Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS MEETING

Thursday 25th May 2017 commencing at 1330

Venue: Large Meeting Room, Institute in the park

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action	Preparation
Board Business						
1.	**17/18/53**	**1330**	**Apologies**	Chair	Michael Beresford, Catherine McLaughlin	--
2.	**17/18/54**	**1331**	**Declarations of Interest**	All	Board Members to declare an interest in particular agenda items, if appropriate	--
3.	**17/18/55**	**1332**	**Minutes of the Previous Meeting**	Chair	To consider the minutes of the previous meeting for amendments and approve held on: **2 May 2017** **27 April 2017**	Read Minutes
4.	**17/18/56**	**1334**	**Matters Arising and Board Action List** - Global Digital Exemplar (GDE)	Chair P Young	To discuss any matters arising from previous meetings and provide updates and review where appropriate. To provide an update on the "Global Digital Exemplar Programme"	Verbal Verbal
Financial Growth and Safeguarding Core Business						
5.	**17/18/57**	**1340**	**2016/17 Annual Report and Accounts**	E Saunders/ J Grinnell/ S Igoe	To approve the Annual report and Accounts	Read report
6.	**17/18/59**	**1355**	**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
7.	**17/18/60**	**1357**	**Board Assurance Framework**	E Saunders	To receive the monthly BAF update	Read report

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action	Preparation
8.	**17/18/61**	**1400**	**Resources & Business Development Committee** - **Annual report 2016/17**	I Quinlan	To receive and review the 2016/17 Committee Annual report	Read report
9.	**17/18/62**	**1405**	**Audit Committee** - **Annual report 2016/17** - **January Minutes**	S Igoe	To receive and review the 2016/17 Committee Annual report To note the minutes from the last meeting	Read report
Strategic Update						
10.	**17/18/63**	**1415**	**External Environment** - **5YFV progress** **Progress against strategic themes:** - **Liverpool Community Services** - **Liverpool Women's Reconfiguration Options/Neonatal** - **Tier 4 CAMHS Cheshire and Merseyside Bid**	L Shepherd D Herring		Verbal
Delivery of outstanding care						
11.	**17/18/64**	**1435**	**Serious Incidents Report**	H Gwilliams	To inform the Board of the recent serious incidents at the Trust in the last calendar month	Read Report
12.	**17/18/65**	**1440**	**Clinical Quality Assurance Committee** - **Annual report** - **April Minutes**	A Marsland	To receive and review the 2016/17 Committee Annual report To note the minutes from the last meeting	Read report
13.	**17/18/66**	**1445**	**Alder Hey in the Park update**	D Powell	To receive an update on key outstanding issues / risks and plans for mitigation.	Read report

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action	Preparation
The best people doing their best work						
Strong Foundations						
14.	**17/18/67**	**1450**	**Programme Assurance update** - **Deliver Outstanding Care**	J Gibson	To receive an update on programme assurance	Read Report
Any Other Business						
15.	**17/18/68**	**1500**	**Any Other Business**	All	To discuss any further business before the close of the meeting	Verbal
1230	**Date and Time of Next Meeting: Tuesday 4th July 2017** at **10:00am, Room 14, Level 2, Alder Hey**					

REGISTER OF TRUST SEAL
The Trust Seal was not used during the month of **May 2017.**

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Minutes of the extra-ordinary meeting held on **Tuesday 27th April 2017, at 1.00 pm,** Executive Office at Alder Hey

Present:	Sir D Henshaw	Chairman (Chair)	(SDH)
	Mrs L Shepherd	Chief Executive	(LS)
	Dr S Ryan	Medical Director	(SR)
	Mrs S Gwilliams	Chief Nurse	(HG)
	Mr J Grinnell	Director of Finance	(JG)
Dial in	Dame J Williams	Non-Executive Director	(JW)
Dial in	Mrs J France-Hayhurst	Non-Executive Director	(JFH)
Dial in	Mr S Igoe	Non-Executive Director	(SI)
In Attendance:	Mrs D Herring	Director of Strategic Development & Clinical Service Partnerships	(DH)
	Ms E Saunders	Director of Corporate Affairs	(ES)
	Mrs M Swindell	Director of HR and OD	(MS)
	Mrs K Critchley	Committee Administrator	(KC)
Apologies:	Mrs A Marsland	Non-Executive Director	(AM)
	Mr I Quinlan	Non-Executive Director	(IQ)
	Mrs C Dove	Non-Executive Director	(CD)

17/18/21 Declarations of Interest

None declared.

17/18/22 Liverpool Community Health

DH and LS gave the background to the scheduling of the extra-ordinary Board meeting. Alder Hey had been asked to lead the short term management of Liverpool Community Health, with support from Aintree University Hospital NHS Foundation Trust and the Royal Liverpool and Broadgreen University Hospitals NHS Trust, from 1 May 2017. It was anticipated that this would be for a period of 6 months, or shorter if a decision was reached to make the transition into another organisation before then.

A Management Agreement had been prepared setting out the obligations on Alder Hey to manage Liverpool Community Health as a statutory NHS organisation. This would be financially and clinically governed in accordance with NHSI guidance with the expectation to improve services in line with NHSI requirements.

The Executive Team had reviewed the risks associated with the proposed arrangements in detail and how those risks could be mitigated. Discussion had taken place with NHSI regarding the potential financial risk to Alder Hey and it had been agreed that the arrangements being entered into would not pose any financial detriment to Alder Hey.

LS said that due diligence would be undertaken before end of May and discussions would be ongoing with NHSI regarding any issues/risks that emerge. SI said that he would meet with ES to revisit the BAF and risk profile.

DH said that in addition to improving LCH services to ensure they are fit for purpose, the proposed arrangements presented an opportunity to create an integrated care system. This would enable services to be built around families and the needs of patients. This approach was supported by the CCG, Local Authority and other partners. In order to move in that direction, a Shadow Integrated Care System Board would be established with Alder Hey taking a leadership role in this regard.

Discussion took place on the additional demands that would be placed on the Executive Team at Alder Hey who would be working across two Trusts. There was recognition that additional support would have to be secured, particularly around HR, communications and nursing leadership. Other gaps were being assessed and solutions would be identified.

DH agreed to brief the Lead Governor, to write to Governors informing them of the arrangements and to discuss the detail with Governors at the meeting scheduled for 20 June.

IT WAS AGREED:
That authority be delegated to the Chief Executive to sign the Management Agreement.

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Minutes of the last meeting held on **Tuesday 2nd May 2017, at 10am,**
Boardroom, Liverpool Community Health, 2nd Floor, Babbage House, L7 0NJ

Present:	Sir D Henshaw	Chairman (Chair)	(SDH)
	Mrs C Dove	Non-Executive Director	(CD)
	Mrs J France-Hayhurst	Non-Executive Director	(JFH)
	Mr J Grinnell	Acting Director of Finance	(JG)
	Mrs H Gwilliams	Chief Nurse	(HG)
	Mr S Igoe	Non-Executive Director	(SI)
	Mrs A Marsland	Non-Executive Director	(AM)
	Mr I Quinlan	Non-Executive Director	(IQ)
	Mrs L Shepherd	Chief Executive	(LS)
	Mr S Ryan	Medical Director	(RT)
	Mrs M Swindell	Director of HR & OD	(MS)
	Dame J Williams	Non-Executive Director	(JW)
In Attendance:	Mrs M Barnaby	Interim COO	(MB)
	Prof M Beresford	Assoc. Director of the Board	(PMB)
	Ms L Dunn	Director of Marketing & Comms	(LD)
	Mr C Duncan	Director of Surgery	(CD)
	Ms S Falder	Director of Clinical Effectiveness and Service Transformation	(SF)
	Ms R Greer	Associate Chief Operating Officer for Community & CAMHS	(RG)
	Mrs D Herring	Director of Strategic Development & Clinical Service Partnerships	(DH)
	Ms E Saunders	Director of Corporate Affairs	(ES)
	Mrs J Tsao	Committee Administrator	(JT)
	Ms J Reilly	Chief Operating Officer, Liverpool Community Health	
Agenda item:			
37.	Mrs A Hyson	Complaints and PALs Manager	
38.	Prof R Cooke	Director of Infection and Control	
42.	Mrs K Turner	Listening into Action Lead	
42.	Ms E Sager	Listening into Action, PA	
43.	Mr J Gibson	Programme Director	
Apologies:	Mrs C McLaughlin	Director of Integrated Community Services	

17/18/29 Declarations of Interest
None declared.

17/18/30 Minutes of the previous meetings held on 4th April 2017
Resolved:
The Board received and approved the minutes from the meeting held on 4th April 2017.

17/18/31 Matters Arising and Action Log
Johanna Reilly, Chief of Operations, Liverpool Community Health

The Chair welcomed Johanna Reilly to her first Board meeting and thanked her for hosting at the Liverpool Community Health Offices.

John Grinnell, Director of Finance
The Chair welcomed John Grinnell to his first Board meeting as Director of Finance.

Global Digital Exemplar (GDE)
John Grinnell updated the Board on behalf of Peter Young. As previously reported the GDE Business Case had now been approved by the Treasury securing £9.6m funding over a 3 year period. Formal confirmation of the funding was due to be received shortly.

The GDE programme manager was now in place and meetings with the operational leads had been arranged. Christian Duncan, requested a separate meeting with Adam Bateman, John Grinnell and Peter Young for support within a number of areas.

External Clinical Research review
The Chair and Michael Beresford updated the Board on the last two dinners held to discuss the External Clinical Research review hosted by the University of Liverpool and Liverpool Health Partners respectively. The next meeting with some of the LHP Trust Chairs is due to be held at the end of the month.

The Chair reminded the Board that last year's bid for a BRC had been unsuccessful. A discussion was held on developing a strategy and methodology to resolve issues with regard future Clinical Research in Liverpool, Alder Hey's support for Liverpool Health Partners and Alder Hey's contribution to Liverpool's wider efforts to address the issues being faced. It was agreed that 'Liverpool Health Partners' would be a standing item on the Board agenda.

The Chair proposed and the Board agreed to invite Professor Sir Ian Gilmore, Board Chairman of LHP, and Professor Sir Munir Pirmohamed, Executive Director of LHP, to a future Board meeting, and to include an update on the Alder Hey Research Strategy at that time.

Well Led Review
Louise Shepherd reported on the outcome of the recent unannounced CQC Inspection. The Board agreed the inspection had gone well, areas requiring further assurance had been responded to and follow up data requests were still in process.

17/18/32 Key Issues/Reflections:
Annual Report 2016/17
The Audit committee held on 28th April had received the Head of Internal Audit's opinion as overall 'significant'. The Annual Report would be presented at the Board meeting on 25th May 2017.

17/18/33 External Environment/STP/Progress against Strategic Themes

NHS 5 Year Forward View progress

Louise Shepherd updated the Board noting the focus on implementing 'Next Steps on the NHS 5 Year Forward View' published by the Chief Executive of NHS England.

Liverpool Community Services

The management contract for the Liverpool Core adult and children's services had now commenced and work was being undertaken between the outgoing interim Executive Team from Liverpool Community Health NHS Trust and the Alder Hey Board members designated within the contract. A full suite of assurance committee meetings would be held in May in accordance with the LCH corporate calendar.

Neonatal Network

Following submission of the preferred option for a consolidation of Neonatal Services across Cheshire and Merseyside to be provided from two sites to NHS England was approved.

Liverpool Women's NHS Foundation Trust

As requested by Liverpool Women's NHS Foundation Trust the North West Clinical Senate will commence an independent review of the reconfiguration of women's services to date. The Senate will be visiting Liverpool on 7th and 8th June 2017 however a visit to neither Liverpool Women's nor Alder Hey had been included in their itinerary. Debbie Herring is continuing to request that a visit is included.

17/18/34 Serious Incidents Report

Hilda Gwilliams presented the report for March 2017. There had been two new SIRIs reported; one ongoing and none closed.

Resolved

The Board received the Serious Incident Report for March noting:
Two new SIRIs, one ongoing and none closed. There had been one new safeguarding incident reported, none ongoing or closed.

17/18/35 Clinical Quality Assurance Committee: Chair's Update

Resolved:

The Board received and noted the Minutes from the CQAC meeting held on 22nd March 2017.

17/18/36 Quarterly Mortality Report

Steve Ryan presented the quarterly report on the work of the Hospital Mortality Review Group (HMRG) including the number and types of death at Alder Hey during the calendar year to date and how the HMRG is meeting its aims.

The HMRG primary review figure of only 4% is obviously disappointing however this is an improvement from the last report. Reassuringly most (88%) of in–hospital deaths had a least one full mortality review within 2 months of their death – i.e. reviewed by a service group within the 2-month limit.

Resolved:
The Board received and noted the quarterly report.

17/18/37 Complaints report

The Trust had received 19 formal complaints for quarter 4 this is a slight decrease compared to this time last year.

Three complaints where upheld within this quarter and two were not upheld. Twelve complaints are still ongoing as 9 had been received in March, there are three complex cases with re-negotiated timeframes.

Resolved:
The Board received and noted the quarter 4 complaints report.

17/18/38 Infection Prevention and Control Report

Professor Richard Cooke presented the IPC report for quarter 4 with progress to date against the delivery plan. Ten objectives remain outstanding, an action plan with timescales for completion was received.

Resolved:
The Board received and noted the quarter for IPC report.

17/18/39 Nasogastric Tube Safety Alert

A national patient safety alert to provide assurance on compliance of nasogastric tube safety had been received.

As part of the assessment the Trust's Nasogastric Tube Placement policy was reviewed and amended to include additional safeguards which have been incorporated into the Trust's Meditech 6 EPR (general) system. This checklist is now automatically included in the nursing data fields which have been made mandatory). Specific alerts have been included, if a pH above 5.5 is documented, a message is generated 'Do not feed. Re-check and see Policy'. The policy is due to be approved at the Clinical Quality Steering Group on 9th May 2017.

Concerns had been raised on the quality of the pH strips, this was to be reviewed by Procurement with clinical engagement.

Resolved:
a) The Board received and noted the Nasogastric Tube Safety Alert update.
b) Going forward the Clinical Quality and Assurance committee will oversee the relevant on-going assurance to ensure National Patients Safety Alerts are met.

17/18/40 Alder Hey in the Park

David Powell updated the Board on the following projects:

Decommissioning and Demolition
Demolition of the old hospital had commenced. The phases are under constant review.

Research and Education Build Phase II
The 14 month programme had commenced.

Alder Centre
25 Expressions of interest had been received on the design and location for the Centre.

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

17/18/41 People Strategy
The Board received the people strategy report for April 2017.

Quality Health will be visiting Alder Hey to present the survey results to staff on Thursday 4th May at 9:30am.

Alder Hey had been approached by Health Education North West to support the paediatric placement element of the Physician's Associates training programme. Between August and November 33 students will be supported for a three week placement each. There are number of benefits to us agreeing to support this cohort; it enables us to test out the role and see if this is something that would work for Alder Hey, and it will generate a supporting placement of tariff of just under £25k.

Resolved:
The Board received:
- People Strategy report April 2017
- Workforce and Development Committee minutes from the meeting held on 15th February 2017.
- Staff Survey 2016 action plan.

17/18/42 Listening into Action
Kerry Turner and Emma Sager gave a presentation on progress to date with Listening into Action in the first year and proposals for year two.

158 'quick win' projects had been recorded with 89 resolved.

Three clinical teams: BME Staff group, cardiac surgical pathway and staffside are almost completed. Projects continuing this year include medical devices safety and reducing the burden of emails. Six teams have been selected for year two.

Monthly network meetings are being held with the listening into action team at Aintree to learn from experiences and share good practice.

Resolved:
The Board noted LiA progress to date and proposals for year two.

17/18/43 Programme Assurance Update
Programme Assurance is in the process of completing a review of current programme content with all Executive Sponsors, with a view to increase focus on

fewer projects but with increased benefits. This would be presented for approval at the next Operational Board on 25th May 2017.

Resolved:
The Board received the Programme Assurance update and agreed with the approach.

17/18/44 Corporate Report

Performance
Activity has significantly improved against the same period last year; the 4 hour standard and YTD position had been achieved despite increased attendances. RTT, cancer and diagnostic standards achieved despite pressures, volume of longest waiting patients has as increased slightly.

Quality
An increase in patients involved in play and learning had been recorded for March.

Finance
For the month of March the Trust is reporting a trading surplus of £5.2m.Year to date the trading surplus is £2.8m which is £3m ahead of plan. As the Trust overachieved on its control total we are eligible for additional Sustainability and Transformation Funding of £1.7m which is included in the financial position.

Resolved:
The Board noted the Corporate Report for Month 12.

17/18/45 Board Assurance Framework
The Board received the latest BAF noting a review of the outstanding risks was to take place.

Resolved:
Board received the BAF.

17/18/46 Resources and Business Development Committee
Resolved:
Board received RABD minutes from the meeting held on 29th March 2017.

Date and Time of next meeting: Tuesday 25th May 2017, at 1:30pm, Large Meeting Room, Institute in the Park.

Alder Hey Children's NHS

NHS Foundation Trust

Annual Report & Accounts 2016/17

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

Contents

A Message from our Chair and Chief Executive

We are delighted to share with you our Annual Report for 2016/17; a reflection of our challenges and achievements during our first full year within the new 'Alder Hey in the Park'.

We remain extremely proud of our new Alder Hey, the first hospital in a park in Europe and one which has been designed with the help of children and young people. We were incredibly honoured to welcome Her Majesty the Queen and His Royal Highness the Duke of Edinburgh to officially open 'Alder Hey in the Park' on the 22nd June. It was an unforgettable day for everyone at Alder Hey and we feel very privileged to have had the opportunity to show Her Majesty and His Royal Highness to our brand new home.

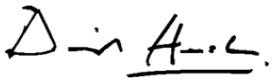
This year has been an extremely tough period across the whole of the NHS as we face greater financial constraints and an ever challenging environment. Despite the significant turmoil the NHS continues to face, we are pleased with the progress we have made towards securing our financial stability during 2016/17, whilst also achieving all of the national performance standards. This includes delivering the A&E four hour waiting target against a backdrop of the worst ever winter performance across the NHS. The Secretary of State for Health Jeremy Hunt recently congratulated Alder Hey on being the Trust with the greatest improvement in this area.

Throughout the year we have been focused upon improving quality, increasing performance and efficiency, enhancing patient experience, engaging with staff and creating the very best environment for them to do their best work. Through the determined efforts and outstanding dedication of our staff we have been able to make significant progress in all these areas and this has enabled us to over-achieve against our financial targets; an incredibly impressive achievement which highlights how Alder Hey continues to perform well compared with many other acute providers.

At the heart of all our achievements remains our highly skilled and dedicated staff. The last twelve months have enabled us to settle into our new home while continuing to make real improvements to our services. Engaging with our front line staff has been key to improving our performance; our *'Listening into Action'* approach and 'Big Conversations' with staff have empowered colleagues across the Trust to continue to make Alder Hey the very best it can be.

Our staff continue to go above and beyond in their commitment to providing the very best care to our patients. Thousands more children and young people have benefitted from this care over the past twelve months. The feedback we receive from our families is further confirmation of what the CQC told us last year; that we remain 'outstanding' for caring.

Our achievements this year will now provide us with the perfect platform to move from good to great as we continue on our journey to become a world leading centre for children's healthcare and research. Our aspirations remain high and we have refreshed our overall strategy for the next three years to deliver on our '2020 Vision' to provide a healthier future for children and young people.



Sir David Henshaw
Chairman

Louise Shepherd
Chief Executive

Performance Report

Overview

The following section of the report is designed to provide a brief picture of Alder Hey: what are about, what we are aiming to achieve for our patients and families, the risks to delivery and how successful we have been in the last year.

About the Trust

Alder Hey Children's NHS Foundation Trust is a provider of specialist health care to 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 clinicians help deliver care closer to patients' homes by holding local clinics at locations from Cumbria to Shropshire, in Wales and the Isle of Man. The Trust also provides 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 3246 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 £217m of which £192m 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 £57m contract on behalf of 21 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 and from April 2016 NHS Improvement, 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 2016/17 the Trust planned and achieved a use of resources risk rating of 3 (financial risk rating). This represents a higher financial risk than historically, but improved upon the previous year and reflects the continued stabilisation of the organisation from the impact of the implementation of the new electronic patient care system and the move to the new hospital in 2015.

Our services are managed through a Clinical Business Unit (CBU) model, each led by a senior clinician, a senior manager and a senior nurse, who together with service leads and managers are responsible and accountable for the overall clinical, workforce and financial performance of their area.

The Trust has a thriving research portfolio in partnership with NHS, academic and commercial partners. It is known that research intensive organisations are associated with better health outcomes. Since the inception of the National Institute for Health Research (NIHR) Clinical Research Network, the Trust has enrolled 30,000 children and young people into research studies, more than any children's healthcare provider in the UK. The NIHR Alder Hey Clinical Research Facility for Experimental Medicine is now helping us to translate scientific discoveries into clinical studies which will ultimately support new treatment options for babies, children and young people. The Trust remains a significant leader and contributor to applied clinical research studies improving the health and wellbeing of children and their families.

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.

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 a range of hospital activities and plans, as well as playing a key role in 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. From October 2016 the five existing CBUs were restructured into three somewhat larger clinical Divisions, to achieve greater economies of scale, deliver clinical synergies and to enable greater investment in clinical leadership. A new leadership model was also created with a medically or clinically qualified Director as the accountable officer, supported by a senior manager in the role of Associate Chief Operating Officer and an Associate Chief Nurse. The specialties comprising each Division were in turn reorganized into Clinical Business Units, each with a Clinical Director and Service Manager.

The three Clinical Divisions are comprised as follows:

Medicine	Surgery
• Accident and Emergency Department • General paediatrics • Diabetes • Respiratory medicine • Infectious diseases • Immunology • Metabolic diseases • Nephrology • Rheumatology • Gastroenterology • Dermatology • Endocrinology • Dietetics • Oncology • Haematology • Palliative Care • Bereavement services • Radiology • Pathology • Pharmacy • Psychology • Therapies • Long term ventilation • EBME • Bed management • Medical records • Outpatients • Phlebotomy • Medical day care • Booking and scheduling	• Cardiac surgery and Cardiology • Paediatric Intensive Care • High Dependency Unit • Burns Unit • General surgery • Urology • Gynaecology • Neonatal surgery • Theatres • Anaesthesia and chronic pain • Ear nose and throat and audiology • Cleft lip and palate • Ophthalmology • Maxillofacial surgery • Dentistry and orthodontics • Neurosurgery and neurology • Craniofacial surgery • Orthopaedics • Plastic surgery

Community Services and CAMHS
• Children's community nursing team • Homecare • Community matrons • Community therapies • Neurodevelopmental paediatrics • Community paediatrics • Safeguarding services • Fostering and adoption • Child and Adolescent Mental Health Services

Our CQC Ratings

The Trust received its last full inspection in June 2015 and was rated as follows:

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 Strategy

The Board reviewed the Trust's overarching strategy in April 2016, having come to the end of the strategic plan developed in 2011 which had culminated in the delivery of the new Alder Hey at the end of 2015. The Board believes that the organisation's original purpose and vision remain relevant today and will be fundamentally unchanged to 2020, re-committing to its ambition to provide world leading children's services.

Alder Hey's 2020 Vision is built upon a small number of key strategic pillars which continue to be refined to reflect the changing landscape in which the NHS operates. For 2016/17, our strategic aims continued to reflect the organisation's focus on quality improvement and the goal of providing exceptional care from exceptional new facilities.

The Trust's values underpin all that we do and how we do it.

Delivering on our Strategic Aims and our Operational Plan: Highlights from 2016/17

2016/17 was another successful year for Alder Hey. Highlights of progress against our plans during the year include the following:

Excellence in Quality

- The Trust continued to take forward our refreshed Quality Strategy, underpinned by the principles of clinical leadership and engagement and supported our Listening into Action approach.

- Progress against a number of our Quality Aims resulted in measurable improvements:
    - Incident reporting – in the top 3 trusts nationally for overall incident reporting, with severe and moderate harms down
    - Medication errors down
    - Infections down
    - Reportable pressure sores down

- The Trust recruited to all its nurse staffing vacancies to eliminate the use of agency staff almost entirely

- A sepsis pathway based on NICE guidance was implemented to improve the quality of care we provide for patients with early sepsis; this was supported by a large scale training programme, the appointment of 1.5 new sepsis nurse specialists and a communication campaign to improve the recognition and timely treatment of a potentially life-threatening condition.

For a more detailed description of Alder Hey's quality journey in 2016/17 please read our Quality Report on page 93

Patient Centred Services

- Alder Hey became the only paediatric trust nationally to be invited to participate in the elite Global Digital Excellence programme, designed to drive new ways of using digital technology in the NHS and supporting the Trust to deliver its aim to become paperless

- A new, specially designed 'hybrid' operating theatre opened in February 2017 at Alder Hey, the first of its kind in a stand-alone paediatric setting in the UK

- In 2016/17 a significant amount of hard work has been undertaken to improve waiting times for Community Services (CAMHS and Developmental Paediatrics) which means that access to our community teams are now within the 18 week referral to treatment requirements

- A self-referral system was introduced by the CAMHS Team to enable young people to access the service quickly; this has been very positively received by service users

- The transfer of specialist paediatric therapy services from Liverpool Community Health NHS Trust to Alder Hey was successfully completed on 31st March 2017 and the staff are now welcomed to the Alder Hey family.

Great Talented People - *Listening into Action*

- Since early 2016, Alder Hey has been undertaking a Listening into Action journey. Focussed around staff empowerment and positive change, Listening into Action (LiA) is a Trust wide drive to identify issues and blockages, bring together all the right people into the same room and then work together on a solution.

- Through this initiative, dozens of clinical teams from across the Trust have been involved in positive change. Some examples of solutions have included developing a CAMHS self-referral service, rolling out a new cardiac surgical pathway and investigating staff diversity.

- Many more staff has supported a growing list of quick wins and other longer term solutions around catering information, thermometer supply in the Emergency Department, phlebotomy equipment, recycling and a staff running club.

- Alongside this, a monthly network meeting has been established between Alder Hey and Aintree University Hospital focusing on Listening into Action and Freedom to Speak Up issues. Through these meetings both trusts are able to keep each other informed, share good practise and learn from each other's experience.

- The Trust is now aiming to embed the LiA way of working across the Trust more widely.

Growing our Services and Safeguarding Core Business

Alder Hey delivered an excellent set of year end results, particularly in the challenging financial and operational context of the wider NHS, we:

- Over–achieved on our financial plan delivering a surplus of more than £3m
- Achieved all of the nationally mandated access targets including the 4 hour A&E target and the 18 week referral to treatment target

- Delivered 8% more elective operations, 8% more non-elective procedures and 13% more outpatient appointments compared to last year

- Carried out over 400 congenital cardiac operations on children to meet the national requirement for this highly specialised service.

International Research, Education and Innovation

- Alder Hey delivered a strong performance across a range of research programmes and in partnership with a range of higher education institutions, the charitable sector and commercial sector.

- Successful application to the National Institute for Health Research (NIHR) for a Clinical Research Facility (CRF) for Experimental Medicine. This renewed contract for a further five years will enable the Trust to take forward experimental medicine research programmes in a number of priority areas including inflammatory diseases, cancer and neurosciences, providing the city of Liverpool with experimental clinical research facilities for all of its inhabitants across the lifecourse.

- Applied clinical research performance has again excelled within the Trust. Over 4,000 children and young people have been enrolled into clinical research studies registered with the NIHR Clinical Research Network, more than any other children's healthcare provider in England & Wales and places Alder Hey within the top 10% of NHS organisations with respect to research volume.

- Continued to nurture and develop an expert multi-professional research workforce. In the past year, the Trust has secured a prestigious NIHR Clinical Academic Training Doctoral Fellowship for a Physiotherapist, has secured a NIHR Intention for Innovation award of over £1m led by a Nurse and has supported its second Pharmacist to post-doctoral level within its Paediatric Medicines Research Unit.

- The Trust has been at the forefront of novel collaborations and funding partnerships to ensure that children and young people have access to life changing clinical trials. Agreements and investments have been secured with the Cystic Fibrosis Trust for Alder Hey to be one of the first tranche of Clinical Trials Accelerator Platform centres. Similarly, Duchenne UK has invested in a number of key posts within the Trust to enable more clinical trials to be made available at Alder Hey to boys with Duchenne Muscular Dystrophy. The experience of Alder Hey in implementing these new funding partnerships will be of great value to the wider research community in the UK.

Performance Analysis

Alder Hey's approach

The Trust continues to develop and refine 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. An online Integrated Performance Report has now been developed which focuses on four key domains of Quality, Performance, Finance and Workforce. This now forms the basis of our newly developed monthly Executive review where each Division leads the discussion and presents by exception on areas that require improvement.

Performance against national priorities

The Trust met all of its access targets in 2016/17. A robust Winter Plan was developed with a multidisciplinary approach which created sufficient capacity to manage the predicted increases in emergency demand whilst providing enough flexibility to support the elective programme. A revised approach to managing activity across the hospital was successfully implemented which ensured patient flow was maximized through the challenging periods and minimized the amount of delays and subsequent 4 hour breaches. The whole system approach therefore supported the delivery of all of our access standards.

The Trust continues to review productivity and look at how the new estate can support safe, effective and efficient delivery of care. Bespoke programmes have been developed with a view to maximizing efficiency and productivity which continue to support achievement of targets. The Trust has successfully implemented the Specialist Commissioner Clinical Utilisation Review CQUIN across two wards which improves reliability within the hospital and we will move to full roll out in 2017/18.

The Trust's performance against national access and other mandated targets for 2016/17 are set out below:

Target or Indicator	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**	**1**	**0**
C. Difficile - Rates per 100,000 Bed days	**0**	**6.9**	**0**	**0**	**5.8**	**0**

18 Week RTT Target Open Pathways (Patients still waiting for Treatment	**92%**	**90.0%2**	**92.1%**	**92.1%**	**92.2%**	**92.1%**
All cancers: two week GP referrals	**100%**	**95.1%3**	**100.0 %**	**100.0 %**	**94.4%**	**100.0 %**
All cancers: one month diagnosis (decision to treat) to treatment	**100%**	**97.5%3**	**100.0 %**	**100.0 %**	**100.0%**	**100.0 %**
All cancers: 31 day wait until subsequent treatments	**100%**	**97.5%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 Trust Board)	**95%**	**89.0%4**	**95.00 %**	**96.55 %**	**93.11%**	**96.71 %**
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:**	**8.3%** **2.4%**	**8.2%** **7.3%**	**9.3%** **8.4%**	**8.3%** **6.3%**
Financial & Service performance Ratings[6]			2	2	3	3
Rate of Patient Safety Incidents per 1000 bed days			54	63	78	69
Patient Safety Incidents and the Percentage that result in Severe Harm or Death			0 0%			

[1]Specialist trusts are excluded from SHMI reporting
[2] National Performance based on most recent published data for April 2016 - February 2017.
[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 2016 - February 2017.
[5] Quarter 1 reported under the old CSR ratio. From Quarter 2 ratings have been reported under the new FSRR ratio.

External Awards and Achievements in 2016/17

Alder Hey set to become UK's first 'cognitive' hospital

In May 2016, Alder Hey announced a ground-breaking multi-year collaborative programme with the Science and Technology Facilities Council's (STFC) Hartree Centre, supported by IBM (NYSE: IBM), to create the United Kingdom's first 'cognitive' hospital by harnessing 'big data' and the power of IBM's Watson technology platform.

This is the first time that Watson technology will be applied to improve patient experience in the United Kingdom. Alder Hey and the Hartree Centre believe that by applying Watson — an innovation in computing technology — it will enhance patient care and potentially generate savings for both the hospital and the NHS as a whole.

Using Watson to analyse any feedback that is voluntarily and securely provided by the patients, with appropriate consent as needed, it is anticipated that Alder Hey will be able to greatly enhance patient experience by; identifying patient anxieties and providing information and reassurance on-demand; reminding young patients and their parents about appointments and about aftercare; and providing insightful feedback to clinicians based on the tone and sentiment of these interactions. Using this valuable insight, clinicians at Alder Hey will be able to make a hospital stay for a child less daunting, by providing a more personalised service for a child while also being able to identify clinical trends more quickly that could affect patient flow and effectively make significant cost savings.

The first stage of this multi-year project is underway, with an initial version of the platform expected to be ready for testing in the hospital around the end of the year. Over the last few months, Alder Hey patients and their parents have been asked a range of questions on everything from parking, to what they would like to eat, to their favourite games and films, and what they want their bedroom to look like. They have also been asked what questions they have about clinical procedures, general anaesthetic, and surgery. A team of experts from the Hartree Cognitive team, made up of the Hartree Centre and IBM, are using this information to train 'Watson' to anticipate and respond to questions from patients and families before they come into hospital.

Dr Richard Appleton receives Epilepsy award

Alder Hey neurologist Dr. Richard Appleton was awarded the Lord Hastings award by national charity Epilepsy Action in June 2016.

The award recognises Dr Appleton's outstanding personal contribution to the improvement of the quality of life of children with Epilepsy and their families. He was presented with his award by a previous patient Carl Foster, 28 who now works for Epilepsy Action.

The Lord Hastings Award was set up in 1990 to recognise outstanding personal contributions to people with epilepsy. Since it was created by Epilepsy Action, it has only been awarded to eleven people. Dr. Appleton's work at Alder Hey has made a huge impact on the lives of children with Epilepsy. He helped to establish the first full-time nurse specialist post in paediatric epilepsy within the UK, initially funded by the Roald Dahl Foundation. He also established the first transitional epilepsy clinic in the UK, managing teenage patients' transition from child to adult services. In 2004, Dr. Appleton was instrumental in establishing the Paediatric Neurosciences Foundation at Alder Hey, another first in the UK.

Royal approval for Alder Hey in the Park
Alder Hey in the Park was officially opened by Her Majesty the Queen and the Duke of Edinburgh on 22nd June 2016, during an historic and unforgettable day.

Hundreds of well-wishers including Alder Hey patients, families and staff gathered outside the hospital entrance and waved Union Jack flags to welcome the Queen and the Duke to the new Alder Hey.

Before entering the hospital, the Queen was presented with a posey by two year old patient Lewis Connett. Lewis, a Young Ambassador for Alder Hey who has helped raise thousands for the new hospital, has been making the regular journey from his home in Halifax to Alder Hey since he was diagnosed with Apert Syndrome when he was a baby. So far, Lewis has had four surgeries at Alder Hey with his first at only five months old.

The Royal Party then began a tour of the new hospital accompanied by Alder Hey Chair Sir David Henshaw and Chief Executive Louise Shepherd. Beginning with a visit to the Outpatients Garden (funded by the Steven Gerrard Foundation), they listened to Alder Hey's Staff Choir perform while meeting children involved in the design of the hospital. Children and young people have been involved in designing the new hospital since an initial consultation back in 2009, where almost 1000 patients drew pictures and shared their views on what their new hospital should look like. Alder Hey's Children and Young People's Design Group have had their say throughout the design process on everything from the colour of the rooms, to the artwork displayed in the new hospital and what their wards should look like.
The Queen and the Duke then continued to the hospital's Oncology and general medical wards. On ward 3C, patients and families greeted the Queen while enjoying a Royal Tea Party especially prepared by Alder Hey's ward chefs. The hospital has a unique food offering; chefs are based on every ward and are able to make fresh food on demand for patients as and when they want them.

The Royal Party concluded their tour in the hospital atrium, where they were introduced to major donors of Alder Hey Children's Charity who have helped fund lifesaving equipment, vital research and arts and play activities in the new hospital. Watched by dozens of staff, patients, families and supporters of the hospital, Sir David Henshaw invited the Queen to unveil a plaque and officially open Alder Hey in the Park.

Congenital heart disease services centred in Liverpool
In July 2016, NHS England announced that all patients who require surgery for congenital heart disease (CHD) including those with complex and life threatening conditions in the North West of England, North Wales and the Isle of Man would be treated in Liverpool.

A partnership of four Liverpool hospitals including Alder Hey Children's Hospital NHS Foundation Trust; Liverpool Heart and Chest Hospital NHS Foundation Trust; The Royal Liverpool University Hospital and Liverpool Women's Hospital NHS Foundation Trust will provide this specialist service ensuring a high quality service and a single and seamless pathway for patients of all ages with CHD.

Alder Hey Children's Hospital NHS Foundation Trust was commissioned to provide a Level 1 service for paediatric patients with Liverpool Heart and Chest Hospital NHS Foundation Trust

delivering the level 1 service for adult patients. Level 1 service centres will provide the most highly specialised diagnostics and care including all surgery and most interventional cardiology.

The decision to base this service in Liverpool after 3 years of deliberations by NHSE is a massive vote of confidence in the excellence of specialist services in the City and demonstrates the high esteem with which the care and treatment provided for children and young people by the whole Alder Hey team is held at local, regional and national levels.

Alder Hey in the Park wins Prime Minister's Award
Alder Hey Children's Hospital won the Prime Minister's Better Public Building award at the British Construction Industry Awards in October 2016. The Prime Minister's Better Public Building Award recognises publicly-funded projects that demonstrate innovative and productive construction, deliver value for money and bring real change for their communities. It is the pinnacle of the British Construction Industry Awards, organised by the Institution of Civil Engineers.

Minister for the Cabinet Office, Ben Gummer, said: *"Alder Hey is a great example of how to transform public services in an innovative and cost effective way. Engaging the community in the design and using local apprentices to support the construction will ensure the hospital will continue to be at the heart of the community for generations to come."*

Ophthalmology win national award
Alder Hey's Ophthalmology Team saw off strong competition from hospitals across the country to be awarded winner at the Bayer Honours 2016 awards. Held at the prestigious Royal College of Surgeons in London in December, the team were singled out for their innovation, hard work and absolute commitment to their patients for their Paediatric Intraocular Clinic.

Developed as an MDT approach to each child's journey through the department, the pathway has been shown to greatly ease the anxieties of the parents and to give as much as possible a smooth and consistent experience. The patient sees, where possible, the same team members at the same clinic, keeping their experience friendly, familiar and focussed.

The judging panel commented, "*This is an excellent example of improved communication in the paediatric setting. A well thought out approach and a novel idea. The team recognised the lack of education and support for patients and as a result they successfully developed the service to meet these needs*."

Alder Hey CRF awarded £2million grant
Alder Hey's Clinical Research Facility (CRF) received a £2million grant over five years from the UK Government via the National Institute for Health Research (NIHR).

The grant will fund the infrastructure costs for early translational (experimental medicine) research to help speed up the translation of scientific advances for the benefit of patients. The funding application was made by Alder Hey in partnership with the University of Liverpool. Every year thousands of children at Alder Hey participate in clinical studies to help find new medicines and treatments for children with both common and rare childhood illnesses.

Alder Hey nurse honoured
In November 2016, specialist children's nurse Anne Sweeney was honoured for her dedicated work caring for seriously ill children.

In May 1993 Anne became the first ever Roald Dahl nurse: her post at Alder Hey Children's Hospital was created and initially funded by Roald Dahl's Marvellous Children's Charity (then known as the Roald Dahl Foundation), which provides specialist children's nurses and family support for seriously ill children across the UK.

The charity held a special presentation ceremony for Anne at the end of its annual nurses' conference, which took place at Alder Hey's Institute in the Park. Anne is very proud to have been the first Roald Dahl Nurse, a post which was also the first paediatric epilepsy nurse specialist in the UK. She was presented with special gifts by Liccy Dahl – Roald Dahl's widow, Martin Goodwin – the Chair of Trustees and Jane Miles – the charity's CEO.

Alder Hey joins forces with Al Jalila to improve children's health
Alder Hey and Al Jalila Children's Hospital in Dubai signed an official agreement in November 2016 to help enhance children's healthcare across the world. The agreement was signed during an official visit by the Duchess of Cornwall to the newly opened and first specialised paediatric hospital in the United Arab Emirates.

His Highness Sheikh Mohammed Bin Rashid Al Maktoum, Vice-President and Prime Minister of the UAE, and Ruler of Dubai, has developed the new dedicated children's hospital with an aim to deliver care to children at the highest level and on par with international standards. As part of this they were looking to establish an official international affiliation agreement with an existing world-class institution. Following a comprehensive search and after discussions with many reputed healthcare organisations, Alder Hey was identified as the ideal partner.

Alder Hey and Al Jalila share a vision and capability of creating a healthier future for children and young people worldwide. Together they will aim to deliver the highest quality care in outstanding facilities, with continuous improvements made through medical education, innovation, and clinical research, prominent in both institutions.

Having recently opened a brand new hospital facility of comparable size to Al Jalila Children's, Alder Hey will also be able to provide guidance to meet the challenges often faced when opening a new hospital. Children requiring very specialised treatments not currently available in the UAE, such as complex neurosurgery and neuro-oncology, will now also benefit from being able to access those treatments at Alder Hey in a seamless manner. Furthermore, as part of this collaboration, Al Jalila Children's will aim to establish dedicated education programmes for health professionals, providing valuable training that will develop the next generation of paediatric specialists and services in the UAE. Alder Hey will also have access to a variety of patients with rare diseases which will support vital research, thus creating the potential for future joint treatment programmes.

BBC Children's 'Hospital Take Over' at Alder Hey
Alder Hey hosted a live broadcast by BBC Children's as part of a special 'Hospital Takeover' in December 2016.

CBBC, CBeebies and BBC Interactive all helped launched Christmas at Alder Hey during a memorable day in the hospital. Alongside pre-recorded content and live links, presenters were filmed meeting patients, families and staff and also visited patients across the hospital wards.

The broadcast reflected a longstanding relationship with BBC Children's following Alder Hey's involvement in BAFTA award winning medical show *Operation Ouch!* The show returned to Alder Hey for a fifth series in 2016 which was broadcast on CBBC in the Autumn. This series is aimed at children (6-12 years) and is a fun insight into the world of medicine, while removing some of the fear for children coming into hospital. The series is made specifically for children and aims to give its audience a proper knowledge and appreciation of hospitals and how fantastic and adaptable the human body is in a fun yet informative way.

Operation Ouch! featured familiar faces from Alder Hey including staff and patients from our Emergency, Radiology, ENT, Oncology, Haematology, Cardiac, Physiotherapy and Anaesthetics departments along with staff and families across our wards, including the ward chefs, and our theatre, post room, arts, domestics and maintenance teams.

Innovation Award for Surgeon Iain Hennessey
Mr Iain Hennessey, Clinical Director of Innovation at Alder Hey, was presented with a gold award in January 2017 for his pioneering leadership of innovation by the Innovation Agency.
As an Innovation Scout, Iain actively promotes and supports innovation among colleagues, from ward to Board level. Innovation Scouts are senior clinicians, academics and managers who actively promote and support innovation among their colleagues, from ward to Board level. They learn from other organisations, through events, visits and study trips organised by the Innovation Agency – the Academic Health Science Network for the North West Coast.

Mr Iain Hennessey leads an Innovation Team at Alder Hey which is working with world leading companies and local small businesses, using gaming technology, sensors and cognitive computing to predict the progression of illnesses and plan individualised treatments.

Revolutionary hybrid operating theatre opened at Alder Hey
A hybrid theatre contains all the high tech equipment and software required to perform high resolution diagnostic imaging *and* operations at the same time. Alder Hey's new theatre is the first in the country suitable for operating on children from different specialties including heart, brain or spinal surgery.

Access to high resolution imaging in theatre means the surgical team at Alder Hey has much more information available to them in real time during an operation. Operations can take less time and there is no need to move the patient out of theatre for a scan which reduces infection risks. High quality 360 imaging and BrainLab navigation systems ensure much more precise diagnosis and surgery, significantly increasing survival rates. This software and technology helps to minimise potential side effects of surgery and exposure to radiation, while reducing the need for repeat operations and the number of times a child needs to be anaesthetised. State of the art imaging also enables minimally invasive surgery to take place by providing a clear visual of a small area. Rather than performing open surgery, surgeons are therefore able to access this small part of the body using a catheter or endoscope. The size of the theatre is also helpful as it provides more space for a greater amount of equipment and more clinicians, which can be particularly helpful during intensive procedures.

The new hybrid operating theatre cost £1.23m and was made possible thanks to funding provided by Alder Hey Children's Charity.

Trio of research and innovation awards for Alder Hey

Alder Hey Children's Hospital received three awards at the annual North West Coast Research and Innovation Awards, which recognise outstanding work from around the region. The awards are jointly organised by the Innovation Agency; the National Institute for Health Research (NIHR) Clinical Research Network North West Coast; and NIHR Collaboration for Leadership in Applied Health Research and Care (CLAHRC) North West Coast.

Alder Hey received the Most Innovative Collaboration Award for the 'Digital Alder Hey' project, which involves developing an app to help families familiarise themselves with the hospital and distract young patients while they are being treated.

A dedicated team of researchers organised by Alder Hey also won a special anniversary accolade. The network of research nurses, clinicians and managers was started ten years ago, covering nine hospitals in Cheshire, Merseyside and North Wales, to involve young patients in clinical trials to improve treatments. The Local Research Network was presented with the NIHR @10 Award for Clinical Research Outstanding Impact – marking the tenth year of the National Institute of Health Research. In the network's first year, 35 children were recruited in trials; after ten years, more than 30,000 children have been recruited and a total of 226 research studies are underway.

Finally, a young patient who brought together other young people, teachers, parents and researchers to highlight the impact of lupus, won the Outstanding Contribution to Patient and Public Involvement in Research Award. Young patient research ambassador, 17 year old Sophie Ainsworth set up an 'Invisible illness support group' called RAiSE – Raising Awareness of Invisible Illnesses in Schools and Education two years ago and led a project to develop resources for schools to support students with invisible illnesses. She was nominated by Jenny Preston, Patient and Public Involvement Manager at Alder Hey's NIHR Clinical Research Facility.

Alder Hey to trailblaze digital revolution in the NHS

Alder Hey Children's NHS Foundation Trust has been selected to join an elite group of NHS hospital trusts who will drive new ways of using digital technology in the NHS. These "digital exemplars" were selected from the most digitally advanced hospitals in the NHS and will lead the way in delivering radical improvements in the care of patients. Alder Hey is the only specialist children's NHS Trust to be selected.

As a digital exemplar, Alder Hey will receive £9.6m over the next four years to achieve Global Digital Excellence. The funding will support the digitisation of 43 clinical pathways, enabling Alder Hey to improve efficiency and effectiveness, enhance operational processes, improve clinical evidence of high quality care and strengthen staff engagement.

The new funding will accelerate and enhance the Trust's plans to deliver:

- A fully digital and paperless medical record for every child, including test results and scans.

- A web portal for patients and families that provides them with direct and secure access to medical information and their medical records, allowing them to make and change appointments.
- A web portal for healthcare professionals that provides secure access to records for patients who are in the care of a number of different NHS organisations.
- A patient 'app' platform with several elements: familiarisation with the hospital environment; gaming and rewards for compliance with treatment; and distraction and entertainment.

Key Risks to Delivery in 2016/17

The Trust's key risks were articulated in the Board Assurance Framework, which was reviewed on a monthly basis by the Board and its assurance committees throughout the year. The chief risk to quality related to sustaining the Trust's ability to provide the best possible care to our children given the financial challenges across the system. The Board agreed that as far as possible front line services must be safeguarded and the work carried out in the last three years to ensure optimum nurse staffing levels should be protected. The Trust was able to continue with its nurse recruitment programme and avoid the acute staffing shortages suffered by many NHS organisations, also enabling it to cease utilising agency nursing other than for areas experiencing skills deficits nationally, such as critical care.

The Trust's other key risk concerned the delivery of the activity plan, which was central to the organisation's ability to achieve the control total set by NHS Improvement. Threats to securing the requisite run rate are traditionally most acutely felt during the winter period when peaks of childhood respiratory conditions impact upon the elective surgical programme. The trust-wide work undertaken to develop and implement a robust Winter Plan meant that the activity plan was delivered and the organisation achieved a strong set of financial results which are described below.

Financial Performance

The Trust ended the year with a surplus of £2.6m. Included within this were 'normalising items' which are one-off technical adjustments that are not part of the Trust's normal business activities and financial performance. In 2016/17 the Trust reported 'normalising income and expenditure' that related to items purchased by the charity on behalf of the Trust, expenditure relating to the continued development of the hospital site and profit on the sale of property. The Trust reported a trading surplus (or 'Control Total') of £3.5m

The Trust's surplus/(deficit) on a control total basis:

	2016/17 £000		2015/16 £000
Surplus/(deficit) for the year	2,582		(40,699)
Exceptional items			
Impairment	2,239		45,189
Donated income	(2,704)		(14,137)
Donated depreciation	1,814		934

Gain/loss on disposal of assets	(402)		5,133
NHS Improvement surplus / (deficit) on control total basis	**3,529**		**(3,580)**

Capital expenditure for the year was £7.6m. This investment related to medical equipment, IT and the continued development of the Alder Hey site.

The Trust had a cash balance of £6.5m at the end of March 2017.

Regulatory Ratings

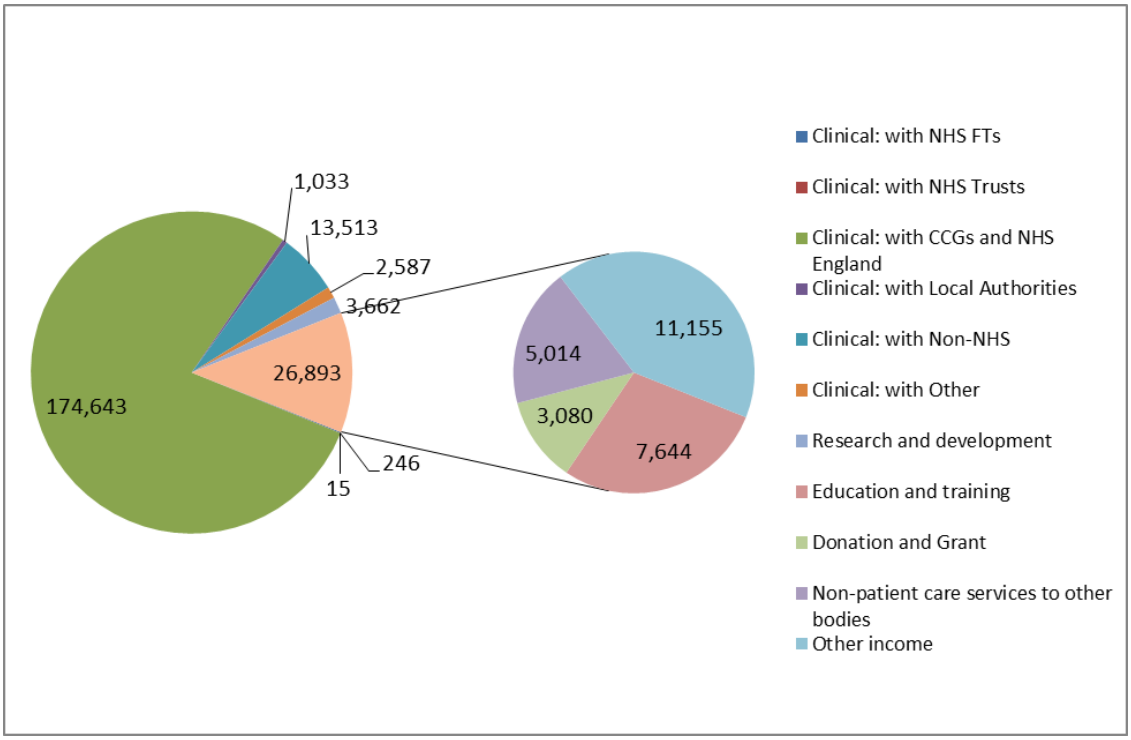
From October 2016 the Trust was monitored on NHS Improvement's new Use of Resources measure, replacing the financial metrics used by Monitor under the Risk Assessment Framework. NHS Improvement uses the metrics to assess financial performance by scoring each metric from 1 (best) to 4 (worst). The Trust has achieved an overall UOR rating of 2 which is better than the planned rating of 3. The breakdown of our rating is provided below.

Criterion	Measure	Weighting	2016/17 Metric	2016/17 UOR
Liquidity (days)	Shows ratio of liquid assets to total assets	20%	-1.416	2
Capital Service Cover	Shows revenue available for capital service	20%	1.344	3
I&E Margin	Shows underlying performance	20%	1.60%	1
I&E Variance	Shows performance against plan	20%	1.72%	1
Agency	Shows Agency spend performance against cap	20%	-9.78%	1
Use of Resources Rating				**2**

Income

The total income received by the Trust in the year ended 31st March 2017 was £220m with £193m (88%) 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 £109m. The Trust also has a contract hosted by Liverpool CCG to provide secondary services with a value of £59m. In addition the Trust has a contract with Welsh commissioners to provide secondary and tertiary services with a value of £13m. The £27m 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 by source 2016/17:

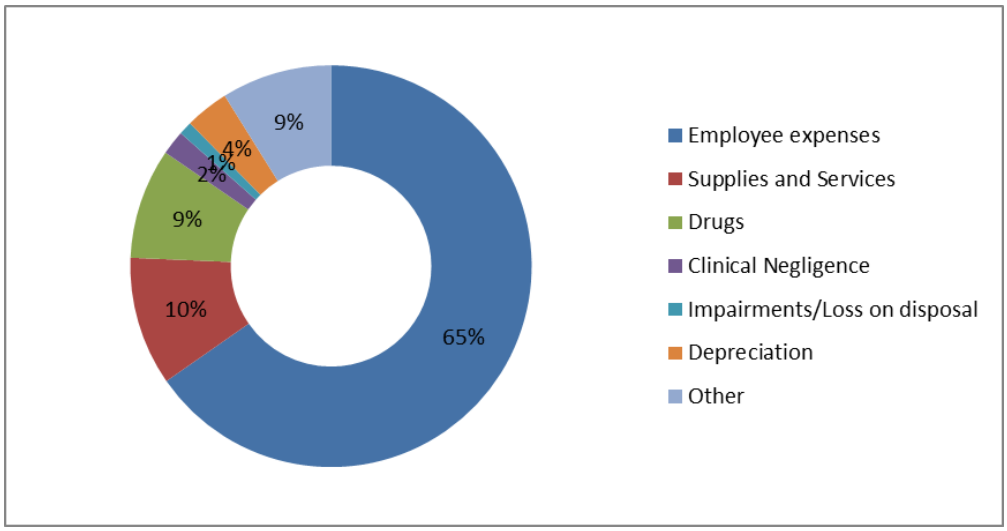


Clinical income by Point of Delivery

	2016/17 £000s	2015/16 £000s
Elective income	43,295	38,739
1 Non-elective income	31,172	26,942
2 Outpatients income	28,496	21,844
3 A&E income	5,103	4,837
4 Critical Care	24,875	22,025
5 drugs and devices	19,892	18,266
6 Other income	67,055	68,925
	219,888	201,578

Expenditure

Operating expenses totalled £209.6m for the year and as in previous years, staff costs account for the largest use of resources - 65%. An analysis of operating expenses by type is shown in the graph below:



Financial and Operating Risk

A&E activity exceeded plan for the year, whereas elective and non elective activity were both below plan. Outpatient activity was broadly in line with plan.

Total clinical income for the year was £193m, which exceeded the plan figure of £187m. Total normalised expenditure (excluding technical issues) for the year was £216.4m which was £3.4m higher than the plan of £213m. Expenditure on pay exceeded the plan by £1.7m which included agency staff totalling £3.3m although this is partly offset by vacancies in substantive posts. Drugs expenditure was £3m higher than planned although some of this was recovered via income for specialist drugs not funded through Payment by Results (PBR).
.
£6.3m of cost improvements (CIP) and efficiency savings were achieved during the year.

Capital Investment Programme

During the year the Trust completed £7.6m 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	2,075
Research and Education Buildings	Final costs of phase 1 of the Research and Education building and initial costs for stage 2	483
IM & T capital schemes	Investment in IM&T including Electronic Patient Record costs	1,561

Medical Equipment	Investment in medical equipment inclusive of equipment replacement cycle	1,117
Hybrid Theatre	New theatre equipment purchased by charity	1,209
Alder Hey in the Park	New hospital non-medical equipment and site development costs	1,137
Total Capital Investment 2016/17		**7,582**

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.

	2016/17	2015/16
% of invoices paid within 30 days	84%	90%

Accounting Policies

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

The Trust has 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 NHSI. 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 Trusts financial plan for 2017/18 will achieve a 'normalised surplus' of £0.1m and achieve a Use of Resources ratio of 2.

After making enquiries, the directors have assessed the reasonable expectation that Alder Hey Children's NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future.

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. The Trust was awarded the Liverpool and Sefton contract to provide £5,832,000 of community services transferred from Liverpool Community Health Trust on 1st April 2017.

Board Statement

The Board of Directors approved the foregoing Performance Report at its meeting on 25th May 2017.

Signed on behalf of the Board

Louise Shepherd
Chief Executive
25th May 2017

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 and in December 2016 the Council of Governors approved his re-appointment for a further twelve months in order to ensure leadership continuity on the Board. 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 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 2013 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 for twelve months from March 2016. In March 2017 Sir David was appointed as the chair of National Museums Liverpool.

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 lead the Five Year Forward View planning process for the Cheshire and Merseyside footprint and has continued in this role throughout the year.

- **Executive Directors**

Rick Turnock – Medical Director

Rick was appointed as interim Medical Director in May 2014, the role being made substantive 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 five years, moving to his first period as the Trust Executive Medical Director in 2000 for three 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.

Hilda Gwilliams – Chief Nurse (from July 2016)

Hilda joined Alder Hey in February 2013 as Deputy Director of Nursing and has recently 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.

Gill Core – Chief Nurse (to April 2016)

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.

Jonathan Stephens – Director of Finance and Deputy Chief Executive (to January 2017)

Jonathan took up post in June 2013; he has over twenty years' experience working with**in 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.**

Claire Liddy – Acting Director of Finance (from January 2017)

Claire was Acting Director of Finance from January 2017 until April 9th 2017. Claire has over fifteen years' experience working for and with the NHS; operating at a senior level in the sectors of Specialist and Acute Teaching hospitals, acute district hospitals and as a consultancy advisor whilst working for one of the Big Four accountancy firms. She has operated at Deputy Director level for the past five years and joined Alder Hey in 2014. Claire has a proven track record of delivering key financial targets year on year and leading and developing financial strategy with a specific focus on financial improvement and transformation. Claire has led Trusts to foundation status, and was a key member of the team that led to the opening of the new Alder Hey in the Park Hospital on time and in budget. Claire has a clinical background and is particularly passionate about driving the value for money agenda through making improvements to quality of care.

Mags Barnaby – Interim Chief Operating Officer (non-voting)

Mags has extensive senior level experience in planning and delivering services to achieve national and local targets, and in the strategic and operational management of change. She is passionate about the NHS and driven by a desire to make a positive difference to the quality of services for patients and staff. One of her key strengths is an innate ability to identify the links in complex problems, particularly the human dimension, in order to develop strategic vision and problem solving. In over 25 years working at a senior level in the NHS, Mags has held substantive appointments as Director of Human Resources, Director of Operations, and Director of Planning and Strategy in England and Wales. She was awarded a BA (Hons) at Warwick University in 1984, following which she studied a number of professional and post-graduate courses including MSc Strategic Human Resources Management (Leeds Business School 1991), MIPD (1997), Postgraduate Certificate with the National Leadership and Innovation Agency (Birkbeck College 2007). In 2016 Mags attended Harvard Business School to study Advanced Negotiation Skills for Strategic Decision Making.

Melissa Swindell – Director of Human Resources and Organisational Development (from October 2016)

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 led 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.

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 as well as a BA (Hons) degree from the University of Liverpool.

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 (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 Children's Charity.

- **Non-Executive Directors**

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

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. In September 2016 the Council of Governors approved Steve's re**-appointment for a further twelve month period in order to ensure continuity on the Board. Steve 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 A**udit Committee Steve also chairs the Integrated Governance Committee.**

Ian Quinlan - Non-Executive Director/Vice Chair of the Board 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.

Jeannie France-Hayhurst – Non-Executive Director

Jeannie took up her role at Alder Hey in July 2013 and was re-appointed for a second term of three years in June 2016. 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 OBE – Non-Executive Director and Chair of the Workforce and Organisational Development Committee

Claire joined the Alder Hey Board in October 2013 and was re-appointed for a second term in September 2016. She is a high impact leader of social change and 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 MBE – Non-Executive Director and Chair of the Clinical Quality Assurance Committee

Anita was appointed to the Board in July 2014. She 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 Chief Executive appointments between an NHS organisation 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.

Dame Jo Williams – Non-Executive Director

Dame Jo joined Alder Hey in November 2016. She trained at Keele University as a social worker alongside studying for a dual honours degree. Once qualified she spent the next 30 years in the public sector; the last ten as a Director of Social Services firstly in the Metropolitan Borough of Wigan and then Cheshire County Council. She then worked for five years as Chief Executive of the Royal Mencap Society. Her full time working career concluded with a three year period as Chair of the Care Quality Commission. Twice honoured by the Queen, she received a CBE in 2000 and a DBE in 2008. Dame Jo has always been driven by a passion for equality of opportunity, fairness and justice and is a strong believer in team work and partnership. Currently the Chair of Vivo Care Services, a member of Keele University Council, a trustee of Dartington Hall Trust and a Deputy Lieutenant in Cheshire.

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 2016/17.

Quality Governance

The Board at Alder Hey continues to review its governance arrangements and underpinning systems and processes on a regular basis. During the year, there were two key drivers for this: the refreshed Quality Strategy, with its basis in clinical leadership and engagement and the restructure of the Clinical Business Unit management model to three larger clinical Divisions, based on the same principle of clinical leadership. These two factors led to the three Divisional Directors and the newly appointed Directors of Transformation and Clinical Effectiveness being invited to sit on the Board as associate members in order to strengthen the clinical dialogue at Board level.

The Clinical Quality Assurance Committee, whose membership has previously included all Clinical Directors as well as Board directors, also renewed its purpose. In the context of the new structure and the approach set out in the Quality Strategy, the Committee revised its approach to quality walkarounds towards the end of the year, approving a new programme of 'Quality Ward Rounds' to inform the Trust's ward to Board governance. The Committee carries out more detailed scrutiny under its delegated authority from the Board for oversight of the Trust's performance against the Quality Governance Framework originally published by

Monitor in 2010 and now adopted by NHS Improvement; it also monitors the delivery of the Quality Strategy incorporating measures of clinical effectiveness, patient safety and positive patient experience.

The Integrated Governance Committee, chaired by the Trust's Senior Independent Director, has delegated authority to seek assurance on the management of risk across the whole of the organisation's activities and to hold each responsible officer to account for the effective management and mitigation of risks in their area. It operates an assurance mechanism that links together 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. The new Divisional Heads of Quality joined the membership of the Committee in year, undertaking 'deep dive' reviews into their risk registers within three months of the new structure being implemented to provide assurance to the Committee that the new entities were sighted on all associated risks. Relevant risks have also continued to be monitored each month by each of the assurance committees throughout the year.

The work of the Audit Committee complements this by discharging its responsibility for the maintenance of an effective system of internal control across the totality of integrated governance and risk management.

The monthly Quality Report, as part of the Corporate Performance Report presented to the Board has been reviewed again during the past year, to ensure the robustness of the data supporting the key performance measures against the Trust's quality aims and to inform the improvement actions required. The report includes information on nurse staffing in order to provide further level of assurance against this key quality indicator.

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.

As part of the 2016/17 internal audit plan, the Trust engaged MIAA to undertake a review of its evidence and approach to the Quality Governance Framework. The Clinical Quality Assurance Committee had continued to scrutinise self-assessments of Alder Hey's position against the various elements of the framework, but it had not been independently audited since mid-2015 when KPMG undertook a review which indicated a good level of assurance using Monitor's own scoring methodology. The MIAA review also resulted in an opinion of 'significant assurance' with only a small number of recommendations to improve the process; these have already been implemented in the most recent iteration of the assessment. The Trust will continue to use the framework to keep its approach to quality governance under review and regularly consider the evidence available from both internal and external assurance sources.

Further details about the Trust's approach to quality and quality governance can be found within the Quality Report (page 93) and Annual Governance Statement (page 80).

Patient Care

Infection Prevention and Control

Following the external service review undertaken in 2015/16 a substantive Associate Director of Infection Prevention and Control was appointed in January 2017 and will take up post at the beginning of May 2017. This role will provide strategic leadership for delivery of the IPC agenda and management of the infection prevention, intravenous access service and tissue viability teams. Educational development within the infection prevention and control nursing team has led to the successful completion of the formal Infection Control qualification by all IPCNs.

The move into the new hospital and the increase in single rooms has continued to impact favourably on the incidence of outbreaks of infectious disease during 2016/17. The Trust has seen no outbreaks of respiratory viruses and a decrease in periods of increased incidence of diarrhea and vomiting.

As a paediatric trust our patients are particularly vulnerable to respiratory viruses such as influenza. The importance that staff place on protecting our children from acquiring respiratory viruses is demonstrated in the Trust achieving the 75% staff vaccination target again in 2016/17.

The appointment of a dedicated data analyst in 2015/16 has enabled the Trust to generate data on the incidence of hospital acquired infections and the overall incidence of monitored HAIs has decreased in 2016/17. Improvements have been made in the monitoring and validation of line related infections caused by central vascular catheters. Multidisciplinary meetings have commenced with PICU and the Gastroenterology nurse specialist for TPN patients to manage, monitor and validate these infections.

2016/17 has seen the commencement of surveillance for ventilator associated pneumonia and the expansion of surgical site surveillance to include K wire insertion in Orthopedics and additional specialties such as Plastics. Additionally in 2016/17 the Trust has seen the introduction of a Theatre safety board to support continuous improvement in reduction of surgical site infections.

Multi-antibiotic resistant organisms such as Carbapenemase producing enterbactericeae (CPE) provide significant challenges to the NHS due to the reduced treatment options available and the ease in which they may be transmitted. 2016/17 has seen a steady increase in compliance with screening for CPE carriage at the Trust and early identification of carriers. There have been no hospital acquired cases of CPE and through close management and early identification of CPE carriers there have been no outbreaks at the Trust.

Following the close working with the Authorized Engineers for water, decontamination and ventilation in 2015/16 to ensure that the new hospital building was compliant with the Health Technical Memorandum during the commissioning process, the Trust Decontamination Lead and DIPC have established formal contracts with Authorized Engineers (AE) in 2016/17.

Matrons

Alder Hey appointed a Matron role in the Theatre department in 2017, a role which has been key in providing visible clinical leadership and driving improvements in patient care.

Following the restructuring of the CBU's in November 2016 to three larger Clinical Divisions, the Chief Nurse, supported by the divisional nursing leads, proposed the reintroduction of the matron role across the medical and surgical Divisions from within existing funding. It is expected that the new structure will be in place by mid-2017.

Devolved Risk and Governance model

In line with the introduction of the three larger Clinical Divisions and following feedback from previous CBU teams, the Trust implemented a system of devolved quality, risk and governance in December 2016 to provide local autonomy and ownership of quality and safety, enabling the CBU's and departments to have greater control and accountability for quality at a local level. The delivery of the strategy requires ongoing effective and robust local quality and governance systems and processes across all Divisions, CBU's, wards and departments to provide a truly embedded and integrated system of quality and governance. The model enables CBU's to have an improved focus on quality improvement and safety, increase compliance with regulatory standards at a local level and assurance of robust governance from 'Ward to Board'.

To assist the delivery of this agenda, each Division has employed a Head of Quality to lead a Quality Improvement Team and create a truly integrated governance system thereby strengthening and enhancing the focus on quality and safety at all levels of the organisation and ensuring there are sufficient resources within the Divisions and CBU's to drive further improvement in the delivery of no harm, best experience and best outcomes for our children and families.

Ward based Pharmacy Technician project

Alder Hey was successful in securing a Forerunner bid from Health Education North West to support the role of a Pharmacy Technician at ward level, to prepare and administer medications. A research project is underway to understand the impact of the role on patient experience, medication safety, and the impact of the role on nursing time by releasing time to care.

Patient Safety Champions

The Trust has maintained the number of Patient Safety Champions from last year; 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. Patient Safety Champions have been involved in supporting their clinical area in undertaking Ward Accreditation and patient safety audits and will continue to be involved in reviewing these tools for continuous improvement.

Ward Accreditation scheme

The Ward Accreditation Scheme was 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 '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 Safety Scan, maintaining engagement of both users and providers of service, along with reviewing practice against known service standards. In addition, it strengthens Board assurance and aligns with the Care Quality Commission key lines of enquiry and Essence of Care benchmarks. The tool has now been utilized in several clinical areas and is now being reviewed to identify whether any further improvements can be made to the Ward Accreditation Scheme.

Volunteering Programme

This has been an exciting and productive year for the Volunteering Services Department. The team has further developed the Volunteering Services Programme and through a comprehensive recruitment plan has increased the volunteer workforce from 20 to 395 active volunteers since October 2013.

During the last year, the Volunteering Programme has introduced a Pet Therapy Dog which visits the Atrium and Outpatients Department. This has been an extremely positive project that we are planning to roll out further this year.

To enhance the patient's experience in the Atrium and for those patients well enough to leave their ward, a performance calendar has been developed. These performances have included many local schools and performance groups and are hugely popular with our children, families and staff.

Complaints

During 2016/17 the Trust received a total of 70 formal complaints, three of which were withdrawn. One complaint was also investigated using the route cause analysis (RCA) process, following the Trust's Being Open policy and application of the Duty of Candour as appropriate. This was identified during the latter stage of the complaints process.

There was a 4% reduction of formal complaints compared with 2015/16; whilst a significantly lower reduction than previous years, this sustained low number of formal complaints can be attributed to quick intervention and resolution of issues as they arise, involving many key professionals to ensure the family's concerns are acted upon as soon as possible. The complainants were all that advised if they remained dissatisfied when the investigation process has concluded they should contact the complaints team for further advice and support.

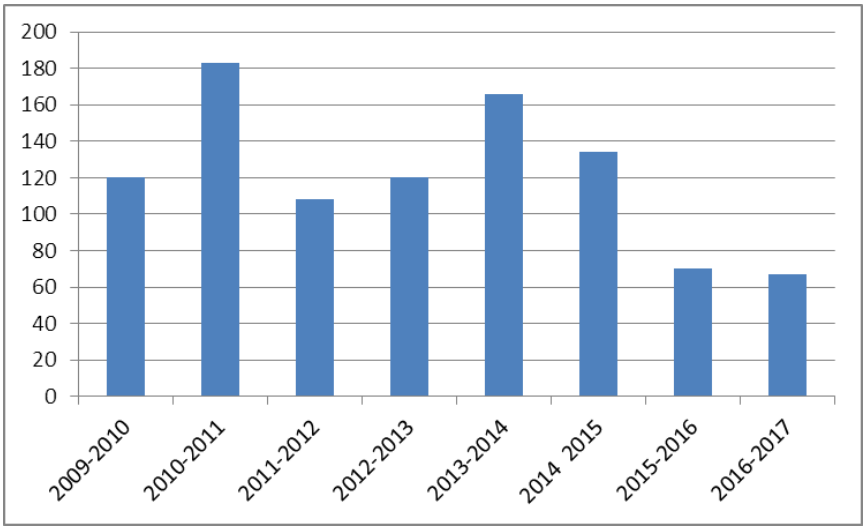


Table 1 – formal complaints received each year

As the Trust continues to intervene for complainants earlier in the process and provide real time resolution and a much more positive patient experience, the remainder of complaints within the formal system have become more complex in nature and can be more difficult to respond to within the 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.

It should be noted that any complainant who remains dissatisfied can ask that we re-look at their complaint. Any such case is then reopened and the 'clock' continues to the count length of time taken to respond in total from the original date received.

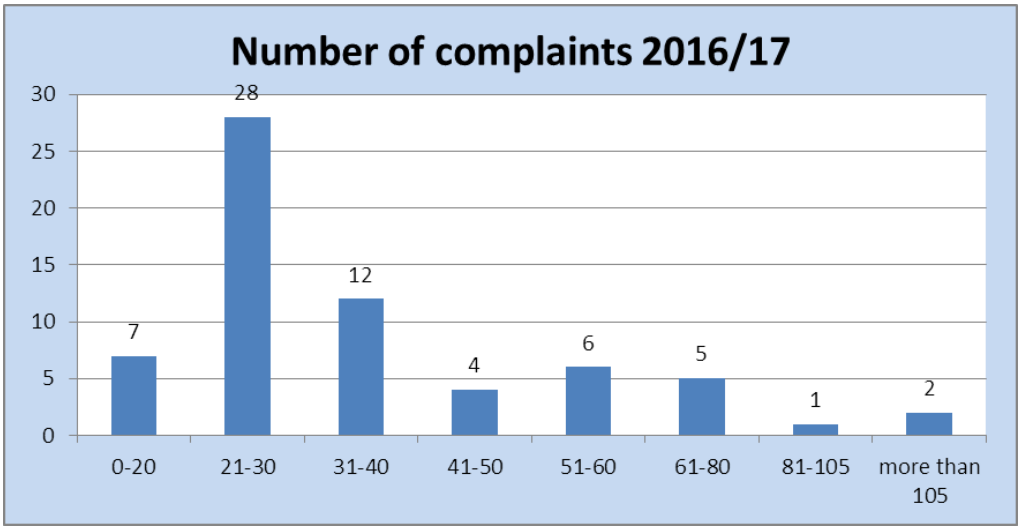


Table 2 - length of time the formal response has taken

All complainants are offered the opportunity to attend a meeting to resolve their concerns or 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.

It should be noted that 16% of the complaints received were investigated and responded to within the Trust's timeframe of 25 working days and no extension was required. 16% where responded to in under 30 days.

Learning from complaints

Actions taken as a result of complaints during this period:

- Improved communication relating to Advance care planning to ensure families understand the purpose of the document and its use as a guideline to assist Clinicians when assessing their child.
- Issues relating to cancellations of outpatient clinics and letters not being received – a full review looking into outpatients as a service is now underway with outcomes expected to enhance the future visits for families.
- Issue relating to access to an interpreter when child was admitted as an emergency – approval by Executives to proceed with the purchase of a new system for booking interpreters within the Emergency department to meet the needs of children and their parents who require this service.

Stakeholder Relations

Involvement in the Local Health Economy

Alder Hey is committed to building greater collaboration and developing shared models of care with a wide range of strategic partners. In order to achieve this, the Trust has continued to work proactively with local regional and national stakeholders. The focus during 2016/17 has been to strengthen existing partnerships and develop new ones to achieve the following aims:

- Develop greater partnership working with trusts across Cheshire and Merseyside in order to sustain and improve the quality of care provided to children and young people and their families
- Increase the number of regional collaborative agreements to gain efficiencies to improve quality and access and to maintain the national sustainability of certain specialist services

Key relationships are outlined in the table below:

Key Partner(s) & Purpose	Programme
Liverpool Women's NHS Foundation Trust (LWH) **Purpose** Compliance to NHS England (NHSE) Neonatal Service Specifications	The NHSE Neonatal Operational Delivery Network (ODN) in March 2017 endorsed a two site single service model for neonates requiring surgery and level 3 Critical Care. Alder Hey and LWH have been working in partnership to develop and deliver this joint model of care that will streamline patient transfers and improve quality of care, outcomes and patient experience. Work is now underway to implement this new model of care.
Congenital Heart Diseases (CHD) North West Service Liverpool Partnership: Liverpool Heart and Chest NHS Foundation Trust Royal Liverpool and Broadgreen University Hospital Liverpool Women's NHS Foundation Trust **Purpose** Compliance with NHS England national Standards specification	Alder Hey has worked with partners in Liverpool to form a North West CHD Partnership and has submitted a bid to provide a fully compliant, resilient and clinically safe service model for adults and children across the North West of England, North Wales and the Isle of Man. NHS England have stated they are mindful to accept the North West CHD Partnership model pending the outcome of the public consultation on national configuration which is expected to conclude in the summer of 2017. The phased implementation of this service will commence soon as commissioning arrangements are finalised.
Liverpool Local Delivery System (LDS) Children's Transformation Board: Liverpool Clinical Commissioning Group (LCCG), Liverpool City Council, Liverpool Women's NHS Foundation Trust, Liverpool Community Health Trust **Purpose** Transforming Children's Community Services	Alder Hey co-chairs the Children's Transformation Board with Liverpool CCG to lead the development of an integrated model for children's care in the community. Work has progressed to build an integrated community model across the city to improve patients experience for children and their families to ensure the future sustainability of services. A number of integrated pathways have been developed and implemented already to improve patient care and experience.
Cheshire and Merseyside Women's and Children's Service Partnership Vanguard: All providers and commissioners of children's	As one of the seven cross cutting work-streams of the Cheshire and Merseyside 5 year forward plan Alder Hey is playing a leading role in developing a model for children's services. An options appraisal process to develop the future configuration of the Women's and Children's services across the region to achieve better

services across C&M **Purpose** Building a sustainable model of care and improving clinical care, access and affordability	health, care and value for staff and local communities.

International Partnerships

Alder Hey has been very active internationally for some time with wide ranging links and partnerships with lower and middle income countries, the hosting of clinicians from overseas in observerships or training programmes and research activities. The Trust works in partnerships with many other organisations and charities including Liverpool University and Liverpool School of Tropical Medicine and the Royal College of Paediatrics and Child Health (RCPCH).

Following the opening of the new 'Alder Hey in the Park', we have engaged in more proactive and commercial business development. Our first commercial partnership agreement was signed with Al Jalila Specialist Children's Hospital in Dubai in 2016. Together Alder Hey and Al Jalila will aim to deliver the highest quality care in outstanding facilities, with continuous improvements made through medical education, innovation, and clinical research prominent in both institutions.

Having recently opened 'Alder Hey in the Park', the Trust will be able to provide guidance to Al Jalila to meet the challenges often faced when opening a new hospital. Children requiring very specialised treatments not currently available in the UAE, such as complex neurosurgery and neuro-oncology, will now also benefit from being able to access those treatments at Alder Hey in a seamless manner. Furthermore, as part of this collaboration, Al Jalila will aim to establish dedicated education programmes for health professionals, providing valuable training that will develop the next generation of paediatric specialists and services in the UAE. Alder Hey will also have access to a variety of patients with rare diseases which will support vital research, thus creating the potential for future joint treatment programmes.

The Trust continues to build its international portfolio and is in discussions with a number of providers in China about consultancy support for the design, build, equipping and commissioning of new hospital facilities. Partnerships with other hospitals in low and middle income countries continue to be explored, either enabling international patients to be treated at Alder Hey or creating opportunity for the Trust to assist local teams through remote consultations and diagnosis. This has included close work with Kanti Hospital in Nepal, the University of Malawi College of Medicine and Queen Elizabeth Central Hospital in Blantyre, Malawi.

Other international activity during 2016/17 has focused on the provision of paediatric education and training to overseas partners e.g. Sony Europe have become a key partner in research and innovation.

International collaboration is still relatively new to Alder Hey and the Trust recognises that a proactive business development approach is needed to fully benefit from overseas opportunities. The Trust has established an International Liaison Team to work with overseas partners in the following areas:

***Education and Training*:** Alder Hey has particular expertise in paediatric medical and nurse training and can offer a range of standard and bespoke packages.

***Infrastructure for Health*:** Alder Hey can provide expert support for the feasibility assessment, design and clinical modelling of safe, high quality paediatric facilities. This service can be scalable according to the client and the brief, and could range from an entire hospital build to a small theatre or out-patient extension.

***Clinical Services*:** Alder Hey clinical teams can treat patients at our hospital in the UK or in their home country. We can also provide remote clinical support and patient management using digital technology. Patients can be referred to specialist clinicians at Alder Hey for neurosurgery (Selective Dorsal Rhizotomy), neuro-oncology, specialist paediatric surgery, plastic surgery (particularly laser surgery port wine), rheumatology (particularly Lupus), gait analysis and neurology (outpatient only).

***Health Systems Development*:** Alder Hey can provide professional support in establishing the governance and clinical management processes for the delivery of complex health services, to ensure clinical safety and quality requirements are implemented and maintained.

Alder Hey in the Park

Alder Hey is the first paediatric hospital in Europe to be built in a park. This gives us a once-in-a-lifetime chance to capitalise on our natural environment and harness the opportunities this gives us to empower our local community to interact with nature to improve their health, wellbeing, quality of life and provide opportunities for lifelong learning. Alder Hey aim to inspire healthcare providers across the world to change behaviours and offer new solutions for healthy cities.

The Springfield Park development project aims to create an exciting, innovative, inclusive, sustainable destination greenspace for Liverpool fostering health and wellbeing for generations to come.

Our vision for a new Springfield Park has been directly developed in response to feedback from a community consultation event carried out in 2015 and is therefore a park for the community designed by the community. It has been developed around four key themes of 'Events', 'Innovative play' 'Sport for all' and 'Grow your own'. The new park will offer an improved environment that is innovative, vibrant and safe and is a valuable community asset that will attract usage from a wide catchment area. Work has started already with events and developments responding to the overarching themes taking place.

Woodland walk and Forest School initiative

Work has started on the development of the woodland area in Springfield Park to offer the local community access to a rich multi-sensory nature experience and restorative environment that delivers physical and mental health benefits. An interactive interpretation trail is being created in partnership with local schools providing information on the species

throughout the woodland walk meaning visitors can learn about the environment as they walk. A new path accessible to wheelchair and pram users is being installed to allow inclusive access to the area.

In partnership with Lancashire Wildlife Trust (a registered charity dedicated to protecting wildlife and natural habitats throughout Lancashire, Manchester and North Merseyside), a Forest School area has been built in the woodland. The Forest Schools initiative will commence in May 2017, where local primary schools will be trained to become Forest School leaders using the brand new Springfield Park site as the venue. Forest Schools develop social and emotional intelligence, confidence, practical and creative skills and team building. These skills and benefits transfer to the classroom environment with a positive effect on learning overall. The Forest School initiative will form the basis of the park education programme and resources.
Liverpool is one of 5 local authorities with the highest proportions of neighbourhoods among the most deprived in England[i]; The Forest Walk and school will link with the local community and schools and increase the number of children from low-income families that engage with and benefit from this urban wild space.

Grow Your Own
The woodland area also marks the start of our edible planting scheme. Following the model of 'Incredible Edible' Todmorden in Yorkshire, we will bridge the disconnection between people and nature by promoting the importance of the environment, local food and soil, fostering healthy futures for generations to come. We will empower our community to reconnect with their landscape and food sources. We will also work with AHCH's Food Advisory Board and chefs to use organic food grown on-site in patient meals, reducing food mileage and ensuring our patients have a healthy diet promoting recovery. Recipes will be available for the public.

We will further develop community growing areas throughout Springfield Park where the local community, patients and staff can plant and grow food. Environmental specialists and artists will design and deliver horticultural courses, social events and information trails, where people can relax, learn about sustainable living and improve their health and wellbeing through taking part in physical exercise outdoors.

Events
A number of successful events have taken place this year in the park including a Hackathon, bringing companies and individuals together from the health, digital, environmental and cultural sectors to generate innovative solutions to children's health issues, an arts and craft fair and a community Bluebell wood planting project involving local schools.

We have also recently formed a brand new partnership with the Woodland Trust and are pleased to announce Springfield Park has been chosen as one of the sites for a Tree Charter Marker sculpture – one of 10 that will be installed in sites around the UK as a national monument to mark the launch of the Charter for Trees, Woods and People in November.

Each pole represents one of the principles underpinning the new charter, which will guide society towards a future in which trees and people stand stronger together. The sculpture will be made made from UK-sourced oak from the Crown Estate, and is the only one in England with carvings and commissioned poetry to specifically represent the importance of trees to health and wellbeing.

This national monument will serve as a legacy in the landscape for the Tree Charter, ensuring it and the Principles that underpin it remain in public consciousness. It will also highlight the work Alder Hey are doing to promote health and wellbeing through connection with the natural environment.

All of the work carried out this year has been underpinned by a programme of key community and stakeholder engagement.

The Alder Hey Children's Charity

Following a successful appeal for the new hospital which saw Alder Hey Charity raising over £25million toward lifesaving medical equipment, enhanced facilities for parents and patients and entertainment for children in waiting areas and on wards, the Charity raised a further £5million in the financial year 2016/2017.

The campaign to support the development of the Institute in the Park, Alder Hey's bespoke research facility, continued with the Charity raising just over £2.5million of the £6million total appeal.

In a challenging regulatory environment, the Charity continues to broaden its fundraising bases to maximize income. Activities cover: individual philanthropy, corporate partnerships and support, community fundraising (including running and challenge events, bespoke fundraising events e.g. Alternative Ascot and schools fundraising), trust & foundation fundraising, community lottery, legacy gifts, trading of merchandise and brand licensing.

The Charity continues to increase its strong community fundraising base, particularly throughout the North West. Income through sponsored events came in at over £650,000. Our own bespoke events are all now well established and continue to be successful, grossing over £250,000. We will be looking to expand our event portfolio in 2017/18 with an additional bespoke Hoe-Down and also by entering into partnership with Sports Tours International and holding our own Alder Hey 10K.

Lottery membership continues to grow steadily and is particularly successful where canvassers work from within the hospital. Attrition rate has fallen and membership is now over 15,000.

We now have 22 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.

We have recruited a new member of staff to work within the community team who will be looking into areas of potential growth including schools fundraising, in memory giving and voluntary groups/ambassadors.

Our corporate fundraising continues to make significant impact at Alder Hey not only through financial donations but also through the sharing of expertise and knowledge.

In September 2015, the 4,700-strong team at Shop Direct voted for Alder Hey Children's Charity as its charitable partner of the year for 2015/16. Since then, colleagues across the e-

tail giant's sites in Liverpool and Manchester have undertaken a variety of fundraising activities, from climbing mountains, singing, running, cycling, abseiling, playing 'beat the goalie' and completing their own version of The Biggest Loser, smashing their initial target of £200,000.

Members of Shop Direct's multi-award winning ecommerce team have also been working with Alder Hey's innovation team to develop the app – the first of its kind in the country – providing expert insight and advice on design, development and personalisation. The shared vision of the Alder Hey and Shop Direct teams is to revolutionise the patient experience by harnessing the power of consumer technology to help patients be better informed, calmer, more entertained and, as a result, healthier.

Matalan unveiled this year's exciting Christmas campaign for the third year running. The highly anticipated 'Get Your Stripes' campaign built on the retailer's previous Christmas fundraising appeals, Alphabet Scarves and Beanie vs Bobble, which raised more than £1.3m combined and was backed by celebrities including Justin Bieber and Britney Spears. The money raised went towards the development of the hospital's new state-of-the-art research Institute.

Our international links continue to develop through the support of the I.T.T. which is one of the largest trade sectors in the UK. Members must have at least five years' experience in the travel and tourism industry or hold one of the following positions; CEO; Chairman; Director or Owner. To-date this membership organization has raised over £1.5m through member activities and individual giving. We continue to work with this global group to secure both income and Strategic Partnerships.

Liverpool John Lennon Airport continue their support of Alder Hey through their pledge of £200,000 to support the next phase of our digital app development. The Airport has also given significant time and expertise in assisting the hospital improve its signage and patient check-in process to improve how patients get to their outpatient appointment. In addition, the sharing of cross-sector knowledge was taken further when theatre staff were given the opportunity to attend Human Factors training courses in March this year with the Air Traffic Control team.

Looking to 2017/18, the Charity will continue its appeal to support the development of Alder Hey's research, education and innovation Centre, the Institute in the Park, while also developing the digital App and supporting projects to enhance the patient experience while in the hospital.

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.

A strategic decision was made three years ago to hold the levels of Executive Director remuneration until such time that a number of achievements had been realised, most notably the safe move into the new hospital site, the implementation of the new electronic patient record and a successful CQC inspection, despite Executive Director salary levels at Alder Hey falling below national average benchmark salaries.

The economic imperative to restrict salary increases needs however, to be balanced with the operational requirement to successfully recruit, retain and fairly reward a high performing Executive Team focused on the successful delivery of the Alder Hey strategic vision. Therefore, in response to these achievements, a review was undertaken during 2016 to benchmark the existing Executive Directors' salaries with the sector, with a view to recognizing and rewarding the significant progress that has been made.

The Committee's focus was also upon succession planning and arrangements for Executive Director vacancies. The Committee received 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.

The Chief Executive and Executive Directors are employed on permanent contracts of employment; they are entitled to receive three months' notice and may give six months' notice. Provision is included within contracts of employment for contracts to be terminated with immediate effect and without compensation in certain circumstances. In accordance with the Trust's policy on senior managers' remuneration, 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. Executive directors are not permitted to serve as directors elsewhere in accordance with the Trust's Constitution.

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 comparative organisations. Remuneration rates for Non-Executive Directors have remained at the level set by the Nominations Committee in 2009/10.

During 2016/17 there was a total of 14 voting Board Directors in post across the period. Of these, nine individuals claimed £10,498 in expenses; for 2015/16 the figures were 14 directors claiming £9,891.62 in expenses. In the year there were 27 governors in office, seven of whom received £3,310.36 in expenses; whereas in 2015/16 six governors claimed £1,552.30.

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 2.32 and paragraphs 2.48 to 2.52), 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.

The remuneration of the median salary and multiple to the highest paid employee of the Trust for 2016/17 and the prior year comparative is provided below:

	2016/17	**2015/16**
Band of highest paid director (bands of £5,000)	£155-160	£145-150
Median total remuneration	£30,547	£27,357
Ratio	5.2	5.4

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
25th May 2017

Salary and pension entitlements of senior managers

Total Remuneration

		A	B	E	Total				
Name	**Title**	**2016/2017**				**2015/2016**			
		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	155-160	2,540	150-152.5	310-315	145-150	8200	22.5-25	165-170
Jonathan Stephens	Director of Finance	90-95	0	70-72.5	160-165	115-120	0	2.5-5	120-125
Claire Liddy	Acting Director of Finance	20-25	0	7.5-10	30-35	0	0	0	0
Gill Core	Director of Nursing	15-20	0	2.5-5	15-20	95-100	0	7.5-10	105-110
Hilda Gwilliams	Director of Nursing	75-80	0	110-112.5	185-190	20-25	0	7.5-10	30-35
Richard Turnock	Medical Director	85-90	0	0	85-90	85-90	0	0	85-90
Melissa Swindell	Director of Human Resources	90-95	0	75-77.5	165-170	40-45	0	32.5-35	70-75
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	10-15	0	0	10-15
Dame Jo Williams	Non-Executive Director (R)	5-10	0	0	5-10	0	0	0	0
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 (R)(A)	10-15	0	0	10-15	10-15	0	0	10-15
Anita Marsland	Non-Executive Director (R)(A)	10-15	0	0	10-15	10-15	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

- Jonathan Stephens, Director of Finance - left employment 8th January 2017
- Claire Liddy, Acting Director of Finance - commenced in Acting role 9th January 2017
- Gill Core, Chief Nurse - left employment 1st June 2016
- Hilda Gwilliams became Chief Nurse in June 2016
- Judith Adams, Chief Operating Officer - left the Trust 5th April 2016
- Rick Turnock does not have accrued pension or CETV as at 31 March 2017 his pension is in payment
- Jo Williams, Non-executive Director - joined the Trust 1st November 2016

The above table follows the guidance for 'Disclosure of Senior Managers' Remuneration (Greenbury) 2017 (NHS BSA)'. The Pension related benefits (bands of £2,500) are a notional figure to denote forecast Annual Pension payments (subject to a x20 multiplier) and lump sum. This is the aggregate input amounts, calculated using the method set out in section 229 of the Finance Act 2004. This figure will include those benefits accruing to senior managers from their membership of the 1995/2008 Scheme and 2015 Scheme. Any pension contributions made by the senior manager or any transferred in amounts are excluded from this figure. The amount to be included here is the annual increase (expressed in £2,500 bands) in pension entitlement.

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 2017 (bands of £5,000) £000s	Lump sum at age 60 related to pension at 31 March 2017 (bands of £5,000) £000s	Cash Equivalent Transfer Value at 1 April 2016 £000s	Real Increase in Cash Equivalent Transfer Value £000s	Cash Equivalent Transfer Value at 31 March 2017 £000s	Employer's contribution to stakeholder pension £000s
Louise Shepherd Chief Executive	7.5-10	22.5-25	55-60	175-180	935	205	1,140	0
Jonathan Stephens Director of Finance	0-2.5	2.5-5	50-55	150-155	858	39	908	0
Judith Adams Chief Operating Officer	0-2.5	0-2.5	25-30	70-75	410	0	423	0
Gill Core Chief Nurse	0-2.5	0-2.5	45-50	135-140	904	5	934	0
Claire Liddy Acting Director of Finance	2.5-5	2.5-5	15-20	40-45	186	14	200	0
Melissa Swindell Director of Human Resources	2.5-5	5-7.5	15-20	40-45	186	55	241	0
Hilda Gwilliams Acting Chief Nurse	5-7.5	15-17.5	30-35	95-100	507	145	652	0

- As Non-Executive Directors do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive Directors.
- Jonathan Stephens, Director of Finance - left employment 8th January 2017
- Claire Liddy, Acting Director of Finance - commenced in Acting role 9th January 2017
- Gill Core, Chief Nurse - left employment 1st June 2016
- Hilda Gwilliams became Chief Nurse in June 2016
- Judith Adams, Chief Operating Officer - left the Trust 5th April 2016
- Rick Turnock does not have accrued pension or CETV as at 31 March 2017 his pension is in payment

Staff Report

Analysis of Trust staff during the year is set out in the table below, together with a comparison with 2015/16:

Note 4.2 Average number of employees (WTE basis)	2016/17 Total Number	2016/17 Permanent Number	2016/17 Other Number	2015/16 Total Number	2015/16 Permanent Number	2015/16 Other Number
Medical and dental	**391**	390	1	**375**	371	4
Ambulance staff	**0**			**0**		
Administration and estates	**648**	588	60	**595**	568	27
Healthcare assistants and other support staff	**224**	208	16	**240**	161	79
Nursing, midwifery and health visiting staff	**1,174**	1,105	69	**1,122**	1,112	10
Nursing, midwifery and health visiting learners	**0**			**0**		
Scientific, therapeutic and technical staff	**540**	533	7	**541**	538	3
Healthcare science staff	**0**			**0**		
Social care staff	**0**			**0**		
Agency and contract staff	**0**			**0**		
Bank staff	**0**			**0**		
Other	**0**			**0**		
Total average numbers	**2,977**	**2,824**	**153**	**2,873**	**2,750**	**123**
Of which						
Number of employees (WTE) engaged on capital projects	**35**	35		**20**	20	

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

	Male	Female
Directors	5	10
Senior Managers	5	3
Employees	524	2624

Sickness absence data

The Trust closely monitors its performance against sickness absence targets and the position as at the end of March 2017 was 4.7%.

Staff Policies and Actions

Disability Symbol Employer

The disability symbol is a recognition given by Jobcentre Plus to employers based in Great Britain who have agreed to take action to meet five commitments regarding the employment, retention, training and career development of disabled employees. These commitments are:

1. To interview all disabled applicants who meet the minimum essential criteria for a job vacancy and consider them on their abilities

2. To ensure there is a mechanism in place to discuss, at any time, but at least once a year, with disabled employees what can be done to make sure they can develop and use their abilities

3. To make every effort when employees become disabled to make sure they stay in employment

4. To take action to ensure that all employees develop the appropriate level of disability awareness needed to make these commitments work

5. To each year review the five commitments and what has been achieved, plan ways to improve on them and let employees and Jobcentre Plus know about progress and future plans

By using the symbol we are making it clear to disabled people that we welcome applications from them and that we are positive about their abilities. It will also show existing employees that we value their contribution and will treat them fairly if they become disabled. We provide employees with ongoing access to Occupational Health support and advice, Access to Work support, and health and safety advice, including bespoke risk assessments.

Communication

Internal communication within the Trust has benefitted greatly from the *Listening into Action* process adopted early in 2016 at Alder Hey. The focus on engagement through open events (Big Conversations), surveys (Pulse Checks) and action groups for specific issues (Clinical Teams) has allowed the Trust to better gather and use intelligence from our staff.

The move into the new hospital building opened up opportunities to communicate to staff in novel ways, specifically through the numerous digital screens located throughout the building. Via a central system it has been possible to target tailored messages through specific screens in support of a number of information and campaign aims, including the annual influenza campaign and our ongoing *Inspiring Quality* Programme. These screens have also been useful in allowing the Trust to present information directly to families and patients in the Atrium and in waiting areas, including welcome messages, smoking information, signage and wayfinding and public broadcast campaigns from partners such as Liverpool Clinical Commissioning Group and RCPCH.

A review of the monthly Trust-wide ‘Team Brief’ has created a more engaging and accessible event for staff. This has proven useful in boosting both attendance and subsequent cascade to departments and teams. Communication between staff has been further facilitated through a new Staff Directory, published in November.

In 2016 it became apparent that the current Staff Intranet was no longer fit for purpose. It was also noted that the external Website needed a review and refresh to

maintain accessibility and accuracy. A project has been launched to redevelop both the Intranet and Website into one integrated 'Extranet', which will allow staff to access Trust information remotely in a seamless and secure fashion. The new sites are set to be launched in 2017.

Since moving into the new hospital, the Trust has benefitted from a number of external opportunities to raise awareness nationally of the Alder Hey brand. Between January 2016 and January 2017, coverage of Alder Hey Children's Hospital and Alder Hey Children's Charity reached 1,529,538,584 people in print, online and broadcast media outlets. The Trust continues to grow its social media following (almost 50,000 Facebook followers and almost 30,000 on Twitter) and the hospital website remains our most important digital communications asset, receiving 50,000-70,000 visits a month.

Over the last 12 months, the focus externally has switched to building Alder Hey's reputation in innovation, research and specialist paediatric care. The new Alder Hey in the Park campus, with its Research Institute and Innovation Hub facilities, has increased the hospital profile which has never been more positive. Alongside developments in research and innovation, we now have the perfect platform for exciting opportunities in PR/marketing and partnership working.

Joint collaboration with key partners has been key to securing national media coverage. CBBC returned to Alder Hey to film another series of BAFTA winning children's series *Operation Ouch!* which was broadcast in Autumn 2016. We also welcomed Children's BBC to Alder Hey at Christmas for a full day live broadcast across CBeebies, CBBC and BBC Interactive. A Christmas fundraising campaign with retailer Matalan generated coverage in several consumer publications, a campaign with Everton Football Club secured coverage in national print and sports publications while our partnerships with Sony and IBM Watson have helped to generate coverage across national and international publications.

Compelling content remains integral to our strategy and we continue to target the North West region through patient stories. However to gain wider coverage we recognise the need to focus on areas of interest to the UK as a whole. Ground-breaking research, innovation or equipment taking place at Alder Hey will provide further opportunity to develop and maintain our national profile.

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 2016/17. 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.

Health and Safety Performance and Occupational Health

During the year the Health and Safety Team continued to develop the systems and processes required for the organisation to maintain compliance with core functions as well as support staff to adapt to the new hospital environment. This included the recruitment of a manual handling trainer to support the drive to achieve compliance with practical manual handling training Trust-wide. The Health and Safety Team has a programme of training scheduled for 2017/18, which will cover risk assessment, COSHH and stress risk assessment training. In addition, the team is also supporting the building development projects on site, together with the demolition of the old hospital.

We continue to work successfully in partnership with our Occupational Health provider, Team Prevent, to offer a range of supportive interventions for staff. We have seen benefits from the introduction of the early intervention service which provides rapid treatment for staff encountering stress and musculo-skeletal conditions. In the coming year, the Trust will be piloting the services of a health trainer who will focus on mental wellbeing and training for managers.

Expenditure on Consultancy

Expenditure on consultancy in 2016/17 was for specialist advice and operational delivery on an interim basis to ensure safe services for children and families, whilst a new divisional, clinically-led management model was established.

Off Payroll Engagements

The Trust has continued with its policy to use off-payroll arrangements only in circumstances where the skills market is limited in providing the level of expertise and availability required to fulfil a particular role or provide professional advice.

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 2017, for more than £220 per day and that last longer than 6 months

No.of existing engagements as at 31 March 2016		13
of which		
	No. that have existed for less than 1 year at time of reporting	5
	No. that have existed for between 1 and 2 years at time of reporting	4
	No. that have existed for between 2 and 3 years at time of reporting	1
	No. that have existed for between 3 and 4 years at time of reporting	1
	No. that have existed for 4 or more years at time of reporting	2

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 2016 and 31 March 2017, 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		7
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		7
No. for whom assurance has been requested		7
of which		
	No. for whom assurance has been received	7
	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 2016 and 31 March 2017.

No. of off-payroll engagements of board members, and/or senior officials with significant financial responsibility, during the financial year	3
No. of individuals that have been deemed "board members and/or senior officials with significant financial responsibility" during the financial year.	30

Exit Packages

Reporting of compensation schemes - exit packages 2016/17

	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	-	5	**5**
£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		**6**	**6**
Total resource cost (£)		£125,000	**£125,000**

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 (£)	£7,000	£29,000	**£36,000**

Exit packages: other (non-compulsory) departure payments

	2016/17		2015/16	
	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	4	89	1	29
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	2	36	-	-
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT approval	-	-	-	-
Total	**6**	**125**	**1**	**29**

Staff Survey

Staff engagement

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

In addition to the Staff Survey, throughout 2016 we have continued to administer a monthly questionnaire, the 'Temperature Check', to measure staff engagement which includes the 'Staff Friends and Family' questions. Sharing feedback with staff remains a key priority, and we have an ongoing feedback campaign throughout the year to ensure staff are kept informed about progress against key actions.

In 2016, we signed up to *Listening into Action* (LiA), a key enabler for improving both patient experience and staff engagement. Over 30 clinical teams have engaged with LiA over the course of the year to make improvements in their local areas, and it has been welcomed by staff as a way to help them unblock issues and take ownership of making changes in their local areas. We have committed to continuing this journey with staff in 2017.

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 2015 and 2016.

The Trust response rate was 39%, below the overall national response rate for all organisations in England of 44%, but higher that in 2015.

Areas of improvement

The Trust has seen overall improvements in staff appraisal rates; less staff reporting feeling unwell as a result of work related stress; improved satisfaction rates with resourcing and support, and improved satisfaction rates with the quality of work and care they are able to deliver.

Top ranking scores and progress since 2015

The top ranking scores in 2016 reflect how the Trust has supported staff with improved incident reporting, work-life balance, bullying and harassment and discrimination.

The positive actions taken by the Trust regarding discrimination and bullying and harassment can be demonstrated by the responses for KF20, KF 23 and KF 26, which have been identified as three of our top ranking scores. One of our top ranking scores for the second year (KF 29) is a positive indicator of staff actively reporting incidents and supporting a safety culture. KF16 (% of staff working extra hours) has also been identified as one of our top ranking scores for a second year.

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). Two of the Key Findings are new for 2015, KF 21 (%of staff believing that the organization provides equal opportunities for career progression or promotion) and KF32 (Effective use of patient/service user feedback).

As in 2015, we surveyed all staff in 2016, so we have been able to break down the results by department. Each department has been provided with their own survey data and are all undertaking a local 'LiA style' conversation with teams in order for them to identify their top areas for local improvement.

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:

- Supporting leadership and management development
- Specific focus on accelerating staff communication and engagement
- Taking steps to improve staff wellbeing

These actions, amongst others to improve communications and engagement, have been identified as a specific project on the Trust's Change Programme for 2017/18, and will be monitored via the Trust Workforce and OD sub-committee of the Board.

Future priorities and targets

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 2017
- Ensure continued engagement with staff side representatives
- Encourage local ownership for survey outcomes, especially at department level
- Change to quarterly ‘all staff’ ‘Temperature Checks’ and monitor progress and trends Trust wide and locally.
- Monitor performance regularly at the Board, Workforce and Organisational Development Committee and Divisional Performance Boards.

Table 1- Summary of Performance - Results from the NHS staff survey 2015 and 2016

	2015		2016		Trust Improvement/ Deterioration since 2015
Response Rate	**Trust**	**National Average**	**Trust**	**National Average**	
	35%	45%	39%	44%	Increase of 4%
	2015 %		**2016 %**		**Trust Improvement/ Deterioration since 2015**
Top 5 ranking Scores (2016)	**Trust**	**National Average**	**Trust**	**National Average**	
KF16. Percentage of staff working extra hours	70%	75%	69%	74%	Decrease of 1% (improvement)
KF20. Percentage of staff experiencing discrimination at work in last 12 months	8%	8%	8%	9%	No movement
KF24. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	24%	23%	24%	25%	No movement
KF23. Percentage of staff experiencing physical violence from staff in last 12 months	1%	1%	1%	2%	No movement
KF29. Percentage of staff reporting errors, near misses or incidents witnessed in the last month	93%	92%	96%	92%	Increase of 3% (improvement)
	2015 %		**2016 %**		**Trust Improvement/ Deterioration since 2015**
Bottom 5 ranking Scores (2016)	**Trust**	**National Average**	**Trust**	**National Average**	
KF21. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	82%	88%	81%	86%	Decrease of 1% (deterioration)
KF3. Percentage of staff agreeing that their role makes a difference to patients / service users	86%	92%	87%	92%	Increase of 1% (improvement)
KF19. Organisation and management interest in and action on health and wellbeing	3.34	3.72	3.39	3.71	Increase of 0.5 (improvement)
KF4. Staff Motivation at work	3.72	3.98	3.76	3.98	Increase of 0.4 (improvement)
KF32. Effective use of patient/service user feedback	3.45	3.80	3.46	3.81	Increase of 0.1 (improvement)

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/NHS Improvement 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

2016/17 again saw a number of changes on the Council of Governors following the annual elections. The Governors' Induction programme was reviewed with the assistance of a small group of longer–serving members of the Council to ensure that the content remains relevant and set out in a clear and concise manner, to enable incoming governors to understand their new role as rapidly as possible. A number of Alder Hey governors also took advantage of the ongoing development programme offered by NHS Providers, which is an invaluable resource.

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 at topic basied workshops/joint awaydays, one of which was held in June 2016, providing an opportunity for governors to discuss key strategies with Board members in a more interactive setting. The topics for the day included, the Quality Strategy, Park development, the People Strategy and financial plans. There was also an opportunity to brief the governors on the emerging Sustainability and Transformation Plans and discuss the potential implications for children's services.

The Council met formally six times during the year; one of the meetings was held to appoint the Trust's external auditors following a full tender process. 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 2016 Annual Members' Meeting was held in November at the Trust's Innovation Hub, with keynote speaker Mr Rafael Guerrero, Consultant Congenital Cardiac Surgeon and one of the Trust's clinical leaders in innovation. The title of his inspiring talk was *'To be the best or to be the best…there is no question'* which was followed by an opportunity for attendees to explore some of the leading edge technology being tested by the Trust's innovation team including a virtual reality heart which is being used to plan cardiac surgery for children.

The Council appointed one new Non-Executive Director during the year – Dame Jo Williams – with candidates having been subject to a rigorous selection process, including a focus group with members of Alder Hey's Children and Young Peoples' Forum. In addition, two of the existing Non-Executives were re-appointed for a second term, whilst the Council took the decision to exercise its authority under the provisions of the Code of Governance to extend the appointments of both the Chairman and the Senior Independent Director for a further 12 month period in order to ensure stability and continuity on the Board, given changes taking place among the Executive Directors during the year. 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.

The Lead Governor continued to hold regular meetings with the governors without members of the Board present; these discussions now generate items for discussion at formal Council meetings to provide governors with additional assurance on key topics such as nurse staffing and the plans for the development of Springfield Park.

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. Key activities in the year included:

- ✓ Acting as Editorial Board for the members' newsletter supported by members of the Communications and Marketing team
- ✓ Appointing an intern from the University of Liverpool Business School to undertake a major project to update the mechanisms for communicating with members to reflect technological developments and the preferences of our demographic profile
- ✓ Public health, with a continued emphasis on smoking issues in families
- ✓ Patient experience, through developing links with members of the Children and Young Peoples' Forum
- ✓ Planning and organisation of the Annual Members' meeting
- ✓ 'Critical friend' role in reviewing and commenting on the Quality Report

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 Lead Governor, Kate Jackson who was elected to this role in October 2014 and which has continued throughout 2016/17. 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 2016/17	Total no. of attendances at Council meetings
Barbara Murray**	Appointed	Liverpool City Council	n/a	5	4
Sarah O'Brien	Appointed	University of Liverpool	n/a	2	2
Janice Monaghan	Appointed	The Back Up Trust	n/a	5	0
Julie Williams	Appointed	Edge Hill University	n/a		3
Colette O'Brien	Appointed	Liverpool City Council	n/a	5	1
Dawn Holdman	Patient	Parent & Carer	17.09.15 - 16.09.18	5	4
Georgina Tang	Patient	Parent & Carer	26.09.16 – 31.08-19	2	1
Dot Brannigan	Patient	Parent &Carer	26.09.16 – 31.08-19	5	5
Pippa Hunter-Jones	Patient	Parent & Carer	01.06.14 – 31.05.17	5	5
Claire Blanchard	Patient	Parent & Carer	01.09.14 – 31.08.17	3	0
Vacant	Patient	Patient & Carer	01.03.16 – 28.03.19	1	1
Alice Matthews	Patient	Merseyside	26.09.16 – 31.08-19	2	0
Niamh Rose McCann	Patient	Merseyside	26.09.16 – 31.08-19	1	1
Lydia Brady	Patient	Merseyside	01.09.15 31.0818	5	2
Oliva Cole	Patient	Rest of England & North Wales	17.09.15 – 16.09.18	5	2
Rabia Aftab	Patient	Rest of England & North Wales	26.09.16 – 31.08-19	2	1
Naomi Grannell	Public	Cheshire	01.06.14 – 31.05.17	5	1

Governor	Constituency	Class	Term of Office	Council Meetings eligible to attend in 2016/17	Total no. of attendances at Council meetings
Paul Denny	Public	Merseyside	01.09.14 – 31.08.17	5	4
Cath Gorst	Public	Merseyside	17.09.15 – 31.08.17	5	
Norma Gilbert	Public	Merseyside	01.08.10 – 31.07.16	1	1
Hilary Peel	Public	Merseyside	26.09.16 – 31.08-19	5	4
Mark Peers	Public	Merseyside	26.09.16 – 31.08-19	2	2
Kate Jackson**	Public	Greater Manchester	01.06.14 – 30.05.17	5	5
VACANT	Public	Cumbria & Lancashire	n/a	n/a	n/a
Matthew Jones	Staff	Doctors and Dentists	25.09.15 – 24.09.18	5	5
Tony Hanmer	Staff	Other Staff	26.09.16 – 31.08-19	5	5
Jeanette** Chamberlain	Staff	Other Staff	01.09.14 – 31.08.17	5	4
Adrian Williams	Staff	Nurses	26.09.16 – 31.08-19	2	1
VACANT	Staff	Other Clinical Staff	n/a	n/a	n/a
Elizabeth Grady	Staff	Nurses	01.06.14 – 31.05.17	5	4

** Members of the Nominations Committee

Attendance at Council of Governors by Board members	Number of meetings held in 2016/17
	5
Sir David Henshaw	4
Ian Quinlan	2
Steve Igoe	4
Anita Marsland	5
Claire Dove	4
Jeannie France-Hayhurst	1
Louise Shepherd	4
Margaret Barnaby	5
Jonathan Stephens	2
Melissa Swindell	5
Rick Turnock	2
Hilda Gwilliams	2
Erica Saunders	5
David Powell	3
Louise Dunn	5
Jo Williams	1
Debbie Herring	1

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 remained in place during the year and its implementation is owned and led by a committee of the Council of Governors called the Membership Strategy Committee. During 2016/17 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 Membership Strategy Committee is supported by the Trust's Communications Team and works to an agreed set of objectives created to reflect the overall aims of the Membership Strategy. The objectives for 2016/17 were a consolidation of work commenced in the previous year, given the ongoing nature of the governors' role around communication.

- **Newsletter** - to continue on a quarterly basis.
- **Member Communications** – this was a major focus in the year. The Trust recruited to a 12 month internship role in partnership with the Management School at the University of Liverpool, the aim of which was to cleanse and update the membership database, populate a greater number of email addresses and ultimately move to an electronic communication platform rather than using print. The benefits of this were twofold: to move Alder Hey towards a greater social media presence as befits our core demographic, as well as to generate a cost saving by radically reducing the amount of printing and postage associated with member communications.
- **New Governor Induction** – a review of the Induction programme was undertaken to ensure the content remains fit for purpose and a list of "buddies" and or "mentors" to be established for new governors to support their introduction into the role.
- **Training** – as many Governors as possible to attend GovernWell events to support efforts in respect of member engagement.
- **Links to the Children and Young Peoples' Forum** – another major focus in the year and beyond. A former governor whose term had expired and who is now a Trust volunteer, agreed to champion the link between the Council of Governors and the Children and Young People's Forum. She facilitates joint working and provides a regular link from the Forum to the Council, for example through young people attending Governors' meetings to share issues and potentially encourage forum members of the right age group to stand for election as governors.
- **Annual Members' meetings** - the Committee also acts as a steering group for the planning and organisation of the Annual Members' meeting, the theme of which for 2016 was the Trust's innovation effort, as well as the delivery of the statutory elements. In the coming years, consideration will be given to reinstating Trust Open Days within the new facilities.
- **Public Health** – one of the local authority governors to continue work to re-establish attendance at the Trust Grand Round to raise awareness of Health Liverpool initiatives and more general Trust/City Council collaboration. In addition, the Governors continue to be central to the Trust's work to address key public health issues such as smoking and how this problem can be alleviated on the hospital site.

Throughout our membership activities, the Trust endeavours to ensure that all the communities that it serves are provided every opportunity to become an engaged 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 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
- Greater social media presence and as a method to elicit feedback
- Annual Members' Meeting
- Lay reader scheme for patient information, linked to the Volunteer Scheme
- External consultations, eg Springfield Park
- Trust consultations
- Members' zone on the new Trust website due to launch early in 2017
- Participation in elections to the Council of Governors.

Membership Profile

Constituency	Number of members 2016/17 (actual as at 31st March 2017)	Number of members 2017/18 (planned)
Public	**3,744**	**3,818**
Patients	**6,681**	**6,814**
Staff	**3,041**	**3,101**
Total	**13,466**	**13,733**

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 2016/17 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 both Executive and Non-Executive Directors. Following the introduction in November 2014 by the CQC of the *Fit and Proper Persons Requirement*, the Board amended the documentation and processes associated with directors' appointments. It also introduced an additional proactive declaration in relation to the requirement which is completed regularly by all directors.

The Board of Directors operates to clear terms of reference and an annual work plan which reflect the Trust's constitution and Provider Licence 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. The Corporate Governance Manual was reviewed and updated during the year.

It is the role of the Board to set the organisation's strategic direction in the context of an overall operational planning framework set by NHS regulators. It is responsible for all key business decisions but delegates the operationalisation of these to an appropriate committee or the Trust's Operational Delivery 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 Trust's strategic priorities which in turn also reflect 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 organisation has performed against key local and national metrics, including 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 Key Board Committee Meetings

	Board of Directors	Audit Committee	Clinical Quality Assurance Committee	Resources & Business Development Committee	Workforce & OD
No of Meetings held 2016/17	**11**	**5**	**12**	**12**	**6**
Sir David Henshaw	9	not a member	not a member	not a member	not a member
Louise Shepherd	10	not a member	not a member	not a member	not a member
Ian Quinlan	8	not a member	not a member	12	3
Steve Igoe	6	5	10	not a member	not a member
Claire Dove	9	not a member	not a member	7	5
Anita Marsland	9	3	11	not a member	not a member
Jo Williams	3/5	not a member	2/2	Deputy	not a member
Jeannie France-Hayhurst	10	3	11	not a member	5
Jonathan Stephens	8/8	4 attendee	7/9	7/9	not a member
Claire Liddy	3/11	1 attendee	not a member	3/3	not a member

Margaret Barnaby	11	not a member	11	11	2
Erica Saunders	10 (attendee)	5 (attendee)	12 (attendee)	11 (attendee)	not a member
Melissa Swindell	11	not a member	10	11	6
Rick Turnock	8	not a member	8	7	2
Hilda Gwilliams	10	not a member	11/12	not a member	0
David Powell	6 (attendee)	not a member	not a member	not a member	not a member
Louise Dunn	5 (attendee)	not a member	not a member	10 (attendee)	not a member

Due to her role as lead for the Cheshire and Merseyside Sustainability and Transformation Plan, the Board agreed that Louise Shepherd would cease to be a member of the Trust's assurance committees for the period in order to accommodate this important national work. The Deputy Chief Executive represented Mrs Shepherd at these meetings.

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 2016/17 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 2016 for a further three year period, following a full tender process. This service will however need to be re-tendered in the coming months as a consequence of new National Audit Office regulations for the sector which requires separate entities to provide audit and tax services to NHS bodies from April 2017.

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 2016/17 were £53,100 excluding VAT, which represents a significant discount on the previous year (which were £62,545) reflecting KPMG's commitment to retaining the Trust's business through the tender process conducted in the summer of 2016.

In 2016/17 KPMG provided other services throughout the year - Tax advice on the Research and Education building (fee £10,000 charged to capital, exclusive of VAT), VAT advice (fee £20,096 exclusive of VAT); £270,585 (exclusive of VAT) was paid for work as host of the Cheshire and Merseyside Service Transformation Plan. The Trust's share of this fee was 3% amounting to £8,117.

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 2016/17 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 bi-monthly Integrated Assurance Report
- Internal Audit Reports in accordance with the approved 2016/17 work plan
- Counter Fraud reports by the MIAA specialist in accordance with the approved 2016/17 work plan.

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

- Annual Governance Statement
- Consideration of the 2015/16 Annual Accounts
- NHS Improvement quarterly returns and feedback letters
- External Assurance Report on the quality account
- External Audit report on the financial statements to 31st March 2016 and ISA 260
- Losses and special payments
- Counter Fraud reports by the MIAA specialist in accordance with the approved 2016/17 work plan
- Reports on progress against the Risk Management Improvement Plan
- Approval of the Treasury Management Policy
- Internal Audit work plan for 2016/17
- External Audit strategy relating to the Audit of the Trust's 2015/16 Accounts
- Financial Statement audit risks for 2016/17
- Accounting policies for the 2016/17 Financial Statements
- Audit Committee work plan 2016/17
- 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 the annual accounts represented a true position of the Trust's finances. The External Audit Plan 2016/17 highlighted two significant audit risks in relation to NHS income and receivables and the valuation of land and buildings. The risk around NHS income and receivables was added as a new risk due to an increased risk of misstatement from the estimation of income from Sustainability and Transformation funding (STF).

The Committee discussed the approach taken by the Trust in 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 discussed the approach taken by the Trust in relation to valuation of land and buildings. The Trust has robust processes in place to assess for impairments and appropriate valuation arrangements.

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 2016/17. 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 2016/17 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 2016/17 the Committee made one appointment utilising the services of an executive recruitment agency; the process was carried out in accordance with the terms of reference of the Nominations Committee and having regard to the existing balance of skills and experience on the

Board as well as the strategic context of the Trust. The Trust was fortunate to attract a strong field of candidates but ultimately the recommendation to appoint Dame Jo Williams, following a robust two part selection process, was unanimous. The Council of Governors was assured with regard to both the process and the suitability of the appointee and unanimously approved the appointment, which was subject to the relevant checks including those specified by the Fit and Proper Persons test.

• 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 2016/17 the Committee substantively appointed Hilda Gwilliams as the Trust's Chief Nurse and Melissa Swindell as Director of Human Resources and Organisational Development, following a period of acting in their respective roles. The Committee also appointed John Grinnell as Director of Finance and Deputy Chief Executive, with support from an executive recruitment agency. The same robust two part selection process was followed as for Non-Executive Directors.

NHS Improvement's Single Oversight Framework

NHS Improvement's Single Oversight Framework provides the framework for overseeing providers and identifying potential support needs. The framework looks at five themes:

- Quality of care
- Finance and use of resources
- Operational performance
- Strategic change
- Leadership and improvement capability (well-led)

Based on information from these themes, providers are segmented from 1 to 4 where '4' reflects providers receiving the most support and '1' reflects providers with maximum autonomy. A foundation trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence.

The Single Oversight Framework applied from Quarter 3 of 2016/17/ Prior to this Monitor's *Risk Assessment Framework* (RAF) was in place. Information for the prior year and first two quarters relating to the RAF has not been presented as the basis of accountability was different. This is in line with NHS Improvement's guidance for annual reports.

Segmentation

Alder Hey has been placed in segment 2, which is defined as 'providers offered targeted support'.

This segmentation information is the trust's position as at 31st March 2017. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website.

Finance and Use of Resources

The finance and use of resources theme is based on the scoring of five measures from 1 to 4, where 1 reflects the strongest performance. These scores are then weighted to give an overall score. Given that finance and use of resources is only one of the five themes feeding into the Single Oversight Framework, the segmentation of the trust disclosed above might not be the same as the overall finance score here.

The Trust scored an overall 2 at the end of 2016/17 which represents an improved score compared to the plan submitted to NHS Improvement, which was forecast as 3.

Area	Metric	2016/17 Q3 score	2016/17 Q4 score
Financial sustainability	Capital service capacity	4	3

	Liquidity	3	2
Financial efficiency	I&E margin	4	1
Financial controls	Distance from financial plan	1	1
	Agency spend	1	1
Overall scoring		**3**	**2**

Voluntary disclosures

Equality Report

Alder Hey continues with its commitment to try to ensure that 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 groups and individuals concerned. This reflection has contributed to a revision of the overall Equality and Diversity process, in order to most effectively prioritise those areas of development that will bring the greatest benefit to those most disadvantaged.

During 2016, 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 Alder Hey's 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 resulting in a review of E&D priorities and actions to align with the revised EDS2 outcomes for 2016/17. 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 ongoing Healthwatch engagement and

partnership working with community groups will continue to be a focus for embedding equality and diversity practice and approach during 2017.

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 a patient profile milestone plan to improve the quality of patient data supported by process across equality demographics. The self-service aspects of the employee staff record system is currently being rolled out that should improve the quality of staff equality demographic information. Improvement in data monitoring of access to learning and development opportunities of staff will also be supported by the new Trust system. The Trust continues to strive to improve the diversity of the workforce, particularly from Black and Minority Ethnic (BME) groups. This commitment is included in the Trust's 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. In the last year progress has been made in identifying the priorities for BME staff that will be developed through a refreshed workforce race equality standard (WRES) supported by a BME network.

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. Work is ongoing to strengthen the assurance process regarding equality analysis and to provide support to project and policy leads to ensure lawful decision making.

The continued implementation of interpreting and translation services has progressed during 2016, 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 five most frequently requested languages during 2016 have been Polish, Mandarin, Cantonese, Romanian 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.

Plans for 2017 will continue to be to improve the quality of patient and staff information and broaden opportunities to engage with different community groups to progress the Trust's equality objectives. The development of a Trust Black and Minority Ethnic (BME) network will support the work involved in increasing the BME representation of the workforce and findings relating to the Workforce Race Equality

Standard (WRES). Training opportunities in cultural competence and unconscious bias will continue to be made available for staff. There will be continued attention to supporting the organisational processes and strategic leadership for equality and diversity and communicating any gaps wherever these may be identified. Equality and Diversity is an integral part of the evolvement of the newly developed Trust Quality Strategy with a shared approach of improving the experiences of public and staff through engagement. The Trust will continue to explore a variety of opportunities to engage with different community groups to progress the Trust's equality objectives.

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 NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the National Health Service Act 2006, has given accounts directions which require Alder Hey Children's NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those directions. 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.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the *Department of Health Group Accounting Manual* and in particular to:

- observe the Accounts Direction issued by NHS Improvement, 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 (and the Department of Health Group Accounting 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
25h May 2017

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 updated and reviewed by the Integrated Governance Committee on behalf of the Board in January 2017. 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 Nurse is the Executive lead for

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) Directors and senior officers 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. Associate Chief Nurses and Heads of Quality 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 Ulysses, 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 sustained its high rate of incident reporting via the NRLS system, which from last year placed it among the best performers for patient safety incident reporting nationally: the most recent report – March 2017 – positioned Alder Hey third in the country. 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, work to improve the functionality of the Ulysses incident reporting system continued during the year. Following the implementation of the risk module on Ulysses in September 2015, risk registers continue to be used more interactively and are used by the Trust Executive Team, the Board, its sub-committees and CBU Risk and Governance Groups to better drive the management and mitigation of risks.

Work continues to improve the risk register format and reports and supporting local areas in completing and reviewing risks. On arrival in post in December, the newly appointed Heads of Quality immediately began the process to thoroughly understand and review the risks relevant to their services and each had presented a 'deep dive' report of their findings to the Integrated Governance Committee by the end of the year. Training sessions continue to be available to all staff as well as one to one support on the use of the Ulysses system.

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 review gave a 'green' rating in all areas: structure, engagement and quality and alignment, evidencing that the Alder Hey Assurance Framework fully meets the expected requirements.

The Trust received a rating of 'significant assurance' confirmed by the Director of Audit Opinion for 2016/17.

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 strategic risks to the organisation at corporate level, is 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 Clinical Business Units and corporate functions in the Trust. In order to achieve that, each CBU and corporate function 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 2016/17: Implemented a model of devolved governance within the CBUs, giving clearer responsibility and ownership of risk and governance at local level; appointed to a new role of Associate Director of Nursing and Governance (due to commence May 2017); undertook a full refresh of the corporate risk register and BAF; completed a full review of local risk registers; received a positive report from internal audit of Risk Management and Incident Management and instituted a strong focus on a risk ‘maturity model’ in the new Risk Management Strategy for the Trust.

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 resulted in a rating of ‘Good’ for the hospital overall with a rating of ‘Outstanding’ in the Caring domain. The Trust was also rated ‘Good’ in the Well-led domain, reflecting the focus on improving the Trust’s risk and governance arrangements since the previous inspection, although there were some additional recommendations made with particular reference to risk management at individual service and departmental level. This action was incorporated into the Trust’s Risk Management Improvement Plan and implemented as described above.

In terms of monitoring compliance with registration requirements and essential standards, the Clinical Divisions provide assurance via regular submissions of their key issues reports through to the Clinical Quality Steering Group. This incorporates a

set of quality indicators reflecting the Trust's Quality Strategy, Quality Aims and associated KPIs. The key issue reports include compliance against CQC standards and other regulatory targets. They also incorporate assurance against clinical effectiveness, patient experience and patient safety indicators such as incidents, risks, medication errors and infections. The Divisions report against CQC Fundamental Standards as part of the assurance framework and action plans from serious incidents are also presented and monitored with dissemination to Divisions for shared learning. CQSG also provides a key issues report to CQAC for further assurance, highlighting any exceptions or risks that may need to be addressed or escalated.

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 2016/17.

The Clinical Quality Assurance Committee, whose membership includes all CBU 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 the year. Following the move to the new hospital at the end of 2015, the focus of walkarounds was on key areas that had been faced with immediate operational or patient experience issues. One such example was the waiting area in the Emergency Department, which underwent re-modelling as a result of CQAC's involvement. Committee members also visited the community CAMHS service in its new location on the main hospital site, supporting the young people from the 'Fresh CAMHS' participation group. During 2016/17, it was agreed that in line with the Committee's new role in assuring the Trust's change programme, walkarounds would engage with the key projects within this including 'Best in Operative Care' and 'Improving Outpatients'; visits continued to incorporate discussions with staff, patients and families about their experiences and highlighting areas for improvement. At the end of the year, the Committee chair initiated a refresh of the walkaround process, which resulted in a proposal to change the process somewhat

and re-brand it as a Quality Ward Round, with a renewed focus on supporting ward to board assurance. This new process will commence from 2017/18.

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, a key part of the Corporate Report has been kept under review by the chair of the Clinical Quality Assurance Committee and the Chief Nurse.

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 in 2010, subsequently adopted by NHS Improvement and which also informs the Well Led Governance Framework published by NHS Improvement. The Trust has continued to undertake regular self-assessments of its position against each element of the framework, under the auspices of the Clinical Quality Assurance Committee. A follow up of the external quality governance review commissioned from KPMG in 2015, which resulted in a score of 3 against the Monitor scoring system then in place, was carried out by the Trust's internal auditors at the end of 2016/17. The review gave this process 'significant assurance' and demonstrates that the Trust remains committed to a culture of continuous improvement. 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 2017 ahead of the formal declarations required by Monitor/NHS Improvement 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 September 2016, NHS Improvement published its Single Oversight Framework which replaced Monitor's Risk Assessment Framework and set out NHSI's approach to regulation and new ratings system. It introduced the concept of segmentation as an indicator of the level of support required for each provider in the context of an extremely challenging financial environment. Alder Hey was subsequently placed in segment 2 of the new system – providers offered targeted support - reflecting the Trust's planned financial

deficit, which had consistently been forecast for the year following the move to the new hospital.

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 2016/17 the Board established a Research, Education and Innovation Committee as a full Board assurance committee in recognition of the strategic importance of these areas of activity for the Trust.

Following a review undertaken in 2015, the Trust has continued to incorporate Equality Impact Assessments 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. The EIA process is 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 EIA process was embedded into the Quality Impact Assessment process to inextricably link the two key priorities.

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 organisation. 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; during the year the Trust's most recently appointed NED took a special interest in the development of the report and this oversight remains ongoing..

The principal risks to the organisation during 2016/17 were focused predominantly on two main areas: settling staff and patients in to the new hospital environment and delivering the planned activity in this context, in order to achieve the financial control total. By April 2016, the new Alder Hey in the Park had been in operation for six months. Whilst a significant number of 'snagging' issues had been dealt with, a range of post occupation risks remained to be worked through, some of which had the potential to impact upon the delivery of activity. The Trust's robust risk identification and assessment systems and processes, coupled with responsive and proactive management teams helped to maintain service where such issues arose or resolve matters as rapidly as possible. Later in the year, a Partnership Charter was agreed with the Trust's PFI landlord to clarify and improve the existing contractual

relationship in terms of the management of building related issues, based on the fundamental principle that patient safety is paramount.

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. The Trust's compliance with the Toolkit has been assessed as 85% for 2016/17. The internal audit review of a small number of IG toolkit elements resulted in 'limited assurance', however the auditors recognised that the Trust has continued to make significant progress in this area following the year of the move to the new hospital during which the focus had been on the specific risk of data loss as a consequence of such a large scale logistics exercise. To support the ongoing moves of the Trust's corporate teams from part of the old hospital site due for demolition, to newly refurbished accommodation on the retained estate, the 'Dump the Junk' initiative remained in place in order to continue 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. In addition, the Trust's Information Governance and Environment Managers carried out a joint schedule of post move inspections, as they had done with the main move in the previous year, to ensure that no person identifiable data was left behind in the old buildings. The Trust had no serious incidents relating to Information Governance during the period and suffered no data loss as a consequence of any of the moves around the site. During the year, work began within the Trust to prepare for the introduction of the General Data Protection Regulations (GDPR) which will reform Data Protection legislation and will apply in the UK from 25th May 2018.

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 2017/18. The Equality Objectives will be aligned with NHS EDS 2 and the WRES and will respond to the associated 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 Planning process that was established nationally to take forward the vision set out in the Five Year Forward View 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. I have continued in this role throughout the last year.

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 via monthly performance review meetings with CBU senior teams. The Board of Directors reviews performance against objectives on a monthly basis through the Corporate Performance Report which is also reviewed by key Board assurance committees.

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 or potential risk 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. During the last 12 months the Committee chair has strengthened and enhanced the processes around the monitoring of internal audit recommendations and the provision of regular reports both from lead officers and internal audit, to ensure that any areas of limited assurance are followed up and relevant action taken.

In view of the principal financial risks described above, the Trust made the decision to place itself in 'internal recovery' during the early part of the year, instituting weekly meetings to track progress against the cost improvement programme and as a forum for bringing forward ideas for increasing efficiency and productivity. This process has proved to be highly effective such that the Trust was able to deliver its activity plan, its CIP and its control total for the year.

A range of specific initiatives to improve the use of resources were in place during 2016/17, 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 real time daily activity reporting and forward look with drill through to outpatient and theatre productivity to ensure contract activity plans achieved and capacity utilised.

- Enhanced materials management stock control continued in the new hospital with demonstrable reduction to stockholding.
- Procurement strategy agreed aimed at delivering best in class purchasing, and service to our clinical services at best price, incorporating the 'Give me 10' initiative to encourage VFM ideas and solutions from the shop floor.
- A first of its kind 'Procurement Symposium' event in which Alder Hey brought together a roomful of its key suppliers to work on joint solutions to the challenges of securing best value for patients.
- Continued development of service line reporting and patient level costing information with specialty teams resulting in increased clinical engagement in costing and performance improvement.
- 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.
- Extensive recruitment to clinical roles to reduce the reliance on temporary staffing

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. NHS Improvement (in exercise of the powers conferred on 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 Nursing and Associate Director of Risk and Governance.

The Trust's Quality Strategy was refreshed during 2015/16 and the revised version approved by the Board in April 2016. The key elements of the strategy include:

- Strong clinical leadership driving quality improvement
- Engaging our workforce to get involved
- Improved culture of risk management and quality improvement through a devolved quality and governance structure
- Improvements in workforce health and wellbeing based on the principle of 'happy staff = happy patients'
- Greater patient and carer involvement – 'giving patients a voice'

Underpinning each of these elements is a range of projects and initiatives which in turn are designed to deliver the fundamental building blocks of the Quality Strategy which remain:

- Patients will not suffer harm in our care
- Patients will receive the most effective evidence based care
- Patients will have the best possible experience

It is these fundamentals and their associated Quality Aims that have been consistently at the core of the Trust's approach to quality since 2012/13 and which enable a coherent and authentic narrative for staff.

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, which is embedded within the Corporate Report, was reviewed to ensure consistency of information tracking against the Quality Aims, a range of safety, effectiveness and experience measures that also allow for 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 and that actions taken to achieve the aims incorporate learning from elsewhere in the NHS.

Significant work has been undertaken during the year to assure the accuracy of the quality data contained within the report. In 2016/17 MIAA carried out an audit focusing on patient data flows in the EPR system. The review focused on the systems and processes in place for collection, validation, analysis and review of patient pathway data recorded. Validation processes are carried out to ensure data accuracy for recording of A&E waiting times, referral to treatment (RTT) pathway information and Cancer waiting times. This information is validated by the service and reviewed at the weekly performance meeting prior to sign off for reporting. Information procedures are maintained to ensure they reflect changes in reporting processes. There have been improvements made to managing RTT and Cancer pathways this year to introduce central process and team to manage referrals.

At Alder Hey we have undertaken a range of measures to ensure we have accurate and robust waiting times data. In June 2016 we re-established our Data Quality Steering group to review recording and reporting of patient information including waiting times information. This process is supported by internal audit programme which includes audit of mandatory waiting times reporting. A review of the EPR data recording and reporting was carried out in September 2016. Our Patient Access Policy, although not due for review is currently being reviewed and relaunched in May 2018. A follow up review of waiting times was carried out by internal audit in January 2016. Our Patient Access Policy was reviewed and updated to reflect current processes and reporting requirements and a weekly performance group is in place to monitor all aspects of RTT performance and identify and resolve issues. We have also have focused improvement work on patient pathways in outpatients, with a 10 week task and finish looking at improving pathways and processes completed in Jan 2017, and a OPD improvement programme for 2017/18 agreed.

The Trust regularly validates patients on pathways which in turn feeds into our Data Quality Steering group which meets weekly. The OPD task and finish group highlighted the need to central and focused validation and a plan is in progress to implement this structure This will be audited as part of the Data Quality Audit Plan

2017/18 . 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. We have also rolled out a programme focusing on clinical activity validation with the clinical coding team and clinical teams, to allow them to review, benchmark and improve clinical activity recording

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;
- 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:
- Inspection by the Medicines and Healthcare products Regulatory Agency (MHRA) of the Hospital Transfusion Team under the Blood Safety and Quality Regulations 2005;
- The Pharmacy Aseptic Services Unit underwent two audits from Quality Control North West, in 2016 in July and December 2016;
- The annual PLACE inspection of the hospital's facilities from a patient's perspective

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 2016/17 no significant internal control issues have been identified.

Signed:

Louise Shepherd
Chief Executive
25th May 2017

Quality Report - *'Outstanding care delivered by outstanding people'*

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

As I look back on Alder Hey's many achievements in the past year, I do so with a feeling of great pride in the immense team effort that has gone in to delivering such impressive results, in the context of an NHS that was faced with more challenges than at any point in its 70 year history. The fact that the Trust delivered on all of the national access standards, in particluar the 4 hour A&E target, is a clear indication of our continued commitment to ensuring that we provide the best care to our patients, a feat which was lauded by the Secretary of State in a personal thank you letter to the team here at Alder Hey on its performance.

The fact is, this year many more children have benefited from Alder Hey's outstanding care; an astonishing statistic given that we were still in the first full year in our new home. A fantastic example of this is the performance of over 400 congenital heart operations in the last 12 months to fully meet the Central Cardiac Audit Database (CCAD) national criteria. Whilst this achieves both the standards set nationally and our local plans for numbers of operations, my first thoughts are always about the families whose lives have been enhanced by Alder Hey's outstanding teams of dedicated professionals.

The Quality Report set out below represents a year's worth of hard work by staff across the organisation to fulfil the ambition described in our refreshed Quality Strategy to do just that. I have seen examples of this in action on a daily basis and crucially, staff talking together in more and more innovative ways, about what it means to them and to the children they care for. For instance, the introduction of Schwartz Rounds has led to some incredibly powerful discussions about the experiences of patients, parents and the teams who look after them – ranging from exceptional and life changing, to challenging and at times distressing, but always focused on what we can learn from and use to improve how we deliver care.

At the end of March we learned that we had retained our position as third overall nationally in terms of our reporting of incidents. In the context of healthcare, a higher level of reports is a good thing as it means we are being open, reporting and importantly, learning from mistakes and near misses. The key aspect of this is that whilst we had more incidents reported compared to other trusts, far fewer of these related to incidents that led to patient harm. Again, this is testimony to the willingness of our staff to engage and participate in a culture of openness and learn together about how we can do better.

To support our continual drive for quality improvement, we are increasingly reliant on robust information systems and data. For this reason, we were particularly pleased to receive nearly £10m national funding to join an elite group of NHS trusts who have been selected to drive new ways of using digital technology in the NHS. Known as 'digital exemplars' these organisations were selected from the most technologically advanced hospitals in the NHS and will lead the way in delivering radical improvements in the care of patients. Alder Hey is the only specialist children's trust to be selected. This means national recognition of our hard work to apply new technology to how we look after our patients - from basics like how we invite them to

appointments, through to creating personalised avatars to give friendship and comfort to children during their stay in hospital. All of this will enhance our existing plans to continually improve quality, ensuring that our creative, innovative and professional staff are at the heart of it all.

As Chief Executive, I commend our Quality Report for 2016/17 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: Priorities for Improvement and Statements of Assurance from the Board

2.1 Priorities for improvement

This section of the report describes an overview of the Trust's plans for improving quality over the next 3-5 years and specifically details the key quality improvement priorities for 2017-18, including the rationale for selection of the priorities.

In April 2016 the Trust Board approved the new 5 year quality strategy, 'Inspiring Quality', which maintains a key focus on patient safety, patient experience and clinical effectiveness, plus recognises the significance of staff health and wellbeing and our environment in supporting the delivery of a high quality service.

These 5 domains of Inspiring Quality each have a key area of focus for 2017-18 which are identified in the table below and will represent the key quality improvement priorities for the Trust over the next 12 months.

These focus areas have been consulted widely within the Trust through Clinical Quality Assurance Committee (CQAC) and Clinical Business Units (CBUs), Heads of Quality. Additionally they have been discussed and agreed with the Children & Young People's Forum, Governors and with Healthwatch organisations.

The improvement priorities are also aligned with the Trust's 2 year operational plan for 2017-19 which was submitted to NHS Improvement (previously Monitor), including the local Sustainability and Transformation Plan (STP) to reduce variation and improve quality.

	Quality domain	Priority area
Aim 1	**Patients will not suffer harm in our care**	*Further embed a safety culture throughout the organisation*
Aim 2	**Patients will have the best possible experience**	*Increase engagement of children, young people & families in improving quality and developing services*
Aim 3	**Patients will receive the most effective evidence based care**	*Increase number of defined clinical care pathways across our clinical specialties*
Aim 4	**Improve workforce health & wellbeing**	*Provide support that will enable our staff to feel valued and respected by the organisation and actively contribute to the organisation's success*
Aim 5	**Our environment will enable us to deliver an excellent service**	*Continue to improve the environment to make it work for both patients and staff*

Aim: Patients will not suffer harm in our care

Priority 1	Further embed a safety culture throughout the organisation
Rationale	The Trust has made great improvements in it's incident reporting culture, with evidence of moving from the lowest quartile to the top quartile of specialist Trusts reporting incidents through the National Reporting & Learning System (NRLS). Additionally the percentage of incidents causing avoidable harm has improved significantly. In continuing to monitor and review serious incidents and never events, and following the national drive on sepsis and hospital acquired infections, the Trust Board agree that there should be continued and specific focus on: - ***Prompt recognition and treatment of deteriorating patients including implementation of the sepsis pathway*** - ***Reducing Hospital Acquired Infections***
Measuring	Remain in top quartile of number of incidents reported through NRLS compared with peer Trusts. All appropriate patients follow the sepsis pathway. Deliver HAI targets as agreed through Sign up to Safety campaign
Monitoring	Number of reported incidents monitored weekly through Weekly Meeting of Harm. NRLS provides a ranking report against peers. Monthly reporting of incidents and never events monitored through Clinical Quality Steering Group (CQSG), and individual CBU Executive Review meetings Sepsis Implementation Group monitors compliance with national requirements and reports to CQSG
Reporting	Reported through CQSG, Clinical Quality Assurance Committee (CQAC) to Trust Board

Aim: Patients will have the best possible experience

Priority 2	Increase engagement of children, young people & families in improving quality and developing services
Rationale	The first 12 months of implementing Inspiring Quality included excellent engagement and working with children & young people. There remains a national drive to ensure children have an input into their care, and the Trust Board has agreed to place specific focus on involving children and families in improvement initiatives and in particular in service developments to ensure the views of children and young people are captured, in particular children with protected characteristics. Specific focus will be placed on: - **Improvements in outpatients** - **Ensuring children with protected characteristics are not disadvantaged through any service development proposals.**
Measuring	Service development and quality improvement proposals will be required to include a section on how they have engaged children, young people and families in developing proposals, including completion of an Equality Analysis. Measurement will be through audit of service development proforma and triangulation with patient and family feedback through local reporting. Improve data capture of patients with protected characteristics
Monitoring	Performance will be monitored through CQSG and Executive Team
Reporting	Reporting will be through CQSG, and CQAC to Trust Board.

Aim: Patients will receive the most effective evidence based care

Priority 3	Increase number of defined clinical care pathways across our clinical specialties
Rationale	In reviewing complaints, incidents, mortality and morbidity reports and other forms of feedback from patients and staff, the Trust recognises there is a high degree of variation in care provided by a number of specialties. There is an opportunity to utilise best practice, NICE guidelines, national service specifications and other evidence to ensure the same standardised, high quality care is delivered to all patients 7 days a week. Specific focus will be placed on: - **Developing care pathways across clinical specialties** - **Developing a system of 7 day working**
Measuring	Services will be assessed for compliance with relevant NICE guidance and national standards. Evidence of newly developed care pathways across the Trust
Monitoring	The development of evidence based care pathways will be supported by the Trust's Clinical Effectiveness leads and monitored through the Trust Change programme 7 day working will operate as a specific project within the Trust's Change programme sponsored by a member of the Executive Team
Reporting	Progress will be reported through Clinical Quality Assurance Committee (CQAC) to Trust Board

Aim: Improve workforce health & wellbeing

Priority 4	Provide support that will enable our staff to feel valued and respected by the organisation and actively contribute to the organisation's success
Rationale	As part of the Trust's strategic plan to 'do the basics brilliantly', we are committed to supporting, recognising and celebrating the great work our staff do in contributing to the organisation's success. Having reviewed the national staff survey for 2016, the Trust Board recognises that there are opportunities to improve staff overall health & wellbeing. Additionally the Board recognises that the workforce is under-represented in terms of Black and Minority Ethnic (BME) employees. This area will also be given particular attention during 2016-17 and beyond. The Trust will therefore place a specific focus on - **Reward / recognition and celebrating success** - **Improving BME representation in the workforce**
Measuring	5% improvement in baseline measure of 'staff that recommend Alder Hey as a place to work' 1% year on year increase in proportion of BME employees in the Trust
Monitoring	National staff survey (annual) and local staff 'temperature checks' (quarterly) will be used to monitor performance. Regular HR statistical analysis of workforce demographics.
Reporting	Performance will be reported through Workforce & Organisational Development Committee (WOD), and through Trust corporate report to Trust Board

Aim: Our environment will enable us to deliver an excellent service

Priority 5	Continue to improve the environment to make it work for both patients and staff
Rationale	The Trust has now been located in the new building for 18 months, and the vast majority of the 'snagging' issues have now been resolved. However, the Trust recognises there are ongoing frustrations for staff in relation to reporting and correction of faults. Additionally whilst the Trust has made significant improvements in the distraction and play opportunities for children in many areas, 'engagement in play' remains one of the poorer areas of performance fedback by our children and families. The patient and public supported PLACE inspection also highlighted a number of areas requiring improvement. Particular focus will be placed on: - **Improving Arts, Performance and Play** - **Improved signage and wayfinding for children and families**
Measuring	Family and Friends feedback, in particular improvement in 'engagement in play' measures. PLACE assessment feedback.
Monitoring	Monitoring will be through the Quality Improvement Team
Reporting	Performance will be reported through CQSG, CQAC, to Trust Board

2.2 Quality Improvements in 2016-17

The key priorities for improvement as reported in the 2015-16 Quality Account stemmed from the ongoing work in relation to Sign up to Safety, and from the refresh of the quality strategy. These were agreed by the Trust Board as:

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.

Details of progress against these key priorities from 2016-17 is provided in Section 3 of this report.

2.3 Statements of Assurance from the Board

2.3.1 Review of services

During 2016/17 Alder Hey Children's NHS Foundation Trust [Alder Hey] provided 44 relevant health services. Alder Hey has reviewed all the data available to them on the quality of care in all of these relevant health services. The income generated by the relevant health services reviewed in 2016/17 represents 100% of the total income generated from the provision of relevant health services by Alder Hey for 2016/17.

2.3.2 Participation in clinical audits and national confidential enquiries.

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 Programme3 (NCAPOP) or funded through other means. Priorities for the NCAPOP are set by NHS England with advice from the National Clinical Audit Advisory Group (NCAAG)

During the reporting period 1st April 2016 to 31st March 2017, 11 National Clinical Audits and 5 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 90% (10 out of 11) National Clinical Audits and 100% (5 out of 5) 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 2016 to 31st March 2017 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 2016 to 31st March 2017, 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.

National Audit	Participation	% Cases submitted
Children		
Paediatric Pneumonia (British Thoracic Society)	Yes	Data Collection ongoing till 30th April 2017
Paediatric intensive care (PICANet)	Yes	Submitted 964 records, which was 100% of cases available
Potential donor audit (NHS Blood & Transplant)	Yes	Submitted 64 records, which was 100% of cases available
Asthma care in Emergency Departments Royal College of Emergency Medicine	Yes	Submitted 100 cases, which was 100% of cases available.
Acute care		
Severe trauma (Trauma Audit & Research Network)	Yes	Submitted 173 approved. TARN applicable cases, which is 100% of cases available
Cardiac		
Cardiac arrest (National Cardiac Arrest Audit) (NCAA).	No	Alder Hey has not submitted any data to date due to technical difficulties. We aim

National Audit	Participation	% Cases submitted
		to submit data to NCAA by the June 2017 deadline.
Paediatric cardiac surgery (National Institute for Cardiovascular Outcomes Research (NICOR) Congenital Heart Disease Audit)	Yes	Submitted 866 cases, which was 100% of cases available
Cardiac arrhythmia (Cardiac Rhythm Management (CRM)	Yes	Submitted 23 cases which was 100% of cases 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	Data collection is ongoing. 419 patients will be included in NPDA (National Paediatric Diabetes Audit) for 2016/2017
Renal Replacement therapy (UK Renal Registry)	Yes	Submitted 60 cases, which was 100% of cases available. (Transplants: 47, Peritoneal dialysis : 6, Haemodialysis: 7)

National Confidential Enquiries	Participation	% cases submitted
Chronic Neurodisability - National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Yes	9 cases submitted which was 90% of cases available. This study is ongoing into 2017.
Young People's Mental Health - National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Yes	3 cases submitted which was 100% of cases available. This study is ongoing into 2017.
Cancer in Children, Teens and Young Adults	Yes	9 cases submitted which was 100% of cases available. This study is ongoing into 2017.
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)	Yes	21 cases submitted which was 100% of cases available.

National Confidential Enquiries	Participation	% cases submitted
- MBRRACE-UK - National Perinatal Epidemiology Unit (NPEU)		

2.3.3 Actions arising from National Clinical Audits

The reports of three National Clinical Audits were reviewed by the provider in the reporting period April 1st 2016 to March 31st 2017 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 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)	We are awaiting confirmation of data and publication of the national audit report for 2016/17.
Severe trauma (Trauma Audit & Research Network)	For the period 2016 - 2017 our data completeness and data quality are both 95%+. There are 173 applicable entries for this period. 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

National Clinical Audit	Actions
	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.
Cardiac arrest (National Cardiac Arrest Audit)	Although no data has been submitted to the network, we are still listed as a participant with the National Cardiac Arrest Audit (NCAA). Actions are being taken to resolve the technical issues that will enable submission of data to recommence before the June 2017 deadline
Paediatric cardiac surgery (NICOR Congenital Heart Disease Audit)	The publication of the annual National Congenital Heart Disease Audit Report for 2016 will be delayed until further notice by NICOR due to delays in processing their Data Sharing Agreement with NHS Digital.The Data Quality report showed that we have achieved an overall Data Quality Indicator of 99.9% compared to 97.3% 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 2015/2016 was reviewed and Alder Hey is meeting the audit standards. There are no actions required. We are awaiting the publication of the 2016/2017 report.
Ulcerative Colitis and Crohn's Disease (National UK IBD Audit) Biological Therapies	The UK IBD audit has now merged with the IBD Registry, moving towards an improved system for data capture and quality improvement in IBD (inflammatory bowel disease). On-going collection of our biological therapies data will be through the UK IBD Registry. We are registered to continue entering data to this component of the audit. The final National Audit report was published in September 2016.
Diabetes (RCPH National Paediatric Diabetes Audit)	Data collection for the audit has improved following our use of the TWINKLE system (diabetes specific data collection software) for data entry. Twinkle enables automated data capture and reporting for the Best Practice Tariff (BPT).
Renal Replacement therapy (UK Renal Registry)	Awaiting the publication of the 2016/17 annual report.

2.3.4 Actions arising from Local Clinical Audits

There were a total of 162 local audits registered in the reporting period 1st April 2016 to 31st March 2017. There are 40 (25%) local audits completed. There are 116 (72%) audits that will continue in 2017/18. There are 3 audits not yet started and 3 audits have been cancelled (3%).

The reports of the completed local clinical audits were reviewed by the provider in the reporting period April 1st 2016 to March 31st 2017 and examples of the outcomes are listed below.

Local Audit	Actions
An audit of patient experience in the new Alder Hey hospital	The audit was presented at the Alder Hey Orthopaedic Departmental meeting in May 2016. Action/ Recommendation: • To improve the induction for junior doctors. • Re-audit in 3 months.
Audit of timing of Parenteral Nutrition (PN) in the Paediatric Intensive Care Unit (PICU)	The audit was submitted as an abstract for the 30th Annual Paediatric Intensive Care (PICS) conference 2016, 3-5 October in Southampton. Action/ Recommendation • We evaluated our practice with regards to Total parenteral nutrition (TPN) which was very helpful and now we have a baseline to compare interventions. • No actions arise from this audit as it was a baseline audit.
Management of congenital hypothyroidism	The audit was presented at MERPENG (Mersey Paediatric Endocrinology Group Meeting) in July 2016. Action/ Recommendation • Improve communication between the neonatal screening service and our neonatal service to find ways of ensuring that preterm infants have the neonatal screening blood samples regardless of whether or not the infants are fed or ill. • Discuss the need for an audit of blood sampling for newborn screening on the neonatal unit at Liverpool Women's Hospital with the neonatologist. • Develop a pathway that enables infants with congenital hypothyroidism to be seen and commenced on treatment over weekends. • Re-audit in 12 months.
Investigation of potential of hydrogen (pH) of burn wounds	The audit is to be presented at the British Burn association meeting in May 2017. Action/ Recommendation: • To lessen the irrigation of chemical burns wounds. • To create a simple advice leaflet to help guide the management of chemical burns in

Local Audit	Actions
	the Alder Hey Burns Unit with an estimated completion date of April 2017. • No re-audit is necessary as it would be unlikely to provide any valuable information.
Adherence to National Burn Care Review referral criteria in a paediatric Emergency Department: a re-audit following implementation of a burns assessment proforma.	The audit was presented at the Alder Hey Plastic Surgery Clinical Governance Meeting in July 2016. <u>Action/ Recommendation</u> • To disseminate the findings to the Emergency Department. • To re-examine the data-set for missing patients. Those triaged as "chemical splash" etc. • Encourage the use of the burns assessment pro-forma in the Emergency Department. • Re-audit in 12 months.
Audit of coding of activities/procedures carried out in fracture clinics	The audit was presented at the Alder Hey Orthopaedics department monthly audit meeting in June 2016. <u>Action/ Recommendation</u> • We have designed a new coding form, combining the current coding form and a follow up form. • Fracture clinic staff to write patient details on this form when the patient arrives. • Form to be used for all the activities (for example plaster room, splints, wound checking) • Doctor managing the patient on the day completes / ticks all the relevant boxes at the end of the appointment including the follow up plan. • Re-audit in 6 months.
Cleft Patient (and Parent) Reported Experience Measure (PREM) Feasibility Study	The patient data for this audit was being collected nationally by all cleft teams. The data was being collated online by the Cleft Registry and Audit Network (CRANE). <u>Action/ Recommendation</u> • The Feasibility Study Team will present a summary of findings at the 18 May 2017 Cleft Development Group (CDG) meeting. • CRANE plan to provide an individual

Local Audit	Actions
	summary to each of the cleft sites who gained patient feedback once CDG have signed off on the findings.
Are Children (16 years and under) with disabilities more at risk of abuse?	The audit was presented and discussed at the Alder Hey Community Paediatrics Clinical Governance meeting in October 2016. <u>Action/ Recommendation</u> • Documentation was generally good although it could be improved particularly for domestic violence cases. By not writing yes we cannot assume the answer is no. • Update our existing training so as to make trainees at induction aware of the need for asking about any domestic violence and identifying developmental concerns. • Re-audit in 12 months.
High Resolution Computed Tomography (HRCT) features in children with severe asthma: A retrospective analysis.	The audit was presented at the European Respiratory Society Conference in London, 3 -7 September 2016. <u>Action/ Recommendation</u> • Our results suggest that HRCT may help identify other diagnoses in some children and these findings had implications on their clinical management. • To update the existing guideline on Difficult Asthma. • Re-audit in 2 years.
Multicentre National Audit of Current Management and Outcomes for children affected by Juvenile Localised Scleroderma (JLS)	The audit was presented at the Alder Hey Rheumatology Departmenl academic meeting in March 2017. <u>Action/ Recommendation:</u> • Update the existing guidelines on screening for brain, eye and dental involvement in JLS. • Introduce new training for the team on the importance of screening for brain, eye and dental involvement (Already actioned). • Design the guideline on screening of JLS patients by June 2018. • Re-audit in twelve months.
Audit on outcomes of coblation tonsillectomies	The audit was presented at the Alder Hey Ear Nose and Throat (ENT) Departmental Meeting in July 2016. The results of the audit were discussed in comparison to the National Prospective Tonsillectomy Audit. <u>Action/ Recommendation</u>

Local Audit	Actions
	• To continue with the current practice and it was agreed that there is always a steep learning curve with a new surgical technique. • A future audit to evaluate the pain scores post-surgery is planned. • Re-audit in 12 months.
A re-audit of knowledge, attitude and practice of completion of Liverpool Upper-limb Fracture Assessment (LUFA) forms at Alder Hey Childrens Hospital	The audit was presented at the Alder Hey Orthopaedic departmental meeting in June 2016. <u>Action/ Recommendation</u> • Continue with the improved junior Doctor induction programme. • Make LUFA forms available in the wards and Accident and Emergency Department. • Re-audit in 6 months.
Hydrotherapy Programme to Improve Participation and Enjoyment of Swimming in Duchenne Muscular Dystrophy: A service evaluation	The audit was presented to the Alder Hey Physiotherapy team involved in June 2016. Previous discussions were also held with the aquatic therapist for feedback. <u>Action/ Recommendation</u> • To evaluate the use of the individual exercise plans to see if children continued to use them and view their activity as therapy. • **Review of the exercise plans with a potential for more focus on self-management.** • **To improve the outcome assessments in conjunction with other members of the neuromuscular team to better evaluate the effect of the programme.** • **The session is to be run again this year but offered to a broader caseload.** • **Offer more sessions within the same time period.** • Re-audit in six months.
An audit of the demographics of patients attending Early Bird Clinic and subsequent procedures	The audit was presented at the Alder Hey Burns Unit Multidiscipinary Team meeting in July 2016. <u>Action/ Recommendation</u> • A pro-forma has been introduced for the Early Bird Clinic with appropriate sections to help improve problems that have been

Local Audit	Actions
	identified in the audit. • Re-audit in 3 months.
Community Upper Limb Splinting	The audit was discussed with the Community service manager in September 2016. <u>Action/ Recommendation</u> • There is a clinical need for this service so funding is to continue for a further year. • A Community Service for Upper Limb splinting is to continue until review. • No re-audit is necessary as all relevant information has been collated.
An audit of staff experience in the Orthopaedic ward in the new Alder Hey hospital	The audit was presented at the Alder Hey Orthopaedic department audit meeting in July 2016. <u>Action/ Recommendation</u> • Improve length of wait for take home medications and discharge times from ward as soon as possible. • Provide a designated nurse for the ward round. • Improve communication between doctors and nursing staff after the ward round. • Increase training opportunities for nursing staff. • Re-audit in 12 months.
Does grade of first Slipped Upper Femoral Epiphysis (SUFE) predict grade of subsequent slip?	The audit was presented at the Mersey Deanery registrars day and the Alder Hey alumni event in November 2016. <u>Action/ Recommendation</u>: • Grade of initial SUFE may be a useful adjunct to decision making when considering the risk or benefit of prophylactic contralateral surgery. • In cases of initial mild slip re-presentation with a severe contralateral SUFE is unlikely and a higher threshold for prophylactic intervention may be appropriate. • No re-audit is needed as the current follow up for the series is 5 -10 years. Further study will be in the distant future or ideally as part of a research study.
Re-audit of completion of Liverpool Upper-limb Fracture Assessment (LUFA) forms in	The audit was be presented at the Alder Hey Orthopaedic Department meeting in July 2016.

Local Audit	Actions
patients with upper limb fractures July 2016.	Action/ Recommendation • Everyone's responsibility to complete forms • Awareness raised of use in improved induction • Further re-audits to ensure standards are continued. • Re-audit in six months
Audit of timeliness of letters and completion of Routine Outcome Measures (ROM) in Sefton Child and Adolescent Mental Health Services (CAMHS)	The audit was disseminated in a business meeting to all staff and also discussed at task force to look at the strategic implications in December 2016. Action/ Recommendation • Continue with the ROMS work stream. • Look at first partnership letters. • Develop a guideline about what letters are to be produced and by when. • Increase Routine Outcome Measures compliance which provides solutions and to think about standard guidance. • Offer training on standard guidance. • Re-audit in 12 months to see if changes have been implemented.
Cleft Transition Project: Measuring the Outcomes of a Cleft Transition Package	The audit was presented at the Craniofacial Society of Great Britain and Ireland Conference in Newcastle in April 2017. Action/ Recommendation: • To create new Cleft transition guidelines. • A bespoke information package and transition pathway were agreed upon and created ready to be piloted. • No re-audit required at present.
An audit of incident reporting in the Orthopaedic Department	The audit report was presented to the Alder Hey Orthopaedic Department Mortality and Morbidity meeting in March 2017. Action/ Recommendation: • We recommend that steps are taken to continue to raise the profile of the incident reporting process amongst all staff groups in the Orthopaedics Department to encourage continued engagement with the system. • Ongoing efforts during educational sessions to raise the profile of incident reporting amongst medical staff.

Local Audit	Actions
	• Re-audit in six months.
Re-audit of Early Bird Clinic data - Use of local anaesthetic, referral data & coding	The audit was presented at the Alder Hey Burns & Plastic Surgery Department Clinical Governance Meeting in December 2016. Action/ Recommendation: • We are considering if directed education to certain health care centres about appropriate referrals may be useful. • Coding was much improved since the introduction of the pro forma. Continue using the pro forma and encourage its use over the weekend. • Consider education about appropriate referrals. • Re-audit of data over a longer period of time to show the trend of data throughout the year. • Re-audit in 12 months.
Does the introduction of a neonatal clerking proforma in the Accident and Emergency department improve record keeping in infants under 6 weeks.	The audit was presented at the Alder Hey Emergency Department audit meeting in August 2016. Action/ Recommendation: • The neonatal clerking pro-forma will be updated and formatted to a higher standard. It will also be included in the future electronic hospital system (Meditech) to allow the pro-forma to make the transition to the integrated paperless system. • Re-audit once integration to the new system has been completed.
Audit of Management of patients with Clavicular Fractures against Departmental Guidelines at Alder Hey Emergency Department	The audit was presented at the Alder Hey Emergency Department audit meeting in September 2016. Action/ Recommendation: • Very good compliance with the new pathway. • This audit indicates that children are not coming to harm by following this new, less conservative approach to management of clavicle fractures. Families are being saved unnecessary follow-up. • Changes have already been made. This was a re-audit to confirm that change has been effective. • Re-audit in one to two years.
Prescribing of Proton Pump Inhibitors at Alder Hey	The audit was presented at the Alder Hey Pharmacy clinical forum and the Alder Hey

Local Audit	Actions
	Medicines Management and Optimisation Committee meeting in September 2016. Action/ Recommendation: • Alert pharmacists to remain extra vigilant when clinically checking prescriptions. • Disseminate the audit findings to the relevant clinical teams. • Re-audit in 12 months.
Paediatric Recovery Pain Assessment Audit	The audit is due to be presented in 2017. Action/ Recommendation: • Update pain assessment training, with help from the Pain Team. • Pain assessment will now be added to the hospital system (Meditech). • Re-audit in 6 months.
Use of Methotrexate in patient with psoriasis	The audit was presented at the Dermatology Audit meeting at Liverpool Broadgreen Hospital in November 2016. Action/ Recommendation: • This was a regional audit and the Alder Hey centre performed at a higher standard than the rest of the regional centres in the auditable criteria. • No changes are necessary as we performed at a high standard and already have the policies in place to achieve the audit goals. • Re-audit in three years.
Evaluation of rapid access tongue tie service	The audit was presented at the Alder Hey Ear Nose and Throat (ENT) Department meeting in November 2016. Action/ Recommendation: • Overall patient satisfaction with the service was reported as good. Waiting times for an appointment were the main issue. • Hopefully introduce more clinic slots and a breastfeeding nurse. • Re-audit in one year.
Management of patients with Urinary Tract Infection (UTI) presenting to and discharged by Emergency Department	The audit was presented at the Alder Hey Emergency Department audit meeting in December 2016. Action/ Recommendation: • Aim to improve urine sampling techniques to reduce contaminants and ensure results are more accurate. • Induction presentation completed for new trainees rotating into the department so that they are aware of practice. • Improved cleanliness in obtaining samples.

Local Audit	Actions
	• Introduction of a dipstick flowchart above urinalysis machines. • Better classification of Upper versus Lower UTI • Re-audit in six months.
Audit of management of non-blanching rash in Emergency Department	The audit was presented at the Alder Hey Emergency Department audit meeting in February 2017. Action/ Recommendation: • Update the departmental guideline for the management of non-blanching rash. • A new patient information leaflet has been drafted. • A re-audit is recommended at a time to be decided by the Emergency Department team.
Review on horse related traumas and appropriateness of the imaging carried out during initial presentation and subsequent follow-ups.	The audit was discussed with the clinical supervisor and submitted for presentation at the British Society of Emergency Radiology (BSER) conference in April 2017. Action/ Recommendation: • Good awareness, knowledge and adequate training will help minimise the number of untoward incidents due to horse riding. • We also found out that the initial assessment from Accident and Emergency doctors would also help us in suggesting appropriate initial imaging and save the radiation burden on a young population. • No re-audit needed as we are following the guidelines appropriately.
Cardiac arrest in paediatric intensive care	The audit was presented at the Alder Hey Paediatric Intensive Care Unit audit meeting in February 2017 Action/ Recommendation: • Improve documentation of Cardio Pulmonary Resucitation (CPR). • Clearer documentation including the duration of CPR. • Re audit (prospective) in 6 months.
Radiological imaging in tiptoe walking children	The audit was presented at the Alder Hey Children's Orthopaedics Alumni meeting: (Mersey Deanery Regional meeting). Action/ Recommendation: • We will offer further advice and counselling to parents. • We have devised an algorithm for assessing the requirement for Magnetic resonance

Local Audit	Actions
	imaging (MRI), with the aim of reducing the number of unnecessary scans. • Inform other specialties in the Trust of the findings of the audit. • Re-audit in one year after implementation of the new algorithm.
Epistaxis - National Audit of Management 2016	No patients presented that met the audit criteria during the audit period. Therefore no patients details were collected or sent to the central data collection point. Action/ Recommendation: • The second audit cycle will be performed next year by the new incoming registrars.
A Survey of Patient/Carer Satisfaction at Alder Hey Orthopaedic Outpatients Department	The audit was presented at the Alder Hey Orthopaedics Department audit meeting in December 2016. Action/ Recommendation: • Disseminate feedback to fracture clinic department to inform them of progress made. • Consider asking for dedicated out-patient fracture clinic service (as opposed to current shared service) so that nursing and medical staff can focus attention on seeing fracture clinic patients in a more streamlined manner (the department is aware this recommendation will be difficult to follow through on actually implementing). • Continue to work to the high standards identified in our audit. Consider being able to ask for dedicated fracture clinic to streamline patients being seen. • This project was a re-audit.
A service evaluation of Alder Hey Primary Child and Adolescent Mental Health Services (CAMHS) offer to schools	The audit was presented at the North of England Psychiatry conference on 25th November 2016 and the North West Royal College of Psychiatry conference on 2nd December 2016.This work has also served as an early identification of mental health concerns for young people. It has enabled appropriate signposting for young people for continued intervention if mental health concerns are identified by referral to the appropriate CAMHS Services. Action/ Recommendation: • Information leaflets were developed detailing roles and menu of interventions offered.

Local Audit	Actions
	• Training packs used by clinicians have been formulated. • One to one supervision of key workers by link workers as well as group reflective practice peer supervision. • Standardisation of feedback forms and qualitative questionnaires to schools. • Link clinicians to screen referrals by key workers. • There was a wide range in uptake of the services offered. Some schools took up more sessions compared to a few others schools who did not request any sessions. This will be explored further in an ongoing research project. • Schools report they feel more contained by having better links with key workers and CAMHS link workers. This will be further examined by questionnaire data.
Auditory Brainstem Response (ABR) under melatonin and general anaesthesia	The audit was presented at a National audit meeting in Sheffield in November 2016. Audit observations were subsequently revised as final in December 2016. Action/ Recommendation: • A business case for a dedicated ABR under General Anaesthetic list has already commenced. Proposed two half day lists every 3 months. • Identifying the correct time for maximum efficacy with melatonin; we will discuss this with our pharmacy; afternoon rather than morning lists are suggested. • Re-audit in 12 months.
Outcome of current dosing of growth hormone in children	The audit was presented at the 2016 Royal College of Paediatric Child Health (RCPCH) Spring meeting (as a poster presentation) and has been submitted to PlosOne (online medical journal) for publication. Action/ Recommendation: • We are awaiting publication and then it will be fed back to national leaders in endocrinology regarding dosing adjustments. • Update our existing policy to include new dosing for obese children.

Local Audit	Actions
	• Update our existing guidelines to include new dosing for obese children. • Changes to our clinical practice to include new dosing for obese children. • No re-audit required as this could/should be done via national data collection schemes.
An audit of Propranolol use for infantile haemangiomas	The audit was presented at Liverpool Broadgreen Hospital Dermatology audit meeting in January 2017. Action/ Recommendation: • The guidelines from the British association of paediatric dermatology were being followed. • To develop a pro-forma to capture the audit data by May 2017. • Re-audit in five years.
Towards Fast Tracking following Paediatric Cardiac Surgery: Strategy and Initial Experience with Early Extubation	The audit was presented at the British Congenital Cardiac Association meeting in Nottingham in November 2016. Action/ Recommendation: • Early extubation can be accomplished safely following cardiac operations in an age-selected paediatric population and it is associated with low morbidity, mortality with reduced Paediatric Intensive Care (PICU) and Hospital length of stay. • This preliminary study demonstrates that a fast-tracking model is feasible. • Re-audit in twelve months.

2.3.5 Participation in Clinical Research 2016/17

The number of patients receiving NHS services provided or subcontracted by Alder Hey Children's NHS Foundation Trust (Alder Hey) in 2016/17 that were recruited to participate in NIHR Portfolio adopted clinical research was 3784.

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 242 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. Over the last 10 years Alder hey has achieved this for 16 of its patients.

Our clinical staff and associated academics lead and contribute to studies of the latest and newest 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 96 open, NIHR portfolio adopted clinical research studies and 14 non-portfolio studies during 2016/17, 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 Specialities reflecting the prevalence of available research studies locally and nationally.

01/04/2016 to 31/03/2017				
	NIHR Studies	**Number of Participants**	**Non-NIHR Studies**	**Number of Participants**
SG1 *(Oncology, Haematology, Palliative Care)*	31	148	10	22
SG2 *(Nephrology, Rheumatology, Gastro, Endocrinology, Dietetics)*	44	373	9	9
SG3 *(Respiratory, Infectious Diseases, Allergy, Immunology, Metabolic Diseases)*	26	1770	6	4
SG4 *(A&E, Gen Paeds, Diabetes, Dermatology, CFS/ME)*	8	410	4	1
SG5 *(CAMHS tier 3 & 4, Psychological Services & Dewi Jones)*	4	147	1	2
SG6 *(Comm. Child Health, Safeguarding, Social Work Dept., Comm Clinics, Neurodisability Education,*	2	33	4	12

Fostering, Adoption, Audiology)				
SG7 *(PICU, HDU, Burns)*	3	31	6	18
SG8 *(Theatres, Daycase Unit, Anaesthetics Pain Control)*	1	1	1	0
SG9 *(Gen Surgery, Urology, Gynae, Neonatal)*	8	48	1	0
SG10 *(Cardiology, Cardiac Surgery)*	0	0	1	0
SG11 *(Orthopaedics, Plastics)*	3	104	3	22
SG12 *(Neurology, Neurosurgery, Craniofacial, LTV)*	20	77	5	9
SG13 *(Specialist Surgery, ENT, CL&P, Ophthalmology, Maxillofacial, Dentistry, Orthodontics)*	7	161	3	14
SS1 *(Radiology)*	0	0	2	1
SS2 *(Pathology)*	0	0	0	0
SS3 *(Pharmacy)*	0	0	2	0
SS4 *(Therapies, EBME, Central Admissions, Bed Management, Medical Records, Generic Outpatients)*	0	0	0	0
NON-CBU	3	0	2	0
CNRU	0	0	1	0
Non Classified	2	9	1	0
TOTAL	162	3311	61	150

The Quality Account deals with research activity during the 2016/17 period. In addition to this, the CRBU published performance data on the Trust website indicating the time it takes to set up a study and the time taken to recruit the first patient once all permissions have been granted. Over 71% of studies conducted at Alder Hey recruit the agreed number of patients within a set timeframe (75% 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 24 hour 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. The CRF has just been awarded a new 5 year contract to expand early phase and experimental research through to 2022.

There were over 350 members of clinical staff participating in research approved by a research ethics committee at Alder Hey during 2016/17. 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 30 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. 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. Duchenne Muscular Dystrophy research has grown significantly with new compounds being developed that address the root cause of the disease. Alder Hey has been selected as one of 3 centres of excellence in England for DMD research and two patients with DMD have been global firsts. 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. The Trust has recently been successful in its application to be a Cystic Fibrosis Clinical Trials Accelerator and will receive 3 years funding to employ a part time trial co-ordinator dedicated to CF research.

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. There are 2 devices under development and these will use the hospital environment and its patients to test prototypes.

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. In 2016 Alder Hey was shortlisted for 5 research awards (Rising Star, Delivery of Life Sciences, Most Innovative Collaboration, Patient Ambassador and NIHR@10). Alder Hey won 3 and received awards for Most Innovative Collaboration, Patient Ambassador and 10 years of outstanding impact 2006 – 2016 from the North West Coast Clinical Research Network. These awards represent the significant contribution the Trust makes to high quality clinical research.

For more information on the research portfolio at Alder Hey please visit
www.alderhey.nhs.uk/research

2.3.6 Use of the Commissioning for Quality and Innovation (CQUIN) payment framework.

A proportion of Alder Hey's income in 2016/17 was conditional on achieving quality improvement and innovation (CQUIN) goals agreed between Alder Hey and any

person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services through the Commissioning for Quality and Innovation payment framework. During 2016/17, these commissioning bodies were Liverpool CCG and consortia North West CCG partners for non-specialist services and NHS England for specialist services.

For 2016/17 the baseline value of CQUIN was £3 million which was 1.9% of the total contract value. This means that if Alder Hey did not achieve an agreed quality goal, a percentage of the toal CQUIN money would be withheld. For 2016/17, Alder Hey expects to receive 96% of the CQUIN money which is reflective of failure to deliver full compliance with the sepsis targets for Quarters 1-3, and the Learning Disabilities target for Quarter 1 only.

The tables below reflect the position as at Quarter 3, as the Quarter 4 position is not fully validated at the time of publication, although this is not expected to change in Quarter 4.

Local Commissioner CQUINs 2016-17

Indicator	Indicator Description	Target	Weighting	Financial Value	Quarter 3 Performance
Digital Maturity	Digital Maturity Assessment	Participation & Submit reports	0.35%	£172,654	Achieved
	Communication Information Sharing	Participation & Submit reports			Achieved
	Communication Shared Records	Participation & Submit reports			Achieved
	ICE Order Comms Deployment	Participation & Submit reports			Achieved
	Digital Maturity Interoperability	Participation & Submit reports			Achieved
Transition from CAMHS to Adult Mental Health & Learning Disabilities		Submit reports	0.5%	£246,649	Achieved
Learning Disabilities Equality & Diversity: Reasonable Adjustments		Submit reports	0.4%	£197,319	Partially Achieved

National Commissioner CQUINs 2016-17

Indicator	Indicator Description	Target	Weighting	Financial Value	Quarter 3 Performance
Sepsis	Timely identification & treatment of sepsis in emergency departments	Audit 50 cases (all if fewer) monthly	0.25%	£123,325	Not achieved
		Audit 30 cases (all if fewer) monthly			

	Timely identification & treatment of sepsis in acute inpatient settings	Audit 50 cases (all if fewer) monthly			Not achieved
		Audit 30 cases (all if fewer) monthly			
Antimicrobial resistance	Reduction in antibiotic consumption per 1,000 admissions	1% reduction	0.25%	£123,325	Achieved
		1% reduction			
		1% reduction			
	Empiric review of antibiotic prescriptions	Submit reports			
Improving health and well being of NHS staff	1A: Option B selected: Introduction of health & wellbeing initiatives covering physical activity, mental health & improving access to physiotherapy for people with MSK issues.	Submit reports	0.75%	£369,974	Achieved
	1B: Healthy food for NHS staff, visitors & patients	Submit reports			
	1C: Improving uptake of flu vaccinations for front line clinical staff	75% front line clinical staff vaccinated			

NHSE North West Specialist Commissioner CQUINs 2016-17

Indicator	Target	Weighting	Financial Value	Quarter 3 Performance
Clinical Utilisation Review	Submit report	1.04%	£926,399	Fully achieved
HSS Audit: Craniofacial Surgery	Participation	0.1%	£75,000	Fully achieved
HSS Audit: ECMO	Participation	0.1%	£75,000	Fully achieved
Difficult to Control Asthma Assessment within Twelve Weeks	70%	0.2%	£170,000	Fully achieved
Univentricular Infants Home Monitoring	100%	0.2%	£170,000	Fully achieved
Planned Transition to Adult Services for Specialised Paediatric Patients	Submit report	0.2%	£170,000	Fully achieved
Haemoglobinopathy Improving Pathways through Operational Delivery Networks	Submit report	0.2%	£188,609	Fully achieved

2.3.7 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 2016/17.

Latest inspection result from CQC - June

Alder Hey has participated in special reviews or investigations by the Care Quality Commission (CQC) relating to the following areas during 2016/17: a national data collection exercise in June 2016 relating to the Trust's mortality review process following the publication of the Mazar's Report into events at Southern Healthcare NHS Trust.

Alder Hey continued to work towards full completion of the action plan developed in response to the inspection undertaken in June 2015 both in relation to the Trust's acute services and community CAMHS. All actions were completed during the year, although there are a small number of actions which can be characterised as process issues which will be rolled forward into the relevant local system.

2.3.8 Data Quality

Alder Hey Children's NHS Foundation Trust submitted records during 2016/17 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:

- 100% for admitted patient care;
- 100%for outpatient care;
- 100% for accident and emergency care.

The percentage of records in the published data which included the patient's valid General Medical Registration Code/Practice code was

- 100%for admitted patient care;
- 100% for outpatient care;
- 100% for accident and emergency care

Alder Hey Children's NHS Foundation Trust will be taking the following actions to maintain the excellent standard of data quality/validation

- 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 Steering group
- 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.

2.3.9 Information Governance Toolkit attainment levels

Alder Hey's Information Governance Assessment Report overall score for 2016/17 was 85% and was graded as satisfactory (green).

2.3.10 Clinical Coding Error Rate

Alder Hey was not subject to the Payment by Results clinical coding audit during 2016/17 by the Audit Commission. However the Trust employs a qualified auditor who undertook the audit locally for the period 2016/17. The error rates reported for that period for diagnoses and treatment coding (clinical coding) were:

- Primary Diagnoses Incorrect 8%
- Secondary Diagnoses Incorrect 18%
- Primary Procedures Incorrect 5%
- Secondary Procedures Incorrect 10%

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

2.4 Reporting against Core Indicators

The Trust is required to report performance against a core set of indicators using data made available to the Trust by NHS Digital

For each indicator the number, percentage, value, score or rate (as applicable) is presented in the table at Appendix 1. In addition, where the required data is made available by NHS Digital, a comparison of the numbers, percentages, values, scores or rates of each indicator is made, with:

- The national average for the same
- Those NHS Trusts with the highest and lowest for the same

Part 3: Other information – Quality Performance in 2016/17

3.1 Quality Performance

This section provides an update on the Trust's quality performance during 2016/17, including an update on performance against priorities identified in the previous quality report, plus an update on specific indicators under patient safety, clinical effectiveness and patient experience.

Alder Hey Children's NHS Foundation Trust has maintained a strong focus on quality improvement throughout 2016-17. The revised quality strategy, 'Inspiring Quality', describes the Trust's focus on quality improvement for the next 5 years. The first 12 months of implementing the strategy have been focussed on gathering and sharing quality improvement initiatives, establishing the Quality Strategy Steering Group, and implementing a system of devolved governance to drive improvements in ward to board reporting of quality and risk, and in local governance systems and processes. Having reported on the move into the new hospital building in last year's quality account, we are now well established in the new facility and are continuing to deliver fantastic care to our children and young people. Staff are now much more settled into the new building and we have sought to improve our staff engagement by putting Listening into Action at the helm of all of our quality improvement work.

The Children and Young People's Forum continues to go from strength to strength and we have maintained a strong focus on ensuring we keep the patient at the heart of everything we do, giving a voice to our children and families wherever possible.

3.2 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 24th June 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 Children's NHS Foundation Trust joined the Sign up to Safety campaign and developed a Trust Wide Safety Improvement Plan with specific improvement outcomes as highlighted in the previous quality report. The aim is that by March 2018, against a 2014/15 baseline, we will:

- Achieve no never events year on year
- Reduce all avoidable harm by 30%
- Reduce avoidable moderate, severe harm or death by 50%
- Achieve a 95% patient satisfaction score

Progress against the Sign up to Safety campaign is reflected below as part of the Trust's key priorities for improvement for 2016-17, which were agreed by the Trust Board. These were derived from national and regional priorities, Trust performance

against quality and safety indicators, risk trend analyses and patient and public feedback and are reflected in the Safety Improvement Plan.

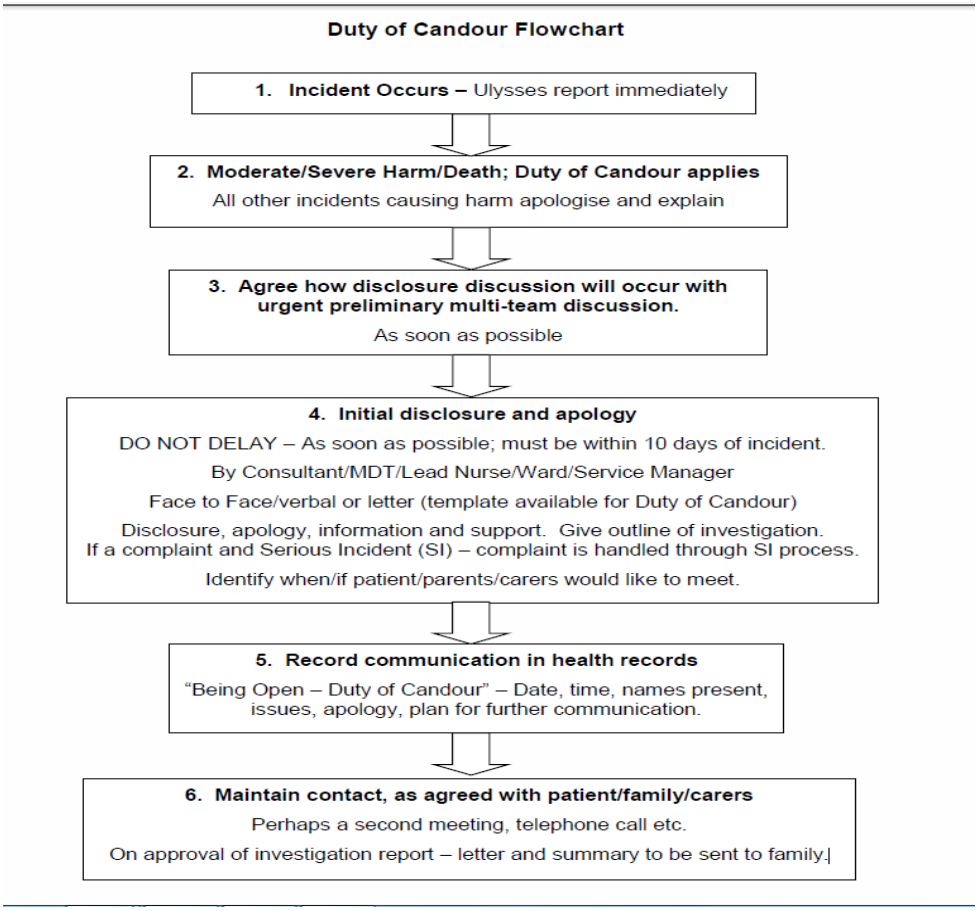
3.2.1 Duty of Candour

The Trust is firmly committed to maintaining an open, no blame, learning culture and in support of this operates a 'Being Open and Duty of Candour Policy' which describes how the Trust implements the National Patient Safety Agency (NPSA) safety alert "Being Open Framework 2009: Being Open – Saying Sorry When Things go Wrong" and the "Duty of Candour CQC Regulation 20 (2015)".

The policy provides a framework for:

- Patients and carers to receive open, accurate and timely communication, an apology as appropriate and the support they need when mistakes have been made.
- Staff to be encouraged to admit shortcomings and mistakes, learn from errors and to be supported
- Root Cause Analysis, investigation and learning to occur systematically

The Duty of Candour (DoC) Flowchart below shows how the Trust implements DoC



During 2016/17, the Trust implemented formal Duty of Candour on 9 out of 10 occasions when the DoC requirement was triggered. On the 10th occasion, the incident involved two Trusts and the formal Duty of Candour letter was issued appropriately by the other Trust.

3.3 Key Priorities for Improvement in Quality 2016/17

Aim: **No drug errors resulting in avoidable harm**.
Targets were set in the Sign up to Safety improvement plan 2015-18

***Targets*:** From 2014/15 baseline:

1. Reduce all medication errors that result in harm by 15% by March 2017; this represents Baseline: 128 Target: 108.
2. Reduce medication errors that result in moderate, severe harm or death by 30% by March 2017; Baseline: 4 Target: 2

***Outcomes*:**

1. 47.6% reduction in all medication errors that result in harm; this represents 67.
2. 75% reduction in medication errors that result in moderate, severe harm or death; this represents 1.
3. 52% increase in medication incident reporting since 2014-15. From 703 to 1069 medication incidents reported
4. Decrease from 18.2% to 6.3% of medication incidents reported with harm attached since 2014-15

3.3.1 PRIORITY 1. - Medication safety

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.

Table 1: Shows ongoing increase in reporting of medication incidents. This has increased from a baseline in 2014-15 from 703 incidents to 1069 in 2016-17 [52% increase in reporting]

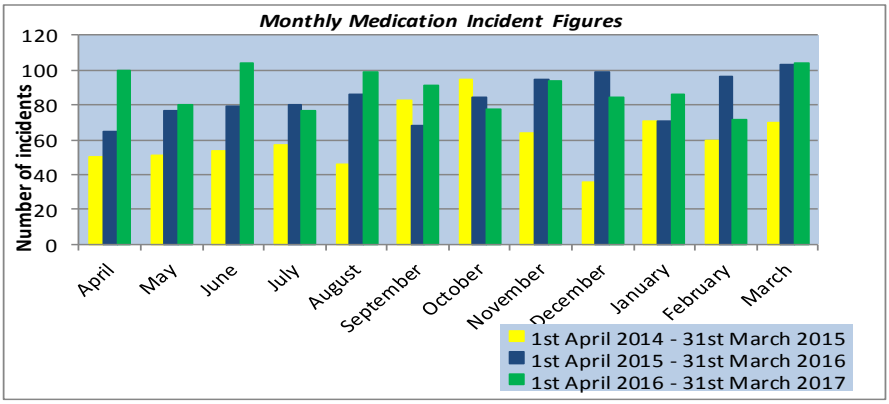
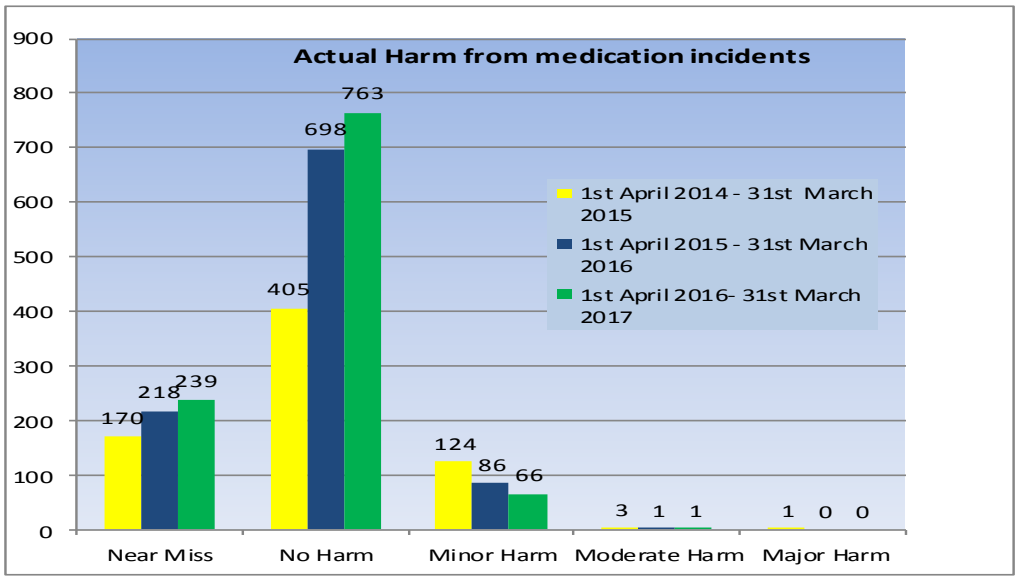


Table 2: Shows the number of incidents that resulted in harm. This has decreased from 128 in 2014-15 to 67 in 2016-17 [48% improvement]. Plus moderate, severe harm or death has decreased from 4 in 2014-15 to 1 in 2016-17.

This exceeds our Sign up to Safety goals ahead of the 2018 targets to reduce all harm from medication errors by 25% and to reduce moderate, severe harm and death by 50%.



The tables above reflect an improvement in safety culture and increased support since the appointment of the Medication Safety Officers (MSOs). The work undertaken to achieve these results is reflected below.

Improvements

1. Improved the quality of incident report data by implementing a more consistent approach to follow up and ensuring minimum data is completed prior to incidents being uploaded to the National Reporting and Learning System.

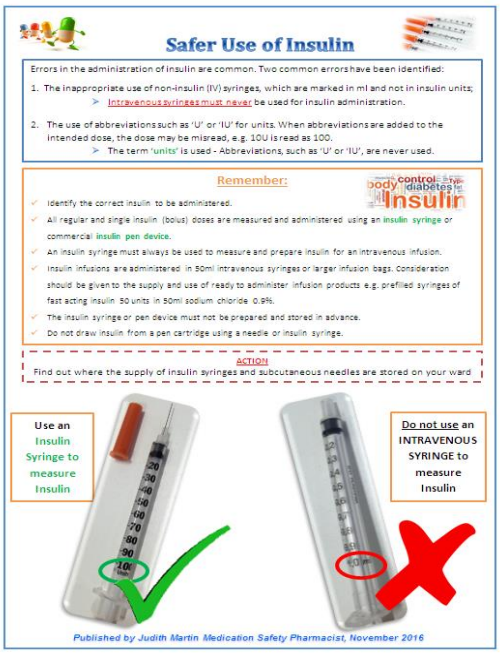
2. The implementation of the MERP (Medication Error Reporting Program) grading structure for harm caused by a medication error provides a much more objective method of assessment.

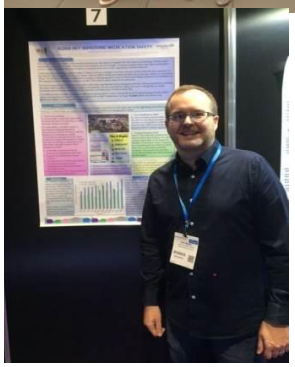
3. A more formal process for involving educational supervisors in follow up of prescribing errors by junior doctors has been well received. This is supported by circulation of a monthly summary of incidents caused by prescribing errors.

4. Developed a medication safety mandatory training workbook. This has been approved by the Medicines Management Committee (MMC) and implemented 1st April 2017.

5. Working with the handover co-ordinator a monthly, 'Prescribing Learning Outcome' from incidents is identified and repeated at handover. In this way the knowledge is registered in the prescriber's thought process.

6. Line managers are offered support when investigating incidents by MSOs. This has improved the response time for investigations.





7. When managers need support in completing/reviewing incidents we set up 'Medication Safety Surgeries' to offer advice and analyse reported incidents. This ensures the reporters know their incidents are followed up to avoid a repeat.

8. Ensuring any medication errors involving the Meditech Electronic Prescribing and Medication Administration (EPMA) system are fed back to the Meditech team and used to shape and prioritise developments.

9. Developed links with universities which have increased the delivery of medication safety training to student nurses who are placed within Alder Hey.

10. Showcased our successes at the Sign up to Safety event held at Alder Hey to re-iterate to staff to follow the five rights and encourage reporting.

11. The Nurse MSO was a speaker at the Medication Safety Summit in London in June 2016.

12. The MSOs poster on improving the safety culture in the Trust with regard to medication errors was shortlisted at the "Patient Sign up to Safety conference" in Manchester in July 2016.

13. The MSOs presented a poster at the Patient Safety Congress conference in London in November 2016 on the role of MSO within Alder Hey.

14. Provide regular training on many aspects of prescribing, administering and dispensing medicines to medical, theatre, nursing and pharmacy staff.

15. Circulate monthly reports for nursing staff regarding medication errors and specific medication reports are provided to each CBU and also the education department for the medics.

16. An intranet page dedicated to medication safety has been developed which includes recent alerts and lessons learned.

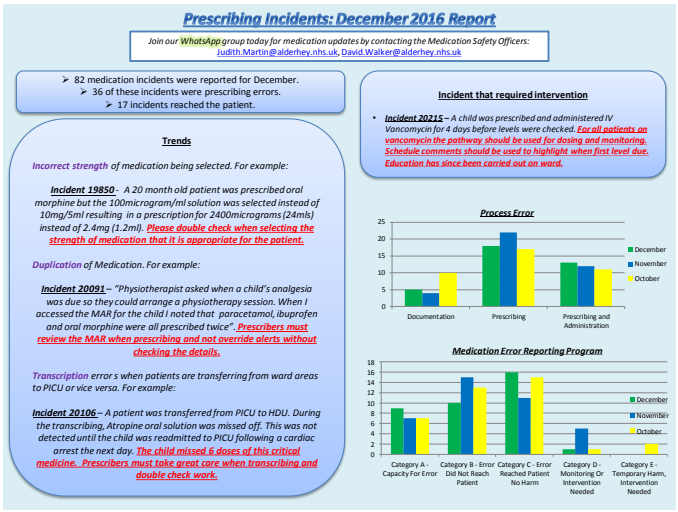
17. Publicised the need to report more adverse drug reactions within pharmacy and the medical teams. There is currently a running competition. Since this was set up, the

number of adverse drug reactions reported to the MHRA via the Yellow card scheme has increased by 557% (7 in 2014/15 to 39 in 2016/17).

18. We set up a TPN working group and workshop which highlighted 3 key areas for improvement:
    - Criteria for when TPN is appropriate to start.
    - Develop a training package on TPN for nurses and doctors.
    - Develop a new TPN prescription form

19. Developed a MSO dashboard to monitor our progress.

20. Successful forerunner bid secured from Health Education North West to support the role of a ward based Pharmacy Technician at ward level to prepare and administer medications. A research project is underway to understand the impact of the role on patient experience, medication safety, and the impact of the role on nursing time by releasing time to care.



Prescribing Incidents: December 2016 Report

Join our WhatsApp group today for medication updates by contacting the Medication Safety Officers: Judith.Martin@alderhey.nhs.uk, David.Walker@alderhey.nhs.uk

- 82 medication incidents were reported for December.
- 36 of these incidents were prescribing errors.
- 17 incidents reached the patient.

Incident that required intervention

- **Incident 20215** – A child was prescribed and administered IV Vancomycin for 4 days before levels were checked. For all patients on vancomycin the pathway should be used for dosing and monitoring. Schedule comments should be used to highlight when first level due. Education has since been carried out on ward.

Trends

Incorrect strength of medication being selected. For example:

Incident 19850 - A 20 month old patient was prescribed oral morphine but the 100microgram/ml solution was selected instead of 10mg/5ml resulting in a prescription for 2400micrograms (24mls) instead of 2.4mg (1.2ml). Please double check when selecting the strength of medication that it is appropriate for the patient.

Duplication of Medication. For example:

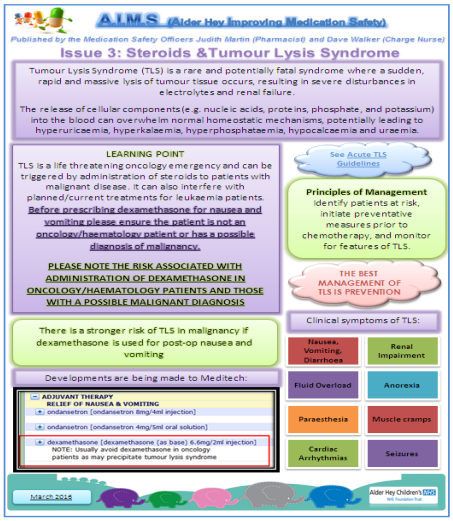
Incident 20091 – "Physiotherapist asked when a child's analgesia was due so they could arrange a physiotherapy session. When I accessed the MAR for the child I noted that paracetamol, ibuprofen and oral morphine were all prescribed twice". Prescribers must review the MAR when prescribing and not override alerts without checking the details.

Transcription error s when patients are transferring from ward areas to PICU or vice versa. For example:

Incident 20106 – A patient was transferred from PICU to HDU. During the transcribing, Atropine oral solution was missed off. This was not detected until the child was readmitted to PICU following a cardiac arrest the next day. The child missed 6 doses of this critical medicine. Prescribers must take great care when transcribing and double check work.

Process Error

Medication Error Reporting Program



A.I.M.S (Alder Hey Improving Medication Safety)

Published by the Medication Safety Officers Judith Martin (Pharmacist) and Dave Walker (Charge Nurse)

Issue 3: Steroids &Tumour Lysis Syndrome

Tumour Lysis Syndrome (TLS) is a rare and potentially fatal syndrome where a sudden, rapid and massive lysis of tumour tissue occurs, resulting in severe disturbances in electrolytes and renal failure.

The release of cellular components (e.g. nucleic acids, proteins, phosphate, and potassium) into the blood can overwhelm normal homeostatic mechanisms, potentially leading to hyperuricaemia, hyperkalaemia, hyperphosphataemia, hypocalcaemia and uraemia.

LEARNING POINT

TLS is a life threatening oncology emergency and can be triggered by administration of steroids to patients with malignant disease. It can also interfere with planned/current treatments for leukaemia patients. Before prescribing dexamethasone for nausea and vomiting please ensure the patient is not an oncology/haematology patient or has a possible diagnosis of malignancy.

PLEASE NOTE THE RISK ASSOCIATED WITH ADMINISTRATION OF DEXAMETHASONE IN ONCOLOGY/HAEMATOLOGY PATIENTS AND THOSE WITH A POSSIBLE MALIGNANT DIAGNOSIS

See Acute TLS Guidelines

Principles of Management

Identify patients at risk, initiate preventative measures prior to chemotherapy, and monitor for features of TLS.

THE BEST MANAGEMENT OF TLS IS PREVENTION

There is a stronger risk of TLS in malignancy if dexamethasone is used for post-op nausea and vomiting

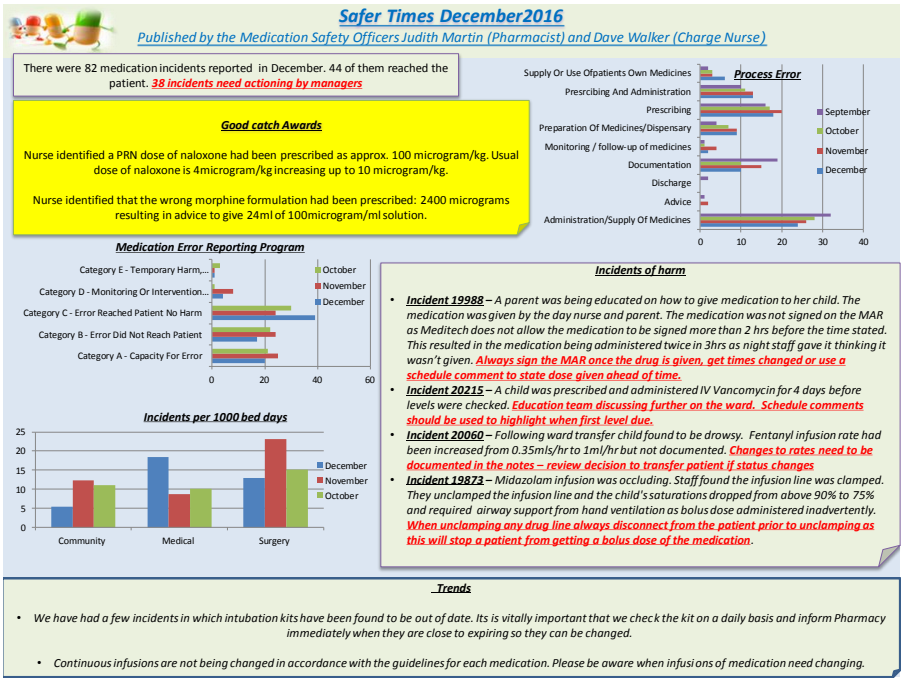
Developments are being made to Meditech:

ADJUVANT THERAPY
RELIEF OF NAUSEA & VOMITING
ondansetron [ondansetron 8mg/4ml injection]
ondansetron [ondansetron 4mg/5ml oral solution]
dexamethasone [dexamethasone (as base) 6.6mg/2ml injection]
NOTE: Usually avoid dexamethasone in oncology patients as may precipitate tumour lysis syndrome

Clinical symptoms of TLS:

Nausea, Vomiting, Diarrhoea | Renal Impairment | Fluid Overload | Anorexia | Paraesthesia | Muscle cramps | Cardiac Arrhythmias | Seizures

March 2016



Safer Times December2016

Published by the Medication Safety Officers Judith Martin (Pharmacist) and Dave Walker (Charge Nurse)

There were 82 medication incidents reported in December. 44 of them reached the patient. 38 incidents need actioning by managers

Good catch Awards

Nurse identified a PRN dose of naloxone had been prescribed as approx. 100 microgram/kg. Usual dose of naloxone is 4microgram/kg increasing up to 10 microgram/kg.

Nurse identified that the wrong morphine formulation had been prescribed: 2400 micrograms resulting in advice to give 24ml of 100microgram/ml solution.

Process Error

Medication Error Reporting Program

Incidents per 1000 bed days

Incidents of harm

- **Incident 19988** – A parent was being educated on how to give medication to her child. The medication was given by the day nurse and parent. The medication was not signed on the MAR as Meditech does not allow the medication to be signed more than 2 hrs before the time stated. This resulted in the medication being administered twice in 3hrs as night staff gave it thinking it wasn't given. Always sign the MAR once the drug is given, get times changed or use a schedule comment to state dose given ahead of time.
- **Incident 20215** – A child was prescribed and administered IV Vancomycin for 4 days before levels were checked. Education team discussing further on the ward. Schedule comments should be used to highlight when first level due.
- **Incident 20060** – Following ward transfer child found to be drowsy. Fentanyl infusion rate had been increased from 0.35mls/hr to 1ml/hr but not documented. Changes to rates need to be documented in the notes – review decision to transfer patient if status changes
- **Incident 19873** – Midazolam infusion was occluding. Staff found the infusion line was clamped. They unclamped the infusion line and the child's saturations dropped from above 90% to 75% and required airway support from hand ventilation as bolus dose administered inadvertently. When unclamping any drug line always disconnect from the patient prior to unclamping as this will stop a patient from getting a bolus dose of the medication.

Trends

- We have had a few incidents in which intubation kits have been found to be out of date. Its is vitally important that we check the kit on a daily basis and inform Pharmacy immediately when they are close to expiring so they can be changed.
- Continuous infusions are not being changed in accordance with the guidelines for each medication. Please be aware when infusions of medication need changing.

Examples of typical monthly reports and education / alert notices.

Future Goals and Plans:

1. A WhatsApp group for Junior Doctors was initiated to communicate medication alerts. Currently we are not utilising this service as intended and is to be revaluated for the following year.
2. To improve the process of involving prescribers in the incident by forging closer links with the Medical Leads. We are hoping to meet with the new Medical Director to outline the plans we have with prescribers involved in incidents.
3. Developing close working links with the Medical Device Safety Officer (MDSO).
4. Developing an app with the Innovation team. This app will allow the patients to have a better understanding of their medications. This is being driven by feedback from Children, young people and parent's workshop.
5. Decreasing the incidents that involve TPN and Heparin. To embed the work from the workshops that has been done.
6. Develop more audits with attention to TPN, controlled drugs etc. and involve more staff in undertaking these audits and taking ownership for resulting actions
7. Introducing SN@P as an education tool for staff who struggle with numeracy.
8. Introduce Script for prescribers. This safe prescribing toolkit will be available from 1st April 2017 for medical and non-medical prescribers.
9. Developing links with Patient Safety Champions.
10. To complete and roll out the new electronic Root Cause Analysis tool for all medication errors that result in harm, which includes identification of harm, contributory factors and financial implications.
11. Developed an independent checking process. This has to be approved by Medicines Management Committee (MMC) and training provided on the new process to clinical staff.
12. Reviewing Ulysses layout to make it easier to report (e.g. more drop down functions)
13. Review the findings from the ward based Pharmacy Technician project to inform of potential future changes in workforce to support medication safety

Aim: No avoidable pressure ulcers.

Targets: From the 2014/15 baseline:

1. Reduce avoidable hospital acquired grade 2 pressure ulcers by 20%; this represents 18.
2. Reduce avoidable hospital acquired grade 3 pressure ulcers by 50%; this represents 1.
3. Zero avoidable hospital acquired grade 4 pressure ulcers.

Outcomes:

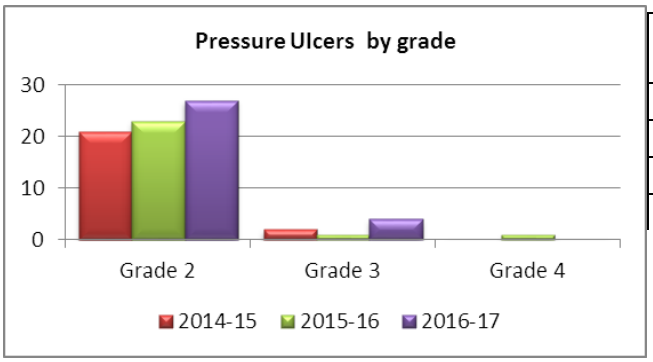
1. Increase of 6 grade 2 hospital acquired pressure ulcers: this represents 27.
2. Increase of 2 hospital acquired grade 3 pressure ulcers: this represents 4.
3. Achieved zero grade 4 hospital acquired pressure ulcers.
4. Total number of pressure ulcers of grades 2-4 is 31, compared to 23 in 2014/15.

3.3.2 PRIORITY 2. Reducing Harm to Patients as a result of developing a Pressure Ulcer

A pressure ulcer is an injury that breaks down the skin and underlying tissue due to pressure, friction and shear or a combination of these. They can be very painful and debilitating and are often preventable. It is recognised that immobilised and acutely ill neonates and children are at risk of developing pressure ulcers, particularly in a critical care environment. Most pressure ulcers within our organisation are associated with medical devices such as cannulas, which is reflective of national research showing that most paediatric pressure ulcers are device related.

Since the appointment of a new Tissue Viability nurse at Alder Hey, there has been a strong focus on education and training in the prevention, recognition and treatment of pressure ulcers and clarifying and simplifying the reporting procedures.

Whilst the reported figures in the table below reflect an increase in numbers of pressure ulcers reported, these include all pressure ulcers, avoidable and unavoidable. We have now introduced an improved system of defining when pressure ulcers are avoidable and are taking specific steps to address these through undertaking Root Cause Analysis and sharing lessons learned. The increase in numbers is reflective of a greater awareness and improved education across the Trust which has led to increased reporting. Future reports will reflect avoidable and unavoidable pressure ulcers.



Month	2014-15	2015-16	2016-17
Grade 2	21	23	27
Grade 3	2	1	4
Grade 4	0	1	0

Source: Ulysses

Improvements

- Developed a Trust wide 'pressure ulcer action plan' with emphasis on education and training in prevention, recognition and treatment of pressure ulcers
- Implemented an e-learning package on Pressure Ulcer Prevention and Management and embedded advice on recommended grading of pressure ulcers according to European Pressure Ulcer Advisory Panel.
- Developed an improved pressure ulcer investigation tool to determine if it was avoidable / unavoidable
- Embedded the investigation tool in the incident reporting system (Ulysses) for easy access for staff
- Implemented Standard Operating Procedure on the reporting process when a pressure ulcer is identified or suspected
- All avoidable hospital acquired Grade 3 and Grade 4 pressure ulcers have a comprehensive Root Cause Analysis with action plans developed and implemented
- Deliver monthly training sessions as part of critical care mandatory training requirements

Future Plans

- Deliver monthly classroom training sessions from June 2017 as part of mandatory clinical skills day
- Link e-learning package with Electronic Staff Record (ESR)
- Work with community nursing team to support management of pressure ulcers in the community
- Develop a practical competency tool, specifically for PICU staff
- Develop a Standard Operating Procedure to support development of tissue viability skills for out of hours staff when specialist nurse is unavailable
- Replace the use of the Braden Q risk assessment tool, which does not provide adequate assessment of risks associated with devices such as cannulas. Most pressure ulcers in children are device related.
- Undertake pressure ulcer summit to explore how the Trust is addressing pressure ulcers and identify further opportunities for improvement

3.3.3 PRIORITY 3. Reducing Harm from Hospital Acquired Infections

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 30% from the 2014/15 baseline of 147; this represents 103 infections

Outcomes – 2016/17

1. 2x MRSA bacteraemia
2. 1x *Clostridium difficile* infection
3. 29% decrease in the number of outbreak organisms and hospital acquired organisms: this represents 104

Data source – corporate report 12.4.17

Effective infection prevention and control (IP&C) practice 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 preventable by vaccination.
- They have closer contact with other visitors such as parents and siblings.
- Their poor hygiene practices present more opportunities for infection to spread.

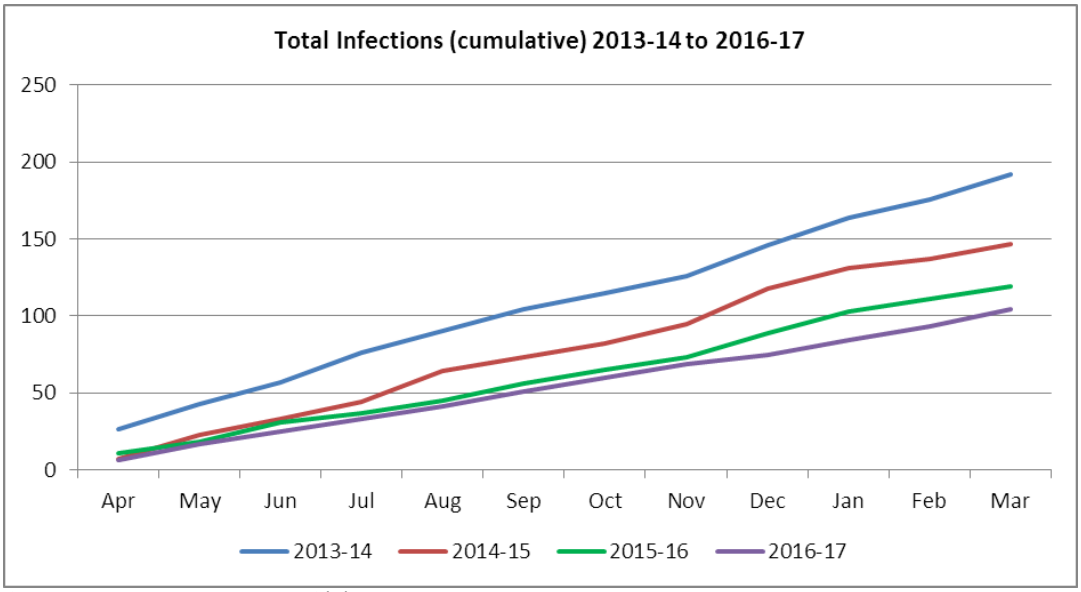
- They may also interact more closely with their environment, making them more likely to come into contact with contaminated surfaces and items.
- Communicable diseases affect a higher percentage of paediatric patients than adults increasing the likelihood of cross infection.

Improvements 2016-17

- There has been Post Infection Review (PIR) investigations conducted following the occurrence of MRSA bacteraemia and *Clostridium difficile* infections, resulting in the development and implementation of improvement plans.
- Development of hand hygiene improvement group in critical care - adopted innovative methods of hand hygiene compliance audit using mobile phone apps. This has provided larger and greater amounts of data which has assisted in targeting staff or groups with poor hand hygiene compliance
- Hand hygiene awareness week held in October 2016
- The introduction of SNAP* audits for isolation practice has improved data collection and feedback to clinical teams
- Introduction of SSIS (surgical site infection surveillance) in plastics and agreement on methodology for k-wire (SSI) surveillance.
- Introduction of Orthopaedic care bundles and reinstatement of cardiac and neurosurgery care bundle monitoring.
- Participation in the Cardiac and Neurosurgery SSI modules by Public Health England (PHE) allowing the Trust to benchmark against other organisations
- Development of Theatre safety board chaired by Consultant Neurosurgeon
- All central line associated blood stream infections (CLABSI) in critical care are now being validated by a MDT (multi-disciplinary team meeting) on a monthly basis, as are Ventilator Associated Pneumonias.
- In service evaluation of CUROS (70% alcohol impregnated caps for the end of lines) and the Braun needle free devices in an attempt to reduce the incidence of CLABSI within the organisation.
- Participated in PHE prevalence survey in November 2016 and local prevalence survey in March 2017. This provides a snap shot of the rate of HAI for the Trust and identifies areas and prevalence of different types of infection.
- PIR for serious infections - in addition to those required for mandatory reporting, e.g. increased incidence of cardiac infections
- The introduction of a level 1 RCA (Root Cause Analysis) proforma on SNAP has made it easier for clinical teams to carry out reviews of blood stream infections and other reportable hospital acquired infections. This information determines the requirement for a formal RCA process
- Introduced IPC key performance indicators (KPIs). These are reported quarterly. Associate Chief nurses feedback on the KPIs to the Infection Prevention & Control Committee. The ward with the highest score on the KPI will be named Infection Control ward of the year.
- Maintained improvement in rapid diagnosis and appropriate patient isolation during the bronchiolitis RSV (Respiratory Syncytial Virus) season
- Reduced the number of hospital acquired RSV infections compared to previous 3 years.

**SNAP is a bespoke electronic audit tool*

The graph belows shows that continued improvements in reducing hospital acquired infections have resulted in 104 HAIs in 2016/17 which is a 46% reduction compared to 2013/14.



Source: KM – corporate report 12/4/17

The table below shows the reduction in hospital acquired RSV infection during the winter period in 2016/17

RSV	Nov	Dec	Jan	Feb	Mar	Total
2012/2013	7	0	2	1	2	12
2013/2014	1	6	1	1	1	10
2014/2015	1	9	0	0	0	10
2015/2016	1	5	4	1	0	11
2016/2017	5	1	1	1	0	8

Future plans

- Roll out of use of hand hygiene audit app throughout the Trust
- Develop Policy on Management of Measles for CF patients.
- Production of checklist to ensure appropriate investigation of hospital acquired diarrhoea
- Investigation of all Hospital acquired cases of Influenza and RSV during the winter season to ascertain if they could have been prevented and reporting back to the clinical teams the hospital acquired RSV and Influenza A rates by 1000 bed days

- Undertake a gap analysis for the new Public Health England Toolkit for reducing *E. coli* bacteraemia once this is published in 2017/18
- Commencement of 1.5 WTE Sepsis nurses to audit compliance with Sepsis management
- Business case for the appointment of an Immunisation Co-ordinator
- SSI surveillance for K-wires insertion commencing in April 2017
- Audit of compliance with NICE guideline 139 (baseline review of urinary catheter management)

Further details of improvement plans are captured in the Infection Prevention and Control Delivery Plan which will continue to be rolled out in 2017-18.

3.3.4 PRIORITY 4. Further Enhance Children, Young People and their Parents/Carers Involvement in Patient Safety

Aim:

To continue to improve patient safety by engaging children and young people in different methodologies for capturing the voice of the patients and designing safer systems of work

Children and young people are key stakeholders of the NHS and their interests must be at the centre of everything we do. Alder Hey has placed a strong focus on engaging with children, young people and their parents / carers, ensuring they have their voices heard on all matters of their care with a particular emphasis on patient safety.

Following on from the work in 2015-16, we have explored further means of involving patients and carers through group work and through individual involvement. Supported by our Children and Young People's Forum who have been working closely with the Royal College of Paediatrics and Child Health (RCPCH) and other partners

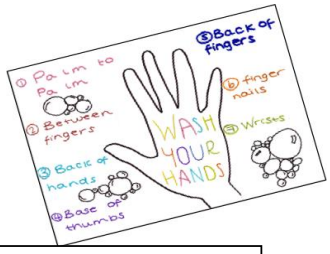
IMPROVEMENTS

Aim:

To continue to improve patient safety by engaging children and young people in different methodologies for capturing the voice of the patients and designing safer systems of work

- Continued to work with local schools on infection related issues and hand hygiene.
  See the video link (below) about the importance of handwashing which was created by Prescot Primary School as part of a collaborative piece of work facilitated by the Trust's Patient Information Manager

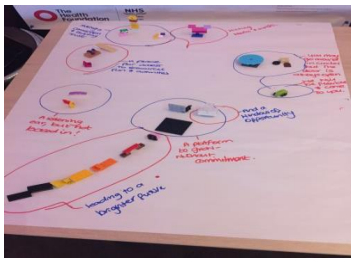
  https://vimeo.com/162676248



Infection control / hand washing posters designed by school children

- Identified pros and cons of different methods of gaining views of patients, for example: use of interview questionnaires / drawing

/ video blogs / workshops / drama / parents & carers / social media / daily blogs / apps



- Parents and C&YP Forum members supported the PLACE assessment of environment and food in wards and departments

- Developed Quality & Safety video blog "I like it when….." in which the children & young people expressed their views of what quality and safety means to them

Follow this link https://youtu.be/GDQSKXSbVaQ

- Use of patient stories in improving cardiac surgical pathway – described later in the quality account

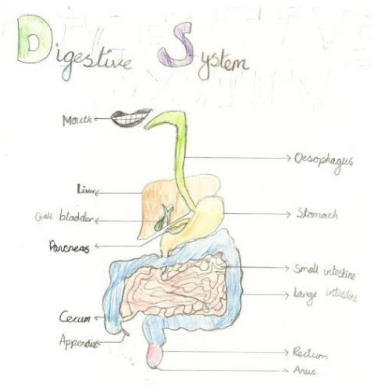
- Consulted families on the establishment of a self-referral mechanism for CAMHS services

- Children & Young People's forum members contributed to development of transition services and materials, including the '10stepstransition' website to support safer transition to adult services.

- Members of the Children & Young People's forum also took part in a 'peer consultation' project, working with the Royal College of Paediatric and Child Heath '& Us' team to gain patient views and comments on their experiences – further information later in the quality account.

- Children & Young People continued to contribute to ongoing development of Safe Together & Always Right (STAR) Ward Accreditation programme

- Regular patient attendance at Trust Board to deliver stories of their experiences of Alder Hey.



Drawing of digestive system from Year 4 pupil at St Nicholas Catholic Primary School during an educational visit by one of our consultants and registrars in paediatric surgery

Work with children and young people on transition pathway presented to The Health

Future plans
To further maximize opportunities for children and young people's involvement in patient safety work with a particular focus on early involvement in quality improvement initiatives.

3.3.5 Children & Young People's Forum

The Children & Young People's Forum continues to meet every two months and is well supported by Alder Hey staff. The Forum was established in 2009 and meets in three groups: children (7-11yrs); young people (11-18yrs); and a parents / carers group. Membership is increasing as the groups grow in confidence and esteem.

The Forum is in great demand partcularly in terms of projects, research and evaluations and has been very busy during 2016/17, participating in hospital projects, sharing and representing patient's views, concerns, ideas and experiences. In particular, involvement in formal consultations and opportunities for patients to link into projects that directly affect the development of the hospital and its services.

The forum members also link into external group participation in promoting opportunities for young people for personal self –development. This is demonstrated in recent research project work with the Royal College of Paediatrics and Child Health patient groups

The following summary presents key aspects of Forum projects from April 2016 to present.

Working with the Royal College of Paediatrics & Child Health (RCPCH) '& Us' 'The voices of Children, Young People and Families'

April 2016- National Conference

The young people's group were invited to participate in a National Conference at Liverpool Convention Centre facilitated by the RCPCH and Institute of Child Health London**.**

Five members planned for the event and gave a presentation and remained as part of the panel for a Question & Answer session. Delegates gave exceptional feedback on their passion and presentation skills. This resulted in further consultation regarding collaboration on future surveys. Since then the RCPCH project lead has attended Alder Hey twice to discuss future project work with the Forum.

Quotes from feedback from Conference:

"The group were fantastic, very articulate about their views and you could clearly see their passion during the Q&A which they managed so well and asked some great questions back!"

"They had some very strong messages which had an impact with the audience with their top tips at the end being on point."

"We've had some great feedback from attendees of that session who found me the next day to say how well the group did and how powerful their insight was. For their first public speaking event outside of AlderHey. They did amazingly and are a credit to themselves and your team."

Peer Consultation project

RCPCH &Us

In Autumn the Forum received a request to participate in a peer consultation project, with a particular aim of identifying the best ways of 'giving patients a voice' regarding who to speak to with good or bad experiences in healthcare. This is a project linked to NHS England as part of a Clinical Reference Group. Training was offered for young people to undertake peer interviews and become involved in the project.

Several young people attended a 2 day workshop for training and peer interviews in outpatient clinics and wards, followed by evaluation. The young people agreed a series of questions to identify if patients / families were aware of who to communicate with in respect of their experience, positive or negative and if patients and families felt they were 'listened' to.

The Forum members also took part in group discussions and carried out practical training in interaction and interpersonal skills and then went around the hospital to

interview cildren and young people in outpatient clinics and wards. The research was followed up by a further session of Forum members interviewing those members who had not attended the workshop and also the children's group members, thus ensuring all members' views were facilitated.

This was an important piece of work which the Forum members enjoyed and which will influence national guidelines. Further work is ongoing externally to complete the NHS England report. The Forum will be credited with participation. The young people gained new skills and a certificate which can be used to evidence activity for the Duke of Edinburgh award scheme or National Citizens Service award.

Further the group have learnt of potential new award scheme the Forum members may benefit from for the future. We are currently looking into this opportunity.

The group are also developing a poster to publicise the outcomes of the work.

Pictured here is the Young People's Group receiving their certificates for attending the National Paediatric College Conference and the Peer Clinical

Referencing Project.

Staff Recruitment

- The young people's group has participated in focus groups for several senior staff recruitment, including the appointment to a Non Executive Director in the Summer. The young people now offer feedback to the selection panel themselves with staff support.

Council of Governors

- Two members of the Forum attended a Council of Governors meeting to discuss the role of the Forum. They gave an account of the forum activity and key aspects of forum achievements outlining what they do and what their aims are. They also spoke of the difficulties in getting the children and young people out of school for projects / focus groups for recruitment and other activities.

- The Governors also shared information with the Young People about the role of Governors, and one of the Young People from the forum has now been appointed as a new patient Governor.

PLACE inspection

- Several parents and members of the young people's group supported PLACE inspection of food and wards and departments. (Further report provided below)

Other areas of enagagement with C&YP Forum

- Two of the Trust Innovation leads attended the Forum to discuss digital apps / technology:

  Discussion included digital technology for play and distraction / décor in waiting areas and treatment areas / use of apps for appointments and patient information. The Forum indicated interest in further involvement in apps and technology / distraction ideas.

- The Forum worked with a BBC producer and artist to devise a vinyl mural now on display in the teenage area of surgery day care.

- Members of the Forum also visited the operating theatre and commented that the theatres are bland and there is a need for more décor / distraction technology. The Trust has an ongoing piece of work to improve the environment in theatres.

- The Forum recently participated in group activity for a research project from JMU and Public Health regarding views on health and health resources.

- Representatives from outpatients attended the Forum in January to discuss clinic and waiting areas improvements and gain patient views on décor, colour schemes, design of the environment and they considered themes for the naming of the clinics.

Schools Parliament

Jeff Dunn, Director of Liverpool Schools Parliament continues to attend Forum meetings and several members of the Forum attend school parliament participating in debates and projects, linking in with local developments and various projects.

Janani Murageshi was recently elected to represent the patient forum as Young Lord Mayor for the Liverpool Schools Parliament and Ava has been elected as Junior Lord Mayor. They will each hold office for a month of attending events with the Lord Mayor.

Here is Janani at the inauguration ceremony having taken her oath and is pictured signing the register:

Quality and Safety

- Trust Quality and Safety leads visited the young people's group and the parents group to discuss engagement oportunities in improving quality and safety, including the ongoing development of the ward accreditation programme, 'Journey to the Stars'.

- The communications team worked with the children and young people, plus patients and created a video blog for the Alder Hey intranet to promote the new Quality Strategy, Inspiring Quality. The children and young people expressed their views of what a great experience in the hospital means to them, using the phrase "I like it when…..". The video was shared widely across the Trust, including Trust Board members, Executives, Governors and through Team Brief and other means, and is regularly shown on the TV screens in the Atrium. This is available at the following link… https://youtu.be/GDQSKXSbVaQ

- The communications team are also working with the Forum to develop the new Trust extranet which will have important CY&P Forum website links.

Transition
The Trust Lead Transition Nurse attended the Forum to discuss transition which is a subject close to several of the Young People's group as they approach adulthood.

The Young People expressed their views on how the Trust prepares people for transition and included and highlighted the '10 Steps to Transition' model created by the Trust and a limerick which young people going through the transition process can engage with.

Future projects
We have maintained our contact with RCPCH '& Us' association who would like to discuss new projects for all three Forum groups. In particular they are keen to involve the parents and carers group in developing an assessment process about how medics communicate with patients. RCPCH will provide training for this activity for parents in developing this work.

There are also plans to undertake bigger projects linking up with other paediatric hospitals.

We are also looking into gaining external accreditation for long term Forum members for their support and participation in hospital projects.

The Forum will continue working towards promoting positive patient experiences and quality standards linking more closely with the new Clinical Business Units.

3.3.6 PLACE Assessment – Patient Led Assessment of the Care Environment

Aim: To undertake a voluntary self assessment of the care environment from the patient's and public's point of view and benchmark nationally to support the Trust in identifying areas for improvement

Outcomes: Assessment was undertaken by 10 staff members and 27 independent assessors over 4 sessions

1. Food & ward food – above national average.
2. Organisation food – below national average.
3. Cleanliness & condition / appearance – below national average
4. Privacy, dignity & wellbeing and disability –

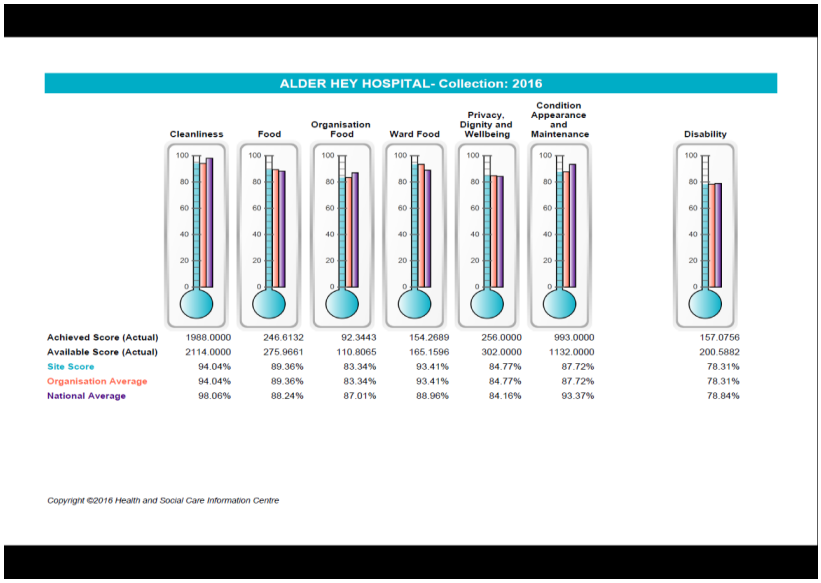
The PLACE assessment is designed to focus on the areas which patients say matter by encouraging and facilitating the involvement of patients, the public and other bodies with an interest in healthcare (e.g. Local Healthwatch) in assessing providers in equal partnership with NHS staff to both identify how they are currently performing against a range of criteria and to identify how services may be improved for the future.

Participation is voluntary and the assessment provide a snapshot of how an organisation is performing against a range of non-clinical activities which impact on the patient experience of care – Cleanliness; the Condition, Appearance and Maintenance of healthcare premises; the extent to which the environment supports the delivery of care with Privacy and Dignity; and the quality and availability of food and drink. The 2016 assessment included an additional measure of Disability. The Disability assessment focusses on issues of access including wheelchair, mobility

(e.g. handrails), signage and provision of such things as visual/ audible appointment alert systems, hearing loops, and aspects relating to food and food service.

The assessment was undertaken by 10 staff members and 27 independent assessors, including patients, parents, Children & Young People's Forum members, volunteers, healthwatch members, Trust governor.

The results of the assessment are produced by NHS Digital (formerly Health and Social Care Information Centre) and are summarised here.



Improvements

The Trust recognises the value of feedback from patients and users of the services at Alder Hey and the outputs of the PLACE assessment include a mix of positive feedback and areas for improvement. The assessment outputs, including individual and specific comments, have been shared with ward and department leads and a number of improvements have already been implemented, both corporately and locally:

- Commissioned an external 'Facilities Management Services' review and started implementation of recommendations
- Appointed to a new role of Domestic Operations Manager to provide a consistent approach and oversight of domestic services
- Developed cleanliness action plan through Infection Prevention & Control
- Worked with children and young people to improve environment in theatres and designed a vinyl mural for teenage area of surgical day care
- Improved healthy options offer in restaurant, removed fizzy drinks and high fat high salt snacks,
- Introduced 'free fruit' lunch offer
- Improved freshly cooked offer - fresh cooked soups daily, fresh cooked produce (not frozen) daily
- Rapeseed oil now used, best oil on the market for cooking with unsaturated fats

Future plans

- Create a dedicated helpdesk for logging domestic service calls and agree Key Performance Indicators
- Review equipment and processes and introduce improved technology to improve effectiveness and consistency of cleaning processes

- Introduce quarterly cleanliness audits to validate cleanliness standards
- Continue to work with children and young people on environmental improvement through involvement in app development.
- Recognised improvement is required in engagement of children in play and identified as key priority for 2017-18

The Trust will continue to work with patients, the public and external organisations such as Healthwatch, and will again undertake a PLACE assessment in 2017 to identify further opportunities for improvement.

3.3.7 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 20%; this represents: baseline 842, target 674.
3. Reduce incidents resulting in moderate, severe harm or death by 20%; this represents 37.

Outcomes:

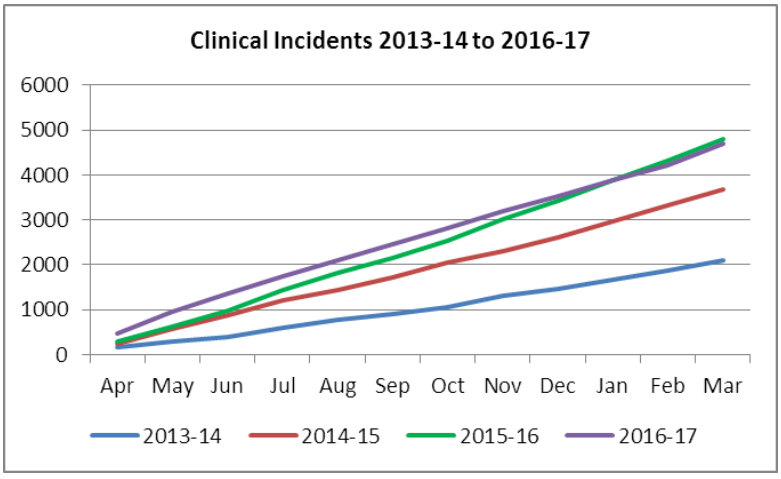
5. 2 Never Events.
6. 10% reduction in all incidents of harm; this represents 758.
7. 81% reduction in moderate, severe or death incidents; this represents 10.

Source data – corporate report 12.4.17

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; 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.

All organisations continue to upload their incident data into the National Reporting and Learning System (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 last year's Quality Account, the Trust reported how it had made great strides in improving the safety culture and had moved from being in the lowest 25% of NRLS reporters to being in the top 25%. The most recent report for the time period of 1st April 2016 to 30th September 2016 confirms that the trust remains in the top 25% of reporters and is ranked 3rd highest reporter out of 19 acute specialist organisations.

The Trust continues to promote all incident reporting, including near miss and no harm incidents. This graph shows that the Trust has maintained a high level of incident reporting compared to previous years, equating to 122% increase in reporting compared with 2013-14.



Data source: Ulysses 12/4/17

In 2016/17 there were 2 Never Event incidents reported, which have undergone comprehensive investigations and the development and implementation of improvement plans to prevent reoccurrence.

Whilst the target of reducing incidents of harm by 20% has not been achieved this year, there is evidence of a significant reduction in the incidents of moderate or higher harm which have reduced from 46 in 2014/15 to 10 in 2016/17.

Improvements

- The Trust places a strong emphasis on learning from errors and incidents and has a number of different mechanisms for ensuring lessons learned are shared widely
- Weekly Meeting of Harm – an open invite meeting that is well attended by clinical and non clinical staff where specific incidents from the previous week are discussed in detail, with specific actions appointed and lessons learned shared widely.
  The output from the meeting includes a poster summarising the key lessons learned and providing recognition for staff that have intervened before an error has reached the patient – 'good catch' award
  This meeting has recently adopted a 'deep dive' approach to common themes or rising trends, with a view to exploring issues more widely and developing appropriate action plans
- Implemented model of devolved governance – newly appointed Heads of Quality have been appointed to each CBU with a view to implementing a system of local risk management and governance and continuous quality improvement, thereby improving the ward to board reporting of risk and quality.
- Medication Safety Officers work closely with clinical and non clinical Trust staff to share information and provide education regarding medication prescribing and administration and provide monthly medication incident reports to each CBU and medication safety alerts.
- Action plans from serious incidents and never events are monitored at CBU risk and governance meetings and via the Trust Clinical Quality Steering Group. Action plans are also monitored at the monthly serious incident review meeting with commissioners. Progress has been made in the completion of completed action plans

3.3.8 Perioperative care

The previous quality report for the theatre department outlined the creation and development of the theatre quality assurance team and the overarching plan in relation to risk and governance within the theatre department. This set out 9 key aims for the year ahead alongside a strategy for achieving those aims. On reflection, at the close of 2016-2017 all but one of these aims has been achieved or work has commenced. The remaining aim is to create and implement a never event task force, although within the past year there was only 1 never event within theatres in comparison to 3 the previous year.

Aims and objectives 2016/2017	Achieved
Review and relaunch WHO 5 steps to safer surgery.	Embedded teaching into theatre induction.
Transfer ownership of weekly governance and risk meetings to speciality teams.	Local meetings now held monthly and risks reviewed weekly by band 7's.
Comply with National Safety Standards for Invasive Procedures (NatSSIPs).	NatSSIPs now launched, audit underway.
Establish focus groups to prevent all surgical and anaesthetic never events.	Not yet achieved.
Develop and implement a theatre specific infection control policy.	Policy complete, to be ratified via IPCC next month.
Improve MDT attendance at the weekly meeting of harm.	Matron and R+G practitioner attend weekly, clinical leads and medical staff attend ad hoc.
Implement actions from the internal AfPP audit.	Work has started but not complete.
Improve compliance with all medicines regulations.	Regular audit underway, work being undertaken in relation to storage in theatre.

The year closes on an established quality team, with a focus on all areas of improvement; encompassing infection prevention and control strategies, as well as key areas for development in relation to risk, governance, medical device management, health and safety, training and staff wellbeing and development. The appointment of the new theatre Matron in September and Chief of Operative Care in November completes the collective and will support the continual driving forward of standards and change.

A new structure for the management of risk and governance within the department has been implemented to maintain oversight and governance of all risks within theatre:

Key Quality Improvements made in 2016/2017:

- Development of the theatre infection prevention and control (IPC) policy and supplementary theatre cleaning procedure.
- Well established robust environmental audits undertaken which are consistently demonstrating high standards of cleanliness.

- Development of the theatre 'top 10' key performance indicators and dashboard.
- Launch of the theatre national safety standards for invasive procedures (NatSSIPs)
- Band 7 clinical lead in post to support and develop improved efficiency in the running of emergency theatre.

Infection Prevention & Control:
One of the biggest achievements for 2016/2017 is consistent compliance above 98% in environmental cleanliness audits across the department. The appointment of an advanced practitioner for infection control within the department has driven a focussed approach to IPC and enabled the formation of the theatre IPC policy and cleaning policy. Supporting the weekly environmental audits will be the twice-yearly overarching review of the department using the Opp-Gen care audit which is a care setting process improvement tool, in partnership with the trust infection, prevention and control team.

The top aims for 2017/2018 within IPC will be to look at creating surgical site surveillance and a standardised theatre care bundle for all specialities. The IPC practitioner will also work with the whole quality assurance team to develop a peer review audit tool to support in undertaking benchmarking within the region.

Improving the quality of care provided:
The NaatSSIPs have now been launched within the theatre department and audit is underway to assess the standards of care provided. There will be teaching delivered based around the results of audit and safety observations within the department. NatSSIPs will be added to the induction training for all new theatre staff, as well as the yearly update for existing staff.

The 'top 10' key performance indicators have been defined for theatres and will be reported via the new departmental dashboard. This will allow the clinical leaders and management team within the department to have oversight of the quality of care provided and support a structured approach to further improvement.

Improving care for patients requiring emergency surgery:
Last year brought the introduction of a band 7 clinical lead into the emergency theatre to improve access and quality of care for patients requiring emergency procedures. This has seen improvement in efficiency not only in the emergency list, but in supporting patients to receive surgery within other available free slots within the department. This not only provides more timely treatment for patients, but ensures improved utilisation across the floor.

The team in the emergency theatre have also worked alongside the IM&T department to create a bespoke system for the booking and management of the emergency list. This system will allow clear visibility of patients booked onto the emergency list, an estimated time to theatre, highlight any patients who have been starved longer than necessary and support prioritisation of patients.

2017/2018 will see the role extend later into the day and over 6 days to improve the emergency service for even more patients. The bespoke IT system is planned to 'go live' within the next 3 months and the efficacy will be audited and reviewed with feedback to the theatre safety board 3 months following implementation.

Key points of focus for the year ahead:

- ❖ Creation of theatre/anaesthetics quality dashboard.
- ❖ Development of 'in-department' mandatory training package for all theatre staff to access.
- ❖ Plan for human factors training development and implementation.
- ❖ Review of all standard operating procedures and policies to update and ensure relevance in line with NatSSIPs.
- ❖ Development of peer review strategy with other regional trusts to support benchmarking and consistency of care within the region.
- ❖ Creation of a clear development plans for staff, encompassing clinical skills training, human factors and access to leadership courses.

The quality assurance team will continue to support and involve staff from across the department in delivering the above goals for the year ahead. Staff are currently engaged in continual audit within the department and link roles will be defined and developed across the year to ensure shared learning and further improvement in the quality of care provided throughout the department.

3.3.9 Best in Operative Care

The best in operative care (BIOC) group aimed to maintain a consistent focus on quality in theatre throughout the year 2016-2017. Key aims in relation to safety, excellence and wellbeing were mapped out at the start of the year and the below score card shows the achievements within these key aims.

	Performance Scorecard	Actual
Safety	▪ 25% reduction in patient harm	8% reduction in patient harm YTD
	▪ 25% reduction in rate of surgical site infection	17/18 target to develop measures for SSI
	▪ 95% staff recommend for treatment	89% of staff recommend for treatment (as of Jan 2017)
	▪ 5% reduction in unplanned readmission to critical care	1% increase – no current data set just for surgery

Excellence	▪ We will increase the number of children we provide operative care to, treating 8,230 children in our Surgical Daycare Unit	8,234 children treated in the SDC Unit for calendar year 2016
	▪ 90% theatre utilisation	Overall utilisation 85.6% (financial YTD) 90.6% adjusted to regional standard
	▪ 50% reduction in short-notice cancellation of patients	30% reduction YTD (87 less pts)
	▪ 50% reduction in short-notice cancellation of theatre lists	Achieved – now delivering 124 sessions per week
	▪ 95% patients and families recommend for treatment	97.8% Dec 2016
	▪ 5% reduction in conversion rate from day case to inpatients	1.14% increase YTD
Wellbeing	▪ 95% theatre staff recommend Alder Hey as a place to work	67% as of latest survey (Jan 2017)
	▪ Less than 5% of theatre sessions overrun by more than 30 minutes	11.4% YTD, downward trend, 9.1% Jan 2017

There are clear areas of improvement within the score card, as well as areas which still require input and improvement to reach planned targets. The BIOC steering group reflected on both the goals and approach used over the last 12 months and have put in place the following recommendations and changes for 2017/2018:

- ❖ Triumvirate approach to each work stream (manager, clinical lead and clinician).
- ❖ Project initiation document, aims, objectives, finances and milestones to be developed and tracked by each individual team.
- ❖ Information and technology management identified as key enablers within most work streams, to be invited to each meeting.
- ❖ Theatre utilisation and performance will be monitored via the theatre utilisation group and reported to BIOC.
- ❖ Each work stream will be reviewed monthly against milestones and benefits by BIOC steering group.

The BIOC steering group has formed below plans for the year ahead, with a clearly defined triumvirate leading each initiative.

The BIOC group will maintain momentum with ongoing projects above whilst beginning new initiatives to continually improve standards of care within the department.

Quality within the department will be continually reviewed throughout the year via the departmental risk and governance structure, with a supportive escalation pathway for any issues requiring further support. The BIOC group will oversee the progression of plans within the strategy and provide necessary support to ensure that initiatives can progress. The new dashboard will be a key tool in facilitating oversight of results across the department and will provide assurance to management teams throughout the surgical division as well as the wider organisation.

3.3.10 Equality & Diversity

Aim: For Alder Hey to be an inclusive and accessible place for all to visit and work, to meet our duties and in so doing to provide the best patient care possible.

Targets: From the 2015/16 Equality Objectives Plan:

1. To increase the representation of black and minority (BME) ethnic staff
2. To improve the experience of families with learning disability/autism that visit Alder Hey
3. To improve the involvement of patient and staff stakeholders in decision making
4. To improve the quality of staff data
5. To improve the quality of patient data
6. To ensure equality is embedded through the quality strategy

We are able to monitor our performance in meeting our public sector equality duties (PSED) as required by the Equality Act 2010, the NHS Constitution, CQC inspection questions and NHS commissioners as follows:
Equality Delivery System (EDS2) that has eighteen outcomes and four goals:
1. Better Health Outcomes
2. Improved Patient Access and Experience
3. A Representative and supported workforce
4. Inclusive Leadership

Workforce Race Equality Standard (WRES) that has 9 indicators comparing the data for white and black and minority ethnic (BME) staff. Four are based on workforce profile data, four on data from the NHS staff survey questions and one on BME representation at board level.

Engagement:

We can also monitor our performance by how well we listen to staff and patient groups to influence the decisions we make. We recognise the importance of engagement with diverse stakeholders to represent the views of those who belong to minority groups. This will ensure that Alder Hey provides innovative and effective services that consider the needs of all our children, young people and families and a workforce that feels supported and valued.

Impact Assessment:

Timely consideration of the impact of decisions on minority groups and assurance by relevant committees will ensure that the outcome of decisions is less likely to be unlawful.

Improvements:

1. There have been interventions in the recruitment process and we hosted a pre-employment programme to attract people belonging to black and minority ethnic groups. Steps have been taken to improve monitoring the appointment, progression and experiences of BME staff.
2. Progress has been made following the appointment of a Consultant LD liaison nurse in October 2016. The Trust has employed three LD nurses to support our strategy to ultimately have an LD trained nurse on every ward
3. There has been greater community engagement this year with the organisation of a cultural event in September 2016 and involvement in the community advisory group (CAG).

4. Supported by the Trust Listening into Action programme, a 'big conversation event' was arranged to support the development of a Black and Minority Ethnic (BME) network. The lead presented the priorities for this group of staff to Trust Board in March 2017.
5. There has been progress in identifying the gaps, process and IM&T requirements in improving the quality of patient data resulting in a patient profile data action plan for 2017/18.
6. The quality metrics for 2017/18 reflects progress made in the past 12 months.
7. Cultural Competency training has been extended from CAMHS to Trust-Wide. Unconscious bias training is underway for BME staff and the recruitment manager. Relevant Equality and Diversity training is included in a new line management training programme including student nurse induction.
8. Non Executive Directors attended specific training on 'responsibilities from the Mental Health Act'
9. Agreed a local objective of 1% increase in BME staff in the workforce per year for the next 5 years
10. Delivered on specific project to improve the experience of children with a Learning Disability (LD) and/ or Autistic Spectrum Condition (ASC) (further details provided later in the document)

Future plans

To continue to make progress relating to the equality objectives updated to commissioners on a quarterly basis.

3.3.11 Arts for Health

Alder Hey has had an Arts for Health programme since 2002 which has become increasingly active in enhancing the physical environment, improving the patient experience and supporting clinical objectives using knowledge of proven research into the benefits of arts participation.

The Trust Arts Co-ordinator along with the Arts Strategy Team and children and young people were instrumental in the development of arts in the new hospital, inspired by the theme of nature and the outdoors – connecting with the environment.

The Arts Co-ordinator has continued to develop an interactive arts programme through consultation with patients and families. Together they have developed participatory programmes that are patient centered and patient led, and involve patients in a wide range of art forms including music, dance, animation, digital development & sound art, and craft making.

We have also established a number of strategic arts partnerships through a Cultural Champions programme including: Tate Liverpool, FACT, Merseyside Dance Initiative, Live Music Now, Royal Liverpool Philharmonic, DadaFest, Bluecoat Display Centre, Manchester Metropolitan University, Small Things Dance Collective and Twin Vision.

Achievements

General

- Work directly with over 3,000 patients each year
- Delivered over 250 workshops in all art forms.
- Worked across many areas of the Trust including A&E, waiting room, wards, clinics and community sites, and regularly support Dewi Jones and the Fresh CAMHS group
- Developed projects with a specific focus on supporting long term patients and their families.

Music Mentoring project

- Funded by Youth Music – documentary film on Alder Hey website.
- These musicians on this scheme are now fully trained and confident to deliver music with patients.
- 76% of patients who took part in the project said that it enabled them to forget about their illness or condition
- 85% of patients felt that the hospital experience had been significantly improved due to music making.

Live performance

- Delivering live music and dance in the performance space in the atrium every 2-3 weeks

Dance

"From Where We Are" project

- Research project developed with 'Small Things Dance Collective'
- Using improvised somatic dance practice to support long term patients on Neuro rehabilitation and Cardiac wards
- Used established pain assessment tools to determine improved outcomes.
- Found that participation in dance and movement significantly improved patients experience of pain: 92% saw improvement and for 80% of patients, improvement was by over 50%.

"From There to Here" project

- Further project with 'Small Things Dance Collective'
- Used the outdoor environment to support dance and movement in the new hospital.
- During 2016, developed a performance piece in collaboration with patients, 'Taking Flight', which was a response to the move from old hospital to new.

"Breathe"

- Continued delivery of a dance programme supporting patients with chronic asthma
- Patients are assessed throughout a 6 week programme for lung function

- Significant improvement seen in some patients
- Supports social interaction with children and families and gives confidence to participate in physical activity

The Trust's dance programme was reviewed in the Journal of Nursing Children & Young People – November 2016

Animation

- Completed 8th major animation project. Film projects include:
  - Radiotherapy treatment – "Our Special X-Rays"
  - Infection control - "Don't Be A Bug Rug"
  - Healthy teeth for cardiac patients - "The Lonely Toothbrush"
  - Introducing children to the Oncology unit – "Welcome"
- Worked with young people transitioning into adult epilepsy services
- Film premiere events for all participants and award of an 'Oscar' for their hard work and creativity

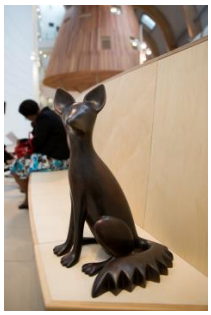
Digital Development

- In November 2016, we launched an app, 'Little George and the Dragon' which supports patients with sickle cell disease and offers advice and information to manage pain through a series of interactive games. It's based on a patient booklet of the same name and was developed by a storyteller working with patients, one of whom George and his mum, feature in the app.

Drawing by Kate Pankhurst

Future Plans

- Deliver next stage of Music Mentoring project by training new musicians through a buddy system and produce a film resource to support other musicians wishing to work in paediatric music in health
- Collaboration with Tate Liverpool and Twin Vision on the Tate Exchange Programme. Work with patients to create an animated short film exploring ideas about beds. This will link to an exhibition at Tate Liverpool and patients will explore aspects of the Tate's collection, as well as learn new skills in animation production. Final work will be exhibited at Tate Liverpool.
- Developing a dance app, offering parents, carers and staff, simple techniques in supporting their child with dance, movement and relaxation. The app will feature filmed demonstrations with patients, insight from dancers and clinicians and a step by step guide
- Work with Australian sound artist and composer Vic McEwan exploring sound within the hospital. He will be launching an EP of compositions based on sounds within the hospital throughout 2017



3.3.12 Improving the transition from Children and Young People Services to Adult Services 2016/2017

Aim:
To establish a good quality, safe, effective and seamless transition to adult services, for children with complex long term conditions.

Transition to adult services (transition) is defined as "a purposeful, planned process that addresses the medical, psychosocial and educational/vocational needs of adolescents and young people with [long term] conditions as they move from child-centred to adult-oriented health care systems (DfES 2006).

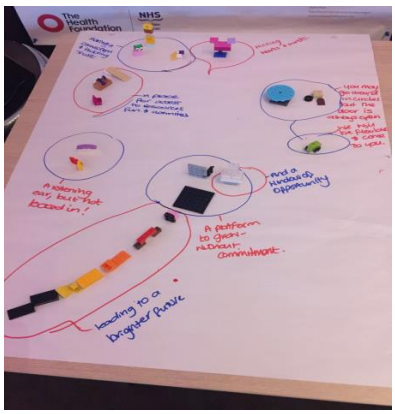
Transition to adult services ensures that young people are able to access the most appropriate services according to their age, developmental needs and the nature of their long term condition. If young people are not adequately supported through transition they may not engage with adult health care providers, and this increases the risk of deterioration of their long term condition. Transition to adult services can be a traumatic period for young people, who commonly fall between services or 'disappear' during transition, disengaging from services and becoming lost to follow up, only to present later in life with potentially avoidable complications. Additionally, if young people remain inappropriately in children's services there is less capacity within the Trust for younger children and babies.

Achievements in 2016/17

- Developed a brand new transition service to Broadgreen orthopaedic surgeon for CP [cerebral palsy] patients who were previously discharged to their GP's. First joint transition clinic held on 2nd December 2016
- Created a transition website at www.10stepstransition.org.uk to provide easily accessible and user friendly information for professionals, young people and families. Further development of the website is in progress
- Won an award of £75K from The Health Foundation to continue to develop the Carer Skills Passport which is a key enabler for transition of complex neurodisability patients (www.carerskillspassport.org.uk)

- Secured a CQUIN to implement transition into 4 identified subspecialties within orthopaedics, diabetes, cystic fibrosis and rheumatology and completed baseline audits in all four subspecialties
- Built strength and numbers within the transition steering group increasing membership from about 15 to 40
- Ratified the 'Transition to Adult Services' policy
- Finalised and ratified 'core transition' training and delivered 12 sessions over a 2 day period, plus delivered bespoke training to individuals
- Gained regular input from the Trust Children and Young People's Forum in the development of transition services and materials
- Presented Trust transition work to a number of national centres including Leeds and Manchester.
- Planned and delivered a national transition conference at Alder Hey in May 2016 attended by over 100 delegates. Excellent evaluations
- National engagement and attendance at Alder Hey from other Trusts interested in improving transition developments.
- Ten Steps Transition pathway poster presentation at National Conference 2016.
- Developed a pull up 'roller banner' display to promote Ten Steps Transition pathway locally and at national events.
- Developed and distributed 'banner pens' with 10 steps Transition pathway information incorporated into pen
- National publication of a transition article in the ENT & Audiology 25th anniversary journal

Front page of transition website at www.10stepstransition.org.uk



Fu

- Work with children and young people on transition pathway presented to the Health Foundation
- s and discussed the complex patient business case, discussing potential to further develop this work as a CQUIN for 2017-18.
- 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.
- Developed a transition story book / poem. Planning to develop an audio version, as requested by the young people as being more engaging, and share on the transition website.

- Finalise development of a 10 steps transition folder for children with a long term condition, to hold all their transition specific information in and their personal transition plan
- Planning a second National Transition Conference, to be delivered in partnership with Lancashire, Manchester, NW Coast SCN, and Alder Hey, as a North West approach to Transition to be held in June 2017
- 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.
- Embed the generic Trust Transition Pathway supported by the Trust Transition to Adult Services policy and supporting material into the four identified sub specialties
- Work has begun with the Trust Innovation team to develop a Trust App, supported by the children and young people and incorporate transition into this
- 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 these are not confirmed or are currently fragmented.
- Continue to share the Trust Nationally recognised transition tool kit.
- Deliver universal and core Transition Training internally.
- 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.
- Implement Transition Policy within the Trust in a phased way including active monitoring of critical incidents.
- 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.
- Finalise and publish the Transition engagement report
- Develop patient and parent information leaflet on consent and the law
- Develop delegated responsibility and accountability information for parents and carers

3.3.13 Learning Disability Strategy

Aims:

- To improve the experience of children with a Learning Disability (LD) and/ or Autistic Spectrum Condition (ASC).
- Improve Trust's ability to identify children with LD on Trust's electronic patient record
- Raise awareness of LD amongst staff through bespoke training

Approximately 1.5 million people in the UK have a learning disability (LD), including approximately 286,000 children. Research shows that men with a LD die 13 years sooner than peers, and women die 20 years sooner than peers.
In partnership with Edge Hill University and supported by commissioners, Alder Hey has made significant improvements to the LD pathway.

Reasons for change

Children and Young people with LD can present to any service or specialty in the hospital and community and the Trust recognises the need identify these children as early as possible to ensure the necessary adjustments and support are put into place to give these patients the best experience possible.

The Trust agreed a CQUIN (Commissioning for Quality & Innovation) to improve several aspects of the LD pathway, including ensuring parent and carer feedback is included in any proposed changes, working within the Liverpool Learning Disabilities Liaison Network, undertaking risk assessments and making reasonable adjustments where necessary and delivering training in LD awareness and other key skills to support delivery of care to children with a LD.

Improvements

- Appointed to two secondments
  1. Consultant LD Nurse
  2. Acute liaison LD nurse
- Appointed to 3x LD nurses (commencing in May 2017)
- Established Learning Disability and Autistic Spectrum Condition Steering Group
- Participate in CCG Acute liaison network
- Training – approx. 120 staff and volunteers received LD/ risk assessment/ mental health first aid and / or Positive Behaviour Support (PBS) training across the trust (rolling programme available to all areas)
- Rolled out Mandatory training LD awareness e-learning pack rolled out
- Developed LD indicator for easy LD identification on Meditech (Trust wide computer system)
- Developed 'LD champions' training and new champions identified
- Developed LD resource pack and pilot in clinical areas
- Pilot of hospital passport/ risk assessment and reasonable adjustment tools as per Liverpool acute liaison Network strategy
- Worked with Mencap to develop a pan-Liverpool health training pack
- Developed academic and practice links across Edge Hill University and Alder Hey.

Future Plans

- Development of 5 day acute liaison service across site (LD nurse workload model and supervision)
- Trust strategy to have an LD trained nurse on every ward. Further recruitment planned.
- Development of LD parents reference group
- Development of Alder Hey information pack for children and families with LD/ASC
- Roll out of hospital passport, 1 page profile, communication passport (following agreement across Liverpool acute liaison network)
- Continued attendance and benchmarking across Liverpool acute network and nationally re best practice
- Further implementation of risk assessment and reasonable adjustment tools
- Continued rolling programme of training across all clinical areas May- Oct 17
- Implementation of toy library proposals- across site access to sensory and specialist toys for all children with LD and additional sensory
- Roll out of resource boxes to all clinical areas
- Continue programme of developing LD champions
- Identify pilot areas for specific pathways for children with LD
- Improve communication with families- e.g. through electronic/media etc.
- Develop communication tools across areas- staff awareness
- Identification of research streams and dissemination of best practice across professional networks e.g. LD Consultant Nurse Network , Learning Disability Research Network.

3.3.14 Positive and Proactive Care

Positive and Proactive Care has been adopted by the Trust as a compliance measure within the Quality Contract. This entails ensuring the appropriate leadership, workforce, plans to use effective restrictive intervention reduction tools, and service user empowerment methodologies are in place, plus a commitment to effective models of post incident review.

The Trust has provided regular updates to commissioners in respect of progress against the relevant compliance standards throughout the year 2016-17. This includes our approach to adopting positive behavioural support and provide appropriate training for staff including 'Approach' training and our local in house training programme. The Trust has committed to producing a separate annual report which will be made available in the public domain.

3.3.15 Improvements in Cardiac Surgical Pathway

Aims:

- To improve the experience of patients and families as they attend for cardiac surgery.
- To reduce the numbers of cancelled operations (currently equivalent to 2.25 sessions per week).
- To revise the cardiac surgical pathway to provide an equitable service for all patients.

When a child requires cardiac surgery there is already a high degree of stress placed on parents and carers, and it is the responsibility of the hospital staff to ensure the journey is as comfortable and successful as it could possibly be. Our cardiac team had received feedback from children in the form of

patient stories and were prompted to make changes to the pathway to improve the experience of the children and their parents/carers.

Patient 1. *"I came into pre admission clinic and then admitted for my operation on Monday, I waited 8 days to go to theatre. Each day I thought it would happen but there were no beds. I had to have my bloods repeated 3 times".*

Reasons for change

Upon reviewing the data, there had been 111 cancelled theatre sessions in almost 12 months, and 209 planned cardiac operations had been cancelled and rearranged. This was not providing a good experience for our children and families.
The pathway was plotted and was found to have:

- Inequitable service.
- Late planning of theatre list, leading to cancellations and often meaning re-bleeding of the child.
- No continuity of planning for the patient prior to discussion
- Pressure on beds on cardiac ward/PICU
- Poor availability of doctors/surgeons in pre admission clinics.
- Clinics under-utilised as poor list planning.

Future Plans

Further improve pre-operative Echocardiogram provision
Follow up audit and seek further opportunity for improvement

Improvements

The pathway was reviewed and streamlined so that it best suited the needs of the children and families:

- Equitable service for all patients, consistent information.
- Reduction in risk of re-bleeding.
- Improved flow for the patient from discussion to discharge.
- Reduce pressure on ward, beds, nursing, doctors, help flow through Critical Care.
- Free up junior doctors on ward with no pre admissions to do.
- Less time on waiting list.
- Improve management of theatre list.
- Minimise cancellations of patients
- Better structure of all members of cardiac team.
- Informed consent nurse specialist then by

3.3.16 Introduction of CAMHS self referrals

The Child and Adolescent Mental Health Service (CAMHS) provided by Alder Hey Children's Foundations Trust has made great improvements in the past few years. One of the outstanding issues, which forms part of the Children & Young People's Improving Access to Psychological Therapies (CYP IAPT) commitments, is the ability for children and families to self refer to the service. The team are already receiving email contacts for young people seeking help for mental health matters they are struggling with, but the referral system makes it difficult for some children to access the service.

Aims:

- To improve access to CAMHS services for children, young people and their families.
- Comply with National Service Specification for self-referrals for CAMHS service.
- Address the needs of young people already making enquiries who are finding difficulty accessing the service.

The CAMHS team adopted a Listening into Action approach to addressing this issue, beginning with defining their mission…… '*to adapt the referral systems into CAMHS so that young people and their families can self-refer into Single Point of Access by October 2016*'.

At the first Team Conversation they identified a number of pros and cons in relation to introducing self-referrals, which included a degree of concern about the amount of unsolicited referrals that would be received.
It was agreed to pilot a self-referral service over the summer, but without publicising it, as there were already some young people contacting the service directly. These would be encouraged as self-referrals and it was felt the self-referral option would spread by word of mouth.

EXTRACTS FROM A PATIENT EMAIL.

"I am a 16 yr old school student"….
"I also have severe mood swings…….it has led to me having some self harm"
"Recently I have been struggling with eating issues. This week I have lost 2lbs"
"I find it hard to talk about such a sensitive area with my parents….when I am around people I try to put a brave face on it, but it has of course been noticed by my partner"
"It has taken a lot of courage to write this email so I hope you can help me"

Listening into Action

No of current families that said they would have benefitted from a self referral service to CAMHS, had it been available

90%

A survey was undertaken of the current families as to whether or not they would have found it useful to be able to self-refer, with a resounding 90% of families saying "YES".

Improvements

- Actively taking self-referrals for Liverpool & Sefton CAMHS services and the Specialist Eating Disorder service
- Triaging referrals as routine / urgent initial assessment as appropriate
- Signposting referrals to partner agencies as appropriate
- Taken 106 self-referrals between August 2016 and February 2017
- Majority of referrals by telephone to CAMHS duty team by parents / carers
- Some of the main presenting problems include:
    - Anxiety
    - Self harm
    - OCD, ADHD, Autism related concerns
    - Poor school attendance
    - Suspected eating disorders
- Shared improvement with other CAMHS service providers through presentation at North West CAMHS transformation event

Future Plans

- Capacity and demand predictions as service becomes widely publicised
- Continue to improve service and data collection as self referral route continues to grow
- Control growth in publicity and in service to avoid service becoming overwhelmed

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.
The Trust has continued to seek to recruit to vacancies through improved working with our education providers, national recruitment days and bespoke recruitment in specialty areas. Additionally there has been a key focus on reducing the use of agency staff, which in addition to reducing expenditure, also provides safer nursing care with staff employed directly by the Trust.

Safe staffing levels and compliance with RCN guidelines

To continue to improve staffing levels, an audit against the RCN standards has been undertaken involving the Ward Managers and Associate Chief Nurses for all in patient and day case wards. A previous audit against the core standards conducted in July 2013 showed overall Trust compliance with 9 out of 16 standards as shown in the thermometer below:

The audit of compliance against the core standards in February 2017 demonstrated overall Trust compliance with 12 standards, partial compliance with 3 standards, and none compliance with 1 standard as shown in the thermometer below:

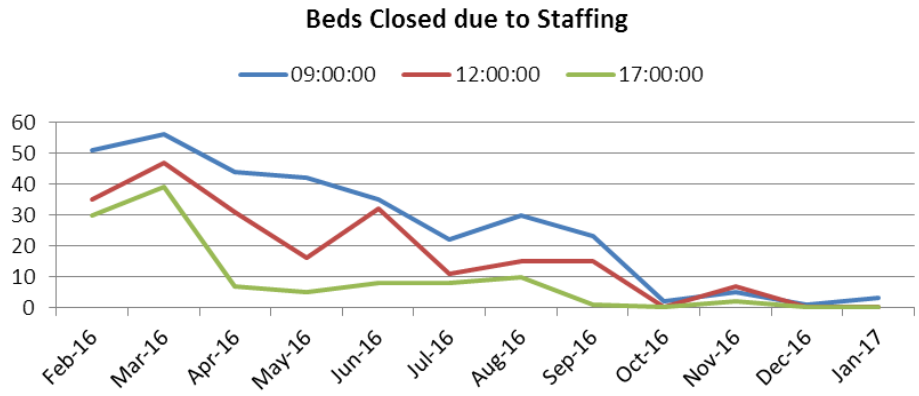
The areas for improvement rated amber and red above relate to:

- All clinical areas are required to have a supernumerary shift supervisor. Not all wards have an establishment funded for a supernumerary shift supervisor. This is being explored further to seek a resolution.
- There should be at least one nurse per shift on every ward trained in APLS / EPLS. There are currently insufficient numbers of nurses trained in APLS to meet this standard. Ward Managers of areas that are partially compliant or non compliant have identified in their local Training Needs Analysis that all Band 6 staff will be trained in the first instance followed by senior Band 5 nurses to improve / achieve compliance
- There should be a 25% increase in nursing establishment to cover annual leave, sickness and study leave. Alder Hey has operated at 23% uplift since 2013/14. We will continue to monitor and evaluate the impact of this.
- There should be access to a senior (Band 8a) children's nurse for advice at all times. An experienced Band 6 or 7 currently provides to the nursing team. This support is currently provided through the Patient Flow, Night Matron and Senior Nurse bleep holder.

In further progressing the work towards the aim of having no nurse vacancies, the Trust has made the following improvements:

Improvements

- 104.4 WTE front line nursing staff recruited in the last 12 months.
- Nurse pool of 20 nurses established to cover maternity leave, sickness and vacancies
- Significant reduction month on month in the closure of beds to admissions due to nurse staffing levels as shown in the graph below:



- Reduction in cancelled operations for "staffing unavailable".
- Extended the recruitment engagement processes with HEIs so we now attend recruitment events at Manchester, Edge Hill, LJMU, UCLAN, Salford and Lancaster.
- Held 2 national recruitment days where over 100 nurses have been recruited from all parts of the country
- Migrated agency staff across to our own nurse bank thereby reducing agency costs and improving nursing workforce resilience.
- Partnership working with HEI to run the first national non commissioned cohort of student nurses ahead of the changes requiring student nurses to pay tuition fees from August 2017. Cohort of 5 students commenced in the Trust in September 2016.
- Bespoke recruitment continues in speciality areas such as critical care and cardiac
- Partnership working with HEI to run a new training programme for individuals educated to Masters level to undertake a shortened course to become a registered Children's nurse.
- The implementation of a Matron role in the Theatre department with CBU support to establish the Matron role more widely within CBU's.
- Worked with commissioners to fund some specific acuity challenges particularly our complex orthopaedic/spinal patients on 4A and on 3C so staffing levels increased in both areas
- Realigned resources from general HDU to maintain 8 cardiac HDU beds with appropriate staffing
- Review of nurse staffing in Out Patients department undertaken (concludes March 2017).

The improvement outcomes are shown in the table below.

Future Plans

- Continue proactive recruitment of student nurses.
- Developing an offer of nursing rotational posts
- Seek to create a HCA pool to help support areas with increased dependency (further commissioner discussions ongoing)
- Undertake audit of impact of the implementation of Meditech 6 on nursing capacity
- Continue monitoring vacancies, turnover rates and daily staffing levels.

3.3.18 Patient Feedback and Friends and Family Test

During 2016-17 the Trust has modernised the way it collects feedback from patients and families in an attempt to capture real time information from as wide a population as possible in the Trust. Since June 2016, we have been entering data into a new database called 'SNAP'. This provides analytical software that enables us to breakdown and analyse patient feedback in several different ways, and present it in graphical and tabular form, thereby highlighting priority areas that require action or intervention.

With the support of volunteers, we have been able to take tablet computers to individual patients and families across the Trust and leave them to enter the data without the feeling of being pressured with a member of staff sat next to them whilst they responded.

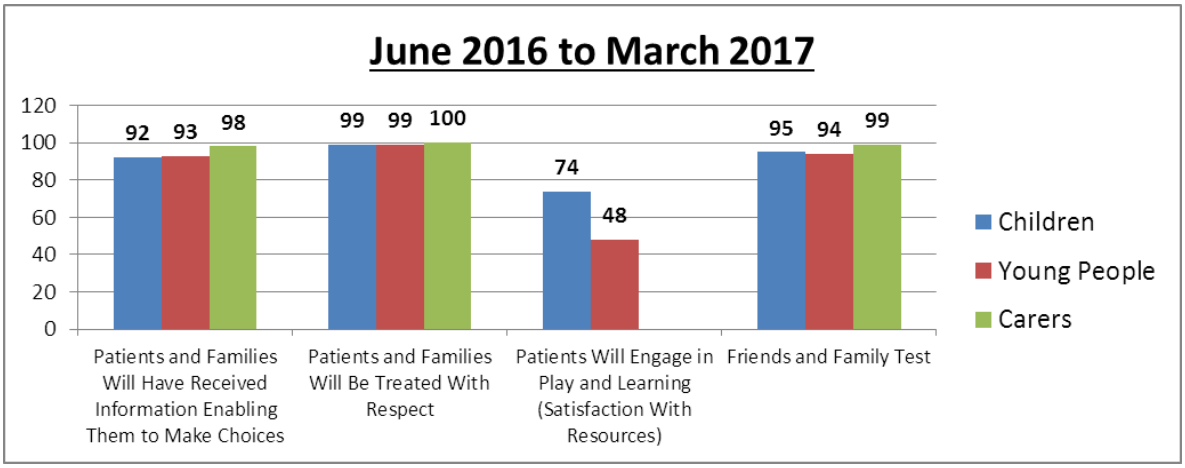
Patients and families are still able to access the Friends and Family Test via our website / NHS Choices, plus we continue to encourage patients to use the specific Family & Friends feedback cards, which we then manually enter onto the SNAP system.

We recognise there is still work to be done to gather feedback from all patient populations, in particular our community based services. However we are now able to identify the gaps and put appropriate mechanisms in place to improve information capture.

The following table shows the response from patients and families to the Family & Friends Test.

Patient feedback questions	Total responses	Total responding positively
Friends & Family Test (How likely are you to recommend our hospital to friends and family if they needed similar care?)	2083	2040 (98.0%)

The graph below shows feedback from children (up to 11 years old), young people (12-18 years old), and parents / carers to four key questions around patient experience. The Trust recognises the opportunity for improvement in how we communicate with children and young people, in particular in the area of 'engagement in play and learning'. This has been adopted as a key priority for the Trust for 2017-18 and will be reported in next year's Quality Account.



3.3.19 Management of Complaints and Concerns

The model of devolved governance implemented through the quality strategy is intended to drive early supportive intervention by the relevant clinical teams / clinical business units so that children, young people and their families / carers have the best experience, with any issues raised locally being dealt with immediately and appropriately.

	2013/14	2014/15	2015/16	2016/17	Comments
Formal complaints	166	134	70	66	The formal complaints have decreased again for the third consecutive year – this is a 6% decrease from 2015/16 but a 60% decrease from 2013/14 Feedback continues to be sourced from a variety of methods however much earlier and proactive engagement at ward and department level by clinical staff has been welcomed when responding to parental concerns. This results in a positive patient experience and safer care
PALS	1248	1133	1246	1294	A 4% increase in PALS is noted this year. Despite the increase the Trust is aware of local resolution taking place within teams and departments that may not be captured on the reporting system. This again is a positive experience for parents, having concerns listened to and resolved on the spot, and helping to avoid issues

					being taken further to a formal complaint.

Improvements

- Implemented model of devolved governance to drive early supportive intervention by the relevant clinical teams / clinical business units
- Further reduction in formal complaints.

Appendix 1 Reporting against core indicators

The report provides historical data and benchmarked data where available, and includes the prescribed indicators based on Appendix A of the Risk Assessment Framework (for 1st April to 30th September) and the Single Oversight Framework (for 1st October to 31st March)

Target or Indicator	Threshold	National Performance	Qtr1	Qtr2	Qtr3	Qtr4
Summary Hospital level Mortality Indicator (SHMI)[1]	n/a	n/a	n/a	n/a	n/a	n/a
C. Difficile Numbers – due to lapses in care	0		0	0	1	0
C. Difficile - Rates per 100,000 Bed days	0	6.9	0	0	5.8	0
18 Week RTT Target Open Pathways (Patients still waiting for Treatment	92%	90.0%[2]	92.1%	92.1%	92.2%	92.1%
All cancers: two week GP referrals	100%	95.1%[3]	100.0%	100.0%	94.4%	100.0%
All cancers: one month diagnosis (decision to treat) to treatment	100%	97.5%[3]	100.0%	100.0%	100.0%	100.0%
All cancers: 31 day wait until subsequent treatments	100%	97.5%[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%	89.0%[4]	95.00%	96.55%	93.11%	96.71%

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 [5]	National data collection methodology currently under review	0-15 Years: 16 Years & over:	8.3% 2.4%	8.2% 7.3%	9.3% 8.4%	8.3% 6.3%
% of Staff who would recommend the trust as a provider of care to their family or friends		80%[6]	85%	88%	Not required	Not available
Staff Survey results: % staff experiencing harassment, bullying or abuse from staff in the last 12 months [7]		24%	26%			
Staff Survey results: % believing that trust provides equal opportunities for career progression or promotion for the Workforce Race Equality Standard [7]		85%	81%			
Financial & Service performance Ratings[8]			2	2	3	3
Rate of Patient Safety Incidents per 1000 bed days [9]			79	67	63	69
Patient Safety Incidents and the Percentage that result in Severe Harm or Death [9]			0 0%	0 0%	1 0.08%	1 0.08%

NOTE: Unless otherwise indicated, the data in the table above has been obtained from local Patient Administration Service, to enable the Trust to provide the most recent available data. Most of this data is accessible through the NHS England website

[1]Specialist Trusts are excluded from SHMI reporting

[2] National Performance based on most recent published data for Feb 2017, NHSE website.

[3] National Performance is based on most recent published Quarter 3 data for 2016/17, NHSE website

[4] A&E National Performance based on most recent published data for April 2016- Feb 2017, NHSE website.

[5] Data source: Trust Patient Administration System – not published nationally

[6] National Performance is based on most recent published Quarter 2 data for 2016/17, NHSE website.

[7] Data source: 2016 Staff Survey http://www.nhsstaffsurveyresults.com

[8] Performance was the same throughout the year, the ratings differ due to changes in the rating criteria introduced in October 2016, Trust corporate report.

[9] Data source: Trust Incident Reporting System (Ulysses) – national data only available for first 6 months of the year

Alder Hey Children's NHS Foundation 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 via the Data Quality Steering Group

The Trust is taking the following actions to improve the scores and so the quality of its services, by

- Placing further focus on implementation of Infection Control Delivery Plan.
- Changed the referral pathway for all suspect cancer referrals so that they all go initially to Oncology and are then allocated to the individual specialty as appropriate, with a clear flag if it is relevant to the 2 week cancer wait target.

For all other indicators the trust is maintaining and improving current performance where possible.

Appendix 2. Alder Hey Strategic Vision and Aims 'Plan on a Page'

Our Vision: A healthier future for children and young people
Our aspiration: To be world-leading
Our inspiration: We are inspired by children

Do the basics brilliantly

Delivery of outstanding Care

- Alder Hey gets it right for every child first time, every time using consistent clinical pathways
- Learning is embedded when things don't go to plan
- Hospital acquired infections are eliminated
- Sepsis is recognised early and prevented
- Zero medication errors
- A named responsible consultant for every child
- Every child and family's experience is positive
- We listen and respond to what children and families tell us
- We create, maintain and operate world-class facilities

The best people doing their best work

- Staff understand and support the Trust priorities
- Great work in support of Alder Hey is recognised and celebrated
- Managers bring the best out in their people.
- All staff realise their full potential through performance and development opportunities.
- Empowered and engaged employees who own and implement change
- Proactive workforce and succession planning
- A healthy workplace that supports employee wellbeing
- Our diverse workforce reflects our local community

Grow the Future

Sustainability through external partnerships

- Lead the development of integrated services for children and young people across Cheshire & Merseyside and beyond
- Grow community services to better meet the needs of local children
- Make specialist services available to more children, and develop new services
- Develop and implement a business plan for International partner countries
- Establish the Alder Hey Academy as the best place to train in paediatric healthcare

Game-changing research and innovation

- Every child has an opportunity to participate in research to benefit themselves and others
- Develop more new medicines and treatments through research partnerships
- Discover new ways to apply the latest technology to transform children's healthcare
- Active input from many Alder Hey healthcare professionals into research and innovation projects

Strong foundations

- Living our values : Respect, Excellence, Innovation, Openness, Together
- Children and families are involved in everything we do
- Deliver business plans and achieve financial targets
- Work productively, spend wisely and reduce waste
- Reliable infrastructure, slick systems and processes, used consistently, supported by training
- A digitally enabled way of working that effectively uses information technology

Statement on the Quality Report by partner organisations

Commentary from Governors

"These accounts reflect what I know to have been, another very busy, engaged year of activity at Alder Hey. All credit to all staff involved."

Pippa Hunter-Jones, Parent and Carer Governor

"Thank you for sharing this with us. I generally find myself struggling to comprehend such documents due to the complex ways in which information is shared. However, it was pleasure reading the draft version of the report. It's logical, clear and thorough. The fact that the trust is generally doing so well is the 'icing on the cake'.

The section on participation in audits and actions arising from them is particularly good as a lot for reflection has been used in order to propose actions.

Dr Rabia Aftab, Public - Rest of England Governor

Commentary from Healthwatch organisations

xx

Commentary from Clinical Commissioning Groups

xx

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.

NHS Improvement 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 2016/17 and supporting guidance
- 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 2016 to March 2017
  - papers relating to quality reported to the board over the period April 2016 to March 2017
  - feedback from commissioners dated XX/XX/20XX
  - feedback from governors dated XX/XX/20XX
  - feedback from local Healthwatch organisations dated XX/XX/20XX
  - feedback from Overview and Scrutiny Committee dated XX/XX/20XX
  - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated XX/XX/20XX
  - the 2015 national patient survey
  - the 2016 national staff survey dated March 2017
  - the Head of Internal Audit's annual opinion of the trust's control environment dated April 2017
  - CQC inspection report dated December 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 NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report

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

----------Date----------Chairman

----------Date----------Chief Executive

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF ALDER HEY CHILDREN'S NHS FOUNDATION TRUST ONLY

NHS foundation trust accounts template - Trust accounts

Version: 3.2 (issued March 2017)

Background to this accounts template

This accounts template has been developed by NHS Improvement for use by NHS foundation trusts and is entirely optional for use. This is the third version.

NHS foundation trusts are able to determine their own format of accounts, subject to achieving compliance with the Department of Health's Group Accounting Manual (DH GAM) and NHS Improvement's *NHS Foundation Trust Annual Reporting Manual* (FT ARM). This template has been developed to assist any foundation trusts who may struggle with that need, and keeping abreast of changing requirements. NHS Improvement has no current intention of mandating use of this accounts template in future periods.

The requirements for a foundation trust's accounts are set out in chapter 4 of the DH GAM. This optional accounts template does **not** form part of Monitor's accounts direction to NHS foundation trusts. If at any point this template appears inconsistent with the DH GAM, the DH GAM is the primary source of direction. Any such inconsistency would, however, be unintentional as the purpose of this template is to assist foundation trusts in complying with the DH GAM when determining the format of their accounts.

We recognise that every NHS foundation trust is different, and will have slightly differing disclosure requirements. As such the spreadsheet is entirely unprotected: in using this tool you will need to hide rows/columns as appropriate or you may wish to aggregate immaterial rows or columns and update the mapping to the FTC schedules. As such NHS Improvement cannot guarantee that a set of accounts prepared using this tool will be compliant with the DH GAM to an extent that will satisfy the trust's auditors. In using this tool foundation trusts will need to adapt it for local circumstances and NHS Improvement accepts no responsibility for the accounts that are produced.

The last tab of this template, tab 'Staff report tables', contains tables for disclosures that should be included in the annual report and not the accounts (per the FT ARM).

Trust and Group template versions

Many NHS foundation trusts prepare group accounts, as they consolidate an NHS charitable fund or other subsidiaries. Many other foundation trusts do not prepare group accounts. As such there are two versions of this template:

Trust accounts: This is a single entity version of the accounts template, with the figures linked to the totals in the FTC file.

Group accounts: This version should be used by foundation trusts preparing group accounts. The Group numbers are linked to the total column of the FTC file. The Trust numbers are not populated, and you can link these either to your own working papers or to the optional 'Trust' columns in the FTC file. Alternatively you may have your own working papers for the consolidation and replace the source formulas for both the Group and Trust numbers.

Except for the presence of separate Group and Trust columns/tables in the first version, the two versions are the same.

The Group version of the template assumes that the Trust takes advantage of the Companies Act exemption repeated in the DH GAM (paragraph 4.51) which allows the parent (i.e. Trust) statement of comprehensive income and related notes to be omitted. The SOCI and its supporting notes therefore omit 'Trust' columns. Some foundation trusts may wish to add these back in, or in some cases add additional disclosure explaining what the difference between group and trust numbers would be.

For notes where Group and Trust should be included, paragraph 4.52 of the DH GAM states "*Where the entity determines that the difference between the 'Group' and 'Parent Entity' numbers is immaterial for a particular note, the 'Parent Entity' version of that note may be omitted from the accounts. The omission and the extent of the immaterial differences should be explained.* " This template has been prepared with Group and Trust versions of all balance sheet notes, which the user may wish to amend.

How to use this accounts template

This accounts template is designed to be easy to work with in Microsoft Excel, but is also formatted in such a way that when printed, the end result is a presentable set of accounts. Different local printers will change how page margins work and some editing of column widths in particular may be required to achieve the right formatting for printing for each user.

The accounts template is linked to an FTC file. Cells linked to the FTC file contain defined file paths which are easily updated by the FT if you choose to map cells in the FTC differently. The file as issued contains links directed at a dummy FTC file held by NHS Improvement. **When opening the file for the first time, you should select 'do not update links' when prompted.**

Follow the instructions below to direct the links to your local FTC file.

Step 1: Link the accounts template to your FTC file

As a starting point you should update the information on the Settings sheet. Then, you need to change the source file for the links as follows:

1. Select the 'Data' tab on the ribbon at the top of Excel (if this tab is not visible it may need to be added by customising the ribbon in excel options)
2. Within the 'Connections' section, select 'Edit Links'.
3. In the dialogue box that appears, highlight the existing source file (the dummy file) and select 'Change Source'.
4. Navigate to your locally saved FTC file and select.
5. All links within this workbook should now be redirected to your local file. Due to the number of links this may take some time. Please be patient and do not attempt to perform other tasks in excel at the same time.

Step 2: Check that the FTC linking is working and the accounts hold together

In preparing this accounts template we have linked cells to the FTC but you should verify that these are correct, and that nothing has been affected by changing the link to your FTC.

There are no validation checks within this accounts template, so at this point we recommend you review the document for reasonableness (not presentation at this stage) - checking that note totals agree between the FTC and accounts, checking that primary statements are accurate, and so forth.

Step 3: Tailor the document to become your accounts

Tailoring the document may involve some or all of the following:
◦ aggregating rows or columns within disclosure notes - care then needs to be taken to update the FTC mapping

◦ hiding /deleting unnecessary columns or rows - for example unused categories of intangible asset. Care then needs to be taken to ensure that total formulae still work and column widths for row descriptions may need to be changed to ensure tables are right aligned on the page when printed.

◦ hiding /deleting whole notes or sheets in some cases - then need to check that the primary statements are unaffected and update note numbering. Please read Step 4 below in relation to note numbering.
◦ tailoring existing notes where manual inputs/updates are required. [These are identified by red text in square brackets]
◦ adding in extra notes

◦ updating accounting policies - this template includes the example accounting policies issued by NHS Improvement. These require local tailoring or replacing with the FT's own accounting policy disclosures.

Step 4: Presentation

Note numbers for each note use hidden text in column A to compute the note number adding on from the last note. Where you have added or deleted a note, this formula will need updating in the subsequent note, but then all subsequent notes will renumber. Note references on the primary statements are linked to the hidden numbers in column A so should update automatically when notes are updated. Note references within the example accounting policies are highlighted as red text and these should be updated locally.

In Print Preview mode, you can see how the accounts template will look when printed. Each worksheet (tab) of the file should be checked individually for print preview. If necessary, adjust the column widths on a tab to improve how the document fits on a page. Add/amend page breaks within a tab if necessary (most easily done from page break view).

There are currently no headers and footers set in the template. The Trust may wish to insert the name of the Trust into the header - this is not currently done because of limitations in Excel not making it simple to link this to a cell for the user to edit. If you wish to add headers of footers, highlight the desired worksheets and edit the header/footer tab in the Page Setup box, which is accessible from the Page Layout tab of the ribbon > Margins > Custom margins > Header and footer tab. These options can be set for each tab individually, or for a collection of sheets at once if these tabs are selected when the Page Setup options are amended. Please note that if these settings are changed with multiple sheets selected, all of the settings in the dialog box are applied to the selected sheets - including page orientation. Therefore to assist the user if you wish to change headers/footers for multiple sheets, sheets that are set to landscape orientation are coloured light blue for ease of identification.

The trust may wish to add the page number as a footer. Follow the instructions above for adding a footer. As the accounts follow the annual report, you may not wish to start the accounts page number at 1. In order to change this firstly click on the first tab you want to have a page number, select the Page Layout tab from the ribbon > in the page setup section select the small arrow in the bottom right hand corner > a pop up box will appear, on the Page tab change the last option 'First page number' to whatever page number you want > click 'ok'. All subsequent tabs will follow this page numbering system.

Step 5: Submission of accounts to NHS Improvement (Monitor)

Where foundation trusts opt to use this template as a basis for their annual accounts, links to the FTC file (and all other working papers) should be broken before uploading the file to the trust's Monitor portal (for both the draft and final accounts submission). This will prevent #REF! errors appearing when NHS Improvement attempts to view the accounts. Links to the FTC file can be broken as follows:

1. Select the 'Data' tab on the ribbon at the top of excel (if this tab is not visible it may need to be added by customising the ribbon in excel options)
2. Within the 'Connections' section, select 'Edit Links'.
3. In the dialog box that appears, highlight the FTC source file (and any other linked working papers in turn) and select 'Break Link'.

Feedback and comments

Your comments on this tool are very welcome. Is it useful? If you find it useful, do you have suggestions for how we should develop it further?

Please send any comments to FT.Accounts@improvement.nhs.uk

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)	31/03/2017
Start of current year (dd/mm/yyyy)	01/04/2016
Comparative year end (dd/mm/yyyy)	31/03/2016
Start of comparative year (dd/mm/yyyy)	01/04/2015
Year for financial reporting (20XX/YY)	2016/17
Year for comparative year (20XX/YY)	2015/16
Year for year end (20XX)	2017
Year for comparative year (20XX)	2016
Opening Year (20XX)	2015
Next financial year (20XX/YY)	2017/18
Date of approval of financial statements (dd/mm/yyyy)	25/05/2017

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 NHS Improvement via your Monitor p

Alder Hey Children's NHS Foundation Trust

Annual accounts for the year ended 31 March 2017

Foreword to the accounts

Alder Hey Children's NHS Foundation Trust

These accounts, for the year ended 31 March 2017, 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 **Louise Shepherd**
Job title **Chief Executive**
Date **25 May 2017**

Statement of Comprehensive Income

	Note	2016/17 £000	2015/16 £000
Operating income from patient care activities	3	192,037	175,245
Other operating income	4	30,555	40,471
Total operating income from continuing operations		**222,592**	**215,716**
Operating expenses	5, 7	(209,644)	(244,892)
Operating surplus/(deficit) from continuing operations		**12,948**	**(29,176)**
Finance income	9	28	107
Finance expenses	10	(9,815)	(5,334)
PDC dividends payable	11	(981)	(1,163)
Net finance costs		**(10,768)**	**(6,390)**
Gains/(losses) of disposal of non-current assets	12	402	(5,133)
Surplus/(deficit) for the year from continuing operations		**2,582**	**(40,699)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	6	-	(116)
Revaluations	16	4,644	86
Total comprehensive income/(expense) for the period		**7,226**	**(40,729)**

Other operating income for 2015/16 differs from the prior year audited figure as profit on disposal (£270,000) is now disclosed elsewhere in the Statement of Comprehensive Income

Statement of Financial Position

	Note	31 March 2017 £000	31 March 2016 £000
Non-current assets			
Intangible assets	13	11,650	11,783
Property, plant and equipment	14	208,232	205,550
Trade and other receivables	18	139	183
Total non-current assets		**220,021**	**217,516**
Current assets			
Inventories	17	2,511	2,702
Trade and other receivables	18	16,612	9,943
Non-current assets for sale and assets in disposal groups	19	13	572
Cash and cash equivalents	20	6,516	10,551
Total current assets		**25,652**	**23,768**
Current liabilities			
Trade and other payables	21	(17,010)	(23,170)
Other liabilities	22	(2,264)	(2,367)
Borrowings	23	(4,197)	(4,169)
Provisions	25	(443)	(1,035)
Total current liabilities		**(23,914)**	**(30,741)**
Total assets less current liabilities		**221,759**	**210,543**
Non-current liabilities			
Other liabilities	22	(3,769)	(3,906)
Borrowings	23	(152,235)	(148,117)
Provisions	25	(699)	(690)
Total non-current liabilities		**(156,703)**	**(152,713)**
Total assets employed		**65,056**	**57,830**
Financed by			
Public dividend capital		45,745	45,745
Revaluation reserve		5,670	1,042
Income and expenditure reserve		13,641	11,043
Total taxpayers' equity		**65,056**	**57,830**

The notes on pages X to X form part of these accounts.

Name **Louise Shepherd**
Position **Chief Executive**
Date **25 May 2017**

Statement of Changes in Equity for the year ended 31 March 2017

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2016 - brought forward	**45,745**	**1,042**	**11,043**	**57,830**
Surplus/(deficit) for the year	-	-	2,582	**2,582**
Other transfers between reserves	-	(14)	14	**-**
Revaluations	-	4,644	-	**4,644**
Transfer to retained earnings on disposal of assets	-	(2)	2	**-**
Taxpayers' and others' equity at 31 March 2017	**45,745**	**5,670**	**13,641**	**65,056**

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)**
Other transfers between reserves	-	(17)	17	**-**
Impairments	-	(116)	-	**(116)**
Revaluations	-	86	-	**86**
Public dividend capital received	409	-	-	**409**
Taxpayers' and others' equity at 31 March 2016	**45,745**	**1,042**	**11,043**	**57,830**

Information on reserves

Public dividend capital
Public dividend capital (PDC) 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. Additional PDC may also be issued to NHS foundation trusts by the Department of Health. A charge, reflecting the cost of capital utilised by the NHS foundation trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the NHS foundation trust.

Statement of Cash Flows

	Note	2016/17 £000	2015/16 £000
Cash flows from operating activities			
Operating surplus/(deficit)		12,948	(29,176)
Non-cash income and expense:			
Depreciation and amortisation	5.1	7,390	5,285
Net impairments	6	2,239	45,189
Income recognised in respect of capital donations	4	(2,704)	(11,786)
Amortisation of PFI deferred credit	4	(137)	(69)
(Increase)/decrease in receivables and other assets		(6,519)	66,552
(Increase)/decrease in inventories		191	(1,175)
Increase/(decrease) in payables and other liabilities		(5,917)	(2,405)
Increase/(decrease) in provisions		(594)	(1,412)
Other movements in operating cash flows		-	-
Net cash generated from/(used in) operating activities		**6,897**	**71,003**
Cash flows from investing activities			
Interest received		28	107
Purchase of intangible assets		(1,247)	(6,680)
Purchase of property, plant, equipment and investment property		(5,046)	(24,012)
Sales of property, plant, equipment and investment property		1,009	270
Receipt of cash donations to purchase capital assets		1,368	10,163
Net cash generated from/(used in) investing activities		**(3,888)**	**(20,152)**
Cash flows from financing activities			
Public dividend capital received		-	409
Movement on loans from the Department of Health		6,234	(1,802)
Capital element of finance lease rental payments		(44)	(44)
Capital element of PFI, LIFT and other service concession payments		(2,044)	(68,670)
Interest paid on finance lease liabilities		(4)	(6)
Interest paid on PFI, LIFT and other service concession obligations		(8,719)	(4,317)
Other capital receipts		-	-
Other interest paid		(1,067)	(993)
PDC dividend paid		(1,400)	(925)
Cash flows from (used in) other financing activities		-	-
Net cash generated from/(used in) financing activities		**(7,044)**	**(76,348)**
Increase/(decrease) in cash and cash equivalents		**(4,035)**	**(25,497)**
Cash and cash equivalents at 1 April		**10,551**	**36,048**
Cash and cash equivalents at 31 March	20	**6,516**	**10,551**

Notes to the Accounts

Note 1 Accounting policies and other information

1 **Basis of preparation**

NHS Improvement, in exercising the statutory functions conferred on Monitor, is responsible for issuing an accounts direction to NHS foundation trusts under the NHS Act 2006. NHS Improvement has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the Department of Health Group Accounting Manual (DH GAM) which shall be agreed with the Secretary of State. Consequently, the following financial statements have been prepared in accordance with the DH GAM 2016/17 issued by the Department of Health. The accounting policies contained in that manual follow IFRS and HM Treasury's FReM 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 **Going concern**

These accounts have been prepared on a going concern basis. The Trust is planning to be financially sustainable over the next five year NHS planning horizon. The Trust is planning a trading surplus of £0.1m in 2017/18 and £1.2m in 2018/19. Forecast cash position for March 2018 is £3.5m. The Trust is not planning to apply for any interim funding during 2017/18.

1.3 **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 affects 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 Cushman & Wakefield. The valuations are carried out in accordance with the Royal Institute of Chartered Surveyors Valuation Standards. The valuations for the new buildings were carried out during 2015/16 and were applied to the 31 March 2016 land and buildings values. Asset values have been uplifted to reflect latest estimate of BCIS "All in" Tender Price Indices. 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 2017 reflect the valuation indicated by Cushman & Wakefield given that most of the hospital buildings are in the process of being demolished.

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 2017. The provision is £ 996,000 (31 March 2016: £926,000) and includes a provision of £389,000 (31 March 2016: £465,000) 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 15**%** (31 March 2016: 21.99%) to reflect recoverability of more recent incidents.

Holiday pay accrual

The accrual for outstanding leave has been calculated on an actual basis.

The amount of outstanding annual leave as at 31st March has been requested from all managers from across the Trust. The accrual is calculated based on the returns from those managers. The Trust's annual leave policy clearly states that annual leave is expected to be taken in the year it relates to and only carried forward on an exceptional basis and with agreement from managers.

1.4 **Income**

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the trust is contracts with commissioners in respect of health care services.
Where income is received for a specific activity which is to be delivered in a subsequent financial year, that income is deferred.
Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

1.5 **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. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period on an exceptional basis and with agreement from managers.

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of 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.

1.6 **Other expenses**

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.7 **Property, plant and equipment**

Property, plant and equipment is capitalised where:

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 Valuation Standards. Valuation of the new hospital building (Inpatients and Outpatients) took place as at valuation date of 30 September 2015 and the Research and Education building with a valuation date of 31 July 2015. The 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. Building indices advised by Cushman & Wakefield have increased since the last valuation. This increase has been applied to the Trust's building asset values at 31 March 2017. There has been no change to land indices.

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 DH GAM 2016/17. 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

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. 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. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation

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 is charged, on a straight-line basis, to write off the costs or valuation of property, plant and equipment, less any residual value, over their estimated 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 in year. 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 the 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:

	Minimum Life Years	Maximum Life Years
Buildings excluding dwellings	1	90
Dwellings	40	40
Plant and machinery	2	15
Information technology	5	10
Furniture and fittings	10	10

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. In accordance with IAS 17, the underlying assets are recognised as property, plant and equipment, together with an equivalent finance lease liability. Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate.

The annual contract payments are apportioned between the repayment of the liability, a finance cost 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 at their fair value.

1.8 **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 is not capitalised.

As it cannot be demontrated 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.

Amortisation
Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

Useful economic life of intangible assets
Intangible assets which comprise computer software have a minimum life of 1.5 years and a maximum life of 9 years.

1.9 **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.

The profit or loss arising on the disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Income. On disposal, the balance for the asset on the revaluation reserve is transferred to retained earnings.

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.

1.10 **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, uplifted to reflect latest BCIS indices. 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’.

1.11 **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.

1.12 **Leases**

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the NHS 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 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.

Operating leases

Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

1.13 **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.

1.14 **Cash and cash equivalents**

Cash is cash in hand and deposits with commercial bank and Government Banking Service.

1.15 **Provisions**

Provisions are recognised where 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 in the Statement of Financial Position 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 mandated by HM Treasury.

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. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS foundation trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the NHS foundation trust is disclosed at note 25.2 but is not recognised in the NHS foundation trust's accounts.

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.

1.16 **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 de-recognised 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.

1.17 **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.

1.18 **Value Added Tax**

Most of the activities of the NHS foundation 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 fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.19 **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.

1.20 **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 2017.

1.21 **Public dividend capital (PDC) and PDC dividend**

of establishment of the predecessor NHS trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

1.22 **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 that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure 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 revenue expenditure).

However 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.

1.23 **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.

1.24 **Corporation tax**

The Trust has determined that it has no corporation tax liability as it does not carry out significant commercial activities that are not part of healthcare delivery.

1.25 **Donations**

Any donations received by an NHS Foundation Trust from a body or an individual which is not a government body and which does not result in the donating party having any financial interest in the Trust are recognised as follows:

Donations received to support operating expenditure by the Foundation Trust are recognised in operating income when, and to the extent to which the conditions attached to them, e.g.: incurring the expenditure, have been met.

1.26 **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.

1.27 **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.

1.28 **Early adoption of standards, amendments and interpretations**

No new accounting standards or revisions to existing standards have been early adopted in 2016/17.

1.29 **Standards, amendments and interpretations in issue but not yet effective or adopted**

The DH GAM does not require the following standards and Interpretations to be applied in 2016/17. These Standards are still subject to HM Treasury FReM adoption, with IFRS9 and IFRS15 being for implementation in 2018/19, and the Government implementation date for IFRS16 is still subject to HM Treasury consideration.

IFRS 9 Financial Instruments	Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the *FReM*: early adoption is not therefore permitted.
IFRS 15 Revenue from Contracts with Customers	Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the *FReM*: early adoption is not therefore permitted.
IFRS 16 Leases	Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the *FReM*: early adoption is not therefore permitted.
IFRIC 22 Foreign Currency Transactions and Advance Consideration	Application required for accounting periods beginning on or after 1 January 2018.

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 the 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)

	2016/17 £000	2015/16 £000
Acute services		
Elective income	43,313	38,739
Non elective income	31,373	27,202
Outpatient income	29,688	26,281
A & E income	5,103	4,837
Other NHS clinical income	61,550	56,711
Mental health services		
Block contract income	10,007	10,177
Community services		
Community services income from CCGs and NHS England	9,442	9,982
Community services income from other commissioners	831	842
All services		
Private patient income	309	90
Other clinical income	421	384
Total income from activities	**192,037**	**175,245**

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	**2016/17 £000**	**2015/16 £000**
CCGs and NHS England	174,643	159,879
Local authorities	1,033	1,055
Department of Health	-	-
Other NHS foundation trusts	246	774
NHS trusts	15	20
NHS other	-	-
Non-NHS: private patients	309	90
Non-NHS: overseas patients (chargeable to patient)	8	-
NHS injury scheme (was RTA)	416	279
Non NHS: Welsh specialised commissioners	12,677	11,562
Non NHS: other	2,690	1,586
Total income from activities	**192,037**	**175,245**
Of which:		
Related to continuing operations	192,037	175,245

NHS injury scheme income is subject to a provision for impairment of receivables to reflect expected rates of collection. This amounts to £389,000 at 31 March 2017 (£465,000 at 31 March 2016).

Note 3.3 Overseas visitors (relating to patients charged directly by the NHS foundation trust)

	2016/17	2015/16
	£000	£000
Income recognised this year	8	-
Cash payments received in-year	8	-
Amounts added to provision for impairment of receivables	-	-
Amounts written off in-year	-	-

Note 4 Other operating income

	2016/17	2015/16
	£000	£000
Research and development	3,662	4,129
Education and training	7,644	8,249
Receipt of capital grants and donations	2,704	14,137
Charitable and other contributions to expenditure	376	222
Non-patient care services to other bodies	5,014	3,391
Sustainability and Transformation Fund income	6,206	-
Amortisation of PFI deferred credits	137	69
Other income	4,812	10,274
Total other operating income	**30,555**	**40,471**
Of which:		
Related to continuing operations	30,555	40,471
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.

Other operating income for 2015/16 differs from prior year audited accounts because profit on disposal is now reported elsewhere.

Note 4.1 Analysis of other operating income: Other

	2016/17	2015/16
	£000	£000
Car parking	784	517
Clinical excellence awards	609	625
Catering	892	828
Funding for project costs for Alder Hey in the Park	804	6,385
Innovation Hub	155	280
Improved Organisation Safety	-	187
Other	1,568	1,452
	4,812	**10,274**

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:

	2016/17	2015/16
	£000	£000
Income from services designated (or grandfathered) as commissioner requested services	184,504	168,487
Income from services not designated as commissioner requested services	7,534	6,758
Total	**192,037**	**175,245**

The split of income for 2015/16 differs from prior year audited accounts because of interpretation of NHS England guidance

Note 4.3 Profits and losses on disposal of property, plant and equipment

	Net Book Value	Sales Proceeds	Profit/(loss) on disposal
Rose Hill House	298	491	191
Seymour Terrace	274	501	224
B1/D1 Extension	-	9	9
Rainbow Extension	-	1	1
Equipment disposals	35	12	(23)
	607	**1,014**	**402**

Profit on disposal property assets is after deduction of cost of sale

Clinical services provided in the building assets disposed of have transferred to the new building or retained estate on Alder Hey site.

Note 5.1 Operating expenses

	2016/17	2015/16
	£000	£000
Purchase of healthcare from non NHS bodies	534	324
Employee expenses - executive directors	855	837
Remuneration of non-executive directors	127	134
Employee expenses - staff	135,929	132,477
Supplies and services - clinical	18,175	15,246
Supplies and services - general	3,551	3,247
Establishment	2,701	3,779
Research and development *	807	1,456
Transport	50	74
Premises	11,515	12,530
Increase/(decrease) in provision for impairment of receivables	107	222
Drug costs	18,644	18,419
Depreciation on property, plant and equipment	5,852	4,692
Amortisation on intangible assets	1,538	593
Net impairments	2,239	45,189
Audit fees payable to the external auditor		
audit services- statutory audit	53	59
other auditor remuneration (external auditor only)	302	39
Clinical negligence	4,113	2,971
Legal fees	79	366
Consultancy costs	1,211	188
Internal audit costs	126	84
Training, courses and conferences	402	731
Patient travel	102	100
Car parking & security	478	474
Redundancy	209	36
Early retirements	12	22
Insurance	360	236
Losses, ex gratia & special payments	142	266
Other **	(569)	101
Total	**209,644**	**244,892**
Of which:		
Related to continuing operations	209,644	244,892

* Research and development expenditure reflects payments to other organisations in respect of research contracts. Employee expenses - staff, include £2,130,000 (2015/16 £2,299,000) relating to research and development activities.

** Other expenditure includes write back of unused other provision

The Trust is the host organisation for the Sustainability and Transformation Plan and has incurred £846,000 of expenditure, of which £745,000 is part of the consultancy costs above.

Note 5.2 Managed Service Arrangements (MSA)

The Trust had 4 managed service arrangements being the outpatients and modular ward (now being used for other purposes), the patient information system 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.

	2016/17	2015/16
	£000	£000
Amounts included within operating expenses in respect of MSA transactions	2,844	3,627

The Trust is committed to making the following payments during the year:

	Buildings		Other	
	31-Mar-17	31-Mar-16	31-Mar-17	31-Mar-16
	£000	£000	£000	£000
Schemes which expire:				
Within 1 year	0	919	0	0
2nd to 5th Years (inclusive)	828	1,094	1,961	2,400

Expenditure for 2015/16 differs from prior year audited accounts because expenditure has been re-classified as MSA. Amounts in operating expenses for MSA transactions has increased by £884,000 whilst the other commitments have increased by £2,195,000.

Note 5.3 Operating Leases

This note discloses costs and commitments incurred in operating lease arrangements where the Trust is the lessee.

	2016/17	2015/16
	£000	£000
Operating lease expense		
Minimum lease payments	6	7
Contingent rents	-	-
Less sublease payments received	-	-
Total	**6**	**7**
Future minimum lease payments due:		
- not later than one year	6	-
- later than one year and not later than five years	-	-
- later than five years	-	-
Total	6	-

The Trust held no operating leases in respect of land and buildings during 2016/17.

Note 5.4 Other auditor remuneration

	2016/17	2015/16
	£000	£000
Other auditor remuneration paid to the external auditor:		
Other non-audit services including Business Advice	302	39
Total	**302**	**39**

£20,096 was paid to KPMG for VAT advice.

£270,585 was paid for work as host of the Cheshire & Merseyside Service Transformation Plan. The Trust's share was 3% amounting to £8,117.
£10,800 was paid for Quality Accounts Audit

£10,000 was also paid for VAT advice on the Research & Education Phase 2 extension. This was charged to property, plant and equipment additions.

Note 5.5 Limitation on auditor's liability

The limitation on auditors' liability for external audit work is £1m (2015/16: £1m).

Note 6 Impairment of assets

	2016/17	2015/16
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	-	50
Other	2,239	45,139
Total net impairments charged to operating surplus / deficit	**2,239**	**45,189**
Impairments charged to the revaluation reserve	-	116
Total net impairments	**2,239**	**45,305**

	2016/17	2015/16
Impairment of assets	**£000**	**£000**
Impairment of expenditure on retained estate	2,239	1,246
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 assets held for sale - to market value	-	166
	2,239	45,305

Note 7 Employee benefits

Note 7.1 Employee expenses	2016/17 Total £000	2015/16 Total £000
Salaries and wages	**111,917**	110,787
Social security costs	**9,614**	7,816
Employer's contributions to NHS pensions	**12,339**	11,740
Pension cost - other	**-**	-
Other post employment benefits	**-**	-
Other employment benefits	**-**	-
Termination benefits	**-**	-
Temporary staff (including agency)	**6,449**	6,029
Total gross staff costs	**140,319**	**136,372**
Recoveries in respect of seconded staff	**(1,386)**	(1,378)
Total staff costs	**138,933**	**134,994**
Of which		
Costs capitalised as part of assets	1,940	1,644

Note 7.2 Retirements due to ill-health

During 2016/17 there was1 early retirement from the trust agreed on the grounds of ill-health (1 in the year ended 31 March 2016). The estimated additional pension liabilities of these ill-health retirements is £61,000 (£32,000 in 2015/16).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 7.3 Employee benefits

There were no employee benefits during 2016/17.

Note 8 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 2017, is based on valuation data as 31 March 2016, updated to 31 March 2017 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.

The next actuarial valuation is to be carried out as at 31 March 2016. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

Note 9 Finance income

Finance income represents interest received on assets and investments in the period.

	2016/17	2015/16
	£000	£000
Interest on bank accounts	28	107
Interest on loans and receivables	-	-
Total	**28**	**107**

Note 10 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money.

	2016/17	2015/16
	£000	£000
Interest expense:		
Loans from the Department of Health	1,081	1,000
Finance leases	4	6
Interest on late payment of commercial debt	-	-
Main finance costs on PFI scheme obligations	8,249	4,154
Contingent finance costs on PFI scheme obligations	470	163
Total interest expense	**9,804**	**5,323**
Other finance costs - unwinding of discount on provisions	11	11
Total	**9,815**	**5,334**

Finance costs on PFI scheme were for part year only in 2015/16

Note 11 Public dividend capital dividend

The Trust is required to pay a dividend to the Department of health of £981,000. This represents 3.5% of the average net relevant assets of £28,042,000.

Note 12 Gains/losses on disposal/derecognition of non-current assets

	2016/17	2015/16
	£000	£000
Profit on disposal of non-current assets	425	270
Loss on disposal of non-current assets	(23)	(5,403)
Net profit/(loss) on disposal of non-current assets	**402**	**(5,133)**

Note 13 Intangible assets - 2016/17

	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Valuation/gross cost at 1 April 2016 - brought forward	**12,642**	**318**	**12,960**
Additions	980	425	**1,405**
Reclassifications	318	(318)	**-**
Disposals / derecognition	(30)	-	**(30)**
Gross cost at 31 March 2017	**13,910**	**425**	**14,335**
Amortisation at 1 April 2016 - brought forward	**1,177**	**-**	**1,177**
Provided during the year	1,538	-	**1,538**
Disposals / derecognition	(30)	-	**(30)**
Amortisation at 31 March 2017	**2,685**	**-**	**2,685**
Net book value at 31 March 2017	**11,225**	**425**	**11,650**
Net book value at 1 April 2016	**11,465**	**318**	**11,783**

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	6,001	318	**6,319**
Reclassifications	5,356	(3,717)	**1,639**
Disposals / derecognition	(704)	-	**(704)**
Valuation/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**

There is no balance in the Revaluation Reserve in respect of intangible assets.

Note 14 Property, plant and equipment - 2016/17

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2016 - brought forward	**4,131**	**224,427**	**152**	**1,943**	**27,261**	**9,623**	**3,767**	**271,304**
Additions	-	2,296	-	1,121	2,332	326	102	**6,177**
Impairments	-	(2,239)	-	-	-	-	-	**(2,239)**
Reclassifications	-	(48,437)	(7)	(1,134)	-	1,134	-	**(48,444)**
Revaluations	-	4,641	3	-	-	-	-	**4,644**
Transfers to/ from assets held for sale	-	-	-	-	(179)	-	-	**(179)**
Disposals / derecognition	-	(166)	-	-	(339)	(1,337)	-	**(1,842)**
Valuation/gross cost at 31 March 2017	**4,131**	**180,522**	**148**	**1,930**	**29,075**	**9,746**	**3,869**	**229,421**
Accumulated depreciation at 1 April 2016 - brought forward	**-**	**52,050**	**3**	**-**	**10,369**	**3,232**	**100**	**65,754**
Provided during the year	-	2,176	4	-	2,527	795	350	**5,852**
Reclassifications	-	(48,437)	(7)	-	-	-	-	**(48,444)**
Transfers to/ from assets held for sale	-	-	-	-	(166)	-	-	**(166)**
Disposals/ derecognition	-	(166)	-	-	(304)	(1,337)	-	**(1,807)**
Accumulated depreciation at 31 March 2017	**-**	**5,623**	**-**	**-**	**12,426**	**2,690**	**450**	**21,189**
Net book value at 31 March 2017	**4,131**	**174,899**	**148**	**1,930**	**16,649**	**7,056**	**3,419**	**208,232**
Net book value at 1 April 2016	**4,131**	**172,377**	**149**	**1,943**	**16,892**	**6,391**	**3,667**	**205,550**

Note 14.1 Property, plant and equipment - 2015/16

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£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	-	184,803	-	1,358	7,649	3,296	3,755	**200,861**
Impairments	-	(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	-	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 financing - 2016/17

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2017								
Owned	4,131	3,388	148	1,172	3,595	6,727	3,419	**22,580**
Finance leased	-	-	-	-	97	-	-	**97**
On-SoFP PFI contracts and other service concession arrangements	-	164,419	-	-	-	-	-	**164,419**
Donated	-	7,092	-	758	12,957	329	-	**21,136**
NBV total at 31 March 2017	**4,131**	**174,899**	**148**	**1,930**	**16,649**	**7,056**	**3,419**	**208,232**

Note 14.3 Property, plant and equipment financing - 2015/16

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£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 15 Donations of property, plant and equipment

The Trust has received a new hybrid theatre, paid for by Alder Hey Children's Charity, in 2016/17 and also medical equipment assets directly purchased by the Charity.

The Trust has also purchased medical equipment and incurred cost on the Research and Education Phase 2, funded by charity donations.

Note 16 Revaluations of property, plant and equipment

Values of building assets have been reviewed as at 31 March 2017 and have been uplifted to reflect building indices advised by independent valuers. There has been no change to land values.

Note 17 Inventories

	31 March 2017 £000	31 March 2016 £000
Drugs	733	885
Work In progress	-	-
Consumables	1,712	1,745
Energy	66	72
Inventories carried at fair value less costs to sell	-	-
Other	-	-
Total inventories	**2,511**	**2,702**

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Stock values in March 2017 include ward stocks which have been counted for the first time due to new working practices in the new hospital.

Note 17.1 Inventory Movements

	31 March 2017 £000	31 March 2016 £000
Carrying value at 1st April 2016 as previously stated	2,702	1,527
Additions	27,298	26,128
Inventories recognised in expenses	(27,485)	(24,953)
Write down of inventories	(4)	-
	2,511	**2,702**

Note 18.1 Trade receivables and other receivables

	31 March 2017 £000	31 March 2016 £000
Current		
Trade receivables due from NHS bodies	5,329	3,103
Other receivables due from related parties	330	417
Provision for impaired receivables	(996)	(926)
Prepayments (non-PFI)	2,796	3,487
Accrued income	6,930	2,362
PDC dividend receivable	106	-
VAT receivable	469	531
Other receivables	1,648	969
Total current trade and other receivables	**16,612**	**9,943**
Non-current		
Prepayments (non-PFI)	139	183
Total non-current trade and other receivables	**139**	**183**

Accrued income includes Sustainability and Transformation Fund income due to be paid to the Trust, together with incompleted spells as at 31 March 2017.

The great majority of trade is with Clinical Commissioning Groups and NHS England, as commissioners for NHS patient care services. As these bodies are funded by government to buy NHS patient care services, no credit score of them is considered necessary.

Other related parties receivables include Local Authorities which are funded by 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

	2016/17	2015/16
	£000	£000
At 1 April	**926**	**716**
Increase in provision	310	360
Amounts utilised	(37)	(12)
Unused amounts reversed	(203)	(138)
At 31 March	**996**	**926**

Provision for impairment of receivables is made where amounts are past due and are uncertain to be recovered. Usually the debtors have indicated that the charge is queried or that payment may not be made. The provision includes £389,000 of Injury Cost Recovery debt to reflect expected rates of collection.

Note 18.3 Analysis of impaired receivables

	31 March 2017 Trade and other receivables	31 March 2016 Trade and other receivables
Ageing of impaired financial assets	£000	£000
0 - 30 days	64	66
30-60 Days	47	21
60-90 days	24	15
90- 180 days	18	43
Over 180 days	843	781
Total	**996**	**926**
Ageing of non-impaired financial assets past their due date		
0 - 30 days	401	28
30-60 Days	318	471
60-90 days	62	99
90- 180 days	1	72
Over 180 days	29	66
Total	**811**	**736**

Receivables are not impaired until amounts are uncertain to be received - usually when debtors indicate that there is a query.

Note 19 Non-current assets for sale and assets in disposal groups

	Land	Buildings excluding dwellings	Property, plant & equipment	Total	2015/16 Total
	£000	£000	£000	£000	£000
NBV of non-current assets for sale and assets in disposal groups at 1 April	**139**	**433**	**-**	**572**	**-**
Plus assets classified as available for sale in the year	0	0	13	**13**	**572**
Less assets sold in year	(139)	(433)	-	**(572)**	**-**
NBV of non-current assets for sale and assets in disposal groups at 31 March	**-**	**-**	**13**	**13**	**572**

The assets held for sale at 31 March 2017 are X-ray equipment assets which have been taken out of use, ready to be auctioned.

Note 20 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.

	2016/17	2015/16
	£000	£000
At 1 April	**10,551**	**36,048**
Net change in year	(4,035)	(25,497)
At 31 March	**6,516**	**10,551**
Broken down into:		
Cash at commercial banks and in hand	52	115
Cash with the Government Banking Service	1,164	1,186
Deposits with the National Loan Fund	5,300	9,250
Total cash and cash equivalents as in SoFP	**6,516**	**10,551**
Bank overdrafts (GBS and commercial banks)	-	-
Total cash and cash equivalents as in SoCF	**6,516**	**10,551**

Note 21 Trade and other payables

	31 March 2017 £000	31 March 2016 £000
Current		
NHS trade payables	1,125	3,328
Amounts due to other related parties	2,270	2,782
Other trade payables	2,098	1,998
Capital payables	2,320	2,367
Social security costs	-	-
VAT payable	-	-
Other taxes payable	2,648	2,478
Other payables	867	1,885
Accruals	5,682	8,019
PDC dividend payable	-	313
Total current trade and other payables	**17,010**	**23,170**

Related party payables includes £1,746,000 (£1,709,000 at 31 March 2016) outstanding pension contributions at 31 March 2017.

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 2017. It is expected that this will be used before 31 March 2018.

Note 22 Other liabilities

	31 March 2017 £000	31 March 2016 £000
Current		
Deferred goods and services income	1,020	350
Other deferred income	1,107	1,880
Deferred PFI credits	137	137
Total other current liabilities	**2,264**	**2,367**
Non-current		
Deferred PFI credits	3,769	3,906
Total other non-current liabilities	**3,769**	**3,906**

Note 23 Borrowings

	31 March 2017 £000	31 March 2016 £000
Current		
Loans from the Department of Health	2,081	2,081
Obligations under finance leases	46	44
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	2,070	2,044
Total current borrowings	**4,197**	**4,169**
Non-current		
Loans from the Department of Health	45,351	39,117
Obligations under finance leases	48	94
Obligations under PFI, LIFT or other service concession contracts	106,836	108,906
Total non-current borrowings	**152,235**	**148,117**

Note 24 Finance leases

Note 24.1 Alder Hey Children's NHS Foundation Trust as a lessee

Obligations under finance leases where Alder Hey Children's NHS Foundation Trust is the lessee.

	31 March 2017 £000	31 March 2016 £000
Gross lease liabilities	**98**	**146**
of which liabilities are due:		
- not later than one year;	49	49
- later than one year and not later than five years;	49	97
- later than five years.	-	-
Finance charges allocated to future periods	(4)	(8)
Net lease liabilities	**94**	**138**
of which payable:		
- not later than one year;	46	44
- later than one year and not later than five years;	48	94
- 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 25.1 Provisions for liabilities and charges analysis

	Current		Non-Current	
	31 March 2017	31 March 2016	31 March 2017	31 March 2016
	£000	£000	£000	£000
Pensions - early departure costs	93	100	699	690
Legal claims	197	176	0	0
Other	153	759	0	0
	443	**1,035**	**699**	**690**

	Pensions - early departure costs	Other legal claims	Other	Total
	£000	£000	£000	£000
At 1 April 2016	**790**	**176**	**759**	**1,725**
Change in the discount rate	69	-	-	**69**
Arising during the year	11	139	120	**270**
Utilised during the year	(89)	(86)	(38)	**(213)**
Reversed unused	-	(32)	(688)	**(720)**
Unwinding of discount	11	-	-	**11**
At 31 March 2017	**792**	**197**	**153**	**1,142**
Expected timing of cash flows:				
- not later than one year;	93	197	153	**443**
- later than one year and not later than five years;	236	-	-	**236**
- later than five years.	463	-	-	**463**
Total	**792**	**197**	**153**	**1,142**

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.

Other provisions includes an amounts for ongoing employment disputes.

Note 25.2 Clinical negligence liabilities

At 31 March 2017, £100,725,000 was included in provisions of the NHSLA in respect of clinical negligence liabilities of Alder Hey Children's NHS Foundation Trust (31 March 2016: £98,238,000).

Note 26 Contingent assets and liabilities

The Trust has no contingent assets or liabilities.

Note 27 Contractual capital commitments

	31 March 2017 £000	31 March 2016 £000
Property, plant and equipment	3,159	428
Intangible assets	21	135
Total	**3,180**	**563**

Contractual capital commitments relate to capital items/work which has been ordered but not received at 31 March 2017.

Note 28 On-SoFP PFI, LIFT or other service concession arrangements

The PFI scheme relates to the new hospital which became operational in October 2015.

The Trust has the right to use the buildings, however Alder Hey (Special Purpose Vehicle) Limited (Acorn Consortium) have responsibility for maintaining the buildings to an agreed standard. All lifecycle replacement is also the responsibility of Alder Hey (Special Purpose Vehicle) 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.

The contract with Alder Hey (Special Purpose Vehicle) Limited expires on 21st June 2045, after which time the Trust will become responsible for the maintenance and lifecycle costs of those buildings.

Note 28.1 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 2017	31 March 2016
	£000	£000
Gross PFI, LIFT or other service concession liabilities	**295,817**	**306,582**
Of which liabilities are due		
- not later than one year;	10,717	10,763
- later than one year and not later than five years;	43,072	43,027
- later than five years.	242,028	252,792
Finance charges allocated to future periods	(186,911)	(195,632)
Net PFI, LIFT or other service concession arrangement obligation	**108,906**	**110,950**
- not later than one year;		
- later than one year and not later than five years;	2,070	2,044
- later than five years.	9,238	8,868
	97,598	100,038

Note 28.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

The trust's total future obligations under these on-Statement of Financial Position schemes are as follows:

	31 March 2017	31 March 2016
	£000	£000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	483,998	497,729
Of which liabilities are due:		
- not later than one year;	13,916	13,732
- later than one year and not later than five years;	57,532	56,776
- later than five years.	412,550	427,221

Note 28.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the trust's payments in 2016/17:

	31 March 2017	31 March 2016
	£000	£000
Unitary payment payable to service concession operator	13,566	6,828
Consisting of:		
- Interest charge	8,249	4,154
- Repayment of finance lease liability	2,044	787
- Service element and other charges to operating expenditure	2,803	1,724
- Contingent rent	470	163
Other amounts paid to operator due to a commitment under the service concession contract but not part of the unitary payment	-	-
Total amount paid to service concession operator	**13,566**	**6,828**

Note 29 Financial instruments

Note 29.1 Financial risk management

Financial reporting standard IFRS7 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 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 interst rate risk.

Foreign currency risk

The Trust is prinicipally a domestic organisation with the majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has limited business with overseas clients. 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 commisioners 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 29.2 Financial assets

	31 March 2017	31 March 2016
	£000	£000
Assets as per SOFP as at 31 March		
Trade and other receivables excluding non financial assets	13,816	6,456
Cash and cash equivalents at bank and in hand	6,516	10,551
Total at 31 March	**20,332**	**17,007**

Note 29.3 Financial liabilities

	31 March 2017	31 March 2016
	£000	£000
Liabilities as per SoFP as at 31 March 2017		
Borrowings excluding finance lease and PFI liabilities	47,432	41,198
Obligations under finance leases	94	138
Obligations under PFI, LIFT and other service concession contracts	108,906	110,950
Trade and other payables excluding non financial liabilities	14,362	20,692
Total at 31 March 2017	**170,794**	**172,978**

Note 29.4 Maturity of financial liabilities

	31 March 2017	31 March 2016
	£000	£000
In one year or less	18,559	24,861
In more than one year but not more than two years	4,362	4,195
In more than two years but not more than five years	21,339	13,122
In more than five years	126,534	130,800
Total	**170,794**	**172,978**

Note 30 Losses and special payments

	2016/17		2015/16	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	18	24	12	11
Fruitless payments	-	-	-	-
Bad debts and claims abandoned	44	13	26	1
Stores losses and damage to property	1	4	1	157
Total losses	**63**	**41**	**39**	**169**
Special payments				
Extra-contractual payments	-	-	-	-
Extra-statutory and extra-regulatory payments	-	-	-	-
Compensation payments	-	-	-	-
Special severence payments	1	120	-	-
Ex-gratia payments	36	138	24	91
Total special payments	**37**	**258**	**24**	**91**
Total losses and special payments	**100**	**299**	**63**	**260**
Compensation payments received				

Note 31 Events after the reporting date

The Trust was awarded the Liverpool and Sefton contract to provide £5,832,000 of community services transferred from Liverpool Community Health Trust on 1 April 2017.

Note 32 Related parties

Alder Hey Children's NHS Foundation Trust is a public interest body authorised by NHS Improvement.

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 the 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.

	Income £'000	Expenditure £'000	Receivables £'000	Payables £'000	Impairment recognised as expense £'000
Central Manchester University Hospital NHS FT	1,511	1,034	387	102	
Liverpool Women's Hospital NHS FT	910	427	27	102	
Royal Liverpool & Broadgreen University Hospitals NHS T	1,410	593	451	52	
NHS Halton CCG	1,273	-	-	39	
NHS Knowsley CCG	6,512	-	153	-	
NHS Liverpool CCG	30,393	-	490	-	
NHS South Cheshire CCG	546	-	17	-	
NHS South Sefton CCG	8,995	-	139	-	
NHS Southport & Formby CCG	2,719	-	55	-	
NHS St Helens CCG	2,127	-	52	-	
NHS Vale Royal CCG	429	-	-	10	
NHS Warrington CCG	1,346	-	-	50	
NHS West Cheshire CCG	1,125	-	100	-	
NHS West Lancashire CCG	1,358	-	169	-	
NHS Wigan Borough CCG	602	-	-	-	
NHS Wirral CCG	2,213	-	-	-	
Health Education England	7,561	-	-	-	
Department of Health: Core trading	1,669	-	-	-	
NHS Litigation Authority	-	4,149	-	34	
NHS England - Core	7,059	-	3,431	-	
NHS England - Cheshire & Merseyside Local Office	1,975	-	162	-	
NHS England Lancashire Local Office	313	-	10	-	
NHS England - North West Specialised Commissioning Hub	110,319	-	2,329	-	
NHS Blood & Transplant	4	1,107	-	30	
All other NHS bodies	6,518	2,001	2,287	754	

Note 32 Related parties continued

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 £'000	Expenditure £'000	Receivables £'000	Payables £'000	Impairment recognised as expense £'000
Liverpool City Council	794	2840	110	0	
Welsh Assembly Government (incl all other Welsh Health Bodies)	12846	61	9	102	
Northern Health & Social Care Trust - Northern Ireland	608	0	164	0	
NHS Pension Scheme		12339	18	1746	
HM Revenue & Customs - VAT			469		
HM Revenue & Customs - Other taxes and duties		10383		2648	
NHS Professionals	1	4340	1	598	
National Loans Fund			5300		
Other WGA bodies	342	1318	49	104	

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. £117,000 was incurred in expenditure during 2016/17. Outstanding receivables at 31 March 2017 were £2,000 whilst outstanding payables were £87,000

Expenditure with Liverpool Health Partners Ltd was £80,000 (£80,000 2015/16).

Transactions with related parties are on a normal commercial basis.

In line with the HM Treasury requirements, some previous accounts disclosures relating to staff costs are now required to be included in the staff report section of the annual report instead. The following tables link to data contained in the FTC and are included here for ease of formatting for the annual report. They should not be included in the annual accounts and these tables are not a complete list of numerical disclosures for the staff report.

Staff costs

	Group			
			2016/17	2015/16
	Permanent	Other	Total	Total
	£000	£000	£000	£000
Salaries and wages	100,289	11,628	**111,917**	110,787
Social security costs	9,614	-	**9,614**	7,816
Employer's contributions to NHS pensions	12,339	-	**12,339**	11,740
Pension cost - other	-	-	**-**	-
Other post employment benefits	-	-	**-**	-
Other employment benefits	-	-	**-**	-
Termination benefits	-	-	**-**	-
Temporary staff	-	6,449	**6,449**	6,029
Total gross staff costs	**122,242**	**18,077**	**140,319**	**136,372**
Recoveries in respect of seconded staff	(1,386)	-	**(1,386)**	(1,378)
Total staff costs	**120,856**	**18,077**	**138,933**	**134,994**
Of which				
Costs capitalised as part of assets	1,940	-	**1,940**	1,644

Average number of employees (WTE basis)

			2016/17	2015/16
	Permanent	Other	Total	Total
	Number	Number	Number	Number
Medical and dental	390	1	**391**	375
Ambulance staff	-	-	**-**	-
Administration and estates	588	60	**648**	595
Healthcare assistants and other support staff	208	16	**224**	240
Nursing, midwifery and health visiting staff	1,105	69	**1,174**	1,122
Nursing, midwifery and health visiting learners	-	-	**-**	-
Scientific, therapeutic and technical staff	533	7	**540**	541
Healthcare science staff	-	-	**-**	-
Social care staff	-	-	**-**	-
Agency and contract staff	-	-	**-**	-
Bank staff	-	-	**-**	-
Other	-	-	**-**	-
Total average numbers	**2,824**	**153**	**2,977**	**2,873**
Of which:				
Number of employees (WTE) engaged on capital projects	35	-	**35**	20

Reporting of compensation schemes - exit packages 2016/17

[A narrative description of any exit packages agreed in the period should be provided]

	Number of compulsory redundancies Number	Number of other departures agreed Number	Total number of exit packages Number
Exit package cost band (including any special payment element)			
<£10,000	-	-	**-**
£10,001 - £25,000	-	5	**5**
£25,001 - 50,000	-	1	**1**
£50,001 - £100,000	-	-	**-**
£100,001 - £150,000	-	1	**1**
£150,001 - £200,000	-	-	**-**
>£200,000	-	-	**-**
Total number of exit packages by type	**-**	**7**	**7**
Total resource cost (£)	£0	£245,000	**£245,000**

Reporting of compensation schemes - exit packages 2015/16

[A narrative description of any exit packages agreed in the comparative period should be provided]

	Number of compulsory redundancies Number	Number of other departures agreed Number	Total number of exit packages 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**

Exit packages: other (non-compulsory) departure payments

	2016/17		2015/16	
	Payments agreed Number	Total value of agreements £000	Payments agreed Number	Total value of agreements £000
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignations (MARS) contractual costs	4	89	1	29
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	2	36	-	-
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT approval	1	120	-	-
Total	**7**	**245**	**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	-	-	-	-

[Where more than one non-contractual payment requiring HMT approval has been made, FTs must disclose here, the minimum, maximum and median of the payments made.]

[Where applicable the following should be disclosed:
- The amount of any non-contractual payments in lieu of notice.
- A further line discloses the number and value of non-contractual payments made to individuals where the payment was more than 12 months' annual salary. The reference salary for this disclosure is the annualised salary at the date of termination of employment, and excludes bonus payments and employer's pension contributions.]

For all off-payroll engagements as of 31 Mar 2017, for more than £220 per day and that last for longer than six months

	2016/17 Number of engagements
Number of existing engagements as of 31 Mar 2017	**13**
Of which:	
Number that have existed for less than one year at the time of reporting	5
Number that have existed for between one and two years at the time of reporting	4
Number that have existed for between two and three years at the time of reporting	1
Number that have existed for between three and four years at the time of reporting	1
Number that have existed for four or more years at the time of reporting	2

[Please 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.]

For all new off-payroll engagements, or those that reached six months in duration, between 01 April 2016 and 31 March 2017, for more than £220 per day and that last for longer than six months

	2016/17 Number of engagements
Number of new engagements, or those that reached six months in duration between 01 April 2016 and 31 March 2017	7
Number of the above which include contractual clauses giving the trust the right to request assurance in relation to income tax and national insurance obligations	7
Number for whom assurance has been requested	7
Of which:	
Number for whom assurance has been received	7
Number for whom assurance has not been received	-
Number that have been terminated as a result of assurance not being received	-

[In cases where, exceptionally:
- the trust has engaged without including contractual clauses allowing the trust to seek assurance as to their tax obligations; or
- where assurance has been requested and not received, without a contract termination
please specify reasons]

For any off-payroll engagements of board members, and/or senior officials with significant financial responsibility, between 01 April 2016 and 31 March 2017

	2016/17 Number of engagements
Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	-
Number of individuals that have been deemed "board members and/or senior officials with significant financial responsibility". This figure should include both off-payroll and on-payroll engagements.	22

[In any cases where individuals are included within the first row of this table, please explain:
- Details of the exceptional circumstances that led to each of these engagements; or
- Details of the length of time each of these exceptional engagements lasted]

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF ALDER HEY CHILDREN'S NHS FOUNDATION TRUST ON THE QUALITY REPORT

We have been engaged by the Council of Governors of Alder Hey Chilldren's NHS Foundation Trust to perform an independent assurance engagement in respect of Alder Hey Chilldren's NHS Foundation Trust's Quality Report for the year ended 31 March 2017 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2017 subject to limited assurance consist of the following two national priority indicators (the indicators):

- percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period;
- A&E: maximum waiting time of four hours from arrival to admission.

We refer to these national priority indicators collectively as the 'indicators'.

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* issued by NHS Improvement.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us 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* and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the *Detailed requirements for quality reports for foundation trusts 2016/17* ('the 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 Requirements for external assurance for quality reports for foundation trusts 2016/17.*

We read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

- Board minutes and papers for the period April 2016 to May 2017;
- papers relating to quality reported to the board over the period April 2016 to May 2017;
- feedback from commissioners, dated [DD] May 2017;
- feedback from governors, dated [DD] May 2017;
- feedback from local Healthwatch organisations, dated [DD] May 2017;
- feedback from Overview and Scrutiny Committee, dated [DD] May 2017;
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
- the [latest] national patient survey, dated [DD MMMM] 2017;
- the [latest] national staff survey, dated [DD MMMM] 2017;

- Care Quality Commission Inspection, dated 23 December 2015;
- the 2016/17 Head of Internal Audit's annual opinion over the trust's control environment, dated [DD] May 2017; and
- any other information included in our review.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the 'documents'). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of Alder Hey Chilldren's NHS Foundation Trust as a body, to assist the Council of Governors in reporting the NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2017, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicator. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Alder Hey Chilldren's NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information', issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicator;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; and
- reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* and supporting guidance.

The scope of our assurance work has not included governance over quality or the non-mandated indicator, which was determined locally by Alder Hey Chilldren's NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2017:

- 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 and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the Guidance; and
- the indicator in the Quality Report subject to limited assurance has not been 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 Guidance.

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

[##] May 2017

kpmg

Draft Management Representation Letter

We have prepared and agreed with the Director of Finance the following management representation letter which we will require at the same time as the financial statements are signed. This is usually signed by the Chief Executive or Director of Finance for and on behalf of the Board. The content is largely driven by matters we wish you to confirm to support your compliance with accounting and auditing standards. Exceptions to that are:

- Paragraph 12: which is a specific representation we ask of all our NHS clients and support the returns we complete to the National Audit Office on your consolidation return; and
- Paragraph 15: which is a specific representation in relation to balances included within your financial statements.

Should you have any concern about providing these representations please ensure that you discuss any amendments with us prior to signing the letter. We would also ask you to note that these representation are not the only audit evidence that we seek in relation to these matters.

Alder Hey Children's NHS
NHS Foundation Trust

Eaton Road
Liverpool
L12 2AP

Telephone: 0151 282 4692
www.alderhey.com

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

24th May 2017

Dear Amanda,

This representation letter is provided in connection with your audit of the Trust financial statements of Alder Hey Children's NHS Foundation Trust ("the Trust"), for the year ended 31 March 2017, 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 2017 and of the Trust's income and expenditure for the financial year then ended;
- whether the Trust's financial statements have been prepared in accordance with the Department of Health Group Accounting Manual (GAM); and
- whether the Trust's Annual Report has been prepared in accordance with the NHS Improvement Annual Reporting Manual (ARM).

These financial statements comprise the Trust Statement of Financial Position (SOFP), 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 2017 and of the Trust's income and expenditure for that financial year; and

   ii. have been prepared in accordance with the GAM 2016/17.

   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. There are no uncorrected adjustments above £200k following the audit of the 2016/17 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.

      Included in the Appendix to this letter are the definition of fraud, including misstatement arising from fraudulent financial reporting and from misappropriation of assets.

   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. Included in the Appendix to this letter are the definitions of both a related party and a related party transaction as we understand them and as defined in IAS 24.

12. The Board confirms that all intra-NHS balances included in the Statement of Financial Position (SOFP) at 31 March 2017 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.

14. The Board provides the following specific representations as follows:

    a) There are no circumstances of which the Trust Board is aware which indicate that a material change in the value of the Trust's land and building assets has taken place since the last full valuations in 2015/16, save for those indicated by the indices review provided by the Trust's expert valuers, Cushman and Wakefield. There are no indications, of which the Board is aware, of impairment to any of the Trust's land and building assets during 2016/17.

This letter was tabled and agreed at the meeting of the Board of Directors on 25th May 2017.

Yours sincerely

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.

kpmg

Draft Management Representation Letter

We are required by International Standard on Assurance Engagements (ISAE) 3000 to obtain appropriate representations from management before our assurance 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.

Alder Hey Children's NHS
NHS Foundation Trust

Eaton Road
Liverpool
L12 2AP

Telephone: 0151 282 4692
www.alderhey.com

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

24th May 2017

Dear Amanda

QUALITY REPORT 2016/17 - 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 2017 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 Improvement publications the *NHS Foundation Trust Annual Reporting Manual 2016/17* and *Detailed requirements for quality reports for foundation trusts 2016/17*;
- the Quality Report is not consistent in all material respects with the sources specified in the NHS Improvement 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 Improvement *Detailed requirements for quality reports for foundation trusts 2016/17* and the six dimensions of data quality set out in the *Detailed Requirements for external assurance for quality reports for foundation trusts 2016/17* (the Guidance').

The Board confirms that:

a) The Quality Report has been prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2016/17 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 NHS Improvement's annual reporting manual and supporting 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 25th May 2017.

Yours sincerely

Louise Shepherd

Chief Executive
for and on behalf of the Board of Alder Hey Children's NHS Foundation Trust

Certificate on FT Consolidation Schedules

FTC Summarisation Schedules for Alder Hey Children's NHS Foundation Trust
Summarisation schedules numbers FTC01 to FTC40 and accompanying WGA sheets for 2016/17 are attached.

Finance Director Certificate
1. I certify that the attached FTC schedules have been compiled and are in accordance with:

- the financial records maintained by the NHS foundation trust
- accounting standards and policies which comply with the Department of Health Group Accounting Manual issued by the Department of Health and
- the template accounting policies for NHS foundation trusts issued by NHS Improvement, or any deviation from these policies has been fully explained in the Confirmation questions in the FTC.

2. I certify that the FTC schedules are internally consistent and that there are 3 validation errors which have been agreed with the financial accounting team at NHS Improvement.

3. I certify that the information in the FTC schedules is consistent with the financial statements of the NHS Foundation Trust

John Grinnell, Director of Finance
25th May 2017

Chief Executive Certificate
1. I acknowledge the attached FTC schedules, which have been prepared and certified by the Finance Director, as the FTC schedules which the Foundation Trust is required to submit to NHS Improvement.

2. I have reviewed the schedules and agree the statements made by the Director of Finance above.

Louise Shepherd, Chief Executive
25th May 2017

Alder Hey Children's NHS
NHS Foundation Trust

Monitor Provider Licence Self-Assessment - Update as at April 2017

Licence Condition	Current position	Assurance	Gap	Action
Section 1 – General Conditions				
G1 - Provision of information	All monitoring submissions provided by deadline via the portal. Additional documents provided on request, eg following quarterly telecon.	• Quarterly reports scrutinised and approved by RBD and submitted to Audit Committee to oversee assurance process • DoF checks financial returns before submission and reports to RBD • Annual Report and Accounts audited and scrutinised by Audit Committee then BoD	None identified at present	Keep NHSI reporting requirements under review via monthly bulletins
G2 – Publication of information	Trust reports placed in the public domain in accordance with NHSI requirements, eg Annual Report and Accounts	• Hard copies of reports available at AMM and within Trust premises; summary sent to members • Trust website • Trust Publication Scheme	None identified at present	NHSI bulletins and guidance for any new requirements
G3 – Payment of fees to Monitor	This condition reflects the power given to NHSI/Monitor under the Act to require licensees to pay fees in relation to its regulatory functions. Fees are not currently in place, not has any decision yet been taken as to whether	N/A	N/A	None required at present. Provision has never been implemented

Licence Condition	Current position	Assurance	Gap	Action
	NHSI/Monitor will begin to charge fees.			
G4 - Fit and proper persons as Governors and Directors	Trust arrangements have been updated to reflect new CQC regulation 19 (applies to directors only). This includes a separate declaration and amendments to Directors' contracts/letters of appointment.	• New declaration process • Directors undergo enhanced DBS checks and other robust pre-employment checks • Existing directors undergoing DBS refresh	None at present	Need to create a SOP for external checks within recruitment team
G5 – Monitor guidance	Guidance consistently and stringently followed	• Reports to Board Committees eg. Annual Plan, Annual Report and Accounts, Corporate Report (Single Oversight Framework) • MIAA review of Quality Governance Framework.	None identified at present	Continue to track new guidance through appropriate committee on publication
G6 – Systems for compliance with licence conditions and related obligations (ie. NHS Acts and Constitution)	Systems and processes are currently set up to ensure compliance with provisions of the Licence and other mandatory requirements; risk set out in BAF. Constitution amended to reflect 2012 Act.	• Corporate Report links to Single Oversight Framework • Quarterly Reports to NHSI reviewed by RBD • Certification produced in accordance with paras 10 and 11 of this Condition in May 2016 covering financial year.	None identified at present	Compliance with Licence conditions formally reviewed by the Board as part of its annual work plan.
G7 – Registration with the Care Quality Commission	Currently registered without conditions for all relevant services	All inspection and registration issues reported through CQAC and BoD	None identified at present	Continue with regular engagement meetings with CQC; ensure NHSI

Licence Condition	Current position	Assurance	Gap	Action
				informed of all key issues.
G8 – Patient eligibility and selection criteria	This condition requires licensees to set and publish transparent patient eligibility criteria and to apply these in a transparent manner. Explicit eligibility criteria are not currently published for individual AH services, however they are covered in a range of activities: • Declarations of compliance with specialist service specifications; • Information on individual services provided on trust website; • Clinical discussions at MDT level including where any ambiguity exists for example with regard to age limits (16 – 18) and where adult transition services are not established	• At MDT level • Compliance with service specifications issued by Spec Comm. • Quality contract monitoring by CCG	Individual eligibility and selection criteria not currently published together in one place.	Explicit statement to be published in Annual Report
G9 – Application of S.5 (Continuity of Services)	All previous Mandatory Services migrated to Commissioner Requested Services as of 1st April 2013. Five services were derogated as part of original Spec Comm assessment of trusts against service specifications in 2013/14, three now remain outstanding. New spec issued for CHD in	NHSE (Spec Comm) contract monitoring meetings	Derogation remains in place for Neonatal, Haemoglobinopathies and Palliative Care.	Strategic discussions to be concluded with key partners within 2017/18

Licence Condition	Current position	Assurance	Gap	Action
	2015/16.			
Section 2 – Pricing				
P1 – Recording of Information	Under this condition NHSI may require licensees to record information on their costs in line with guidance. They may also require licensees to record other information, e.g. quality and outcome data to support NHSIr in carrying out its pricing functions. PLICS has been developed and rolled out to Divisions; and finance team have developed a suite of reports in support of service line reporting.	• Reports to RBD and Audit Committee • Trust submits reference costs data to DH in line with timetable and guidance • Trust takes part in voluntary exercise to share Patient Level Costing data with NHSI. • Suite of quarterly reports to Divisions/CBUs regarding service line, consultant, procedure and patient level cost and income performance. • The Trust was awarded the highest MAQS score in the country	None identified at present	Continue to develop and refine reporting / costing at service line level / patient level costing.
P2 – Provision of information	As G1 above. NHSI places particular emphasis on the availability of consistently recorded and accurate information on costs to enable them to set prices for NHS services at an appropriate level.	Reports to RBD and Audit Committee. Trust has self-assessed its data quality and costing processes against NHSI's assessment framework and has scored gold which is the highest in the country.	None identified at present	As above P1

Licence Condition	Current position	Assurance	Gap	Action
P3 – Assurance report on submissions to Monitor	Links to P2 above – NHSI will require assurance on the accuracy of the costing information provided.	Reports to RBD and Audit Committee as required	N/A	N/A
P4 – Compliance with the National Tariff	This condition imposes an obligation on providers as well as commissioners to charge for NHS services in line with National Tariff.	Reports to RBD and Audit Committee as required. Contracts signed with commissioners based on national standard contracts. Impact of national tariffs reflected in 2017/18 financial plans agreed by the Board.	None currently identified	None in terms of compliance with the Licence condition, however the impact of the 2017/18 tariff on the Trust will need to be closely monitored and discussed with NHSI as part of the quarterly reporting cycle.
P5 – Constructive engagement concerning local tariff modifications	The Act gives NHSI responsibility for setting the process and rules around local pricing modifications. This condition requires licensees to engage constructively with commissioners to try to reach local agreement before applying to NHSI for a local modification. Head of Contracting works closely with local commissioners to address specific service issues.	Reports to RBD	None currently identified	Trust will follow guidance as and when applicable and where local pricing modifications are agreed with Commissioners which meet NHSI's criteria for notification.
Section 3 – Choice and Competition				
C1 – The right of patients to make choices	This condition requires licensees to notify their patients when they have a choice of provider either	Reports to RBD re contract performance.	None currently identified	Patient information leaflets to be updated as required to include aspects on

Licence Condition	Current position	Assurance	Gap	Action
	under the NHS Constitution or conferred locally by commissioners. It requires providers to tell patients where they can find information about the choices they have in a way that is not misleading. Any information provided to AH patients would be on the basis of clinical need. No inducements are offered to referring clinicians by the Trust under any circumstances. Patients are informed of their NHS Constitution right to choosing alternative providers for those waiting longer than 18 weeks from RTT.			choice where appropriate
C2 – Competition oversight	This condition prohibits the licensee from entering into or maintaining agreements that have the object or effect of preventing, restricting or distorting competition to the extent that it is against the interests of health care users.	This will be considered on a case by case basis when the Trust bids for or establishes contractual arrangements for the provision of services. Trust follows EU guidance where applicable. Major contract changes reviewed and approved by the Board and or R&BD.	None currently identified	None currently identified
Section 4 – Integrated care				
IC1 – Provision of integrated care	Trust actively pursuing plans to deliver better integration of	Reports to BoD	None currently identified	None from a compliance perspective

Licence Condition	Current position	Assurance	Gap	Action
	children's services in the city with Liverpool CCG and other partners.			
Section 5 – Continuity of Services				
CoS1 – Continuing provision of Commissioner Requested Services	All services currently delivered as per contract/agreed specification issued by commissioners	Quality meetings with commissioners. Reports by exception to Board Contract performance review meetings with Commissioners	See G9 above	See G9 above
CoS2 – Restriction on the disposal of assets	Trust has an up to date asset register which is kept and maintained by the Finance team	Reports to Audit Committee.	None currently identified	None currently identified
CoS3 – Standards of corporate governance and financial management	Trust has robust corporate and financial governance arrangements that are compliant with all relevant guidance including that issued by NHSI	Internal and external audit reports provided to Audit Committee, Board and Governors	None currently identified	Track any updates and changes to guidance
CoS4 – Undertaking from the ultimate controller	NHSI/Monitor defines the 'ultimate controller' as being anybody that could instruct the licensee to carry out particular actions, ie. the parent company of a subsidiary that has been licensed by Monitor. If there is no single body that could instruct the licensee in this way, the licensee does not have an ultimate controller and there is no need for an undertaking under this condition. Monitor has	N/A	N/A	N/A

Licence Condition	Current position	Assurance	Gap	Action
	clarified that governors and directors of FTs are not regarded as ultimate controllers and will not need to provide undertakings.			
CoS5 – Risk pool levy	In the event of a provider entering special administration, the costs of administration will be met by a central fund known as the risk pool. This condition requires the licensee to contribute to the funding of the pool if NHSI/Monitor requests it.	N/A	N/A	N/A
CoS6 – Co-operation in the event of financial distress	This condition applies when a licensee fails to meet the test of sound financial management (as per CoS3) under the RAF, in which case the licensee is required to provide information to 3rd parties as directed by NHSI and allow access to premises. We are currently rated as 2 under the SOF.	Corporate Report scrutinised by RBD and BoD Ops Board and Exec Performance Reviews oversee operational delivery	None identified	Trust financial position continues to be subject to regular review and update
CoS7 – Availability of resources	This condition sets out the Board certification requirement which aims to provide NHSI with reassurance that the Board has given consideration to the resources to be dedicated to the provision of CRS over the coming 12 month period.	All previous updates to certification requirements have been fulfilled either by the entire Board or by RBD as part of its delegated authority	None identified	Certificate to be drafted for consideration by the Board to the required timescale and to be available for NHSI audit purposes

Licence Condition	Current position	Assurance	Gap	Action
Section 6 – NHS Foundation Trust Conditions				
FT1 – Information to update the register of NHS foundation trusts	Trust constitution, annual report, annual accounts and auditor's report have been consistently provided to NHSI/Monitor within the specified timescales.	Reports to the Board. Publication of Trust information on NHSI's website	None identified	Ensure any changes to guidance are tracked eg. New requirements in the ARM
FT2 – Payment to Monitor in respect of registration and related costs	This condition creates the provision for Monitor to charge fees specifically to FTs for the cost of regulation eg maintaining registers etc. No decision has yet been taken by NHSI/Monitor as to whether this will be put into practice however a separate consultation is planned. NB Monitor has had the power to levy fees from FTs since 2004 but has chosen not to do so.	N/A	N/A	Keep watching brief
FT3 – Provision of information to advisory panel	Monitor has set up its 'Panel for Advising Governors' as described by the 2012 Act. The panel has been created as a source of independent advice to governors in order to help them fulfil their role; the focus is on governors using the panel when their trust has failed in its obligations either under the constitution or the Act. Licensees are required to provide information to the panel when requested.	Governors are provided with all Board papers and full information about the Trust via Basecamp and at regular meetings. Key issues presented to Governors at every meeting Governors are regularly reminded that Board meetings are open to the public	None currently identified	Ensure any new Governors are aware of the process for submitting a query to the Panel as part of induction

Licence Condition	Current position	Assurance	Gap	Action
	NB. The Act requires a majority of governors to support the submission of a query following consideration at a full meeting of the Council of Governors.			
FT4 – NHS foundation trust governance arrangements	This condition builds upon the existing requirements set out in the Code of Governance and other guidance documents including the ARM. The Trust has consistently complied with the requirements to demonstrate the effectiveness of its governance arrangements.	External and internal audit reports to Audit Committee	None identified at present	Continue to ensure requirements are adhered to.

Erica Saunders
May 2017

Self-Certification Template - Conditions G6 and CoS7

Alder Hey Children's NHS Foundation Trust

Foundation Trusts and NHS trusts are required to make the following declarations to NHS Improvement:

Systems or compliance with licence conditions - in accordance with General condition 6 of the NHS provider licence
Availability of resources and accompanying statement - in accordance with Continuity of Services condition 7 of the NHS provider licence (Foundation Trusts designated CRS providers only)

These Declarations are set out in this template.

Templates should be returned via the Trust portal.

How to use this template
1) Save this file to your Local Network or Computer.
2) Enter responses and information into the yellow data-entry cells as appropriate.
3) Once the data has been entered, add signatures to the document.

Worksheet "G6 & CoS7"

Declarations required by General condition 6 and Continuity of Service condition 7 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 (FTs and NHS trusts)

1	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied 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	OK

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

3a	After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.	Confirmed	Please fill details in cell E22

OR

3b	After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.	Confirmed	Please fill details in cell E22

OR

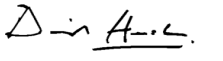
3c	In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.	Confirmed	Please fill details in cell E22

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

[e.g. key risks to delivery of CRS, assets or subcontractors required to deliver CRS, etc.]

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Sir David Henshaw	**Name**	Louise Shepherd
Capacity	Chairman	**Capacity**	Chief Executive
Date	25th May 2017	**Date**	25th May 2017

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

A

Self-Certification Template - Condition FT4
Alder Hey Children's NHS Foundation Trust

Foundation Trusts and NHS trusts are required to make the following declarations to NHS Improvement:

Corporate Governance Statement - in accordance with Foundation Trust condition 4 (Foundations Trusts and NHS trusts)
Certification on training of Governors - in accordance with s151(5) of the Health and Social Care Act (Foundation Trusts only)

These Declarations are set out in this template.

How to use this template
1) Save this file to your Local Network or Computer.
2) Enter responses and information into the yellow data-entry cells as appropriate.
3) Once the data has been entered, add signatures to the document.

Worksheet "FT4 declaration"

Corporate Governance Statement (FTs and NHS trusts)

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

1	Corporate Governance Statement	Response	Risks and Mitigating actions
1	The Board is satisfied that the Licensee 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'] Please complete Risks and Mitigating actions
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	[including where the Board is able to respond 'Confirmed'] Please complete Risks and Mitigating actions
3	The Board is satisfied that the Licensee has established and 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	[including where the Board is able to respond 'Confirmed'] Please complete Risks and Mitigating actions
4	The Board is satisfied that the Licensee has established and 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 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.	Confirmed	[including where the Board is able to respond 'Confirmed'] Please complete Risks and Mitigating actions
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 Licensee, 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 Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	[including where the Board is able to respond 'Confirmed'] Please complete Risks and Mitigating actions
6	The Board is satisfied that there are systems to ensure that the Licensee 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	[including where the Board is able to respond 'Confirmed'] Please complete Risks and Mitigating actions

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature **Signature**

Name Sir David Henshaw **Name** Louise Shepherd

Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4.

A

Please Respond

Worksheet "Training of governors"

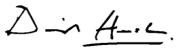
Certification on training of governors (FTs only)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements. Explanatory information should be provided where required.

2 Training of Governors

1	The Board is satisfied that during the financial year most recently ended the Licensee 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	OK

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Sir David Henshaw	**Name**	Louise Shepherd
Capacity	Chairman	**Capacity**	Chief Executive
Date	25th May 2017	**Date**	25th May 2017

Further explanatory information should be provided below where the Board has been unable to confirm declarations under s151(5) of the Health and Social Care Act

A

Alder Hey Children's NHS
NHS Foundation Trust

Board of Directors
Tuesday, 23 May 2017

Report of	Director of Corporate Affairs
Paper prepared by	Executive Team, and Quality Assurance Officer
Subject/Title	2017/18 BAF Report
Background papers	Monthly BAF updates/reports
Purpose of Paper	To provide the Board with the BAF May report
Action/Decision required	The Board is asked to note the May position relating to the Board Assurance Framework
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	By 2020, we will: ➢ be internationally recognised for the quality of our care ***(Excellence in Quality)*** ➢ be recognised for the exceptional care we provide to our children, that is technologically enabled and matched by exceptional facilities ***(Patient Centred Services)*** ➢ have a fully engaged workforce that is actively driving quality improvement ***(Great Talented Teams)*** ➢ be a world class, child focussed centre of research & innovation expertise to improve the health and wellbeing outcomes for babies, children & young people ***(International Research, Innovation & Education)*** ➢ have secured sustainable long term financial and service growth supported by a strong international business ***(Growing our Services and Safeguarding Core Business)***
Resource Impact	Non achievement of the Trust's objectives could have a negative impact on the services provided by the Trust.

Alder Hey Children's NHS
NHS Foundation Trust

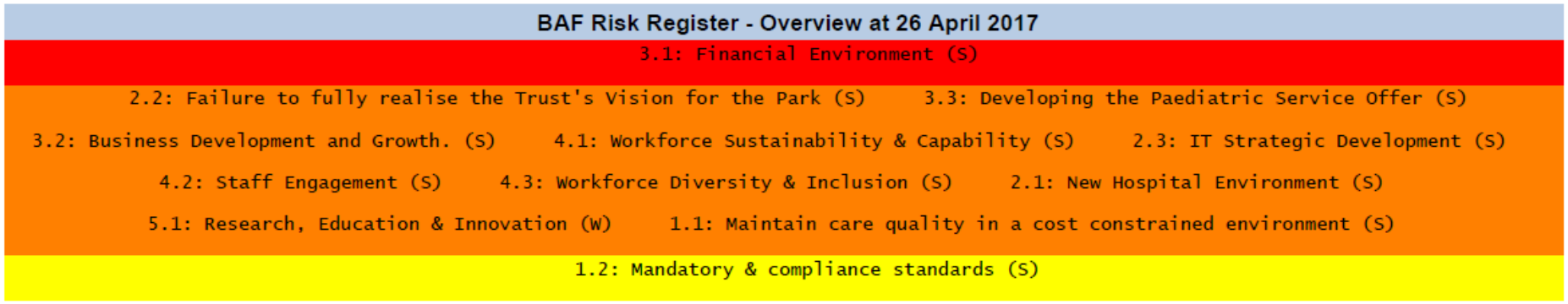
Board Assurance Framework 2017/18

1. Purpose

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

2. Review of the BAF

The diagram below gives a high level view of the current version, followed by a summary and a brief on the changes since the last Board meeting. The full document is included as Appendix A.



Alder Hey Children's NHS
NHS Foundation Trust

Ref, Owner	Risk Title	Risk Rating: I x L		Monthly Trend	
		Current	Target	Last	Now
STRATEGIC PILLAR: Excellence in Quality					
1.1 HG	**Maintain care quality in a cost constrained environment**	4-2	4-2	STATIC	
1.2 MB	**Mandatory & Compliance Standards**	5-1	3-2	**BETTER**	
STRATEGIC PILLAR: Patient Centred Services					
2.1 DP	**New Hospital Environment**	4-2	4-1	STATIC	
2.2 DP	**Failure to fully realise the Trust's Vision for the Park**	4-2	4-1	STATIC	
2.3 JG	**IT Strategic Development**	3-4	3-2	STATIC	
STRATEGIC PILLAR: Growing our Services & Safeguarding Core Business					
3.1 JG	**Financial Environment**	5-4	4-2	STATIC	
3.2 JG	**Business Development & Growth**	4-3	4-2	STATIC	
3.3 SR	**Developing the Paediatric Service Offer**	4-3	4-2	STATIC	
STRATEGIC PILLAR: Great Talented Teams					
4.1 MS	**Workforce Sustainability & Capability**	4-3	4-2	STATIC	
4.2 MS	**Staff Engagement**	3-3	3-2	STATIC	
4.3 MS	**Workforce Diversity & Inclusion**	3-3	3-1	STATIC	
STRATEGIC PILLAR: International Innovation, Research & Education					
5.1 DP	**Research, Education & Innovation**	4-2	4-1	**WORSE**	

Changes since 2nd May 2017 Board meeting

The diagram above shows that the majority of the risks on the BAF remained broadly static.

External risks

- ***Business development and growth (DH)***
  No change in-month.

- ***Mandatory and compliance standards (ES)***
  All access targets achieved at 31/3. Letter of congrats received from SoS for most improved ED 4 hour performance.

- ***Developing the Paediatric Service Offer (DH)***
  The ODN recommendation single service, single workforce, two site model has been accepted by NHS England and AH and LWH are now working on an implementation plan together with Alder Hey leading. There will be a need for some Capital funding to support the reconfiguration of the ICU and the number of cots required. This is a key work stream of the Trusts Change Programme for 2017/18. Alder Hey has been awarded a Management Contract for 6 months to deliver the LCH Community Services.

Internal risks:

- ***Maintain care quality in a cost constrained environment (HG)***
  The Trust continues to maintain appropriate workforce levels ensuring care quality in a cost constrained environment. Achieving Monitor capped nursing agency targets

- ***Management Contract arrangement with Liverpool Community Health Trust (LS)***
  Plans continue to be developed to ensure services at both AH & LCH are managed safely and effectively

- ***New Hospital Environment (DP)***
  Review and agree actions from H&S Report.

- ***Financial Environment (JG)***
  16/17 control overachieved. 17/18 risks remain as CIP £4m, Activity run rate £3m, pay cost pressures (ward related) £3m

- ***Failure to fully realise the Trust's Vision for the Park (DP)***
  Compile draft Consultation Strategy. Consultation process held for purdah.

- ***IT Strategic Development (JG)***
  Email confirmation from NHSE highlighting treasury approval - awaiting final confirmation

- ***Workforce Sustainability & Capability (MS)***
  Apprenticeship PID approved at WOD. Draft Education Strategy presented to Education Governance Committee.

- ***Staff Engagement (MS)***
  Progress continues with LiA and development of C&E Project. Quarterly Temperature Check launched.

- ***Workforce Diversity & Inclusion (MS)***
  Scoping apprenticeship opportunities for local communities as part of our strategy development.

- ***Research, Education & Innovation (DP)***
  Institute Phase 2 building commenced

Erica Saunders
Director of Corporate Affairs
May 2017

DRAFT

Alder Hey Children's NHS
NHS Foundation Trust

Resources and Business Development Committee Annual Report 2016/17

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:

- Approval of the two year Operational Plan for NHS Improvement as a delegated responsibility from the Trust Board.
- Oversight of the Trust's internal recovery plan including scrutiny of financial data in particular leading/lagging KPIs, income/expenditure and the CIP.
- Review and challenge of CBU operational/run rate 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 NHSI Quarterly narrative report.
- The financial outcome for the year end with an FRR of 2.
- Approval of the Operational and Capital Budgets for 2017/18.
- Review and challenge of the Business Development Strategy for 2016/17 including the development of international work.
- Regular review of the Board Assurance Framework and adjustments to this as required.
- Scrutiny of workforce leading indicators including compliance with agency cap requirements;
- Review of Nursing workforce requirements going forward;
- Scrutiny of threats to income arising from the wider NHS landscape and financial environment including the development of Sustainability and Transformation Plans locally and nationally;
- Oversight of the development of the strategic IM&T agenda including the emerging Global Digital Excellence programme;
- Oversight of the new PFI contract and how this is monitored;

In addition, from April 2016, the Committee took over the programme assurance function from the previous Trust wide Programme Board, which had been disbanded by the Board in favour of a more devolved approach to the 2016/17 change programme. A portion of each meeting was devoted to monitoring the progress of

those projects which came under the purview of RBD in accordance with the process developed via the PMO.

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 incorporating a review of the key elements of the Terms of Reference, as follows:
  - 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.
  - Review of progress against key financial and external targets, including performance ratings (e.g. NHSI metrics).
  - Consideration of any regulatory developments eg. Single Oversight Framework.
  - Ensure appropriate contracting arrangements are in place and review overall performance against contract.
  - Review of the Site Development Strategy and scrutiny of associated business cases.
  - Examine specific areas of financial risk and highlight these to the Board as appropriate.
  - Review of key workforce/HR performance indicators.
  - 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 strategy.
  - Identify key risks associated with the delivery of the IM&T strategy and ensure these are reported to the Board.

Independent Assurances / Audit

During the course of the year the Committee ensured that regular progress reports were received from the following sources:

1) Formal feedback from NHSI.
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 2017/18:

- 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 2017/18 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 2017/18 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.
- The governance arrangements that underpin the Change Programme and its specific projects will again be a key focus for the Committee in the coming year.
- The Committee will continue to hold the Divisions and CBUs to account for their performance and will seek to drive measurable improvements in efficiency and productivity.

Ian Quinlan
Committee Chair
April 2017

RESOURCES AND BUSINESS DEVELOPMENT COMMITTEE - RECORD OF ATTENDANCE 2016/17

Member/Date of Meeting	2016									2017		
	27th April	***25th May***	***29th June ****	***27th July***	***30th August***	***28th Sept***	***04th Nov***	***30th Nov***	***21st Dec***	***27th Jan***	***1st March***	***29th March***
Mr Ian Quinlan (Non-Executive Director)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)
Mrs Claire Dove (Non-Executive Director)	×	×	✓	✓	×	×	✓	✓	✓	×	✓	✓
Mrs Louise Shepherd (Chief Executive)	×	×	✓	✓	×	×	×	×	×	n/a	n/a	n/a
Mr Jonathan Stephens (Director of Finance)	✓	✓	✓	✓	✓	✓	×	×	✓	n/a	n/a	n/a
Mrs Mags Barnaby (Interim Chief Operating Officer)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	×
Mrs M Swindell (Interim Director of HR)	✓	✓	✓	✓	×	✓	✓	✓	✓	✓	✓	✓
Ms E Saunders (Director of Corporate Affairs)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mrs C Liddy (Deputy Director of Finance)	✓	×	✓	✓	×	✓	✓	✓	✓	✓	✓	✓
Ms L Dunn (Director of Marketing and Coms)	✓	✓	✓	✓	×	✓	×	✓	✓	×	✓	✓

Alder Hey Children's NHS
NHS Foundation Trust

Draft Audit Committee Annual Report 2016/17

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 three 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 2016/17 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 2016/17 work plan
- External Audit Reports in accordance with the approved 2016/17 work plan

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

- Annual Governance Statement
- Consideration of the 2015/16 Annual Accounts
- NHS Improvement (Monitor) quarterly returns and feedback letters
- External Assurance Report on the quality account
- External Audit report on the financial statements to 31st March 2016 and ISA 260
- Losses and special payments
- Counter Fraud reports by the MIAA specialist in accordance with the approved 2016/17 work plan
- Reports on progress against the Risk Management Improvement Plan
- Regular reports of the Trust's Policy Review schedule
- A review and update of the Trust's Corporate Governance Manual
- Oversight of changes to the Trust's Programme Assurance arrangements including a follow up effectiveness review after six months of operation
- Approval of the Treasury Management Policy
- Internal Audit work plan for 2016/17
- External Audit strategy relating to the Audit of the Trust's 2015/16 Accounts
- Financial Statement audit risks for 2016/17
- Accounting policies for the 2016/17 Financial Statements
- Audit Committee work plan 2016/17
- 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. During 2016/17 the Committee chair strengthened and enhanced the scrutiny process around follow up actions in order to ensure the closure of any potential gaps in the control environment.

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. A full re-tender exercise was run during the year overseen by the Trust's Council of Governors, which resulted in the re-appointment of KPMG for a further three years. 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 2016/17 was provided to the Board on the 30th May 2017.

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 2016/17 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 2016/17 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 2016/17. The Committee also received the results of the Compound Indicators Assessment for 2016/17 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 continue 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
28th April 2017

APPENDIX A

AUDIT COMMITTEE - RECORD OF ATTENDANCE 2016/17

Member/Date of Meeting	2016				2017
	23rd April	21st May	25th Sept	19th Nov	21st Jan
Mr Steve Igoe (Non-Executive Director)	✓ **(Chair)**	✓ **(Chair)**	✓ **(Chair)**	✓ **(Chair)**	✓ **(Chair)**
Mr Jonathan Stephens (Director of Finance/Deputy CEO)	✓	✓	✘	✓	✓
Ms Erica Saunders (Director of Corporate Affairs)	✓	✓	✘	✓	✓
Mrs Anita Marsland (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)

Audit Committee
Minutes of the meeting held on **Thursday 26th January 2017,**
Room 7, Mezzanine, Level 1

Present:	Mr S Igoe (Chair)	Non-Executive Director	(SI)
	Mrs A Marsland	Non-Executive Director	(AM)
In Attendance:	Mrs C Liddy	Acting Director of Finance	(CL)
	Mrs L Cobain	Assistant Director, MIAA	(LC)
	Miss E Kirby	Assistant Manager KPMG	(EK)
	Mrs J Lewis	Audit Manager KPMG	(JL)
	Mrs V Martin	Counter Fraud Specialist, MIAA	(VM)
	Mrs M McMahon-Joseph	Senior Audit Manager, MIAA	(MMc)
	Mr T Rigby	Quality Assurance Officer	(TR)
	Mrs E Saunders	Director of Corporate Affairs	(ES)
	Mrs M Swindell	Director of HR	(MS)
	Mrs J Tsao	Corporate Administrator	(JT)
Apologies:			
	Mrs J France-Hayhurst	Non-Executive Director	(JFH)
	Mrs K Wheatcroft	Director of MIAA	(KW)

16/17/60 Minutes of the previous meeting held on 24th November 2016
Resolved:
The Committee approved the minutes of the previous meeting.

16/17/61 Matters Arising and Action list
There were no matters arising; the action list was updated accordingly.

16/17/62 Internal Audit Progress Report
The following five audits have been completed since the last Audit Committee:
Cash Office Processes – Limited Assurance
Issues had been identified and were being resolved by the team.

Recruitment Processes and Strategy
Staff - Significant Assurance
Volunteers - Limited Assurance
Although strong controls are in place a number of issues have been raised around the volunteers procedures and they are being addressed.

Core Financial Systems (Key Controls)
General Ledger - Significant Assurance
Income & Debtors - High Assurance
Non Pay Expenditure - Significant Assurance
Budgetary Control - High Assurance

Composite Follow Up
The report will be presented at the April Audit Committee.

Assurance Framework Benchmarking
It was agreed to discuss this under the substantial item on the agenda.

In addition, we have completed Phase 1 of the Information Governance Toolkit and provided interim feedback to the Trust. Further support was also provided to the Trust

following a request received to review and feedback on the Trust's revised Risk Management Strategy.
The 2016/17 internal audit plan has been profiled and a number of reviews in respect of IG Toolkit, PFI Contract Management, Service Infrastructure, ESR and CBU Performance Management are in progress. The Quality Strategy Implementation will focus on the Quality Governance Framework

Resolved
Audit Committee:
a) Received the content of the Internal Progress report.

16/17/63 Follow up Audits
A follow up report on January 2016 position was given. The findings showed: 12 reviews had taken place with 52 recommendations, a large number had no evidence of responding.

Resolved
Audit Committee:
a) Received the Follow up report.
b) The committee agreed for a review to take place against the outstanding recommendations to confirm if they had been completed or were still required. A report would be presented at the April meeting.

16/17/64 MIAA Insight – FT and Trust Assurance Framework Benchmarking
Resolved:
The MIAA Insight report titled: What keeps the Board awake at night was received for information.

16/17/65 MIAA Insight – Audit Committee update January 2017
Resolved:
Louise Cobain reported on the Audit Committee Chairs Network event being held tomorrow and agreed to circulate slides to Audit committee.

16/17/66 External Quality Assessment of MIAA
Resolved:
Audit Committee received the positing findings of the External Quality Assessment of MIAA report.

16/17/67 Anti Fraud Progress report
Virginia Martian presented the Counter Fraud Progress report from 10th September 2016 – 13th January 2017. Since 2nd November 2016 the fraud and corruption line has been managed by Crime-stoppers. The new contact details have been circulated to staff.

SRT an annual declaration of compliance against NHS Protects anti-crime Standards for providers have requested a one month earlier submission to ensure requirement standards are met.

7 questions were included in the report for a response. Virginia Martian and Claire Liddy agreed to present a report with the responses on activity proportion to risk at the next Audit Committee.

A total of 6 fraud referrals had been made since 2016. An update on 3 reports closed was given.

A discussion was held on the gifts and hospitality register that would be presented at the April Meeting. Virginia Martian and Erica Saunders agreed to discuss and provide an update against the Sunshine rule also at the next meeting.

Resolved:
Audit Committee received the Anti-Fraud progress update.

16/17/68 Update on review of NHS Protect
Resolved:
Audit Committee received the above document for information.

16/17/69 MIAA Benchmarking – Fraud Investigations
Resolved:
Audit Committee received the above document for information.

16/17/70 External Audit plan for 2016/17
The proposals for the annual external audit plan was presented with the deadline of 31st May 2017 being confirmed.

Resolved:
Audit Committee received and approved the external audit plan 2016/17.

16/17/71 KPMG Technical update
Claire Liddy reported on a meeting taking place next with KPMG on improvement transformation.

A discussion was held on the Off-payroll working in the public sector. Claire Liddy and Melissa Swindell provided assurance their teams are working towards the new proposals and would provide an update at the next meeting.

Resolved:
Audit Committee received the content of the KPMG Technical report.

16/17/72 6 month programme assurance review
At the last meeting, Audit Committee received a report on the KPMG review of programme assurance. The report included 9 recommendations. A report highlighting actions taken to ensure the recommendations were now completed was received.

It was agreed an implementation review would take place once Programme Assurance had been in place for 12 months.

Resolved:
Audit Committee
a) Received positive assurance.
b) Agreed to review Programme Assurance once it had been in place for 12 months.

16/17/73 Draft Accounting Policies
The main differences from the accounting policies adopted for 2015/16 accounts are:

Provision for impairment of receivables

The provision for Injury Costs Recovery debt has increased from 21.99% to 22.94%. This reflects recoverability rates and is in line with DH guidance. However the Trust is reviewing how our own rate of recovery compares with this and may use this once known.

Holiday Pay Accrual
We are reviewing our methodology with other Trusts and may change our approach. This is work in progress so the policy remains the same for now but may change for the final version.

Provisions
There is a change in the discount rate for general provisions:

Short term	Cash flows between 0 and 5 year	Rate is - 2.70% (was -1.55%)
Medium term	Cash flows over 5 to 10 years	Rate is - 1.95% (was -1.00%)
Long term	Cash flows over 10 years	Rate is - 0.80% (was -0.80%)

HM Treasury have also changed the discount rate for post-employment benefits from 1.37% to 0.24%.

Audit Committee also received the proposed accounting policies for inclusion within the annual accounts.

Resolved:
Audit Committee approved the accounting policies for the annual accounts.

16/17/74 Integrated Board Assurance report

Tony Rigby, Deputy Director of Risk & Governance gave a presentation on 12 month progress of the Risk Management Improvement Plan following an internal and external review.

Previous recommendations included: continue to implement the risk management improvement plan, refresh the Board Assurance Framework and Corporate Risk Register. An update on progress against these three areas was given.

It was highlighted that the recommendations in the Risk Management Improvement Plan were now implemented, and a new plan would be developed following the pending re-audit of Risk & Governance systems and processes, commencing in Quarter 4 of 2016-17.

The Chair thanked the Quality Assurance team for progress to date.

Resolved:
a) Audit Committee received and noted the content of the Integrated Board Assurance report.
b) Agreed to receive a further update on Risk Management Improvement plan in September 2017.

16/17/75 Policy Register report

The policy review report highlighting progress and policies outstanding was received. Whilst there had been progress it was agreed this item would be standard item on the agenda.

A discussion was held on strengthening the report. Phil O'Connor agreed to advise Elvina White of the changes to be made.

As requested at the last meeting Melissa Swindell presented a report on the 12 outstanding HR polices with timescales when they would be completed.

Resolved:

a) Audit Committee received the progressed policy report
b) Agreed for this to be a standard item on the agenda.

16/17/76 Committee Work-plan

Resolved:

Audit Committee received and approved the work-plan subject to a number of items being added following this meeting.

16/17/77 Meeting Review

Audit Committee agreed the meeting had gone well and ran to time.

16/17/78 Any other business

NHS Trust Accounting Manual

Claire Liddy provided an update on the statutory requirements and options in respect of the valuation of the Trust's Non-current Assets for 2016/17.

A discussion was held on the high cost of an evaluation and whether this was required, mainly due to the hospital being a new build. Jerri Lewis agreed to contact Amanda Latham and confirm with Claire Liddy if there are any other options.

Resolved:

a) Audit Committee received an update on NHS Trust Accounting Manual.
b) Jerri Lewis agreed to contact Amanda Latham to confirm if it is mandatory for the Trust to carry out an evaluation.

Date and Time of next meeting: - Thursday 28th April 2017 at 1400, Room 7, Level 1 Mezzanine.

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday 25th May 2017

Report of:	Chief Nurse
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. 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 Committee (CQAC).

2. SIRI performance data:

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

3. Recommendations:

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

New SIRI Incidents reported between the period 01/04/2017 to 30/04/2017:								
Reference Number	**Date investigation started**	**CBU**	**Incident Description**	**RCA Lead Investigator**	**72 hour review completed**	**Progress**	**60 working day compliance**	**Duty of Candour/ Being Open policy implemented**
StEIS 2017/ 10352	14/04/2017	Surgery	Grade 3 Pressure Ulcer on patient's back. Patient on ECMO, open chest, nursed on repose mattress but unable to position side to side due to open chest.	Sue Tickle, Clinical Nurse Manager PICU	Yes - immediate actions – patient already on appropriate equipment, referral to Tissue Viability made and pressure ulcer investigation commenced.	Pressure ulcer investigation completed. Findings concluded that the pressure ulcer was unavoidable, report to be sent to CCG.	Yes	Being open completed – family informed of pressure ulcer. Duty of Candour letter not to be sent per Chief Nurse as patient sadly passed away.
StEIS 2017/9448	12/04/2017	Surgery	Sudden unexpected death – Patient had PDA stent inserted, deteriorated unexpectedly and cardiac arrest. Patient subsequently died.	Dianne Topping, Senior Nurse & Colin Dryden, Consultant Anaesthetist	Yes	Information gathering ongoing, RCA panel meeting scheduled for 19th May 2017.	Yes	Yes
StEIS 2017/9937	12/04/17	Surgery	Sudden unexpected death – patient had adenotonsillectomy with subsequent deterioration, admitted to HDU, subsequent cardiac arrest and sadly died.	Christine Murray, Sister, HDU	Yes – immediate actions included request for statements and chronology of events completed.	Information gathering ongoing, panel meeting to be arranged.	Yes	Yes

New Safeguarding investigations reported 01/04/2017 to 30/04/2017: For information							
Reference Number	**Date investigation started**	**CBU**	**Incident Description**	**RCA Lead Investigator**	**Progress**	**60 working day compliance**	**Being Open policy implemented**
Nil							

On-going SIRI incident investigations (including those above)							
Reference Number	**Date investigation started**	**CBU**	**Incident Description**	**RCA Lead Investigator**	**Progress**	**60 working day compliance (or within agreed extension)**	**Duty of Candour/ Being Open policy implemented**
RCA 332 2016/17 **Internal**	28/03/2017	Community	During a complaint investigation it became apparent that some elements of the child's inpatient stay had not been managed as robustly as they should have been. During the 4 days of the child's stay there were a number of times where his clinical condition and monitoring of vital signs triggered his PEWS score and required a review by a doctor - all required reviews do not appear to have taken place.	Dianne Topping, Senior Nurse	Information gathered, panel meeting held May 2017.	Yes	Being open completed, level of harm unknown.
RCA 333	28/03/2017	Community	The patient was	Amanda Turton,	Information gathering	Yes	Being open

2016/17 **Internal**			brought to ED in November 2016 as an emergency with seizures and hypertension. Despite resuscitation and intensive care she died 2 days later. Subsequent post-mortem has revealed previously undiagnosed structural kidney disease which is the likely cause of the malignant hypertension. The child had presented to ED in June 2013 and October 2015 with a diagnosis of Bell's Palsy. Blood pressure should have been recorded on each of these occasions but was not recorded.	ED Manager	ongoing, panel meeting to be arranged.		completed, level of harm unknown.

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

SIRI incidents closed since last report						
Reference Number	**Date investigation started**	**CBU**	**Incident Description**	**RCA Lead Investigator**	**Outcome**	**Duty of Candour/Being open policy Implemented**
StEIS 2017/3539	06/02/2017	Surgery	The patient (complex) attended the Trust for an elective orthopaedic procedure on the 27/01/17. The patient suffered an extravasation injury from the neck line intraoperatively. Following completion of the surgery, the patient was transferred to the inpatient recovery room where they suffered a cardiac arrest. The patient was transferred from recovery to the High Dependency Unit rather than the ward in case of tracheostomy adjustment. Sadly, the patient died the following day (28/01/17).	Rachael Hanger, Theatre Matron	Reported completed and sent to CCG.	Yes
RCA 208 2016/17 **Internal**	29/10/2016	Surgery	Patient was prepared for intubation on the ward during resuscitation; delay in emergency alarm being raised and in following resuscitation protocol.	Pete Murphy, Consultant Anaesthetist	Report completed.	N/A (no patient harm).

Safeguarding investigations closed since last report
Nil

Alder Hey Children's NHS
NHS Foundation Trust

Draft Clinical Quality Assurance Committee Annual Report 2016/17

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 authority 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 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* approach.
- 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 2016. 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 monthly while Quality walkrounds, which are open to all Board Directors and Governors, were held every other month for the majority of the year. A new approach to the walkaround process was agreed for 2017/18. A schedule of attendance is shown in Appendix A which shows full compliance with quoracy. It should however be noted that due to her role as Lead across Cheshire and Merseyside for the Sustainability and

Transformation Plan, it was agreed by the Board that the Chief Executive would not participate in any committee work for the duration of 2016/17.

From April 2016 to March 2017 twelve meetings of CQAC were held and three quality walkarounds undertaken. The quality walkarounds were structured around the major projects within the change programme but retained the overall process structure previously in place, with a presentation beforehand, a debrief afterwards and the creation of an action plan by the relevant CBU, monitored through the programme assurance system with good practices also highlighted. Any key findings, issues and concerns are fed back at each Board meeting by the Committee Chair.

Achievements in 2016/17

- Following the June 2015 inspection by the Care Quality Commission which resulted in an overall rating of 'Good' with 'Outstanding' in the Caring domain, the Committee took responsibility for overseeing the implementation of the associated action plan, which was fully completed during the year.
- From April 2016, the Committee took over the programme assurance function from the previous Trust wide Programme Board, which had been disbanded by the Board in favour of a more devolved approach to the 2016/17 change programme. A portion of each meeting was devoted to monitoring the progress of those projects which came under the purview of CQAC in accordance with the process developed via the PMO.
- The Committee initiated a Quality Summit process, approved by the Board, which would be triggered by two or more never events, SIRI's or near miss serious incidents, or any combination that have common elements or demonstrate repeated failure to learn or implement improvement. Two such summits were held during the year and were agreed to be an effective process by which changes in practice could be rapidly adopted.
- In the second half of the year, the Committee had a particular focus upon the implementation of the Trust's sepsis strategy, requesting regular updates from the clinical leads in order to ensure pace and delivery of the NICE guidelines and associated processes relating to the care of the deteriorating child.
- 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.

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 2017/18

- A key focus for the Committee in the coming year will be the implementation of the new Quality Ward Round process which was agreed at the end of 2016/17; this will provide an in depth understanding for Committee members of the issues facing different parts of the organisation, using the CQC's KLOE's as the basis for assessment.
- The Committee will continue to oversee the implementation of the Quality Strategy and associated aims in the context of the Trust's overall strategic direction and re-stated ambition to achieve an overall Outstanding rating from CQC.

- The governance arrangements that underpin the Change Programme and its specific projects will again be a key focus for the Committee in the coming year.
- The Committee will continue to hold the Divisions and CBUs to account for quality performance and will seek to drive measurable improvements in key quality indicators linked to the Quality Aims.

Anita Marsland
Committee Chair
April 2017

APPENDIX A

CQAC - RECORD OF ATTENDANCE 2016/17

CLINCIAL QUALITY ASSURANCE COMMITTEE (CQAC)

ATTENDANCE LOG 2016/17

A quorum shall consist of the Chair or nominated deputy, one other NED, two Executive Directors (one of whom must be the Medical Director or Nursing Director, or their designated deputy.
In exceptional circumstances, teleconference participation by a member will be permitted and this will count towards a quorum.

Member/Date of Meeting	2016									2017		
	20th April	18th May	15th June	20th July	17th Aug	21st Sept	19th Oct	16th Nov	13th Dec	18th Jan	15th Feb	22nd Mar
Mrs Anita Marsland (Non-Executive Director)	✓ **(Chair)**	✓ **(Chair)**	✓ **(Chair)**	✓ **(Chair)**	✓ **(Chair)**	✓ **(Chair)**	✓ **(Chair)**	✓ **Chair**	X	✓ **(Chair)**	✓	✓
Mr Steve Igoe (Non-Executive Director)	✓	✓	X	X	✓	✓	✓	✓	✓	✓	✓	✓
Mrs Jeannie France-Hayhurst (Non-Executive Director)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Mr R Turnock (Medical Director)	✓	✓	✓	X	X	✓	✓	X	✓	X	✓	✓
Ms Gill Core (Chief Nurse)	✓	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Mrs Hilda Gwilliams (Director of Nursing)	✓	✓	✓	✓	✓	✓	X	✓	✓	✓	✓	✓
Mrs Louise Shepherd (Chief Executive) *Due to her role as Cheshire and Merseyside STP lead during 2016/17 Mrs Shepherd stepped down as a full member of CQAC; Mr Stephens deputised in his capacity as Deputy CEO	✓	~~X~~ n/a*	~~X~~ n/a	~~X~~ n/a	~~X~~ n/a	~~X~~ n/a	~~X~~ n/a	~~X~~ n/a	~~X~~ n/a	~~X~~ n/a	~~X~~ n/a	~~X~~ n/a
Mr J Stephens (Director of Finance)	✓	✓	✓	X	✓	✓	✓	✓	X	n/a	n/a	n/a
Ms Erica Saunders (Director of Corporate Affairs)	✓	✓	✓	✓	X	✓	✓	✓	✓	✓	✓	✓

Mrs M Swindell (Interim Director of HR & OD)	✓	✓	✓	✓	x	✓	✓	✓	x	✓	✓	✓
Mrs Mags Barnaby (Interim Chief Operating Officer)	✓	✓	✓	x	✓	✓	✓	✓	✓	✓	✓	✓

Alder Hey Children's NHS
NHS Foundation Trust

Clinical Quality Assurance Committee
Minutes of the last meeting held on Wednesday 19th April 2017
10:00am, Large Meeting Room, Institute in the Park

Present:	Anita Marsland	(Chair), Non-Executive Director	AM
	Jeannie France-Hayhurst	Non-Executive Director	JFH
	Dame Jo Williams	Non- Executive Director	JW
	Adam Bateman	Associate Chief Operating Officer (Surgery)	AB
	Tony Rigby	General Manager, Quality Strategy	TR
	Paul Newland	CD, Clinical Support CBU, /Co Biochemistry	PN
	Glenna Smith	Interim General Manager, Medicine CBU	GS
	Melissa Swindell	Interim Director of HR	MS
	John Grinnell	Director of Finance & Information	
In Attendance:-	Richard Cooke	Director Infection Prevention Control	RC
	Joe Gibson	External Programme	JG
	Jannette Richardson	Programme Manager	JR
	Catherine McLaughlin	Director of Community Services	CM
	Julie Creevy	EA, Executive Team	JC

Agenda item: 16/17/167

16/17/168 Apologies:	Pauline Brown	Director of Nursing	PB
	Christian Duncan	Director of Surgery CBU	CD
	Hilda Gwilliams	Chief Nurse	HG
	Steve Igoe	Non-Executive Director	SI
	Steve Ryan	Medical Director	RT
	Mark Peers	Public Governor	MP
	Erica Saunders	Director of Corporate Affairs	ES
	Lachlan Stark	Head of Planning & Performance	LS
	Julie Williams	Appointed Governor	JW

16/17/169 Declarations of Interest
None declared.

16/17/170 Minutes of the previous meeting held on 22nd March 2017
Resolved:
CQAC approved the minutes of the last meeting held on 22nd March 2017.

16/17/171 Matters Arising and Action list

It was noted in the absence of H Gwilliams that the action log would be reviewed offline with AM & HG.

Action: Chair and HG to review the outstanding actions, in preparation of a full update at the next meeting.

Equality – MS would liaise with H Ainsowrth regarding this action.

CQAC noted that the Chair & M Swindell had completed an informal walkabout, which was extremely welcomed by visitors and staff. It was noted that a programme for Walkabouts with Execs and Non Executive Directors is currently in the process of being drafted, to improve visibility.

It was noted HG/ES are in the process of finalising the new Quality Ward Round programme.

16/17/172 Review of Clinical Investigations

N Barnes provided an update as follows:-

It was noted that the electronic system to ensure clinical investigation notices continues to be problematic. NB is currently working with the appropriate team to improve this issue. Several productive meetings had taken place to date, however this issue still remained unresolved. Issue had been previously escalated at meditech meetings, however meditech required appropriate time to work through the problem, and needed time to fully understand the issue. NB indicated that the proposal is to clear the existing notices on the system, however new notices will soon increase, with individuals then having to request for notices to be cleared, and at that time training would be given to individuals.

NB confirmed that the team are still working through the technical way to ensure the clearance of the notices. The team are currently meeting fortnightly with meditech to progress this further, and during the next meditech meeting in two weeks time, the outstanding actions will be discussed.

The Chair queried the risk element, with regards to the notices. PN confirmed that with any high risk lab results that these are communicated by phone to the appropriate clinician.

CQAC noted that no further significant progress had been made in terms of the functionality of the system for notices.

Action: NB to attend future CQAC in due course with a further update.

Action: To confirm whether this issue is to be included on the Corporate Risk Register

Action: J Grinnell to address meditech and GDE issue.

Chair thanked NB for his update.

16/17/173 Sepsis Update

G Smith provided an update on Sepsis as follows:-

CQAC noted that the Business Case had been approved, with both posts now advertised and closed, with interviews scheduled for a couple of weeks time.

Sepsis had been rolled out to wards 3C, 4C and 3B. With a further roll out for HDU and Burns during week commencing 24th April 2017. Followed by roll out to ED within the next few weeks, with only the surgical ward remaining. Sepsis team are in the process of liaising with meditech with regards to slight 'tweaks', which are required. With the team on track to complete all actions by June 2017. Sepsis team are working with Pauline Brown and the Heads of Quality to fully embed Sepsis within the organisation.

CQAC noted the positive progress made to date, and noted the significant achievement of approval of the business case.

R Cooke indicated that it would be helpful for sight of validation evidence, indicating that children with sepsis are being appropriately managed. G Smith confirmed that the team are currently working with the informatics team to facilitate receiving information in a formatable way, as the information currently isn't formatatted clearly.

CQAC would continuing to receive a monthly Sepsis update.

Action: GS to share the validated data at the next CQAC meeting

Chair thanked GS for her positive update.

16/17/174 Programme Assurance Update

J Gibson provided a programme assurance update as follows:-

CQAC noted on page 1 - from the 6 projects identified 4 are in the process of definition,/have PID with the remaining projects highlighted as amber.

JG confirmed that the 7 day service project and the Reduce infection projects had been discussed with Steve Ryan, with SR currently reviewing. SR is currently in the process of establishing a Stakeholder group to review and provide a stocktake, to identify financial benefit/progress further.

JG emphasied the importance of reviewing whether schemes are actually a project, and indicated that the Exec sponsors needed to be really clear on the benefit led project and programmes.

JG indicated that HG is in the process of establishing a Steering Group to meet on a weekly basis to ensure that the template is in place.date on each of the projects.

It was noted that it would be helpful for corporate leads for each project to be invited to next CQAC to provide CQAC with a detailed update.

CQAC noted that progress needs to be accelerated, prior to the next CQAC meeting.

Action: CQAC to scrutinise further at the next CQAC meetings and corporate leads to be invited.

Action: Exec sponors to determine actual projects, in preparation of a full detailed update at the next CQAC meeting.

CQAC noted that the programme approach is being discussed further at Executive Team meeting on 20th April 2017.

.

Chair thanked JG for his update.

16/17/175 CQAC Annual work plan

CQAC received the CQAC Annual work plan.

CQAC noted that the DIPC report (Jo Keward) – should be amended to reflect the new DIPC – Valya Weston who commences in post in May 2017.

Following discussion it was agreed that a form of words are required to amend the section on page 1 'All patients treated following ***recognised*** protocols./pathways/guidelines' – CQAC agreed that the word recognised needs to be further strengthened and further clarity is needed regarding the wording.

Page 1 - 'No acute admission of patients with long term conditions (epilepsy, diabetes, asthma, lower respiratory disease' – it was noted that this section requires rewording.

Action: CQAC noted that the bullet points made on page 1 needed to be reviewed and amended as appropriate in order to provide further clarity.

CQAC noted that the quality revievs also need to be included.

Page 2 – 'Patients will not suffer harm in our care – no hospital acquired infection' –CQAC requested that this should be changed to 'no healthcare associated infection, with the Trust aiming to minimise the risk of acquiring an infection'.

CQAC requested further clarity on the bulletted headings contained on pages 1 & 2, indicating that it is currently unclear, in terms of what is actually being presented – with these sections requiring amending/further clarity.

Action: bulletted headings on page 1 & 2 to be amended (ES)

CQAC noted that Equality is discussed through CQSG and that any exception reports are shared at CQAC as and when appropriate.

Jo W queried whether the Trut monitors cultural sensitivities, MS confimed that the Trust reviews cultural sensitivies, however MS could not confirm that they were currently being monitored. AB confirmed that a structured assessment takes place throught the quality impact assessment process.

Action: MS to liaise with HG & H Ainsworth regarding equality.

Action: MS to liaise with H Ainsworth with regards to mapping equality in order to provide CQAC with appropriate assurance.

CQAC received and noted the CQAC Workplan for 2017/18.

16/17/176 CQAC Annual Report

CQAC received the CQAC Annual Report .
CQAC noted detailed information regarding assurance statement, together with achievements made in 2016/17 and Committee Priorities for 2017/18.

The Committee received and noted the CQAC annual report.
.

16/17/177 Update Quality Account

T Rigby presented the early draft of the Quality account .

JW queried whether there was any any internal challenge, and queried whether there is any opportunity for internal/peer challenge. JW queried whether actions are followed up on a quarterly basis. TR confirmed that there is not a central place for all actions to be followed up, with some of the actions being addressed at the Clinical Quality & Performance Group meeting with commissioners.

Action: AB agreed to liaise with Heads of Quality with regards to any surgery outstanding actions.

Action: TR to liaise with Sarah Stephenson offline regarding establishing what is currently being managed.

JFH raised the issue regarding staff training, and queried what training is provided to staff.

Action: TR to liaise with appropriate HR personnel to provide JFH with an update regarding training for staff.

RC indicated that it would be helpful to receive actual numbers, or volume of cases, with regards to validation of data, given that there are currently no thresholds within the Quality Account. TR indicated that the Trust will be unable to include a threshold, if the Trust had not been working to a threshold. CQAC agreed it would be helpful to include a benchmark/comparator, or to relate to previous information, as a comparison. TR agreed to review this issue further.

CQAC noted the additional section section - 3.2.1 regarding Duty of Candour and noted section 3.3.2 regarding Reducing harm to patients as a result of developing a Pressure Ulcer, which had been amended with regards to advice received from the Tissue Viability Nurse. Additional Section – 3.3.10 Equality & Diversity was noted.

Chair indicated that CQAC required sight of the Chief Executive Statement, TR confirmed that the CEO statement would be electronically shared with CQAC once the statement was completed.

Action: TR to share CEO statement with CQAC members once completed.

CQAC agreed that that once the additional sections had been fully completed, CQAC were content for the document to be shared with partners as necessary.

16/17/178 Corporate Report – Quality Metrics

In the absence of H Gwilliams, the Chair confirmed that an offline discussion would be held with herself and HG to review quality metrics and following that discussion any issues which needed to be shared with CQAC members would be shared electronically, in advance of a further update at the next meeting on 17th May 2017.

16/17/179 External Visits Register

CQAC received and noted the External Visits register.
Committee noted that the Pharmacy issue is ongoing.

16/17/180 Pregnancy testing policy

CQAC received the Pregnancy testing policy.
Committee noted the good consultation process, together with the very clear and helpful narrative included within the policy.The policy was well received by CQAC.

Discussion took place regarding training and implementation to ensure that all staff are aware of the policy, and whether this could be shared on an app.

CQAC noted that the elephant logo on the policy neeed to be removed, given that this is the charity logo.

Resolved: CQAC ratified the policy, subject to the issue of training being addressed and the removal of the elephant logo.

16/17/180 Key issues report November 2016

Clinical Quality Key issues report was received and noted.

The committee noted the significant work achieved by CQSG

16/17/181 Any other business

None

Date and Time of next meeting: - Wednesday 17th May at 10am, Large Meeting Room, Institute in the Park.

ALDER HEY IN THE PARK PROJECT

HIGHLIGHT REPORT Site & Park Development	Date: 18/05/17 Report Number:	Period: May 2017 11	SRO: David Powell Author: Sue Brown
Programme 2017/18	Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17		
Week Commencing	3 10 17 24 1 8 15 22 29 5 12 19 26 3 10 17 24 31 7 14 21 28 4 11 18 25		
Decommissioning & Demolition (Phase 1 & 2)			Programme progressing on track. In response to the concerns raised regarding dust levels, a dust management plan has been developed and actioned with DIPC approval. The management plan will address two sources of dust: 1. demolition of retained estate; 2. R&E II construction.
Residential			Revised bids evaluated and recommendation of Preferred Bidder, including a first reserve, presented to Executive Team and approved. Bidders have been informed and subsequent feedback meetings held. Public consultation delayed slightly due to the General Election and extension of PURDA. so now set to commence from the 9th June, commencing with Local Councillors.
Research & Education Phase II			Back on track. Morgan Sindell set up on site with building commencement the 22nd May.
Alder Centre			On Track. ITPD process with 5 bidders for the Design of the Alder Centre via the RIBA process has commenced Bidders have presented their initial designs and the process is due for conslusion by 27th June.
Park			Planning application for woodland path and multi-sensory, technology-assisted, interactive interpretation trail submitted. - First forest school area built with schools starting on site June 17. - New partnership with Woodland Trust forged and acquisition of newly commissioned national monument for Springfield secured for Nov 17.- Corporate sponsorship pitch to B&Q carried out.
International Design & Build Consultancy			Pricing structure and format for design advice prepared and provided to Xl'AN, awaiting response.
Community			Paper taken to the executive team was approved to further explore and conduct a financial analysis of proposed developments and locations for Community services; Onsite Neurodevelopmental new build for Community Paediatrics and an offsite potential lease for CAMHS.
Corporate Offices/Clinical on-site			**Project now wrapped up in the whole estate strategy for the site.**
On-site Residual			**Project now wrapped up in the whole estate strategy for the site.**

Alder Hey Children's NHS
NHS Foundation Trust

Programme Assurance Summary
Change Programme

Programme Summary (to be completed by **Executive Sponsor** of the assurance framework)

In response to the delays in fully defining and de-risking the change programme this year a number of actions are in hand:

- External Programme Assurance has now completed a review with all Executive Sponsors of current programme content, with a view to increased focus on fewer projects but with increased benefits , see slide 2 where projects in red font are being amalgamated/under review.
- Following workshops to cement divisional buy-in to the programme, the Executive Team and divisional leadership will be coming together on 25 May as a 'Programme Delivery Board' and this function will remain in place to assure, as one team, the scope and delivery of the projected benefits and quality outcomes.
- Executive and divisional leadership will bring the refined and improved programme scope, describing the improved delivery vehicle, to the Trust Board meeting on 4 July 2017; the focus will be on ensuring optimal grip to deliver sufficient gains to meet 17/18 objectives.

J Grinnell 17 May 17

Programme Summary (to be completed by **External Programme Assessment**)

1. This Board reports integrates the assurance report submitted to the following sub-Committee: CQAC, 16 May 17.
2. In the two weeks since the previous Trust Board was compiled there has been further progress made on project PIDs – some of which now meet the assurance standard – a full breakdown of the programme definition will form part of the wider assurance report to the 4 July 2017 Trust Board. I will review the SharePoint site immediately before the Trust Board of 4 July and would like to be able to report significant progress at that time.
3. As stated in both the February/March/April Assurance reports to Trust Board: it is evident that the planning process for FY17/18 is proceeding but needs further acceleration; Executive Sponsors of all programmes need to focus on driving the programme in FY 2017/18.

J Gibson 17 May 17

CIP Summary (to be completed by **Programme Assurance Framework**)

The Month 1 CIP performance across the Trust showed an underachievement **of £52k (18%) in January.** The largest variances are Community (£19k behind plan) and Alder Hey in the Park (£15k behind plan). The main reason for the slippage is the timing of schemes starting. The full year forecast is **£5.3m a gap of £2.7m**. There are further ideas of £2.4m and these need to be converted into schemes and the remaining gap identified urgently.

Change Programme
Outline 5.5.17 v5.1
(Showing projects under review/deferred)

Trust Board

Alder Hey Children's NHS
NHS Foundation Trust

CQAC | **R&BD** | **WOD** | **R&BD** | **R&BD**

Internal Delivery Group (CiP) ⟷ **Programme Assurance Framework** ⟷ **Execs**

22/33 = £ indicated projects

Deliver Outstanding Care
Hilda / Steve

1. **Deteriorating Patient** SG
2. **Experience in Outpatients £**
3. **Best in Operative Care £**
4. **7 Day Services**
5. **Reduce Infections £** SG

Growing Through External Partnerships
Debbie

SG

1. **Establish Alder Hey as Leader of Children's Health across C & M**
   a) High Quality Acute & Emergency Care **£**
   b) Develop Clinical Support Services Offer **£**
   c) Single Service, 2 Site, Neonatal Service **£**
   d) Expand Mental Health Offering **£**
   e) Step Down Care Unit for Patients with Complex Needs **£**
2. **Strengthen the Stoke Partnership £**
3. **International Health & Non-NHS Patients £**

The Best People Doing Their Best Work
Melissa/Hilda

SG

1. **Staff Engagement & Development**
   a) Apprenticeships **£**
   b) Engagement & Communication
2. **Workforce Reviews**
   a) Specialist Nurse Review **£**
   b) AHP Review **£**
   c) Portering **£**
   d) Domestics **£**
3. **Agile Working**

Global Digital Exemplar
John/Steve

SG

1. **Project 1 £**
2. **Project 2 £**
3. **Project 3 £**
4. **Project 4 £**
5. **Project 5 £**
6. **Project 6 £**

Park, Community Estate & Facilities
David

SG

1. **Decommission & Demolition**
2. **R&E 2**
3. **Alder Centre**
4. **Park**
5. **Residential Development**
6. **International Design & Build Consultancy £**

RE&I

Game Changing Research & Innovation
David

1. **The Academy £**
2. **The Innovation Co £**
3. **Implement New Apps for Alder Hey**
4. **Expand Commercial Research £**

Listening into Action - *A staff-led process for the changes we need*

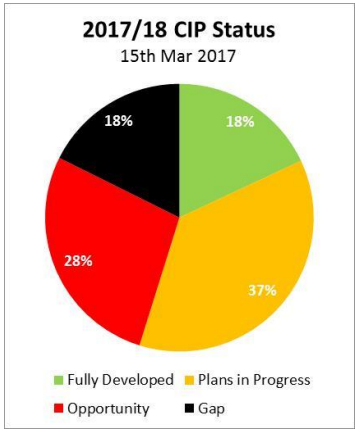
Alder Hey Children's NHS
NHS Foundation Trust

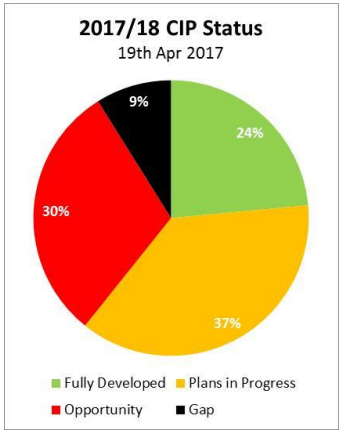
CIP Status at Month 01

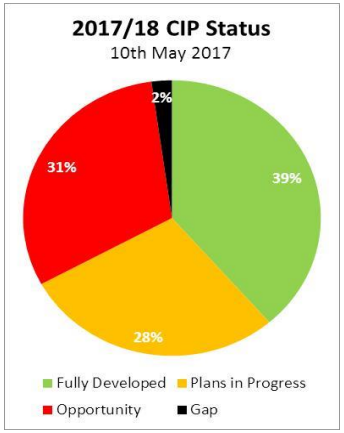
By Strategic Work Stream

Workstream	Risk Rating (In Year)					
	Implemented (Posted) £000's	Fully Developed £000's	Plans in Progress £000's	Opportunity £000's	Gap £000's	Total £000's
Deliver Outstanding Care	133		22	63		218
Growing Through External Partnerships	69			158		227
The Best People Doing Their Best Work			292	90		382
Game Changing Research and Innovation	130					130
Solid Foundations						0
Subtotal: Strategic Workstreams	332	0	314	311		957
Business as Usual	2,279	481	1,957	2,148		6,865
Unidentified					177	177
Grand Total	2,611	481	2,272	2,459	177	8,000

Progress over the last 3 months







Inspired by Children

Alder Hey Children's NHS
NHS Foundation Trust

Programme Assurance Summary
Delivering Outstanding Care

Work Stream Summary (to be completed by Executive Sponsor of the assurance framework)

2017/18 Change Programme remains around a quarter behind schedule; Out standing care work stream has made progress with PiDs and quality benefits, however the financial benefits still require further work with a focus needed on operational efficiency and productivity.
The latest forecast is savings of £0.3m, which is very low, and has worsened since April 17. The Executive sponsor is requested to review the saving potential as a matter of urgency, progressing the red risk savings to amber and green and increasing the value of the overall forecast.

Claire Liddy, Deputy DoF, 5.5.17

Work Stream Summary (to be completed by External Programme Assessment)

Only one of the six projects still awaits a draft PID; the outstanding project, '7 Day Services', is the subject of a merger with another project 'High Quality Acute and Emergency Care' under the auspices of the Medical Director. Of the projects that are rated, significant progress has been made on the 'Outpatients' project which is now green rated and sets a good standard for the other projects in this work stream to follow.

Notwithstanding good progress in certain areas, the work stream is remains at high risk of not delivering the quality and financial ambitions it aims to deliver. Definition and planning (including benefits) should be brought up to the standard of the 'Outpatients' project asap.

Joe Gibson, External Programme Assurance 4 May 17

Alder Hey Children's NHS
NHS Foundation Trust

Programme Assurance Framework
Delivering Outstanding Care (Completed by Assurance Team)

Sub-Committee	CQAC	Report Date	May 2017
Workstream Name	Delivering Outstanding Care	Executive Sponsor	Hilda Gwilliams/Steve Ryan

Current Dashboard Rating:

Project Ref	Project Title	Project Description	Executive Sponsor Assures the project	OVERALL PROJECT RAG status	An effective project team is in place	Scope and Approach is defined	Targets / benefits defined/on track	Milestone plan is defined/on track	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	Comments for attention of the Project Team, Steering Group and sub-Committee
CQAC 1.1	Deteriorating Patient	This project will ensure prompt recognition and management of the deteriorating patient and implementation of the Sepsis Pathway	Hilda Gwilliams										Project implementation meeting notes available. Draft PID available on SharePoint - requires finalisation. Benefits to be fully defined, to include metrics. Milestone Plan has been revised, to be fully defined. Comms/ Engagement Plan available, evidence required Risk log complete and up-to-date. EA/QIA complete. **Last updated 4 May 2017**
CQAC 1.2	Reduce Variation by Developing Clinically Effective Pathways	This project will drive the development of clinically effective care pathways across all specialities, using various methodologies including ImERSE, LiA and PFCC	Steve Ryan										Project to be removed from dashboard, not in programme scope. **Last updated 5 May 2017**
CQAC 1.2	Experience in Outpatients	The project will improve patient & staff experience; understand demand and capacity; improve flow and environment	Hilda Gwilliams										Steering Group meeting notes available. PID is complete. Benefits fully defined in PID and tracking/dashboard to SG . Milestone Plan defined and initial actions on track. Detailed comms/engagement plan available. Risk log available. EA/QIA complete. **Last updated 2 May 2017**
CQAC 1.3	Best in 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 rates	Steve Ryan										Steering Group notes to be uploaded to SharePoint. Draft PID available - requires completion. Targets/benefits to be fully defined, including completion of financial appendix. Milestone Plan to be fully defined. Comms tracker available. Risk Log complete. EA/QIA to be completed and signed. **Last updated 5 May 2017**
CQAC 1.4	7 Day Services	The project aims to deliver 7 day services in line with NHS recommendations	Steve Ryan										Links to project 2.1a STP AH @ C&M High Quality Acute & Emergency Care - currently under review. **Last updated 5 May 2017**
CQAC 1.5	Reduce Infections	This project will ensure we achieve best in class for infection prevention and control	Steve Ryan										Draft/outline PID available on SharePoint - all project documentation to be fully developed. **Last updated 3 May 2017**

Financial Reporting:

Project Title	RAG Rating	Budget £	Forecast £	Variance £	Comments
Deteriorating Patient	Black	0	0	0	No financial benefits identified to date
Reduce Variations by Developing Clinically Effective Pathways	Black	0	0	0	No financial benefits identified to date
Experience in Outpatients	Red	180	127	-53	Financial target based on 3% reduction in DNA rate in Medical specialities. High risk regarding delivery of full target value. In addition, plans to improve booking and reduce postage are expected to deliver £108k non pay savings (risk rated Amber) .
Best in Operative Care	Green	407	155	-252	Financial target based on indicative 2% growth in Elective and Daycase income in all Surgical specialties. Following detailed review and activity forecast, there is high confidence of increased income in Urology, Plastics and Pre-Op Assessment.
7 Day Services	Black	0	0	0	No financial benefits identified to date
Reduce Infections	Black	0	0	0	No financial benefits identified to date
Total		587	282	-305	