their individual roles and responsibilities at successive meetings of the Council during the year. Many of the Trust's Governors have participated in the GovernWell Programme run by NHS Providers and the North West Governors' Forum meetings. A further positive development has been the establishment of regular separate meetings of Governors, chaired by the Lead Governor, to enable more fluid communication and focus on planning the agenda for the formal sessions.

In addition to the full Council meetings, governors have been involved in the Membership Strategy Committee, whose activities area summarized below, as well as time-limited working groups focused on specific issues.

The Membership Strategy Committee continued to take forward its work plan and objectives in support of the Membership Strategy, which underwent a comprehensive review by the Committee and approved by the Council in the previous year and is on a three year review cycle. Key activities in the year included:

- ✓ Acting as Editorial Board for the members' newsletter supported by members of the Communications and Marketing team
- ✓ Public health, with a continued emphasis on smoking issues in families
- ✓ Support for the work of the Fiveways Partnership and in particular the work of the Health Ambassadors at Broadgreen International School
- ✓ Patient experience, through involvement in the consultation on the new hospital interior in local schools
- ✓ Recruiting new members in a variety of locations including the outpatient department
- ✓ Planning and organisation of the Annual Members' meeting in December 2015
- ✓ 'Critical friend' role in reviewing the Annual Report (incorporating the Quality Report)

Its main areas of focus for the coming year are:

- **Newsletter** - to continue on a quarterly basis.
- **Member Communications** - Governors will work with the Trust to undertake a major project to identify e-mail addresses for members following a data cleansing project
- **Public Health** – local authority governor will work to re-establish attendance at the Trust Grand Round to raise awareness of Health Liverpool initiatives and more general Trust/City Council collaboration.
- **New Governor Induction** – a list of "buddies" and or "mentors" will be established for new governors to support their introduction into the role.
- **Training** - Governors from the group will look at attending the Govern Well Engagement workshop in Manchester on 14.09.16. to further our efforts in respect of member engagement.
- **Links to the Children and Young Peoples' Forum** – the governor representative on this group to continue to work to identify young people who would be interested in becoming governors.

Governors are contactable through the Trust's Committee Administrator based at Alder Hey on 0151 252 5092 or by email at membership@alderhey.nhs.uk.

Composition of the Council of Governors

The Council of Governors is comprised of six staff governors (elected by staff), nine public governors, four patient governors, six parent and carer governors (elected by members), together with nine appointed governors from nominated organisations. The Council represents, as far as possible, every staff group and the communities that Alder Hey serves across England and North Wales. Elected Governors are chosen as part of an independent process managed on behalf of the Trust by the Electoral Reform Service, in accordance with the Constitution. Elections to the Council of Governors take place annually, in the summer. On election or appointment all governors are required to sign the Council's Code of Conduct and to complete their declaration of interests in accordance with the Trust's policy.

The Council of Governors operates under the leadership of the Trust Chair and its endeavours are supported by the senior governor, Mrs Kathryn Jackson who was elected to this role in October 2014 and which has continued throughout 2015/16. The roles and responsibilities of governors are set out in the Trust's Constitution and Council of Governors' Standing Orders.

Governor	Constituency	Class	Term of Office	Council Meetings eligible to attend in 2015/16	Total no. of attendances at Council meetings
Barbara Murray**	Appointed	Liverpool City Council	n/a	5	5
Ahmed Elsheikh	Appointed	University of Liverpool	n/a	5	2
Janice Monaghan	Appointed	The Back Up Trust	n/a	5	0

Governor	Constituency	Class	Term of Office	Council Meetings eligible to attend in 2015/16	Total no. of attendances at Council meetings
Rod Thomson	Appointed	Shropshire County Council	n/a	5	0
Julie Williams	Appointed	Edge Hill University	n/a	5	3
Colette O'Brien	Appointed	Liverpool City Council	n/a	5	1
Dawn Holdman	Patient	Parent & Carer	17.09.12 - 16.09.15	5	3
Belinda Shaw	Patient	Parent & Carer	01.08.13 – 31.07-16	5	3
Dot Brannigan	Patient	Parent &Carer	01.08.13 – 31.07-16	2	2
Pippa Hunter-Jones	Patient	Parent & Carer	01.06.14 – 31.05.17	5	4
Claire Blanchard	Patient	Parent & Carer	01.09.14 – 31.08.17	5	1
Elizabeth Brown	Patient	Patient & Carer	01.03.16 – 28.03.19	1	1
Jonathan McKay	Patient	Merseyside	01.04.15 – 31.03.16	5	0
Lydia Brady	Patient	Merseyside	01.09.15 31.0818	4	2
Olivia Cole	Patient	Rest of England & North Wales	17.09.12 – 16.09.15	2	0
Naomi Grannell	Public	Cheshire	01.06.14 – 31.05.17	5	2
Paul Denny	Public	Merseyside	01.09.14 – 31.08.17	5	3
Norma Gilbert	Public	Merseyside	01.08.10 – 31.07.16	5	4
Gwen Blackmore	Public	Merseyside	17.09.12 – 16.09.15	2	1
Mark Peers	Public	Merseyside	01.08.13 – 31.07-16	5	1
Kathy Hawkins	Public	Rest of England	01.06.14 – 31.05.17	5	1
Kate Jackson	Public	Greater Manchester	01.06.14 – 30.05.17	5	5
Judith Harrison	Public	Cumbria & Lancashire	17.09.12 - 16.09.15	1	0
Imogen Billingham	Staff	Doctors and Dentists	11.03.13 - 10.03.16	1	0
Tony Hanmer	Staff	Other Staff	01.08.10 – 31.07.16	5	3
Jeanette** Chamberlain	Staff	Other Staff	01.09.14 – 31.08.17	5	2
Hilary Peel	Staff	Nurses	01.09.14 – 31.08.17	5	4
Karen Dean	Staff	Other Clinical Staff	01.08.13 – 31.07.16	3	0
Elizabeth Grady	Staff	Nurses	01.06.14 – 31.05.17	5	2

** Members of the Nominations Committee

Attendance at Council of Governors by Board members	Number of meetings held in 2015/16
	5
Sir David Henshaw	4
Ian Quinlan	1
Steve Igoe	4
Philip Huggon	2
Anita Marsland	3
Claire Dove	2
Jeannie France-Hayhurst	0
Louise Shepherd	5
Jonathon Stephens	4
Jude Adams	5
David Alexander	1/1
Melissa Swindell	2/4
Rick Turnock	2
Gill Core	0
Hilda Gwilliams	2
Erica Saunders	2
David Powell	2
Louise Dunn	0

Declaration of Interests

A copy of the Council's Register of Interests is available on request from Erica Saunders, Director of Corporate Affairs via the Executive Office on 0151 282 4672 or by email at membership@alderhey.nhs.uk.

Our Membership

It is important to us that membership is relevant to all sections of the communities we serve and we continue to make every effort to reach all groups within our membership constituencies. We seek to ensure that our membership reflects the social and cultural mix of our catchment population. We also need to ensure that our Council of Governors reflects our membership and we aim to address this challenge by encouraging a large, genuine membership from all areas served by the Trust.

Alder Hey has three broad membership constituencies: public, patients and staff. Within these there are different classes, each of which has at least one governor representing them. The wide geographical basis for the public constituencies is derived from the Trust's patient footprint, since we are also a super-regional centre which means that patients from all over the country (and the world!) are referred to us for treatment. In addition, a specific class for parents and carers reflects the vital role played by individuals who support and care for our patients. Membership is open to anyone over the age of seven who lives in the electoral wards specified. Once a patient reaches 20 years of age they are required to transfer to the public or parent and carer category (whichever is most applicable).

Membership Strategy

The Trust's Membership Strategy was refreshed again in the year and is led by a committee of the Council of Governors called the Membership Strategy Committee. During 2015/16 the Committee was chaired by one of our public governors, Kate Jackson who is also Lead Governor. The terms of reference of the Committee were approved by the Council of Governors to undertake the following:

- Devise a Membership Development Strategy on behalf of the Council, which describes clearly the processes by which the Trust will develop as a membership organisation.
- Ensure that regular analysis of the existing membership is undertaken to inform recruitment of new members, ensuring that the membership remains representative of the communities served by the Trust.
- Devise a system of effective communication with the wider membership so that members are actively engaged with activities such as elections.
- Develop and implement appropriate monitoring systems to evaluate the membership strategy in terms of openness, diversity, representativeness and sustainability.
- Engage with other membership based organisations on best practice recruitment and communication to determine if there is transferability to the Trust.

The objectives of the Membership Strategy are to:

- Ensure that our membership reflects the diversity of the population we serve;
- Provide a range of opportunities for Members to be involved at varying levels according to their wishes;
- Set out the communication mechanisms in place for the Trust to communicate with Members and for Members to communicate with the Trust;
- Set out clearly the support mechanisms which will be in place to enable those Members to be elected and appointed onto the Council of Governors, to fulfill their role and to communicate with the wider membership;
- Put into place open and transparent systems to enable Members to influence the work of the Trust; and
- Define the role of Members.

Throughout all our recruitment activities the Trust will endeavour to ensure that all the communities the Trust serves are given every opportunity to become a member. It is our intention to continue to maintain our membership population at around 13,500 overall but with a focus on recruitment of more children and young people as members in the coming year. This strategy will be carried out in line with the Trust's Quality Strategy and in line with all legislation pertaining to equality and diversity issues.

A number of mechanisms will be used for membership engagement including:

- Regular newsletters
- E-mail bulletins

- Invitations to specific events
- Annual Members' Meeting
- Lay reader scheme for patient information, linked to the Volunteer Scheme
- External consultations
- Trust consultations
- Members' zone on the Trust website
- Participation in elections to the Council of Governors

Membership Profile

Constituency	Number of members 2015/16 (actual as at 31st March 2016)	Number of members 2016/17 (planned)
Public	3789	4121
Patients	6,739	7090
Staff	3051	3111
Total	13579	14322

Our Board of Directors

The Trust's Constitution provides for a Board of Directors which is comprised of no more than seven Executive and no more than eight Non-Executive Directors including the Chairman. All Director roles have been occupied during 2015/16 in accordance with the policy developed by the Trust in support of the Constitution. The Trust considers that it operates a balanced, complete and unified Board with particular emphasis on achieving the optimum balance of appropriate skills and experience; this is reviewed whenever any vacancy arises and was rigorously tested in the year as part of the process to recruit a new Non-Executive Director. Following the introduction in November 2014 by the CQC of the *Fit and Proper Persons Requirement*, the Board reviewed its current policies and processes and amended the associated documentation. It also introduced an additional proactive declaration in relation to the requirement which was put in place immediately and completed by all directors. The Council of Governors was informed of the Board's response to the regulation.

The Board of Directors operates to clear terms of reference and annual work plan which underpin the Trust's constitution and which are in turn supported by detailed Standing Financial Instructions and Standing Orders, a scheme of delegation and a Schedule of Matters Reserved for the Board, which are set out in the Trust's Corporate Governance Manual and Constitution. It is the role of the Board to set the organisation's strategic direction in the context of an overall operational planning framework. It is responsible for all key business decisions but delegates the operationalisation of these to an appropriate committee, the Trust's Operational

Delivery Board or relevant programme board in order to receive assurance that the organisation is fulfilling its responsibilities including compliance with standards and targets and the conditions set out in the Trust's Provider Licence.

The Board meets on the first Tuesday of each month, with the exception of August. Board meetings are fully and accurately minuted, including challenges and concerns of individual directors as appropriate. The Chairman meets separately with the Non-Executive Directors directly before each meeting. All Board meetings are held in public; dates, times and agendas are published on the Trust's website prior to meetings and the papers posted shortly after. The Board's agenda is structured around the Care Quality Commission's five key questions: *Are we safe? Are we effective? Are we caring? Are we responsive to patients' needs? Are we well-led?* Each meeting begins with a patient story which is designed to ensure that patients remain at the centre of all discussions and decisions. At each meeting the Board receives a corporate performance report which describes in detail how the organization has performed against key local and national metrics, as well as a Quality Report which focuses on progress against the Trust's quality aims. Accompanying the performance information is the Board Assurance Framework which demonstrates to the Board how the principal risks to the organisation's business are being controlled and mitigated.

Board governance is supported by a number of assurance committees which have oversight of key activities:

- Clinical Quality Assurance Committee
- Resources and Business Development Committee
- Audit Committee
- Workforce and Organisational Development Committee
- Integrated Governance Committee
- Remuneration and Nominations Committee

Each assurance committee submits an annual report to the Board describing how it has fulfilled its terms of reference and work plan during the year; these are also considered by the Audit Committee in the context of its role on behalf of the Board to ensure that the Trust's control environment is effective and fit for purpose.

Non-Executive directors are appointed by the Council of Governors at a general meeting, following a selection process undertaken on behalf of the Council by its Nominations Committee. The Council of Governors has adopted a standard term of office of three years for all Non-Executive appointments, in accordance with the '*NHS Foundation Trust Code of Governance*.' The Chairman and Non-Executive directors can also be removed by the Council of Governors through a process which is described in section 24 of the Constitution.

Members can contact all governors and directors by the following methods:

- In writing, care of the Committee Administrator, Alder Hey Children's NHS Foundation Trust, Eaton Road, Liverpool, L12 2AP.
- By telephone on 0151 252 5128
- By email at membership@alderhey.nhs.uk

Independence of Non-Executive Directors

The Board considers all of its current Non-Executive Directors to be independent. All appointments and re-appointments are made by the Council of Governors specifically to meet the requirements set out in Monitor's '*NHS Foundation Trust Code of Governance'*.

Board Performance

Each member of the Board of Directors undergoes an annual appraisal to review his or her performance against agreed objectives, personal skills and competencies and progress against personal development plans. Since 2014/15 the Trust's appraisal process has included an assessment of how individuals have performed in relation to the Trust's values of *Excellence, Openness, Respect, Innovation and Togetherness*. Non-Executive Director assessments and that of the Chief Executive are undertaken by the Chair of the Trust and Executive Director performance is assessed by the Chief Executive. The appraisal of the Chair includes input from all Board members and the Council of Governors, led by the Senior Independent Director, working closely with the Lead Governor.

Attendance at Board of Directors and Board Committee Meetings

	Board	Audit Committee	Clinical Quality Assurance Committee	Resources & Business Development Committee
No of Meetings held 2015/16	**10**	**5**	**11**	**10**
Sir David Henshaw	10	not a member	not a member	not a member
Louise Shepherd	10	not a member	8	2
Ian Quinlan	10	not a member	not a member	9
Steve Igoe	9	5	8	not a member
Claire Dove	9	not a member	not a member	5
Anita Marsland	9	4	11	not a member
Jonathan Stephens	10	4 attendee	8	6
David Alexander	5/5	not a member	5/5	5/5
Jeannie France-Hayhurst	7	4	6	not a member
Judith Adams	10	not a member	10	5
Gill Core	6	not a member	6	not a member
Phillip Huggon	6	0	8	7
Erica Saunders	8 (attendee)	4 (attendee)	9 (attendee)	6 (attendee)
Rick Turnock	10	not a member	4	not a member

Hilda Gwilliams	6	not a member	8/11	not a member
David Powell	6 (attendee)	not a member	not a member	not a member
Louise Dunn	5 (attendee)	not a member	not a member	5 (attendee)

Audit Committee Report

The Audit Committee is comprised of Non-Executive Directors only, excluding the Trust Chair. The Committee was chaired by Steve Igoe throughout the year, a Non-Executive Director with 'recent relevant financial experience' which is best practice. The Director of Finance and Director of Corporate Affairs together with the Deputy Director of Finance are invited to attend, and the Committee may request the attendance of the Chief Executive and any other officer of the Trust to answer any points which may arise. Attendance by members is set out above.

The aim of the Audit Committee is to provide one of the key means by which the Board of Directors ensures effective internal control arrangements are in place. In addition, the Committee provides a form of independent check upon the executive arm of the Board. As defined within the NHS *Audit Committee Handbook* (2014), the Committee has responsibilities for the review of governance, risk management and internal control covering both clinical and non-clinical areas. In discharging these duties the Committee is required to review:

- Internal financial control matters, such as safeguarding of assets, the maintenance of proper accounting records and the reliability of financial information.
- Risks regarding disclosure statements (for example the Annual Governance Statement) which are supported by the Head of Audit Opinion and other opinions provided
- The underlying assurances as detailed in the Board Assurance Framework.
- The adequacy of relevant policies, legality issues and Codes of Conduct.
- The policies and procedures related to fraud and corruption.

The conduct of this remit is achieved firstly, through the Committee being appropriately constituted, and secondly by the Committee being effective in ensuring internal accountability and the delivery of audit and assurance services.

Internal Audit

The Internal Audit service is provided by Mersey Internal Audit Agency (MIAA), an independent NHS organisation. The Director of Audit Opinion and Annual Report for 2015/16 reports that MIAA have demonstrated their compliance with NHS mandatory Internal Audit Standards. Internal Audit provides an independent and objective appraisal service embracing two key areas:

- The provision of an independent and objective opinion to the Accountable Officer, the Board and the Audit Committee on the degree to which risk management, control and governance support the achievement of the agreed objectives of the organisation.

- The provision of an independent and objective consultancy service specifically to help line management improve the organisation's risk management, control and governance arrangements.

External Audit

The provision of External Audit services is delivered by KPMG, who were re-appointed by the Council of Governors in September 2013 for a further two year period, having successfully demonstrated their performance against the terms of their initial three year engagement in a report that was submitted to a formal Council meeting by the Audit Committee Chair, Director of Finance and Director of Corporate Affairs. The Council of Governors granted a further extension of tenure by a period of 12 months in March 2015, in order to minimize disruption ahead of the move to the new hospital. The service will be re-tendered in the summer of 2016. The work of External Audit can be divided into two broad headings:

- To audit the financial statements and provide an opinion thereon,
- To form an assessment of our use of resources.

The Committee has approved an External Audit Plan and receives regular updates on the progress of work including audit work undertaken on the quality account.

The external audit fees for 2015/16 were £62,545 excluding VAT. KPMG waived its usual inflationary increase of 3.5% in 2015/16 on both the financial statements and the quality account opinion in recognition of the financial pressure on the NHS.

In 2015/16 KPMG provided other services throughout the year - Tax advice on the Outpatients build (fee £53,841 exclusive of VAT), VAT advice (fee £31,672 exclusive of VAT), PFI accounting support (fee £4,872 exclusive of VAT) and Quality Governance follow up (fee of £5,000 exclusive of VAT).

The Audit Committee members have had regular opportunities to meet in private with internal audit and external audit during the year.

Five meetings were held during the financial year 2015/16 of which one, in May, was devoted to consideration of the auditors' report on the Annual Accounts and ISA 260. The Committee has an annual work plan with meetings timed to consider and act on specific issues within that plan.

At each meeting the Audit Committee considered a range of key issues and tested the underpinning control and assurance mechanisms, including:

- The monthly Board Assurance Framework report and/or Integrated Assurance Report
- Internal Audit Reports in accordance with the approved 2015/16 work plan
- Counter Fraud reports by the MIAA specialist in accordance with the approved 2015/16 work plan.

In addition throughout the year the Audit Committee has reviewed and dealt with the following matters:

- Annual Governance Statement
- Consideration of the 2014/15 Annual Accounts
- Monitor quarterly returns and feedback letters

- External Assurance Report on the quality account
- External Audit report on the financial statements to 31st March 2015 and ISA 260
- Losses and special payments
- Counter Fraud reports by the MIAA specialist in accordance with the approved 2015/16 work plan
- Reports on progress against the Risk Management Improvement Plan
- Approval of the Treasury Management Policy
- Internal Audit work plan for 2015/16
- External Audit strategy relating to the Audit of the Trust's 2014/15 Accounts
- Financial Statement audit risks for 2015/16
- Accounting policies for the 2015/16 Financial Statements
- Audit Committee work plan 2015/6
- Review and approval of the terms of reference for the Audit Committee
- Annual Reports of the Trust's assurance committees, including Clinical Quality Assurance Committee

Scrutiny of the management of the financial and operational risks to the organisation is the responsibility of the Resources and Business Development Committee. However, the Audit Committee maintains a regular overview of these key risks via its consideration of the Board Assurance Framework which details the controls in place to mitigate them, any gaps in assurance and the action being taken to address them. The Board Assurance Framework is reviewed on a monthly basis by the Board as a whole and is also used by the Resources and Business Development Committee to inform its standing agenda items. In this way the cycle of control is maintained between the various elements of the governance framework.

The Audit Committee considered the financial statements audit risks including the areas where the Trust has applied judgement in the treatment of revenues and costs to ensure that annual accounts represented a true position of the Trust's finances. The External Audit Plan 2015/16 highlighted one significant audit risk in relation to PFI accounting.

The Committee discussed the approach taken by the Trust relation to income recognition. The Trust has robust processes in place which ensure that income is actively monitored and debtors are followed up on a timely basis. The Trust also acknowledges that there is no specific risk in relation to fraudulent income recognition.

The Committee also discussed the significant transaction risk in relation to management override of controls and is satisfied that there are no issues arising from the work of internal audit that would suggest that this could lead to a material misstatement within the accounts.

The Audit Committee contributed to the risk assessment to inform and subsequently approved the content of the Internal Audit Plan for 2015/16. This plan was structured to provide the Director of Audit Opinion which gives an assessment of the:

- design and operation of the underpinning Assurance Framework and supporting processes;
- range of individual opinions arising from risk-based audit assignments contained within internal audit risk-based plans that have been reported throughout the year, this assessment has taken account of the relative materiality of these areas and management's progress in respect of addressing control weaknesses; and
- effectiveness of the overall governance and assurance processes operating within the Trust.

The key conclusion from their work for 2015/16 as provided in the Director of Audit Opinion and Annual Report was that 'Significant Assurance' was given; that there were generally sound systems of internal control to meet the organisation's objectives and that controls are generally being applied consistently. However, there are some weaknesses in the design or inconsistent application of controls which could put the achievement of a particular objective at risk. Action plans to remedy any residual weaknesses in a timely manner are agreed with managers and monitored by both MIAA and the Committee.

Nominations Committees

The Trust has established separate Nominations Committees to oversee the appointment of Executive and Non-Executive Directors.

• The **Nominations Committee of the Council of Governors** is responsible for the appointment and removal of Non-Executive Directors. It is chaired by the Trust Chair apart from when it is concerned with the appointment or re-appointment of the Trust Chair. Other members of the Committee are Jeanette Chamberlain, Barbara Murray, Kate Jackson and Louise Shepherd. During 2015/16 there were no Non-Executive Director vacancies, therefore Committee was not required to make any appointments.

• The **Appointments and Remuneration Committee of the Board of Directors** is responsible for the appointment of Executive Directors. It is chaired by the Trust Chair; other members are a minimum of three other Non-Executives and the Chief Executive, as appropriate to the post under consideration. During 2015/16 the Committee substantively appointed Mr Rick Turnock as the Trust's Medical Director and agreed the interim appointment of Melissa Swindell as Director of Human Resources and Organisational Development.

Regulatory Ratings

Monitor, the sector regulator for health services in England assigns each NHS foundation trust a risk rating for its governance and ability to provide continuity of services to its population, on a quarterly basis during the year. The role of ratings is to indicate when there is a cause for concern at a provider.

The Continuity of Services rating aims to identify whether the financial situation at a provider could result in any NHS services being put at risk. Using two key financial metrics Monitor rates NHS providers on a scale of 1 to 4, with 4 being lowest risk. The governance rating is derived from a range of indicators, including the views of third parties and the Care Quality Commission, in addition to performance against national access targets. A provider will be rated green if there are no concerns, red if regulatory action is to be taken. Where Monitor has material cause for concern, it will replace its green rating with a description of the issue and steps being taken to address it.

Monitor uses the measures of financial robustness and efficiency underlying the financial sustainability risk rating as indicators to assess the level of financial risk and the above targets (amongst others) as indicators to assess the quality of governance at foundation trusts. A failure by a foundation trust to achieve a financial sustainability risk rating of 3 or above and the targets applicable to it, could indicate that the trust is providing health care services in breach of its licence. Accordingly, in such circumstances, Monitor could consider whether to take any regulatory action under the Health and Social Care Act 2012, taking into account, as appropriate, its published guidance on the licence and enforcement action including its Enforcement Guidance and the Risk Assessment Framework.

A summary of Alder Hey's performance against the ratings for 2015/16 is set out below, including a comparison with the previous year. From Quarter 2 onwards the Trust was allocated a financial sustainability risk rating of 2, which triggered Monitor to consider the requirement for further regulatory action, due in addition to the Trust's position with regard to the A&E 4 hour target.

Given that the causes of this rating were largely a short term effect of the move into the new build hospital in October 2015 Monitor elected not to take any further action but requested that the Trust take steps to achieve financial sustainability and sustainable compliance with the targets promptly.

Summary of Ratings

	Annual Plan 2015/16	Q1 2015/16 Actual	Q2 2015/16 Actual	Q3 2015/16 Actual	Q4 2015/16 Actual
Continuity of Service rating	**2**	**4**	**2**	**2**	**2**
Governance rating	**Green**	**Green**	**Green**	**Green**	**Green**

	Annual Plan 2014/15	Q1 2014/15 Actual	Q2 2014/15 Actual	Q3 2014/15 Actual	Q4 2014/15 Actual
Continuity of Service rating	4	4	4	4	4
Governance rating	Green	Green	Green	Green	Green

Voluntary disclosures

Sustainability and Climate Change

Energy

During the year, the Trust has continued in its efforts to reduce energy utilization, the outcome of which has seen an improvement in the energy mix as a result of deployment of the Combined Heat and Power unit. In addition, the majority of staff moving from the old to the new site has also had an impact.

The energy consumption for the old site is set out below:

Year	2015/16			2014/15			2013/14		
Aspect	Units consumed		Value of units	Units consumed		Value of units	Units consumed		Value of units
Electricity	5,092,768	Kwh	£571,066	8,460,963	Kwh	£ 743,161	6,124,389	Kwh	£696,254
Gas	18,019,616	Kwh	£ 587,781	17,504,983	Kwh	£ 527,976	20,777,066	Kwh	£585,384
Carbon	Data not submitted until July 2016			7117	Tonnes	£116,718	7281	Tonnes	£83,372.00
Water	53,313	m³	£227,518	33,388	m³	£170,214	59,221	m³	£220,719
			£1,502,357			**£1,502,357**			**£1,502,357**

As a result of the move to the new hospital, the Trust has commenced using new technologies to reduce energy consumption. The new building encompasses some of the following features:

- A gas-fired CHP sized to produce a 500 kW electrical load and 516 kW thermal load with a fuel input of 1,295 kW;
- A Biofuel CHP which is sized to produce 500 kW electrical load and 524 kW thermal load with a fuel input of 1,219 kW;
- Ground Source Heat Pumps which have a rated output 500 kW (heating) and 278 kW (cooling);
- Air Source Heat Pumps capable of producing 463 kw of heating / cooling;
- A Photovoltaic (PV) array which is rated at 50 kWe.

This mean that 8.8% of energy generated is from renewables.

The energy consumption for the new site is as follows:

Year	*2015/16 (6months)*		
Aspect	*Units consumed*		*Value of units*
Electricity	2,233,386	Kwh	£ 286,835
Gas	10,515,443	Kwh	£ 235,697
Carbon	N/A at Present		
Water	20,942	m^3	£ 71,831
			£ 594,363

Waste

A substantial amount of waste has been produced this year resulting from the continuation of the '*Dump the Junk'* campaigns prior to the move to the new hospital. These campaigns were instigated to reduce the amount of unused materials that had accumulated over the decades of occupation of the old site.

The reusable sharps system is functioning very well and has been accepted as a part of the overall clinical processes and has added value in that staff can provide care without compromising safety.

Year	***2015/16***			***2014/15***			***2013/14***		
Resource	*Units disposed*		*Value of units*	*Units disposed*		*Value of units*	*Units disposed*		*Value of units*
Land Fill	165.133	Tonnes	£ 22,492	129	Tonnes	£ 18,462	146	Tonnes	£ 22,763
Clinical Waste	86.99	Tonnes	£ 43,506	122	Tonnes	£61,884	203	Tonnes	£ 67,796
Offensive Waste	202.93	Tonnes	£ 71,627	163	Tonnes	£107,857	40	Tonnes	£ 18,038
Recycled	687.532	Tonnes	£ 91,049	516	Tonnes	£62,420	619	Tonnes	£ 74,619
Confidential	103	Tonnes	£ 14,100	89	Tonnes	£12,565	75	Tonnes	£ 10,516
WEEE	15.65	Tonnes	£ 7,909	8	Tonnes	£ 4,115	13	Tonnes	£ 5,875
			£ 250,683			**£267,302**			**£199,607**

Travel

The Trust continues to promote the Cycle to Work Scheme and has an active cycling community within the workforce. We have received ongoing training support from Bike Right. The Trust is an active member of Liverpool City Council Cycle forum and have input into the strategic direction of the local area cycle plan.

The new cycle centre built as part of the new facilities is now operational and staff are using this asset to its fullest with over one hundred and twenty five members of staff as regular users.

We have had installed an electric vehicle charging point and this is available for use by staff and visitors alike and has been utilized quite well to date.

Equality Report

Alder Hey continues with its commitment to try to ensure that all its services offer equal access for all communities who need to use them and that all employees experience equal opportunity in employment. This means that we actively seek to engage with patients, parents and carers, as well as members of staff, to ensure that we do not discriminate against any individual and that the diversity of each individual is valued. The principles of equality and diversity are core elements of the Trust's stated Values, which are reinforced through the Trust's induction programme and personal development review for all staff.

Whilst aspiring to greater achievement in the area of equality and diversity, the Trust also recognises the need to implement realistic approaches which can deliver measurable improvements in day to day experience for all the various different groups and individuals concerned. This reflection has contributed to a current revision of the overall E&D process, in order to most effectively prioritise those areas of development that will bring the greatest benefit to those most at a disadvantage.

During 2015, the Trust has continued to present updates of progress alongside quality and patient experience aspects to local Healthwatch groups as part of continuing development of the NHS Equality Delivery System (EDS). In response to some key messages from this engagement, developments to support the strategic process for equality and diversity have been progressed. The Trust's Equality, Diversity and Human Rights group has ongoing responsibility to regularly review the Equality Objectives and oversee progress towards meeting these, as part of the organisation's obligations under the Equality Act 2010. A refreshed EDS2 was launched nationally in late 2013 and there is current revision of E&D priorities and actions to align with the revised EDS2 outcomes for 2015/16. The EDS 2 outcomes relate to all areas of the Trust's functions, having four main goal areas – better health outcomes, improved patient access and experience, a represented and supported workforce and inclusive leadership. Arrangements for continuing Healthwatch engagement and partnership working with community groups will continue to be a focus for embedding equality and diversity practice and approach during 2016.

In compliance with the Public Sector Equality Duties the Trust publishes equality information annually about its service users and staff, identifying where data needs to be improved in both patient and staff profiles. This work is ongoing, with recent changes in the electronic patient record during 2015 and plans to roll out the self-service aspects of the employee staff record system during 2016. Improvement in data monitoring of access to learning and development opportunities of staff will be a priority for 2016. For service users a primary focus is to improve data and information which can be used to support any disability related needs of children and young people as patients.

In response to the findings of the workforce profile data 2015, we are working with the local community to improve the accessibility of employment opportunities at Alder Hey to improve the diversity of the workforce particularly from Black and Minority Ethnic (BME) groups. This commitment is included in the Trust Recruitment Strategy and is reinforced via the underpinning Equality, Diversity and Human Rights

Policy which sets out the Trust's commitment to creating an inclusive organisation, which seeks to recognise diversity, promote equal opportunities and supports Human Rights in the provision of health services for the communities it serves and in its practice as a leading employer.

An amended equality analysis policy and process was implemented in November 2015 that provided for equality analysis to be undertaken for all projects following the same operating principles of quality impact assessments. The Trust has invested in purchasing bespoke equality analysis e-learning training available to all relevant staff. The Trust understands that building equality analysis into the early stages of policy and project development will help ensure that equality considerations are at the forefront of everything that we do.

The continued implementation of interpreting and translation services has progressed during 2015, with significant improvement in data and coordination for this area of provision. This means that there is more accurate identification of both the uptake of services as well as understanding the language needs of our patients and families. Reflecting the diverse needs of our communities, the four most frequently requested languages during 2015 have been Polish, Mandarin, Cantonese and Arabic. Providing support for limited English speakers is essential for patient safety, quality assurance and enhanced patient experience and this will continue to be available where a need is made known. Further work is ongoing looking at how our services can be made more accessible in relation to information formats and communication support for families and recording these preferences on patient records. This will be an integral part of the evolvement of the newly developed Trust Quality Strategy.

Plans for 2016 will be to improve our involvement of staff in equality priorities. This is following the training of Diversity and Inclusion Champions who are members of the Equality, Diversity and Human Rights Steering Group. The Trust is represented at the Regional NHS Black and Minority Ethnic Network; there are also plans to develop a Trust Black and Minority Ethnic (BME) network to support the work involved in increasing the BME representation of the workforce and findings relating to the Workforce Race Equality Standard (WRES). There will be continued attention to supporting the organisational process and strategic leadership for equality and diversity and communicating any gaps wherever these may be identified. Continued engagement with the Children and Young People's Forum will also contribute towards supporting overall improvement in patient experience for everyone.

Statement of the Chief Executive's responsibilities as the accounting officer of Alder Hey Children's NHS Foundation Trust

The National Health Service Act 2006 states that the Chief Executive is the accounting officer of the NHS Foundation Trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the *NHS Foundation Trust Accounting Officer Memorandum* issued by Monitor.

Under the National Health Service Act 2006, Monitor has directed Alder Hey Children's NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Alder Hey Children's NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year. The directors consider that the annual report and accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and stakeholders to assess the Trust's performance, business model and strategy.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the *NHS Foundation Trust Annual Reporting Manual* and in particular to:

- Observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- Make judgments and estimates on a reasonable basis;
- State whether applicable accounting standards as set out in the *NHS Foundation Trust Annual Reporting Manual* have been followed, and disclose and explain any material departures in the financial statements;
- Ensure the use of public funds complies with the relevant legislation, delegated authorities and guidance; and
- Prepare the financial statements on a going concern basis.

The Accounting Officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS Foundation Trust and to enable him/her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS Foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief the information in the document is accurate; I have properly discharged the responsibilities set out in Monitor's *NHS Foundation Trust Accounting Officer Memorandum.*

Signed

Louise Shepherd
Chief Executive
23rd May 2016

Annual Governance Statement

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS foundation trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Foundation Trust Accounting Officer Memorandum*.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Alder Hey Children's NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Alder Hey Children's NHS Foundation Trust for the year ended 31st March 2016 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

Every member of staff at Alder Hey has an individual responsibility for the management of risk within the organisation. Managers at all levels must understand the Trust's Risk Management Strategy and be aware that they have the authority to manage risk within their area of responsibility.

The Board of Directors approves the Risk Management Strategy on behalf of the organisation; the strategy was reviewed by the Integrated Governance Committee on behalf of the Board during the previous year. As Chief Executive and Accounting Officer, I have overall responsibility and accountability for risk management. As a member of both the Board of Directors and the Integrated Governance Committee, the Chief Executive is informed of significant risk issues and therefore is assured that her role for risk management is fulfilled. The Medical Director is accountable to the Board of Directors and the Chief Executive for clinical risk management and clinical governance; he reports to the Chief Executive and the Board as appropriate. The Chief Nurse is the Executive lead for risk management and is accountable to the Board and the Chief Executive for the Trust's risk management activities; she is also responsible for embedding compliance with CQC standards across the organisation. The Director of Nursing is the operational lead for risk management, accountable to the Chief Nurse and has line management responsibility for the Trust's Risk Management team. They are responsible for ensuring that the Trust's risk management systems and process are effective and operate in accordance with best practice. The Chief Operating Officer is the Executive lead for Estates and Facilities

and is responsible for the effective management of risk in those areas. The Director for Human Resources retains an overview of statutory and mandatory training for the organisation and is responsible for Health and Safety management. The Director of Finance is responsible for ensuring that the Trust carries out its business within sound Financial Governance arrangements that are controlled and monitored through effective audit and accounting systems. He is also responsible for Information Management and Technology risk. The Director of Corporate Affairs is responsible for Information Governance and is the nominated Senior Information Risk Owner, whilst the Chief Nurse is the Trust's Caldicott Guardian.

Clinical Business Units (CBU) General Managers and Clinical Directors are responsible for ensuring that risk management systems within the CBUs are effective and also meet the objectives outlined within the Risk Management Strategy. CBU Boards have a key role in assuring the effectiveness of risk management, including regular scrutiny of CBU risk registers. Lead Nurses monitor and review incidents, risk assessments, claims and complaints and ensure that agreed actions are carried out and feedback is given to staff.

Ward and department line managers ensure that relevant staff are trained on the incident reporting system and that incidents are reported and actions taken when required. They provide feedback to staff, ensuring that Trust policies, procedures and guidelines are followed to minimise risk. Individuals are responsible for reporting any identified risks in order that they can be addressed and are accountable for ensuring their own competency and that their training needs are met in discussion with their line managers. They attend induction and statutory and mandatory training as required, including Risk Management. They ensure that they practice within the standards of their professional bodies, national standards and Trust policies, procedures and guidelines.

During the year the Trust continued to improve its rate of incident reporting via the NRLS system, such that it is now among the best performers for patient safety incident reporting nationally, a point which was recognized by the CQC in its inspection report in December 2015. This ongoing trend demonstrates the commitment of staff to the Trust's Quality Improvement culture and the benefits to be gained from open reporting and learning from incidents. As part of the overall risk management improvement plan, a review of the functionality of the Ulysses incident reporting system had been undertaken during the previous year and its results were implemented during 2015/16. The Trust went 'live' with the new risk module on in September 2015; the Risk Management team worked closely with key individuals to deliver the training and support required to use the new module including all relevant aspects of updating risk registers, matching risks to business objectives and escalation processes. Work continues to improve the risk register format and reports, capturing the new hospital structure and supporting local areas in completing and reviewing risks; a number of reports have been developed to enable service teams to see their risks at a glance, known as 'heliviews' and a combined report created for review at CBU level which shows 'risks that have moved in month' and 'risks that are past their review dates' as well as actions that remain outstanding. Training sessions continue on a monthly basis and are open to all staff.

The Board of Directors maintained its regular and robust oversight of the Board Assurance Framework during the year, with the assurance committees also keeping their related risks under regular review. The report continues to support the delivery of the Board agenda and has contributed towards the achievement of a positive statement from the Trust's Internal Auditors under the annual review of the Assurance Framework which states that:

- The organisation's Assurance Framework is structured to meet the NHS requirements.
- The Assurance Framework is visibly used by the Board.
- The Assurance Framework clearly reflects the risks discussed at the Board.

The Trust received a rating of 'significant assurance' confirmed by the Director of Audit Opinion for 2015/16.

The risk and control framework

Implementation of the Trust's Risk Management Strategy is monitored through the Integrated Governance Committee. The Board of Directors and its assurance committees have maintained their focus on key risks during the year. The strategy provides a robust framework for the systematic identification, assessment, treatment and monitoring of risks, whether the risks are clinical, organisational, business, financial or environmental. Its purpose is to minimise risks to patients, staff, visitors and the organisation as a whole by ensuring that effective risk management systems and processes are implemented in all areas of service provision, and that these are regularly reviewed. The key elements of the strategy include:

- a definition of risk management;
- the Trust's policy statement and organisational philosophy in relation to risk management as an integral part of our corporate objectives, goals and management systems;
- strategic vision for risk management across the organisation;
- roles, responsibilities and accountabilities;
- governance structures in place to support risk management, including terms of reference of key committees.

The Board Assurance Framework, which focuses on identifying and monitoring the principal risks to the organisation at corporate level, has been embedded within the Trust and is regularly reviewed and updated. The Assurance Framework has been reviewed by the Board of Directors on a monthly basis during the year; it covers the following elements:

- strategic aims and objectives;
- identification of principal risks to the achievement of objectives;
- an assessment of the level of risk in-month, calculated in accordance with the Trust's risk matrix, described below;
- internal controls in place to manage the risks;
- identification of assurance mechanisms which relate to the effectiveness of the system of internal control;
- identification of gaps in controls and assurances;
- a target risk score that reflects the level of risk that the Board is prepared to accept;

- the actions taken by the Trust to address control and assurance gaps.

Risks are analysed to determine their cause, their potential impact on patient and staff safety, the achievement of local objectives and strategic objectives, the likelihood of them occurring or recurring and how they may be managed. Risks are evaluated using the Trust Framework for the Grading of Risks. This framework provides a consistent approach to the grading of risks arising within the Trust and enables all risks to be graded in the same manner against the same generic criteria. This allows for comparisons to be made between different types of risk and for judgements and decisions about risk appetite and the prioritisation of resource allocation to be made on that basis. It enables decisions to be taken about the level of management of each risk within the Trust.

A key philosophy of this strategy is to facilitate greater embedding of risk management across the various Clinical Business Units and corporate functions and programmes in the Trust. In order to achieve that, each CBU, corporate function or major programme has a lead for risk and governance who acts as the focus of the various aspects of governance and risk management within their area. They coordinate all such work and liaise with the Risk Management team and with other governance professionals across the Trust. Regular updates to departmental and CBU risk registers are fed in to the Corporate Risk Register. The Integrated Governance Committee engages in an active analysis of the Corporate Risk Register at each meeting, including consideration of risk escalation and de-escalation, which in turn links to the Board Assurance Framework.

The ongoing implementation of the Risk Management Improvement Plan resulted in the following actions during 2015/16: completion of the recommendations from two internal audit reports undertaken the previous year with regard to risk management and risk maturity; a six monthly process for the quality assurance of all risk registers in terms of their content, format, appropriateness was put in place and the new risk module went live as described above.

The Trust remains registered with CQC without conditions and is fully compliant with the registration requirements. In June 2015 the Trust underwent a planned re-inspection by CQC which predominantly covered the areas which required improvement within the 2014 inspection, but additionally looked at Diagnostic services for the first time. The overall outcome of the inspection was a rating of ‘Good’ for the hospital overall with a rating of ‘Outstanding’ in the Caring domain. The report, published in December 2015, recognised the hard work and commitment of Trust staff in making significant improvements in response to the recommendations made in the 2014 report, especially with regard to the recruitment of nursing staff and strengthening the arrangements for medical leadership in the High Dependency Unit. The Trust was also rated ‘Good’ in the Well-led domain, reflecting the focus on improving the Trust’s risk and governance arrangements, although there were some additional recommendations this year with particular reference to risk management at individual service and departmental level. This action has been incorporated into the Trust’s Risk Management Improvement Plan which is monitored by the Integrated Governance Committee with oversight by the Audit Committee on behalf of the Board.

In terms of monitoring ongoing compliance with registration requirements and fundamental standards, the CBU's continue to provide regular exception reports to the Clinical Quality Steering Group across the full range of quality aims and indicators, including compliance with CQC standards, patient safety incidents and key clinical risks at local level. The reporting templates associated with this process were reviewed and strengthened to ensure that the CQC Fundamental Standards were incorporated in to 'ward to board' reporting. The CBU reports also contain areas of shared learning and notable good practice.

The Board at Alder Hey continues to review its quality governance arrangements and underpinning systems and processes on a regular basis. The Board's agenda reflects the five key questions signalled by the Care Quality Commission as being the cornerstones of its hospital inspection process:

- Are we safe?
- Are we effective?
- Are our services caring and compassionate?
- Are our services responsive to patients' needs?
- Are we well led?

In taking this approach the Board has been able to better retain quality as its key focus, with substantive reports that aim to provide real assurance and address principal strategic and operational risks. This system has proved an effective means of triangulation with CQC standards and has remained in place throughout 2015/16.

The Clinical Quality Assurance Committee, whose membership includes all Clinical Directors as well as Board directors, carries out more detailed scrutiny under its delegated authority from the Board for oversight of the Trust's performance against Monitor's Quality Governance Framework, the delivery of the Quality Strategy incorporating measures of clinical effectiveness, patient safety and positive patient experience. The work of the Audit Committee complements this by discharging its responsibility for the maintenance of an effective system of integrated governance, risk management and internal control across the whole of the organisation's activities.

The Clinical Quality Assurance Committee walkaround process has continued during 2015/16, although scheduling had to take into account the period immediately before and after the move into the new hospital in October. Quality Walkarounds involve visits by Committee members, wider Board members and governors to clinical departments throughout the month preceding the Committee meeting, with one CBU as the focus each time. The aim of this is to provide multiple opportunities for Committee members to meet with staff, view service delivery at close quarters and meet with patients and parents to establish first hand feedback of quality of care. The result of this process is a comprehensive action plan agreed with the CBU management team to be achieved in subsequent months and evaluated through the Committee.

The Board has continued to work toward improving the information received to describe the performance of the organisation with regard to quality. Reporting processes have continued to develop and the quality report now forms a key part of the Corporate Report.

The Board Assurance Framework is scrutinised by the Board at its meeting each month to enable the Board to be fully sighted on key risks to delivery and the controls put in place to manage and mitigate them, as well as enabling all members to have an opportunity to identify key issues, concerns or changes. The Board has continued to receive an Integrated Assurance Report following each Integrated Governance Committee, which is designed to provide evidence to ensure that strategic and operational risks are being addressed as part of a coherent system. In addition, the relevant risks are monitored each month by each of the Board's assurance committees.

The Trust has been keen to ensure that it optimises the Quality Governance Framework published by Monitor and as well as placing this at the heart of the model that underpins the Quality Strategy, we have also undertaken regular self-assessments of our current position against each element of the framework and identified the actions required for improvement. A follow up of the external quality governance review commissioned from KPMG in 2014 was undertaken in mid-2015 and the Trust achieved an improved score of 3. The recommendations from the follow up report formed the basis of an action plan which has been monitored via the Clinical Quality Assurance Committee, which received a follow up self-assessment report in December 2015. The Trust remains committed to a culture of continuous improvement and the Board will ensure that it remains sighted on the effectiveness of its quality governance arrangements going forward.

The Board undertook its annual formal gap analysis against the conditions contained within its Provider Licence during the year. With regard to Condition FT4 – NHS foundation trust governance arrangements, the exercise did not identify any material risks to compliance with this condition.

A comprehensive gap analysis of the Trust's Corporate Governance Statement under the Provider Licence, was undertaken in May 2015 ahead of the formal declarations required by Monitor. This did not identify any material gaps in compliance. The Board continues to keep its governance arrangements under regular review and itself appraised of any new guidance or best practice advice that is published through the year. In November 2014 the CQC issued its Fit and Proper Persons requirement; the Board at Alder Hey undertook an initial piece of work to test the robustness of its existing arrangements against the new regulations and as a result introduced an additional declaration process for all Board members and associates, as well as updating the contracts of employment and terms of service of the Executive and Non-Executive Directors respectively, to reflect the requirements. This was followed up in July 2015 with the creation of a specific assurance framework checklist for FPPR which includes new recruitment procedures and the agreement to re-run DBS checks for existing directors.

The Board's main assurance committees each provides an annual report on its work to the Board, describing how the committee has fulfilled its terms of reference and annual work plan and outlining key areas of focus during the year, together with an overview of its priorities for the coming year. These are also submitted to the Audit Committee to for it to assure itself that the activities of the committees are contributing effectively to the Trust's overall control environment and that the work of

the assurance committees is directly linked to the Board Assurance Framework. The assurance committees review their terms of reference on an annual basis to provide assurance to the Board that its structures continue to reflect the changing needs of the organisation and the environment in which it operates, including clear lines of accountability. In 2015/16 the Board agreed that the Workforce and Organisational Development Committee should operate as a full Board assurance committee in recognition of the importance of understanding and addressing issues that affect staff.

In the autumn of 2015, the Trust undertook a review of the way in which Equality Impact Assessments are incorporated into the organisation's decision making processes. The purpose of this was to secure better integration from a process perspective and ensure that the Trust is properly responding to the different needs of staff and patients to meet its statutory and policy obligations, as well as its own values and the commitments made under the NHS Constitution. It was agreed that going forward, EIA will be carried out in relation to the development of Trust policies or procedures, service redesign or development, strategic or business planning, organisational changes affecting patients, employees or both, procurement, cost improvement programmes and the commissioning or decommissioning of services. Subsequently, the decision was taken to embed the EIA process into the Quality Impact Assessment process to inextricably link the two key priorities.

During the year each assurance committee included within its terms of reference oversight of specific aspects of the transition to the new hospital, in accordance with its overall purpose, in order to reinforce the monthly Programme Assurance report to the Board. In relation to 'business as usual' activity, the Corporate Report remains the principal mechanism for ensuring that the Board and its committees receive timely, accurate and comprehensive information on the performance of the organization. The report is kept under review by the Executive Team to ensure that it is fulfilling this function as effectively as possible; the Non-Executive Directors provide regular feedback on the report and on the presentation of individual indicators.

The principal risks to the organisation during 2015/16 were focused predominantly on two main areas: delivering a safe move to the new hospital in October 2015 and the delivery of the Trust's new Electronic Patient Care System in June and the impact that both of these significant changes would have upon the activity plan, given the prevailing financial environment within the NHS. The change process was monitored through the year via a robust Programme Management Office that provides a structured external assurance system, with a Programme Board that reports each month to the Board of Directors. For each major element, risks were identified and managed by project steering groups which comprised multi-disciplinary membership. To support the implementation of the EPCS, the Trust brought in additional hands on personnel to work alongside clinicians for the first few weeks after 'go-live'. The Chief Operating Officer personally led the Transition and Mobilisation team responsible for the new hospital move.

One of the risks associated with the large scale movement of staff and records to the new hospital site was that of potential data loss or security breach. The Trust has an Information Governance Framework that incorporates an on-going programme of

work to ensure that data held is handled appropriately and securely and any risks within the Information Governance remit are managed and controlled. This incorporates completion of the annual Information Governance Toolkit assessment which is overseen by the Information Governance Steering Group and is subject to internal and external review. During 2015/16, the Trust's Audit Committee agreed that the Information Governance resource should be focused upon the area of greatest risk of loss, namely the new hospital move. The audit of the IG toolkit was therefore postponed until the first quarter of 2016/17 in order to respond to the exceptional circumstances which prevailed. To support the aim of a safe move, the 'Dump the Junk' initiative continued throughout the year up to the move; this was designed to provide support and guidance for staff to make informed decisions about those clinical and corporate records that the organisation should keep and in what format and those that should be disposed of, in accordance with the NHS records retention schedules. The Trust had no serious incidents relating to Information Governance during the period and suffered no data loss as a consequence of the move to the new hospital.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Control measures are in place to ensure that the organisation's obligations under equality, diversity and human rights legislation are complied with. The Trust maintains continuing compliance with the statutory and regulatory duties that are related to Equality, Diversity and Human Rights, with publication of information to meet the Public Sector Equality Duty. Arrangements for the strategic oversight of progress towards the Trust's Equality Objectives have been a key priority during the year; this process will continue to be reinforced during 2015/16. The Equality Objectives will be aligned with NHS EDS 2 and will respond to the related commissioning requirements.

The foundation trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Review of economy, efficiency and effectiveness of the use of resources

As Accounting Officer, I am responsible for ensuring arrangements are in place for securing value for money in the use of the Trust's resources. To do this, I have implemented a robust system to set, review and implement strategic objectives. Trust objectives are informed by the views of its Council of Governors and other key stakeholders. In 2015/16 the Trust engaged with the emerging Sustainability and Transformation Plan and I was invited to chair the Cheshire and Merseyside group in March 2016, ensuring that Alder Hey is well placed to understand this wider context.

The Trust produces an annual operational plan that sets out organisational objectives which are cascaded to local level. CBU activity is reviewed throughout the year to monitor progress and agree corrective action where necessary by the Performance Management Group. The Board of Directors reviews performance against objectives on a monthly basis through the Corporate Performance Report which is also reviewed by the Performance Management Group and key Board assurance committees prior to submission to the Board. CBU operational plan performance is reviewed through the CBU Boards and twice yearly by the Board of Directors.

The Board's assurance system is underpinned by the work of the Trust's internal auditors which is overseen by the Audit Committee. Each year the Committee agrees an audit programme which aims to focus on areas of weakness in internal control and make recommendations to address deficits where these are identified. The Audit Committee retains a database of remedial actions agreed as a result of audits and these are followed up by the Committee until completed.

The Trust's focus remains to fulfil its ambition to deliver exceptional care to match the exceptional design of the new hospital. During the preparation phase for the move, the major pathway transformation projects were brought together under the '*How We Will Work in the Future*' project which involved teams from right across the organisation; within this there were eight work streams, ranging from work to develop streamlined clinical pathways through to initiatives aimed at improving efficiency within corporate support areas. The Trust's Programme Management Office (PMO) continued to ensure that robust systems underpin the change programme, using widely recognised tools and methodologies. During the year, in order to support the transformation process and to oversee the Trust's transition to the new health park, the Board of Directors regularly reviewed the progress of the three key strategic programmes: the delivery of Alder Hey in the Park, overarching change programme and the implementation of the major IM&T projects, including the Electronic Patient Care System.

Alongside this, the Board tasked the Trust's Operational Delivery Board, with Non-Executive Director input, to oversee the delivery of the Cost Improvement Programme; the PMO provides assurance around each of the schemes and overall progress reported back via the Performance Management Group and the Resources and Business Development Committee. In addition, project management support was in place across the change programme via the Transformation team with project managers directly aligned to specific elements of HWWWIF.

A range of specific initiatives to improve the use of resources were put in place during 2015/16, including:

- Further development of the InfoFox Business Intelligence Self-service Portal which provides interactive dashboards reporting finance, quality and operational performance information. Reporting enhanced and now includes "Value intelligence Reporting" which makes the link between quality outcome and financial improvement.

- Continued development of service line reporting and patient level costing information resulting in increased clinical engagement in costing and performance improvement. Trust secured a national HFMA award for costing.
- Enhanced materials management stock control introduced in the new hospital.
- Systems and processes enhanced to support the compliance with national rules regarding the management and control of agency staff costs and framework agreements. Includes Pay cost “10 point plan” aimed at reducing pay cost pressures and budget overruns.
- Procurement strategy agreed aimed at delivering best in class purchasing, and service to our clinical services at best price.
- CIP Core team and implementation of a PMO style bi-weekly assurance tracking.
- Weekly reporting and forward look review of elective and outpatient activity schedules to ensure contract activity plans achieved and capacity utilised.

Annual Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the *NHS Foundation Trust Annual Reporting Manual*.

The Medical Director and Chief Nurse are jointly responsible at Board level for leading the quality agenda within the Trust, supported by the Director of Nursing, Deputy Director of Quality and Head of Patient Experience.

The Trust’s Quality Strategy was approved by the Board and embedded throughout the organisation during 2011/12 and was intended to be a four year plan to take the Trust into the new hospital. During the latter half of 2015/16, the Chief Nurse led an inclusive process to engage the clinical workforce in a refresh of the Quality Strategy based on a fundamental principle of clinical ownership that will see clinicians in the driving seat right across the organisation.

The Quality Account is a core element of measuring the delivery of the Quality Strategy. The quality outcome measures identified in the Trust’s Quality Account are identified and reviewed on an annual basis in consultation with our Governors and other stakeholders.

In support of this, during the year the Trust’s internal Quality Report was further developed to incorporate regular tracking of progress against the Quality Aims, incorporating a range of safety, effectiveness and experience measures that will also allow for consistent comparison with other providers and can be used as assurance for regulators. The Quality Report is reviewed in detail by the Clinical Quality Assurance Committee and by the Board of Directors on a monthly basis. The Report is kept under review to ensure that content remains responsive to key national drivers, such as reporting on nurse staffing levels and that actions taken to achieve the aims incorporate learning from failure in NHS provider settings as well

as newer regulations such as the Duty of Candour. In year developments of the Quality Report in 2015/16 included a review of the effectiveness measures by the lead Clinical Director for this area.

Significant work has been undertaken during the year to assure the accuracy of the quality data contained within the report. In 2015/16 MIAA carried out follow up reviews on the data quality audit for the Corporate Report, three of which were also in the Quality Report, namely: medication errors, pressure ulcers, and cancelled operations. The original review focused on the systems and processes in place for collection, validation, analysis and review of data. Validation processes are carried out to ensure data accuracy; information received from Risk Management is checked against information held in the Data Warehouse to ensure consistency, and discrepancies followed up with Risk Management. Medication errors are scrutinised by Pharmacy and pressure ulcers by the Tissue Viability Team. The Infection Prevention and Control Team sends through validated data for hospital acquired infections/outbreaks. Information procedures are maintained to ensure they reflect changes in reporting processes.

At Alder Hey we have undertaken a range of measures to ensure we have accurate and robust waiting times data. A follow up review of waiting times was carried out by internal audit in January 2016. A weekly waiting times group is in place to monitor all aspects of RTT performance and identify and resolve issues. A data validation exercise was undertaken by the Trust in Quarter 4 as part of a national programme to review the management of 18 weeks focusing on the over 18 week waiters. In addition, the Trust has established a data quality group that has been tasked with reviewing systems and processes to manage the ongoing system and administrative processes implemented with the new EPCS system (Meditech 6) which went live in June 2015. Clinical and non-clinical staff have been trained in accurate data inputting which will ensure we are stopping and starting RTT accurately (amongst other benefits the new system will bring). We also embarked on a significant transformational programme as part of the move into the new hospital with specific focus on the administration of patient flow to ensure that we have robust and resilient administrative processes which will ensure we have timely and accurate data. We continue to engage with the ‘Civil Eyes’ Programme who benchmark the majority of children’s hospitals in the UK and Northern Ireland across a range of indicators and specialty areas to ensure we are not an outlier. The Trust experienced difficulty in meeting the 4 hour A&E target from October 2015 onwards, following the move to the new hospital due to the increase in attendances, a trend which has continued to the year end. The increase above the same period in the previous year was 18% in October peaking at 22% in February 2016; the majority of these attendances were in the Trust’s ‘green’ category, which means that the patients could have been seen outside hospital, for example by a GP or at a walk-in centre. The Trust has been working with the local CCG to find solutions to this issue, as well as developing an internal plan in order to recover the position by June 2016.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the

executive managers and clinical leads within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to this Annual Report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee and Integrated Governance Committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The process that has been applied in maintaining and reviewing the effectiveness of the system of internal control includes the following elements:

- the Board of Directors provides active leadership of the Trust within a framework of prudent controls that enable risk to be assessed and managed;
- the Audit Committee, as part of an integrated governance structure, is pivotal in advising the Board on the effectiveness of the system of internal control;
- the Committees of the Board are key components by which I am able to assess the effectiveness and assure the Board of risk management generally and clinical risk in particular via the Clinical Quality Assurance Committee, supported by the Clinical Quality Steering Group and by the Integrated Governance Committee which was established to strengthen the Trust's overall risk and governance arrangements;
- members of the Trust's Council of Governors are involved in a variety of scrutiny activities including quality 'walkarounds';
- Internal Audit provides quarterly reports to the Audit Committee and full reports to the Director of Finance and other Trust Officers;
- the Director of Finance also meets regularly with internal and external Audit Managers;
- the Integrated Governance Committee holds Clinical Business Units and corporate departments to account for the effective management of their key risks;
- other explicit review and assurance mechanisms include Clinical Business Unit risk registers linked to the Operational Plan and a range of independent assessments against key areas of control, as set out in the Assurance Framework;
- continuous registration without conditions by the Care Quality Commission 1st April 2010 onwards;
- retention of the Trust's Human Tissue Authority Licence; all HTA standards were met on inspection and areas of good practice highlighted in the report;
- retention of Clinical Pathology Accreditation for the year.

Any significant internal control issues would be reported to the Board via the appropriate Committee.

I receive reports from the Royal Colleges and following Deanery visits. In addition, there are a range of other independent assessments against key areas of control which are co-ordinated and monitored under the auspices of the Trust's External Visits policy, for example:

- A visit by the Northern Burn Care Network
- Assessment of the laboratories by the Health and Safety Executive

- Inspection by the Human Tissue Authority
- Inspection by the Medicines and Healthcare products Regulatory Agency.

The Board of Directors is committed to continuous improvement and development of the system of internal control and the recommendations from all visits and inspections are monitored through the Trust's governance processes until completion.

Conclusion

In conclusion, for 2015/16 no significant internal control issues have been identified.

Signed:

Louise Shepherd
Chief Executive
23rd May 2016

Quality Report - 'Quality is everybody's business'

Part 1: Statement on quality from Louise Shepherd, Chief Executive

2015/16 was a year of incredible achievement for Alder Hey: we successfully moved into our brand new state of the art hospital, implemented an up to date Electronic Patient Care Record system and hosted a Care Quality Commission inspection which resulted in an overall rating of 'Good' with 'Outstanding' in the Caring domain. All of these endeavours had quality improvement at their heart.

This time last year I wrote this introduction from the brink of a period of huge change for our organisation and it is now my privilege to reflect on how far we have come. Of course, none of this would have been possible without the sustained commitment, focus and drive of our highly professional and indeed outstanding staff. During the latter part of the year our Chief Nurse led the work to begin to refresh the Trust's Quality Strategy; she found herself rapidly usurped by a team of clincians bent upon grasping the nettle of quality and making it their business. The result is a new approach to quality which I firmly believe will take us to a place where we will see tangible benefits for our patients and the realisation of a long held ambition to be recognised for the exceptional care that we provide for our children and young people.

Although our large scale change programme was the focus of much of our work during the year, the daily drive of our staff to provide the best possible care to each and every child continued to bear fruit. Some of the key successes centred upon improving our systems and processes to make our services safer and more effective for our patients; we significantly increased our level of incident reporting on to the national reporting and learning system such that Alder Hey is now in the top 25% of peer trusts. Linked to this improved transparency, we remained fully committed to the Duty of Candour and other best practice recommendations from the review undertaken by Sir Robert Francis into the events at Mid Staffordshire and we were gratified that the CQC commended the Trust upon its improved governance arrangements.

I am also very proud of the work of our senior nursing team to ensure that we meet appropriate staffing levels as a major paediatric provider; in the last two years we have successfully recruited 250 nurses, which represents a net increase of 50 full time posts. In addition, we have employed 32 more medical and surgical consultants over a similar period. Taken together this signifies a major investment in our service and symbolises our commitment to excellence in quality.

As Chief Executive, I commend our Quality Report for 2015/16 to you. I am confident that the information set out in the document is accurate and a fair reflection of the key issues and priorities that clinical teams have developed within their services. The Board remains fully committed to supporting those teams in every way they can to continuously improve care for our children and young people.

Louise Shepherd
Chief Executive

Part 2: Our Achievements in 2015/16

In order to ensure that we provide the best quality services to everyone who is part of the Alder Hey community, we recognise that we must continue to stretch ourselves and set goals that we can measure and monitor through the Trust's governance structures and report to the Trust Board, in order to demonstrate that we truly put quality at the heart of everything we do. In 2015/16, in consultation with our staff, governors and patients we agreed that further improvements should be made in relation to the Quality Strategy developmental quality aims within the 'domains' of patient safety, clinical effectiveness and patient experience.

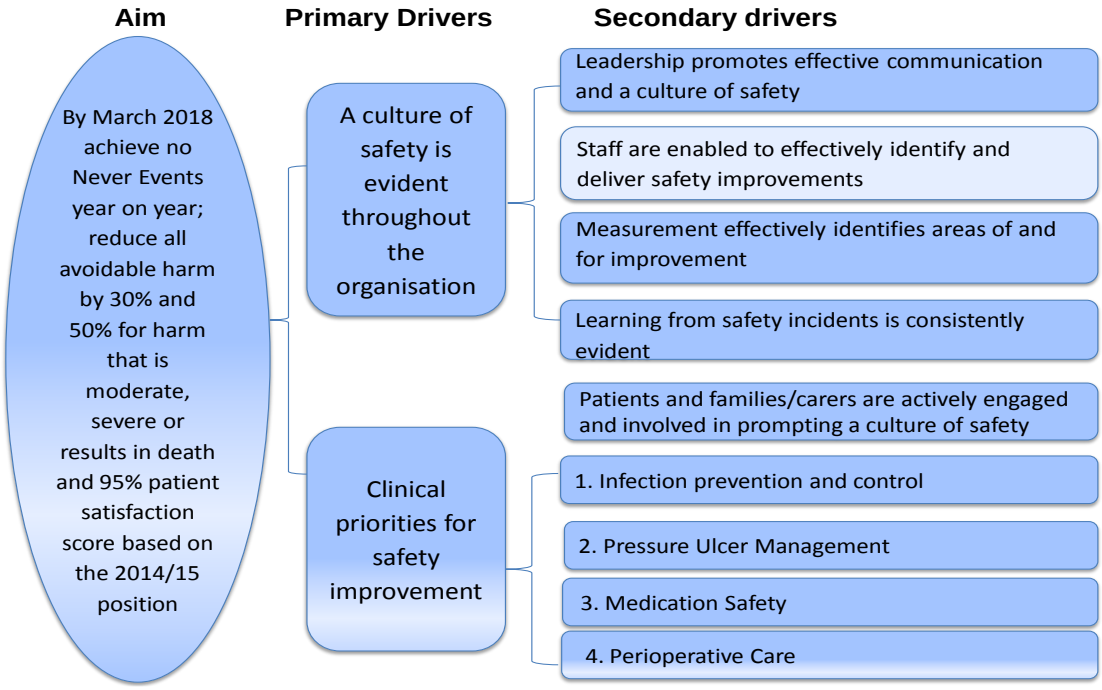
This section of the Quality Report provides an overview of the progress made against the 2015/16 priorities.

Sign up to Safety

'Sign up to Safety' is a national patient safety campaign whose vision is for the whole NHS to become the safest healthcare system in the world, aiming to deliver harm-free care for every patient every time. The campaign was launched on June 24th 2014 with an ambition of halving avoidable harm in the NHS over the next three years and saving 6,000 lives as a result.

As an organisation committed to improving patient safety, Alder Hey has joined the Sign up to Safety Campaign, developed a Trust-wide Safety Improvement Plan with specific improvement outcomes:

Trust wide Safety Improvement Plan 2015 – 2018



In addition to the plan, Alder Hey has made the following **five Sign up to Safety pledges**:

1. Put safety first. Commit to reduce avoidable harm in the NHS by half and make public our goals and plans developed locally.

We will:

- Strive to achieve our patient safety aim that patients will not suffer harm in our care. Our commitment is reflected in the Trust's Quality Strategy and Quality Report and supported by a set of Patient Safety Quality Aims that were developed in partnership with our patients, their families, our staff and our governors.
- Implement robust processes and workforce plans to ensure consistent safe nurse staffing levels. The staffing levels will be made visible to children, young people, their parents and the public, through the use of ward staffing display boards and the Trust intranet site.
- Continue to publish the monthly Trust Board Assessment of Quality Report on the Trust intranet site.
- Conduct engagement events with local stakeholders to share progress against safety priorities, gain feedback and identify opportunities for partnership working.

2. Continually learn. Make our organisation more resilient to risks, by acting on the feedback from patients and by constantly measuring and monitoring how safe our services are.

We will:

- Develop a process that actively engages children, young people and their parents in raising their safety concerns and provides them with feedback on improvements.
- Conduct an annual staff Safety Attitudes Survey to understand our safety culture.
- Continue to utilise the Weekly Meeting of Harm to analyse incidents, monitor incident trends and near miss incidents, identify improvement actions, recognise good practice and provide feedback to staff.
- Continue to monitor patient safety 'Ward to Board', utilising the Ward Dashboard and monthly Trust Board Assessment of Quality Report.

3. Honesty. Be transparent with people about our progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong.

We will:

- Continue to meet our Duty of Candour to patients and families by:
  - Making sure we act in an open and transparent way with our patients and families;

- Telling patients and families in person as soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred and providing support to them in relation to the incident, including when giving the notification;
- Providing an account of the incident which, to the best of our knowledge, is true of all the facts we know about the incident as at the date of the notification;
- Advising patients and families what further enquiries we believe are appropriate;
- Offering an apology;
- Following this up by giving the same information in writing and providing an update on the enquiries;
- Keeping a written record of all communication with those involved.

- Promote a culture of openness and transparency.
- Ensure staff have the skills and support to enable them to communicate effectively with children, young people and their parents, following any patient safety incident or concern.
- Display progress against key Patient Safety quality aims to staff, children, young people and their parents through the '*Knowing how we are doing'* boards displayed in each clinical area.

4. Collaborate. Take a leading role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use.

We will:

- Utilise existing networks to facilitate learning across the health economy.
- Work in partnership with adult trusts and Clinical Commissioners, to improve the transition of children with complex needs from Alder Hey to adult services.
- Actively participate in the Patient Safety Collaborative through the Academic Health Science Network.
- Continue to be an active member of the 'Making it Safer Together' paediatric patient safety collaborative.

5. Support. Help people understand why things go wrong and how to put them right. Give staff the time and support to improve and celebrate the progress.

We will:

- Provide a Root Cause Analysis training programme that incorporates knowledge of Human Factors, which are the environmental, organisational and job factors, and individual characteristics which influence behaviour at work.
- Utilise the Clinical Quality Assurance Committee Walkabouts and the Quality Review Programme, as an opportunity for staff to provide feedback on patient

safety issues, the actions they have taken and celebrate the progress they have made.

- Provide post Quality Review posters for all areas allowing all staff to celebrate what is positive about their area, what they have identified as patient safety issues and what actions have been taken.
- Promote 'Raise it, Change it', to enable staff to make suggestions for improvement direct to the Chief Executive.

Safely moving to Alder Hey in the Park (2015/16 quality priority)

As one of Europe's biggest and busiest children's hospitals, Alder Hey treats around 275,000 patients each year. The new 'Alder Hey in the Park' features a uniquely designed hospital alongside a dedicated children's research and innovation facility, creating a leading-edge centre for children's healthcare and research.The new hospital has 270 beds, including 48 critical care beds, with a play area on every ward and a dedicated chef on each floor to prepare fresh evening meals.

A hospital built entirely in a park is something new in the treatment and care of children. It's not just a first for the UK, there's nothing like it anywhere in Europe and in the design of the new hospital we listened carefully to children who shared their own vision for the new hospital and thousands of families took part in one of the NHS's biggest ever public consultations. In fact, many suggestions like better access to fresh air and nature were made important parts of the plans and it was a drawing of a flower by 15-year-old Eleanor Brogan that impressed architects and inspired their final design. Her drawing was one of 1,000 submitted by young patients who were canvassed for their views on what the new hospital needed.

Eleanor said: "A child in hospital has no freedom and I wanted to think of open spaces, greenery and natural light - about as opposite to a hospital as you could possibly get.

"When I drew my picture seven years ago, I didn't expect I would play such an important part in the design."

Ensuring the move was undertaken safely was a key quality priority for 2015/16. The move was undertaken from Friday 2nd to Tuesday 6th October 2015. On the Friday, 20 articulated removal lorries began transporting equipment on the first day of the

move with 14 more continuing to transport supplies on each of the remaining days. About 1500 devices were moved and almost 13,000 pieces of medical equipment. 120 patients were moved into the new Alder Hey in the Park over the weekend; 93 patients were safely transferred to the new hospital on the Saturday with another 26 transferred on the Sunday, including one on a heart and lung bypass machine (ECMO).

The move to the new building was meticulously planned to ensure a safe and smooth transition for Alder Hey patients and their families. Patients were moved across via a purpose-built corridor which had been carefully designed to transport patients from one site to another. They were transferred from the old site to the new by 22 transfer teams involving clinician's porters and volunteers.

The first patient to receive treatment at the new Alder Hey in the Park was 13 year old Natasha Pleavin who received dialysis on Ward 4C.

Other patients making the move included Liam Denner (1) Helena Green (12) and William Ballyntyne (1). Liam's mum Zoe said: "The old hospital has been our home for the last 18 months so I feel a bit sad to leave it but the new hospital is amazing! It's more homely and doesn't look like a hospital. It's fantastic. The play decks are amazing. Liam can now go out and get some fresh air."

William's mum Becky said: "The new hospital is amazing. The ward is great and really colourful. It's definitely more family orientated. We have Jamie (William's 4 year old brother) to think about too and it's much easier to occupy him here."

Helena commented "wow it's really cool" while her mum Stacy added "It's gorgeous – I can't get the smile of my face!"

Alder Hey in the Park atrium

Gareth Jones demonstrates how the hospital has been designed to be child friendly.

Gracie Lee looks out at the view from the open air play decks.

Inside the Outpatient Department outdoor garden area. It contains astro-turf, teepee tents and large bean bags. The garden was built using money donated by former Liverpool Football Club Captain, Steven Gerrard so that children have somewhere to relax and play before, after and in between appointments.

Lila Perry happy after the move with staff Helen Dunbavin and Megan Malone

The move to the new Alder Hey Children's Health Park was safely and successfully completed due to the tremendous efforts of the staff, who implemented the meticulous plans and with the fantastic co-operation and support of all the patients and their parents, families and carers.

Alder Hey in the Park was fully operational on Wednesday October 7th 2015 exactly as planned.

Promoting a Safety Culture

Aim: To promote incident reporting and reduce incidents of harm.
Targets: From the 2014/15 baseline:

1. No Never Events
2. Reduce incidents resulting in harm by 10%; this represents 758.
3. Reduce incidents resulting in moderate, severe harm or death by 10%; this represents 68.

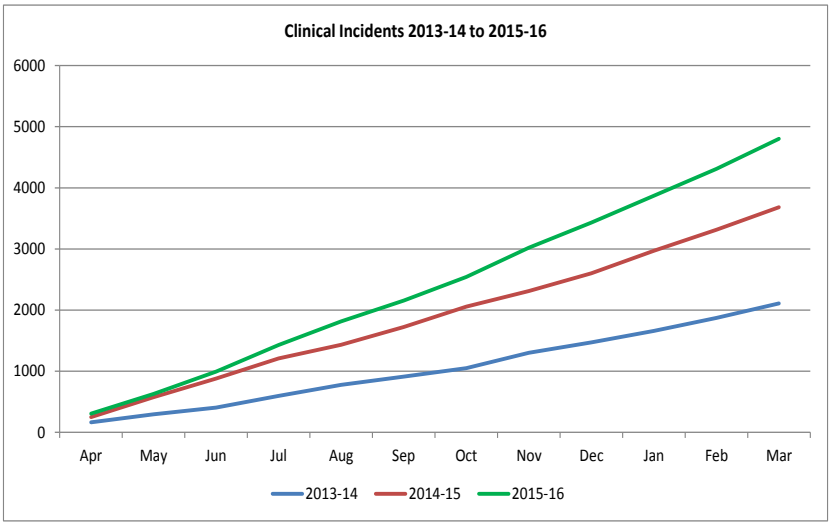
Outcomes:

1. Three Never Events.
2. 20% reduction in all incidents of harm; this represents 667.
3. 55% reduction in moderate, severe or death incidents; this represents 25.

Safety is a fundamental aspect of high quality, responsive and accessible patient care. We aim to deliver higher standards of patient safety year on year, demonstrated through a culture of openness and where staff have a constant awareness of the potential for things to go wrong, are confident to report all incidents and near misses, learn lessons and continuously improve safety.

The National Patient Safety Agency established a National Reporting and Learning System (NRLS) before it was transferred to the NHS Commissioning Board Special Health Authority in June 2012. All organisations continue to upload their incident data into the NRLS and receive comparative reports on their culture of reporting. It is recognised that organisations that report more incidents usually have a better safety culture. In March 2012 Alder Hey was in the lowest 25% of reporters within the peer group of 20 comparable acute specialist trusts, by September 2014 the trust was in the top 25% of reporters. The most recent report for the time period of April 2015 to September 2015 confirms that the Trust remains in the top 25% of reporters.

The Trust promotes all incident reporting, including near miss incidents and in 2015/16 has had three Never Event incidents reported, which have undergone comprehensive investigations and the development and implementation of improvement plans to prevent reoccurrence.



In addition there has been a 56% increase in incident reporting since 2013/14. Whilst incident reporting has increased, the proportion of incidents of harm has decreased from 23% to 13%.

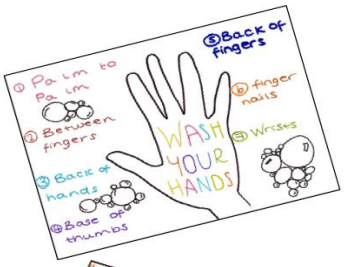
Increasing children, young people and their parents/carers involvement in patient safety (2015/16 quality priority)

***Aim*:**
To co-design safety improvements with children and their families to enhance communication and assist with a partnership approach to safe and effective care.

Children and young people are key stakeholders of the NHS and their interests must be at the centre of health care. Participation and involvement must take place on two levels: individual involvement, with people making their own healthcare choices and being confident in their interaction with health professionals; and group involvement, either as a service user or member of the public.

Health systems need to have governance and policies in place to ensure that children and young people can participate in a systematic and non-tokenistic way. This links in with the Government's aims to increase participation with the "No decisions about me without me" policy. It is important that children and young people understand why they are being consulted, what the process is, how their feedback will be used and, crucially, how their involvement will lead to change or help professionals. Children and young people need to be engaged early in the design of new health organisations and structures to ensure their views are included right from the start and regularly in the future.

Improvements



- Work involving hand hygiene awareness has taken place in local primary and secondary schools, with the children designing hand hygiene awareness posters.
- The quality team have engaged and sought ideas from the children's and parent's forum.
- Conducted a Safety Workshop with parents, children and young people.
- A key group of children, young people and parents have nominated themselves to participate in quality work.
- The quality team have engaged with local primary and secondary schools discussing patient safety work.
- Invited children from local primary and secondary schools into the Trust for a visit to meet and discuss patient safety and quality work within the Trust.
- Worked with local schools and patients on the wards to gain understanding of children and young people's expectations of information prior to an admission.
- Involvement of children and young people in the development of the STAR (Safe Together & Always Right) Ward Accreditation.

Future plans

To maximize opportunities for the children and young people's involvement in patient safety work and to continue to build strong relationships with the community to engage with patient safety work.

Medication safety (2015/16 quality priority)

Aim: No drug errors resulting in avoidable harm.

***Targets*:** From the 2014/15 baseline:

1. Reduce all medication errors that result in harm by 5% by March 2016; this represents 121.
2. Reduce medication errors that result in moderate, severe harm or death by 10% by March 2016; this represents 8.

***Outcomes*:**

1. 35% reduction in all medication errors that result in harm; this represents 83.
2. 89% reduction in medication errors that result in moderate, severe harm or death; this represents 1.
3. 119% increase in medication incident reporting.
4. Decrease from 20% to 8% of incidents reported with harm attached

Almost every patient who is admitted to hospital requires medication. Prescribing, administering and dispensing medicines for children are complex processes and require specialist knowledge and experience. Medication errors are the most common type of incident reported in most hospitals in the UK. We want to reduce the number of medication errors happening in Alder Hey for 3 main reasons:

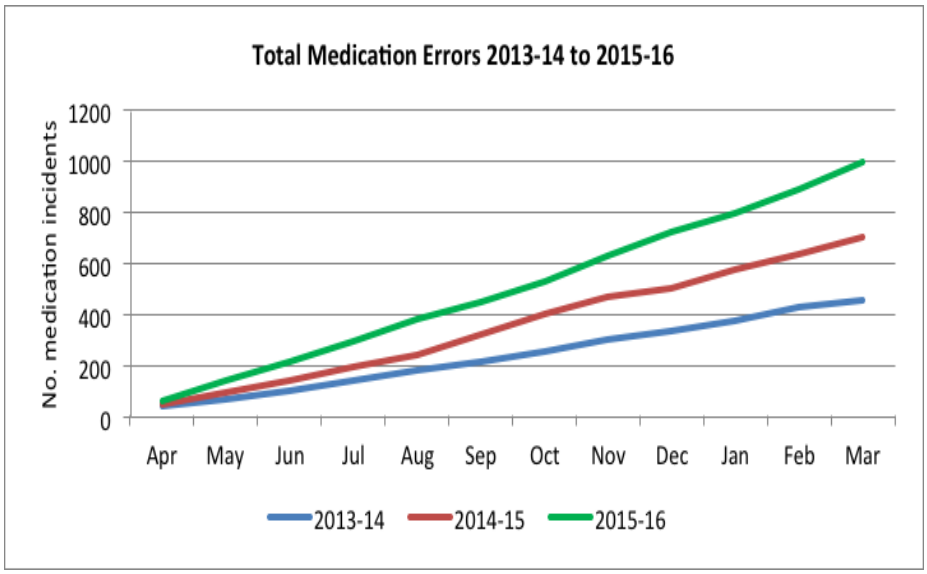
1. Medication errors can harm patients. The majority of the errors which have happened in Alder Hey have not caused harm to patients but a small number have caused harm or might have caused harm if they had not been discovered before reaching a patient.
2. Medication errors can increase the length of time a patient stays in hospital or increase the cost of their stay because more tests, investigations or treatments are needed.
3. Being involved in a medication error can be a very difficult experience for patients, their families and the staff involved.

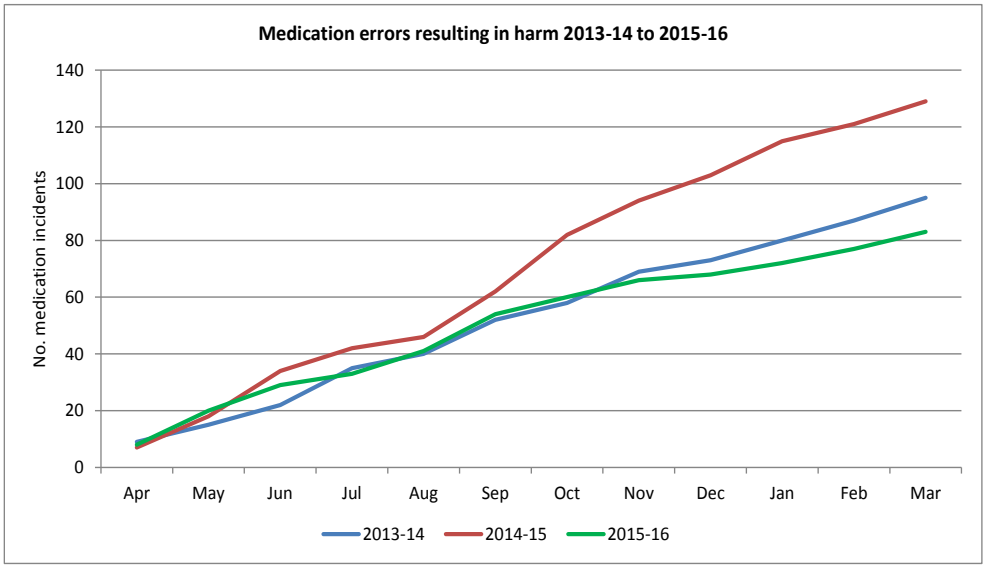
Improvements

- Appointed one Nurse and one Pharmacist as Medication Safety Officers each working 18.75 hours per week. Their roles focus on medication safety and support for staff involved in medication incidents.
- The Medication Safety Officer- Nurse has presented safety work at a Sign up to Safety conference and is presenting at the Medication Errors Conference in London in June 2016.
- .Supported staff during the implementation of an EPS (Electronic Prescribing System).
- Have improved the data quality of incident reports by validating the accuracy of incident reports prior to being uploaded into to the National Reporting and Learning System.

- Implementation of the MERP (Medication Error Reporting Program) to give more depth to the classification of medication incidents.
- Strengthened the process of medical prescribing incident management by sending a copy of any incident to the junior doctor's educational supervisor, which adds an additional level of review and support for junior medical staff.
- Improved the response time by line managers by offering to support them whilst investigating incidents.
- Developed links with the Higher Education Institutes. This has allowed us to deliver Medication Safety Training to student nurses who are placed within the Hospital.
- Delivering training to staff that are starting their Intravenous Administration course.
- Developed a new electronic Root Cause Analysis tool for all medication errors that result in harm, which includes identification of harm, contributory factors and financial implications.
- Developed a What's app group for Junior Doctors to enhance learning by communicating with them about medication safety alerts or when we need to speak them regarding an incident.

Medication incident reporting has increased by 119% since 2013/14.





In 2013/14 there were 20% of medication incident with harm attached. In 2015/16 this has reduced to 8%.

Future Goals and Plans:

- Further expand the What's App group for Junior Doctors.
- To improve the formal process of involving medical staff in the incident by forging closer links with the medical Leads.
- Developing an app with the innovation team. This app will allow the patients to have a better understanding of their medications and is driven by feedback from a Children, young people and parents Safety Workshop.
- Making staff more aware of the Yellow card scheme. We are having an open day forum around Yellow card reporting.
- Decreasing the incidents that involve total parental nutrition (TPN) and Heparin.
- Develop more audits with attention to TPN, Controlled drugs etc.
- Introducing a more up to date teaching package that includes on line learning as well as yearly mandatory training. Introducing SN@P as an education tool to support staff with their numerical skills.
- Update the Ulysses system by reviewing and undertaking any improvements in the medication sections, which will enhance reporting and support learning.
- To introduce Independent checking of medication.
- Embed the electronic RCA tool.

Pressure Ulcers (2015/16 quality priority)

Aim: No avoidable pressure ulcers.

Targets: From the 2014/15 baseline:

1. Reduce grade 2 hospital acquired pressure ulcers by 10%; this represents 20.
2. Reduce hospital acquired grade 3 pressure ulcers by 50%; this represents 1.
3. Zero grade 4 hospital acquired pressure ulcers.

Outcomes:

1. 5% increase in grade 2 hospital acquired pressure ulcers: this represents 1.
2. 67% reduction in hospital acquired grade 3: this represents 1.
3. 100% increase in grade 4 hospital acquired pressure ulcers; this represents 1.
4. Total number of pressure ulcers of all grades is 25, which is the same as 2014/15.

Pressure ulcers are often preventable and more likely to occur, in patients who are seriously ill, have neurological conditions, impaired mobility, poor posture or impaired nutrition. They were once thought to only occur in the elderly population, however there is increasing awareness that immobilised and acutely ill neonates and children are at risk of developing pressure ulcers, particularly in the critical care environment. Therefore the Paediatric Intensive Care Unit (PICU) has been an area of focus or improvement work.

Improvements

- Comprehensive RCA level 2 investigations conducted for grade 3 and 4 pressure ulcers, with the development and implementation of improvement plans to prevent reoccurrence.
- Revised SSKIN care bundle for use in the PICU, to include explicit recording of a ‘top to toe skin inspection’.
- PICU audit programme to ensure compliance with the SSKIN care bundle documentation.
- PICU Braden Q assessment of risk of pressure ulcers score incorporated into the Badger IT nursing documentation.
- PICU training programme including:
    - Learning from all root cause analysis (RCA) investigations.
    - Discussing pressure ulcer prevention on the PICU mandatory training.
    - Monthly updates in pressure ulcer prevention provided by the Tissue Viability Specialist Nurse
    - Reiterating the importance of micro movements during all practical manual handling training.
- Braden Q Risk Assessment and SSKIN bundle now mandatory in Meditech 6 the new electronic nursing assessment documentation.
- Appointment of a full time Tissue Viability Lead Nurse at Band 8a. Service now has two specialist nurses, one full time and one half-time.
- Delivery of training to all new nursing staff on induction week with regard to pressure ulcer prevention and management.
- Health Care Assistants trained prior to commencing MSC nursing programme and becoming student nurses.

- RCA template being incorporated into the SNAP Audit System to enhance quality of reporting.

The chart below shows that compared to 2014/15 there has been 9 less pressure ulcers in PICU during 2015/16 this represents 30% reduction. There has also been a reduction in harm.

PICU pressure ulcers by grade	Apr 13- Mar 14	Apr 14- Mar 15	Apr 15- Mar 16
Grade 1	20	18	11
Grade 2	9	12	9
Grade 3	0	0	1
Grade 4	1	0	0
Total	29	30	21

Future Plans

- Reformatting of Ulysses Reporting Form to improve data quality around incidence of pressure ulceration.
- Implementation of electronic learning package in relation to pressure ulcer prevention and management.
- Implementation of Standard Operating Procedure regarding reporting and investigation of hospital acquired grade 2, 3 and 4 pressure ulcers.
- Reformatting and implementation of Pressure Ulcer Root Cause Analysis Tool to assist in early identification of avoidable and non-avoidable ulceration.
- Sharing Lessons Learned organisationally around the topic of pressure ulcers.
- Revitalisation of the Tissue Viability Link Nurse Role.

Nurse Staffing

Aims:

- To have no nursing vacancies.
- To establish a nurse pool to cover maternity leave and long term sick cover and fill ward/department vacancies.
- To have a proactive recruitment campaign.

Changes or deficiencies in the nursing workforce can have a detrimental impact on the quality of care. Patient outcomes and particularly safety are improved when organisations have the right people, with the right skills, in the right place at the right time (RPRSRPRT). This has been highlighted as lessons learnt from inquiries such as, the Mid Staffordshire NHS Foundation Trust Public Inquiry.

In November 2013 the NHS Quality Board published the new guide to nursing, midwifery and care staffing capacity and capability – RPRSRPRT setting out its position for greater transparency in the way in which Trusts set and deliver nursing, midwifery and care staffing levels. All Trusts are mandated to provide nurse staffing information on a monthly return via the National Reporting and Learning System and publish this data at ward level and the information is to be made available to the public.

Acting on the lessons learned from various reports, strategies and inquiries the Trust has comprehensively reviewed all wards/departments nurse staffing establishments and significantly invested in additional nurses. As all Trusts have undertaken this process the impact has led to a national challenge in relation to recruitment. The Trust has risen to this challenge, resulting in the following improvements:

Improvements

- A ward/department staffing review was undertaken in 2014/15 and repeated in 2015/16 prior to the move into the Children's Health Park.
- Engagement with Higher Education Institutions, to showcase Alder Hey and attract students as future employees.
- Recruitment Events; the most recent in March 2016 which resulted in the recruitment of 39 staff who will take up post in 2016/17.
- Within the European Union, only Ireland and Italy train nursing staff specifically in paediatrics. As Ireland had a nursing deficit we focused international recruitment in Italy. The recruitment was successful with:
    - 12 nurses recruited and commenced in post in 2015/16.
    - 5 nurses recruited 2015/16 and will take up post in 2016/17.
- Developed joint Paediatric Nurse and Social Worker role. There are 4 staff undertaking post graduate Social Work year in supported learning and they have successfully reduced the number of patients with complex discharge needs, who were fit for discharge and have had an extended length of stay over 30 days

The improvement outcomes are shown in the table below.

Recruitment and Retention Improvement Outcomes				
	March 2014	**March 2015**	**March 2016**	**Comments**
Patients fit for discharge with an extended length of stay over 30 days.	N/A	45	28	38% reduction form March 2015.
Trust wide nursing vacancies.	61.04	19.74	12.34	80% reduction from March 2014.
Whole time equivalent (wte) registered nurse posts.	1007.17	1036.04	1080.00	7% increase since March 2014; this is an increase of 72.83 wte's.
The percentage of nursing budget spent for bank and agency within the wards and critical care.	6%	13%	8%	The 2014/15 staffing review increased the numbers of registerd nurses required.
The percentage of nursing budget spent for bank and agency within theatres.	0.77%	1.15%	1.50%	Agency and bank staff are required whilst new staff are being trained.

Future Plans

- Continue proactive recruitment of student nurses.
- Continue monitoring vacancies, turnover rates and daily staffing levels.
- Review Recruitment and Retention Plan for 2016/17.

Infection prevention and control

Aim: No hospital acquired infection.

Targets: From the 2014/15 baseline:

1. No hospital acquired MRSA bacteraemia
2. No clostridium difficile infections due to lapses in care
3. Reduce the number of outbreak organisms and hospital acquired organisms by 10% from the 2014/15 baseline of 157; this represents 141

Outcomes:

1. 3 MRSA bacteraemia
2. 2 clostridium infections (not due to lapses in care)
3. 27% decrease in the number of outbreak organisms and hospital acquired organisms: this represents 114

Effective infection prevention and control practice (IP&C) is essential to ensure that patients receive safe and effective care. In order to provide the best possible outcome for the children in our care it is vitally important that we identify and manage all infections that affect our children and young people to reduce the risk of healthcare acquired infection.

Children and young people can present unique IP&C challenges, such as:

- They are susceptibile to infections, which are prevented, in older patients due to previous exposure or vaccination.
- They have closer contact with other visitors such as parents and siblings.
- Their poor hygiene practices present more opportunities for infection to spread.
- They may also interact more closely with their environment, making them more likely to come into contact with contaminated surfaces and items.
- Communicable diseases affect a higher percentage of paediatric patients than adults increasing the likelihood of cross infection.

Improvements

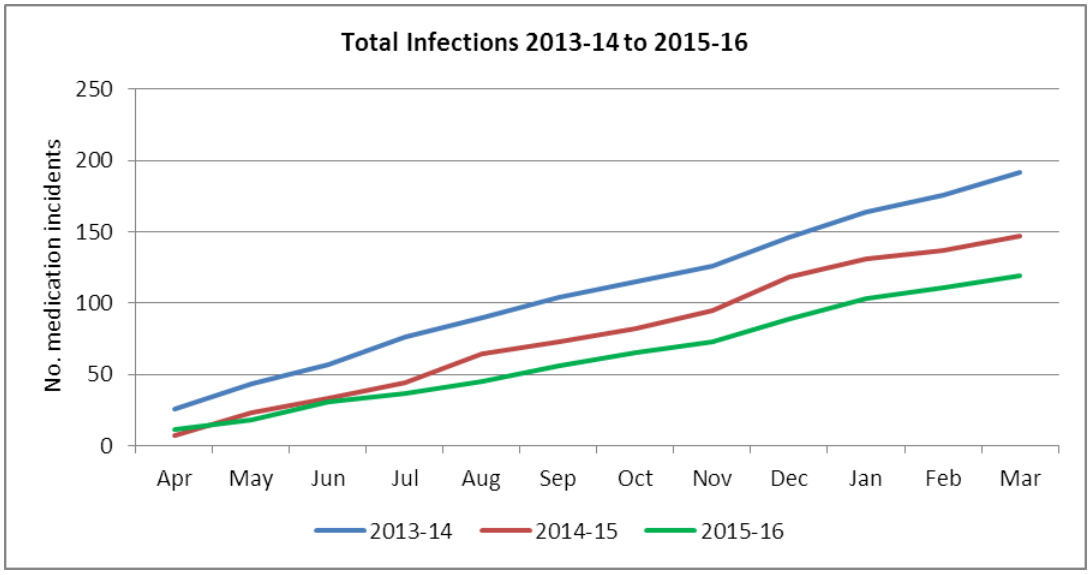
There has been Post Infection Review investigations conducted following the occurrence of MRSA bacteraemia and clostridium difficile infections, resulting in the development and implementation of improvement plans and establishing that the clostridium difficile infections were not due to lapses in care.

There has also been a focus on reducing the risks of any increase in hospital acquired infections as a result of moving into the new Alder Hey Children's Health Park and a drive to futher strengthen medical engagement in the IP&C agenda, for example:

- Collaborative work with medical team leaders and Ward Managers to produce ward specific Infection control policies, including formulation of specific key performance indicators.
- IP&C team attendance at Critical Care Safety Huddles to provide pre-emptive infection control advice.
- External IP&C service review has been undertaken to identify any service gaps since moving to the Children's Health Park.

- Director of IP&C attendance at Clinical Business Unit Risk and Governance Boards to strengthen focus on IP&C issues.
- Establishment of infection control/antimicrobial ward rounds with Director of IP&C and medical teams to provide immediate feedback to clinicians on their compliance with infection control practices and antibiotic prescribing.
- Review of the Infection Control Committee has resulted in an increase in medical representation and a discussion forum that strengthens staff engagement.
- Trust wide hospital acquired infection prevalence survey.
- Collaborative work with finance and the information team to look at the financial implications of hospital acquired infection.
- The introduction of Isolation Cards that fit behind staff identification badges to assist clinical teams in appropriately isolating patients.
- Development of a hand hygiene audit tool to engage families in infection prevention.

The graph below shows that the improvements have resulted in 119 hospital acquired infections which is a 38% reduction compared to 2013/14.



Future plans

- To implement IPC Delivery Plan this incorporates the Sign up to Safety IPC plan and key quality improvement work.
- To maximize opportunities for the children and young people's involvement and empowerment in prevention and control of infection.

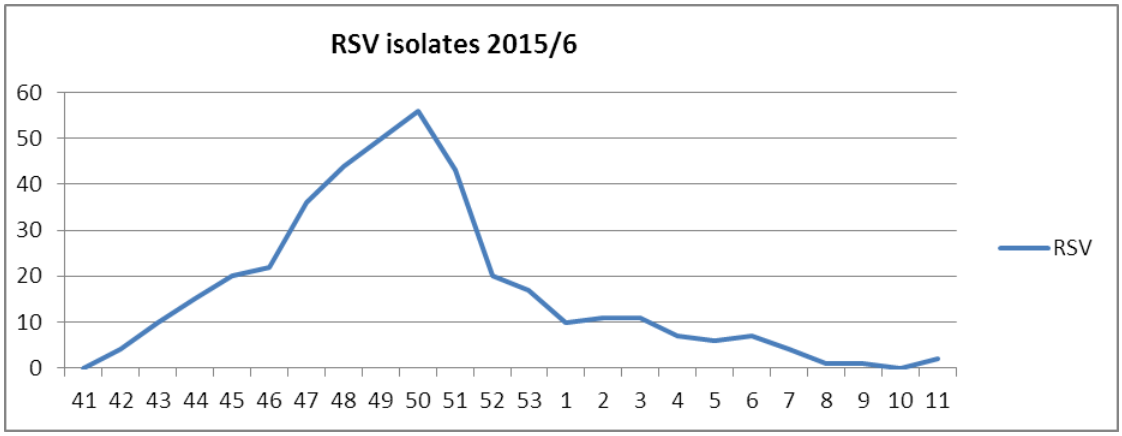
Respiratory Syncytial virus (RSV)

Aims:

- Review and trial of laboratory systems that enable quick turnaround times for the detection of respiratory viruses.
- Introduce the system (Film Array) within high risk areas including Critical care PICU/HDU and oncology all year round.
- Use of the system (Film Array) during the respiratory virus season (November–March) Trust wide in order to increase the turnaround time for the detection of respiratory viruses.
- Provide information to IP&C Team and patient flow, facilitating the cohorting of patients with the same respiratory virus together, thus improving patient flow and availability of cubicles for patients.
- Quicker isolation of infectious patients.
- Reducing the incidence of hospital acquired respiratory viruses, including outbreaks.
- Rapid diagnosis of influenza can allow treatment to be given at the time of presentation. The Trust influenza pathway states that in “at risk” children, Oseltamivir must be given within 48 hours of the onset of symptoms to be effective.

Respiratory Syncytial virus (RSV) is the commonest cause of respiratory illness (bronchiolitis) in children particularly those less than 2 years of age. The virus is seasonal and normally occurs for a 6 week period during the winter months between November and February. RSV is the commonest cause of hospital admissions due to acute respiratory illness in young children and the high numbers of babies requiring admission to the Trust during the winter months places huge pressures on the Trust.

Respiratory viruses season



Trust Infection Prevention Policy requires any child admitted with acute respiratory illness, including bronchiolitis/pneumonia/empyema or with any unexplained febrile illness should be placed in a single room. When a single room is not available, the

patient should be placed in a room with patients who have the same infection (cohorting).

At Alder Hey rapid testing was available only for RSV with the results being available within 4 hours. As patients may have co-infection with other respiratory viruses they cannot be nursed together in a cohort area unless it has been established that they only have RSV infection. Therefore respiratory samples had to be sent to the Royal Liverpool University Hospital for PCR (Polymerase Chain Reaction) testing. The turnaround for these tests during the winter was a minimum of 36 hours during the week.

The average duration of stay for patients with Bronchiolitis on the Medical Admissions Unit in previous RSV seasons had been less than 3 days, so patients Respiratory PCR results were frequently unavailable until the baby was nearing or already discharged from the Trust. As patients couldn't be cohorted together until these results were available they required isolation in a cubicle for the duration of their stay. The overall aim was to increase the turnaround time for the detection of respiratory viruses.

Improvements

Film array was trialled and introduced in the paediatric intensive care unit (PICU) in autumn 2013.

The provision of a 2nd machine in November 2013 allowed patients admitted with respiratory illness to have respiratory viruses detected within 2 hours, often whilst still in accident and emergency department (AED). This allowed patients with only RSV to be admitted directly into cohort bays, freeing up cubicles for patients with other infections requiring isolation.

During the peak RSV season 2013/14 there were 3 cohort areas for RSV patients (Winter ward 6 bedded bay, ward E2, 4 bed bay and ward M3 4 bed bay.

This had a positive effect on patient flow and patient experience as families didn't have as many ward moves.

This improvement in rapid diagnosis and appropriate patient isolation has been maintained during the RSV season 2014/15 and 2015/16.

<u>Incidence of Hospital acquired RSV & Influenza Nov 2012- Mar 2013 and Nov 2013- Mar 2014</u>

Month	Number of HA- RSV	Number of HA-Influenza	Month	Number of HA- RSV	Number of HA-influenza
Nov 2012	7	0	Nov 2013	1	0
Dec 2012	0	0	Dec 2013	6	0
Jan 2013	2	0	Jan 2014	1	0
Feb 2013	1	2	Feb 2014	1	0
Mar 2013	2	0	Mar 2014	1	0

Incidence of Hospital acquired RSV & influenza Nov 2014- Mar 2015 and Nov 2015 – Mar 2016

Month	Number of HA- RSV	Number of HA-Influenza	Month	Number of HA- RSV	Number of HA- influenza
Nov 2014	1	0	Nov 2015	1	0
Dec 2014	9	2	Dec 2015	5	0
Jan 2015	0	3	Jan 2016	4	2
Feb 2015	0	0	Feb 2016	1	0
Mar 2015	0	1	Mar 2016	0	2

The number of HAI respiratory infections with RSV and influenza has remained stationary between 2014-16. The source of HA respiratory infection within paediatrics can be the parents or siblings of the hospitalised child and not as a consequence of poor infection prevention & control practices by health care workers.

The rapid identification of the causative agent with the film array has reduced the incidence of respiratory virus outbreaks and the prompt appropriate treatment of children with antivirals. This has included prophylactic treatment i.e. Oncology patients exposed to influenza as well as patients diagnosed with influenza A. This has been particularly marked during 2015/16 due to the increase in numbers and duration of winter season for influenza A.

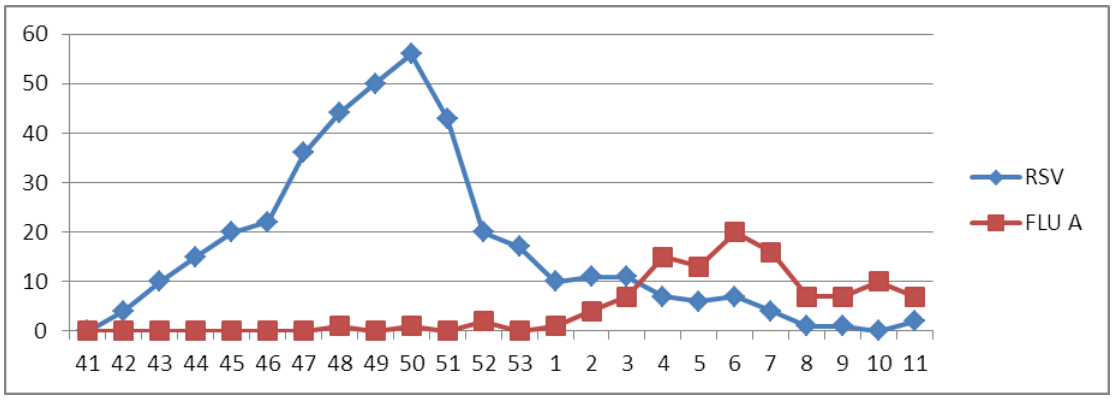
Respiratory virus outbreaks 2012-3 November – March	Respiratory virus outbreaks 2013-14 November-March
1.hMPV -HDU -3 patients (2 patients required prolonged PICU admission) 2.RSV- NMW – 5 patients (1 patient required HDU admission)	Nil

Respiratory virus outbreaks 2014-5 November – March	Respiratory virus outbreaks 2015-6 November-March
1. RSV – Neo – 3 patients- Unit closed to admission	Nil

Future Plans

A review of 'lessons learnt' from recent winter season 2015/16 involving a multidisciplinary approach. The move into the Alder Hey Children's Health Park has increased the number of cubicles available for isolation of patients and reduced the requirement for cohorting patients during the 2015/16 season.

RSV & Influenza isolates at Alder Hey 2015/16



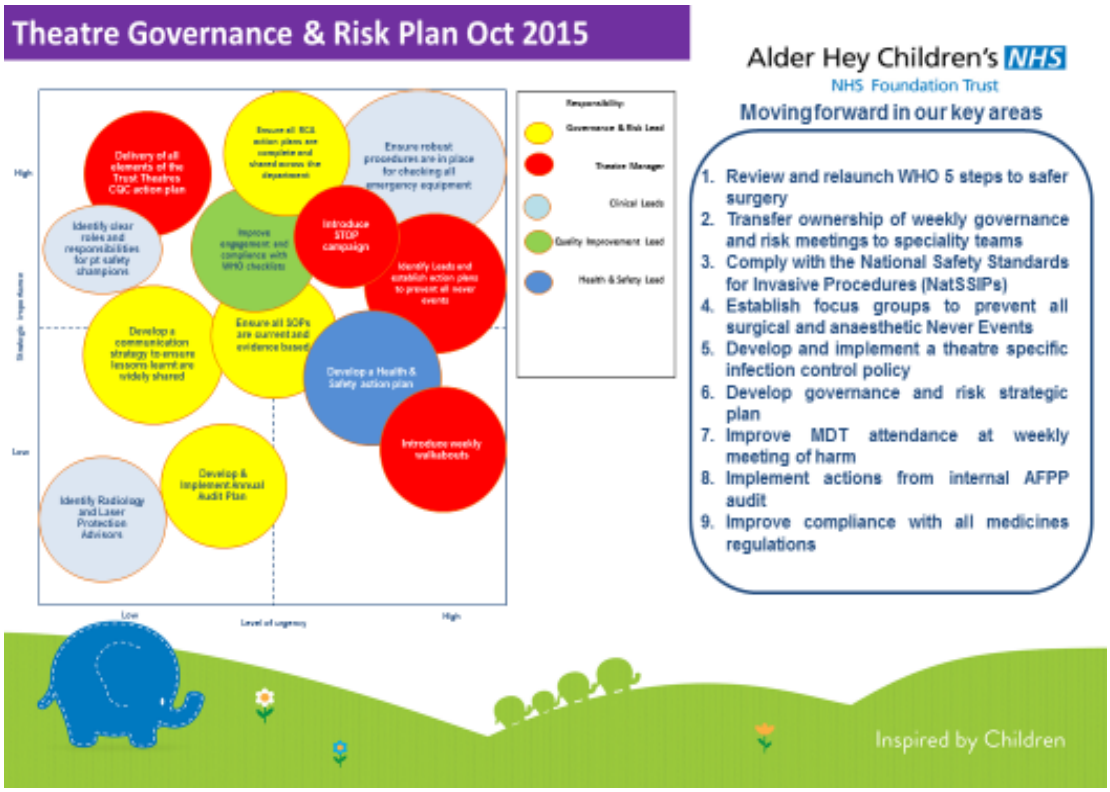
In the 2015/16 season the number of influenza cases has risen dramatically (see graph above). Identification of the best type of respiratory testing platform (e.g. RSV and Influenza alone for lower risk areas reserving film array for high risk locations) will be explored to ensure efficient use of resources.

Perioperative care

In August 2015 the Theatre Manager commissioned an independent audit designed by the Association for Perioperative Practitioners examining the quality management systems in theatre. The purpose of the audit tool is to provide accreditation that assists users in identifying a perioperative environment that has high quality processes and practices. The audit tool aims to identify and shape implementation of effective risk strategies for all those involved in the care of the patient

This extremely comprehensive tool provided a framework for the department to examine service performance and identify potential improvements in delivery of services using a peer review process, this is approached by following patients through the perioperative journey.The audit tool has the potential to improve patient care, it is not designed to accredit an individual's capability, but does assess the whole perioperative process and evidence that processes and procedures have met a defined set of criteria to assist in the delivery of safe and effective healthcare.

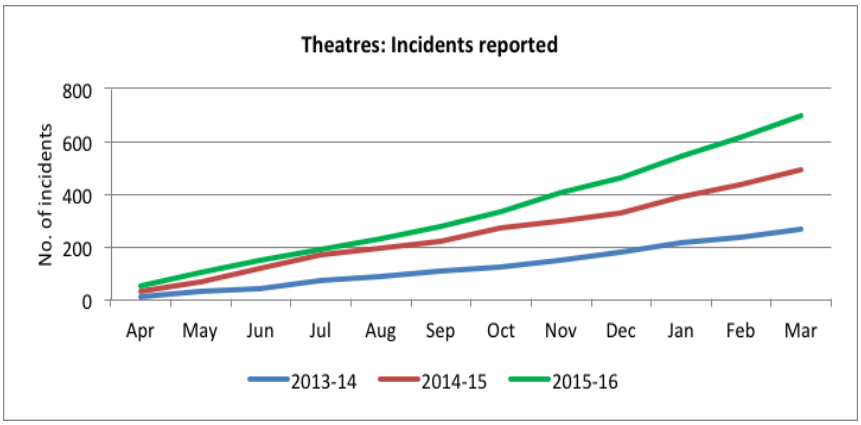
The utilisation of this tool built on the work of the Theatre Safety Board and newly appointed Theatre Risk and Governance Lead and Theatre Safety Champions and underpins the Theatre Risk and Governance Plan.



Improvements

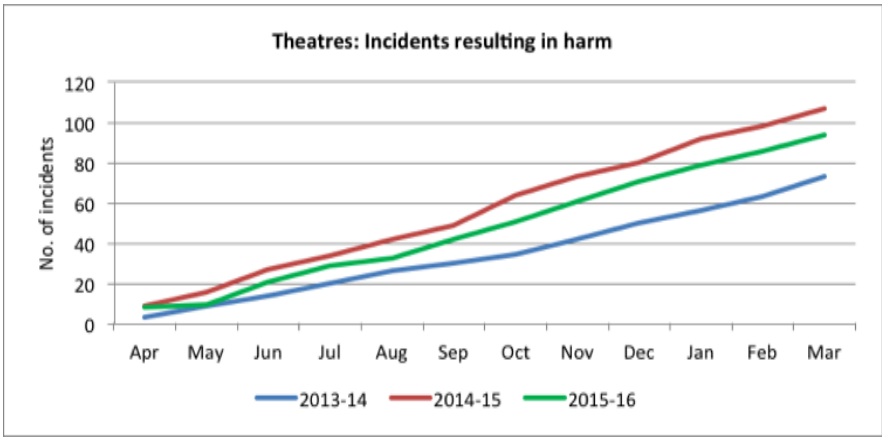
- Introduction of a dedicated risk and governance coordinator for the theatre department to improve the way incidents are managed
- Development of a dedicated theatre risk register in addition to the existing Clinical Business Unit.
- Development of governance and risk plan on a page.
- WHO 5 Steps to Safe Surgery review at project mid-point.
- Weekly governance & risk meetings now led by speciality teams.
- National Safety Standards for Invasive Procedures project commenced, expected completion September 2016
- Introduction of a resident 24 hour, 7 day Operating Department Practitioner to respond to all emergency calls and ensure all critical emergency equipment is checked daily
- Funding secured for Theatre Matron post to lead the Safety and Quality Strategy for theatres

The graphs below show that whilst there has been an increase in the number of incidents reported, there has been a reduction in the number of incidents of harm. However, the 3 Never Event incidents reported were surgical Never Events; which have undergone comprehensive investigations, the development and implementation of improvement plans and have informed the Best in Operative Care project.



Since 2013/14 there has been a 159% increase in incident reporting.

Since 2013/14 there has been a 29% decrease in the number of incidents of harms.



Best in Operative Care

Aims:
The "Best in Operative Care" strategy aims to deliver the best paediatric operative care in the world, as measured by low rates of mortality and harm, and high staff satisfaction.

1. Increase the safety and reliability of care.
2. Improve team performance and staff well-being.
3. Add value and improve efficiency.

Targets: Specified in the Performance Score Card.

The Best in Operative Care project, which commenced in March 2016, helps theatre teams to work more effectively together to improve the quality of patient experience, the safety and outcomes of surgical services, the effective use of theatre time and staff experience. This focus on quality and safety helps theatres run more productively and efficiently, which subsequently can lead to significant financial savings.

Best in Operative Care Performance Score Card	
Safety	▪ No Surgical Never Events ▪ 25% reduction in patient harm ▪ 25% reduction in rate of surgical site infection ▪ 5% reduction in unplanned readmission to critical care ▪ 95% staff recommend for treatment
Excellence	▪ We will increase the number of children we provide operative care to, treating 8,230 children in our Surgical Daycase Unit ▪ 90% theatre utilisation ▪ 50% reduction in short-notice cancellation of patients ▪ 50% reduction in short-notice cancellation of theatre lists ▪ 95% patients and families recommend for treatment ▪ 5% reduction in conversion rate from day case to inpatient
Wellbeing	▪ 95% theatre staff recommend Alder Hey as a place to work ▪ Less than 5% of theatre sessions overrun by more than 15 minutes

Improvements

The improvement plan focuses on the following:

- Safe and effective perioperative management that reflects best practice:
  - Staff will be enabled to safely perform their role within the perioperative environment.
  - The Productive Operating Theatre is utilised.
  - Communication between perioperative teams and the wider trust is effective.
  - An effective perioperative monitoring programme is in place.

- A culture of safety is evident throughout the perioperative environment:
  - Perioperative incident reporting is improved.
  - Perioperative incidents are appropriately and timely investigated.
  - Dissemination to trust wide staff of lessons learnt from perioperative investigations is improved.
  - Lessons learnt drive safety improvements.

- Patients and families/carers are actively involved in their own perioperative management:
  - Patients, families/carers are involved in decisions about their perioperative management.
  - Patients, families/carers have access to information about their perioperative care.
  - Patients, families/carers are actively engaged and enabled to participate in ensuring safe perioperative management.

Every operative procedure is recorded with a focus on the following measures:

- Harm.
- Surgical Site Infection.
- Unplanned admissions to critical care
- Staff recommend Alder Hey as a place for treatment.
- Increase in number of patients treated in the Surgical Daycase Unit.

- In theatre utilisation.
- Decrease in patient operations cancelled at short-notice.
- Decrease in theatre lists cancelled with less than 6 weeks' notice.
- Patient satisfaction.
- Conversion rate from daycase to overnight stay.
- Temperature check of staff satisfaction.
- Theatre session overruns.

Future Plans

Data will continue to be collected and analysed in the coming year as per departmental and Trust requirements. The reporting mechanism will be the Best in Operative Care Steering Group will continue to report progress to the Clinical Quality Assurance Committee.

Ward Accreditation

Aim:

- To develop a Ward Accreditation scheme in partnership with children, young people, their families and carers that will provide assurance of the quality and safety of care in our wards and departments.

Targets:

- To develop a Ward Quality and Safety Assessment Tool (QASAT).
- To utilise Observational Audit incorporating Human Factors to assess ward activity, checking and discussing nursing standards of practice and asking patients and their parents or carers about their experiences.
- To ensure the 5 STAR award is aligned to the CQC Assessment Standards.

Ward accreditation schemes have been shown to promote safer patient care by motivating staff and sharing best practice between ward areas (Coward et al. 2009; Central Manchester University Hospitals NHS Foundation Trust 2013). To date they have been implemented predominately in adult services.
To achieve the recognised benefits for children and young people in Alder Hey, we have committed to the development and implementation of a Paediatric Ward Accrediation scheme in partnership with children, young people and their parents/carers.

Improvements

- Consultation on QASAT contents, with Ward Managers, Lead Nurses and Patient Safety Champions.
- Development of Ward QASAT which strengthens Trust Board assurance and aligns with the Care Quality Commission key lines of enquiry, post Francis enquiry and Essence of Care benchmarks.
- Pilot of QASAT on 4 wards.
- Children and young people proposed title of ward accreditation scheme should be STAR, as in reaching for the stars.
- STAR agreed as Safe, Together and Always Right.
- STAR scheme agreed as a continuous journey to achieve and sustain STAR accreditation.
- STAR accreditation panel includes patients and parents/carers.

STAR Ward Accreditation Scheme		
	CQC Assessment Standard	**STAR Quality & Safety Assessment Tool Elements**
	Safe	Patient Safety Pressure Ulcer Medication Safety
	Effective	Pain Deteriorating Patient Infection Prevention & Control
	Caring	Fluid Balance & Nutrition Care Planning
	Responsive	Patient Experience Environment
	Well Led	Corporate Targets

Future Plans

- Develop department specific and speciality specific QASAT
- Complete QASAT for all wards.
- Assess effectiveness of supportive interventions for wards who do not achieve any of the desired standards within the STAR Accreditation Scheme.

Improving the transition from Children and Young People Services to Adult Services

Aim:
To establish a good quality, safe, effective and seamless transition to adult services, for children with complex long term conditions.

The transition from childhood to adulthood involves a period of significant change. During puberty, young people move from childhood into physical maturity. The sudden and rapid physical changes can make adolescents very self-conscious, sensitive, and worried about their own body. Young people begin to separate from their parents, with increased emphasis on friendships and establishing their own identity. In mid-to-late adolescence, young people often feel the need to establish their sexual identity through romantic friendships and experimenting. Adolescents become stronger and more independent before they've developed good decision-making skills, with an increase in risk-taking behaviours.

Young people with long term health conditions face significant additional challenges as they move from childhood to adulthood.

The changes of adolescence may result in increasing instability of the young person's condition, because of the effect of the physiological changes of puberty and because of the associated psychological and emotional changes. These challenges are also associated with the need to move from children's to adult health services. The manner in which this care is transferred to the adult healthcare system is essential to the continuing wellbeing of the young person and their willingness to continue and comply with health support and treatment. Additional challenges are faced when adult services are very different in their approach to the equivalent children's service or where there is no equivalent service in the adult sector. There is increasing evidence that planned, co-ordinated and supported transition can significantly improve outcomes for young people.

Improvements

- Continue to work with information technology team towards identifying a sensitive, reliable and reproducible method for identifying the cohort of young people of transition age with complex neurodisability.
- Continue to work with information technology team towards identifying a sensitive, reliable and reproducible method for identifying any patients of transitional age.
- Continue to work with information technology team towards identifying basic demographic and diagnostic data on the above cohorts and all patients with a LTC through application of the above process.
- Repeat baseline assessment to identify classification of transition status of all young people of transition age who have accessed Alder Hey Children's Hospital in the last two years.
- Assist with the development of a model for a multispecialty multidisciplinary service in the adult sector for young people with complex neurodisability, including continued commissioning support to progress with a business case and setting up the service.

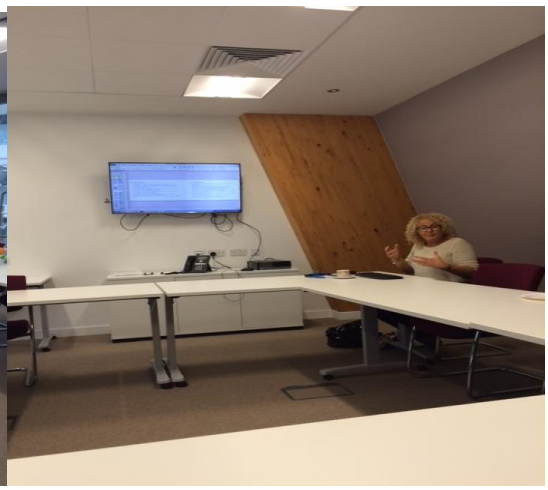
- Embed the Generic Trust Transition Pathway supported by a draft Trust Transition Policy and supporting materials.
- To finalise the development of transition training using the evaluation of the current level of knowledge and understanding of children's healthcare providers regarding transition, including knowledge and understanding of competencies relating to transition to adult services and complex long term conditions management, through the Trust Transition Survey.
- To deliver and embed Transition training in line with the identified competencies across long term and complex long term conditions management and transition at three levels: universal, core and specialist.
- Ratification of core documents to support safe, effective transition including a visual representation of the transition pathway, what good looks like and an overarching Trust Transition Policy.
- Increased awareness of the challenges of transition to adult services across the Trust.
- Measures of staff engagement with the Trust Transition Training Program.
- Measures of specialty services where Transition is being developed and implemented within the Trust.
- Identification of an Executive Lead for Transition.
- Engagement of:
    - Children, young people and parent Focus Groups.
    - Over 200 clinical staff in the Trust through the Transition Survey.
    - Over 100 clinical and managerial staff through the Transition Roadshows.
    - 62 clinical staff through the Transition Away Day.
    - 24 Transition Champions across the Trust.
    - A number of Trust Transforming Transitions Newsletter.
    - A series of Trust Transition Steering Group meetings, also dates planned for 2016-2017.
- Further patient and parent participation via meetings and forums.
- Engagement in the Trust parent and patient forum.
- Presentation at Clinical Quality Assurance Committee.
- Baseline assessment (to be repeated annually).
- Presented Trust Transition work nationally.
- Assisted NICE with development of Transition Guidance/ standards.
- Assisted NHS Specialist commissioners with Transition CQUIN.
- Assisted NHS England with Transition service specification.
- The Trust recognised nationally as Transition lead.
- Planned Trust Study day 'Transforming Transition a Ten Step Pathway' to be held in May 2016 to be delivered to colleagues from around the country.
- Transition team has presented their work at a number of National events.
- The Transition Team Worked collaboratively, and hosted the AQuA National redesign of the paediatric 'Ask three questions' event held in Alder Hey.
- The Transition team presented their APP proposal to the Hackathon in 2016.
- Development of a film outlining the difficulties experienced by a parent of a young person with multiple complex long term conditions relating to carers, carer skills, finances and transition
- Development of a 'complex patient' transition preparation tool (out to consultation).

- Presentation of Alder Hey Transition work at the Royal College of Paediatric Physicians 2015.
- National engagement from other Trusts interested in Alder Hey Transition developments.
- Clinical Lead nominated for a National 'Clinical Lead' of the year award.
- Transition Ten Step Pathway Poster Presentation successful at National Conference 2015.
- Development with children's forum of 'Transition - Our Promise to You'.
- Transition draft policy assessed against and meets the equality and diversity standards.
- Development of Trust transition map.
- Colleagues visited from Singapore Hospital Transition team- Alder Hey Transition toolkit shared, also shared with colleagues in Australia.

Future plans

- Repeat baseline assessment as above.
- Consult on, finalise, ratify and embed the Trust Transition Policy across the Liverpool sector including Adults and Children's providers in primary, secondary and tertiary care, young people and families.
- Further work to develop and define the role of the GP.
- Further work to identify the Lead Consultant and Keyworkers will be within specialties.
- Recruit to Keyworker and Lead Consultant in transition and care of patients with complex long term conditions.
- Develop and invest in the Transition Champions.
- Develop and invest in Transition Leads within CBUs and clinical teams.
- Identify markers of complexity and set up relevant data fields within Meditech 6 (patient care information system) to capture, and an audit process to ensure these fields are reliably and consistently completed.
- Implement Transition Policy within the Trust including active monitoring of critical incidents.
- Continue to develop and monitor the Trust transition map and the Trust Special Transition "register" of young people where transition to the adult sector is delayed either for appropriate clinical reasons or because of a lack of appropriate services in the adult sector, or previously agreed commissioning arrangements mean patients remain within the Trust past their 18th birthday.
- Continue to work with the Adult Sector to develop their business case and set up the multispecialty multidisciplinary service in the adult sector for young people with complex neurodisability.
- Continue to work with the Adult Sector to develop links and pathways where there are no confirmed or fragmented pathways currently.
- Continue to share the Trust Nationally recognised transition tool kit.
- Deliver universal and core Transition Training.
- Finalise the design and deliver specialist transition training for professionals within the Trust and in adult services including experiential learning techniques such as simulation and video materials.
- Further participation and engagement work with young people and their parents/carers to inform the above, including Carer skills training.

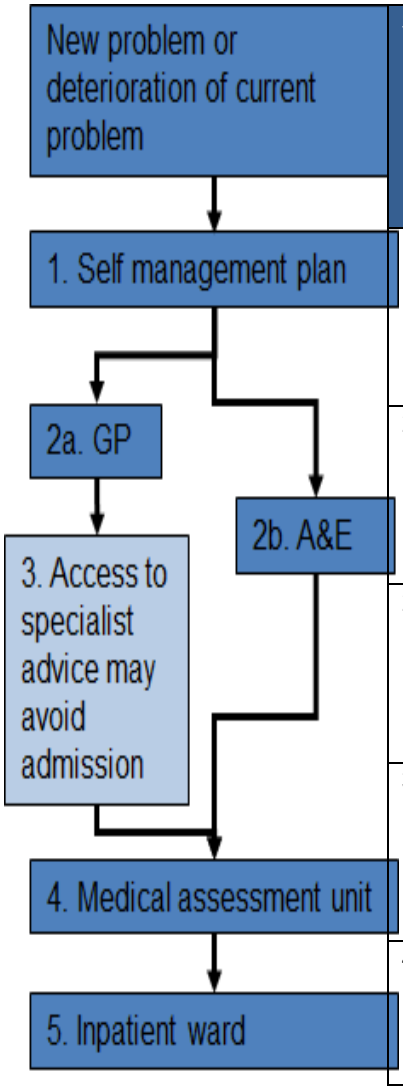
The C&YP Transition Artwork- 2015

Transition team presenting Transition developments at C&YP Forum 2016

Transition team, collaboratively working with AQuA on the National redesign of the 'Ask 3 Questions' event held at Alder Hey in the Park- ensuring it is C&YP friendly. December 2015

Figure 1 Transition to Adult Services: Plotting your route into urgent care- 2015



Stage	Where will this happen?	Who will be involved	What knowledge and skills will be needed?	How can we ensure the right information & support is available?
1				
2a				
2b				
3				
4				

Aims:

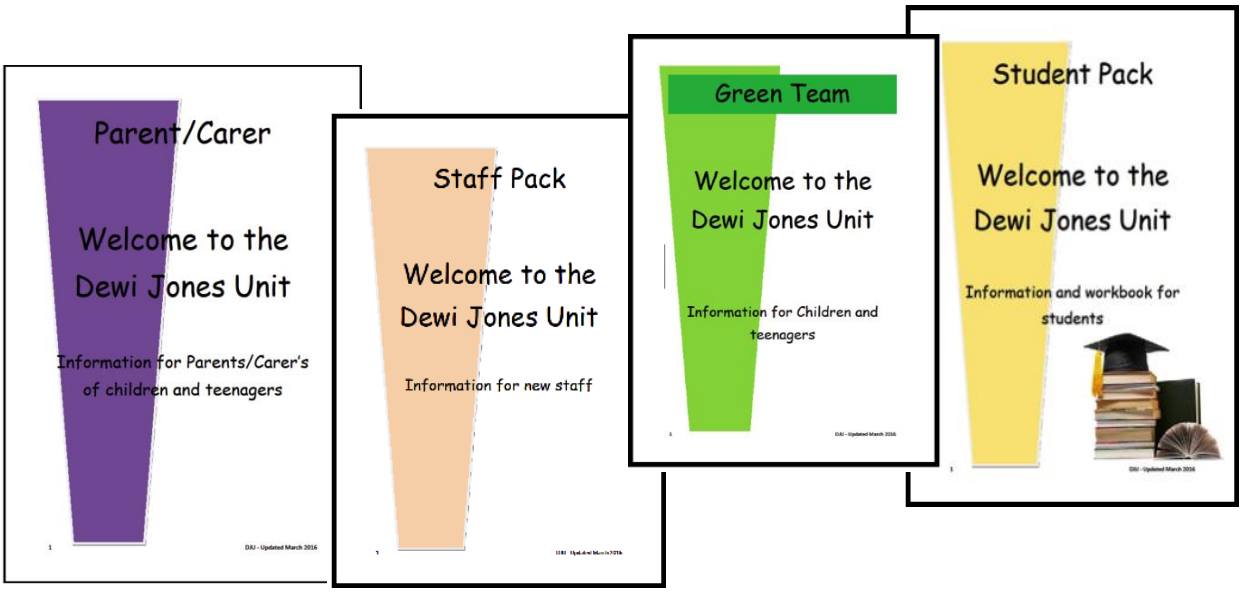
- To produce a tangible, friendly up-to-date document with enough salient information to provide a clear over-view of our service from the perspective of a service user.
- To break down barriers and attempt to alleviate any anxiety which may arise before planned admissions onto the unit.
- To offer a basic understanding of our service to reduce the likelihood of misinformation or of people feeling 'unable' to ask questions.
- To promote an open and transparent service and celebrate our high quality.

Dewi Jones Unit – Welcome pack

The Dewi Jones Unit is an inpatient mental health facility, designed to help children and young people aged 5 to 13 who are going through a difficult time or struggling because of their way of thinking, their feelings, or with some difficult behaviour. As part of the units commitment to implement the 6Cs nursing values within the workplace, communication was identified as a key area of focus. The Dewi Jones Unit Welcome Pack was identified as a key component of how we, as a service, communicate with our patients and their families. The idea arose from feedback received by a patient and their family highlighting that they felt under-informed about our service during their experience at the unit.

The reformulated welcome pack was based upon a much older version in order to capture and maintain the ethos and values of the organisation. Professional standards and guidelines were examined to formulate a raw structure which could be used as a foundation to capture and build upon relevant information. Patients, families and staff were collaborated with throughout the process to illicit information which was considered relevant from multiple perspectives. School's council group were also consulted, alongside advocacy and the parent / carer group.

Multiple changes were made based upon combined service user recommendations. Although very much a whole-team effort, ownership of the project was delegated to a single member of staff to avoid confusion within the concept of the project. Development opportunities were considered from verbal feedback received from patients and their families which resulted in several new work-streams resulting in a new 'range' of bespoke welcome packs. These currently include:



All packs are considered a continuous 'work in progress'. Consultation since implementation has revealed that those people who have received the new welcome packs feel "very informed" prior to their individual experiences on the unit.

The unique selling proposition of the welcome packs in their current format very much lies in their appropriate mix of broader service-related information combined

with a very specific, targeted (and, in some cases personalised) information pack. This has facilitated both an over-view and identifiable, useful and credible information resource. This demonstrates a cost effective patient-centred improvement (which has also been proven to have transferable qualities) when benchmarked against patient feedback gained prior to the implementation of the project.

Future Plans

The essence of this project lies in the delivery of accurate, relevant information at the point of need. Moving forward the service will focus on a robust system whereby multiple members of the healthcare team can invest their time and energy into maintaining the current format whilst updating information retrieved from continued evaluation. Opportunities will be considered for further expansion of the core elements of the pack as and when they present themselves. The practical and innovative implementation of this service improvement will be fostered within the team and potentially modelled for additional areas of quality care improvement.

Patient Feedback through Fabio

The Trust is committed to ensuring that we have a robust model of patient and family engagement and involvement throughout the organisation that makes a real difference not only to the services we deliver but also to the overall patient experience.

We continue to develop strong links with the children and families who access the services of Alder Hey. Engagement occurs on a daily basis in both a formal and very informal basis. We endeavour to ensure that learning from experience is an integral part of service evaluation and design, so that decisions at all levels are made by teams that are well informed in terms of what is important to patients, families and visitors to the Trust.

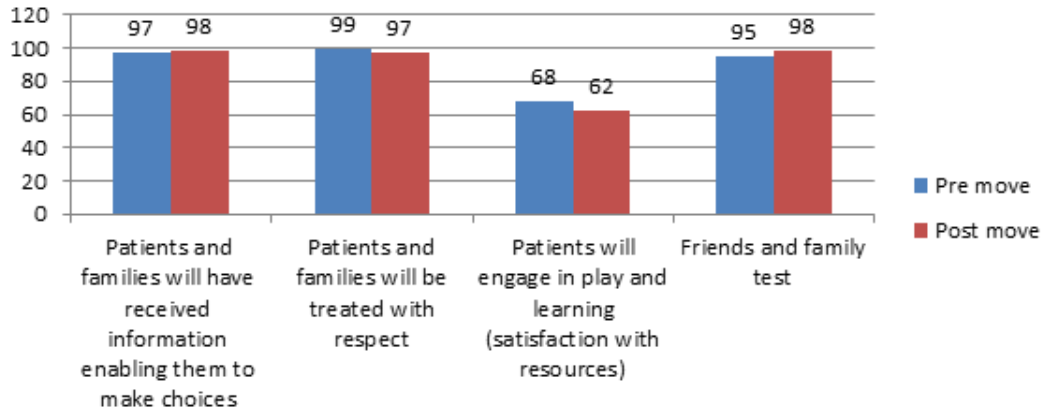
This has been a most exciting year planning for the opening and transition to the Children's Health Park, a new hospital designed with the children's interests at heart. It has been equally important that we continue to learn from experiences and proactively use this information to maintain a safe and pleasant environment with current resources. The actual move impacted on the process of collecting feedback, this is mainly due to the safe move and settling in period taking priority for all teams. This has resulted in a period of approximately 3 months where the amount of data collected was significantly reduced.

The 'Fabio' is an electronic device in the form of a tablet, which contains software enabling patient and carer feedback to be collected and analysed providing 'real time' data.
The Trust's volunteers continue to support the Patient Experience team and clinical teams in improving the volume of feedback from patients and families prior to discharge from hospital.

During this period, 3041 responses were obtained using the Fabio device. The data has given an initial view on the impact that relocation of the hospital has had on patients and families.

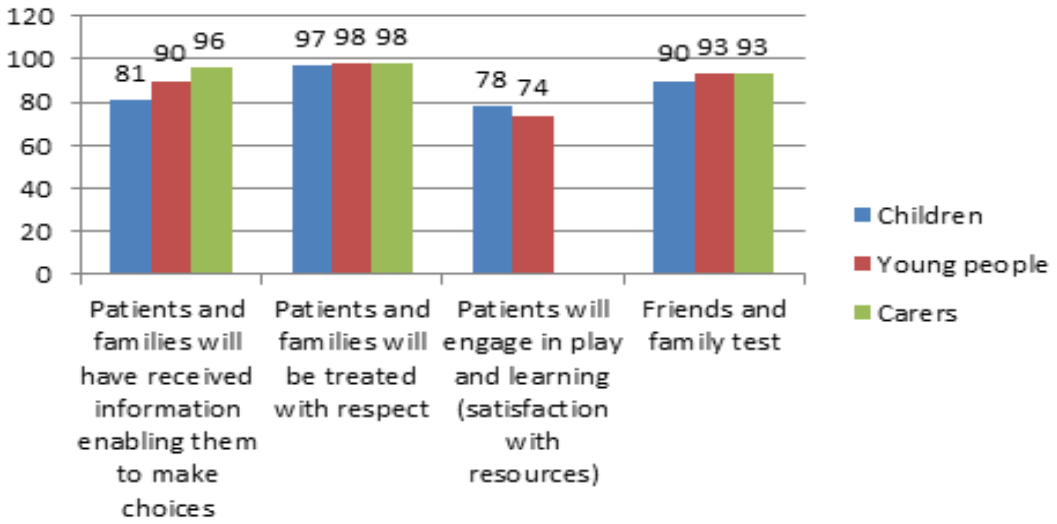
The following graph indicates the positive responses to the quality aims questions regarding the provision of information, whether patients and carers were treated with respect and the quality of play resource available – Graph A provides an initial view of the impact that the move to the new hospital has had.

Graph A

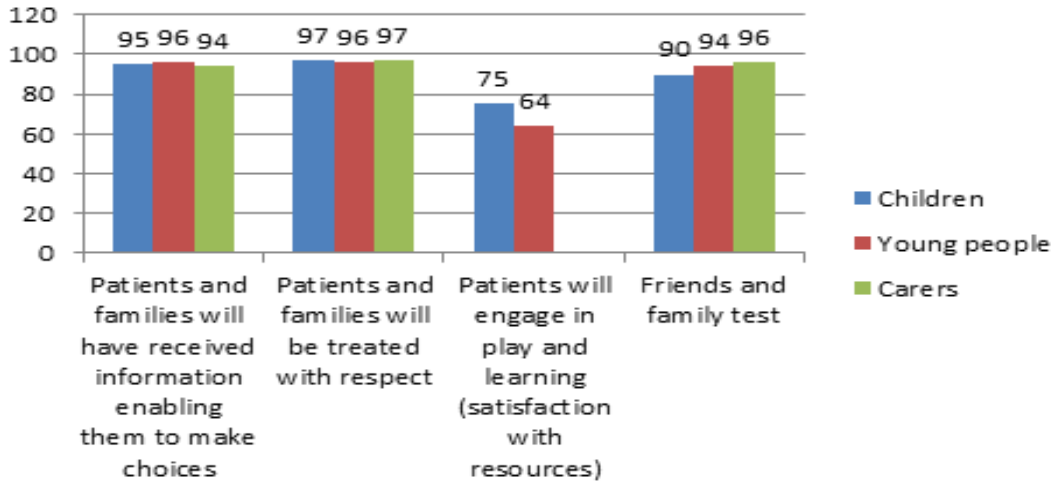


Graph B shows findings prior to the move and Graph C, the same information following the move to the new hospital. It remains disappointing that children show relatively low satisfactions scores in relation to play and learning resources and a more focussed piece of work will be instigated to address this.

Graph B - Before move to Children's Health Park



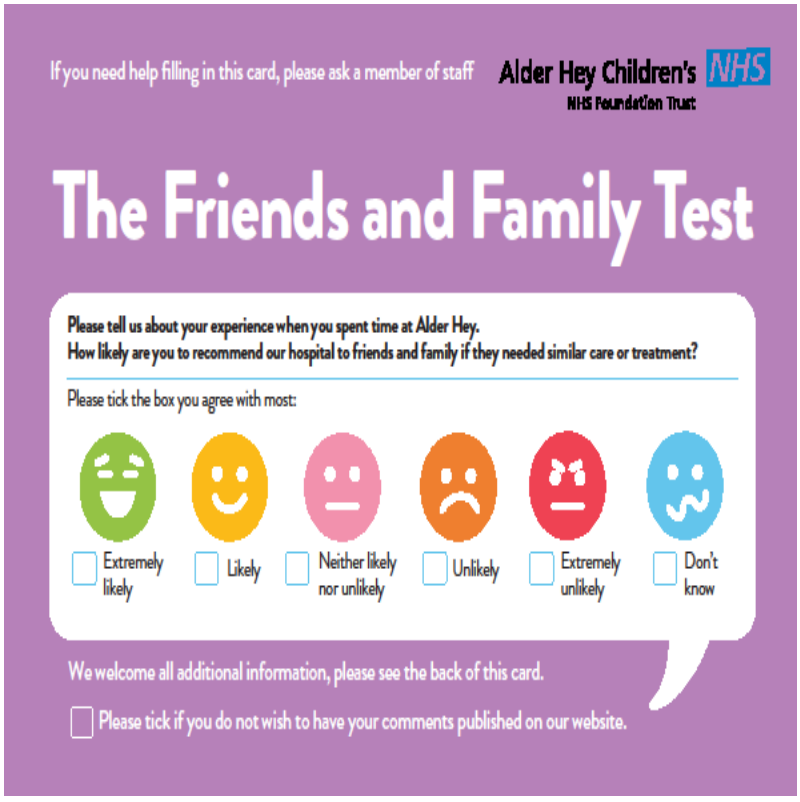
Graph C – After move to Children's Health Park



The Friends and Family Test

The Friends and Family Test (FFT) has been used in adult care since 2013 and has provided a wealth of information which is useful when improving and developing services. Patients are asked how likely they would be to recommend Alder Hey to friends and family if they required similar treatment or care.

From April 1st 2015 the FFT became a mandatory collection in children's services. The FFT was implemented with use of a card.



The card is available for all patients and carers attending the Trust. Additionally this data can be entered by patients and family members directly using the Trust web site.

The patients and families are also asked to report what was good about their stay and how we could improve their experience.

A total of 4327 responses have been recorded since the implementation in April 2015.

A Trust wide and ward/area specific report is published each month; this includes details of the free text responses. This data provides valuable information which can inform quality improvement plans.

The findings of the FFT are published on the NHS Choices web site and we have achieved on average, 93% of respondents indicating that they would recommend Alder Hey Children's Hospital to family and friends.

Management of Complaints and Concerns

The introduction of the Complaint Manager role within the Patient Experience team has influenced a more patient/carer focused process for responding to complaints and concerns. Additionally, the Patient Advice and Liaison (PALS) and Complaints team have adopted a more flexible process for addressing and monitoring concerns that is tailored to the complainants needs.

	2013/14	2014/15	2015/16	Comments
Formal complaints	166	134	70	This is a 58% decrease from 2013/14; this represents 96. Prompt resolution of concerns, early meetings with Clinical Business Unit staff and discussions with the Complaints Team has had a positive impact on resolving concerns which may have otherwise escalated to a formal complaint.
PALS	1248	1133	1246	Whilst there was a reduction in 2014/15 this was not sustained during 2015/16.

Improvements

- Pharmacy team reviewing the process for prompt issue of medication to take home.
- Appointment of Orthopaedic Consultant Surgeon to improve waiting times for surgery.
- Issues with complaints handling, poor service, resulted in the appointment of the Complaints Manager.
- Clinicians are all reminded of the Trusts "Values and Behaviours" framework which contains what are the expected behaviours of all staff employed by the trust including how we communicate to each other.

The Children & Young People's Forum

The Forum has been established for 10 years and membership consists of 3 groups:

- Children aged 7 to 11 years.
- Young people aged 11 to 18 years.
- Parents and carers.

The Forum meets every 2 months for formal meetings and in addition undertakes various activities.

The Forum agenda consists of items requested by members and Trust staff who are seeking children, young people, parents and carers views on existing services or when developing new services, initiatives or innovations.

Many of the Forum members have enjoyed participation in the planning of the new hospital as part of the Children's Health Park Design Group. The group has participated in engagement with contract bidders, building plans, interior design, assisting in recruitment, and planning of art for the internal and external environment for the new building.

The following is an overview of key projects from April 2015 through to March 2016.

- Supporting the Quality Improvement team in developing the Ward Accreditation Scheme.
- Participation in the development of the new Trust Quality Strategy.
- Learning about transition to adult services.
- Development of a leaflet to support recruitment to the Forum.
- Act as a judging panel for various information sources.
- Participation in recruitment process for senior clinical staff.
- Participation in a Safety Workshop.

Improvements

- Implementation of Friends and Family Test.
- Improved process for responding to complaints and concerns.
- Completion of National Patient Survey.
- An increase in amount of feedback regarding Quality Aims questions and FFT following move to the new site.
- Successful recruitment to Patient and Young people's Forum.

Future Plans

- Further development of systems and resources for collecting real-time and right time patient and family feedback.
- Continue to focus FFT feedback from community and mental health settings.
- Streamline process for collecting patient and family feedback into one central repository.
- Ensure collection of feedback is an integral part of the discharge process.
- Establish process for formally reporting the lessons learnt and action taken from findings of all feedback, in line with newly developed Quality Strategy.
- Further explore the process of data collection following discharge from hospital.
- Explore use of Patient Opinion to increase feedback from patients and families.
- Develop Parent and Carers Forum.
- Improve process for responding to actions identified from patient and carer feedback – to be incorporated into the new Ward Accreditation process.

Part 3: Future plans for improvement and statements of assurance from the Board.

QUALITY STRATEGY 2016 – 2021: "Quality is everybody's business, let's make it better….together"

The Trust has undertaken a review of its quality strategy to be taken forward over the next 5 years and beyond. This has been developed with input from our children, young people, carers and staff through wide consultation and engagement, and adopts a novel approach of combining strong clinical leadership with greater use of technology to secure widespread engagement of staff.

A clinical cabinet will be established that will provide a forum for discussion and prioritisation of improvement ideas, ensuring they impact positively on our previously agreed quality aims whilst taking account of the impact on our workforce and ensuring optimal use of our environment.

The Quality Aims will only be achieved with Trustwide staff engagement and understanding of the importance of everybody's role in the delivery of quality improvement.

The strategy will be a virtual, live, flexible entity with discussion forums, graphics, video blogs from staff and patients, and with hyperlinks to data, information and other reference material. Our children and carers will provide quarterly reports on quality through video blogs, giving them a voice in improving our quality systems and processes, so that the strategy becomes highly engaging and interactive.

The Trust has implemented an improvement methodology, 'Listening into Action', which provides a means of engaging staff in making change in a positive and sustainable way and will be a key vehicle for implementing the Quality Strategy, thus providing strong emphasis on empowering staff to influence and deliver a high quality service in an environment that supports the delivery of the best possible care, under the mandate…..'*quality is everybody's business, let's make it better…. together*'.

The new Quality Strategy the 2016-2021 will support the delivery of a number of quality initiatives in addition to the quality improvement priorities that the Trust Board have agreed. The key priorities for improvement have been derived from national and regional priorities, the Trust's performance against quality and safety indicators, risk trend analyses and patient and public feedback. The Trust has agreed to build on the 2015/16, improvement work by further:

1. Reducing harm to patients from a medication error.
2. Reducing harm to patients as a result of the development of a pressure ulcer.
3. Reducing harm from hospital acquired infections.
4. Further enhance children, young people and their parents/carers involvement in patient safety.

The Board will monitor progress against these priority areas through the Clinical Quality Assurance Committee. Progress will be reported to commissioners through Clinical Performance and Quality Group meetings, dedicated Healthwatch and Trust meetings and to patients and careers through a range of communication approaches and engagement activities. The Trust continues to develop the skills of the workforce to deliver quality improvements, through the utilisation of a variety of improvement methodologies.

Review of services

During 2015/16 Alder Hey has provided 27 NHS services. Alder Hey has reviewed all the data available to them on the quality of care in all of these services. The income generated by the NHS services reviewed in 2015/16 represents 100% of the total income generated from the provision of NHS services by Alder Hey for 2015/16.

Participation in clinical audits and national confidential enquires.

Clinical Audit is a key aspect of assuring and developing effective clinical pathways and outcomes.

National Clinical Audits are either funded by the Health Care Quality Improvement Partnership (HQIP) through the National Clinical Audit and Patient Outcomes Programme (NCAPOP) or funded through other means. Priorities for the NCAPOP are set by the Department of Health with advice from the National Clinical Audit Advisory Group (NCAAG)

During the reporting period 1st April 2015 to 31st March 2016, 11 National Clinical Audits and 4 National Confidential Enquiry covered NHS services that Alder Hey Children's NHS Foundation Trust provides.

During that period Alder Hey Children's NHS Foundation Trust participated in 100% National Clinical Audits and 100% National Confidential Enquiries of the National Clinical Audits and National Confidential Enquiries which it was eligible to participate in. The National Clinical Audits and National Confidential Enquiries that Alder Hey Children's NHS Foundation Trust was eligible to participate in during the reporting period 1st April 2015 to 31st March 2016 are contained in the table below.

The National Clinical Audits and National Confidential Enquiries that Alder Hey Children's NHS Foundation Trust participated in, and for which data collection was completed during the reporting period 1st April 2015 to 31st March 2016, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Participation in National Clinical Audits and National Confidential Enquiries during 2015/16

National Audit	Participation	% Cases submitted
Children		
Paediatric asthma (British Thoracic Society)	Yes	Submitted 70 cases, which was 100% of cases available
Paediatric intensive care (PICANet)	Yes	Submitted 959 records, which was 100% of cases available
Potential donor audit (NHS Blood & Transplant)	Yes	Cases for 2015/16 under review by NHS Blood and Transplant
Vital Signs (Children) (College of Emergency Medicine)	Yes	Submitted 100 cases, which was 100% of cases available.
Acute care		
Severe trauma (Trauma Audit & Research Network)	Yes	Submitted 150 cases, which is 100% of cases available
Cardiac		
Cardiac arrest (National Cardiac Arrest Audit)	Yes	Submitted 35 cases, which was 100% of cases available
Paediatric cardiac surgery (National Institute for Cardiovascular Outcomes Research (NICOR) Congenital Heart Disease Audit)	Yes	Submitted 742 cases, which was 100% of cases available
Cardiac arrhythmia (Cardiac Rhythm Management (CRM)	Yes	Submitted 30 cases which was 100% required for the audit sample
Long term conditions		
Ulcerative colitis & Crohn's disease (National IBD Audit) Biological Therapies	Yes	Submitted 30 cases, which was 100% of cases available
Paediatric Diabetes (RCPH National Paediatric Diabetes Audit)	Yes	Submitted 1013 records to the audit which was 100% of cases available
Renal Replacement therapy (UK Renal Registry)	Yes	Submitted 50 cases, which was 100% of cases available. (Transplants: 39, PD: 6, HD: 5)

National Confidential Enquiries	Participation	% cases submitted
Confidential Enquiry into Major Burns in Children (CEMBIC)	Yes	No applicable cases in 2015/16
Chronic Neurodisability - National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Yes	
Young People's Mental Health - National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Yes	26 cases submitted which was 100% of cases available. This study is ongoing into 2016-17
Suicide in children and young people (CYP) - National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) - University of Manchester	Yes	0 cases submitted
Perinatal mortality and morbidity confidential enquiries (term intrapartum related neonatal deaths) - MBRRACE-UK - National Perinatal Epidemiology Unit (NPEU)	Yes	22 cases submitted which was 100% of cases available.

Actions arising from National Clinical Audits

The reports of 6 National Clinical Audits were reviewed by the provider in the reporting period April 1st 2015 to March 31st 2016 and Alder Hey Children's NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

National Clinical Audit	Actions
Paediatric asthma (British Thoracic Society)	The national audit report for 2015/16 data has not been published yet.
Paediatric intensive care (PICANet)	The national audit report was reviewed and discussed on the Paediatric Intensive Care Unit (PICU). We are always commended for the quality of the PICANET data set.
Potential donor audit (NHS Blood & Transplant)	Awaiting publication of national audit report for 2015/16.
Vital Signs (Children) (College of Emergency Medicine)	Presented and discussed in the Emergency Department meeting in November 2015. Action/ Recommendation: • Poster in the Emergency Department hub to prompt: "Please document if your vital signs are abnormal and action taken" and/or include in local induction. • Consider giving card/sticker for ID badges with reference ranges for vital signs especially for those

National Clinical Audit	Actions
	new to paediatrics. • Poster in triage to prompt: “If your observations abnormal, flag/handover for repeat set in 60 minutes”. • Re-audit in 12 months.
Initial Management of the Fitting Child (College of Emergency Medicine)	The audit report was reviewed by the Emergency Department audit lead. Recommendations included the development of a fitting child proforma that could possibly help doctors to record all the relevant information. Written information at discharge should be given to families.
Severe trauma (Trauma Audit & Research Network)	For 2015 - 2016 Our data completeness and Data quality are both 95%+ Alder Hey Hospital serves as a Major Trauma Centre for Children for Cheshire and Merseyside, Lancashire and South Cumbria, North Wales and the Isle of Man. TARN data is the primary data source that supports the clinical governance of the Major Trauma Service within Alder Hey, and across the North West Children’s Major Trauma Network. A quarterly validated Clinical Dashboard enables key performance indicators across the service within Alder Hey to be monitored. This data is discussed at regular Trauma Support Group meetings to monitor trends, identify areas to improve and highlight areas of good practice. Three themed Clinical Reports are produced each year, one per year focussing on a specific injury group. These are presented and discussed at Trauma Committee and used to inform a quality improvement programme. These dashboards and reports are also shared through the North West Children’s Trauma Network Governance meeting whose membership includes Commissioners, Trauma Units, North West Ambulance Service, North West Air Ambulance as well as both Children’s Major Trauma Centres. TARN data from across the network is used to understand both clinical issues and the development of the network, helping to identify items for the workplan of the network. The data completeness measure has improved and data accreditation has remained high for Alder Hey, indicating that the information is reliable and providing confidence that discussions and decisions are based on an accurate representation of the trauma service. The data has provided evidence of the effectiveness of the trauma system resulting in a positive National Major Trauma Peer Review, and has shown compliance with Commissioning for Quality and Innovation (CQUIN) targets for complex lower limb injuries.

National Clinical Audit	Actions
Cardiac arrest (National Cardiac Arrest Audit)	Awaiting publication of national audit report for 2015/16.
Paediatric cardiac surgery (NICOR Congenital Heart Disease Audit)	The National Congenital Heart Disease Audit report was published on 04 April 2016. The audit report showed that the Trust achieved an overall Data Quality Indicator of 97.3% compared to 94.75% last year. An action plan was not required as the audit standards are being met.
National Cardiac Rhythm Management Audit (NICOR)	The national audit report was reviewed and Alder Hey is meeting the audit standards.
Ulcerative Colitis and Crohn's Disaese (National UK IBD Audit) Biological Therapies	The UK IBD audit is now transitioning to and merging with the IBD Registry, moving towards an improved system for data capture and quality improvement in IBD. The national report will be published in September 2016 with site reports distributed approximately two weeks prior. Once transition has taken place on-going collection of biological therapies data will be through the UK IBD Registry. We are registered to continue entering data to this component of the audit.
Diabetes (RCPH National Paediatric Diabetes Audit)	The quality of our data collection has improved and we are using the TWINKLE system (diabetes specific data collection software) for data entry. Data entry is continuing until June 2016.
Renal Replacement therapy (UK Renal Registry)	Awaiting publication of the national audit report for 2015/16.

Actions arising from Local Clinical Audits

There were a total of 163 local audits registered in the reporting period 1st April 2015 to 31st March 2016. There are 42 (26%) local audits completed. There are 107 (66%) audits that will continue in 2016/17. There are 4 audits not yet started and 10 audits have been cancelled (6%).

The reports of the completed local clinical audits were reviewed by the provider in the reporting period April 1st 2015 to March 31st 2016 and examples of the outcomes are listed below.

Local Audit	Actions
Audit of the efficacy and adverse effects of Lacosamide in Paediatric Epilepsy	The audit was presented at the International Child Neurology Congress at Amsterdam, May, 2016. This audit was a joint collaboration between The Royal Manchester Children's Hospital, The Royal Preston Hospital , The Great North Children's Hospital Newcastle and Alder Hey. Action/ Recommendation • Lacosamide can be prescribed for generalised epilepsy in children (apart from its use in focal epilepsy) given the efficacious results and side effect profile. • Lacosamide monotherapy can be considered in focal epilepsy, especially in older children (currently used as an adjunct in generalised seizures with favourable outcomes). • The results will be disseminated within the paediatric neurology departments of all 4 sites. • Re-audit in 3 years.
Audit of post-operative haemoglobin testing after primary corrective spinal deformity surgery	The audit was presented at the Trauma and Orthopaedics mortality and morbidity meeting in May 2015. Action/ Recommendation • Day 3 haemoglobin blood tests should be performed on a patient/ diagnosis specific basis to prevent unnecessary tests being performed. • Post-operative instructions have been changed to reflect this action plan. • Re-audit in 12 months.
Retrospective review of outcomes of patients with primary sclerosing cholangitis	The audit was discussed with the Gastroenterology lead in July 2015. Action/ Recommendation • No need for further action other than agree to collaboration for data collection on a multicentre basis so as to enhance the evidence behind the diagnosis, management and follow up of this rare morbidity. • No change in practice as uniform and good quality care according to limited evidence. • Re-audit in 12 months.
Direct inpatient admissions	The audit recommendations were agreed with the

Local Audit	Actions
unit audit	audit supervisor in August 2015. Action/ Recommendation • Change of culture of proactive rather than reactive. • Electronic list updating system. • Change of procedure: Phone the ward post huddle. Or even move away from AM and PM list distinction. • Evaluate the pre-operative information we provide and the understanding of parents. • Re-audit in 6 months.
360 degree feedback on the perception of Infection prevention and control team at Alder Hey	The audit was presented to the Infection Control Team in July 2015. Action/ Recommendation • In order to obtain meaningful data, this survey should be repeated and should try and capture feedback from all grades of staff. • This will require an agreed strategy between the Trust's Infection Prevention Control and Communications teams. • Re-audit in 12 months.
Evaluating patients' perspectives of the usefulness of an intervention-specific workshop, for cardiology patients and their families.	The audit was presented at the Psychology/Paediatric Cardiac Nurse Specialists meeting in September 2015. Action/ Recommendation • We have determined from this audit that there is limited interest in developing an intervention-specific workshop for this particular patient group. • The Paediatric Cardiac Nurse Specialists are taking a lead on this to consider the benefit of developing a condition-specific workshop for a wider client group. If this is successful, this may be repeated on a more regular basis. • No re-audit required.
National clinical audit of inpatient care for young people with ulcerative colitis This is a prospective audit of inpatients admitted for	The audit was presented at the National Inflammatory Bowel Disease (IBD) audit meeting in December 2015. Action/ Recommendation

Local Audit	Actions
management of ulcerative colitis	• PUCAI (Paediatric Ulcerative Colitis Activity Index) score proforma to be used by nurses and doctors – when available on Meditech 6. • To use steroid reduction scheme – when available on Meditech 6. • IBD clinics to identify patients for anaemia and Nobe protection – In the process of setting up clinics in 2016. • All IBD patients to go on the IBD registry. • Update the existing Trust policy to reflect steroid use and the steroid reduction scheme. • Re-audit in 12 months.
NICE Quality Standard 53 Anxiety Disorders Audit	The audit was presented at the Integrated Community Services Clinical Governance meeting in Decenber 2015. <u>Action/ Recommendation</u> • We should aim for 100% compliance with NICE quality standard 53. • Ensure more rigorous documentation of patient's or carer's consent for initiation of medication. • Patients are to be provided with a suitable leaflet about medication. • Unlicensed use of medication needs to be explained to the patients and carers and documented suitably in the case notes. • Re-audit in 12 months.
Re-audit of adherence to guidelines for the management of open fractures to the lower limb.	The audit was presented at the Department of Plastic Surgery in September 2015. <u>Action/ Recommendation</u> • Provide a joint Orthopaedics/Plastics Open tibial fracture (OTF) education session. • Review out of hour's service. • Emergency Department to bleep Orthopaedics and Plastics. • Provide paper versions of OTF pro forma • Display posters in the New Hospital Emergency Department and Theatres. • Re-audit in 12 months.
How good are we at coding	The audit was presented at the Community

Local Audit	Actions
our clinics?	Paediatric Clinical Governance meeting in November 2015. Action/ Recommendation • Develop a 'favourite list' of codes on the hospital system in liaison with the coding department that is succinct, comprehensive, user friendly and derived from ICD-10 codes / Snowmed. (International Statistical Classification of Diseases and Related Health Problems 10th Revision). • Train clinicians regarding coding on the new hospital system. • Provide regular reminders to clinicians if coding has not been completed. • Re-audit in 12 months.
Lithotripsy for paediatric renal stone clearance	The audit was presented at the Liverpool-Manchester Paediatric Urology Meeting in June 2015. Action/ Recommendation • To reconsider the use of lithotripsy in larger renal stone burdens. • Re-audit in 5 years.
Quality of BadgerNet documentation for PICU admissions	The audit was presented at the Paediatric Intensive Care Departmental meeting in September 2015. Action/ Recommendation • Improve the documentation of ward rounds. Responsibility for this may be transferred to Specialist Registrars (SpR) /Advanced Nurse Practitioner (ANP) looking after patient on the day. • Family communications may be included in daily day time reviews on BadgerNet. • Ensure family communication is recorded on BadgerNet soon after admission by the consultant /SpR/ANP. • Trigger on BadgerNet regarding named consultant allocation if not done after 14 days of stay. • Spot checks on standards of documentation quality to be carried out on a weekly basis

Local Audit	Actions
	especially focusing on family communication and ward rounds. • Share these audit results with other team members including SpR/ANP and new doctors during induction. • Re-audit in 6 months.
Post-operative urinary retention in orthopaedic frame application procedures in children: a baseline audit to establish local guideline for intraoperative catheterisation	The audit was presented at the Alder Hey Orthopaedic Departmental mortality and morbidity meeting in July 2015. Action/ Recommendation • For discussion at Alder Hey Orthopaedic Departmental Mortality and Morbidity meeting. • Re-audit in 12 months.
Service evaluation of the Chronic Fatigue Syndrome (CFS) service	The audit was presented at the CFS Multi-Disciplinary Team meeting in January 2016. The recommendations were agreed between the team. Action/ Recommendation • To reduce the waiting time for a first appointment by restructuring clinics. • To create a clear pathway for out of area referrals working with primary/secondary care teams as applicable to improve cohesion. • Case by case liaison to be considered for out of area needs and liaison. • To create a clear inpatient pathway in order to establish appropriate support for inpatient rehabilitation. • The team agreed to continue to deliver a consistently high standard of care, and in particular to continue to sensitively consider engaging young people in difficult, personal conversations and to respond to each individual's needs as appropriate. • No re-audit was required as the actions specified have been completed.
Management of clavicle fractures	The audit was presented at the Alder Hey Orthopaedic Departmental mortality and morbidity meeting in July 2015. Action/ Recommendation • Introducing a new referral pathway

Local Audit	Actions
	(September 2015). • Designing patient information leaflets for clavicle fractures. • Re-audit monthly for first 6 months after the new referral pathway has been implemented.
A Training Needs Analysis of Parents and Carers of Children & Young People with Complex Healthcare Needs to Develop Competencies for a Carer Skills Passport	The audit was presented at the Carer Skills Passport steering group meeting and to HENW (Health Education North West) as part of the Carer Skills Passport report in January 2016. Action/ Recommendation • Continue Carer Skills Passport development and implementation. • Develop and implement standardised training competencies training materials and assessment tools all as part of carer skills passport project. • On-going evaluation as part of the next phase of the project. • First formal reassessment to take place in approximately 2 years after implementation is completed.
Chronic Fatigue Service / Myalgic Encephalopathy (CFS/ME) audit	The audit was presented at the CFS/ME team meeting in January 2015. Action/ Recommendation • To reduce waiting time to 8 weeks. • To achieve 100% in ensuring screening bloods are undertaken for all patients. • Re-audit in 12 months.
Treatment of non- idiopathic clubfoot using Ponseti method	The audit was presented at the Alder Hey Registrar Alumni meeting in December 2015. Action/ Recommendation • Our results are comparable to international results. • Re-audit in 5 years.
Monitoring Urea and Electrolyte (U+E's) in patients on Intravenous Fluid Therapy	The audit was presented at the General Paediatrics Departmental audit meeting in March 2015. Action/ Recommendation: • Raise awareness of following guidelines through departmental meetings. • Inform the pharmacy team of any poor compliance/knowledge of guidelines so that they can emphasise during pharmacy training for junior doctors at the start of each rotation. • Changes to Senior House Officer (SHO)

Local Audit	Actions
	teaching. Ensure greater emphasis is placed on prescribing isotonic solutions and U+E monitoring during this session. • Re-audit in 6 months.
Audit on outcome following use of Unilateral Foot Abduction Orthosis	The audit was presented at the Orthopaedics Departmental audit meeting and the Alder Hey Alumni meeting in December 2015. Action/ Recommendation • To re-audit the compliance and outcomes following the use of the Denis Brown Boot. • Re-audit in 12 months.
Re-audit of NICE Quality Standard 48 Depression in children and young people	The audit is to be presented at an Emergency Department meeting in April 2016. Action/ Recommendation • We should aim for 100% documentation of diagnosis, severity of depressive episodes. • We should aim for 100% documentation of Risk Assessment. • All patients diagnosed with depression should be given age appropriate information about diagnosis and this should be documented in case notes. • Consent to treatment should be recorded in all cases. • Risk management, including discussion around an appropriate place of safety if indicated should be documented. • Re-audit in June 2017.
Association for Perioperative Practitioners (AfPP) Quality Management System in Theatres	The audit was presented at the Surgical Cliniical Business Unit Board meeting and the Clinical Quality Steering group in August 2015. Action/ Recommendation • The Audit report is shared with the Surgical Clinical Business Unit (CBU) Board and the Clinical Quality Steering group. • A comprehensive action plan is drawn up which provides solutions and timescales for all identified gaps, assigning a priority level to each action to support focus on key issues. • A Task and Finish group approach is taken to addressing the current gaps.

Local Audit	Actions
	• Repeat the audit with the same tool in 6 to 9 months' time following the move to the Children's Health Park and then on a regular 12 month basis.
Impact analysis of the introduction of the Carer Skills Passport	The Initial audit report was presented to HENW (Health Education North West) as part of the Carer Skills Passport project meeting in January 2016. Further work to finalise the report and recommendations is in progress. Action/ Recommendation: • Further development and implementation of standardised competencies and training as part of the Carer Skills Passport project. • Development of a new policy to support the implementation of the Carer Skills Passport. • Development of new training competencies, a standardised training package and assessment protocol to support implementation of the Carer Skills Passport. • Re-audit after implementation of the Carer Skills Passport. • Further work will be undertaken as part of the implementation process and after completion in 2 years.
Re-audit of the completion of Liverpool Upper-limb Fracture Assessment (LUFA) forms in the Orthopaedic department of Alder Hey Children's Hospital	The audit was discussed at the Orthopeadic departmental meeting with the consultant supervisor in January 2016. Action/ Recommendation: • To make changes to the induction programme for Orthopaedics junior doctors. • Recommend an audit of completion rates between different staff grades. • Re-audit in 6 months.
An audit of knowledge, attitude and practice of completion of Liverpool Upper-limb Fracture Assessment (LUFA) forms at Alder Hey Childrens Hospital	The audit findings were discussed with the audit supervisor. This was a snap shot of prescribing practice over 4 to 6 weeks. The evidence was not strong enough to warrant changes to practice at this stage. Action/ Recommendation: • To make the induction process for junior doctors more robust LUFA forms are to be placed in the Orthopaedic SHO "Man-Bag". (This action has already been implemented).

Local Audit	Actions
	• LUFA forms to be placed in the ward with the case notes. • Re-audit in 6 months to monitor LUFA use.
Patient Satisfaction Audit for Sleep Unit (January-September 2015)	The audit was presented within the Sleep Unit in October 2015.and forwarded onto the wider team via email. <u>Action/ Recommendation:</u> • The patient feedback highlighted issues with the Sleep Unit in its original location on the old Alder Hey Hospital site, including lack of ensuite facilities and the need to vacate the unit early the following morning. • These issues have been addressed since the sleep unit was moved to the new hospital. • A leaflet has been produced to send out to all the patients and their families to give them feedback on the survey and to give them details of our new unit. • Re-audit in 12 months.
Awareness of paediatric nurses about management of hypoglycaemic children	The audit was presented at the Endocrine department meeting in January 2016. <u>Action/ Recommendation:</u> • To set up a mandatory teaching session for all staff nurses on “Essential information on how to manage hypoglycaemia”. • Develop written guidance on the emergency management of hypoglycaemia. The endocrine team will take a lead in this regard. • Re-audit in 6 months.
Refractions from Secondary Visual Screening Service	The audit was presented at the Ophthalmology Department meeting. The results were discussed with line manager, contents agreed and then forwarded to service managers and consultants in December 2015. <u>Action/ Recommendation:</u> • A problem/system orientated approach is needed to verify and analyse the cause of the failure of patients to receive a timely appointment or indeed any appointment with the Optometric service. • There is a requirement for the efficient

Local Audit	Actions
	utilization of human, financial and other resources including information systems. All this requires a collaborative approach and consideration should be given to the establishment of a named service lead in Optometry to liaise with other service providers • Re-audit in 12 months.
Management of paediatric femoral shaft fractures	The audit was presented at the Alder Hey annual registrars meeting in 2015. <u>Action/ Recommendation:</u> • The audit demonstrated there is still debate in the literature and no one method of management was demonstrated to be superior. • The patient numbers involved in the audit were too small to have a major significance. • Re- audit after a set number of sub muscular plating's have been undertaken.
Follow-up Chest X-ray in Simple Community Acquired Pneumonia: an Audit of Practice and Outcome.	The audit was presented at the Radiology Departmental meeting in February 2016. <u>Action/ Recommendation:</u> • Our results demonstrate the validity of the guidelines and literature review that a routine follow-up Chest X -Ray is not necessary or indicated in children with simple community acquired pneumonia managed in the community. • Follow-up chest X- Ray only to be performed on patients with radiological indication (round pneumonia, collapse) and clinical indication; ongoing or worsening symptoms after treatment. • To document indication for follow-up chest X-Ray on the initial chest X-Ray (to implement in practice from now on). • If possible, to book an appointment for follow-up chest X-Ray in 4-6 weeks, if not, then write to GP to request follow-up chest x-ray in 4-6 weeks.

Local Audit	Actions
	• Re-audit in 12 months.
Alder Hey Rainbow – Initial Health Assessment (IHA) Audit	The audit was presented at the Community Team meeting in February 2016 Action/ Recommendation: • To develop a new pathway for Child Protection examination to IHA (initial health assessment).
Rate of Prescribing Errors in Alder Hey pre and post introduction of Meditech 6.	The audit was presented at the Medication Safety Prescribing Committee meeting.in November 2015. Action/ Recommendation: • Provide monthly feedback to prescribing clinicians on significant/serious errors. • Meditech V6 prescribing training to include highlighting system defaults which may lead to a prescribing error. • Ensure documentation of prescribing errors is robust including highlighting the potential severity of the error. • Re-audit in 3 months.
Audit on treatment of viral warts in paediatric patients	The audit was presented at the Dermatology departmental audit meeting in January 2016. The key points audited were: the number of treatments (Cantharidine, the strength of treatments used, discussion of side effects and whether a patient information leaflet was distributed. Action/ Recommendation: • Introduction of a policy regarding the treatment of viral warts is to be implemented. • Improve the documentation on the prescription charts. • Improve the documentation of the discussion regarding the adverse effects of Cantharidine. • Improve the documentation of patient information being given. • Nursing staff are now documenting on the prescription charts when a patient is clear from viral warts and when they have been discharged from treatment. • Re-audit in 2 to 3 years.

Local Audit	Actions
Spectrum of Children's Palliative Care audit	Audit completed and writing up. Collation of data with other sites is in progress. Action/ Recommendation: • A new policy will link to nursing use of Spectrum of Palliative Care needs as part of the nursing assessment for activity of daily living 12 on Meditech 6 nursing documentation section. • Create a new guideline on identifying patients with palliative care needs. • Develop training for the implementation of routine identification of patients with palliative care needs. • Re-audit once an action plan has been implemented and embedded.
Audit of management of radial neck fractures using elastic stable intramedullary nailing	The audit is due to be presented at the Orthopaedic Department mortality and morbidity meeting in May 2016. Action/ Recommendation: • To not use sharp tipped nails. • To not use blunt tipped nails as only a fixation tool if not used to effect reduction. • To follow up patients weekly for at least 6 weeks. • Re-audit in 2 years.
Management of Child Tuberculosis Contacts: Impact of proposed new NICE guidelines	The audit was a review of the proposed NICE guidance. Action/ Recommendation: • Implementation of 2015 NICE guideline will increase the requirement for IGRA tests. Relevant resources to meet increased demand to be identified. • No re-audit required.
Management and outcome of high grade blunt renal trauma at Alder Hey over the last 10 years	The audit was presented at the Alder Hey Surgical Department audit meeting in January 2016. Action/ Recommendation: • No changes were recommended as our current practice is in line with National guidelines. • Re-audit in 3 years.
An audit into the practice of	The audit was presented at the Urology

Local Audit	Actions
chemotherapy ototoxicity monitoring in paediatric audiology.	Departmental audit meeting in January 2016. Action/ Recommendation: • Update the information we provide to parents and patients with renal trauma. • Re-audit in 2 years.
Audit of Audit (Trauma and Orthopaedic Department)	The audit results were discussed with the audit supervisors at the Trauma and Orthopaedic departmental meeting in March 2016. Action/ Recommendation: • Recommend changes to the training agreement between Clinical Supervisors and the trainee. • Recommended changes to the custom and practice of audit and quality improvement projects will need to be reviewed with the consultant body. • Re-audit in 2 years.
Audit of the use of methotrexate in inflammatory bowel disease patients.	Presented to the Gastroenterology audit lead and the Inflammatory Bowel Disease Specialist Nurses in a local gastroenterology meeting in March 2016. Action/ Recommendation: • Ongoing recommendations are being formulated around a new protocol for the follow up of patients on methotrexate. • Re- audit in 12 months.
Orthopaedic ward round documentation audit - October 2015	Presented and discussed in the daily departmental trauma meeting in January 2016. Action/ Recommendation: • The audit recommends that ward rounds should always have a registrar present to lead them. • A mobile computer should be made available by the ward staff for the doctors to use on the ward round. • A nurse should either be available to accompany the doctors on the ward run in their pod or to update the doctors regarding the patients on arrival at the pod. • A ward round pro-forma should be considered to prompt full and thorough documentation. • Re-audit in 3 months.
An audit for BAPRAS/BOA standards for management of open fractures of the lower limb. (British Association of Plastic, Reconstructive and Aesthetic	Presented and discussed at the Orthopaedic team meeting in March 2016. Action/ Recommendation: • Raise awareness of the guidelines in the Emergency Department. To include a BAPRAS/BOA tick box in the existing open

Local Audit	Actions
Surgeons). (British Orthopaedic Association).	fracture pathway, in order to improve the quality of care delivered. • Improve communication with plastics regarding first operation. Include Plastic Specialist Registrars in Trauma Call to ensure plastic participation in first assessment. An early Plastic input would help operation planning. • Early pre-operation planning would result in an appropriate and definite cover within 72 hours. • As part of the Good Surgical Practice, post-operative notes should be printed out and physically kept in the notes. This would improve data collection and clarify the discharge plan. • Following antibiotic guidelines at the first assessment in the Emergency Department and Theatre at induction and at first debridement would improve quality of care but would also help meeting the BAPRAS standards for treatment of lower limb open fracture. • No re-audit required as this was already a re-audit to complete the cycle.
Incidence of Hypercalcaemia in patients with posterior urethral valves (PUV)	Presented and discussed in the Nephrology Department meeting in December 2015. <u>Action/ Recommendation:</u> • It would be good practice for clinicians to check adjusted calcium of infants with PUV, especially in the 1st and 2nd weeks of life. This would to allow early diagnosis and treatment of possible hypercalcaemia, which may accelerate improvement of renal function, reducing the risk of long term complications. • No re-audit required.

Participation in clinical research

The number of patients receiving NHS services provided or subcontracted by Alder Hey Children's NHS Foundation Trust (Alder Hey) in 2015/16 that were recruited to participate in NIHR Portfolio adopted clinical research was 2322.

All research is governed by the EU Clinical Trial Directive, UK ethics committees and the Trusts clinical Research Business Unit who carry out safety and quality checks to provide organisational permission. This is a highly robust mechanism that ensures oversight of every research study in the organisation. International Research, Education and Innovation is one of the Trust's four strategic pillars of excellence and as such elicits full support of the Board of Directors. Furthermore, the Alder Hey/University of Liverpool refreshed ten year research strategy states that "Every child (should be) offered the opportunity to participate in a research study / clinical trial". The strategy is patient focused and supports research from all disciplines. The Trust is a member of Liverpool Health Partners (LHP), a consortium of seven hospitals, the University of Liverpool and the Liverpool School of Tropical Medicine working together to provide a world class environment for research and health education across a regional footprint. As a significant stakeholder in LHP, Alder Hey demonstrates a strong commitment to contributing to evidence-based, cutting edge healthcare aimed at improving quality of care whilst holding patient safety, dignity and respect at the centre of everything we do. One of the main strengths of Liverpool is that of pharmacology – developing better safer medicines for children and young people and contributing to the personalised medicine agenda. Being an organisation undertaking high quality patient centred research means that Alder Hey contributes to the health and wealth of Liverpool and the UK as a whole as well as having an international impact on treatments developed for children. The infrastructure of expertise available at Alder Hey for setting up and successfully delivering clinical research are led and managed by a dedicated team who form the Clinical Research Business Unit (CRBU). The CRBU employs 40 research nurses, supports approximately 226 studies at any one time and rigorously manages performance to ensure high quality delivery to time and target. Alder Hey has an excellent track record of recruiting the first patient globally to clinical trials, demonstrating that the organisation is at the forefront of drug development in paediatrics.

Our clinical staff and associated academics lead and contribute to studies of the latest and new treatment options, genetic profiling of diseases and research looking at drug safety including adverse drug reactions (side effects).

Alder Hey was involved in recruiting patients to 193 open, NIHR portfolio adopted clinical research studies and 75 non-portfolio studies during 2015/16, which is significant for a Trust of its size. Whilst some studies report outcomes fairly quickly most will not be ready for publication for a few years. The majority were research in the area of Medical Specialties reflecting the prevalence of available research studies locally and nationally.

01/04/2015 to 31/03/2016				
	NIHR Studies	**Number of Participants**	**Non-NIHR Studies**	**Number of Participants**
SG1 *(Oncology, Haematology, Palliative Care)*	38	190	13	20
SG2 *(Nephrology, Rheumatology, Gastro, Endocrinology, Dietetics)*	50	173	10	136
SG3 *(Respiratory, Infectious Diseases, Allergy, Immunology, Metabolic Diseases)*	31	654	11	14
SG4 *(A&E, Gen Paeds, Diabetes, Dermatology, CFS/ME)*	10	370	5	15
SG5 *(CAMHS tier 3 & 4, Psychological Services & Dewi Jones)*	5	0	1	0
SG6 *(Comm. Child Health, Safeguarding, Social Work Dept., Comm Clinics, Neurodisability Education, Fostering, Adoption, Audiology)*	2	1	4	51
SG7 *(PICU, HDU, Burns)*	3	18	9	36
SG8 *(Theatres, Daycase Unit, Anaesthetics Pain Control)*	2	2	1	8
SG9 *(Gen Surgery, Urology, Gynae, Neonatal)*	13	41	1	5
SG10 *(Cardiology, Cardiac Surgery)*	2	0	1	0
SG11 *(Orthopaedics, Plastics)*	2	52	3	22
SG12 *(Neurology, Neurosurgery, Craniofacial, LTV)*	27	99	5	9
SG13 *(Specialist Surgery, ENT, CL&P, Ophthalmology, Maxillofacial, Dentistry, Orthodontics)*	4	80	3	14
SS1 *(Radiology)*	1	0	3	3
SS2 *(Pathology)*	0	0	0	0
SS3 *(Pharmacy)*	1	295	1	0
SS4 *(Therapies, EBME, Central Admissions, Bed Management, Medical Records, Generic Outpatients)*	0	0	0	0
NON-CBU	2	0	2	12
CNRU	0	0	1	0
Non Classified	1	0	1	0
TOTAL	193	1977	75	345

The Quality Report deals with research activity during the 2015/16 period. In addition to this, the CRBU published performance data on the Trust website indicating the time it takes to set up and study and the time taken to recruit the first patient once all permissions have been granted. Alder Hey performs well in this respect. Furthermore, over 80% of studies conducted at Alder Hey recruit the agreed number of patients within a set time and to agreed targets (100% for commercial research). In September 2012 Alder Hey opened a National Institute for Health Research Clinical Research Facility (CRF). This was a capital project supported with investment from the Trust and is a clinical area utilised purely for research patients providing a dedicated research environment. This resource helps facilitate research by providing a bespoke location for research on a day to day basis and has successfully been used to care for research participants overnight who need regular intervention or tests on a 24hour basis. One of the many advantages of having a fully operational CRF is that it will enable investigators to not only undertake later phase research studies but also to undertake more complex and earlier phase studies (Experimental Medicine types of activity) dealing with developing new cutting edge medicines and technologies which are often lacking in children's healthcare. This has become the main focus of the CRF over the last few years. The CRF will lead to improvement in patient health outcomes in Alder Hey demonstrating a clear commitment to clinical research which will lead to better treatments for patients and excellence in patient experience.

There were over 350 members of clinical staff participating in research approved by a research ethics committee at Alder Hey during 2015/16. These included consultants, nurse specialists, pharmacists, scientists, clinical support staff and research nurses from across all Clinical Business Units.

Over the past four years the Trust has witnessed a growth in commercially sponsored studies. There are over 40 commercial studies open to recruitment and much focus on the use of novel monoclonal antibodies (mAbS) or disease modifiers. mAbS have been used primarily in Rheumatology and Oncology but are becoming available in other sub-specialities such as Respiratory Medicine and Diabetes. They work by acting on the immune system to overcome the cause of the disease rather than treating the symptoms. Duchenne Muscular Dystrophy research has grown with new compounds being developed that address the root cause of the disease. Significant quality of life improvements have been witnessed, particularly in rheumatology patients treated with mAbS leading to increased mobility and a reduction in pain and inflammation. These drugs are now being licensed for use in children for the first time ever. Several patients at Alder Hey have been the first global recruits into some studies and as such this bodes well as it demonstrates Alder Hey's commitment to supporting the speedy set up of clinical trials. The Trust has an established critical mass of research activity in Pharmacology, Oncology, Rheumatology, Infectious Diseases, Respiratory, Endocrinology/Diabetes, Critical Care and Neurosciences but is witnessing a growth in research activity in Gastroenterology, General and Neuro Surgery Nephrology, Emergency Medicine and Community Paediatrics.

Innovation projects such as those developing devices are also now supported by the CRBU. This is the beginning of research and innovation coming together to share

expertise and to maximise engagement with small medium UK enterprises and large global companies.

Several of our consultants have been commended on their contribution to research and the Trust is acknowledged by the National Institute for Health Research Clinical Research Network as one of the top performing Trusts.

For more information on the research portfolio at Alder Hey please visit www.alderhey.nhs.uk/research

Use of the Commissioning for Quality and Innovation Framework (CQUIN) payment framework

Alder Hey's income in 2015/2016 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework because the Trust adopted the Default Tariff Option for that year.

Statements from the Care Quality Commission (CQC)

Alder Hey is required to register with the Care Quality Commission and its current registration is in place for the following regulated activities: diagnostic and screening procedures, surgical procedures, treatment of disease, disorder or injury and assessment or medical treatment for persons detained under the 1983 Act. Alder Hey remains registered without conditions.

The Care Quality Commission has not taken any enforcement action against Alder Hey during 2015/16.

Alder Hey has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2015/16:

- A focused re-inspection on 15th and 16th June 2015 to check whether improvements had been made following the inspection May 2014 and in addition:
  - An inspection of Child and Adolescent Mental Health Service wards
  - An inspection of Specialist community mental health services for children and young people
  - An inspection of the Trust's diagnostic services as part of the Outpatient service

- Focused inspection of the new build on 22nd September 2015 prior to its opening in October to review the building, environment and process for transfer into the new hospital, based upon the most relevant parts of the 'safe' and 'well-led' domains.

During the focused re-inspection in June 2015 the CQC inspected the following core services in full:

- Critical Care
- Outpatients and diagnostic imaging services

- Transitional services

and looked at the 'Safe' domain in the following services:

- Medical care
- Surgery

An overall rating of 'good' was given, with an 'outstanding' rating for the 'caring' domain.

The inspection of Dewi Jones Child and adolescent mental health wards resulted in an overall rating of 'good', with an 'outstanding' rating for the 'caring' domain. The inspection of Specialist community mental health services for children and young people resulted in an overall rating of 'requires improvement', with 'good' ratings for the 'effective', 'caring' and 'well led' domains.

The inspection that took place prior to the move to the new hospital in September 2015, did not assign any ratings. Three recommendations for actions the Trust should take were made focusing on: security risk assessments, the female changing area in Theatres and the nurse call system in Intensive Care. These have subsequently been actioned. The inspection also noted a number of areas of outstanding practice.

Data Quality

Alder Hey Children's NHS Foundation Trust submitted records during 2015/16 to the Secondary Users service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

- Which included the patient's valid NHS Number was: 99.49% for admitted patient care; 99.66%for outpatient care; and 99.26% for accident and emergency care.
- Which included the patient's valid General Medical Registration Code was: 100% for admitted patient care; 99.99% for outpatient care; and 99.96% for accident and emergency care

Alder Hey Children's NHS Foundation Trust will be taking the following actions to improve data quality:-

- A suite of data quality reports will continue to be run daily and weekly to ensure data is monitored and corrected, where necessary.
- Work closely with the Information Dept. to identify any data issues or areas of data weakness, which will be investigated and remedial action agreed
- Fulfil a schedule of regular data audits, reporting findings to relevant managers and monthly Data Quality committee
- Develop and utilise a Data Quality dashboard, which includes key data items from throughout the patient pathway, to monitor data quality and facilitate improvement
- Workshops and refresher training sessions arranged to ensure staff are fully aware of the importance of Data Quality and the integrity of the data is accurate at source

- A review of the Trust's data quality framework will form part of a broader internal refresh of quality, resource and governance, to consolidate 'best practice.

Information Governance Toolkit attainment levels

Alder Hey Children's NHS Foundation Trust Information Governance Assessment Report overall score for 2015/16 was 83% and was graded as satisfactory (green).

Clinical Coding Error Rate

Alder Hey Children's NHS Foundation Trust was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission and the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were:

- Primary Diagnoses Incorrect 7.5%
- Secondary Diagnoses Incorrect 14%
- Primary Procedures Incorrect 7 %
- Secondary Procedures Incorrect 13%

The results should not be extrapolated further than the actual sample audited and the services audited during this period included:

- 200 Random Finished consultant episodes.

Performance against national priorities

The Trust achieved all national priorities as indicated below. The performance of Alder Hey against the Compliance Framework 2015/16 is demonstrated below:

Target or Indicator (per 2013-14 Risk Assessment Framework)	Threshold	National Performance	Qtr1	Qtr2	Qtr3	Qtr4
Summary Hospital level Mortality Indicator (SHMI)[1]			n/a	n/a	n/a	n/a
C. Difficile Numbers – due to lapses in care			0	0	0	0
C. Difficile - Rates per 100,000 Bed days		6.9	0	10.8	0	0
18 Week RTT Target Open Pathways (Patients still waiting for Treatment	92%	92.6%[2]	92.2%	92.1%	92.2%	92.1%
All cancers: two week GP referrals	100%	94.8%[3]	100.0%	100.0%	100.0%	100.0%
All cancers: one month diagnosis (decision to treat) to treatment	100%	97.8%[3]	100.0%	100.0%	100.0%	100.0%
All cancers: 31 day wait until subsequent treatments	100%	97.8%[3]	100.0%	100.0%	100.0%	100.0%
A&E - Total time in A&E (95th Percentile) <4 hours (This data has been subjected to a cleansing exercise and therefore may differ from data previously submitted to the	95%	92.8%[4]	95.8%	95.3%	82.8%	84.5%

Trust Board)						
Target or Indicator (per 2013-14 Risk Assessment Framework)	**Threshold**	**National Performance**	**Qtr1**	**Qtr2**	**Qtr3**	**Qtr4**
Readmission rate within 28 days of Discharge		0-15 Years: 16 Years & over:	7.0% 3.6%	6.9% 8.2%	8.2% 5.7%	7.4% 7.4%
% of Staff who would recommend the trust as a provider of care to their family or friends			86%	84%	Not required	88%
Staff Survey results: % staff experiencing harassment, bullying or abuse from staff in the last 12 months		23%	24%			
Staff Survey results: % believing that trust provides equal opportunities for career progression or promotion) for the Workforce Race Equality Standard		88%	82%			
Financial & Service performance Ratings[5]			4	2	2	2
Rate of Patient Safety Incidents per 1000 bed days			54	63	78	82
Patient Safety Incidents and the Percentage that result in Severe Harm Death			0 0%	1 0.1%	2 0.2%	2 0.1%

[1]Specialist Trusts are excluded from SHMI reporting
[2] National Performance based on most recent published data for April 2015- Jan 2016.
[3] National Performance is based on most recent published Quarter 3 data for 2015/16. Alder Hey had 1 breach of the Children's Cancer standard (1 month from Referral to Treatment) and this was as a result of delay for clinical reasons
[4] A&E National Performance based on most recent published data for April 2015- Jan 2016.
[5] Quarter 1 reported under the old CSR ratio. From Quarter 2 rating has been reported under the new FSRR ratio.
The Trust considers that this data is as described for the following reasons.

- The indicators are subject to a regular schedule of audit comprising completeness and accuracy checks which are reported monthly to the Performance Management Group
- The Data Quality Audit Plan will increase the frequency and scope of audits for 2014-15.

The Trust is taking the following actions to improve the scores and the quality of its services, by

- For RTT Performance – increasing capacity and improving waiting times for first appointment.

For all other indicators the trust is maintaining and improving where possible, current performance.

Statements on the Quality Report by Partner Organisations

Commentary from Governors

'The draft quality report represents a fair reflection of my understanding of the Trust's approach to and participation in a broad range of quality activities. I believe the report represents a Trust wide focus on delivering safe and effective care for our patients and a desire for continuous improvement and innovation.

In particular, the partnerships with Liverpool University and the Local Authority and with international companies such as Sony and the Virtual Engineering Centre are to be welcomed for bringing relevant external influence which should make a positive contribution to developments in the way our services are delivered.

In terms of recent achievements, the recruitment of 250 additional nurses, from a small pool of appropriately qualified specialist nurses, is a real achievement as is the reduction in medication errors which result in harm and also those which cause moderate/severe harm.

The range of clinical audits and research activity in which our staff participate is a clear demonstration of a Trust wide desire to bring about positive change in the way we deliver care.

As a governor, I welcome the report and support the Trust's approach to ongoing quality improvement.'

Kate Jackson, Lead Governor

'I have read through the Quality Account 2015/2016 and can confirm that this provides a sound reflection of the ongoing Hospital activity I have been aware of in my role as Parent and Carer Governor. With new staff, new premises and new systems eg Electronic Patient Record, this period has been one of unprecedented change for the Trust. The pursuit of quality has remained central to the work of the Trust and has provided continuity and reassurance throughout this exciting transitional period.'

Pippa Hunter-Jones, Parent and Carer Governor

Commentary from Healthwatch Sefton

'Healthwatch Sefton welcomes the opportunity to comment on this Quality Account and would like to thank the Trust for their open and transparent way of working. Regular quarterly meetings have been held with the Deputy Director of Quality and the lead officers for patient experience and equality.

The readability of the account is helped by the inclusion of a simple process for showing the quality achievements made by the Trust since 2014-15. Similar to last year we would welcome the inclusion of a glossary.

The Trust should be congratulated on the achievement of the safe move to 'Alder Hey in the Park'. Healthwatch Sefton has received a tour of the new building.

Work undertaken on medication safety is noted. There has been a decrease from 20% to 8% of reported medication incidents of harm. The increase of 119% in medication incident reporting shows that an open and honest culture is further embedded. The appointment of a nurse and a pharmacist as medication safety officers has been a positive step. We look forward to the app which will allow patients to have a better understanding of their medications.

Work to increase children, young people and their parents/carers involvement in patient safety has been shared with us regularly, including updates on the co-development of the 'STAR' ward accreditation scheme.

We note the 5% increase in grade 2 hospital acquired pressure ulcers and the grade 4 pressure ulcer which occurred during this period. The target to reduce hospital acquired grade 3 pressure ulcers by 50% was met with 67% achievement. It is good to see improvements being put in place which includes staff training and the appointment of a full time Tissue Viability Nurse.

It was disappointing that there have been 3 MRSA bacteraemia against the target of 'zero'. There were 2 clostridium difficile infections although we note not due to lapses in care. It is good to see the development and implementation of improvement plans to address infection control.

The CQC inspection of specialist community mental health services for children and young people and the resulting overall rating of 'requires improvement' was noted. It would have been good to read about the work which has been undertaken to improve this service.

In reviewing responses from the Friends and Family test, 93% of respondents indicated that they would recommend Alder Hey Children's Hospital. It would have been useful within the account to have a summary of suggestions for improving experiences from patients and families which inform quality improvement plans.

The introduction of a complaint manager role within the patient experience team has lead to a more focussed and integrated way of responding to complaints and concerns. During September 2015, the complaints manager worked in partnership with Healthwatch Sefton to help resolve a communication issue for a parent in Sefton with the result being support for the parent/Trust from the Sefton CVS Community Volunteer Bi-Lingual Project. It is good to see that the team is working in a more flexible and partnership approach to address complainants needs.'

Diane Blair, Manager Healthwatch Sefton

Commentary from Halton Clinical Commissioning Group

'Many thanks for the submission of the Quality Report 2105-2016; this letter forms the response to this report from Halton Clinical Commissioning Group. Liverpool CCG are the coordinating commissioner for the trust on behalf of NHS Halton CCG with good reporting and feedback via the contractual processes.

NHS Halton CCG congratulates the trust on the safe and successful move into Alder Hey in the Park and the delivery of a number of key quality priorities. The report provides good information in the relation to engagement of children and young people in the design of their care and highlights some innovative approaches to engagement and involvement of which the trust can be rightly proud.

The CCG notes the plans for quality improvement in 2016-2017 and is supportive of the plans; we are particularly interested in the plans for transition to adult care. We look forward to working with the trust in 2016-2017 ensuring safe and effective care for the children.'

Jan Snodden, Chief Nurse, NHS Halton CCG

Statement of Directors' responsibilities in respect of the Quality Report

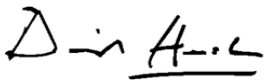
The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.
Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.
In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2015/16;
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
    - Board minutes and papers for the period April 2015 to March 2016
    - Papers relating to Quality reported to the board over the period April 2013 to March 2016
    - Feedback from the commissioners dated 11th May 2016
    - Feedback from governors dated 3rd May 2016
    - Feedback from Local Healthwatch organisations dated 16th May 2016
    - The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated April
    - The 2015 national staff survey dated March 2016
    - The 2014 National Inpatient and Day Case Survey dated March 2015
    - The 2015 Young Emergency Department Survey dated July 2015
    - The 2015 Young Outpatient Survey dated July 2015
    - The Head of Internal Audit's annual opinion over the trust's control environment dated April
    - CQC Intelligent Monitoring Report dated May 2015
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor.gov.uk/annualreportingmanual).

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board.

NB: sign and date in any colour ink except black

..23rd May 2016.....Date.....  .....Chairman

..23rd May 2016 ...Date.....  .....Chief Executive

ANNUAL ACCOUNTS

FOREWORD

The accounts for the year ended 31st March 2016 have been prepared by the Alder Hey Children's Foundation Trust under Schedule 7, Sections 24 and 25 of the National Health Service Act 2006 in the form which Monitor, the Independent Regulator of NHS Foundation Trust has, with the approval of the Treasury, directed.

Signed 

Chief Executive

NHS foundation trust accounts template - Trust accounts

Inputs

MARSID	ALDERHEY
Name of Foundation Trust	Alder Hey Children's NHS Foundation Trust
Date of year end (dd/mm/yyyy)	31/03/2016
Start of current year (dd/mm/yyyy)	01/04/2015
Comparative year end (dd/mm/yyyy)	31/03/2015
Start of comparative year (dd/mm/yyyy)	01/04/2014
Year for financial reporting (20XX/YY)	2015/16
Year for comparative year (20XX/YY)	2014/15
Year for year end (20XX)	2016
Year for comparative year (20XX)	2015
Opening Year (20XX)	2014
Next financial year (20XX/YY)	2016/17
Date of approval of financial statements (dd/mm/yyyy)	xx/05/2016

Updating links:

This file contains links to a dummy FTC file. To update the links to your locally completed FTC select 'Data' on the ribbon and within the 'Connections' section select 'Edit Links'. In the dialogue box, select the existing source (linked to a dummy file) and choose 'Change source'. Then navigate to where your local FTC file is saved and select. This will redirect all links in this workbook to your trust's FTC file.

Links should be broken before submitting this file (as draft or audited) to monitor via your portal.

Alder Hey Children's NHS Foundation Trust

Annual accounts for the year ended 31 March 2016

Foreword to the accounts

Alder Hey Children's NHS Foundation Trust

These accounts, for the year ended 31 March 2016, have been prepared by Alder Hey Children's NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed .....

Name
Job title
Date **May 2016**

Statement of Comprehensive Income

	Note	2015/16 £000	2014/15 £000
Operating income from patient care activities	3	175,245	177,771
Other operating income	4	40,741	32,261
Total operating income from continuing operations		**215,986**	**210,032**
Operating expenses	5, 6	(250,295)	(191,736)
Operating surplus/(deficit) from continuing operations		**(34,309)**	**18,296**
Finance income	8	107	114
Finance expenses	9	(5,323)	(412)
Finance expense - unwinding of discount on provisions		(11)	(16)
PDC dividends payable		(1,163)	(1,725)
Net finance costs		**(6,390)**	**(2,039)**
Surplus/(deficit) for the year from continuing operations		**(40,699)**	**16,257**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	12	(116)	(1)
Revaluations	16	86	-
Total comprehensive income/(expense) for the period		**(40,729)**	**16,256**

The notes on pages 6 to 52 form part of these accounts.

The Surplus/(deficit) for the year excluding exceptional items:	2015/16 £000	2014/15 £000
Surplus/(deficit) for the year	(40,699)	16,257
Exceptional Items		
Impairment	45,189	512
Loss on disposal	5,403	10
Redundancy	36	-
Normalised Surplus/(deficit) for the year excluding exceptional items	**9,929**	**16,779**

Normalised position includes £14.1m (£8.9m 2014/15) of donated income to support purchase of property, plant & equipment.

Statement of Financial Position

	Note	31 March 2016 £000	31 March 2015 £000
Non-current assets			
Intangible assets	13	11,783	4,418
Property, plant and equipment	14	205,550	62,214
Trade and other receivables	18	183	135
Total non-current assets		**217,516**	**66,767**
Current assets			
Inventories	17	2,702	1,527
Trade and other receivables	18	9,943	76,543
Non-current assets for sale	21	572	-
Cash and cash equivalents	19	10,551	36,048
Total current assets		**23,768**	**114,118**
Current liabilities			
Trade and other payables	20	(23,170)	(25,746)
Other liabilities	22	(2,367)	(10,681)
Borrowings	23	(4,169)	(2,124)
Provisions	24	(1,035)	(2,372)
Total current liabilities		**(30,741)**	**(40,923)**
Total assets less current liabilities		**210,543**	**139,962**
Non-current liabilities			
Other liabilities	22	(3,906)	-
Borrowings	23	(148,117)	(41,058)
Provisions	24	(690)	(754)
Total non-current liabilities		**(152,713)**	**(41,812)**
Total assets employed		**57,830**	**98,150**
Financed by			
Public dividend capital		45,745	45,336
Revaluation reserve		1,042	1,089
Income and expenditure reserve		11,043	51,725
Total taxpayers' equity		**57,830**	**98,150**

The financial statements and notes on pages 6 to 52 were approved by the Board on xxth May 2015 and signed on its behalf by:

Name
Position
Date **xx/05/2016**

Statement of Changes in Equity for the year ended 31 March 2016

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2015 - brought forward	**45,336**	**1,089**	**51,725**	**98,150**
Surplus/(deficit) for the year			(40,699)	**(40,699)**
Transfer of excess of current cost depreciation over historical cost depreciation to the income and expenditure reserve	-	(17)	17	**-**
Impairments		(116)		**(116)**
Revaluations - property, plant and equipment		86		**86**
Public dividend capital received	409			**409**
Taxpayers' and others' equity at 31 March 2016	**45,745**	**1,042**	**11,043**	**57,830**

Statement of Changes in Equity for the year ended 31 March 2015

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2014 - brought forward	**44,833**	**1,108**	**35,450**	**81,391**
Surplus/(deficit) for the year			16,257	**16,257**
Transfer of excess of current cost depreciation over historical cost depreciation to the income and expenditure reserve	-	(18)	18	**-**
Impairments		(1)		**(1)**
Public dividend capital received	503			**503**
Taxpayers' and others' equity at 31 March 2015	**45,336**	**1,089**	**51,725**	**98,150**

Statement of Cash Flows

	Note	2015/16 £000	2014/15 £000
Cash flows from operating activities			
Operating surplus/(deficit)		(34,309)	18,296
Non-cash income and expense:			
Depreciation and amortisation	5.1	5,285	5,810
Impairments	12	45,189	512
(Gain)/loss on disposal of non-current assets	5.1	5,133	6
Income recognised in respect of capital donations	4	(11,786)	(8,910)
Amortisation of PFI deferred credit	4	(69)	-
(Increase)/decrease in trade and other receivables		66,552	(44,082)
(Increase)/decrease in inventories		(1,175)	(129)
Increase/(decrease) in trade and other payables		1,934	3,527
Increase/(decrease) in other liabilities		(4,339)	7,074
Increase/(decrease) in provisions		(1,412)	(681)
Net cash generated from/(used in) operating activities		**71,003**	**(18,577)**
Cash flows from investing activities			
Interest received		107	114
Purchase of intangible assets		(6,680)	(2,941)
Purchase of property, plant, equipment and investment property		(24,012)	(26,323)
Sales of property, plant, equipment and investment property		270	4
Receipt of cash donations to purchase capital assets		10,163	8,837
Net cash generated from/(used in) investing activities		**(20,152)**	**(20,309)**
Cash flows from financing activities			
Public dividend capital received		409	503
Loans received from the Department of Health		279	39,000
Loans repaid to the Department of Health		(2,081)	-
Capital element of finance lease rental payments		(44)	(41)
Capital element of PFI, LIFT and other service concession payments		(68,670)	-
Interest paid		(993)	(376)
Interest element of finance lease		(6)	(7)
Interest element of PFI, LIFT and other service concession obligations		(4,317)	-
PDC dividend paid		(925)	(1,570)
Net cash generated from/(used in) financing activities		**(76,348)**	**37,509**
Increase/(decrease) in cash and cash equivalents		**(25,497)**	**(1,377)**
Cash and cash equivalents at 1 April		**36,048**	**37,425**
Cash and cash equivalents at 31 March	19	**10,551**	**36,048**

Notes to the Accounts

1 Accounting policies and other information

Monitor is responsible for issuing an accounts direction to NHS foundation trusts under the NHS Act 2006. Monitor has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the NHS Foundation Trust Annual Reporting Manual, which shall be agreed with the Secretary of State. Consequently, the following financial statements have been prepared in accordance with the 2015/16 NHS Foundation Trust Annual Reporting Manual issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards and HM Treasury's Financial Reporting Manual to the extent that they are meaningful and appropriate to NHS foundation trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.2 Critical accounting judgements and key sources of estimation uncertainty

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision effects only that period, or in the period of the revision and future periods if the revision affects both current and future periods.

The following are the critical judgements that management have made in the process of applying the entity's accounting policies, together with the key assumptions concerning the future and other key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying amount of assets and liabilities within the next financial year.

Asset valuation and lives

The value and remaining useful lives of land and buildings have been estimated by DTZ Debenham Tie Leung Ltd. The valuations are carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) Valuation Standards. The valuations for the new buildings were carried out during 2015/16 and were applied to the 31st March 2016 land and building values. Valuations are carried out using the Modern Equivalent Asset basis to determine the Depreciated Replacement Cost for specialised operational property and Existing Use Value for non-specialised operational property. The value of retained land and buildings at 31 March 2016 reflect the valuation indicated by Cushman & Wakefield given that most of the hospital buildings will be demolished during 2016/17.

The lives of equipment assets are estimated using historical experience of similar equipment lives with reference to national guidance and consideration of the pace of technological change. Operational equipment is carried at current value. Where assets are of low value and/or have short useful economic lives, these are carried at depreciated historical cost as this is not considered to be materially different from fair value.

Software licences are depreciated over the shorter of the term of the licence and the useful economic life.

Provisions

Pensions provisions relating to former employees, including Directors, have been estimated using the life expectancy from the Government's actuarial tables.

Other legal claims provisions relate to employer and public liability claims and expected costs are advised by the NHS Litigation Authority.

Provision for impairment of receivables

A provision for the impairment of receivables has been made for amounts which are uncertain to be received from organisations at 31 March 2016. The provision is £926,000 (31 March 2015: £716,000) and includes a provision of £465,000 (31 March 2015: £347,000) against the Injury Costs Recovery debt. The recoverability of the Injury Costs Recovery debt has been assessed and as the level of debt has increased, the Trust has fully provided for Injury Costs Recovery incidents that are over 10 years old. The balance of the Injury Costs Recovery NHS Injury Scheme debt has been provided for at 21.99% (31 March 2015: 18.9%) to reflect recoverability of more recent incidents and recommended by Department of Health.

Holiday pay accrual

The accrual for outstanding leave has been calculated on a sample basis.

For non medical staff the amount of outstanding annual leave as at 31st March is requested from a representative sample from across the Trust. The accrual is then calculated on a pro-rata basis according to the numbers of staff within the sample compared to the total staff in post in March. The accrual is split between the various staff groups based on the results of the sample.

For consultants, the accrual is based on actual annual leave outstanding for those consultants who provided details and it is assumed that 4 days are outstanding for the consultants whose details were not available, being the average days from information received.

1.3 Income

Income is accounted for applying the accruals convention. The main source of income for the Trust is from commissioners in respect of healthcare services provided under local agreements. Income is recognised in the period in which the services are provided. Income is measured at the fair value of the consideration receivable. Income relating to partially completed spells is accounted for where material.

Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

1.4 Employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. If annual leave is carried forward into the following year an accrual is included.

Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pension website at www.nhsbsa.nhs.uk/pensions. The Scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. It is not possible for the NHS foundation trust to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme. Employer's pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

1.5 Other expenses

Other operating expenses for goods or services are recognised when, and to the extent that, they have been received. They are measured at the fair value of the consideration payable. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment

1.6 Property,plant & equipment

Recognition

Property, plant and equipment is capitalised where:

• it is held for use in delivering services or for administrative purposes
• it is probable that future economic benefits will flow to, or service potential be provided to, the Trust
• it is expected to be used for more than one financial year and
• the cost of the item can be measured reliably.
• the item has a cost of at least £5,000; or
• collectively, a number of assets have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they have broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
• Items form part of the initial equipping and setting up cost of a new building or refurbishmenr of a ward or unit, irrespective of their individual or collective cost. These are capitalised as a grouped equipment asset.

Where a large asset , for example a building , includes a number of components with significantly different lives, e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

Valuation

All property, plant and equipment assets are shown at fair value. This is measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are subsequently stated at the lower of replacement cost and the present value of the asset's remaining service potential.

Land and buildings used for the Trust's services or for administrative purposes are stated in the Statement of Financial Position at their revalued amounts, being the existing use value at the date of the revaluation less any subsequent accumulated depreciation and impairment losses. The Trust use professional valuers to inform its judgement of the revalued amount. Professional valuations have been carried out by Cushman & Wakefield, a market-leading real estate adviser, in accordance with the Royal Institute of Chartered Surveyors (RICS) Valuation Standards. Valuation of the new hospital building (Inpatients and Outpatients) took place as at valuation date of 30 September 2015. Valuation of the new Research & Education building took place with valuation date of 31 July 2015. The last last valuations for retained estate were undertaken in 2012 as at the valuation date of 1 November 2012 and were applied on 31 March 2013. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the year end date. Existing use values are determined as follows:

- Land and non-specialised buildings - market value for existing use
- Specialised buildings - depreciated replacement cost

The Depreciated Replacement Cost approach assumes that the asset would be replaced with a modern equivalent, not a building of identical design, with the same service potential as the existing asset. The modern equivalent may well be smaller than the existing asset, for example, due to technological advances in plant and machinery.

Valuations are reviewed annually

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as stipulated by the Annual Reporting Manual 2015/16. Depreciation commences when they are brought into use.

Increases arising on revaluation are recognised in the revaluation reserve except to the extent that they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income. A revaluation loss, caused by circumstances other than a clear consumption of economic benefit, is recognised as an impairment and charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to operating expenses. Impairments caused by a clear consumption of economic benefit are charged directly to operating expenses even where a revaluation reserve balance exists for the asset. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is added to the asset's carrying value. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Where subsequent expenditure restores the asset to its original specification assumed by its economic useful life then the expenditure is charged to operating expenses.

1.7 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust; where they are capable of being used in a Trust's activities for more than one year; they can be valued; and they have a cost of at least £5,000.

Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research activities is not capitalised, it is recognised as an operating expense in the period in which it is incurred.

As it cannot be demonstrated that the IAS38 criteria for capitalisation can be met, expenditure on development is not capitalised.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Intangible assets acquired separately are initially recognised at fair value by reference to an active market, or, where no active market exists, at amortised replacement cost.

1.8 Private Finance Initiative (PFI) transactions

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's *FReM* , are accounted for as 'on-Statement of Financial Position' by the Trust. The PFI asset will be recognised as Property, Plant and Equipment when it is brought into use, together with an equivalent finance lease liablity. Assets contributed (cash payments) by the Trust to the operator before the asset is brought into use , are recognised as prepayments during the construction phase of the contract. These then reduce the finance lease liability on bringing the asset into use.

The annual contract payments are apportioned between the repayment of the liability, a finance cost, lifecycle costs and the charges for services.

The service charge is recognised in operating expenses and the finance cost is charged to finance costs in the Statement of Comprehensive Income.

Components of the asset replaced by the contractor during the contract (lifecycle costs) are capitalised where they meet the Trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

1.9 Depreciation and amortisation

Freehold land and properties under construction are not depreciated. Land is deemed to have an infinite life and properties under construction are only depreciated when they are brought into use. Otherwise, depreciation and amortisation are charged, on a straight-line basis, to write-off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated remaining useful economic lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each period end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives.

Property, plant and equipment which has been reclassified as "held for sale" ceases to be depreciated upon reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the trust, respectively.

Asset lives for property, plant and equipment are detailed below:

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	2	90
Dwellings	40	40
Plant & machinery	2	15
Information technology	5	10
Furniture & fittings	10	10

Intangible assets which comprise computer software have a minimum life of 1.5 years and a maximum of 5 years.

1.10 Non current assets held for sale

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use.

This condition is regarded as met when the sale is highly probable, the asset is available for immediate sale in its present condition and management is committed to the sale, which is expected to qualify for recognition as a completed sale within one year from the date of classification. Non-current assets are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life adjusted. The asset is de-recognised when it is scrapped or demolished.

1.11 Revaluation and impairment

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease previously recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

At each reporting period end, the Trust reviews the residual values and useful lives of its property, plant and equipment and intangible non-current assets. Equipment assets with a net book value of over £100,000 as at 31 March are reviewed for their carrying value and their remaining useful life. The carrying value of land and building retained estate is in line with the latest valuation carried out during 2012/13, the new buildings.in line with valuation during 2015/16. If there are any indications of a clear consumption of economic benefits for any assets, then these assets would be impaired, with the impairment charged directly to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating income to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of "other impairments" are treated as revaluation gains.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item under 'other comprehensive income'.

1.12 Donated assets

Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to income. They are valued, depreciated, revalued and impaired as described above for purchased assets.

1.13 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are borne by the foundation trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for as an item of property, plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability is de-recognised when the liability is discharged, cancelled or expires.

All other leases are classified as operating leases.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term.

Where a lease is for land and buildings, the land and building components are separated. Leased buildings are assessed to determine whether they are operating or finance leases.

1.14 Inventories

Inventories are valued at the lower of cost and net realisable value using the first-in first-out cost formula. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks. In most cases, cost equates to direct purchase cost. Net realisable value represents the estimated selling price less all the estimated costs to completion and selling costs to be incurred.

1.15 Cash & cash equivalents

Cash is cash in hand and deposits with commercial bank and Government Banking Service.

1.16 Provisions

Provisions are recognised when the Trust has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised as a provision is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and maintained by HM Treasury, except for early retirement provisions and injury benefit provisions, which both use the HM Treasury's pension discount rate of 1.37% in real terms (2014/15: 1.3%).

The HM Treasury discount rates are (with 2014/15 in brackets):

Short term	Cash flows between 0 and 5 years	Rate is -1.55% (-1.50%)
Medium term	Cash flows between 5 and 10 years	Rate is -1.00% (-1.05%)
Long term	Cash flows over 10 years	Rate is -0.80% (2.20%)

1.17 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. The contribution is charged to the Statement of Comprehensive Income. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed at note 24 but is not recognised in the Trust's accounts.

1.18 Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHS Litigation Authority and, in return, receives assistance with the costs of claims arising.

The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses when the liability arises.

The Trust has also taken commercial insurance to cover property damage and business interruption.

1.19 Financial assets

Financial assets are recognised when the Trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are initially recognised at fair value

Financial assets are classified into the following categories: financial assets 'at fair value through income and expenditure'; 'available for sale' financial assets and 'loans and receivables'. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition. The Trust only has loans and receivables.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the net carrying amount of the financial asset.

Interest is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

At the end of the reporting period, the Trust assesses whether any financial assets, other than those held at 'fair value through income and expenditure' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in operating expenses and the carrying amount of the asset is reduced through a provision for impairment of receivables.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

The Trust's loans and receivables comprise cash and cash equivalents, NHS receivables, receivables with related parties, accrued income and other receivables.

1.20 Financial liabilities

Financial liabilities are recognised on the statement of financial position when the Trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received.

Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Financial liabilities are initially recognised at fair value.

Financial liabilities are classified as either financial liabilities 'at fair value through income and expenditure' or other financial liabilities. The Trust only has other financial liabilities.

Other financial liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability.

1.21 Value Added Tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of non-current assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.22 Foreign currencies

The Trust's functional currency and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are restated at the rates prevailing at the statement of financial position date. Resulting exchange gains and losses are recognised in the Trust's surplus or deficit for the period in which they arise.

1.23 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. The Trust has no third party assets at 31 March 2016.

1.24 Public Dividend Capital (PDC) and PDC dividend

Public Dividend Capital is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS Trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS32.

A charge reflecting the cost of capital utilised by the NHS Foundation Trust, is paid over as Public Dividend Capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS Foundation Trust during the financial year. Relevant net assets are calculated at the value of all assets less the value of all liabilities, except for donated assets, average daily cash balances held with the Government Banking Service and National Loans Fund deposits, excluding cash relating to a short-term working capital facility and any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustments to net assets occur as a result of the audit of the annual accounts.

1.25 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way each individual case is handled.

Losses and special payments are charged to the relevant functional headings in the income statement on an accruals basis, including losses which would have been made good through insurance cover had Trusts not been bearing their own risks (with insurance premiums then being included as normal operating expenditure).

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

1.26 Contingencies

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust. Contingent assets are not recognised as assets but are disclosed where an inflow of economic benefits is probable.

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. Contingent liabilities are not recognised but are disclosed unless the possibility of a payment is remote.

1.29 Segmental Reporting

The Trust has adopted IFRS8 which requires disclosure of information to enable the users of the financial statements to evaluate the nature and financial effects of the business activities in which it engages. Where the Chief Operating Decision Maker uses information pertaining to operating segments to make decisions about allocation of resources and performance assessment, and where there is sufficient and appropriately discreet information available in this respect, disclosure of that information is made in the financial statements. Note 2 to the financial statements shows the financial reporting disclosures for segmental reporting.

1.30 Charitable Funds

Alder Hey Charity is governed by independent Trustees and has independent processes. The Trust does not have power to govern the financial and operating policies of the charitable fund and therefore the charity is not consolidated.

1.31 Going Concern

The financial statements are prepared on a going concern basis and the Trust is planning to be financially sustainable over the next five year NHS planning horizon. The Trust is however planning a deficit in 2016/17 of £5.9m (excluding fixed asset impairments) which reflects the time needed to bring operational performance back on track over the first part of the year and to allow new ways of working to become embedded following the move to the new hospital. In addition, the Trust is having to manage cost increases in 2016/17 which are over and above the level funded in national prices. In planning a deficit of £5.9m in 2016/17 the Trust has applied to NHS improvement (NHSi) for interim cash support of £8m which it requires in 2016/17 to underpin the Trust's operational cash flow funding requirements. At the time of preparing these accounts, the cash funding has not been confirmed and therefore remains an uncertainty, but the Trust is liaising directly with NHSi to ensure this matter is resolved and its required cash position secured. The Trust is also working with its stakeholders to ensure the overall operational plan for 2016/17 is delivered.

In addition to the matter referred to above, the Trust anticipates the continuation of the provision of services in the foreseeable future as evidenced by the inclusion of financial provision for those services in published documents and contracts for services with commissioners.

Based on these indications, the directors believe that it remains appropriate to prepare the financial statements on a going concern basis. The financial statements do not include any adjustments that would result from the basis of preparation being inappropriate.

1.32 Standards and interpretations in issue not yet adopted

The following standards have been issued but are not yet effective:

Change Published	Published by IASB	Financial year for which the change first applies
IFRS 11 (amendment) – acquisition of an interest in a joint operation	May-14	Not yet EU adopted. Expected to be effective from 2016/17.
IAS 16 (amendment) and IAS 38 (amendment) – depreciation and amortisation	May-14	Not yet EU adopted. Expected to be effective from 2016/17.
IAS 16 (amendment) and IAS 41 (amendment) – bearer plants	Jun-14	Not yet EU adopted. Expected to be effective from 2016/17.
IAS 27 (amendment) – equity method in separate financial statements	Aug-14	Not yet EU adopted. Expected to be effective from 2016/17.
IFRS 10 (amendment) and IAS 28 (amendment) – sale or contribution of assets	Sep-14	Not yet EU adopted. Expected to be effective from 2016/17.
IFRS 10 (amendment) and IAS 28 (amendment) – investment entities applying the consolidation exception	Dec-14	Not yet EU adopted. Expected to be effective from 2016/17.
IAS 1 (amendment) – disclosure initiative	Dec-14	Not yet EU adopted. Expected to be effective from 2016/17.
IFRS 15 Revenue from contracts with customers	May-14	Not yet EU adopted. Expected to be effective from 2017/18.
Annual improvements to IFRS: 2012-15 cycle	Sep-14	Not yet EU adopted. Expected to be effective from 2017/18.
IFRS 9 Financial Instruments	Jul-14	Not yet EU adopted. Expected to be effective from 2018/19.

2 Operating segments

The Trust has considered segmental reporting and the Chief Executive and the Board receive sufficient and appropriate high level information to enable the business to be managed effectively and to monitor and manage the strategic aims of the Trust. Sufficiently detailed information is used by middle and lower management to ensure effective management at an operational level. Neither of these are sufficiently discrete to profile operating segments, as defined by IFRS8, that would enable a user of these financial statements to evaluate the nature and financial effects of the business activities that this Trust undertakes. Therefore the Trust has decided that it has one operating segment for healthcare.

Note 3 Operating income from patient care activities

Note 3.1 Income from patient care activities (by nature)

	2015/16	2014/15
	£000	£000
Elective income	38,739	39,344
Non elective income	27,202	27,777
Outpatient income	26,281	26,384
A & E income	4,837	4,791
Private patient income	90	94
Community & mental health	19,570	20,136
Critical care	22,025	21,273
Drugs & devices	18,266	16,805
Clinical services	17,076	19,280
Other clinical income	1,159	1,887
Total income from activities	**175,245**	**177,771**

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2015/16	2014/15
	£000	£000
CCGs and NHS England	159,879	161,031
Local authorities	1,055	813
Department of Health - grants	-	-
Department of Health - other	-	111
Other NHS foundation trusts	774	981
NHS trusts	20	120
NHS other	-	-
Non-NHS: private patients	90	94
Non-NHS: overseas patients (chargeable to patient)	-	-
NHS injury scheme (was RTA)	279	392
Non-NHS: Welsh specialist commissioners	11,562	12,608
Non NHS: other	1,586	1,621
Total income from activities	**175,245**	**177,771**
All income related to continuing operations	-	-

Injury cost recovery income is subject to a provision for impairment of receivables to reflect expected rates of collection. This amounts to £465,000 at 31 March 2016 (£347,000 at 31 March 2015).

Note 4 Other operating income

	2015/16	2014/15
	£000	£000
Research and development	4,129	3,796
Education and training	8,249	8,659
Received from NHS charities: Donation of physical assets (non-cash)	-	73
Received from NHS charities: Cash donations / grants for the purchase of capital assets	-	5,161
Received from NHS charities: Other charitable and other contributions to expenditure	-	214
Received from other bodies: Donation of physical assets (non-cash)	1,623	-
Received from other bodies: Cash donations / grants for the purchase of capital assets	12,514	3,677
Received from other bodies: Other charitable and other contributions to expenditure	222	37
Non-patient care services to other bodies	3,391	3,370
Other income	10,274	7,270
Profit on disposal of other property, plant and equipment	270	4
Amortisation of PFI deferred credits	69	-
Total other operating income	**40,741**	**32,261**
Of which:		
Related to continuing operations	40,741	32,261
Related to discontinued operations		

The education and training income arises from the provision of mandatory education and training set out in the Trust's terms of authorisation.

Note 4.1 Analysis of other operating income: Other

	2015/16	2014/15
	£000	£000
Car parking	517	480
Clinical excellence awards	625	916
Catering	758	948
Government programme for Information Technology	-	509
Funding for project costs for Alder Hey in the Park	6,385	4,199
Innovation Hub	280	-
Improved Organisation Safety	187	-
Other	1,522	218
Total other operating income	**10,274**	**7,270**

Note 4.2 Income from activities arising from commissioner requested services

Under the terms of its Provider License, the trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider license and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2015/16	2014/15
	£000	£000
Income from services designated (or grandfathered) as commissioner requested services	162,046	**162,808**
Income from services not designated as commissioner requested services	13,199	**14,963**
Total	**175,245**	**177,771**

Note 5.1 Operating expenses

	2015/16	2014/15
	£000	£000
Purchase of healthcare from non NHS bodies	324	2
Employee expenses - executive directors	837	1,018
Remuneration of non-executive directors	134	134
Employee expenses - staff	132,477	126,984
Supplies and services - clinical	15,246	17,281
Supplies and services - general	3,247	2,964
Establishment	3,673	3,165
Research and development*	1,456	1,197
Transport	74	87
Premises	12,530	8,816
Increase/(decrease) in provision for impairment of receivables	222	274
Drug costs	18,419	18,414
Depreciation on property, plant and equipment	4,692	5,451
Amortisation on intangible assets	593	359
Impairments of property, plant and equipment	45,189	512
Audit fees payable to the external auditor		
audit services- statutory audit	59	60
other auditor remuneration	39	109
Clinical negligence	2,971	1,825
Loss on disposal of other property, plant and equipment	5,403	10
Legal fees	472	385
Consultancy costs	188	402
Internal audit costs	84	78
Training, courses and conferences	731	585
Patient travel	100	138
Car parking & security	474	411
Redundancy	36	-
Early retirements	22	6
Insurance	236	207
Losses, ex gratia & special payments	266	115
Other	101	747
Total	**250,295**	**191,736**
Of which:		
Related to continuing operations	250,295	191,736
Related to discontinued operations		

* Research and development expenditure reflects payments to other organisations in respect of research contracts. Employee expenses - staff, include £2,296,000 (2014/15 £2,221,000) relating to research and development activities.

Note 5.2 Managed Service Arrangements (MSA)

The Trust had 4 managed service arrangements being the outpatients ward, the modular ward, the hospital information system (ended June 2015) and the pathology managed service. The Trust has reviewed these leases against the criteria set out in IAS17 and has concluded that they do not meet the definition of a finance lease.

	2015/16	2014/15
	£000	£000
Amounts included within operating expenses in respect of MSA transactions	**2,783**	3,701

The Trust is committed to making the following payments during the year:

	Buildings		**Other**	
	31st March 2016	31st March 2015	**31st March 2016**	31st March 2015
	£000	£000	**£000**	£000
Schemes which expire:				
Within 1 year	**919**	0	**0**	228
2nd to 5th years (inclusive)	**1,094**	2,266	**205**	205

Note 5.3 Operating leases

Alder Hey as a Lessee

This note discloses costs and commitments incurred in operating lease arrangements where Alder Hey Children's NHS Foundation Trust FT is the lessee.

	2015/16	**2014/15**
	£000	**£000**
Operating lease expense		
Minimum lease payments	7	9
Contingent rents	-	-
Less sublease payments received	-	-
Total	**7**	**9**

	31 March 2016	**31 March 2015**
	£000	**£000**
Future minimum lease payments due:		
- not later than one year;	-	9
- later than one year and not later than five years;	-	-
- later than five years.	-	-
Total	**-**	**9**
Future minimum sublease payments to be received		

The Trust held no operating leases in respect of land and buildings during 2015/16. Details of Managed Service Arrangements are discussed in Note 5.2

Note 6 Employee expenses

Note 6.1 Employee expenses

	Permanent	Other	2015/16 Total	2014/15 Total
	£000	£000	£000	£000
Salaries and wages	103,705	5,704	**109,409**	104,930
Social security costs	7,816	-	**7,816**	7,189
Pension cost - defined contribution plans employer's contributions to NHS pensions	11,740	-	**11,740**	10,834
Other pension costs	-	-	**-**	-
Other post employment benefits	-	-	**-**	-
Termination benefits	-	-	**-**	-
Agency/contract staff	-	6,029	**6,029**	6,339
Total gross staff costs	**123,261**	**11,733**	**134,994**	**129,292**

There have been 9 (7 2014/15) executive directors during 2015/16 who have benefits accruing under defined benefits schemes.

Salaries & wages cost include £1.644m charged to capital in 2015/16 (£1.290m in 2014/15)

Note 6.2 Retirements due to ill-health

This note discloses the number and additional pension costs for individuals who retired early on ill-health grounds during the year. There was 1 retirement at a value of £32,000 in 2015/16 (5 costing £248,000 in 2014/15). These costs are borne by NHS Pensions. This information has been supplied by NHS Pensions.

Note 6.3 Directors' remuneration

The aggregate amounts payable to directors were:

	2015/16	2014/15
	£000	£000
Salary	798	951
Taxable benefits	8	8
Performance related bonuses	0	0
Employer's pension contributions	86	84
Total	**892**	**1,043**

Further details of directors' remuneration can be found in the remuneration report.

Note 6.4 Employee benefits

There were no employee benefits during 2015/16.

Note 7
Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2016, is based on valuation data as 31 March 2015, updated to 31 March 2016 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account their recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012.

The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

National Employment Savings Pension Scheme (NEST).

Under the Pensions Act 2008 employers must offer a pension scheme to all its employees. As from the 1st July 2013 when the scheme came into operation in the trust (its staging date), staff who are not eligible to join the NHS Pension Scheme are automatically enrolled into NEST. The scheme is a defined contribution pension scheme. Under a defined contribution plan, an entity pays fixed contributions to a separate entity (a fund) and has no obligation to pay further contributions if the fund does not hold sufficient assets to pay employee benefits.

Contributions payable to a defined contribution plan are recognised as an expense as the employee provides services in exchange for the contribution. The trust contributes 1% of their pensionable pay. The total contribution by the trust for 2015/16 has been fully charged to expenses in the period. Details of the scheme can be found on the NEST Pensions website at

http://www.nestpensions.org.uk/schemeweb/NestWeb/includes/public/docs/understanding-NEST.PDF.pdf

Note 8 Finance income

Finance income represents interest received on assets and investments in the period.

	2015/16	2014/15
	£000	£000
Interest on bank accounts	107	114
Interest on loans and receivables	-	-
Total	**107**	**114**

Note 9 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money.

	2015/16	2014/15
	£000	£000
Interest expense:		
Capital loans from the Department of Health	1,000	405
Finance leases	6	7
Interest on late payment of commercial debt	-	-
Main finance costs on PFI and LIFT schemes obligations	4,154	-
Contingent finance costs on PFI and LIFT scheme obligations	163	-
Total interest expense	**5,323**	**412**
Other finance costs		
Total	**5,323**	**412**

Note 10 Public dividend capital dividend

The Trust is required to pay a dividend to the Department of Health of £1,163,000. This represents 3.5% of the average net relevant assets of £33,220,000

Note 11 Other auditor remuneration

	2015/16	2014/15
	£000	£000
Other auditor remuneration paid to the external auditor:		
Other non-audit services including Business Advice	39	109
Total	**39**	**109**

£39,000 was paid to KPMG for VAT advice, quality accounts audit, quality governance review and business advice.
£72,000 was also paid for tax advice on the new building. This was charged to property, plant & equipment additions.

Note 11.1 Limitation on auditor's liability

There is a £1,000,000 limited liability agreement in place with the external auditors, KPMG LLP

Note 12 Impairment of assets

	2015/16	2014/15
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	50	-
Other	45,139	512
Total net impairments charged to operating surplus / deficit	**45,189**	**512**
Impairments charged to the revaluation reserve	116	1
Total net impairments	**45,305**	**513**

Note 12.1 Impairments in 2015/16

	£000
Impairments for 2015/16 are as follows:	
Impairment of new PFI building on being brought into use	41,318
Impairment of new Research & Education building on being brought into use	2,575
Impairment of expenditure on retained estate	1,246
Impairment of assets held for sale - to market value	166
	45,305

Note 13 Intangible assets

Note 13.1 Intangible assets - 2015/16

	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Valuation/gross cost at 1 April 2015 - brought forward	**1,989**	**3,717**	**5,706**
Additions - purchased / internally generated	**6,001**	**318**	**6,319**
Reclassifications	**5,356**	**(3,717)**	**1,639**
Disposals / derecognition	**(704)**	**-**	**(704)**
Gross cost at 31 March 2016	**12,642**	**318**	**12,960**
Amortisation at 1 April 2015 - brought forward	**1,288**	**-**	**1,288**
Provided during the year	**593**	**-**	**593**
Disposals / derecognition	**(704)**	**-**	**(704)**
Amortisation at 31 March 2016	**1,177**	**-**	**1,177**
Net book value at 31 March 2016	**11,465**	**318**	**11,783**
Net book value at 1 April 2015	**701**	**3,717**	**4,418**

Note 13.2 Intangible assets - 2014/15

	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Valuation/gross cost at 1 April 2014 - as previously stated	**2,080**	**547**	**2,627**
Additions - purchased / internally generated	**84**	**3,272**	**3,356**
Reclassifications	**102**	**(102)**	**-**
Disposals / derecognition	**(277)**	**-**	**(277)**
Valuation/gross cost at 31 March 2015	**1,989**	**3,717**	**5,706**
Amortisation at 1 April 2014 - as previously stated	**1,206**	**-**	**1,206**
Provided during the year	**359**	**-**	**359**
Disposals / derecognition	**(277)**	**-**	**(277)**
Amortisation at 31 March 2015	**1,288**	**-**	**1,288**
Net book value at 31 March 2015	**701**	**3,717**	**4,418**
Net book value at 1 April 2014	**874**	**547**	**1,421**

There is no balance in the Revaluation Reserve in respect of intangible assets

Note 13.3 Intangible assets financing 2015/16

	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Net book value at 31 March 2016			
Purchased	11,465	318	**11,783**
Donated and government grant funded	-	-	**-**
NBV total at 31 March 2016	**11,465**	**318**	**11,783**

Note 13.4 Intangible assets financing 2014/15

	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Net book value 31 March 2015			
Purchased	701	3,717	**4,418**
Donated and government grant funded	-	-	**-**
NBV total at 31 March 2015	**701**	**3,717**	**4,418**

Note 14 Property, plant and equipment

Note 14.1 Property, plant and equipment - 2015/16

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2015 - brought forward	4,184	13,331	152	41,671	24,030	-	6,145	187	89,700
Additions - purchased	-	1,295	-	730	467	-	3,208	3,755	9,455
Additions - leased	-	179,620	-	-	-	-	-	-	179,620
Additions - donations of physical assets (non-cash)	-	-	-	248	1,375	-	-	-	1,623
Additions - assets purchased from cash donations / grants	-	3,888	-	380	5,807	-	88	-	10,163
Impairments charged to the revaluation reserve	-	(116)	-	-	-	-	-	-	(116)
Reclassifications	-	32,082	-	(41,086)	4,538	-	2,826	1	(1,639)
Revaluations	86	-	-	-	-	-	-	-	86
Transfers to/ from assets held for sale	(139)	(531)	-	-	-	-	-	-	(670)
Disposals / derecognition	-	(5,142)	-	-	(8,956)	-	(2,644)	(176)	(16,918)
Valuation/gross cost at 31 March 2016	4,131	224,427	152	1,943	27,261	-	9,623	3,767	271,304
Accumulated depreciation at 1 April 2015 - brought forward	-	5,034	-	-	17,161	-	5,151	140	27,486
Provided during the year	-	1,946	3	-	1,944	-	691	108	4,692
Impairments charged to operating expenses	-	45,189	-	-	-	-	-	-	45,189
Transfers to/ from assets held for sale	-	(98)	-	-	-	-	-	-	(98)
Disposals/ derecognition	-	(21)	-	-	(8,736)	-	(2,610)	(148)	(11,515)
Accumulated depreciation at 31 March 2016	-	52,050	3	-	10,369	-	3,232	100	65,754
Net book value at 31 March 2016	4,131	172,377	149	1,943	16,892	-	6,391	3,667	205,550
Net book value at 1 April 2015	4,184	8,297	152	41,671	6,869	-	994	47	62,214

Note 14.2 Property, plant and equipment - 2014/15

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2014 - as previously stated	4,184	13,132	-	13,041	23,633	31	6,457	194	60,672
Additions - purchased	-	241	152	20,379	835	-	62	-	21,669
Additions - donations of physical assets (non-cash)	-	-	-	-	73	-	-	-	73
Additions - assets purchased from cash donations / grants	-	-	-	8,486	351	-	-	-	8,837
Impairments charged to operating expenses	-	(219)	-	-	(215)	-	(71)	(7)	(512)
Impairments charged to revaluation reserve	-	-	-	-	(1)	-	-	-	(1)
Reclassifications	-	177	-	(235)	58	-	-	-	-
Disposals / derecognition	-	-	-	-	(704)	(31)	(303)	-	(1,038)
Valuation/gross cost at 31 March 2015	4,184	13,331	152	41,671	24,030	-	6,145	187	89,700
Accumulated depreciation at 1 April 2014 - as previously stated	-	2,398	-	-	16,013	25	4,505	122	23,063
Provided during the year	-	2,636	-	-	1,844	4	949	18	5,451
Disposals / derecognition	-	-	-	-	(696)	(29)	(303)	-	(1,028)
Accumulated depreciation at 31 March 2015	-	2,636	-	-	1,148	(25)	646	18	4,423
Net book value at 31 March 2015	4,184	10,695	152	41,671	22,882	25	5,499	169	85,277
Net book value at 1 April 2014	4,184	10,734	-	13,041	7,620	6	1,952	72	37,609

Note 14.3 Property, plant and equipment financing - 2015/16

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2016									
Owned	4,131	3,367	149	1,315	4,497	-	6,301	3,667	**23,427**
Finance leased	-	-	-	-	130	-	-	-	**130**
On-SoFP PFI contracts and other service concession arrangements	-	161,916	-	-	-	-	-	-	**161,916**
Donated	-	7,094	-	628	12,265	-	90	-	**20,077**
NBV total at 31 March 2016	**4,131**	**172,377**	**149**	**1,943**	**16,892**	**-**	**6,391**	**3,667**	**205,550**

Note 14.4 Property, plant and equipment financing - 2014/15

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2015									
Owned	4,184	4,581	152	32,987	5,347	-	979	32	**48,262**
Finance leased	-	-	-	-	173	-	-	-	**173**
On-SoFP PFI contracts and other service concession arrangements	-	-	-	-	-	-	-	-	**-**
Donated	-	3,716	-	8,684	1,349	-	15	15	**13,779**
NBV total at 31 March 2015	**4,184**	**8,297**	**152**	**41,671**	**6,869**	**-**	**994**	**47**	**62,214**

Note 14.5 Net book value of property, plant and equipment in the Revaluation Reserve

	Land	Buildings	Dwellings	Assets under	Plant and	Transport	Information	Furniture &	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
1st April 2014	**0**	**1,105**	**0**	**0**	**3**	**0**	**0**	**0**	**1,108**
Movement in 2014/15	**0**	**(17)**	**0**	**0**	**(2)**	**0**	**0**	**0**	**(19)**
31st March 2015	**0**	**1,088**	**0**	**0**	**1**	**0**	**0**	**0**	**1,089**
Movement in 2015/16	**86**	**(132)**	**0**	**0**	**(1)**	**0**	**0**	**0**	**(47)**
31st March 2016	**86**	**956**	**0**	**0**	**0**	**0**	**0**	**0**	**1,042**

Note 15 Donations of property, plant and equipment

The Trust has received donations to contribute to the construction of the new Research and Education facility which opened in July 2015.

All donations have been spent as intended by the donor.

Alder Hey Charity has also donated funds to purchase medical equipment for the move into the new hospital.

Note 16 Revaluations of property, plant and equipment

The new hospital was revalued on being brought into use. The valuation took place as at 30 September 2015.

The new Reseach and Education building was revaluated on being brought into use. The valuation took place as at 31 July 2015.

Both valuations were carried out by Cushman & Wakefield, independent valuers, complying the RICS standards. They used the Depreciated Replacement Cost (DRC) approach, assuming asset would be replaced by a modern equivalent asset on an alternative site.

Two community properties have also been revalued in the year to reflect expected market value - following the decision to sell the assets.

Note 17 Inventories

Note 17.1 Inventories

	31 March 2016 £000	31 March 2015 £000
Drugs	885	847
Work In progress	-	-
Consumables	1,745	614
Energy	72	66
Inventories carried at fair value less costs to sell	-	-
Other	-	-
Total inventories	**2,702**	**1,527**
Of which held at net realisable value	0	0

Note 17.2 Inventory movements

	2015/16 £000	2014/15 £000
Carrying value at 1st April 2015 as previously stated	**1,527**	1,398
Additions	**26,128**	17,432
Inventories recognised in expenses	**(24,953)**	(17,303)
Write down of inventories	**-**	-
Carrying value at 31st March 2016	**2,702**	**1,527**

Stock values in March 2016 include theatre stores which have been counted for the first time due to the move to the new hospital.

Note 18 Trade and other receivables

Note 18.1 Trade and other receivables

	31 March 2016 £000	31 March 2015 £000
Current		
NHS receivables - revenue	3,103	7,849
Other receivables with related parties - revenue	417	1,226
Provision for impaired receivables	(926)	(716)
Prepayments (non-PFI)	3,487	3,569
PFI prepayments:		
Capital contributions	-	57,763
Accrued income	2,362	4,007
VAT receivable	531	812
Other receivables - revenue	969	2,033
Total current trade and other receivables	**9,943**	**76,543**
Non-current		
Prepayments (non-PFI)	183	135
Total non-current trade and other receivables	**183**	**135**

The great majority of trade is with Clinical Commissioning Groups, as commissioners for NHS patient care services. As these bodies are funded by government to buy NHS patient care services, no credit scoring of them is considered necessary.

Other related parties receivables include Local Authorities which are funded by the government. No credit score is considered necessary.

Other related parties receivables include Welsh Health bodies funded by the Welsh Assembly Government. No credit score is considered necessary.

Note 18.2 Provision for impairment of receivables

	2015/16	2014/15
	£000	£000
At 1 April	**716**	**444**
Increase in provision	360	280
Amounts utilised	(12)	(2)
Unused amounts reversed	(138)	(6)
At 31 March	**926**	**716**

Provision for impairment of receivables is made where amounts are past due and are uncertain to be received. Usually the debtors have indicated that the charge is queried or that payment may not be made. The provision includes £465,000 of Injury Cost Recovery debt to reflect expected rates of collection.

Note 18.3 Analysis of impaired receivables

	31 March 2016		31 March 2015	
	Trade receivables	Other receivables	Trade receivables	Other receivables
Ageing of impaired receivables	£000	£000	£000	£000
0 - 30 days	56	10	-	26
30-60 Days	21	-	-	12
60-90 days	12	3	-	43
90- 180 days	43	-	-	73
Over 180 days	100	681	25	537
Total	**232**	**694**	**25**	**691**
Ageing of non-impaired receivables past their due date				
0 - 30 days	28	-	5,822	-
30-60 Days	471	-	245	-
60-90 days	99	-	533	-
90- 180 days	72	-	-	-
Over 180 days	66	-	7	-
Total	**736**	**-**	**6,607**	**-**

Receivables are not impaired until amounts are uncertain to be received - usually when debtors indicate that there is a query.

Note 19 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2015/16	2014/15
	£000	£000
At 1 April	**36,048**	**37,425**
Net change in year	(25,497)	(1,377)
At 31 March	**10,551**	**36,048**
Broken down into:		
Cash at commercial banks and in hand	115	98
Cash with the Government Banking Service	1,186	35,950
Deposits with the National Loan Fund	9,250	-
Total cash and cash equivalents as in SoFP	**10,551**	**36,048**
Bank overdrafts (GBS and commercial banks)	-	-
Total cash and cash equivalents as in SoCF	**10,551**	**36,048**

Note 20 Trade and other payables

	31 March 2016 £000	31 March 2015 £000
Current		
NHS payables - revenue	3,328	3,340
Amounts due to other related parties - revenue	2,782	1,808
Other trade payables - capital	2,367	7,122
Other trade payables - revenue	1,998	2,788
Social security costs	-	4
Other taxes payable	2,478	2,461
Other payables	1,885	1,876
Accruals	8,019	6,272
PDC dividend payable	313	75
Total current trade and other payables	**23,170**	**25,746**

Related party payables includes £1,709,000 (£1,585,000 at 31 March 2015) outstanding pension contributions at 31 March 2016.

NHS payables, other trade payables and accruals are expected to be paid within 30 days of receipt of a valid invoice.

Other payables includes the accrual for untaken annual leave at 31 March 2016. It is expected that this will be used before 31 March 2017.

Note 21 Non-current assets for sale and assets in disposal groups

	2015/16					2014/15
	Intangible assets	Property, plant & equipment	Investments in associates & joint ventures	Investment properties	Total	Total
	£000	£000	£000	£000	£000	£000
NBV of non-current assets for sale and assets in disposal groups at 1 April	**-**	**-**	**-**	**-**	**-**	**-**
Plus assets classified as available for sale in the year	-	572	-	-	**572**	**-**
NBV of non-current assets for sale and assets in disposal groups at 31 March	**-**	**572**	**-**	**-**	**572**	**-**

Two community properties have been reclassified as held for sale as the decision has been taken to auction the buildings early in 2016/17.

Note 22 Other liabilities

	31 March 2016 £000	31 March 2015 £000
Current		
Deferred goods and services income	350	1,155
Other deferred income	1,880	9,526
Deferred PFI credits	137	-
Total other current liabilities	**2,367**	**10,681**
Non-current		
Deferred PFI credits	3,906	-
Total other non-current liabilities	**3,906**	**-**

Note 23 Borrowings

	31 March 2016 £000	31 March 2015 £000
Current		
Capital loans from Department of Health	2,081	2,081
Obligations under finance leases	44	43
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	2,044	-
Total current borrowings	**4,169**	**2,124**
Non-current		
Capital loans from Department of Health	39,117	40,919
Obligations under finance leases	94	139
Obligations under PFI, LIFT or other service concession contracts	108,906	-
Total non-current borrowings	**148,117**	**41,058**

The Department of Health Capital Loan is for the new hospital

Note 24 Provisions for liabilities and charges analysis

	Current		Non-current	
	31st March 2016	31st March 2015	**31st March 2016**	31st March 2015
	£000	£000	**£000**	£000
Pensions relating to former directors	**10**	10	**11**	**21**
Pensions relating to former staff	**90**	88	**679**	**733**
Legal claims	**176**	164	**0**	**0**
Other	**759**	2,110	**0**	**0**
Total	**1,035**	2,372	**690**	754

Other provisions include £0.8m expenditure commitments for the Children's Health Park

Movement in current and non current provisions	**Pensions - former directors**	**Pensions - other staff**	**Other legal claims**	**Redundancy**	**Other**	**Total**
	£000	**£000**	**£000**	**£000**	**£000**	**£000**
At 1 April 2014	**40**	**846**	**216**	**-**	**2,689**	**3,791**
Change in the discount rate	-	33	-	-	-	**33**
Arising during the year	-	6	123	-	-	**129**
Utilised during the year - cash	(10)	(79)	(140)	-	(579)	**(808)**
Reversed unused	-	-	(35)	-	-	**(35)**
Unwinding of discount	1	15	-	-	-	**16**
At 31 March 2015	**31**	**821**	**164**	**-**	**2,110**	**3,126**
At 1 April 2015	**31**	**821**	**164**	**-**	**2,110**	**3,126**
Change in the discount rate	-	(4)	-	-	-	**(4)**
Arising during the year	-	22	159	-	-	**181**
Utilised during the year - cash	(10)	(81)	(112)	-	(1,351)	**(1,554)**
Reversed unused	-	-	(35)	-	-	**(35)**
Unwinding of discount	-	11	-	-	-	**11**
At 31 March 2016	**21**	**769**	**176**	**-**	**759**	**1,725**
Expected timing of cash flows:						
- not later than one year;	10	90	176	-	759	**1,035**
- later than one year and not later than five years;	11	255	-	-	-	**266**
- later than five years.	-	424	-	-	-	**424**
Total	**21**	**769**	**176**	**-**	**759**	**1,725**

Note 24 Provisions for liabilities and charges analysis (con'd)

Pensions for former employees have been estimated using life expectancy from the Government's actuarial tables.

Legal claims relate to third party and employer liability claims and have been estimated by the NHS Litigation Authority. It is expected that these claims will be settled in the next year.

£98,238,000 (£38,411,000 at 31 March 2015) is included in the provisions of the NHS Litigation Authority at 31 March 2016 in respect of clinical negligence liabilities of the Trust.

Note 25 Contingent Liabilities

The Trust has no contingent liabilities.

Note 26 Related party transactions

Alder Hey Children's NHS Foundation Trust is a public interest body authorised by Monitor, the Independent Regulator for NHS Foundation Trusts.

During the period none of the Trust Board members or members of the key management staff, or parties related to any of them, has undertaken any transactions with Alder Hey Children's NHS Foundation Trust.

The Department of Health is regarded as a related party. During the period Alder Hey Children's NHS Foundation Trust has had a significant number of transactions with the Department, and with other entities for which the Department is regarded as the parent Department. The transactions relate mainly to the provision of healthcare services and purchase of services in the ordinary course of business.

Note 26 Related parties (cont'd)

	Income	Expenditure	Receivables	Payables	Impairment recognised as expense
	£000s	£000s	£000s	£000s	£000s
Aintree University Hospital NHS Foundation Trust	6	323	0	69	0
Central Manchester University Hospitals NHS Foundation Trust	1,462	1047	200	82	0
Liverpool Womens Hospital NHS Foundation Trust	956	649	101	100	0
Warrington and Halton Hospitals NHS Foundation Trust	150	323	87	26	0
Royal Liverpool & Broadgreen University Hospitals NHS Trust	1236	602	653	136	0
St Helens and Knowsley Hospitals NHS Trust	132	371	30	0	0
NHS Halton CCG	1,201	0	159	0	0
NHS Knowsley CCG	6,347	0	51	0	0
NHS Liverpool CCG	28,155	0	419	55	0
NHS South Cheshire CCG	522	0	0	72	0
NHS South Sefton CCG	8,226	0	0	338	0
NHS Southport and Formby CCG	2,356	0	77	0	0
NHS St Helens CCG	2,287	0	152	0	0
NHS Vale Royal CCG	423	0	0	0	0
NHS Warrington CCG	1,337	0	0	0	0
NHS West Cheshire CCG	1,016	0	0	53	0
NHS West Lancashire CCG	1,303	0	0	37	0
NHS Wigan Borough CCG	613	0	3	0	0
NHS Wirral CCG	2,070	0	93	0	0
Health Education England	8,181	0	61	1	0
Department of Health: Core trading & NHS Supply Chain	1,952	0	0	313	0
NHS Business Services Authority	0	3	0	329	0
NHS Litigation Authority	0	2,988	0	18	0
NHS England – Core	3,701	4	111	0	0
NHS England Cheshire & Merseyside Local Office	1,792	0	0	196	0
NHS Cheshire & Merseyside Commissioning Support Unit	1,373	101	0	1	0
NHS England North West Commissioning Hub	100,485	0	0	1500	0
NHS Blood & Transplant	0	951	0	15	0
All Other NHS Bodies	3,791	2,592	906	905	0

Note 26 Related parties cont'd

In addition, the Trust has had a number of material transactions with other Government Departments and other central and local government bodies. Most of these transactions have been with:

	Income	Expenditure	Receivables	Payables	Impairment recognised as expense
	£000s	£000s	£000s	£000s	£000s
Liverpool City Council	788	515	192	926	0
Welsh Assembly Government (incl all other Welsh Health Bodies)	11,595	56	30	753	0
National Insurance Fund (Employer contributions only – Revenue Expenditure)	0	7816	0	1161	0
NHS Pension Scheme (Own staff employers contributions only plus other invoiced charges)	0	11740	0	1709	0
HM Revenue & Customs – VAT	0	0	531	0	0
HM Revenue & Customs – Other taxes and duties (including o/s PAYE creditor)	0	0	0	1215	0
NHS Professionals	0	3844	0	1040	0
National Loans Fund	0	0	9250	0	0
Other WGA Bodies	423	182	182	130	0

The Trust has a number of transactions with Edge Hill University. Steve Igoe, non-executive director is the Pro Vice-Chancellor for Resources of the University. £126,000 was incurred in expenditure during 2015/16. Outstanding receivables at 31 March 2016 were £14,000 whilst outstanding payables were £0

In 2012/13 Liverpool Health Partners Ltd, a company limited by guarantee, was set up between The University of Liverpool, Aintree University Hospital NHS FT, Alder Hey Children's NHS FT, Clatterbridge Cancer Centre NHS FT, Royal Liverpool & Broadgreen Hospitals NHS Trust, Liverpool Women's NHS FT, The Walton Centre NHS FT, Liverpool Heart & Chest NHS FT and Liverpool School of Tropical Medicine. The objects of the company are to advance education, health, learning and research by facilitating world class research among the partners. Each organisation has a single share in the company and the Chief Executives are ex-office directors of the company. A grant of £80,000 (£80,000 2014/15) was made to the company to enable it to carry out its objectives.

Transactions with related parties are on a normal commercial basis.

Note 27 Finance leases

Note 27.1 Alder Hey Children's NHS Foundation Trust as a lessee

	31 March 2016 £000	31 March 2015 £000
Gross lease liabilities	**146**	**195**
of which liabilities are due:		
- not later than one year;	49	49
- later than one year and not later than five years;	97	146
- later than five years.	-	-
Finance charges allocated to future periods	(8)	(13)
Net lease liabilities	**138**	**182**
of which payable:		
- not later than one year;	44	43
- later than one year and not later than five years;	94	139
- later than five years.	-	-
Total of future minimum sublease payments to be received at the reporting date	**-**	**-**
Contingent rent recognised as an expense in the period	-	-

Note 28 Contingent assets and liabilities

The Trust has no contingent assets or liabilities

Note 29 Contractual capital commitments

Contracted capital commitments at 31st March 2016 not otherwise included in these financial statements

	31 March 2016 £000	31 March 2015 £000
Property, plant and equipment	428	7,452
Intangible assets	135	814
Total	**563**	**8,266**

Contracted capital commitments relate to capital items/work which has been ordered but not received at 31 March 2016.

Note 30 On-SoFP PFI, LIFT or other service concession arrangements

The Trust has a PFI arrangement for the new hospital which became operational in October 2015.

In April 2012, Alder Hey announced that Acorn were selected as Preferred Bidder for the construction of the new Alder Hey Children's Health Park. Acorn is a consortium comprising of John Laing Investments Limited (40%), Laing O'Rourke PLC (40%) and Interserve Developments No. 1 Limited (20%). Laing O'Rourke Construction Limited is the design and build contractor, with Interserve (Facilities Management) Limited providing the Hard FM Services. BDP were architects.

The project achieved financial close on 21st March 2013. The agreement was between Alder Hey and Alder Hey (Special Purpose Vehicle) Limited, which comprises of the Acorn Consortium listed above.

The new Children's Health Park consists of

- 100% new purpose built hospital with views over Springfield Park
- 260 inpatient beds, of which there are 43 critical care and 5 burns beds. Each ward has an external playdeck with views over the parkland
- Approximately 80% of patient beds are within single en-suite rooms
- In addition to the above there is also 28 surgical daycase beds (recovery)
- There are 12 new inpatient theatres, complete with inter-operative MRI and 4 daycase theatres
- Centralised radiology department
- Integral Outpatients department, providing dental, audiology and ophthalmology
- 8 bed Clinical Research Facility
- Innovation hub
- Centralised atrium and access to play spaces within courtyards
- 1200 space multi-storey car park with direct covered access into the central hospital atrium

The Contract with Alder Hey (Special Purpose Vehicle) Limited expires on 21st June 2045.

The Trust has the right to use the buildings, however Alder Hey (SPV) Limited have the responsibility for maintaining the buildings to an agreed standard. All lifecycle replacement is also the responsibility of Alder Hey (SPV) Limited.

A key feature of the PFI scheme is that the operator is responsible for ensuring that the property is maintained to an agreed standard for the entire life of the contract. These are known as lifecycle costs. The costs which the operator expects to incur in doing this is reflected in the unitary payment and reflects two elements:

maintenance (planned and reactive); and

replacement of components as they wear out during the contract - this is known as capital lifecycle.

After the expiry of the contract, the license with Alder Hey (SPV) Limited to operate out of these buildings will expire and the Trust will become responsible for the maintenance and lifecycle costs of those buildings.

Note 30.1 Imputed finance lease obligations

The trust has the following obligations in respect of the finance lease element of on-Statement of Financial Position PFI and LIFT schemes:

	31 March 2016 £000	31 March 2015 £000
Gross PFI, LIFT or other service concession liabilities	**306,582**	**-**
Of which liabilities are due		
- not later than one year;	10,763	-
- later than one year and not later than five years;	43,027	-
- later than five years.	252,792	-
Finance charges allocated to future periods	(195,632)	-
Net PFI, LIFT or other service concession arrangement obligation	**110,950**	**-**
- not later than one year;	2,044	-
- later than one year and not later than five years;	8,868	-
- later than five years.	100,038	-

Note 30.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

The trust is committed to make the following payments in respect of the service element of on-Statement of Financial Position PFI and LIFT obligations:

	31 March 2016 £000	31 March 2015 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	497,729	-
Of which liabilities are due:		
- not later than one year;	13,732	-
- later than one year and not later than five years;	56,776	-
- later than five years.	427,221	-
Net present value of total future commitments	**497,729**	**-**

Note 30.3 Analysis of amounts payable to service concession operator

	31 March 2016 £000	31 March 2015 £000
Unitary payment payable to service concession operator	6,828	-
Consisting of:		
- Interest charge	4,154	-
- Repayment of finance lease liability	787	-
- Service element	1,724	-
- Contingent rent	163	-
Other amounts paid to operator due to a commitment under the service concession contract but not part of the unitary payment	-	-
Consisting of:		
- Services purchased	-	-
- Other	-	-
Total amount paid to service concession operator	**6,828**	**-**

Note 31 Financial instruments

Note 31.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with clinical commissioning groups (CCGs) and the way those CCGs are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the Board of Directors. Trust treasury activity is subject to review by the Trust's internal auditors.

Liquidity risk

Alder Hey Children's NHS Foundation Trust net operating costs are incurred under legally binding contracts with local clinical commissioning groups (CCGs). The Trust receives regular monthly payments from CCGs based on an agreed contract value with adjustments made for actual services provided.

The Trust finances its capital expenditure from internally generated funds or Public Dividend Capital made available by the Department of Health. The Trust is therefore not exposed to significant liquidity risks.

Interest rate risk

All of the Trust's financial assets carry nil or fixed rates of interest. The Trust is not exposed to significant interest rate risk.

Foreign currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Price risk

The contracts from NHS commissioners in respect of healthcare services have a pre-determined price structure which negates the risk of price fluctuation.

Credit risk

The contracts from NHS commissioners in respect of healthcare services are agreed annually and take into account the commissioners' ability to pay and hence the credit risk is minimal.

Note 31.2 Financial assets

	31 March 2016 £000	31 March 2015 £000
Trade and other receivables excluding non financial assets	**6,456**	15,211
Cash and cash equivalents at bank and in hand	**10,551**	36,048
Total at 31 March 2016	**17,007**	**51,259**

Note 31.3 Financial liabilities

	31 March 2016 £000	31 March 2015 £000
Liabilities as per SoFP as at 31 March 2016		
Borrowings excluding finance lease and PFI liabilities	**41,198**	43,000
Obligations under finance leases	**138**	182
Obligations under PFI, LIFT and other service concession contracts	**110,950**	-
Trade and other payables excluding non financial liabilities	**20,692**	23,285
Total at 31 March 2016	**172,978**	**66,467**

Note 32 Losses and special payments

NHS foundation trusts are require to record payments and other adjustments that arise as a result of losses and special payments

	2015/16		2014/15	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses of cash due to:				
- Theft or Fraud	-	-	-	-
- Overpayment of salaries	12	11	-	-
- Other causes	-	-	2	2
Bad debts and claims abandoned in relation to:				
- Private patients	3	-	3	-
- Other bad debts	23	1	18	2
-Stores losses	1	157	-	-
Total losses	**39**	**169**	**23**	**4**
Special payments				
Ex-gratia payments				
- Personal injury with advice	21	89	30	143
- Other	3	2	5	3
Special severence payments	-	-	-	-
Total special payments	**24**	**91**	**35**	**146**
Total losses and special payments	**63**	**260**	**58**	**150**
Compensation payments received				

Alder Hey Children's NHS
NHS Foundation Trust

Board of Directors
Monday 23rd May 2016

Report of	Director of Corporate Affairs
Paper prepared by	Director of Corporate Affairs
Subject/Title	Corporate Governance Statement 2016/17
Background papers	Monitor's *Risk Assessment Framework 2013* Alder Hey Provider Licence issued by Monitor
Purpose of Paper	To present the Trust's Corporate Governance Statement including risks and mitigating actions
Action/Decision required	The Board is asked to approve the Corporate Governance Statement for 2016/17
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	**Ensuring Good Governance**
Resource Impact	None

BOARD OF DIRECTORS
Corporate Governance Statement 2015/16

Statement element	Assurance, Risks and mitigating actions
The Board is satisfied that Alder Hey Children's NHS Foundation Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	No specific risks identified at present. Assurance evidence provided by internal and external audit. Head of Internal Audit Opinion for 2015/16 gave 'significant assurance'. Appropriate balance of skills and expertise on the Board; one NED vacancy currently under consideration in terms of skill gaps/opportunities.
The Board has regard to such guidance on good corporate governance as may be issued by Monitor from time to time	No specific risks identified at present. Assurance evidence provided by internal and external audit.
The Board is satisfied that Alder Hey Children's NHS Foundation Trust implements: (a) effective board and committee structures; (b) clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) clear reporting lines and accountabilities throughout its organisation.	Major review of Board committees undertaken in Q4 2015/16 as part of move to new change programme governance arrangements.
The Board is satisfied that Alder Hey Children's NHS Foundation Trust effectively implements systems and/or processes (a) to ensure compliance with the Licence holder's duty to operate efficiently, economically and effectively; (b) for timely and effective scrutiny and oversight by the Board of the Licence holder's operations; (c) to ensure compliance with health care standards binding on the Licence holder including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) for effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licence holder's ability to continue as a going concern); (e) to obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;	2015 CQC inspection resulted in overall Good rating demonstrating compliance with fundamental standards. Recommendations from inspection report reflected in updated action plan which is being monitored through CQAC.

(f) to identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) to generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) to ensure compliance with all applicable legal requirements.	
The Board is satisfied: (a) that there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) that the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) the collection of accurate, comprehensive, timely and up to date information on quality of care; (d) that the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) that Alder Hey Children's NHS Foundation Trust including its Board actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) that there is clear accountability for quality of care throughout Alder Hey Children's NHS Foundation Trust including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	No specific risks identified at present. The Board gains assurance through the monthly Quality Report and other regular substantive reports presented by the Chief Nurse and Medical Director, who provide Board level leadership on the quality agenda. The Trust's external auditors, KPMG undertook a review of the Trust's self-assessment position against Monitor's Quality Governance Framework which resulted in a score of 3 at re-review, taking the Trust below Monitor's threshold for applicant trusts. This work provides a robust piece of independent assurance and has been followed up with two further self-assessments demonstrating progress.
The Board of Alder Hey Children's NHS Foundation Trust effectively implements systems to ensure that it has in place personnel on the Board, reporting to the Board and within the rest of the Licence holder's organisation who are sufficient in number and appropriately qualified to ensure compliance with the Conditions of this Licence.	No specific risks identified at present. The Trust has a clear workforce strategy in place and keeps current and future staffing requirements under review through its risk and governance processes.

ES/May 2016

Self-Certification Template

FT Name: Alder Hey Children's NHS Foundation Trust

Organisation Name:

NHS Foundation Trusts are required to make the following declarations to NHS Improvement :

1 & 2 *Systems for compliance with licence conditions - in accordance with General condition 6 of the NHS provider licence*
3 *Availability of resources and accompanying statement - in accordance with Continuity of Services condition 7 of the NHS provider licence*
4 *Corporate Governance Statement - in accordance with the Risk Assessment Framework*
5 *Certification on AHSCs and governance - in accordance with Appendix E of the Risk Assessment Framework*
6 *Certification on training of Governors - in accordance with s151(5) of the Health and Social Care Act*

Declarations 1 and 2 above are set out this template, which is required to be returned to NHS Improvement by 31 May 2016.
Declaration 3 is included in the APR 2016/17 Final Financial Template, which is required to be returned to NHS Improvement per communications on final operational plan submissions.
Declarations 4, 5 and 6 above are set out in a separate template, which is required to be returned to NHS Improvement by 30 June 2016.

Templates should be returned via the Trust portal, marked as a Trust Return with the activity type set to Annual Plan Review.

How to use this template

1) Copy this file to your Local Network or Computer.
2) Select the name of your organisation from the drop-down box at the top of this worksheet.
3) In the Certifications G6 worksheet, enter responses and information into the yellow data-entry cells as appropriate.
4) Once the data has been entered, add signatures to the document, as described below.
5) Use the Save File button at the top of this worksheet to save the file to your Network or Computer - note that the name of the saved file is set automatically - please do not change this name.
6) Copy the saved file to your outbox in your NHS Improvement Portal.

Notes: *NHS Improvement will accept either:*
1) electronic signatures inserted into this worksheet (save signature file locally and use 'Insert - Picture' from the toolbar/ribbon to do this) or
2) hand written signatures on a paper printout of this declaration posted to NHS Improvement to arrive by the submission deadline.

In the event than an NHS foundation trust is unable to fully self certify, it should NOT select 'Confirmed' in the relevant box. It must provide commentary (using the section provided at the end of this declaration) explaining the reasons for the absence of a full self certification and the action it proposes to take to address it.

Worksheet "Certification G6"

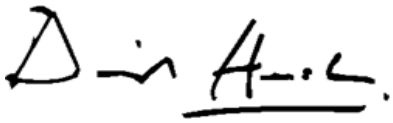
Declarations required by General condition 6 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with license conditions

1	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied, as the case may be that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.	Confirmed
	AND	
2	The board declares that the Licensee continues to meet the criteria for holding a licence.	Confirmed

Signed on behalf of the board of directors, and having regard to the views of the governors

Signature		Signature	
Name	Louise Shepherd	**Name**	Sir David Henshaw
Capacity	Chief Executive	**Capacity**	Chairman
Date	23rd May 2016	**Date**	23rd May 2016

Further explanatory information should be provided below where the Board has been unable to confirm declarations 1 or 2 above.

A

B

Self-Certification Template

FT Name: Alder Hey Children's NHS Foundation Trust

Organisation Name:

NHS Foundation Trusts are required to make the following declarations to NHS Improvement:

1 & 2 *Systems for compliance with licence conditions - in accordance with General condition 6 of the NHS provider licence*
3 *Availability of resources and accompanying statement - in accordance with Continuity of Services condition 7 of the NHS provider licence*
4 *Corporate Governance Statement - in accordance with the Risk Assessment Framework*
5 *Certification on AHSCs and governance - in accordance with Appendix E of the Risk Assessment Framework*
6 *Certification on training of Governors - in accordance with s151(5) of the Health and Social Care Act*

Declarations 1 and 2 above are set out in a separate template, which is required to be returned to NHS Improvement by 31 May 2016.
Declaration 3 is included in the APR 2015/16 Final Financial Template, which is required to be returned to NHS Improvement per communications on final operational plan submissions.
Declarations 4, 5 and 6 above are set out in this template, which is required to be returned to NHS Improvement by 30 June 2016.

Templates should be returned via the Trust portal, marked as a Trust Return with the activity type set to Annual Plan Review.

How to use this template

1) Copy this file to your Local Network or Computer.
2) Select the name of your organisation from the drop-down box at the top of this worksheet.
3) In the Corporate Governance Statement and Other Certifications worksheets, enter responses and information into the yellow data-entry cells as appropriate.
4) Once the data has been entered, add signatures to the document, as described below.
5) Use the Save File button at the top of this worksheet to save the file to your Network or Computer - note that the name of the saved file is set automatically - please do not change this name.
6) Copy the saved file to your outbox in your NHS Improvement Portal.

Notes: *NHS Improvement will accept either:*
1) electronic signatures inserted into this worksheet (save signature file locally and use 'Insert - Picture' from the toolbar/ribbon to do this) or
2) hand written signatures on a paper printout of this declaration posted to NHS Improvement to arrive by the submission deadline.

In the event than an NHS foundation trust is unable to fully self certify, it should NOT select 'Confirmed' in the relevant box. It must provide commentary (using the section provided at the end of this declaration) explaining the reasons for the absence of a full self certification and the action it proposes to take to address it.

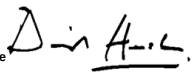
Worksheet "Corporate Governance Statement"

Corporate Governance Statement

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

4	Corporate Governance Statement	Response	Risks and mitigating actions
1	The Board is satisfied that the Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	[including where the Board is able to respond "Confirmed"]
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	
3	The Board is satisfied that the Trust implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	
4	The Board is satisfied that the Trust effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and NHS Improvement delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed	
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Trust, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Trust including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	
6	The Board is satisfied that there are systems to ensure that the Trust has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	

Signed on behalf of the board of directors, and having regard to the views of the governors

Signature  **Signature** 

Name Louise Shepherd **Name** Sir David Henshaw

The board are unable make one of more of the above confirmations and accordingly declare:

A

B

C

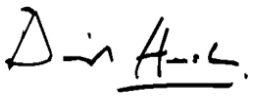
Worksheet "Other declarations"

Certification on AHSCs and governance and training of governors

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements. Explanatory information should be provided where required.

5	**Certification on AHSCs and governance**	**Response**
	For NHS foundation trusts: • that are part of a major Joint Venture or Academic Health Science Centre (AHSC); or • whose Boards are considering entering into either a major Joint Venture or an AHSC.	
	The Board is satisfied it has or continues to: • ensure that the partnership will not inhibit the trust from remaining at all times compliant with the conditions of its licence; • have appropriate governance structures in place to maintain the decision making autonomy of the trust; • conduct an appropriate level of due diligence relating to the partners when required; • consider implications of the partnership on the trust's financial risk rating having taken full account of any contingent liabilities arising and reasonable downside sensitivities; • consider implications of the partnership on the trust's governance processes; • conduct appropriate inquiry about the nature of services provided by the partnership, especially clinical, research and education services, and consider reputational risk; • comply with any consultation requirements; • have in place the organisational and management capacity to deliver the benefits of the partnership; • involve senior clinicians at appropriate levels in the decision-making process and receive assurance from them that there are no material concerns in relation to the partnership, including consideration of any re-configuration of clinical, research or education services; • address any relevant legal and regulatory issues (including any relevant to staff, intellectual property and compliance of the partners with their own regulatory and legal framework); • ensure appropriate commercial risks are reviewed; • maintain the register of interests and no residual material conflicts identified; and • engage the governors of the trust in the development of plans and give them an opportunity to express a view on these plans.	Confirmed
6	**Training of Governors**	
	The Board is satisfied that during the financial year most recently ended the Trust has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.	Confirmed

Signed on behalf of the Board of directors, and having regard to the views of the governors

Signature		Signature	
Name	Louise Shepherd	**Name**	Sir David Henshaw
Capacity	Chief Executive	**Capacity**	Chief Executive
Date	23 May 2016	**Date**	23 May 2016

Where boards are unable to self-certify, they should make an alternative declaration by amending the self-certification as necessary, and including any significant prospective risks and concerns the foundation trust has in respect of delivering quality services and effective quality governance

The Board are unable make one of more of the confirmations on the preceding page and accordingly declare:

A

B

C

Corporate Report

Apr 2016

Corporate Report

Alder Hey Children's NHS
NHS Foundation Trust

Table of Contents

Executive Summary

Apr 2016

Alder Hey Children's NHS Foundation Trust

Is there a Governance Issue?

May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
N	N	N	N	N	N	N	N	N	N	N	N

Highlights

ED performance exceeded 95% standard in April 2016. Focus to reduce ED breaches attributable to delays in General Paediatrics is underway. This action will better support continued improved ED performance for Q1 and Q2. Focus on Outpatient bookings to improve utilisation has continued into April. However, sustainable improvement will be delivered through the Service Improvement Workstream. Diagnostic, Cancer and RTT incomplete pathway standards have been achieved.

Challenges

Streamlined performance management arrangements to improve sustainability of delivery across the key patient centred metrics, quality, workforce and finance is being introduced in May 2016. This strengthens Trust response to day to day issues and resilience in terms of a forward look. Strengthening data quality so that reported performance is 'right first time' is a key area for improvement, that will better support overall improvement against patient access standards. There are some emerging challenges with delivery of run rate and RTT, which require whole-Trust solutions and this will be delivered through a new 6-week Task and Finish Group to deliver the Run Rate for 2016-2017.

Patient Centred Services

The Trust has made a good start to 2016 – 2017 performance against Patient Access Targets.

Excellence in Quality

All patient safety and clinical effectiveness improvement targets for April have been achieved or exceeded, with the exception of acute readmission of patients with long term conditions within 28 days, which has exceed the monthly target by 1. In addition there has been 2 SIRI's in April.

Financial, Growth & Mandatory Framework

"At the end of April the Trust is reporting a deficit position of £2.5m which is £0.4m behind plan.
Income is behind plan by £0.4 largely relating to elective activity which is behind plan by 9% and outpatient activity which is behind by 10%.
Pay budgets are £0.1m overspent relating to use of agency staffing. The Trust is £0.2m behind the CIP target.
Cash in the Bank is £6.9m. Monitor risk rating of 1 for the year."

Great Talented Teams

Sickness absence rates remain static at 5.3%. PDR compliance has dropped to 2.8% as the PDR window reopened on 1 April. There are reduced rates of compliance for both Mandatory Training and Corporate Induction. Work continues to progress all KPIs.

Leading Metrics

Apr 2016

Alder Hey Children's NHS Foundation Trust

Patient Centered Services

Metric Name	Goal	Mar 2016	Apr 2016	Trend	Last 12 Months
ED: 95% Treated within 4 Hours	95.0 %	82.5 %	95.7 %	▲	
RTT: 90% Admitted within 18 weeks		88.3 %	88.3 %	▲	
RTT: 95% Non-Admitted within 18 weeks		85.7 %	89.6 %	▲	
RTT: 92% Waiting within 18 weeks (open Pathways)	92.0 %	92.3 %	92.2 %	▼	
Diagnostics: Numbers waiting over 6 weeks		1	0	▼	
Average LoS - Elective (Days)		3.0	2.8	▼	
Average LoS - Non-Elective (Days)		2.6	2.5	▼	
Daycase Rate	0.0 %	75.0 %	70.0 %	▼	
Theatre Utilisation - % of Session Utilised	85.0 %	77.4 %	75.5 %	▼	
28 Day Breaches	0.0	7	7	–	
Clinic Session Utilisation	90.0 %	81.7 %	79.4 %	▼	
DNA Rate	12.0 %	11.5 %	9.5 %	▼	
Cancelled Operations - Non Clinical - On Same Day		48	34	▼	

Excellence in Quality

Metric Name	Goal	Mar 2016	Apr 2016	Trend	Last 12 Months
Never Events	0.0	1	0	▼	
IP Survey: % Received information enabling choices about their care	90.0 %	93.7 %	95.2 %	▲	
IP Survey: % Treated with respect	90.0 %	98.4 %	99.3 %	▲	
IP Survey: % Know their planned date of discharge		44.2 %	62.0 %	▲	
IP Survey: % Know who is in charge of their care		84.9 %	85.5 %	▲	
IP Survey: % Patients involved in play and learning		52.4 %	60.4 %	▲	
Pressure Ulcers (Grade 2 and above)	3.0	24	3	▲	
Total Infections (YTD)	10.0	119	6	▼	
Medication errors resulting in harm (YTD)	7.0	85	7	▼	
Clinical Incidents resulting in harm (YTD)	57.0	670	50	▼	

Great and Talented Teams

Metric Name	Goal	Mar 2016	Apr 2016	Trend	Last 12 Months
Corporate Induction	100.0 %	87.1 %	64.3 %	▼	
PDR	90.0 %	90.1 %	2.8 %	▼	
Medical Appraisal	100.0 %	92.0 %	96.9 %	▲	
Sickness	4.5 %	5.3 %	5.2 %	▼	
Mandatory Training	90.0 %	82.3 %	81.2 %	▼	
Staff Survey (Recommend Place to Work)		44.2 %	27.8 %	▼	
Actual vs Planned Establishment (%)		90.6 %	88.4 %	▼	
Temporary Spend ('000s)		1210	971	▼	

Financial, Growth and Mandatory Framework

Metric Name	Mar 2016	Apr 2016	Last 12 Months
CIP In Month Variance ('000s)	-368	-179	
Monitor Risk Ratings (YTD)	2	1	
Normalised I & E surplus/(deficit) In Month ('000s)	687	-2455	
Capital Expenditure YTD % Variance	2.8 %	0.3 %	
Cash in Bank (£m)	11	7	

Exceptions

Apr 2016

Alder Hey Children's NHS Foundation Trust

Positive (Top 5 based on % change)

Metric Name	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	Last 12 Months
DNA Rate	11.7%	12.1%	14.0%	15.5%	14.6%	13.4%	13.4%	11.8%	12.9%	12.0%	11.3%	11.5%	9.5%	
IP Survey: % Know their planned date of discharge	47.2%	57.8%	53.1%	44.4%	52.9%	58.7%	53.3%	42.9%	34.9%	40.0%	35.3%	44.2%	62.0%	
Pressure Ulcers (Grade 2 and above)	2	3	5	7	8	8	11	13	13	15	22	24	3	
Total Infections (YTD)	11	18	31	37	45	56	65	73	89	103	111	119	6	
Normalised I & E surplus/(deficit) In Month ('000s)	-262	-392	505	160	-1,276	-101	-1,570	-907	-439	-608	-276	687	-2,455	

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

Metric Name	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	Last 12 Months
RTT: 92% Waiting within 18 weeks (open Pathways)	92.2%	92.1%	92.0%	92.1%	92.1%	92.1%	92.1%	92.2%	92.2%	92.2%	92.5%	92.3%	92.2%	
Average LoS - Non-Elective (Days)	2.7	2.8	2.6	2.8	2.6	2.4	2.3	2.5	2.6	2.2	2.4	2.6	2.5	
Theatre Utilisation - % of Session Utilised	83.0%	82.5%	83.9%				68.8%	74.2%	69.3%	72.5%	75.8%	77.4%	75.5%	
IP Survey: % Received information enabling choices about their care	95.8%	94.3%	95.7%	95.1%	94.9%	96.7%	95.6%	97.3%	90.7%	96.0%	96.1%	93.7%	95.2%	
Mandatory Training	64.9%	62.0%	71.7%	72.0%	76.4%	78.9%	77.2%	84.0%	83.7%	83.4%	82.7%	82.3%	81.2%	

Challenge (Top 5 based on % change)

Metric Name	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	Last 12 Months
28 Day Breaches	5	2	1	12	5	4	2	3	10	4	5	7	7	
Clinic Session Utilisation	83.8%	90.3%	81.3%	84.0%	79.2%	80.0%	75.2%	81.9%	80.3%	83.6%	81.3%	81.7%	79.4%	
Corporate Induction	46.4%	71.4%	70.8%	85.0%	82.1%	100.0%	80.9%	91.7%	96.8%	85.7%	72.2%	87.1%	64.3%	
PDR	27.7%	30.3%	89.3%	89.3%	90.1%	90.1%	90.1%	90.1%	90.1%	90.1%	90.1%	90.1%	2.8%	
Monitor Risk Ratings (YTD)	4	3	4	4	2	2	2	2	2	2	2	2	1	

Patient Safety

Apr 2016

Alder Hey Children's NHS Foundation Trust

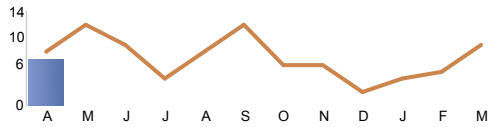
Summary

All patient safety improvement targets for April have been achieved or exceeded. In addition there has been 2 SIRI's.

16/17 15/16 Threshold

Medication Errors

Medication errors resulting in harm (YTD) — 7 (goal: 7.0)



YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
16/17	7											
15/16	8	20	29	33	41	53	59	65	67	71	76	85

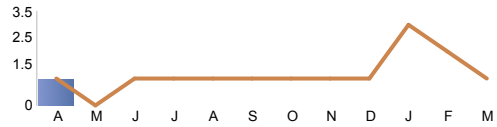
Pressure Ulcers

Pressure Ulcers (Grade 2 and above) — 3 (goal: 3.0)

YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
16/17	3											
15/16	2	3	5	7	8	8	11	13	13	15	22	24

Readmissions to PICU within 48 hrs

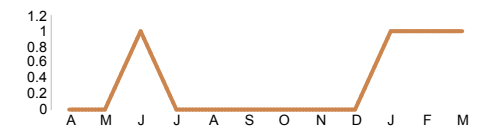
Readmissions to PICU within 48 hrs (YTD) — 1 (goal: 2.0)



YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
16/17	1											
15/16	1	1	2	3	4	5	6	7	8	11	13	14

Never Events

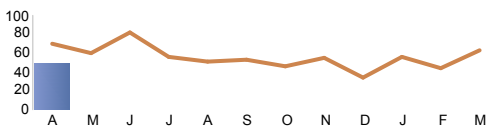
Never Events — 0 (goal: 0.0)



YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
16/17	0											
15/16	0	0	1	1	1	1	1	1	1	2	3	4

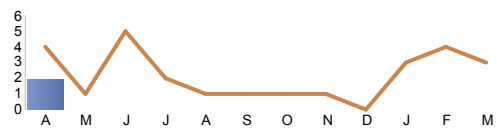
Incidents

Clinical Incidents resulting in harm (YTD) — 50 (goal: 57.0)



YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
16/17	50											
15/16	70	130	212	268	319	372	418	473	507	563	607	670

Clinical Incidents resulting in moderate, severe harm or death (YTD) — 2 (goal: 5.0)



YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
16/17	2											
15/16	4	5	10	12	13	14	15	16	16	19	23	26

Serious incidents requiring investigation

Serious Incidents Requiring Investigation (Total) — 2

YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
16/17	2											
15/16	1	1	5	5	6	8	9	9	11	12	14	16

Patient Experience

Apr 2016

Alder Hey Children's NHS Foundation Trust

Summary

Complaints and PALs are undergoing revalidation and may not reflect accurate picture, this is to be resolved May 2016. Patient and carer feedback via Fabio regarding planned date of discharge/availability of play resources continue to show low satisfaction scores. This requires more detailed analysis, to be presented CQSG May 2016. Number of Friends and Family Test responses has increased. Aim to increase the amount of feedback in community and CAMHS which will be discussed with ICS management.

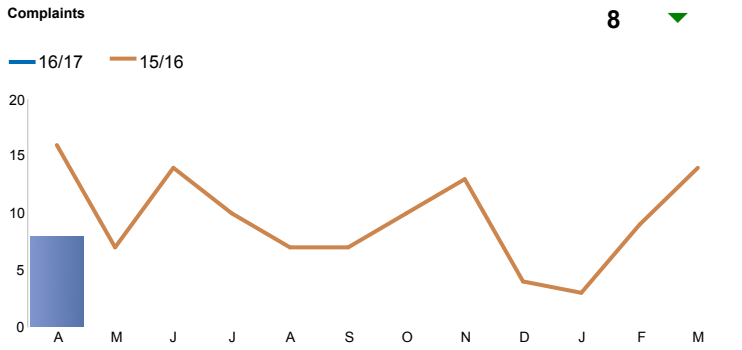
Inpatient Survey

Metric Name	Goal	Mar 2016	Apr 2016	Trend	Last 12 Months
% Know who is in charge of their care		84.9 %	85.5 %	▲	
% Patients involved in play and learning		52.4 %	60.4 %	▲	
% Know their planned date of discharge		44.2 %	62.0 %	▲	
% Received information enabling choices about their care	90.0 %	93.7 %	95.2 %	▲	
% Treated with respect	90.0 %	98.4 %	99.3 %	▲	

Friends and Family

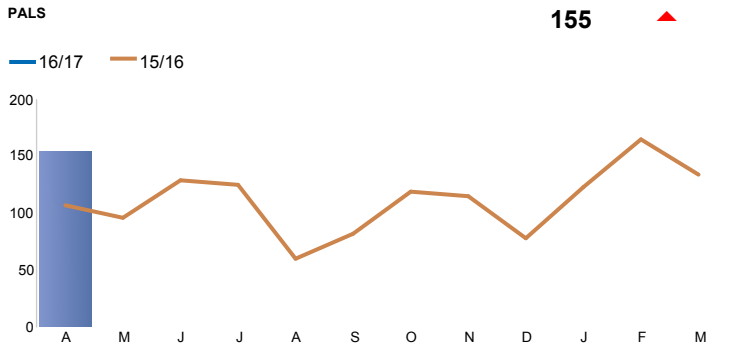
Metric Name	Number of Responses	Mar 2016	Apr 2016	Trend	Last 12 Months
A&E - % Recommend the Trust	75	86.6 %	84.0 %	▼	
Community - % Recommend the Trust	0	TBC	TBC		
Inpatients - % Recommend the Trust	131	94.0 %	86.3 %	▼	
Mental Health - % Recommend the Trust	3	90.0 %	100.0 %	▲	
Outpatients - % Recommend the Trust	300	77.6 %	80.3 %	▲	

Complaints



YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
16/17	8											
15/16	16	23	37	47	54	61	71	84	88	91	100	114

PALS



YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
16/17	155											
15/16	107	203	332	457	517	599	718	833	911	1,034	1,199	1,333

Clinical Effectiveness

Apr 2016

Alder Hey Children's NHS Foundation Trust

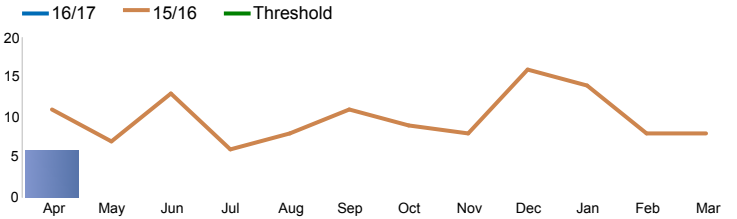
Summary

All clinical effectiveness improvement targets for April are being met or exceeded, with the exception of acute readmission of patients with long term conditions within 28 days, which has exceed the monthly target by 1.

Infections

Total Infections (YTD)

6 (goal: 10.0)



YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
16/17	6											
15/16	11	18	31	37	45	56	65	73	89	103	111	119

Total Infections (YTD)

6 (goal: 10.0)

Hospital Acquired Organisms - MRSA (BSI) (YTD)

0 (goal: 0.0)

Hospital Acquired Organisms - C.difficile (YTD)

0 (goal: 0.0)

Outbreak Infections (YTD)

0

Cluster Infections (YTD)

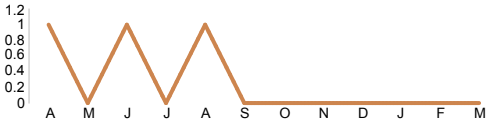
0

Legend

16/17
15/16
Threshold

Hospital Acquired Organisms - MRSA (BSI)

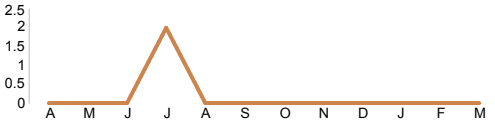
0 (goal: 0.0)



YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
16/17	0											
15/16	1	1	2	2	3	3	3	3	3	3	3	3

Hospital Acquired Organisms - C.difficile

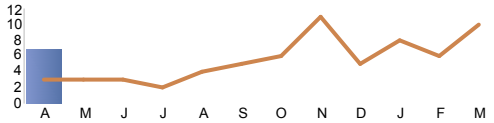
0 (goal: 0.0)



YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
16/17	0											
15/16	0	0	0	2	2	2	2	2	2	2	2	2

Acute readmissions of patients with long term conditions within 28 days

7 (goal: 5.0)

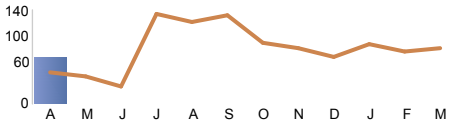


YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
16/17	7											
15/16	3	6	9	11	15	20	26	37	42	50	56	66

Admissions & Discharges

Patients with an estimated discharge date discharge later than planned (only surgical)

71 (goal: 84.0)



% of patients with an estimated discharge date discharge later than planned (only surgical)

YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
16/17	71											
15/16	47	88	114	248	370	502	593	676	746	835	913	996

YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
15/16	3.4%	3.3%	2.8%	4.6%	5.5%	6.1%	6.5%	6.4%	6.4%	6.4%	6.3%	6.3%

Access

Apr 2016

Alder Hey Children's NHS Foundation Trust

Summary

Incomplete pathway, cancer and diagnostic standards achieved; admitted and non admitted standards failed in line with planning assumptions. Increased levels of admissions/discharges and activity noted against the same period last year. Referrals received continues to increase showing strong demand however this needs to be offset with capacity to manage. Choose & Book availability has improved with challenges noted in a small number of specialties. This is currently being reviewed to ensure demand and capacity are matched.

18 Weeks

RTT: 90% Admitted within 18 weeks 88.3 %

Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
90.3%	89.3%	91.5%	86.0%	88.3%

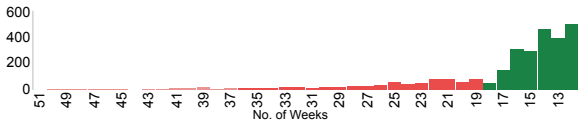
RTT: 95% Non-Admitted within 18 weeks 89.6 %

Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
95.2%	93.7%	88.3%	85.7%	89.6%

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

Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
92.1%	92.1%	92.2%	92.3%	92.2%

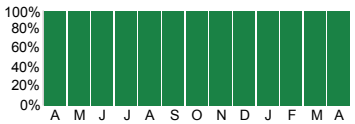
Open Pathways Weekly Profile Apr 2016



0-18 Wks	19-36 Wks	36-51 Wks
2,198	714	129

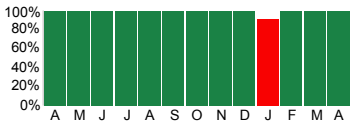
Cancer

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



Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
100.0%	100.0%	100.0%	100.0%	100.0%

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



Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
100.0%	100.0%	100.0%	96.3%	100.0%

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

Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
100.0%	100.0%	100.0%	100.0%	100.0%

Diagnostics

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

Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
98.6%	100.0%	99.7%	99.9%	100.0%

Waiting Times Failed 0

Waiting Times Passed 7

Number of Diagnostics

500

Admissions and Discharges

Bed Occupancy

Bed Occupancy (Funded Beds) 80.6 %

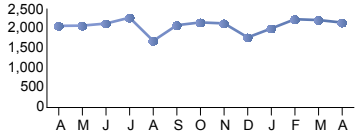
Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
		79.0%	79.8%	80.6%

Provider

Convenience and Choice: Slot Availability 95.6 % *(goal: 96.0 %)*

Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
99.9%		99.6%	93.7%	95.6%

Referrals Received (GP)



Emergency Department

Apr 2016

Alder Hey Children's NHS Foundation Trust

Summary

The 4 hour access target was achieved for the month of April, this was a combination of attendances returning to predicted levels, the introduction of slots for GP patients and the on-going development to streamline the triage process

ED

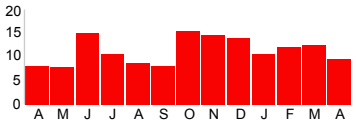
ED: 95% Treated within 4 Hours — 95.7 % (goal: 95.0 %)

Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
96.0%	95.3%	83.1%	84.5%	95.7%

ED: Total Time in ED (95th Percentile) — 239.0 mins (goal: 240.0 mins)

Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
730.0	736.0	1,101.4	1,046.0	239.0

ED: Longest Wait Time (Hrs) — 9.8 (goal: 0.0)



Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
31.4	27.8	44.6	35.7	9.8

ED: Number Treated Over 4 Hours

194

ED to Inpatient Conversion Rate

19.0 %

Apr 2016

ED

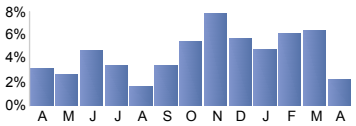
ED: 15 minute 'Time to Initial Assessment' (95th Percentile) — 0

Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
0.0	0.0	0.0	0.0	0.0

ED: 60 minute 'Time to Treat Decision' (Median) — 68.0 mins (goal: 60.0 mins)

Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
231.0	205.0	273.0	270.0	68.0

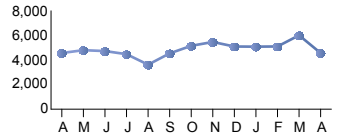
ED: Percentage Left without being seen — 2.3 %



Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
3.6%	3.0%	6.5%	5.9%	2.3%

ED: Number of Attendances

4563 Apr 2016



Ambulance Services

Ambulance: Acute Compliance — 90.7 % (goal: 85.0 %)

Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
75.9%	81.9%	82.8%	85.9%	90.7%

Ambulance: Average Notification to Handover Time (mins) — 3.3 mins (goal: 15.0 mins)

Ambulance: Patients Waiting between 30 and 45 minutes — 3

Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
16.0	10.0	7.0	16.0	3.0

Ambulance: Patients Waiting between 45 and 60 minutes — 1

Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
3.0	3.6	0.0	0.0	1.0

Productivity & Efficiency

Apr 2016

Alder Hey Children's NHS Foundation Trust

Summary

Elective activity negatively affected by the strike resulting in skewed admission profile. Low volumes of discharges due to acuity has impacted upon flow and delayed theatre start times and utilisation. OP utilisation has plateaued and continues to be subject to weekly review and intervention. DNA rates have improved despite an increase in hospital initiated cancellations primarily due to the 48 hr strike. Cancelled ops on the day have reduced and 28 day relists have plateaued despite a high number of cancellations last month.

Length of Stay

Average LoS - Elective (Days) 2.8

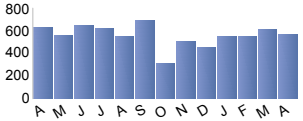
Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
2.7	2.8	3.0	2.9	2.8

Average LoS - Non-Elective (Days) 2.5

Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
2.7	2.6	2.5	2.4	2.5

Day Case Rate

Daycases (K1/SDCPREOP) 577



Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
1,856	1,892	1,300	1,737	577

Daycase Rate 70.0 % (goal: 0.0 %)

Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
75.8%	75.6%	75.0%	74.6%	70.0%

Bed Refusals

Bed Refusals 0 (goal: 0.0)

Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
0	0	1	0	0

Theatres / Surgery

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

Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
83.1%		71.0%	75.3%	75.5%

Cancelled Operations - Non Clinical - On Same Day (%) (YTD) 1.6 % (goal: 0.8 %)

Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
0.9%	1.0%	1.3%	1.5%	1.6%

Cancelled Operations - Non Clinical - On Same Day 34

Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
60	64	70	96	34

28 Day Breaches 7 (goal: 0.0)

Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
8	21	15	16	7

Outpatients

Clinic Session Utilisation * 79.4 % (goal: 90.0 %)

Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
85.2%	81.1%	79.5%	82.2%	79.4%

OP Appointments Cancelled by Hospital % 15.8 % (goal: 5.0 %)

Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
16.4%	14.2%	15.7%	14.9%	15.8%

DNA Rate 9.5 % (goal: 12.0 %)

Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
12.6%	14.5%	12.6%	11.6%	9.5%

OP: New/Follow Up 2.3

Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
2.3	2.3	2.3	2.4	2.3

Facilities

Apr 2016

Alder Hey Children's NHS Foundation Trust

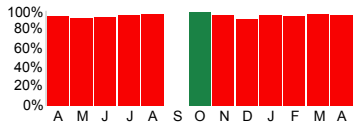
Summary

Audit Compliance (85%) April 2016 62/79 78% (below national standard due to Auditors working/cleaning new areas of retained estate. VHR Critical Care (98%) - 97.1% - Lower than national standard High Risk General Wards (95%) - 96.28 1.28% above national standard Significant Risk - Clinics (85%) -98% 13% Higher than National Standard Low- Non Cllinical Areas - non scheduled Of 75 audits undertaken 9 areas reached nursing scores of between 98-100% meeting or exceeding the national standard. Critical care requires further monitoring Patient Food Wastage - Ward 0% due to making meals on request.

Facilities

Cleanliness Performance VH

97.1 % (goal: 98.0 %)



Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
94.5%	97.0%	96.3%	96.5%	97.1%

Cleanliness Performance H

96.3 % (goal: 95.0 %)

Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
94.0%	95.0%	97.0%	94.8%	96.3%

Cleanliness Performance S

98.5 % (goal: 85.0 %)

Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
86.4%	93.4%	95.0%	94.6%	98.5%

Cleanliness Performance L

0.0 % (goal: 75.0 %)

Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
70.0%	82.0%	96.0%	0.0%	0.0%

Facilities

Patient Food Wastage

0.0 %

Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
		0.0%	0.0%	0.0%

Audit Compliance

78.0 % (goal: 85.0 %)

Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
100.0%	85.1%	98.8%	98.4%	78.0%

Facilities - Other

Routine Maintenance Resolution

99.2 % (goal: 85.0 %)

Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
96.8%	97.7%	95.6%	67.3%	99.2%

PPM%

96.3 % (goal: 85.0 %)

Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
95.5%	96.3%	30.8%	92.6%	96.3%

CAMHS

Apr 2016

Alder Hey Children's NHS Foundation Trust

Summary

Slight increase in waiting times to initial assessment during March due to Easter and bank holidays. On-going monitoring to ensure plan falls back min line with trajectory.

Waiting Times

CAMHS: Avg Wait to Choice Appt (Weeks) 0.0

Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
0.0	0.0	14.2	18.8	0.0

CAMHS: Avg Wait to Partnership Appt (Weeks) 0.0

Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
0.0	0.0	17.4	26.9	0.0

DNA Rates

CAMHS: DNA Rate - New 13.1 % (goal: 10.0 %)

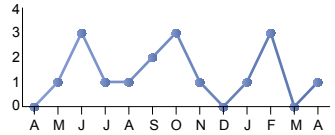
Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
19.3%	22.9%	18.6%	18.6%	13.1%

CAMHS: DNA Rate - Follow Up 12.9 % (goal: 14.0 %)

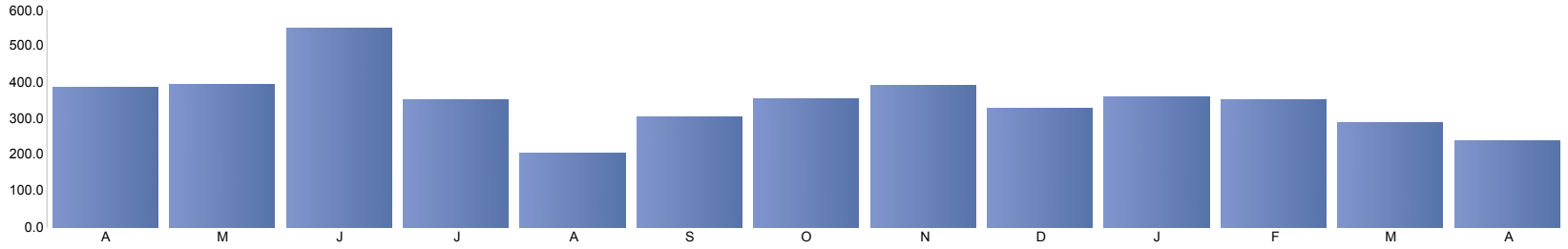
Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
16.9%	17.0%	15.2%	13.4%	12.9%

Tier 4 Admissions

CAMHS: Total Admissions to DJU 1



CAMHS: Referrals Received



External Regulation

Apr 2016

Alder Hey Children's NHS Foundation Trust

Summary

Monitor: The Trust continues to be fully compliant with its Provider Licence. CQC: The Trust was awarded an overall rating of 'Good' following the inspection in June 2015. It remains registered without conditions.

Monitor - Governance Concern

May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16
N	N	N	N	N	N	N	N	N	N	N	N

Monitor - Risk Rating

May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16
3	4	4	2	2	2	2	2	2	2	2	1

Monitor Apr 2016

Metric Name	Goal	Mar 16	Apr 16	Trend
ED: 95% Treated within 4 Hours	95.0 %	82.5 %	95.7 %	▲
RTT: 90% Admitted within 18 weeks		88.3 %	88.3 %	▲
RTT: 95% Non-Admitted within 18 weeks		85.7 %	89.6 %	▲
RTT: 92% Waiting within 18 weeks (open Pathways)	92.0 %	92.3 %	92.2 %	▼
Monitor Risk Ratings (YTD)	3.0	2	1	▼
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals	100.0 %	100.0 %	100.0 %	–
All Cancers: 31 day wait referral to treament	100.0 %	100.0 %	100.0 %	–
All Cancers: 31 day wait until subsequent treatments	100.0 %	100.0 %	100.0 %	–
Hospital Acquired Organisms - C.difficile	0.0	0	0	–

Monitor - 18 Weeks RTT

RTT: 90% Admitted within 18 weeks

Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
90.3%	89.3%	91.5%	86.0%	88.3%

RTT: 95% Non-Admitted within 18 weeks

Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
95.2%	93.7%	88.3%	85.7%	89.6%

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

Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
92.1%	92.1%	92.2%	92.3%	92.2%

Monitor - All Cancers

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

Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
100.0%	100.0%	100.0%	100.0%	100.0%

All Cancers: 31 day wait referral to treament

Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
100.0%	100.0%	100.0%	96.3%	100.0%

All Cancers: 31 day wait until subsequent treatments

Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
100.0%	100.0%	100.0%	100.0%	100.0%

Monitor - A&E 4 Hour Target

Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
96.0%	95.3%	83.1%	84.5%	95.7%

Monitor - C difficile

Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
0	2	0	0	0

Monitor - Data Completeness

No Data Available

Workforce

Apr 2016

Alder Hey Children's NHS Foundation Trust

Summary

Sickness absence rates remain static at 5.3%. PDR compliance has dropped to 2.8% as the PDR window reopened on 1 April. There are reduced rates of compliance for both Mandatory Training and Corporate Induction. Work continues to progress all KPIs.

Staff Group Analysis

Sickness Absence (rolling 12 Months)

Staff Group	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	Last 12 Months
Add Prof Scientific and Technic	3.0%	3.6%	4.0%	3.2%	1.3%	2.7%	2.8%	4.3%	4.1%	4.5%	4.2%	2.0%	2.4%	
Additional Clinical Services	8.9%	7.0%	5.3%	5.7%	6.5%	7.0%	7.5%	8.6%	7.6%	6.8%	6.7%	7.5%	6.9%	
Administrative and Clerical	3.8%	4.0%	3.6%	3.3%	3.2%	3.3%	3.8%	4.6%	4.7%	4.0%	4.5%	3.7%	4.2%	
Allied Health Professionals	1.8%	2.4%	1.6%	1.4%	1.4%	1.4%	1.4%	2.3%	2.4%	3.6%	2.4%	2.7%	2.6%	
Estates and Ancillary	5.5%	6.5%	6.8%	5.7%	4.8%	5.6%	5.5%	7.6%	9.8%	9.2%	9.6%	8.1%	8.2%	
Healthcare Scientists	5.0%	5.5%	4.4%	2.8%	1.0%	0.9%	1.5%	1.3%	2.0%	2.2%	2.2%	1.6%	2.4%	
Medical and Dental	2.4%	2.2%	2.5%	2.1%	1.2%	1.3%	0.8%	1.7%	1.5%	1.8%	2.2%	2.4%	1.9%	
Nursing and Midwifery Registered	5.0%	4.8%	5.5%	5.8%	5.2%	6.1%	5.8%	6.8%	6.5%	7.4%	7.6%	7.0%	6.7%	
Trust	4.8%	4.6%	4.6%	4.4%	3.9%	4.5%	4.6%	5.6%	5.5%	5.7%	5.8%	5.3%	5.2%	

Staff in Post FTE (rolling 12 Months)

Staff Group	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	Last 12 Months
Add Prof Scientific and Technic	185	186	187	184	187	193	171	174	174	177	179	180	185	
Additional Clinical Services	360	353	354	352	351	359	352	346	348	359	360	360	360	
Administrative and Clerical	528	530	533	542	538	534	532	534	531	529	532	525	536	
Allied Health Professionals	120	121	124	126	125	126	126	127	127	126	126	127	126	
Estates and Ancillary	145	147	148	148	147	153	169	172	173	172	173	172	188	
Healthcare Scientists	99	100	98	100	102	102	102	102	100	100	99	100	101	
Medical and Dental	232	228	228	229	229	229	229	231	235	237	230	234	236	
Nursing and Midwifery Registered	900	907	907	903	898	914	948	946	945	947	951	946	939	

Staff in Post Headcount (rolling 12 Months)

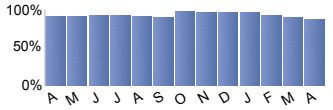
Staff Group	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	Last 12 Months
Add Prof Scientific and Technic	209	211	212	207	210	218	192	195	196	197	198	200	205	
Additional Clinical Services	416	411	414	411	411	420	414	410	411	422	423	425	425	
Administrative and Clerical	616	618	621	633	630	624	622	624	621	618	622	613	624	
Allied Health Professionals	148	148	153	155	153	154	155	156	156	155	155	156	155	
Estates and Ancillary	185	190	192	194	193	198	212	214	213	211	211	210	237	
Healthcare Scientists	109	110	108	110	113	113	113	113	111	111	110	111	111	
Medical and Dental	270	267	265	268	268	267	266	268	271	274	269	273	275	
Nursing and Midwifery Registered	1,024	1,032	1,032	1,025	1,020	1,039	1,076	1,073	1,070	1,073	1,077	1,070	1,063	

Finance

Temporary Spend ('000s) 971

Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
3	3	3	3	1

Actual vs Planned Establishment (%) 88.4 %



Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
92.0%	92.0%	97.7%	93.4%	88.4%

Appraisals

Medical Appraisal 96.9 % (goal: 100.0 %)

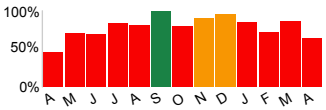
Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
97.1%	97.1%	97.1%	90.5%	96.9%

PDR 2.8 % (goal: 90.0 %)

Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
45.4%	89.9%	90.1%	90.1%	2.8%

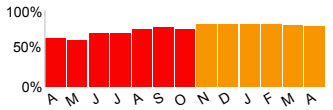
Training

Corporate Induction 64.3 % (goal: 100.0 %)



Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
63.8%	87.1%	88.2%	83.5%	64.3%

Mandatory Training 81.2 % (goal: 90.0 %)



Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
65.5%	75.8%	81.7%	82.8%	81.2%

Health and Safety

RIDDOR 0

Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17
1	4	9	6	0

Performance by CBU

Apr 2016

Alder Hey Children's NHS
NHS Foundation Trust

Operational

Metric name	ICS	MED SPECS	NMSS	SCACC
Clinic Session Utilisation	62.1%	81.0%	88.0%	84.3%
Convenience and Choice: Slot Availability	85.3%	95.5%	97.0%	98.1%
DNA Rate (Followup Appts)	12.4%	7.7%	9.0%	8.1%
DNA Rate (New Appts)	13.7%	9.6%	9.0%	7.4%
Normalised I & E surplus/(deficit) In Month ('000s)	402	719	1,707	-391
Referrals Received (GP)	591	370	861	331
Temporary Spend ('000s)	185	80	156	274
Theatre Utilisation - % of Session Utilised		74.3%	80.9%	77.3%

Patient

Metric name	ICS	MED SPECS	NMSS	SCACC
Average LoS - Elective (Days)	1.3	3.3	2.6	3.0
Average LoS - Non-Elective (Days)	1.7	2.8	2.6	3.3
Cancelled Operations - Non Clinical - On Same Day	0	1	15	15
Daycases (K1/SDCPREOP)	1	76	330	165
Diagnostics: % Completed Within 6 Weeks	100.0%	100.0%	100.0%	100.0%
Hospital Initiated Clinic Cancellations < 6 weeks notice	1	4	29	1
OP Appointments Cancelled by Hospital %	14.8%	14.7%	17.6%	13.4%
RTT: 90% Admitted within 18 weeks		100.0%	86.7%	88.8%
RTT: 92% Waiting within 18 weeks (open Pathways)	91.9%	97.0%	89.5%	96.6%
RTT: 95% Non-Admitted within 18 weeks	84.7%	91.7%	89.1%	93.1%

Quality

Metric name	ICS	MED SPECS	NMSS	SCACC
Cleanliness Scores	98.0%	99.0%	96.3%	96.4%
Hospital Acquired Organisms - C.difficile	0	0	0	0
Hospital Acquired Organisms - MRSA (BSI)	0	0	0	0
Medication Errors (Incidents)	7	1	0	16

Workforce

Metric name	ICS	MED SPECS	NMSS	SCACC
Corporate Induction	60.0%	100.0%	66.7%	50.0%
Mandatory Training	75.0%	85.4%	85.3%	86.9%
PDR	0.9%	3.6%	10.1%	3.5%
Sickness	5.1%	6.6%	4.9%	5.8%

CBU Performance - Clinical Support

Apr 2016

Alder Hey Children's NHS
NHS Foundation Trust

Key Issues

All CSS CBU Metrics subject to review following agreement at latest CBU Performance Meeting following concerns raised regarding validity and usefulness of current KPIs.

Revised CSS CBU Performance Report anticipated for Q2 2016/7.

Support Required

All CSS CBU Metrics subject to review following agreement at latest CBU Performance Meeting following concerns raised regarding validity and usefulness of current KPIs. Revised CSS CBU Performance Report anticipated for Q2 2016/7.

Operational

Metric Name	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	Last 12 Months
Theatre Utilisation - % of Session Utilised	79.5%	88.8%	85.1%				53.2%	59.1%	59.1%	32.0%	46.6%	54.9%	42.4%	
Temporary Spend ('000s)	131	66	64	80	-5	66	67	63	48	64	58	52	89	
Normalised I & E surplus/(deficit) In Month ('000s)	-1,337	-1,134	-1,228	-1,176	-1,262	-1,333	-1,068	-1,179	-1,155	-1,253	-1,346	-1,300	-1,273	
Expenditure vs Budget ('000s)	0	0	0	0	0	0	0	0	0	0	0	0	0	

Patient

Metric Name	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	Last 12 Months
Imaging - % Report Turnaround times GP referrals < 24 hrs	95.0%	92.0%	95.0%	96.0%	97.0%	86.0%	93.0%	96.0%	97.9%	91.6%	98.0%	95.0%	85.0%	
Imaging - % Reporting Turnaround Times - ED	67.0%	80.0%	60.0%	78.0%	70.0%	76.0%	76.0%	72.0%	100.0%	91.0%	92.0%	91.0%	83.0%	
Imaging - % Reporting Turnaround Times - Inpatients	75.0%	86.0%	79.0%	90.0%	79.0%	86.0%	93.0%	81.0%	83.0%	93.0%	89.0%	83.0%	83.0%	
Imaging - % Reporting Turnaround Times - Outpatients	98.0%	97.0%	96.0%	97.0%	97.0%	96.0%	96.0%	97.0%	98.0%	98.0%	96.0%	97.0%	93.0%	
Imaging - Waiting Times - MRI % under 6 weeks	95.0%	99.0%	96.6%	97.7%	92.5%	100.0%	100.0%	95.0%	96.0%	85.0%	91.0%	90.0%	90.0%	
Imaging - Waiting Times - CT % under 1 week	90.0%	86.6%	85.0%	89.9%	85.6%	87.9%	87.9%	88.0%	96.0%	88.0%	88.0%	86.0%	94.0%	
Imaging - Waiting Times - Plain Film % under 24 hours	90.0%	94.2%	95.0%	91.7%	91.8%	95.4%	96.1%	95.0%	94.0%	95.0%	95.0%	95.0%	95.0%	
Imaging - Waiting Times - Ultrasound % under 2 weeks	90.0%	98.8%	97.8%	99.2%	99.0%	99.6%	99.6%	92.0%	85.0%	85.0%	85.0%	91.0%	92.0%	
Imaging - Waiting Times - Nuclear Medicine % under 2 weeks	94.7%	100.0%	100.0%	88.9%	81.2%	100.0%	100.0%	88.0%	91.0%	86.0%	95.0%	76.0%	96.0%	
BME - High Risk Equipment PPM Compliance	89.0%	89.0%	89.5%	88.0%	90.5%	88.0%	87.0%	89.0%	87.0%	89.0%	90.0%	88.0%	89.0%	
BME - Low Risk Equipment PPM Compliance	75.0%	75.0%	76.0%	74.0%	79.0%	87.0%	75.0%	76.0%	78.0%	78.0%	78.0%	78.0%	80.0%	
BME - Equipment Pool - Equipment Availability	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Pharmacy - Dispensing for Out Patients - Routine	61.0%	55.0%	49.0%	34.0%	50.0%	57.0%	63.0%	59.0%	87.0%	84.0%	85.0%	76.0%	74.0%	
Pharmacy - Dispensing for Out Patients - Complex	67.0%	79.0%	73.0%	67.0%	57.0%	65.0%		100.0%	100.0%	100.0%	100.0%	97.0%	100.0%	
Comm Therapy - % 1st Contact times following Pt opt in < 12 weeks	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	

Quality

Metric Name	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	Last 12 Months
Medication Errors (Incidents)	0	0	0	0	0	0	0	0	0	0	0	0	0	
Hospital Acquired Organisms - MRSA (BSI)	0	0	0	0	0	0	0	0	0	0	0	0	0	
Hospital Acquired Organisms - C.difficile	0	0	0	0	0	0	0	0	0	0	0	0	0	
Pathology - % Turnaround times for urgent requests < 1 hr	87.6%	88.9%	82.3%	76.4%	82.0%	78.2%	71.9%	75.1%	79.6%	79.2%	82.9%	87.0%		
Pathology - % Turnaround times for non-urgent requests < 24hrs	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.8%	98.5%	95.1%	98.0%	99.0%		
Reporting times for perinatal autopsies in 56 Calendar Days	100.0%	98.8%	73.0%	92.9%	98.6%	98.7%	90.9%	100.0%	81.0%	68.8%	81.0%	88.9%		

Workforce

Metric Name	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	Last 12 Months
Corporate Induction	71.4%	90.0%	75.0%	100.0%	40.0%	100.0%	77.8%	100.0%	87.5%	71.4%	0.0%	75.0%	50.0%	
PDR	43.4%	44.9%	91.4%	91.4%	91.4%	91.4%	91.4%	91.4%	91.4%	91.4%	91.4%	91.4%	0.8%	
Sickness	3.8%	4.0%	2.9%	1.7%	1.8%	2.4%	3.2%	3.7%	4.4%	5.1%	5.1%	4.2%	4.8%	
Mandatory Training	69.4%	66.1%	77.4%	79.1%	80.5%	84.2%	80.3%	87.2%	87.2%	86.8%	86.2%	86.5%	85.6%	

CBU Performance - ICS

Apr 2016

Alder Hey Children's NHS Foundation Trust

Key Issues

With support from colleagues in finance the team continues to monitor the position against forecasts. Work is being carried out to validate all fields within PTL. PCOs are contacting all patients 72 hours before their appointment to ensure attendance, with robust monitoring of the DNA policy.

Support Required

NA

Operational

Metric Name	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	Last 12 Months
Theatre Utilisation - % of Session Utilised														
Clinic Session Utilisation	75.0%	75.9%	77.7%	81.5%	74.2%	73.3%	70.9%	75.4%	73.6%	75.4%	69.2%	69.5%	62.1%	
DNA Rate (New Appts)	13.4%	17.7%	24.2%	21.2%	20.4%	17.6%	19.6%	14.8%	17.5%	16.2%	16.6%	15.8%	13.7%	
DNA Rate (Followup Appts)	13.0%	14.3%	19.7%	16.7%	14.6%	14.9%	14.1%	13.3%	14.9%	13.7%	12.6%	13.9%	12.4%	
Convenience and Choice: Slot Availability	100.0%	100.0%						100.0%	100.0%	100.0%	98.8%	87.2%	85.3%	
Referrals Received (GP)	568	621	717	639	469	648	649	659	555	618	670	643	591	
Temporary Spend ('000s)	211	197	269	186	178	203	260	232	247	204	272	297	185	
Normalised I & E surplus/(deficit) In Month ('000s)	569	608	686	334	454	534	530	692	446	651	728	401	402	

Patient

Metric Name	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	Last 12 Months
RTT: 90% Admitted within 18 weeks											100.0%			
RTT: 95% Non-Admitted within 18 weeks	88.6%	90.4%	95.4%	97.2%	98.5%	90.6%	92.3%	87.8%	86.7%	84.4%	86.3%	84.6%	84.7%	
RTT: 92% Waiting within 18 weeks (open Pathways)	91.2%	90.9%	92.0%	92.2%	94.0%	93.3%	93.8%	91.1%	92.3%	91.8%	91.4%	92.4%	91.9%	
Average LoS - Elective (Days)	2.50	2.40	3.00	4.00	3.75	3.50	5.00	3.80	4.50	6.00	1.00	1.00	1.33	
Average LoS - Non-Elective (Days)	2.39	2.26	2.21	2.25	1.93	1.88	1.96	2.04	2.14	1.98	1.81	1.86	1.74	
Hospital Initiated Clinic Cancellations < 6 weeks notice	2	5	12	4	2	18	46	33	1	3	0	6	1	
Daycases (K1/SDCPREOP)	0	0	0	0	0	1	0	0	0	0	0	1	1	
Cancelled Operations - Non Clinical - On Same Day	0	0	0	0	0	0	0	0	0	0	0	0	0	
OP Appointments Cancelled by Hospital %	12.4%	11.0%	18.0%	13.9%	13.5%	11.4%	14.6%	13.7%	14.8%	11.9%	12.0%	12.9%	14.8%	
Diagnostics: % Completed Within 6 Weeks			100.0%							100.0%	100.0%	100.0%	100.0%	

Quality

Metric Name	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	Last 12 Months
Medication Errors (Incidents)	2	4	5	5	8	12	15	23	25	26	30	34	7	
Cleanliness Scores	94.7%		97.3%		98.5%			99.0%	99.0%	95.0%	98.0%	95.0%	98.0%	
Hospital Acquired Organisms - MRSA (BSI)	0	0	0	0	0	0	0	0	0	0	0	0	0	
Hospital Acquired Organisms - C.difficile	0	0	0	0	0	0	0	0	0	0	0	0	0	

Workforce

Metric Name	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	Last 12 Months
Corporate Induction	80.0%	85.7%	100.0%	66.7%	100.0%	100.0%	81.8%	100.0%	100.0%	93.8%	75.0%	50.0%	60.0%	
PDR	14.2%	19.8%	92.2%	92.2%	92.2%	92.2%	92.2%	92.2%	92.2%	92.2%	92.2%	92.2%	0.9%	
Sickness	4.8%	4.3%	4.2%	4.1%	3.2%	4.7%	5.3%	6.4%	4.8%	4.3%	5.3%	5.3%	5.1%	
Mandatory Training	65.4%	62.9%	71.9%	59.4%	74.4%	75.8%	76.2%	79.1%	76.6%	77.3%	76.8%	75.0%	75.0%	

CBU Performance - Medical Specialties

Apr 2016

Alder Hey Children's NHS
NHS Foundation Trust

Key Issues

Key issue is in month financial performance related to underachievement against income plan. CBU have set up an activity task and finish group to focus on action that will turn this position around quickly over a 6 week timeframe.

Support Required

None

Operational

Metric Name	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	Last 12 Months
Theatre Utilisation - % of Session Utilised	78.3%	83.9%	82.0%				58.0%	72.4%	69.9%	68.3%	74.1%	69.7%	74.3%	
Clinic Session Utilisation	79.9%	90.9%	75.5%	78.1%	76.0%	78.5%	76.9%	80.0%	77.1%	81.1%	79.9%	83.1%	81.0%	
DNA Rate (New Appts)	10.5%	11.7%	13.5%	15.7%	16.0%	12.3%	11.5%	13.2%	13.0%	11.9%	11.6%	11.3%	9.6%	
DNA Rate (Followup Appts)	9.7%	10.8%	10.8%	17.2%	16.4%	14.3%	16.6%	12.9%	15.5%	13.6%	11.3%	9.7%	7.7%	
Convenience and Choice: Slot Availability	100.0%	100.0%						100.0%	100.0%	93.7%	89.2%	86.2%	95.5%	
Referrals Received (GP)	400	358	366	397	261	348	329	320	308	349	387	385	370	
Temporary Spend ('000s)	107	86	66	77	66	100	74	82	63	58	60	55	80	
Normalised I & E surplus/(deficit) In Month ('000s)	1,097	716	894	1,237	915	572	722	1,180	1,117	1,080	982	1,157	719	

Patient

Metric Name	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	Last 12 Months
RTT: 90% Admitted within 18 weeks	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.4%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
RTT: 95% Non-Admitted within 18 weeks	97.8%	96.8%	94.3%	92.3%	88.6%	93.6%	90.5%	90.1%	83.9%	85.0%	89.2%	86.2%	91.7%	
RTT: 92% Waiting within 18 weeks (open Pathways)	95.0%	94.2%	94.9%	96.9%	95.4%	95.6%	94.0%	95.9%	95.7%	96.4%	96.8%	97.7%	97.0%	
Average LoS - Elective (Days)	2.85	2.41	3.70	3.87	3.32	3.00	3.23	3.85	3.54	4.80	2.98	3.54	3.25	
Average LoS - Non-Elective (Days)	2.57	3.74	3.00	3.92	2.88	2.60	3.16	2.22	2.63	2.05	2.31	3.88	2.82	
Hospital Initiated Clinic Cancellations < 6 weeks notice	8	2	2	13	13	16	22	8	3	0	3	6	4	
Daycases (K1/SDCPREOP)	75	69	78	60	54	74	31	71	73	74	76	70	76	
Cancelled Operations - Non Clinical - On Same Day	3	1	0	0	0	1	2	2	1	2	2	3	1	
OP Appointments Cancelled by Hospital %	16.2%	13.7%	18.1%	13.0%	12.3%	12.3%	16.1%	12.0%	12.7%	10.5%	12.6%	12.8%	14.7%	
Diagnostics: % Completed Within 6 Weeks	100.0%	100.0%	66.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	

Quality

Metric Name	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	Last 12 Months
Medication Errors (Incidents)	3	4	7	8	9	11	13	17	20	22	25	27	1	
Cleanliness Scores	91.2%	94.8%	93.2%	96.4%	96.0%	97.0%		95.5%	96.5%	94.5%	98.0%	98.0%	99.0%	
Hospital Acquired Organisms - MRSA (BSI)	0	0	0	0	0	0	0	0	0	0	0	0	0	
Hospital Acquired Organisms - C.difficile	0	0	0	1	0	0	0	0	0	0	0	0	0	

Workforce

Metric Name	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	Last 12 Months
Corporate Induction	0.0%	100.0%	0.0%		50.0%		100.0%	66.7%	100.0%	66.7%	100.0%	100.0%	100.0%	
PDR	64.0%	62.2%	92.2%	92.2%	92.2%	92.2%	92.2%	92.2%	92.2%	92.2%	92.2%	92.2%	3.6%	
Sickness	4.1%	4.4%	5.2%	6.2%	5.6%	5.4%	3.5%	5.1%	5.0%	6.9%	7.5%	6.7%	6.6%	
Mandatory Training	73.5%	66.0%	76.2%	81.1%	80.4%	85.8%	81.3%	86.9%	87.2%	87.3%	85.5%	84.8%	85.4%	

CBU Performance - NMSS

Apr 2016

Alder Hey Children's NHS
NHS Foundation Trust

Key Issues

The CBU delivered improvements across a range of quality metrics during April. Significant challenges remain in improving the number of patients on an open 18 week pathway as performance remains below 90%, this is also having an impact on financial performance resulting in income position of -£111k on elective activity. CBU is focussed on improving the run rate for the rest of the quarter through although the service is experiencing an increase in emergency trauma impacting on patient flow. PDR compliance in April is low related to the resetting of performance at the start of the year.

Support Required

In order to continue to focus on achieving the levels of activity required, the CBU will actively be part of the overall improvement projects in the Trust.

Operational

Metric Name	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	Last 12 Months
Theatre Utilisation - % of Session Utilised	85.4%	83.4%	86.3%				72.6%	75.5%	68.7%	74.7%	78.0%	79.9%	80.9%	
Clinic Session Utilisation	85.0%	89.7%	80.2%	87.6%	80.5%	82.6%	74.6%	82.7%	81.5%	86.3%	83.7%	85.5%	88.0%	
DNA Rate (New Appts)	12.1%	11.1%	12.6%	15.6%	14.9%	12.3%	10.7%	12.5%	12.5%	11.4%	10.4%	10.2%	9.0%	
DNA Rate (Followup Appts)	11.1%	10.4%	11.2%	13.2%	12.8%	12.4%	10.4%	9.4%	10.4%	9.8%	10.0%	10.6%	9.0%	
Convenience and Choice: Slot Availability	99.6%	100.0%						99.3%	99.6%	96.1%	97.5%	98.5%	97.0%	
Referrals Received (GP)	800	815	766	873	708	798	826	816	652	738	841	866	861	
Temporary Spend ('000s)	208	114	200	187	154	147	134	121	132	123	134	224	156	
Normalised I & E surplus/(deficit) In Month ('000s)	1,417	1,777	1,496	1,779	1,295	1,736	1,498	1,283	1,330	1,803	1,646	1,474	1,707	

Patient

Metric Name	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	Last 12 Months
RTT: 90% Admitted within 18 weeks	86.9%	88.4%	87.9%	87.0%	86.0%	81.5%	83.0%	100.0%	80.4%	79.7%	75.9%	86.5%	86.7%	
RTT: 95% Non-Admitted within 18 weeks	96.7%	95.9%	94.9%	95.5%	94.3%	92.6%	92.8%	84.7%	86.0%	87.3%	80.2%	84.2%	89.1%	
RTT: 92% Waiting within 18 weeks (open Pathways)	90.4%	90.3%	89.8%	89.8%	89.6%	89.6%	89.9%	90.0%	90.0%	89.8%	90.5%	89.8%	89.5%	
Average LoS - Elective (Days)	2.12	1.71	2.33	2.27	1.71	2.55	2.09	2.20	2.51	2.02	2.40	2.72	2.55	
Average LoS - Non-Elective (Days)	1.78	2.51	1.93	2.14	2.08	1.82	1.81	2.38	2.79	1.68	2.13	2.87	2.61	
Hospital Initiated Clinic Cancellations < 6 weeks notice	29	20	36	19	3	51	9	49	39	39	64	24	29	
Daycases (K1/SDCPREOP)	410	358	372	351	381	416	234	317	284	356	371	360	330	
Cancelled Operations - Non Clinical - On Same Day	4	17	13	22	8	11	7	29	3	11	9	10	15	
OP Appointments Cancelled by Hospital %	15.2%	13.7%	21.1%	16.4%	14.7%	14.6%	18.8%	14.8%	18.2%	19.4%	18.3%	18.4%	17.6%	
Diagnostics: % Completed Within 6 Weeks	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	

Quality

Metric Name	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	Last 12 Months
Medication Errors (Incidents)	1	6	6	6	9	11	12	14	15	19	22	30	0	
Cleanliness Scores	92.0%	98.0%	94.2%	94.0%	94.5%	98.3%		98.7%	98.0%	96.3%	91.0%	95.0%	96.3%	
Hospital Acquired Organisms - MRSA (BSI)	0	0	0	0	0	0	0	0	0	0	0	0	0	
Hospital Acquired Organisms - C.difficile	0	0	0	0	0	0	0	0	0	0	0	0	0	

Workforce

Metric Name	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	Last 12 Months
Corporate Induction	33.3%	77.8%	0.0%	0.0%	75.0%		88.9%	100.0%	100.0%	100.0%	100.0%	100.0%	66.7%	
PDR	44.3%	49.3%	79.7%	79.7%	80.7%	80.7%	80.7%	80.7%	80.7%	80.7%	80.7%	80.7%	10.1%	
Sickness	4.2%	4.2%	5.7%	5.3%	4.4%	3.6%	4.4%	4.6%	5.6%	5.4%	4.1%	5.1%	4.9%	
Mandatory Training	70.8%	68.4%	76.1%	78.4%	80.7%	82.2%	79.7%	86.8%	86.9%	87.8%	84.1%	84.3%	85.3%	

CBU Performance - SCACC

Apr 2016

Alder Hey Children's NHS Foundation Trust

Key Issues

Theatre session utilisation: focus on improving start times; in May Pharmacy supplied botox in DSU to improve start times for some lists. Clinic session utilisation: below standard but continues to improve with highest utilisation for 12 months. Improvement driven by booking to 100% of slots. Sickness: Has improved from 6.6% to 5.8%. Rigorous case management undertaken in critical care with several staff now returned to work. Financial performance: actions in place to address non-budget pay spend by July 16. critical care recruitment plan to increase capacity and deliver financial plan.

Support Required

Clinic session utilisation: Resolve issues with Trust franking machine that has broken down frequently and delays correspondence to patients. Sickness: specialist occupational health service support for pregnant women and for line managers of staff who are pregnant. New sickness absence policy required that is more robust and less protracted. Theatre utilisation: commission review of theatre information system to assess risks, benefits and cost of alternative theatre systems that better support booking, scheduling and safety data.

Operational

Metric Name	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	Last 12 Months
Theatre Utilisation - % of Session Utilised	80.8%	79.4%	80.1%				68.9%	76.1%	70.7%	74.5%	76.5%	79.8%	77.3%	
Clinic Session Utilisation	98.1%	111.4%	105.8%	86.4%	84.5%	81.5%	81.9%	88.5%	88.4%	88.5%	90.1%	82.2%	84.3%	
DNA Rate (New Appts)	13.2%	12.9%	12.1%	12.6%	9.6%	10.3%	13.9%	9.7%	10.3%	9.7%	10.4%	12.5%	7.4%	
DNA Rate (Followup Appts)	12.3%	12.5%	12.5%	12.3%	12.4%	11.9%	11.6%	9.6%	7.2%	9.8%	10.0%	11.5%	8.1%	
Convenience and Choice: Slot Availability	100.0%	100.0%						100.0%	97.9%	98.4%	84.8%	88.8%	98.1%	
Referrals Received (GP)	302	282	280	369	251	292	352	336	262	299	340	323	331	
Temporary Spend ('000s)	465	361	322	345	227	250	268	218	222	237	221	319	274	
Normalised I & E surplus/(deficit) In Month ('000s)	1	-70	-211	-133	-449	457	-267	-119	253	-179	-156	1,351	-391	

Patient

Metric Name	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	Last 12 Months
RTT: 90% Admitted within 18 weeks	97.8%	94.1%	96.4%	94.8%	91.6%	95.9%	91.5%	100.0%	86.1%	94.5%	96.6%	89.0%	88.8%	
RTT: 95% Non-Admitted within 18 weeks	97.0%	97.2%	97.0%	95.1%	87.7%	95.5%	83.8%	94.7%	88.4%	90.1%	92.2%	91.1%	93.1%	
RTT: 92% Waiting within 18 weeks (open Pathways)	97.1%	98.0%	97.2%	96.0%	96.1%	96.8%	97.3%	97.3%	96.6%	96.1%	96.0%	95.7%	96.6%	
Average LoS - Elective (Days)	3.29	4.43	2.93	3.45	2.62	4.30	3.36	3.22	2.93	3.38	3.18	3.22	3.05	
Average LoS - Non-Elective (Days)	4.59	4.01	3.87	3.83	4.10	4.62	3.01	3.91	3.58	3.19	4.85	3.35	3.30	
Hospital Initiated Clinic Cancellations < 6 weeks notice	0	0	3	0	5	4	1	3	1	0	1	1	1	
Daycases (K1/SDCPREOP)	135	110	169	190	105	183	56	118	104	118	112	175	165	
Cancelled Operations - Non Clinical - On Same Day	4	7	10	4	13	4	9	9	7	8	15	11	15	
OP Appointments Cancelled by Hospital %	17.8%	19.3%	25.5%	15.6%	17.7%	15.8%	22.2%	16.8%	19.1%	15.0%	12.5%	13.5%	13.4%	
Diagnostics: % Completed Within 6 Weeks	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	

Quality

Metric Name	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	Last 12 Months
Medication Errors (Incidents)	2	11	20	28	32	41	48	57	70	77	89	100	16	
Cleanliness Scores	92.9%	93.5%	96.0%	95.2%	95.9%	96.5%		97.4%	92.2%	95.0%	94.6%	97.0%	96.4%	
Hospital Acquired Organisms - MRSA (BSI)	1	0	1	0	1	0	0	0	0	0	0	0	0	
Hospital Acquired Organisms - C.difficile	0	0	0	1	0	0	0	0	0	0	0	0	0	

Workforce

Metric Name	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	Last 12 Months
Corporate Induction	37.5%	44.4%	70.0%	80.0%	100.0%	100.0%	88.9%	75.0%	100.0%	92.3%	25.0%	100.0%	50.0%	
PDR	14.8%	17.6%	89.1%	89.1%	91.2%	91.2%	91.2%	91.2%	91.2%	91.2%	91.2%	91.2%	3.5%	
Sickness	7.0%	6.3%	6.2%	6.5%	5.7%	6.9%	6.5%	7.5%	6.9%	7.0%	7.0%	6.6%	5.8%	
Mandatory Training	64.6%	61.9%	73.6%	77.3%	83.1%	85.2%	81.3%	89.1%	88.3%	85.8%	87.5%	87.1%	86.9%	

3. Financial Strength

3.1 Trust Income & Expenditure Report period ended April 2016

	In Month			Year to Date			Full Year		
	Budget £'000	Actual £'000	Variance £'000	Budget £'000	Actual £'000	Variance £'000	Budget £'000	Forecast £'000	Variance £'000
Clinical Income									
Elective	3,475	3,160	(315)	3,475	3,160	(315)	42,982	42,982	0
Non Elective	2,261	1,911	(350)	2,261	1,911	(350)	26,512	26,512	0
Outpatients	2,272	2,061	(212)	2,272	2,061	(212)	28,190	28,190	0
A&E	437	377	(59)	437	377	(59)	5,310	5,310	0
Critical Care	1,902	2,012	110	1,902	2,012	110	23,739	23,739	0
Non PbR Drugs & Devices	1,553	1,584	31	1,553	1,584	31	18,665	18,665	0
Excess Bed Days	392	328	(63)	392	328	(63)	4,765	4,765	0
CQUIN	245	245	(0)	245	245	(0)	2,942	2,942	0
Contract Sanctions	0	0	0	0	0	0	0	0	0
Private Patients	15	0	(14)	15	0	(14)	176	176	0
Other Clinical Income	2,266	2,892	626	2,266	2,892	626	24,308	24,308	0
Non Clinical Income									
Other Non Clinical Income	1,630	1,464	(166)	1,630	1,464	(166)	31,177	31,177	0
Total Income	**16,448**	**16,035**	**(413)**	**16,448**	**16,035**	**(413)**	**208,765**	**208,765**	**0**
Expenditure									
Pay Costs	(11,499)	(11,611)	(112)	(11,499)	(11,611)	(112)	(135,779)	(135,779)	0
Drugs	(1,362)	(1,635)	(274)	(1,362)	(1,635)	(274)	(16,570)	(16,570)	0
Clinical Supplies	(1,375)	(1,431)	(56)	(1,375)	(1,431)	(56)	(16,725)	(16,725)	0
Other Non Pay	(2,455)	(1,997)	457	(2,455)	(1,997)	457	(25,979)	(25,979)	0
PFI service costs	(290)	(287)	3	(290)	(287)	3	(3,526)	(3,526)	0
Total Expenditure	**(16,979)**	**(16,961)**	**19**	**(16,979)**	**(16,961)**	**19**	**(198,578)**	**(198,578)**	**0**
EBITDA	**(531)**	**(926)**	**(395)**	**(531)**	**(926)**	**(395)**	**10,186**	**10,186**	**0**
PDC Dividend	(97)	(97)	0	(97)	(97)	0	(1,161)	(1,161)	0
Depreciation	(683)	(669)	14	(683)	(669)	14	(8,323)	(8,323)	0
Finance Income	1	4	3	1	4	3	15	15	0
Interest Expense (non-PFI/LIFT)	(80)	(80)	0	(80)	(80)	0	(1,042)	(1,042)	0
Interest Expense (PFI/LIFT)	(666)	(687)	(21)	(666)	(687)	(21)	(7,995)	(7,995)	0
Trading Surplus / (Defecit)	**(2,056)**	**(2,455)**	**(399)**	**(2,056)**	**(2,455)**	**(399)**	**(8,320)**	**(8,320)**	**0**
One-off normalising items									
Government Grants/Donated Income	14	6	(8)	14	6	(8)	2,352	2,352	0
Normalised Surplus/(Deficit)	**(2,042)**	**(2,449)**	**(407)**	**(2,042)**	**(2,449)**	**(407)**	**(5,968)**	**(5,968)**	**0**
MASS/Restructuring	0	0	0	0	0	0	0	0	0
Fixed Asset Impairment	0	0	0	0	0	0	(1,920)	(1,920)	0
(Gains)/Losses on asset disposals	0	0	0	0	0	0	0	0	0
Reported Surplus/(Deficit)	**(2,042)**	**(2,449)**	**(407)**	**(2,042)**	**(2,449)**	**(407)**	**(7,888)**	**(7,888)**	**0**

Key Metrics	In Month			Year to date			Full Year		
	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Forecast	Variance
Income £000	16,448	16,035	(413)	16,448	16,035	(413)	208,765	208,765	0
Expenditure £000	(18,504)	(18,490)	14	(18,504)	(18,490)	14	(217,085)	(217,085)	0
Trading Surplus/(Deficit) £000	(2,056)	(2,455)	(399)	(2,056)	(2,455)	(399)	(8,320)	(8,320)	0
WTE	2,970	2,950	20	2,970	2,950	20			
CIP £000	274	96	(179)	274	96	(179)	7,200	5,225	(1,975)
Cash £000	7,249	6,919	(330)	7,249	6,919	(330)			
CAPEX FCT £000	312	313	(1)	312	313	(1)	10,167	11,377	(1,210)
Risk Rating	1	1	0	1	1	0	2	2	0

Activity Volumes	In Month			Year to date			Full Year		
	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Forecast	Variance
Elective	2,182	1,995	(187)	2,182	1,995	(187)	26,950	26,950	0
Non Elective	1,324	1,170	(154)	1,324	1,170	(154)	16,071	16,071	0
Outpatients	16,157	14,589	(1,568)	16,157	14,589	(1,568)	199,463	199,463	0
A&E	4,584	4,558	(26)	4,584	4,558	(26)	55,899	55,899	0

Alder Hey Children's NHS Foundation Trust
CAPITAL PROGRAMME 2016/17

	Prior Year Expenditure	IN MONTH BUDGET	IN MONTH ACTUAL	IN MONTH VARIANCE	YEAR TO DATE BUDGET	YEAR TO DATE ACTUAL	YEAR TO DATE VARIANCE	FULL YEAR BUDGET	FULL YEAR FORECAST	FULL YEAR VARIANCE
	£000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
ESTATES	*1,506*	**8**	**201**	**(192)**	**8**	**201**	**(192)**	**2,270**	**3,460**	**(1,190)**
RESEARCH & EDUCATION	*4,697*	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
ESTATES TOTAL CAPITAL	*6,203*	**8**	**201**	**(192)**	**8**	**201**	**(192)**	**2,270**	**3,460**	**(1,190)**
NETWORKING, INFRASTRUCTURE & OTHER IT	*3,072*	31	14	17	31	14	17	440	440	0
ELECTRONIC PATIENT RECORD	*6,172*	58	34	24	58	34	24	700	720	(20)
IM & T TOTAL CAPITAL	*9,244*	**90**	**49**	**41**	**90**	**49**	**41**	**1,140**	**1,160**	**(20)**
MEDICAL EQUIPMENT		24	6	18	24	6	18	2,761	2,761	0
CHILDRENS HEALTH PARK		150	21	129	150	21	129	3,514	3,514	0
ALDER HEY IN THE PARK TOTAL	*17,320*	**174**	**27**	**147**	**174**	**27**	**147**	**6,275**	**6,275**	**0**
OTHER		40	37	4	40	37	4	482	482	0
OTHER	*802*	**40**	**37**	**4**	**40**	**37**	**4**	**482**	**482**	**0**
CAPITAL PROGRAMME 16/17	*33,569*	*312*	*313*	*(1)*	*312*	*313*	*(1)*	*10,167*	*11,127*	*(1,210)*

M1 SLAM Report

CBU	Specialty	POD	Activity Plan	Activity Actual	Activity Variance	Price Plan	Price Actual	Price Variance	Price Variance (Casemix)	Price Variance (Volume)
ICS	Accident & Emergency	Daycase	0	0	0	£143	£0	-£143	0	-143
		Elective	0	0	0	£157	£0	-£157	0	-157
		Non-Elective	476	386	-90	£218,726	£332,200	£113,474	154,950	-41,475
		Excess Bed Days	6	0	-6	£2,313	£0	-£2,313	0	-2,313
		Outpatient New	205	149	-56	£69,211	£49,971	-£19,240	-245	-18,995
		Outpatient Follow-up	22	3	-19	£7,299	£1,013	-£6,286	0	-6,286
		Ward Attender	0	0	0	£164	£0	-£164	0	-164
		A&E Attendance	4,584	4,558	-26	£435,445	£377,275	-£58,170	-55,728	-2,443
	Accident & Emergency Total		**5,294**	**5,096**	**-198**	**£733,458**	**£760,459**	**£27,001**	**98,977**	**-71,975**
	CAMHS	Elective	0	0	0	£236	£0	-£236	0	-236
		Outpatient New	191	208	17	£0	£0	£0	0	0
		Outpatient Follow-up	952	1,127	175	£13,286	£6,606	-£6,680	-9,125	2,445
	CAMHS Total		**1,143**	**1,335**	**192**	**£13,522**	**£6,606**	**-£6,916**	**-9,125**	**2,209**
	Community Medicine	Outpatient New	362	206	-156	£29,249	£8,967	-£20,281	-7,667	-12,615
		Outpatient Follow-up	713	383	-330	£4,350	£4,305	-£45	1,967	-2,012
		Outpatient Procedure	0	0	0	£14	£0	-£14	0	-14
		Ward Based Outpatient	1	0	-1	£0	£0	£0	0	0
	Community Medicine Total		**1,076**	**589**	**-487**	**£33,613**	**£13,272**	**-£20,340**	**-5,700**	**-14,641**
	Diabetes	Outpatient New	29	20	-9	£6,253	£4,222	-£2,031	-28	-2,003
		Outpatient Follow-up	3	10	7	£282	£988	£706	-102	807
		Ward Based Outpatient	0	0	0	£40	£0	-£40	0	-40
	Diabetes Total		**32**	**30**	**-2**	**£6,575**	**£5,210**	**-£1,365**	**-130**	**-1,235**
	Paediatrics	Daycase	31	10	-21	£25,889	£10,149	-£15,740	1,788	-17,528
		Elective	13	3	-10	£14,553	£4,938	-£9,614	1,576	-11,190
		Non-Elective	273	295	22	£309,287	£333,971	£24,684	-524	25,208
		Excess Bed Days	64	222	158	£23,864	£83,375	£59,511	894	58,617
		Outpatient New	305	241	-64	£70,279	£55,635	-£14,644	138	-14,783
		Outpatient Follow-up	418	357	-61	£59,018	£50,116	-£8,901	-262	-8,639
		Outpatient Procedure	0	0	0	£31	£0	-£31	0	-31
		Ward Based Outpatient	161	23	-138	£22,673	£3,229	-£19,444	-17	-19,427
		Ward Attender	18	9	-9	£2,485	£1,264	-£1,221	-7	-1,215
	Paediatrics Total		**1,283**	**1,160**	**-123**	**£528,078**	**£542,678**	**£14,599**	**3,586**	**11,013**
ICS Total			**8,828**	**8,210**	**-618**	**£1,315,246**	**£1,328,225**	**£12,979**	**87,608**	**-74,629**
Med Specs	Allergy	Daycase	0	14	14	£0	£6,176	£6,176	0	6,176
		Elective	0	1	1	£0	£1,240	£1,240	0	1,240
		Outpatient New	62	50	-12	£14,234	£11,624	-£2,610	110	-2,720
		Outpatient Follow-up	69	57	-12	£9,773	£8,068	-£1,706	24	-1,729
		Outpatient Procedure	0	0	0	£46	£0	-£46	0	-46
		Ward Based Outpatient	0	0	0	£30	£0	-£30	0	-30
		Ward Attender	0	0	0	£44	£0	-£44	0	-44
	Allergy Total		**132**	**122**	**-10**	**£24,127**	**£27,107**	**£2,980**	**134**	**2,846**
	Dermatology	Daycase	2	0	-2	£1,180	£0	-£1,180	0	-1,180
		Outpatient New	165	144	-21	£22,329	£19,466	-£2,863	-21	-2,841
		Outpatient Follow-up	541	619	78	£53,323	£60,505	£7,182	-491	7,673
		Outpatient Procedure	88	85	-3	£10,108	£9,742	-£365	-29	-336
		Ward Based Outpatient	8	9	1	£778	£880	£102	-7	109
		Ward Attender	1	0	-1	£60	£0	-£60	0	-60
	Dermatology Total		**804**	**857**	**53**	**£87,778**	**£90,594**	**£2,815**	**-548**	**3,364**
	Endocrinology	Daycase	91	75	-16	£95,134	£77,862	-£17,272	-397	-16,875
		Elective	7	3	-4	£10,556	£4,095	-£6,461	-199	-6,262
		Non-Elective	2	2	0	£3,873	£2,057	-£1,816	-1,102	-714
		Excess Bed Days	14	51	37	£4,989	£15,274	£10,284	-3,524	13,808
		Outpatient New	64	38	-26	£25,835	£15,213	-£10,622	-40	-10,582
		Outpatient Follow-up	359	223	-136	£69,464	£43,874	-£25,590	747	-26,338
		Ward Based Outpatient	33	75	42	£6,294	£14,507	£8,212	2	8,210
		Ward Attender	16	20	4	£3,124	£3,868	£745	1	744
	Endocrinology Total		**587**	**487**	**-100**	**£219,269**	**£176,749**	**-£42,520**	**-4,512**	**-38,008**
	Gastroenterology	Daycase	128	116	-12	£140,689	£123,308	-£17,381	-4,041	-13,340
		Elective	40	50	10	£77,511	£88,446	£10,934	-7,353	18,287
		Non-Elective	11	7	-4	£28,582	£11,351	-£17,231	-7,126	-10,105
		Excess Bed Days	181	11	-170	£71,466	£3,294	-£68,172	-1,052	-67,120
		Outpatient New	101	82	-19	£26,781	£21,914	-£4,866	164	-5,030
		Outpatient Follow-up	271	187	-84	£43,046	£29,168	-£13,878	-539	-13,338
		Ward Based Outpatient	206	138	-68	£32,653	£21,527	-£11,126	-326	-10,800
		Ward Attender	6	20	14	£942	£3,120	£2,178	-47	2,225
	Gastroenterology Total		**944**	**611**	**-333**	**£421,669**	**£302,128**	**-£119,541**	**-20,320**	**-99,221**

Med Specs	Haematology	Daycase	23	10	-13	£28,271	£10,296	-£17,976	-1,749	-16,226
		Elective	3	2	-1	£20,569	£1,538	-£19,031	-12,419	-6,613
		Non-Elective	17	3	-14	£50,058	£6,522	-£43,537	-2,487	-41,050
		Excess Bed Days	4	0	-4	£1,737	£0	-£1,737	0	-1,737
		Outpatient New	22	20	-2	£9,883	£9,386	-£497	225	-722
		Outpatient Follow-up	150	41	-109	£32,705	£9,147	-£23,559	198	-23,757
		Outpatient Procedure	0	0	0	£15	£0	-£15	0	-15
		Ward Based Outpatient	0	0	0	£27	£0	-£27	0	-27
		Ward Attender	78	117	39	£17,096	£25,064	£7,968	-473	8,440
	Haematology Total		**297**	**193**	**-104**	**£160,362**	**£61,951**	**-£98,411**	**-16,705**	**-81,706**
	Immunology	Daycase	0	3	3	£0	£2,183	£2,183	0	2,183
		Outpatient New	13	9	-4	£2,908	£2,078	-£831	5	-836
		Outpatient Follow-up	9	55	46	£1,303	£7,831	£6,527	69	6,459
		Ward Based Outpatient	16	0	-16	£2,300	£0	-£2,300	0	-2,300
		Ward Attender	4	0	-4	£585	£0	-£585	0	-585
	Immunology Total		**42**	**67**	**25**	**£7,097**	**£12,091**	**£4,994**	**74**	**4,920**
	Metabolic Disease	Outpatient New	5	2	-3	£1,896	£768	-£1,128	0	-1,128
		Outpatient Follow-up	30	17	-13	£11,440	£6,528	-£4,912	0	-4,913
	Metabolic Disease Total		**35**	**19**	**-16**	**£13,337**	**£7,296**	**-£6,041**	**0**	**-6,041**
	Nephrology	Daycase	94	5	-89	£60,488	£5,009	-£55,479	1,784	-57,263
		Elective	31	16	-15	£19,657	£20,804	£1,147	10,618	-9,471
		Non-Elective	4	2	-2	£7,369	£9,172	£1,803	5,414	-3,611
		Excess Bed Days	17	13	-4	£6,448	£5,606	-£842	725	-1,567
		Outpatient New	16	22	6	£1,840	£2,597	£757	0	757
		Outpatient Follow-up	124	344	220	£14,655	£40,606	£25,951	0	25,951
		Ward Based Outpatient	56	0	-56	£6,608	£0	-£6,608	0	-6,608
		Ward Attender	79	0	-79	£9,289	£0	-£9,289	0	-9,289
		(blank)	0	3	3	£0	£0	£0	0	0
	Nephrology Total		**420**	**405**	**-15**	**£126,354**	**£83,793**	**-£42,561**	**18,540**	**-61,101**
	Oncology	Daycase	176	127	-49	£133,762	£129,529	-£4,233	32,754	-36,987
		Elective	163	217	54	£204,429	£252,026	£47,597	-20,566	68,163
		Non-Elective	36	46	10	£91,054	£121,534	£30,480	5,303	25,178
		Excess Bed Days	30	19	-11	£13,616	£6,387	-£7,228	-2,244	-4,984
		Outpatient New	10	8	-2	£2,589	£2,072	-£518	0	-518
		Outpatient Follow-up	248	401	153	£63,983	£103,576	£39,593	10	39,583
		Ward Based Outpatient	18	0	-18	£4,642	£0	-£4,642	0	-4,642
		Ward Attender	14	0	-14	£3,544	£0	-£3,544	0	-3,544
	Oncology Total		**694**	**818**	**124**	**£517,618**	**£615,124**	**£97,506**	**15,257**	**82,248**
	Respiratory Medicine	Daycase	10	10	0	£9,668	£10,347	£679	452	227
		Elective	5	2	-3	£11,609	£3,376	-£8,233	-1,379	-6,855
		Non-Elective	64	57	-7	£60,443	£74,040	£13,597	20,464	-6,867
		Excess Bed Days	50	102	52	£15,795	£37,004	£21,209	4,655	16,554
		Outpatient New	74	77	3	£22,155	£22,829	£674	-86	761
		Outpatient Follow-up	251	242	-9	£37,721	£38,214	£493	1,869	-1,376
		Outpatient Procedure	137	0	-137	£19,780	£0	-£19,780	0	-19,780
		Ward Based Outpatient	135	27	-108	£20,249	£4,240	-£16,010	191	-16,201
		Ward Attender	1	2	1	£127	£157	£30	-143	172
	Respiratory Medicine Total		**727**	**519**	**-208**	**£197,547**	**£190,206**	**-£7,341**	**26,022**	**-33,363**
	Rheumatology	Daycase	170	188	18	£142,072	£147,007	£4,934	-10,541	15,475
		Elective	20	5	-15	£20,064	£5,831	-£14,233	750	-14,982
		Non-Elective	1	1	0	£1,478	£1,311	-£166	307	-473
		Excess Bed Days	11	55	44	£4,175	£22,401	£18,226	1,291	16,935
		Outpatient New	55	46	-9	£8,228	£6,918	-£1,310	-8	-1,302
		Outpatient Follow-up	166	130	-36	£24,922	£19,551	-£5,371	-21	-5,350
		Outpatient Procedure	0	0	0	£15	£0	-£15	0	-15
		Ward Based Outpatient	12	0	-12	£1,826	£0	-£1,826	0	-1,826
		Ward Attender	25	0	-25	£3,744	£0	-£3,744	0	-3,744
	Rheumatology Total		**459**	**425**	**-34**	**£206,524**	**£203,019**	**-£3,505**	**-8,222**	**4,717**
Med Specs Total			**5,141**	**4,523**	**-618**	**£1,981,681**	**£1,770,058**	**-£211,624**	**9,720**	**-221,344**
NMSS	Audiology	Outpatient New	689	569	-120	£65,331	£53,776	-£11,555	-205	-11,350
		Outpatient Follow-up	236	299	63	£22,285	£28,258	£5,973	0	5,973
		Outpatient Procedure	1	0	-1	£140	£0	-£140	0	-140
	Audiology Total		**926**	**868**	**-58**	**£87,756**	**£82,034**	**-£5,721**	**-205**	**-5,517**
	Burns Care	Daycase	0	5	5	£139	£7,257	£7,118	-1,303	8,421
		Elective	6	0	-6	£16,360	£0	-£16,360	0	-16,360
		Non-Elective	27	23	-4	£69,076	£44,639	-£24,436	-13,673	-10,763
		Outpatient New	30	14	-16	£6,020	£2,576	-£3,444	-193	-3,252
		Outpatient Follow-up	84	89	5	£9,619	£10,174	£554	16	539
		Outpatient Procedure	0	1	1	£15	£112	£97	-13	110
		Ward Based Outpatient	11	0	-11	£1,277	£0	-£1,277	0	-1,277
		Ward Attender	4	0	-4	£458	£0	-£458	0	-458
	Burns Care Total		**164**	**132**	**-32**	**£102,964**	**£64,758**	**-£38,205**	**-15,165**	**-23,040**

NMSS	Dentistry	Daycase	97	107	10	£56,218	£61,051	£4,833	-944	5,777
		Elective	11	3	-8	£6,823	£1,883	-£4,940	17	-4,956
		Non-Elective	1	0	-1	£1,197	£0	-£1,197	0	-1,197
		Excess Bed Days	1	0	-1	£323	£0	-£323	0	-323
		Outpatient New	113	115	2	£4,062	£4,091	£29	-29	58
		Outpatient Follow-up	145	78	-67	£5,164	£2,774	-£2,389	-4	-2,385
		Outpatient Procedure	30	18	-12	£4,896	£2,920	-£1,976	17	-1,993
	Dentistry Total		**399**	**321**	**-78**	**£78,683**	**£72,719**	**-£5,963**	**-943**	**-5,020**
	ENT	Daycase	109	84	-25	£123,911	£87,595	-£36,316	-7,801	-28,515
		Elective	92	59	-33	£130,158	£89,743	-£40,415	6,341	-46,756
		Non-Elective	23	22	-1	£35,452	£40,283	£4,831	5,952	-1,121
		Excess Bed Days	28	30	2	£11,156	£10,295	-£862	-1,711	849
		Outpatient New	344	242	-102	£38,057	£26,926	-£11,130	133	-11,264
		Outpatient Follow-up	495	343	-152	£33,809	£23,540	-£10,269	123	-10,392
		Outpatient Procedure	170	194	24	£22,281	£24,514	£2,233	-893	3,125
		Ward Based Outpatient	5	0	-5	£323	£0	-£323	0	-323
		Ward Attender	0	0	0	£17	£0	-£17	0	-17
	ENT Total		**1,266**	**974**	**-292**	**£395,163**	**£302,895**	**-£92,267**	**2,145**	**-94,412**
	Epilepsy	Outpatient New	11	9	-2	£2,490	£1,993	-£496	-5	-491
		Outpatient Follow-up	26	25	-1	£4,760	£4,419	-£340	-152	-188
	Epilepsy Total		**37**	**34**	**-3**	**£7,249**	**£6,413**	**-£836**	**-157**	**-679**
	Maxillo-Facial	Outpatient New	71	38	-33	£10,199	£5,058	-£5,141	-394	-4,747
		Outpatient Follow-up	140	61	-79	£20,355	£8,369	-£11,986	-470	-11,516
		Outpatient Procedure	0	0	0	£42	£0	-£42	0	-42
		Ward Attender	0	0	0	£18	£0	-£18	0	-18
	Maxillo-Facial Total		**212**	**99**	**-113**	**£30,614**	**£13,427**	**-£17,187**	**-865**	**-16,322**
	Neurology	Daycase	8	6	-2	£9,587	£7,085	-£2,502	188	-2,690
		Elective	6	11	5	£12,718	£19,682	£6,964	-3,538	10,502
		Non-Elective	8	9	1	£16,538	£22,174	£5,635	4,315	1,321
		Excess Bed Days	54	126	72	£21,902	£51,966	£30,064	899	29,166
		Outpatient New	89	104	15	£24,742	£28,830	£4,088	-103	4,190
		Outpatient Follow-up	258	211	-47	£70,525	£58,491	-£12,033	811	-12,845
		Ward Based Outpatient	24	0	-24	£6,531	£0	-£6,531	0	-6,531
		Ward Attender	2	0	-2	£606	£0	-£606	0	-606
	Neurology Total		**449**	**467**	**18**	**£163,149**	**£188,228**	**£25,079**	**2,572**	**22,507**
	Neurosurgery	Daycase	1	2	1	£704	£1,326	£622	-38	660
		Elective	17	19	2	£104,785	£89,815	-£14,970	-27,179	12,209
		Non-Elective	30	17	-13	£189,693	£103,300	-£86,394	-4,083	-82,311
		Excess Bed Days	71	19	-52	£23,832	£6,277	-£17,556	-89	-17,466
		Outpatient New	64	63	-1	£5,797	£5,606	-£190	-57	-134
		Outpatient Follow-up	178	197	19	£15,545	£17,531	£1,986	314	1,672
		Outpatient Procedure	0	0	0	£28	£0	-£28	0	-28
		Ward Based Outpatient	0	0	0	£11	£0	-£11	0	-11
		Ward Attender	39	0	-39	£3,437	£0	-£3,437	0	-3,437
	Neurosurgery Total		**401**	**317**	**-84**	**£343,831**	**£223,855**	**-£119,976**	**-31,131**	**-88,845**
	Ophthalmology	Daycase	41	24	-17	£36,164	£24,028	-£12,136	2,718	-14,854
		Elective	9	7	-2	£12,407	£12,936	£530	3,157	-2,628
		Non-Elective	2	1	-1	£2,276	£971	-£1,305	-458	-848
		Excess Bed Days	6	0	-6	£2,323	£0	-£2,323	0	-2,323
		Outpatient New	298	322	24	£45,253	£50,030	£4,777	1,116	3,661
		Outpatient Follow-up	1,110	927	-183	£110,711	£96,129	-£14,582	3,660	-18,242
		Outpatient Procedure	0	0	0	£63	£0	-£63	0	-63
		Ward Based Outpatient	2	3	1	£218	£256	£38	-43	81
	Ophthalmology Total		**1,468**	**1,284**	**-184**	**£209,415**	**£184,350**	**-£25,065**	**10,150**	**-35,215**
	Oral Surgery	Daycase	34	16	-18	£29,244	£11,935	-£17,309	-1,753	-15,557
		Elective	15	15	0	£33,273	£44,885	£11,612	12,197	-585
		Non-Elective	13	8	-5	£13,655	£10,698	-£2,957	2,015	-4,972
		Excess Bed Days	2	1	-1	£1,145	£563	-£582	13	-596
	Oral Surgery Total		**64**	**40**	**-24**	**£77,318**	**£68,081**	**-£9,237**	**12,472**	**-21,709**
	Orthodontics	Daycase	0	0	0	£87	£0	-£87	0	-87
		Outpatient New	5	0	-5	£837	£0	-£837	0	-837
		Outpatient Follow-up	16	2	-14	£1,361	£162	-£1,199	-4	-1,194
		Outpatient Procedure	13	10	-3	£1,673	£1,304	-£369	28	-397
	Orthodontics Total		**35**	**12**	**-23**	**£3,959**	**£1,466**	**-£2,492**	**24**	**-2,516**
	Plastic Surgery	Daycase	64	66	2	£65,521	£66,826	£1,305	-1,039	2,344
		Elective	24	3	-21	£36,612	£3,974	-£32,638	-576	-32,062
		Non-Elective	101	84	-17	£124,935	£104,291	-£20,645	718	-21,363
		Excess Bed Days	4	1	-3	£833	£299	-£533	73	-606
		Outpatient New	229	220	-9	£32,546	£31,401	-£1,145	90	-1,235
		Outpatient Follow-up	431	299	-132	£47,737	£32,646	-£15,091	-449	-14,642
		Outpatient Procedure	64	68	4	£7,637	£8,136	£499	6	493
		Ward Based Outpatient	10	1	-9	£1,094	£109	-£985	-2	-983
		Ward Attender	2	8	6	£270	£874	£603	-16	620
	Plastic Surgery Total		**929**	**750**	**-179**	**£317,185**	**£248,556**	**-£68,629**	**-1,196**	**-67,434**

NMSS	Sleep Studies	Elective	24	23	-1	£44,356	£35,565	-£8,791	-6,418	-2,373
		Excess Bed Days	0	28	28	£0	£8,560	£8,560	0	8,560
	Sleep Studies Total		**24**	**51**	**27**	**£44,356**	**£44,125**	**-£231**	**-6,418**	**6,187**
	Spinal Surgery	Daycase	0	1	1	£609	£1,219	£610	-438	1,048
		Elective	13	12	-1	£350,914	£398,199	£47,285	81,267	-33,982
		Outpatient New	21	19	-2	£3,555	£3,201	-£354	-8	-346
		Outpatient Follow-up	73	84	11	£7,734	£8,648	£914	-283	1,197
	Spinal Surgery Total		**107**	**116**	**9**	**£362,812**	**£411,267**	**£48,455**	**80,538**	**-32,083**
	Trauma And Orthopaedics	Daycase	42	40	-2	£61,555	£59,897	-£1,658	1,228	-2,886
		Elective	62	63	1	£230,977	£226,783	-£4,194	-9,408	5,213
		Non-Elective	64	47	-17	£159,562	£127,454	-£32,108	9,726	-41,833
		Excess Bed Days	36	31	-5	£12,271	£9,293	-£2,978	-1,238	-1,739
		Outpatient New	739	691	-48	£133,000	£124,613	-£8,387	288	-8,674
		Outpatient Follow-up	1,085	1,477	392	£127,895	£163,885	£35,989	-10,245	46,234
		Outpatient Procedure	41	57	16	£7,248	£9,068	£1,820	-938	2,758
		Ward Attender	0	5	5	£25	£489	£464	-16	480
	Trauma And Orthopaedics Total		**2,069**	**2,411**	**342**	**£732,532**	**£721,482**	**-£11,050**	**-10,603**	**-448**
NMSS Total			**8,550**	**7,876**	**-674**	**£2,956,984**	**£2,633,656**	**-£323,328**	**41,218**	**-364,546**
SCACC	Cardiac Surgery	Elective	27	23	-4	£352,389	£249,652	-£102,737	-45,450	-57,287
		Non-Elective	14	4	-10	£273,663	£66,948	-£206,715	-10,506	-196,209
		Excess Bed Days	65	0	-65	£28,927	£0	-£28,927	0	-28,927
		Outpatient New	9	15	6	£6,237	£10,800	£4,563	0	4,563
		Outpatient Follow-up	27	16	-11	£19,790	£11,520	-£8,270	0	-8,270
	Cardiac Surgery Total		**142**	**58**	**-84**	**£681,005**	**£338,919**	**-£342,086**	**-55,956**	**-286,130**
	Cardiology	Daycase	17	15	-2	£47,502	£44,825	-£2,677	3,863	-6,540
		Elective	18	19	1	£72,299	£69,512	-£2,787	-5,354	2,567
		Non-Elective	13	19	6	£58,908	£75,802	£16,894	-13,259	30,153
		Excess Bed Days	17	79	62	£6,887	£33,410	£26,523	1,429	25,093
		Outpatient New	161	150	-11	£38,492	£35,719	-£2,773	-41	-2,732
		Outpatient Follow-up	396	468	72	£52,371	£60,832	£8,461	-995	9,457
		Ward Based Outpatient	28	0	-28	£3,753	£0	-£3,753	0	-3,753
		Ward Attender	11	5	-6	£1,395	£650	-£746	-10	-735
	Cardiology Total		**662**	**755**	**93**	**£281,609**	**£320,751**	**£39,142**	**-14,367**	**53,509**
	Gynaecology	Daycase	1	3	2	£1,006	£2,923	£1,916	303	1,613
		Elective	1	1	0	£632	£1,239	£607	43	564
		Outpatient New	23	21	-2	£3,326	£3,014	-£313	-3	-310
		Outpatient Follow-up	38	29	-9	£3,588	£2,684	-£904	-42	-862
		Outpatient Procedure	0	0	0	£15	£0	-£15	0	-15
		Ward Attender	0	0	0	£11	£0	-£11	0	-11
	Gynaecology Total		**63**	**54**	**-9**	**£8,578**	**£9,859**	**£1,281**	**301**	**980**
	Intensive Care	Elective	0	0	0	£806	£0	-£806	0	-806
		Non-Elective	16	15	-1	£35,890	£135,873	£99,983	102,002	-2,019
		Excess Bed Days	29	39	10	£11,054	£11,680	£626	-3,120	3,745
		Outpatient New	9	10	1	£6,370	£7,372	£1,002	-8	1,010
		Outpatient Follow-up	33	67	34	£23,484	£47,182	£23,698	108	23,591
		Outpatient Procedure	0	0	0	£54	£0	-£54	0	-54
		Ward Based Outpatient	4	0	-4	£3,032	£0	-£3,032	0	-3,032
	Intensive Care Total		**92**	**131**	**39**	**£80,690**	**£202,107**	**£121,417**	**98,982**	**22,435**
	Paediatric Surgery	Daycase	114	128	14	£134,366	£139,581	£5,215	-10,738	15,953
		Elective	46	33	-13	£196,089	£93,484	-£102,605	-46,653	-55,952
		Non-Elective	122	118	-4	£475,331	£257,060	-£218,271	-203,130	-15,141
		Excess Bed Days	247	55	-192	£97,607	£19,735	-£77,872	-1,988	-75,884
		Outpatient New	184	181	-3	£32,653	£31,997	-£657	-43	-614
		Outpatient Follow-up	290	276	-14	£33,580	£31,611	-£1,969	-322	-1,647
		Outpatient Procedure	0	0	0	£14	£0	-£14	0	-14
		Ward Based Outpatient	31	18	-13	£3,569	£2,059	-£1,510	-24	-1,486
		Ward Attender	71	81	10	£8,191	£9,266	£1,074	-106	1,180
	Paediatric Surgery Total		**1,106**	**890**	**-216**	**£981,400**	**£584,793**	**-£396,607**	**-263,004**	**-133,604**
	Urology	Daycase	140	216	76	£130,713	£202,355	£71,642	185	71,457
		Elective	12	14	2	£47,471	£44,472	-£2,999	-10,227	7,228
		Non-Elective	3	1	-2	£10,772	£1,279	-£9,493	-2,236	-7,257
		Excess Bed Days	6	3	-3	£2,321	£1,294	-£1,028	48	-1,075
		Outpatient New	102	118	16	£18,394	£21,228	£2,834	-24	2,858
		Outpatient Follow-up	213	225	12	£32,435	£33,692	£1,256	-583	1,839
		Outpatient Procedure	0	0	0	£21	£0	-£21	0	-21
		Ward Based Outpatient	0	0	0	£56	£0	-£56	0	-56
		Ward Attender	3	3	0	£500	£449	-£50	-8	-42
	Urology Total		**479**	**580**	**101**	**£242,681**	**£304,768**	**£62,087**	**-12,845**	**74,932**
SCACC Total			**2,546**	**2,468**	**-78**	**£2,275,964**	**£1,761,197**	**-£514,767**	**-246,888**	**-267,879**
Clinical Support	Radiology	Daycase	107	117	10	£108,449	£145,194	£36,745	26,436	10,309
		Elective	14	3	-11	£23,157	£10,867	-£12,290	5,874	-18,165
		Non-Elective	3	3	0	£18,758	£27,290	£8,532	7,329	1,203
		Excess Bed Days	62	7	-55	£25,341	£1,529	-£23,813	-1,324	-22,488
	Radiology Total		**186**	**130**	**-56**	**£175,705**	**£184,879**	**£9,174**	**38,315**	**-29,141**
Clinical Support Total			**186**	**130**	**-56**	**£175,705**	**£184,879**	**£9,174**	**38,315**	**-29,141**
Grand Total			**25,251**	**23,207**	**-2,044**	**£8,705,580**	**£7,678,014**	**-£1,027,566**	**-70,027**	**-957,539**

Alder Hey Children's NHS
NHS Foundation Trust

Programme Assurance Summary

Change Programme – 8 Work streams (work stream reports attached for reference)

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

1. The change programme remains some 3 months behind the optimal progress against our initial planning assumptions ; 6 of 23 'live' projects are yet to fully complete a Project Initiation Documents (PIDs). It is essential all projects have clearly outlined the scope of the project, the key targets and benefits together with the miles stones for delivery. The supporting dashboards identify those projects where this is not the case.
2. The work streams will now need to pursue additional measures and projects to augment all aspects of quality that - as well as improving safety, care and experience - will close the finance and efficiency gap to fully meet CIP targets.

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

1. The Sub-Committees of the Board now governing the eight work streams of the change programme - WOD, 'Developing Our Workforce'; CQAC, 'Our Patients at the Centre'; RE&I, 'Research Education and Innovation'; R&BD: 'Developing Our Business', 'Services in Communities', 'Developing IM&CT and EPR', 'Supporting Front Line Staff', 'Park, Community Estate & Facilities' – will need to actively direct actions and deadlines to support the programme aims in terms of both quality and efficiency.
2. This delegated task from the Trust Board to the Sub-Committees, namely the responsibility for 'assurance, performance management and direction' of the work streams comprising the programme of change will clearly take further time to fully embed.
3. The Executive Team is supporting the drive and tempo required to resolve all the key issues at its weekly meetings.

N.B. Due to the date on which the 23 May Trust Board falls, some reports do not contain Exec Sponsors reports to sub-Committees and the WOD report is an interim version; however, all of the relevant assurance commentary is in the place to allow Trust Board assessment.
J Gibson

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

1. Trust target is £7.2m, at month 1, forecast is £5.2m, a gap of £2.0m. To achieve Monitor targets the trust needs to deliver £5.2m, however the trust needs to be planning for at least £2m headroom to allow for failed schemes and ensure full recurrent delivery.
2. Since last Trust Board the following actions have been taken;
    a) Business development - Workshop to take place in June close the £800k gap
    b) Workforce - Fortnightly workforce Steering Group to ensure full in year delivery of £1m workforce, and identification of £2.5m recurrent workforce gap.
    c) Our patients - Re-submission of Outpatient, Complex Care & Clinical Support PiDs to include accurate and more stretching financials.
    d) Deadlines to be set for planning work to be completed and financial assessments reported for R&E&I and community projects.

Programme Assurance Framework

Developing Our Workforce (Completed by Assurance Team)

Alder Hey Children's NHS Foundation Trust

Sub-Committee	WOD	Report Date	17 May 2016
Workstream Name	Developing Our Workforce	Executive Sponsor	Melissa Swindell/Louise Dunn

Current Dashboard Rating:

Project Ref	Project Title	Project Description	Executive Sponsor Assures the project	OVERALL PROJECT RAG status	An effective project team is in place	Scope and Approach is defined	Targets / benefits defined/on track	Milestone plan is defined/on track	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	Comments for attention of the Project Team, Steering Group and sub-Committee
1.0 Developing Our Workforce 16/17 £3.5m and 17/18 £1m													
WOD 1.1	Workforce Capability & Sustainability	To support the development of a capable, sustainable workforce; sufficiently flexible to meet the changing needs of our services in the hospital & the community	Melissa Swindell										Steering Group meeting arranged for 17/5. Overarching PID is complete, however detailed plans and financial information to be fully developed (only 5 available on Sharepoint). Risk Log is available to be fully completed. EA/QIA to be completed and signed off for each individual plan. **Last updated 4 May 2016**
WOD 1.2	Developing High Quality Leadership & Management	To implement a Trust wide Leadership and Management Strategy which supports leaders at all levels to develop a positive, high performance culture	Melissa Swindell										Steering Group meeting arranged 17/5. PID complete and contains details of benefits, tracking to be commenced. Milestone Plan shows actions broadly on track, evidence to be uploaded to Sharepoint where available. Comms activities being tracked, clarification required re some actions. Risk Log complete. EA/QIA sign off process to commence. **Last updated 9 May 2016**
WOD 1.3	Improving Employee Communication & Engagement	To implement a Trust wide employee communication and engagement plan which supports the development of a positive, high performance culture	Melissa Swindell/ Louise Dunn										Executive Sponsors advise that this project is now superceded by the Trust LIA roll-out; Trust Board of 5 Apr 16 decided to receive assurance/feedback directly from the first 10 LIA teams in 3 months (July 2016).
WOD 1.4	Starters & Leavers Process	To establish the internal processes with regards to sharing and maintaining information on staff starters, leavers and changes, also to establish an agreed process for those non-employees	Melissa Swindell										First Project Team meeting today. PID complete which contains details of benefits. Milestone Plan on Sharepoint shows actions up-to-date. Comms Plan to be developed and further stakeholder engagement required (gaps in attendance at meeting today). Risk Log available. EA/QIA has been completed - to be signed off by Execs. **Last updated 9 May 2016**

Project Title	RAG Rating	Budget £	Forecast £	Variance £	Comments
Capability & Sustainability	**A**	1,135,121	**1,051,972**	**(83,149)**	Several CBU's currently have not returned 7/13, some of the plans received are lacking in detail and focus on non-recurrent savings, which requires resolution. The full year target is £3.5m.
Leadership & Management					*Non Financial*
Starters & Leavers					*Non Financial*
Total		1,135,121	**1,051,972**	**(83,149)**	

Alder Hey Children's NHS
NHS Foundation Trust

Programme Assurance Summary
Developing Our Business

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

1. The CIP target for the projects in this work stream equates to £1.5 in 16/17 and £2m in 17/18. The 16/17 forecast amounts to £0.8m and is underpinned by plans to date. The gap is £0.7m and is across all projects and relates to part year effect slippage. Therefore, it is imperative the team expedite the plan to mitigate this. A workshop is planned for June and needs to include all relevant stakeholders to ensure project can then move at pace.
2. The projects needed to ensure all relevant documentation is uploaded to SharePoint, to allow the assurance of both projects be assessed. The pilot phase of the international project should be included in the milestone plans as requested in April.

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

1. The Equality Assessment and Quality Impact Assessment (EA/QIA) for the 'Strategic Partnerships' project needs to be fully signed off.
2. Given the financial gap across the work stream, the reporting of 'Other Business Development' initiatives (as per the dashboard) needs to be put in place as soon as possible to show where any CIP mitigation will accrue.

J Gibson

Programme Assurance Framework

Developing Our Business

Alder Hey Children's NHS
NHS Foundation Trust

Sub-Committee	RABD	Report Date	12 May 2016
Workstream Name	Developing Our Business	Executive Sponsor	Jonathan Stephens

Current Dashboard Rating:

Project Ref	Project Title	Project Description	Executive Sponsor Assures the project	OVERALL PROJECT RAG status	An effective project team is in place	Scope and Approach is defined	Targets / benefits defined/on track	Milestone plan is defined/on track	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	Comments for attention of the Project Team, Steering Group and sub-Committee
2.0 Developing Our Business 16/17 £1.5m and 17/18 £2m													
R&BD 2.1	Strategic Partnerships	To grow and strengthen existing partnerships, as well as to look for new opportunities as a means to improve the quality of care across the region	Jonathan Stephens										March Steering Group meeting notes available (M&BD Group). Benefits to be confirmed (WHH) and tracking established for non-financial benefits. Milestone Plan shows some delays, some actions outstanding, with evidence uploaded to Sharepoint where available. Evidence required of stakeholder engagement. QIA/EA to be fully signed. **Last updated 9 May 2016**
R&BD 2.2	International Clinical Business and Non-NHS Patient Services	The aim of the project is to grow existing operations and brand name beyond the domestic region by increasing our international footprint	Jonathan Stephens										Steering Group meeting notes available to March (M&BD Group). Benefits defined, tracking process to be confirmed once delivery commences. Milestone Plan is available, full details of dates for Pilot Phase to be populated. Comms Plan available. Risk Log up-to-date. EA/QIA to be signed off and uploaded to Sharepoint.. **Last updated 27 April 2016**
R&BD 2.3	Other Business Development	CBU Business Development Plans	Jonathan Stephens										Financial tracking information now available. Programme Assurance information/details to be reviewed end of June 2016.

Project Title	RAG Rating	Budget £	Forecast £	Variance £	Comments
CBU Business Development	R	1,273,400	548,900	(724,500)	Stretch target of £724,500
International Patients	G/A	112,000	112,000	0	
Strategic Partnerships	R	114,600	47,934	(66,666)	Stretch target of £66,666
Total	R	1,500,000	708,834	(791,166)	

Alder Hey Children's NHS
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Programme Assurance Summary
Our Patients at the Centre

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

1. There is a critical minimum CIP savings dependency upon the projects in this work stream amounting to circa £1m. Of this total, £0.8m has been identified in PIDs, however £271k of this figure relates to Complex Care Made Simple and is under review following the Vanguard statement. A re-forecast of the Complex Care Made Simple project will be provided in the next update. A financial gap, ranging from £300k best case or £600k worst case, needs to be mitigated and resolved as a matter of urgency by the Executive Sponsors for the work stream.

2. Minimal financial opportunity has been identified for Outpatients, the project team are to undertake a full opportunity assessment by the date of the next sub-Committee and report back.

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

1. The assurance process for those elements of this work stream to be run through 'Listening Into Action' (LIA) will need to be described to the sub-Committee once the LIA initiatives are up and running.
2. A project launch date needs to be established for the 'Clinical Support Services' project to ensure that the initiative does not drift.
3. Across the work stream, stakeholder engagement is an issue on 2 projects while updating of plans is not systematically happening on 3 of the projects; these issues should be rectified by this stage of the project cycle.
4. The delay in completion of the EA/QIA for the 'Improving Outpatients' project is of concern and this piece of work and complete sign-off should be expedited.

J Gibson

Alder Hey Children's NHS
NHS Foundation Trust

Programme Assurance Framework

Our Patients at the Centre Update (to be completed by Executive Sponsor)

Work Stream Summary:

This Work Stream Comprises 6 projects with Executive Sponsorship discharged by the Director of Nursing and the COO. There are 5 projects with completed definition documents (PID's) – see below. The focus now is on ensuring that fully populated (managerial/clinical) partnerships are in evidence at the Steering Groups for each project and that milestone plans of progress are being updated each week on SharePoint.
There has been an agreement to defer the outstanding work stream to ensure robust staff engagement and deliverability.
The Improving Outpatients work stream has a dependency on improving usability of IM&T systems within OPD, agenda item at data quality steering group.

Work Stream Progress:

Project	Key tasks delivered in month	Milestones on Track (Y/N)
Implementing New Quality Strategy	PID Complete	y
Best Operative Care	PID Complete	Y
Improving Outpatients	PID Complete	y
Complex Care Made Simple	PID Complete	Y
Improving Flow	PID Complete	y
Clinical Support Services	Agreed deferral to enable staff engagement	

Milestones for Next Month:

Project	Key tasks to be delivered in month
Improving Outpatients	Complete finance tracker to deliver CIP
Work stream	Fully establish Steering Groups for all remaining projects
Work Stream	Ensure detailed plans are on SharePoint (updated) for all remaining projects

Issues for Escalation to Sub-Committee:

None

Programme Assurance Framework

Our Patients at the Centre (Completed by Assurance Team)

Alder Hey Children's NHS Foundation Trust

Sub-Committee	CQAC	Report Date	10 May 2016
Workstream Name	Our Patients at the Centre	Executive Sponsor	Hilda Gwilliams/COO

Current Dashboard Rating:

Project Ref	Project Title	Project Description	Executive Sponsor Assures the project	OVERALL PROJECT RAG status	An effective project team is in place	Scope and Approach is defined	Targets / benefits defined/on track	Milestone plan is defined/on track	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	Comments for attention of the Project Team, Steering Group and sub-Committee
3.0 Our Patients at the Centre 16/17 £1m and 17/18 £2m													
CQA 3.1	Implementing New Quality Strategy	To implement a Quality Strategy characterised by a strong Clinical Cabinet with strong clinical leadership to deliver improvements in patient safety, patient experience and clinical effectiveness	Hilda Gwilliams		G	G	G	G	G	G	G	G	Steering Group information on Sharepoint. Plan shows actions on track., Comms/Engagement activities to be tracked against plan, however information available on Sharepoint. Risk Log up-to-date. QIA/EA complete. **Last updated 29 April 2016**
CQA 3.2	Best Operative Care	The "Best in Operative Care" strategy aims to deliver the best paediatric operative care in the world, as measured by low rates of mortality and harm, and high staff satisfaction	COO		G	G	A	A	G	A	G	G	Steering Group notes available. Benefits detailed in PID (1 baseline now O/S), tracking process to start. Milestone Plan updated, currently shows some delays (1 month+), evidence to be uploaded to Sharepoint where possible. Good engagement at Steering Group, more evidence of other activities required. Evidence required of risk management. **Last updated 9 May 2016**
CQA 3.3	Improving Outpatients	The project will improve patient & staff experience; understand demand and capacity; review processes & communication; & improve the flow & environment	COO/ Hilda Gwilliams		G	G	G	G	A	G	R	R	Steering Group notes available on Sharepoint - some gaps with attendance. Benefits tracking to be confirmed. Detailed milestone plan shows actions on track, with evidence being uploded to Sharepoint . Comms/ stakeholder engagement documents on Sharepoint - plan to be confirmed. Risk Log reviewed at SG. EA/QIA to be completed/signed . **Last updated 9 May 2016**
CQA 3.4	Complex Care Made Simple	The aim of this project is to improve the quality of care at Alder Hey to Children and Young People with complex health needs	COO		G	A	G	A	G	G	G	G	Steering Group notes available on Sharepoint. Benefits tracker has been created. Detailed plan is available. Rehab position key milestone missed, this may affect scope - to be clarified at meeting 10/5. Comms tracker available and parent rep on SG. Risk Log is up-to-date. EA/QIA has been completed and signed off. **Last updated 6 May 2016**
CQA 3.5	Improving Flow	The aim of the project is to provide the most efficient and effective means of supporting patient flow across the organization	Hilda Gwilliams		G	G	G	A	A	G	G	G	Project Team meeting papers available. PID complete with full details of benefits. Milestone Plan to be fully updated (actions marked complete or missed) and evidence uploaded to Sharepoint where possible. Some gaps with meeting attendance, evidence of stakeholder engagement/comms to be confirmed. Risk Log up-to-date. EA/QIA complete **Last updated 9 May 2016**
CQA 3.6	Clinical Support Services	Resolve the potentially conflicting priorities of making efficiencies whilst continuing to provide a flexible approach to supporting clinical services, maintaining a focus on delivering high quality services to patients	COO										21/4/16 Advised project is to be re-framed and re-phased to allow clinical/professional engagement and ownership.

Project Title	RAG Rating	Budget £	Forecast £	Variance £	Comments
Implementing New Quality Strategy	Non Financial				
Improving Flow	Non Financial				
Best Operative Care	G/A	505,304	**493,536**	**(11,768)**	
Improving Outpatients	Black	156,250	**0**	**(156,250)**	Some financial values given. Savings not identified to cover implementation costs.
Complex Care Made Simple	Under Review	291,571	**291,571**	**0**	Full funding for investment not identified. Financial forecast under review
Clinical Support Services	Black	93,750	**0**	**(93,750)**	No financial Values given in PID
Total		1,046,875	**785,107**	**(261,768)**	Stretch target of £261,768

Alder Hey Children's NHS
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Programme Assurance Summary
New Services in Communities

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

1. Existing Community - The PID should be completed at the earliest opportunity. The CIP target for the projects in this work stream equates to £0.2m in 16/17 and £2m in 17/18. The 16/17 forecast remains at £0 and is not yet underpinned by clear plans.
2. Developing Partnership Model – it is noted the expected financial benefit (£2m per annum) of this project has been deferred until 2017/18 given the long lead in time of any acquisition or transfer of services. However, the Executive Sponsor is requested to provide a preliminary assessment and review the total annual revenue gain opportunity and estimate the trust contribution before full due diligence commences.

For both projects, information should be uploaded to SharePoint to meet the standards required (see comments on the dashboard dated 10 May 2016)

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

1. The Steering Groups for 'Developing a Partnership Model for Community Services' and 'Existing Community Services – Quality Improvement' need to address the significant amount of 'amber' rated domains for project governance.
2. The arrangements for accelerating the initiation and development of the 'Existing Community Services – Quality Improvement' project should be given high priority.

J Gibson

Programme Assurance Framework

New Services in Communities

Alder Hey Children's NHS
NHS Foundation Trust

Sub-Committee	RABD	Report Date	12 May 2016
Workstream Name	New Services in Communities	Executive Sponsor	Therese Patten & Mags Barnaby

Current Dashboard Rating:

Project Ref	Project Title	Project Description	Executive Sponsor Assures the project	OVERALL PROJECT RAG status	An effective project team is in place	Scope and Approach is defined	Targets / benefits defined/on track	Milestone plan is defined/on track	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	Comments for attention of the Project Team, Steering Group and sub-Committee
R&BD 4.1	Developing a Partnership Model for Community Services	The aim of the project is to work with partners to work out what an integrated model for childrens services in Liverpool will look like	Therese Patten										No visibility of Project Team notes. SG minutes for January on Sharepoint. PID shows some gaps in team and current services(scope). Deliverables and benefits detailed within PID, however total annualgain Y1 and 2 to be confirmed. Plan available on Sharepoint, shows some delays (currently being updated). Risk Log to be reviewed. EA/QIA complete. **Last updated 19 April 2016**
R&BD 4.2	Existing Community Services - Quality Improvement	To deliver quality improvement of existing services within the ICS CBU, specifically in the following services: Child & Adolescent Mental Health Services (CAMHS), Neurodisability and General Paediatrics'	COO										No Project Manager details available. PID and other project documentation commenced but to be fully completed. Milestone Plan to be fully developed Evidence of stakeholder engagement/comms to be provided. Risk Log to be completed. EA/QIA complete. **Last updated 9 May 2016**

Project Title	RAG Rating	Budget £	Forecast £	Variance £	Comments
Developing a Partnership Model for Community Services					Non Financial
Existing Community Services – Quality Improvement	B	200,000	0	(200,000)	No savings identified in PID on SharePoint
Total		200,000	0	(200,000)	

Alder Hey Children's NHS
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Programme Assurance Summary
Research Education & Innovation

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

1. The pace of identification of CIP opportunities across the four projects that comprise this work stream - in project 5.1 'Digital Hospital', 5.2 'The Innovation Machine', 5.3 Commercial Research Offers' and 5.4 'Commercial Education Offers' - needs to be increased as a matter of urgency. The initial opportunity assessment identified £400k worth of CIP 'ideas' and there is currently just £60k identified, a £340k gap against the FY 16/17 target. These opportunities will require full project documentation to cover the schemes. As agreed at the Programme Board on 31 Mar 16, all projects should have been green rated for evidence of project working by 30 Apr 16.
2. The current dashboard ratings give low confidence of delivery in this work stream.

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

1. The work stream is significantly behind track in the definition of project and maintenance of project evidence. There should be urgent consideration of what needs to change and/or additional support to bring this back on track.
2. For the projects, 5.3 Commercial Research Offers' and 5.4 'Commercial Education Offers', the respective Executive Sponsors have advised that the date for commencement of project(s) is dependent upon discussions at the RE&I sub-Committee and Executive Team. These discussions and associated decisions need to have positive impact and deadlines attached.
3. The Project Team meetings for those projects which are 'live' need to be established and evidenced on SharePoint as a matter of urgency.

J Gibson

Alder Hey Children's NHS
NHS Foundation Trust

Programme Assurance Framework
Research, Education & Innovation Workstream Update

Sub-Committee	Research, Education & Innovation	Report Date	6 May 2016
Workstream Name	Research, Education & Innovation	Executive Sponsor	David Powell/Rick Turnock/Louise Dunn/Melissa Swindell

Current Dashboard Rating:

Project Title	Project Description	Executive Sponsor Assures the project	OVERALL PROJECT RAG status	An effective project team is in place	Scope and Approach is defined	Targets / benefits defined/on track	Milestone plan is defined/on track	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	Comments for attention of the Project Team, Steering Group and sub-Committee
Digital Hospital	Create & deploy application to allow state of the art interaction to achieve tech integration with IBM Watson cognitive computing platform provided by Hartree as part of government funded deployment	David Powell/ Rick Turnock										No visibility of Project Team meetings. The PID needs to be fully completed including Financial Information. Milestone Plan to be developed with weekly tracking on Sharepoint. No visibility of Comms or Risk Log. EA/QIA to be completed and signed off. **Last Updated 19 April 2016**
The Innovation Machine	The development directorate is seeking to restructure its team to enable fluid exploration, creation, and commercialisation of technology products through the innovation team	David Powell/ Rick Turnock										No visibility of Project Team meetings. The PID needs to be fully completed including Financial Information. Milestone Plan to be developed with weekly tracking on Sharepoint. No visibility of Comms or Risk Log. EA/QIA to be completed and signed off. **Last updated 19 April 2016**
Commercial Research Offers	The aim of the project is to	Louise Dunn										Executive Sponsor advises that the date for commencement of project dependent upon discussions at the RE&I sub-Committee and Executive Team.
Commercial Education Offers	The aim of the project is to	Melissa Swindell										Executive Sponsor advises that the date for commencement of project dependent upon discussions at the RE&I sub-Committee and Executive Team.

Financial Reporting:

Project Title	RAG Rating	Budget (£)	Forecast (£)	Variance (£)	Comments
Innovation Machine	A	100,000	60,000	(40,000)	60% of Target identified, £40k still to find.
Commercial Education	B	200,000	0	(200,000)	No PID submitted.
Commercial R&D	B	100,000	0	(100,000)	No PID Submitted.
Total		**400,000**	**60,000**	(340,000)	Stretch target of £340,000.

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Programme Assurance Summary
Developing IM&CT and EPR

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

1. These projects are planned to have PIDs completed by the 31 May 16 and therefore are not subject to assurance commentary at this time.
2. There is no financial CiP target attributed to this work stream.

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

1. Given the deadline for all PIDs to be completed by 31 May 16, and the programme standard of using SharePoint to ensure transparency, it was good to see high quality PIDs being submitted to the relevant Steering Group on 17 May 16. This gives a level of confidence that the PIDs will be complete by the end of May 16, ready for approval by the relevant groups in June 2016.

J Gibson

Alder Hey Children's NHS
NHS Foundation Trust

Programme Assurance Framework

IM&T Update (to be completed by Executive Sponsor)

Work Stream Summary:

Project Initiation documents and planning work in development and on track.

Work Stream Progress:

Project	Key tasks delivered in month	Milestones on Track (Y/N)
EPR Development (MEDITECH 6)	Draft PID reviewed and accepted by Clinical Systems Informatics Steering group on 17th May 2016 (although group not quorate). Updated PIDs to Programme Manager for review by 23/05/16.	Y
Connectivity	Extensive project and resource planning underway .	Y
Imaging	Approval process below proposed and agreed by CSI Steering group.	Y
Other Clinical Systems		Y

Milestones for Next Month:

Project	Key tasks to be delivered in month
EPR Development (MEDITECH 6)	Final version of PIDs to be completed by 31/05/16 and submitted for approval to R&BD Committee in June 2016
Connectivity	
Imaging	
Other Clinical Systems	

Issues for Escalation to Sub-Committee:

None

Programme Assurance Framework

Developing IM&CT and EPR

Alder Hey Children's NHS
NHS Foundation Trust

Sub-Committee	RABD	Report Date	12 May 2015
Workstream Name	Developing IM&CT and EPR	Executive Sponsor	Jonathan Stephens

Current Dashboard Rating:

Project Ref	Project Title	Project Description	Executive Sponsor Assures the project	OVERALL PROJECT RAG status	An effective project team is in place	Scope and Approach is defined	Targets / benefits defined/on track	Milestone plan is defined/on track	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	Comments for attention of the Project Team, Steering Group and sub-Committee
6.0 Developing IM&CT and EPR													
R&BD 6.2	EPR Development	O/S issues from P1& 2 (technical & process related) as well as deferred work from P1 & the list of potential projects for P3: need prioritisation & wider discussion to ensure org ownership	Jonathan Stephens										Due to the implementation of the findings of the recent strategic review of IM&T, these projects PIDs will be commenced and completed by 31 May 2016 as advised by the Executive Sponsor and Corporate Lead.
R&BD 6.1	Imaging	Project aims to digitise all existing paper records, implement a full electronic patient record solution and provide a repository for all clinical images	Jonathan Stephens										Due to the implementation of the findings of the recent strategic review of IM&T, these projects PIDs will be commenced and completed by 31 May 2016 as advised by the Executive Sponsor and Corporate Lead.
R&BD 6.3	Other Clinical Systems	To implement full electronic patient record in PICU, allowing recording, maintenance & reporting, in addition to interface with relevant systems including PAS, pathology & key medical devices	Jonathan Stephens										Due to the implementation of the findings of the recent strategic review of IM&T, these projects PIDs will be commenced and completed by 31 May 2016 as advised by the Executive Sponsor and Corporate Lead.
R&BD 6.4	Community Infrastructure	This workstream will cover IT connectivity at off site locations and interoperability and projects that it is hoped to implement as part of the iLinks programme	Jonathan Stephens										Due to the implementation of the findings of the recent strategic review of IM&T, these projects PIDs will be commenced and completed by 31 May 2016 as advised by the Executive Sponsor and Corporate Lead.

Project Title	RAG Rating	Budget £	Forecast £	Variance £	Comments
Total	Not applicable				Non financial projects

Alder Hey Children's NHS
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Programme Assurance Summary
Supporting Front Line Staff

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

1. The CIP target for the projects in this work stream equates to £2.9m in 16/17 and £3m in 17/18. The 16/17 forecast amounts to £2.6m and underpinned by plans to date. Overall good progress demonstrated by the work stream and the teams should focus on closing gaps. The two outstanding QIA should be completed a matter of urgency
2. £0.1m gap is in the Facilities project and relates to a delay in implementation of the car parking initiatives and the need to find other opportunities to close the gap, the project team will be hosting workshop to do this over the next four weeks.
3. £0.2m gap in medicines optimisation. This gap need to be addressed as a matter of high importance
4. Coding and capture, on track for delivery, however the team are requested to stretch savings to potentially mitigate 2 & 3 above.

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

1. The Executive Sponsors, through the established Steering Groups, should ensure that the Trust policy for both Equality Assessment and Quality Impact Assessment (EA/QIA) is applied without further delay for the 'Coding and data Capture' and 'Pathfinders' projects and that the EA/QIA forms are completed and signed off.
2. The arrangements for initiating and evidencing team meetings for the 'Pathfinders' project should be afforded the highest priority.

J Gibson

Programme Assurance Framework

Supporting Front Line Staff

Alder Hey Children's NHS Foundation Trust

Sub-Committee	RABD	Report Date	12 May 2016
Workstream Name	Supporting Front Line Staff	Executive Sponsor	Jonathan Stephens, Rick Turnock, Hilda Gwilliams

Current Dashboard Rating:

Project Ref	Project Title	Project Description	Executive Sponsor Assures the project	OVERALL PROJECT RAG status	An effective project team is in place	Scope and Approach is defined	Targets / benefits defined/on track	Milestone plan is defined/on track	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	Comments for attention of the Project Team, Steering Group and sub-Committee
R&BD 7.1	Procurement	Deliver best in class purchasing. Action the team 10 point plan to ensure service delivered to CBUs is high standard, with great customer service and releases £1m	Jonathan Stephens										Steeering Group meeting notets available. Benefits to be tracked via Financial Tracker. Detailed workplan is available on Sharepoint and will be updated regularly. Stakeholder Engagement information is available showing planned activities. Risk Log fully completed. QIA/EA signed off by Execs. **Last updated 9 May 2016**
R&BD 7.2	Coding & Data Capture	To deliver best in class coding service that improves the depth of doing. To ensure the trust is getting paid for activity it delivers; to educate and train end users and clinicians to capture all activity	Jonathan Stephens										Steering Group meeting notes available. Targets & benefits detailed in PID, tracking required for non-financial benefits. Detailed Milestone Plan, shows actions on track. Evidence required of Stakeholder engagement. Risk Log up-to-date. EA/QIA sign off process tobe commenced. **Last updated 29 April 2016**
R&BD 7.3	Medicines Optimisation	Medicines optimisation is a patient-focused approach to getting the best from investment in and use of medicines. It requires a holistic approach, an enhanced level of patient centred professionalism	Rick Turnock										Steering Group meeting notes available. PID complete. Workplan available - tracking process to be confirmed with team. Evidence of Comms/engagement available on Sharepoint - plan to be confirmed. Risk Log up-to-dateavailable. QIA/EA signed off by Execs. **Last updated: 25 April 2016**
R&BD 7.4	Facilities	The project aims to review all Facilities Services to ensure that all services are maximising quality at the lowest cost resulting in a CIP contribution of £500k	Hilda Gwilliams										Steering Group meeting notes (and workstream notes) available. Tracking of benefits commenced. Milestone plan has one outstanding section for AGV, shows actions broadly up-to-date and evidence is being uploaded to Sharepoint. Risk Log to be fully completed. QIA/EA signed off by Execs. **Last updated: 28 April 2016**
R&BD 7.5	Pathfinders	To embed SLR costing information and introduce Pathfinders to improve Trust financial health and clinical engagement	Jonathan Stephens										No evidence of team meetings for workstreams underway. PID complete and contains details of benefits comms/engagement - tracking to be confirmed. Risk Log is complete. EA/QIA sign off process to be commenced. **Last updated 9 May 2016**

Project Title	RAG Rating	Budget £	Forecast £	Variance £	Comments
Procurement	G/A	1,018,000	**1,018,000**	**0**	£16,122 posted in April
Coding & Data Capture	G/A	900,000	**900,000**	**0**	£66,666 posted in April
Medicines Optimisation	A	500,000	**313,248**	**(186,756)**	Stretch target of £186,756, £41,667 Posted in April
Facilities	G/A	500,000	**388,131**	**(111,869)**	Stretch target of £111,869, £12,847
Pathfinders					Non Financial
Total	G/A	**2,918,004**	**2,619,379**	**(298,625)**	

Alder Hey Children's NHS
NHS Foundation Trust

Programme Assurance Summary
Park, Community Estate & Facilities

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

1. The projects in this work stream do represent a key area of strategic importance for the Trust and require the management of significant Capex budget. There is a critical dependency that the projects remain within budget and meet milestone plans. Specifically the following projects contain financial risk that require immediate mitigation.

    a) Demolition tenders amount to minimum £1.7m above budget. This presents a significant financial and programme risk, the Exec Sponsor is requested to prepare a mitigation plan and highlight the associate delay given the potential requirement to apply there are interdependencies and a requirement for DH funding and Trust board tender approval.

    b) Corporate office, the project team are required to ensure the design lives within the £15m budget and all associated IT costs are included.

    c) The Park, the Exec sponsor is to ensure commercial agreements are formalised through trust governance.

The current assurance ratings give rise to concern that there is still work to be done to ensure that all key people are working closely on the priorities and assessing and mitigating any blocks to the critical path; Steering Group coherence and assurance will be critical.

2. There is no financial CIP target attributed to this work stream.

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

1. With the exception of the 'Temporary Move' project, four projects across the work stream have not yet met the assurance standard. The right evidence (see the guide to assurance ratings) to meet the assurance standard needs to be posted onto SharePoint to provide transparency. Therefore, the arrangements for taut management of the 'Decommission & Demolition', 'Park', 'Corporate Offices' and 'On-Site Residual Services' projects should be given high priority. Following a meeting with the Executive Sponsor and the Executive Lead for Assurance on 17 May 16, there is commitment to achieving this aim with the next 4 weeks.
2. The Executive Sponsor, through the established Steering Group(s), should ensure that the Trust policy for both Equality Assessment and Quality Impact Assessment (EA/QIA) is applied without further delay and the EA/QIA forms are completed and signed off; only one project, 'Decommission & Demolition', has currently met this standard.

J Gibson

Programme Assurance Framework

Developing The Park, Our Community Estate and Facilities

Alder Hey Children's NHS Foundation Trust

Sub-Committee	RABD	Report Date	12 May 2016
Workstream Name	Developing The Park, Our Community Estate & Facilities	Executive Sponsor	David Powell & Melissa Swindell

Current Dashboard Rating:

Project Ref	Project Title	Project Description	Executive Sponsor Assures the project	OVERALL PROJECT RAG status	An effective project team is in place	Scope and Approach is defined	Targets / benefits defined/on track	Milestone plan is defined/on track	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	Comments for attention of the Project Team, Steering Group and sub-Committee
8.0 Developing The Park, Our Community Estate and Facilities													
R&BD 8.1	Decommission & Demolition	The aim of the project is to move out from and make safe the old hospital ready for demolition	David Powell										Steering Group notes available. The PID is complete and contains details of expected benefits (where possible). Plan on Sharepoint shows delays of 1 month (award of contract). Workstream Risk Register available, shows financial risk which is being monitored closely. **Last updated 6 May 2016**
R&BD 8.2	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 notes available, however no Project Manager for this project. Plan has been updated but shows a significant number of missed milestones. All documentation to be reviewed/updated, including Risk Log and EA/QIA. Evidence of comms/stakeholder engagement to be provided. **Last updated 6 May 2016**
R&BD 8.3	Temporary Move	Project aims to survey and establish departments to be retained on-site, not already incorporated in new build, and provide the office estate to achieve this	David Powell										Steering Group notes available. Evidence of benefits to be provided where possible. Milestone Plan to be fully updated (some O/S tasks). Workstream Risk Log available. QIA to be completed/signed. **Last updated 25 April 2016**
R&BD 8.4	Agile Working	The aim of the project is to deliver an agile working solution for the Trust that complements the on site and off-site developments	Melissa Swindell										PID is to be completed by 30 June 2016, when capacity is released to complete the work
R&BD 8.5	Research & Education	The aim of the project is to complete Phase 2 of the RI & E building to a world class standard	David Powell										Design work may continue - subject to approval - in advance of funding being secured
R&BD 8.6	Community Services	The aim of the project is to create a suitable home for our network of community services	David Powell										Project work is to commence in June 2016 (irrespective of the bid outcome) to ensure that viable solution (s) are in place
R&BD 8.7	Corporate Offices and On-site clinical Services	The aim of the project is to create a suitable home for the corporate clinical and associated staff/services on the Alder Hey campus	David Powell										Steering Group notes available. PID completed - to be reviewed/approved. Milestone Plan is available on Sharepoint, showing missed milestone re design/cost alignment. Project documentation to be fully developed. QIA to be fully completed and signed. **Last updated 6 May 2016**
R&BD 8.8	On Site Residual Services	The aim of the project is to create a suitable home for the residual services on the Alder Hey campus	David Powell										Steering Group notes available. No PID available and details of this project are unclear. All project documentation to be fully developed. EA/QIA to be completed.
R&BD 8.9	Residential Development		David Powell										PID will be available at the end of May.

Project Title	RAG Rating	Budget £	Forecast £	Variance £	Comments
Total	Not applicable				Non financial projects

Alder Hey Children's NHS
NHS Foundation Trust

Board of Directors
Monday, 23 May 2016

Report of	Director of Corporate Affairs
Paper prepared by	Executive Team, and Quality Assurance Officer
Subject/Title	2016/17 BAF
Background papers	Monthly BAF updates/reports Developing our '2020 Vision' – Alder Hey in the Park and beyond *(presentation to April Board)*
Purpose of Paper	To receive the proposed BAF for 2016/17
Action/Decision required	The Board is asked to discuss and approve the BAF for the forthcoming year
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	By 2020, we will: ➢ be recognised for the **exceptional quality of care** we provide to our children, that is technologically enabled and matched by exceptional facilities ➢ be a **world class,** child-focussed **Centre of Research**, innovation and education expertise to improve the health and wellbeing outcomes for children and young people ➢ have a fully **engaged workforce** that is actively driving quality improvement ➢ have secured sustainable long term **financial and service growth** supported by a **strong international business**
Resource Impact	Non achievement of the Trust's objectives could have a negative impact on the services provided by the Trust.

Board Assurance Framework 2016/17

1. Introduction

The BAF is a tool for the Board to corporately assure itself about successful achievement of the organisation's strategic objectives and how the risks to delivery are managed and mitigated.

The BAF directly underpins the Annual Governance Statement (AGS) and is the subject of annual review by Internal and External Audit, with the former providing a formal opinion on the fitness for purpose of the process and approach.

2. Key issues

Following the presentation at the April Trust Board '*Achieving our Ambition; Our Strategic Pillars by 2020'* and associated SWOT analysis 2016, an exercise was undertaken looking at strengths, weaknesses, opportunities and threats and cross-referencing these with high level content of the existing BAF (as *detailed in Table 1*).

A number of suggestions have been made on the current principal risks to reflect progress in the achievement of the strategic objectives (2011-16) and to account for emerging external factors that are likely to present a risk to delivery of the Trust's refreshed strategic objectives to 2020.

The Board is asked to consider changes to the risk ratings in this regard taking into account the following questions:

- Have all strategic risks been identified and accurately captured?
- Are there any changes required to the causes and effects?
- Are controls and assurances in place?
- Are the controls in place sufficiently robust to manage risks?
- Is there sufficient assurance regarding the operation of controls to manage the risks?
- Are there any concerns in respect of the assurance given?
- Is the progress on actions sufficient to address gaps in controls and assurance?
- Are there any out of date assurances or overdue actions?

3. Recommendation

The Board is asked to:

- note the closure of the 2015/16 BAF;
- discuss and agree any changes to risk ratings, and
- discuss and approve the proposed changes to the 2016/17 BAF.

Describing our Ambition for 2020 – future analysis against 2016 SWOT

Table 1

	Referenced currently in BAF?
Weaknesses	
Staff engagement with Strategy	4.2
Engagement / grip to deliver throughput plans and targets – elective, outpatients, diagnostics etc.	4.2
Lack of cash for investments in business development	6.1 – suggest to re-word
Workforce diversity	No, MS to consider if wrap into existing workforce risk (4.1) or create standalone
Lost opportunity of the Public Health Strategy signalled in 2011	No, requires discussion at Board level
IT needs strategic development	Consider re-wording 6.2 to be all encompassing
Opportunities	
Local context – viability of some organisations	5.1
Potential for service reconfiguration across women and children's services	6.3 & 6.4
Strategic partnerships	6.3
International offer	Consider re-wording 2.1 to be all encompassing
Thorough leadership for paediatric services in the north west and beyond including public health	No
Education and new business	1.4?, 4.1
Research & innovation new sources of growth	Consider re-wording 2.1 to be all encompassing
Threats	
Financial environment – pressure across the sector	1.1, 2.1?, 5.1,
Political environment – junior doctors contract, seven day services etc.	Not currently a BAF risk (sitting on CRR)
Regulatory focus / lack of clear national strategic leadership	6.4
Local Authority pressures especially social care – need for new approaches	6.1

BOARD ASSURANCE FRAMEWORK 2016/17

Alder Hey Children's NHS Foundation Trust

BAF 1.1	**Strategic Objective:** By 2020, we will be recognised for the exceptional quality of care we provide to our children, that is technologically enabled and matched by exceptional facilities	***Risk Title:*** ***Maintain care quality in a cost constrained environment***		
Related CQC Themes: Safe, Caring, Responsive, Well-led				
Exec Lead: Hilda Gwilliams	**Type:** Internal, known	***Current IxL:*** ***4-2***	**Target IxL:** **4-2**	**Trend: STATIC**
Risk Description				
Failure to maintain appropriate levels of care quality in a cost constrained environment *(suggest explicit reference to include threat: Financial environment – pressure across the sector; failure to deliver Recruitment & Retention Strategy * 'futureproof' workforce)*				

BOARD ASSURANCE FRAMEWORK 2016/17

Alder Hey Children's NHS Foundation Trust

BAF 1.2	**Strategic Objective:** By 2020, we will be recognised for the exceptional quality of care we provide to our children, that is technologically enabled and matched by exceptional facilities	***Risk Title:*** ***Mandatory & compliance standards***		
Related CQC Themes: Safe, Caring, Responsive, Well-led, Effective				
Exec Lead: Margaret Barnaby	**Type:** Internal, known	***Current IxL:*** ***4-5***	**Target IxL:** **4-2**	**Trend: STATIC**
Risk Description				
Failure to deliver on all mandatory and compliance standards including those of the regulators Monitor and CQC *(suggest to re-word to include weakness: engagement / 'grip' to deliver throughput plans and targets – elective, outpatients, diagnostics etc.)*				

BOARD ASSURANCE FRAMEWORK 2016/17

Alder Hey Children's NHS Foundation Trust

BAF 1.3	**Strategic Objective:** By 2020, we will be recognised for the exceptional quality of care we provide to our children, that is technologically enabled and matched by exceptional facilities	***Current Risk Title: Non-compliant estate*** ***Suggested new: Failure to fully realise the Trust's vision for the Park***		
Related CQC Themes: Safe, Well-led, Effective				
Exec Lead: Melissa Swindell	**Type:** Internal, known	***Current IxL: 4-3***	**Target IxL: 4-1**	**Trend: STATIC**

Risk Description

Risk of enforcement action arising from safety incidents due to a failure to maintain a compliant estate and robust and embedded health & safety practices in the work place.

(majority of risks on CHP post occupation risk register now closed; suggest to re-word this risk to reflect failure to realise the Trusts vision for the park and campus as a legacy for future generations.)

BOARD ASSURANCE FRAMEWORK 2016/17

Alder Hey Children's NHS Foundation Trust

BAF 1.4	**Strategic Objective:** By 2020, we will be recognised for the exceptional quality of care we provide to our children, that is technologically enabled and matched by exceptional facilities	***Risk Title: Training & development of clinical workforce***		
Related CQC Themes: Safe, Well-led, Effective, Caring, Responsive				
Exec Lead: Melissa Swindell	**Type:** Internal, known	***Current IxL: 4-3***	**Target IxL: 4-1**	**Trend: STATIC**

Risk Description

Failure to ensure high standards of care through lack of training/development of clinical workforce.

(suggest to re-word this risk to incorporate education & new business opportunities)

BOARD ASSURANCE FRAMEWORK 2016/17

Alder Hey Children's NHS Foundation Trust

BAF 1.5	**Strategic Objective:** By 2020, we will be recognised for the exceptional quality of care we provide to our children, that is technologically enabled and matched by exceptional facilities	***Risk Title:*** ***Failure to provide effective systems to ensure appropriate Ward to Board reporting***		
Related CQC Themes: Safe, Well-led, Effective, Caring, Responsive				
Exec Lead: Erica Saunders	**Type:** Internal, known	***Current IxL:*** ***4-3***	**Target IxL:** **3-2**	**Trend: STATIC**

Risk Description

Failure to provide effective systems to ensure appropriate Ward to Board reporting

(suggest to re-score and drop down to Corporate Risk Register)

BOARD ASSURANCE FRAMEWORK 2016/17

Alder Hey Children's NHS Foundation Trust

BAF 2.1	**Strategic Objective:** By 2020, we will be a world class, child-focussed Centre of Research, innovation and education expertise to improve the health and wellbeing outcomes for children and young people	***Current Risk Title: Finance for phase 2 of the Research facility*** ***Suggested new: Delivery of phase 2 of Institute in the Park by 2018/19***		
Related CQC Themes: Well-led, Responsive				
Exec Lead: Jonathan Stephens	**Type:** Internal, known	***Current IxL:*** ***4-4***	**Target IxL:** **2-3**	**Trend: STATIC**

Risk Description

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

(suggest to incorporate:; Remain a key player in creation of Liverpool Biomedical Research Centre development; Develop a single integrated approach across research, education and innovation; Develop a robust commercial Education Business model; Become the educator of choice for paediatrics; Work with our Charity colleagues to raise the profile of our research and innovation capability and attract high level sponsorship and financial support)

BOARD ASSURANCE FRAMEWORK 2016/17

Alder Hey Children's NHS Foundation Trust

BAF 4.1	**Strategic Objective:** By 2020, we will have a fully engaged workforce that is actively driving quality improvement	***Risk Title: Sustain workforce capability***		
Related CQC Themes: Well-led, Responsive, Safe, Effective				
Exec Lead: Melissa Swindell	**Type:** Internal, known	***Current IxL: 3-4***	**Target IxL: 3-3**	**Trend: STATIC**
Risk Description				
Failure to achieve the Trust's strategic and operational targets due to an inability to sustain workforce capability *(Reference to 'education & new business' opportunity. Perhaps incorporate workforce diversity weakness here?)*				

BOARD ASSURANCE FRAMEWORK 2016/17

Alder Hey Children's NHS Foundation Trust

BAF 4.2	**Strategic Objective:** By 2020, we will have a fully engaged workforce that is actively driving quality improvement	***Current Risk Title: Workforce engagement and support*** ***Suggested new: Staff engagement***		
Related CQC Themes: Well-led, Responsive, Safe, Effective				
Exec Lead: Melissa Swindell	**Type:** Internal, known	***Current IxL: 3-3***	**Target IxL: 3-2**	**Trend: STATIC**
Risk Description				
Lack of workforce engagement which impacts upon operational performance and achievement of strategic aims *(Incorporate: failure to deliver the new programme of change; develop a healthy workplace which supports the physical, social and emotional wellbeing of staff; Political environment – junior doctors contract, seven day services etc.)*				

BOARD ASSURANCE FRAMEWORK 2016/17

Alder Hey Children's NHS Foundation Trust

BAF 5.1	**Strategic Objective:** By 2020, we will have secured sustainable long term financial and service growth supported by a strong international business	***Current Risk Title: Income & expenditure plan*** ***Suggested new: Financial environment***		
Related CQC Themes: Well-led, Responsive, Safe, Effective				
Exec Lead: Jonathan Stephens	**Type:** Internal, known	***Current IxL: 4-4***	**Target IxL: 4-2**	**Trend: STATIC**

Risk Description

Failure to deliver 2016/17 Income and Expenditure plan and planned Continuity of Service Risk Rating

BOARD ASSURANCE FRAMEWORK 2016/17

Alder Hey Children's NHS Foundation Trust

BAF 6.1	**Strategic Objective:** By 2020, we will have secured sustainable long term financial and service growth supported by a strong international business	***Risk Title: Business development & growth***		
Related CQC Themes: Well-led, Responsive, Effective				
Exec Lead: Jonathan Stephens	**Type:** External, known	***Current IxL: 4-3***	**Target IxL: 4-2**	**Trend: STATIC**

Risk Description

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

(suggest to incorporate threat: regulatory focus / lack of clear national strategic leadership)

BOARD ASSURANCE FRAMEWORK 2016/17

Alder Hey Children's NHS Foundation Trust

BAF 6.2	**Strategic Objective:** By 2020, we will be recognised for the exceptional quality of care we provide to our children, that is technologically enabled and matched by exceptional facilities	***Current Risk Title: EPR Implementation*** ***Suggested new: IT Strategic Development***		
Related CQC Themes: Well-led, Responsive, Safe, Effective				
Exec Lead: Jonathan Stephens	**Type:** Internal, known	***Current IxL: 4-4***	**Target IxL: 4-2**	**Trend: STATIC**
Risk Description				
Risk to business development/growth due to NHS financial environment and constraints on internal infrastructure to deliver business as usual as well as maximise growth opportunities *(suggest to reference failure to effectively implement the next phase of EPCS and other ICT enablers including IT infrastructure and innovations)*				

BOARD ASSURANCE FRAMEWORK 2016/17

Alder Hey Children's NHS Foundation Trust

BAF 6.3	**Strategic Objective:** By 2020, we will have secured sustainable long term financial and service growth supported by a strong international business	***Risk Title: Sustaining national designations for specialist services***		
Related CQC Themes: Well-led, Responsive, Safe, Effective				
Exec Lead: Jonathan Stephens	**Type:** External, known	***Current IxL: 4-3***	**Target IxL: 4-2**	**Trend: STATIC**
Risk Description				
Risk to sustaining national designations for specialist services due to failure to meet all required standards. *(suggest to incorporate threat: Local Authority pressures especially social care – need for new approaches)*				

BOARD ASSURANCE FRAMEWORK 2016/17

Alder Hey Children's NHS Foundation Trust

BAF 6.4	**Strategic Objective:** By 2020, we will have secured sustainable long term financial and service growth supported by a strong international business	***Risk Title:*** ***Relationships with new Commissioners***		
Related CQC Themes: Well-led, Responsive, Safe, Effective				
Exec Lead: Jonathan Stephens	**Type:** External, known	***Current IxL:*** ***4-3***	**Target IxL:** **4-2**	**Trend: STATIC**

Risk Description

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

(suggest to incorporate threat: regulatory focus / lack of clear strategic leadership)

Summary of BAF

Ref, Owner	Risk Title	Risk Rating: I x L	
		Current	Target
STRATEGIC OBJECTIVE 1: By 2020, we will be recognised for the **exceptional quality of care** we provide to our children, that is technologically enabled and matched by exceptional facilities			
1.1 HG	**Maintain care quality in a cost constrained environment**	4-2	4-2
1.2 MB	**Mandatory & compliance standards**	4-5	4-2
1.3 MS	**Failure to fully realise the Trust's vision for the Park**	4-3	4-1
1.4 MS	**Training & development of clinical workforce**	4-3	4-1
1.5 JS	**IT Strategic Development**	4-4	4-2
STRATEGIC OBJECTIVE 2: By 2020, we will be a **world class**, child-focussed **Centre of Research**, innovation and education expertise to improve the health and wellbeing outcomes for children and young people			
2.1 JS	**Delivery of phase 2 of Institute in the Park by 2018/19**	4-4	2-3
STRATEGIC OBJECTIVE 3: By 2020, we will have a fully **engaged workforce** that is actively driving quality improvement			
3.1 MS	**Sustain workforce capability**	3-4	3-3
3.2 MS	**Staff engagement**	3-3	3-2
STRATEGIC OBJECTIVE 4: By 2020, we will have secured sustainable long term **financial and service growth** supported by a **strong international business**			
4.1 JS	**Financial environment**	4-4	4-2
4.2 JS	**Business development and growth**	4-3	4-2
4.3 JS	**Sustaining national designations for specialist services**	4-3	4-2
4.4 JS	**Relationships with new commissioners**	4-3	4-2

Alder Hey Children's NHS
NHS Foundation Trust

Board of Directors
Monday, 23 May 2016

Report of	Director of Corporate Affairs
Paper prepared by	Quality Assurance Officer
Subject/Title	Board Assurance Framework 2016/17 – proposal / Integrated Governance Committee Assurance Report (May 2016)
Background papers	Monthly BAF updates/reports Bi-monthly IGC Assurance Reports Quarterly Corporate Risk Register Reports Developing our '2020 Vision' – Alder Hey in the Park and beyond *(presentation to April Board)*
Purpose of Paper	The purpose of this report is twofold: 1. To initiate discussion and obtain Board approval on the BAF Risks for 2016/17 2. To provide the Board with the assurance report from the May IGC meeting
Action/Decision required	The Board is asked to: • discuss and note the IGC Assurance Report (May 2016) • approve the closure of the 2015/16 BAF and proposed 2016/17 BAF
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	By 2020, we will: ➢ be recognised for the **exceptional quality of care** we provide to our children, that is technologically enabled and matched by exceptional facilities ➢ be a **world class,** child-focussed **Centre of Research**, innovation and education expertise to improve the health and wellbeing outcomes for children and young people ➢ have a fully **engaged workforce** that is actively driving quality improvement ➢ have secured sustainable long term **financial and service growth** supported by a **strong international business**
Resource Impact	Non achievement of the Trust's objectives could have a negative impact on the services provided by the Trust.

Alder Hey Children's NHS
NHS Foundation Trust

Board of Directors – 23 May 2016

Assurance Report from the Integrated Governance Committee held 11 May 2016

1. Purpose

This report is a summary of the key points of assurance that were discussed at the Integrated Governance Committee (IGC) held on the 11 May 2016. It also provides a summary of the current corporate risk register.

2. Recommendation

The Committee is asked to review the report and provide any feedback to the Chair of IGC.

3. Key Points of Assurance and any associated gaps

3.1. Update on overall management, Strategies and Policies:

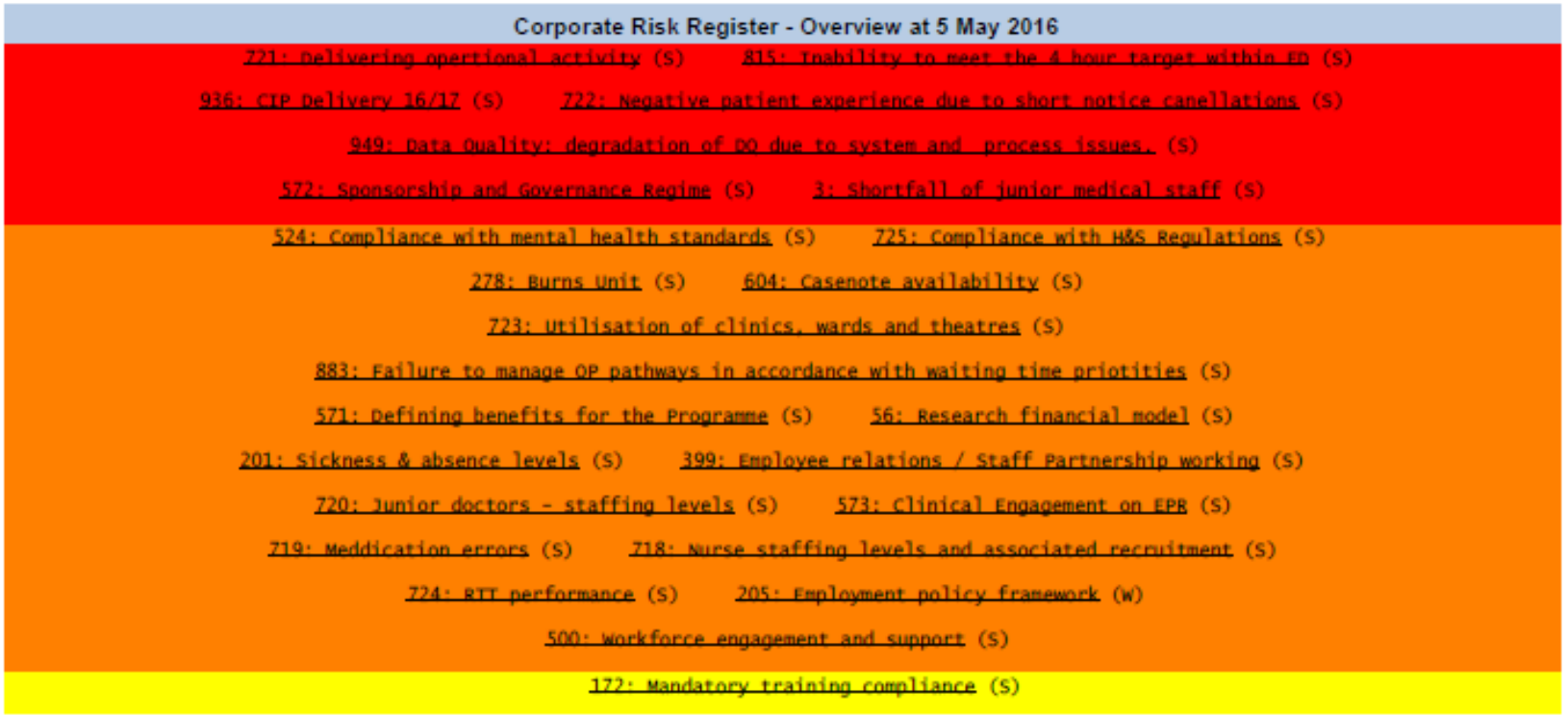
- **2015/16 IGC Annual Report.**
  This was approved as an accurate reflection of the Committees achievements in-year for onward submission to the Board.
- **Risk Management Improvement Plan.**
  Progress since the last meeting was highlighted with the majority of the improvement actions identified in the Plan now implemented. Outstanding improvements are largely linked to the implementation of the devolved model of risk and governance. Once the new model is implemented, it is intended to undertake a full refresh of the RMIP to identify further actions necessary to further improve risk management systems and processes.
  - **Develop Risk Management Maturity Model (with MIAA):** Following a visit from MIAA in February 2016 to assess progress against the previous MIAA Action Plan, an initial report has been received in relation to the 'Incident Management and Reporting' follow up. There were five recommendations outstanding from the previous report, all of which have now been reported as implemented. A further report is expected from MIAA in relation to 'Risk Management' in the near future.
  - **Changes to Ulysses:** A member of the team has undergone intensive training in the functionality and set up of Ulysses to enable continued improvements to be implemented. A new report has been developed which provides a 6 monthly overview of BAF and corporate risks that highlights ongoing trends on the risk register. If this is felt to be useful it could be developed further to CBU level. An initial meeting with Ulysses representative has taken place to provide a greater understanding of the requirements to develop a H&S Risk Assessment form on Ulysses. Following the March IGC, risk owners have updated and/or closed risks that are no longer relevant or have sufficient mitigation in place.

- **Risk Management Awareness and Training:** General Risk Management training and RCA training sessions are ongoing. Further emphasis will be placed on training with the implementation of the devolved risk management structure, with specific / tailored training sessions for all relevant staff.

4. Risk Registers

4.1. Corporate Risk Register

The following diagram gives a high level view of the corporate risk register following a thorough refresh of risks:



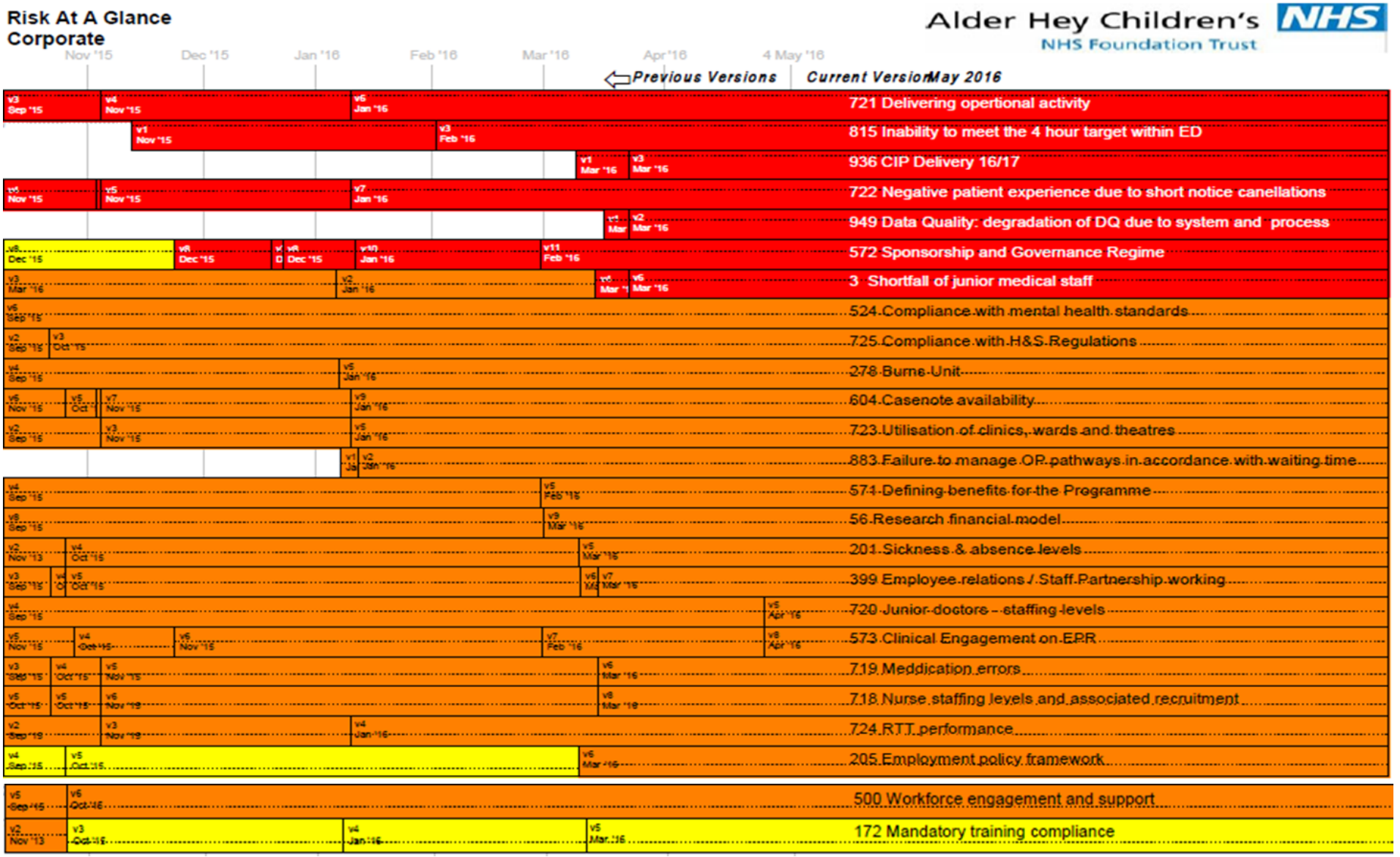
The table below provides an overview of which risks were considered for escalation / de-escalation / closure at the meeting.

CRR Risks presented for escalation this meeting	Decision
1. No system established for cleaning seating, sleep systems and other equipment loaned to patients 2. Risk of Hospital acquired infection due to Pseudomonas in the water outlets in the CHP 3. The Emergency Department Decontamination Shower Room is not sealed – risk of contamination **Risks escalated at the meeting = none**	Not escalated Not escalated Not escalated
Risks presented for closure / de-escalation	**Decision**
None	n/a

Risk movements since the last IGC meeting (not reflected on the heliview)

Ulysses Ref	Title	Action taken
321	Community Buildings	Now a residual risk on ICS Risk Register
569	Programme capability and capacity	
593	Integration of ALL necessary IM&T solutions	Successfully moved to CHP. CLOSED
570	Engagement of staff and stakeholders in the hospital move	Successfully moved to CHP. CLOSED
603	No CAMHS cubicles in CHP	Robust risk assessment process in place. CLOSED
646	Commission and make ready new hospital	Successfully moved to CHP. CLOSED
710	IT issues in the community	Community teams re-located to hospital retained estate – associated IT issues now resolved. CLOSED.
727	Increased risk of injury due to staff being exposed to construction risks	Successfully moved to CHP. CLOSED
885	Transition for metabolic patients	Now being managed at CBU level (Med Specs)

A new ‘at a glance’ risk report has been developed which shows the six-monthly position of corporate risks.



4.2. CHP - Post Occupation Risk Register

The diagram below gives a high level view of the CHP Post Occupation Risk Register

Risk movements since the last meeting (not reflected on the heliview)

Ulysses Ref	Risk Register	Title	Action taken
827	**CHP Post Occupation**	Playdeck balconies	Mitigating actions successful. CLOSED
828	**CHP Post Occupation**	External patio area adjacent to ICU Reception and off parents room	Temporary fencing erected (Jan 2016) deemed effective. CLOSED
830	**CHP Post Occupation**	Section 136 Room	Two outstanding actions: swipe access and CCTV being completed w/c 2.5.16. Confident that will completely mitigate any residual risk. CLOSED
831	**CHP Post Occupation**	Manual Handling in CHP	Electricians undertaking work to add power to doors – risk therefore mitigated. CLOSED
833	**CHP Post Occupation**	R&E Phase 1 Build Compliance	Building now been occupied for 9 months; no longer considered a risk. CLOSED
834	**CHP Post Occupation**	Fall from Roof	Additional fencing being erected w/c 9/5/16 to mitigate any residual risk. CLOSED

CHP Risks discussed at this meeting	Decision
1. R&E Build (Institute in the Park)	A report would be submitted to the Health & Safety Committee to propose closing this risk following agreement from the Exec Team that the Trust had addressed corporately mitigated this risk to the best of its ability
2. External patio areas adjacent to ICU reception and off parents room	These had been closed during the winter, but were now being accessed. A Standard Operating Procedure was in use for appropriate use and control of infection. This would need to be monitored for effectiveness.
3. Skylights (Steven Gerrard Garden)	Stress testing / measurements is underway with a view to closing this risk before the July IGC meeting.
4. Floor finishes	Work was ongoing to install anti-slip mats in affected areas. This risk was expected to close prior to the July IGC meeting.

5. Assurance reports from Sub Committees and Groups:

5.1. Fire Safety Training

- The Committee received an update on the risk relating to fire safety arrangements in the CHP and retained estate (Ulysses Risk ID: 838). A number of outstanding issues were highlighted including:
  - Evacuation of the CHP atrium: the option of utilising the TV screens in the atrium was being considered to display information whether or not to evacuate and where to go;
  - Improvements in the current fire alarm system: this still requires reconfiguration following the move as well as updating; and
  - Fire safety training: theatre/ lecture room training is thought not be conducive for staff to be confident regarding the practical elements of evacuating patients and visitors; a plan would be developed to address this.

  A full update on the outstanding issues was requested for the July IGC meeting by way of a comprehensive action plan, responsible officer and timescales for completion.

5.2. Emergency Preparedness

- Further Junior Doctor Strike Action took place on 26 & 27 April when total service was withdrawn during 8:00am – 5:00pm each day. Individual CBU business continuity plans were developed in response to this. Going forward, NHS England have requested that contingency plans are developed in the event of an indefinite withdrawal of junior doctor labour for:
  - 24 hour emergency and elective care
  - 24 hour elective care only
  - 12 hour emergency care
- An NHS England Pandemic Flu 'Exercise Bluebird' event was held on 13 April and was attended by the Consultant Medical Microbiologist & DIPC and Emergency Preparedness Manager. The Trusts Pandemic Flu Plan will now be updated to reflect learning from this exercise.
- The Trust's Emergency Department decontamination suits have been re-serviced this year and are due to expire May 2017 and July 2017. Advice is required from NHS England regarding whether to purchase new suits or whether there is a more cost effective solution that will be available. This will be raised at the NHS England Emergency Preparedness Practitioners meeting (Ulysses Risk ID: 973).
- A number of areas are yet to complete their Business Continuity Plans. A further meeting will be organised with the aim of receiving these outstanding plans for ratification. This risk is referenced on the Emergency Planning Risk Register, Ulysses Risk ID: 584.
- It was noted that the Emergency Department decontamination shower room is not adequately sealed. This has been flagged with Laing O'Rourke as a building defect with instruction to resolve the situation as a priority. (Ulysses Risk ID: 972).

5.3. Health & Safety

- Control of Contractors across the two sites remains a concern. David Powell undertook to develop correspondence to Interserve highlighting the continued non-compliance of health & safety regulations, clearly outlining their contractual obligations and to make clear that systems are in place that must be adhered to. A reminder to Alder Hey staff would also be issued to this effect.

- Pressure Systems Safety Regulations. The H&S Team are still awaiting report confirming (i) details of all pressure vessels in CHP (ii) all are in receipt of written scheme of examination.
- Concern was raised that a full and comprehensive list of Planned Preventative Maintenance Schedules has not been provided to the H&S Team, in order to ensure that the Trust is compliant against Regulations.
- It was brought to the Committees attention that the procedure for calling 2222 in case of a cardiac arrest was no longer applicable to staff on the retained estate who should now call 999. A plan to refresh first aid training along with an investment in defibrillators would be taken to Strategic Project Lead, Sue Brown.

5.4. Infection Control

- Four risks that have been on the IPC Register and remained static for two years were brought to the Committees attention:
  - Pandemic Influenza
  - Inadequate information on Infection Prevention Mandatory Training Compliance
  - Hospital Acquired Infection
  - Risk of hospital acquired infection due to Pseudomonas in water supply in the child health park

  Support from the Medical Director and Chief Nurse would be sought in identifying additional mitigating actions and reducing these risks along with support from the Clinical Quality Assurance Committee and Water Safety Group where appropriate.

5.5. Information Governance

- The Trust has successfully maintained a score of 83% compliance with the IG Toolkit.
- The use of WhatsApp as a method of communication between staff members within a group has been approved; guidelines for use will be incorporated into the Social Media Policy prior to roll-out.
- A Privacy Impact Assessment has been completed on patient call screens. Actions have been agreed to reduce risk to privacy.
- 2 IG policies reviewed and approved: (i) Registration Authority Policy (ii) Information Security Policy.
- An increase in the number of FoI requests being received was noted across the patch. A number of different options were being explored to try and limit the amount of requests by adopting a proactive approach by way of a Trust publication scheme and having information readily available.

5.6. Clinical Records & Data Quality

- The Clinical Records & Data Quality Committee is very much in its infancy. A named chair and deputy have been identified and a draft Terms of Reference developed. Membership is still being established. Duties of the Committee are being established in terms of remit and scope of committee to ensure full understanding of the organisations records management requirements.
- A clear message is to be cascaded throughout the organisation that any scanning not included in the original scope of the paper light project requires local ownership.

5.7. Fix-It Team

- The IGC received the list of issues that the Fix-It Team is currently addressing and noted progress to date.

Board Assurance Framework 2016/17

2. Introduction

The BAF is a tool for the Board to corporately assure itself about successful achievement of the organisation's strategic objectives and how the risks to delivery are managed and mitigated.

The BAF directly underpins the Annual Governance Statement (AGS) and is the subject of annual review by Internal and External Audit, with the former providing a formal opinion on the fitness for purpose of the process and approach.

3. Key issues

Following the presentation at the April Trust Board '*Achieving our Ambition; Our Strategic Pillars by 2020'* and associated SWOT analysis 2016, an exercise was undertaken looking at strengths, weaknesses, opportunities and threats and cross-referencing these with high level content of the existing BAF (as *detailed in Table 1*).

A number of suggestions have been made on the current principal risks to reflect progress in the achievement of the strategic objectives (2011-16) and to account for emerging external factors that are likely to present a risk to delivery of the Trust's refreshed strategic objectives to 2020.

The Board is asked to consider changes to the risk ratings in this regard taking into account the following questions:

- Have all strategic risks been identified and accurately captured?
- Are there any changes required to the causes and effects?
- Are controls and assurances in place?
- Are the controls in place sufficiently robust to manage risks?
- Is there sufficient assurance regarding the operation of controls to manage the risks?
- Are there any concerns in respect of the assurance given?
- Is the progress on actions sufficient to address gaps in controls and assurance?
- Are there any out of date assurances or overdue actions?

4. Recommendation

The Board is asked to:

- note the closure of the 2015/16 BAF;
- discuss and agree any changes to risk ratings, and
- discuss and approve the proposed changes to the 2016/17 BAF.

Describing our Ambition for 2020 – future analysis against 2016 SWOT

Table 1

	Referenced currently in BAF?
Weaknesses	
Staff engagement with Strategy	4.2
Engagement / grip to deliver throughput plans and targets – elective, outpatients, diagnostics etc.	4.2
Lack of cash for investments in business development	6.1 – suggest to re-word
Workforce diversity	No, MS to consider if wrap into existing workforce risk (4.1) or create standalone
Lost opportunity of the Public Health Strategy signalled in 2011	No, requires discussion at Board level
IT needs strategic development	Consider re-wording 6.2 to be all encompassing
Opportunities	
Local context – viability of some organisations	5.1
Potential for service reconfiguration across women and children's services	6.3 & 6.4
Strategic partnerships	6.3
International offer	Consider re-wording 2.1 to be all encompassing
Thorough leadership for paediatric services in the north west and beyond including public health	No
Education and new business	1.4?, 4.1
Research & innovation new sources of growth	Consider re-wording 2.1 to be all encompassing
Threats	
Financial environment – pressure across the sector	1.1, 2.1?, 5.1,
Political environment – junior doctors contract, seven day services etc.	Not currently a BAF risk (sitting on CRR)
Regulatory focus / lack of clear national strategic leadership	6.4
Local Authority pressures especially social care – need for new approaches	6.1

BOARD ASSURANCE FRAMEWORK 2016/17

Alder Hey Children's NHS Foundation Trust

BAF 1.1	**Strategic Objective:** By 2020, we will be recognised for the exceptional quality of care we provide to our children, that is technologically enabled and matched by exceptional facilities	***Risk Title:*** ***Maintain care quality in a cost constrained environment***		
Related CQC Themes: Safe, Caring, Responsive, Well-led				
Exec Lead: Hilda Gwilliams	**Type:** Internal, known	***Current IxL:*** ***4-2***	**Target IxL:** **4-2**	**Trend: STATIC**
Risk Description				
Failure to maintain appropriate levels of care quality in a cost constrained environment *(suggest explicit reference to include threat: Financial environment – pressure across the sector; failure to deliver Recruitment & Retention Strategy * 'futureproof' workforce)*				

BOARD ASSURANCE FRAMEWORK 2016/17

Alder Hey Children's NHS Foundation Trust

BAF 1.2	**Strategic Objective:** By 2020, we will be recognised for the exceptional quality of care we provide to our children, that is technologically enabled and matched by exceptional facilities	***Risk Title:*** ***Mandatory & compliance standards***		
Related CQC Themes: Safe, Caring, Responsive, Well-led, Effective				
Exec Lead: Margaret Barnaby	**Type:** Internal, known	***Current IxL:*** ***4-5***	**Target IxL:** **4-2**	**Trend: STATIC**
Risk Description				
Failure to deliver on all mandatory and compliance standards including those of the regulators Monitor and CQC *(suggest to re-word to include weakness: engagement / 'grip' to deliver throughput plans and targets – elective, outpatients, diagnostics etc.)*				

BOARD ASSURANCE FRAMEWORK 2016/17

Alder Hey Children's NHS Foundation Trust

BAF 1.3	**Strategic Objective:** By 2020, we will be recognised for the exceptional quality of care we provide to our children, that is technologically enabled and matched by exceptional facilities	***Current Risk Title: Non-compliant estate*** ***Suggested new: Failure to fully realise the Trust's vision for the Park***		
Related CQC Themes: Safe, Well-led, Effective				
Exec Lead: Melissa Swindell	**Type:** Internal, known	***Current IxL: 4-3***	**Target IxL: 4-1**	**Trend: STATIC**

Risk Description

Risk of enforcement action arising from safety incidents due to a failure to maintain a compliant estate and robust and embedded health & safety practices in the work place.

(majority of risks on CHP post occupation risk register now closed; suggest to re-word this risk to reflect failure to realise the Trusts vision for the park and campus as a legacy for future generations.)

BOARD ASSURANCE FRAMEWORK 2016/17

Alder Hey Children's NHS Foundation Trust

BAF 1.4	**Strategic Objective:** By 2020, we will be recognised for the exceptional quality of care we provide to our children, that is technologically enabled and matched by exceptional facilities	***Risk Title: Training & development of clinical workforce***		
Related CQC Themes: Safe, Well-led, Effective, Caring, Responsive				
Exec Lead: Melissa Swindell	**Type:** Internal, known	***Current IxL: 4-3***	**Target IxL: 4-1**	**Trend: STATIC**

Risk Description

Failure to ensure high standards of care through lack of training/development of clinical workforce.

(suggest to re-word this risk to incorporate education & new business opportunities)

BOARD ASSURANCE FRAMEWORK 2016/17

Alder Hey Children's NHS Foundation Trust

BAF 1.5	**Strategic Objective:** By 2020, we will be recognised for the exceptional quality of care we provide to our children, that is technologically enabled and matched by exceptional facilities	***Risk Title:*** ***Failure to provide effective systems to ensure appropriate Ward to Board reporting***		
Related CQC Themes: Safe, Well-led, Effective, Caring, Responsive				
Exec Lead: Erica Saunders	**Type:** Internal, known	***Current IxL:*** ***4-3***	**Target IxL:** **3-2**	**Trend: STATIC**
Risk Description				
Failure to provide effective systems to ensure appropriate Ward to Board reporting *(suggest to re-score and drop down to Corporate Risk Register)*				

BOARD ASSURANCE FRAMEWORK 2016/17

Alder Hey Children's NHS Foundation Trust

BAF 2.1	**Strategic Objective:** By 2020, we will be a world class, child-focussed Centre of Research, innovation and education expertise to improve the health and wellbeing outcomes for children and young people	***Current Risk Title: Finance for phase 2 of the Research facility*** ***Suggested new: Delivery of phase 2 of Institute in the Park by 2018/19***		
Related CQC Themes: Well-led, Responsive				
Exec Lead: Jonathan Stephens	**Type:** Internal, known	***Current IxL:*** ***4-4***	**Target IxL:** **2-3**	**Trend: STATIC**
Risk Description				
Failure to raise adequate finance for the second phase of the Research & Education facility. *(suggest to incorporate:; Remain a key player in creation of Liverpool Biomedical Research Centre development; Develop a single integrated approach across research, education and innovation; Develop a robust commercial Education Business model; Become the educator of choice for paediatrics; Work with our Charity colleagues to raise the profile of our research and innovation capability and attract high level sponsorship and financial support)*				

BOARD ASSURANCE FRAMEWORK 2016/17

Alder Hey Children's NHS Foundation Trust

BAF 4.1	**Strategic Objective:** By 2020, we will have a fully engaged workforce that is actively driving quality improvement	***Risk Title:*** ***Sustain workforce capability***		
Related CQC Themes: Well-led, Responsive, Safe, Effective				
Exec Lead: Melissa Swindell	**Type:** Internal, known	***Current IxL:*** ***3-4***	**Target IxL:** **3-3**	**Trend: STATIC**
Risk Description				
Failure to achieve the Trust's strategic and operational targets due to an inability to sustain workforce capability *(Reference to 'education & new business' opportunity. Perhaps incorporate workforce diversity weakness here?)*				

BOARD ASSURANCE FRAMEWORK 2016/17

Alder Hey Children's NHS Foundation Trust

BAF 4.2	**Strategic Objective:** By 2020, we will have a fully engaged workforce that is actively driving quality improvement	***Current Risk Title: Workforce engagement and support*** ***Suggested new: Staff engagement***		
Related CQC Themes: Well-led, Responsive, Safe, Effective				
Exec Lead: Melissa Swindell	**Type:** Internal, known	***Current IxL:*** ***3-3***	**Target IxL:** **3-2**	**Trend: STATIC**
Risk Description				
Lack of workforce engagement which impacts upon operational performance and achievement of strategic aims *(Incorporate: failure to deliver the new programme of change; develop a healthy workplace which supports the physical, social and emotional wellbeing of staff; Political environment – junior doctors contract, seven day services etc.)*				

BOARD ASSURANCE FRAMEWORK 2016/17

Alder Hey Children's NHS Foundation Trust

BAF 5.1	**Strategic Objective:** By 2020, we will have secured sustainable long term financial and service growth supported by a strong international business	***Current Risk Title: Income & expenditure plan*** ***Suggested new: Financial environment***		
Related CQC Themes: Well-led, Responsive, Safe, Effective				
Exec Lead: Jonathan Stephens	**Type:** Internal, known	***Current IxL: 4-4***	**Target IxL: 4-2**	**Trend: STATIC**

Risk Description

Failure to deliver 2016/17 Income and Expenditure plan and planned Continuity of Service Risk Rating

BOARD ASSURANCE FRAMEWORK 2016/17

Alder Hey Children's NHS Foundation Trust

BAF 6.1	**Strategic Objective:** By 2020, we will have secured sustainable long term financial and service growth supported by a strong international business	***Risk Title: Business development & growth***		
Related CQC Themes: Well-led, Responsive, Effective				
Exec Lead: Jonathan Stephens	**Type:** External, known	***Current IxL: 4-3***	**Target IxL: 4-2**	**Trend: STATIC**

Risk Description

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

(suggest to incorporate threat: regulatory focus / lack of clear national strategic leadership)

BOARD ASSURANCE FRAMEWORK 2016/17

Alder Hey Children's NHS Foundation Trust

BAF 6.2	**Strategic Objective:** By 2020, we will be recognised for the exceptional quality of care we provide to our children, that is technologically enabled and matched by exceptional facilities	***Current Risk Title: EPR Implementation*** ***Suggested new: IT Strategic Development***		
Related CQC Themes: Well-led, Responsive, Safe, Effective				
Exec Lead: Jonathan Stephens	**Type:** Internal, known	***Current IxL: 4-4***	**Target IxL: 4-2**	**Trend: STATIC**
Risk Description				
Risk to business development/growth due to NHS financial environment and constraints on internal infrastructure to deliver business as usual as well as maximise growth opportunities *(suggest to reference failure to effectively implement the next phase of EPCS and other ICT enablers including IT infrastructure and innovations)*				

BOARD ASSURANCE FRAMEWORK 2016/17

Alder Hey Children's NHS Foundation Trust

BAF 6.3	**Strategic Objective:** By 2020, we will have secured sustainable long term financial and service growth supported by a strong international business	***Risk Title:*** ***Sustaining national designations for specialist services***		
Related CQC Themes: Well-led, Responsive, Safe, Effective				
Exec Lead: Jonathan Stephens	**Type:** External, known	***Current IxL: 4-3***	**Target IxL: 4-2**	**Trend: STATIC**
Risk Description				
Risk to sustaining national designations for specialist services due to failure to meet all required standards. *(suggest to incorporate threat: Local Authority pressures especially social care – need for new approaches)*				

BOARD ASSURANCE FRAMEWORK 2016/17

Alder Hey Children's NHS Foundation Trust

BAF 6.4	**Strategic Objective:** By 2020, we will have secured sustainable long term financial and service growth supported by a strong international business	***Risk Title:*** ***Relationships with new Commissioners***		
Related CQC Themes: Well-led, Responsive, Safe, Effective				
Exec Lead: Jonathan Stephens	**Type:** External, known	***Current IxL:*** ***4-3***	**Target IxL:** **4-2**	**Trend: STATIC**

Risk Description

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

(suggest to incorporate threat: regulatory focus / lack of clear strategic leadership)

Summary of BAF

Ref, Owner	Risk Title	Risk Rating: I x L	
		Current	Target
STRATEGIC OBJECTIVE 1: By 2020, we will be recognised for the **exceptional quality of care** we provide to our children, that is technologically enabled and matched by exceptional facilities			
1.1 HG	**Maintain care quality in a cost constrained environment**	4-2	4-2
1.2 MB	**Mandatory & compliance standards**	4-5	4-2
1.3 MS	**Failure to fully realise the Trust's vision for the Park**	4-3	4-1
1.4 MS	**Training & development of clinical workforce**	4-3	4-1
1.5 JS	**IT Strategic Development**	4-4	4-2
STRATEGIC OBJECTIVE 2: By 2020, we will be a **world class**, child-focussed **Centre of Research**, innovation and education expertise to improve the health and wellbeing outcomes for children and young people			
2.1 JS	**Delivery of phase 2 of Institute in the Park by 2018/19**	4-4	2-3
STRATEGIC OBJECTIVE 3: By 2020, we will have a fully **engaged workforce** that is actively driving quality improvement			
3.1 MS	**Sustain workforce capability**	3-4	3-3
3.2 MS	**Staff engagement**	3-3	3-2
STRATEGIC OBJECTIVE 4: By 2020, we will have secured sustainable long term **financial and service growth** supported by a **strong international business**			
4.1 JS	**Financial environment**	4-4	4-2
4.2 JS	**Business development and growth**	4-3	4-2
4.3 JS	**Sustaining national designations for specialist services**	4-3	4-2
4.4 JS	**Relationships with new commissioners**	4-3	4-2

Alder Hey Children's NHS
NHS Foundation Trust

Integrated Governance Committee - Annual Report 2015/16 – DRAFT

The Integrated Governance Committee

The purpose of the Integrated Governance Committee is to:

- Oversee the design and effective operation of the risk management process across the Trust including the management of the production of the Corporate Risk Register and Board Assurance Framework.
- Provide the Trust Board with a bi-monthly Assurance report on the outcome of the meeting including an updated BAF, a summary of the corporate risk register and any key issues arising from the meeting. Extracts from the BAF and corporate risk register will also be produced to inform Board Committees including RABD and CQAC of the latest position on their related risks.
- Oversee the continuing evolution of risk management processes across the CBUs, business areas and the Programme.
- Oversee the integration of all aspects of managing risk across the Trust, including clinical, organisational, programme, project and financial risk and associated links to corporate business planning.
- Take remedial action to resolve weaknesses and incorporate best practice.

Constitution

Membership remained unchanged from 2014/15 and comprises one Non-Executive Director, who currently chairs the committee, all the Executive Directors. Senior Heads of Department including CBU General Managers, Research Manager, Head of Risk Deputy Director of Quality and Head of External Programme Assurance are expected to be in attendance at each meeting.

To ensure that there is a link to the detailed risk work undertaken across the Trust, the Committee is supported by a number of sub groups, including Emergency Preparedness, Health & Safety and Information Governance.

IGC meets bi-monthly and the schedule of attendance for 2015/16 is shown in Appendix A, which shows full compliance with quoracy.

From April 2015 to March 2016 there were six meetings of the IGC. All sub groups provide a key issues report for each IGC meeting and there is an Assurance report provided to the proceeding Board on the key issues and outcomes from the Committee meeting.

Achievements in 2015/16

- The Trust was subject to a re-inspection by the Care Quality Commission in June 2015. Two particular areas were flagged for improvement in respect of Risk Management processes which are being addressed in an effective and timely manner.
- The Trust went 'live' with the new risk module on 7 September 2015. The risk management team (RMT) worked closely with key individuals to deliver training and support required to use the new module and ensure all the relevant aspects of updating risk registers, matching risks to business objectives, risk scoring and escalation processes etc. were clearly understood.
  The RMT continues to work closely with CBUs / departments and the Ulysses expert to improve the risk register structure and reports, capturing the new hospital structure and supporting local areas in completing and reviewing risks and to date, and have developed

a number of reports which allow local areas / CBUs to see their risks at a glance (Heliviews), as well as a combined report for review at CBUs which shows 'risks that have moved in month' and 'risks that have missed their review dates' as well as actions that remain outstanding passed their planned completion date. Improving the information available on the corporate risk register and BAF is helping the Committee instigate a more rigorous challenge on what is being considered for escalation, de-escalation and the progress on the set of open risks.

- In order to provide appropriate levels of assurance in respect of the risks relating to and arising from the move to the CHP, a separate risk register was established immediately following the move and continues to be closely scrutinised and monitored by the Committee.
- In February 2016, MIAA undertook a follow up of the review of the risk management arrangements and the content of the associated risk registers and BAF. The outcome of this report is awaited.
- The sub groups of the Committee provide concise Assurance reports from their activities, highlighting positive assurances, gaps and any resultant key issues that they need action from the committee on. This is providing a clearer focus not just for the reporting to the committee but also for the sub groups themselves.
- The Committee approved and monitored its annual work programme and the effectiveness of each meeting is assessed by the Chair and Director of Corporate Affairs. The meeting is subject to scrutiny by Internal Audit as part of their ongoing review of the risk management systems and processes.

Unlike previous years, the Committee agreed to pilot a new review process seeking the views of members of the committee on its performance and provide the opportunity to identify three activities that could be undertaken to improve effectiveness. This was done through completion of an evaluation questionnaire.

Disappointingly, only 3 Committee members out of 7 (43%) responded to the questionnaire.

Overall, the results were positive with a good balance of skills and experience as well as appropriate challenge. The papers submitted to the Committee were considered to be suitable to enable it to fulfil its purpose and duties as outlined in the terms of reference.

The focus for 2016/17 would be on ensuring the effective use of the Ulysses System to proactively manage corporate risks and timely submission of reports.

Assurance Statement

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

Committee Priorities for 2016/17

- Continue to further embed the recommendations from the internal review of the trust's risk management arrangements.
- Continue to work with Ulysses to further develop more robust reports providing positive assurances.
- Continue to focus on scrutinising the risks associated with the CQC action plan.

Steve Igoe
Committee Chair
April 2016

APPENDIX A

IGC - RECORD OF ATTENDANCE 2015/16

Quorum: Chair or nominated deputy, two Executive Directors (one of whom is a clinical lead)

	15 May 2015	9 Jul 2015	16 Sept 2015	11 Nov 2015	20 Jan 2016	22 Mar 2016	Attendance	
Mr S Igoe **(Non-Executive Director)**	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	6 / 6	100%
Mrs J Adams **(Chief Operating Officer)**	✓	✓	✓	✓	✓	✓	6 / 6	100%
Mr D Alexander **(Director of HR)**	✓	✓	x	✓	n/a	n/a	3 / 4	75%
Mrs M Swindell **(Interim Director of HR)**	-	-	-	✓	✓	✓	3 / 3	100%
Mrs H Berg **(Director of Communications)**	x	x	x	n/a	n/a	n/a	0 / 3	0%
Miss G Core **(Chief Nurse)**	x	x	✓	x	✓	x	2 / 6	50%
Mrs H Gwilliams **(Director of Nursing)**	✓	✓	✓	✓	x	✓	5 / 6	83%
Miss E Saunders **(Director of Corporate Affairs)**	✓	✓	x	✓	✓	x	4 / 6	67%
Mrs L Shepherd **(Chief Executive)**	✓	x	✓	✓	x	✓	4 / 6	67%
Mr J Stephens **(Director of Finance)**	x	✓	✓	✓	✓	✓	5 / 6	83%
Mr D Powell **(Development Director)**	x	x	✓	✓	✓	✓	4 / 6	67%
Mr R Turnock **(Medical Director)**	x	✓	✓	✓	x	✓	4 / 6	67%

DRAFT

Alder Hey Children's NHS
NHS Foundation Trust

Resources and Business Development Committee Annual Report 2015/16

The Resources and Business Development Committee

The Resources and Business Development Committee was established by the Board of Directors to be responsible for overseeing financial, operational and contractual performance, workforce metrics, business development and strategic IM&T issues and the approval of business cases to limits delegated by the Board.

The principal devolution of the Board's responsibilities are as follows:

- Review and recommend business, operational and financial plans to the Board
- Monitor performance, assuring the Board that performance is in line with plans
- Ensure value for money is obtained by the Trust
- Identify related areas of strategic and business risk and report these to the Board
- Oversee the development of the Trust's long term financial strategy, its Business Development Strategy and its Investment Strategy

The conduct of this remit was achieved firstly through the Committee being appropriately constituted and secondly by the Committee being effective in ensuring internal accountability and the delivery of assurance on specific issues.

This report outlines how the Committee has complied with the duties delegated by the Board through its terms of reference and identifies key actions to address developments in the Committee's role.

Constitution

In accordance with the terms of reference, the membership comprises:

- Non-Executive Directors x 3 [one of whom is the Chair]
- Chief Executive
- Director of Finance and Business Development
- Deputy Director of Finance
- Chief Operating Officer
- Director of Human Resources

The Committee may request the attendance of any Non-Executive Directors, any Executive Directors and any other persons by invitation. A schedule of attendance at the meetings is provided in Appendix A which demonstrates full compliance with the quorate requirements. The Committee has an annual work plan with meetings timed to consider and act on specific issues within that plan.

Minutes of the Committee were presented to the Board and are supported by a verbal report from the Committee Chair.

Achievements

In discharging its duties the Committee met its responsibilities through self assessment and review, requesting assurances from Trust officers and directing and receiving reports from relevant individuals.

The following areas were the main focus of the Committee's attention:

- Scrutiny of the Monitor Operational Plan for onward transmission/ recommendation to the Trust Board.
- Scrutiny of financial data in particular leading/lagging KPI indicators, income/expenditure and the CIP.
- Review and challenge of CBU operational and financial recovery plans.
- Review of progress against the key challenges and risks identified by the Committee as part of its work plan.
- Scrutiny and approval on behalf of the Board of the Monitor Quarterly Return and review of Monitor's recommendations.
- The financial outcome for the year end with an FRR of 2.
- Approval of the Operational and Capital Budgets for 2016/17.
- Review and challenge of the Business Development Strategy for 2015/16 including the plans to develop international work.
- Regular review of the Board Assurance Framework and adjustments to this as required.
- Scrutiny of workforce leading indicators.
- Scrutiny of threats to income arising from changes to the structure of the NHS; changes to tariff; changes in GP and commissioner behaviour.
- Scrutiny of the critical path for the implementation of the EPR project.
- Oversight of the development of the strategic IM&T partnership with BT and consideration of the strategic direction for IM&T.
- Oversight of the new PFI contract and how this is monitored.

Self Assessment

During the year the Committee has complied with 'good practice' recommended through:-

- Agreement and monitoring of an annual work programme.
- Prepared an Annual Report of its activities

- An audit undertaken annually by the Committee Administrator to monitor compliance with the Terms of Reference, using the "effective committee" checklist, the key elements of which are set out below:

  - Review of the annual financial plan for revenue and capital for recommendation to the Board.
  - Advising the Board on all proposals for major Capital expenditure over £500,000 and to approve proposals under £500,000.
  - Approval of DH loan on behalf of the Board.
  - Review of progress against key financial and external targets, including performance ratings (e.g. Monitor metrics).
  - Ensure appropriate contracting arrangements are in place and review overall performance against contract.
  - Review of the Site Development Strategy and approve the Business case for the Corporate Office Block.
  - Examine specific areas of financial risk and highlight these to the Board as appropriate.
  - Review of key workforce/HR performance indicators including sickness absence, appraisal and mandatory training, temporary staffing costs, equality & diversity and recruitment & retention/turnover, ensuring appropriate actions are agreed and progressed as required utilizing benchmarking data where appropriate.
  - Review the Trust's business development plan.
  - Maintain an oversight on all major investments and business developments
  - Scan the environment and identify strategic business risks and report to the Board on the nature of those risks and their effective management
  - Oversee delivery of the marketing strategy, including brand management, market positioning, marketing activity, market research and competitor analysis.
  - Advise and provide insight to the board on changing dynamics in the market and stakeholders
  - Approve the Information Technology and Information Systems procurement and implementation processes with particular reference to EPR.
  - Identify key risks associated with the delivery of the IM&T strategy and ensure these are reported to the Board.

<u>Independent Assurances / Audit</u>

During the course of the year the Committee ensured that regular progress reports were received from the following sources:

1) Formal feedback from Monitor quarterly/annual returns.
2) Internal/external audit reports and recommendations from Audit Committee, together with the results of specific reviews by internal audit commissioned by the Committee.

Assurance Statement

Through the various mechanisms set out above, the Committee has gained assurance that the Trust's financial, operational and contractual systems and processes were operating at a satisfactory level, although actual performance fell short of plan. It has clearly expressed its expectations in relation to areas where controls need to be strengthened and these will be addressed in the coming year.

Committee Developments

Whilst the Committee has performed its duties as delegated by the Board it has identified a number of areas to focus on during 2016/17:

- Ensure the activities and areas of the focus by the Committee take proper recognition of the effects on the organisation of moving into the new hospital.
- Ensure that particular attention is given to the CIP and Business Development initiatives in 2016/17 and beyond, in the context of the national financial environment.
- Refresh and agree the five areas which would receive increased focus from the Committee in 2016/17 which would enable the Trust to deliver its clinical, operational and financial targets.
- Enhance the monitoring and reporting of follow-up actions taken in respect of its areas of responsibility.
- Its new remit to oversee the assurance process relating to the next phase of the Trust's change programme.

Ian Quinlan
Committee Chair
April 2016

RESOURCES AND BUSINESS DEVELOPMENT COMMITTEE - RECORD OF ATTENDANCE 2015/16

Member/Date of Meeting		2015								2016		
	29th April	27th May	24th June *	2nd July	19th Aug	30th Sept	28th Oct	25th Nov	16th Dec	27th Jan	23rd Feb *	30th Mar
Mr Ian Quinlan (Non-Executive Director)	✓ (Chair)	C	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	C	✓ (Chair)	✓ (Chair)	✓ (Chair)	✗
Mr Phil Huggon (Non-Executive Director)	✓	A	✓	✓	✗	✓	✗	A	✗	✓	✓	✓ (Chair)
Mrs Claire Dove (Non-Executive Director)	✓	N	✗	✗	✓	✗	✓	N	✓	✓	✗	✓
Mrs Louise Shepherd (Chief Executive)	✗	C	✗	✗	✗	✗	✓	C	✓	✓	✗	✗
Mr Jonathan Stephens (Director of Finance)	✓	E	✓	✓	✓	✓	✗	E	✓	✗	✗	✓
Mrs Jude Adams (Chief Operating Officer)	✓	L	✗	✓	✓	✗	✗	L	✓	✓	✓	n/a
Mr David Alexander (Director of HR and OD)	✓	L	✓	✓	✓	✓	n/a	L	n/a	n/a	n/a	n/a
Mrs M Swindell (Interim Director of HR)	n/a	n/a	n/a	n/a	n/a	n/a	✗	E	✓	✓	✓	✓
Ms E Saunders (Director of Corporate Affairs)	✓	E	✓	✓	✓	✗	✗	D	✗	✓	✗	✓
Mrs C Liddy (Deputy Director of Finance)	✗	D	✓	✓	✓	✓	✓	-	✓	✓	✓	✓

Alder Hey Children's NHS
NHS Foundation Trust

Draft Audit Committee Annual Report 2015/16

The Audit Committee

The aim of the Audit Committee is to provide one of the key means by which the Board of Directors ensures effective internal control arrangements are in place. In addition, the Committee provides a form of independent check upon the executive arm of the Board.

As defined within the NHS *Audit Committee Handbook* (2014), the Committee has responsibilities for the review of governance, risk management and internal control covering both clinical and non-clinical areas. In discharging these duties the Committee is required to review:

- Internal financial control matters, such as safeguarding of assets, the maintenance of proper accounting records and the reliability of financial information.
- Risks regarding disclosure statements (for example the Annual Governance Statement) which are supported by the Head of Audit Opinion and other opinions provided.
- The underlying assurances as detailed in the Board Assurance Framework.
- The adequacy of relevant policies, legality issues and Codes of Conduct.
- The policies and procedures related to fraud and corruption.

The conduct of this remit is achieved firstly, through the Committee being appropriately constituted, and secondly by the Committee being effective in ensuring internal accountability and the delivery of audit and assurance services.

This report outlines how the Committee has complied with the duties delegated by the Board through its terms of reference and identifies key actions to address developments in the Committee's role.

Constitution

In accordance with the terms of reference which are reviewed on an annual basis, the membership of the Committee comprises four Non-Executive Directors. Its chair has 'recent relevant financial experience' which is best practice. The Director of Finance and Director of Corporate Affairs together with the Deputy Director of Finance are invited to attend, and the Committee may request the attendance of the Chief Executive and any other officer of the Trust to answer any points which may arise. In addition, the Internal and External auditors are invited to each meeting, together with regular attendance from the Local Counter Fraud Specialist. A schedule of attendance at the meetings is provided in Appendix A which demonstrates full compliance with the quorum requirements and regular attendance by those invited by the Committee. The Audit Committee members have also had the opportunity through the year to meet in private with internal audit and external audit.

Five meetings were held during the financial year 2015/16 of which one, in May was devoted to consideration of the auditors report on the Annual Accounts and ISA 260. The Committee has an annual work plan with meetings timed to consider and act on specific issues within that plan.

Minutes of the Audit Committee are presented to the Board and are supported by a verbal report from the Committee Chair.

Achievements

In discharging its duties, the Committee meets its responsibilities through self assessment and review, requesting assurances from Trust officers and directing and receiving reports from the auditors and fraud specialists.

Self-Assessment

During the year the Committee has complied with 'good practice' recommended through:-

- Agreement and monitoring of an annual work programme aimed at testing the adequacy of the control environment

- Prepared an Annual Report of its activities
- Reviewed and updated its terms of reference

Work undertaken

At each meeting the Audit Committee has considered:

- The bi-monthly Integrated Assurance Report or Board Assurance Framework report
- Internal Audit Reports in accordance with the approved 2015/16 work plan
- External Audit Reports in accordance with the approved 2015/16 work plan

In addition throughout the year the Audit Committee has reviewed and dealt with the following matters:

- Annual Governance Statement
- Consideration of the 2014/15 Annual Accounts
- Monitor quarterly returns and feedback letters
- External Assurance Report on the quality account
- External Audit report on the financial statements to 31st March 2015 and ISA 260
- Losses and special payments
- Counter Fraud reports by the MIAA specialist in accordance with the approved 2015/16 work plan
- Approval of the suite of policies relating to conflicts of interest
- Reports on progress against the Risk Management Improvement Plan
- Approval of the Treasury Management Policy
- Internal Audit work plan for 2015/16
- External Audit strategy relating to the Audit of the Trust's 2014/15 Accounts
- Financial Statement audit risks for 2015/16
- Accounting policies for the 2015/16 Financial Statements
- Audit Committee work plan 2015/16
- Review and approval of the terms of reference for the Audit Committee
- Annual Reports of the Trust's assurance committees, including Clinical Quality Assurance Committee

Key Conclusions

The key role of the Committee is to establish the following:

- Assurance Framework is fit for purpose
- Systems for risk management identify and allow for the management of risk
- Organisation has robust governance arrangements
- Organisation has self-assessed against the CQC Standards
- Organisation has robust systems of financial control
- Organisation operates a robust control environment

Based on the information provided, the Committee members can confirm that they agree to the declaration reported to the Board of Directors in respect of the Annual Governance Statement.

This opinion is based upon the Committee's processes for gaining assurance as summarised below.

Internal Processes

In accordance with the Committee's authority, in addition to the Director of Finance, other officers of the Trust were called to attend the Committee to provide updates.

Following receipt of audit reports the Committee has directed audit resources to complete follow-up reviews into specific issues and high risk areas. The Committee will review outstanding actions until completion. A database is maintained of all audit recommendations which is reviewed by exception. Additionally, to support the Committee's control of implementation of key actions, internal audit include within their plan provision for follow-up of the implementation of audit recommendations.

The Annual Report and Accounts and the Quality Account were reviewed by External Audit and the reports arising from their review presented to the Committee.

The Committee reviewed the findings of other significant assurance functions of the Trust including the Clinical Quality Assurance Committee and Resources and Business Development Committee by receiving and scrutinising the Annual Reports in support of approving the Annual Governance Statement.

Independent Assurances / Audit

External Audit

The provision of External Audit services was delivered by KPMG. The work of External Audit can be divided into two broad headings:-

- To audit the financial statements and provide an opinion thereon,
- To form an assessment of our use of resources.

The Committee has approved an External Audit Plan and receives regular updates on the progress of work including audit work undertaken on the quality account.

An unqualified opinion on the accounts for 2015/6 was provided to the Board on the 23rd May 2016.

Internal Audit

The Internal Audit service is provided by Mersey Internal Audit Agency (MIAA), an independent NHS organisation. The Director of Audit Opinion and Annual Report for 2015/16 reports that MIAA have demonstrated their compliance with NHS mandatory Internal Audit Standards. Internal Audit provides an independent and objective appraisal service embracing two key areas:-

1. The provision of an independent and objective opinion to the Accountable Officer, the Board and the Audit Committee on the degree to which risk management, control and governance support the achievement of the agreed objectives of the organisation.

2. The provision of an independent and objective consultancy service specifically to help line management improve the organisation's risk management, control and governance arrangements.

The Audit Committee contributed to the risk assessment and subsequently approved the content of the Internal Audit Plan. This plan was structured to provide the Director of Audit Opinion which gives an assessment of the:

- design and operation of the underpinning Assurance Framework and supporting processes;
- range of individual opinions arising from risk-based audit assignments contained within internal audit risk-based plans that have been reported throughout the year, this assessment has taken account of the relative materiality of these areas and management's progress in respect of addressing control weaknesses; and
- process by which the organisation has taken steps to implement and embed the systems and processes to ensure regulatory compliance with the CQC fundamental standards.

The key conclusion from their work for 2015/16 as provided in the Director of Audit Opinion and Annual Report was that 'Significant Assurance' was given that there were generally sound systems of internal control to meet the organisation's objectives and that controls are generally being applied consistently.

During the course of the year the Committee ensured that regular progress reports were received from MIAA on the delivery of the Internal Audit Plan. As part of this process the Committee have influenced changes to the plan to direct work to risk areas identified during the course of the year.

Fraud

As with the Internal Audit Service, Counter Fraud is provided by Mersey Internal Audit Agency.

As requested by the Committee to meet mandated requirements, an annual report was provided outlining the delivery of the fraud plan for 2015/16. The Committee also received the results of the Compound Indicators Assessment for 2015/16 which assessed the Trust at "Level 2 adequate

performance". The Counter Fraud service provided regular updates to the Committee on work undertaken to prevent and detect fraud including any investigations.

Assurance Statement

Through the various mechanisms set out above, the Audit Committee has gained assurance that the Trust's control environment is operating at a satisfactory level. It has clearly expressed its expectations in relation to areas where controls need to be strengthened and these will be addressed in the coming year.

Committee Developments

Whilst the Committee has performed its duties as delegated by the Board and mandated through governance requirements, in the forthcoming year focus will be given to developing and responding to the system reforms and risks as detailed below:-

- To maintain a review of our Terms of Reference and activities to fully support the governance arrangements within the Trust and to ensure the Board continues to be appropriately briefed on our activities.
- To develop our work plan based on the Assurance Framework and focus audit resources into risk areas and the provision of assurances from the organisation.
- To undertake oversight of the revised governance and assurance arrangements relating to the delivery of the Trust's change programme as discharged through the Board's key assurance committees;
- To enhance assurance through the attendance of key officers to account for actions taken in respect of internal and external reviews.
- To embed the monitoring and reporting of follow-up actions taken in respect of internal audit reports and especially those reported as "Limited Assurance".
- To receive formal reports from the Trust's key assurance committees to provide effective oversight of the systems and processes of assurance
- To ensure the Annual Governance Statement is presented and reviewed by the Audit Committee prior to Board approval.

Steve Igoe, Audit Committee Chair
25th April 2016

APPENDIX A

AUDIT COMMITTEE - RECORD OF ATTENDANCE 2015/16

Member/Date of Meeting	2015				2016
	23rd April	21st May	25th Sept	19th Nov	21st Jan
Mr Steve Igoe (Non-Executive Director)	✓ **(Chair)**	✓ **(Chair)**	✓ **(Chair)**	✓ **(Chair)**	✓ **(Chair)**
Mrs Louise Shepherd (Chief Executive)	✓				
Mr Jonathan Stephens (Director of Finance)	✓	✓	✗	✓	✓
Ms Erica Saunders (Director of Corporate Affairs)	✓	✓	✗	✓	✓
Mrs Anita Marsland (Non-Executive Director)	✓	✓	✓	✗	✓
Mr Phil Huggon (Non-Executive Director)	✗	✗	✗	✗	✗
Mrs Jeannie France-Hayhurst (Non-Executive Director)	✓	✓	✓	✓	✗
KPMG (External Audit)	**AL/JB**	**AL/JB**	**AL**	**AL/JB**	**AL/JB**
MIAA (Audit Agency)	**KW/LC**	**LC**	**LC**	**LC**	**LC**
Local Counter Fraud Service	**VM**		-	**-**	**VM**

Quorum: Two Non Executive Directors

KPMG Representatives:
Mrs A Latham (AL); Ms J Burrows (JB); Ms E Kirkby (EK)

Mersey Internal Audit Agency Representatives:
Ms K Wheatcroft (KW); Ms L Cobain (LC)

Local Counter Fraud Service – Representatives attend for presentation of fraud related reports
Ms V Martin (VM)