Alder Hey Children's NHS
NHS Foundation Trust









QUALITY ACCOUNT 2015/16

INSPIRED BY CHILDREN

CONTENTS

QUALITY REPORT

'QUALITY IS EVERYBODY'S BUSINESS'

PART 1: STATEMENT ON QUALITY FROM LOUISE SHEPHERD, CHIEF EXECUTIVE

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

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

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

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

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

Louise Shepherd
Chief Executive

PART 2: OUR ACHIEVEMENTS IN 2015/16

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

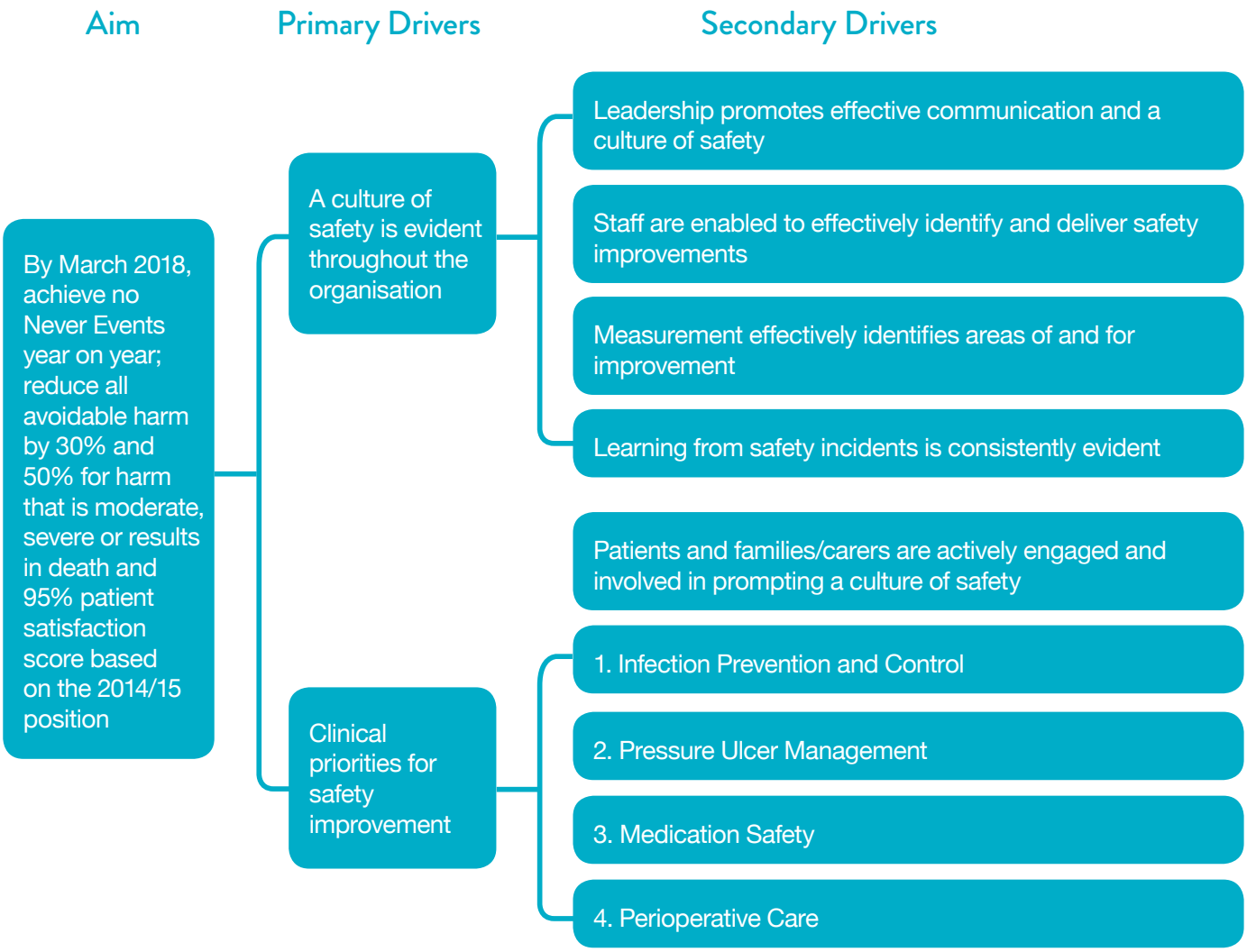
This section of the Quality Report provides an overview of the progress made against the 2015/16 priorities.

Sign Up to Safety

'Sign Up to Safety' is a national patient safety campaign whose vision is for the whole NHS to become the safest healthcare system in the world, aiming to deliver harm-free care for every patient every time. The campaign was launched on 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 has joined the 'Sign Up to Safety' campaign, developing a Trust-wide Safety Improvement Plan with specific improvement outcomes:

Trust-wide Safety Improvement Plan 2015-2018



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

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

We will:

• Strive to achieve our patient safety aim that patients will not suffer harm in our care. Our commitment is reflected in the Trust's Quality Strategy and Quality Report and is supported by a set of patient safety quality aims that were developed in partnership with our patients, their families, our staff and our governors.

• Implement robust processes and workforce plans to ensure consistent safe nurse staffing levels. Staffing levels will be made visible to children, young people, their parents and the public, through the use of ward staffing display boards and the Trust intranet site.

• Continue to publish the monthly Trust Board Assessment of Quality Report on the Trust intranet site.

• Conduct engagement events with local stakeholders to share progress against safety priorities, gain feedback and identify opportunities for partnership working.

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

We will:

• Develop a process that actively engages children, young people and their parents in raising their safety concerns and provides them with feedback on improvements.

• Conduct an annual Staff Safety Attitudes Survey to understand our safety culture.

• Continue to utilise the Weekly Meeting of Harm to analyse incidents, monitor incident trends and near miss incidents, identify improvement actions, recognise good practice and provide feedback to staff.

• Continue to monitor patient safety 'Ward to Board', utilising the Ward Dashboard and monthly Trust Board Assessment of Quality Report.

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

We will:

• Continue to meet our Duty of Candour to patients and families by:

- Making sure we act in an open and transparent way with our patients and families;

- Telling patients and families in person as soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred and providing support to them in relation to the incident, including when giving the notification;

- Providing an account of the incident which, to the best of our knowledge, is true of all the facts we know about the incident as at the date of the notification;

- Advising patients and families what further enquiries we believe are appropriate;

- Offering an apology;

- Following this up by giving the same information in writing and providing an update on the enquiries;

- Keeping a written record of all communication with those involved.

• Promote a culture of openness and transparency.

• Ensure staff have the skills and support to enable them to communicate effectively with children, young people and their parents, following any patient safety incident or concern.

• Display progress against key patient safety quality aims to staff, children, young people and their parents through the 'Knowing How We Are Doing' boards displayed in each clinical area.

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

We will:

• Utilise existing networks to facilitate learning across the health economy.

• Work in partnership with adult trusts and clinical commissioners, to improve the transition of children with complex needs from Alder Hey to adult services.

• Actively participate in the Patient Safety Collaborative through the Academic Health Science Network.

• Continue to be an active member of the 'Making it Safer Together' paediatric patient safety collaborative.

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

We will:

• Provide a root cause analysis training programme that incorporates knowledge of human factors, which are the environmental, organisational and job factors and individual characteristics that influence behaviour at work.

• Utilise the Clinical Quality Assurance Committee Walkabouts and the Quality Review Programme as an opportunity for staff to provide feedback on patient safety issues, the actions they have taken and celebrate the progress they have made.

• Provide post quality review posters for all areas allowing all staff to celebrate what is positive about their area, what they have identified as patient safety issues and what actions have been taken.

• Promote ‘Raise it, Change it’, to enable staff to make suggestions for improvement direct to the Chief Executive.

Safely Moving to Alder Hey in the Park (2015/16 Quality Priority)

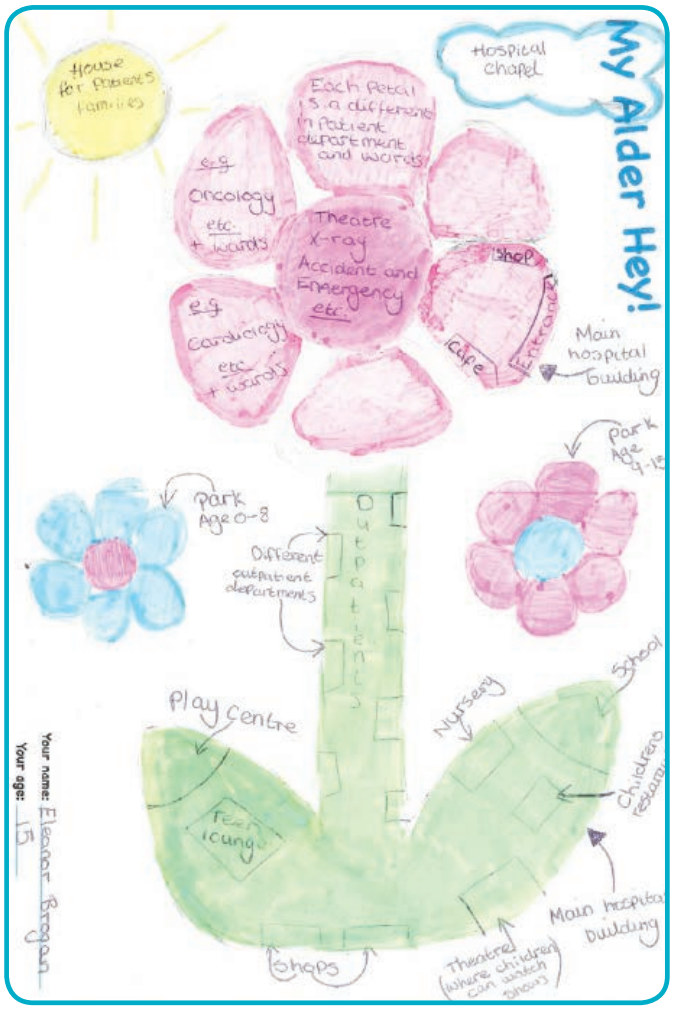
As one of Europe’s biggest and busiest children’s hospitals, Alder Hey treats around 275,000 patients each year. The new ‘Alder Hey in the Park’ features a uniquely designed hospital alongside a dedicated children’s research, education and innovation facility, creating a leading-edge centre for children’s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

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

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

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

Drawing by 15 year old patient Eleanor Brogan.



Ensuring the move was undertaken safely was a key quality priority for 2015/16. The move was undertaken from Friday 2nd to Tuesday 6th October 2015. On the Friday, 20 articulated removal lorries began transporting equipment on the first day of the move with 14 more continuing to transport supplies on each of the remaining days. About 1,500 devices were moved and almost 13,000 pieces of medical equipment. 120 patients were moved into the new Alder Hey in the Park over the weekend; 93 patients were safely transferred to the new hospital on the Saturday with another 26 transferred on the Sunday, including one on a heart and lung bypass machine (ECMO).

The move to the new building was meticulously planned to ensure a safe and smooth transition for Alder Hey patients and their families. Patients were moved across via a purpose-built corridor which had been carefully designed to transport patients from one site to another. They were transferred from the old site to the new by 22 transfer teams involving clinicians, porters and volunteers.

The first patient to receive treatment at the new Alder Hey in the Park was 13 year old Natasha Pleavin who received dialysis on Ward 4C.

Other patients making the move included Liam Denner (1) Helena Green (12) and William Ballyntyne (1). Liam's mum Zoe said: "The old hospital has been our home for the last 18 months so I feel a bit sad to leave it but the new hospital is amazing! It's more homely and doesn't look like a hospital. It's fantastic. The play decks are amazing. Liam can now go out and get some fresh air."

William's mum Becky said: "The new hospital is amazing. The ward is great and really colourful. It's definitely more family orientated. We have Jamie (William's 4 year old brother) to think about too and it's much easier to occupy him here."

Helena commented "wow it's really cool" while her mum Stacy added "It's gorgeous – I can't get the smile off my face!"

Alder Hey in the Park Atrium

A patient demonstrates how the hospital has been designed to be child friendly.

Alder Hey in the Park has play decks on the end of every ward.

Inside the Outpatients Department outdoor garden area. It contains astro-turf, teepee tents and large bean bags. The garden was built using money donated by the Steven Gerrard Foundation so that children have somewhere to relax and play before, after and in between appointments.

Lila Perry happy after the move with staff Helen Dunbavin and Megan Malone.

The move to the new Alder Hey in the Park was safely and successfully completed due to the tremendous efforts of the staff, who implemented the meticulous plans and with the fantastic co-operation and support of all the patients and their parents, their families and carers.

Alder Hey in the Park was fully operational on Wednesday October 7th 2015, exactly as planned.

Promoting a Safety Culture

Aim: To promote incident reporting and reduce incidents of harm.

Targets: From the 2014/15 baseline:
1. No 'Never Events'
2. Reduce incidents resulting in harm by 10%; this represents 758.
3. Reduce incidents resulting in moderate, severe harm or death by 10%; this represents 68.

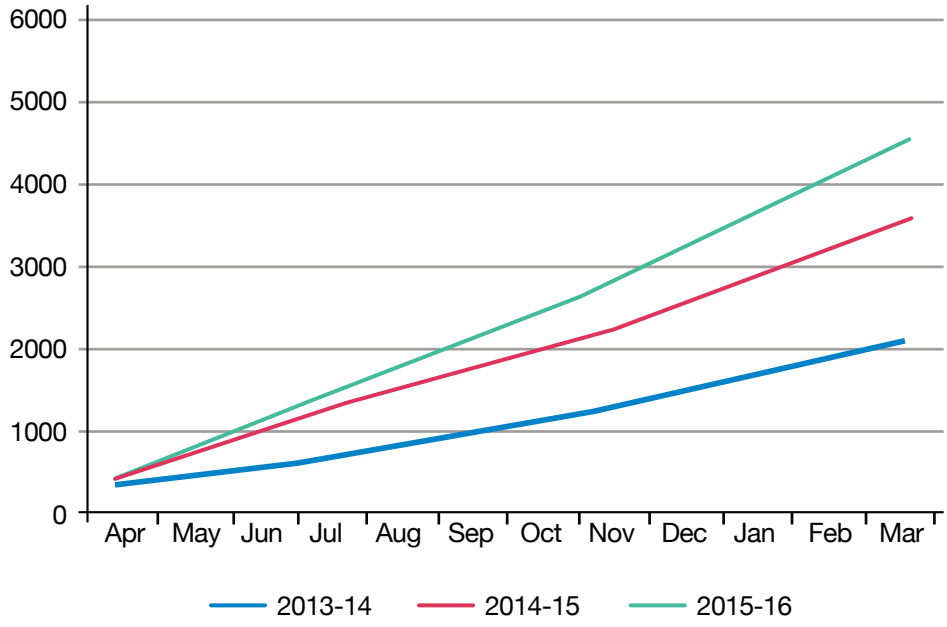
Outcomes:
1. Three 'Never Events'.
2. 20% reduction in all incidents of harm; this represents 667.
3. 55% reduction in moderate, severe or death incidents; this represents 25.

Safety is a fundamental aspect of high quality, responsive and accessible patient care. We aim to deliver higher standards of patient safety year on year, demonstrated through a culture of openness and where staff have a constant awareness of the potential for things to go wrong, are confident to report all incidents and near misses, learn lessons and continuously improve safety.

The National Patient Safety Agency established a National Reporting and Learning System (NRLS) before it was transferred to the NHS Commissioning Board Special Health Authority in June 2012. All organisations continue to upload their incident data into the NRLS and receive comparative reports on their culture of reporting. It is recognised that organisations that report more incidents usually have a better safety culture. In March 2012 Alder Hey was in the lowest 25% of reporters within the peer group of 20 comparable acute specialist trusts. By September 2014, the Trust was in the top 25% of reporters. The most recent report for the time period of April 2015 to September 2015 confirms that the Trust remains in the top 25% of reporters.

The Trust promotes all incident reporting, including near miss incidents. In 2015/16 The Trust had three 'Never Event' incidents reported, which have undergone comprehensive investigations and the development and implementation of improvement plans to prevent recurrence.

Clinical Incidents 2013-14 to 2015-16



In addition there has been a 56% increase in incident reporting since 2013/14. Whilst incident reporting has increased, the proportion of incidents of harm has decreased from 23% to 13%.

Increasing Children, Young People and Their Parents/ Carers Involvement in Patient Safety (2015/16 Quality Priority)

Aim:
To co-design safety improvements with children and their families to enhance communication and assist with a partnership approach to safe and effective care.

Children and young people are key stakeholders of the NHS and their interests must be at the centre of healthcare. Participation and involvement must take place on two levels: individual involvement, with people making their own healthcare choices and being confident in their interaction with health professionals; and group involvement, either as a service user or member of the public.

Health systems need to have governance and policies in place to ensure that children and young people can participate in a systematic and non-tokenistic way. This links in with the Government's aims to increase participation with the "No decisions about me without me" policy. It is important that children and young people understand why they are being consulted, what the process is, how their feedback will be used and, crucially, how their involvement will lead to change or help professionals. Children and young people need to be engaged early in the design of new health organisations and structures to ensure their views are included right from the start and regularly in the future.

Improvements

Safe
Together
Always
&
Right

- Work involving hand hygiene awareness has taken place in local primary and secondary schools, with children designing hand hygiene awareness posters.
- The Quality Team has engaged and sought ideas from children's and parents' forums.
- We have conducted a safety workshop with parents, children and young people.
- A key group of children, young people and parents have nominated themselves to participate in quality work.
- The Quality Team has engaged with local primary and secondary schools discussing patient safety work.
- We invited children from local primary and secondary schools into the Trust for a visit to meet and discuss patient safety and quality work within the Trust.
- We worked with local schools and patients on the wards to gain understanding of children and young people's expectations of information prior to an admission.
- Children and young people involved in the development of the STAR (Safe Together and Always Right) Ward Accreditation.

Future Plans

To maximise opportunities for children and young people's involvement in patient safety work and to continue to build strong relationships with the community to engage with patient safety work.

Medication Safety (2015/16 Quality Priority)

Aim: No drug errors resulting in avoidable harm.

Targets: From the 2014/15 baseline:
1. Reduce all medication errors that result in harm by 5% by March 2016; this represents 121.
2. Reduce medication errors that result in moderate, severe harm or death by 10% by March 2016; this represents 8.

Outcomes:
1. 35% reduction in all medication errors that result in harm; this represents 83.
2. 89% reduction in medication errors that result in moderate, severe harm or death; this represents 1.
3. 119% increase in medication incident reporting.
4. Decrease from 20% to 8% of incidents reported with harm.

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 three main reasons:

1. Medication errors can harm patients. The majority of the errors which have happened at Alder Hey have not caused harm to patients but a small number have caused harm or might have caused harm if they had not been discovered before reaching a patient.

2. Medication errors can increase the length of time a patient stays in hospital or increase the cost of their stay because more tests, investigations or treatments are needed.

3. Being involved in a medication error can be a very difficult experience for patients, their families and the staff involved.

Improvements

• The Trust appointed one Nurse and one Pharmacist as medication safety officers, each working 18.75 hours per week. Their roles focus on medication safety and support for staff involved in medication incidents.

• The Medication Safety Officer (Nurse) has presented safety work at a 'Sign Up to Safety' conference and is presenting at the Medication Errors Conference in London in June 2016.

• We supported staff during the implementation of an EPS (Electronic Prescribing System).

• We improved the data quality of incident reports by validating their accuracy prior to being uploaded into the National Reporting and Learning System.

• Implementation of the MERP (Medication Error Reporting Programme) has given more depth to the classification of medication incidents.

• We strengthened the process of medical prescribing incident management by sending a copy of any incident to the junior doctors' educational supervisor, which adds an additional level of review and support for junior medical staff.

• We improved the response time by line managers by offering to support them while investigating incidents.

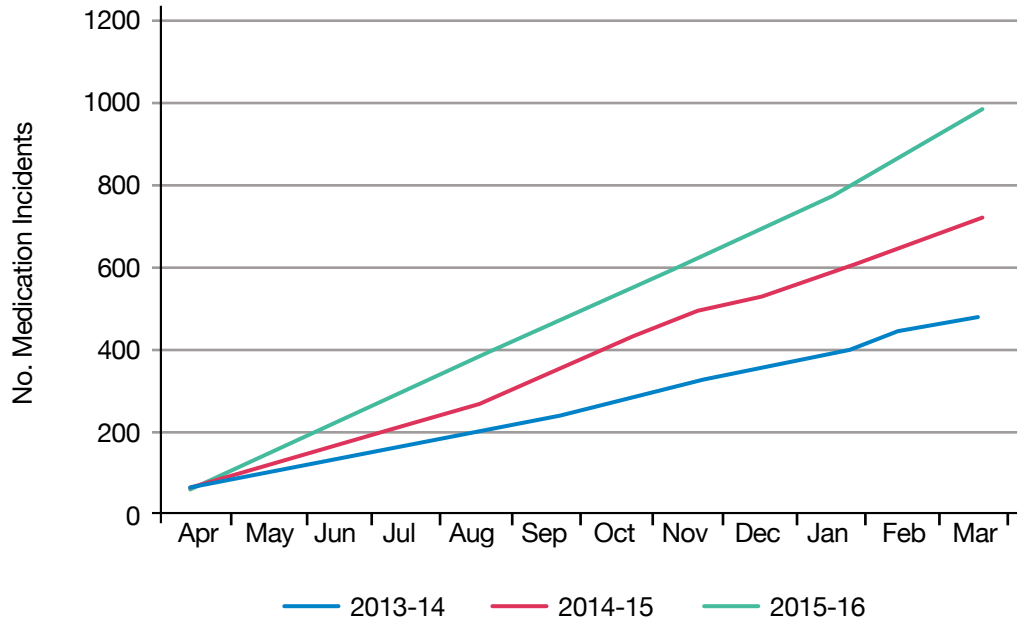
• We developed links with the Higher Education Institutes; this has allowed us to deliver medication safety training to student nurses who are placed within the hospital.

• We delivered training to staff that are starting their Intravenous Administration course.

• A new electronic root cause analysis tool was developed for all medication errors that result in harm, which includes identification of harm, contributory factors and financial implications.

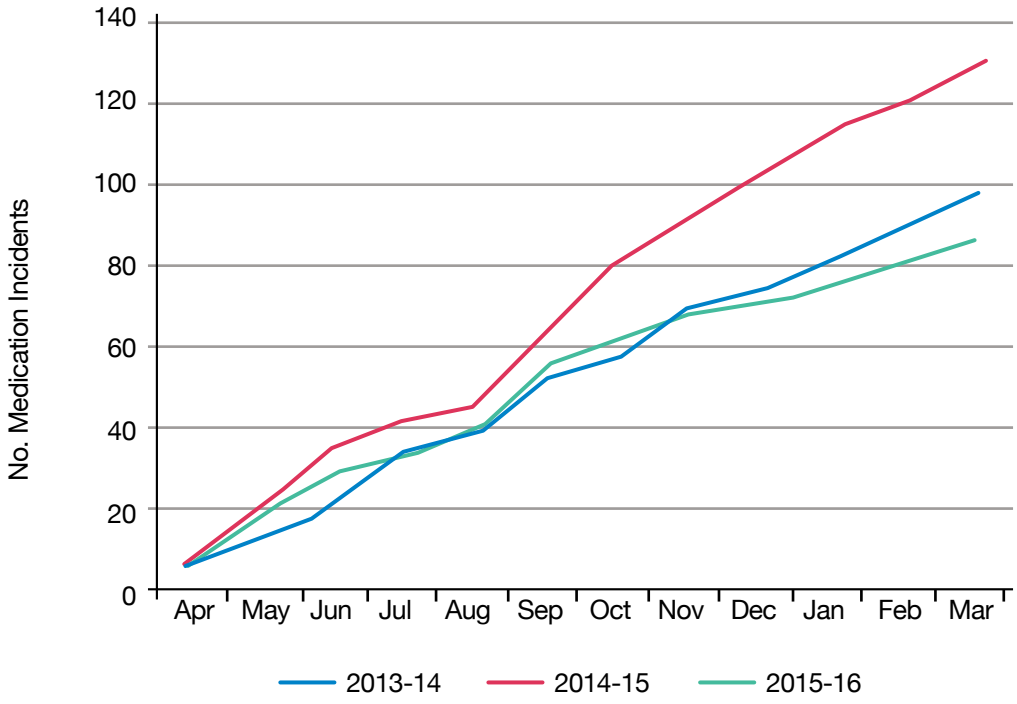
• We developed a 'What's App' group for junior doctors, to enhance learning by communicating with them about medication safety alerts or when we need to speak to them regarding an incident.

Total Medication Errors 2013-14 to 2015-16



Medication incident reporting has increased by 119% since 2013/14.

Medication Errors Resulting in Harm 2013-14, to 2015-16



In 2013/14 20% of medication incidents resulted in harm. In 2015/16 this has reduced to 8%.

Future Plans

- Further expand the 'What's App' group for junior doctors.
- Improve the formal process of involving medical staff in the incident by forging closer links with medical leads.
- Develop an app with the Innovation Team to allow patients to have a better understanding of their medications, driven by feedback from a children, young people and parents safety workshop.
- Make staff more aware of the Yellow Card scheme by holding an open day forum around Yellow Card reporting.
- Decrease the incidents that involve total parental nutrition (TPN) and Heparin.
- Develop more audits with attention to TPN, controlled drugs etc.
- Introduce a more up to date teaching package that includes online learning as well as annual mandatory training.
- Introduce SN@P as an educational tool to support staff with their numerical skills.
- Update the Ulysses system by reviewing and undertaking any improvements in the medication sections, which will enhance reporting and support learning.
- Introduce independent checking of medication.
- Embed the electronic RCA tool.

Pressure Ulcers (2015/16 Quality Priority)

Aim: No avoidable pressure ulcers.

Targets: From the 2014/15 baseline:
1. Reduce hospital acquired grade 2 pressure ulcers by 10%; this represents 20.
2. Reduce hospital acquired grade 3 pressure ulcers by 50%; this represents 1.
3. Zero hospital acquired grade 4 pressure ulcers.

Outcomes:
1. 5% increase in hospital acquired grade 2 pressure ulcers; this represents 1.
2. 67% reduction in hospital acquired grade 3 pressure ulcers; this represents 1.
3. 100% increase in hospital acquired grade 4 pressure ulcers; this represents 1.
4. Total number of pressure ulcers of all grades is 25, which is the same as 2014/15.

Pressure ulcers are often preventable and more likely to occur in patients who are seriously ill, have neurological conditions, impaired mobility, poor posture or impaired nutrition. They were once thought to occur only in the elderly population. However, there is increasing awareness that immobilised and acutely ill neonates and children are at risk of developing pressure ulcers, particularly in the critical care environment. Therefore the Intensive Care Unit (ICU) has been an area of focus of improvement work.

Improvements

• Comprehensive RCA level 2 investigations have been conducted for grade 3 and 4 pressure ulcers, with the development and implementation of improvement plans to prevent recurrence.

• We have revised the SSKIN (Surface, Keeping moving, Incontinence, Nutrition) care bundle for use in the ICU, to include explicit recording of a 'top to toe skin inspection'.

• ICU audit programme ensures compliance with the SSKIN care bundle documentation.

• ICU Braden Q assessment of risk of pressure ulcers score incorporated into the Badger IT nursing documentation.

• The Trust has an ICU training programme including:

- learning from all root cause analysis (RCA) investigations;

- discussing pressure ulcer prevention on the ICU mandatory training;

- monthly updates in pressure ulcer prevention provided by the Tissue Viability Specialist Nurse;

- reiterating the importance of micro movements during all practical manual handling training.

• Braden Q Risk Assessment and SSKIN bundle are now mandatory in Meditech 6 electronic nursing assessment documentation.

• The appointment of a full time Tissue Viability Lead Nurse at Band 8a means that the service now has two specialist nurses, one full time and one half-time.

• Training has been delivered to all new nursing staff on induction week with regard to pressure ulcer prevention and management.

• Health care assistants trained prior to commencing MSC nursing programme and becoming student nurses.

• The RCA template is being incorporated into the SNAP Audit System to enhance quality of reporting.

The chart below shows that compared to 2014/15, there were nine less pressure ulcers in ICU during 2015/16; this represents 30% reduction. There has also been a reduction in harm.

ICU Pressure Ulcers by Grade	Apr 13-Mar 14	Apr 14-Mar 15	Apr 15-Mar 16
Grade 1	20	18	11
Grade 2	9	12	9
Grade 3	0	0	1
Grade 4	1	0	0
Total	**29**	**30**	**21**

Future Plans

• Re-format Ulysses Reporting Form to improve data quality around incidence of pressure ulceration.

• Implement electronic learning package in relation to pressure ulcer prevention and management.

• Implement Standard Operating Procedure regarding reporting and investigation of hospital acquired grade 2, 3 and 4 pressure ulcers.

• Re-format and implement pressure ulcer root cause analysis tool to assist in early identification of avoidable and non-avoidable ulceration.

• Share lessons learned organisationally around the topic of pressure ulcers.

• Revitalise the Tissue Viability Link Nurse role.

Nurse Staffing

Aims:

• To have no nursing vacancies.

• To establish a nurse pool to cover maternity leave and long term sick cover and fill ward/department vacancies.

• To have a proactive recruitment campaign.

Changes or deficiencies in the nursing workforce can have a detrimental impact on the quality of care. Patient outcomes and particularly safety are improved when organisations have the Right People, with the Right Skills, in the Right Place at the Right Time (RPRSRPRT). This has been highlighted as lessons learnt from inquiries such as the Mid Staffordshire NHS Foundation Trust Public Inquiry.

In November 2013, the NHS Quality Board published the new guide to nursing, midwifery and care staffing capacity and capability (RPRSRPRT) setting out its position for greater transparency in the way in which trusts set and deliver nursing, midwifery and care staffing levels. All trusts are mandated to provide nurse staffing information on a monthly return via the National Reporting and Learning System. This data is published at ward level and made available to the public.

Acting on the lessons learned from various reports, strategies and enquiries, the Trust has comprehensively reviewed all wards/departments' nurse staffing establishments and significantly invested in additional nurses. As all trusts have undertaken this process, the impact has led to a national challenge in relation to recruitment. We have risen to this challenge, resulting in the improvements below.

Improvements

• A ward/department staffing review was undertaken in 2014/15 and repeated in 2015/16 prior to the move into the new hospital.

• The Trust has engaged with Higher Education Institutions, to showcase Alder Hey and attract students as future employees.

• Recruitment events have taken place. The most recent in March 2016 resulted in the recruitment of 39 staff who will take up post in 2016/17.

• Within the European Union, only Ireland and Italy train nursing staff specifically in paediatrics; as Ireland had a nursing deficit we focused on international recruitment in Italy. The recruitment was successful with:
  - 12 nurses recruited and commenced in post in 2015/16;
  - 5 nurses recruited in 2015/16 and will take up post in 2016/17.

• We developed a joint Paediatric Nurse and Social Worker role. There are four staff undertaking a post graduate social work year in supported learning. They have successfully reduced the number of patients with complex discharge needs, who were fit for discharge and have had an extended length of stay over 30 days.

The improvement outcomes are shown in the table below.

Recruitment and Retention Improvement Outcomes

	March 2014	March 2015	March 2016	Comments
Patients Fit for Discharge With an Extended Length of Stay Over 30 Days	N/A	45	28	38% reduction from March 2015.
Trust-wide Nursing Vacancies	61.04	19.74	12.34	80% reduction from March 2014.
Whole Time Equivalent (WTE) Registered Nurse Posts	1007.17	1036.04	1080.00	7% increase since March 2014; this is an increase of 72.83 WTE's.
The Percentage of Nursing Budget Spent on Bank and Agency Within the Wards and Critical Care	6%	13%	8%	The 2014/15 staffing review increased the numbers of registered nurses required.
The Percentage of Nursing Budget Spent on Bank and Agency Within Theatres	0.77%	1.15%	1.50%	Agency and bank staff are required while new staff are being trained.

Future Plans

• Continue proactive recruitment of student nurses.

• Continue monitoring vacancies, turnover rates and daily staffing levels.

• Review Recruitment and Retention Plan for 2016/17.

Infection Prevention and Control

Aim: No hospital acquired infection.

Targets: From the 2014/15 baseline:
1. No hospital acquired MRSA bacteraemia.
2. No Clostridium Difficile infections due to lapses in care.
3. Reduce the number of outbreak organisms and hospital acquired organisms by 10% from the 2014/15 baseline of 157; this represents 141.

Outcomes:
1. Three MRSA bacteraemia.
2. Two Clostridium infections (not due to lapses in care).
3. 27% decrease in the number of outbreak. organisms and hospital acquired organisms: this represents 114.

Effective infection prevention and control practice (IP&C) is essential to ensure that patients receive safe and effective care. In order to provide the best possible outcome for the children in our care, it is vitally important that we identify and manage all infections that affect our children and young people to reduce the risk of healthcare acquired infection.

Children and young people can present unique IP&C challenges, such as:

- They are susceptible to infections which are preventable in older patients due to previous exposure or vaccination.
- They have closer contact with other visitors such as parents and siblings.
- Their poor hygiene practices present more opportunities for infection to spread.
- They may also interact more closely with their environment, making them more likely to come into contact with contaminated surfaces and items.
- Communicable diseases affect a higher percentage of paediatric patients than adults, increasing the likelihood of cross infection.

Improvements

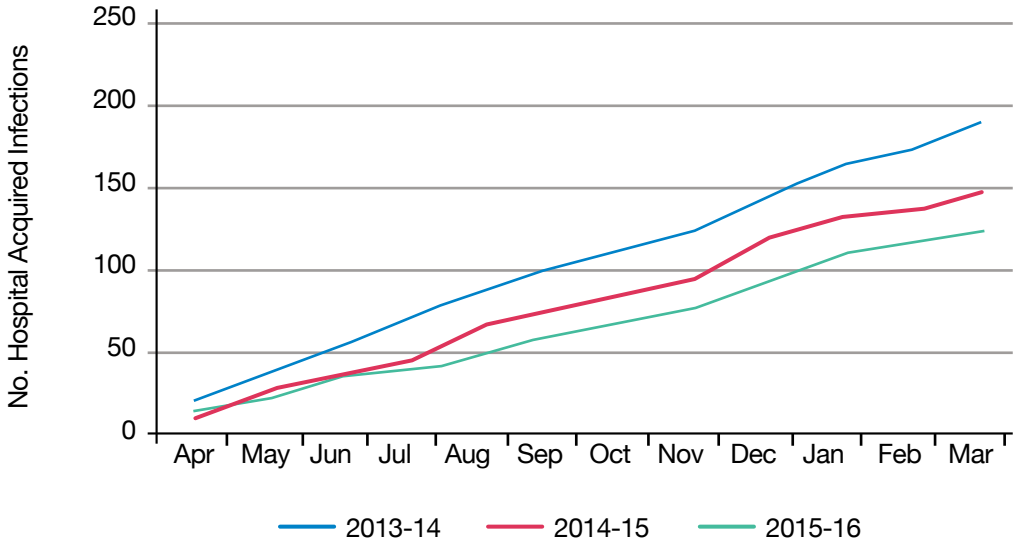
There have been post infection review investigations conducted following the incidence of MRSA bacteraemia and Clostridium Difficile infections, resulting in the development and implementation of improvement plans and which established that the Clostridium Difficile infections were not due to lapses in care.

There has also been a focus on reducing the risks of any increase in hospital acquired infections as a result of moving into the new hospital and a drive to further strengthen medical engagement in the IP&C agenda, for example:

- Collaborative work with medical team leaders and ward managers has produced ward specific infection control policies, including formulation of specific key performance indicators.
- The IP&C Team attend critical care safety huddles to provide pre-emptive infection control advice.
- An external IP&C service review has been undertaken to identify any service gaps since moving to the new hospital.
- The Director of IP&C attends Clinical Business Unit Risk and Governance Boards to strengthen focus on IP&C issues.
- The establishment of infection control/antimicrobial ward rounds with the Director of IP&C and medical teams provides immediate feedback to clinicians on their compliance with infection control practices and antibiotic prescribing.
- A review of the Infection Control Committee has resulted in an increase in medical representation and a discussion forum that strengthens staff engagement.
- We have delivered a Trust-wide hospital acquired infection prevalence survey.
- Collaborative work with the finance and information teams looks at the financial implications of hospital acquired infection.
- We have introduced isolation cards that fit behind staff identification badges to assist clinical teams in appropriately isolating patients.
- A hand hygiene audit tool has been developed to engage families in infection prevention.

The graph overleaf shows that the improvements have resulted in a 38% reduction in hospital acquired infections compared to 2013/14.

Total Infections 2013-14 to 2015-16



Future Plans

• To implement the IPC Delivery Plan, this incorporates the 'Sign Up to Safety' IPC plan and key quality improvement work.

• To maximise opportunities for children and young people's involvement and empowerment in prevention and control of infection.

Respiratory Syncytial Virus (RSV)

Aims:

• Review and trial of laboratory systems that enable quick turnaround times for the detection of respiratory viruses.

• Introduce the system (Film Array) within high risk areas including critical care (ICU/HDU) and Oncology all year round.

• Use of the system (Film Array) during the respiratory virus season (November - March) Trust-wide, in order to increase the turnaround time for the detection of respiratory viruses.

• Provide information to the IP&C Team and patient flow, facilitating the cohorting of patients with the same respiratory virus together, thus improving patient flow and availability of cubicles for patients.

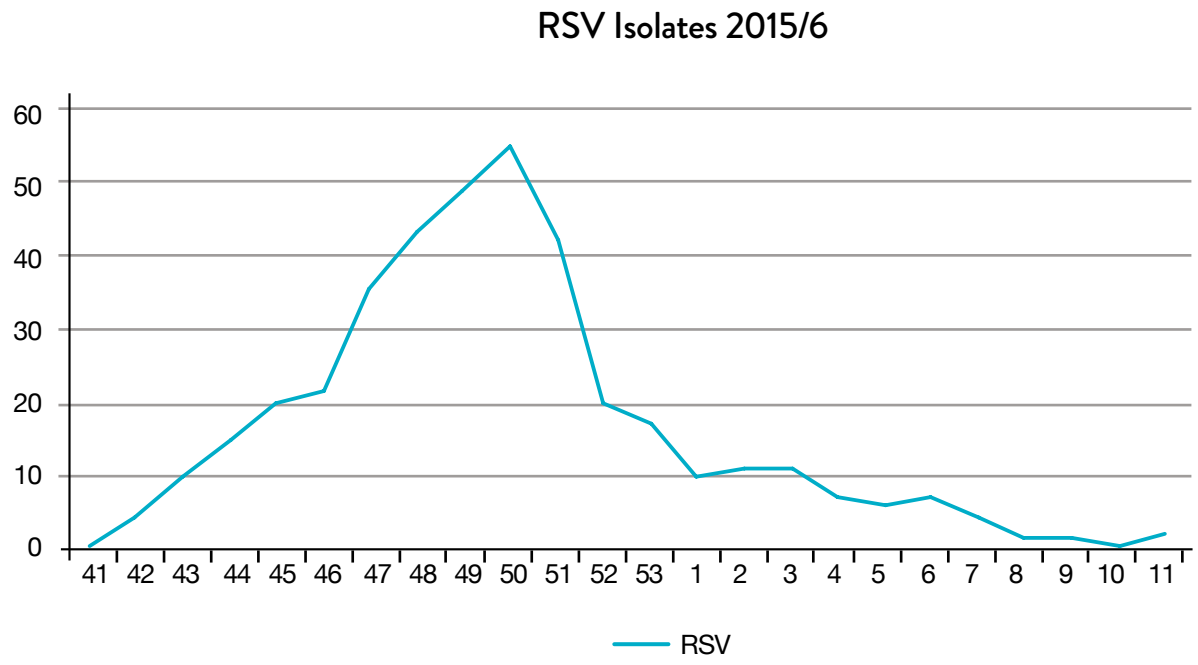
• Quicker isolation of infectious patients.

• Reduce the incidence of hospital acquired respiratory viruses, including outbreaks.

• Rapid diagnosis of Influenza can allow treatment to be given at the time of presentation. The Trust Influenza pathway states that in "at risk" children, Oseltamivir must be given within 48 hours of the onset of symptoms to be effective.

Respiratory Syncytial Virus (RSV) is the most common cause of respiratory illness (Bronchiolitis) in children, particularly those less than two years of age. The virus is seasonal and normally occurs for a six week period during the winter months between November and February. RSV is the most common cause of hospital admissions. This is due to acute respiratory illness in young children and the high numbers of babies requiring admission to the Trust during the winter months, placing huge pressures on the Trust.

Respiratory Viruses Season



The Trust Infection Prevention Policy requires that any child admitted with acute respiratory illness, including Bronchiolitis/Pneumonia/Empyema or with any unexplained febrile illness should be placed in a single room. When a single room is not available, the patient should be placed in a room with patients who have the same infection (cohorting).

At Alder Hey, rapid testing was available only for RSV with the results being available within four hours. As patients may have co-infection with other respiratory viruses they cannot be nursed together in a cohort area, unless it has been established that they only have RSV infection. Therefore respiratory samples had to be sent to the Royal Liverpool University Hospital for PCR (Polymerase Chain Reaction) testing. The turnaround for these tests over the winter was a minimum of 36 hours during the week.

The average duration of stay for patients with Bronchiolitis on the Medical Admissions Unit in previous RSV seasons had been less than three days, so patients respiratory PCR results were frequently unavailable until the child was nearing or already discharged from the Trust. As patients couldn't be cohorted together until these results were available, they required isolation in a cubicle for the duration of their stay. The overall aim was to increase the turnaround time for the detection of respiratory viruses.

Improvements

The Film Array was trialed and introduced in the Intensive Care Unit (ICU) in autumn 2013.

The provision of a second machine has allowed patients admitted with respiratory illness to have respiratory viruses detected within two hours, often while still in the Emergency Department (ED). This resulted in patients with only RSV being admitted directly into cohort bays, freeing up cubicles for patients with other infections requiring isolation.

During the peak RSV season in 2013/14 there were three cohort areas for RSV patients (winter ward six bedded bay, ward E2 four bed bay and ward M3 four bed bay).

This had a positive effect on patient flow and patient experience as families did not have to make as many ward moves.

This improvement in rapid diagnosis and appropriate patient isolation has been maintained during the RSV season 2014/15 and 2015/16.

Incidence of Hospital Acquired RSV and Influenza November 2012 - March 2013 and November 2013 - March 2014

Month	Number of HA- RSV	Number of HA-Influenza	Month	Number of HA-RSV	Number of HA- Influenza
Nov 2012	7	0	Nov 2013	1	0
Dec 2012	0	0	Dec 2013	6	0
Jan 2013	2	0	Jan 2014	1	0
Feb 2013	1	2	Feb 2014	1	0
Mar 2013	2	0	Mar 2014	1	0

Incidence of Hospital Acquired RSV and Influenza November 2014- March 2015 and November 2015 – March 2016

Month	Number of HA- RSV	Number of HA-Influenza	Month	Number of HA-RSV	Number of HA- Influenza
Nov 2014	1	0	Nov 2015	1	0
Dec 2014	9	2	Dec 2015	5	0
Jan 2015	0	3	Jan 2016	4	2
Feb 2015	0	0	Feb 2016	1	0
Mar 2015	0	1	Mar 2016	0	2

The number of HAI respiratory infections with RSV and Influenza has remained static between 2014 and 2016. The source of HA respiratory infection within paediatrics can be the parents or siblings of the hospitalised child and not as a consequence of poor infection prevention and control practices by health care workers.

The rapid identification of the causative agent with the Film Array has reduced the incidence of respiratory virus outbreaks and the prompt appropriate treatment of children with antivirals. This has included prophylactic treatment i.e. Oncology patients exposed to Influenza as well as patients diagnosed with Influenza A. This has been particularly marked during 2015/16 due to the increase in numbers and duration of the winter season for Influenza A.

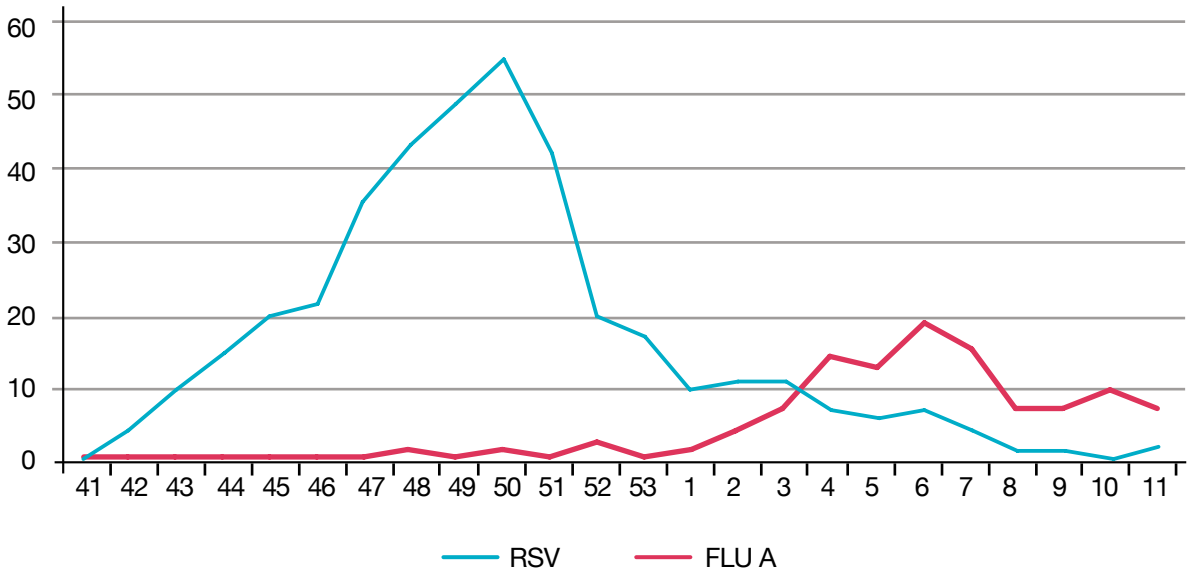
Respiratory Virus Outbreaks 2012-13 November – March	Respiratory Virus Outbreaks 2013-14 November-March
1. hMPV - HDU: Three patients (Two patients required prolonged PICU admission) 2. RSV - NMW: Five patients (One patient required HDU admission)	Nil

Respiratory virus outbreaks 2014-15 November – March	Respiratory Virus Outbreaks 2015-6 November-March
1. RSV - Neo: Three patients. Unit closed to admission	Nil

Future Plans

A review of 'lessons learnt' from recent winter season 2015/16, involving a multidisciplinary approach. The move into the new hospital has increased the number of cubicles available for isolation of patients and reduced the requirement for cohorting patients during the 2015/16 season.

RSV and Influenza Isolates at Alder Hey 2015/16



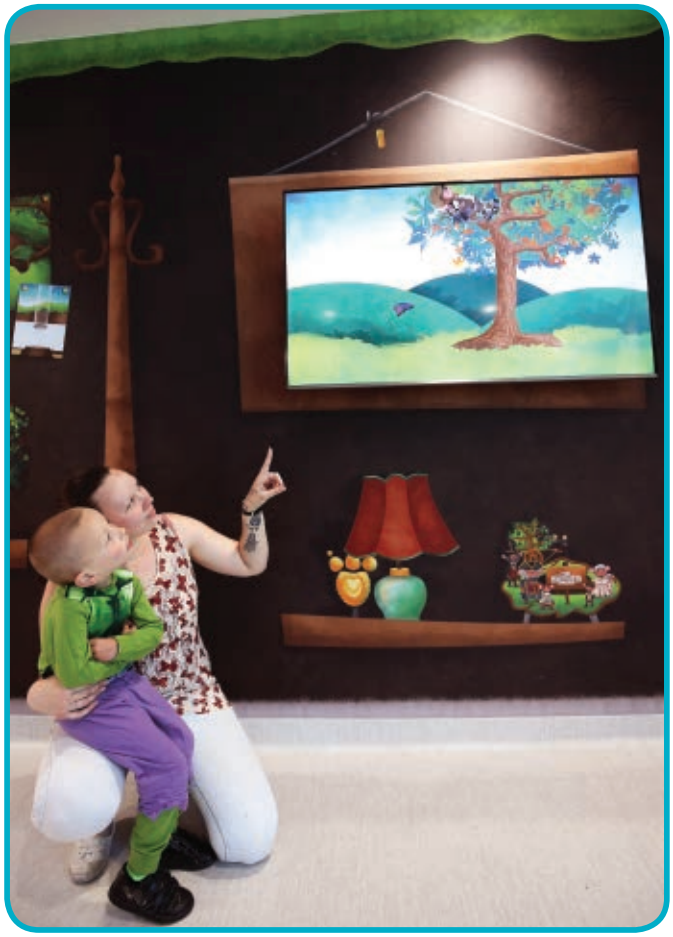
In the 2015/16 season, the number of Influenza cases has risen dramatically (see graph above). Identification of the best type of respiratory testing platform (e.g. RSV and Influenza alone for lower risk areas reserving Film Array for high risk locations) will be explored to ensure efficient use of resources.

Peri-Operative Care

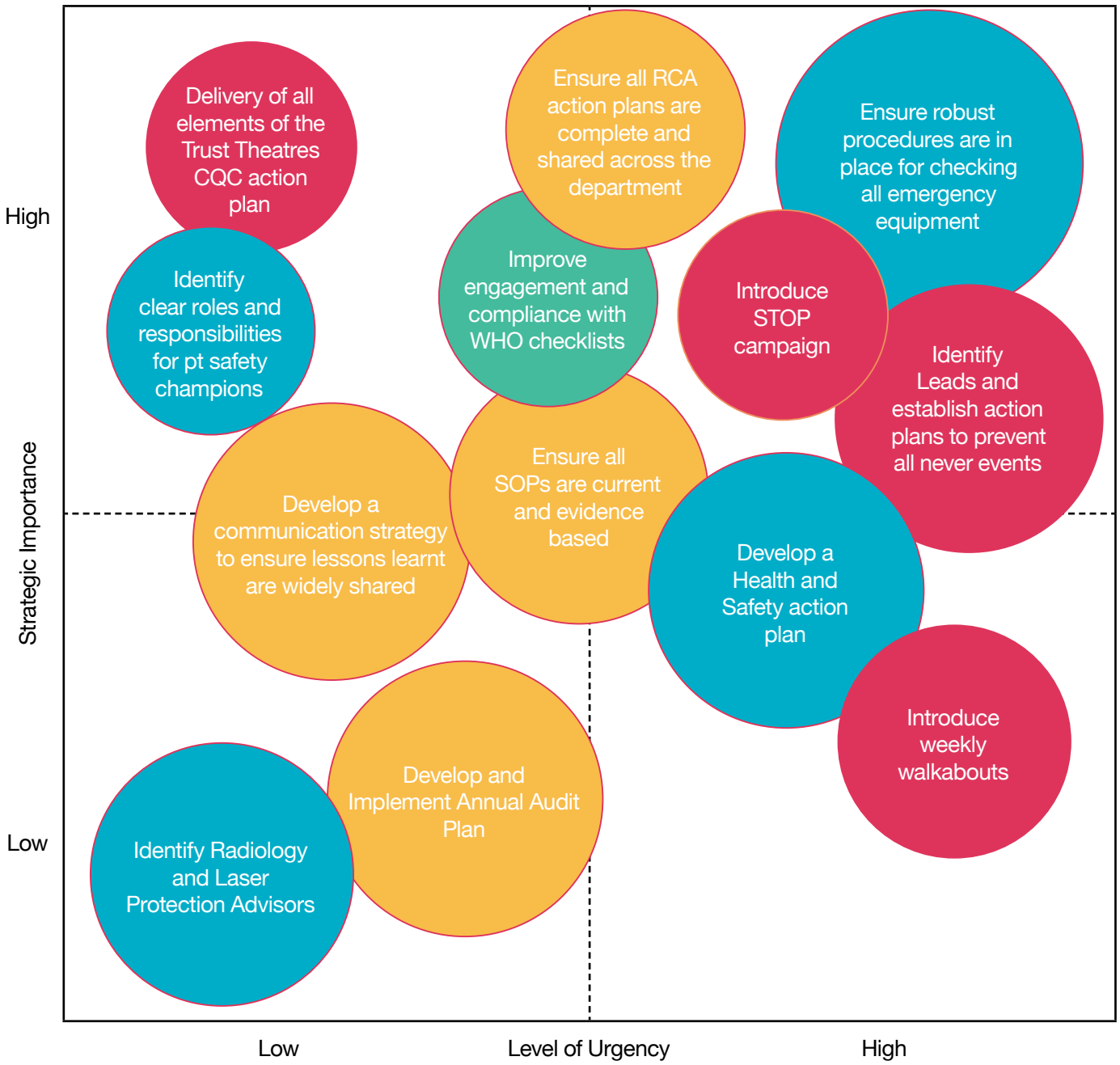
In August 2015, the Theatre Manager commissioned an independent audit designed by the Association for Peri-Operative Practitioners to examine the quality management systems in theatre. The purpose of the audit tool is to provide accreditation that assists users in identifying a peri-operative environment that has high quality processes and practices. The audit tool aims to identify and shape implementation of effective risk strategies for all those involved in the care of the patient.

This extremely comprehensive tool provided a framework for the department to examine service performance and identify potential improvements in delivery of services using a peer review process. This is approached by following patients through the peri-operative journey. The audit tool has the potential to improve patient care. It is not designed to accredit an individual's capability, but does assess the whole peri-operative process and is evidence that processes and procedures have met a defined set of criteria to assist in the delivery of safe and effective healthcare.

The utilisation of this tool built on the work of the Theatre Safety Board, newly appointed Theatre Risk and Governance Lead, theatre safety champions and underpins the Theatre Risk and Governance Plan.



Theatre Governance & Risk Plan Oct 2015



Responsibility:

- Governance and Risk Lead
- Theatre Manager
- Clinical Leads
- Quality Improvement Lead
- Health and Safety Lead

Moving Forward in Our Key Areas

1. Review and relaunch WHO 5 steps to safer surgery.
2. Transfer ownership of weekly governance and risk meetings to speciality teams.
3. Comply with the National Safety Standards for Invasive Procedures (NatSSIPs).
4. Establish focus groups to prevent all surgical and anaesthetic Never Events.
5. Develop and implement a theatre specific infection control policy.
6. Develop governance and risk strategic plan.
7. Improve MDT attendance at weekly meeting of harm.
8. Implement actions from internal AFPP audit.
9. Improve compliance with all medicines regulations.

Improvements

• A dedicated risk and governance coordinator for the theatre department has been introduced to improve the way incidents are managed.

• A dedicated theatre risk register has been developed in addition to the existing Clinical Business Unit.

• Development of governance and risk plan on a page.

• WHO '5 Steps to Safe Surgery' has been reviewed at project mid-point.

• Weekly governance and risk meetings are now led by speciality teams.

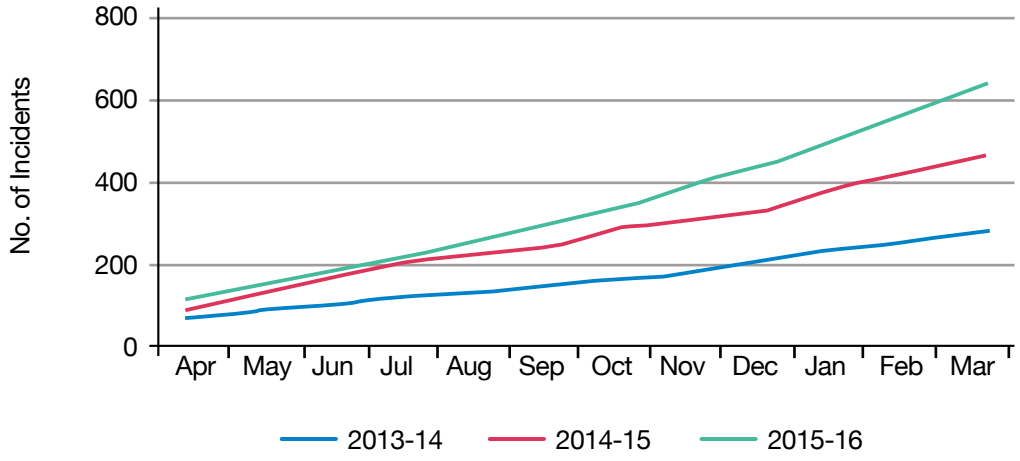
• National Safety Standards for Invasive Procedures project has commenced, with expected completion September 2016.

• A resident 24 hour, seven day Operating Department Practitioner has been introduced to respond to all emergency calls and ensure all critical emergency equipment is checked daily.

• Funding has been secured for a Theatre Matron post to lead the Safety and Quality Strategy for theatres.

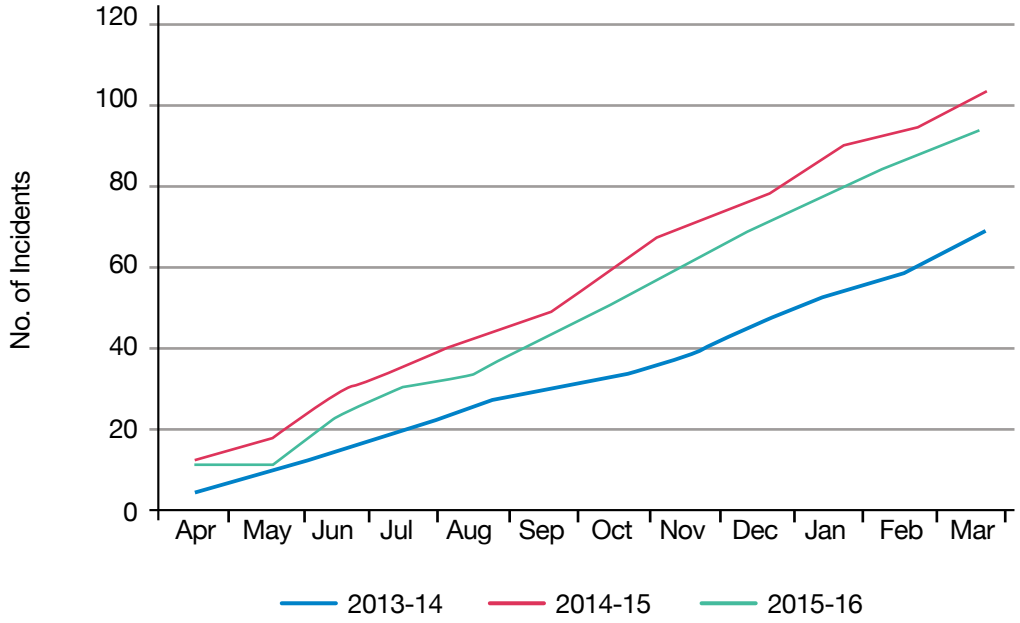
The graphs below show that while there has been an increase in the number of incidents reported, there has been a reduction in the number of incidents of harm. However, the three 'Never Event' incidents reported were surgical 'Never Events' which have undergone comprehensive investigations. The development and implementation of improvement plans have informed the 'Best in Operative Care' project.

Theatres: Incidents Reported



Since 2013/14 there has been a 159% increase in incident reporting.

Theatres: Incidents Resulting in Harm



Since 2013/14 there has been a 29% decrease in the number of incidents of harm.

Best in Operative Care

Aims:
The 'Best in Operative Care' strategy aims to deliver the best paediatric operative care in the world, as measured by low rates of mortality and harm and high staff satisfaction.
1. Increase the safety and reliability of care.
2. Improve team performance and staff wellbeing.
3. Add value and improve efficiency.

Targets: Specified in the performance score card.

The 'Best in Operative Care' project, which commenced in March 2016, helps theatre teams to work more effectively together to improve the quality of patient experience, the safety and outcomes of surgical services, the effective use of theatre time and staff experience. This focus on quality and safety helps theatres run more productively and efficiently, which subsequently can lead to significant financial savings.

Best in Operative Care Performance Score Card

Safety	• No surgical 'Never Events'. • 25% reduction in patient harm. • 25% reduction in rate of surgical site infection. • 5% reduction in unplanned readmission to critical care. • 95% staff recommend for treatment.
Excellence	• We will increase the number of children we provide operative care to, treating 8,230 children in our Surgical Daycase Unit. • 90% theatre utilisation. • 50% reduction in short-notice cancellation of patients. • 50% reduction in short-notice cancellation of theatre lists. • 95% patients and families recommend for treatment. • 5% reduction in conversion rate from day case to inpatient.
Wellbeing	• 95% theatre staff recommend Alder Hey as a place to work. • Less than 5% of theatre sessions overrun by more than 15 minutes.

Improvements

The improvement plan focuses on the following:

• Safe and effective peri-operative management that reflects best practice:
- Staff will be enabled to safely perform their role within the peri-operative environment.
- The Productive Operating Theatre methodology is utilised.
- Communication between peri-operative teams and the wider Trust is effective.
- An effective peri-operative monitoring programme is in place.

• A culture of safety is evident throughout the peri-operative environment:
- Peri-operative incident reporting is improved.
- Peri-operative incidents are appropriately and timely investigated.
- Dissemination to Trust-wide staff of lessons learnt from peri-operative investigations is improved.
- Lessons learnt drive safety improvements.

• Patients and families/carers are actively involved in their own peri-operative management:
- Patients, families/carers are involved in decisions about their peri-operative management.
- Patients, families/carers have access to information about their peri-operative care.
- Patients, families/carers are actively engaged and enabled to participate in ensuring safe peri-operative management.

Every operative procedure is recorded with a focus on the following measures:

• Harm
• Surgical Site Infection
• Unplanned admissions to critical care
• Staff recommend Alder Hey as a place for treatment
• Increase in number of patients treated in the Surgical Daycase Unit
• In theatre utilisation
• Decrease in patient operations cancelled at short-notice

- Decrease in theatre lists cancelled with less than six weeks' notice
- Patient satisfaction
- Conversion rate from daycase to inpatient stay
- Temperature check of staff satisfaction
- Theatre session overruns

Future Plans

Data will continue to be collected and analysed in the coming year as per departmental and Trust requirements. The reporting mechanism will be the 'Best in Operative' Care Steering Group who will continue to report progress to the Clinical Quality Assurance Committee.

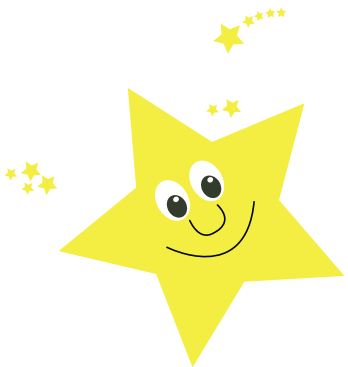
Ward Accreditation

Aims:

- To develop a ward accreditation scheme in partnership with children, young people, their families and carers that will provide assurance of the quality and safety of care in our wards and departments.

Targets:

- To develop a Ward Quality and Safety Assessment Tool (QASAT).
- To utilise Observational Audit incorporating Human Factors to assess ward activity, checking and discussing nursing standards of practice and asking patients and their parents or carers about their experiences.
- To ensure the 5 STAR award is aligned to the CQC Assessment Standards.



Safe
Together
Always
&
Right

Ward accreditation schemes have been shown to promote safer patient care by motivating staff and sharing best practice between ward areas (Coward et al. 2009; Central Manchester University Hospitals NHS Foundation Trust 2013). To date they have been implemented predominately in adult services.
To achieve the recognised benefits for children and young people in Alder Hey, we have committed to the development and implementation of a paediatric ward accreditation scheme in partnership with children, young people and their parents/carers.

Improvements

- Consultation on QASAT contents took place, with ward managers, lead nurses and patient safety champions.
- Ward QASAT was developed, which strengthens Trust Board assurance and aligns with the Care Quality Commission key lines of enquiry, post Francis enquiry and Essence of Care benchmarks.
- QASAT piloted on four wards.
- Children and young people proposed the title of ward accreditation scheme should be STAR, as in reaching for the stars.
- STAR agreed as Safe, Together and Always Right.
- The STAR scheme was agreed as a continuous journey to achieve and sustain STAR accreditation.
- The STAR accreditation panel includes patients and parents/carers.

STAR Ward Accreditation Scheme

	CQC Assessment Standard	STAR Quality and Safety Assessment Tool Elements
★	Safe	Patient Safety Pressure Ulcer Medication Safety
★	Effective	Pain Deteriorating Patient Infection Prevention and Control
★	Caring	Fluid Balance and Nutrition Care Planning
★	Responsive	Patient Experience Environment
★	Well Led	Corporate Targets

Future Plans

• Develop department specific and speciality specific QASAT.

• Complete QASAT for all wards.

• Assess effectiveness of supportive interventions for wards who do not achieve any of the desired standards within the STAR accreditation scheme.

Improving the Transition From Children and Young People Services to Adult Services

Aims:

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

The transition from childhood to adulthood involves a period of significant change. During puberty, young people move from childhood into physical maturity. Sudden and rapid physical changes can make adolescents very self-conscious, sensitive and worried about their own body. Young people begin to separate from their parents, with increased emphasis on friendships and establishing their own identity. In mid-to-late adolescence, young people often feel the need to establish their sexual identity through romantic friendships and experimenting. Adolescents become stronger and more independent before they have developed good decision-making skills, with an increase in risk-taking behaviours.

Young people with long term health conditions face significant additional challenges as they move from childhood to adulthood.

The changes of adolescence may result in increasing instability of the young person's condition, because of the effect of the physiological changes of puberty and because of the associated psychological and emotional changes. These challenges are also associated with the need to move from paediatric to adult health services. The manner in which this care is transferred to the adult healthcare system is essential to the continuing wellbeing of the young person and their willingness to continue and comply with health support and treatment. Additional challenges are faced when adult services are very different in their approach to the equivalent children's service or where there is no equivalent service in the adult sector. There is increasing evidence that planned, co-ordinated and supported transition can significantly improve outcomes for young people.

Improvements

• We continued to work with the Information Technology Team towards identifying a sensitive, reliable and reproducible method for identifying the cohort of young people of transition age with complex neuro-disability.

• We continued to work with the Information Technology Team towards identifying a sensitive, reliable and reproducible method for identifying any patients of transitional age.

• We continued to work with the Information Technology Team towards identifying basic demographic and diagnostic data on the above cohorts and all patients with a long term condition through application of the above process.

• We repeated baseline assessment to identify classification of transition status of all young people of transition age who have accessed Alder Hey in the last two years.

• We assisted the development of a model for a multi-specialty, multi-disciplinary service in the adult sector for young people with complex neuro-disability, including continued commissioning support to progress with a business case and setting up the service.

• Ratification of core documents took place to support safe, effective transition including a visual representation of the transition pathway, what good looks like and an overarching Trust Transition Policy.

• We increased awareness of the challenges of transition to adult services across the Trust.

• Measures of specialty services where transition is being developed and implemented within the Trust.

• We identified an Executive Lead for transition.

• Engagement took place via:
  - Children, young people and parent focus groups
  - Over 200 clinical staff in the Trust through the Transition Survey
  - Over 100 clinical and managerial staff through transition roadshows
  - 62 clinical staff through a transition away day
  - 24 transition champions across the Trust
  - A number of Trust 'Transforming Transitions' newsletters
  - A series of Trust Transition Steering Group meetings. Dates are also planned for 2016-17

• Further patient and parent participation via meetings and forums.

• Engagement in the Trust parent and patient forum.

• Presentation at the Clinical Quality Assurance Committee.

• Baseline assessment (to be repeated annually).

• We presented the Trust transition work nationally.

• We assisted NICE with development of transition guidance/standards.

• We assisted NHS specialist commissioners with transition CQUIN.

• We assisted NHS England with transition service specification.

• The Trust was recognised nationally as a transition lead.

• Our Transition Team has presented their work at a number of national events.

• Our Transition Team worked collaboratively and hosted the AQuA National redesign of the paediatric 'Ask Three Questions' event held in Alder Hey.

• Our Transition Team presented their APP proposal to the Hackathon in 2016.

• We developed a film outlining the difficulties experienced by a parent of a young person with multiple complex long term conditions relating to carers, carer skills, finances and transition.

• We developed a 'complex patient' transition preparation tool (out to consultation).

• Presentation of Alder Hey Transition work at the Royal College of Paediatric Physicians 2015.

• National engagement from other trusts interested in Alder Hey transition developments.

• Alder Hey clinical lead was nominated for a national 'Clinical Lead' of the year award.

• The Transition Ten Step Pathway Poster Presentation was successful at National Conference 2015.

• We worked with our children's forum to develop 'Transition - Our Promise to You'.

• The transition draft policy was assessed against and meets equality and diversity standards.

• We continue to develop our Trust Transition map.

• Colleagues from Singapore Hospital Transition Team visited the Trust; Alder Hey transition toolkit was shared. It was also shared with colleagues in Australia.

• We have had visitors from Trusts across the country interested in our 10 step pathway and all Alder Hey transition work.

Future Plans

• Repeat baseline assessment as above.

• Consult on, finalise, ratify and embed the Trust Transition Policy across the Liverpool sector, including adults and children's providers in primary, secondary and tertiary care, young people and families.

• Further work to develop and define the role of the GP.

• Further work to identify the lead Consultant and keyworkers will be within specialties.

• Recruit to Keyworker and Lead Consultant in transition and care of patients with complex long term conditions.

• Develop and invest in the transition champions.

• Develop and invest in transition leads within CBUs and clinical teams.

• Identify markers of complexity and set up relevant data fields within Meditech 6 (patient care information system) to capture and an audit process to ensure these fields are reliably and consistently completed.

• Implement the Transition Policy within the Trust, including active monitoring of critical incidents.

• Continue to develop and monitor the Trust transition map and the Trust special transition "register" of young people where transition to the adult sector is delayed, either for appropriate clinical reasons, because of a lack of appropriate services in the adult sector, or because previously agreed commissioning arrangements mean patients remain within the Trust past their 18th birthday.

• Continue to work with Aintree to develop their business case44 and set up the multispecialty, multidisciplinary service for young people with complex neurodisability.

• Continue to work with the adult sector to develop links and pathways where there currently are no confirmed pathways or the pathways are fragmented.

• Continue to share the Trust's nationally recognised transition toolkit.

• Deliver universal and core transition training.

• Finalise the design and deliver specialist transition training for professionals within the Trust and in adult services, including experiential learning techniques such as simulation and video materials.

• Further participation and engagement work with young people and their parents/carers to inform the above, including carer skills training.

• The Trust will embed the Generic Trust Transition Pathway supported by a draft Trust Transition Policy and supporting materials.

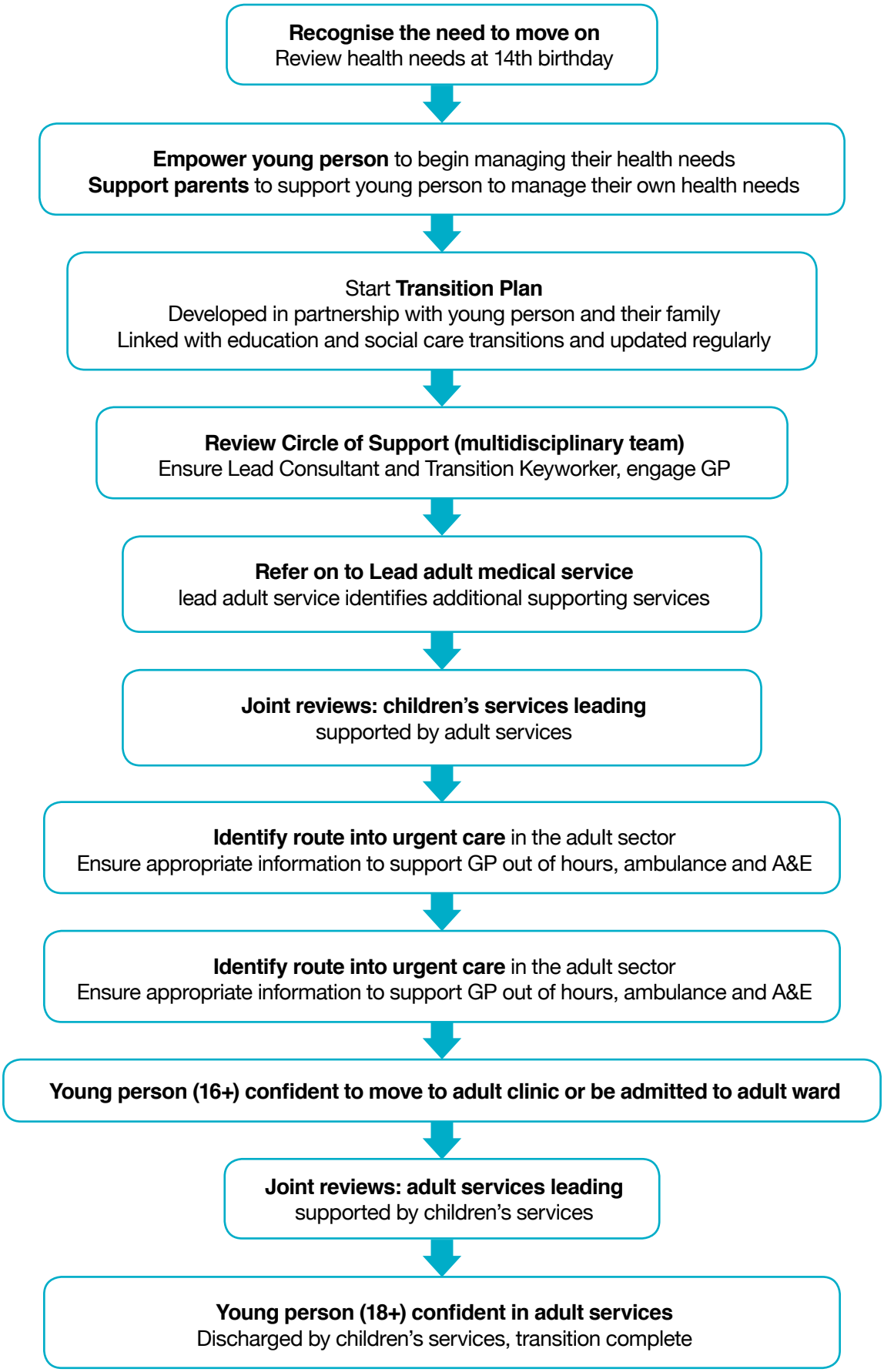
• We will finalise the development of transition training using the evaluation of the current level of knowledge and understanding of children's healthcare providers regarding transition, including knowledge and understanding of competencies relating to transition to adult services and complex long term conditions management through the Trust Transition Survey.

• We will deliver and embed future training transition training in line with the identified competencies across long term and complex long term conditions management and transition at three levels: universal, core and specialist. Planned Trust study day 'Transforming Transition a Ten Step Pathway' to be held in May 2016 to be delivered to colleagues from around the country.

• Staff engagement in transition training programmes will be measured.

Children and Young People Transition Artwork 2015

Transition Pathway: Ten Steps to Adult Care for Young People with Long Term Conditions



Dewi Jones Unit Welcome Pack

Aims:

- To produce a tangible, friendly up-to-date document with enough salient information to provide a clear overview of our service from the perspective of a service user.
- To break down barriers and attempt to alleviate any anxiety which may arise before planned admissions onto the Unit.
- To offer a basic understanding of our service to reduce the likelihood of misinformation or of people feeling 'unable' to ask questions.
- To promote an open and transparent service and celebrate our high quality.

The Dewi Jones Unit is Alder Hey's inpatient mental health facility, designed to help children and young people aged 5 to 13 who are going through a difficult time or struggling because of their way of thinking, their feelings, or with some difficult behaviour. As part of the Unit's commitment to implement the '6C's' nursing values within the workplace, communication was identified as a key area of focus. The Dewi Jones Unit Welcome Pack was identified as a key component of how we, as a service, communicate with our patients and their families. The idea arose from feedback received by a patient and their family, highlighting that they felt under-informed about our service during their experience on the Unit.

The reformulated welcome pack was based upon a much older version in order to capture and maintain the ethos and values of the organisation. Professional standards and guidelines were examined to formulate a raw structure, which could be used as a foundation to capture and build upon relevant information. Patients, families and staff were collaborated with throughout the process to elicit information which was considered relevant from multiple perspectives. Schools' council groups were also consulted, alongside advocacy and the parent/carer group.

Multiple changes were made based upon combined service user recommendations. Although very much a whole-team effort, ownership of the project was delegated to a single member of staff to avoid confusion within the concept of the project. Development opportunities were considered from verbal feedback received from patients and their families, which resulted in several new workstreams resulting in a new 'range' of bespoke welcome packs.

These currently include:

All packs are considered a continuous 'work in progress'. Consultation since implementation has revealed that those people who have received the new welcome packs feel "very informed" prior to their individual experiences on the Unit.

The unique selling proposition of the welcome packs in their current format very much lies in their appropriate mix of broader service-related information, combined with a very specific, targeted (and in some cases personalised) information pack. This has facilitated both an overview and identifiable, useful and credible information resource. This demonstrates a cost effective patient-centred improvement (which has also been proven to have transferable qualities) when benchmarked against patient feedback gained prior to the implementation of the project.

Future Plans

The essence of this project lies in the delivery of accurate, relevant information at the point of need. Moving forward the service will focus on a robust system whereby multiple members of the healthcare team can invest their time and energy into maintaining the current format while updating information retrieved from continued evaluation. Opportunities will be considered for further expansion of the core elements of the pack, as and when they present themselves. The practical and innovative implementation of this service improvement will be fostered within the team and potentially modelled for additional areas of quality care improvement.

Patient Feedback Through 'Fabio'

The Trust is committed to ensuring that we have a robust model of patient and family engagement and involvement throughout the organisation that makes a real difference, not only to the services we deliver but also to the overall patient experience.

We continue to develop strong links with the children and families who access the services of Alder Hey. Engagement occurs on a daily basis on both a formal and very informal basis. We endeavour to ensure that learning from experience is an integral part of service evaluation and design, so that decisions at all levels are made by teams that are well informed in terms of what is important to patients, families and visitors to the Trust.

This has been a most exciting year planning for the opening and transition to Alder Hey in the Park, a new hospital designed with children's interests at heart. It has been equally important that we continue to learn from experiences and proactively use this information to maintain a safe and pleasant environment with current resources. The actual move impacted on the process of collecting feedback, mainly due to the safe move and settling in period taking priority for all teams. This resulted in a period of approximately three months where the amount of data collected was significantly reduced.

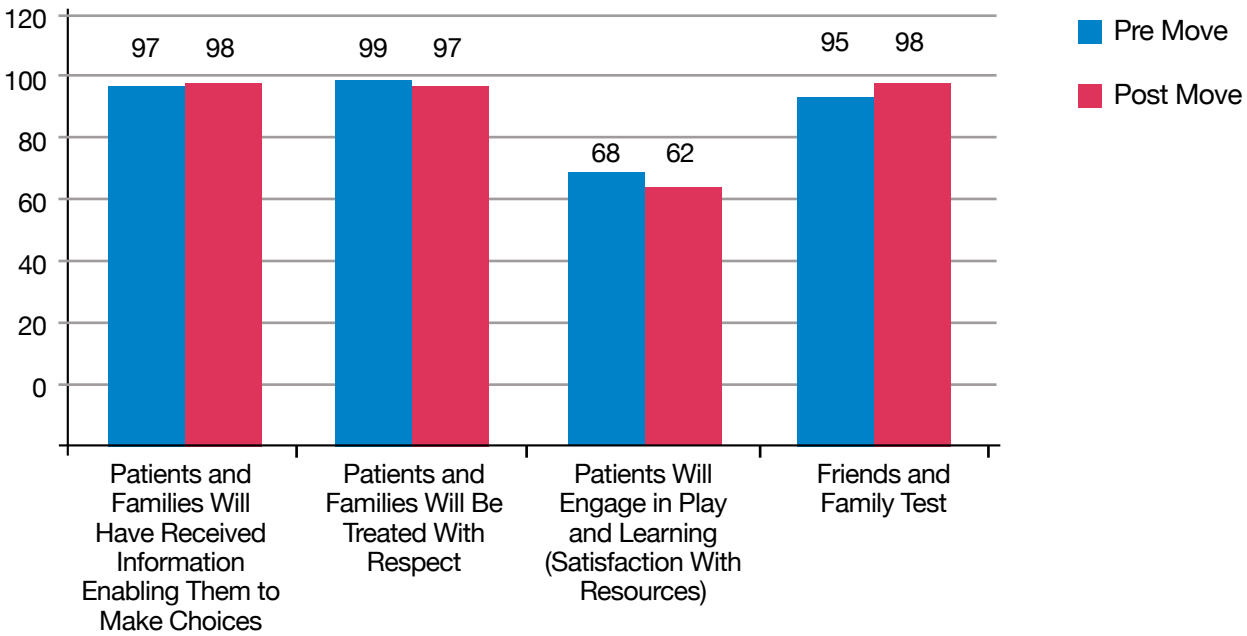
'Fabio' is an electronic device in the form of a tablet, which contains software enabling patient and carer feedback to be collected and analysed providing 'real time' data.

The Trust's volunteers continue to support the Patient Experience Team and clinical teams in improving the volume of feedback from patients and families prior to discharge from hospital.

During this period, 3,041 responses were obtained using the Fabio device. The data has given an initial view on the impact that the relocation of the hospital has had on patients and families.

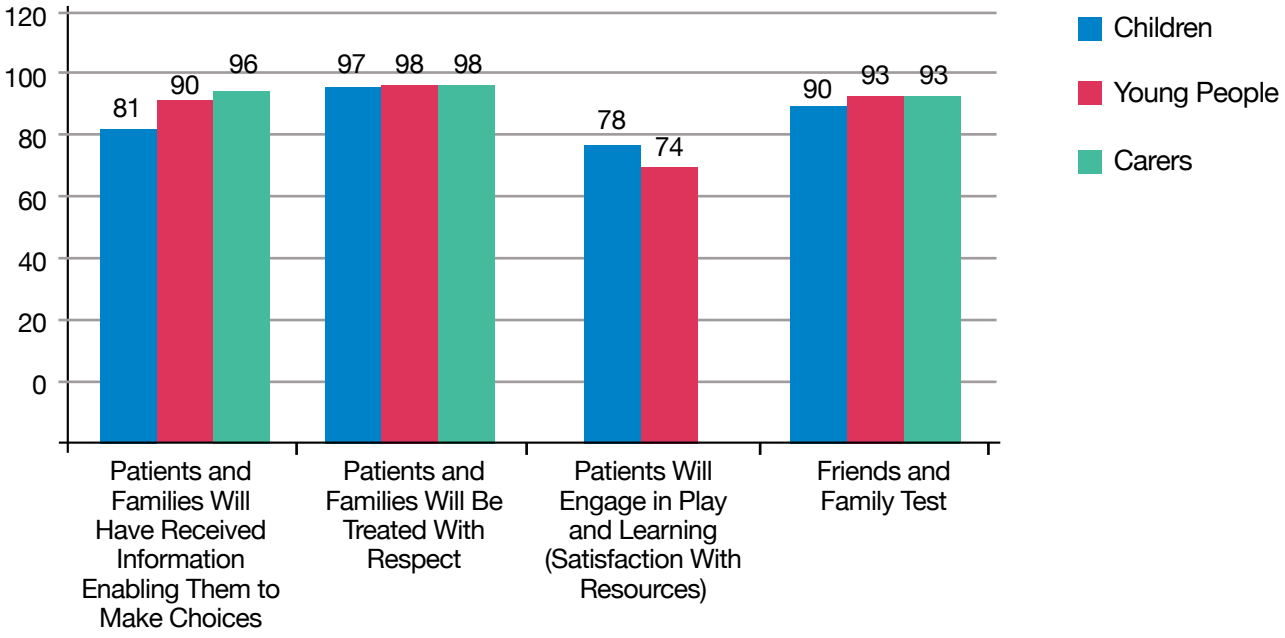
The following graph indicates the positive responses to the quality aims questions regarding the provision of information, whether patients and carers were treated with respect and the quality of play resource available. Graph A provides an initial view of the impact that the move to the new hospital has had.

Graph A

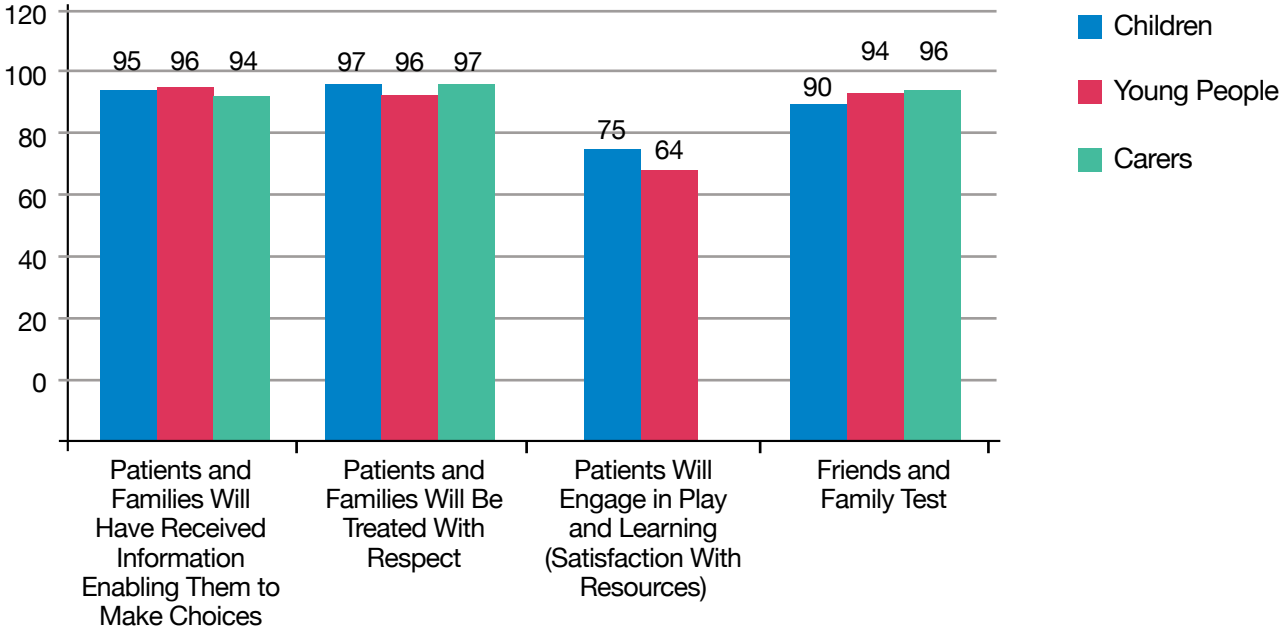


Graph B shows findings prior to the move and Graph C shows the same information following the move to the new hospital. It remains disappointing that children show relatively low satisfaction scores in relation to play and learning resources. A more focused piece of work will be instigated to address this.

Graph B - Before Move to Alder Hey in the Park



Graph C – After Move to Alder Hey in the Park



The Friends and Family Test

The Friends and Family Test (FFT) has been used in adult services since 2013 and has provided a wealth of information which is useful when improving and developing services. Patients are asked how likely they would be to recommend Alder Hey to friends and family if they required similar treatment or care.

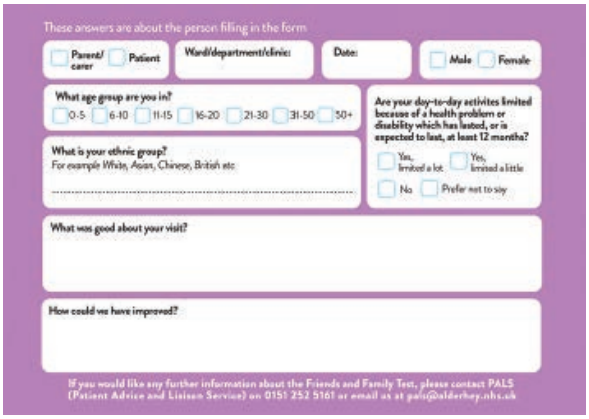
From 1st April 2015, the FFT became a mandatory collection in children's services. The FFT was implemented using a card, available for all patients and carers attending the Trust. Additionally this data can be entered by patients and family members directly using the Trust website.

Patients and families are also asked to report what was good about their stay and how we could improve their experience.

A total of 4,327 responses have been recorded since the implementation in April 2015.

A Trust-wide and ward/area specific report is published each month; this includes details of free text responses. This data provides valuable information which can inform quality improvement plans.

The findings of the FFT are published on the NHS Choices website and we have achieved on average, 93% of respondents indicating that they would recommend Alder Hey to family and friends.



Management of Complaints and Concerns

The introduction of the Complaint Manager role within the Patient Experience Team has influenced a more patient/carer focused process for responding to complaints and concerns. Additionally, the Patient Advice and Liaison (PALS) and Complaints Team have adopted a more flexible process for addressing and monitoring concerns, tailored to the complainants needs.

	2013/14	2014/15	2015/16	Comments
Formal Complaints	166	134	70	This is a 58% decrease from 2013/14; this represents 96. Prompt resolution of concerns, early meetings with Clinical Business Unit staff and discussions with the Complaints Team has had a positive impact on resolving concerns which may have otherwise escalated to a formal complaint.
PALS	1248	1133	1246	While there was a reduction in 2014/15, this was not sustained during 2015/16.

Improvements

- Our Pharmacy Team reviewed the process for prompt issue of medication to take home.
- We appointed an Orthopaedic Consultant Surgeon to improve waiting times for surgery.
- Issues with complaints handling and poor service have resulted in the appointment of a Complaints Manager.
- Clinicians are all reminded of the Trusts 'Values and Behaviours' framework, which contains what are the expected behaviours of all staff employed by the Trust, including how we communicate with each other.

The Children and Young People's Forum

The Forum has been established for 10 years and membership consists of three groups:

- Children aged 7 to 11 years
- Young people aged 11 to 18 years
- Parents and carers

The Forum meets every two months for formal meetings and in addition undertakes various activities.

The Forum agenda consists of items requested by members and Trust staff who are seeking children, young people, parents and carers views on existing services or when developing new services, initiatives or innovations.

Many of the Forum members have enjoyed participation in the planning of the new hospital as part of the Children's Health Park Design Group. The group has participated in engagement with contract bidders, building plans, interior design, assisting in recruitment, and planning of art for the internal and external environment for the new building.

The following is an overview of key projects from April 2015 through to March 2016.

- Supporting the Quality Improvement Team in developing the Ward Accreditation Scheme.
- Participating in the development of the new Trust Quality Strategy.
- Learning about transition to adult services.
- Developing of a leaflet to support recruitment to the Forum.
- Acting as a judging panel for various information sources.
- Participating in recruitment process for senior clinical staff.
- Participating in a safety workshop.

Improvements

- The Trust implemented the Friends and Family Test.
- We improved the process for responding to complaints and concerns.
- Completion of National Patient Survey.
- There has been an increase in the amount of feedback regarding quality aims questions and FFT following move to the new site.
- Successful recruitment to Children and Young People's Forum.

Future Plans

- Further development of systems and resources for collecting real-time and right time patient and family feedback.
- Continue to focus FFT feedback from community and mental health settings.
- Streamline process for collecting patient and family feedback into one central repository.
- Ensure collection of feedback is an integral part of the discharge process.
- Establish process for formally reporting the lessons learnt and action taken from findings of all feedback, in line with newly developed Quality Strategy.
- Further explore the process of data collection following discharge from hospital.
- Explore use of patient opinion to increase feedback from patients and families.
- Develop Parent and Carers' Forum.
- Improve process for responding to actions identified from patient and carer feedback – to be incorporated into the new ward accreditation process.

PART 3: FUTURE PLANS FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE FROM THE BOARD

QUALITY STRATEGY 2016 – 2021: "Quality is Everybody's Business, Let's Make it Better... Together"

The Trust has undertaken a review of its Quality Strategy to be taken forward over the next five years and beyond. Developed with input from our children, young people, carers and staff through wide consultation and engagement, the Quality Strategy adopts a novel approach of combining strong clinical leadership with greater use of technology to secure widespread engagement of staff.

A Clinical Cabinet will be established that will provide a forum for discussion and prioritisation of improvement ideas, ensuring they impact positively on our previously agreed quality aims, while taking account of the impact on our workforce and ensuring optimal use of our environment.

Clinical Leadership Through 'Clinical Cabinet'

The Quality Aims will only be achieved with Trust-wide staff engagement and understanding of the importance of everybody's role in the delivery of quality improvement.

The strategy will be a virtual, live, flexible entity with discussion forums, graphics, video blogs from staff and patients and with hyperlinks to data, information and other reference material. Our children and carers will provide quarterly reports on quality through video blogs, giving them a voice in improving our quality systems and processes, so that the strategy becomes highly engaging and interactive.

The Trust has implemented an improvement methodology, 'Listening into Action', which provides a means of engaging staff in making change in a positive and sustainable way. This will be a key vehicle for implementing the Quality Strategy, thus providing strong emphasis on empowering staff to influence and deliver a high quality service in an environment that supports the delivery of the best possible care, under the mandate 'quality is everybody's business, let's make it better… together'.

The new Quality Strategy 2016-21 will support the delivery of a number of quality initiatives in addition to the quality improvement priorities that the Trust Board has agreed. The key priorities for improvement have been derived from national and regional priorities, the Trust's performance against quality and safety indicators, risk trend analyses and patient and public feedback. The Trust has agreed to build on the 2015/16 improvement work by further:

1. Reducing harm to patients from a medication error.
2. Reducing harm to patients as a result of the development of a pressure ulcer.
3. Reducing harm from hospital acquired infections.
4. Further enhancing the involvement of children, young people and their parents/carers in patient safety.

The Board will monitor progress against these priority areas through the Clinical Quality Assurance Committee. Progress will be reported to commissioners through Clinical Performance and Quality Group meetings, dedicated Healthwatch and Trust meetings and to patients and carers through a range of communication approaches and engagement activities. The Trust continues to develop the skills of the workforce to deliver quality improvements, through the utilisation of a variety of improvement methodologies.

Review of Services

During 2015/16, Alder Hey has provided 27 NHS services. Alder Hey has reviewed all the data available to them on the quality of care in all of these services. The income generated by the NHS services reviewed in 2015/16 represents 100% of the total income generated from the provision of NHS services by Alder Hey for 2015/16.

Participation in Clinical Audits and National Confidential 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 Programme (NCAPOP) or funded through other means. Priorities for the NCAPOP are set by the Department of Health with advice from the National Clinical Audit Advisory Group (NCAAG).

During the reporting period 1st April 2015 to 31st March 2016, 11 national clinical audits and four national confidential enquiries covered NHS services that Alder Hey Children's NHS Foundation Trust provides.

During that period Alder Hey Children's NHS Foundation Trust participated in 100% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in. The national clinical audits and national confidential enquiries that Alder Hey Children's NHS Foundation Trust was eligible to participate in during the reporting period 1st April 2015 to 31st March 2016 are contained in the table below.

The national clinical audits and national confidential enquiries that Alder Hey Children's NHS Foundation Trust participated in and for which data collection was completed during the reporting period 1st April 2015 to 31st March 2016, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Participation in National Clinical Audits and National Confidential Enquiries During 2015/16

National Audit	Participation	% Cases Submitted
Children		
Paediatric Asthma	Yes	Submitted 70 cases, which was 100% of cases available.
Paediatric Intensive Care (PICANet)	Yes	Submitted 959 records, which was 100% of cases available.
Potential Donor Audit (NHS Blood and Transplant)	Yes	Cases for 2015/16 under review by NHS Blood and Transplant.
Vital Signs (Children) (College of Emergency Medicine)	Yes	Submitted 100 cases, which was 100% of cases available.
Acute Care		
Severe Trauma (Trauma Audit and Research Network)	Yes	Submitted 150 cases, which is 100% of cases available.
Cardiac		
Cardiac Arrest (National Cardiac Arrest Audit)	Yes	Submitted 35 cases, which was 100% of cases available.
Paediatric Cardiac Surgery (National Institute for Cardiovascular Outcomes Research (NICOR) Congenital Heart Disease Audit)	Yes	Submitted 742 cases, which was 100% of cases available.
Cardiac Arrhythmia (Cardiac Rhythm Management (CRM)	Yes	Submitted 30 cases, which was 100% required for the audit sample.

National Audit	Participation	% Cases Submitted
Long Term Conditions		
Ulcerative Colitis and Crohn's Disease (National IBD Audit) Biological Therapies	Yes	Submitted 30 cases, which was 100% of cases available.
Paediatric Diabetes (RCPH National Paediatric Diabetes Audit)	Yes	Submitted 1,013 records to the audit, which was 100% of cases available.
Renal Replacement Therapy (UK Renal Registry)	Yes	Submitted 50 cases, which was 100% of cases available. (Transplants: 39, PD: 6, HD: 5).

National Confidential Enquiries	Participation	% Cases Submitted
Long Term Conditions		
Confidential Enquiry into Major Burns in Children (CEMBIC)	Yes	No applicable cases in 2015/16.
Young People's Mental Health - National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Yes	26 cases submitted, which was 100% of cases available. This study is ongoing into 2016-17.
Suicide in Children and Young People (CYP) - National Confidential Inquiry into Suicide and Homicide by People With Mental Illness (NCISH) - University of Manchester	Yes	0 cases submitted.
Perinatal Mortality and Morbidity Confidential Enquiries (Term Intrapartum Related Neonatal Deaths) - MBRRACE-UK - National Perinatal Epidemiology Unit (NPEU)	Yes	22 cases submitted, which was 100% of cases available.

Actions Arising From National Clinical Audits

The reports of six national clinical audits were reviewed by the provider in the reporting period 1st April 2015 to 31st March 2016 and Alder Hey Children's NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

National Clinical Audit	Actions
Paediatric Asthma (British Thoracic Society)	The national audit report for 2015/16 data has not been published yet.
Paediatric Intensive Care (PICANet)	The national audit report was reviewed and discussed on the Intensive Care Unit (ICU). We are always commended for the quality of the PICANET data set.
Potential Donor Audit (NHS Blood and Transplant)	Awaiting publication of national audit report for 2015/16.

National Clinical Audit	Actions
Vital Signs (Children) (College of Emergency Medicine)	Presented and discussed in the Emergency Department meeting in November 2015. **Action/Recommendation:** • Poster in the Emergency Department hub to prompt: 'Please document if your vital signs are abnormal and action taken' and/or include in local induction. • Consider giving card/sticker for ID badges with reference ranges for vital signs especially for those new to paediatrics. • Poster in triage to prompt: 'If your observations abnormal, flag/handover for repeat set in 60 minutes'. • Re-audit in 12 months.
Initial Management of the Fitting Child (College of Emergency Medicine)	The audit report was reviewed by the Emergency Department audit lead. Recommendations included the development of a fitting child proforma that could possibly help doctors to record all the relevant information. Written information at discharge should be given to families.
Severe Trauma (Trauma Audit and Research Network)	For 2015/16 our data completeness and data quality are both 95%+. Alder Hey Children's Hospital serves as a Major Trauma Centre from 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 the Trauma Committee and used to inform a quality improvement programme. These dashboards and reports are also shared through the North West Children's Trauma Network Governance meeting whose membership includes Commissioners, Trauma Units, North West Ambulance Service, North West Air Ambulance as well as both children's major trauma centres. TARN data from across the network is used to understand both clinical issues and the development of the network, helping to identify items for the workplan of the network. The data completeness measure has improved and data accreditation has remained high for Alder Hey, indicating that the information is reliable and providing confidence that discussions and decisions are based on an accurate representation of the trauma service. The data has provided evidence of the effectiveness of the trauma system resulting in a positive National Major Trauma Peer Review and has shown compliance with Commissioning for Quality and Innovation (CQUIN) targets for complex lower limb injuries.
Cardiac Arrest (National Cardiac Arrest Audit)	Awaiting publication of national audit report for 2015/16.
Paediatric Cardiac Surgery (NICOR Congenital Heart Disease Audit)	The National Congenital Heart Disease Audit Report was published on 04 April 2016. The audit report showed that the Trust achieved an overall Data Quality Indicator of 97.3% compared to 94.75% last year. An action plan was not required as the audit standards are being met.
National Cardiac Rhythm Management Audit (NICOR)	The national audit report was reviewed and Alder Hey is meeting the audit standards.

National Clinical Audit	Actions
Ulcerative Colitis and Crohn's Disaese (National UK IBD Audit) Biological Therapies	The UK IBD audit is now transitioning to and merging with the IBD Registry, moving towards an improved system for data capture and quality improvement in IBD. The national report will be published in September 2016 with site reports distributed approximately two weeks prior. Once transition has taken place, on-going collection of biological therapies data will be through the UK IBD Registry. We are registered to continue entering data to this component of the audit.
Diabetes (RCPH National Paediatric Diabetes Audit)	The quality of our data collection has improved and we are using the TWINKLE system (diabetes specific data collection software) for data entry. Data entry is continuing until June 2016.
Renal Replacement Therapy (UK Renal Registry)	Awaiting publication of the national audit report for 2015/16.

Actions Arising from Local Clinical Audits

There were a total of 163 local audits registered in the reporting period 1st April 2015 to 31st March 2016. There are 42 (26%) local audits completed. There are 107 (66%) audits that will continue in 2016/17. There are four audits not yet started and 10 audits have been cancelled (6%).

The reports of the completed local clinical audits were reviewed by the provider in the reporting period 1st April 2015 to 31st March 2016 and examples of the outcomes are listed below.

Local Audit	Actions
Audit of the Efficacy and Adverse Effects of Lacosamide in Paediatric Epilepsy	The audit was presented at the International Child Neurology Congress in Amsterdam, May 2016. This audit was a joint collaboration between the Royal Manchester Children's Hospital, The Royal Preston Hospital, The Great North Children's Hospital Newcastle and Alder Hey. **Action/Recommendation:** • Lacosamide can be prescribed for generalised Epilepsy in children (apart from its use in focal Epilepsy) given the efficacious results and side effect profile. • Lacosamide monotherapy can be considered in focal Epilepsy, especially in older children (currently used as an adjunct in generalised seizures with favourable outcomes). • The results will be disseminated within the paediatric neurology departments of all four sites. • Re-audit in three years.
Audit of Post-Operative Haemoglobin Testing After Primary Corrective Spinal Deformity Surgery	The audit was presented at the Trauma and Orthopaedics mortality and morbidity meeting in May 2015. **Action/Recommendation:** • Day 3 haemoglobin blood tests should be performed on a patient/diagnosis specific basis to prevent unnecessary tests being performed. • Post-operative instructions have been changed to reflect this action plan. • Re-audit in 12 months.
Retrospective Review of Outcomes of Patients With Primary Sclerosing Cholangitis	The audit was discussed with the Gastroenterology lead in July 2015. **Action/Recommendation:** • No need for further action other than agree to collaboration for data collection on a multicentre basis so as to enhance the evidence behind the diagnosis, management and follow up of this rare morbidity. • No change in practice as uniform and good quality care according to limited evidence. • Re-audit in 12 months.

Local Audit	Actions
Direct Inpatient Admissions Unit Audit	The audit recommendations were agreed with the audit supervisor in August 2015. **Action/Recommendation:** • Change of culture of proactive rather than reactive. • Electronic list updating system. • Change of procedure: phone the ward post huddle or even move away from AM and PM list distinction. • Evaluate the pre-operative information we provide and the understanding of parents. • Re-audit in six months.
360 Degree Feedback on the Perception of Infection Prevention and Control Team at Alder Hey	The audit was presented to the Infection Control Team in July 2015. **Action/Recommendation:** • In order to obtain meaningful data, this survey should be repeated and should try and capture feedback from all grades of staff. • This will require an agreed strategy between the Trust's Infection Prevention Control and Communications teams. • Re-audit in 12 months.
Evaluating Patients' Perspectives of the Usefulness of an Intervention-Specific Workshop, for Cardiology Patients and Their Families.	The audit was presented at the psychology/paediatric cardiac nurse specialists meeting in September 2015. **Action/Recommendation:** • We have determined from this audit that there is limited interest in developing an intervention-specific workshop for this particular patient group. • The paediatric cardiac nurse specialists are taking a lead on this to consider the benefit of developing a condition-specific workshop for a wider client group. If this is successful, this may be repeated on a more regular basis. • No re-audit required.
National Clinical Audit of Inpatient Care for Young People With Ulcerative Colitis This is a Prospective Audit of Inpatients Admitted for Management of Ulcerative Colitis	The audit was presented at the National Inflammatory Bowel Disease (IBD) audit meeting in December 2015. **Action/Recommendation:** • PUCAI (Paediatric Ulcerative Colitis Activity Index) score proforma to be used by nurses and doctors (when available on Meditech 6). • To use steroid reduction scheme (when available on Meditech 6). • IBD clinics to identify patients for Anaemia and Nobe protection. In the process of setting up clinics in 2016. • All IBD patients to go on the IBD registry. • Update the existing Trust policy to reflect steroid use and the steroid reduction scheme. • Re-audit in 12 months.
NICE Quality Standard 53 Anxiety Disorders Audit	The audit was presented at the Integrated Community Services Clinical Governance meeting in December 2015. **Action/Recommendation:** • We should aim for 100% compliance with NICE quality standard 53. • Ensure more rigorous documentation of patient's or carer's consent for initiation of medication. • Patients are to be provided with a suitable leaflet about medication. • Unlicensed use of medication needs to be explained to the patients and carers and documented suitably in the case notes. • Re-audit in 12 months.

Local Audit	Actions
Re-Audit of Adherence to Guidelines for the Management of Open Fractures to the Lower Limb	The audit was presented at the Department of Plastic Surgery in September 2015. **Action/Recommendation:** • Provide a joint Orthopaedics/Plastics Open tibial fracture (OTF) education session. • Review out of hour's service. • Emergency Department to bleep Orthopaedics and Plastics. • Provide paper versions of OTF pro forma. • Display posters in the new hospital Emergency Department and Theatres. • Re-audit in 12 months.
How Good Are We at Coding Our Clinics?	The audit was presented at the Community Paediatric Clinical Governance meeting in November 2015. **Action/Recommendation:** • Develop a 'favourite list' of codes on the hospital system in liaison with the coding department that is succinct, comprehensive, user friendly and derived from ICD-10 codes/ Snowmed (International Statistical Classification of Diseases and Related Health Problems 10th Revision). • Train clinicians regarding coding on the new hospital system. • Provide regular reminders to clinicians if coding has not been completed. • Re-audit in 12 months.
Lithotripsy for Paediatric Renal Stone Clearance	The audit was presented at the Liverpool-Manchester Paediatric Urology Meeting in June 2015. **Action/Recommendation:** • To reconsider the use of Lithotripsy in larger renal stone burdens. • Re-audit in five years.
Quality of BadgerNet Documentation for PICU Admissions	The audit was presented at the Paediatric Intensive Care departmental meeting in September 2015. **Action/Recommendation:** • Improve the documentation of ward rounds. Responsibility for this may be transferred to the Specialist Registrar (SpR)/Advanced Nurse Practitioner (ANP) looking after patient on the day. • Family communications may be included in daily day time reviews on BadgerNet. • Ensure family communication is recorded on BadgerNet soon after admission by the consultant /SpR/ANP. • Trigger on BadgerNet regarding named consultant allocation if not done after 14 days of stay. • Spot checks on standards of documentation quality to be carried out on a weekly basis, particularly focusing on family communication and ward rounds. • Share these audit results with other team members including SpR/ANP and new doctors during induction. • Re-audit in six months.
Post-Operative Urinary Retention in Orthopaedic Frame Application Procedures in Children: a Baseline Audit to Establish Local Guideline for Intra-operative Catheterisation	The audit was presented at the Alder Hey Orthopaedic departmental mortality and morbidity meeting in July 2015. **Action/Recommendation:** • For discussion at Alder Hey Orthopaedic departmental mortality and morbidity meeting. • Re-audit in 12 months.

Local Audit	Actions
Service Evaluation of the Chronic Fatigue Syndrome (CFS) Service	The audit was presented at the CFS multi-disciplinary team meeting in January 2016. The recommendations were agreed between the team. **Action/Recommendation:** • To reduce the waiting time for a first appointment by restructuring clinics. • To create a clear pathway for out of area referrals working with primary/secondary care teams as applicable to improve cohesion. • Case by case liaison to be considered for out of area needs. • To create a clear inpatient pathway in order to establish appropriate support for inpatient rehabilitation. • The team agreed to continue to deliver a consistently high standard of care and in particular to continue to sensitively consider engaging young people in difficult, personal conversations and to respond to each individual's needs as appropriate. • No re-audit was required as the actions specified have been completed.
Management of Clavicle Fractures	The audit was presented at the Alder Hey Orthopaedic departmental mortality and morbidity meeting in July 2015. **Action/Recommendation:** • Introducing a new referral pathway (September 2015). • Designing patient information leaflets for clavicle fractures. • Re-audit monthly for first six months after the new referral pathway has been implemented.
A Training Needs Analysis of Parents and Carers of Children and Young People With Complex Healthcare Needs to Develop Competencies for a Carer Skills Passport	The audit was presented at the Carer Skills Passport steering group meeting and to HENW (Health Education North West) as part of the Carer Skills Passport Report in January 2016. **Action/Recommendation:** • Continue the Carer Skills Passport development and implementation. • Develop and implement standardised training competencies training materials and assessment tools all as part of the Carer Skills Passport project. • On-going evaluation as part of the next phase of the project. • First formal reassessment to take place in approximately two years after implementation is completed.
Chronic Fatigue Service / Myalgic Encephalopathy (CFS/ ME) Audit	The audit was presented at the CFS/ME Team meeting in January 2015. **Action/Recommendation:** • To reduce waiting time to eight weeks. • To achieve 100% in ensuring screening bloods are undertaken for all patients. • Re-audit in 12 months.
Treatment of Non-Idiopathic Clubfoot Using Ponseti Method	The audit was presented at the Alder Hey Registrar alumni meeting in December 2015. **Action/Recommendation:** • Our results are comparable to international results. • Re-audit in five years.
Monitoring Urea and Electrolyte (U+E's) in Patients on Intravenous Fluid Therapy	The audit was presented at the General Paediatrics departmental audit meeting in March 2015. **Action/Recommendation:** • Raise awareness of following guidelines through departmental meetings. • Inform the Pharmacy Team of any poor compliance/knowledge of guidelines so that they can emphasise during pharmacy training for junior doctors at the start of each rotation. • Changes to Senior House Officer (SHO) teaching. Ensure greater emphasis is placed on prescribing isotonic solutions and U+E monitoring during this session. • Re-audit in six months.

Local Audit	Actions
Audit on Outcome Following Use of Unilateral Foot Abduction Orthosis	The audit was presented at the Orthopaedics departmental audit meeting and the Alder Hey Alumni meeting in December 2015. **Action/Recommendation:** • To re-audit the compliance and outcomes following the use of the Denis Brown Boot. • Re-audit in 12 months.
Re-audit of NICE Quality Standard 48 Depression in Children and Young People	The audit is to be presented at an Emergency Department meeting in April 2016. **Action/Recommendation:** • We should aim for 100% documentation of diagnosis, severity of depressive episodes. • We should aim for 100% documentation of risk assessment. • All patients diagnosed with depression should be given age appropriate information about diagnosis and this should be documented in case notes. • Consent to treatment should be recorded in all cases. • Risk management, including discussion around an appropriate place of safety if indicated should be documented. • Re-audit in June 2017.
Association for Peri-Operative Practitioners (AfPP) Quality Management System in Theatres	The audit was presented at the Surgical Clinical Business Unit Board meeting and the Clinical Quality Steering Group in August 2015. **Action/Recommendation:** • The audit report is shared with the Surgical Clinical Business Unit (CBU) Board and the Clinical Quality Steering Group. • A comprehensive action plan is drawn up which provides solutions and timescales for all identified gaps, assigning a priority level to each action to support focus on key issues. • A task and finish group approach is taken to addressing the current gaps. • Repeat the audit with the same tool in six to nine months' time following the move to Alder Hey in the Park and then on a regular 12 month basis.
Impact Analysis of the Introduction of the Carer Skills Passport	The initial audit report was presented to HENW (Health Education North West) as part of the Carer Skills Passport project meeting in January 2016. Further work to finalise the report and recommendations is in progress. **Action/Recommendation:** • Further development and implementation of standardised competencies and training as part of the Carer Skills Passport project. • Development of a new policy to support the implementation of the Carer Skills Passport. • Development of new training competencies, a standardised training package and assessment protocol to support implementation of the Carer Skills Passport. • Re-audit after implementation of the Carer Skills Passport. • Further work will be undertaken as part of the implementation process and after completion in two years.
Re-audit of the Completion of Liverpool Upper-limb Fracture Assessment (LUFA) Forms in the Orthopaedic Department of Alder Hey Children's Hospital	The audit was discussed at the Orthopaedic departmental meeting with the consultant supervisor in January 2016. **Action/Recommendation:** • To make changes to the induction programme for Orthopaedics junior doctors. • Recommend an audit of completion rates between different staff grades. • Re-audit in six months.

Local Audit	Actions
An Audit of/Knowledge, Attitude and Practice of Completion of Liverpool Upper-Limb Fracture Assessment (LUFA) Forms at Alder Hey Children's Hospital	The audit findings were discussed with the audit supervisor. This was a snap shot of prescribing practice over four to six weeks. The evidence was not strong enough to warrant changes to practice at this stage. **Action/Recommendation:** • To make the induction process for junior doctors more robust, LUFA forms are to be placed in the Orthopaedic SHO 'Man-Bag'. This action has already been implemented. • LUFA forms to be placed in the ward with the case notes. • Re-audit in six months to monitor LUFA use.
Patient Satisfaction Audit for Sleep Unit (January- September 2015)	The audit was presented within the Sleep Unit in October 2015 and forwarded onto the wider team via email. **Action/Recommendation:** • Patient feedback highlighted issues with the Sleep Unit in its original location on the old hospital site, including lack of ensuite facilities and the need to vacate the Unit early the following morning. • These issues have been addressed since the Sleep Unit was moved to the new hospital. • A leaflet has been produced to send out to all the patients and their families to give them feedback on the survey and to provide them with details of our new Unit. • Re-audit in 12 months.
Awareness of Paediatric Nurses about Management of Hypoglycaemic Children	The audit was presented at the Endocrine department meeting in January 2016. **Action/Recommendation:** • To set up a mandatory teaching session for all staff nurses on 'Essential information on how to manage Hypoglycaemia'. • Develop written guidance on the emergency management of Hypoglycaemia. The Endocrine Team will take a lead in this regard. • Re-audit in six months.
Refractions From Secondary Visual Screening Service	The audit was presented at the Ophthalmology Department meeting. The results were discussed with the line manager, contents agreed and then forwarded to service managers and consultants in December 2015. **Action/Recommendation:** • A problem/system orientated approach is needed to verify and analyse the cause of the failure of patients to receive a timely appointment or indeed any appointment with the Optometric service. • There is a requirement for the efficient utilisation of human, financial and other resources including information systems. All this requires a collaborative approach and consideration should be given to the establishment of a named service lead in Optometry to liaise with other service providers. • Re-audit in 12 months.
Management of Paediatric Femoral Shaft Fractures	The audit was presented at the Alder Hey annual registrars' meeting in 2015. **Action/Recommendation:** • The audit demonstrated there is still debate in the literature and no one method of management was demonstrated to be superior. • The patient numbers involved in the audit were too small to have a major significance. • Re-audit after a set number of sub muscular plating's have been undertaken.

Local Audit	Actions
Follow-Up Chest X-ray in Simple Community Acquired Pneumonia: an Audit of Practice and Outcome	The audit was presented at the Radiology departmental meeting in February 2016. **Action/Recommendation:** • Our results demonstrate the validity of the guidelines and literature review that a routine follow-up chest X -Ray is not necessary or indicated in children with simple community acquired Pneumonia managed in the community. • Follow-up chest X- Ray only to be performed on patients with radiological indication (round Pneumonia, collapse) and clinical indication; ongoing or worsening symptoms after treatment. • To document indication for follow-up chest X-Ray on the initial chest X-Ray (to implement in practice from now on). • If possible, to book an appointment for follow-up chest X-Ray in four to six weeks. If not, then write to GP to request follow-up chest X-ray in four to six weeks. • Re-audit in 12 months.
Alder Hey Rainbow – Initial Health Assessment (IHA) Audit	The audit was presented at the Community Team meeting in February 2016. **Action/Recommendation:** • To develop a new pathway for Child Protection examination to IHA (initial health assessment).
Rate of Prescribing Errors in Alder Hey Pre and Post Introduction of Meditech 6	The audit was presented at the Medication Safety Prescribing Committee meeting in November 2015. **Action/Recommendation:** • Provide monthly feedback to prescribing clinicians on significant/serious errors. • Meditech V6 prescribing training to include highlighting system defaults which may lead to a prescribing error. • Ensure documentation of prescribing errors is robust including highlighting the potential severity of the error. • Re-audit in three months.
Audit on Treatment of Viral Warts in Paediatric Patients	The audit was presented at the Dermatology departmental audit meeting in January 2016. The key points audited were: the number of treatments (Cantharidine), the strength of treatments used, discussion of side effects and whether a patient information leaflet was distributed. **Action/Recommendation:** • Introduction of a policy regarding the treatment of Viral Warts is to be implemented. • Improve the documentation on the prescription charts. • Improve the documentation of the discussion regarding the adverse effects of Cantharidine. • Improve the documentation of patient information being given. • Nursing staff are now documenting on the prescription charts when a patient is clear from Viral Warts and when they have been discharged from treatment. • Re-audit in two to three years.
Spectrum of Children's Palliative Care Audit	Audit completed and writing up. Collation of data with other sites is in progress. **Action/Recommendation:** • A new policy will link to nursing use of spectrum of palliative care needs as part of the nursing assessment for activity of daily living 12 on Meditech 6 nursing documentation section. • Create a new guideline on identifying patients with palliative care needs. • Develop training for the implementation of routine identification of patients with palliative care needs. • Re-audit once an action plan has been implemented and embedded.

Local Audit	Actions
Audit of Management of Radial Neck Fractures Using Elastic Stable Intramedullary Nailing	The audit is due to be presented at the Orthopaedic Department mortality and morbidity meeting in May 2016. **Action/Recommendation:** • To not use sharp tipped nails. • To not use blunt tipped nails as only a fixation tool if not used to effect reduction. • To follow up patients weekly for at least six weeks. • Re-audit in two years.
Management of Child Tuberculosis Contacts: Impact of Proposed New NICE Guidelines	The audit was a review of the proposed NICE guidance. **Action/Recommendation:** • Implementation of 2015 NICE guideline will increase the requirement for IGRA tests. Relevant resources to meet increased demand to be identified. • No re-audit required.
Management and Outcome of High Grade Blunt Renal Trauma at Alder Hey Over the Last 10 Years	The audit was presented at the Alder Hey Surgical Department audit meeting in January 2016. **Action/Recommendation:** • No changes were recommended as our current practice is in line with national guidelines. • Re-audit in three years.
An Audit into the Practice of Chemotherapy Ototoxicity Monitoring in Paediatric Audiology	The audit was presented at the Urology Departmental audit meeting in January 2016. **Action/Recommendation:** • Update the information we provide to parents and patients with Renal Trauma. • Re-audit in two years.
Audit of Audit (Trauma and Orthopaedic Department)	The audit results were discussed with the audit supervisors at the Trauma and Orthopaedic departmental meeting in March 2016. **Action/Recommendation:** • Recommend changes to the training agreement between clinical supervisors and the trainee. • Recommended changes to the custom and practice of audit and quality improvement projects will need to be reviewed with the consultant body. • Re-audit in two years.
Audit of the Use of Methotrexate in Inflammatory Bowel Disease Patients	Presented to the Gastroenterology audit lead and the Inflammatory Bowel Disease specialist nurses in a local gastroenterology meeting in March 2016. **Action/Recommendation:** • Ongoing recommendations are being formulated around a new protocol for follow up of patients on Methotrexate. • Re-audit in 12 months.
Orthopaedic Ward Round Documentation Audit - October 2015	Presented and discussed in the daily departmental trauma meeting in January 2016. **Action/Recommendation:** • The audit recommends that ward rounds should always have a registrar present to lead them. • A mobile computer should be made available by ward staff for the doctors to use on their ward round. • A nurse should either be available to accompany the doctors on the ward round in their pod or to update doctors regarding the patients on arrival at the pod. • A ward round pro-forma should be considered to prompt full and thorough documentation. • Re-audit in three months.

Local Audit	Actions
An Audit for BAPRAS/ BOA Standards for Management of Open Fractures of the Lower Limb (British Association of Plastic, Reconstructive and Aesthetic Surgeons) (British Orthopaedic Association)	Presented and discussed at the Orthopaedic Team meeting in March 2016. **Action/Recommendation:** • Raise awareness of the guidelines in the Emergency Department. To include a BAPRAS/ BOA tick box in the existing open fracture pathway, in order to improve the quality of care delivered. • Improve communication with plastics regarding first operation. Include plastic specialist registrars in trauma call to ensure plastic participation in first assessment. An early plastic input would help operation planning. • Early pre-operation planning would result in an appropriate and definite cover within 72 hours. • As part of the Good Surgical Practice, post-operative notes should be printed out and physically kept in the notes. This would improve data collection and clarify the discharge plan. • Following antibiotic guidelines at the first assessment in the Emergency Department and Theatre at induction and at first debridement would improve quality of care, but would also help meet the BAPRAS standards for treatment of lower limb open fracture. • No re-audit required as this was already a re-audit to complete the cycle.
Incidence of Hypercalcaemia in Patients With Posterior Urethral Valves (PUV)	Presented and discussed in the Nephrology Department meeting in December 2015. **Action/Recommendation:** • It would be good practice for clinicians to check adjusted calcium of infants with PUV, especially in the first and second weeks of life. This would allow early diagnosis and treatment of possible Hypercalcaemia, which may accelerate improvement of renal function, reducing the risk of long term complications. • No re-audit required.

Participation in Clinical Research

The number of patients receiving NHS services provided or subcontracted by Alder Hey Children's NHS Foundation Trust in 2015/16 that were recruited to participate in NIHR Portfolio adopted clinical research was 2,322.

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 the 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 all 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, while 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 is led and managed by a dedicated team who form the Clinical Research Business Unit (CRBU). The CRBU employs 40 research nurses, supports approximately 226 studies at any one time and rigorously manages performance to ensure high quality delivery to time and target. Alder Hey has an excellent track record of recruiting the first patient globally to clinical trials, demonstrating that the organisation is at the forefront of drug development in paediatrics.

Our clinical staff and associated academics lead and contribute to studies of the latest and 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 193 open NIHR portfolio adopted clinical research studies and 75 non-portfolio studies during 2015/16, which is significant for a Trust of its size. While some studies report outcomes fairly quickly, most will not be ready for publication for a few years. The majority were research in the area of medical specialties, reflecting the prevalence of available research studies locally and nationally.

01/04/2015 to 31/03/2016

	NIHR Studies	Number of Participants	Non-NIHR Studies	Number of Participants
SG1 (Oncology, Haematology, Palliative Care)	38	190	13	20
SG2 (Nephrology, Rheumatology, Gastroenterology, Endocrinology, Dietetics)	50	173	10	136
SG3 (Respiratory, Infectious Diseases, Allergy, Immunology, Metabolic Diseases)	31	654	11	14
SG4 (A&E, General Paediatrics, Diabetes, Dermatology, CFS/ME)	10	370	5	15
SG5 (CAMHS Tier 3 & 4, Psychological Services and Dewi Jones)	5	0	1	0
SG6 (Community Child Health, Safeguarding, Social Work Dept., Comm Clinics, Neurodisability Education, Fostering, Adoption, Audiology)	2	1	4	51
SG7 (PICU, HDU, Burns)	3	18	9	36
SG8 (Theatres, Daycase Unit, Anaesthetics Pain Control)	2	2	1	8
SG9 (General Surgery, Urology, Gynaecology, Neonatal)	13	41	1	5
SG10 (Cardiology, Cardiac Surgery)	2	0	1	0
SG11 (Orthopaedics, Plastics)	2	52	3	22
SG12 (Neurology, Neurosurgery, Craniofacial, Long Term Ventilation)	27	99	5	9
SG13 (Specialist Surgery, Eare Nose and Throat, Cleft Lip and Palatte, Ophthalmology, Maxillofacial, Dentistry, Orthodontics)	4	80	3	14
SS1 (Radiology)	1	0	3	3
SS2 (Pathology)	0	0	0	0
SS3 (Pharmacy)	1	295	1	0
SS4 (Therapies, EBME, Central Admissions, Bed Management, Medical Records, Generic Outpatients)	0	0	0	0
NON-CBU	2	0	2	12
CNRU	0	0	1	0
Non Classified	1	0	1	0
TOTAL	**193**	**1977**	**75**	**345**

The Quality Report deals with research activity during the 2015/16 period. In addition to this, the CRBU published performance data on the Trust website indicating the time it takes to set up and study and the time taken to recruit the first patient once all permissions have been granted. Alder Hey performs well in this respect. Furthermore, over 80% of studies conducted at Alder Hey recruit the agreed number of patients within a set time and to agreed targets (100% for commercial research). In September 2012, Alder Hey opened a National Institute for Health Research Clinical Research Facility (CRF). This was a capital project supported with investment from the Trust and is a clinical area utilised purely for research patients, providing a dedicated research environment. This resource helps facilitate research by providing a bespoke location for research on a day-to-day basis and has successfully been used to care for research participants overnight who need regular intervention or tests on a 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.

There were over 350 members of clinical staff participating in research approved by a Research Ethics Committee at Alder Hey during 2015/16. These included consultants, nurse specialists, pharmacists, scientists, clinical support staff and research nurses from across all clinical business units.

Over the past four years the Trust has witnessed a growth in commercially sponsored studies. There are over 40 commercial studies open to recruitment and much focus on the use of novel monoclonal antibodies (mAbS) or disease modifiers. MAbS have been used primarily in Rheumatology and Oncology but are becoming available in other sub-specialties such as Respiratory Medicine and Diabetes. They work by acting on the immune system to overcome the cause of the disease rather than treating the symptoms. Duchenne Muscular Dystrophy research has grown, with new compounds being developed that address the root cause of the disease. Significant quality of life improvements have been witnessed, particularly in Rheumatology patients treated with mAbS leading to increased mobility and a reduction in pain and inflammation. These drugs are now being licensed for use in children for the first time ever. Several patients at Alder Hey have been the first global recruits into some studies and as such this bodes well as it demonstrates Alder Hey's commitment to supporting the speedy set up of clinical trials. The Trust has an established critical mass of research activity in Pharmacology, Oncology, Rheumatology, Infectious Diseases, Respiratory, Endocrinology/Diabetes, Critical Care and Neurosciences but is witnessing a growth in research activity in Gastroenterology, General and Neurosurgery, Nephrology, Emergency Medicine and Community Paediatrics.

Innovation projects such as those developing devices are also now supported by the CRBU. This is the beginning of research and innovation coming together to share expertise and to maximise engagement with small medium UK enterprises and large global companies.

Several of our consultants have been commended on their contribution to research and the Trust is acknowledged by the National Institute for Health Research Clinical Research Network as one of the top performing trusts.

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

Use of the Commissioning for Quality and Innovation (CQUIN) Payment Framework

Alder Hey's income in 2015/16 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework because the Trust adopted the Default Tariff Option for that year.

Statements From the Care Quality Commission (CQC)

Alder Hey is required to register with the Care Quality Commission and its current registration is in place for the following regulated activities: diagnostic and screening procedures, surgical procedures, treatment of disease, disorder or injury and assessment or medical treatment for persons detained under the 1983 Act. Alder Hey remains registered without conditions.

The Care Quality Commission has not taken any enforcement action against Alder Hey during 2015/16.

Alder Hey has participated in special reviews or investigations by the Care Quality Commission relating

to the following areas during 2015/16:

• A focused re-inspection on 15th and 16th June 2015 to assess whether improvements had been made following the inspection May 2014 and in addition:
  - An inspection of Child and Adolescent Mental Health Service wards.
  - An inspection of specialist community mental health services for children and young people.
  - An inspection of the Trust's diagnostic services as part of the outpatient service.

• Focused inspection of the new build on 22nd September 2015 prior to its opening in October to review the building, environment and process for transfer into the new hospital, based upon the most relevant parts of the 'safe' and 'well-led' domains.

During the focused re-inspection in June 2015 the CQC inspected the following core services in full:

• Critical care

• Outpatients and diagnostic imaging services

• Transitional services

They also looked at the 'Safe' domain in the following services:

• Medical care

• Surgery

An overall rating of 'good' was given, with an 'outstanding' rating for the 'caring' domain.

The inspection of the Dewi Jones Child and Adolescent Mental Health wards resulted in an overall rating of 'good', with an 'outstanding' rating for the 'caring' domain. The inspection of specialist community mental health services for children and young people resulted in an overall rating of 'requires improvement', with 'good' ratings for the 'effective', 'caring' and 'well led' domains.

The inspection that took place prior to the move to the new hospital in September 2015 did not assign any ratings. Three recommendations for actions the Trust should take were made, focusing on security risk assessments, the female changing area in Theatres and the nurse call system in Intensive Care. These have subsequently been actioned. The inspection also noted a number of areas of outstanding practice.

Data Quality

Alder Hey Children's NHS Foundation Trust submitted records during 2015/16 to the Secondary Users service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data which included:

• The patient's valid NHS Number was 99.49% for admitted patient care; 99.66% for outpatient care; and 99.26% for accident and emergency care.

• The patient's valid General Medical Registration Code was 100% for admitted patient care; 99.99% for outpatient care; and 99.96% for accident and emergency care.

Alder Hey will be taking the following actions to improve data quality:

• A suite of data quality reports will continue to be run daily and weekly to ensure data is monitored and corrected where necessary.

• Work closely with the Information Department to identify any data issues or areas of data weakness which will be investigated and remedial action agreed.

• Fulfil a schedule of regular data audits, reporting findings to relevant managers and monthly Data Quality Committee.

• Develop and utilise a data quality dashboard which includes key data items from throughout the patient pathway, to monitor data quality and facilitate improvement.

• Workshops and refresher training sessions arranged to ensure staff are fully aware of the importance of data quality and the integrity of the data is accurate at source.

• A review of the Trust's data quality framework will form part of a broader internal refresh of quality, resource and governance to consolidate best practice.

Information Governance Toolkit Attainment Levels

Alder Hey Children's NHS Foundation Trust Information Governance Assessment Report overall score for 2015/16 was 83% and was graded as satisfactory (green).

Clinical Coding Error Rate

Alder Hey Children's NHS Foundation Trust was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission. The error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were:

• Primary diagnoses incorrect: 7.5%

• Secondary diagnoses incorrect: 14%

• Primary procedures incorrect: 7%

• Secondary procedures incorrect: 13%

The results should not be extrapolated further than the actual sample audited and the services audited during this period included 200 random finished consultant episodes.

Performance Against National Priorities

The performance of Alder Hey against the Risk Assessment Framework 2015/16 is demonstrated below:

Target or Indicator (Per 2015-16 Risk Assessment Framework)	Threshold	National Performance	Qtr1	Qtr2	Qtr3	Qtr4
Summary Hospital Level Mortality Indicator (SHMI)[1]			n/a	n/a	n/a	n/a
C. Difficile Numbers - Due to Lapses in Care			0	0	0	0
C. Difficile - Rates Per 100,000 Bed Days		6.9	0	10.8	0	0
18 Week RTT Target Open Pathways (Patients Still Waiting for Treatment)	92%	92.6%[2]	92.2%	92.1%	92.2%	92.1%
All Cancers: Two Week GP Referrals	100%	94.8%[3]	100.0%	100.0%	100.0%	100.0%
All Cancers: One Month Diagnosis (Decision to Treat) to Treatment	100%	97.8%[3]	100.0%	100.0%	100.0%	100.0%
All Cancers: 31 Day Wait Until Subsequent Treatments	100%	97.8%[3]	100.0%	100.0%	100.0%	100.0%
A&E - Total Time in A&E (95th Percentile) <4 Hours (This data has been subjected to a cleansing exercise and therefore may differ from data previously submitted to the Trust Board; the Trust's auditors are providing an adverse limited assurance opinion on the Accident and Emergency waiting time indicator. This is as a result of the validation backlog which impacts on the accuracy of the data reported).	95%	92.8%[4]	95.8%	95.3%	82.8%	84.5%

Target or Indicator (Per 2016-16 Risk Assessment Framework)	Threshold	National Performance	Qtr1	Qtr2	Qtr3	Qtr4
Readmission Rate Within 28 Days of Discharge		0-15 Years:	7.0%	6.9%	8.2%	7.4%
		16 Years & over:	3.6%	8.2%	5.7%	7.4%
% of Staff Who Would Recommend the Trust as a Provider of Care to Their Family or Friends			86%	84%	Not required	88%
Staff Survey Results: % Staff Experiencing Harassment, Bullying or Abuse From Staff in the Last 12 Months		23%			24%	
Staff Survey Results: % Believing That the Trust Provides Equal Opportunities for Career Progression or Promotion for the Workforce Race Equality Standard		88%			82%	
Financial and Service Performance Ratings[5]			4	2	2	2
Rate of Patient Safety Incidents Per 1000 Bed Days			54	63	78	82
Patient Safety Incidents and the Percentage That Result in Severe Harm or Death			0 0%	1 0.1%	2 0.2%	2 0.1%

[1] Specialist trusts are excluded from SHMI reporting.

[2] National performance based on most recent published data for April 2015 - January 2016.

[3] National performance is based on most recent published Quarter 3 data for 2015/16. Alder Hey had one breach of the children's cancer standard (one month from Referral to Treatment) and this was as a result of delay for clinical reasons.

[4] A&E national performance based on most recent published data for April 2015 - January 2016.

[5] Quarter 1 reported under the old CSR ratio. From Quarter 2, rating has been reported under the new FSRR ratio.
The Trust considers that this data is as described for the following reasons:

- The indicators are subject to a regular schedule of audit comprising completeness and accuracy checks which are reported monthly to the Performance Management Group.
- The Data Quality Audit Plan will increase the frequency and scope of audits for 2014-15.

The Trust is taking actions to improve the scores and the quality of its services for RTT performance by increasing capacity and improving waiting times for first appointment.

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

STATEMENTS ON THE QUALITY REPORT BY PARTNER ORGANISATIONS

Commentary From Governors

"The draft quality report represents a fair reflection of my understanding of the Trust's approach to and participation in a broad range of quality activities. I believe the report represents a Trust-wide focus on delivering safe and effective care for our patients and a desire for continuous improvement and innovation.

"In particular, the partnerships with Liverpool University and the Local Authority and with international companies such as Sony and the Virtual Engineering Centre are to be welcomed for bringing relevant external influence which should make a positive contribution to developments in the way our services are delivered.

"In terms of recent achievements, the recruitment of 250 additional nurses, from a small pool of appropriately qualified specialist nurses, is a real achievement as is the reduction in medication errors which result in harm and also those which cause moderate/severe harm.

"The range of clinical audits and research activity in which our staff participate is a clear demonstration of a Trust-wide desire to bring about positive change in the way we deliver care.

"As a governor, I welcome the report and support the Trust's approach to ongoing quality improvement."

Kate Jackson, Lead Governor

"I have read through the Quality Account 2015/2016 and can confirm that this provides a sound reflection of the ongoing Hospital activity I have been aware of in my role as Parent and Carer Governor. With new staff, new premises and new systems eg Electronic Patient Record, this period has been one of unprecedented change for the Trust. The pursuit of quality has remained central to the work of the Trust and has provided continuity and reassurance throughout this exciting transitional period."

Pippa Hunter-Jones, Parent and Carer Governor

Commentary From Healthwatch Sefton

"Healthwatch Sefton welcomes the opportunity to comment on this Quality Account and would like to thank the Trust for their open and transparent way of working. Regular quarterly meetings have been held with the Deputy Director of Quality and the lead officers for patient experience and equality.

"The readability of the account is helped by the inclusion of a simple process for showing the quality achievements made by the Trust since 2014-15. Similar to last year we would welcome the inclusion of a glossary.

"The Trust should be congratulated on the achievement of the safe move to 'Alder Hey in the Park'. Healthwatch Sefton has received a tour of the new building.

"Work undertaken on medication safety is noted. There has been a decrease from 20% to 8% of reported medication incidents of harm. The increase of 119% in medication incident reporting shows that an open and honest culture is further embedded. The appointment of a nurse and a pharmacist as medication safety officers has been a positive step. We look forward to the app which will allow patients to have a better understanding of their medications.

"Work to increase children, young people and their parents/carers involvement in patient safety has been shared with us regularly, including updates on the co-development of the 'STAR' ward accreditation scheme.

"We note the 5% increase in grade 2 hospital acquired pressure ulcers and the grade 4 pressure ulcer which occurred during this period. The target to reduce hospital acquired grade 3 pressure ulcers by 50% was met with 67% achievement. It is good to see improvements being put in place which includes staff training and the appointment of a full time Tissue Viability Nurse.

"It was disappointing that there have been 3 MRSA bacteraemia against the target of 'zero'. There were 2 clostridium difficile infections although we note not due to lapses in care. It is good to see the development and implementation of improvement plans to address infection control.

"The CQC inspection of specialist community mental health services for children and young people and the resulting overall rating of 'requires improvement' was noted. It would have been good to read about the work which has been undertaken to improve this service.

"In reviewing responses from the Friends and Family test, 93% of respondents indicated that they would recommend Alder Hey Children's Hospital. It would have been useful within the account to have a summary of suggestions for improving experiences from patients and families which inform quality improvement plans.

"The introduction of a complaint manager role within the patient experience team has lead to a more focussed and integrated way of responding to complaints and concerns. During September 2015, the complaints manager worked in partnership with Healthwatch Sefton to help resolve a communication issue for a parent in Sefton with the result being support for the parent/Trust from the Sefton CVS Community Volunteer Bi-Lingual Project. It is good to see that the team is working in a more flexible and partnership approach to address complainants needs."

Diane Blair, Manager Healthwatch Sefton

Joint Commentary by Knowsley Council Health Scrutiny Sub-Committee and Healthwatch Knowsley

"The Quality Account for Alder Hey Children's NHS Foundation Trust was considered at a meeting of the Health Scrutiny Sub-Committee on Wednesday 13th April 2016. Representatives from Healthwatch Knowsley were invited to attend the meeting and contribute to the discussions and commentary.

"Those present at the meeting acknowledged that the Trust had recently moved to a brand new building which offered a great deal of benefits for patients and staff. However, it was felt that the new waiting area did not offer sufficient privacy for some patients and that the design was overwhelming for children with autism. Members wanted to ensure that some action was taken in relation to addressing these issues. It was also suggested that the road signage from Huyton to the new site needed some consideration and could be improved.

"Members of the Sub-Committee and Healthwatch Knowsley recognised the good practice carried out by the Trust in relation to ensuring that children were at the heart of decision-making and were exploring new technologies such as a new 'app' which would support young people to understand their medications and prescriptions. Members felt it was important that the Trust kept equality and diversity at the heart of their involvement to ensure that those who may not be able to read, use or interpret information could be supported in the most appropriate way and acknowledged that the equality and diversity advocate was important to ensure all views were heard.

"It was acknowledged that there had been a reduction in beds as a result of the move to a new site but members felt reassured that there had not been a reduction in staff and pleased that additional staff had been recruited in line with national standards.

"The group felt it was important for the Trust to provide information about mortality rates and it was agreed that this information would be provided separately to members of the Sub-Committee and Healthwatch Knowsley.

"It was recognised that the Trust was developing CQUINs around children with disabilities and children with mental health issues and this was supported and welcomed. It was acknowledged that the Trust was working collaboratively with other Trusts such as Aintree and Merseycare to explore better ways of working, particularly around transition from children to adults. Members felt that this should continue to be significant focus for the Trust.

"Members welcomed the Trust's open and honest approach to highlighting areas of improvement and supported the Trust in working to deliver these. The Sub-Committee was grateful for the Trust's detailed presentation and Quality report and thanked the representatives for taking time to attend the meeting and provide information."

Commentary From Healthwatch Liverpool

"Healthwatch Liverpool is pleased to take this opportunity to comment on the 2015 – 2016 Quality Account of Alder Hey Children's Hospital NHS Foundation Trust. This commentary relates to the contents of a draft Quality Account document that was made available to Healthwatch prior to publication. Given the level of detail in the Quality Account, this commentary can only focus on some of the aspects of the document.

"The Quality Account sets out the key quality initiatives that Alder Hey Children's Hospital is undertaking to ensure that it continues to provide the standard of service that patients and their families deserve. The document is relatively clear and easy to understand from the perspective of a lay person and provides useful information for anybody wanting to know how well the organisation is serving its patients.

"This has been a highly significant year for Alder Hey Children's Hospital with its move into the new much improved premises. Throughout the year Alder Hey has met regularly with Healthwatch Liverpool and kept us informed of progress regarding the quality and equality of its service. Healthwatch has also had similar updates regarding the patient experience gathered by the hospital. So, Healthwatch Liverpool is satisfied that Alder Hey Children's Hospital has engaged with stakeholders in choosing the priorities set out.

"Alder Hey Children's Hospital has been making notable progress over the last year in how it deals with equality, and it would have been beneficial had this positive work been given some emphasis in this Quality Account, given the high relevance of equality to quality matters.

"In the view of Healthwatch Liverpool the achievements set out in this Quality Account are significant and the Trust has done good work on its priorities from last year with their focus on patient safety and the recognition of the important role of children, young people and their parents/carers in this. Healthwatch Liverpool is also supportive of these continuing as the priorities for the coming year. We look forward to engaging further with Alder Hey Children's Hospital and observing continued progress on these priorities."

Commentary From Halton Clinical Commissioning Group

"Many thanks for the submission of the Quality Report 2015-2016; this letter forms the response to this report from Halton Clinical Commissioning Group. Liverpool CCG are the coordinating commissioner for the trust on behalf of NHS Halton CCG with good reporting and feedback via the contractual processes.

"NHS Halton CCG congratulates the trust on the safe and successful move into Alder Hey in the Park and the delivery of a number of key quality priorities. The report provides good information in the relation to engagement of children and young people in the design of their care and highlights some innovative approaches to engagement and involvement of which the trust can be rightly proud.

"The CCG notes the plans for quality improvement in 2016-2017 and is supportive of the plans; we are particularly interested in the plans for transition to adult care. We look forward to working with the trust in 2016-2017 ensuring safe and effective care for the children."

Jan Snodden, Chief Nurse, NHS Halton CCG

Commentary From Liverpool Clinical Commissioning Group

Not received prior to publication date.

Commentary From Liverpool City Council Overview and Scrutiny Committee

No direct request for feedback was made to Liverpool Overview and Scrutiny Committee for the year 2015/16. The Trust relied upon a longstanding arrangement with local authority partners whereby organisations make contact with the Trust when they wish to review the Quality Report. No feedback has been received from Liverpool.

STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE QUALITY REPORT

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2015/16;
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2015 to March 2016
  - Papers relating to Quality reported to the board over the period April 2015 to March 2016
  - Feedback from Halton CCG dated 11th May 2016
  - Feedback from Governors dated 3rd May 2016
  - Feedback from Healthwatch Sefton dated 16th May 2016
  - Feedback from Knowsley Council Health Scrutiny Sub-Committee and Knowsley Healthwatch dated 20th May 2016
  - Feedback from Healthwatch Liverpool dated 20th May 2016
  - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated April
  - The 2015 national staff survey dated March 2016
  - The 2014 National Inpatient and Day Case Survey dated March 2015
  - The 2015 Young Emergency Department Survey dated July 2015
  - The 2015 Young Outpatient Survey dated July 2015
  - The Head of Internal Audit's annual opinion over the trust's control environment dated April
  - CQC Intelligent Monitoring Report dated May 2015
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor.gov.uk/annualreportingmanual).

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board.

NB: sign and date in any colour ink except black.

David Henshaw

Sir David Henshaw
Chairman
23rd May 2016

Louise Shepherd

Louise Shepherd
Chief Executive
23rd May 2016

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF ALDER HEY CHILDREN'S NHS FOUNDATION TRUST ONLY

Opinions and Conclusions Arising From Our Audit

1. Our Opinion on the Financial Statements is Unmodified

We have audited the financial statements of Alder Hey Children's NHS Foundation Trust for the year ended 31 March 2016. These financial statements comprise the Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Taxpayers' Equity, Statement of Cash Flows and related notes. In our opinion:

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

2. Our Assessment of Risks of Material Misstatement

We have identified one new risk in the year relating to the Trust bringing the new hospital and the associated liability under the Private Finance Initiative (PFI) on to its balance sheet. We have removed the risk relating to income recognition from the audit report as we do not consider NHS income to be at high risk of material misstatement or to be subject to a significant level of judgement.

In arriving at our audit opinion above on the financial statements the risks of material misstatement that had the greatest effect on our audit were as follows:

Recognition of the new hospital development, Alder Hey Children's Health Park, £162.4 million and related net PFI liability £111 million.

This is a new risk for 2015/16.

Refer to the Audit Committee Report within the 'Directors Report' on the Trust's Annual Report and Accounts, Section 1.6 of Note 1 to the Accounts (accounting policies) and Property, plant and equipment financial disclosures at Note 14 to the Accounts.

The risk: During 2015/16, the Trust moved into a new hospital which was funded through a PFI scheme. The PFI asset and the related long-term liability were brought on balance sheet on 30 September 2015, when the asset became operational, at the cost of the asset per the operator's financial model (OFM). The asset was immediately revalued to depreciated replacement cost (DRC) at the date it came into use in accordance with the requirements of the FT Annual Reporting Manual. The revaluation led to a significant loss of £41.3 million on revaluation as the DRC does not take into account costs that have been capitalised by the developer and included in the cost of the asset per the OFM.

Due to the level of professional judgement required in determining DRC of the new hospital and the complexities of accounting for PFI assets and liabilities we identified accounting for this transaction as a significant risk.

Our response: In this area our audit procedures included:

- Agreeing the initial asset to the cost of the asset per the operator's financial model;
- Agreeing the subsequent valuation of the PFI asset and its useful economic life to the valuation provided by the Trust's independent external valuer;
- Determining whether the recognition of the loss on revaluation in the financial statements complied with the requirements of the FT ARM;
- Assessing the competence, capability, objectivity and independence of the Trust's external valuer and considering the terms of engagement of, and the instructions issued to, the valuer for consistency with the Trust's accounting policies for the valuation of property, plant and equipment and also RICS Valuation Professional Standards;
- Critically assessing the use of DRC as the basis of the valuation of the PFI asset by reference to the NHS Foundation Trust Annual Reporting Manual 2015/16 guidance;
- Determining whether the DRC valuation was based on a modern equivalent asset value and whether the assumptions made by the valuer in relation to the

treatment of VAT complied with guidance issued by the Department of Health and HM Treasury;

• Confirming that the information provided to the valuer, including information on the use of buildings and details of land area and floor space, was complete and accurate;

• Critically assessing the other assumptions in the valuation model, in relation to title, condition, environmental matters, flooding and area;

• Testing the accuracy and completeness of the calculation of the PFI liabilities including an assessment of whether there is an appropriate split between non-current and current liabilities and between the interest charge, repayment of finance lease liability, service element and contingent rent by reference to the operator's financial model; and

• Considering the adequacy of the disclosures about the key judgments and degree of estimation involved in arriving at the valuation and the related sensitivities.

3. Our Application of Materiality and an Overview of the Scope of Our Audit

The materiality for the financial statements was set at £3.8 million (2014/15 £3.8 million), determined with reference to a benchmark of income from operations (of which it represents 1.8% (2014/15 1.8%). We consider income from operations to be more stable than a surplus-related benchmark.

We report to the Audit Committee any corrected and uncorrected identified misstatements exceeding £190,000 (2014/15 £190,000), in addition to other identified misstatements that warrant reporting on qualitative grounds.

Our audit of the Trust was undertaken to the materiality level specified above and was all performed at the Trust's headquarters in Liverpool.

4. Our Opinion on Other Matters Prescribed by the Audit Code for NHS Foundation Trusts is Unmodified

In our opinion:

• the parts of the Remuneration and Staff Reports to be audited have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2015/16; and

• the information given in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

5. We Have Nothing to Report in Respect of the Matters On Which We are Required to Report by Exception

Under ISAs (UK&I) we are required to report to you if, based on the knowledge we acquired during our audit, we have identified other information in the annual report that contains a material inconsistency with either that knowledge or the financial statements, a material misstatement of fact, or that is otherwise misleading. In particular, we are required to report to you if:

• we have identified material inconsistencies between the knowledge we acquired during our audit and the directors' statement that they consider that the annual report and accounts taken as a whole is fair, balanced and understandable and provides the information necessary for patients, regulators and other stakeholders to assess the Trust's performance, business model and strategy; or

• the Audit Committee report does not appropriately address matters communicated by us to the audit committee.

Under the Audit Code for NHS Foundation Trusts we are required to report to you if in our opinion:

• the Annual Governance Statement does not reflect the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2015/16, is misleading or is not consistent with our knowledge of the Trust and other information of which we are aware from our audit of the financial statements.

• the Trust has not made proper arrangement for securing economy, efficiency and effectiveness in its use of resources.

In addition we are required to report to you if:

• any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006.

• any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit.

We have nothing to report in respect of the above responsibilities.

Certificate of Audit Completion

We certify that we have completed the audit of the accounts of Alder Hey Children's NHS Foundation Trust in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice issued by the National Audit Office.

Respective Responsibilities of the Accounting Officer and Auditor

As described more fully in the Statement of Accounting Officer's Responsibilities the accounting officer is responsible for the preparation of financial statements which give a true and fair view. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the UK Ethical Standards for Auditors.

Scope of an Audit of Financial Statements Performed in Accordance with ISAs (UK and Ireland)

A description of the scope of an audit of financial statements is provided on our website at www.kpmg.com/uk/auditscopeother2014. This report is made subject to important explanations regarding our responsibilities, as published on that website, which are incorporated into this report as if set out in full and should be read to provide an understanding of the purpose of this report, the work we have undertaken and the basis of our opinions.

Respective Responsibilities of the Trust and Auditor in Respect of Arrangements for Securing Economy, Efficiency and Effectiveness in the Use of Resources

The Trust is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources, to ensure proper stewardship and governance, and to review regularly the adequacy and effectiveness of these arrangements.

Under Section 62(1) and Schedule 10 paragraph 1(d), of the National Health Service Act 2006 we have a duty to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Scope of the Review of Arrangements for Securing Economy, Efficiency and Effectiveness in the Use of Resources

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General (C&AG), as to whether the Trust has proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The C&AG determined this criterion as necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2016.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all significant respects, the Trust had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

The Purpose of Our Audit Work and to Whom We Owe Our Responsibilities

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors of the Trust, as a body, for our audit work, for this report or for the opinions we have formed.

A Latham

Amanda Latham
for and on behalf of KPMG LLP, Statutory Auditor

Chartered Accountants
1 St Peter's Square
Manchester M2 3AE
25 May 2016

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 Children's Hospital NHS Foundation Trust to perform an independent assurance engagement in respect of Alder Hey Children's NHS Foundation Trust's Quality Report for the year ended 31 March 2016 (the 'Quality Report ') and certain performance indicators contained therein.

Scope and Subject Matter

The indicators for the year ended 31 March 2016 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/transfer/discharge.

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 Monitor.

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 Guidance for External Assurance on Quality Reports 2015/16 ('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 supporting guidance and the six dimensions of data quality set out in the Guidance.

We read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual and supporting guidance 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 2015 to May 2016;
- papers relating to quality reported to the board over the period April 2015 to May 2016;
- feedback from NHS Halton CCG dated 11 May 2016;
- feedback from governors dated 3 May 2016;
- feedback from local Healthwatch organisations dated 16 and 20 May 2016;
- feedback from Knowsley MBC Overview and Scrutiny Committee dated 20 May 2016;
- the latest trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 dated April 2016;
- the 2014 National Inpatient and Day Case Survey dated March 2015;
- the 2015 Young Emergency Department Survey dated July 2015
- the 2015 Young Outpatient Survey dated July 2015;
- the 2015 national staff survey dated March 2016;
- the 2015/16 Head of Internal Audit's annual opinion over the trust's control environment dated April 2016; and
- the May 2015 CQC Intelligent Monitoring Report.

We have not been able to review consistency with feedback from NHS Liverpool CCG. This was requested on 20 April 2016 but not received.

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 Children's 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 2016, 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 Children'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.

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.

The scope of our assurance work has not included governance over quality or the non-mandated indicator, which was determined locally by Alder Hey Children's Hospital NHS Foundation Trust.

Basis for Qualified Conclusion

As set out on page 117 of the Trust's Quality Report, the Trust currently has concerns with the accuracy of data on which the percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge at the end of the reporting period indicator is based. This is due to a backlog in the validation of data since the move to the new Patient Administration system in June 2015.

As a result of the issue described above we are unable to conclude that nothing has come to our attention that causes us to believe that the percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge for the year ended 31 March 2016 has been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and supporting guidance and the six dimensions of data quality set out in the Guidance.

Qualified Conclusion

Based on the results of our procedures, except for the effects of the matters described in the 'Basis for qualified conclusion' section above, nothing have come to our attention that causes us to believe that, for the year ended 31 March 2016:

• 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 remaining indicator in the Quality Report subject to limited assurance (the indicator percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period) has not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and supporting guidance and the six dimensions of data quality set out in the Guidance.

KPMG LLP

Chartered Accountants
Manchester
26 May 2016

NHS LIVERPOOL CLINICAL COMMISSIONING GROUP - QUALITY ACCOUNT STATEMENTS - ALDER HEY CHILDREN'S NHS FOUNDATION TRUST

South Sefton, Liverpool and Knowsley CCGs welcome the opportunity to jointly comment on the Alder Hey Children's NHS Foundation Trust Draft Quality Account for 2015/16. We have worked closely with the Trust throughout 2015/16 to gain assurances that the services delivered were safe, effective and personalised to service users. The CCGs share the fundamental aims of the Trust and supports their strategy to deliver high quality, harm free care. The account reflects good progress on most indicators.

This Account indicates the Trust's commitment to improving the quality of the services it provides with commissioners supporting the key priorities for the improvement of quality during 2015/16.

Priority 1: To ensure a safe move to the new Alder Hey Children's Health Park

Priority 2: To reduce harm to patients from a medication error

Priority 3: To reduce harm to patients as a result of the development of a pressure ulcer

Priority 4: To increase children, young people and their parents/carers involvement in patient safety

This is a comprehensive report that clearly demonstrates progress within the Trust. It identifies where the organisation has done well, where further improvement is required and what actions are needed to achieve these goals, in line with their Quality Strategy.

We have reviewed the information provided within the Quality Account and checked the accuracy of data within the account against the latest nationally published data where possible.

Through this Quality Account and on-going quality assurance process the Trust clearly demonstrates their commitment to improving the quality of care and services delivered. Alder Hey Children's NHS Foundation Trust continues to develop innovative ways to capture the experience of patients and their families in order to drive improvements in the quality of care delivered.

The Trust places significant emphasis on its safety agenda, with an open and transparent culture, and this is reflected throughout the account with work continuing on the reporting of incidents and the embedding of learning across the organisation.

Of particular note is the work the Trust has undertaken to improve outcomes on the following work streams:

- Significantly increased the level of incident reporting on the national reporting and learning systems is the top 25% of peer trusts.
- Developed a What's app group for Junior Doctors to enhance learning by communicating with them about medication safety alerts or when required to speak them regarding an incident
- Worked with local schools involving hand hygiene awareness.
- Developed and implementation of a Paediatric Ward Accreditation scheme in partnership with children, young people and their parents/carers.
- Conducted a Safety Workshop with parents, children and young people, and in general strived to improve patient safety through the involvement of children, young people and their parents/carers.

The CCGs would like to acknowledge the Trusts work on successfully moving into the brand new state of-the-art hospital which included the consultation of thousands of children and families regarding the design of the building.

Commissioners are aspiring through strategic objectives and 5 year plans to develop an NHS that delivers great outcomes, now and for future generations. This means reflecting the government's objectives for the NHS set out in their mandate to us, adding our own stretching ambitions for improving health and delivering better services to go even further to tailor care to the local health economy. Providing high quality care and achieving excellent outcomes for our patients is the central focus of our work and is paramount to our success.

It is felt that the priorities for improvement identified for the coming year are both challenging and reflective of the current issues across the health economy. We therefore commend the Trust in taking account of new opportunities to further improve the delivery of excellent, compassionate and safe care for every patient, every time.

Liverpool CCG

Signed

Katherine Sheerin
Chief Officer
3rd June 2016

South Sefton CCG

Signed

Fiona Taylor
Chief Officer
26th May 2016

Knowsley CCG

Signed

Dianne Johnson
Accountable Officer
31st May 2016

Alder Hey Children's NHS
NHS Foundation Trust

If you would like any more information about any of the details in this report, please contact:

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