BOARD OF DIRECTORS PUBLIC MEETING

Tuesday 28th May 2019 commencing at 10:00

Venue: Tony Bell Board Room, Institute in the Park

AGENDA

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action	Preparation
PATIENT STORY (1000 – 1015)						
1.	**19/20/66**	**10:15**	**Apologies**	Chair	To note apologies: Kerry Byrne Hilda Gwilliams Louise Shepherd	For noting
2.	**19/20/67**	**10:16**	**Declarations of Interest**	All	Board Members to declare an interest in particular agenda items, if appropriate.	For noting
3.	**19/20/68**	**10:16**	**Minutes of the Previous Meeting**	Chair	To consider the minutes of the previous meeting to check for amendments and approve held on: **Tuesday 7th May 2019**	Read Minutes
4.	**19/20/69**	**10:20**	**Matters Arising and Action Log:**	Chair	To discuss any matters arising from previous meetings and provide updates and review where appropriate.	Verbal
5.	**19/20/70**	**10:30**	**Key Issues/Reflections**	All	Board to reflect on key issues.	Verbal
Strategy						
6.	**19/20/71**	**10:35**	**Integrated Care Partnership**	D Jones	To update the Board on progress of the Strategy	Verbal
Delivery of Outstanding Care						
7.	**19/20/72**	**10:40**	**Complaints report Quarter 4 report**	A Hyson	To receive the quarter 4 report.	Read report
8.	**19/20/73**	**10:50**	**Serious Incidents Report**	C Umbers	To inform the Board of the recent serious incidents at the Trust in the last calendar month.	Read report
9.	**19/20/74**	**11:00**	**Digital update**	J Grinnell	To update the Board on the programme.	Read report
10.	**19/20/75**	**11:10**	**Alder Hey in the Park Site Development update**	D Powell	To receive an update on key outstanding issues / risks and plans for mitigation.	Verbal

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action	Preparation
11.	19/20/76	11:15	**Clinical Quality Assurance Committee: Chair's report:** - **Chair's verbal update from the meeting on 15.05.19** - **Minutes from the meeting held on 17.04.19**	A Marsland	To receive a verbal report of key issues from the May meeting and the approved minutes from April 2019.	Read minutes
Strong Foundations						
12.	19/20/78	11:20	**2018/19 Draft Annual Report and Accounts.** - **Ernst and Young External Audit Year-end Draft Report, 2018/19.** - **Draft Letter of Representation.** - **Draft Letter of Representation for the Quality Accounts.**	E Saunders/ J Grinnell/ K Byrne H Rohimun R Tyler	To approve the Annual report and Accounts.	Read report
13.	19/20/79	11:45	**Board Self – Certification of Compliance with the Provider License**	E Saunders	To approve the declaration in relation to general condition 6 and the corporate governance statement, AHSC's and Governor Training.	Read report
14.	19/20/80	12:00	**Register of Shareholder interests** - **Acorn Agreement**	D Powell	To provide a monthly update.	To follow
15.	19/20/81	12:10	**Tariff and Contract Risks**	J Grinnell	To highlight current and future risks	To follow
16.	19/20/82	12:15	**Programme Assurance update:** - **Deliver Outstanding Care.** - **Growing External Partnerships.** - **Solid Foundations.** - **Park Community Estates**	J Grinnell	To receive an update on programme assurance.	Verbal

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action	Preparation
			and Facilities.			
17.	19/20/83	12:20	**Resources & Business Development Committee Report:** - **Chair's verbal update from the meeting held on 22.05.19** **Minutes from the meeting held on 29.04.19**	I Quinlan	To receive a verbal report of key issues from the last meeting and the approved minutes from 29th April 2019.	Read minutes
18.	19/20/84	12:22	**Audit Committee Report:** - **Verbal update from the last meeting held on 23rd May 2019** - **Minutes from the meeting held on 18th April 2019**	K Byrne	To receive a verbal report of key issues from the May meeting and the approved minutes from April 2019.	To follow
19.	19/20/85	12:24	**Finance Month 1 Report**	J Grinnell	To note delivery against financial metrics.	Presentations
20.	19/20/86	12:27	**Board Assurance Framework**	Executive leads	To receive an update.	Read report
Lunch (1230 – 1300)						
The Best People Doing Their Best Work						
21.	19/20/87	13:00	**People Strategy:** - **Workforce and Organisational Development Committee: Chair's Report:** **Chair's verbal update from the meeting on 03.05.19** - **Minutes from the meeting held on 01.03.19**	M Swindell C Dove	To provide an update. To present the current position to the Board To receive a verbal report of key issues from the April meeting and the approved minutes from March 2019.	Read report Read report Read minutes

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action	Preparation
Sustainability Through External Partnerships						
22.	**19/20/88**	**13:10**	**Joint Neonatal Partnership – Alder Hey and Liverpool Women's Hospital.**	A Bateman	To update the Board on progress towards the single service model.	Read report
23.	**19/20/89**	**13:15**	**Any Other Business**	All	To discuss any further business before the close of the meeting.	Verbal
Date And Time of Next Meeting: 2nd July 2019 at 10:00am, Tony Bell Board Room, Institute in the Park.						

REGISTER OF TRUST SEAL
The Trust Seal was not used in April 2019

Alder Hey Children's NHS
NHS Foundation Trust

PUBLIC MEETING OF THE BOARD OF DIRECTORS

Minutes of the meeting held on **Tuesday 7th May 2019 at 10:00am,**
Tony Bell Board Room, Institute in the Park

Present:	Dame Jo Williams	Chair	(DJW)
	Mr. A. Bateman	Chief Operating Officer	(AB)
	Mrs K Byrne	Non-Executive Director	(KB)
	Mrs J France-Hayhurst	Non-Executive Director	(JFH)
	Mr J Grinnell	Director of Finance	(JG)
	Mrs H Gwilliams	Chief Nurse	(HG)
	Mrs A Marsland	Non-Executive Director	(AM)
	Dr N Murdock	Medical Director	(NM)
	Mr I Quinlan	Vice Chair	(IQ)
	Mrs L Shepherd	Chief Executive	(LS)
	Mrs M Swindell	Director of HR & OD	(MS)
In Attendance:	Ms L Cooper	Director of Community Services	(LC)
	Mr M Flannagan	Director of Communications	(MF)
	Dr A Hughes	Director of Medicine	(AH)
	Mrs D Jones	Director of Strategy	(DJ)
	Mr D Powell	Development Director	(DP)
	Ms E Saunders	Director of Corporate Affairs	(ES)
	Mrs K Warriner	Chief Information Officer	(KW)
	Mr S Hooker	Public Governor	(SH)
	Mrs J Tsao	Committee Administrator (minutes)	(JT)
Apologies:	Prof M Beresford	Assoc. Director of the Board	(PMB)
	Mrs C Dove	Non-Executive Director	(CD)
	Mr C Duncan	Director of Surgery	(ChrD)
	Ms S Falder	Director of Clinical Effectiveness and Service Transformation	(SF)
	Prof L Kenny	Executive Pro Vice Chancellor	(PLK)
	Ms J Minford	Director of Clinical Effectiveness and Service Transformation	(JM)

Agenda item:

Item 44	Valya Weston	Associate Director of Infection, Prevention and Control
	Natalie Deakin	Programme Assurance Manager

Staff Story
The Chair welcomed Dr Richard Cooke former Director of Infection Prevention and Control at the Trust; he described the selection process used by the Trust for moving projects forward via Hackathon events. Having been successful at a Hackathon last year, Dr Cooke was now leading a project with Acorn Partnership to provide a solution to hand hygiene compliance. Funding had been successful and the project was coming to the end of year one in its three year programme. Funding was being used to trial automated monitoring of hand hygiene on ward 4A. As Dr Richard Cooke was to retire during the last year of the programme a succession plan was being developed.

The Chair thanked Dr Richard Cooke for attending the meeting and sharing his transition experiences from (DIPC) to medical innovator. Dr Richard Cooke accepted an invitation to present a further update to the Board in 12 months' time.

19/20/38 Declarations of Interest

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There were none to declare.

19/20/39 Minutes of the previous meetings held on 2nd April 2019

Subject to an action for Board members to complete a practical part of Infection Control mandatory training the Board APPROVED the minutes from the meeting held on 2nd April 2019.

19/20/40 Matters Arising and Action Log

Due to timing of approving the complaints report for quarter 4 this item and action had been deferred to the next Trust Board on 28th May 2019.

All other actions had either been completed or are on the agenda for a further update.

19/20/41 Key Issues/Reflections

Louise Shepherd reported on the Emergency Department recognition event held on 1st May to thank staff for achieving the 95% target for the national four hour standard for access to emergency care during March, which had been an extremely busy month in terms of attendances.

Cheshire and Merseyside Children's and Women's services

Findings from the Cheshire and Merseyside Women and Children's partnership review conducted two years ago under STP had been shared with partners. To support providing 24/7 services across five locations two roadshows are being held this month at Alder Hey Children's NHS FT and Liverpool Women's NHS FT. A roadshow had already been completed in Southport and Ormskirk.

Liverpool Integrated Care Partnership (LICP)

Louise Shepherd reported that Liverpool Integrated Care Partnership Group (ICPG) - a collaboration of healthcare organisations with Liverpool City Council - has been established a to address health priorities across the city. The ICPG has commissioned a System Capability Programme which is running workshops, two of which were held in March both attend by herself and the Chair. Through this programme all organisations had been asked for their top priorities to be included in a five year strategy. The Board noted the wider health care agenda around poverty and poor housing needed to be a focus for the Partnership.

Doctors' Mess

Nicki Murdock thanked the Executive team for its support in allocating the top of the treehouse in the atrium as the new Doctors' mess, noting this had been very well received.

The Forum

Lisa Cooper said 10 members from the Alder Hey Forum had travelled to London to meet with Simon Stevens, Chief Executive of NHS England and Baroness Dido Harding, Chair of NHS Improvement to share views of the NHS Long Term Plan. The Forum members are preparing a report on their experience.

End of Year Thanks

The Chair thanked staff at Alder Hey for the strong end of year performance delivered by the organisation, which made it one of the most successful in the country in 2018/19.

19/20/42 Liverpool Integrated Care Partnership (LICP)

Further to the key reflections above, Dani Jones noted that the 12 week System Capability Programme comes to an end next week. A session to go through the findings and to agree a shared vision is scheduled for Wednesday 15th May 2019.

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Dani Jones noted that a key resulting action will be the refresh of the "One Liverpool" plan, of which the Children's transformation plan is a core component.

19/20/43 Review of 2018/19

Members of the Executive Team presented highlights at the year-end reflecting the Trust's position and achievements:

Quality

Hilda Gwilliams noted:

- Safe staffing levels above 90% for whole year.
- Higher level of Advanced Nurse Practitoners than other trusts.
- 'Must do' actions from CQC action plan have all been completed.
- No operations cancelled due to staffing shortage.
- 19% reduction in medication incidents since 2014/15.

Operational

Adam Bateman had met with the three Divisions noting their achievements:

Surgery

- Anaesthesia Clinical Services Accreditation.
- Reduction in the number of cancelled operations.
- 410 Congenital Heart Disease operations had been carried out.

Medicine

- Emergency Department rated seventh in the NHS for waiting times
- Acute Care Team case approved
- Fully delivery of national cancer RTT and diagnostics

Community

- Lead for Mental Health Trailblazer
- No delays for medically fit patient's discharge.

Finance

John Grinnell presented the 2018/19 draft financial results: a £49.9m control total surplus, £17.7m ahead of plan. The reported control includes £35.8m Provider Sustainability Funding (PSF) of which £29.6m is incentive funding.

This represents a £(1.4)m underlying deficit after exclusion of one-off transactions and PSF. The Trust achieved a Use of Resources risk rating of 1, the best achievable and ended the year with £33m cash in bank and £6.9m (99%) CIP delivery. The successful land sale and PFI deal are currently going through audits.

Going forward there would be a further meeting to finalise estates capital projects.

Ian Quinlan commended the whole team for delivering such a strong end of year position; as chair of the Resources and Business Development Committee he felt both assured and proud.

19/20/44 Infection, Prevention and Control Quarter 4 report

Valya Weston presented the report for quarter 4. The majority of metrics and aims had been delivered.

The Community IPC business case was being processed however funding was yet to be identified. It was agreed this would be actioned at Operational Delivery Board.
Action: HG/JG

Valya Weston reported that a five year IPC strategy was currently being developed. She also referenced some of the work she was doing nationally around vascular

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access with the aim of joint learning with other paediatric organisations and academic institutions.

Resolved:
The Board received the Infection, Prevention and Control report for quarter 4.

19/20/45 Serious Incident Report

The Board received and noted the content of the Serious Incident report for March 2019. Hilda Gwilliams stated that during this reporting period there were no new Serious Incidents. Of the five ongoing cases, two reports had been submitted to Liverpool Clinical Commissioning Group to date.

The outcome from the unexpected death report completed jointly with Liverpool Women's NHS FT highlighted the requirement for a single site Neonatal service that was being progressed currently by both organisations. The Care Quality Commission had requested further details of the incident and a response had been provided.

Resolved:
The Board received the Serious Incident report for March 2019.

19/20/46 Digital Update

Following an action from the last Board meeting to provide an update on IT operational delivery, Kate Warriner presented the report noting around 2,500 operational IT incidents are reported each month.

The Board received an update regarding the development of the Alder Hey Digital Strategy. This would be presented at the July Board.
Action: KW

Kate Warriner reported that she had commissioned an independent review of the IT service and the outcome was awaited.

Kerry Byrne noted the update report answered a number of queries raised previously.

Going forward, the Trust would be progressing its 'paper-free' agenda as well as continuing with standardising documentation and specialty packages.

Received:
The Board received the digital and GDE update.

19/20/47 Alder Hey in the Park Site Development Update

David Powell provided this month's update to the Board with regard to the key components of the site as they currently stand.

Park and Land
Harry Dhaliwal from Step is supporting Alder Hey with submission of the planning application for the park. The application is for the area to be developed into a community park with exercise equipment for all to use.

Engagement meetings are taking place with the community who are keen for the development to be completed quickly. Representatives from the Health and Wellbeing group are also in attendance.

Alder Centre
The construction contract has now been agreed.

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Community Cluster
The construction contract for the community cluster is currently out to tender. David Powell commented on the rising cost of construction which would need to be closely monitored.

Pipework issues
David Powell presented a paper with the current position in relation to corroded pipework. The Board have previously been informed of burst pipework incidents. The paper outlines work completed to identify further corrosion and proposed next steps.

A specialist consultant had been appointed to undertake a survey of the pipework and components including water quality. The survey completed in February 2019.

Early progress reports issued on a monthly basis since February 2018, focused on the replacement of the pipework. However, since August 2018 the reports have indicated that a monitoring process was the preferred solution.

The current proposal from the independent consultant for Alder Hey is to use new technology thermal imaging to assess the condition of the pipes. This is a new proposal and further discussions are required in order to ascertain it suitability.

The Board expressed concerns in relation to the ongoing corroded pipework. The Board noted issues would continue to be closely monitored and reported into regular meetings with Liaison Committee, Executive team and reported into the Integrated Governance Committee.

Resolved:
The Board received:
- Park Site Development update.
- Corrosion of pipework to continue to be closely monitored.
- Liaison Committee Minutes, 15th March 2019

19/20/48 Clinical Quality Assurance Committee
Anita Marsland briefed the Board on the key issues from the recent CQAC joint meeting with the Clinical Quality Steering Group. Going forward it had been agreed for a joint meeting to take place at least once a year.

Resolved:
The Board received and noted:
- The minutes from the Clinical Quality Assurance Committee meeting held on 20th March 2019.

19/20/49 People Strategy Update
The Board received and noted the contents of the People Strategy report for April 2019. The following points were highlighted and discussed:

- The Trust has signed up to the Employer Time to Change Pledge, which is run by mental health charity, Mind.
- The process to transfer band 1 staff to a band 2 has now been completed with 114 out of 150 staff transferring.
- Two tutors have been appointed to deliver internal apprenticeships. These posts will be funded from the apprenticeship scheme levy.

Louise Shepherd asked for assurance that post apprenticeship implementation reviews are taking place.
Action: MS

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John Grinnell said it would useful for the Board to receive an update from a member of staff who had been through the apprenticeship scheme. Melissa Swindell agreed to look into this.
Action: MS

Junior Doctors
Nicki Murdock presented an update on progress against the Junior Doctors' Strategy noting as Junior Doctors are employed by Health Education England (HEE) the paper focuses on factors that can be influenced at Alder Hey. As there currently aren't any Masters (one year courses) available for Junior Doctors this was going to be discussed further with (HEE).

Resolved:
The Board received and noted:
- People Strategy report for April 2019.
- Junior Doctors' Strategy.

19/20/50 Joint Neonatal Partnership – Alder Hey and Liverpool Women's Hospital
The three work streams for the joint Neonatal partnership established to date are:
- Estates and infrastructure
- Governance for a single site service
- Workforce requirements

Adam Bateman agreed to present a paper on progress to date at the next Board meeting on 28th May 2019.
Action: AB

Reference was made to the original proposals of joint Board to Board meetings taking place annually or bi-annually; these are to be arranged.
Action: Karen McKeown

Resolved:
The Board received an update on the Joint Neonatal Partnership.

19/20/51 Business Continuity Plan for European Union Exit
John Grinnell reported that as exit from the EU has been further delayed until 31st October 2019, the reporting cycle has been reduced to every three weeks until closer to October.

Operational walkabouts have been taking place across the Divisions and are to continue.

Resolved:
The Board received the business continuity plan in relation to the EU Exit noting a further update would be received in September.

19/20/52 Programme Assurance Update
Natalie Deakin presented the Programme Assurance report for April 2019.

The Board noted the number of red rated projects has decreased.

As the Research, Innovation and Education Committee was currently being reviewed agreement was still to be reached on the reporting structure for the related projects.

Resolved:

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

19/20/53 Committee Annual Reports

Resolved:

Board received the following sub committees' annual reports, noting their achievements and future priorities:

- Audit Committee
- Resource and Business Development Committee
- Workforce and Organisational Development

19/20/54 Resources and Business Development Committee

Nicki Murdock queried why there wasn't a clinician included in the membership of the Committee; she agreed to join if it would be of assistance.

Resolved:

The Board received and noted the approved minutes from the Resources and Business Development Committee held on 1st April 2019.

19/20/55 Audit Committee

Kerry Byrne briefed the Board on the key issues from the most recent Audit Committee, noting going forward no further draft Audit progress reports are to be received at the end of year (April) Audit Committee

Resolved:

The Board received and noted the approved Audit Committee minutes from the meeting held on 24th January 2019.

18/19/56 Corporate Report

Performance

Adam Bateman reported on significant disruption to the radiopharmacy service due to production challenges at the Royal Liverpool Hospital. This was being monitored at the weekly safety huddle.

Finance

John Grinnell reported on the review of the corporate report to include benefits and outcomes with the statutory requirements.

Safe

As agreed at the last Board meeting, Hilda Gwilliams and Nicki Murdock are reviewing the reporting and escalation process for patients with suspected sepsis not receiving antibiotics within an hour.

Resolved:

The Board received and noted the contents of the Corporate Report for month 12.

19/20/57 Board Assurance Framework (BAF)

Resolved:

The Board received and noted the content of the BAF update and the end of year report.

19/20/58 Register of Interest

Resolved:

The Board received the first digital report from the new software that the Trust had purchased for more efficient recording of staff interests, gifts and hospitality, which formed the basis of the register of interests for 2018/19. The Board noted the report would be received on an annual basis.

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19/20/59 Any Other Business
No further business was discussed.

Date and Time of next meeting: Tuesday 28th May 2019 at 10.00 in the Tony Bell Board Room, Institute in the park.

Alder Hey Children's NHS Foundation Trust
Trust Board - Part 1
Action Log

	A	B	C	D	E	F	G	H
1	**Meeting date**	**Ref**	**Item**	**Action**	**By whom?**	**By when?**	**Status**	**Update**
2	**Actions for May 2019**							
3	05.03.19	18/19/328	Complaints Quarter 3 Report	Going forward Anne Hyson agreed to carry out a deep dive on one of the high categories of concern.	Anne Hyson	7.5.19		Due to timing of reporting to sub committee for apprpoval this item had been deferred to 28.05.19
4	02.04.19	19/20/04	Matters Arising and Action Log	In line with new guidance all staff are required to complete a practical as part of the Infection Control MT. It was agreed that this would be actioned outside of the meeting.	Valya Weston	May-18		In progress- VW is meeting with Execs and Non Execs to complete.
5	07.05.19	19/20/49	People Strategy update	To provide assurance that post apprenticeship implementation reviews are taken place.	Melissa Swindell	28.05.19		
6	07.05.19	19/20/49	People Strategy update	To look into a staff member sharing their experiences of the apprenticeship scheme	Melissa Swindell	28.05.19		In Progress: Due to present on 2nd July 2019
7	07.05.19	19/20/50	Joint Neonatal Partnership – Alder Hey and Liverpool Women's Hospital	To present a paper on progress to date	Adam Bateman	28.05.19		Completed: Agenda item included
8	07.05.19	19/20/50	Joint Neonatal Partnership – Alder Hey and Liverpool Women's Hospital	To arrange an annual joint Board to Board meeting	Julie Tsao	28.05.19		To be arranged
9	**Actions for July 2019**							
10	05.03.19	18/19/328	Complaints Quarter 3 Report	To provide an update on the review of ADHD/ASD services	Lisa Cooper	02.07.19		
11	07.05.19	19/20/46	Digital Update	To present the Alder Hey Digital Strategy at the July Board	Kate Warriner	02.07.19		
12								
13								
14	**Status**							
15	Overdue							
16	On Track							
17	Closed							
18								

NHS
Alder Hey Children's
NHS Foundation Trust

Report of	Chief Nurse
Paper prepared by	Head of Quality – Corporate Services Trust Complaints and PALS Lead
Subject/Title	Quarter 4 2018 – 2019 Complaints & PALS report
Background papers	n/a
Purpose of Paper	To receive the Current Complaints Performance report and update regarding previous concerns.
Action/Decision required	The Group are asked to note the report.
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Deliver **Clinical Excellence** in all of our services
Resource Impact	None

Quarter 4:- January 2019 – March 2019

Complaints summary

The Trust received 30 formal complaints during this period. One complaint from this quarter was subsequently withdrawn from the process at Mums request after a meeting had taken place with the Consultant and Service Manager and Mum agreed there were no issues she now required addressing and advised to withdraw the complaint. As a comparison in 2017/18 Q4 the Trust received 30 formal complaints.

The category of complaints received in this quarter are:-

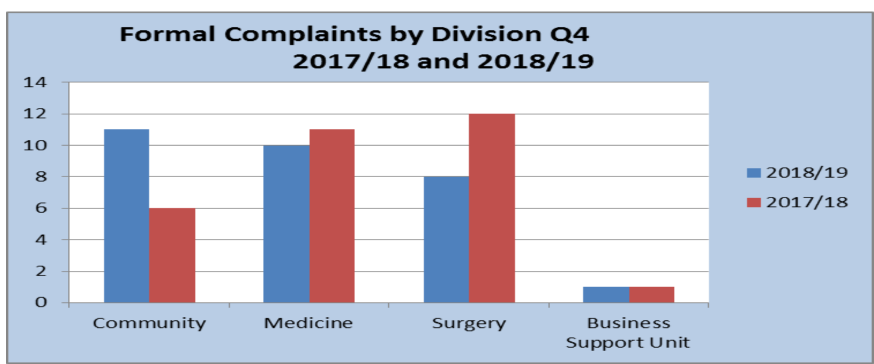
Category	Number
Consent, Communication, Confidentiality	9
Treatment/Procedure	8
Access, Admission, Transfer, Discharge	8
Medication	2
Data Protection	1
Clinical Assessments (Diag, Scans, Tests)	1
Documentation (Records, Identification, IT System)	1

Looking into the highest category of *Consent/Communication/Confidentiality* information relating these cases has been detailed below. The information aims to provide a greater understanding of the type of complaints recorded in this category.

S005294:- relate to admission process for HDU patient when Mum questions relevance of another child being a pt. on department as she is able to leave the dept. for periods of time while her child has to wait in ED for a bed to become available.
SO05265:- Attitude of Orthopaedic Dr
SO04968:- Content of letter from Dr worded insensitively
So05184:- communication during the whole of the babies admission poor. Parents feel complaint process will provided them with information they should have received when they were at Alder Hey.
S05312:- Dad states in complaint letter relating to Oncology "poor, no or mixed levels of communication "as primary complaint.
SO05305:- Mum states " problems with all levels of communication" within General surgery
SO05113:- sensitive letter with highly confidential information in it delivered to wrong address by Royal mail.
SO05212:- Staff member did not introduce herself or communicate to a young person with Learning disability.
SO05287:- Letter to Mum not sufficiently clear from Mums perspective – requesting a full report but child not seen by Consultant for over 12 months. Attitude of staff – during phone calls to assist Mum with complaint.

Complaints by Division in Quarter 4

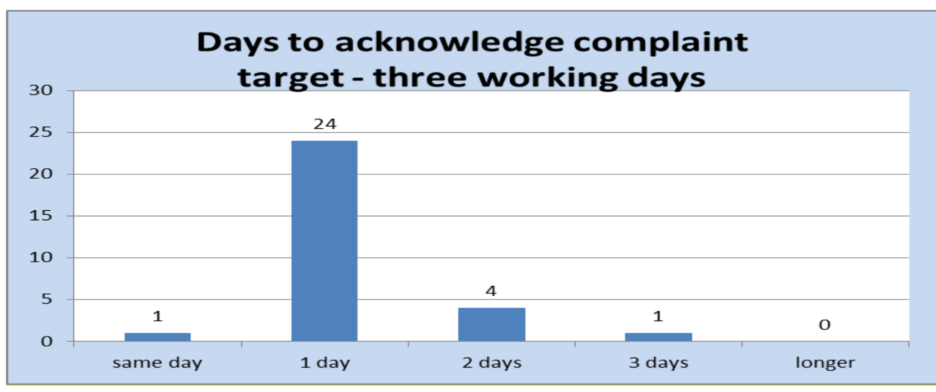
The following graph demonstrates the amount of complaints received within each Division during Quarter 4 2018 – 19 and includes a comparison from the same time period in 2017/18.



Report against three day acknowledgement

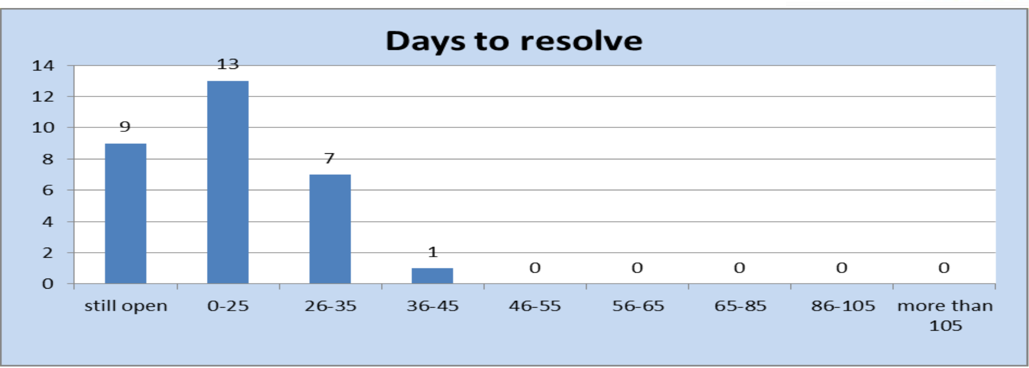
The Trust has three working days to formally acknowledge a complaint; this can be in an email or by phone. The Trust has a generic formal complaint acknowledgement letter that is sent out to the complainant; this includes a named contact for the complainant to contact should they require to do so (including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

In Q4 30 out of 30 complaints were acknowledged within 3 days.



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

The graph below now shows the timeframes the Trust has responded to a formal complaint within Q4 .



Of the 9 complaints still open the table below shows how many days the case has been open so far and the comments to identify why (correct at time of written report 7 May 2019 10:04hrs)

Site	Date Received	Complaint Type	Case Number	Department	Age Of Case	Comments
Community	28/02/2019	Complaint	SO05207	Community Paediat	45	meeting took place 18 April 2019 within timeframe.Letter sent to CN for QC 7 May .
Medicine	22/02/2019	Complaint	SO05184	Endocrinology	49	Complex complant received from Wales - Additional questions asked bear the end of the process and reqeusted we delayed resposne to include responses to additional questions
Medicine	15/03/2019	Complaint	SO05288	AED	34	meeting took place within timeframe - summary letter being pulled together along with actions required
Medicine	25/03/2019	Complaint	SO05312	Oncology	28	Meeting date 14 May 2019
Surgery	25/02/2019	Complaint	SO05212	Cardiology	48	meeting took place 2 May - just out of timeframe but with familys agreement
Surgery	12/03/2019	Complaint	SO05261	Orthopaedics	37	Meeting scheduled 7 May 2019
Surgery	13/03/2019	Complaint	SO05265	Orthopaedics	36	letter required additonal work after QC by Chief Nurse
Surgery	20/03/2019	Complaint	SO05305	General Surgery	31	Meeting took place 1 May 2019
Surgery	28/03/2019	Complaint	SO05329	Pain Service	25	delayed in compiling response

Withdrawn complaints

One complaint from this quarter was subsequently withdrawn from the process at Mums request after a meeting had taken place with the Consultant and Service Manager and Mum agreed there were no issues she now required addressing and advised to withdraw the complaint.

Complaint outcome

13 complaints where not upheld within this quarter and 7 where upheld. 9 complaints are still ongoing and one was withdrawn.

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

Referrals to Parliamentary & Health Service Ombudsman

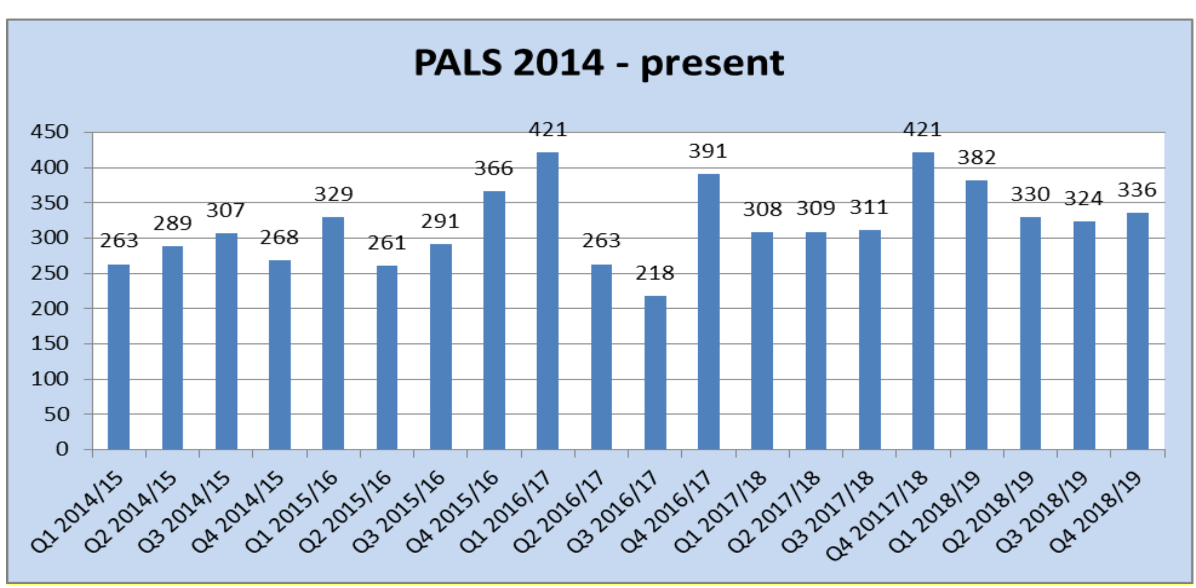
Two cases from earlier in the year are still being assessed by the Ombudsman with a view as to whether they will go ahead investigate or not.

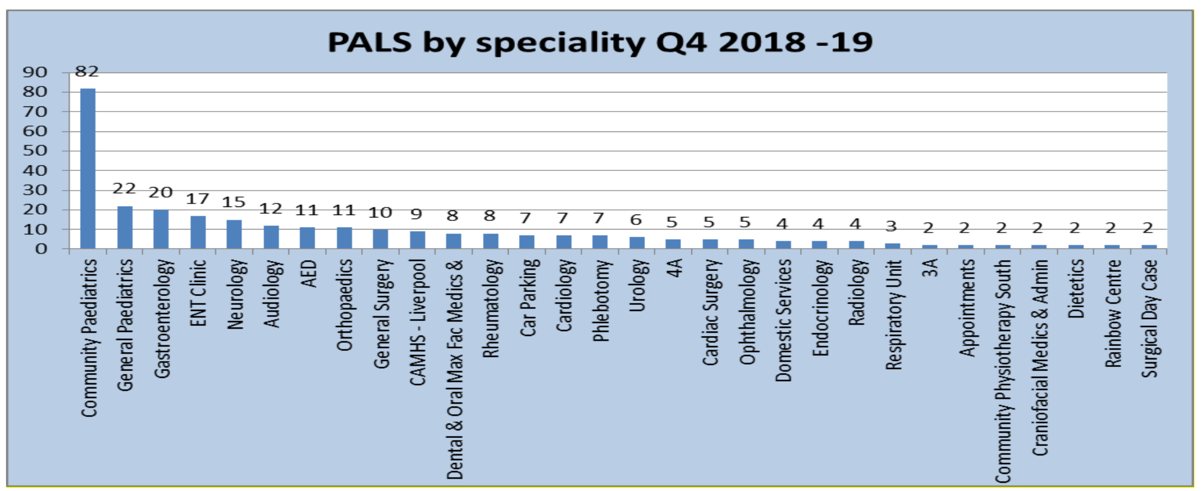
PALS summary

In Q4 2018 -2019 PALS contacts received total 336, in comparison to the same quarter in 2017/18 this is a very slight increase of 12 .

PALS concern are received in a variety of methods, phone call, email, written and face: face. Phone calls and face: face account for 68% of the contacts whilst the written concerns account for 32%

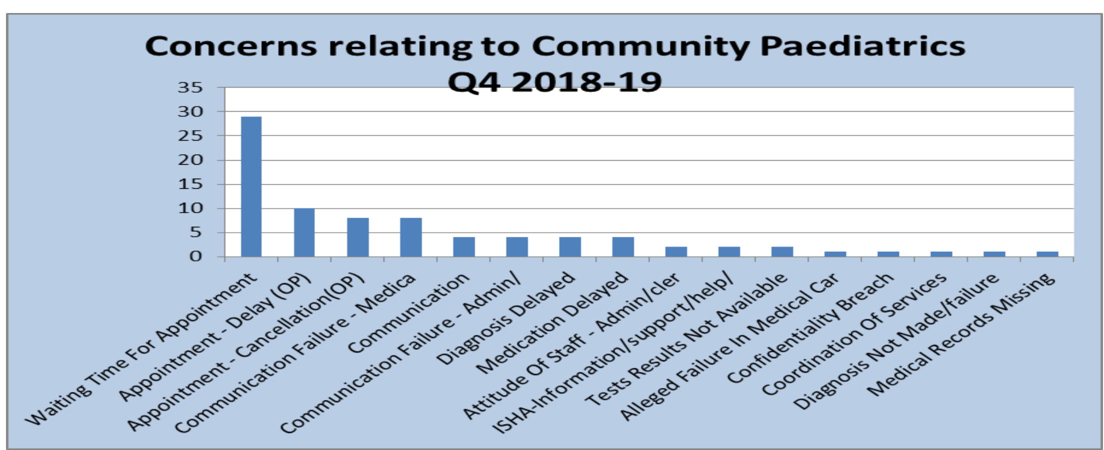
Fig 3- PALS contacts from 2014/15 – Q4 2018/19 to show rising and falling trends.





The table above clearly demonstrates the amount of PALS contacts received by specialities - Community Paediatrics remains the highest area and this quarter has seen an increase for the second quarter.
Q1 – 69
Q2 – 55
Q3 – 77
Q4 – 82

The table below shows the category of PALS concerns raised relating to Community Paediatrics in total for the full timeframe of Q4,



Key actions & lessons learnt from PALS during Quarter 4

The main issues identified within Q4 relates to appointments management –waiting times. The table below identifies the departments that this relates to

Row Labels	**Count of Category**
Waiting Time For Appointment	**52**
Audiology	4
CAMHS - Liverpool	1
Cardiology	1
Community Paediatrics	29
Dental & Oral Max Fac Medics &	1
Endocrinology	1
ENT Clinic	4
Gastroenterology	3
General Surgery	1
Neurology	3
Orthopaedics	1
Urology	1
(blank)	2

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

Compliments

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

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

1. Patients Mum and Grandmother into PALS office 25.02.2019.

Mum wanted to compliment and thank the staff on ward 4C, in particular the two nurses called Rebecca and a nurse called Amy.

Mum and Nan say all the staff have been amazing and they cannot fault the ward. They were also very positive about their experience in ED and the care they received on EDU.

2. Email Notification from parent;
I would just like to thank nurse Shelley Cobley who showed us such compassion while in Pre Op clinic yesterday. Shelley really took her time to explain the procedure to my husband who missed the initial ENT appointment, Shelley went completely out of her way to help us and even took time to call us and follow up how our Son was as we were sent to A&E. Such a kind Nurse with a fantastic holistic approach to nursing! Thank you.

3. Hi,

Im not sure this is the correct email address or if this email will reach its intended target but I felt I had to reach out following yesterday's visit to the A and E department.

My daughter (Arabella) was admitted after being poorly and the care and attention she received was second to none. She was seen to really quickly by trained, competent staff who reassured us throughout and could not do enough.

I want to give a special mention to 2 ladies: Anne Kerr (consultant) and Julie Ruling (healthcare assistant).. I hope I got their names correct. They went above and beyond in their roles, massively enthusiastic and made the baby really happy with constant attention and understanding of working with small children. They were incredible and really reassured me she was in safe hands in Alder hey.

Thanks

Staff support

Staffing within the PALS & Complaints service remains a challenge due to rise in activity of complaints and resources within the team.

Annual report
The Annual report is embedded and requires approval for publishing on external facing webpage.

DRAFT Annual Pals and Complaints repor

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

END

BOARD OF DIRECTORS

Tuesday 28th May 2019

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

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1. **Background:**

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

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

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

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

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

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

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

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

Current position

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

During this reporting period, there were no serious incidents reported. There were no safeguarding incidents reported and no never events. There were no SIRI's closed during this reporting period.

Table 2 shows the cumulative position; there are three open serious incident investigations.

Table 3 shows the Trust had no moderate harm incidents during this reporting period.

Table 4 shows there were two closed SIRIs during this reporting period.

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

	SIRI (General)													
	2017/18	2018/19												
Month	**Mar**	**Apr**	**May**	**Jun**	**July**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**
New	0	0	1	1	1	1	0	0	0	1	2	2	0	0
Open	3	3	2	3	2	2	4	3	0	0	3	5	5	3
Closed	0	0	0	0	2	1	1	1	3	0	0	0	0	2
	Safeguarding													
Month	**Mar**	**Apr**	**May**	**Jun**	**July**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**
New	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Open	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Closed	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Never Events													
Month	**Mar**	**Apr**	**May**	**Jun**	**July**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**
New	0	0	0	0	0	2	0	0	0	0	1	0	0	0
Open	0	0	0	0	0	0	0	0	0	0	0	1	0	0
Closed	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Cumulative Position													
	3													

Table 2 Ongoing serious incidents requiring investigation (cumulative):

On-going SIRI incident investigations							
Reference Number	**Date investigation started**	**Division**	**Incident Description**	**RCA Lead Investigator**	**Progress**	**60 working day compliance (or within agreed extension)**	**Duty of Candour applied**
StEIS 2019/3312	08/02/2019	Medicine	**Unexpected death:** The patient was admitted to Paediatric Intensive Care Unit from Emergency Department (ED) with septic shock on	**Investigation lead:** Amanda Turton, Head of Acute Care	Final report sent to CCG 08/05/2019.	Yes - Report was due for submission to CCG and CQC 08/05/2019.	Completed.

			4th January 2019. Full intensive Care support provided, but patient deteriorated, (multiple organ failure), and sadly died at 12.17 hours on 6th January 2019 Post Mortem finding: Influenza A positive (H1N1).				
StEIS 2019/3163	07/02/2019	Surgery	**Unexpected death:** The patient was admitted from the Emergency Department (ED) on the 03 February 2019, following collapse at home. Gastro-jej tube changed on the 01.02.19. Perforated bowel secondary to migration of Gastro-jej tube following the procedure on the 01 February 2019. Laparotomy and repair of bowel perforation performed on the 04 February 2019 (01.30), patient returned to PICU (03.00). Multiple inotropic support was provided; patient sadly went into multi organ failure. Extensive discussion with teams involved in the care. Decision to withdraw treatment; patient sadly died at 16:38.	Kelly Black, Surgical Matron	Final draft report received for quality check.	Yes – An extension was granted for submission to CCG and CQC 24/05/2019.	Completed.

StEIS 2019/1718	22/01/2019	Medicine	**Unexpected death:** Four month old baby was admitted to Alder Hey via Emergency Department (ED) on 15th January 2019, with a bronchiolitis type illness, admitted to Ward 4C. The patient was managed with Airvo and nasal cannula oxygen plus a mixture of bottle and NGT feeds. Respiratory PCR positive for coronavirus, human metapneumovirus and rhino/enterovirus. The baby previously had multiple attendances to the Trust. Just over 12 hour's pre acute collapse, the baby became tachycardic (fast pulse) and had episodes of fever, for which she was given paracetamol and ibuprofen on the ward. At 12:00 on 19 January 2019, a cardiac arrest call was issued because the baby had been found moribund and peri-arrest on the ward by her mother. The cardiac arrest team resuscitated her with assisted ventilation, dextrose and fluid boluses, IM and IV antibiotics. The baby was intubated on the ward, a high dose adrenaline	**Nursing lead:** Amanda Turton, Head of Acute Care **Medical lead:** Theo Anbu, Consultant	Second panel meeting being held 20/05/2019.	Yes - Report due for submission to CCG and CQC 28/06/2019.	Completed.

			infusion started and quickly transferred to PICU. Shortly after arriving in PICU, she went into PEA and CPR was commenced at 12:55hrs. Sadly, the baby did not respond to resuscitation and this was discontinued; baby sadly died at 13:20 hours.				

Table 3 Moderate harm incidents:

	Duty of Candour (excluding SIRIs)							
Reference Number	**Date investigation started**	**Type of investigation**	**Division**	**Incident Description**	**Lead Investigator**	**Progress**	**60 working day compliance (or within agreed extension)**	**Duty of Candour applied**
				Nil				

Table 4 Closed SIRIs:

On-going SIRI incident investigations							
Reference Number	**Date investigation started**	**Division**	**Incident Description**	**RCA Lead Investigator**	**Progress**	**60 working day compliance (or within agreed extension)**	**Duty of Candour applied**
StEIS 2019/1967	24/01/2019	Surgery	**Never Event Wrong Site Surgery - Wrong site anaesthetic block:** A wrong site block was performed on a patient. Full checks were completed and the 'stop before you block' undertaken, however this was before the local anaesthetic was drawn up. Markings were noted as part of the check; however the operator position changed for ergonomics with the ultrasound scan. The error was identified and immediate action was taken, including the declaration of the incident as a 'never event' and a discussion held with the family.	Paula Clements, Theatre Matron	Final report sent to CCG and family.	Yes	Completed.
StEIS 2018/30070	19/12/2018	Surgery	**Unexpected death:** 24 week gestation baby, transferred from Liverpool Women's Hospital for central line	Stefan Verstraelen, Head of Quality, Surgery	Final report sent to CCG and family.	Yes	Completed.

			insertion. The baby had undergone previous surgery for NED and had previous line insertion problems. The baby had many known co-morbidities. The baby died following transfer to the Intensive Care Unit at Alder Hey Children's Hospital.	**Nursing lead:** Joanna McBride, Head of Nursing, Cardiac and Critical Care Services **Medical lead:** Peter Murphy, Consultant			

END

Trust Board
28th May 2019

Subject/Title	Digital and Information Technology Update
Paper prepared by	Kate Warriner, Chief Digital and Information Officer
Action/Decision required	Trust Board is asked to note the update on Digital and Information Technology current position and planned next steps
Background papers	None
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Inspiring Quality, Strong Foundations Significant contribution to the strategic objectives for: - Brilliant Basics - Digitally Enabled Care - Outstanding Care - Game Changing Innovation - Positive patient experience - Improving financial strength

Digital and Information Technology Update

1.0 Purpose of Paper

The purpose of this paper is to provide the Trust Board with an update on Alder Hey's emerging digital strategy, 19/20 change programme priorities and operational Information Technology progress.

2.0 Digital Strategy

Work commenced in April 2019 with regards to the development of a new digital strategy for Alder Hey. Recognising developments to date including progress through the Global Digital Exemplar programme and wider digital innovation, the strategy aims to strategically align several areas of ambition into a single strategy and narrative.

Following engagement and feedback from clinical teams, the Alder Hey Forum, divisions and subject matter experts, the emerging focus of the strategy is in relation to a theme of digital excellence. This incorporates a range of ambitions including having the best digital experience for our staff, our children, young people and their families.

The strategy starts to explore the concept of digital excellence including outstanding digital excellence – on a par with clinical excellence, a 'digital first' culture and a focus on digital quality improvement, moving towards an intelligence and outcomes driven approach.

Crucially, the term digital excellence focusses on the experience of both our staff, children, young people and families with regards to both the internal and external experiences of digital at Alder Hey. This ranges from an exemplar approach to the day to day use of core systems and technologies with an 'invisible IT' aspiration that things work so well for staff that they are 'invisible' and having an innovative and impressive 'digital front door' for our children, young people and families and the wider external world.

The strategy development incorporates our thinking and ambitions with regards to external partnerships and key digital and med tech developments including artificial intelligence, sensors and visualisation/immersive technologies.

The strategy will be further developed over the course of May/June, be presented to GDE Board / RABD in June and Trust Board in July 2019.

3.0 19/20 Change Programme

As part of the development of the digital strategy, the wider committed external programmes and the internal review of the Trust change programme, 19/20 digital transformation programmes have been reviewed.

The priorities for 19/20 are:

- Global Digital Exemplar and HIMSS Level 7 Accreditation
- Electronic Patient Record Upgrade Planning
- Paperfree

3.1 Global Digital Exemplar (GDE) & HIMSS Level 7 Accreditation

Alder Hey is in the final year of the GDE programme. To date, progress has been good with all payment milestones achieved.

There are 2 payment milestones remaining, these are in December 2019 and March 2020.

The overall objectives of the GDE programme from a national perspective are focussed on two key accreditations:

- Healthcare Information and Management Systems Society (HIMSS) Level 7
- National GDE Accreditation through the NHS England/Digital Definition of Done

Both areas of accreditation demonstrate a high degree of digital excellence and care and are in alignment with the Trust's aims 'To digitally enable Alder Hey to help deliver enhanced patient outcomes, service efficiency and patient and staff experience' and 'Demonstrate Alder Hey as an Exemplar and leader in healthcare technology'.

From a financial perspective, the final payment milestones equate to 1.3M and 350K respectively. In terms of accreditation, there are a number of gaps and actions being managed via the GDE programme board.

3.2 Electronic Patient Record Upgrade Planning

In line with improving staff experience of core clinical applications, a previous paper has been presented to RABD and Trust Board with regards to recommending an upgrade to the Trust's EPR.

There are a number of factors which are currently being progressed with regards to the EPR upgrade. These include:

- Engagement with clinical teams with regards to functionality linked to contractual discussions
- Infrastructure direction
- Disaster Recovery and Resilience
- Implementation Resources

Once a clear proposal is in place, a further report will be prepared for internal approval. For planning assumptions, July 2020 is the target implementation date.

3.3 Paperfree

Whilst significant progress has been made with regards to the digitisation of care processes through speciality packages, there is work to be done with regards to moving the Trust to a paperfree at the point of care environment.

A review is underway with some external subject matter expertise to support us with moving to a paperfree environment which will conclude with recommendations over the forthcoming weeks.

Due to the operational and safety records risks, it is recommended that a 12 month paperfree programme, linked to GDE and the EPR upgrade is commenced to address In Patients, Out Patients and Community services.

4.0 Operational Information Technology Delivery

As previously reported with regards to operational Information Technology delivery, there are a range of services delivered to staff with a blended approach of in house, NHS shared service and external supplier partnerships.

There are a number of areas of good practice and a range of areas requiring development in terms of operational IT. An independent review was undertaken in May 2019 with a number of key recommendations identifying areas requiring strengthening.

These include areas linked to the emerging strategy in terms of the end user experience, a focus on an end to end review of service delivery with a focus on staff and integration with the divisional structure.

The review highlighted some areas for immediate action including a review of service resilience, disaster recovery, infrastructure strategy and operational processes.

In addition, the review highlighted a known priority with regards to a programme of work focussed on ‘non GDE’ Information Technology Programmes and a Service Improvement Plan for Community IT.

An Interim Associate Director of Operational Information Technology has commenced to develop and oversee an improvement plan and a substantive appointed to develop our service for the future.

5.0 Risks

There are a number of emerging risks to delivery of both the transformation and operational areas of Digital and Information Technology including:

- HIMSS accreditation: Closed Loop Medications complexity - impact to GDE and HIMSS accreditation. Detailed plans in development
- Risk of dual paper and digital records compounded by scanning delays – to be mitigated via proposed paperfree programme
- Service and Information Technology resilience – lack of secondary data centre / disaster recovery infrastructure. Options appraisal in progress
- Investment post 19/20 – to be quantified as part of the digital strategy and immediate risks in terms of resilience and service delivery
- Microsoft support – requirement to move to Windows 10 and Office 365 by the end of December 2019 due to lack of support nationally post this date

6.0 Summary and Recommendations

In summary, there are areas of great practice and areas to strengthen in terms of digital and Information Technology in Alder Hey.

Trust Board is asked to note the content of this report and planned next steps:-

- Digital strategy development – to be presented to Trust Board in July 2019
- 19/20 Change Programmes aligned to strategy and organisational priorities
- GDE / HIMSS progress and Closed Loop Medication complexity
- Operational IT areas of focus
- EPR upgrade report to be developed
- Paperfree programme development
- Key delivery risks

Kate Warriner
Chief Digital and Information Officer

Alder Hey Children's NHS
NHS Foundation Trust

Joint Clinical Quality Assurance Committee & Clinical Quality Steering Group meeting
Minutes of the last meeting held on Wednesday 17th April 2019
10.00 am, Lecture Theatre 4, Institute in the Park

Present:	Anita Marsland	(Chair) Non-Executive Director
	Dame Jo Williams	Chair
	Denise Boyle	Associate Chief Nurse - Surgical Division
	Pauline Brown	Director of Nursing
	John Grinnell	Deputy Chief Executive/Director of Finance
	Dani Jones	Director of Strategy
	Hilda Gwilliams	Chief Nurse
	Anne Hyson	Head of Quality – Corporate Services
	Phil O'Connor	Deputy Director of Nursing
	Erica Saunders	Director of Corporate Affairs
	Pauline Brown	Director of Nursing
	Mark Flannagan	Director of Communications and Marketing
	Nicki Murdock	Medical Director
	Lesley Robinson	Quality Assurance & Compliance Manager, Medicine Division
	Sarah Stephenson	Head of Quality – Community
	Melissa Swindell	Director of HR & OD
	Cathy Umbers	Associate Director of Nursing & Governance
	Will Weston	Associate Chief of Operations, Medicine Division
	Tony Rigby	Deputy Director of Risk & Governance
	Val Shannon	Voluntary Services Manager

In Attendance:
Agenda Item:

	Geri Sefton	ICU Clinical Development Team
	Fulya Mehta	Consultant, Diabetes Team
	Jill Preece	Governance Manager
	David Porter	Consultant Infect
	James Ashton	Sepsis Specialist Nurse
	Rachel Greenwood-Bibby	Staff Nurse, AED Department
	Natalie Deakin	Change Programme Manager
	Val Shannon	Voluntary Services Manager
	Jude Scott	Client Manager, Meridian
	Julie Creevy	Executive Assistant (Minutes)

19/20/01	**Apologies:**	
	Jackie Allen	Senior Nurse
	Stephen Almond	Medical Devices Safety Officer
	Catrin Barker`	Chief Pharmacist
	Adam Bateman	Chief Operating Officer
	Paula Clements	Clinical Lead, Recovery
	Lisa Cooper	Director of Children & Young People Community & Mental Health
	Jeannie France-Hayhurst	Non-Executive Director
	Adrian Hughes	Acting Joint Medical Director & Director, Medicine Division

Rachel Greer	Chief Operating Officer, Community Division
Rachael Hanger	Theatre Matron, Surgery Division
Jo McPartland	Clinical Director for Cancer Services & Laboratory Medicine
Matthew Peak	Director of Research
Louise Shepherd	Chief Executive
Lachlan Stark	Head of Performance & Planning
Cathy Wardell	Associate Chief Nurse – Medicine Division
Julie Williams	Appointed Governor

19/20/02 Declaration of Interest

None declared

AM welcomed all to the first Joint Clinical Quality Assurance Committee & Clinical Quality Steering Group. AM confirmed that the aim was for the Joint committees to meet twice per year. AM stated that on behalf of CQAC members that she wanted to thank CQSG members personally for continued support to date, AM expressed her disappointment at the small numbers of CQSG members in attendance, whilst also appreciated that it was the half term holiday period, which contributed to low CQSG members in attendance.

PoC thanked CQAC members for close engagement and support to date, and stated that the CQSG hoped to learn more by attending the joint meeting on

HG reiterated AM comments, adding the benefit of experiencing information flow from ward to board is invaluable.

AM welcome JP, Governance Manager who had returned from maternity leave.

19/20/03 Minutes of the previous meeting held on 20th March 2019

Resolved:

CQAC approved the minutes of the previous meeting held on 20th March 2019.

19/20/04 Matters Arising and Action Log

Transition Update

The Committee noted update paper received from J Rogers, following attendance at Triumvirate meeting on 26TH March 2019 the paper would also be circulated for those not in attendance. Committee noted that limited progress had been made, however there is still further improvements required. HG queried whether any regional information had been received – NM stated that there is a pilot project which Alder Hey Children's NHS Foundation Trust had applied to be involved in, however it had been disappointing to hear that the Trust was not successful in being involved with the pilot and that the Trust would be involved with the next phase/wave. NM agreed that a briefing position statement paper would be completed by JR and shared with Exec Team for further discussion.

Action: NM to ensure a Briefing paper is shared with Exec Team (when). DJ stated that she was due to meet with Martin Farrow, from Liverpool City Council on 19th April 2019.

ES stated that for the next CQC Engagement meeting scheduled on 11th June 2019, Alder Hey would be requesting if CQC could acknowledge that Alder Hey

Children's NHS Foundation Trust had actioned as much as feasibly possible, with the blockages occurring from the Adult providers who do not have the capacity/element of skill mix to accept the transition patients. The committee noted that there is no similar CQUIN in adult services. Dame Jo highlighted the importance of continuing to follow this up, especially given the support that had been provided to date, in order to prepare families for transition.

HG stated that informal feedback had been received from the parents of a renal patient whose young adult son had been fully prepared for transition process, and Alder Hey Children's NHS Foundation Trust staff then having to inform the family that he could not be accepted by the Adult provider, with the patient and parents then feeling significantly let down, and resulting in a lack of trust.

JG stated that this is being discussed at Exec level, with a further update to CQAC in due course.

Action: CQAC to receive an update at the July CQAC meeting.

TR stated that there had been close engagement regarding Transition CQUIN and that this is close to sign off.

Update on Safer Bundle
The committee received and noted update slides regarding Safer bundle for 3A and 4C, slides would be circulated to those not in attendance prior to the next meeting. The committee agreed it beneficial to receive a further update at May CQAC meeting.

Action: CQAC to receive Safer Bundle update for May 2019 meeting.

19/20/05 **Sepsis Project**
D Porter, J Ashton, R Greenwood-Bibby & G Smith presented the Sepsis update, key issues as follows:-

- ED – mean time 44.9 mins (median 41.5 mins, n=34)
- Inpatients – mean time 53.7 mins (median 36 mins, n=31)
- Sepsis Status – January – total cases 47, number with initial concern – 15, - 32%
- Feb – Total cases – 39, number with initial concern/sepsis status activitated = 18 – = 46%
- March (all patients now have a status)
  Total cases = 31, number with sepsis status activated = 15 - = 48%

Key issues: progress
Standard docs / sepsis status
– Live Feb 2019
– Improved data recording, efficiency of collection
– Further highlighted confusion – 'what is sepsis?'
– Subset of 'treating as sepsis' – trend to better times

March: overall treated <60 min 74% of 'treat as sepsis' subset 87%
– Implementation for ED
– Dashboards

DETECT implementation
- Challenges with systems integration
– ?Double data entry or manual data sync
– Not losing aspects of sepsis assessment

MIAA audit
- Completed in Sept 2018, with report now circulated for management response

Action: CQAC to receive MIAA report including recommendations at the July 2019 CQAC meeting.

AM thanked all for update.

Detect Project
Gerri Sefton & Fulya Mehta presented the Dynamic Electronic Tracking and Escalation to reduce Critical Care Transfer (DETECT) Study, which detailed Trajectory of deterioration, Chain of prevention, 'Life saving' technology, Critical deterioration events, Baseline data, Intervention phase & Organisation governance.
Key issues as follows:-

- Baseline data had been collected from March 2018 – February 2019
- NIHR i4i funded study 1.25M to evaluate Careflow Vitals & Connect (VitalPAC)
- The Clinical Effectiveness
- The cost-effectiveness
- Hardware and software is provided within the research grant.

Critical Deterioration Events – Impact of Rapid Response System Implementation on Critical Deterioration Events in Children

- PICU or HDU admission + any of the following within 12 Hours:
  - Non invasive ventilation
  - Mechanical ventilation
  - Inotropes

  13 x increased risk of death

Baseline problem – 1 year

- 332 unplanned admissions/critical deterioration events to PICU and/or HDU 257 patients
- 4.2 CDE per 1,000 non ICU beds days "Sepsis" 27%
- Monitoring; 85% completed PEWS assessment
- Frequency cannot assess, PEWS 3+ blood pressure not done 39% & 62%
- Recognition; delay in documentation >30 mins, 25% & 29% of vital signs, variance across wards. (11.5K set obs)
- Escalation & Response; escalation to NIC, escalation to Dr/ANP (n=788) 37% within 30 minutes, 2% remained with patient, 31% attended, no documentation, 30% >30 minutes.

Outcomes

- Critical care mortality 4.6% per CDE event, 5.8% per patient
- 7% hospital mortality, 10% with CC discharge to hospice.
  PICU 12, HDU 3, ward 3, discharge to hospice/palliative care 7
- Significant critical care and ward bed utilisation.
- 5 PICU beds per day + 6 HDU beds per day + 10- ward beds per stay, resulting in a staggering cost for bed days.
- 50% of events potential for preventability and/or reducing CC utilisation

Intervention phase – Careflow Vitals, Stepwise Roll out, from 8th May 2019.

NM sought clarification regarding improvement project and queried the retrieval of data and expressed concern that this would be using another parallel system. FM stated that this had been trialled on wards and that the system is beneficial, although the team recognise that there is still further improvements to be made. HG stated that the issue regarding interface is well made, and that team are looking for a solution as meditech does not have sufficient capacity at present, and that feedback from the nursing cohort had been received. HG stated that the issue regarding the interface requires resolving and agreed that it would be beneficial for NM/HG & Kate Warriner to meet with regards to next steps/options appraisal to fully review further.

PB queried the reasoning why Neonatal was not included, DETECT team confirmed that Neonatal had changed to badger and that the team had no capacity therefore Neonatal was not included.

PB questioned the issue regarding the recording of blood pressure – and whether the system mandated blood pressure. GS confirmed that through the weekly reporting process, that this would be reviewed and addressed in order to change behaviours.
AM thanked GS & FM for detailed update.

Action: Meeting to take place to agree next steps/options appraisal.

CQAC received and noted the DETECT study position statement.

19/20/06 Sepsis training figures & Junior doctor training figures update

MS presented an update on Mandatory training figures. CQAC noted that the current overall compliance for this group is 47.64% with Sepsis training – 70% which is made up of competencies gained from trainees at other organisations, online using e-learning for healthcare and competencies gained at Alder Hey during induction and through other training. MS stated that this is the first time that the Trust had reported on compliance for this staff group, and that this was a first step in order to improve compliance for this group. Second stage of improvements would be to identify a clear escalation structure for following up/prompting individuals, in order to complete their outstanding training. This will initially be supported by Medical Education Team, but should there be a resistance/unwillingness from the trainees to update their training then an additional escalation point would need to be identified. There may be a requirement to review how the Trust inducts new rotations at it is not clear from the data that – topics are included on their induction, vastly outperform others and whether topics that are delivered at all hospitals i.e. health and safety outperform Alder Hey Specific requirements i.e. Safeguarding Children Level 3 due to the fact that all new rotations will be unlikely to have completed this prior to joining the Trust.

MS emphasised that all individuals who are working within the organisation and are on the payroll, can access ESR and can access mandatory training. MS stated that the HR team are working in collaboration with the subject matters with agreement required from the lead employer. NM stated that she intends to work with G Cleary with regards to orientation programme for the future. HG stated that she welcomed the position statement, however from an assurance

perspective that there is a need to review the escalation process in a timely manner, enabling a recovery period.

Action: CQAC agreed that the overall Trust position would be shared at Exec team to ensure high level discussion, with CQAC receiving a further update at the July CQAC meeting.

AM reminded the committee that training is everyone's responsibility. MS stated that mandatory training had dramatically improved over the last 12 months, with core subjects equating to approx. 90%, MS stated that there had been a slight decrease over the last few months. MS confirmed that training data is distributed regularly to divisions and confirmed that data is improving now that there is a dedicated resource. However there is a need to develop an escalation process for areas of non compliance.

DP stated that despite staff being able to access ESR that the sepsis continue to experience difficulties with accessible data in order to collate data. DP requested whether Sepsis team could receive a list of staff members who could provide assistance.

AM thanked MS for update.

19/20/07 **Friends & family feedback/action plan**

V Shannon, presented the High Level Family Friends/Survey action plan, highlighting themes and trends which included 21 actions which were currently being monitored through CQSG on a quarterly basis.

CQAC received and noted the High Level Family Friends/Survey action plan.

VS introduced Jude Scott, Client Manager from Meridian. Jude provided an overview of functionality of the Family & Friends online feedback software tool used to enable teams to assist with monitoring compliance with standards, measuring the quality of processes across the organisation, conduct a patient feedback programme in which the patient is held firmly at the centre of its services and drive improvement. This tool will enable the Executive Team and the Board of Directors to have a real-time awareness of the level of care being provided to our Children & Young People, complete with early warning indicators highlighting potential problems. The tool enables the Trust to gather high volumes of feedback using a number of different methods of data collection (online, web, kiosk, mobile, paper, telephone, QR code and SMS) and importantly have dynamic reporting in one consolidated, real time environment. Reports can be tailored to Trust requirements and to the position and responsibilities of those individuals accessing the reporting.

Dame Jo W queried whose role it would be to review issues and themes and expressed concern regarding the manpower to review issues and themes. HG stated that there is currently a plethora of staff who have had to review data manually and that this new tool was extremely welcomed in order to provide divisions and wards with real time reporting.

CQAC welcomed the use of the online feedback tool.
AM thanked VS and Jude Scott for update.

19/20/08 **Programme Assurance Update**

N Deakin presented the Programme Assurance update, key issues as follows:-

- The 'Delivery of Outstanding Care' programme governance is satisfactory, with all projects rated amber or green. Delivery ratings still require improvement and have in fact deteriorated further this month.
- The 'Sepsis' project had seen a deterioration in overall governance rating this month and agreement of the new target thresholds and a detailed plan for 'year 2' had been outstanding for a number of months.
- The 'Comprehensive Mental Health' project had seen further deterioration this month and the lack of any positive trends on metrics should be promptly addressed by the Exec Sponsor.
- Clarification of metrics for success are still required for the 'Models of Care' Project.

ND tabled and presented a devised assurance report which detailed a baseline, target/quality metrics and asked the committee whether this report would be more helpful to provide to the committee in the future. JG stated that this new assurance report had been created following comments requesting broader challenge, with JG keen to view corporate performance/mandatory measures/keeping patients safe measures. JG stated that he and ND welcomed comments regarding the new report and how this works for teams.

ND confirmed that this report would obviously lengthen the committee pack, however ND could provide a summary cover sheet highlighting key issues for committee attention. JG stated that there may be other areas in order to stretch and improve further, in order to ensure smarter working with regards to any 'red flags', and with regards to holding staff to account.

TR queried whether there is a process in place to capture what action is required, in order to bring the project to 'green status' and the benefit of including comments which would be visible to the committee. WW stated it would be helpful if the report could display progress/timeline detailing how long/short action had taken to be resolved. HG stated that CQAC is an assurance committee and it would not be in the remit of CQAC given the time critical agenda items on CQAC agenda. AM stated that the strategic element is important with the requirement for a 'deep dive'. It was agreed that operational matters to be discussed via Programme Board.

CQAC/CQSG noted the importance of Exec leads taking prompt action in order to address issues/lack of progress relating to 'The Delivery of Outstanding Care', The Sepsis Project and the Comprehensive Mental Health Projects.

Action: Execs Leads to address (AB/HG/LC/AH)

AM thanked ND for update.

19/20/09 **CQC Action plan update**

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

- ES stated that those items that remained on CQC Trust wide action plan generally are longer term actions, i.e. MIAA review.
- Improving Diversity on Board of Directors – ES stated that this action would be a longer term goal.
- Transition issue longer term action/maintenance issue.
- DBS checks – MS confirmed that a meeting is scheduled with staff side on 1st May 2019, MS stated that she is not unduly concerned

- Strategic plan - Divisions are all aligned and have received the timetable as appropriate, all are content with wider discussion with regards to CQC at CQC engagement meeting on 11th June 2019. CQAC/CQSG noted the residual items on the Trust wide action plan.
- Community Division – currently on plan, SS stated that support would be required regarding 'assigning a case co-ordinator for ASD/ADHD Co-ordinator'. as the Community Division are not able to currently action this, and that this item is not currently of high priority.
- Community Division – IT Action Plan regarding migrating surfaces, staff transitioning to LCH. SS stated that the migration plan is due to take place on 30th August 2019, and that this item would remain on the action plan until the migration had taken place. HG sought clarification as to the reasoning for the timeframe for the migration taking place on 30th August. SS stated that there are significant number of different owners, together with different networks and that this wasn't a straight forward migration. HG stated the importance of linking in with Kate Warriner, IM&T lead to enable Kate to determine whether there is any possibility of escalating and expediting an earlier date of planned migration.

  Action: HG to liaise with KW to determine any possibility of bringing forward migration date.

ES requested all divisions to consider and agree how to progress further. ES stated that a pre meeting during end of May 2019, in advance of CQC engagement meeting would be beneficial. With the need for Medical & Community Divisions to review and consider outstanding actions within Divisional meetings.

End of Life – WW stated that there were a couple of outstanding actions which remained on the Action Plan – with organisational change due to conclude at the end of March 2019. WW confirmed that the Division would require support and assistance with regards to Patient Information Leaflets.

Radiology - GDE meditech and dashboard – both are progressing as planned.

CU emphasised the need for focus by divisions on the remaining actions.
AM thanked ES and teams for update.

19/20/10 **Corporate Report – Quality Metrics**

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

There had been 2 catastrophic incidents in February resulting in unexpected deaths, 1 within Surgery and 1 with Medicine Division.

Surgery - Day case child who had undergone a procedure to change from a Freka Gastro-jejunal tube to Mickey jejunal tube under radiology guidance, 1/2/2019; the child was brought back to hospital 2 days later (3/2/2019) and underwent emergency surgery to repair a jejunal perforation. Unfortunately, the child deteriorated rapidly following surgery. After extensive discussion amongst the teams involved and with parents, it was decided that withdrawal of intensive care was in the best interest of the child; the child sadly passed away on 5/2/2019. This incident is currently being investigated by the Division via a Root Cause Analysis (RCA) Level 2.

Medicine - The other unexpected death related to a child who had flu, and suffered multi organ failure and very sadly passed away. Duty of Candour had been completed in line with regulation 20. The 72 hour review had been completed in line with National standards and Trust policy and submitted to the CQC and CCG. Leads had been identified and the level 2 RCAs for both incidents are currently underway.

- There had been 4 medication errors resulting in harm, three mild non-permanent, and one moderate semi-permanent harm incidents. Two related to omitted doses of medicines. The Medication Safety Committee are working with Information Department to develop a report from the EPMA system to review delayed and omitted does and will work with relevant teams to develop an action plan in order to reduce occurrence. The incident which caused moderate harm involved the administration of 1000 times the intended dose of hydrocortisone. An investigation into this incident is being conducted currently by senior staff AMR (MSO).
- There had been 3 Hospital Acquired Organisms – Gram Negative BSi during February. With all bacteraemia being reviewed though the RCA process. All lessons are identified and are fed back to the specific division for action. All 3 children did not come to harm
- There had been 0 grade 3 pressure ulcers since May 2018.
- PALS – during February 2019 complaints remained low, however the team had seen a peak during March 2019, AH confirmed that it is common to see seasonal fluctuations.
- EDD, PB stated that the changes to white boards had resulted in positive improvements.

JG asked whether a more detailed report could be shared with CQAC with regards to clinical incidents resulting in minor harm. PB reminded the committee that the Trust is one of the highest incident reporting Trusts in the country. PB stated that the outputs from the Patient Safety weekly meetings is staggering with regards to work generated in order to improve care and improve patient safety.

Action: CQAC to receive analysis of minor harm incidents at the July 2019 CQAC meeting.

AM thanked PB for update.

19/20/11 CQAC Annual Report

AM presented the CQAC Annual Report for 2018/19 which detailed the purpose and principles of the committee, together with details regarding constitution, record of attendance and Committee priorities.

AM asked the committee whether they were in agreement with the committee priorities. Dame J W queried whether the committee needed to link priorities to the Overall Trust Strategy with regards to ensuring that the message was conveyed regarding ‘Safest place for children. All agreed that the link to the overall strategy should be included within the Committee priorities for 2019/20, ES agreed to update as appropriate, prior to this being presented to Audit Committee on 23rd May 2019.

Action: ES to amend committee priorities as appropriate.
CQAC received and noted the CQAC Annual report.

19/20/12 Board Assurance Framework

ES presented the Board Assurance Framework and confirmed that the team were in the process of closing down 1 BAF and opening a new BAF. ES stated that Dani Jones, Director of Strategy had presented a list of themes at a recent Exec Strategy day on 11th April 2019. ES stated that there is a requirement to reflect whether the strategic risk is articulated correctly. ES stated that the Trust did receive full assurance from MIAA, in the end of year Assurance Framework Opinion, and that Kerry Byrne, NED is currently undertaking a deep dive into BAF Risks at the Integrated Committee Committee meetings.

AM stated that a discussion is required with regards to any potential for duplication with regards to scrutiny, and that there is a need for clarity to ensure no duplication. AM had been requested to share some scrutiny issues through Audit Committee. AM was not in favour of this approach, and reminded the committee that there is an absolute requirement to ensure that CQAC are fully assured regarding managing risks etc. AM stated that it was encouraging to see that the outcome of MIAA findings provided committee with assurance.
AM thanked ES for her update.

19/20/13 Accessible Information Standard report

A Hyson presented the Accessible Information Standard report which detailed the current position for the Trust in relation to implementation of Accessible Information Standard. The Accessible Information Standard (AIS) was introduced by the government in 2016 to ensure that people with a disability or sensory loss are given information in a way they can fully understand. AH confirmed that a meeting had taken place with the Head of Clinical Systems for IM&T and the Director of Nursing to review the proposal for capturing AIS information on Meditech and the feasibility of building this within the system. The System requirements are already built and can be implemented easily within a few days once the team are notified. What is however required is an understanding of how this information when received from a child or relative/ carer should be inputted on the system and by who. This will require some process mapping to determine the most appropriate way to input the information.
Once this mapping has been completed IM&T can be advised of the outcomes and will then be in a position to make the module live and implement this.
Anticipated timeframe for this to be concluded is the end of April 2019.

Liverpool CCG leading a Reasonable Adjustments Task and Finish Group

The CCG have started a T&F group with representatives from all of the local providers looking at reasonable adjustments – staff included in this piece of work also. Currently there had been two meetings with the third planned on 4th April 2019.
Plans are to have a Standard Operating Procedure (SOP) that can be used by all Trusts, to use consistent external communication tools e.g.: - BSL video on website advising people how to make a complaint and to examine examples of all providers policies and use as support for Trusts who don't currently have policies in place

AH stated that the team are currently looking to procure an appropriate system to contact deaf family members in order to relay relevant information to deaf patients.

Mobile phone is in use within PALS office, Makaton training session had been arranged to take place on 23rd April 2019. CQAC noted progress.
AM thanked AH for update.

19/20/14 Nutritional Steering Group update

In the absence of LC & RD, Denise Boyle presented the Nutrition Steering Group Update following the Nutrition Steering Group meeting held on 8th March 2019 key issues as follows:-

- The first Nutrition Steering Group took place on 8th March 2019, the ratified minutes of the Nutrition Steering Group meeting will be presented formally to Clinical Quality Steering Group in due course. DB confirmed that priorities had been agreed for 2019/20, detailing a number of performance indicators/standards and reviews of enteral feeding procedure.
- Significant focus on work plan and regulatory and advisory standards.
- Discussion took place regarding the Nutrition Terms of Reference – HG queried whether there was a chef included within the membership. HG also questioned whether a gastroenterologist was included within the core membership and advised that currently no medical representation.

- The Committee noted the work priorities for Nutrition Steering Group for 2019/20
  Review of current nutrition policy with view to developing nutrition strategy
  - Review of current nutrition standards and collection of evidence to demonstrate compliance and improved outcomes for children and young people
  - Review of performance indicators; incidents, complaints and compliments relating to nutrition and hydration
  - Review of current enteral feeding procedures

Action: Offline discussion with HG & NM re ToR – medical representation required.

AM thanked DB for her update.

19/20/15 Duty of Candour Audit

CU reported that there had been 3 incidents, - 2 unexpected deaths and 1 Moderate harm. CU confirmed that the Trust are compliant with regards to Regulation 20. Jo Gwilliams had presented annual audit, CQAC would receive update by exception.
AM thanked CU for update.

19/20/16 CQUIN Update

TR presented update on delivery of CQUINs, key issues as follows:-

- **Those red rating CQUINs as follows:-**
  - Reducing the impact of serious infections – AMR and Sepsis (CCG)
  - NHS staff health & wellbeing
  - Paediatric Networked Care (NHSE)

Amber rating:-
  - Improving services for people with Mental Health needs who present at A&E (CCG)
  - Haemtrack (NHSE)

The financial risk associated with the local/national (CCG) CQUINs, in part, mitigated through the 'Acting as One contract.

- The total value attributable to the delivery of CQUIN schemes for 2018/19 is £3.4M across all commissioners.
- The financial risk for the year end based on the Q4 forecast position is circa £400k, the largest proportion of which is due to the non delivery of the paediatric network care CQUIN worth £332k. Work is ongoing to identify and mitigate risks to delivery of CQUINs.

- Committee noted the proposed CQUINs for 2019/20. The proposed initial list included 3 CQUINs for Alder Hey. No proposed financial valued had been received to date.
- Staff flu vaccination – 80% accepted
- Community based PICC lines secured using a Secur /Acath – rejected as not used in children

Commissioners had also suggested that there may be an option of extending or proposed local CQUINs.

Paediatric CQUIN – team currently working with Manchester, there are some challenges with regards to engagement, this had been escalated by John Grinnell, JG had discussed with commissioners in order to reach agreement.

ES queried whether TR had shared information with relevant teams and whether discussion had taken place with D Jones, Director of Strategy. TR confirmed that no dialogue had been made with DJ and that he would follow this up. SS also confirmed that she had not had sight of CQUINs for Community Division.

19/20/17 Divisional Governance Reports

DB presented the Surgery Division governance report, key issues as follows:-

- There were 205 incidents reported in February 2019: 112 were 'no harm', 47were 'minor/non-permanent harm', 45 were a 'near miss' and 1 was a 'moderate harm'. Three incidents were reported as 'catastrophic / death'. With regards to the 3 'catastrophic / death' incidents, 2 of these incidents Concerned the same child (incidents 33746 and 33652 are linked). A child re-attended AHCH with possible post-operative complications following change of a Freka Gastro-jejunal tube to Mickey jejunal tube under radiology guidance on 1/2/2019; the child was brought back to hospital 2 days later (3/2/2019) and underwent emergency surgery to repair a jejunal perforation. Unfortunately, the child deteriorated rapidly following surgery. After extensive discussion amongst the teams involved and with parents, it was decided that withdrawal of intensive care was in the best interest of the child; the child sadly passed away on 5/2/2019. This incident is currently being investigated by the Division via a Root Cause Analysis (RCA) Level 2.

  With regards to the second 'catastrophic / death' incident (33710): this incident originated in AED, but was reported by CCU. This incident is being investigated by the Medicine Division via an 'After Action Review' (AAR) and is supported by the Surgical Division, with input from a PICU Consultant and the Head of Nursing Critical Care & Cardiac Services.

- The 'moderate harm' incident concerns a 1000 times drug error / overdose of

hydrocortisone (prescribed 500 micrograms, received 500 milligrams); appropriate clinical actions were taken post-incident; the patient required additional monitoring and the staff involved were managed and supported in line with policy. An RCA Level 1 has been completed.

- There were 56 medication errors; 18 of these were: wrong dose / wrong dose prescribed / duplicate dose and 11 were: wrong frequency / delay in administering medication / dose given at the wrong time / missed dose / dose omitted. Other causes include: wrong storage, missing stock and labelling error. None of the medication errors resulted in harm.
- There were 3 10x errors (2 overdose and 1 underdose).
- There had been 45 near miss incidents, the top two being medication errors (including: documentation errors, inappropriate disposal, missing stock, wrong frequency, wrong dose prescribing, missed dose and 10x overdose).
- Documentation (records, identification, IT system) (including: incorrect patient details entered into Meditech, Filescan issue and Meditech issue).
- 3 SIRI's had been reported in February 2019. One SIRI which was reported in December 2018, concerned an incident regarding the care and treatment of a neonatal baby, who sadly passed away on 12 December 2018. The incident has been investigated via a joint RCA L2 between AHCH and LWH and a comprehensive investigation report is currently going through the quality assurance stages before Executive sign off.
- Investigations and action plans are proactively managed and monitored in the Surgical Division: over the last 12 months, there have been 21 RCA Level 1 investigations (12 open, 9 closed) and 7 RCA Level 2 investigations (5 open, 2 closed). There are 21 closed RCA Level 1 and 7 closed RCA Level 2 investigations on the log, with a total of 201 actions completed.
- There are currently (as per April 2019) 17 open RCA Level 1 investigations (6 minor/non-permanent harm, 8 no harm, 1 near miss, 2 moderate/semi-permanent harm) and 9 open RCA Level 2 investigations (4 catastrophic/death, 2 moderate/semi-permanent harm, 1 severe/permanent harm, 1 minor/non-permanent harm, 1 no harm) on the Divisional log, with 72 actions completed and 24 actions due to be completed (mostly awaiting supporting evidence).

LR presented the Medicine Division governance report, key issues as follows:-

- 177 incidents: 100 were 'no harm', 35 were 'minor/non-permanent harm', 40 were a 'near miss'
- No (0) Grade 3 and no (0) Grade 4 pressure ulcers.
- Three formal complaints received during February 2019
- Hand hygiene 93% compliance.
- Excellence and Compliments now received via Ulysses reporting
- Ward accreditation: 1/8 Gold, 4/8 Silver, 2/8 Bronze.
- A Turton reviewing harm levels, with the Divisional patient safety meetings allowing teams to review and prepare as appropriate in order to review harm details in great detail.
- 40 open investigations, 18 investigations currently underway,
- 22 investigations reported with Action plans being monitored
- Medicine division are working closely with C Umbers to discuss progress and allow team engagement.
- 3 formal complaints received in February, team are working with A Todd,

PALS Officer to address complaints received

- There are 4 high risks which are all being closely reviewed and managed as appropriate at the monthly Divisional risk meetings.
- Monthly meetings had been established within Division to review and manage risks
- Hand hygiene – 93%

HG queried whether there was any medical representation at the weekly meeting, LR confirmed that there wasn't any medical representation at the weekly meetings.

SS presented the Community Division governance report, key issues as follows:-

- As at February 2019 64 incidents within Community Division, this is increased from January.
- Issues regarding Community Paeds – medication/transition, with parents ringing the team to advise that they had not received prescription for medication. This had been discussed previously at CQSG. This is an ongoing issue, with RD planning to visit the prescription team to address this issue. A meeting with Andrea Gill and appropriate personnel is currently in the process of being arranged.
- Documentation – human error, connectivity issues/viewing notes in the community – closing down live during meetings, followed by sending out monthly reports.
- There are no serious investigations currently within Community Division. In 2018/19 54 investigations, 2 RCA level 2 and 45 now completed.
- 2 formal complaints received with regards to paediatrics – regarding 2 recurrent cancelled appointments for patient, this was due to the reallocation process with the patient rebooked in advance, then subsequently leave was booked for medic, resulting in patient being cancelled on 2 occasions, process has now been rectified to ensure this is not repeated.
- 31 PALS issues regarding communication and access re ASD patients
- 82% Family and Friends response – which showed a slight increase in January
- 5 complaints
- Ward Accreditation process had been adopted for CAMHS Liverpool and Sefton, Dewi Jones with all achieving Silver.
- Speech and Language therapy hold 2 sessions per month, which had demonstrated positive service improvement.
- No new risks, ongoing risk regarding ADHD.
- Medical Records/archive/closed records had been escalated to Divisional Board regarding record storage and scanning team.
- No infection control support – business case had been established to enable support for Community Division.
  HG expressed concern re lack of IPC support for the division and stated that this would be signed off at Investment Review Group and Ops Board imminently.

Action: HG to meet with JG to discuss appropriate ate support for Community Division.

19/20/18 Introducing new procedures, equipment, technology or Medication policy

EW presented the Introducing new procedures, equipment, technology or Medication policy. EW confirmed that there had been small changes to the previous policy and that the changes reflected audit changes with regards to the devolved governance models. Policy ensured scrutiny with regards to any new techniques introduced. Further work is required regarding notification to NICE and issues around quoracy re medics. Policy had been discussed with Liz Edwards who intends to meet with NM to address issue further. EW stated that C Barker is a member of the Area prescribing committee and that the Area Prescribing team are content with the Trust process when decisions are reached on behalf of the area prescribing team.

Committee ratified the Introducing new procedures, equipment, technology or medication policy.

19/20/19 Any Other Business

AM reflected on the joint CQAC & CQSG meeting and stated that the two committees were working well and inter dependencies were clearly evident, with clear added value regarding scrutiny and board to ward flow.

AM welcomed comments from both committee members – all agreed that the joint meeting was beneficial.

AM confirmed that the Joint meetings would take place twice per year – with the next Joint Clinical Quality Steering Group meeting scheduled for 16th October 2019 at 10.00 am .

19/20/20 Date and Time of Next meeting

10.00 am – Wednesday 15th May 2019, Large meeting room, Institute in the Park

Alder Hey Children's NHS

NHS Foundation Trust

Annual Report & Accounts 2018/19

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

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A Message from our Chair and Chief Executive

During 2018/19 we treated more children and young people than ever before, while facing the myriad challenges of an increasingly pressured NHS environment.

In spite of this our fantastic staff once again went the extra mile to ensure Alder Hey ended the year as one of the most outstanding performers in the NHS. Their incredible efforts have ensured that Alder Hey continues to deliver the very best care for children and young people, highlighted by our 'Outstanding' for Caring rating from the Care Quality Commission. We are immensely proud.

Once again we delivered all access standards required of us, including waiting time in our Emergency Department - finishing the year as one of the top ten performers in the country - as well as for cancer treatment, for elective care and for cardiac surgery. More patients than ever have been treated by our outpatient and physiotherapy teams; our theatre teams have transformed the delivery of emergency lists and our highly dedicated colleagues in ICU have continued to provide outstanding care to some of our sickest and most complex patients. We have also improved our support for children with complex healthcare needs and have introduced a new 24/7 crisis care service for patients experiencing mental health distress. Individual services have continued to strive to be the very best, with special mention for our laboratories, which passed stringent quality standards tests with flying colours and our Anaesthetic Department who became the first paediatric unit in the country to gain Royal College accreditation.

Alongside these achievements, it was extremely pleasing that through the annual staff survey more colleagues than ever before said they would recommend Alder Hey as a place to work. We will continue to do everything we can to ensure that our amazing staff are able to work within the best facilities, while receiving the support and full recognition that they deserve.

During 2018/19 we have continued to develop our unique world-leading campus for children's health. Our dedicated research, education and innovation Institute was completed this year, encouraging further vital collaboration with partners that will ensure better children's healthcare in the future. We also launched our International Child Health Department as we aim to lead the way in global paediatric care.

The success of 2018/19 has placed us in a strong position to move forward with our plans for future growth. We will soon be breaking ground on a brand new family bereavement centre and will progress our plans to build specialist facilities for community and mental health services. To complete the vision, we recently submitted exciting proposals for a renewed Springfield Park to fulfil our aim to create something really special for our local community as well as our patients, visitors and staff.

Meanwhile, we remain committed to playing our part in supporting Liverpool City Council's ambition to become a UNICEF child-friendly city. We are also working closely with the Children's Transformation Programme to ensure children's healthcare within Merseyside has the needs of patients at its heart. Our long held vision has always been to build a healthier future for children and young people. Together with our partners, we have an unrivalled opportunity to shape the lives of children and young people and break new ground in the global development of children's healthcare, giving children and young people everywhere the best possible future.

Dame Jo Williams
Chair

Louise Shepherd CBE
Chief Executive

DRAFT

Performance Report

Overview
The following section of the report is designed to provide a broad summary of Alder Hey as an organisation: what we are about, what we are aiming to deliver for our patients and families, the risks to achieving this and how successful we have been in the last year.

About the Trust
Alder Hey Children's NHS Foundation Trust is a provider of specialist health care to over 330,000 children and young people each year. In addition to the hospital site at West Derby in north Liverpool, Alder Hey has a presence at a number of community outreach sites and in collaboration with other providers, our clinicians help deliver care closer to patients' homes by holding local clinics at locations from Cumbria to Shropshire, in Wales and the Isle of Man. The Trust also provides inpatient care for children with complex mental health needs at our Alder Park building in the nearby borough of Sefton.

The Trust employs a workforce of 3,354 staff who work across our community and hospital sites and as a teaching and training hospital we provide education and training to around 540 medical and over 500 nursing and allied health professional students each year.

Our operating turnover is £294m of which £232m directly relates to the clinical services we provide; 33% of our clinical income is non-specialised and 67% is specialised. Our principal contract is with NHS England for tertiary and quaternary care. The Trust also serves a wide population base for secondary care with Liverpool Clinical Commissioning Group (CCG) hosting the £64m contract on behalf of 21 associate CCG's in the North West of England. In addition we have a contract with of £16m with commissioners in Wales.

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

Alder Hey continues to be a top performing trust. We remain registered with the Care Quality Commission (CQC) without conditions. Our ratings from the health sector regulator, Monitor - since April 2016, NHS Improvement - have been generally among the highest available since authorisation as an NHS foundation trust in 2008 and we have consistently achieved the government's NHS Constitution access and quality targets. In 2018/19 the Trust achieved a use of resources risk rating of 1 (NHS Improvement's financial risk rating) due to our financial performance.

The year saw much progress and achievement against the Trust's Integrated Research Strategy for Child Health in partnership with the University of Liverpool and other academic institutions.

In Autumn 2018, the Alder Hey Institute in the Park building became fully occupied enabling partnerships with universities to continue to grow. The building now houses three other academic partners: Edge Hill University, Liverpool John Moores University and the University of Central Lancashire. This visibly demonstrates Alder Hey's continued drive to be the premier partner for children's health research and provides a unique opportunity for multi-institutional research to benefit the population locally, nationally and internationally.

The Trust has continued to deliver research at volume and to the highest standards of safety and quality. Increasing evidence has established the association between research volume and intensity in the hospital and improved health outcomes for patients. In 2018/19, Alder Hey recruited over 3,000 children and young people into its research studies, maintaining its position as the highest recruiting centre to studies in children since the inception of the National Institute for Health Research (NIHR) Clinical Research Network (CRN).

Research is now included as part of CQC's inspection framework which emphasises the importance of the safety and quality of research, given the proven association between research volume and improved outcomes/decreased mortality in NHS trusts.

Alder Hey is an organisation focused on innovation, finding novel solutions to challenges and delivery of exciting new therapies. This year, researchers from Alder Hey alongside the University of Liverpool were at the forefront of identifying a 'user friendly' treatment for the most common life-threatening neurological emergency in children – epilepsy. This trial was undertaken in emergency departments across the UK; a tremendous example of delivering the highest quality research in this challenging environment.

The Trust places meaningful involvement and engagement of children, young people and families at the heart of its research activities. In 2018/19, through monies awarded by the National Institute for Health Research (NIHR) Efficacy and Mechanism Evaluation Programme (EME), the Trust led a national research project to test a new treatment for babies with bronchiolitis enhancing its reputation for public engagement in research and leadership in the field.

The Trust is supported by two main registered charities and through the work that they do to support the hospital, we can ensure that Alder Hey's pioneering work continues to make a difference to the lives of children. In addition to the Alder Hey Children's Charity, Ronald McDonald House, located in the grounds of the hospital is able to offer support and a safe place to stay in a 'home away from home' environment for families at the toughest time in their life. We continue to work closely and strengthen our relationship with our charitable partners.

We have been authorised as a foundation trust since August 2008 and have an active Council of Governors representing patients, parents, carers, staff, the general public and partner organisations. The Council represents our membership which currently totals just over 15,000 people across the regions we serve. We have a well-established Children and Young Peoples' Forum which was re-launched during the year with a revitalised membership and a new 'brand' – re-naming itself 'The Forum' and developing new ideas for how they can be at the centre of the Trust's plans and activities, including continuing to play a key role in the recruitment of key Board level posts.

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Our Services

The Trust remains committed to its model of managing services through three Clinical Divisions: medicine, surgery and community services and mental health, each led by a triumvirate leadership team, comprising a clinical Director (as the accountable officer), supported by a senior manager in the role of Associate Chief Operating Officer and an Associate Chief Nurse who, together with service leads and managers, are responsible and accountable for the overall clinical, workforce and financial performance of their area.

The three Clinical Divisions are comprised of the following services:

Community and Mental Health

- Children's community nursing team
- Homecare
- Community matrons
- Community therapies
- Neurodevelopmental paediatrics
- Community paediatrics
- Safeguarding services
- Fostering and adoption
- Rainbow Centre
- Child and Adolescent Mental Health Services
- Outpatients

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

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• Therapies • Long term ventilation • EBME (medical equipment) • Bed management • Medical records • Phlebotomy • Medical day care • Booking and scheduling	

Our CQC Ratings
The Trust's current ratings are as follows:

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Our Purpose and Vision

Our purpose and vision were agreed by the Board in 2011 and remain at the core of all of our strategies, plans and decisions.

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

Our Vision

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

Our Strategy
Throughout 2018/19 the Board continued to see progress against our Strategic Plan (2018-2021), to take us towards our Vision of *'a healthier future for children and young people'*. At the close of the year, in line with the NHS Long Term Plan published in January 2019, we commenced development of the next phase of our five year strategy (2019 - 24).

The Board believes that the organisation's long term purpose and vision remain relevant today and will be fundamentally unchanged to 2024, re-committing to its ambition to provide world leading children's services.

Alder Hey's strategy remains built upon a small number of key strategic pillars which continue to be refined to reflect the changing landscape in which the NHS operates. For 2018/19, our strategic aims reflected the organisation's continued focus on high quality services and 'brilliant basics' through 'delivery of outstanding care' with 'the best people doing their best work' whilst maintaining a focus on growing the future with 'game-changing research and innovation' and 'sustainability through external partnerships'.

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

Delivering on our Strategic Aims and our Operational Plan: Highlights from 2018/19
2018/19 was another successful year for Alder Hey. Highlights of progress against our plans during the year include the following:

Delivery of Outstanding Care

- Through our *Sign up to Safety* pledge that we made in 2014, we have seen an annual upward trend of strong incident reporting coupled with a significant downward trend in medication incidents reaching patients that result in harm, achieving an 87% reduction. In addition the Trust has reduced the number of hospital acquired MSSA bacteraemia infections by 25% from the 2017/18 baseline.

- The Trust achieved a 17% reduction in non-clinical cancelled operation on the day, improving patient experience and performance during 2018/19

- Nationally the Trust has improved its position, attaining second highest reporter overall of incidents amongst our peer group of acute specialist trusts and the top performing children's trust, in data published by the National Reporting and Learning System (NRLS). In addition we are the top performing Trust in relation to the median number of days between incidents occurring and being reported to NRLS.

- The Trust has seen the eradication of grade 4 pressure ulcers for last three years and significant reduction in grade 3 pressure ulcers, from six in 2017/18 to one in 2018/19.

For a more detailed description of Alder Hey's quality improvement journey in 2018/19 please read our Quality Report starting on page 117

The Best People doing their Best Work

- The Trust continued with the delivery of the Apprenticeship Strategy during 2018/19, with 63 staff recruited on an apprenticeship between Level 2 and Masters. Alder Hey was the recipient of an employment award for outstanding contribution from Southport College. The Trust's Vocational Placement Programme also continued to be rolled-out in-year, supporting students from a range of schools and colleges with work experience, careers fairs and student placements.

- The Trust has continued its efforts towards the reward and recognition of its workforce during 2018/19, hosting a number of events including International Nurses' Day, the provision of Mental Health Fitness Courses, Mentoring Scheme and the annual 'Staff Fab Week'. Monthly Star Awards continued during the year with our Annual Star Award ceremony held in February.

- Our 2018 staff survey produced more responses than ever before with 60% of staff responding; the highest that the Trust has ever had. This included many positive improvements in staff feedback, including a 9% improvement in staff reporting that they

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would recommend Alder Hey as a place to work, at 72%. Alder Hey showed improvement across all themes, with statistically significant improvements in four areas: relationships with line managers, quality of appraisals, safety culture and staff engagement.

- Alder Hey's '*Listening into Action'* journey continued to embed within the organisation in 2018/19 and to remain focused around staff empowerment and positive change and supporting staff in providing safe, high quality patient care. LiA is a Trust-wide drive to identify issues and blockages, bring together all the right people into the same room and then work together on a solution. Through this initiative, dozens of clinical and non-clinical teams from across the Trust have been involved in positive change. Examples of this include the establishment of the Reward and Recognition group, the Staff Disability, BAME and LGBTQ+ Networks, as well as being a way of unblocking issues that came to light during recent debriefing sessions held with a variety of staff across the Trust.

Sustainability through external partnerships

- Partnership work with the University of Liverpool, Liverpool John Moores University, Edge Hill University and the University of Central Lancashire continued during the year, and has been significantly enhanced through co-location of these key partners together in the newly completed Institute in the Park. This supports the expansion of our portfolio of training programmes to meet the current and future needs of healthcare professionals both in the UK and Internationally.

- Alder Hey continues as a key member of the North West Congenital Heart Disease Partnership, working together to provide a fully compliant, resilient and clinically safe service model for adults and children across the North West of England, North Wales and the Isle of Man.
- The Trust has continued working in partnership with Liverpool Women's NHS Foundation Trust to deliver our two-site single service model for neonates requiring surgery and level 3 Critical Care.

- Joint working with Manchester Children's Hospital is supporting our jointly hosted clinical networks to work together to improve standards, and leading the way for the development of more joined up care in the region, for example in Neurosciences, Cardiology, and Burns.

- The international team has developed a partnership with the government-led international trade organisation Healthcare UK to help further our international work.

Game-changing research & innovation

- In the past 12 months, over 3,000 babies, children and young people were enrolled into clinical research studies at Alder Hey, maintaining its position as the highest recruiting centre to studies in children since the inception of the National Institute for Health Research (NIHR) Clinical Research Network (CRN).

- The Trust's partnerships with universities has continued to grow, exemplified by the full opening of the Alder Hey Institute in the Park in which the Trust occupies research space with the University of Liverpool, Liverpool John Moores University (LJMU), University of Central Lancashire (UCLan) and Edge Hill University.

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- Clinical and research teams have been responsible for some outstanding achievements during the year with global importance, including:
    - Leadership in the £5 million 'CLUSTER Consortium' (the first paediatric-standalone stratified medicine programme);
    - Global leadership of patient and public involvement and engagement with children and young people, exemplified in delivering the International Children's Advisory Network global conference;
    - Clinical and research leadership in the licensing by the US Food and Drug Agency of Epidiolex, a cannabis oil based drug, and the first available medicine for children and young people with severe, refractory epilepsies;
    - Global first administration in the Alder Hey Clinical Research Facility of the first 3D printed, ingestible tablet to a child as part of the Paediatric Medicines Research Unit research portfolio;
    - Completion and publication of major, multi-centre clinical trials funded by NIHR in evaluating the mode of insulin delivery in children newly diagnosed with Type 1 Diabetes and comparison of anti-epileptic drugs given to children presenting to the emergency department with refractory seizures; and
    - The Appointment of three Alder Hey staff onto the NIHR CRN NW Coast Research Scholars Programme, including the first non-medical Scholar, who is a Pharmacist.

- The Trust reviewed its innovation function in October 2018, resulting in a new strategy focused on a portfolio approach: artificial intelligence, sensors and immersive / visualisation supplemented by a funding strategy.

- Digital Innovation is now integrated into the 'Inspiring Quality' programme, with an artificial intelligence competition completed with 1st phase funding as part of Global Digital Exemplar.

- A new partnership was created with Hollow Lens and Microsoft. Alder Play live achieved App store/Android downloads of 800 per month; child size Tesla cars were provided to the Trust for use on wards as distraction for patients as part of project MOVE.

- Alder Hey innovation saw the world's first 3D printed Hypospadia trainer as part of a joint initiative with Al Jalila Children's Hospital in the United Arab Emirates and Sony. Other firsts included a simulation week and virtual reality teaching for University of Liverpool Medical Students.

Strong Foundations

- The Trust delivered its financial plan and generated a control total surplus of £49.9m which is ahead of plan by £17.7m. £15.5m of the surplus relates to one off technical opportunities and £35.8m relates of PSF income. These will both provide investment into the Trust 5 year capital programme.

- Alder Hey continued to progress with its plans as part of NHS England's Global Digital Exemplar programme, which aims to lead the way for the entire system to move faster in getting better information technology on the ground, delivering benefits for patients and sharing learning and resources with other local organisations through networks. Alder

Hey's GDE programme has delivered a range of speciality packages to clinical services, supporting a direction towards being a digitally mature organisation. Additionally, Alder Hey has played a lead role across Cheshire and Merseyside working with partners to develop and implement a shared health information exchange for the local population.

- The Trust delivered its obligations to patients under the NHS Constitution, meeting all mandated access targets.
- We had a strong end to the year with regard to operational delivery of effective services. We were ranked seventh in the NHS for the proportion of patients treated in the Emergency Department in less than 4 hours.
- Alder Hey also demonstrated full compliance against its Provider Licence issued by NHS Improvement and with its CQC registration.

Performance Analysis

The Trust's Corporate Performance Report has continued to be used as the key vehicle through which all relevant performance metrics are monitored by the Board, its assurance committees and the Divisional teams. It not only reflects CQC Key Lines of Enquiry, but also a range of locally determined measures, with a focus on SMART actions being taken to recover the position of any indicator going off track in a timely way. The report is supported by an electronic business intelligence system which enables the Divisions to drill down into key financial, operational and clinical metrics at service line and even individual patient level. This forms the basis of monthly Executive reviews where each Division leads the discussion and presents by exception on areas that require improvement.

Once again, a range of programmes have been developed aiming to deliver on quality and patient experience improvements which will support the optimization of efficiency and productivity.

Quality Improvement

This year Alder Hey had five collaborative improvement programmes: Brilliant Booking System; SAFER; Best in Outpatient Care; Best in Mental Health Care; and Models of Care. These have delivered notable improvements in experience and quality of care across a range of outpatient, inpatient and community services. The benefits of this include: a reduction (by two-thirds) in operations cancelled on the day of surgery; a reduction in the rate of children not brought to a clinic appointment; and an increase in families and clinician's experience of outpatient services; and proving mental health services to children in schools.

Achievement of National Standards of Care

Alder Hey has consistently delivered national standards for access to planned care, as measured by open pathway referral to treatment times, and cancer care. Moreover, we are delivering timely access to diagnostic investigations, fully in line with national standards.

Unplanned Care

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Alder Hey has had a successful Winter Plan ensuring timely access to emergency care for patients. Through the year our Emergency Department has consistently been ranked within the top 20 performing Emergency Departments in the country, and in March 2019 over 95% of patients attending.

The Trust's performance against national access and other mandated targets for 2018/19 are set out below:

Target or Indicator	Threshold	National Performance	Qtr1	Qtr2	Qtr3	Qtr4
Summary Hospital level Mortality Indicator (SHMI) [1]	n/a	n/a	n/a	n/a	n/a	n/a
C. Difficile Numbers – due to lapses in care	0		0	0	0	1*
C. Difficile - Rates per 100,000 Bed days	0		0	0	0	7.2*
18 Week RTT Target Open Pathways (Patients still waiting for Treatment)	92%	87.00%[2]	92%	92%	92%	92%
All cancers: two week GP referrals	93%	93.4%[3]	100%	100%	97%	97%
All cancers: 62 day wait for first treatment from: urgent GP referral for suspected cancer	85%	76.1%[3]	100%	100%	100%	100%
All cancers: 31 day wait until subsequent treatments	94%	96.97%	100%	100%	100%	97%
A&E - Total time in A&E (95th Percentile) <4 hours	95%	79.47%[4]	95.28%	96.09%	93.32%	92.91%
Readmission rate within 28 days of Discharge [5]	National data collection methodology currently under review	0-15 Years: 16 Years & over:	10% 10%	9% 13%	11% 13%	8% 11%
Financial and Service Performance Ratings			3	2	1	1
Rate of Patient Safety incidents per 1000 Bed Days		50	77	88	77	95
Patient Safety Incidents and the Percentage that Result in Severe Harm or Death		0.48%[4]	1350 (0.00%)	1335 (0.00%)	1286 (0.00%)	1306 (0.23%)

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* The case of *C. difficile* is under review and is awaiting a decision regarding whether this was due to lapse of care
NOTE: Unless otherwise indicated, the data in the table above has been obtained from local Patient Administration Service, to enable the Trust to provide the most recent available data. Most of this data is accessible through the NHS England website

[1]Specialist Trusts are excluded from SHMI reporting
[2] RTT National Performance based on most recent published data for Feb 2019, NHSE website.
[3] Cancer Waiting Times National Performance is based on most recent published data for Feb 2019, NHSE website
[4] A&E National Performance based on most recent published data for March 2019 for Type 1 A&E Depts, NHSE website.
[5] Data source: Trust Patient Administration System – not published nationally.

Improving Services through Partnerships
In congenital cardiac surgery our partnership in Liverpool has increased the number of children and adults receiving life-changing cardiac surgery. In care for babies born premature, our collaboration with Liverpool Women's Hospital to reduce transfers between our hospitals is providing 7 day medical cover.

Caring for our Environment
Alder Hey is committed to environmental sustainability and delivering a "Green and Clean" environment as part of our mission for a healthier future for children and young people. To this end we are now fully developing a Sustainable Development Plan that is focused on waste minimisation; plastic reduction; increased procurement of local produce for feeding patients and staff; encouraging staff to walk, cycle or take public transport to work; development of an allotment; working with social enterprises for the redirection of redundant furniture and assets and reduced energy consumption. This Plan will be delivered through our core Programme Management mechanism, with specific oversight and ownership of the Plan by the Board.

Energy
This is the last year of the Carbon Reduction Commitment. Our energy demand from the retained estate has reduced as we have relocated staff into our Institute in the Park building.

Year	***2018/19***			***2017/18***			***2016/17***		
Aspect	*Units consumed*		*Value of units*	*Units consumed*		*Value of units*	*Units consumed*		*Value of units*
Electricity	17,302,393	Kwh	£ 2,114,811	15,995,437	Kwh	£ 2,127,176	5,092,768	Kwh	£571,066
Gas	21,016,427	Kwh	£ 565,711	24,077,023	Kwh	£ 562,699	18,019,616	Kwh	£587,781
Carbon	Data not submitted until July 2019			1507	Tonnes	£26,674	2705	Tonnes	£ 46,526
Water	158734	m³	£ 277,606	58,317	m³	£963,133	53313	m³	£227,518
			£2,958,129			£3,679,682			£1,432,891

As demolition activity has increased across the site this has contributed to an increase in water resulting from 'damping down'. The consequences of this have been a reduction in our surface water drainage charges. We continue to promote energy efficiency and where possible provide staff with the tools to reduce energy at home as well as work.

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Travel

We continue to promote the Cycle to Work Scheme and have an active cycling community within the Trust; we have received ongoing training support from Bikeright. We are active members of Liverpool City Council Cycle forum and have input into the strategic direction of the local area cycle plan. The new cycle centre is now operational and staff are using this asset to its fullest with over 125 members of staff accommodated. We have had installed electric vehicle charging points and these are available for use by staff and visitors alike and are being utilised well. We have commenced loading data into our Health Outcomes of Travel (HoTT) tool which we expect will drive down the amount of C02, PM 10's and other emissions being produced by the Trust

Waste

We continue on our drive to reduce waste and particularly single use items. A group of staff have been co-opted to focus on the use of single use plastic items and have had some successes to date. This has also increased recycling rates across the Trust. We now have zero waste to landfill as all our residual waste is utilized as refuse derived fuel.

Year	***2018/19***			***20117/18***			***2016/17***		
Resource	*Units disposed*		*Value of units*	*Units disposed*		*Value of units*	*Units disposed*		*Value of units*
Land Fill	0	Tonnes	£0		Tonnes		146	Tonnes	£22,763
Clinical Waste	25	Tonnes	£ 13,899	47	Tonnes	£ 32,020	203	Tonnes	£67,796
Offensive Waste	281	Tonnes	£ 90,878	246	Tonnes	£ 128,926	40	Tonnes	£18,038
Recycled	817	Tonnes	£ 122,944	748	Tonnes	£ 119,420.	619	Tonnes	£74,619
Confidential	82	Tonnes	£15,472	70	Tonnes	£11,420	75	Tonnes	£10,516
WEEE	18	Tonnes	£8,950	14	Tonnes	£6,520	13	Tonnes	£5,875
			£252,143			**£ 298,306**			**£199,607**

External Awards and Achievements in 2018/19

Care Quality Commission Inspection 2018

Alder Hey was rated 'Outstanding' in the caring domain and 'Good' overall following a CQC inspection of five of its core services and a review of leadership through a 'Well Led' inspection.

CQC's Chief Inspector of Hospitals, Professor Ted Baker said that "children were at the centre of the service at Alder Hey and we saw examples of the highest quality of care". Professor Baker also commented that "parents we met told us their children were treated with dignity and respect and had all their needs met by kind and caring staff who are truly outstanding."

In response to the findings of the report, Alder Hey's Chief Executive, Louise Shepherd said: "The CQC has recognised the outstanding work that happens here every day at Alder Hey,

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which was strongly endorsed by the children, young people and families they spoke to. We are delighted that Alder Hey's official overall rating remains 'good' with 'outstanding' for caring. This is a clear testament to the unstinting commitment of our fantastic staff, who are driven by a shared vision to do the very best for the children and young people we serve."

The CQC highlighted many examples of outstanding care and innovation drawn from across every service inspected. There were some key areas for improvement within the report, which were addressed at the time of the inspection. The report contains a range of additional recommendations which the Trust has actioned already or is working towards.

ENT Bring ESPO to Alder Hey
Alder Hey's ENT Department secured the coveted ESPO (European Society of Paediatric Otolaryngology) meeting for 2022, beating off stiff competition from Prague at a conference in Stockholm.

The European Society of Otolaryngology aims to promote high quality of care for children with otolaryngologic disorders (ear/nose/throat) across Europe. ESPO is the leading paediatric otolaryngology meeting worldwide, bringing together experienced clinicians and professionals to exchange knowledge and skills.

Thanks to a successful pitch by Mr Ray Clarke, Miss Sujata De and Mr Sunil Sharma, supported by the M&S Arena, Alder Hey will be the main Trust involved in hosting parts of the prestigious meeting in 2022.

Play Specialists' crucial role in patient care
Play Specialist Pip Bradshaw won the 2018 Suzanne Storer Profile of the Year Award, an annual award given to a registered health Play Specialist by governing body Health Play Specialist Educating Trust (HPSET).

Pip also came third nationally for the 'Starlight Foundation Health Play Specialist of the Year Award' for 'excellent techniques employed to prepare a child for treatment and the way she willingly shares her knowledge and skills with nursing staff, doctors and students'.

Helen Pinder, Lead for Play Services at Alder Hey said "I would like to congratulate Pip on an outstanding achievement. The Play Team are extremely proud of Pip and feel this is a very well deserved recognition for all her years of dedicated hard work.

"Pip is an excellent role model for play specialists within Alder Hey and is a shining example of what it takes to be a health Play Specialist. I am very honoured as the lead for play services to have such a dedicated and enthusiastic play specialist on my team. I feel Pip embodies the Trust values perfectly. Well done Pip"

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Another First at Alder Hey

Alder Hey received the Anaesthesia Clinical Services Accreditation (ACSA) from the Royal College of Anaesthetists, the first children's hospital to achieve this high standard.

The accreditation is well known to be rigorous which makes this achievement all the more impressive. The Review Team gave Alder Hey a glowing report, highlighting in particular “a dedicated, hardworking, flexible and passionate team, with excellent team work between both anaesthetists and non-clinicians”.

Alder Hey Launch International Child Health Department

Alder Hey launched a new International Child Health (ICH) Department at Alder Hey to bring together the existing humanitarian work of staff and coordinate their efforts to lead the way in global paediatric health care.

The Department is the first of its kind in a paediatric hospital in the UK and aims to save the lives of children and promote health in under-resourced countries by assisting in research, education and development.

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It will coordinate the humanitarian and other international work of all members of staff, enabling them to develop their skills in a new environment. It will also help with grants and visa applications as well as providing information and support.

Department Director, Consultant Paediatric Oncologist Professor Barry Pizer said: “Our vision is that Alder Hey will contribute to improving the health of the world’s children, building on our international reputation and leading the way in paediatric health care.

“Staff at Alder Hey have been using their skills to help children in developing countries, who may not otherwise have access to free health care, for more than 20 years. The new department aims to bring this work together with education and research activities to develop best practice in a number of partner nations.”

The humanitarian work will also link in with the Alder Hey Academy based at the Institute in the Park, which has academic partnerships with the University of Liverpool, Liverpool John Moores University, UCLan and Edge Hill. In addition, the Department will look at increasing existing partnerships with nations such as China to deliver education and training in the UK.

The humanitarian work will also link in with the Alder Hey Academy based at the Institute in the Park, which has academic partnerships with the University of Liverpool, Liverpool John Moores University, UCLan and Edge Hill.

In addition, the Department will look at increasing existing partnerships with nations such as China to deliver education and training in the UK.

Alder Hey Awarded Centre of Clinical Excellence

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Alder Hey was recognised by Muscular Dystrophy UK for providing outstanding care for people with muscle-wasting conditions.

The Trust was awarded Centre of Clinical Excellence status by the charity, alongside 16 other centres across the UK. The awards recognise excellence across a range of criteria, including the care received by patients and help to drive up the standards of clinical support for people with muscle-wasting conditions.

Rob Burley, Director of Campaigns, Care and Support at Muscular Dystrophy UK, said: “We would like to congratulate Alder Hey, which has deservedly been awarded Centre of Clinical Excellence status. Alder Hey provides a comprehensive service for people with muscle-wasting conditions and promotes best practice, ensuring patients have access to the best possible healthcare near where they live. Improved clinical care means faster access to treatments and potential cures.”

Dr Stefan Spinty, Consultant Paediatric Neurologist at Alder Hey said: “We are delighted to once again be awarded “Neuromuscular Centre of Clinical excellence” by Muscular Dystrophy UK following a rigorous audit process. At Alder Hey, we see around 550 children and young people and their families with this rare and complex condition. We provide them with the highest standards of specialist care, while increasing awareness of the condition and continuing to develop new treatments.”

New Model of Care: Post-Operative Cardiac Care Unit
Consultant Cardiac Surgeon, Mr. Rafael Guerrero led and developed a new model of care for patients undergoing cardiac surgery at Alder Hey. Several patients have benefited from this

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new model of care and clinical pathway, expediting their treatment and recovery contributing to the increase of patients operated on and releasing capacity with more cost effective use of resources and increase productivity and income

Rafeal has also led the creation of the new Adult Congenital Heart Disease service at Liverpool Heart & Chest Hospital as part of the Liverpool Health Partnership Congenital Heart Disease. Surgical activities as a Level 1 centre commenced in October 2018. In the first 6 months of activities safe and sustainable services have been delivered beyond the NHSE expectation on volume and complexity of cases. Alongside this, we have developed a novel piece of collaborative work with the aortic and mitral team at Liverpool Heart & Chest Hospital for the benefit of the patients offering the best care combining the best skills available

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Academy Wins Prestigious North West England Greater China Awards 2019

Alder Hey Academy won the Education Business Links Award at the Greater China Awards 2019!

Held annually by the Department for International Trade, the Academy was nominated following the successful implementation of the Alder Hey Chinese Observership Programme which began in 2017/18.

These innovative training and education partnerships in Greater China (mainland, Hong Kong, Macau and Taiwan) were up against three other nominees including Access China UK Education, Intern China Ltd and the University of Liverpool.

Cath Kilcoyne, Head of the Academy said: "This award is imperative to the future success of international business opportunities for Alder Hey Academy and Alder Hey's Children's Hospital both in China and worldwide.

"However it could not have been achieved without the support and expertise of the clinicians across the Trust who support the Academy's Chinese Observership programme. Their commitment and input remains crucial in delivering a three year contract for clinical observerships awarded to the Academy in 2018."

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Well Child Award Winner Alf Bass

Alder Hey surgeon Mr Alf Bass won the Well Child 2018 Doctor Award at a glittering awards ceremony in London. Well Child is the national charity for seriously ill children, committed to improving the quality of life for children across the UK with serious illness, or exceptional health needs.

Mr Bass specialises in the care of children with neuromuscular conditions including cerebral palsy and was nominated for his role in leading the development of surgery in this field,

enabling children with severe mobility and neurodevelopmental needs to manage their pain and to improve their mobility.

This work included the creation of one of the main Gait Labs in the UK, which allows a range of professionals to study the movement of children and has radically redesigned the whole service at Alder Hey shifting the emphasis from surgery to rehabilitation.

Hundreds of nominations for the awards were received from across the country, with the winners chosen by an esteemed panel of judges including leading health professionals and children and young people who face serious illness themselves.

Mr Bass said: "It was an incredible honour to be named winner of the Doctor Award by WellChild. Treating children is incredibly rewarding because you establish a relationship with the child and their family. It's being part of this relationship, which makes the job completely different from any other form of orthopaedic surgery. If I can make a difference to the quality of their lives - that's what makes my job worthwhile."

The Well Child Awards ceremony was attended by charity patron The Duke of Sussex and the Duchess of Sussex.

Speaking at the awards ceremony HRH Prince Harry said: "Every one of you is truly amazing. You have shown all of us what it means to be a champion – whether for yourself, your family, your community, or someone in need."

General Manager for Medicine Glenna Smith, who nominated him for the award said: "Watching Mr Bass work with these children is a joy to behold. His skill in engaging with children who cannot always express themselves in a traditional way is so impressive. He treats these patients with the care and respect they deserve. As an individual who had never worked with children with severe health needs I have learned so much observing him. I cannot speak highly enough of him."

Liverpool to Lead on £1.6m Vital Bronchiolitis Research

A national research project, led by Alder Hey Children's Hospital and the University of Liverpool, was awarded over £1.6m to test a new treatment for babies with bronchiolitis. The pioneering research, which uses a natural substance produced by the lungs called surfactant to make it easier for babies with bronchiolitis to breathe, has been awarded the monies by the Efficacy and Mechanism Evaluation Programme (EME), a MRC and NIHR partnership.

Bronchiolitis is a winter viral disease that causes breathing problems and feeding difficulties in babies. In severe cases, breathing fails and these babies need intensive care where their breathing is supported by a mechanical ventilator. Each year one thousand infants with bronchiolitis are admitted to paediatric intensive care units in England. There is currently no vaccine or specific treatment for bronchiolitis.

The Bronchiolitis Endotracheal Surfactant Study (BESS) will test if treating babies with surfactant will reduce the time they depend on a mechanical ventilator. Surfactant is naturally

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produced in the lungs to help ease the work of breathing. Infants suffering from bronchiolitis have less surfactant, which makes breathing much harder.

BESS is an investigator-led collaboration between the Universities of Liverpool, Southampton and Leeds. The study is led by Dr Calum Semple, Professor of Child Health and Outbreak Medicine at the University of Liverpool and Consultant in Paediatric Respiratory Medicine at Alder Hey Children's Hospital, and is expected to run in 14 hospitals in England, Ireland and Scotland over three winters.

Professor Semple, said: "There is a pressing need to develop treatments for this nasty disease, which affects so many babies each year. Bronchiolitis is the commonest single cause of hospital admission for babies in the UK and now a leading cause of death in babies worldwide.

"It is vital to increase our understanding of how surfactant can help babies with breathing problems to enable us to develop effective treatment strategies for the future. We are extremely grateful to the EME Programme for their support. This major grant could enable our team to make a significant contribution to the future health of our youngest and most vulnerable children."

BESS is funded by the Efficacy and Mechanism Evaluation programme, a Medical Research Council and NIHR partnership contributions from the Chief Scientist Office (CSO) in Scotland, Health and Care Research Wales, and the Health and Social Care Research and Development (HSC R&D) Division, Public Health Agency in Northern Ireland.

Innovation at Alder Hey

2018/19 has been another great year for innovation at Alder Hey. From advanced 3D printing to high speed electric car chases, the rate of new ideas and partnership creation has been growing at an exponential rate. To help in the process of nurturing an idea from its inception to a commercial release, we have welcomed a number of new members to our team to provide commercial, project and technical expertise.

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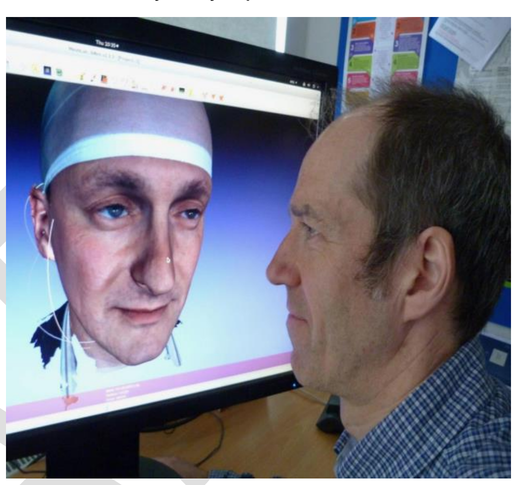
Our cardiac, orthopaedic, plastic and craniofacial surgical teams have been working on the application of 3D printed models for pre and intra-operative planning. We continue to develop our partnership with 3D Lifeprints to create a fully embedded team of biomedical engineers to help in case selection, 3D modelling and material choice.

In partnership with the Al Jalila Children's Specialty Hospital in the United Arab Emirates, 3DLP and Sony Olympus we have created a high fidelity multi material operative training model for hypospadias to allow trainees to practice fine operative skills. The use of surgical simulation is a key step in ensuring safer surgery, by allowing trainees to advance their operative skills in a controlled environment while at the same time allowing experienced operators to hone their skills and even perform pre-operative workouts. In one example we combined a high fidelity silicon model with a state of the art 4K 3D robotic microscope to test new operative approaches.



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Christian Duncan, Director of Surgery and Craniofacial Surgeon, has made great strides forward leading the Headspace project. By taking hyper accurate scans of heads to understand what "normal" looks like, craniofacial surgeons will better be able to judge how successful their operations have been and allow for improved surgical techniques.

Reacting to the slow advancement of powered wheelchair design, one of our Innovation Team and Paediatric Surgeon Will Calvert has led a wide ranging team of technologists, industrial designers, engineers and car manufacturers to create Project MOVE. This partnership includes the University of Liverpool, Dragon Mobility, NHS Innovation Agency and even the Tesla owners group. The ambitious aim is to design an affordable and cutting edge solution for disabled children of all ages to explore the world around them. To promote this scheme we raced 2 high powered children's Tesla cars around the hospital, creating a viral youtube video (we also got to keep the Teslas!).

Iain Hennessey, Clinical Director of Innovation, has undertaken a secondment to help lead the implementation of a new healthcare technology and design course at the University of Liverpool. This groundbreaking curriculum will be the first implementation of a dedicated

healthcare technology and design theme at a UK medical school, responding to Health Educations England's plans to modernise training in the medical workforce.

Rafael Guerrero, Chief of Cardiac Surgery and Co-Director of Innovation, has been working with Microsoft and Black Marble to design new applications of the latest Hololense augmented reality goggles for use in operative environments. The ability to see multiple images in an entirely configurable environment, coupled with interactive gesture control, has enormous potential for the future.

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In 2018, we launched the Alder Play app with one of the world's first dedicated artificial intelligence patient assistants. The app uses gaming and augmented reality to distract patients having procedures in hospital. Young patients choose and name their own avatar which will help them understand their hospital visit before they arrive and help calm them during their stay. Their avatar 'pops up' at various hospital locations during their visit and helps patients collect 'rewards' following procedures that allows them to access new content.

Within Alder Play, parents will also be able to interact with a chatbot called "Ask Oli" to ask questions about the hospital and what may happen to their child. Alder Hey has been working with the Hartree Centre (part of the UK's Science and Technology Facilities Council and supported by IBM), using IBM's Watson technology to enable questions to be answered in real time. This will be the first time cognitive technologies have been applied in any hospital in the UK, in this way.

Alder Hey Innovation is looking forward to another great year of finding, creating and experimenting with the latest technologies and inventions. It will be 2020 after all!

Key Risks to Delivery in 2018/19

The Trust's key risks were articulated in the Board Assurance Framework, which was reviewed on a monthly basis by the Board and its assurance committees throughout the year. The three most significant risks were: financial sustainability in a challenging environment and delivery of the control total; ensuring we develop plans to enable Alder Hey to continue to grow; commissioning risks relating to the new hospital environment; and more recently a 'No-Deal' exit from the European Union in terms of safeguarding the organisation's ability to deliver services safely and maintain business continuity.

The chief risks to quality related to the ability to maintain and enhance our specialist workforce. The Trust has been fortunate enough to continue with its recruitment drive to ensure optimum nurse staffing levels and safeguard frontline services at times of high volume and pressure on capacity; thanks to a robust Winter Plan the Trust maintained its elective programme and kept cancelled operations to a minimum, delivering on all the key access targets.

Financial Performance

The Trust ended the year with a reported surplus of £40.2m. NHS Improvement measures the Trust against a Control Total which excludes exceptional items; the impact of these exceptional items results in the Trust reporting a £49.9m Control Total surplus. This represents a significant over performance against the original control total plan, this is driven by a set of one off items that include a land disposal proceeds, a credit for service failures relating to the Trusts PFI contract and an amount awarded to the Trust for Provider Sustainability Incentive and Bonus Funding (£35.8m) which relates to over delivery against financial targets.

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

	2018/19 £000	2017/18 £000
Reported Surplus/(deficit) for the year	40,172	6,008
Exceptional items		
Impairment	5,987	18,631
Donated income	1,649	(4,681)
Donated depreciation	2,082	2,101
STF funding relating to 2016/17		(93)
NHS Improvement surplus / (deficit) on control total basis	**49,890**	**21,966**

Capital expenditure for the year is £16.4m. This expenditure related to medical equipment, IT and the continued development of the hospital site.

The Trust had a cash balance of £33.7m at the end of March 19.

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Regulatory Ratings
NHS Improvement use metrics to assess financial performance by scoring each metric from 1 (best) to 4. The Trust has achieved an overall Use of Resources rating of 1 which is in line with the planned rating. The breakdown of our rating is provided below.

Criterion	Measure	Weighting	18/19 Metric	18/19 UOR
Liquidity (days)	Shows ratio of liquid assets to total assets	20%	80.9	1
Capital Service Cover	Shows revenue available for capital service	20%	4.1	1
I&E Margin	Shows underlying performance	20%	16.90%	1
I&E Variance	Shows performance against plan	20%	4.90%	1
Agency	Shows Agency spend performance against ceiling	20%	-54.60%	1
Use of Resources Rating				**1**

Income
Total income received by the Trust in the year ended 31st March 2019 was £294m with £232m (79%) coming from the delivery of clinical services. The Trust's clinical income comes from 3 main contracts. Our principal contract is with NHS England to provide tertiary services with a value of £139m. The Trust also has a contract hosted by Liverpool CCG to provide secondary services with a value of £64m. In addition the Trust has a contract with Welsh commissioners to provide secondary and tertiary services with a value of £16m. The £62m non-clinical income includes STF, donations from charities, education & training levies, research activities, services provided to other organisations and commercial activities such as the provision of catering services.

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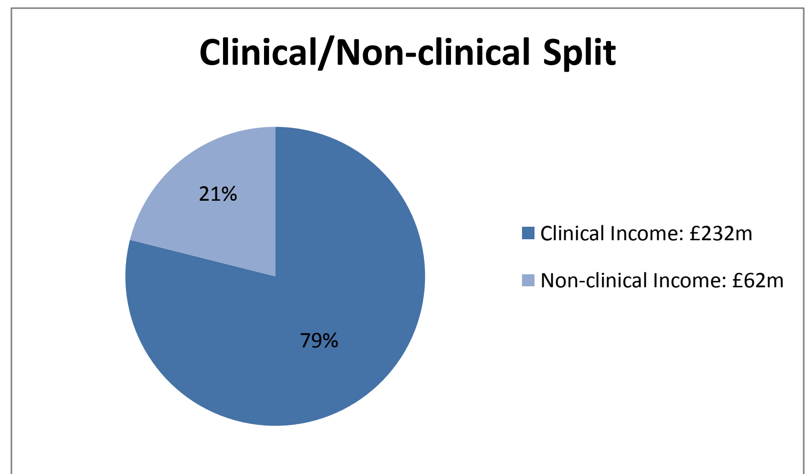
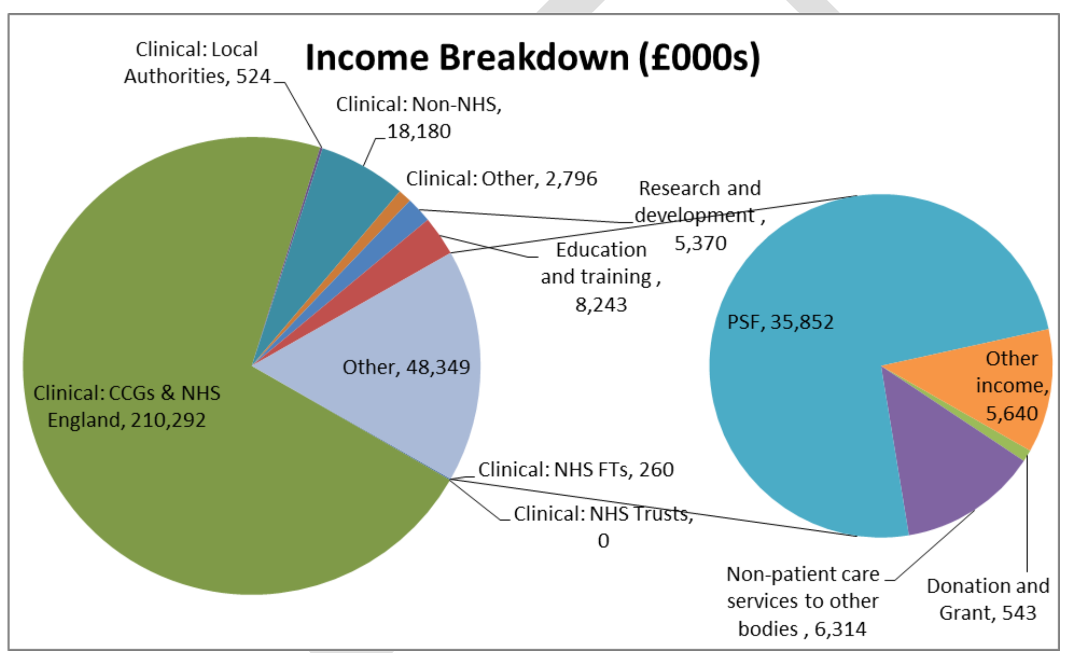
Income by source 2018/19:





Clinical Income by Point of Delivery

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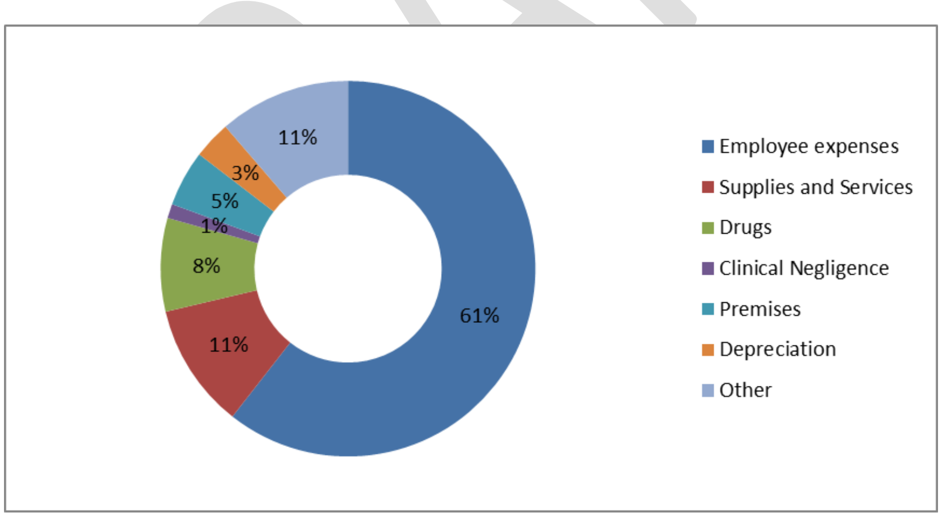
	2018/19 £000s	2017/18 £000s
Elective income	50,197	46,527
Non-elective income	41,236	37,489
Outpatient income	29,707	25,925
A&E income	6,594	6,057
Private patient income	236	434
Community and Mental Health	26,500	22,476
Critical Care	28,757	26,487
Drugs and devices	25,388	23,995
Other	23,437	24,101
	232,052	213,491

Expenditure

Operating expenses totalled £247.8m for the year and, as in previous years, staff costs account for the largest use of resources, 61%. An analysis of operating expenses by type is shown in the graph below:



Financial & Operating risk

A&E activity, non-electives and critical care exceeded plan for the year whereas electives and outpatients were below plan.

Total clinical income for the year was £232.1m, which exceeded the plan figure of £220.2m. Total normalised expenditure (excluding technical issues) for the year was £250.4m which

was £7.3m higher than the plan of £243.1m. Expenditure on pay exceeded the plan by £3m which included agency staff totalling £1.4m although this is partly offset by vacancies in substantive posts. Drugs expenditure was £1.5m higher than planned although some of this was recovered via income for specialist drugs not funded through PBR.

£6.9m of Cost Improvements Projects (CIP) and efficiency savings were achieved during the year.

Capital Investment Programme
During the year the Trust completed £16.4m of capital investments which will significantly improve services for both patients and staff. A summary of capital investment undertaken in the year is provided in the table below:

Capital Investment Scheme	Investment Benefit from activities	Value £'000
Planned Capital Estates	Includes interim & retained estates associated with hospital move and demolition	1,040
Research and Education Buildings	Completion of the Research and Education building Phase 2	3,979
IM & T capital schemes	Investment in IM&T including GDE and Electronic Patient Record costs	4,679
Medical Equipment	Investment in medical equipment inclusive of equipment replacement cycle	3,385
Leased Medical Equipment	Finance leases taken out for essential medical equipment - defibrilators and vitrectomy	599
Alder Hey in the Park	New hospital non-medical equipment and site development costs	2,715
Total Capital Investment 2018/19		**16,397**

Better Payments Practice Code – Measure of Compliance
In line with other public sector bodies, NHS organisations are required to pay invoices within 30 days or within the agreed payment terms whichever is sooner. This is known as the Better Payment Practice code. NHS trusts are required to ensure that at least 95% of invoices are dealt with in line with this code. Performance against this code is provided in the table below.

	2018/19	2017/18
% of invoices paid within 30 days	85%	88%

The total amount of interest the Trust paid during the year as a result of failing to pay invoices within the 30 days where obligated to do so was £138,413.

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Accounting Policies

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

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

Going Concern

The Trusts financial plan for 2019/20 will achieve a control total surplus of £1.6m and achieve a Use of Resources ratio of 2.

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

Post Balance Sheet Events

There are no material contingent liabilities or material litigation as far as the Board is aware; to the extent that if there is potential litigation it is believed that this will be covered by the NHS Litigation Authority. For these reasons, the Trust continues to adopt the going concern basis in preparing the accounts.

Board Statement

The Directors consider the Annual Report and Accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess Alder Hey's performance, business model and strategy.

The Board of Directors approved the foregoing Performance Report at its meeting on 28th May 2019.

Signed on behalf of the Board.

Louise Shepherd CBE
Chief Executive
28th May 2019

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Accountability Report

Directors' Report

Composition of the Board of Directors

- **Chair and Chief Executive**

Sir David Henshaw – Chair (to February 2019)

Sir David took up post as Chair of Alder Hey in February 2011; he was re-appointed in January 2014 for a second term of three years and in December 2016 and December 2017 the Council of Governors approved his re-appointment for a further twelve months in order to ensure leadership continuity on the Board. Among his many achievements, Sir David was responsible for the review of the child support system in the UK in 2007. He was also involved in the Prime Minister's Delivery Unit Capability Review Programme of central government departments. Alongside his valuable experience within the health arena, including as Chair of NHS North West for four years, Sir David has worked extensively in local government. He spent ten years at Knowsley Borough Council before being appointed as Chief Executive of Liverpool City Council, a role which he occupied for seven years. Today, Merseyside residents see and are enjoying the benefits from many of the regeneration initiatives his team brought to the region, including securing the award of European Capital of Culture in 2008. Alongside his role at Alder Hey, Sir David has also been a Chair and Non-Executive Director for a number of other public and private organisations.

Sir David has been asked by Monitor and subsequently NHS Improvement, to take on the role of Interim Chair at four other NHS organisations over the past six years: between February 2012 and April 2013 at University Hospitals of Morecambe Bay NHS Foundation Trust; at Dorset Healthcare NHS Foundation Trust which he undertook from October 2013 to April 2014; at St Georges NHS Foundation Trust in London for twelve months from March 2016 and most recently at Wirral University Teaching Hospitals NHS Foundation Trust from February 2018 for a period of six months. In March 2017 Sir David was appointed as the Chair of National Museums Liverpool.

Dame Jo Williams – Chair (from February 2019)

Dame Jo joined the board in November 2016 and has enjoyed a successful 30 year career in social services in the North West, including ten years at director level, before becoming Chief Executive of the Royal Mencap Society for five years. She joined the Care Quality Commission as a Non-Executive Director in 2008 and held the position of chair between 2010 and 2013. In addition, Dame Jo has had considerable experience as a trustee in the voluntary sector, including with the NSPCC.

Over the last decade she has been involved in shaping public policy on a number of issues including in her role as chair of the National Advisory Council on Children's Psychological Wellbeing and Mental Health and as part of the team that developed the National Service

Framework for Children. She was also co-chair of the national working group that led to standards in hospital care for children following the enquiry at Bristol Royal Infirmary.

Dame Jo has received a number of honours in recognition of her achievements, including a CBE for services to Social Services in Cheshire and as President of the Association of Directors of Social Services and a DBE for her work with people with a learning disability.

She was appointed as Chair, succeeding Sir David Henshaw, in February 2019.

Louise Shepherd CBE – Chief Executive

Louise joined Alder Hey as Chief Executive in March 2008 and successfully led the Trust through a major transformation into Europe's only Children's Health Park, designed by and for children and young people and opened by Her Majesty the Queen in 2016. The Park aims to provide a unique wellbeing and healing environment for all children and young people and comprises a state of the art specialist children's hospital, dedicated research and education facilities, an innovation centre, clinical research facility and family support and bereavement centre.

Previously CEO of Liverpool Women's Hospital, Louise first joined the NHS as Director of Business Development at Birmingham Heartlands Hospital in 1993 from KPMG, where she spent four years as a financial and management consultant to the public sector. A qualified accountant, Louise was Director of Finance at the Countess of Chester NHS Foundation Trust before she took over as CEO at Liverpool Women’s Hospital. From March 2016 Louise was the lead for the Cheshire and Merseyside Sustainability and Transformation Programme, working with partners across the system to take forward the NHS Five Year Forward View in the local area. She stepped down from this role in May 2017.

A graduate of the University of Cambridge, Louise has a strong interest in the Arts and served on the Board of The Liverpool Philharmonic for six years and plays violin for the Liverpool Mozart Orchestra. Louise was awarded a CBE for services to Healthcare in 2017.

- **Executive Directors**

Dr Steve Ryan – Medical Director (to January 2019)

Having graduated from the University of Leeds, Steve completed his medical training as a paediatrician in and around Leeds and Manchester. He took up his first consultant role in Liverpool working as an academic and general and neonatal paediatrician. He developed a major interest in the use of effective communication skills, joining the faculty established by Merseyside GPs.

Subsequently he focussed his clinical work on general paediatrics, establishing a headache specialist service and a service for the medical treatment of brittle bone disease. Increasingly interested in leadership he was first appointed as Medical Director of Alder Hey Children’s Hospital in 2004, and was there when it became a Foundation Trust in 2008. At about that

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time he was invited to be Clinical Chair of the Next Stage (Darzi) National review subsequently becoming the Deputy Medical Director for NHS North West England.

In 2010 Steve was appointed as Medical Director at Barts and the London NHS Trust, then in 2012 as Barts Health's inaugural Medical Director. He maintained a long-standing interest in public health and appointed a Director of Public Health to his team to join a Director of Primary Care. Steve aimed to work closely with local GPs to build more effective care pathways, as well as facilitating reconfiguration of specialist cancer and cardiac services.

During 2015 Steve was Strategic Transformation Lead for the Healthy London Partnership for Mental Health Care Transformation for children and young people – supporting the implementation of the national strategy "Future in Mind" across London. He has also supported the clinical leaders in two London STPs, been a governing body member of Barking and Dagenham and Havering CCGs and acted as an adviser to the a Royal Free Hospital on clinical equipment procurement. Steve returned to Alder Hey as interim Medical Director in April 2017.

Dr Nicki Murdock (from January 2019)

Nicki joined Alder Hey in January 2019, returning to the UK after a successful career across the Australian health care system. Nicki has served as the Executive Director Medical Services at Cairns and Hinterland Hospital and Health Service Australia and is an ex-president of the Paediatrics and Child Health Division of the Royal Australasian College of Physicians. After training in the UK she became a Fellow of the UK Royal College of Paediatrics and Child Health, and then FRACGP, FRACP and FRACMA.

A senior medical leader with qualifications in Paediatrics, General Practice and Medical Administration Nicki qualified in 1983 at Southampton University. She has held the post Executive Medical Director at a number of hospitals in Australia and has led State wide medical Reviews and chaired a number of specialist steering groups.

Hilda Gwilliams – Chief Nurse

Hilda joined the Alder Hey team in February 2013 as Deputy Director of Nursing and was appointed as Chief Nurse in 2017. She started her career in the NHS as an Enrolled Nurse in 1982 before progressing to a dual qualified Registered Nurse.

Hilda has worked in a variety of settings spanning maternity, children and adult acute services throughout the North West region.

Part of her role includes responsibility for maintaining the NMC Professional Standard across the Trust. Hilda also holds the role of the Trust's Caldicott Guardian. In addition to her professional registrations Hilda has attained an MSc in Health and Social Care from Edge Hill University.

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John Grinnell - Director of Finance and Deputy Chief Executive

John joined Alder Hey in April 2017 as Director of Finance and Deputy Chief Executive. His NHS career began via the National Finance Graduate Trainee scheme, and he has worked in a variety of roles, including the Deputy Director of Performance at the University Hospital of North Staffordshire, and Deputy Director of Finance at South Manchester University Hospital.

He joined The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation (RJAH) Trust in Oswestry as Director of Finance in 2008 and played a key role in supporting the organisation's successful Foundation Trust application. He also worked with the Strategic Orthopaedic Alliance (SOA) to ensure that the voice of specialist orthopaedic providers is heard within the national financial agenda.

John became Acting Chief Executive at RJAH in October 2015 until taking up the position of Deputy Chief Executive on 1 April 2016. This was the role in which he remained until joining Alder Hey a year later.

Adam Bateman - Chief Operating Officer

Adam was appointed Chief Operating Officer in April 2018. Prior to this Adam held a number of senior operational management roles in the NHS with responsibility for emergency, medical, surgical and community services.

In 2019 Adam secured the Executive Healthcare Leadership award following completion of the national Nye Bevan leadership programme. He also holds an MSc degree in Healthcare Leadership from the University of Manchester. Through the NHS Leadership Academy Adam successfully undertook a healthcare information fellowship at GlaxoSmithKline.

Adam has a particular interest in quality improvement and has worked on a number of successful projects, including the design and build of new cancer treatment units. He has also played a key role in the development of partnerships in Liverpool to provide high quality congenital cardiac and neonatal services to patients.

Melissa Swindell – Director of Human Resources and Organisational Development

Melissa is the Executive Director of HR and OD, and has worked at Alder Hey since 2009. Following her graduation in Economic and Social History from the University of Liverpool, Melissa started her HR career in the airline industry before joining the NHS. She has worked across HR and OD in a number of NHS organisations both in London and the North West. A Chartered Fellow of the CIPD, Melissa also has postgraduate qualifications in training and a range of personal and team development tools and coaching. Melissa leads the people development agenda at Alder Hey and has a passion for improving leadership, staff engagement and wellbeing.

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

Erica joined the Alder Hey team in September 2010 as Director of Corporate Affairs. She began her NHS career in 1991 through its graduate management training scheme. Erica

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spent over ten years working in primary care and commissioning roles before moving to the acute sector in 2003. Part of her job includes the role of Trust Secretary, advising and supporting the Chair, Board of Directors and Council of Governors on all aspects of regulation and corporate governance. Prior to coming to Alder Hey, Erica was Director of Corporate Affairs at the Liverpool Women's NHS Foundation Trust where she directed the successful application to become the first foundation trust in Merseyside. Erica holds an MBA as well as a BA (Hons) degree from the University of Liverpool.

David Powell – Development Director (non-voting)

David joined Alder Hey as Development Director in December 2012 and has over 30 years' experience working in the NHS. Prior to his role at Alder Hey, David held Development Director posts in Bristol and London overseeing new hospital programmes. David has a history degree from Manchester University and is a qualified accountant.

Dani Jones – Director of Strategy & Partnerships (non-voting)

Dani joined Alder Hey in October 2017 from Liverpool Community Health, where as Deputy Chief Operating Officer she had responsibility for a wide range of services including Public Health, Health Visiting and School Nursing, District Nursing, Rapid Response Therapy, Telehealth, IM&T and the single point of contact. Dani led successful delivery of the trust's Clinical Strategy, working closely with Community staff, GPs and The Kings Fund.

Dani has 15 years' experience in health and social care in Merseyside, and has held a number of lead roles in health and social care integration.

Dani has worked closely with GPs, both as a commissioner and in provision, on developing integrated community care teams, and outcome-based integrated teams for frailty and diabetes. Dani successfully developed partnerships with primary and community care, mental health, acute sector colleagues, community and voluntary sector partners to set up new services that have improved outcomes and experiences for patients. Dani has held roles across Liverpool City Council and Liverpool Community Health joining up health and social care, and has led a programme of telehealth and telemedicine at scale across NHS Merseyside.

Following her graduation in Economics, and subsequent MSc in Health Care Ethics at the University of Liverpool, Dani began her NHS life in technology and innovation. Dani achieved an Executive Leadership in Healthcare award through the 'Nye Bevan' programme in 2017. Dani is incredibly proud to work in the NHS and is passionate about making positive improvements with patients and staff. Dani is also a very proud Mum of a lovely, energetic toddler.

Mags Barnaby – Interim Director of Strategy (non-voting) (March 2018 – Dec 2018)

Mags has extensive senior level experience in planning and delivering services to achieve national and local targets, and in the strategic and operational management of change. She is passionate about the NHS and driven by a desire to make a positive difference to the quality of services for patients and staff. One of her key strengths is an innate ability to identify the links in complex problems, particularly the human dimension, in order to develop strategic

vision and problem solving. In over 25 years working at a senior level in the NHS, Mags has held substantive appointments as Director of Human Resources, Director of Operations, and Director of Planning and Strategy in England and Wales. She was awarded a BA (Hons) at Warwick University in 1984, following which she studied a number of professional and post-graduate courses including MSc Strategic Human Resources Management (Leeds Business School 1991), MIPD (1997), Postgraduate Certificate with the National Leadership and Innovation Agency (Birkbeck College 2007). In 2016 Mags attended Harvard Business School to study Advanced Negotiation Skills for Strategic Decision Making.

Mark Flannagan, Director of Communications and Marketing (non-voting)

Mark joined Alder Hey in July 2017 from the UK Charity Beating Bowel Cancer, where he was Chief Executive. He has a degree in Medieval History from the University of St Andrews and has worked for most of his career in the Third Sector in Communications, Campaigns and Policy. Mark has extensive health experience, having worked at senior level in the Royal College of GPs, Royal College of Nursing, Diabetes UK and elsewhere. Mark is responsible for internal and external communications, including media relations, brand, staff engagement campaigns and the website.

- **Non-Executive Directors**

Steve Igoe – Non-Executive Director/Senior Independent Director and Chair of the Audit Committee (to September 2018)

Steve joined the Alder Hey Board in October 2010 and was re-appointed by the Council of Governors in September 2013 for a further three years. In September 2016 the Council of Governors approved Steve's re-appointment for a further twelve month period in order to ensure continuity on the Board. Steve is the Deputy Vice-Chancellor at Edge Hill University and a Chartered Accountant by training. Prior to working for Edge Hill, he worked for Coopers and Lybrand Deloitte a predecessor firm of Price Waterhouse Coopers as a Senior Manager in their North West offices. In his current role he has Board responsibility for Finance, IT, HR, Infrastructure and Estate Developments, Facilities Management, Learning Services and Strategic Planning. He has previously advised the Government on the regulation of the Higher Education sector and was an adviser to the Higher Education Funding Council for England (HEFCE) Board on leadership, governance and management and costing systems within higher education. Steve has been a Governor of a large acute NHS trust, a trustee of a charity specialising in respiratory education and an executive and founding director of a substantial IT network company. As well as acting as chair of the Trust's Audit Committee Steve also chairs the Integrated Governance Committee and is a member of the Clinical Quality Assurance Committee.

Kerry Byrne - Non-Executive Director and Chair of the Audit Committee (from September 2018)

Kerry is a Fellow Chartered Certified Accountant and finance leader with over 17 years' experience in "Big 4" professional services covering governance, risk management and internal control in the public and private sectors.

She was a Senior Manager at Deloitte, Liverpool for 11 years (1997-2008) where she provided internal audit services for numerous organisations and industries both in the private and public sectors. She then spent 3 years (September 2008-December 2011) as Head of Internal Audit at Universities Superannuation Scheme Ltd: followed by nearly 3 years (January 2012 to November 2014) as the Director of Retail Banking Internal Audit at Ernst & Young.

Since leaving EY she has been managing her own portfolio of 11 rental properties in Widnes and Ellesmere Port. She has also, as from June 2010, been a Non-Executive Director at Liverpool John Moores University where she is currently a member of the Board, Chairman of the Finance Committee, and a member of the Nominations and Remuneration Committees and Chairman's Group. She had previously been a member of the Audit Committee.

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

Ian joined the Alder Hey Board in September 2011 and was re-appointed for a second term of three years in September 2014. He was re-appointed by the Governors for a further 12 months in September 2017. In order to ensure continuity on the Board, Ian was reappointed for a second twelve month period to September 2019. Ian is a Chartered Accountant and joined Ernst and Whinney (now Ernst and Young) in 1974 and in 1982, became a partner. In 1988 he became Group Finance Director of the Albert Fisher Group PLC, a leading global food processor and distributor. From 2003 to 2013, Ian held senior positions with VPS Holdings Limited, which was the largest void property services company in the world. Between 2003 and the beginning of 2011 he was Group Chief Executive, during which time the turnover of the business increased from £3m to £200m. Between January 2011 and October 2013 he was a Deputy Chairman responsible for business development. Ian is now the Group Chief Executive of The Clearway Group Limited, a void property services group operating in the UK and France.

Jeannie France-Hayhurst – Non-Executive Director

Jeannie took up her role at Alder Hey in July 2013 and was re-appointed for a second term of three years in June 2016. She is a highly-regarded family law barrister with wide experience of the voluntary sector, politics and the commercial world. She is known throughout the wider community in the North West as a fearless advocate and is much sought after on the seminar/lecturing circuit. Jeannie has made time in her busy career for voluntary and charitable work and has extensive experience of dealing with vulnerable adults and the socially disadvantaged. She has significant experience of service on boards and committees at both local and national level.

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

Claire joined the Alder Hey Board in October 2013 and was re-appointed for a second term in September 2016. She is a high impact leader of social change and brings a track record of success from a variety of non-executive, executive and community leadership roles – shaping policy and practice in the business, social enterprise and charity worlds. Renowned in

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Merseyside, known nationally and internationally, Claire's work in education, regeneration, anti-poverty, equality and fairness arenas positions her as an independent thinker, experienced practitioner and trusted adviser to many. She was awarded an OBE for services to education in 2012. Claire's achievements cross many decades, fields and roles. Having built the award winning Blackburne House Group (BHG) over the last 30 years, her attention is now moving towards growing a wider portfolio of non-executive roles to complement her work at BHG.

Anita Marsland MBE – Non-Executive Director/Senior Independent Director and Chair of the Clinical Quality Assurance Committee

Anita was appointed to the Board in July 2014 and was re-appointed for a second term in June 2017. She began her career in Local Government in 1974 and is a qualified social worker. She later held a range of senior management posts, rising to Chief Officer. In 2002 Anita became one of the country's first joint Chief Executive appointments between an NHS organisation and a Local Authority. Anita has pioneered integrated working between Local Government and the NHS for many years and the model of partnership working that she has developed has been adopted and implemented successfully in other parts of the country. She has a strong reputation nationally for promoting and implementing innovative solutions to tackle health inequalities. Her work has been acknowledged through several awards including an MBE for services to health and social care in 2008. In 2010 Anita was seconded to the Department of Health as Managing Director (Director General level) to lead the setting up of Public Health England (an executive agency of the DH) as the delivery arm for DH public health policy, in line with changes introduced by the Health and Social Care Act 2012. This included oversight of the transition phase of the transfer of responsibility for the local public health system from the NHS to Local Government. In 2017 Anita was awarded an Honorary Membership of the Faculty of Public Health.

Anita is the Independent Chair of Sefton Transformation Board**.**

Declaration of Interests

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

Political Donations

Alder Hey did not make any political donations during 2018/19.

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NHS Improvement's Well Led Framework

NHS Improvement introduced updated guidance for organisations on the use of the well-led framework in June 2017. The Well Led Framework was developed from the Quality Governance Framework, originally published by Monitor in 2010 and adopted by NHS Improvement; the Trust had consistently monitored its performance against the Quality Governance Framework - via the Clinical Quality Assurance Committee on a quarterly basis up to this year. This process supported Alder Hey's approach to reviewing its governance arrangements and underpinning systems and processes on a regular basis as the national landscape around good governance, quality and leadership has evolved.

The Alder Hey Board commissioned MIAA (Mersey Internal Audit Agency) in partnership with AQuA (Advancing Quality Alliance) to undertake an independent review of the Trust against the Well Led Framework. The comprehensive review was carried out in accordance with the June 2017 guidance and therefore had a strong focus on integrated quality, operational and financial governance and was based upon a number of key lines of enquiry developed by CQC to test out leadership, culture, system working and quality improvement. The methodology for the review consisted of four key areas of interlinked activity to enable in depth triangulation of the findings; these were: a desktop document review; one-to-one interviews; board and sub-committee observation and on-line surveys. The review involved some 40 people; as well as the Trust's Board members and senior managers, views were also sought from a range of external stakeholders including commissioners.

The report from the review was received in late February 2018; it states that '*The overall conclusion from our review is that the Trust is well-led. It is an organisation with lived values, a talented Board, a determined strategic intent and a momentum to developing a clinical leadership model.*' Whilst the Board welcomes such a positive conclusion, it is equally concerned to ensure that the developmental plan derived from such a rich and informative process is created and owned by the whole Trust leadership. A workshop session to discuss the recommendations from the report took place in July 2018 to agree the priorities to inform the Board's development plan, which has been worked through during the latter part of 2018/19.

In addition, the Trust underwent a well-led inspection by the CQC as part of the 2018 inspection of five core services. The Trust received a 'good' rating in this domain; the inspectors said that "The trust had a vision for what it wanted to achieve and workable plans to turn it into action" and "The board and leadership team had developed a set of vision and values that were embedded throughout the organisation. Staff throughout the trust were aware of the vision and values". The recommendations for improvement arising from the inspection formed the basis of an action plan which has been progressed throughout the year.

In May 2018 we held an Inspiring Quality Summit attended by a broad range of over 100 staff, parents, students and external partners; this was followed by a series of workshops attended by senior leaders in order to develop a plan to realise the Trust's Inspiring Quality vision and build on Alder Hey's strong history of quality improvement. Outputs from these events was collated and used to inform three clear and ambitious Inspiring Quality aims; firstly, to put children first; secondly, to be the safest Children's Trust in the NHS and thirdly, to achieve outstanding outcomes for children. The Board was appraised with plans for delivery of the

Inspiring Quality Strategy for 2016-2021 in December 2018 and will continue to receive regular updates through assurance reports to CQAC.

The Clinical Quality Assurance Committee continued to monitor the performance of the Trust against its agreed Quality Aims and all national/regulatory targets and quality standards using the Corporate Report.

The Integrated Governance Committee, chaired by the Trust's Senior Independent Director, has delegated authority to seek assurance on the management of risk across the whole of the organisation's activities and to hold each responsible officer to account for the effective management and mitigation of risks in their area. It operates an assurance mechanism that links together the Board Assurance Framework and Corporate Risk Register, which in turn is informed by individual Divisional and departmental risk registers. The Committee provides a structured process to test controls and ensure that strategic and operational risks are being addressed as part of a coherent system from ward to Board; this was revised and further strengthened during the year as part of the current phase of the risk management improvement plan, which has included a comprehensive risk register revalidation process. An audit of Divisional risk management arrangements was undertaken in-year which achieved 'substantial assurance'.

The work of the Audit Committee complements this by discharging its responsibility for the maintenance of an effective system of internal control across the totality of integrated governance and risk management. During the year it received a report on the progress of the risk management improvement plan.

The Board Assurance Framework is scrutinised by the Board at its meeting each month to enable the Board to be fully sighted on key risks to delivery and the controls put in place to manage and mitigate them, as well as enabling all members to have an opportunity to identify key issues, concerns or changes.

Further details about the Trust's approach to the well-led framework and quality governance can be found within the Quality Report (page 117) and Annual Governance Statement (page 103).

Patient Care

Infection Prevention and Control

The Trust appointed a new Infection Control Doctor in September 2018 and in January 2019 the new Medical Director/ Director of Infection Prevention and Control (DIPC) commenced in post.

The Head of Service/Associate Director of Infection Prevention and Control, continues to oversee the strategic leadership of the Infection Prevention and Control (IPC) agenda both internally within the Trust and externally in the region and nationally, as well as overall responsibility for the day to day management of the IPC, Intravenous Access and the Tissue Viability teams.

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The annual IPC Work Plan which was introduced in 2017/18 fulfils the requirements of the 'Code of Practice' for all providers of healthcare and adult social care on the prevention of infections under the Health and Social Care Act 2008 (revised in 2015) and is mapped against the Trust's values. In conjunction with the IPC Work Plan the IPC team continues the work identified in the Trust-wide action plans targeting key areas including environmental cleanliness, Methicillin Sensitive Staphylococcus Aureus (MSSA) bacteraemia and Surgical Site Infection Surveillance (SSIS). Both the work plan and associated action plans are monitored through the Infection Prevention and Control Committee (IPCC) on a bi-monthly basis and through the Trust Board and Clinical Quality Assurance Committee on a quarterly basis.

As a paediatric trust, our patients are particularly susceptible to respiratory viruses such as influenza. The importance that staff place on protecting our children from acquiring respiratory viruses is demonstrated in the Trust again in 2018/19 achieving the 75% target for staff influenza vaccination.

2018/19 saw the successful integration of the Vessel Health and Preservation (VHP) 2016 framework for vascular access, the 'Right line for the Right patient at the Right time' into the Meditech system across the Trust, through the GDE project.

2018/19 has seen the development of a comprehensive internal reporting system for all surgical site infections (SSI) within the Trust. The 'OneTogether' programme, to reduce the incidence of surgical site infection and to benchmark against best evidence-based practice continues and is reported through the SSI action plan to the IPCC.

2018/19 saw the expansion of the IPC dashboards to include aseptic non-touch technique (ANTT) assessments, sharps injuries and FIT testing. These dashboards are communicated and monitored across the Trust and along with the hand hygiene audits form the basis of the IPC audit programme incorporated in the IPC Work Plan.

During the year a new hand hygiene app. for mobile devices was introduced in order to capture more hand hygiene opportunities across the Trust. In addition, a practical hand hygiene assessment was incorporate into mandatory IPC training.

The team commenced a Post Infection Review (PIR) process for all MRSA, MSSA, E.Coli, Klebsiella and Pseudomonas bacteraemias within the Trust. The process identifies if there are any lessons that can be learned from these incidents and reports outcomes & actions through the divisional goveranance structures.

Multi–antibiotic resistant organisms such as Carbapenamase producing enterbactericeae (CPE) provide significant challenges to the NHS today due to the reduced treatment options available and the ease in which they may be transmitted. 2018/19 has seen a steady increase in the compliance with screening for CPE carriage at the Trust and early identification of carriers. Through close management and early identification of CPE carriers there have been no outbreaks at the Trust in 2018/19.

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Launch of the first annual “Love Bug Day” in February 2019 with the support of Industry Partners, highlighting the work that the IPC team are undertaking to reduce hospital acquired infections.

Safe Together & Always Right (STAR) Review - Ward Accreditation Scheme

The Trust has designed and embedded a programme of ward visits developed using the 13 Care Quality Commission Key Lines of Enquiry to give assurance around standards of practice delivered by wards and department teams. The visits have adopted a risk based approach exploring different aspects of patient care and service.

The inspection team comprises both clinical and non-clinical staff and welcomes patient/parent representation. All reports and action plans are be published on the Trust’s intranet to enable sharing of best practice and any learning across the organisation.

Quality Assurance Ward/Department Rounds

The Quality Assurance Ward/Departments Rounds have continued to evolve throughout the year acting as a mechanism to undertake a ‘deep dive’ process at ward/department/specialty level into quality and performance. Outcomes provide both quantitate and qualitative information to demonstrate that services are safe, effective, responsive, caring and well-led in line with the CQC’s Key Lines of Enquiry. The programme of visits supports the golden thread of ward to board reporting through transparency, by testing out and gaining assurance that what is reported to the Board is consistent with what is happening at a local level.

Devolved Risk and Governance model

Now in its third year, the devolved model of governance has continued to ensure the Trust’s commitment to be a clinically led organisation. The Trust has added divisional clinical directors for medicine, surgery and community services to the executive team and all Clinical Directors attended board meetings on a regular basis. Devolved governance means that clinical directors are empowered to structure their own divisions in a way that will ensure the best outcomes for the children in our care, with the best experience possible for both children and families throughout their journey.

Volunteering Programme

Volunteering is a key enabler in transforming the way the NHS works with people and communities. During 2018 Alder Hey formally reviewed its volunteering programme to ensure we were delivering good practice to our volunteers and staff. Our strategic ambition was to grow and develop volunteering in Alder Hey offering quality volunteering opportunities that would make a huge impact on enhancing our children and young people and their families’ experience as well as the benefits for the volunteer.

Our achievements this year include:

Helpforce

In 2018 Alder Hey joined partnership with Helpforce whose vision is to make volunteering an integral part of everyone’s health and wellbeing. We are the first children’s acute trust to become a member of their learning network and we look forward to sharing our knowledge and experiences and benefitting from that of others.

Heath Careers Passport

The Health Careers Passport scheme is a pathway to allow young people to gain practical experience and show that careers in health are within their reach regardless of their background. The Trust is the first to commit and embed the scheme; pictured below is our volunteer Matthew McIntyre carrying out his role in our laboratory, gaining skills that he can take with him on his career path.

Bedside Play Scheme

In collaboration with the Liverpool Paediatric Society we have implemented the following scheme with our medical students who will donate time, evenings and weekends, were they can come and play with children within the ward environment. The scheme enables children to have one to one play sessions providing entertainment and also supports medical students to develop key skills on how to interact with children.

Feedback from the Friends and Family Test consistently demonstrates how valued our volunteers are and how much they improve the experience of patients and families.

This year we have volunteers engaging with families in wards and the outpatients' department offering

- Face painting
- Reading stories
- Play
- Pet Therapy dog Hollie, our extremely popular golden Labrador.

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Future Plans

Objectives for 2019

- Mental Health First Aid – volunteers to attend training session to provide Mental Health First Aid
- Volunteer Community Champions – to visit schools, retirement villages and colleges to discuss our volunteer programme
- Smoking Advisors – training is provided to our volunteers by Smokefree Liverpool to offer assistance to those who wish to give up smoking
- Health Promotion – volunteers to support the delivery of health and wellbeing within the atrium for the public
- Bleep Volunteers – Volunteers to be on-call to collect medication to speed up discharge
- Concierge Service – Service to be an advocate for families offering support from our volunteers along with Concierge team.
- TheForum@alderhey and Membership – to streamline and develop the links with our Forum and foundation trust members to enable progression and interaction.

Complaints

During 2018/19 the Trust received a total of 126 formal complaints, four of which were withdrawn.

There was a 33% increase of formal complaints in year compared with 2017/18; whilst this represents a higher number than the previous three years, the increase is due to a combination of factors relating to overall increased activity.

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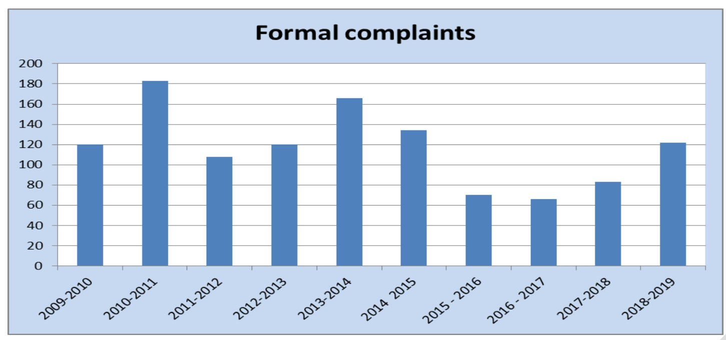

Table 1 – formal complaints received each year

The Trust has continued to support families directly in the clinical areas, providing early intervention when concerns are raised. This will continue to be a key focus area in the coming year to ensure that real-time intervention and actions for parents and carers with concerns are addressed as soon as possible.

A higher proportion of complaints received by the Trust this year have been very complex, given Alder Hey's status as a specialist tertiary centre; many of these involve children whose care has been provided by multiple specialities. In such cases the team engages with the complainant to agree a timescale within which the issues will be investigated and a response provided.

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

Learning from complaints
Alder Hey is a learning organisation and uses complaints as a mechanism for taking forward improvements and changes in practice. Actions taken as a result of complaints during 2018/19 were as follows:

- In response to one significant complaint, a new pathway of care has been designed for children and young people who require a specific procedure. The clinical guidelines and patient information have been designed by clinical staff with full engagement and support from the parents who raised concerns on behalf of their child, utilising their experience to support and drive the changes.
- Following feedback from children and parents of the D/deaf community, a mobile WiFi enabled system for accessing British Sign Language interpreters has been implemented across the Trust and provides BSL interpreters instantly from 8 am to midnight to support families who arrive unplanned or as emergencies.

Management of Complaints and Concerns

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

Patient Advice and Liaison Service

The PALS service has continued to provide essential informal advice to families using Alder Hey; the team is highly visible and accessible via their base in the Atrium.

	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	Comments
PALS	1248	1133	1246	1294	1349	1371	An increase of 2% in PALS queries is noted this year

Improvements

- Earlier intervention from senior staff at a local level to address the concerns raised provides a much more supportive earlier intervention and better outcomes.
- Staff access to the Trust's electronic reporting system to log concerns raised by parents and families in ward and departments has been made available.
- A complaints and concerns form has been made available for families to use on the Trust website – this makes the process of making a complaint more accessible and efficient as the form is structured to source all the required information to process the complaint swiftly.

Stakeholder Relations

Involvement in the Local Health Economy

Alder Hey provides more than 45 clinical specialties for children up to the age of 16 to 18, and in some cases beyond. As part of delivering individual patient care pathways prior to, during and after each child's admission to hospital, clinicians and clinical teams work in partnership with referring general practitioners (GPs), clinicians/hospitals from across the UK and overseas. Alder Hey also works in partnership with Clinical Commissioning Groups (CCGs) and Specialised Commissioners at NHS England to inform and deliver service contracts that meet the needs of children served within available resources. Alder Hey provides community and mental health paediatric services in Liverpool and Sefton. In both places, 'Starting Well' has been identified as a priority for commissioners. During 2018/19 the Liverpool Children's Transformation Board agreed key priorities to improve the well-being of children in Liverpool in partnership with Liverpool City Council, GPs, and community teams; for example resulting in improved collaborative working at neighbourhood level to better support care closer to home. These priorities are also reflected in the City of Liverpool's growth plan and the existing Liverpool CCG 'One Liverpool' Plan; Alder Hey are active partners in the refresh of this plan for 2019/20.

Alder Hey works closely with a wide range of Trade Unions, partner organisations, volunteers and our Council of Governors to continue to improve the quality of our services and patient and family experience. Increasingly, Alder Hey is seeking to build and strengthen partnership

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working with clinicians and wider staff groups through Listening into Action, Hackathons held by the Innovation team, clinical leadership and development and improved communications.

Alder Hey is committed to co-creating system-wide collaboration and shared models of care with our strategic partners. In order to achieve this, the Trust has continued to work proactively with local, regional and national stakeholders. The focus during 2018/19 has been to strengthen existing partnerships and develop new ones to achieve the following aims:

1. **Enhanced partnership working with trusts across Cheshire and Merseyside** in order to sustain and improve the quality of care provided to children and young people and their families. Alder Hey has continued to be a key member of the North West Congenital Heart Disease Partnership working together to provide a fully compliant, resilient and clinically safe service model for adults and children across the North West of England, North Wales and the Isle of Man. The Partnership is now working together to deliver the agreed plan and new model of care, and a new Operational Delivery Network during 2019 and beyond. In addition, partnership working with Liverpool Women's NHS Foundation Trust resulted in an approved business case for delivery of a two site single service model for neonates requiring surgery and level 3 Critical Care. This joint model of care is beginning to streamline patient transfers between hospitals and improve quality of care, outcomes and patient experience, and will continue to develop into 2019/20 and beyond. These new models are being funded through historical funding patterns and/or new business cases for new models of care agreed by commissioners.

2. **Joint working with Manchester Children's Hospital** continues to support and host clinical networks working together to improve standards and consistency of care and reduce unnecessary variation. Alder Hey Executive Directors meet with Manchester Children's Hospital Executives on a quarterly basis, and jointly hold an annual Clinical Network Event to share best practice and promote good governance. There are four mandated clinical networks for paediatric services: Neonatal, Trauma, Burns and Critical Care. Alder Hey itself hosts the Neonatal Clinical Network, Cardiac Network, Trauma Network and Neurosciences Network.

3. As a member of **Liverpool Delivery System** and in support of the Cheshire and Merseyside Sustainability and Transformation 5 year Forward View, Alder Hey is an active member of a number of partnership groups concerned with building a sustainable model of care and improving clinical care, access and affordability. These include:
    - Acute Sustainability Board
    - Women's and Children's Partnership Programme Board
    - Liverpool Provider Alliance (Alder Hey are also members of the Sefton Provider Alliance)
    - Liverpool Children's Transformation Board, which reports directly to Liverpool's Health and Wellbeing Board.

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International Child Health Developments

April 2018 the Trust Board agreed to formally establish the Department of International Child Health (ICH). The Department strives to deliver the key functions that are required to realise the Trust's strategic aim to be an internationally recognised children's hospital of excellence. The Department's focus is on six key themes: international health partnerships, humanitarian 'mission' work, commercial/business development, education and training, research and innovation with an aim for International Child Health to be a core aspect of what we do at Alder Hey.

The department has seen a number of successes since its formation:

- ✓ Our departmental structure has been created
- ✓ We undertook a staff survey in October 2018
- ✓ We held a successful and well attended launch 9th November 2018
- ✓ We worked collaboratively with the Academy to deliver the RCPCH Winter Annual Meeting 19th November 2018
- ✓ We have held monthly meetings with agreed Terms of Reference for governance
- ✓ We have coordinated a number of international visits to Alder Hey
- ✓ Our staff have undertaken humanitarian missions to India and Palestine and partnership work continues with Kanti Hospital, Nepal
- ✓ The communications team have supported the department with articles, social media promotion and the ICH webpage
- ✓ We have developed a strategic delivery plan for 2019-2022

The staff survey enabled us to gain a wider understanding of the range of overseas work our staff participate in and we have begun to explore the benefits this type of work has for staff, the organisation and our patients back here at Alder Hey. We now understand the specific support our staff require to continue to undertake this valuable work. The Department of International Child Health is committed to developing reliable infrastructure that supports our staff to work internationally.

Delivering this vision will establish Alder Hey's reputation as a truly global organisation and will contribute to improving the health of the World's children.

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Pictures from the 2018 visit to India

The Alder Hey Academy

During 2018 the expansion and development of the Academy at Alder Hey has continued to gain pace.

This year the Academy has delivered several successful specialist masterclasses with renowned speakers from Italy, France and Canada

In September 2018 we saw Liverpool John Moors University, Edge Hill University and University and the University of Central Lancashire join ourselves and The University of Liverpool in occupying the newly opened Phase 2 of the Institute in the Park. We see this as an excellent opportunity to work more closely in partnership to build our Education and training portfolio.

In the 2018 annual report we reported that we were working with the Healthcare UK with a view to expanding our international commercial activities which led to a three year contract award with Beijing Huatong Guokang Foundation (BHGF) in Beijing. We are extremely pleased to report that due to this success Alder Hey Academy was awarded first place in the Education Links category for the North West Greater China Awards.

We have recently supported Liverpool City Council and other local businesses and Higher Education Institutions on a Liverpool Business delegation to Shanghai & Suzhou. This mission was also served to celebrate and mark the twentieth anniversary of the Liverpool & Shanghai twinning. The meetings held with both the Deputy Mayor of Shanghai and other local hospitals demonstrated a clear message that Alder Hey is held in great esteem by China and they are ardent in their objectives to learn from Alder Hey how to build a state of the art pediatric hospital and how to care for children in a person centered and effective manner.

Partnership engagement continues to grow both internationally and within the UK. The Academy is currently negotiating further projects in China as well as Spain and India.

In line the NHS Long term Plan (January 2019) the Academy is looking at how we can support our internal workforce to continue to deliver quality driven, patient centered care by offering training, education and continuing professional development (CPD)

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We are exploring how we can support the primary care services and GP's to take on the responsibility of caring for our children and young adults in their homes or community settings.

We continue on our mission to establish the profile of The Alder Hey Academy worldwide and to become a leading innovator of Paediatric Healthcare Training.

Alder Hey in the Park – Our Vision for the Alder Hey 'Campus'

Alder Hey's vision of a specialist campus for Children's Health has progressed with the completion of the Institute in the Park building and preparation of groundwork layouts for the Alder Centre and Community Cluster buildings. The remaining old ward blocks, old education centre and old Institute buildings are all vacated and being prepared for demolition in Summer 2019. 2019/20 will see two exciting Trust buildings commence construction as well as the first phase of the new Springfield Park development.

The Institute in the Park
The second phase of the Institute in the park building was completed in August 2018 and occupied by Trust research and support departments in October 2018. Research and education teams from our four university partners, the University of Liverpool, Edge Hill University, Liverpool John Moores University and the University of Central Lancashire (UCLAN) have also moved into the building, thus realising the vision to bring many different researchers and education faculties into one facility to share and learn for the future benefit of children's health.

The Alder Centre
The Alder Centre will be the first purpose built building to house the counselling service for all those affected by the loss of a child, including the 'National Child Death Helpline'. This very special service will be situated on part of the demolition site identified as Trust expansion space within the master plan. The single storey building with an eye catching roof profile and private garden space with private views of the future parkland was designed via a highly competitive RIBA competition inspired by the vision '*a place like no other'*. Construction will commence on site in early May 2019 and is expected to be complete by early 2020.

The Community Cluster
Developed with the vision of 'a community parkland for children' the community cluster is a campus of buildings that relate to each other but can be built in phases over a period of years as finances and service demands dictate. Designed via a RIBA competition that attracted some of the biggest architectural names in the country, the cluster is a very exciting, innovative and challenging solution that brings several different services into a shared space. The original plan to build in phases has been revisited and the Dewi Jones inpatient mental health unit is now planned to be delivered as part of the first phase which will accommodate CAMHS, Neuro Assessment Outpatients, Psychology, Orthotics and local Police administration offices. The building location and master plan allows for additional optional phases that may follow which could include Sandfield School and a twelve bed Rehabilitation

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Unit. The building will be situated between the Alder Centre and the Institute in the Park on part of the demolition site identified as Trust expansion space within the master plan. The chosen design will feature undercroft parking, views of the future parkland, private garden areas and clear landscaped routes between Eaton Road and the Park, and the adjacent Alder Centre and Institute in the Park in order to optimise the changing land levels. Detailed design workshops with users have produced an innovative design that attempts to create safe spaces for children that meet the highest mental health standards without an overtly institutional or clinical feel. Construction is expected to commence in Autumn 2020.

Springfield Park Initiatives

Access and Health

The recent completion of the Woodland Walk interactive nature and wellbeing trail has enhanced the pre-existing area of Springfield Park, with installations that appeal to local residents, children and families and those interested in nature, art and health. The availability of a rich multi-sensory nature experience and restorative environment will deliver physical and mental health benefits. Much of this work was funded in partnership with a grant from Veolia.
Accessible seating has been placed in six locations across the existing park. Phase 1 of the redelivery of Springfield Park will take place in the autumn of this year. This will include the establishment of a multi-use games area, additional seating and accessible routes to the north park entrance. Plans for new play equipment will also be developed.

Education and Research

In partnership with Lancashire Wildlife Trust (a registered charity dedicated to protecting wildlife and natural habitats throughout Lancashire, Manchester and North Merseyside), the Forest School area built in the woodland and opened in May 2017 has gone from strength to strength. Five local primary schools have now been trained as Forest School leaders and used the venue on a weekly basis to develop social and emotional intelligence, confidence, practical and creative skills and team building in their primary school classes. Recently, a school from Guernsey used the Forest School for enrichment purposes; there has been a family forest fun day and promotion of the benefits of outdoor play and learning on an informal basis. In October, the CAMHS team will be using the Forest School to support patients in a therapeutic outdoor environment. Feedback has been extremely positive, we have invited local primary schools in to assist with planting projects and the local Mini-Police have completed a litter pick in the park. Discussions have been taking place with Liverpool John Moores University to develop an evidence based research project utilising Springfield Park as an outdoor research facility for the University's Environmental Department. Three LJMU students have completed some provisional research on site, identifying barriers to participation in green spaces within the local community.

Art and Health

The Woodland Walk has transformed a corner of Springfield Park into a fully accessible walkway that will encourage visitors to benefit from the natural environment which can boost their health and wellbeing. The highlight of the walk includes a trail made up of 15 activity stations which encourage visitors to interact with, care for and learn about the natural environment. Activities range from an introduction to yoga and meditation, through to facilitating HITT sessions. Other installations will provide a fun and interactive guide to the plants, trees and wildlife along the walk and there's even a specially designed Book Bench creating a spot where people can relax and read in the sunshine and then share their

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favourite books for others to enjoy. There are plans to extend and enhance this woodland walk.

Participation
A Young Friends of Springfield Park group has been established through the support of Priority Youth Project, a local youth group in the East Liverpool area. Meetings, workshops and communications will continue with local schools, residents and the Friends of Springfield Park group to develop future input into the park design and management. The staff Reward and Recognition Group, Wellbeing Steering Group and Blank Canvas Group has each played a part in consultation for the phasing of the park and the site master plan. In the coming months, there will be a steering group established to support the reinstatement of and an ownership model for Springfield Park. From April 2019, there is a weekly delivery of Nature Tots and LFC Foundation's Open Goals activities. These will encourage the local community to engage with learning and play in the natural environment. Monthly litter picks and seasonal events will continue in the park. A series of events in Springfield Park this year are expected to encourage more local use of the park as well as attract hospital visitors and staff. In October 2019, we will host a nature and wellbeing conference showcasing our hospital in the park and the varied activities that have taken place. Recent planning applications highlight the aspirational plans for Springfield Park.

The Alder Hey Children's Charity
Alder Hey Children's Charity supports Alder Hey in achieving its vision of becoming a world class Trust. The Charity raises much needed funds that are spent directly on initiatives that benefit patients, from state of the art equipment to vital enhancements in theatres and IT.

Over the past six years the Charity has grown significantly, doubling its staff and quadrupling its income to bring in over £40m.

As Alder Hey's ambitions continue to grow, the Charity has also increased its aspirations. Alder Hey has been described as the most innovative hospital in Britain by the head of the NHS. The Charity has been integral to this, by introducing new partners who are now changing the way they work to enter the medical field in ways which could not have been imagined a few years ago. This has allowed Alder Hey to lead the way in 3D printing, virtual reality operations and many other innovative ways which have been funded by the Charity.

During the 2018/19 financial year Alder Hey Children's Charity granted funds to support:
- The 'Institute in the Park' - 2018 saw the completion of the second phase of the research, innovation and education centre building.
- Cone Beam CT scanner - this reduces radiation in children needing head, face or dental surgery. These scanning systems are often used in dentistry and provide excellent 3D images of teeth, soft tissue and nerve pathways. The technology has distinct advantages over outdated scanning methods. It dramatically reduces the amount of time it takes (now just 20 seconds) and the amount of radiation that patients are exposed to by around 90%. Repeated radiation exposure of the head and neck area can cause long term problems, including potential damage to the child's eyes.
- Robotic Visualisation System - while undertaking complex neurosurgery, surgeons work at super high magnification and even the slightest vibration can cause distortions

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and mean that areas cannot be properly examined. Also should surgeons need a wider view of the brain, this can result in a larger piece of skull needing to be removed. This technology will lead to improved outcomes for patients and help clinicians make more informed decisions, thanks to both the quality of the images and the way in which this system can provide access and magnification.

- 24 Heated Cots - a key feature of these cots is that they can be heated to help Alder Hey's youngest patients maintain their temperature. Babies who are premature and unwell cannot regulate their own body temperature, so these cots support the treatment of young patients through their time in hospital. These incredibly versatile cots are used for young patients who may have cardiac or respiratory problems. The top and sides of the cot can be detached which enables clinicians to have an open access platform to undertake clinical procedures. These cots will also be used to perform a similar function to a neonatal incubator and are much less daunting for parents and families. They allow more access to the baby when needed but also give the flexibility of being able to be closed up similar to an incubator when necessary.
- Patient distraction throughout the hospital – the Charity plans to transform all treatment rooms at Alder Hey into a more child-friendly and relaxing space. This will have a positive set of consequences for both patients and parents. Patients will be distracted and entertained, making them less anxious and nervous about receiving treatment. Due to feeling relaxed and distracted, patients will be more compliant both in having treatment at all and in receiving treatment in the dedicated treatment room. This programme began in 2018/19 and will continue into 2019/20.
- Sensavue Entertainment System - Alder Hey undertakes around 2000 MRI scans each year. An MRI requires children to stay still often for up to 45 minutes and the sound from an MRI machine is quite loud. For children that need an MRI it's important that clinicians are able to take the best possible images, so they can effectively consider the next steps in their treatment. In order to relax patients and ensure that they remain calm and distracted for the duration of their scan, the Charity has funded a Sensavue entertainment system. This system is entirely free of metal and is a proven way in which to distract children often through the display of television programmes with the patient wearing special headphones. SensaVue can send sound and pictures from a variety of media sources to a high-resolution 32" display, which can be positioned virtually anywhere in the MRI suite. This system ensures children are calmed, distracted and entertained during what can be a traumatic and lenghty examination.
- Epilepsy Equipment - as part of the Northern Children's Epilepsy Surgery Service, Alder Hey is one of just four national centres offering surgery to patients with epilepsy. It has been demonstrated that surgical intervention can reduce seizures by 50-75%. The Charity has funded two pieces of equipment to improve epilepsy surgery. The first is a monitor to help clinicians accurately identify the area of the brain that requires surgery. The current system can only cover part of the brain and so patients sometimes have to return to theatre for a second operation if the part requiring surgery was not identified the first time. This new system will double the area of the brain being monitored, meaning that patients will only require one trip to theatre for this procedure, and where necessary can be referred for surgery earlier. For children who do need surgery it is important we ensure that the surgery avoids any area of eloquent cortex (the areas that deal with sensory processing, linguistic ability, and motor skills). Therefore, in conjunction with the equipment above, the Charity has also funded a

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cortical stimulator that enables clinicians to accurately plan surgery and reduce the risk relating to this procedure.

- Ward Based Catering - the ward based catering programme provides a food on demand service on wards, encouraging healthy eating and nutrition to support patients recovery to health.
- Play and Children's Entertainers – many of Alder Hey's patients are babies who require specialist distraction techniques to calm them during procedures. Often young patients also need specialist therapy before treatment to help them deal with anxiety. Some of the other services the Play Team support include organised daily play and art activities in the playroom or at the bedside and the use of play to maintain a child's level of development during illness.
- The Music Therapist Programme - funded by the Charity since April 2012, music therapy offers children, young people and their families an opportunity for therapy through a non-threatening, non-medical medium. A chance for families to experience something "normal" in an environment that can be incredibly challenging. Although therapy sessions themselves can be very difficult for patients and their families, the overall aim of music therapy is to improve the quality of experience for families, improve their ability to cope, to interact with their child, to express themselves and relate to others in a way that children should. Using music therapy gives a unique insight into the wellbeing of child and family and a basis on which to use music to facilitate change.
- Arts Co-ordinator – since 2006 the Alder Hey Art's Programme has grown exponentially and is extremely successful. It is distinct from those in other paediatric hospitals in that it is focused on patient participation, being both patient centred and patient led. The Arts support an individualised and very positive healthcare experience for many patients, often focusing on those who have long-term conditions. The success of this approach to Arts in Healthcare is borne out of the design of the new hospital where there is an Arts hub in the Atrium which supports performances and one to one working.

In addition to the activities set out above, the Charity continues to increase its strong community fundraising base particularly throughout the North West. Income through sponsored events came in at over £350k and successful bespoke events are all now well established, grossing over £420k. Lottery membership continues to grow steadily and the role of canvassers within the hospital has been particularly successful: membership is now over 20,000.

Corporate fundraising continues to make significant impact at Alder Hey, through financial donations and also through the sharing of expertise and knowledge. The Charity's long standing partnership with Matalan continues to offer significant support both financially and in raising awareness about Alder Hey through an annual campaign. Liverpool John Lennon Airport continues to support the Charity and a partnership with Merseyrail has also been secured.

In June 2018 the Charity held the Alder Hey 'Run with George' Ball at the side of the runway at Liverpool Airport. The event was a tremendous success raising over £700,000 for world class equipment at Alder Hey.

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In 2018/19 the Charity announced the appointment of a new Chair, Graham Morris OBE while four new trustees have also joined its board.

The Charity will continue to be creative in both fundraising and partnership activity as it aims to raise much needed funds for Alder Hey. In 2019/20 the Charity will be launching a new strategy that will focus on working more strategically with the hospital to establish a national footprint to facilitate further growth.

Statement as to Disclosure of Information to Auditors

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

Remuneration Report

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

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

Remuneration Committee membership 2018/19

- Committee Chair Sir David Henshaw
- Non-Executive Director Ian Quinlan
- Non-Executive Director Anita Marsland
- Non-Executive Director Claire Dove
- Non-Executive Director Dame Jo Williams
- Non-Executive Director Steve Igoe
- Non-Executive Director Jeannie France-Hayhurst
- Non-Executive Director Kerry Byrne

The Chair undertakes the annual appraisal of the Chief Executive, who in turn is responsible for assessing the performance of the Executive Directors and Associate Directors.

The Committee convened three times during the year with all Non-Executives attending; the following items of business were approved / supported:

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- Committee Terms of Reference
- Executive Director Performance and Incremental Progression for 2017/18
- Lifetime Allowance Pensions Restructuring Payments Policy
- The application of the Policy for members of the Executive Team
- New Medical Director remuneration proposal
- The national recommendations on very senior manager (VSM) pay awards

Advice which assisted the Committee in their consideration of matters was provided by Louise Shepherd, Chief Executive Officer and Melissa Swindell, Director of HR & OD.

Senior Managers Remuneration Policy
The Trust's remuneration policy applies to Executive Directors and associate Directors, i.e. non-voting Executives and is based upon open, transparent and proportionate pay decisions. All pay decisions are based on market intelligence and are designed to be capable of responding flexibly to recruitment imperatives to secure high calibre people. When setting levels of remuneration, the Trust's Appointments and Remuneration Committees also take into account the remuneration policies and practices applicable to our other employees, along with any guidance received from the sector regulator and the Department of Health and Social Care.

In accordance with the Trust's policy on senior managers' remuneration, rates of pay for all senior managers are based on job size, market intelligence (including nationally published remuneration surveys) and performance. In addition, this assessment has also taken into account NHS Improvement's guidance on 'Established Pay Rates.' They are also set with regard to the remuneration of other trust employees who hold contracts under terms and conditions agreed nationally by assessing relative and proportional rates of pay.

Following the publication of the consolidated VSM pay framework in 2019 by the DHSC, which is still in development, a full review of VSM salaries at Alder Hey will be undertaken.

The Committee also receives professional independent reports based on objective evidence of pay benchmarking across a range of industry comparators. The conclusion reached in professional independent reports is that 'weightings accredited to the various posts in relation to market comparisons had resulted in remuneration that is in line with current pay practice.' The way in which the Committee operates is subject to audit scrutiny. The work of the Committees is subject to an independent level of scrutiny by the Audit Committee and this scrutiny can be exercised at any time.

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Senior Managers Remuneration Package

	Basic Pay	Pension	Car Allowance	R&R Premium	Additional Duties	Bonus/ PRP	Pay in lieu of pension
Executive Directors	✓	✓	x	On a case by case basis	x	x	On a case by case basis

A recruitment and retention premium has been deployed in one instance in order to attract and retain a high calibre international candidate. Pay in lieu of pension will be considered on a case by case basis however no senior manager is currently in receipt of this component.

The Chief Executive and Executive Directors are employed on permanent contracts of employment; they are entitled to receive three months' notice and may give six months' notice. Provision is included within contracts of employment for contracts to be terminated with immediate effect and without compensation in certain circumstances.

There are two senior managers who during the year were paid more than £150,000 (this figure being the threshold used in the Civil Service for approval by the Chief Secretary to the Treasury as per Cabinet Office guidance and considered by NHS Improvement as an appropriate benchmark for NHS foundation trusts). One of these was the Chief Executive; the other is the Trust's Development Director. The Trust is satisfied that for both roles the level of remuneration is reasonable for the responsibilities carried and benchmarks favourably with comparable organisations.

Non-Executive Directors

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

The Trust Chair is responsible for assessing the performance of the Non-Executive Directors. The Chair's appraisal is undertaken by the Senior Independent Director using an inclusive process across members of the Board and Council of Governors, in accordance with a policy which has been developed to reflect best practice nationally. For Non-Executive Directors' remuneration, comparative data is provided to the Nominations Committee from comparative organisations. Remuneration rates for Non-Executive Directors have remained at the level set by the Nominations Committee in 2009/10, with fee levels benchmarked annually against the NHS Providers remuneration survey and other sources.

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During 2018/19 there were a total of 13 voting Board Directors in post across the period. Of these, eight individuals claimed £6,031 in expenses; for 2017/18 the figures were eight directors claiming £8,147 in expenses. In the year there were 29 governors in office, nine of whom received £8,156 in expenses; whereas in 2017/18 seven governors claimed £2,136.

The HM Treasury FReM requires disclosure of the median remuneration of the reporting entity's staff and the ratio between this and the mid-point of the banded remuneration of the highest paid director (as defined as a senior manager in paragraph 2.33 and paragraphs 2.49 to 2.53), whether or not this is the Accounting Officer or Chief Executive. The calculation is based on full-time equivalent staff of the reporting entity at the reporting period end date on an annualised basis.

The remuneration of the median salary and multiple to the highest paid employee of the Trust for 2018/19 and the prior year comparative is provided below:

	2018/19	**2017/18**
Band of highest paid director (bands of £5,000)	£170-175	£170-175
Median total remuneration	£33,681	£30,682
Ratio	5.12	5.6

The range of staff remuneration was £872 to £296,651 (2017/18: £944 to £258,670).

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

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

Signed:

Louise Shepherd CBE
Chief Executive
28th May 2019

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Salary and pension entitlements of senior managers
Total Remuneration

Name	Title	2018/19					2017/18				
		Salary	Taxable benefits	Performance pay & bonuses	Pension related benefits	Total	Salary	Taxable benefits	Performance pay & bonuses	Pension related benefits	Total
		(bands of £5,000)	(to the nearest £100)	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)	(to the nearest £100)	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)
		£000s	£s	£000s	£000s	£000s	£000s	£s	£000s	£000s	£000s
Louise Shepherd	Chief Executive	170-175	0	0	5-7.5	175-180	170-175	0	0	137.5-140	310-315
John Grinnell	Director of Finance / Deputy Chief Executive	130-135	3,600	0	7.5-10	145-150	130-135	0	0-5	35-37.5	170-175
Hilda Gwilliams	Chief Nurse	110-115	0	0	10-12.5	120-125	120-125	0	0-5	112.5-115	235-240
Steve Ryan	Medical Director	60-65	0	0	0	60-65	115-120	0	0-5	0	115-120
Nicola Murdock	Medical Director	35-40	0	0	7.5-10	45-50	0	0	0	0	0
Melissa Swindell	Director of Human Resources	105-110	0	0	32.5-35	135-140	100-105	0	0-5	55-57.5	160-165
Adam Bateman	Chief Operating Officer	110-115	0	0	90-92.5	200-205	10-15	0	0	5-7.5	20-25
Sir David Henshaw	Chair (R)	30-35	0	0	0	30-35	40-45	0	0	0	40-45
Dame Jo Williams	Chair (R)	5-10	0	0	0	5-10	0	0	0	0	0
Dame Jo Williams	Non-Executive Director	10-15	0	0	0	10-15	10-15	0	0	0	10-15
Claire Dove	Non-Executive Director (R)	10-15	0	0	0	10-15	10-15	0	0	0	10-15
Steve Igoe	Non-Executive Director (R)(A)	5-10	0	0	0	5-10	15-20	0	0	0	15-20
Ian Quinlan	Non-Executive Director (R)	10-15	0	0	0	10-15	10-15	0	0	0	10-15
Jean France-Hayhurst	Non-Executive Director (R)(A)	10-15	0	0	0	10-15	10-15	0	0	0	10-15
Kerry Byrne	Non-Executive Director (R)	5-10	0	0	0	5-10	0	0	0	0	0
Anita Marsland	Non-Executive Director (R)(A)	10-15	0	0	0	10-15	10-15	0	0	0	10-15

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

- Steve Ryan, Medical Director left employment 30th September 2018. None of the remuneration relates to a non-managerial role.
- Nicola Murdock, Medical Director commenced employment 28th January 2019. None of the remuneration relates to a non-managerial role.
- Sir David Henshaw, Chair left employment 10th February 2019.
- Dame Jo Williams, Non-Executive Director left this role 10th February 2019 to become Chair.
- Kerry Byrne, Non-Executive Director commenced employment 20th September 2018.

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

For the purposes of this report 'Senior Manager' is defined as those directors holding voting rights during the year.

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From 2017/18 the Trust considered it appropriate for the non-voting Board members detailed below to be disclosed as Senior Managers.

- Mags Barnaby, Interim Director of Strategy left employment on 30th November 2018.
- Christian Duncan, Clinical Director - Surgery. Total pension information is shown. 6/11ths of the remuneration below relates to a clinical, non-managerial role.
- Adrian Hughes, Clinical Director - Medicine, Total pension information is shown. 2.25-11ths of the remuneration below relates to a clinical, non-managerial role.
- Adrian Hughes, Clinical Director – Medicine, and Christian Duncan, Clinical Director – Surgery, were also acting co-Medical Directors during the period October 2018 to January 2019.
- Catherine McLaughlin, Director of Children & Young People Community & Mental Health Division left employment on 30th June 2018. She does not have pension figures as she is not a member of the NHS pension scheme.
- Lisa Cooper, Director of Children & Young People Community & Mental Health Division commenced employment on 1st September 2018.

Name	Title	2018/19					2017/18				
		Salary (bands of £5,000) £000s	Taxable Benefits (nearest £100) £	Performance pay & bonuses (bands of £5,000) £000s	Pension related benefits (bands of £2,500) £000s	Total (bands of £5,000) £000s	Salary (bands of £5,000) £000s	Taxable Benefits (nearest £100) £	Performance pay & bonuses (bands of £5,000) £000s	Pension related benefits (bands of £2,500) £000s	Total (bands of £5,000) £000s
Christian Duncan	Divisional Director, Surgery	140-145	0	0	57.5-60	200-205	125-130	0	0	25-27.5	150-155
Adrian Hughes	Divisional Director, Medicine	175-180	0	0	0	175-180	120-125	0	0	12.5-15	135-140
Catherine McLaughlin	Director, Integrated Community Services & CAMHS	20-25	0	0	0	20-25	80-85	0	0	0	80-85
Lisa Cooper	Director of Children & Young People Community & Mental Health Division	55-60	0	0	105-107.5	165-170	0	0	0	0	0
David Powell	Development Director	150-155	5,400	0	0	155-160	150-155	3,000	0	20-22.5	175-180
Erica Saunders	Director of Corporate Affairs	100-105	0	0	50-52.5	155-160	95-100	0	0-5	92.5-95	190-195
Mark Flannagan	Director of Communications & Marketing	95-100	0	0	22.5-25	120-125	70-75	0	0	7.5-10	75-80
Mags Barnaby	Interim Director of Strategy	30-35	0	0	37.5-70	100-105	10-15	0	0	0-2.5	10-15
Dani Jones	Director of Strategy & Partnerships	55-60	0	0	57.5-60	110-115	10-15	0	0	17.5-20	30-35

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

Name and title	Real increase in pension at age 60 (bands of £2,500) £000s	Real increase in lump sum at aged 60 (bands of £2,500) £000s	Total accrued pension at age 60 at 31 March 2019 (bands of £5,000) £000s	Lump sum at age 60 related to pension at 31 March 2019 (bands of £5,000) £000s	Cash Equivalent Transfer Value at 1 April 2018 £000s	Real Increase in Cash Equivalent Transfer Value £000s	Cash Equivalent Transfer Value at 31 March 2019 £000s	Employer's contribution to stakeholder pension £000s
Louise Shepherd Chief Executive	0-2.5	0-2.5	70-75	195-200	1,310	134	1,507	0
John Grinnell Director of Finance	0-2.5	0-2.5	35-40	75-80	461	67	561	0
Hilda Gwilliams Chief Nurse	0-2.5	0-2.5	40-45	120-125	815	91	944	0
Melissa Swindell Director of Human Resources	0-2.5	0-2.5	20-25	50-55	302	60	385	0
Nicola Murdock Medical Director	0-2.5	0-2.5	0-5	0-5	0	0	12	0
David Powell Development Director	0-2.5	0-2.5	65-70	200-205	1,457	108	1,630	0
Erica Saunders Director of Corporate Affairs	2.5-5	2.5-5	35-40	90-95	597	111	740	0
Mark Flannagan Director of Communicat Marketing	0-2.5	0-2.5	0-5	0-5	16	15	45	0
Mags Barnaby Interim Director of Strategy	2.5-5	7.5-10	25-30	75-80	565	57	644	0
Adam Bateman Chief Operating	2.5-5	5-7.5	20-25	35-40	154	72	245	0

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Officer								
Dani Jones Director of Strategy & Partnerships	2.5-5	2.5-5	15-20	35-40	178	62	254	0
Christian Duncan Divisional Director, Surgery	2.5-5	2.5-5	35-40	85-90	563	111	709	0
Adrian Hughes Divisional Director, Medicine	0-2.5	0-2.5	60-65	175-180	1,311	27	1,399	0
Lisa Cooper Director of Children & Young People Community & Mental Health Division	2.5-5	5-7.5	30-35	70-75	391	74	544	0

As Non-Executive Directors do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive Directors.

- Steve Ryan, Medical Director – left employment on 30th September 2018. None of the remuneration relates to a non-managerial role. His pension is currently in payment
- Nicola Murdock, Medical Director – commenced employment on 28th January 2018. None of the remuneration relates to a non-managerial role
- Mags Barnaby, Interim Director of Strategy – left employment on 30th November 2018
- Catherine McLaughlin, Director of Children & Young People Community & Mental Health Division – left employment on 30th June 2018. She does not have Greenbury figures as she is not a member of the NHS pension scheme.
- Lisa Cooper, Director of Children & Young People Community & Mental Health Division – commenced employment on 1st September 2018
- Christian Duncan, Clinical Director - Surgery. Total pension information is shown. 6/11ths of the remuneration above relates to a clinical, non-managerial role
- Adrian Hughes, Clinical Director – Medicine. Total pension information is shown. 2.25/11ths of the remuneration above relates to a clinical, non-managerial role.

The Pensions Benefit figures in the Total Remuneration table are calculated per the guidance using inflation of 3% applied to prior year comparative figures supplied by the NHS Pensions Agency for accrued pension and lump sum payments (in 2017/18 inflation was applied per guidance at 1%).
The inflation applied to the accrued pension, lump sum (if applicable) and CETV is the percentage (if any) by which the Consumer Prices Index (CPI) for the September before the start of the tax year is higher than it was for the previous September. For 2017/18 the difference in CPI between September 2016 and September 2017 was 3%. Therefore for benefit and CETV calculation purposes CPI is 3%. Additionally in the Pensions Benefit calculation a multiplier of x20 is applied to both the uplifted prior year and the current year projected Annual Pension amounts provided by NHS Pensions Agency.

NHS Pensions are still assessing the impact of the McCloud judgement in relation to changes to benefits in the NHS 2015 Scheme. The benefits and related CETVs disclosed do not allow for any potential future adjustments that may arise from this judgement.

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Staff Report

Analysis of Trust staff by type and cost during the year is set out in the table below, together with a comparison with 2017/18:

	Total 2018/19	Permanent 2018/19	Other 2018/19	Total 2017/18	Permanent 2017/18	Other 2017/18
	No.	No.	No.	No.	No.	No.
Medical and dental	**450**	446	4	**403**	398	5
Ambulance staff	**0**			**0**		
Administration and estates	**852**	824	27	**660**	627	32
Healthcare assistants and other support staff	**489**	430	59	**241**	212	28
Nursing, midwifery and health visiting staff	**1,051**	1,010	41	**1,238**	1,155	83
Nursing, midwifery and health visiting learners	**0**			**0**		
Scientific, therapeutic and technical staff	**513**	511	1	**641**	633	8
Healthcare science staff	**0**			**0**		
Social care staff	**0**			**0**		
Agency and contract staff	**0**			**0**		
Bank staff	**0**			**0**		
Other	**0**			**0**		
Total average numbers	**3,354**	**3,222**	**133**	**3,183**	**3,026**	**157**
Of which:						
Number of employees (WTE) engaged on capital projects	**41**	38	3	**38**	37	1

Staff Costs

	Permanent	Other	2018/19 Total	2017/18 Total
Salaries and wages	119,222	13,053	**132,275**	122,802
Social security costs	11,239	-	**11,239**	10,433
Apprenticeship Levy	569	-	**569**	-
Employer's contributions to NHS pensions	14,376	-	**14,376**	13,482
Pension cost - other	-	-	**-**	531
Other post-employment benefits	-	-	**-**	-
Other employment benefits	-	-	**-**	-
Termination benefits	-	-	**-**	-
Temporary staff	-	6,144	**6,144**	5,312
Total gross staff costs	**145,406**	**19,197**	**164,603**	**152,560**
Recoveries in respect of seconded staff	-1,507	-	**-1,507**	-1,366
Total staff costs	**143,899**	**19,197**	**163,096**	**151,194**
Of which				
Costs capitalised as part of assets	2,745	276	3,021	2,380

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

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	Male	Female
Directors	6	14
Senior Managers	6	8
Employees	567	2950

Sickness absence data
The Trust closely monitors its performance against sickness absence targets and the position as at the end of March 2019 was 5.45%.

Staff Policies and Actions
The Trust recognises that staff are our most important and valuable resource, and are committed to attracting and retaining a diverse and motivated workforce with the right skills, values and knowledge to deliver outstanding care for children and young people. Creating and retaining a diverse and inclusive workforce will enable the organisation to deliver a more inclusive service and improvements in patient care.

In 2018/19 a number of positive initiatives were launched, including the ongoing development and promotion of the BAME and Disability Staff Networks, and the launch of the new LGBTIQ+ staff network, to support staff experience and staff diversity. The organisation also successfully launched the Merseyside Reciprocal Mentoring Programme in partnership with local NHS organisations which aims to enhance the transcultural learning between senior leaders and staff from minority or disabled groups. To support the work of the networks, internal communications have been developed and launched that promotes the positive work of the networks and allows communication between members and the sharing of information and resources.

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

Over the past year we have successfully implemented a number of vocational development opportunities, working directly with the local community to provide alternative career opportunities rather than via traditional recruitment methods. This is enabling us to secure our future talent pipeline and have a positive impact on the local community by offering a variety of career and development opportunities.

Over the past 12 months we have been actively working to ensure that staff feel valued within the organisation and are given the best opportunities to develop the right skills and knowledge to do their role. With this in mind, we've been focusing on improving our development offer within the Trust. During 2018/19 the Trust launched

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the new, internally delivered, Mary Seacole Leadership Programme, rolled out a variety of a new training opportunities for staff and expanded the delivery options for mandatory and clinical training courses with courses now available via e-Learning as well as face to face allowing staff to complete them at a time, place and learning style appropriate to them.

A range of internal communications methods are deployed to ensure matters of concern are shared with staff on a regular basis. These include face to face monthly briefings, the 'Latest from Louise', weekly e-bulletins, the staff newspaper and regular email correspondence. The opportunity for staff to feedback to the Trust is also an integral part of the internal communications process.

Trust management meets with Trade Union colleagues at the Joint Consultation and Negotiation Committee (JCNC) on a monthly basis, where a range of business matters are discussed and shared with staff representatives, ensuring the views of employees can be taken into account in making decisions which are likely to affect their interests. A quarterly Strategic JCNC was launched in 2019, allowing for the Executive Team to meet and discuss issues of a strategic nature with Trade Union colleagues.

Trade Union Facility Time Disclosures
The Trade Union (Facility Time Publication Requirements) Regulations 2017 came into force on 1st April 2017. Under the Regulations, Alder Hey Children's NHS Foundation Trust is required to publish the following information relating to Trade Union officials and facility time.

Trades Union and numbers of Representatives	Numbers
Staff who are Union representatives	**24**
Staff who are union representatives with regular paid facility time	**2**
Unions (included in above)	
BMA(British Medical Association) CSP (Chartered Society of Physiotherapists) GMB RCN (Royal College of Nurses) Unite Unison SoR (Society of Radiographers) BDA (British Dietetic Association)	

Relevant Union Officials
What was the total number of your employees who were relevant union officials during the relevant period and the number of full time equivalent employees
Number of employees who were relevant union officials employed during the relevant period **(24)**
Number of employees (FTE) in the organisation **(2969)**

Percentage of time spent on facility time for each relevant trade union official
How many of your employees who were relevant trade union officials employed during the relevant period spent a) 0-50% b) 51-99% and c) 100% of their time on facility time
a) 0-50% - **24**
b) 51-99% - **0**
c) 100% - **0**

Percentage of pay bill spent on facility time
What is the percentage of pay bill spent on facility time?
0.048%

Paid Trade union activities
As a percentage of total paid facility time hours, how many hours were spent by employees who were relevant trade union officials?
100%

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Communication
An effective communications strategy enables Alder Hey to build awareness of its brand with key stakeholders, inform and support staff, enhance our relationship with the local community and encourage charitable donations.

Throughout the last year, communications has focused on engaging with key stakeholders, delivering internal campaigns, generating both national and regional media coverage and producing a rolling calendar of compelling content to be used across social media channels.

Staff communications
Informing and engaging with our staff remains integral to our communications strategy and we have continued to enhance our internal communication channels over the last twelve months.

Our monthly town hall event 'Latest from Louise' has been refreshed and now includes supporting footage of our Chief Executive Louise Shepherd to assist internal cascade within divisions and teams.

Our Staff magazine 'Alder Hey Life' was re-launched, supported by an editorial steering group with representatives from teams across the Trust. This approach ensures that the magazine has a fresh new feel, focusing on issues that matter to staff.

Once again, we conducted a staff focused engagement campaign in support of the annual national NHS staff survey. By highlighting the ways we had progressed together since the previous year's survey, we were able to ensure the campaign was a big success. Alder Hey staff were part of the campaign and appeared within collateral, including on posters and screensavers. This encouraged staff to talk to others and participate, with a focus on what will change as a result. There was a 60% response rate, the highest ever at Alder Hey and one of the largest nationwide. One of the most pleasing and biggest improvements on the survey was the number of staff who recommend Alder Hey as a place to work.

A dedicated programme of 'Reward and Recognition' has been supported through the creation of a steering group composed of staff from across the Trust and led by colleagues from Human Resources, Staff Engagement and Communications. The ongoing monthly staff award scheme has continued with remarkable individuals and teams being highlighted from across Alder Hey. A major highlight of the year was again our flagship annual Star Awards gala evening which took place on Friday 7th February at the Titanic Hotel in Liverpool. 240 staff were shortlisted across eleven awards and enjoyed an evening of entertainment, as we celebrated outstanding individuals and teams from across the organisation.

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Staff were also at the heart of our NHS 70 celebrations in 2018. Colleagues joined patients and their families as they celebrated working within the NHS, with festivities including fancy dress competition, party games, face painting, balloons and plenty of cake! The celebrations were shared across our social media and included in the Liverpool Echo live NHS70 feed.

Alder Hey also hosted 'Fab Staff Week', bringing staff across the Trust together for a big thank you. A wide range of activities took place in the hospital Atrium, including advice about nutrition, mindfulness and wellbeing support, 'Back to Work' services, our impressive Apprenticeship

programme, staff offers and benefits, personal training, head and neck massages and of course free cake and fruit.

External communications

Our social media presence has risen significantly over the last year and has helped to increase engagement, while generating positive coverage in the media. We expanded our social media channels in 2018, introducing an Instagram account to target a younger audience and re-launching our LinkedIn account (aimed predominantly at staff and other health professionals).

4:10 PM - 23 Jul 2018

9,137 Retweets 36,462 Likes

1.4K 9.1K 36K

Content on Alder Hey channels has led to significant engagement from our audience and has been widely shared across social and digital media. This was highlighted by inclusion of our content within the 'Google - Year in Review 2018'.

The Year in Review film celebrates the most popular 'good news stories of the year and featured Alder Hey patient 'Baby Alex' hearing his mum's voice for the first time after having hearing aids fitted. It received over 112 million views, over 16,000 comments and Baby Alex also appeared on ITV's 'This Morning'.

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Further examples of where our social media content has led to wider coverage included: a story about 3D tablets featured on ITV Online; a post on the hospital Baby Cuddling Project directly led to coverage across local news channels, BBC's Victoria Derbyshire Show and BBC Radio 5 Live; and footage of an Oncology patient ringing the end of treatment bell was picked up on BBCNW.

Our national profile was heightened still further this year when we appeared in the second series of the BBC's flagship documentary series '*Hospital*'. Staff and patients had a starring role in three episodes of the series, which focused on our neurosurgical, oncology and cardiac services. The first episode included the story of a young patient having lifesaving neurosurgery, while another episode focused solely on Alder Hey's cardiac and ICU teams as they provided specialist care to three patients. Finally, Alder Hey neuro and physio teams were featured providing vital Selective Dorsal Rhizotomy

surgery to patients. Some of the Alder Hey stars of the series included neurosurgeons Conor Mallucci and Benedetta Pettorini, cardiac surgeons Ram Dhannupuneni, Rafael Guerrero and Attilio Lotto and oncologist Lisa Howell, as well as Alder Hey's Cardiac Team, ICU and Theatres. The programme generated coverage of Alder Hey across regional and national media, including appearances and mentions on BBC Breakfast. Average audience for each episode was around 1.7million viewers and the programme trended #1 on Twitter in the UK.

Alder Hey was also again heavily featured in series seven of CBBC's 'Operation Ouch' and we continued to build on our partnership with BBC Children's with a live Christmas broadcast at Alder Hey.

For the third year running, CBeebies and CBBC brought all their favourite presenters and stars to our hospital as millions of young viewers (and their parents) tuned in to see Alder Hey on their TV. The event also included visits to our wards by famous children's presenters including Andy and the Odd Socks, Hacker, Maddie Moat, Dodge and RoadTrip.
Other highlights during the year included a behind-the-scenes live broadcast on Radio Five Live, national coverage of Alder Hey's innovation work (ITV, Press Association), an effective Christmas social media campaign (#AlderHeyMagic), a memorable Christmas Light Switch On Event featured on BBC's 'The One Show', visits to the hospital from our VIP supporters (EFC, LFC, The Jockey Club, RAF to name a few) and the highly successful Matalan #BeaSuperstar2018 fundraising campaign, which raised £623,000.

Alongside the above, we continued to directly communicate with our membership through a quarterly magazine 'Membership Matters'.

The Communications Team also supported the Prime Minister's office and NHS England in launching the new NHS Long Term Plan at Alder Hey in January 2019. Prime Minister the Rt Hon Theresa May MP, The Rt Hon Matt Hancock MP (Secretary of State for Health and Social Care) and Simon Stevens (Chief Executive of the NHS) were joined at Alder Hey by colleagues from across the health service, the voluntary sector and local government. The Prime Minister, Secretary of State and NHS England Chief Executive also met patients and families on Ward 3C. The launch was broadcast live on major news networks BBC and Sky News and was also attended by leading journalists from all the major

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national publications. Subsequent coverage of the event at Alder Hey appeared across regional and national media, reaching over 60million people.

Counter Fraud
The Local Counter Fraud Specialist, supported by the Trust, has continued to enhance the overall anti-fraud arrangements at Alder Hey through the conduct of a range of agreed activities specified in the Trust's Anti-Fraud work plan for 2018/19. The key to the success of these activities is the achievement of outcomes across the defined areas of anti-fraud work.

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

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

A self-assessment against compliance with the Standards for Providers issued by NHS Counter Fraud Authority for 2018/19 was undertaken. The Trust has rated itself overall as green. The Counter Fraud service provided regular updates to the Audit Committee on work undertaken to prevent and detect fraud including any investigations.

Health and Safety Performance and Occupational Health
The Trust continues to work successfully in partnership with its Occupational Health provider, Team Prevent, to offer a range of supportive interventions for staff. The Trust is seeing ongoing benefits from the introduction of the early intervention service which provides rapid treatment for staff encountering stress and musculo-skeletal conditions. Following a successful pilot in 2017, the Trust continued with the services of a dedicated health trainer, who has remained focused on supporting mental wellbeing and training for managers, which has been a great success and this is now a permanent feature of our wellbeing offer to staff.

The Health and Safety Team continues to work closely with both the management of the new hospital building and the Trust Estates and Development team to ensure the organisation is a safe environment for all of our patients and staff. In addition, the team continues to support the numerous new building development projects on-site. Following the success of the Health & Safety training programme in 2018/19, there will be an ongoing programme of training scheduled for 2019/20, which will cover risk assessment, COSHH and stress risk assessment training. In 2018/19, additional resource was allocated to support COSHH risk assessments and processes, and this support will continue into 2019/20.

Expenditure on Consultancy
Expenditure on consultancy during 2018/19 was for specialist advice and operational delivery on an interim basis to ensure high quality services for children and families.

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

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

Table 1: Off Payroll engagements as at 31st March 2019, for more than £245 per day and that last longer than six months

No. of existing engagements as at 31 March 2019		11
of which		
	No. that have existed for less than one year at time of reporting	7
	No. that have existed for between one and two years at time of reporting	3
	No. that have existed for between two and three years at time of reporting	1
	No. that have existed for between three and four years at time of reporting	0
	No. that have existed for four or more years at time of reporting	0

Table 2: For all new off-payroll engagements, or those that reached 6 months in duration, between 1 April 2018 and 31 March 2019, for more than £245 per day and that last for longer than six months

Number of new engagements, or those that reached 6 months in duration between 1 April 2018 and 31 March 2019		4
Of which		
	Number assessed as within the scope of IR35	0
	Number assessed as not within the scope of IR35	4
	Number engaged directly (via PSC contracted to Trust) and are on the Trust's payroll	0
	Number of engagements reassessed for consistency/assurance purposes during the year	4
	Number of engagements that saw a change to IR35 status following the consistency review	0

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Table 3: For any off-payroll engagements of board members, and/or, senior officials, with significant financial responsibility, between 1 April 2018 and 31 March 2019.

No. of off-payroll engagements of board members, and/or senior officials with significant financial responsibility, during the financial year	0
No. of individuals that have been deemed "board members and/or senior officials with significant financial responsibility" during the financial year.	29

Exit Packages 2018/19

	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
	Number	Number	Number
Exit package cost band (including any special payment element)			
<£10,000	-	9	**9**
£10,001 - £25,000	-	3	**3**
£25,001 - 50,000	1	-	**1**
£50,001 - £100,000	1	2	**3**
£100,001 - £150,000	-	-	**-**
£150,001 - £200,000	-	-	**-**
>£200,000	-	-	**-**
Total number of exit packages by type	**2**	**14**	**16**
Total resource cost (£)	£87,000	£185,000	**£272,000**

Exit packages 2017/18

	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
	Number	Number	Number
Exit package cost band (including any special payment element)			
<£10,000	-	13	**13**
£10,001 - £25,000	1	1	**2**
£25,001 - 50,000	2	3	**5**
£50,001 - £100,000	-	-	**-**
£100,001 - £150,000	-	-	**-**
£150,001 - £200,000	-	-	**-**
>£200,000	-	-	**-**
Total number of exit packages by type	**3**	**17**	**20**
Total resource cost (£)	£102,000	£197,000	**£299,000**

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Exit packages: other (non-compulsory) departure payments

	2018/19		2017/18	
	Payments agreed	Total value of agreements	Payments agreed	Total value of agreements
	Number	£000	Number	£000
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignations (MARS) contractual costs	2	121	6	160
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	11	54	11	37
Exit payments following Employment Tribunals or court orders	1	10	-	-
Non-contractual payments requiring HMT approval	-	-	-	-
Total	**14**	**185**	**17**	**197**
Of which: Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	-	-	-	-

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Staff Survey

Staff Engagement
Supporting the 'Best People Doing their Best Work' is one of the four key pillars of the Trust's strategy and as part of this, continuously improving staff engagement and staff satisfaction remains a key priority for the Board.

As part of the annual response to the survey, in 2018 every team held a staff survey discussion using their local survey results to agree a set of actions that they would own and take forward in their own area of work. This proved to be a highly successful and powerful way to ensure that the survey was seen by every member of staff and that actions are taken locally to address the issues that really matter to staff. We will be continuing with this action in 2019.

Fundamental to achieving the Trust's strategic goals is the creation of an environment which supports employee health, safety and wellbeing. The Trust is committed to inspiring its talented workforce to actively drive quality improvement and supporting the ongoing development of a positive and healthy culture, in which people can give their best.

The importance of staff health and wellbeing is widely recognised and as an employer we aim to champion the physical, mental, emotional and financial wellbeing of everyone working in the organisation. In 2018/19 we have improved our provision of tools, resources and support for staff to ensure that their health and wellbeing is a priority. In doing so, we will see continued improvements in performance, patient experience and quality of patient care through improved staff engagement. Numerous initiatives have been adopted including the development of health and wellbeing action plan and continuing to develop and enhance the reward and recognition offerings.

Summary of Performance - Results from the NHS Staff Survey
Alder Hey's 2018 Staff Survey shows significant improvements from the previous year's results. A summary of performance can be seen in Table 1, where comparisons can be made with both the Trust and national average scores for acute specialist trusts.

The Trust's response rate was 60%, above the overall national response rate for all organisations in England of 46.6%, and significantly higher than in 2017.

Areas of improvement
The 2018 findings have demonstrated significant improvement on previous years, including:

- ✓ 10% increase in number of staff stating that the organisation values my work
- ✓ 9% increase in number staff reporting receiving recognition for good work
- ✓ 8% increase in number staff stating that care of patients / service users is my organisations top priority
- ✓ 8% increase in number reporting that they would recommend my organisation as a place to work.
- ✓ 8% increase in number reporting that they were given feedback about change made in response to reported errors, near misses and incidents

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- ✓ 6% increase in number stating that the organisation treats staff who are involved in an error, near miss or incident fairly
- ✓ 6% in number of staff reporting that when errors, near misses or incidents are reported my organisation takes action to ensure they don't happen again

Areas for improvement

The results of the staff survey have been analysed and key themes have been identified to inform Trust wide actions that have been agreed and supported by the senior leadership team, aiming to address key areas including:

- Staff feeling unwell due to work related stress
- The perception of staff regarding how much the organisation cares about and takes positive action for their health and wellbeing.
- Staff not being offered appropriate adjustments that they require for their work.
- Senior Management not acting on staff feedback, involving staff in important decisions and communicating effectively with staff.
- Focusing on the quality of appraisals; ensuring they are useful to improve staff outputs and objectives.
- Staff experiencing abuse from service users.

These actions and associated activity will be monitored via the Trust Workforce and Organisational Development Committee of the Board.

Future priorities and targets

In addition, we remain committed to:

- Continuing to engage the whole workforce in the Staff Survey to further increase the Staff Survey response rate and responses
- Ensuring continued engagement with staff side representatives
- Reviewing the local 'Temperature Check' mechanism, and monitor progress and trends Trust wide and locally.
- Monitoring performance regularly at the Board, Workforce and Organisational Development Committee and Divisional Performance Boards.

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Table 1

Theme	2018		2017		2016	
	Trust	Benchmarking Group	Trust	Benchmarking Group	Trust	Benchmarking Group
Equality, Diversity and Inclusion	9.4	9.3	9.3	9.3	9.2	9.3
Health & Wellbeing	6.1	6.3	6.1	6.3	5.8	6.3
Immediate Managers	7.0	7	6.7	6.9	6.3	6.9
Morale	6.4	6.3	n/a	n/a	n/a	n/a
Quality of appraisals	5.6	5.7	5.3	5.5	4.7	5.5
Quality of care	7.4	7.8	7.3	7.7	7.3	7.8
Safe environment – bullying and harassment	8.4	8.2	8.4	8.4	8.2	8.3
Safe environment – violence	9.7	9.7	9.7	9.7	9.7	9.7
Safety culture	6.8	6.9	6.6	6.9	6.3	6.9
Staff engagement	7.3	7.4	7.1	7.4	6.8	7.5

In my capacity as Accounting Officer, I confirm that the foregoing Accountability Report is a fair and balanced representation of the Trust in 2018/19.

Louise Shepherd CBE
Chief Executive
28th May 2019

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NHS Foundation Trust Code of Governance

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

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

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

Our Council of Governors

2018/19 again saw a number of changes on the Council of Governors following the annual elections. A comprehensive Induction programme continues to be delivered to enable incoming governors to understand their new role as rapidly as possible. This training is also offered to existing Governors annually as a means of refreshing their skills. A number of Alder Hey governors also took advantage of the ongoing *GovernWell* development programme offered by NHS Providers, which is an invaluable resource.

The Council has continued to work alongside the Board to understand and contribute to the Trust's plans for the future. All Board reports are made available to the governors to equip them with the information they require to give feedback about the Trust's activities to members and other stakeholders, including the host organisations of appointed governors. The governors use a variety of mechanisms to canvass the view of members and the wider community; some of these are informal and carried out through individuals' networks and others more formal such as inviting comments via the newsletter and direct engagement at the Annual Members' meeting. Such views are fed back to the Board throughout the year at regular formal meetings, providing an opportunity for governors to discuss key strategies with Board members.

The Council met formally five times during the year, a virtual meeting was also arranged to seek approval of the appointment of Ms Kerry Byrne as Non-Executive Director and Chair of the Audit Committee. The Council re-appointed one of the existing Non-Executives during 2018/19 for a second twelve month period; this was to ensure stability and continuity on the Board. The Council also held an extraordinary meeting to approve the appointment of a new Trust Chair.

Executive and Non-Executive Directors attend the Council of Governors' meetings and the Chair and Chief Executive report on the Trust's performance and on key strategic and operational issues and developments. This ensures that the agendas of the two bodies remain closely interlinked and appropriate decisions taken by each in accordance with its Standing Orders.

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The 2018 Annual Members' Meeting was held in November at the Institute in the Park, with keynote speaker Sir David Henshaw, Trust Chairman. The title of his inspiring talk was *"Reflections"* in which Sir David shared stories from his eight years at the Trust. This was followed by presentation of the Trust's Annual Accounts 2017/18 and the report of the Council of Governors delivered by Lead Governor, Kate Jackson.

The governors have also continued to input into a fully inclusive process for the Chair's appraisal and agreement of annual objectives, led by the Senior Independent Director. In addition to its statutory role, the Council contributes to the life of the hospital in a variety of ways, for example as participating in the PLACE inspection of the hospital environment and attending various assurance committee meetings.

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

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

The aim of member communications is to continue to engage with and update members about Alder Hey, encourage active involvement and support further recruitment of members and governors. Together with meeting the requirements of a Foundation Trust, membership communications also has an integral role to play in the wider Trust Communications Strategy. Many of our key stakeholders are current or potential members and we need to regularly engage with them to maintain their support and raise awareness of the Alder Hey brand. Each and every member is a potential advocate of Alder Hey who can support the hospital, build awareness of our brand as a world leading children's healthcare campus and even potentially fundraise.
To achieve this, we need to provide our members with up-to-date information about Alder Hey while also giving them opportunities to be involved and feel part of the Alder Hey family. We recognise that a refresh of membership communications is needed to:

- Encourage current members and governors to become more active and involved with the Trust.
- Provide members with the most up to date information about Alder Hey in a regular and timely way.
- Attract new members from across our constituencies.
- Enhance the profile of Governors and support them in fulfilling their responsibilities.

The Membership Strategy Committee continued to take forward its work plan and objectives in support of the Membership Strategy. Key activities in the year included:

- ✓ Acting as Editorial Board for the members' newsletter supported by members of the Communications and Marketing team
- ✓ Exploring Social Media Platforms for membership purposes
- ✓ Planning and organisation of the Annual Members' meeting

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- ✓ 'Critical friend' role in reviewing and commenting on the Quality Report

Governors are contactable through the Trust's Committee Administrator based at Alder Hey on 0151 252 5128 or by email at membership@alderhey.nhs.uk.

Composition of the Council of Governors

The Council of Governors is made up of 25 elected governors and 10 appointed governors from nominated organisations and comprises six staff governors (elected by staff), nine public governors, four patient governors, six parent and carer governors (elected by members). The Council represents, as far as possible, every staff group and the communities that Alder Hey serves across England and North Wales. Elected Governors are chosen as part of an independent process managed on behalf of the Trust by the Electoral Reform Service, in accordance with the Constitution. Elections to the Council of Governors take place annually, in the summer. On election or appointment all governors are required to sign the Council's Code of Conduct and to complete their declaration of interests in accordance with the Trust's policy.

The Council of Governors operates under the leadership of the Trust Chair and its endeavours are supported by the Lead Governor, Kate Jackson who was re-elected to this role in December 2017 for a further three years (unopposed). The roles and responsibilities of governors are set out in the Trust's Constitution and Council of Governors' Standing Orders.

Governor	Constituency	Class	Term of Office	Council Meetings eligible to attend in 2018/19	Total no. of attendances at Council meetings
Barbara Murray**	Appointed	Liverpool City Council	n/a	5	5
Steve Reddy	Appointed	Liverpool City Council	n/a	5	0
Professor Iain Buchan	Appointed	Liverpool University	n/a	3	2
Julie Williams	Appointed	Edge Hill University	n/a	5	4
Janice Monaghan	Appointed	The Back Up Trust	n/a	5	0
Dot Brannigan	Patient	Parent & Carer	26.09.16 – 31.08-19	5	3
Dawn Holdman	Patient	Parent & Carer	17.09.15 - 16.09.18	1	0
Pippa Hunter-Jones	Patient	Parent & Carer	04.08.17 – 31.08.20	5	4
Georgina Tang	Patient	Parent & Carer	26.09.16 – 31.08-19	5	4
Craig Arnold	Patient	Parent & Carer	04.04.18 – 03.04.21 *Resigned 19.11.18*	2	0
Kate Burnell	Patient	Parent & Carer	04.04.18 – 03.04.21	5	2
Bakare Aliu	Patient	Merseyside	17.09.18 – 16.09.21	4	0
Lydia Brady	Patient	Merseyside	01.09.15 31.08.18	1	0
Oliva Cole	Patient	Rest of England & North Wales	17.09.15 – 16.09.18	1	0

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Governor	Constituency	Class	Term of Office	Council Meetings eligible to attend in 2018/19	Total no. of attendances at Council meetings
Felix Blake	Patient	Rest of England & North Wales	17.09.18 – 16.09.21	4	0
Rabia Aftab	Public	Rest of England & North Wales	26.09.16 – 31.08-19	5	1
Naomi Grannell	Public	Cheshire	03.08.17 – 31.08.19	5	0
Kal Ross	Public	Merseyside	17.09.18 – 16.09.21	4	1
Paul Denny	Public	Merseyside	31.08.17 – 31.08.20	5	1
Cath Gorst	Public	Merseyside	17.09.15 – 31.08.18	1	0
Hilary Peel	Public	Merseyside	26.09.16 – 31.08-19	5	5
Mark Peers	Public	Merseyside	26.09.16 – 31.08-19	5	3
Kate Jackson**	Public	Greater Manchester	04.08.17 – 31.08.20	5	5
Matthew Jones	Staff	Doctors and Dentists	25.09.15 – 24.09.18	2	0
Sujata De	Staff	Doctors and Dentists	17.09.18 – 16.09.21	4	3
Adrian Williams	Staff	Nurses	26.09.16 – 31.08-19	5	0
Mike Travis	Staff	Nurse	04.04.18 – 03.04.21	5	2
Simon Hooker	Public	N. Wales	17.09.18 – 16.09.21	5	5
Glenna Smith**	Staff	Other & Trust Volunteers	04.08.17- 31.08.20	5	4
Anna Parsons	Staff	Other & Trust Volunteers	17.09.18 – 16.09.21	4	2
Paul Walsh	Staff	Other Clinical	04.08.17- 31.08.20	5	3

** Members of the Nominations Committee

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Attendance at Council of Governors by Board members	Number of meetings held in 2018/19
	5
Sir David Henshaw	3/3
Anita Marsland	3
Ian Quinlan	1
Steve Igoe	1/2
Kerry Byrne	2/4

Claire Dove	0
Jeannie France-Hayhurst	0
Jo Williams	3
Nicki Murdock	0/2
Louise Shepherd	5
Margaret Barnaby	0/2
John Grinnell	4
Melissa Swindell	3
Steve Ryan	1/1
Adam Bateman	1
Hilda Gwilliams	3
Erica Saunders	5
David Powell	2
Mark Flanagan	1
Christian Duncan	0
Adrian Hughes	0
Dani Jones	1/3

Declaration of Interests

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

Our Membership

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

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

Membership Strategy

The Trust's Membership Strategy remained in place during the year and its implementation is owned and led by a committee of the Council of Governors called the Membership Strategy Committee. During 2018/19 the Committee was chaired by one of our public governors, Kate

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Jackson who is also Lead Governor. The terms of reference of the Committee were approved by the Council of Governors to undertake the following:

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

The Membership Strategy Committee is supported by the Trust's Communications Team and works to an agreed set of objectives created to reflect the overall aims of the Membership Strategy.
The objectives for 2018/19 included:

- Newsletter – to continue on a quarterly basis.
- Membership Recruitment – the Committee agreed to undertake a focused recruitment drive to seek new members in the 7 to 16 age group; this was done with the help of Trust Volunteers.
- Training – as many Governors as possible to attend GovernWell events to support efforts in respect of member engagement; a number of governors also attended on site social media training.
- Annual Member's Meeting – the Committee also acts as a steering group for the planning and organisation of the Annual Members' Meeting. The opening talk was given by Sir David Henshaw (our outgoing Chairman) and reflected on the past eight years during his leadership. The combination pf experience, anecdotes and personal stories gave an insight into the journey the Trust has been on over the last eight years. In the coming years, consideration will be given to reinstating Trust Open Days to encourage participation.
- Continuous engagement with our members, focused on keeping them up to date with all matters regarding the Trust. The newsletter was refreshed to highlight events throughout the year.

Throughout our membership activities, the Trust endeavours to ensure that all the communities that it serves are provided every opportunity to become an engaged member. It is our intention to continue to maintain our membership population at around 14,000 overall but with a focus on recruitment of more children and young people as members in the coming year. This strategy will be carried out in the line with the Trust's Quality Strategy and with all legalisation pertaining to equality and diversity issues.

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Going forward, a number of mechanisms will be considered to enhance membership engagement including:

- Development of a clear membership engagement pathway - Membership needs to be transformed into an interactive journey to create a sense of purpose and allow opportunity for engagement. Membership Pathways will provide options for members to do this, depending on the level of time and commitment they are willing to give. Example of potential membership pathways and level of engagement are Follower, Team Mate and Leader.
- Incorporating recruitment of new members into already established and used means of communication. As a Trust we communicate with our members on a daily basis, through many existing communication channels such as social media, customer service, contact with patients, utilising digital screens within the Atrium, events etc.
- Establishing an improved membership section on the Trust website, including access to previous communications e.g. newsletter, ability to register and online forums/surveys
- Producing regular member newsletters
- Implementing a planned social media campaign as a method of recruiting new members
- Inclusion of membership within the Trust brand narrative and core story
- Maximising opportunities to increase awareness and recruit by utilising Trust events, careers fairs, open days.
- Annual Members Meeting and potential 'Open Day'
- Trust and external consultations, e.g. Springfield Park
- Hosting membership workshops
- Encouraging further participation in elections to the Council of Governors
- Encouraging further staff engagement by raising the profile of membership and increasing visibility of staff governors across the organisation.
- Providing support and training to governors on how they can communicate and promote Alder Hey to their constituencies and external connections. This could be through a training event or providing them with a support pack.
- Liaising with the community leads within the Trust and Charity to maximise support and sign up from schools and local community groups.
- Collecting feedback from our members through every activity to continue to communicate and interact with members of our community as effectively as possible.

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Membership Profile

Constituency	Number of members 2018/19 (actual as at 31st March 2019)
Public	3,653
Patients & Parent Carer	6,575
Staff	3,400
Total	**13,728**

Our Board of Directors

The Trust's constitution provides for a Board of Directors which is comprised of no more than seven Executive and no more than eight Non-Executive Directors including the Chairman. All Director roles have been occupied during 2018/19 in accordance with the strategy developed by the Trust in support of the constitution. The Trust considers that it operates a balanced, complete and unified Board with particular emphasis on achieving the optimum balance of appropriate skills and experience; this is reviewed whenever any vacancy arises and was rigorously tested in the year as part of the process to appoint Executive Directors and to appoint and re-appoint Non-Executive Directors.

The Board of Directors operates to clear Standing Orders and an annual work plan which reflect the Trust's constitution and Provider Licence and which are in turn supported by detailed standing financial instructions, a scheme of delegation and a schedule of matters reserved for the Board, which are set out in the Trust's Corporate Governance Manual and constitution. The Corporate Governance Manual was reviewed and updated during the year and approved by the Audit Committee. The Trust's Constitution was also amended to remove the Chief Executive from the Nominations Committee of the Council of Governors in accordance with a best practice directive issued by NHS Improvement.

It is the role of the Board to set the organisation's strategic direction in the context of an overall operational planning framework set by NHS regulators. It is responsible for all key business decisions but delegates the operationalisation of these to an appropriate committee or the Trust's Operational Delivery Board in order to receive assurance that the organisation is fulfilling its responsibilities including compliance with standards and targets and the conditions set out in the Trust's Provider Licence.

The Board meets on the first Tuesday of each month, with the exception of August. Board meetings are fully and accurately minuted, including challenges and concerns of individual directors as appropriate. The Chair meets separately with the Non-Executive Directors directly before each meeting. All Board meetings are held in public; dates, times and agendas

are published on the Trust's website prior to meetings and the papers posted shortly after. The Board's agenda is structured around the Trust's strategic priorities set out in the overarching plan. Each meeting begins with a patient or sometimes staff story which is designed to ensure that patients remain at the centre of all discussions and decisions. At each meeting the Board receives a corporate performance report which describes in detail how the organisation has performed against key local and national metrics, including a quality report which focuses on progress against the Trust's quality aims. Accompanying the performance information is the Board Assurance Framework which demonstrates to the Board how the principal risks to the organisation's business are being controlled and mitigated.

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

- Clinical Quality Assurance Committee
- Resources and Business Development Committee
- Audit Committee
- Research, Education & Innovation Committee
- Workforce and Organisational Development Committee
- Integrated Governance Committee
- Remuneration and Appointments Committee

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

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

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

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

Independence of Non-Executive Directors

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

Board Performance

Each member of the Board of Directors undergoes an annual appraisal to review his or her performance against agreed objectives, personal skills and competencies and progress against personal development plans. Since 2014/15 the Trust's appraisal process has

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included an assessment of how individuals have performed in relation to the Trust's values of *Excellence, Openness, Respect, Innovation and Togetherness*. Non-Executive Director assessments and that of the Chief Executive are undertaken by the Chair of the Trust and Executive Director performance is assessed by the Chief Executive. The appraisal of the Chair includes input from all Board members and the Council of Governors, led by the Senior Independent Director, working closely with the Lead Governor.

During 2017/18 the Board commissioned an external well led review, the outcome of which is reported elsewhere in this document. This process illustrates the Board's willingness to reflect upon its performance and be held to account for its actions. It also reflects the culture of openness and shared learning that the Board has set for the Trust as a whole.

Attendance at Board of Directors and Key Board Committee Meetings

	Board of Directors	Audit Committee	Clinical Quality Assurance Committee	Resources & Business Development Committee	Workforce & OD	Integrated Governance Committee	Research, Education & Innovation Committee
No. of Meetings held 2018/19	**11**	**5**	**11**	**11**	**6**	**6**	**2**
Sir David Henshaw	8/10	not a member	not a member	not a member	not a member	not a member	0
Louise Shepherd	10	not a member	not a member	not a member	not a member	not a member	1
Ian Quinlan	10	not a member	not a member	11	3	not a member	2
Steve Igoe	6/6	3/3	4/5	not a member	not a member	3/3	not a member
Claire Dove	6	not a member	not a member	3	6	not a member	not a member
Anita Marsland	11	5	11	Attended 2 meetings for quorum	not a member	not a member	not a member
Jo Williams	11	not a member	10/10	Attended 3 meetings for quorum	not a member	not a member	not a member
Jeannie France-Hayhurst	8	0	9	not a member	4	not a member	not a member
Kerry Byrne	6/6	3/3	not a member	Attended 1 meeting for quorum	not a member	not a member	not a member
John Grinnell	11	4 attendee	6	10	not a member	5	not a member
Margaret Barnaby	7/7 Attendee	not a member	3/7	not a member	not a member	not a member	not a member
Adam Bateman	10	not a member	7	10	3	2	not a member
Erica Saunders	10 attendee	5 attendee	10	11 attendee	not a member	6	2
Melissa Swindell	11	not a member	8	9	6	6	2
Steve Ryan	5/5	not a member	5/5	not a member	2/3	5/5	2
Nicky Murdock	2/2	not a member	2/2	not a member	1/1	1/1	n/a

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Hilda Gwilliams	10	not a member	9	not a member	5	Represented by DoN 6	0
Dani Jones	4/4	not a member	not a member	not a member	not a member	not a member	not a member
David Powell	8 attendee	not a member	not a member	3 attendee	not a member	5	1
Mark Flannagan	11 attendee	not a member	not a member	8 attendee	6	not a member	0

Audit Committee Report

The Audit Committee is comprised of Non-Executive Directors only, excluding the Trust Chair. The Committee was chaired by Steve Igoe to September 2018 when his final term of office came to an end. Kerry Byrne was appointed as the new Audit Committee Chair in September 2018 as a Non-Executive Director with 'recent relevant financial experience' which is best practice. The Director of Finance and Director of Corporate Affairs together with the Operational Director of Finance are invited to attend and the Committee may request the attendance of the Chief Executive and any other officer of the Trust to answer any points which may arise. Attendance by members is set out above.

The aim of the Audit Committee is to provide one of the key means by which the Board of Directors ensures effective internal control arrangements are in place. In addition, the Committee provides a form of independent check upon the executive arm of the Board. As defined within the NHS *Audit Committee Handbook* (2018), the Committee has responsibilities for the review of governance, risk management and internal control covering both clinical and non-clinical areas. In discharging these duties the Committee is required to review:

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

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

Internal Audit

The Internal Audit service is provided by Mersey Internal Audit Agency (MIAA), an independent NHS organisation. The Director of Audit Opinion and Annual Report for 2018/19 reports that MIAA have demonstrated their compliance with NHS mandatory Internal Audit Standards. Internal Audit provides an independent and objective appraisal service embracing two key areas:

- The provision of an independent and objective opinion to the Accountable Officer, the Board and the Audit Committee on the degree to which risk management, control and governance support the achievement of the agreed objectives of the organisation.
- The provision of an independent and objective consultancy service specifically to help line management improve the organisation's risk management, control and governance arrangements.

The Audit Committee contributed to the risk assessment to inform and subsequently approve the content of the Internal Audit Plan for 2018/19. This plan was structured to provide the Director of Audit Opinion which gives an assessment of the:

- design and operation of the underpinning Assurance Framework and supporting processes;

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

The key conclusion from their work for 2018/19 as provided in the Director of Audit Opinion and Annual Report was that 'Substantial Assurance', can be given that that there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently.

External Audit

The provision of External Audit services is delivered by Ernst & Young, who were appointed by the Council of Governors in September 2017 for an initial three year period, with the option to extend for a further two one year extension periods.

The work of External Audit can be divided into two broad headings:

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

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

The external audit fees for 2018/19 were *£48,000 (excluding VAT) which represents a reduction on the previous year from £53,100 when audit services were provided by KPMG.
**This is a fixed price for 5 years.*

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

Five meetings were held during the financial year 2018/19 of which one, in May, was devoted to consideration of the auditors' report on the Annual Accounts and ISA 260. The Committee has an annual work plan with meetings timed to consider and act on specific issues within that plan.

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

- The monthly Board Assurance Framework report
- Internal Audit Reports in accordance with the approved 2018/19 work plan
- Counter Fraud reports by the MIAA specialist in accordance with the approved 2018/19 work plan.

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

- Annual Governance Statement
- Consideration of the 2018/19 Annual Accounts

- NHS Improvement quarterly returns
- Risk Management Improvement Plan
- Capital Accounting Manual 2018/19
- Corporate Governance Manual 2019/20
- External Audit technical briefings
- External Assurance Report on the quality account
- External Audit report on the financial statements to 31st March 2018 and ISA 260
- Losses and special payments
- Counter Fraud reports by the MIAA specialist in accordance with the approved 2018/19 work plan
- Internal Audit work plan for 2018/19
- Ernst & Young External Audit Yearend report 2017/18
- External Audit Strategy and Accounting Issues relating to the Audit of the Trust's 2018/19 Accounts
- Accounting policies for the 2018/19 Financial Statements
- Audit Committee work plan 2018/19
- Review and approval of the terms of reference for the Audit Committee
- Annual Reports of the Trust's assurance committees, including Clinical Quality Assurance Committee.
- Gifts & Hospitality Register
- Financial Statement audit risks for 2018/19

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

The Audit Committee considered the external audit results which confirmed there were no matters to report.

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

• The **Nominations Committee of the Council of Governors** is responsible for the appointment and removal of Non-Executive Directors. It is chaired by the Trust Chair apart from when it is concerned with the appointment or re-appointment of the Trust Chair. Other members of the Committee are Barbara Murray, Kate Jackson and Glenna Smith.

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During 2018/19 the Committee considered:

- the appointment of Non-Executive Director, Anita Marsland as Senior Independent Director;
- a further twelve month extension for Non-Executive Director, Ian Quinlan; this was based on the need for continuity and stability on the Board coupled with strong track record of performance;
- the appointment of a new Non-Executive Director and Audit Chair, Kerry Byrne;
- the appointment of a new Trust Chair, Dame Jo Williams.

• The **Appointments and Remuneration Committee of the Board of Directors** is responsible for the appointment of Executive Directors. It is chaired by the Trust Chair; other members are a minimum of three other Non-Executives and the Chief Executive, as appropriate to the post under consideration. During 2018/19 the Committee appointed Dr Nicki Murdock as the Trust's Medical Director replacing Dr Steve Ryan following his retirement in September 2018.

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NHS Improvement's Single Oversight Framework

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

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

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

Segmentation

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

This segmentation information is the Trust's position as at 31st March 2019. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website.

Finance and Use of Resources

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

The Trust scored an overall 1 at the end of 2018/19 which represents an improved score compared to the plan submitted to NHS Improvement, which was forecast as 2.

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Voluntary disclosures

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

Whilst aspiring to greater achievement in the area of Equality, Diversity and Inclusion, the Trust also recognises the need to implement realistic approaches which can deliver measurable improvements in day to day experience for all concerned. This reflection has contributed to a new process to achieve this in order to most effectively prioritise those areas of development that will bring the greatest benefit to those most disadvantaged.

During 2018, the Trust has taken a collaborative approach working with several Trusts in the area to improve existing EDS2 goals 1 & 2 (patients) in close partnership with Merseyside Clinical Commissioning Groups, this work is ongoing and will identify priorities for 2019/20. In addition, these priorities are included in Patient Equality, Diversity and Inclusion (EDI) Objectives 2018-2021.

EDS2 goal 3 (workforce) continues to be supported by the Trust staff Black, Asian and Minority Ethnic (BAME) Network (extended from BME in 2018 to include 'A' representing Asian staff groups) and Disability Network. In 2018 we established a Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual plus (LGBTQIA+) network. These networks represent the views of these staff groups and have become integral in the policy review process and health and well-being agenda. The BAME network also supports the progress of the Workforce Race Equality Standard (WRES) action plan. Implementing the Workforce Race Equality Standard (WRES) is a requirement for all NHS healthcare providers, and is designed to ensure employees from Black and Minority Ethnic (BME) groups have equal access to career opportunities and receive fair treatment in the workplace. This is important because studies shows that a motivated, included and a valued workforce helps deliver high quality patient care, increased patient satisfaction and better patient safety. The WRES action plan agreed a number of actions to improve the experience of BAME staff working at Alder Hey, and also agreed a target of a 1% year on year increase over the next 5 years in the numbers of BAME staff employed by Alder Hey to ensure the numbers reflect the local community population. This action plan has been incorporated in Workforce Equality, Diversity and Inclusion (EDI) Objectives 2018-2021.

In compliance with the Public Sector Equality Duties the Trust publishes equality information annually about its service users and staff, identifying where data needs to be improved in both patient and staff profiles. The quality of information in the Electronic Staff Record (ESR) has continued to be improved by identifying not stated responses and encouraging staff to complete their personal data. The Trust continues to strive to improve the diversity of the workforce, particularly from Black, Asian and Minority Ethnic (BAME) groups. This commitment is included in the Trust's Recruitment Strategy and is reinforced via the

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

The Trust published its second Gender Pay Gap report 2019 produced to meet the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 which came into force on 31st March 2017. Although not mandatory, the Trust produced a narrative that explains the calculations and provides an organisational context.

Work is ongoing to improve the quality of equality analysis and to provide support to project and policy leads to ensure lawful decision making.

The Trust provides British Sign Language Video Remote Interpreting (VRI) located in the Emergency and Outpatient departments, available to all staff. This provides instant BSL interpretation services when required. The Trust provides interpreting and translation services to meet the communication needs of families; the five most frequently requested languages during 2018 have been Arabic, Polish, Chinese-Mandarin, Romanian and Chinese-Cantonese. Providing support for limited English speakers is essential for patient safety, quality assurance and enhanced patient experience and this will continue to be available where a need is made known. Further work is taking place to look at how our services can be made more accessible in relation to information formats and communication support for families and recording these preferences on patient records.

Plans for 2019 are to continue to improve the quality of patient and staff information and the quality of equality analysis documentation. We will continue to work collaboratively with commissioners and local trusts to broaden opportunities to engage with community groups to progress the Trust's equality objectives. We are committed to support the successful development of staff networks to help make a positive impact on the experiences of BAME, Disabled and LGBTQIA+ Staff; and to support work in relation to the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES), the latter due to be published August 2019. Training opportunities in cultural competence and unconscious bias will continue to be made available for staff. The networks will increasingly shape relevant aspects of leadership training to increase the education of staff. The Trust will undertake a detailed analysis of the results of the Gender Pay Gap Report and take steps to reduce the gender pay gap.

The Trust will establish an Equality, Diversity and Inclusion Steering Group to ensure the operational progress of objectives devolved to various roles in the Trust that will provide assurance to the relevant committees for patients and workforce.

Equality, Diversity and Inclusion will continue to be an integral part of the Trust Quality Strategy with a shared approach of improving the experiences of public and staff through engagement. There will be continued attention to supporting the organisational processes and strategic leadership for Equality, Diversity and Inclusion and communicating any gaps wherever these may be identified.

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

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

NHS Improvement, in exercise of the powers conferred on Monitor by the National Health Service Act 2006, has given accounts directions which require Alder Hey Children's NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Alder Hey Children's NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

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

- observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgments and estimates on a reasonable basis;
- State whether applicable accounting standards as set out in the *NHS Foundation Trust Annual Reporting Manual (and the Department of Health Group Accounting Manual*) have been followed, and disclose and explain any material departures in the financial statements;
- ensure the use of public funds complies with the relevant legislation, delegated authorities and guidance;
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the trusts performance, business model and strategy; and
- prepare the financial statements on a going concern basis.

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

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

Signed.

Louise Shepherd CBE
Chief Executive
28th May 2019

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Annual Governance Statement

Scope of responsibility

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Alder Hey Children's NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

Capacity to handle risk

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

As Chief Executive and Accounting Officer, I have overall responsibility and accountability for risk management. The Chief Executive is informed of significant risk issues via the established reporting mechanisms and assurance committees, ensuring that her role for risk management is fulfilled. The Medical Director is accountable to the Board of Directors and the Chief Executive for clinical risk management and clinical governance; she reports to the Chief Executive and the Board as appropriate. The Chief Nurse is the Executive lead for risk management and is accountable to the Board and the Chief Executive for the Trust's risk management activities; she is also responsible for embedding compliance with CQC standards across the organisation. The Associate Director of Nursing and Governance is the operational lead for risk management, accountable to the Chief Nurse and has line management responsibility for the Trust's Risk Management team. They are responsible for ensuring that the Trust's risk management systems and processes are effective and operate in accordance with best practice. The Chief Nurse is also the Executive lead for Facilities and is responsible for the effective management of risk in those areas. The Director for Human Resources retains an overview of statutory and mandatory training for the organisation and is responsible for Health and Safety management. The Director of Finance is responsible for ensuring that the Trust carries out its business within sound financial governance arrangements that are controlled and monitored through effective audit and accounting systems. He is also responsible for Information Management and Technology risk. The Director of Corporate Affairs is responsible for Information Governance and is the nominated Senior Information Risk Owner, whilst the Chief Nurse is the Trust's Caldicott Guardian.

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Divisional Associate Chief Operating Officers and their senior teams, including Associate Chief Nurses and Heads of Quality, are responsible for ensuring that risk management systems within the Divisions are effective and also meet the objectives outlined within the Risk Management Strategy. Divisional Boards have a key role in assuring the effectiveness of risk management, including regular scrutiny of Divisional risk registers. Associate Chief Nurses and Heads of Quality monitor and review incidents, risk assessments, claims and complaints and ensure that agreed actions are carried out and feedback is given to staff.

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

During the year the Trust sustained its high rate of incident reporting via the NRLS system, which for the past two years has placed it among the best performers for patient safety incident reporting nationally: the most recent published data – April to September 2018 – positioned Alder Hey second overall in terms of the highest rate of incident reporting per 1000 bed days and the highest reporter among specialist paediatric trusts. The Trust also has the shortest time between the incident occurring and being reported to NRLS in the country. This continuing improvement trend demonstrates the commitment of staff to the Trust's Quality Improvement culture and the benefits to be gained from open reporting and learning from incidents. As part of the overall risk management improvement plan, work to improve the functionality of the Ulysses incident reporting system continued during the year. Risk registers continue to be used interactively throughout the organisation and are fully embedded in the Trust's governance structures including the Executive Team, the Board, its sub-committees and Divisional Risk and Governance Groups to better drive the management and mitigation of risks. During the year regular meetings continued to be held to validate all risk registers at departmental level, ensuring that each identified risk has been reviewed and mitigating actions updated as appropriate. In addition, work continues to improve the risk register format and associated reports and supporting local areas in completing and reviewing risks. Training sessions continue to be available to all staff, including one to one and/or team sessions on request. In addition, Ulysses system one to one training is provided to new starters, with refresher training available on request.

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

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

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MIAA's report also shares a number of best practice developments which the Board will consider as it agrees its strategic risks for 2019/20.

The Trust received a rating of 'substantial assurance' confirmed by the Director of Audit Opinion for 2018/19.

The risk and control framework

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

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

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

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

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

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allocation to be made on that basis. It enables decisions to be taken about the level of management of each risk within the Trust.

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

During 2018/19 the Trust has continued to operate its model of devolved governance within the clinical Divisions, which was implemented in 2016 with the aim of giving clearer responsibility and ownership of risk and governance at local level. The Associate Director of Nursing and Governance provides corporate level expert advice and support to the Divisions and has continued to lead on the Trust's Risk Management Improvement Plan. MIAA undertook a follow up audit of the Trust's risk management arrangements in the year with a particular focus on the Divisions, which gave a 'substantial assurance' rating, concluding that *'there is a good system of internal control designed to meet the system objectives, and controls are generally being applied consistently*.'
However, with the emphasis on continuous improvement a number of further actions were agreed and presented to the Audit Committee in September:

- Continue to monitor assurance via the Integrated Governance Committee and the risk register revalidation meetings.
- Regular review of Trust risk register (via Ulysses) to ensure all risks are assigned to assigned to either corporate function or division risk register as appropriate.
- Divisional risk summit meetings will be undertaken as recommended.
- Key staff will be targeted to attend risk management training sessions in line with recommendations.
- Specific bespoke training plans will be devised and implemented for staff across Divisions.

The Trust remains registered with CQC without conditions and is fully compliant with the registration requirements. In February 2018 the Trust underwent an inspection of five core services by CQC – Critical Care, Community, Outpatients, Diagnostics and End of Life – as well as a Well Led review. The overall ratings of 'Good' for the hospital overall with a rating of 'Outstanding' in the Caring domain were maintained. The Trust is also rated 'Good' in the Well-led domain, reflecting the focus on improving the Trust's risk and governance arrangements since the previous responsive inspection in 2017.

In terms of monitoring compliance with registration requirements and essential standards, the Clinical Divisions provide assurance via regular submissions of their key issues reports through to the Clinical Quality Steering Group (CQSG). This incorporates a set of quality indicators reflecting the Trust's Quality Strategy, Quality Aims and associated KPIs. The key issue reports include compliance against CQC standards and other regulatory targets. They also incorporate assurance against clinical effectiveness, patient experience and patient safety indicators such as incidents, risks, medication errors and infections. The Divisions

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report against CQC fundamental standards as part of the assurance framework and action plans from serious incidents are also presented and monitored with dissemination to Divisions for shared learning. CQSG also provides a key issues report to CQAC for further assurance, highlighting any exceptions or risks that may need to be addressed or escalated.

The Board at Alder Hey continues to review its quality governance arrangements and underpinning systems and processes on a regular basis. The Clinical Quality Assurance Committee, whose membership includes all Divisional Directors as well as Board directors, carries out more detailed scrutiny under its delegated authority from the Board for oversight of the Trust's performance against NHS Improvement's Well Led Framework, the delivery of the Quality Strategy incorporating measures of clinical effectiveness, patient safety and positive patient experience. The work of the Audit Committee complements this by discharging its responsibility for the maintenance of an effective system of integrated governance, risk management and internal control across the whole of the organisation's activities.

The Trust was not affected by the 'WannaCry' cyber-attack of May 2017, however significant work has been undertaken to safeguard the organization's systems against similar threats. During 2018/19 MIAA were commissioned to undertake a review to obtain assurance and identify opportunities for improvement; the work covered key risk areas including: perimeter controls, secure configuration, user access controls, malware protection, patch management and data recovery. The review assessed the level of maturity of Trust arrangements in each area and concluded that there were satisfactory controls in all areas with identified examples of good practice in evidence. In addition, the Trust conducts annual internal and external vulnerability scans and penetration testing and has had both Cyber Essential and more recently Cyber Essential Plus testing conducted during this period which demonstrated awareness and compliance against industry security standards.

In 2018/19 the Trust's programme of Quality Assurance Ward/Department Rounds continued. The Quality assurance rounds commenced in September 2017 and the programme has continued to develop and mature since that time. The key purpose of the assurance rounds is to demonstrate to the Board the linked golden thread of assurance from ward to board. The rounds facilitate a deep dive at ward/department/specialty level into quality and performance noting areas of good practice and any actions being taken at a local level to address areas of concern. The assurance rounds provide both quantitative and qualitative information to demonstrate that the services are safe, effective, responsive, caring and well-led in line with the CQC's Key Lines of Enquiry (KLOE).

During the year 38 assurance rounds were undertaken across the full range of Trust services. Some of the key themes to emerge from the process are as follows:

- Strong evidence from all staff groups of understanding and commitment to the Trust vision and values.
- Compassionate, caring multidisciplinary staff evident from all quality assurance rounds, with patients clearly the central focus.
- There has been strong evidence of increased activity across many services in the Trust; staff have risen to the challenge, through excellent multidisciplinary working.
- Strong belief and ongoing work across services to 'growing own talent pool' of staff in house.

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- Good understanding around risk management demonstrated across the Trust, although this is an area for further development which is recognised by front line staff.
- Staff value visibility of senior management including executives and non-executives.
- Staff feel supported by senior management team
- Strong commitment to patient safety including incident reporting and management, infection prevention and control.
- Daily huddles carried out across the Trust
- Weekly nurse led Incident management meeting
- Strong evidence of lessons learned from incidents

In this second year of operation, a number of areas of local shared good practice have also emerged, for example:

- The Theatre department holds a bi-annual quality summit
- Development and implementation of 'after action reviews' i.e. a structured method for multidisciplinary teams involved in incidents to review and learn lessons to prevent same or similar incidents recurring.
- Ophthalmology multidisciplinary team have developed standards of behaviour and professionalism that all staff have signed up to.
- Multidisciplinary away days to develop local strategy and outcomes.

The Board has continued to focus on improving the information received to describe the performance of the organisation with regard to quality and other key performance metrics. The Trust's revised format Corporate Report was implemented from April 2018 and this will continue to be kept under review as the Business Intelligence function develops and becomes more sophisticated. A live clinical intelligence portal has been created to assist with the triangulation of a range of datasets in support of quality improvement initiatives.

The Trust has been keen to ensure that it responds proactively to the Well Led Governance Framework published by NHS Improvement and revised in June 2017. The regular assessments undertaken by the Trust against the previous Quality Governance Framework meant that the Board was well sighted on the developmental benefits for the organisation from commissioning an independent review under the Well Led Governance Framework. The review was undertaken by Mersey Internal Audit Agency in partnership with AQuA (Advancing Quality Alliance), involving a wide range of senior staff from the Trust as well as taking in the views of Governors and external stakeholders. The report was received in February 2018; its overall conclusion was that Alder Hey was well-led, stating: *'It is an organisation that has lived values, a talented Board, a determined strategic intent and a momentum to developing a clinical leadership model.'* The report set out a range of developmental recommendations across the CQC's eight well led Key Lines of Enquiry; the Board subsequently held a workshop session in July 2018 which resulted in a development plan which is partially completed and will continue into 2019/20.

The Board undertook its annual formal gap analysis against the conditions contained within its Provider Licence during the year. With regard to Condition FT4 – NHS foundation trust

governance arrangements, the exercise did not identify any material risks to compliance with this condition.

A comprehensive gap analysis of the Trust's Corporate Governance Statement under the Provider Licence, was undertaken in May 2019 ahead of the formal declarations required by NHS Improvement This did not identify any material gaps in compliance. The Board continues to keep its governance arrangements under regular review and itself appraised of any new guidance or best practice advice that is published through the year. Alder Hey continues to be placed in segment '2' under NHS Improvement's Single Oversight Framework – providers offered targeted support - reflecting the Trust's financial position against control total.

The Board's main assurance committees each provides an annual report on its work to the Board, describing how the committee has fulfilled its terms of reference and annual work plan and outlining key areas of focus during the year, together with an overview of its priorities for the coming year. These are also submitted to the Audit Committee for it to assure itself that the activities of the committees are contributing effectively to the Trust's overall control environment and that the work of the assurance committees is directly linked to the Board Assurance Framework. The assurance committees review their terms of reference on an annual basis to provide assurance to the Board that its structures continue to reflect the changing needs of the organisation and the environment in which it operates, including clear lines of accountability.

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

The Corporate Report remains the principal mechanism for ensuring that the Board and its committees receive timely, accurate and comprehensive information on the performance of the organisation. The report is kept under review by the Executive Team to ensure that it is fulfilling this function as effectively as possible; the Non-Executive Directors provide regular feedback on the report and on the presentation of individual indicators. Toward the end of the year the Trust's newly appointed Medical Director undertook to assist with a further review of the quality and safety metrics in the report alongside the Chief Nurse and Chief Operating Officer; this work will commence in 2019/20 with support from the Business Intelligence team.

The Trust's key risks in 2018/19 were consistent with those identified within the previous year and are described below together with the Trust's mitigations.

- Financial sustainability in a challenging environment
    - Mitigation:
        - develop a broader service base
        - promote a national alliance on paediatric tariff

- Ability to continue to grow
  - Mitigation:
    - develop meaningful partnerships
    - develop new business models with NHS partners
    - develop new NHS business, international operation and innovation
- Workforce
  - Mitigation:
    - Maximise Employer-Provider status for apprenticeships
    - Maintain supply of nurses via nurse pool – 40 WTE above establishment
    - Develop the Alder Hey Academy including collaborative working with HEI's and local schools
    - Develop new and expanded roles e.g. nurse social worker, Advanced Nurse Practitioners to support medical workforce
    - Deliver our health and wellbeing strategy for staff.

Alder Hey's workforce planning process, developed within the context of the Trust's clinical, activity and financial strategies, remains an integral element of the local operational business planning process, and ensures that the Trust has sufficient staffing capacity and capability throughout the year to support the provision of safe, high quality services. The clinical divisions have taken an inclusive, 'bottom up' approach working with each speciality, ensuring their workforce and activity plans are in full alignment. In addition, the Trust's planning process has taken full cognisance of the Cheshire and Merseyside Health and Care Partnership plan; Alder Hey has a leading role in the Women's and Children's, Acute Sustainability, Digital Revolution and Collaboration at Scale programmes. The Trust's plans have also taken into account the workforce objectives in the Long Term Plan, and the system approach to urgent care, congenital heart services, neonates, and children's community and mental health services. The Trust has reviewed the *Developing Workforce Safeguards* recommendations issued by NHS Improvement in October 2018 and is confident that the principles are embedded in the existing workforce planning fr amework. The Chief Nurse reports bi-annually to the Trust Board with regard to standards and processes to provide assurance that staffing is safe, effective and sustainable in accordance with the CQC's well led assessment.

The foundation trust has published an up to date register of interests for decision making staff within the past twelve months, as required by the '*Managing Conflicts of Interest in the NHS*' guidance.

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

Control measures are in place to ensure that the organisation's obligations under equality, diversity and human rights legislation are complied with. The Trust maintains continuing compliance with the statutory and regulatory duties that are related to Equality, Diversity and Human Rights, with publication of information to meet the Public Sector Equality Duty.

Arrangements for the strategic oversight of progress towards the Trust's Equality Objectives have been a key priority during the year; this process will continue to be reinforced during 2018/19. The Equality Objectives will be aligned with NHS EDS 2 and the WRES and will respond to the associated commissioning requirements.

The foundation trust has undertaken risk assessments and has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

In terms of the Trust's Emergency Preparedness, Resilience and Response (EPRR) Core Standards return, the Trust received confirmation that it met the expected timescale and all documentation submitted was signed off at Board level.

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

As Accounting Officer, I am responsible for ensuring arrangements are in place for securing value for money in the use of the Trust's resources. To do this, I have implemented a robust system to set, review and implement strategic objectives. Trust objectives are informed by the views of its Council of Governors and other key stakeholders. In 2018/19 the Trust continued to engage with the Cheshire and Merseyside Health and Care Partnership (C&M HCP) plan. The C&M HCP Vision is to improve the health and wellbeing of the region's 2.6 million population through creating a strong, safe and sustainable health and care system that is fit for the future. Alder Hey is actively engaged in the partnership's various work streams; I am the Senior Responsible Officer for the Share2Care intra-operability programme to create a digital roadmap for all providers; the Trust is also an active participant in the collaboration at scale work to explore options for greater efficiency within support services such as pharmacy and procurement.

Each year the Trust produces an operational plan that sets out organisational objectives which are cascaded to local level. Divisional activity is reviewed throughout the year to monitor progress and agree corrective action where necessary via monthly performance review meetings with Divisional senior teams. The Board of Directors reviews performance against objectives on a monthly basis through the Corporate Performance Report which is also reviewed by key Board assurance committees.

Operationally, the Executive team uses a range of mechanisms through which it monitors performance, identifies emerging risks to delivery and takes mitigating action to address issues as they arise. These processes have continued during the year and include twice daily patient flow huddles, a weekly activity meeting and a weekly Executive 'Communication Cell' huddle which was set up during 2017/18 as a means of sharing information about actual performance over the previous seven days and highlighting issues for the coming week. This process was particularly effective during the winter months to operationalise the Trust's robust Winter Plan, which had been devised this year to flex capacity during weeks in which seasonal illnesses had been predicted to reach their peak, thereby minimising the number of cancelled elective procedures. These operational processes contribute to the Trust's control environment and provide assurance to the Board that performance risks are understood and fully mitigated where they are within the Trust's locus of control.

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The Board's assurance system is underpinned by the work of the Trust's internal auditors which is overseen by the Audit Committee. Each year the Committee agrees an audit programme which aims to focus on areas of weakness or potential risk in internal control and make recommendations to address deficits where these are identified. The Audit Committee retains a database of remedial actions agreed as a result of audits and these are followed up by the Committee until completed. During the last 12 months the Committee chair has retained a strong focus on the processes around the monitoring of internal audit recommendations and the provision of regular reports both from lead officers and internal audit, to ensure that any areas of limited assurance are followed up and relevant action taken.

A range of specific initiatives to improve the use of resources were in place during 2018/19, including:

- As part of established InfoFox Business Intelligence, the launch of new interactive Integrated Corporate Performance report including divisional reports that are used as part of devolved governance. Development of a Clinical intelligence Portal as part of GDE Programme to include quality and outcome measures along with productivity.
- Implementation of Weekly Executive Communication Cell to promote the real time use of data to drive better resource management and improvement.
- The Change Programme updated to include focus on '5 Operational Priorities; which deliver patient care benefits whilst improving use of resources.
- The Trust is a GDE site and has delivered [32] digital speciality packages and a series of digital transformation which has improved outcomes and better use of resources
- Further advancement to the materials management procurement processes to promote just in time and elimination of waste.
- Lead Cheshire and Merseyside 'Theatres Procurement Alliance' to deliver shared savings and standardisation.
- Embedding service line reporting though specialty reviews resulting in increased clinical engagement in costing and performance improvement which has been aligned with Getting it Right First Time Programme.
- Development of a workforce sustainability plan which further builds on the enhanced systems and processes to support the compliance with national rules regarding the management and control of agency staff costs and framework agreements.
- Member of Cheshire and Merseyside Collaboration at Scale programme which is a focus on efficiency and value for money
- Internal rollout NHSi productivity tools used as part of creation of the 'High Impact Changes.'

Information Governance

There have been significant changes during 2018/19 with the General Data Protection Regulation (GDPR) coming into force on 25th May 2018 and the Data Protection Act 1998 (DPA98) repealed to become (DPA18). The previous Information Governance Toolkit has been replaced by the new Data Security and Protection Toolkit that is based on the ten National Data Guardian Security Standards. The Trust has provided 99 out of the 100 mandatory items and received a 'Substantial Assurance' rating from Mersey Internal Audit Agency following its review against the standards. As this is a new monitoring tool, there are no previous scores to compare. The Trust will develop an improvement plan for each of standards in 2019/20 working with MIAA to maintain good practice and improve in areas that require attention.

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There were no data breaches to report to the Information Commissioner's Office during 2018/19.

Annual Quality Report

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

The Medical Director and Chief Nurse are jointly responsible at Board level for leading the quality agenda within the Trust, supported by the Director of Nursing, Deputy Director of Nursing and Associate Director of Risk and Governance. In addition, the Board appointed two Directors of Transformation and Clinical Effectiveness from among the consultant body during 2017/18 to strengthen the team leading the Trust's Quality Improvement agenda.

In May 2018 a team of senior staff from Alder Hey travelled to Canada to visit Toronto Sick Kids' hospital so that they could find out more about the organisation's approach to quality improvement and how far this work could translate into an NHS context. The visit was facilitated by KPMG who had worked with Toronto on their methodology. The learning from the visit helped the Trust to further refine its '*Inspiring Quality*' strategy. A Quality Summit was held in spring 2018, involving over 100 staff, parents/carers and external partners to gather a wide range of views and ideas around putting children first, reducing harm and improving outcomes.

This information, along with views of the children and young people's forum and other sources was collated into themes and used to build the Inspiring Quality Delivery Plan. This requires a significant change in approach to how we deliver quality improvement at Alder Hey and has been approved by the Trust Board along with significant financial investment, reflecting absolute commitment to delivery of the plan.

The three key aims of the Inspiring Quality Delivery Plan are:
1. Put children first
2. Be the safest children's trust in the NHS
3. Achieve outstanding outcomes for children

This will drive the delivery plan in 2019/20.

The refreshed approach to quality improvement is underpinned by fundamental quality governance principles, which remain:
- Patients will not suffer harm in our care
- Patients will receive the most effective evidence based care
- Patients will have the best possible experience

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It is these principles and associated quality aims and metrics that have been consistently at the core of the Trust's approach to quality since 2012/13 and which enable a coherent and authentic narrative for staff, patients and families.

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

In support of this, during the year the Trust's internal Quality Report, which is embedded within the Corporate Report, was reviewed to ensure consistency of information tracking against the Quality Aims, a range of sixteen safety, effectiveness and experience measures that also allow for comparison with other providers and can be used as assurance for regulators. The Quality Report is reviewed in detail by the Clinical Quality Assurance Committee and by the Board of Directors on a monthly basis. The Report is kept under review to ensure that content remains responsive to key national drivers, such as the change to the metrics set out by NHS Improvement in the Single Oversight Framework and that actions taken to achieve the aims incorporate learning from elsewhere in the NHS.

Significant work has been undertaken during the year to assure the accuracy of the quality data contained within the report. Our data quality team undertakes regular audit across a series of metrics, indicators and measures and this work is reported to the Data Quality Steering Group which meets monthly to review data quality in the Trust. The Trust Audit programme for 2018/19 included work to assess the data quality to recording patient demographics, of A&E waiting times, referral to treatment (RTT) referral and pathway information. MIAA also carried out audit focusing on DNA pathway management and follow up on referral and waiting list management and performance management and monitoring carried out in 2017/18. Performance information is validated by the service and reviewed at the weekly operational delivery group prior to sign off for reporting. Information procedures are maintained to ensure they reflect changes in reporting processes. There have been improvements made to recording of patient demographics, waiting list management and recording of patient outcomes in clinic this year with more oversight and monitoring of these processes supported by standard processes and procedures.

At Alder Hey we have undertaken a range of measures to ensure we have accurate and robust waiting times data. We have a Data Quality Steering group that meets monthly to review recording and reporting of patient information including waiting times information. Our Patient Access Policy was reviewed and updated to reflect current processes and reporting requirements and a weekly Operational Delivery Group is in place to monitor all aspects of A&E, Cancer, RTT and waiting list management and performance and identify and resolve issues with the clinical divisions. We have also focused improvement work on booking and scheduling appointments, with a migration to a more clinically prioritised and focused booking system (Hybrid/ Clinical Prioritisation Booking). The Improvement programme at the Trust for 2019/20 continues to focus on further improving our booking and scheduling process with a 'Brilliant Booking and Scheduling' work stream, with the plan to continue to roll out Clinical Prioritisation Booking across all services. Clinical Prioritisation booking will fundamentally change the way we book our patients ensuring we have the right capacity in place to book our patients into, with focus and controls in place. It is also an aspiration of the group to review the use of technology to improve access to book an appointment and improve user

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satisfaction. We will also be rolling out a live interface to be able to check patient demographics easily on the national system as part of our reception process.

The Trust regularly validates patients on pathways which in turn feeds into our Data Quality Steering group which meets on a monthly basis. . A 'Right pathway, Right Care' group was established in October 2018 to ensure that staff are adequately trained and supported in administering patient pathways. User Guides were developed and extensive training completed by December 2018 and all administrative staff involved in pathway management have been trained in accurate pathway management based on this approach The plan for 2019/20 is to improve the training and roll this further and wider in the Trust and to Clinical staff. The plan is also to deliver Pathway training jointly between Divisional and IT Training staff and will include local and national content and guidance, to ensure maximum impact.

The Trust continued to engage with the 'Civil Eyes' Programme during the year, which benchmarks the majority of children's hospitals in the UK and Northern Ireland across a range of indicators and specialty areas, to ensure we are not an outlier. The Trust is also participating in a locally agreed Specialist Children's Hospital Benchmarking group focusing on benchmarking National Specialised Services Indicators with our peers.

Review of effectiveness

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

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

- the Board of Directors provides active leadership of the Trust within a framework of prudent controls that enable risk to be assessed and managed;
- the Audit Committee, as part of an integrated governance structure, is pivotal in advising the Board on the effectiveness of the system of internal control;
- the Committees of the Board are key components by which I am able to assess the effectiveness and assure the Board of risk management generally and clinical risk in particular via the Clinical Quality Assurance Committee, supported by the Clinical Quality Steering Group and by the Integrated Governance Committee which was established to strengthen the Trust's overall risk and governance arrangements;
- Internal Audit provides quarterly reports to the Audit Committee and full reports to the Director of Finance and other Trust Officers;
- the Director of Finance also meets regularly with internal and external Audit Managers;
- the Integrated Governance Committee holds Divisions and corporate departments to account for the effective management of their key risks;

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- other explicit review and assurance mechanisms include divisional risk registers linked to the Operational Plan and a range of independent assessments against key areas of control, as set out in the Assurance Framework;
- continuous registration without conditions by the Care Quality Commission 1st April 2010 onwards;
- retention of the Trust's Human Tissue Authority Licence; all HTA standards were met on inspection and areas of good practice highlighted in the report;
- retention of Clinical Pathology Accreditation for the year.

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

I receive reports from the Royal Colleges and following Deanery visits. In addition, there have been a range of other independent assessments against key areas of control which provide assurance, for example:

- The Anaesthesia Clinical Services Accreditation (ACSA) review report July 2018, confirming Alder Hey as the first children's hospital to achieve this specialist accreditation from the Royal College of Anaesthetists;
- Microbiology Containment Level 3 Laboratory were inspected by the Health & Safety Executive (HSE) in June 2018. All findings cleared;
- Laboratory Medicine/Pathology were inspected by the United Kingdom Accreditation Service (UKAS) to ISO 15189:2012 standard from October 2017 to Jan 2018. All improvement actions were cleared and the laboratories gained UKAS accreditation in September 2018;
- A QNIC accreditation visit to the Trust's inpatient CAMHS facility, the Dewi Jones Unit in March 2019;
- The Community and Mental Health Division participated in a number of system wide inspections in the year including a CQC inspection of looked after children in Sefton; an Ofsted inspection of the Youth Offending Service and a joint CQC/Ofsted inspection of SEND provision;
- The annual PLACE inspection of the hospital's facilities from a patient's perspective.

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

Conclusion
In conclusion, for 2018/19 no significant internal control issues have been identified.

Signed:

Louise Shepherd CBE
Chief Executive
28th May 2019

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Quality Account 2018-19

"Outstanding Care Inspired by Children"

Quality Report 2018-19

"Outstanding care delivered by outstanding staff"

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

When I look back on 2018/19, I see it as the year in which Alder Hey took significant steps towards a new approach to Quality Improvement, building upon almost a decade of continuous progress against three key principles: *that no patient should suffer harm in our care; that every patient should have the best possible experience and that all patients should receive the most effective, evidence based care*. We have remained true to these clear intentions and have demonstrated measurable success, which is illustrated throughout these pages.

Delivering outstanding care has been a key component of Alder Hey's strategy for a number of years. Since we moved into our new hospital in 2015, we have continued to develop our ambitious plans to create a health campus for children and young people. In the last 12 months, it has become increasingly clear that by bringing together the wealth of expertise of our staff across leading edge clinical, innovation, research and technological fields of practice, we have the opportunity to deliver the kind of services and experience that staff, children and families described in the Quality Summit of May 2018. The learning from this event, together with examples of quality improvement work drawn from leading organisations nationally and internationally has helped us reach the next phase of our *Inspiring Quality* strategy.

I am epecially proud of the way in which staff have embraced our drive to further improve the quality of the care that they provide by ensuring that our children and young people are always at the centre of all that we do at Alder Hey. There are many rich examples of how teams have contributed to this in the last year in order to place '*children and families first every time*' – one of our key priorities. In the last year, we have worked hard to respond to feedback from families about some of our frontline services including outpatients and phlebotomy, resulting in significant improvements in both patient and staff experience.

Crucially, we have maintained our focus on our safety culture, learning from events where things could have been improved and changing practice in response. The vital work to ensure early identification and treatment of children whose condition is deteriorating has continued to be at the forefront of our minds as an organisation and has seen significant progress, through the tireless efforts of the whole team.

As Chief Executive, I commend our Quality Report for 2018/19 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, who remain our constant inspiration.

Louise Shepherd CBE
Chief Executive

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Part 2: Priorities for Improvement and Statements of Assurance from the Board.

2.1 Priorities for Improvement

In 2012/13, Alder Hey Children's NHS Foundation Trust set a Quality Strategy with a key focus on three quality domains and 16 quality aims, as described in the table below.

Quality Domains	Quality Aims
Patient Safety Patients will not suffer harm in our care	Patients will not develop a hospital acquired infection
	Patients will not suffer harm as a result of drug errors
	Patients will not develop a hospital acquired pressure ulcer
	Patients will not suffer avoidable death
	Patients will not suffer unexpected deterioration
	Patients will not suffer from a never event
Patient Experience Patients will have the best possible experience	Patients and families will have received information enabling them to make choices
	Patients and families will be treated with respect
	Patients and families will know their planned date of discharge
	Patients and families will know who is in charge of their care
	Patients will engage in play and learning
Clinical Effectiveness Patients will receive the most effective evidence based care	There will be no acute readmissions within 48 hrs of discharge
	All patients will be treated following recognised protocols / pathways / guidelines
	There will be no acute admission of patients with long term conditions (epilepsy, diabetes, asthma, lower respiratory disease)
	Patients will be discharged on the planned day of discharge
	Patient's outcomes will be within nationally defined parameters

Since then the Trust has continued on a journey of improvement, with regular review of the quality strategy and the quality aims, continuing or adjusting our priorities each year to ensure specific focus is always placed on the necessary areas of improvement, whilst not losing sight of our overall strategy and agreed improvement targets. We have made significant improvements over time, which have been reflected in previous quality reports, and we have adapted our approach to work with technological advances and changing legal and regulatory requirements.

We completed the *Sign up to Safety* three year pledge, which delivered a marked improvement in patient safety, in particular reducing harm from medication errors and reducing hospital acquired infections; we have maintained a constant focus on improving the early detection and treatment of deteriorating patients, including children with suspected sepsis; we have maintained our position as one of the top performing trusts in terms of incident reporting, which is reflective of a strong safety culture; we implemented and have continued to improve our ward accreditation programme; we have maintained a strong focus

on improving the experience of our children and families, and this report reflects further improvement initiatives in this area. We have also continued to address the aims identified under the clinical effectiveness domain, which have largely been progressed through the Global Digital Excellence (GDE) work, i.e. utilising best practice evidence to improve and digitise our pathways, and ultimately improve outcomes. The Trust has been invited to participate in the pilot of the National Clinical Improvement Programme, a national programme that has created a portal to allow clinicians to see their outcomes of treatment in real time and use this data to improve practice and inform revalidation.

In 2016, the Trust's refreshed Quality Strategy, Inspiring Quality, was signed off at Trust Board. Whilst retaining a focus on the three quality domains, we recognised the need to formally capture within our strategy a priority relating to staff health and wellbeing, plus having just moved in to a newly built hospital, we added environmental improvements into the quality strategy ensuring the new environment worked for children and families as well as staff. These were added to the key focus areas in the 2017/18 Quality Account with significant improvements reported in last years account.

During 2018/19 we have further strengthened our Inspiring Quality strategy and have developed a more detailed implementation plan for quality improvement. In recognition of the growing number of quality improvement aims and targets, for 2019/20 we will adopt a 'watch and drive' approach whereby we continue to monitor our 16 quality aims plus other quality indicators through our corporate report ('watch') so that any areas that drift from the expected high quality standards can be addressed in a timely manner, whilst putting additional effort and resource into a smaller number of quality improvement focus areas ('drive'), identified through the Inspiring Quality strategy and including: a stronger focus on involving children and families; a continued drive towards being the safest children's trust in the NHS; improved utilisation of digitisation and artificial intelligence; and a development plan that will build an organisational culture of Inspiring Quality.

This section of the quality report describes the specific priority areas for 2019/20, as agreed through wide consultation and approved by Trust Board.

2.1.1 Priorities for improvement in 2019/20

This year has been a pivotal year for Alder Hey. In the past 12 months, we have refined our Inspiring Quality strategy to provide greater clarity on ambition, methodology and measurement of our Inspiring Quality Plan, with a clear trajectory of creating an organisational culture of quality improvement and safety.

We have strengthened our commitment to the three key priorities with a focus on an inclusive approach involving children and families to ensure we always **put children first**, and a clearly stated ambition of becoming **the safest children's trust in the NHS** that delivers **outstanding outcomes for children**.

In May 2018 we held an Inspiring Quality Summit which was attended by a broad range of over a hundred staff, parents, students and external partners. The outputs of the Summit were captured by a graphic artist on a poster display and used to inform our priorities in the

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final Inspiring Quality plan. We also consulted with our Children & Young People's Forum and Parents' Forum and provided opportunities for Healthwatch and other key internal and external stakeholders to contribute to our future plans.

We also sought opportunities to learn from other respected organisations nationally and internationally, including discussions with SickKids Hospital (The Hospital for Sick Children, Toronto, Canada), East London NHS Foundation Trust and Salford Royal NHS Foundation Trust to further develop our ideas.

The Inspiring Quality Delivery Plan was presented to the Clinical Quality Assurance Committee and was approved by Trust Board in December 2018. The plan is represented graphically at Appendix 2.

In creating the plan we consulted widely with staff, parents and families and other stakeholders, to explore what is required to deliver these three priority aims, and have identified four key changes required to the way we work. These are 'do everything with children and families', 'communicate safely', 'transform patient care through digital technology', and 'build a culture of Inspiring Quality'. These are reflected as specific focus areas for the year 2019/20.

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Priority 1	PATIENT EXPERIENCE: To put children first
Rationale	The Trust has a strong history of seeking feedback from children & families and putting plans in place to fix perceived problems. However for a child to truly be at the centre of their care, they should be involved in designing what that care will look like, and have input into service improvements, pathway design and setting their own care goals. In continuing the drive to put the child at the centre of everything we do, the Board have agreed that we should place a strong focus on working in partnership with children and families in the design of pathways and service improvement The Trust Board agree that there should be specific focus on: • **Doing everything *with* children and families**
Measuring	We will measure the following aspects of doing everything *with* children and families: 1. Number of pathways and improvements designed with children and families' involvement 2. No of staff trained in child and family centred care 3. No of specialties using a Goal Based Outcome tool in their practice (children setting their own goal based outcomes)
Monitoring & Reporting	A clinically led work stream will provide updates to the Inspiring Quality Cabinet which will provide regular reports to Clinical Quality Assurance Committee, and ultimately to Trust Board

Priority 2	SAFETY: To be the safest children's Trust in the NHS
Rationale	Communication was a consistent theme highlighted by staff and patients through the Inspiring Quality Summit. In delivering our ambition to be the safest children's Trust in the NHS, we recognise that safe, effective communication is crucial to improving patient safety. It includes not just exchange of information and medical hand-over but also the way we make patients feel, how we work together as teams and with families, how we invite feedback and how we feel safe to report incidents and escalate concerns. Our plan is to improve our safety culture built upon openness and continual learning, by developing a performance aware, resilient workforce, working with children, families and external partners. In support of our aim to be the safest children's Trust in the NHS, the Trust Board agree that there should be specific focus on • **Communicating Safely**
Measuring	We will measure the following aspects of communicating safely: 1. Number of safety culture assessments implemented across the Trust 2. Number of staff trained in communicating safely (including Human Factors) 3. Number of incidents of preventable harm
Monitoring & Reporting	A safety improvement taskforce will track performance against reducing incidents of preventable harm, which will continue to be reported in the Trust's monthly corporate report. Overall performance will be monitored through the Inspiring Quality Cabinet which will provide regular reports to Clinical Quality Assurance Committee, and ultimately to Trust Board

Priority 3	EFFECTIVENESS: To achieve outstanding outcomes for children
Rationale	Alder Hey is one of 16 hospitals that have been selected to be a Global Digital Exemplar (GDE) site. Moving from a predominantly paper-based to an electronic system offers an opportunity to transform our approach to patient care. Digital technology enables us to collect increasing amounts of information electronically, as part of routine care, and will allow us to analyse data in real-time. We are also able to standardise pathways according to best practice using NICE and international guidelines. This will have considerable benefits for staff and children, enabling prospective outcome monitoring, timely moderation of treatment and pathways and facilitating data collection for research studies. We will also use Artificial Intelligence to identify and drive outcome improvements for children. In support of the drive to achieve outstanding outcomes for children the Trust Board agree that there should be specific focus on: • **Transforming patient care through digital technology**
Measuring	We will measure the following aspects of transforming patient care through digital technology: 1. Number of specialities adopting evidence based digital pathways 2. Number of feedback messages received from children using Artificial Intelligence through Alder Play App and the number of improvements made based on machine learning. 3. Number of specialties able to access their own clinical outcome data via the Clinical Intelligence Portal.
Monitoring & Reporting	A clinically led work stream will provide updates to the Inspiring Quality Cabinet which will provide regular reports to Clinical Quality Assurance Committee, and ultimately to Trust Board.

In developing the Inspiring Quality Strategy, it was recognised that the workforce are key to implementing the necessary changes to how we work. The plan therefore includes a further area of focus which is to build a culture of Inspiring Quality

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Priority 4	Build a Culture of Inspiring Quality
Rationale	Inspiring Quality will create a cultural shift in the organisation. We need to create the right conditions to facilitate this cultural change. This includes leadership capacity and capability, a means of involving and supporting all staff and a means of ensuring sustainability. We will develop our leaders to coach and motivate staff working through the framework of the Alder Hey Leadership Strategy and delivered through an in-house leadership programme (“Strong Foundations”) to our leaders at every level. We will launch an ‘Inspiring Quality Faculty’ to deliver learning and development to staff. This will comprise of experts and coaches in quality improvement, including internal and external partner members, and will help to train staff in the use of Inspiring Quality tools, techniques and approaches. The Trust Board agree that there should be specific focus on • **Building a culture of Inspiring Quality**
Measuring	We will measure the following aspects of building a culture of Inspiring Quality: 1. Number of leaders trained in our strong foundations programme 2. Number of staff trained in Inspiring Quality. 3. Number of teams demonstrating use of Inspiring Quality huddle boards / daily routines to make improvements
Monitoring & Reporting	A dedicated work stream lead will monitor progress against the goals and will provide updates to the Inspiring Quality Cabinet which will provide regular reports to Clinical Quality Assurance Committee, and ultimately to Trust Board.

The Trust is adopting a phased approach to implementation of the Inspiring Quality Strategy. The first phase, from April to October 2019, focusses on creating capacity, mobilising people and communicating the change, and the second phase, from October 2019 onwards, focusses on embedding the change, with a third phase that will review and evolve the change over time.

2.1.2 Quality Improvements in 2018/19 – progress update

The key priorities for improvement for 2018/19 were declared in the 2017-18 Quality Account and focussed on three priority areas as detailed below. These areas were identified through the early work in developing the Inspiring Quality Strategy and maintain a consistent focus on improving patient experience, patient safety and clinical effectiveness. These were agreed by the Trust Board as:

1. Children & Families First, Every Time
2. No Preventable Harms or Deaths.
3. Outstanding Clinical Outcomes for Children.

Details of progress against these key priorities is provided in Section 3 of this report.

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2.2 Statements of Assurance from the Board

2.2.1 Review of services

During 2018/19 Alder Hey Children's NHS Foundation Trust provided 42 relevant health services. Alder Hey has reviewed all the data available to it on the quality of care in all of these relevant health services. The income generated by the relevant health services reviewed in 2018/19 represents 100% of the total income generated from the provision of relevant health services by Alder Hey for 2018/19.

2.2.2 Participation in clinical audits and national confidential enquiries.

Clinical Audit is a key aspect of assuring and developing effective clinical pathways and outcomes. National Clinical Audits are either funded by the Health Care Quality Improvement Partnership (HQIP) through the National Clinical Audit and Patient Outcomes Programme (NCAPOP) or funded through other means. Priorities for the NCAPOP are set by NHS England with advice from the National Clinical Audit Advisory Group (NCAAG).

During the reporting period 1st April 2018 to 31st March 2019, 14 National Clinical Audits and 3 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% (14 out of 14) National Clinical Audits and 100% (3 out of 3) 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 2018 to 31st March 2019 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 2018 to 31st March 2019, 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.

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National Audit	Participation	% Cases submitted
Children		
Paediatric intensive care (PICANet)	Yes	Submitted 1005 cases, which was 100% of cases available
Potential donor audit (NHS Blood & Transplant)	Yes	Not available at time of publication.
Feverish Child Audit Royal College of Emergency Medicine	Yes	Submitted 120 cases, which was 100% of cases available.
Acute care		
Severe trauma (Trauma Audit & Research Network)	Yes	Submitted 229 cases, which is 100% of cases available
Cardiac		
Cardiac arrest (National Cardiac Arrest Audit) (NCAA).	Yes	Submitted 4 cases which was 100% of cases available.
Paediatric cardiac surgery (National Institute for Cardiovascular Outcomes Research (NICOR) Congenital Heart Disease Audit)	Yes	Submitted 913 cases, which was 100% of cases available.
Cardiac arrhythmia (Cardiac Rhythm Management (CRM)	Yes	Submitted 98 cases which was 100% of cases available
Long term conditions		
Inflammatory Bowel Disease programme/ IBD Registry (National IBD Audit) Biological Therapies	Yes	Submitted 121 cases, which was 100% of cases available
Paediatric Diabetes (RCPH (Royal College of Paediatrics and Child Health) National Paediatric Diabetes Audit)	Yes	Submitted 422 cases, which was 100% of cases available
Epilepsy 12 (RCPH National audit of seizures and epilepsies in children and young people)	Yes	Submitted 79 cases, which was 100% of cases available
Use of Fresh Frozen Plasma and Cryoprecipitate in neonates and children (National Comparative Audit of Blood Transfusion programme)	Yes	Submitted 30 cases, which was 100% of cases available
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance	Yes	Submitted 3 cases, which was 100% of cases available
Seven Day Hospital Services NHS England	Yes	Submitted 119 cases, which was 100% of cases available
UK Cystic Fibrosis Registry Cystic Fibrosis Trust	Yes	Submitted 80 cases, which was 100% of cases available

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National Confidential Enquiries	Participation	% cases submitted
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 included in the study which was 100% of cases available.
Perinatal mortality and morbidity confidential enquiries (term intrapartum related neonatal deaths) - MBRRACE-UK - National Perinatal Epidemiology Unit (NPEU)	Yes	9 cases submitted which was 100% of cases available
Long Term Ventilation Study - National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Yes	Ongoing Data Collection

2.2.3 Actions arising from National Clinical Audits

The reports of 12 National Clinical Audits were reviewed by the provider in the reporting period April 1st 2018 to March 31st 2019 and Alder Hey Children's NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

National Clinical Audit	Actions
Paediatric intensive care (PICANet)	The National audit report was reviewed and discussed on the Paediatric Intensive Care Unit (PICU). We are always commended for the quality of the PICANET data set.
Potential donor audit (NHS Blood & Transplant)	Report not available at time of publication
Feverish Child Audit Royal College of Emergency Medicine	Reports not available at time of publication. Reports are to be published by the Royal College of Emergency Medicine in late April 2019.
Severe trauma (Trauma Audit & Research Network)	For the period 2018 - 2019 our data completeness and data quality are both 97%+. There are 229 applicable entries for this period. *The TARN database is a national tool for collating and reviewing a number of metrics related to the delivery of care. It is a requirement that Major Trauma Centres such as Alder Hey contribute their data into TARN which provides regular service-level dashboards and Clinical Reports using this data.* *Thankfully, the numbers of seriously injured children is*

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National Clinical Audit	Actions
	very small compared with injured adults, so the ability to systematically collect and analyse data; and to be able to compare the same metrics with peer Major Trauma Centres is very important. These reports enable the Alder Hey Major Trauma Leadership Team to track progress on the delivery of trauma care and identify trends for those metrics. They have led to audit of specific areas of the pathway to identify any potential issues early and assure of good practice. *The themed Clinical Reports are reviewed by specific department leads, such as Neurosurgery and Orthopaedics, with oversight from the Trust Trauma Committee and the regional North West Children's Major Trauma Network Governance group.* *Review of the regional dashboards has highlighted continued long transfer times from local Trauma Unit to Major Trauma Centre. Work is now underway to identify the causes of these delays which will inform the Network Forward Plan for quality improvement.* *The TARN data allows us to monitor our performance against the Major Trauma Best Practice measures, ensuring that we are meeting national quality indicators as well as securing to Best Practice Tariff income so we can continue to deliver and develop the Major Trauma Service at Alder Hey.*
Cardiac arrest (National Cardiac Arrest Audit)	Report not available at time of publication
Paediatric cardiac surgery (NICOR Congenital Heart Disease Audit)	An action plan was not required as the audit standards are being met.
National Cardiac Rhythm Management Audit (NICOR)	It is recommended that Standard Operating Protocols (SOP) are devised for the data collection, to include detailed guidance on and exactly who is responsible for each of the following: • Ensuring consent for data submission and external validation of hospital notes is obtained prospectively from all patients with congenital heart disease and each patient's parent/guardian receives a description of data that is collected, how it is audited and the submission to Organisations such as NICOR or others. • Input of congenital patients NCHDA (National Congenital Heart Disease Audit) required dataset items

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National Clinical Audit	Actions
	and at which point of service delivery • Encouraging every responsible clinician or allied professional to input data for each operation, diagnostic or catheter intervention at the point of the service delivery from admission to discharge and to own their data. • Recording the knife to skin time for all surgical procedures where it can be validated (ie perfusion or anaesthetic record). • Validity checking and completeness and the time intervals for feedback to responsible clinicians on this with a clear time scale and line of responsibility for rectifying any omissions or errors in both surgery and cardiology disciplines • Reverse validation of the data submitted to NCHDA (National Congenital Heart Disease Audit) by responsible clinicians in conjunction with the Data Managers at least monthly. • Running the PRAiS (Paediatric Risk Analysis in Surgery) analysis tool monthly. This will inform the quarterly NHS England Dashboard reports. • Ensuring that dates of death are reported for any Alder Hey patient who has previously had a record submitted to the NCHDA (National Congenital Heart Disease Audit). • Leading the local review (and how frequently and in which forum for both disciplines) • Making timely submissions (monthly is recommended) and including details of manufacturer, model and serial numbers of all implantable devices the procedure record for each patient. • Reviewing/Updating the SOP at timely intervals in liaison with the person responsible for staff training and development in the Trust, regular training must be provided not only for the Auditors, but for all staff in the Department who may be involved with data input. This should include regular Quality Assurance and Governance training and visits to other centres who are involved in NCHDA (National Congenital Heart Disease Audit) data collection and submission.
Ulcerative Colitis and Crohn's Disease (National UK IBD (Inflammatory Bowel Disease) Audit) Biological Therapies	On-going collection of our biological therapies data is now through the UK IBD Registry. We are currently submitting our data to this component of the audit in line with the data submission deadlines for the IBD Biologics Audit during 2018 and 2019.
Diabetes (Royal College of Paediatrics and Child	Data collection for the audit continues to improve through the use of the "TWINKLE" system (diabetes specific data collection software) for data entry. Twinkle enables

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National Clinical Audit	Actions
Health (RCPCH) National Paediatric Diabetes Audit)	automated data capture and reporting for the Best Practice Tariff (BPT). Improvements delivered are as follows; • Adopted a whole team approach to service improvement following a team away day. • A focus group was organised to allow our children and families to help in the service redesign. • Monthly data review introduced as part of departmental governance meeting. • Redesigned patient education package from diagnosis. • Information prescription for use in clinic. • Further improved patient education through new website and Twitter • Reduced the median HbA1c by 4 mmol/mol over 2 years • Increased compliance with 7 key health checks from 17% to 59% over 2 years. (National mean currently 50%) • Improved psychology screening at clinic from 15% to 89%. The team will continue to work towards further lowering the overall median HbA1c and will develop and implement structured rolling education plans for established patients
Epilepsy 12 (RCPH National audit of seizures and epilepsies in children and young people)	Organisational Audit for 2018 Completed. Prospective Data Collection for the Epilepsy 12 audit is on-going for 2019/2020.
Use of Fresh Frozen Plasma and Cryoprecipitate in neonates and children (National Comparative Audit of Blood Transfusion programme)	We currently have reviewed an interim report for the Fresh and Frozen Plasma audit. On the whole we are compliant. This report only looks at the prophylactic use of Fresh and Frozen Plasma and Cryoprecipitate. A report on the management of bleeding is due to be published in Spring 2019.
UK Cystic Fibrosis Registry Cystic Fibrosis Trust	The Annual report allows us to compare our clinical outcomes to those of our peers and identify areas for improvement. We have achieved 100% compliance with the UK CF Registry data here at Alder Hey and for our Network.

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2.2.4 Actions arising from Local Clinical Audits

There were a total of 180 local audits registered in the reporting period 1st April 2018 to 31st March 2019. There are 60 (34%) local audits completed. There are 113 (65%) audits that will continue in 2019/20. There are three audits not yet started and four audits have been cancelled.

The reports of the completed local clinical audits were reviewed by the provider in the reporting period April 1st 2018 to March 31st 2019 and examples of the outcomes are listed below

Local Audit	Actions
Review of pressure areas associated with endotracheal tubes on PICU	The project was discussed and presented at the Alder Hey Paediatric Intensive Care Unit (Nasal Endotracheal Tube Pressure Area Review) - Task and Finish Group Meeting in June 2018. Action/ Recommendation: • Improve documentation by using BadgerNet to act as a prompt for supporting better documentation. • Work with BadgerNet (National Paediatrics Intensive Care Unit Care Record System) team to implement documentation for care bundle. • Produce/laminate bundle/flow sheet for bedspace • Consider skin integrity and ET (Endotracheal Tube) tube documentation separately. • Integrate elements of Hospital Electronic Patient Record system into BadgerNet. • Re-audit in 12 months.
Clinic overbookings within the nurse led tongue tie service	The audit was presented and discussed with the Alder Hey ENT (Ear Nose and Throat) team management and consultants in November 2018. Action/ Recommendation: • A second tongue tie practitioner has had a positive effect on the number of overbookings per clinic and has reduced patient waiting times. • We are setting up weekly tongue tie clinics at Liverpool Women's Hospital to reduce overbookings at Alder Hey tongue tie clinics. • To commence an audit on the affects of frenotomy on feeding and whether the procedure resolves any difficulties. • Re-audit in 12 months.
An evaluation of the SCORE project (Set goals, Commit, Optimise asthma control, Reinforce an active lifestyle, Enable to achieve)	The audit was presented to senior management and commissioners in January 2019. Submitted abstracts to the European Respiratory Society conference for consideration this year. Action/ Recommendation:

Local Audit	Actions
	• The lead consultant is producing a business case to develop a long term service. • No Re-audit is required as this was a quality improvement initiative that has been audited.
Audit on paediatric distal radial fractures	The audit was presented and discussed at the Alder Hey Trauma and Orthopaedics Departmental audit meeting in June 2018. Action/ Recommendation • Changes planned to local guidelines as this audit provides justification for the need of higher quality evidence for the management of paediatric distal radius fractures. • A multicentric RCT (Randomised Control Trial) has been planned and funding has been applied for from The National Institute of Health Reseach. • Re-audit after the completion of the Randomised Control trial.
Upper Limb Fracture – neurovascular status examination 3rd cycle audit	The audit was presented at the Alder Hey Trauma and Orthopaedics Department audit half day in July 2018. Action/ Recommendation • LUFA (Liverpool Upper-limb Fracture Assessment) proforma data to be incorporated in the Orthopaedic specialty package on the hospital Meditech system when it is submitted. Target completion date of July 2019. • Re-audit in 6 months.
Neuropsychological and developmental outcomes in children with sagittal synostosis: an active total vault reconstruction versus extended strip craniectomy with micro barrel-staving	The audit was presented at the Craniofacial National Audit Meeting in May 2018. Action/ Recommendation • The audit is being written up for publication in 2020. • Further statistical analyses required to look at additional demographic variables that may help to reduce variance in the data. • To pool data across all four United Kingdom craniofacial centres and re-run the analyses with a larger sample size. • No re-audit is required as no further data are being collected.
Review of blood sampling on PICU (Paediatric Intensive Care Unit).	The audit was presented at the Alder Hey Paediatric Intensive Care Unit audit meeting in May 2018. Action/ Recommendation • Paediatric Intensive Care (PICU) Team to discuss whether applicable findings from this audit are feasible to reduce repeat sampling. • Re-audit at a time to be agreed.
Are children at high risk of influenza and its complications who attend	The audit is to be presented at the Healthcare Infection Society Spring meeting in May 2019 Action/ Recommendation

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Local Audit	Actions
outpatient clinics at Alder Hey receiving Seasonal Influenza vaccination	• We recommend the provision of seasonal influenza and other vaccines in the Outpatients Department or our pharmacy. • Re-audit in 12 months.
An audit of theatre usage for orthoplastic trauma	The audit was presented at the Alder Hey Trauma and Orthopaedics Department audit half day in June 2018. Action/ Recommendation • Half day trauma list every weekday restarted from July 2018. • Assess the impact of trauma lists. • Assess bed days lost to trauma rollover after implementation of trauma lists. • Re-audit in 3 months.
The review and evaluation of psychological wellbeing outcome measures used at annual reviews for paediatric lupus patients	The audit was presented at the Alder Hey Psychological Services Department audit meeting in March 2019. Action/ Recommendation • To review with the Lupus team and to disseminate information to other teams by August 2019. • Re-audit in the future is possible but would need to wait until different measures are routinely used at other centres.
An audit of surgical technique in patients undergoing emergency scrotal exploration for suspected testicular torsion	The audit was presented at the Alder Hey Department of Paediatric Surgery audit meeting in January 2018. Action/ Recommendation • A new guideline has been developed and circulated to all surgeons. • Guideline to be incorporated into a new GDE (Global Digital Exemplar) Speciality Package. • Re-audit in 3 months.
Audit of quality of written information provided in discharge letters from the general paediatric team	The audit was presented at the Alder Hey Department of General Paediatrics audit meeting in July 2018. Action/ Recommendation • Produce a general paediatric discharge document with guidance on key information to be included. • Aim to follow the above guidance to ensure key information is documented and given to the patient and guardian. • Re-audit in 6 months.
Compliance of NHS Clinical Standards within the Orthopaedic Department	The audit was presented at the Alder Hey Trauma and Orthopaedic Department audit meeting in September 2018. Action/ Recommendation • Consultant led ward round already implemented as of April 2018. • Appropriate documentation of reviews needs to be emphasised.

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Local Audit	Actions
	• Re-audit already initiated to reassess compliance with guidelines.
Lines and Devices audit	The audit was presented at the Alder Hey Paediatric Intensive Care Unit Consultants meeting in October 2018. Action/ Recommendation • Update existing training. Paediatric Intensive Care Unit (PICU) Badger team to give regular training on both new and existing features of Badger. • Staff should update the lines and devices on Badger at handover. • No formal action plan is required as this is an on-going issue and fits into a general picture of more support required to maintain excellent data on PICU. • Re-audit in 6 months.
Assessment of electronic discharge summaries for patients undergoing emergency scrotal exploration	The audit was presented at the Alder Hey Urology Department audit meeting in January 2018. Action/ Recommendation • Developing an electronic pathway that directs the surgeon to initiate the EDS (Electronic Discharge Summary) with the correct information as part of GDE (Global Digital Exemplar). • Re-audit in 12 months.
Recovery Led Intravenous Morphine Audit	The audit was presented at the Alder Hey Anaesthetics Department and Pain Team audit meeting in August 2018. Action/ Recommendation • Liaise with other paediatric recovery units regarding pain management. • Discuss findings with pain team to develop a plan going forward. • Discuss with consultant anaesthetic lead the potential plan for recovery staff to administer prescribed IV (Intravenous) medications when required. • Update the Trust guidelines on Recovery Led Morphine Protocol. • Update existing training in pain management • Re-audit in 12 months.
ECG (Electrocardiogram) requests and reporting in Alder Hey	The audit was presented at the BCCA (British Congenital Cardiac Association) Annual Conference in Liverpool in November 2018. Action/ Recommendation • To assess the impact on workload of ECG's and reporting them on a regular basis. • Re-audit in 6 months.
An audit to identify the	The audit was presented at the Alder Hey Department

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Local Audit	Actions
waiting times for EEG (Electroencephalogram) diagnostic tests in Neurophysiology	of Neurophysiology audit meeting in June 2018. Action/ Recommendation • Data from this audit will inform part of a business case for a second telemetry bed. • Re-audit after a second telemetry bed has been installed.
Occupational Therapy hand therapy service audit	The audit was presented at the Alder Hey Occupational Therapy Department "Hand Huddle" audit meeting in July 2018. Action/ Recommendation • To look at a further audit in October 2018 to determine the length of day need on different days of the week. • To control Trust scheduling templates by making more appointments unavailable at key times. • To liaise with the clinical teams to determine if therapy led plastics clinics can lead to a better balance. • To determine demand from ward patients by a separate audit in September/October 2018. • To determine whether the peaks and troughs in the service are due to either clinical or booking and scheduling issues. • Conduct a staff stress survey by the end of 2018. • To determine how staff skills and time can best be used on quiet days. • Re-audit in 3 months.
Neurovascular injury in supracondylar elbow fractures	The audit was presented at the Alder Hey Trauma and Orthopaedics Department audit meeting in August 2018. Action/ Recommendation • Improve the documentation of Neurovascular status • Consultant lead ward rounds to be dictated including Neurovascular status. Additional notes will be made by the junior team. • To improve the awareness of documentation amongst junior colleagues. • Re-audit in 12 months.
Clinical outcomes of preauricular sinus surgery	The audit was presented at the Alder Hey ENT (Ear Nose and Throat) Department audit meeting in September 2018. Action/ Recommendation • To include data from other surgical specialities and identify the operative technique and clinical outcomes. • Continue with current practice of 'Supra-auricular approach'. • Update existing training to include 'supra-auricular

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Local Audit	Actions
	approach' technique. • Re-audit in 3 years.
MSSA bacteraemia review (Methicillin-susceptible Staphylococcus aureus)	The audit was presented at the Alder Hey (IPC) Infection Prevention and Control Committee meeting in December 2018. Action/ Recommendation • Continue to monitor the situation and review each bacteremia. • Reinforce the need for ANTT. (Aseptic non touch technique) • Update existing training. • ANTT training has been made an annual rquirement and added into the (ESR) Electronic Staff Record system. • Re-audit in 12 months.
Audit of Hybrid OR (Operating Room) use in Scoliosis surgery	The audit was presented at the British Scoliosis Society Annual meeting in November 2018. Action/ Recommendation • Use of Hybrid Operating Room has a learning curve but there has been improvement in efficiency with time. • Review cost savings and radiation dose measurements in comparison to non spinal surgery • No changes to clinical practice but to consider discussion of further studies and validated measures to show the efficacy of navigation. • Re-audit should occur when new measures and standards are to be reviewed.
Patient satisfaction with physiotherapy provision following orthopaedic surgery	The project was presented to the Alder Hey Physiotherapy Department and Orthopaedic Department in October 2018. Action/ Recommendation • To ensure patients and their families are aware if they require follow up following discharge and the process for this. • No re-audit was required as this was a Patient Satisfaction Survey.
Audit of discharge summaries from the paediatric General Surgery Ward	The audit was presented at the Alder Hey Department of Paediatric Surgery audit meeting in November 2018. Action/ Recommendation • Changes to the doctor induction handbook for General Surgery are to include improved guidelines on what information is expected in the discharge letters. • Updates to the Hospital system are in progress from February 2019. • Re-audit in 6 months.
An audit of surgical	The audit was presented at the Alder Hey Department

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Local Audit	Actions
technique in patients undergoing emergency scrotal exploration for suspected testicular torsion	of Paediatric Surgery audit meeting in November 2018. Action/ Recommendation • We hope to introduce a standard operative guideline for surgical technique in scrotal exploration. • Three point fixation with non-absorbable sutures should be used in Orchidopexy for testicular torsion. • The action plan has been implemented. The above recommendation was disseminated at the departmental audit meeting and is now being carried out in practice. • No re-audit required as this was a completed re-audit.
An audit of the initial investigation and management of post-tonsillectomy bleeds	The audit was presented at the Alder Hey ENT (Ear Nose and Throat) Department audit meeting in February 2019. Action/ Recommendation • Developing a new guideline for the management of post-tonsillectomy bleeds in the Emergency Department. • Re-audit in 6 months.
Audit to assess the number of patients with asthma and viral induced wheeze attending the Emergency Department over the last 2 years, and the number of these that led to admission	The audit was presented at the Alder Hey General Paediatrics Department audit meeting in April 2019. Action/ Recommendation • Continue to highlight to Emergency Department and General medical staff that there are asthma/VIW (Viral Induced Wheeze) guidelines that are to be used for patients presenting with these symptoms, as this will help audit collection data in the future. • Update existing Training. • Re-audit in 2 to 3 years to assess any change in the admission rate.
Service Evaluation of CRMO (chronic recurrent multifocal osteomyelitis)	The audit was presented at the Alder Hey Rheumatology Department Multi Disciplinary Team meeting in November 2018. Action/ Recommendation • Ongoing data collection to contribute towards National and Iternational studies to run until November 2020. • Re-audit in 12 months.
3 years outcome of antenatal diagnosis of isolated right and double aortic arch at single cardiac surgical centre. A retrospective study	The audit was presented at the BCCA (British Congenital Cardiac Association) Annual Conference in Liverpool and at the Cardiology Department Quality Improvement meeting in November 2018. Action/ Recommendation • To conservatively manage isolated right aortic arches unless there are clinical concerns. • No active investigations to be done unless symptomatic.

Local Audit	Actions
	• Based on this review, we will implement a departmental SOP (Standard Operating Procedure) that all isolated right aortic arches are not investigated unless they are symptomatic. • Re-audit in 5 years.
Audit of diagnosis of semicircular canal dehiscences in children	The audit was presented at the British Association of Audiovestibular Physicians annual audit meeting in November 2018. Action/ Recommendation • To procure equipment for further elaboration of disease. • Re-audit in 2 years.
Antibiotic Prophylaxis in Trauma & Elective Orthopaedic Surgery	The audit was presented at the Alder Hey Trauma and Orthopaedic Department audit meeting in January 2019. Action/ Recommendation • Improve operation note documentation. • Ensure correct administration of perioperative antibiotics. • Re-audit in 3 months.
Audit of respiratory referrals within Alder Hey	The audit was presented at the Alder Hey General Paediatrics and Respiratory Departments audit meeting in March 2019. Action/ Recommendation • This audit is a useful benchmark for improving the referral process from the General Paediatrics team and the Respiratory team. • Recommendations from both teams are being discussed. • Re-audit in 12 months.
Critical Medicines Audit - November 2018	The audit was presented at the Alder Hey Department of General Paediatrics audit meeting in November 2018. Action/ Recommendation • Findings of the audit to be shared with the Alder Hey Medication Safety Committee, Ward Managers, Practice educators, Intravenous (I.V.) team, Infectious Diseases, Microbiology teams and Sepsis team. • A safety alert summarising the findings of this audit will be circulated along with a summary of the critical medicines list. • Re-audit in 6 months.
Record Keeping Quality Assurance Audit	The audit was presented at the Sefton Children's Occupational Health and Physiotherapy Department audit group meeting in December 2018. Action/ Recommendation

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Local Audit	Actions
	• To disseminate the audit findings across teams to facilitate recommendations by March 2019. • Re-audit in 12 months.
Audit of intimate images stored on external media device (DVD) at the Paediatric Rainbow Centre Alder Hey	The audit was presented at a multi-disciplinary Peer Review group with forensic physicians and paediatricians in November 2018. Action/ Recommendation • Updated existing guidelines with a revised Standard Operating Procedure circulated to all clinicians, paediatricians and forensic physicians. Achieved by December 2018. • Updated existing training. • Re-audit in 12 months
Liverpool Community Physiotherapy Postural Care Pathway Audit	The audit was presented at the Alder Hey Department of Community Physiotherapy audit meeting in February 2019. Action/ Recommendation • Meetings are planned to discuss future developments and next steps. • Update the current Postural Care Guidelines. • Update existing Postural Care Training. • Re-audit in 12 months.
Evaluation of electrodiagnostic testing for diagnosis, investigation and treatment of ophthalmic pathologies in children	The audit was presented as a poster at the Royal College of Ophthalmology Congress in Liverpool in May 2018. Action/ Recommendation • The audit reaffirmed the usefulness of the services and no changes were required to be made. • No re-audit was required as it was an audit to establish the usefulness of the service, rather than the process.
Alder Hey Orthopaedics Fracture clinic services: An audit against BOAST 7 (British Orthopaedic Association Standards for Trauma) guidelines	The audit was presented at the Alder Hey Trauma and Orthopaedic Department audit meeting in November 2018. Action/ Recommendation • Update existing training. • Discussion with the Orthopaedics Department and at the consultant meeting on guidelines for referral and times to be seen in the fracture clinic. • Re-audit in 6 months.
Management of children with epidural infusions	The audit was presented at the Alder Hey Pain Service Study day in March 2019. Action/ Recommendation • Existing training updated and cascaded to staff. • Teaching slides updated to highlight issues identified from the audit for the Pain study days. • National audit started in February 2019.

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Local Audit	Actions
	• Guidelines to be updated by the Pain Service once the National audit is completed and information analysed. • Re-audit would be of benefit once all changes have been made to practice and guidelines.
Use of high flow oxygen in the management of bronchiolitis in Alder Hey Emergency Department	The audit was presented at the Alder Hey Emergency Department audit meeting in March 2019. Action/ Recommendation • Information on the appropriate use of the humidifier system added to the Emergency Department and Hospital induction documentation. • Re-audit in 12 months
Management of Expressed Breast (EBM) Milk	The audit was presented at the Alder Hey Clinical Quality Steering Group (CQSC) in March 2019. Action/ Recommendation • Increase policy awareness so all areas are managing EBM safely. • To work with ward managers to improve policy awareness and aim to have improved attendance on breastfeeding study days. • Recommendations are agreed to be actioned by August 2019. • Re-audit in 6 months.
Timing of post-operative echocardiograms	The audit is to be presented at the Alder Hey Department of Cardiology Quality Assurance and Quality Improvement (QAQI) meeting in May 2019. Action/ Recommendation • Communicate the results to the team: Highlight the importance of completing all the steps of the process: request, bleep, perform echo, upload, report. • Re-audit in 6 months
Sweat Test Clinical Audit	The audit was presented at the Alder Hey Department of Biochemistry Clinical Scientist Metabolic Laboratory meeting in February 2019. Action/ Recommendation • A future review of Sweat Tests should be conducted in order to assess the impact of recent changes to the collection method. • Ensure that each staff member undertaking a Sweat Test maintains competency by undergoing routine assessment and performing a minimum number of tests each year. • Update existing training with new instrumentation. • Re-audit in 12 months

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2.2.5 Participation in Clinical Research 2018/19

The number of patients receiving NHS services provided or subcontracted by Alder Hey Children's NHS Foundation Trust (Alder Hey) in 2018/19 that were recruited to participate in NIHR Portfolio adopted clinical research was 3152. All research is governed by the UK Policy Framework for Health and Social Care Research (2018), EU Clinical Trial Directive, UK Research Ethics Committees, the Health Research Authority and the Trusts Clinical Research Division who carry out safety and quality checks to provide organisational capacity and capability. This process ensures oversight of every research study in the organisation both Alder Hey Sponsored and hosted. International Research, Education and Innovation is one of the Trust's four strategic pillars of excellence and as such elicits full support of the Board of Directors. All three areas are undergoing expansion and the creation of the Academy will further link research with education. Furthermore, the Alder Hey/University of Liverpool refreshed ten year research strategy states that "Every child (should be) offered the opportunity to participate in a research study / clinical trial". The strategy is patient focused and supports research from all disciplines. The Trust is a member of Liverpool Health Partners (LHP), a consortium of seven hospitals, the University of Liverpool and the Liverpool School of Tropical Medicine working together to provide a world class environment for research and health education across a regional footprint. As a significant stakeholder in LHP, Alder Hey demonstrates a strong commitment to contributing to evidence-based, cutting edge healthcare aimed at improving quality of care whilst holding patient safety, dignity and respect at the centre of everything we do.

A clinical research review for Liverpool Health Partners took place in 2018 that made several recommendations and Alder Hey has a strong influence over this and the emergent strategy for child health. One of the main strengths of Liverpool is still that of pharmacology – developing better safer medicines for children and young people and contributing to the personalised medicine agenda. LHP has an Industry Gateway Office that seeks to boost the regions ability to conduct more research of new medicines. Being an organisation undertaking high quality patient centred research means that Alder Hey contributes to the health and wealth of Liverpool and the UK as a whole as well as having an international impact on treatments developed for children. The infrastructure of expertise available at Alder Hey for setting up and successfully delivering clinical research are led and managed by a dedicated team who form the Clinical Research Division (CRD). The CRD employs 40 research nurses, supports approximately 250 studies at any one time and rigorously manages performance to ensure high quality delivery to time and target. Alder Hey has an excellent track record of recruiting the first patient globally to clinical trials, demonstrating that the organisation is at the forefront of drug development in paediatrics. Over the last 10 years Alder Hey has achieved this for 16 of its patients.

Our clinical staff and associated academics lead and contribute to studies of the latest and newest treatment options, genetic profiling of diseases and research looking at drug safety including adverse drug reactions (side effects).

Alder Hey was involved in recruiting patients to 143 open, non-commercial NIHR portfolio adopted clinical research studies, 38 commercial trials and 30 non-portfolio studies during 2018/19, which is significant for a Trust of its size. Whilst some studies report outcomes fairly quickly most will not be ready for publication for a few years. The majority were research in the area of Medical Specialities reflecting the prevalence of available research studies locally and nationally

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01/04/2018 to 31/03/2019				
	NIHR Studies	**Number of Participants**	**Non-NIHR Studies**	**Number of Participants**
SG1 *(Oncology, Haematology, Palliative Care)*	32	75	9	21
SG2 *(Nephrology, Rheumatology, Gastro, Endocrinology, Dietetics)*	38	369	13	31
SG3 *(Respiratory, Infectious Diseases, Allergy, Immunology, Metabolic Diseases)*	32	1251	10	91
SG4 *(A&E, Gen Paeds, Diabetes, Dermatology, CFS/ME)*	5	492	1	1
SG5 *(CAMHS tier 3 & 4, Psychological Services & Dewi Jones)*	9	15	6	0
SG6 *(Comm. Child Health, Safeguarding, Social Work Dept., Comm Clinics, Neurodisability Education, Fostering, Adoption, Audiology)*	1	0	0	0
SG7 *(PICU, HDU, Burns)*	1	141	2	0
SG8 *(Theatres, Daycase Unit, Anaesthetics Pain Control)*	0	0	0	0
SG9 *(Gen Surgery, Urology, Gynae, Neonatal)*	8	18	1	0
SG10 *(Cardiology, Cardiac Surgery)*	0	0	0	0
SG11 *(Orthopaedics, Plastics)*	3	375	3	0
SG12 *(Neurology, Neurosurgery, Craniofacial, LTV)*	19	81	6	88
SG13 *(Specialist Surgery, ENT, CL&P, Ophthalmology, Maxillofacial, Dentistry, Orthodontics)*	3	38	1	0
SS1 *(Radiology)*	0	0	0	0
SS2 *(Pathology)*	0	0	0	0
SS3 *(Pharmacy)*	0	0	0	0
SS4 *(Therapies, EBME, Central Admissions, Bed Management, Medical Records, Generic Outpatients)*	0	0	0	0
NON-CBU	5	108	2	0
CNRU	0	0	0	0
Non Classified	3	189	3	0
TOTAL	**143**	**3152**	**71**	**232**

The Quality Account deals with research activity during the 2018/19 period. In addition to this, the CRD published performance data on the Trust website indicating the time it takes to set up a study and the time taken to recruit the first patient once all permissions have been granted. Over 80% of studies conducted at Alder Hey recruit the agreed number of patients within a set timeframe (76% for commercial research). In September 2012 Alder Hey opened a National Institute for Health Research Clinical Research Facility (CRF). This was a capital project supported with investment from the Trust and is a clinical area utilised purely for research patients providing a dedicated research environment. This resource helps facilitate research by providing a bespoke location for research on a day to day basis and has successfully been used to care for research participants overnight who need regular intervention or tests on a 24 hour basis. One of the many advantages of having a fully operational CRF is that it will enable investigators to not only undertake later phase research studies but also to undertake more complex and earlier phase studies (Experimental Medicine types of activity) dealing with developing new cutting edge medicines and technologies which are often lacking in children's healthcare. This has become the main focus of the CRF over the last few years. The CRF will lead to improvement in patient health outcomes in Alder Hey demonstrating a clear commitment to clinical research which will lead to better treatments for patients and excellence in patient experience. The CRF has just been awarded a new 5 year contract to expand early phase and experimental research through to 2022. In 2017 the new award was triggered and the appointment of several new roles is underway that will increase the CRFs profile and capacity to attract more business.

There were over 350 members of clinical staff participating in research approved by a research ethics committee at Alder Hey during 2018/19. These included consultants, nurse specialists, pharmacists, scientists, clinical support staff and research nurses from across all the Divisions.

Over the past four years the Trust has witnessed a growth in commercially sponsored studies. There are over 30 commercial studies open to recruitment at any one time and much focus on the use of novel monoclonal antibodies (mAbS) or disease modifiers. mAbS have been used primarily in Rheumatology and Oncology but are becoming available in other sub-specialities such as Respiratory Medicine and Diabetes. They work by acting on the immune system to overcome the cause of the disease rather than treating the symptoms. Significant quality of life improvements have been witnessed, particularly in rheumatology patients treated with mAbS leading to increased mobility and a reduction in pain and inflammation. These drugs are now being licensed for use in children for the first time ever. Duchenne Muscular Dystrophy research has grown significantly with new compounds being developed that address the root cause of the disease. Alder Hey has been selected as one of three centres of excellence in England for DMD research and two patients with DMD have been global firsts. The Trust has an established critical mass of research activity in Pharmacology, Oncology, Rheumatology, Infectious Diseases, Respiratory, Endocrinology/Diabetes, Critical Care and Neurosciences but is witnessing a growth in research activity in Gastroenterology, General and Neuro Surgery, Nephrology, Emergency Medicine and Community Paediatrics. The Trust has recently been successful in its application to be a Cystic Fibrosis Clinical Trials Accelerator and will receive 3 years funding to employ a part time trial co-ordinator dedicated to CF research. Both of these initiatives are up and running.

Innovation projects such as those developing devices are also now supported by the CRD This is the beginning of research and innovation coming together to share expertise and to

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maximise engagement with small medium UK enterprises and large global companies. There are a number of devices under development and these will use the hospital environment and its patients to test prototypes. For more information on the research portfolio at Alder Hey please visit www.alderhey.nhs.uk/research

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

A proportion of Alder Hey Children's NHS Foundation Trust's income in 2018/19 was conditional on achieving quality improvement and innovation (CQUIN) goals agreed between Alder Hey and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services through the Commissioning for Quality and Innovation payment framework. During 2018/19, these commissioning bodies were Liverpool CCG and North West CCG consortium for non-specialist services and NHS England for specialist services.

For 2018/19 the baseline value of CQUIN was £3.4 million which was approximately 2.0% of our NHS England and CCG contract. This means that if Alder Hey did not achieve an agreed quality goal, a percentage of the total CQUIN money would be withheld. For 2018/19, Alder Hey anticipates it will receive 92.3% contract CQUIN money; with the amount withheld reflective of paediatric network care milestone failure (NHS England target) and AMR and sepsis milestone failure (CCG target).

The tables below reflect the forecast position as at Q4.

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CCG CQUINs 2018/19

Indicator	Indicator Description	Target	Weighting	Financial Value	Quarter 4 Forecast Performance
Health & Wellbeing	a. Improvement of health & wellbeing of NHS staff	5% point improvement in 2 out of 3 staff survey questions	0.1%	£47,330	Partially achieved (forecast £23,665)
	b. Healthy food for NHS staff, visitors & patients	Introduce required healthy food changes	0.1%	£47,330	Achieved
	c. Improving the uptake of flu vaccinations in frontline clinical staff	70% front line clinical staff vaccinated	0.1%	£47,330	Achieved
AMR & Sepsis	a. Timely identification of sepsis in ED and acute inpatient setting	90% within 1 hour	0.075%	£35,497	Achieved
	b. Timely treatment of sepsis in ED and acute inpatient settings	90% within 1 hour	0.075%	£35,497	Partially achieved (forecast £14,200)
	c. Antibiotic review	90% cases in review	0.075%	£35,497	Achieved
	d. Reduction in antibiotic consumption per 1,000 admissions	Reduction	0.075%	£35,497	Partially achieved (forecast £8,874)
Advice & Guidance	Set up & operate A&G services for non-urgent GP referrals	A&G service available for 75% GP referrals	0.3%	£141,989	Achieved
Improving services for people with mental health needs who present to A&E		20% reduction in A&E attendances from selected cohort	0.3%	£141,989	Achieved
Transitions out of Children and Young People's Mental Health Services		1. Joint-Agency Transition Planning: 80% 2. Pre-Transition / Discharge Readiness: 80% 3. Post-Transition Experience Survey: 70%	0.3%	£141,989	Achieved

Note that a further £473k (1%) is received from CCGs for meeting organisational control total and STP engagement targets.

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NHSE North West Specialist Commissioner CQUINs 2018/19

Indicator	Target	Weighting	Financial Value	Quarter 4 Forecast Perfoance
Clinical Utilisation Review	85% compliance 10.4% reduction in non qualifying bed days	0.71%	£752,204	Achieved
Haemtrack – Patient home monitoring	>80% patients using haemtrack 67% users updating data weekly 75% accuracy of submissions compared to actual medication usage	0.11%	£110,618	Achieved (potential risk regarding accuracy of submissions)
Haemoglobinopathy Improving Pathways through Operational Delivery Networks	Participation in ODN Produce baseline report 85% of registered patients have annual review at specialist centre	0.21%	£221,237	Achieved
Medicines Optimisation	Adoption of prioritised best value medicines Cost effective dispensing routes Reporting of all NHS England excluded drugs data to allow upload to the Pharmex data system	0.21%	£221,237	Achieved
Paediatric Networked Care	Review delivery of activity undertaken in acute hospitals that trigger PCC Minimum Dataset Oversee the review of acute hospitals against PIC Standards and provide a report	0.32%	£331,855	Not achieved
Planned Transition to Adult Services for patients with Complex Neurodisability	Deliver transition preparation for complex neurodisability patients Identify further cohort of patients Provide regular reports to commissioners	0.34%	£353,978	Achieved
CAMHS Screening	Increase number of paediatric patients with long term conditions that have mental health screening	0.21%	£221,237	Achieved

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2.2.7 Statements from the Care Quality Commission (CQC)

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

The Care Qualty Commission has not taken any enforcement action against Alder Hey during 2018-19.

Alder Hey received an unannounced inspection of five core services between 6th and 9th February 2018 (Critical Care, Community, Outpatients, Diagnostics and End of Life) and continues to be rated as 'Good' overall.

A further inspection was held on 26th to 28th February which focused on the 'Well led' aspects of their inspection process.

The Community and Mental Health Division participated in a number of system wide inspections in the year including a CQC inspection of looked after children in Sefton; an Ofsted inspection of the Youth Offending Service and a joint CQC/Ofsted inspection of SEND provision.

The reports resulting from this inspection were published in June 2018 and the Trust developed a detailed action plan in response to the recommendations. This plan has been monitored on a monthly basis by the Trust's Clinical Quality Assurance Committee and Integrated Governance Committee.

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2.2.8 Data Quality

Alder Hey Children's NHS Foundation Trust submitted records during 2018/19 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 patient's valid NHS Number was:

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

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

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

Alder Hey Children's NHS Foundation Trust will continue to take the following actions to maintain the high standard of 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.
- New reports have been created when necessary to support new developments within the Clinical System – Meditech
- Ongoing work is monitored by the Data Quality Steering Group which meets monthly
- Continue to work closely with the Information Department to identify any data issues or areas of data weakness, which will be investigated and remedial action agreed.
- The Data Quality policy has been updated to include escalation process for "repeat offenders" who continue to make mistakes when recording data . User access will be withdrawn if deemed necessary
- A Data Quality dashboard is embedded within our Data Quality Process 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
- The annual audit plan has covered a number of patient and system (Meditech) checks including
    - A&E waiting times
    - Demographic changes
    - Missing NHS numbers
    - 18 weeks Referral to Treatment (RTT) & Outcomes
    - Duplicate registrations
    - Ethnicity monitoring
    - Pathway starts
    - GP checks
    - Dictionary code check – to ensure they are up to date correct and "user friendly" to support correct data entry

As a direct result of all the above measures the Data Quality assurance figures for the year are 100% across Admissions, Outpatient and Emergency Care.

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*2.2.9 Information Governance (IG) Toolkit attainment levels**

Alder Hey's Data Security and Protection Toolkit submitted for 2018/19 based on the 10 National Data Guardian Standards have been published and we have provided 99 of the 100 mandatory evidence items with a Mersey Internal Audit Review of our Toolkit evidence with a 'Substantial' rated level of assurance.

**Note: the previously reported Information Governance (IG) Toolkit has now been replaced by the Data Security and Protection Toolkit, the latter of which is reported in this section.*

2.2.10 Clinical Coding Error Rate

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

- Primary Diagnoses Incorrect 7.5%
- Secondary Diagnoses Incorrect 17.6%
- Primary Procedures Incorrect 2%
- Secondary Procedures Incorrect 6.4%

The results should not be extrapolated further than the actual sample audited and the services audited during this period included:

- 200 Random Finished consultant episodes

2.2.11 Learning from Deaths

During the period 1st April 2018 to 31st March 2019, 55 inpatients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 14 in the first quarter;
- 12 in the second quarter;
- 15 in the third quarter;
- 14 in the fourth quarter.

By 1st April 2019, 26 case record reviews and 4 investigations have been carried out in relation to the 55 deaths included in the previous paragraph. Whilst many adult Trusts only conduct mortality reviews on cases where deaths are unexpected or flagged through an incident, it is the policy of Alder Hey that all inpatient deaths are reviewed.

In two cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 14 in the first quarter;

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- 11 in the second quarter;
- 1 in the third quarter;
- 0 in the fourth quarter. (due to be completed over the next few months)

None (representing 0%) of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

This number has been estimated using the hospital mortality review process established in Alder Hey Children's NHS Foundation Trust. Every child that dies in the Trust has a Hospital Mortality group review (a group consisting of multidisciplinary professionals from a range of specialties across the Trust) and usually at least one departmental review prior to this. The aim is for the departmental reviews to be completed within two months and the hospital mortality review within 4-6 months. There are occasions when the hospital reviews are delayed whilst awaiting completion of Root Cause Analysis (RCA), Coroner's cases and post mortems, as it is essential that each case is discussed thoroughly and with all the relevant information available to the group.

Whilst there are no avoidable deaths identified in the reporting period, the Trust continues to identify learning points through the mortality review process. Some of the recent learning points have included:

- the requirement to strengthen the links between Alder Hey and Liverpool Women's NHS Foundation Trust to improve neonatal care across the city;
- a number of points relating to the effectiveness of 'extracorporeal membrane oxygenation' (ECMO) in overwhelming meningococcal sepsis and the timing of cardiac surgery and ECMO for single ventricle patients;
- the importance of open discussions with receptive parents to enable better care provision;
- early identification of sepsis is essential and parental concern should be listened to;
- the linking of software between PICU and HDU would make completion and maintenance of documentation easier;
- the need to ensure out of hours responsibilities for patients on HDU is clearly defined.

Work is on-going between Alder Hey and Liverpool Women's Hospital, supported by commissioners to improve the neonatal care provision across the city. Future re-organisation of neonatal care will provide safer care and improved experience.

Each child that is commenced on ECMO now receives a full case review so that the selection of which child to put on ECMO is improved.

Sepsis remains a major focus of the Trust and there is a sepsis working group and a sepsis pathway has been established for a number of years. There are multiple prompts on the electronic systems used in the Trust to ensure that sepsis is considered where appropriate, and that all vital signs are recorded before calculating the PEWS (paediatric early warning system, designed to highlight when a patient is beginning to deteriorate). There is clear guidance for escalating concerns and the nursing team are empowered to raise their concerns further when a more urgent response is required.

A working group consisting of multidisciplinary teams and specialists has been formed to continue the improvement work in HDU. The group is exploring the best ways to address clinical responsibilities out of hours for patients on HDU.

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The sepsis work is ongoing and is reviewed and audited by the Sepsis working group. Any concerns that are raised by the Hospital Mortality Review Group (HMRG) are then discussed at Divisional level through the governance and quality meetings to ensure that there is learning throughout the Trust. All deaths are reviewed to ensure that there are no patterns or concerning trends that need to be identified and acted upon.

23 case record reviews were completed after 1st April 2018 which related to deaths which took place before the start of the reporting period.

None (representing 0%) of these deaths in this period are judged to be more likely than not to have been due to problems in the care provided to the patient.

One of the cases received an external review and the discussions are ongoing regarding some of the issues raised and therefore it has not been closed or coded by the Hospital Mortality Group. This number has been estimated using the hospital mortality review process established in Alder Hey Children's NHS Foundation Trust, which includes at least one departmental review with each death then being reviewed by the Hospital Mortality Review Group (HMRG) which is made up of multidisciplinary professionals from a range of specialties across the Trust.

None (representing 0%) of the patient deaths during the period 1st April 2017 to the 31st March 2018 are judged to be more likely than not to have been due to problems in the care provided to the patient.

2.2.12 Freedom To Speak Up

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

Alder Hey Children's NHS Foundation Trust has an established system in relation to Freedom to Speak Up (FTSU), as required by NHS Improvement and the National Guardian's Office. Driven by the Trust Board, we seek to develop a culture that is responsive to feedback and focused on learning and continual improvement.

The Trust places a lot of effort in ensuring staff are aware that they are safe to raise concerns and that there will be no detriment to them. During the process of raising concerns constant contact is maintained with the individuals to ensure that they have experienced no punitive impact, and they are encouraged to make immediate contact with the FTSU Guardian if they feel they experience any discrimination afterwards as a result of this.

Feedback is provided directly to the person who has raised the concern. This is conducted at a meeting with the individual. We are exploring the use of our incident reporting system as a platform for capturing concerns raised through FTSU, which will accommodate electronic feedback to the individual. This would be in addition to the verbal feedback which will always be given face to face.

The Trust completed the "*Freedom to Speak Up self-review tool for NHS trusts and foundation trusts*" (recommended by NHS Improvement) and identified some areas of exemplary practice as well as some areas that need improvement.

Leaders are knowledgeable about FTSU
Senior leaders, including executive and non executive leads, are aware of the guidance from National Guardian's Office. New guidance was shared with Trust Board in May 2018 and regular Board reports are provided. FTSU is included in the corporate induction training and the 'essential skills for managers' training. Plus the Trust's Vision and Values support the drive to creating an open and learning culture.

Leaders have a structured approach to FTSU
The National 'speaking up' policy has been adopted and approved by the Trust's Workforce and Organisational Development Group. The Trust's position in relation to the first National survey was reported to Board in October 2017. The Trust's team of FTSU Advocates are active members of the local network and have all received the training provided by the NGO. Progress and compliance with policy will be included in future papers to Board

Leaders actively shape the speaking up culture
FTSU advocates hold proactive drop in sessions to actively seek feedback from staff. Staff can also raise issues / provide feedback through many other means including our 'Raise it, Change it' programme, Listening into Action, Patient Safety meeting, Quality Assurance ward rounds, Executive shadowing programme, incident reporting system, and through a third party such as staff side reps or govenors.

Leaders are clear about their roles and responsibilities
There is a named Executive and Non-Executive Director with allocated responsibility for speaking up. Other senior leaders will be called upon to support the FTSU Guardian as needed. Refresher training is to be provided every 12 months.

Leaders are confident that wider concerns are identified and managed
The Trust will establish a programme of regular data triangulation to enable them to proactively identify potential concerns arising from 'speak up' issues, plus the FTSU Guardian has direct access to senior leaders should any issues be raised that require immediate intervention or support.

Leaders receive assurance in a variety of forms
FTSU is advertised widely across the Trust including through the intranet to raise awareness of the policy and encourage all staff to speak up when necessary. The Trust BME and Disability Networks also have FTSU as an agenda item on their meetings, so that FTSU is wholly inclusive. A documented progress report is regularly presented to Trust Board.

Leaders engage with all relevant stakeholders
A diverse range of workers' views are sought, heard and acted upon to shape the culture of the organisation in relation to speaking up; these are reflected in the FTSU vision and plan. Additionally there are open discussions with commissioners, CQC and NHS Improvement, as well as National Guardian, other organisations and the wider staff group at Alder Hey, including BME / Disability Networks.

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Next Steps

- Review the Raising Concerns/Whistleblowing Policy
- Launch of Inspiring Quality Strategy will support culture of improvement, openness and learning.
- A programme of sharing lessons learned, both locally and Trust wide will be developed to ensure key themes are shared whilst maintaining confidentiality.
- A quality assurance and audit programme will be established to ensure that
    - the investigation process is of high quality;
    - outcomes and recommendations are reasonable
    - the impact of change is being measured
    - workers are thanked for speaking up, are kept up to date throughout the investigation and are told of the outcome
    - Investigations are independent, fair and objective;
    - recommendations are designed to promote patient safety and learning;
    - change will be monitored

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2.2.13 Seven Day Hospital Services

Aim: To achieve the same level of access to clinical services across all 7 days of the week

Targets: Four core national standards:

1. Std 2 - Time to first consultant review < 14 hours
2. Std 5 – 7 Day access to diagnostics
3. Std 6 – 24 hour access to consultant directed interventions
4. Std 8 - Ongoing review by consultant for high dependency patients. Twice daily or daily according to critical care standards

Self assessment 2018-19

1. Std 2 – not compliant.
2. Std 5 – fully compliant
3. Std 6 – fully compliant
4. Std 8 – compliant for twice daily review, not compliant for once daily review

Evidence exists that lack of access to resources at weekends across the NHS can be associated with delays to care and increased risk of adverse outcomes. The 7 Day Hospital Services programme supports Trust's to reduce this variation in the levels of care and potentially outcomes experienced by patients admitted at the weekend.
This work is built on 10 clinical standards developed by the NHS Services, Seven Days a Week Forum in 2013. With the support of the Academy of Medical Royal Colleges, four of these clinical standards were made priorities for delivery to ensure patients admitted in an emergency receive the same high quality initial consultant review, access to diagnostics and interventions, and ongoing consultant-directed review at any time on any day of the week.

This section of the report provides a statement regarding progress in implementing the four priority clinical standards, which have been self-assessed as guided by the "7-Day Hospital

Services Board Assurance Framework", published by NHS Improvement. Self assessment completed and presented to the Trust Clinical Quality Assurance Committee (CQAC) for Board assurance in February 2019.

Update on Priority Clinical Standards

- **Standard 2:** *Time to initial consultant review. First consultant review within 14 hours for 90% of patients*
  Trust self assessment: Not fully compliant
  Achieved 52% during weekdays and 44% at weekend when audited in April 2018.

- **Standard 5:** *Access to consultant led diagnostics - Assessment based on weekday and weekend availability of six diagnostic tests to appropriate timelines, either on site or by a formal arrangement with another provider*
  Trust self assessment: Fully compliant

- **Standard 6:** *Access to consultant-led interventions - Assessment based on weekday and weekend availability of nine interventions on a 24-hour basis, either on site or by a formal arrangement with another provider.*
  Trust self assessment: Fully compliant

- **Standard 8:** *Ongoing daily consultant-directed review - Assessment based on consultant job plans to deliver 7 day services, robust MDT and escalation protocols, local audits and reference to wider metrics.*
  Trust self assessment: Twice daily standard: Fully compliant (100% compliant)
  Once daily standard: Not fully compliant (77% compliant overall - 76% during week days and 79% at weekend)

Future Plans

- The Trust has commenced a 'Future Models of Care' programme of work, within which a General Paediatric and High Dependency Models of Care Design Group has been established that will focus on designing the optimal way of delivering general paediatric and high dependency care at Alder Hey.
- Define admissions and referral criteria to medical specialties (including general paediatrics) to ensure team responsibilities are fully understood.
- Produce a guideline document that makes it clear to consultants, trainees, other clinical staff and to families, which consultant is leading the patient's care.
- Establish an Acute Care Team that will provide a rapid response in the event of an acute deterioration. This has been approved by the Trust and recruitment to the team has begun.
- The criteria for frequency of HDU assessment will be disseminated to medical and nursing staff.
- The implementation of standard documentation in the electronic care record will offer an opportunity to include prompts to all staff for timely reviews

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It is intended that this approach will achieve a safer and more effective services across 7 days a week, and will reduce preventable deterioration in children.

2.2.14 Statement on junior doctor rota gaps

It is recognised that the specialty of paediatrics faces a junior doctor shortage, with multiple gaps regularly appearing on junior and middle grade rotas across the region. This is more sharply felt at Alder Hey because of the breadth of services and the number of rotas required to support the clinical teams, both in and out of normal working hours.

These issues have escalated in recent years, with concerns regarding inadequate staffing levels, inadequate numbers of junior doctors on out of hours shifts leading to junior doctors feeling exposed and unsafe. This has also impacted on consultant paediatricians increasingly having to 'act down' into junior doctor roles out of hours, and often at very short notice, which can have a demoralising effect on the consultant workforce. Alder Hey has already undertaken much work to attempt to improve matters but rota gaps have continued to increase.

The Trust has received the final Health Education England report following a visit in early 2018. The report includes feedback from junior doctors at Alder Hey and highlights a number of areas with a clear requirement to improve. One of the key requirements of the report states that **The Trust must review the arrangements for out-of-hours paediatric cover and provide assurances that individual trainees on-call are not expected to respond to emergencies for both groups of patients (general and specialty patients)**. This requirement is particularly relevant to junior doctor gaps and the Trust's response to this requirement is provided below:

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

A major project has commenced within the Trust, led by Chief Operations Officer and Director of the Medical Division to review and change the delivery of acute paediatric care. This is referred to as "Future Models of Care". The Medical Education Team has engaged with the project to ensure the needs of doctors in training working on-call and out of hours are met.

The Trust recognises that the reduction in numbers of trainees entering paediatrics is not likely to improve in coming years and that a long-term integrated workforce plan is needed. The plan is likely to include the training and deployment of non-medical practitioners (such as, but not exclusively, advanced paediatric nurse practitioners and physicians associates) to support service delivery and ensure trainee doctors receive both high-quality education and training associated with a positive experience of training.

A dedicated working group has been established to manage the paediatric rota led by senior clinicians, with junior doctor representation and reporting to Divisional Medical Director. Several challenges have been identified by meetings of the Rota Group, Junior Doctor Forum

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and Out Of Hours group, including: increasing complexity of patients; increasing parent/carer demands and expectation; rota gaps arising for multiple reasons including sickness, maternity, consultant appointment in the case of senior trainees. Paediatrics has a high number of LTFT (less than full time) trainees, and this will continue in the future.

A number of actions have been agreed to provide support to the junior doctor rota, for example:

- Recruitment of 3 Trust employed doctors to tier 1 rota (junior medical rota)
- Recruitment of 3 Trust employed doctors to tier 2 rota (middle grade medical rota)
- Refinement of the Escalation Policy to include clearly defined actions, emphasis on joint decision making and escalation process for times of disagreement
- Introduce robust use of the DRS (Doctors Rostering System) rota management system
- Finalise clear process for reporting absence and disseminate to teams
- A new D3 rota tier (middle grade) (08:00-16:00 weekend and 16:00 – 00:00 weekday) – this will provide an additional third middle doctor for these hours.
- Nursing roles implemented – bleep holder and Clinical Nurse Specialist (overnight), business case for Acute Care Team approved, Advanced Nurse Practitioner (ANP) in post. These roles will eventually participate as part of the on-call team.
- Publication and dissemination of new roles and responsibilities document and new escalation policy for unexpected rota gaps.

The action plan will be monitored through the Out Of Hours group, the Medical Education Board, and the Future Models of Care programme which reports through the Trust Programme Board.

The recently appointed Medical Director, Dr Nicki Murdock is undertaking a rapid audit of the programmes which are already in place with a view to working with the senior medical leadership team to create an overall strategy to improve the position of the Junior Workforce, including vocational trainees, within Alder Hey. The strategy will outline a plan encompassing immediate actions, medium term and long term activities to address the identified issues. This outline plan to improve the offering to the Junior Doctors aligns with the Trust priorities, the NHS Long Term Plan and has the support of the whole board, including the personal attention of the new Chair, Dame Jo Williams.

2.3 Reporting against Core Indicators

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

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

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

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Part 3: Other information – Quality Performance in 2018/19

3.1 Quality Performance

This section provides an update on the Trust's quality performance during 2018/19, including progress against the priorities identified in the previous quality report, plus an update on specific indicators under patient safety, clinical effectiveness and patient experience.

Alder Hey Children's NHS Foundation Trust has achieved an enormous amount over the past 12 months, both in terms of quality improvement and staff engagement and satisfaction. A great deal of time and effort has been put into consulting with children and families, along with staff and external partners to extend and improve our Inspiring Quality strategy.

This section of the Quality Account provides some outstanding examples of quality improvement and reflects the Trust's relentless approach to ensuring all of our patients and families have the best possible experience whilst in the care of our organisation, as well as appreciating the value of our staff who are recognised by the Care Quality Commission (CQC) as providing outstanding care.

Our annual staff survey produced the highest return rate we have ever seen at Alder Hey with 60% staff responding, and 77% of questions showing an improved response compared to last year.

The official 'Sign up to Safety' campaign concluded successfully last year, however safety remains a high priority for the organization and we have continued to place a strong focus on reducing harm and learning from incidents, and have again improved our position amongst comparable Trusts for incident reporting, thereby reflecting our continued focus on maintaining a strong safety culture

3.2 Key Priorities for Improving Quality 2018/19

The key quality priorities that we set out for 2018/19 are summarized in the table below. The following sections describe the progress made in these areas throughout the year.

Priority 1	Children and families first, every time
Focus areas	• Improving outpatient care • Improving access to services through brilliant booking systems
Priority 2	**No preventable harms or deaths**
Focus areas	• Achieving zero preventable deaths in hospital • Early intervention for the deteriorating patient • Reduction in preventable pressure ulcers
Priority 3	**Outstanding clinical outcomes for children**
Focus areas	• Developing digitised clinical pathways • Developing and improving outcomes in each specialty

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	• Reduction in hospital acquired infections

3.2.1 PRIORITY 1. – Children and families first, every time

Priority 1	**Children and families first, every time**
Focus areas	• **Improving outpatient care** • **Improving access to services through brilliant booking systems**

As an organisation providing a public service, we strive to ensure that we always put the children and families at the centre of everything we do, ensuring they are involved in decisions about the direct care they receive, but also in how the Trust develops its future plans and strategies. We will continue to seek to create more opportunites for children, young people and families to work in partnership with Trust staff in collaborative teams to codesign service improvements. We report here on improvements that have been made in two of our key programmes of improvement, i.e. improving outpatient care and booking systems, ensuring we put children and families first, every time.

3.2.1.1 Improving outpatient care

Aim:
The provision of an Outpatient Service that enables staff to provide the best possible experience, on every occasion, for all patients and their carers/relatives.

Targets:

1. Improve the Family & Friends Test (FFT) rating for extremely/likely to recommend the Alder Hey Outpatients department
2. Increase percentage of clinicians who report being 'satisfied' with their experience in Outpatients
3. Reduce the number of missing electronic patient pathway forms (ePPF) by 30%

Outcomes:

1. FFT rating fluctuated between 86% and 92%
2. Clinician satisfaction increased from 45% to 60%
3. Missing ePPF forms from April 18 to February 19 as measured on 31st March 19 was 599 (representing 0.3% outpatient attendances). No baseline data was available

Data source: Internal audit data

The Improving Outpatients project was established in 2016/17 following the Care Quality Commission (CQC) inspection in 2015. In 2018/19, the third year of the project **'Best in Outpatient Care'** continued with a focus on delivering an outstanding experience of outpatient services for children, families and professionals; enhanced methods of supporting staff; improved usability and accessibility of clinical and administrative systems; plus further improvements to flow in outpatient and reduced delays in clinic.
Feedback from patients and staff highlighted several opportunities for improvement including:

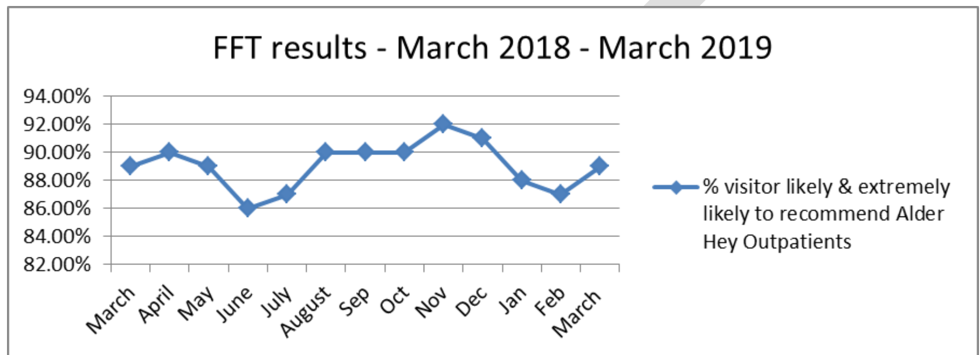
- the need to strengthen communication with staff on project improvements and increase opportunity for staff to feedback
- further improvement in play and distraction in outpatient areas
- a requirement to further reduce delays in the phlebotomy area, thereby reducing stress for both patients and staff
- increase the usage of InTouch (electronic patient flow software) by clinical teams
- improve access to clinical systems by improving computer functionality, thereby reducing unnecessary delays in clinic
- further improve signage across the Outpatient department to support families in navigating their way around the hospital.

Improvements

Patient experience

- **Family & Friends Test (FFT)**
  The FFT feedback showed a decrease in May and June, but with the focussed improvements being put in place during the summer and autumn months, achieved significant improvement reaching a peak of 92%. Unfortunately this trend dropped away again in the winter months, although has begun to show improvement again in March (*refer to graph below).*

  Further effort will be put in to understanding the reasons why some of our children and families would not recommend the service.



Data source: internal audit data

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This section provides information on some of the improvements put in place to enhance the experience of our children and families during their outpatient visits.

-
- **Outpatient seating replacement plan**

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We invited families to vote on their preference for which waiting area seating they would prefer to see across outpatients. **73%** voted for a new cushioned seat, and plans have now been developed to replace the current seating, which will provide an increased number of seats and provide an improved, more comfortable experience for our children and families .

- **Ticketed appointment system for Phlebotomy**
  Feedback from children and families who are sent by their GP to outpatients for phlebotomy (collection of blood samples) included complaints about waiting to have their blood taken and not being given any information about their waiting time. In March 2019, the department introduced a ticketed system in Phlebotomy with 10 minute appointment slots so that each child / family knew what time they would expect to be seen to have their blood taken. This allows them to move to a different part of the hospital, go to watch entertainment in the atrium, or use the restaurant or coffee bar. This has improved flow and reduced congestion in the area.

  A snapshot audit of the ticketed appointment system showed the following:
  a. Number of children seen at or before their allocated slot was 74/107 (69%)
  b. Number of children seen after their allocated slot was 22/107 (20%)
  c. [11% - data not collected]

  This improvement also resulted in a reduction in complaints about the Phlebotomy service. Having seen at least one complaint each month since September (and 6 complaints in February), there were zero complaints in March 2019.

  Improved staff and family experience was also noted through positive feedback.

Staff found it unbelievable to understand how working in a different way made a difference to regulating demand yet still seeing the same number of patients.

Staff found that the time they spent with the patients was more meaningful i.e. talking about their procedure and being able to settle the children rather than spending time apologising and talking

"It was the quickest appointment in AlderHey!!"
Patient

"I can get the next bus home!!!!"
Patient

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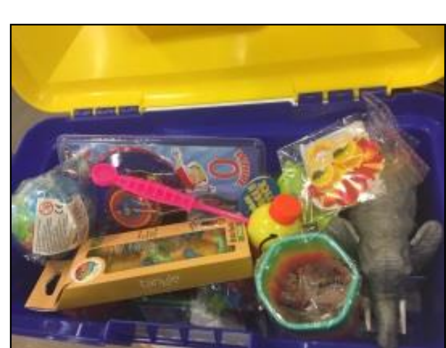
- **Improved Play and Distraction**
  Further improvement in the Phlebotomy waiting area has been provided in the form of a 'Starlight' box containing a variety of toys and games for younger children.
  'Drawing caddys' were also introduced into outpatient waiting areas, which contained children's colouring books, coloured pencils, crosswords, puzzles, and mindfulness drawings.



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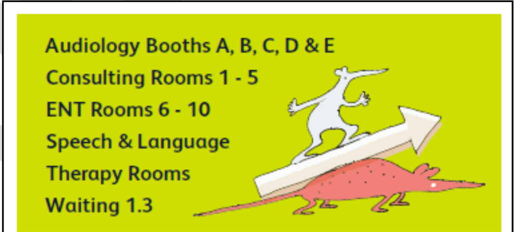
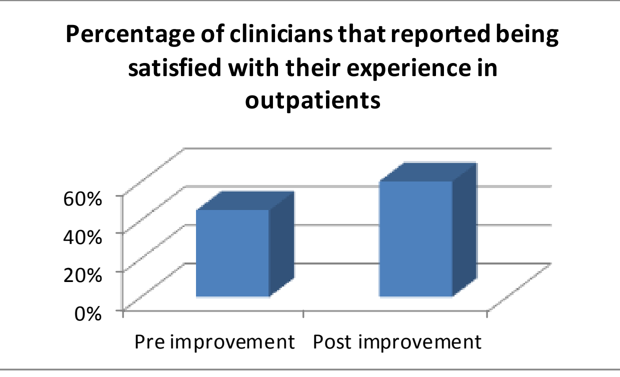
- **Improved information displays**
  A number of new display cabinets have been introduced into outpatient areas, which show key information posters for children and families

- **Improved signage**
  A significant amount of additional signage has been installed across all four floors, making it easier for our families and staff to navigate their way around outpatients



Staff experience

- **Clinician survey**
  Clinicians operating in outpatients were surveyed at the start of the project and again towards the end of the year. The initial percentage of clinicians who reported being satisfied with their experience in outpatients was



45%. In the second survey this position had increased to 60%

This section shows some of the improvements that have been put in place to enhance the experience of clinicians working in outpatients.

- **Newsletter**
  Introduced a bi-monthly project newsletter distributed across the Trust to keep staff informed of developments and improvements within outpatients

"Just to say I enjoyed reading your newsletter and learnt much" **Staff member**

- **Dedicated webpage**
  Maintained the dedicated Improving Outpatients webpage on the staff intranet to allow a central point of information and improved communication with staff and stakeholders

- **Electronic suggestion box**
  Created a bespoke Outpatients suggestion inbox to allow a clear line of communication and gather feedback from staff

- **Improved feedback**
  Installed display frames across Outpatients to display information about cleanliness audits, thereby improving awareness of infection prevention and control and providing feedback to the staff, many of whom will have been involved in the audit but may not have received feedback in the past.

<u>Patient Flow</u>

- **Electronic patient pathway forms (ePPF)**
  The ePPF forms are the methodology used for clinicians to capture and record the outcomes of a clinic appointment for the purpose of tracking the number of appointments and tracking compliance with operational requirements such as 18 week waiting time targets. The information is input into the electronic system at the end of each clinic, which then allows appropriate capture, monitoring and reporting of clinic attendances and outcomes, including providing activity information to commissioners. Occasionally due to overrunning clinics or other reasons, these ePPF forms may not be completed, or may be completed late, and may be recorded as 'missing'. This requires a significant amount of resource to follow up the outstanding ePPF forms and can result in activity not being captured appropriately.

  From April 2018 to February 2019, the number of missing ePPF forms was 599 (which represents 0.34% of the total number of ePPF forms (173,894 outpatient attendances) expected to be completed. Further work is ongoing to reduce the missing ePPF forms further.

- **Improved use of Intouch (electronic patient flow) system**
  Provided additional training to clinicians in the use of the InTouch electronic patient flow system, and introduced clear instruction guides into the clinic rooms

- **Improved clinical IT systems**

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Replaced all computers in outpatients with faster models, thereby speeding up clinical administrative work during the clinic and improving the flow of patients through the clinic.

- **Improved the follow up appointment booking process.**
  Historically, children and families would leave the clinic knowing they needed a follow up appointment but not knowing when that would be. A change was introduced so that if patients require a follow up appointment within 6 weeks, our reception team will book the appointment before the family leaves the clinic, giving peace of mind to our families who now leave the hospital knowing when they are coming back.

Future Plans:

- Roll out the 'status board' software created in-house by our IM&T team which will improve the efficiency of completing and processing the electronic patient pathway (ePPF) forms.
- Roll out the outpatient seating improvement plan, thereby improving comfort and experience for our children and families.
- Continue to explore fracture clinic redesign plans to accommodate increasing activity
- Relocate pre-operative assessment clinic to Outpatients Department to provide a pre-op appointment on the same day as decision to undergo surgery.
- Continue to test and implement a GP led Phlebotomy electronic ordering solution, to further improve flow and patient experience
- Further increase timely use of InTouch to allow waiting times to be published on screen in the waiting areas and improve patient's experience.
- Continue to focus on making improvements in partnership with patients and families
- Repeat audit of time to allocated appointment slot in Phlebotomy

Aim:

To provide a booking system that puts children and families first and meets the needs of clinicians that use it.

Targets:

1. 95% of patients and families are very happy / happy with our booking and scheduling service
2. Increase in clinic utilisation from baseline of 84% to 90%
3. Reduction in postage costs by £40k per annum

Outcomes:

1. FFT results consistently at or above 95%
2. Increased in March 2019 to 89%
3. Postage costs reduced by an estimated £30k per annum

Data source: internal audit data

3.2.1.2 Brilliant Booking Services

The Brilliant Booking project was established in March 2018 as one of Alder Hey's top 5 operational priorities. The project focussed on delivering an outstanding booking and scheduling experience for patients and families as well as meeting the needs of our clinicians.
Feedback from patients and staff highlighted several opportunities for improvement including:

- the need to change processes so that we do not invite patients and families to ring up to make an appointment to then tell them we have no capacity
- the need to make the cancellation and rescheduling of appointments easier for our patients and families
- the need to increase the utilisation of our clinics

- the need for patients to be seen in order of clinical priority
- the need to reduce our postage costs
- the need to reduce the number of hospital cancellations as appointments booked over 6 weeks in advance and therefore not aligned with notice for clinicians' leave
- the need to reduce our DNC (Did Not Contact) list.

To achieve these targets, the project has supported a radical change in process of how appointments are booked at Alder Hey; moving from a invitation to book an appointment, to appointments now being made in order of clinical priority and maximum of 6 weeks in advance. The new process will also see the eradication of the DNC list as all patients will be made an appointment regardless of whether they make contact with the hospital or not. In addition to this process change, bi-directional texting has also been implemented allowing patients to confirm or cancel their appointment via a text messgae without the need of a telephone call. Phase 2 of the project will see the introduction of an app which will allow patients to cancel and reschedule their appointments themselves to a more convenient date with phase 3 implementing a service which supports the co-ordination of appointments for our regular patients called 'My buddy'.

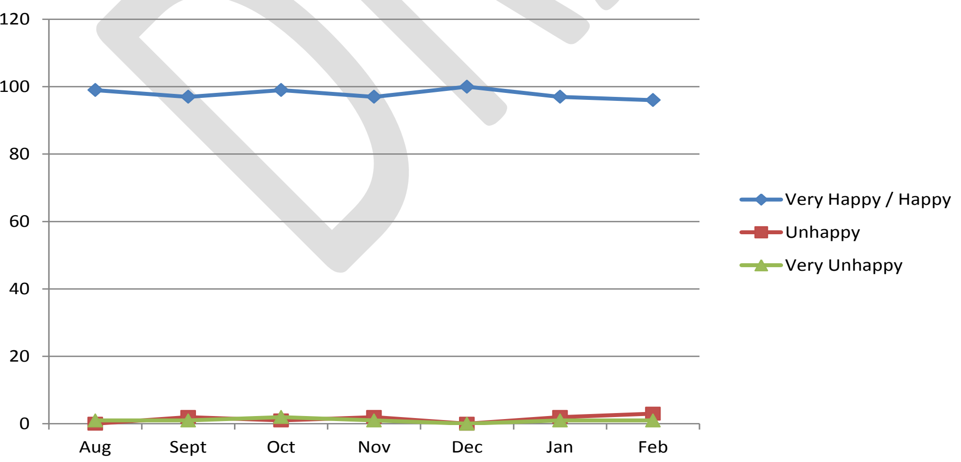
Improvements

Patient experience

- **Family & Friends Test (FFT)**

A total of 1817 patients and families rated their experience of booking their outpatient appointment and these are displayed in the graph below:

FFT Results from August 2018 to February 2019



The FFT feedback has showed a constant high level of satisfaction from our patients and families and their experience of booking and scheduling service.

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27 out of the 30 specialties within the scope of the project are now live with bi-directional texting with the remaining specialities due to go live by April 2019. The text allows our patients and families to easily confirm or cancel their appointment via text message. Statistical analysis of the data has shown that specialties that have gone live with bi-directional texting have shown an average of a 2% increase in both planned and actual utilisation as well as a decrease in patients not attending for their appointment (DNAs).

Clinic Utilisation

The graph below shows that clinic utilisation has seen a dramatic increase in the last two months, reaching a peak of 89% in March 2019.

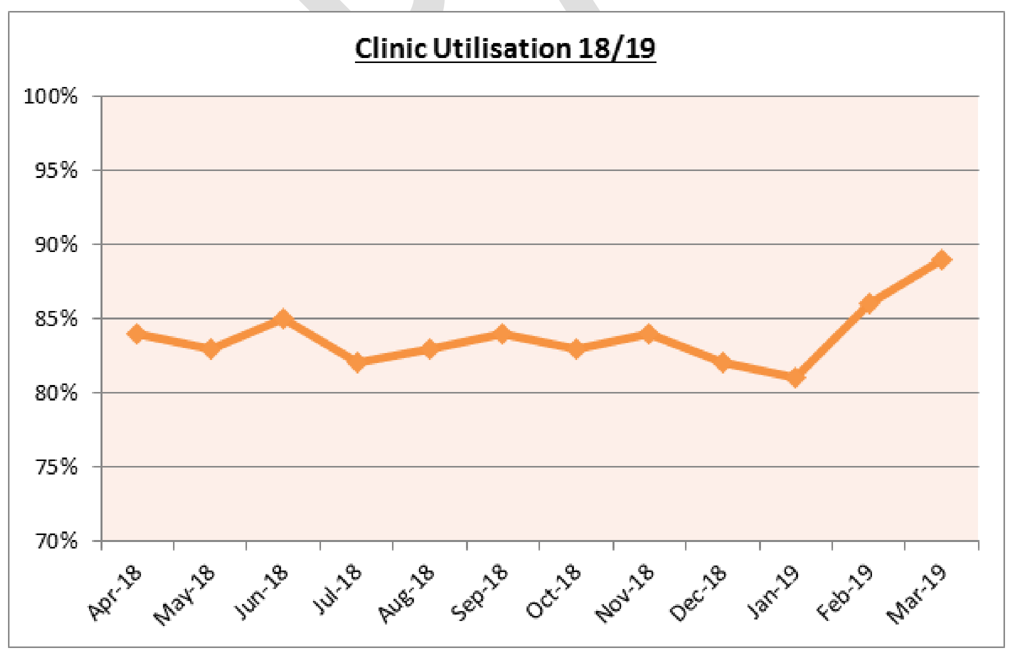
Postage Costs

A reduction of approximately £30k has been seen in our postage cost as a result of no longer sending out an invite letter for patients and families to ring the hospital to make an appointment. (Projected estimate based on figures as at end of December 2018)

Clinician's Experience

8 out of 30 specialties are now live with our new booking process and a bespoke questionnaire for clinicians in these specialities is due to be distributed at the end of this phase of the project in May 2019.

Clinic Utilisation from January 2018 to March 2019



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- ***Future Plans***

- 2019/20 will see the Brilliant Booking Project amalgamate with the Outpatients Project as we focus on moving towards a more digital outpatients service. The outstanding tasks in both phases 2 and 3, implementation of booking and scheduling App and the My Buddy service will therefore form the basis of the 'Booking and Scheduling' work stream within the Outpatients Project.

- The Booking and Scheduling work stream will also include the launch of a DNA communication campaign to let our patients and families know about the difficulties and consequences of patients and families not attending their clinic appointments.

- This year will also see the implementation of an interface between our current medical records system, Meditech with the NHS Spine. This interface will increase the accuracy of the demographics we hold for patients ensuring that all communication is received.

3.2.2 PRIORITY 2. – No preventable harms or deaths

Priority 2	No preventable harms or deaths
Focus areas	• Achieving zero preventable deaths in hospital • Early intervention for the deteriorating patient • Reduction in preventable pressure ulcers

Patient safety has always been a top priority for the Trust, and in last year's quality account we reported a reduction in medication errors leading to harm of 75% over a three year period, alongside a reduction in hospital acquired infections of over 45%. In 2018/19 we maintained a focus on reducing harm, in particular through rapid intervention for patients who deteriorate unexpectedly and further embedding of the sepsis pathway. We also report on actions taken to reduce preventable pressure ulcers.

3.2.2.1 Achieving zero preventable deaths in hospital

Aims:
- To eliminate preventable deaths from Alder Hey

Target:
- Zero preventable in hospital deaths during 2018-19.

Outcome:
- Achieved zero preventable in hospital deaths during 2018-19

(*source: output from review of inpatients deaths by Hospital Mortality Review Group*)

The Trust employs a system of review of all in hospital deaths through the Hospital Mortality Review Group (HMRG), a group of multidisciplinary professionals from across a range of specialties). The group will explore the circumstances surrounding a death to ascertain if the death could have been avoided and if there were any lessons that the Trust could learn from events leading up to the death. There is also usually at least one departmental review prior to the HMRG review.

Full details of numbers of deaths, plus lessons learned and improvements made are described previously in the mandated Section 2.2.11

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3.2.2.2 Early intervention for the deteriorating patient including implementation of the sepsis pathway

Aim: To embed the question "Are you concerned this child has sepsis?" in our routine clinical practice

Targets:
1. Develop and roll out a sepsis pathway to all our inpatient wards and Emergency Department (ED).
2. Deliver sepsis training to nursing and clinical staff based within Alder Hey.
3. Submit against the sepsis CQUIN standards for 2018/19

Outcomes – 2018/19
1. 100% of Inpatient and ED screened for sepsis.
2. Initiation of electronic sepsis status for all inpatients.
3. Initiation of a sepsis status board for the trust
4. Embedded sepsis awareness across the trust
5. E-learning package to support already ongoing training.
6. Targeted sepsis awareness and training within the Community Division.

Background

Sepsis is life-threatening infection when it affects the function of an organ or body system and is caused by a dysregulated response by the body's own defences. Those with 'septic shock' are unable to maintain a normal blood pressure without critical care support. Sepsis and septic shock affect children and adults and are major causes of death and lasting complications in those that survive.

The initial priority was to improve the quality of care provided by the Trust in a condition that carries a high morbidity and mortality. The Sepsis Steering Group has continued to monitor compliance against the sepsis pathway, review patients that were not managed optimally and to identify opportunities to improve the care delivered to suspected and proven septic patients.

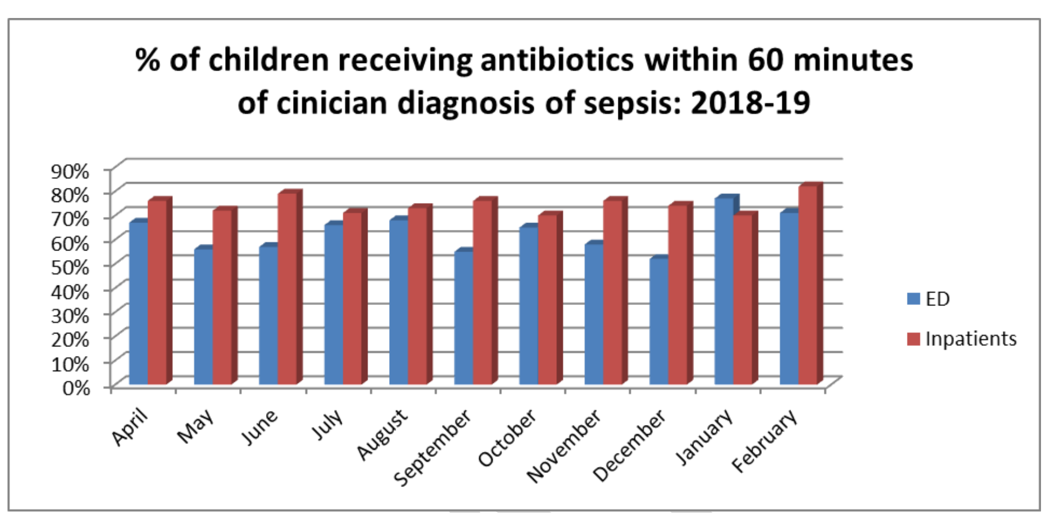
Improvements 2018/19

- Evaluation and improvement of the electronic sepsis pathway.
- Development of electronic training records for staff who have completed sepsis training.
- Updated training materials using case studies and national updates.
- Continued organisational focus and awareness around earlier recognition of children at high risk of sepsis in ED and on the inpatient wards
- Continued organisational focus on timely intervention and provision of treatment for possible sepsis combined with an understanding of the importance of source investigations.
- Compliance with National Institute for Health and Care Excellence (NICE) guidance on sepsis management
- High quality informatics enabling identification of blocks to rapid, efficient care and allowing feedback to individuals and teams to improve service delivery
- Established a Sepsis Team – 1.5 Specialist Nurses and 2 clinical leads.
- Development and roll out of an e-Learning package.
- Organisational World Sepsis Day 2018 awareness session
- Networking with other centres specifically around sepsis in children, the warning signs and treatment.
- Inclusion of a paediatric sepsis nurse specialist into the UK Sepsis Practitioners Forum.

Future plans 2019/20

- Continued sepsis training within the community setting.
- Evaluation of the e-learning package with an update version to be developed in collaboration with the University of Liverpool.
- Evaluation of sepsis status and sepsis pathway within the standard documentation.
- Review the opportunities for a sepsis dashboard to provide live data and improve audit.

- Finalise and embed proposal drawn up with regards to difficult/complex intravenous access in clinically deteriorating patients with concerns of sepsis on inpatient wards.
- Collaboration with DETECT study in relation to the sepsis pathway



3.2.2.3 Reduction in preventable pressure ulcers

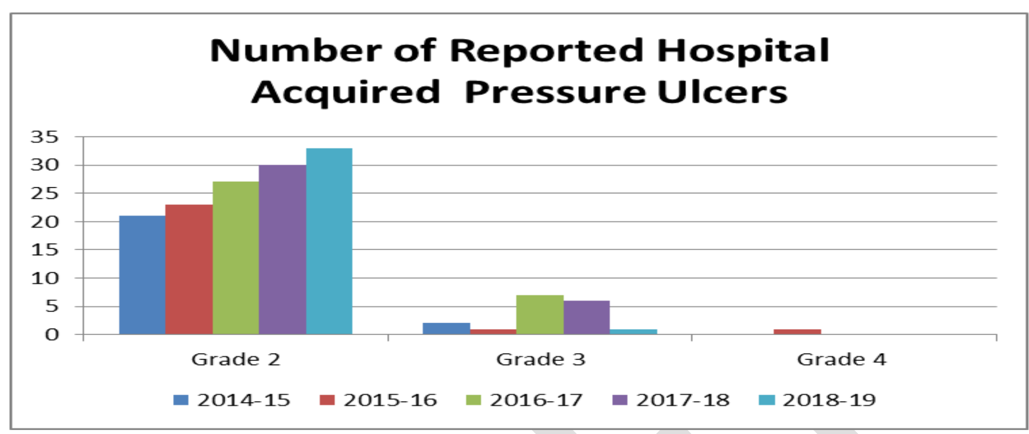
Aim: No healthcare associated pressure ulcers.

Targets:
1. Zero avoidable hospital acquired grade 3 pressure ulcers.
2. Zero avoidable hospital acquired grade 4 pressure ulcers.

Outcomes:
1. There was 1 grade 3 pressure ulcer compared to 6 in 2017-18 (83% reduction)
2. Achieved zero grade 4 hospital acquired pressure ulcers.
3. Total number of pressure ulcers of grades 2-4 is 34 compared to 36 last year.

A pressure ulcer is a localised damage to the skin and /or underlying tissue, usually over a bony prominence (or related to a medical or other device), resulting from sustained pressure (including pressure associated with shear).
The damage can be present as intact skin or an open ulcer.
They can be very painful and debilitating and are often preventable. It is recognised that immobilised and acutely ill neonates and children are at risk of developing pressure ulcers, particularly in a critical care environment. Most pressure ulcers within our organisation are associated with medical devices such as cannula and endo-tracheal tubes which are reflective of national research showing that most paediatric pressure ulcers are device related. Medical device related pressure ulcers are now recognised nationally by NHSI (National Health Service Improvement) and are now reportable. Alder Hey have commenced working with Southampton University to explore innovative solutions to minimise the risks posed by medical devices.

- Alder Hey continues to have a strong focus on education and training in the prevention, recognition and treatment of pressure ulcers and clarifying and simplifying reporting procedures.



	Grade 2	Grade 3	Grade 4	Total
2014-15	21	2	0	23
2015-16	23	1	1	25
2016-17	27	7	0	34
2017-18	30	6	0	36
2018-19	33	1	0	34

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Improvements & Achievements 2018/19

- The new Tissue Viability Service is now embedded across the Trust.
- New classification system for pressure ulcers as directed by NHSI, now implemented into the Trust.
- The results above show a significant reduction in the number of grade/category 3 pressure ulcers reported in 2018/19 (a reduction of 83%).
- 2018/19 figures show the sustained rate of 0 in our grade/category 4 pressure ulcers.
- There was an increase in grade/category 2 pressure ulcers from 30 to 33 compared to last year. This was anticipated and is reflective of a greater awareness and improved education across the Trust which has led to a slight increase in reporting.
- The introduction of an improved system of defining when grade/category 3 and 4 pressure ulcers are avoidable or due to a lapse in care and the targeting specific steps to address these through undertaking Root Cause Analysis and sharing lessons learned.
- Link e-learning package with Electronic Staff Record (ESR). Work with community nursing team to support management of pressure ulcers in the community.

- A support structure for community staff with access to specialised tissue viability knowledge is now in place. Tissue viability link nurses are now established in the community and attend monthly Trust link nurse meetings and training sessions.
- Implementation of a new Tissue Viability Service ensuring continuity of the service seven days per week; consisting of a Tissue Viability Specialist Nurse, Tissue Viability Support Nurse and Tissue Viability Link Nurse System across the Trust.
- Implementation of an improved wound assessment tool on the Meditech System.
- Establishment of a rejuvenated Tissue Viability Link Nurse System with monthly meetings and educational sessions supported by industrial partners.
- Implementation of alternative intravenous dressings through the intravenous Access and Therapy Group to minimise the incidences of cannula acquired pressure ulcers across the Trust.
- Development of a Trust wide wound care formulary, offers rationalisation and evaluation of the wound care products across the Trust. This wound care formulary was launched for staff in November 2018.
- Implemented tissue viability competency assessment. Commenced with Link Nurses and will roll out to all qualified nursing staff.
- Implementation of tissue viability training compliance monitoring which is fed back to ward managers monthly

Future Plans

- Replacement/adaptation of the Braden Q assessment tool with a more suitable to the requirements of Alder Hey.
- Commencement of a working relationship with Southampton University into exploring innovative solutions in the prevention of medical device related pressure ulcers.
- Tissue Viability Specialist Nurse to undertake a Level 7 master course in Tissue Debridement at Bradford University.
- To establish and embed a comprehensive Trust wide mattress service, for both static and dynamic mattresses.
- In collaboration with the Alder Hey events team the Tissue Viability service plan to develop a regional Tissue Viability Conference to support and update staff not only within the Trust but in the North West Region.
- To hold two annual Tissue Viability Study Days for all clinical practitioners with the Trust.
- Development of a business case to expand the Tissue Viability team in order to support staff in the community to deliver safe and effective care to children and young people and families in community settings.

3.2.3 PRIORITY 3. – Outstanding outcomes for children

Priority 3	**Outstanding clinical outcomes for children**
Focus areas	• **Developing digitised clinical pathways** • **Developing and improving outcomes in each specialty** • **Reduction in hospital acquired infections**

Part of the Trust's commitment to delivering outstanding outcomes for children includes a plan to reduce variation by strengthening standardisation of clinical pathways, thereby ensuring the best evidence based pratice is embedded and spread across the organisation. As a Global

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Digital Exemplar, the Trust is already committed to digitising clinical pathways and standardising documentation, using best practice as evidenced in NICE guidance and National Standards. Here we report on progress with developing digitised pathways during 2018/19 and provide an example of how this is improving outcomes. We also provide a further update on progress against reducing hospital acquired infections.

3.2.3.1 Developing Digitised Clinical Pathways

Background:
At Alder Hey Children's NHS Foundation Trust the transition to paper free working has been identified as an opportunity to engage the hospital's specialty teams in a process of service transformation and quality improvement.

***Aim*: To design and implement digitised clinical pathways that are patient centred and evidence based**

***Targets*:**

1. To have supported 52 speciality teams with the development of digitised pathways by November 2019
2. To have embedded the use of the digitised sepsis, learning disabilities and discharge pathways within every inpatient assessment

***Outcomes*:**

1. Digitised pathways have been developed and implemented for 32 speciality teams
2. The use of digitised pathways has allowed clinical teams to use clinical outcome and metric dashboards on the Clinical Intelligence Portal

The project is led by the Clinical Effectiveness Directors as part of the Global Digital Exemplar (GDE) project and reports to the GDE programme board. Resources including an operational project manager, clinical fellow, IM&T development staff and support from the business intelligence team have been allocated to the speciality package project.

The project plan is structured around four "gateways" involving;

- clinical engagement and identification of clinical pathways for digitisation;
- digitisation of documentation and the development of digital tools to support pathway implementation;
- training, testing and launch of digitised processes
- post-implementation review and revisions.

Improvements:

- Digital pathways have helped to standardise clinical assessments and clinical care across 32 specialties
- Pathway implementation has been supported by the development of:
    - Modified, symptom specific Emergency Department (ED) triage documentation,

   - Electronic documentation designed to standardise ED, Inpatient and Clinic assessments
   - The development of condition specific order sets (combined investigation and treatment orders that are designed to reduce variability and improve the consistency of care)
   - Treatment plans generated from operation notes to improve post-operative care planning and communication between the Multi-Disciplinary Team (MDT)
- Pathway specific dashboards are providing clinical teams with up to date data on patient outcomes and key pathway process measures
- A sepsis pathway has been developed and embedded into the nursing and medical assessments completed for all inpatients

Feedback from Rheumatology Team after introduction of specialty package

100% strongly agree the Specialty Package improved access to information

100% agree or strongly agree the ability to see all patient contacts provides a clearer picture of patient care

100% agree or strongly agree this has enabled me to make better informed decisions to improve patient outcomes

100% agree or strongly agree the package supports the standardisation of care

43% agree or strongly agree they can record discussions & process of transition robustly using the transition documents

43% disagree that writing notes directly onto the PC has had a negative impact on my interaction with the patient

"Excellent work by the team that have worked so hard to develop this. Will have a huge positive impact both for patient care but also on our working

Overall 89% Satisfaction with the GDE Rheumatology Specialty Package

Future Plans:

- Continue to roll out digitised clinical pathways to a total of 63 specialty packages by 2020
- Populate and roll out the clinical intelligence portal
- Use digital data to support the quality improvement cycle.

3.2.3.2 *Developing and improving outcomes in each specialty*
Improving outcomes in Diabetes Care

Aim:
1. To improve delivery of diabetes care processes in a streamlined clinic to meet NICE Guidance for Diabetes care in Children & Young people.

2. To improve blood glucose control through patient education leading to a lower HbA1c, signifying a reduced risk of complications in the future.

Outcomes – 2017/18
1. Reduced the median HbA1c by 4 mmol/mol over 2 years
2. Increased compliance with 7 key health checks from 17% to 59% over 2 years. (National mean currently 50%)
3. Improved psychology screening at clinic from 15% to 89%.
4. Presented data at NPDA 2019 National conference.

Data source:National Diabetes Audit Data, plus internally gathered data

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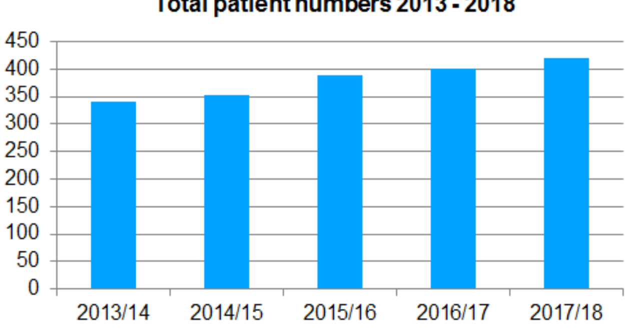
Background
The Alder Hey diabetes team look after 430 children and young people up to 19 years of age within the Liverpool area. There are 50 new patients per year. The patient population has increased significantly over the last 6 years.

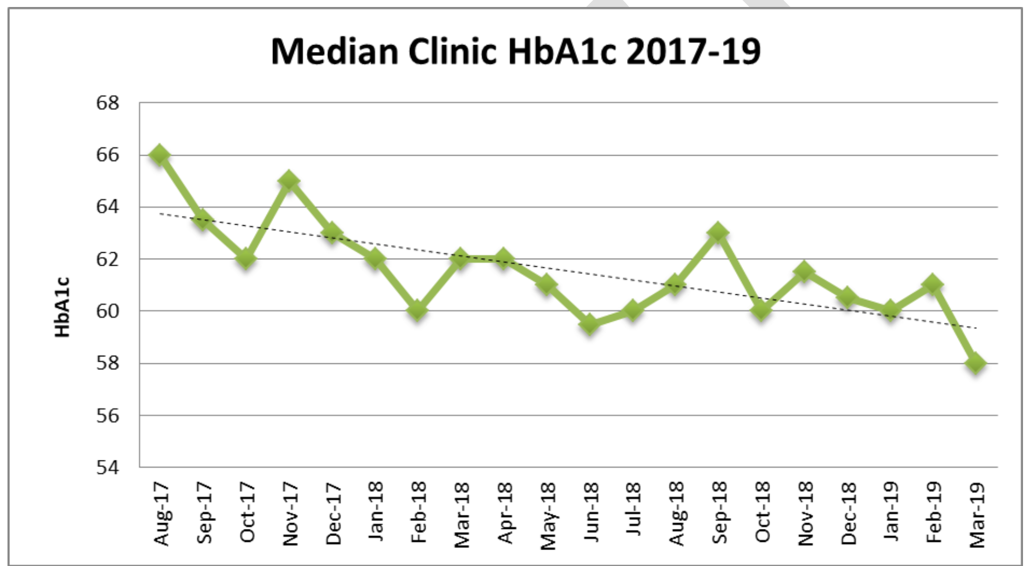
97% of children and young people diagnosed with diabetes are Type 1—caused by an autoimmune destruction of insulin producing cells in the pancreas. These patients require insulin either by injection or pump to maintain healthy blood glucose levels. The levels are monitored by 5 or more fingerstick blood glucose checks per day.
Type 2 diabetes is more common in adults, although it's frequency is increasing in children.



Graph showing increasing patient numbers

National Paediatric Diabetes Audit

The National Paediatric Diabetes Audit (NPDA) is an annual audit cycle run by the Royal College of Paediatrics and Child Health. It collects data on health care provision & outcomes such as the delivery of 7 key healthcare processes (including blood tests, Body Mass Index (BMI), blood pressure, kidney function, eye and foot examination), access to psychological support and long term blood glucose control (as evidenced by measuring levels of the marker, HbA1c in the blood). In the 2016/17 NPDA report, Alder Hey was designated a national negative outlier for delivery of the 7 main health checks. Additionally, it was recognised that our median HbA1c was static for 2 consecutive years, despite a national improvement being evident. We therefore implemented a service redesign with the aim of ensuring our service is fully compliant with NICE guidelines, and through improved education, ensuring our children and families were able to better control their blood glucose levels, as evidenced by regular measurement of the HbA1c marker.



Graph showing reduction in HbA1c levels

Improvements

- Adopted a whole team approach to service improvement following a team away day.
- A focus group was organised to allow our children and families to help in the service redesign.
- Monthly data review introduced as part of departmental governance meeting.
- Redesigned patient education package from diagnosis.
- Information prescription for use in clinic.
- Further improved patient education through new website and Twitter.

Future plans

- Work towards lowering overall median HbA1c to 58mmol/mol
- Develop and implement structured rolling education plans for established patients.

3.2.3.3 Reducing hospital acquired infections

Aim: By the end of March 2019 is to reduce avoidable harm due to hospital acquired infection.

Targets - 2018/19

1. No hospital acquired MRSA bacteraemia
2. No *Clostridium difficile* infections due to lapses in care
3. Reduce the number of hospital acquired MSSA bacteraemia by 25% from the 2017/18 baseline of 14.
4. Reduce the number of hospital acquired gram negative bacteraemia by 10% from the 2017/18 baseline of 16.
5. Reduce number of hospital acquired CLABSI (PICU only) by 10% from the 2017/18 baseline of 20.

Outcomes – 2018/19

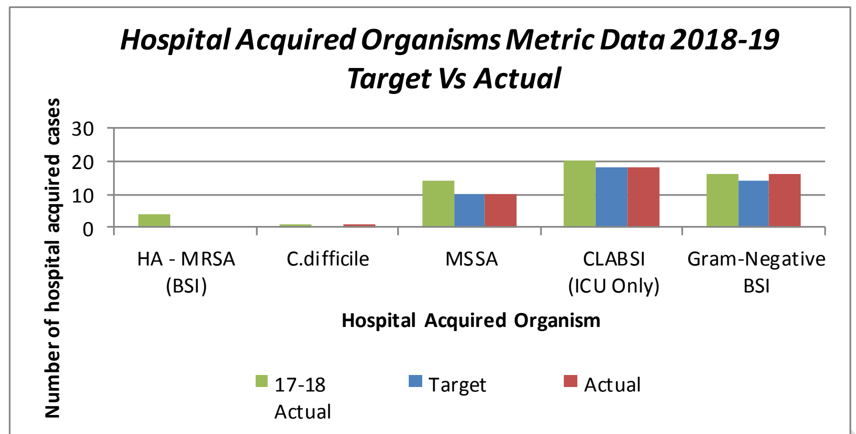
1. 0 MRSA bacteraemia
2. 1 *Clostridium difficile* infection currently under review to determine if there was a lapse in care.
3. 25% decrease in the number of hospital acquired MSSA: this represents 10.
4. Maintained low number of hospital acquired Gram Negative bacteraemia: this represents 16.
5. 10% decrease in the number of hospital acquired CLABSI (PICU only): this represents 18.

Data source: Internal data through IP&C team

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

- They are susceptibile to infections, which are preventable by vaccination.
- They have closer contact with other visitors such as parents and siblings.
- Their lack of regular hand 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 & Achievements 2018/19



Graph shows each of the target areas for hospital acquired infection actual 2017-18 compared to 2018-19 target and 2018-19 actual.

- Plans drawn up and incorporated into the IPC work plan, to incorporate strategies to integrate Community staff, premises and education into the IPC audit and educational plan.
- Successful roll out of new hand hygiene audit tool throughout the Trust.
- Submission of a business case for three ultra violet machines for the enhancement of the deep cleaning and PPM processes throughout the Trust.
- Successful development and submission of a business case to purchase a new 'Cephaid' machine for rapid identification of carbapenamase producing organisms therefore freeing up isolation cubicles.
- Surgical Site Infection surveillance expanded to incorporate all inpatient surgical procedures.
- First launch of the annual "Love Bug Day" in February 2019 with the support of Industry Partners.
- Incorporated practical hand hygiene assessment in mandatory training.
- Successful integration of the Vessel Health and Preservation 2016 (VHP) framework into the Meditech system through the GDE project.
- Commencement of a PIR process for all MRSA, MSSA, E.Coli, Klebsiella and Pseudomonas which are then reported to divisional goveranance teams via a situation report.
- An increase in the percentage of staff compliance in Fit testing.

Future Plans 2019/20

- To continue the work which began in 2018/19 to examine and update the Isolation policy incorporating the most up to date research and best practice available and benchmarking the policy against other Paediatric Specialist Hospitals in the country.
- To continue to explore and develop a process across the whole Trust to monitor Central Line Associated Bloodstream Infections (CLABSI) data per 1000 catheter days and to benchmark these rates against other Paediatric Specialist Hospitals in the country.
- To continue the monthly CLABSI data produced per 1000 catheter days on PICU and continue the collaborative work to try and reduce this rate.
- To continue the work commenced in 2018-19 to reduce the hospital acquired infections by setting internal targets and monitoring this data through Trust Board and IPCC.
- To oversee the first IPS Paediatric Day at National IPS Conference in Liverpool September 2019.
- Commencement of National IPS Paediatric Meetings to network and benchmark with other paediatric Trusts nationally.
- To explore with NHS England the possibilities of increasing vaccination compliance whilst children are visiting the Trust.
- To develop a 5 year strategy for Infection Prevention Services across the whole Trust, incorporating the new NHS 10 year plan (2019) which will be monitored through IPCC and Trust Board.
- Collaboration with NHSi and other paediatric Trusts to reduce the rates of Gram Negative Bloodstream Infections (GNBSI) for paediatric patients who present with unique risk factors for these type of targeted infections.
- Development of a business case to expand the Infection Prevention and Control team in order to support staff in the community to deliver safe and effective care to children and young people and families in community settings

Further details of improvement plans are captured in the Infection Prevention & Control Work Plan which will continue to be rolled out during 2019/20.

3.3 Additional areas of Quality Improvement

This section provides additional examples of quality improvement relative to improving safety, patient experience and clinical effectiveness, as well as a focus on engaging the workforce.

A. Incident Reporting

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Aim: To maintain a high level of incident reporting in a culture of openness and willingness to learn

Targets:
1. Remain in the top quartile of number of incidents per 1000 bed days reported compared with acute specialist Trusts.

Outcomes – 2018/19
1. Alder Hey is the second highest reporter of incidents per 1000 bed days amongst acute specialist Trusts as reported through NRLS.
2. Alder Hey is the highest reporter of incidents per 1000 bed days amongst paediatric Trusts

Data source: NRLS website – March 2019

The Trust recognises the value of reporting incidents whether or not they result in any harm. Higher numbers of reporting of incidents, particularly no harm and near miss incidents, is indicative of a strong safety culture, with a willingness to be open and learn from mistakes.

The latest report from National Reporting and Learning System (NRLS) shows that for the period 1st April 2018 to 30th September 2018, Alder Hey were the second highest reporter of incidents amongst its peer group of acute specialist trusts. We are also the highest reporter of incidents amongst all paediatric trusts.

Improvements

- Weekly Patient Safety meeting learning log review and progress with actions, demonstrating assurance of patient safety improvements.
- Weekly sharing Trust wide 'you said, we did' from incidents raised, via patient safety meeting, to support patient safety, quality improvement and encourage incident reporting.
- Continuous development of Governance and Quality assurance intranet site for all staff which includes, national and local guidance on management of incidents including serious incidents, sharing lessons learned from incidents, investigation reports and action for improvement, safety notices etc.
- Further development of 'Step by step guides' for the management of incidents via the electronic risk management system (Ulysses).
- Patient safety alerts shared Trust wide to ensure learning and minimise patient safety risks
- Continue to promote Lessons learned bulletins shared with all staff promoting learning and continuous improvements in patient safety.
- Human Factors Train the trainer course undertaken by 10 members of different professional groups across the Trust.
- Maintained mechanisms of feeding back reports to staff, via staff notice boards and numerous other governance processes across the Trust.
- Development and implementation of 'after action reviews' to capture lessons learned from incidents to ensure improvement future performance

Future plans

- Multidisciplinary half day Human factors training programme to be rolled out for all clinical staff groups.
- Combined RCA and Human Factors training trust wide.

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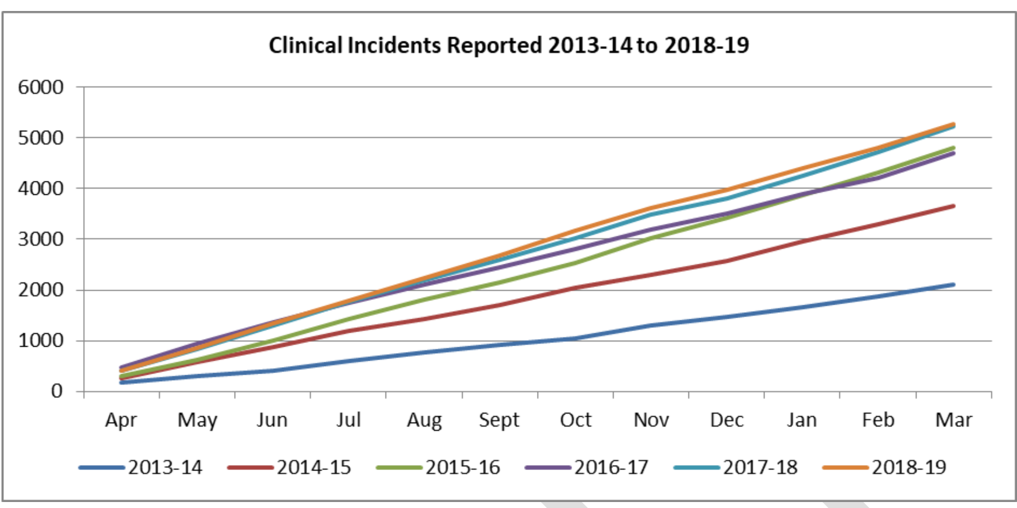

Graph shows year on year increase in incident reporting

B. Improving Medication safety

Aim:
No drug errors resulting in avoidable harm.

Target for 2018/19:

- 25% reduction in incidents resulting in minor harm from 2017/18. Baseline 32: Target 24.
- Zero incidents of moderate harm or above. Baseline: 0 Target: 0

Outcomes:

- 34 incidents of minor harm in 2018/19. This is increase of 2 incidents (6%).
- There were 3 incidents of moderate harm reported in 2018/19.
- There were no incidents of severe harm or death in 2018/19.
- Incidents associated with harm were 2.6% of all medication incident reports, which is equivalent to last year and a reduction of 18.6% since 2014-15.

Data source: Internal audit data through Medication Safety Officers and reported in the corporate report

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 and the Trust. We want to reduce the number of medication errors happening in Alder Hey for 3 main reasons:

- Medication errors can harm patients. The majority of the errors which have happened in Alder Hey have not caused harm to patients. A small number of reported incidents have caused harm or had the potential for causing harm had they not been discovered before reaching a patient.

- 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.

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

Since 2014/15 the Trust has seen an increase in the number of reported medication errors reporting and a reduced number of errors that lead to harm every year (sign of a strong safety culture). We have maintained medication safety as a high priority a sought to further decrease the number of errors leading to harm.

Medication errors are reported on the Trust's incident reporting system (Ulysses). Managers of the area where the error occurred and other key individuals are immediately notified via email of the incident.

The Medication Safety Committee (MSC) (a subgroup of the Drug and Therapeutics Committee) review monthly summaries and identify potential trends in reporting. The Committee develops action plans to reduce errors within the Trust and also responds to national safety alerts and other concerns regarding medication safety

The Trust's Patient Safety Meeting is well attended by a variety of professional groups and divisional representation. The meeting reviews incidents that have caused harm to patients in the previous week, including medication incidents.

The Clinical Quality Steering Group reviews overall trends in medication error reporting.

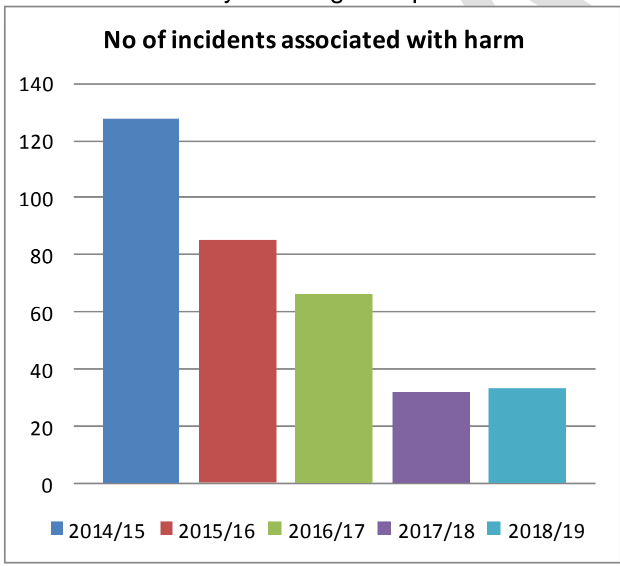

Figure 1: Total number of medication incidents reported per annum
Figure 1 shows an ongoing increase in reporting of medication incidents, from a baseline of 703 in 2014-15 to 1231 in 2018-19 [75% increase in reporting]. This is a dramatic improvement since the introduction of the Medication Safety Officers (MSOs) who have put a great deal of effort into training, encouraging and supporting staff to report medication incidents whether or not they reach the patient.

Figure 2: Total number of incidents with associated harm per annum
Whilst the number of reported medication incidents has increased since the appointment of our MSO staff in 2014-15, the actual harm attributed to incidents has dramatically reduced as demonstrated in Figure 2, which displays the number of incidents that were associated with harm. This has maintained a 75% reduction from 128 in 2014-15 to 33 in 2018-19.

Both of these figures together are reflective of an improved safety culture and willingness to report incidents openly, including those that don't reach the patient.

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This fantastic outcome far exceeds our Sign up to Safety 3 year target for reducing harm from medication set in 2014. Further effort will be put in to reducing the errors associated with harm even further.

Improvements

Initiatives developed to reduce the number of medication errors reaching patients and causing harm include:

Incident Reporting and Awareness

- Improved the quality of incident report data by implementing a more consistent approach to follow up and ensuring minimum data is completed prior to incidents being uploaded to the National Reporting and Learning System (NRLS).
- The implementation of the MERP (Medication Error Reporting Program) grading structure for classification of harm caused by a medication error. This provides a much more objective method of assessment.
- Line managers are offered support when investigating incidents by MSOs. This has improved the response time for investigations following an incident.
- Ensuring any medication errors involving Meditech (our Electronic Prescribing and Medication Administration (EPMA) system) are fed back to the Meditech team and used to shape and prioritise developments and training programmes.
- Monthly reports for nursing staff regarding medication errors and specific medication reports are provided to each division and also the education department for prescribers.
- The MSOs and Consultant Clinical Pharmacologiest have publicised the need to report more adverse drug reactions via the Yellow Care Scheme by running a competition between the doctors and the pharmacists. Since this was set up, the number of adverse drug reactions reported to the MHRA via the Yellow card scheme has increased from 19 to 44 (18/19 by the end of Q3) (176% increase from 2014/2015).
- An intranet page dedicated to medication safety has been developed which includes recent alerts and lessons learned. The MSOs now have access rights to modify the page, ensuring it is both user friendly and updated in a timely manner. In particular this allows safety alerts to be uploaded for access by staff members readily.
- An MSO dashboard is used to monitor progress and training activity
- Supporting staff/divisions in the investigation process around medication incidents.

Education

- Updated a medication safety mandatory training workbook. The new version will be available from April 2019
- Training for PMR (Paediatric Medicines Research) for IV awareness training/medication safety for Undergraduate Pharmacist & Nurses.
- MSOs continue to provide regular training on many aspects of prescribing, administering and dispensing medicines to medical teams, theatre, nursing and pharmacy staff.

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Bespoke training to meet trends in ward areas and specialities. Sessions delivered in 2018/19 increased by 42% from the previous year.

- Developing a new training session for IV training to stream line outcomes and to support staff re-inforcing the 5 rights approach for administration of medicines.
- Implemented and promoted the new independent checking process for all medication.
- Medication safety week was introduced for all staff to attend. We ran 25 workshops based on medication safety awareness, Controlled Drugs and Meditech. This is to be repeated annually to continue to raise awareness of medication safety principles to staff, patients, families and carers.
- The MSC continue to work with Junior Doctors on methods of improving learning from prescribing errors

Reducing errors with Specific Drugs

- Reducing errors related to Parenteral Nutrition.

This is a priority for the Medication Safety Committee and a multi-disciplinary group is working on the following

- *Developing criteria for when PN is appropriate to start.*
- *Develop a training package on PN for nurses and doctors.*
- *Develop a new PN prescription form.*
- *Introduction of Standard PN*

- Reducing errors related to Insulin

Although no serious harm has been reported with insulin, the MSC are working on improving methods of prescribing, education and awareness around the use of insulin for inpatients

- Reducing errors related to opioid medicines

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An audit of incidents relating to Fentanyl has been completed and has shown a reduction in harm over the last 12 months.

- Reducing delayed and omitted medicines

An audit of delayed administration of critical medicines has been undertaken. The MSC are working with the Information department to be able to investigate the scope of delays in more detail.

C. Perioperative care

The improvement focus for this year has been to continue to embed national policy and national safety standards across theatre, paying particular attention to training and audit of National Safety Standards for Invasive Procedures (NatSSIPs) as well as continued improvements to emergency list booking, plus admissions procedures.

We set out seven key aims for the year, alongside a strategy for achieving those aims. By the end of 2018/19 all of these aims have been achieved or work has commenced.

Aims and objectives 2018/19	Achieved
NatSSIPS to form part of theatres mandatory training	Mandatory training delivered in house on all update sessions. We have been identified as an exemplar by the Commissioners
Departmental audit plan for NatSSIP's	On-going departmental audit plan with data feeding into Integrated Governance Committee (IGC) and Clinical Quality Steering Group (CQSG)
Strategy developed to be able to provide peer support for staff suffering from work related stress	Funding approved and 20 Staff attended TRiM (Trauma Risk Management) training
Undertake a second safety culture assessment	Identified areas for improvement regarding improving the culture of near miss incident reporting. Continue to deliver 2nd phase Human Factors training for all staff members along with Clinical SIM training
Review the provision for Plastics trauma patients requiring surgery	Theatre schedule reviewed and plastic surgery lists increased in order to accommodate the trauma patients within scheduled elective lists during the week.
Implement a fully electronic Emergency List booking system (ELIS)	System now live and used as the sole source booking system. Using the data retrieved from the ELIS (Emergency List Information System) dashboard to further enhance and improve patient experience
Introduce batched admissions for all inpatients coming through the Surgical Admissions Lounge	Consultation took place with all specialities to discuss the proposal and how this new practice should enhance patient experience, a trial was commenced with a period of time to feedback. The majority of feedback was positive and a full roll out commenced in November 2018

Key Quality Improvements made in 2018/19:

- Reviewing the NatSSIP's guidelines and amending in line with feedback from Root Cause Analyses and incident reporting

- Audit compliance of the NatSSIP's guidelines in clinical practice; use the data to address any issues within the teams.

- Implementation of Trauma Risk Management (TRiM) training to facilitate staff to support their peers following exposure to work related traumatic events, with a view to helping staff feel supported and prevent sickness absence

- Rearranged the theatre schedule to enable implementation of additional plastic surgery lists in order to accommodate the plastics trauma patients and ensure they receive their surgery in a timely manner.

- Successfully Implemented batched admissions for all inpatient's coming through the Surgical admissions lounge, in order to improve patient experience

Maintaining patient safety by using NatSSIP's guidelines:
The National Safety Standards for Invasive Procedures (NatSSIP's) guidelines were originally introduced in 2016 and were devised in conjunction with the Regional Theatre managers network. These are now part of theatres mandatory training, this training is updated yearly. Following feedback from departmental incident reporting and RCA investigations, we have amended the Local and Regional guidelines (LocSSIP's & RegSSIP's) in order to further enhance patient safety. Alder Hey is recognised as an exemplar by our Clinical Commissioning Group (CCG) for our NatSSIP's guidelines, and supports other regional trusts with completion and implementation of their own standards.

Audit:
We have a departmental audit in place to ensure NatSSIP's compliance within the teams and this compliance data is fed into the Integrated Governance Committee and the Clinical Quality Steering Group.

Improving staff health and wellbeing:
20 Staff members attended TRiM training (Trauma Risk Management) this is training given to staff members (predominantly non-managers) to provide support to all staff members following exposure to a work related traumatic event. This training enabled staff to identify staff members and arrange to meet with them following exposure to a work related traumatic event. The format comprises of initial assessment following set criteria, advice on how the staff members may react and behave following such an event, and what advice to give to the staff members. Guidance of when to plan a follow-up meeting and what guidance/support may be required after the follow-up meeting and where to signpost the staff member to for futher support.

Improving patient safety:
Following on from the Safety Culture survey completed in conjunction with Liverpool Airport in 2017, we undertook a second safety culture survey in conjunction with AQUA (Advancing

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Quality Alliance). The feedback from the survey has been reviewed and fed back to staff and we are now developing a strategy and action plan to address the issues highlighted.

Improving the quality of care provided:
A task and finish group was developed to review the current service for Plastic surgery trauma patients ('early bird' patients). The group reviewed the processes, complaints and feedback received from patients along with the data which identified the length of time between referral to theatre emergency list until their operation. This review showed that there was often disparity between weekday and weekend scheduling, and some patients were having their surgery cancelled due to the other patient demands on the emergency list. Therefore, it was decided to increase the number of plastic surgery elective lists, in order to create capacity within scheduled operating lists to accommodate these patients; this also enabled the patients to be recovered and discharged from the Day Surgery Unit, giving the patients a smooth journey through theatre and enhancing their experience. There are also plans in place to open the Surgical admissions lounge on weekend mornings to review this cohort of patients and prepare them for surgery in a timely manner on the weekend too.

Improving care for patients requiring emergency surgery:
Following the implementation of the ELIS (Emergency List information System) and subsequent upgrade, this is now the sole source for booking emergency patients through the hospital. The system allows the theatre management team to review the data and populate a dashboard to identify the average patient waiting times, the length of fasting times for patients, and the acuity of patients listed for each specialty. This data will help the theatre management team review the semi-urgent requirements for each specialty when devising a new theatre schedule.

Improving patient experience for patients undergoing elective surgery via the Surgical Admissions Lounge (SAL):
Batched admissions works well on our Surgical day care unit. The proposal was to implement this same process for elective inpatient admissions following feedback from patients and their families and the SAL staff. The feedback comprised mainly of a lack of capacity for all morning and afternoon admissions in one batch, resulting in cramped conditions, including standing room only on the busier days. The decision was made to trial batched admissions for the month of September 2018, with a view to full implementation in November 2018. The overall feedback was positive and the new system is working well for both the patients, their families and the medical teams. Batched admissions is a process for booking elective patients in a staggered manner. Rather than bringing all morning admissions in at 07:30am, the first cohort is admitted at 07:30am and the next cohort at 09:30am, similarly in the afternoon session patients are brought in at 11:30am and 1:30pm respectively rather than all afternoon admissions brought in together at 11:30am. This helps to prevent patients waiting excessive periods of time for their procedure, and prevents overcrowding in SAL.

Key points of focus for the year ahead:

- Implement phase 2 of human factors training development in conjunction with the clinical SIM programme.

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- Work with the regional network to develop a peer review strategy to support benchmarking and consistency of care within the region.
- Fully embed the TRiM (Trauma Risk Management) model of peer support within the department to enable rapid debrief and support following traumatic incidents, so this becomes the standard approach within the department.
- Develop and manage a clear Standard Operating Procedure (SOP) database for the whole department which enables us to review our SOPs in a timely way and ensures they are easily locatable for all staff using them.

D. PLACE inspection 2018/19

Alder Hey Children's NHS Foundation Trust is committed to ensuring that 'every NHS patient is cared for with compassion and dignity in a clean, safe environment.'
The **Patient Led Assessment of the Care Environment** (PLACE) is a thorough assessment conducted by members of the public ('patient assessors'), in partnership with NHS staff and volunteers, and designed to focus on the areas which patients say matter to them.

Participation is voluntary and the assessment covers a range of non-clinical activity that takes place within the care environment. The areas covered by the assessment are 'Cleanliness', 'Food and Hydration', 'Privacy, Dignity & Wellbeing', 'Condition, Appearance & Maintenance,' and Disability, which focuses on issues such as wheelchair access, mobility (e.g. handrails), signage and provision of other aids including visual/ audible appointment alert systems, hearing loops, plus aspects relating to food and food service.

The PLACE assessment at Alder Hey took place in May 2018 and included 11 staff members plus 28 independent assessors including: former patients; members of the children and young people's forum; Healthwatch representatives; parents of current inpatients and outpatients; appointed volunteers and a Trust governor.

Outcomes

The results of the assessment are produced by NHS Digital (formerly Health and Social Care Information Centre). The graph below provides a comparison of Alder Hey's performance over the past 4 assessment periods

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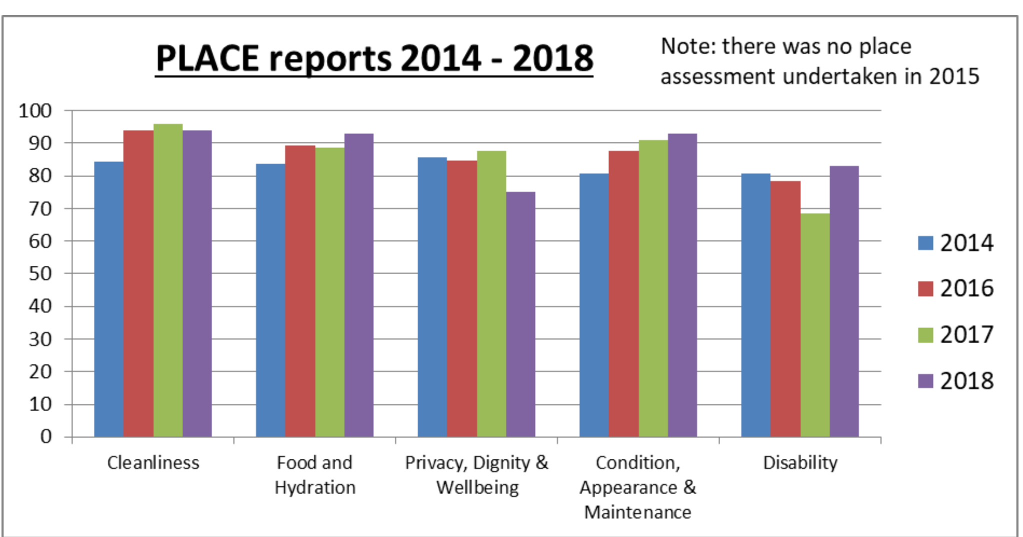

Improvements

- Food and hydration has shown a further improvement this year, with the ward based catering proving popular.
- Disability has shown a big improvement following a disappointing result last year. Wheelchair access has improved and there should be further improvement as the Trust moves out of the retained estate.
- Condition, Appearance and Maintenance has also maintained a consistent improvement over the past four assessments. , with particular focus being placed on improving decoration in several areas.
- Levels of cleanliness have remained above 90%
- Privacy and Dignity showed a significant drop in performance against last year. Upon investigating this further we identified a process issue with regards to how forms were completed and entered onto the database. However it is recognised there are areas requiring improvement in this domain, including overcrowding in outpatient waiting areas, such that privacy is not always protected when families are presenting to the outpatient reception, and at times, there is insufficient seating for the numbers of patients waiting.

Future plans

The Trust has responded to the PLACE report with a robust action plan to address the areas that require improvement. The assessment outcomes and action plan have been reported through the Trust Clinical Quality Steering Group to the Clinical Quality Assurance Committee and ultimately Trust Board.

The Trust received a great deal of positive feedback from the PLACE assessors, although we acknowledge there are still areas for improvement. We will continue to work with patients, the public and external organisations such as Healthwatch, and will again undertake a PLACE

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assessment in 2019 to identify further opportunities for improvement. Prior to the next inspection the process will be reviewed to ensure it remains fit for purpose.

E. Healthwatch – Listening event

Healthwatch organisations act as independent champions for people who use health and social care services. Healthwatch Liverpool conducted an annual 'listening event' at Alder Hey Hospital on Thursday 24 May 2018. This included speaking to as many patients and visitors as possible to gather feedback about the hospital, including the facilities, the food and how the staff interact with children and families. The Healthwatch team set up an information stand in the main atrium, alongside the traditional "hook a duck" game for the children. Some of the team visited wards and outpatients whilst some gathered opinions from children and families as they passed by in the atrium.

Recommendations

Overall the majority of comments made about Alder Hey were very positive. However, both patients and visitors did raise some issues and make some suggestions for improvement. The following recommendations were presented to the Trust in a formal report, which is also available on the Healthwatch website

1. Some people think there needs to be more parking available

2. Some people think there needs to be more variety in the cafe
3. Some people think there needs to be more toys available and more entertainment options for older children
4. Some people think there should be better cooking facilities on wards, especially for parents whose children are inpatients for a long time
5. Some people think that the sofa beds on the wards for visitors are not comfortable for sleeping
6. Some people in both ward and outpatient areas found noise levels to be an issue

These issues have been captured in a Trust wide action plan. Some examples of improvements already being implemented include:

- Senior manager / Executive staff have been requested to park in the retained Estate car park, thereby releasing additional spaces in the multi-storey car park for parent and carer access
- Additional signposting has been put in place to confirm designation of Lower Ground and Ground floor as children and family parking only and a car park attendant has been employed.
- Cleaning schedule document introduced, to be signed for each area
- Ropes and barriers to be introduced at reception areas to support privacy and dignity
- A company has been commissioned to produce a robust sofa bed with no moving parts that meets all the H&S/Infection Control requirements. The sofa bed is currently on trial and comments have been received from various stakeholders.
- Volunteers are now supporting play activities within the waiting room of ED and in the outpatient departments.
- Interactive media products such as Sony tablets and new donated games consoles have been introduced for in patient recreational use on wards & departments
- The play service is working in partnership with the Learning Disability and Autism Acute Liaison service to support the needs of patients who require this service, the funding of a learning disability toy library has been agreed by charities.

F. Improving interpreting services

Aims:

- To improve the experience for children, young people and their families when attending Alder Hey.
- To reduce the numbers of postponed appointments due to no interpreter being booked
- To be more responsive to people's needs at the time they need them

The increasing diversity of our local population has resulted in a growing need for interpreter services for families whose first language is not English. The process for being advised when an interpreter is required and then the subsequent booking has been poorly executed in the last few years and often the need for an interpreter is not identified prior to a child's attendance. Families may go through the whole referral process from their GP, to the allocation of an appointment, booking into clinic using the Intouch scanning system and finally when their name is called in clinic and the consultant starts to speak to them it becomes clear that an interpreter is necessary to

Patient 1: "*I don't like it when we come to hospital, but because Mummy and Daddy need someone to help them understand what the doctor said we have to go home and come back again*"

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deliver a high quality appointment. The will certainly result in delays to the appointment, with a knock effect, delaying subsequent children and families, and may also result in cancelled appointments, so the families have to return when an interpreter is available. In this scenario, the experience for all involved is very poor. An assessment of the interpreter service was undertaken which highlighted several opportunities for improvement:

- There was an inequitable service.
- Regular appointments were being abandoned due to no interpreter present
- Clinic slots were being wasted when appointment was cancelled
- Prolonged waiting lists because of cancellation and re-booking.
- Very dissatisfied families who often, had taken days off work to attend the appointment
- It was also frustrating for the staff
- There is a potential risk to a child's health due to prolonged time to be seen and assessed

Improvements

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

- Developed an interpreter service that has equitable access for all patients
- Reduced on the day cancellations due to no knowledge an interpreter is required
- Access to a video interpreter using a mobile electronic device – providing an interpreter at the time of need, without delay.
- Video interpreter can operate at the bedside, keeping families together
- British Sign Language is also available on video interpreter
- Overall costs reduced as the interpreter does not need to attend the site, so we pay for actual interpretation time, not for time on site (including delays in clinic times)
- Provides access to more interpreters nationally, thereby removing limitation of local availability
- Telephone interpreting remains an option using WiFi – keeps families at the bed-side

Future plans

- Explore ways of ensuring any referral into the Trust identifies the need for an interpreter
- Ability to capture interpreter requirements on our electronic patient records system
- Ensure community services have access to video interpreting; this will require appropriate WiFi infrastructure to be available

G. Family & Friends Test

We have gathered information from children and families through the family and friends test (FFT), a national tool which provides consistent information that is comparable to other organisations and is published externally on both NHS England and NHS Choices websites. In addition we have added our own bespoke survey questions and the table below provides a summary of the responses.

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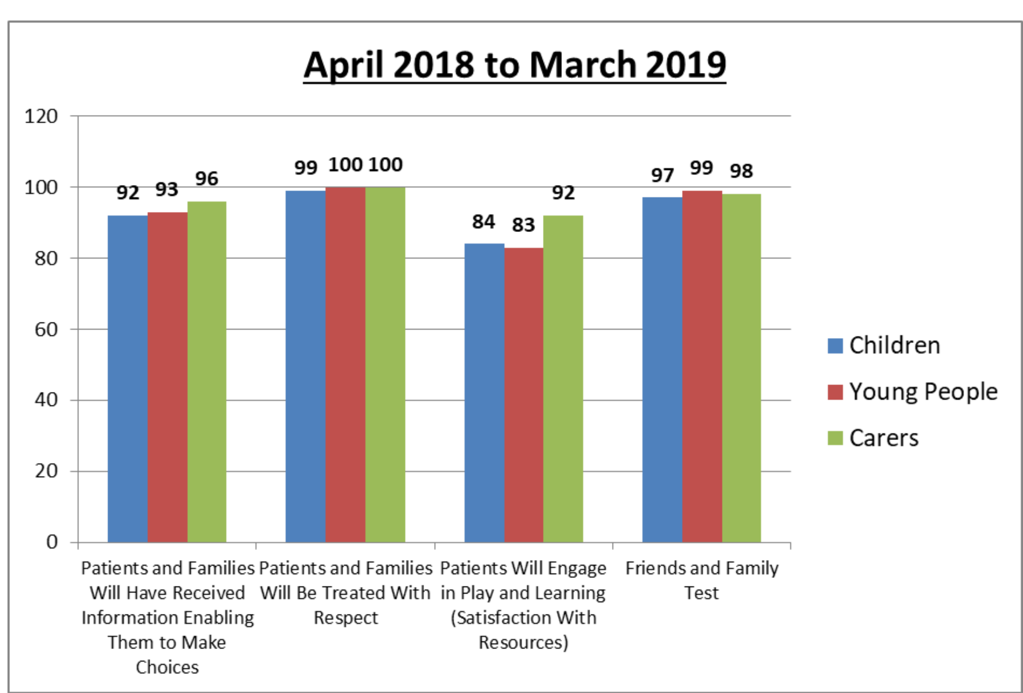

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The following table shows the response from patients and families to the Family & Friends Test.

Patient feedback questions	Total responses	Total responding positively
Friends & Family Test (How likely are you to recommend our hospital to friends and family if they needed similar care?)	5,477	5,335 (97.0%)

H. TheForum@AlderHey

Engaging young people in the NHS can lead to new ideas that benefit the Trust in unexpected ways by getting the children and young people to give their thoughts and ideas about their Alder Hey children's hospital and also the wider NHS. The pace and range of benefits from working with enthusiastic children and young people based on a careful but imaginative representation of the opportunities in the NHS has become invaluable to the Trust.

The Children & Young People's Forum has been long established and has continued to contribute to many quality improvement initiatives over the years. The time is now right to refresh and relaunch the forum and to grow the membership and provide more opportunities for a wider population.
This has prompted the rebranding of the forum. *TheForum@Alderhey* offers a platform for children, young people and their families to share their experiences, raise any issues and share ideas to enable a positive experience.

The Forum provides opportunities to meet other children & young people & parents to share ideas and work as partners in care to make Alder Hey a world renowned service which is truly child centred and where the voices of children and young people and their parents are valued participants in decision making and innovation for the future.
To date the Trust has:

- Rebranded the Children & Young People's Forum as "The Forum@AlderHey" which is *"Inspired by children, a voice for all".*
- Redesigned the web page and leaflet to promote the Forum and established a Twitter account.
- Agreed a uniform for members to wear to help to promote the Forum in the Trust and in the community.
- Established a standard process for staff wanting to present at the Forum

Current activity

- The forum continues to form a focus group to support staff recruitment and has recently supported the recruitment of anaesthetists, plus formed a focus group to interview the new Medical Director.
- Worked with Royal College of Paediatrics & Child Health (RCPCH) to contribute to NHS England guidelines for the Clinical Reference Group – peer consultation
- Parents group chose topic of 'Hidden Disabilities' for presentation at conference in May 2019
- Participated in "15 Steps Challenge" – a means of evaluating the quality aspect of a service including how welcoming the ward / department is, and the information immediately available and visible, as experienced by children and families within the first 15 steps of entering the ward or department.

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- Field trip to the Derbyshire Innovation base in Halton, as part of the Eureka Science project focussed on creating health technology
- Jeff Dunne (Schools Parliament Director) continues to attend forum to update from school parliament. Offering further opportunities for young people to get involved in city projects.
- Andrew and Matilda completed their month as junior and young Lord Mayor. A further election took place and Faith was successfully elected as Young Lord Mayor for 2018/19.
- Participated in creation of the Alder Play App

- Formed a link with North west Ambulance Service patient experience, to provide information about their service, gave the children experience of an ambulance and offered first aid training for the children and young people
- Worked with Twin Vision on creating a puppetry / animation film to represent three characters in the historical context of Public Health, culminating in a red carpet premiere.

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Future Plans

- Promote the service on local radio stations and advertisements and to link in with The NHS Youth Forum.
- Integrate ourselves with in the young person's group in the organisation such as the Chameleons based in Sefton CAMHS, Fresh CAMHS group, Generation R, Young Person's Advisory Group and others.
- Launch a recruitment campaign to increase numbers of participants, extending the membership to anyone that would like to get involved in making things better for children and young people.
- Hy-Genie- Innovation project around infection prevention, hand washing and ways to protect patients, families and staff both here and across other hospitals.
- NHS Youth Forum- involve current forum to join NHS Youth Forum and attend annual meeting

I. Management of Complaints and Concerns

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

	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Formal complaints	166	134	70	66	83	121
PALS	1248	1133	1246	1294	1349	1322

We have seen a significant rise in formal complaints received into the Trust this year compared to the previous three years. Some of the complaints received were historic and came into the Trust in Q1. Further work will be undertaken to

Improvements

- SMS text facility will be available for children/young people and families who are D/deaf to contact the PALS & Complaints team.
- Involved in collaborative work with the Clinical Commissioning Group to develop Quality Standards for Interpreting and Translation – this is to ensure that people who have limited ability to communicate in English are able to access and receive high quality healthcare.
- Appointed a PALS / complaints officer to Community Division which had been identified as a gap.
- Piloted the recording of informal complaints on our risk / incident reporting system (Ulysses) in two wards. Whilst numbers were low during the pilot, there is now an option for staff to record how they have dealt with any matters locally, which may be helpful to review if the family return to PALS at a later date
- Continuation of monthly complaints training session accessible for all staff members in the Trust.
- Training in place and continues to be presented monthly.
- The ability to log a local concern by staff is now live and accessible for all staff with a user guide to assist them.
- Learning from complaints is now monitored and implemented by each Divisional Governance team who ensure any actions from complaints are implemented and the learning is shared within the Division's Integrated Governance meeting.
- Engaged the mother of a young person that had sadly died, in the redesign of the clinical pathway. She worked closely with the clinical team to ensure that communication with families will be better managed and information shared will be clear and concise.

J. Learning Disability Strategy

Approximately 1.5 million people in the UK have a learning disability (LD), including approximately 286,000 children. Recent evidence collated from

Aims:

- To improve the experience of children with a Learning Disability (LD) and/ or Autistic Spectrum Condition (ASC).
- Continue to improve the Trust's response to C/YP with a LD/ASC through the provision of reasonable adjustments (Equality Act 2010)
- Continue to raise awareness of LD/ASC amongst staff through bespoke training
- To build on existing service user/carer and partnership involvement in the LD/ASC strategy across the trust

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the Learning from Deaths Mortality reviews (LeDeR) indicates the average age of death for people with a learning disability as 58 with people with more severe learning disabilities dying earlier (LeDeR 2018). Differences in mortality rates persist with a mean for men of 13 years and women 20 years sooner than their peers (CIPOLD 2013)
During 2018/2019 Alder Hey has made significant improvements to the services and care for people with a learning disability and autistic spectrum condition across the acute site.

Reasons for change

Children and Young people with a learning disability or autistic spectrum condition attend across all services and specialties both within the hospital and community. The Trust recognises the need to identify this group of children as early as possible to ensure the provision of reasonable adjustments (Equality Act 2010). Prevalence figures are now available across the acute site with key areas of attendance identified to support staff training and the provision of reasonable adjustments through the provision of accessible pathways for care and treatment.

Significant progress in identifying and providing bespoke interventions to support equality of access across site have been made based on newly identified prevalence figures supporting the further employment of learning disability nurses across acute areas. Post CQUIN (Commissioning for Quality & Innovation) the trust has continued to be a key partner at the CCG hosted Acute Liaison Network which has developed key strategies to support a pan Liverpool acute approach to areas such as training and documentation.

The acute liaison team formed in January 2018 has developed with all roles recruited to. Key data associated with prevalence, areas for improvement, development and training etc are supported via this team which provides a 5 day week service to support the individual needs of patients, families and clinicians in meeting the diverse needs of the population

Improvements

- Continued long term secondment of the Consultant LD nurse from Edge Hill University
- All posts established across the LD/ASC liaison team including:-
    - Full time LD liaison nurse
    - P/art time play specialist
    - Part time admin support
    - Part time LD nurse contribution (across site release from clinical areas) to team
- Eight LD nurse appointments within the trust across clinical areas- data providing evidence re the most appropriate clinical area (eg OPD)
- Continued facilitation of Learning Disability and Autistic Spectrum Condition Steering Group
- Inclusion of the previously established parent and child reference groups into the relaunched Children and Parents Forum with supported facilitation from the LD/ASC team were required
- Established partnerships with voluntary and independent sector organisations e.g. Contact a Family, Autism Together, Partners in Policymaking, Sefton Carers
- Ongoing participation in CCG hosted Liverpool Acute Liaison Network
- Ongoing training and delivery – e.g. Learning disability and ASC awareness via induction training for all volunteers and nurses that is the pan-Liverpool LD health training pack (used in all acute sites in Liverpool – developed with Liverpool Mencap as

part of the Liverpool Acute Liaison Network). Joint training with Autism Together. Continued 'LD champions' training and new champions identified with key events including a guest speaker Paula McGowan supporting Grand Round (15-3-19 https://www.olivermcgowan.org). Ongoing Positive Behaviour Support (PBS) training across the trust as part of the mandatory training offer for all staff (launched Jan 19- Alder Hey to be the first acute trust in the country to offer PBS as mandatory)
- LD/ASC GDE screen developed, piloted and launched Summer 2018
- Embedding of hospital passport/ risk assessment and reasonable adjustment tools as per Liverpool acute liaison Network strategy continues
- Developed academic and practice links across Edge Hill University and Alder Hey children's hospital to support student journey/ experiences and ultimately recruitment for the trust
- NHSI Learning Disability Benchmark Standards submission completed November 18 which will support ongoing improvements made by the trust.
- Alder Hey currently part of the national acute liaison network facilitated via NHS England
- Consultant Nurse involved on behalf of AH and Edge Hill in the National Skills for Health Advance Clinical Practice guideline development for the role of the learning disability practitioner (Launch May 2019).
- @LD/ASCAlderHey Twitter account launched March 2019

Future Plans

- Review of the LD/ASC teams role and function (LD nurse roles/ workload model and supervision)
- Further recruitment of LD nurses continues (8 across site) development of role and skill mix
- Continued facilitation of LD/ASC steering group
- Facilitation of parent/ child reference groups attending main AH forums
- Continued roll out of LD/ASC appropriate documentation in line with national and local guidance
- Continued attendance and benchmarking across Liverpool and national acute networks re best practice
- Continued rolling programme of training across all clinical areas- bespoke training planned for clinical areas were requested
- Continue development of LD champions and resources
- Continue to support clinical areas in the development of specific pathways for children with LD/ASC
- Improve external communication with families- e.g. through electronic/media etc.
- Develop further the use and availability of communication tools across areas- staff awareness
- Continued identification of research streams and dissemination of best practice across professional networks e.g. LD Consultant Nurse Network , Learning Disability Research Network

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Aim: To enable children and young people with complex needs and their families to be discharged home from hospital with the support they need to be as healthy and happy as they can possibly be.

1. Improve facilitation of referrals to social care / early help to support earlier discharge.
2. Improve co-ordination of Multi Disciplinary Team meetings to discharge discharge options
3. Facilitate Early Help (EH) contact with patients and families
4. Support families in making funding support requests where necessary

K. The Complex Discharge Team

Reason for change

For some children and young people, their length of stay in hospital was far longer than needed. We recognised that children and young people with complex needs want to be at home with their families and in school with their friends. We want to support them to achieve this so we formed a Complex Discharge Team.

The team was formed in June 2018 and is made up of Nurses, a Doctor, Social Workers, an Occupational Therapist and an Operational Support Manager.

Our Pledge

We understand that no matter how caring our staff are at Alder Hey, the hospital is ultimately a place children and young people with complex needs and their families do not want to be in any longer than necessary.

The journey may be full of ups and downs, but our pledge is to, along with the ward team, support children, young people with complex needs and their families throughout their hospital stay and to provide them with the advice and guidance they may require.

The Complex Discharge Team promises to provide a holistic approach to care which means we understand that it is not just children and young people that will require care and support during their hospital admission and beyond within the community, but their family too.

Our mission is to act as quickly as possible to tackle any issues or worries children and young people with complex needs & their families may have regarding going home and work with them to resolve these worries.

We aim to provide the right help early on to ensure children, young people & families receive the best hospital experience possible no matter what the journey taken.
We are a team that are child, young person and family focussed and dedicated to ensuring their safe and effective discharge from Alder Hey.

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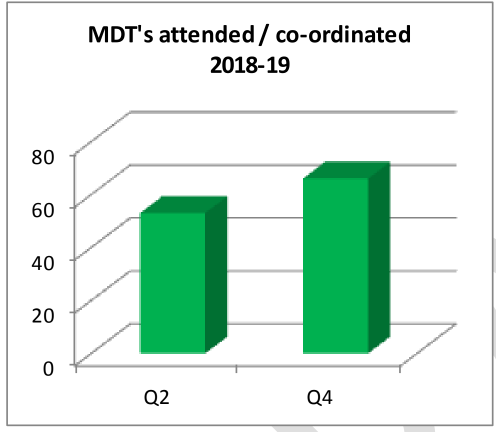
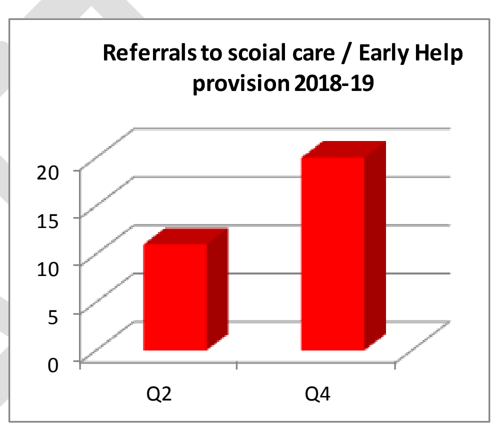
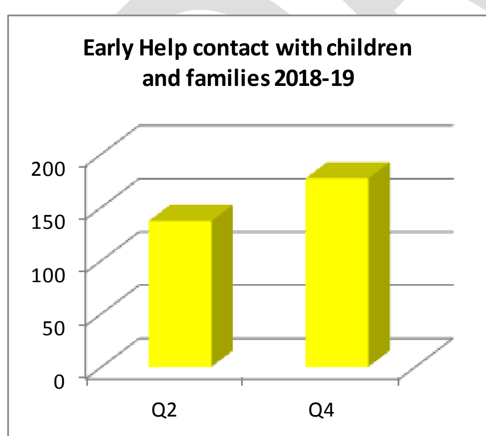
Practical things we do to support children and young people to be at home with their families and go to school with their friends

- We talk to and listen to the children, young people and families to find out what's important to them.
- We organise meetings involving all professionals working with the child or young person so everyone is working to the same goal and timelines.
- We work with outside agencies to ensure home adaptations are made in a timely way.
- We offer support families to access relevant family funds and benefits.
- We undertake Early Help assessments with the family.







Note: Q2 = July to September 2018
Q4 = January to March 2019

The graphs show improvements to all of the processes since the team was established in June 2018

Moving forward - key priorities for 2019/20

- Feedback is important to know we are getting it right for our families. Therefore formal feedback processes are being developed
- Links are also being established with
  - Parent Family and Youth Forums
  - Primary Care
  - The Voluntary sector.
- Work is also underway to develop accurate reporting mechanisms to demonstrate our effectiveness.

Since we started in June 2018 we have successfully supported 106 children and young people with complex needs to be discharged home to be with their families & friends.

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L. Journey to the Stars – Ward Accreditation Scheme

The Journey to the STARs – Ward Accreditation Scheme is a quality and safety audit tool designed to give assurance of standards of practice by measuring the quality of care delivered by wards and department teams.

The assessment tools explore different aspects of patient care and service delivery using the CQC key lines of enquiry as each of the standards. The auditors include clinical and non-clinical staff from across the organisation and we have recently also invited parents to be part of the assessment teams.

The assessment team undertake an aspect of the audit which includes the following:

- Interviewing the ward / departmental manager
- Questions for patients and parents / carers
- Questions for staff
- An observational audit looking at the environment as well as observing interactions and behaviours
- Record keeping and documentation

The information gathered is collated into a report highlighting areas of good practice and areas for improvement. The report is presented to the ward/departmental manager and Matron or Head of Service. The manager and the Matron develop an action plan and progress is reported back through the Divisional Integrated Governance meetings.

The audit helps to recognise the wards/departments hard work, hence the use of a rating system, i.e. a White, Bronze, Silver or Gold award is given to wards depending on the

outcome of the audit and this will also determine when the ward or department will be re-audited.

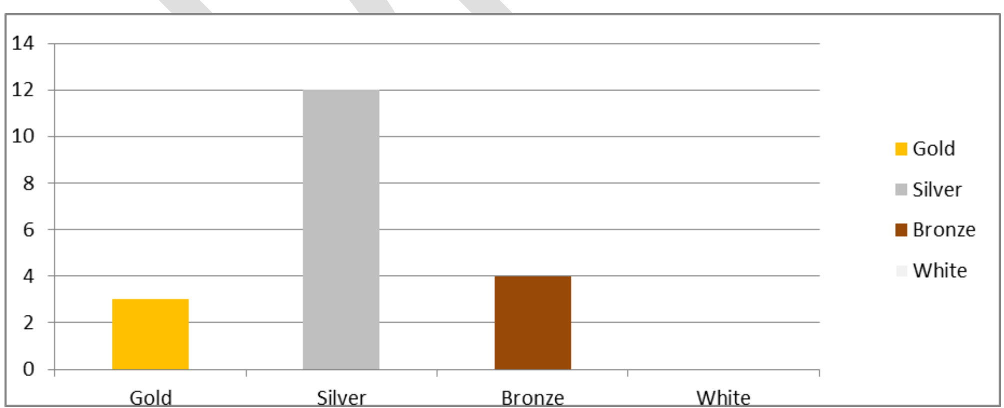
The awards and review schedule is highlighted in the table below:

Award	Overall % for all standards	Review Schedule
Gold	90% or above	Re-audit in 12 – 18 months
Silver	80 – 89.9%	Re-audit in 6 – 12 months
Bronze	70 – 79.9%	Re-audit in 3 – 6 months
White	Below 70%	Re-audit in 3 months

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)

Whilst the initial focus of the ward accreditation scheme was to have an established quality and safety audit process for wards, we had also adapted the assessment tools to enable other departments such as the Emergency department and Outpatients department to be audited. This year work has been undertaken with the Clinical Research Facility and community based services to start to introduce the accreditation scheme within those areas and some of the Child and Adolescent Mental Health services have recently been audited.

There are now 19 wards or departments that have been audited as part of the accreditation scheme. The overall Trust position at the end of the most recent assessments in all areas is shown in the graph below:



All reports and action plans will be published on the Trust's intranet to enable sharing of best practice and learning across the organisation.

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The table below indicates the number of inspections undertaken in each area and the trends in scores.

Ward / Department	Number of inspections	Outcome / Award	Score	Scoring Trend
Burns Unit	2	GOLD	92.0%	↑
Ward 3C	3	GOLD	91.7%	↑
Surgical Day Unit (SDU)	2	GOLD	90.9%	↑
Ward 1C - NEO	2	SILVER	89.5%	↑
Ward 4C	3	SILVER	89.3%	↑
Dewi Jones Unit	2	SILVER	87.9%	↑
Medical Day Unit (MDU)	3	SILVER	86.9%	↑
High Dependency Unit (HDU)	3	SILVER	85.9%	↑
Clinical Research Facility (CRF)	1	SILVER	85.8%	1st Audit
Ward 3A	3	SILVER	85.2%	↓
Ward 3B	3	SILVER	85.0%	↑
Ward 1C – Cardiac	3	SILVER	84.9%	↑
CAMHS - Sefton	1	SILVER	84.2%	1st Audit
Ward 4B	2	SILVER	83.9%	↑
CAMHS - Liverpool	1	SILVER	83.6%	1st Audit
Paediatric Intensive Care Unit (PICU)	3	BRONZE	78.9%	↓
Outpatients	3	BRONZE	75.3%	↑
Emergency Dept / EDU	3	BRONZE	74.0%	↓
Ward 4A	3	BRONZE	72.8%	↓

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There has been an improvement in scores in 12 out of the 19 wards and departments audited. We also see a sense of pride and competition amongst the wards and departments who are striving to achieve higher scores and reach gold.

M. Improvements in training for parents & carers of children with significant Speech, Language & Communication needs

Aims:

- To improve the quality of training received by parents & carers of preschool children with social communication difficulties who have limited verbal communication.
- To reduce the waiting time for parents to receive training on using alternative means of communication with their child.
- To make the most efficient use of clinical Speech & Language Therapy time in delivering interventions.

Outcomes:

- Eliminated the backlog of preschool children / parents & carers waiting for training in alternative means of communication.
- Training provided to 75 parents & carers and 50 nursery staff
- 96% of the parents and nursery staff reported that the training was useful/ very useful
- 94% of the parents and nursery staff reported that the training had left them feeling confident / very confident at using alternative communication techniques

When a child is not yet able to communicate verbally it can be very difficult for parents and carers to understand and meet their needs, leading to frustration on the part of the child. It is part of the Community Speech and Language Therapist's role to help the child and family and other caregivers to find ways of communicating more effectively.

"Informative and useful. Training has given me renewed confidence to attempt to try new communication methods with my son"

Reasons for change

At the beginning of 2018 there were 46 families of preschool children with social communication difficulties in Sefton waiting for training on using alternative means of communication. If each family was offered an hour's treatment session to get a communication system up and running, this would equate to 46 hours of clinical time. By September 2018, another 45 families had been identified as needing this training. The service was struggling to keep up with demand. Upon exploring the situation further, the Sefton Speech & Language Therapists found:

- Inequitable service across the borough with some patients waiting longer than others for this training
- They were repeating the same advice over and over to different families

- An hour often wasn't long enough to explain the rationale and demonstrate and personalise an alternative communication system
- If the appointment took place at the patient's home, nursery staff were missing out on the advice and demonstration, and vice-versa. Everybody working together is crucial to the success of an alternative communication system

Improvements

We ran a 3-hour training session 3 times during 2018, a massive efficiency saving on clinical time but an increase in quality training time for families; all 91 families for whom a need had been identified were invited alongside the child's keyworker from nursery. In total this year, we have trained a total of 75 parents and 50 nursery staff from 31 different nurseries across Sefton.

Feedback mentioned additional benefits to group training including the opportunity to meet other parents and share ideas between parents and nursery.

Several nurseries asked about the possibility of buying in the training session for all their staff

Feedback from parents and carers

96% of the parents and nursery staff reported that the training was useful/ very useful.
94% of the parents and nursery staff reported that the training had left them feeling confident / very confident at using alternative communication techniques.
Other comments from parents and staff included:

"The Speech & Language Therapists are clearly very experienced and knowledgeable. I feel myse[lf] and the parents of the child I am supporting, have gained a great deal from this course – thank you"

Training was very helpful and easy to understand as a father"

"It has been a big help to help us communicate with our child"

"Absolutely everything I've seen and heard today was very helpful and will definitely try it! Thank you for the opportunity!"

"Very helpful for helping to understand why my child may find it difficult to communicate with the world"

Future Plans

To continue to offer this training to families and nursery staff on a rolling programme throughout the year.
To explore further opportunities to run group parent and carer training as an effective and efficient means of delivering high quality intervention

N. Championing Health, Wellbeing and Engagement

"Supporting our outstanding staff to deliver outstanding care"

The Trust is committed to supporting 'the best people doing their best work' and fundamental to achieving this is the creation of an environment which supports our employee's health, safety and wellbeing. We are committed to inspiring our talented workforce to actively drive quality improvement and supporting the ongoing development of a positive and healthy culture, in which our people can give their best.

In support of this commitment, the Trust has set itself an overarching aim as follows:
"By 2021 be recognised as one of the top 20% of Trusts in relation to the Staff Survey results, including 80% of our staff recommending Alder Hey as a place to work"
In striving to deliver this priority, the Trust agreed to place a specific focus on the following areas:

- **Health and Wellbeing**
- **Leadership development**
- **Equality, Diversity and Inclusion**
- **Apprenticeship opportunities**
- **Vocational skills development**

Aim: To create an environment that encourages and enables staff to priortise and support their health and wellbeing

Target:
5% improvement in answer 'yes, definitely' to the question 'does your organisation take positive action on health and well-being' in the national staff survey (2017 baseline: 25.0%)
Outcome:
Increased 'yes, definitely' response to 27.7%
Data source: NHS England – Survey Co-ordination Centre

1. Health and wellbeing

The importance of staff health and wellbeing is widely recognised and as an employer we aim to champion physical, mental, emotional and financial wellbeing of everyone working in the organisation. The aim is to provide staff with the tools, resources and support to ensure that their health and wellbeing is a priority. In doing so we will see continued improvements in performance, patient experience and quality of patient care through improved staff engagement. Numerous

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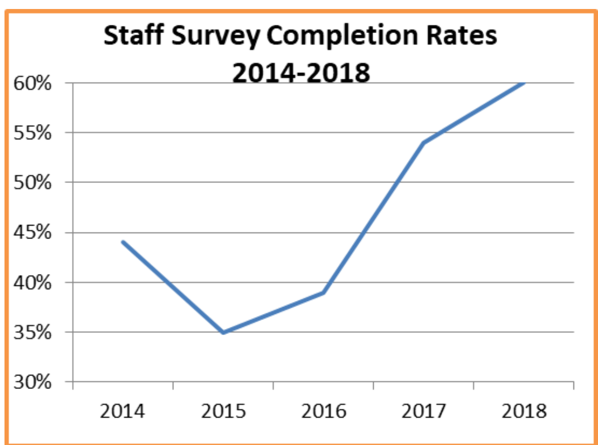
initiatives have been adopted, to support the promotion and championing of health, wellbeing and engagement across the organisation.

Whilst the staff survey results did not quite achieve the targeted 5% improvement against the question '*does your organisation take positive action on health and wellbeing*', the overall staff survey results were significantly improved against last year. The survey response rate was 60%, the highest we have seen at Alder Hey, and there were improved responses in 77% of the questions. Most notably, '*the extent to which my organisation values my work'* (10% improvement), '*the recognition I get for good work'* (9% improvement), '*care of patients / service users is my organisation's top priority'* (8% improvement) and '*I would recommend my organisation as a place to work'* (8% improvement).



Improvements 2018/19

- **Time to Change**

1 in 6 workers experience stress, low mood or poor mental health and mental ill-health is the leading cause of sickness absence in the UK.

In September 2018, 30.3% of absence across the Trust was due to stress, anxiety and depression making it evident that we needed to do more to support our staff and colleagues, having a colleague in your corner can make all the difference. As part of our Health and Wellbeing strategy the Trust is changing how we think and talk about mental health by signing the Time to Change Pledge. The Trust has developed a Time to Change action plan which identifies a number of initiatives to empower people to challenge stigma and speak openly about their own mental health experiences

- **Reward and Recognition**

This year the Trust held its second "fab staff week" that promoted health & wellbeing activities and initiatives available to staff. Staff were also encouraged to pledge to making a simple positive change to support themselves and their colleagues. In addition the Trust continued to recognise staff commitment and achievement through local thank you cards, the monthly 'Star Awards' and the annual Trust award ceremony.

- **NHS Improvement Health and Wellbeing action plan**

In conjunction with NHS Improvement the Trust developed a Health and Wellbeing action plan which details the strategies, initiatives and milestones required to help improve health and wellbeing. Achievements include the introduction of a Health and Wellbeing Steering group to prioritise the sharing of best practice and a consistent approach to the management of health and wellbeing in the workplace. In addition the Trust has published 'A Guide to Staff Services' to highlights all the support, resources and tools available to staff.

Future plans

- To establish a network of Mental Health Champions and advocates across the organisation who are trained in 'Mental Health First Aid' and 'Mental Health in the Workplace'
- To provide Mental Health in Workplace training to the executive and non-executive team in addition to identified senior leaders
- Host a Health and Wellbeing day to promote available support and resources and to launch Time to Change pledge
- Develop and launch a communication platform for Health & Wellbeing

2. *Leadership Development*

Aim:

1. To ensure our staff have the right skills, knowledge and training to do their best work

Target:

- 5% improvement in answer 'yes, definitely' to the question 'My manager supported me to receive this training, learning or development' in the national staff survey (2017 baseline: 44.8%)
- To consistently achieve 90% compliance on mandatory training

Outcomes:

- Increased response to survey question to 50.9%
- Consistently achieved close to 90% compliance on mandatory training (see graph below)

Data source: NHS England – Survey Co-ordination Centre, plus internal data through ESR

Over the past 12 months we have been actively working to ensure that staff feel valued within the organisation and are given the best opportunities to develop the right skills and knowledge to do their role. With this in mind, we've been focusing on improving our development offer within the Trust.

Improvements 2018/19

- Launch of the brand new internally delivered Mary Seacole Leadership Programme
- Roll out and provision of a variety of training sessions for staff to attend including Minute Taking, Delivering High Quality Appraisals and a host of other short courses
- Expanded delivery options for mandatory and clinical training courses - most courses are now available via e-Learning as well as face to face allowing staff to complete them at a time, place and learning style appropriate to them.
- Launch of the updated Trust wide training needs analysis to ensure that funding and support is provided fairly and widely across the organisation to support staff development

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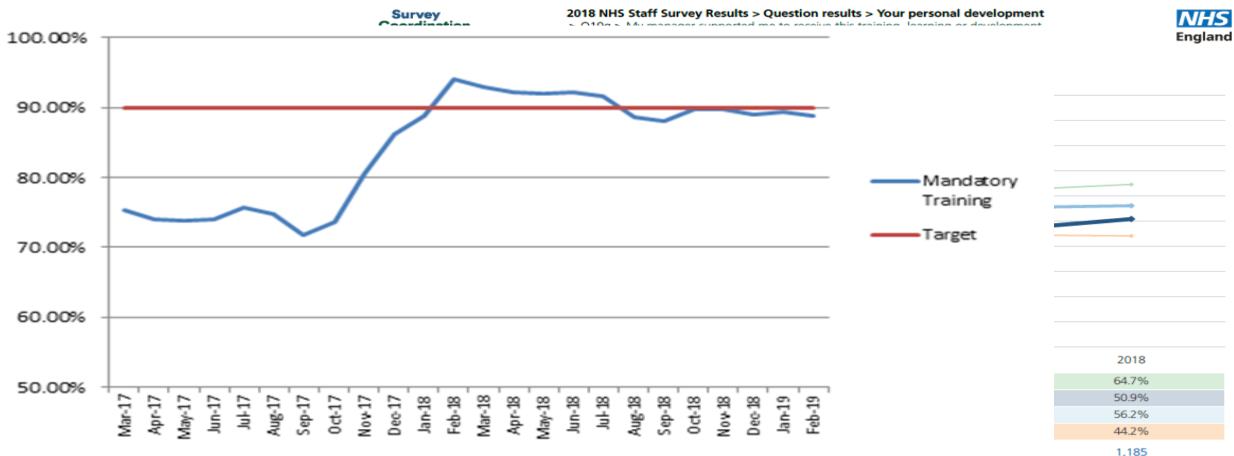
- Provision of Organisational Development (OD) initiatives to support team development, including 360 degree feedback sessions, coaching and a variety of bespoke team development sessions.

All of this combined has enabled the trust to report that our staff survey score for staff accessing non-mandatory training has increased, in a year which saw the average, best and worst scores decrease across our comparators



Future Plans

- Launch of new internal Leadership Faculty including Strong Foundations programme to support all current leaders and managers
- Trust wide 'Big Conversations' based on departmental feedback from the Staff Survey, focusing on improving staff experience whilst working at Alder Hey.
- Continue to explore new and innovative ways of building staff confidence and motivation

3. Equality, diversity and Inclusion (EDI)

Staff

In addition to the Black, Asian, Minority Ethnic (BAME) and Disability Staff Networks, the Trust has recently formed the Lesbian, Gay, Bisexual, Transgender, Intersex and Queer plus (LGBTIQ+) network. The staff networks meet on a regular basis to enable staff to discuss experiences of work-life concerns and gain support from others in a safe and non-threatening environment and to provide expert knowledge to the Trust to enable the development of policies and practices that are reflective of staff needs.

Terms of reference are being updated to better reflect the value placed on staff networks in the Trust and the role of members including the involvement of Human Resource Business Partners (HRBP's) assigned to each network. The networks have an improved assurance process as initiatives discussed at network meetings are progressed through the recently

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established Staff Wellbeing Steering Group. For example this has included the development of reasonable adjustment guidance for line managers identified as a priority by the disability network.

Members from the three networks are involved in developing the training content for the 'Strong Foundations' programme for leaders in the Trust. Network members will develop key learning outcomes that are important across all three networks to try and create more inclusive leadership. The Chairs of the networks are also members of the policy review group so that the networks are able to influence policy development to ensure it better considers the needs of staff belonging to minority groups.
BAME and Disability network members and senior leaders are also participating in the Reciprocal Mentorship Programme (RMP) launched in January 2018 in collaboration with local NHS Organisations including The Walton Centre, Mersey Care and Royal Liverpool and Broadgreen hospitals. Reciprocal Mentoring is an innovative practice that aims to enhance the transcultural learning between participants so that Executive and Senior leaders are better able to understand the challenges that staff working in Alder Hey, from minority groups may experience, in advancing their chosen career path and/or leadership development and offer more appropriate guidance and/or support. Staff members will develop a greater understanding of the knowledge, skills and attributes required of senior leaders. Transcultural learning will hopefully enable participants to develop recommendations that influence change for the better.

The Trust has developed separate Workforce Equality, Diversity and Inclusion (EDI) objectives 2018-2021 with responsibilities within the Human Resources Team reporting to the Director of Human Resources & Organisational Development. Progress will be assured through the Workforce and Organisational Development (WOD) committee.

Patients
The Trust has been working collaboratively with other local NHS organisations to populate an Equality Delivery System (EDS2) template. In September 2018 the Equality and Diversity Manager and representatives from the CCG discussed this template with responsible leads for goals 1 & 2 (patient related) to identify our priorities and how this could be implemented locally. These discussion have been incorporated into a separate Patient Equality, Diversity and Inclusion (EDI) Objectives 2018-2021 with responsible leads identified within the team reporting to the Director of Nursing and Quality. Progress will be assured through the Clinical Quality Steering Group (CQSG) committee. In addition, the Head of Quality (Corporate) has been working collaboratively with local Trusts and the CCG in task and finish groups to progress patient related objectives included in the Quality Contract.

Aim: Increase the BME workforce by 1% each year, over the next 5 years to 2022, thus reflecting the demograhic make up of the local population, with an 11% BME population.
Targets:

- 1% increase each year

Outcomes – 2018/19

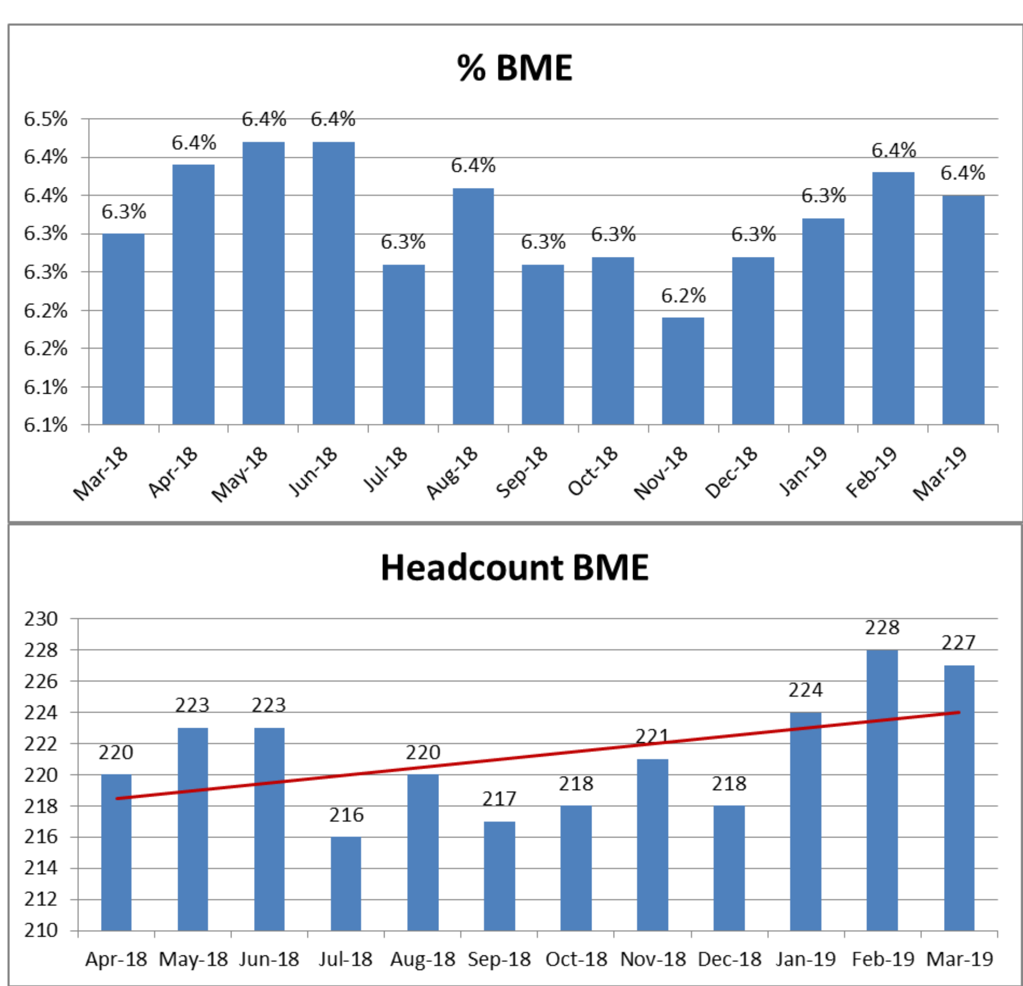
- *April 2017 – 190 BME employees (5.6%)*
- *March 2018 – 222 BME employees (6.3%)*
- *March 2019 – 227 BME Employers (6.3%)*

Increasing the BME workforce representation
The Trust recognises that the staff are the most important and valuable resource and are committed to attracting and retaining a diverse and motivated workforce, with the right skills, values and knowledge to deliver world class care for patients. Creating and retaining a

diverse and inclusive workforce will enable the organisation to deliver a more inclusive service and improvement in patient care. Our staff are our community and we recognise the importance of ensuring our workforce is representative of our local population

Improvements 2018/2019

Whilst the percentage of BME workforce did not increase over the past 12 months, there was an increase in the number of BME employees and the trend graph below shows the Trust is moving in the right direction. Further targeted work is required to continue to further increase the BME workforce numbers



- Development and promotion of the staff BME, Disability and LGBTIQ+ networks to support staff experience and staff diversity
- Successful launch of Merseyside Reciprocal Mentoring Programme in partnership with other organisations which aims to enhance the transcultural learning between senior leader's staff from minority or disabled groups. Following launch 6 partnerships were established

- Launch of network intranet pages that advertises network and allows communication between members and the sharing of information and resources
- Big Conversations hosted with the support of Listening into Action to identify key areas of improvement and development and to identify successes and achievements
- Successful third cohort of our pre-employment programme in partnership with Job Centre plus which has seen 10 individuals secure placements across the organisation

Future Plans

- Launch of cohort 4-6 of the pre-employment scheme
- Become a Stonewall Employer Champion
- Support a further 10 reciprocal mentoring relationships across the organisation
- To continue work promoting NHS Careers to locals schools and colleges and to local networks.

4. Apprenticeship opportunities

Aim: To grow and embed apprenticeship opportunities in 2018/19

Targets – 2018/19
- 50 apprenticeship starts (baseline: 4)
- 6 newly employed apprentices (baseline 3)

Outcomes – as at March 2019
- 63 apprenticeship starts
- 13 newly employed apprentices

Following the successful establishment of the Apprenticeship team at the beginning of 2018 we have stepped up to the challenge and embraced the opportunity to identify and offer new opportunities to attract talent from the local population to the organisation and identify supply pipelines for all key staff groups and roles to support the provision of safe, high quality services

Improvements 2018/19

- Successfully became one of two NHS organisations within Liverpool to acquire provider status in December 2018 that enables us to deliver Apprenticeships to our staff
- 63 individuals successfully engaged in apprenticeship programmes across a variety of subjects from level 2 to level 7
- Identified as Employer and Apprenticeship Ambassadors for the Liverpool City Region Apprenticeship Hub

Future Plans

- Introduction of Apprenticeship programmes under the new standards
- Increasing number of apprenticeships to 120 by March 2020
- Successful enrolment of 10 external students onto Alder Hey led apprenticeship programmes

5. Vocational Skills development

Over the past year we have successfully implemented a number of vocational opportunities that work directly with the local community to provide alternative career opportunities from traditional recruitment methods. This is enabling us to secure our future talent pipeline and

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have a positive impact on the local community by offering a variety of career and development opportunities.

Improvements 2018/19

- Working in partnership with 3 local schools offered clinical placements to 85 Health and Social care students
- Successful placement of 77 students across the organisation in work experience placements
- Hosted the Trust inaugural career fair which showcased career opportunities across 10 specialties within the Trust to students from 6 local schools and community organisations
- Hosted career events for over 50 students from local Higher Education Institutes

Future plans

- To further build on the success of the Vocational Skills development opportunities to date
- To work with Department of Work and pensions to provide career opportunities to Veterans leaving the forces
- To offer structured Internship opportunities to University students across a variety of corporate specialties including Finance and Human Resources

O. Volunteer Programme at Alder Hey

Aims:
To grow and develop volunteering in Alder Hey offering quality volunteering opportunities that would make a huge impact on enhancing our Children and Young People's and their families experience as well as the benefits for the volunteer.

Volunteering is a key enabler in transforming the way the NHS works with people and communities. During 2018 Alder Hey formally reviewed their volunteering programme to ensure we were delivering good practice to our volunteers and staff.

Feedback from the Family & Friends Test (FFT) consistently proves the benefits to patients experience from our volunteers. This year we have volunteers engaging with families in wards and outpatients offering a range of services including

- Facepainting
- Reading stories
- Play
- Hollie – Pets as Therapy

Achievements:

Helpforce
This year we are have joined partnership with Helpforce whose vision is to make volunteering an integral part of everyone's health and wellbeing. We are the first Children's acute Trust to become a member of their learning network and we look forward to sharing our knowledge and experiences and benefitting from others.

Heath Careers Passport

The HCP scheme is a pathway to allow young people to gain practical experience and show that careers in health are within their reach regardless of their background. We have linked with the scheme to be the first Trust on board. Below is one of our volunteers who is carrying out his role in our labraotry, gaining skills that he can take with him on his career path.

Baby Cuddler Volunteer

One strategy that we have introduced on the neonatal surgical unit here at Alder Hey is the 'Volunteer Baby Cuddler Programme', which was lauded on National television recently. Volunteers go to the ward to hold babies when parents are not available. For many years the positive effect of human touch on infants has been clearly demonstrated

Future Plans

Objectives for 2019/20

- Mental Health First Aid (MHFA) – volunteers to attend training sessions to provide Mental Health First Aid
- Volunteer Community Champions – to visit schools, retirement villages and colleges to discuss our volunteer programme
- Smoking Advisors – training is provided to our volunteers by Smokefree Liverpool to offer assistance to those who wish to give up smoking
- Health Promotion – volunteers to support the delivery of health and wellbeing within the atrium for the public
- Bleep Volunteers – Volunteers to be available to collect medication to speed up discharge
- Concierge Service – to be an advocate for families offering support from our volunteers along with concierge team.
- The Forum@alderhey and Membership – to streamline and develop the links with our Forum and members to enable progression and interaction.

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P. Nurse Staffing

Aims:

- To have zero nursing vacancies.
- To sustain a resilient nursing workforce with up to 40 WTE over the baseline frontline nursing establishment to cover maternity leave, long term sick cover and fill ward/department vacancies.
- To have a proactive recruitment campaign.
- To have a nursing workforce who have the right skills and receive the right training for the job.
- To retain our nurses.
- To proactively plan for future workforce requirements.
- To enable all nurses to reach their full potential, to succession plan for the future and to have a clear development plan for nurse career trajectory.
- To promote and herald the nursing contribution to research.

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.

In November 2017, the National Quality Board published improvement tools specifically for the care of children and neonates: *Safe, Sustainable and Productive Staffing: An improvement resource for children and young people's in-patient wards in acute hospitals / neonatal care.* The improvement resources are based on the 2013 NQB guide to nursing, midwifery and care staffing capacity and capability that sets out the need for safe, effective, caring responsive and well led care, on a sustainable basis, that ensures the right staff with the right skills are in the right place at the right time. Specific guidance for safe staffing levels in neonatal and paediatric settings is set in the main by the Royal College of Nursing (2013). The Trust undertakes an annual review of all ward establishments in line with national guidance, reporting to Trust Board.

In line with Department of Health Hard Truths Commitments (2013), all Trusts are mandated to provide nurse staffing information on a monthly return via the National Reporting and Learning System and publish this data at ward level and make the information available to the public. The Trust is compliant with submitting data to the public through NHS website, the Alder Hey website, and at ward level. A monthly ward fill rate of 90% and over is considered acceptable nationally. Fill rates for 2018/19 demonstrated that the overall staffing level was consistently higher than 94% throughout the year. The staffing levels reported are the head count on each shift which does not analyse skill mix or the impact of temporary staff on a shift.

The Trust has continued to successfully recruit to vacancies through collaborative working with our education providers, national recruitment days and bespoke recruitment in specialty areas. The Trust has successfully recruited 92.6 WTE registered nurses in 2018/19. During the course of the year, the Trust has participated in developing a new role in line with the national nurse development programme. The Trust has trained and then appointed two Nurse Associates and committed to supporting up to eight Health Care Assistants per year to undertake training to become a Nurse Associate.

There has been a continued drive to reduce the use of bank and agency staff, which in addition to reducing expenditure, also provides safer nursing care with staff employed directly

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by the Trust. The use of front-line nurse agency staff has been zero in 2018/19, with the only agency nurse usage required to support the specialist CAMHS team. Alder Hey has the lowest use of agency staff in England as evidenced in the comparative data provided by NHSP temporary staffing providers.
In May 2018, the Nursing and Midwifery Council (NMC) launched new NMC standards for nurse training to begin to commence from 2019, with a clear focus on ensuring nurses clinical competence at the point of registration. The *Standards of Proficiency for Registered Nurses* represents the skills, knowledge and attributes all nurses must demonstrate. Practice Educators play an essential role in the development of a workforce that is able to deliver high quality, effective and safe care. The Trust had 2 WTE Practice Education Facilitators (PEF) to support pre-registration students, and Critical Care have an established Education Team to support post registration learning and development, however a need was identified to strengthen the support to the post registration nursing workforce who in turn support students, new staff and the future workforce. A business case was devised, approved and implemented to introduce and successfully recruit a Head of Nurse Education to the Trust, supported by 6 WTE ward based Clinical Educators and an additional PEF, to facilitate the advancement of nurse education in the Trust.

In 2018, a review of the process for newly qualified nurses to join the Trust was undertaken in collaboration with the universities and student nurses which resulted in the development of the Staff Nurse Rotation Programme: a standardised approach to staff working and gaining experience in different areas of the Trust, developing their knowledge and skills, and helping to retain our valued nursing workforce.

Safe staffing levels and compliance with RCN guidelines

To continue to monitor and improve staffing levels, an audit against the RCN standards has been repeated in March 2019 involving the Ward Managers, Matrons and Associate Chief Nurses for all in patient and day case wards.

A previous audit of compliance against the 16 core standards conducted in February 2018 demonstrated Trust compliance with 13 standards and partial compliance with 3 standards as shown in the thermometer below:

2	3	4	6	7	8	9	10	11	12	13	15	16	1	5	14

The recent audit has demonstrated a further improvement against the standards, with core standard 5 moving from Amber (partial compliance) to Green (full compliance) as shown in the thermometer below. Core standard 5 states that a 25% increase to the minimum establishment is required to cover annual leave, sickness and study leave. The wards at Alder Hey have a funded establishment which includes a 23% uplift. The remaining 2% uplift is supported through the funding of the additional 40 WTE Band 5 nurses achieving the full uplift and as such increasing the availability, resilience and support to the front line nursing workforce.

2	3	4	5	6	7	8	9	10	11	12	13	15	16	1	14

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Although two standards have remained at Amber (partially compliant), there have been significant improvements in both standards as follows:

Core standard 1: *All clinical areas are required to have a supernumerary shift supervisor:* Not all wards have an establishment funded for a supernumerary shift supervisor however there have been significant improvements in 2018 with increased funded establishment on two wards resulting in supernumerary shift co-ordinators. Eight wards are fully compliant with this standard. Partially complaint wards allocate a nurse to take charge and co-ordinate the shift. All wards have a Ward Manager who is supernumerary, and benefit from presence of a supernumerary Matron, and have access to a supernumerary Clinical Educator.

Core standard 14: *There should be access to a senior (Band 8a) children's nurse for advice at all times:* A business case has been devised and approved to support the implementation of a nursing team 24 hours per day 7 days a week who support the nursing and medical teams on the wards, the team will be clinically led by an Advanced Nurse Practitioner on each shift. This standard will be achieved by introducing the new model during 2019-20. All clinical areas have access to senior nurses "in hours". An experienced Band 6 or 7 provides support to the nursing team "out of hours" through the Patient Flow, Night Matron and Senior Nurse bleep holder.

In further progressing the work towards the aims of having zero nurse vacancies, sustaining a resilient nursing workforce, recruiting proactively, and ensuring the provision of a nursing workforce who have the right skills and receive the right training for the job, retaining our nurses, planning for future workforce requirements, enabling all nurses to reach their full potential, and promoting the nursing contribution to research, the Trust has made the following improvements:

Improvements 2018/19
Recruitment:

- 92.6 WTE front line registered nursing staff recruited in the last 12 months.
- 2 WTE Nurse Associates appointed in the last 12 months following qualification of the second cohort
- The development of a responsive recruitment culture with evidence of strong partnership between senior nurses and human resource staff, notably working together on successful national recruitment days and a comprehensive induction and preceptorship programme for new nursing staff.
- Development of a "one stop shop" recruitment day
- Additional nurse recruitment sustained to cover maternity leave, sickness and vacancies
- Additional nurse recruitment to safely staff 11 additional beds to manage the increased number of admissions during the winter period
- Revamp of the Nurse Induction Programme and protected induction period
- Improved and standardised preceptorship

Safe staffing levels

- No beds closed to admissions due to nurse staffing levels.
- No cancelled operations for "staffing unavailable".

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- 11 additional beds opened and staffed sustainably to support bed availability due to projected winter pressures.
- Increased ward based funded establishment for registered and unregistered nurses on two wards
- Comprehensive review of nurse staffing on Tier 4 CAMHS ward.
- Increased fill rates via NHSP for both registered and unregistered staff
- No use of front line nursing agency staff

Strong and effective leadership structure

- External recruitment to the new Head of Critical Care role in the Surgical Division.
- External recruitment to the Head of Complex Care role which became vacant. The role has been reviewed and provides a deputy to the Associate Chief Nurse Community role in line with the same structure in the Medical and Surgical Divisions
- Effective succession planning and internal promotion to three Ward Manager posts on the Burns Unit, the Surgical Day Case Unit, and Ward 3A General Surgical Ward following the retirement of the previous post holders.
- Comprehensive review of the nursing structure in the Research Division resulting in additional Band 7 posts which have been successfully recruited to internally.
- Internal promotion to Band 6 Ward Sister / Charge Nurse positions.
- Demonstrable involvement of the Chief Nurse, Director of Nursing and Deputy Director of Nursing in the Cheshire and Merseyside collaborative work regarding the nursing workforce.

Educational developments

- Working collaboratively with our HEI partner the Trust has developed an MSc programme in leadership enabling staff to gain the necessary skills and competencies to successfully fulfil senior nurse roles.
- Internal recruitment to Head of Nurse Education to the Trust, 6 Clinical Educators and a Practice Education Facilitator
- Development and implementation of the new Staff Nurse Rotation programme: Facilitates the development of a wider skill set; access to a wider experience in medical, surgical and specialist fields
- Maintained and recruited to the increased number of places of trainee Advanced Nurse Practitioners to enhance nursing practice and assist in the reduction of Junior Doctors
- Maintained and recruited to the increased number of places of trainee Nurse Associates

Quality metrics

- Reviewed and enhanced monthly Safety Thermometer point of care survey designed to measure commonly occurring harms and support improvements in patient care and experience.
- Reviewed and enhanced Ward Accreditation scheme, a quality initiative where wards across the Trust are regularly inspected by an independent senior team of nurses and

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patient experience leads assessed against a range of measures based on the CQC KLOE's.

- Reviewed and enhanced Ward Dashboards to ensure all staff have access to relevant data to improve patient care

Future Plans

- Agreement to integrate HEI's into new Institute in the Park building enhancing the learning environment.
- Continue proactive recruitment of student nurses and trainee Nurse Associates
- Development of nurse apprenticeship programme.
- Continue monitoring vacancies, turnover rates and daily staffing levels with work feeding in to Workforce sustainability group.
- Implement an E Roster system to support staff management of shifts.
- Review nurse education requirements in line with new NMC standards.
- Implement Improvement Boards on the wards as part of the Trust Inspiring Quality initiative.
- Devise a programme of "Proud to Care", enabling and facilitating outstanding well led wards, as part of the Trust Inspiring Quality initiative.
- Work in partnership with Liverpool Women's Hospital to plan, develop and recruit to the Single Neonatal Service in line with British Association of Perinatal Medicine (BAPM) standards.

Q. Improving Arts, Performance and Play

In the last 12 years Alder Hey has delivered an Arts Programme that brings health benefits on the wards, high profile activities in public spaces, and productive relationships with external arts, educational and health partners. The core purpose of our Arts for Health Programme is to:

- Provide a more positive experience for children and young people during their hospital stay
- Improve the wellbeing of children and young people through participatory arts
- Support children and young people to establish a better quality of life whilst in hospital by addressing the underlying issues associated with prolonged treatment journeys
- Provide opportunities for children and young people to develop new transferable skills and life experiences, such as decision-making and creative expression.

The majority of the Arts for Health programme is delivered in clinical spaces, and is child led and child centred. Highly skilled and experienced artist practitioners deliver a participatory improvised programme which responds directly to the needs and interests of the children and young people. It is based on proven research in the arts and health sector which has established that participation in an arts programme can be beneficial to an individual's health and wellbeing.

We have forged partnerships through our Cultural Champions programme with: Tate Liverpool; FACT; Merseyside Dance Initiative; Live Music Now; Royal Liverpool Philharmonic; DadaFest; Bluecoat Display Centre; Manchester Metropolitan University; Small Things Dance

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Collective; Twin Vision. Our programme is broad, encompassing dance, digital art, music, visual arts and crafts, storytelling, performance and animation.

2017
586 workshops
5000 children

2018
693 workshops
>6000 children

In the last twelve months, we have delivered 693 workshops and worked with over 6,000 children. This compares to 586 workshops and 5,000 children the previous year. The exceptionally high numbers are, in part, due to a number of major high profile projects, which have received funding from the Alder Hey Children's Charity and external charitable sources.
Music Matters

Alder Hey Children's Charity have funded the continuation of the 2017/18 programme, which places a musician on every in-patient ward once a week. We have continued to see the positive benefits of live music on the wards, supporting patients through their treatment journeys. Patients, parents and ward based staff have unanimously supported the continuation of the programme, recognising the influence that live participatory music had on the child's wellbeing, physical ability and emotional state - and particularly with long term patients, their ability to cope with hospital life.

"It is boring being in bed all day and it seems like the day is never ending. Music sessions really cheer me and mummy up. It is fun and then I'm not thinking about being in pain."
Alexa aged 9 years

<u>Music as Medicine</u>
This project, funded by The Youth Music Foundation, started in January 2017 and concluded in September 2018. In partnership with Live Music Now, the project placed 8 musicians into four key areas of the hospital: Oncology, Neuro Rehabilitation, Cardiac Unit, and Dewi Jones mental health unit. Musicians delivered weekly sessions and the project tracked patients' musical progression as well as assessing the impact on wellbeing. Our evaluation showed that **89% of patients said that their confidence had significantly improved** through participation in the project and **95% said that their musical skills had significantly improved.**

It's fun and very useful for learning. It took my mind off the pain I was in. It improved my confidence because I learnt that I shouldn't be nervous about performing. I didn't know about the ukulele, now I do!"
Clara aged 10 on Neuro Rehab Ward

The project also embedded bespoke training for the musicians, equipping them with the skills to work in this sensitive environment and deliver music sessions that the patients and families will enjoy. We also created a film resource to share with other professional musicians interested in working in a paediatric healthcare setting. The film was launched nationally at the Wingbeats Conference in Manchester in November 2018.

Young Makers

Funded by The Big Lottery Fund, these are two craft making residencies for children and young people, developed in partnership with Bluecoat Display Centre. The first residency, held from October to December 2018, brought willow weaver Caroline Gregson onto Wards 4A and 3C. Caroline worked with patients and families, creating individual willow sculpture which patients could take home with them, as well as a collaborative willow sculpture for each of the wards' Play Decks. **84% of patients said that the project significantly improved the experience of being in hospital**.

"It shows Alder Hey is not just about doctors and medicine. I had a headache all day and I forgot about it whilst making the boat."
Luka aged 14

The second residency, from January to March 2019, has brought printmaker and textile artist Rachael Howard into wards 3A and the Oncology Unit. Rachael has created individual pieces using screen printing techniques with patients, as well as delivering a staff training session for Play Specialists and teachers.

Patients Stories

Funded by The Will Charitable Trust and P H Holt, this is a partnership with Comics Youth CIC, an award winning Merseyside based organisation who have built up a strong track record of delivering comic-based projects with disadvantaged and marginalised children and

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young people. Artists from Comics Youth have been delivering weekly workshops across all areas of the hospital to encourage children and young people to tell their stories through the production of comics, cartoons and 'zines'. The project aims to establish a better quality of life for patients whilst in hospital by addressing some of the underlying issues associated with long-term hospital stays such as isolation, anxiety and depression. It also helps participants develop new skills in visual literacy, story-telling and graphic design as well as transferable skills and life experiences such as decision-making and creative expression, which will support both their immediate wellbeing and also their future education and development.

The project will culminate in the production of an Alder Hey publication featuring the stories and drawings created by our patients.

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<u>DadaFest</u>

This is an innovative project, funded by Children in Need, and developed in partnership with DadaFest, a national arts organisation promoting deaf and disability arts. The project gives long term patients the opportunity to have up to 20 hours of contact time with a professional artist of their choice – patients can choose a variety of art forms to engage with, from drumming to dance, song writing to card making. This is a three year project which started in October 2018. Children and young people will be encouraged to create work which can either be performed or exhibited at the Young DadaFest Showcase, which takes place in Liverpool every July. So far, we have 5 long term patients (stay of three months or more) who have participated in the scheme.

The project also brings professional disabled artists to work with and perform for the patients, as part of the International DadaFest Festival. In November, disabled dancers from StopGap Dance Company performed in the hospital's Performance Space as well as delivering workshops on the wards.

<u>Medical Mavericks</u>

Funded by the Heritage Lottery Fund, we are particularly proud of this educational project which explores the lives of three historical medical pioneers, who all had connections to Liverpool. Led by Twin Vision Media, the project engages patients in the history of medical innovation through creating three stop frame animations, each one exploring a different historical character. Patients are involved in all aspects of animation production: research, script development, creating sets and models, filming and editing, and voiceovers. Twin Vision have also worked with The Children & Young People's Forum, who have provided advice on project development. The Forum also attended a research visit to Liverpool Medical Institution and Liverpool Central Library.

The resulting animations will be used to create an educational app, which will be distributed widely to schools and colleges, as well as a touring exhibition of the work, which will include

venues such as Tate Liverpool, Museum of Liverpool, Central Library and Liverpool Medical Institution.

"I'm happy we've done it because it was hard work but worth it. It's mind blowing that I'm helping to create an app and I hope everyone enjoys it!"
Tom, Oncology Patient aged 10

"Tom's really enjoyed the whole experience and was really looking forward to coming in and doing it."
Tom's Mum

Elation

This is a dance and movement programme funded by Children in Need, and led by Small Things Dance Company. The project offers weekly dance and movement sessions on the Cardiac Unit, Neuro Rehabilitation Unit and Renal Unit. The programme has clearly demonstrated the positive benefits of using dance and movement to support patient's mobility, muscle strength, coordination and flexibility, as well as distracting children away from their hospital treatments and pain. As part of the project, dancers and musicians from Small Things have delivered two dance performances on a number of wards in the hospital, inviting children and staff to join in with them.

"He was very happy. He had a lot of fun playing instruments and dancing. He managed to imitate the artist's dance and gestures. He loved playing with the yellow stretchy fabric. My son is autistic, this experience was brilliant for him to discover new textures, movements and toys."

"Excellent for Ellie. Louise (the dancer) managed to get her out of bed and up dancing. Ellie found this the best session she had had since being in hospital as she is a keen dancer out of hospital. It was so great to see her active".
Mum of Ellie aged 10 years

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Music:ED

This is a research project funded by the Hugh Greenwood Foundation in association with the University of Liverpool. Held on A&E Department, the project compares the intervention of live music when treating children with four different medical procedures (burns injury, closing a wound, inserting a cannula and finger prick). A group of patients will experience live music, delivered by Cascade Music, when receiving a treatment, whilst another group of patients will not receive any music at all. The compliance of patients and speed of procedure will be

examined by a Research Nurse and statistician. The results from this study will be available in summer 2019.

Wallace and Gromit Music Residency

Funding from the Wallace and Gromit Children's charity has enabled us to deliver a 12 month music residency on both the High Dependency Unit and Oncology Unit. Delivered by cellist Georgina Aasgaard, a musician with the Royal Liverpool Philharmonic Orchestra, these sessions have been making a profound difference to patients facing life threatening illness.

Performance Space

The hospital's Performance Space was greatly enhanced in May 2018 by the addition of lighting, staging and live streaming equipment. In the last twelve months, Arts for Health have delivered 18 live music and dance performances in the space, attracting hundreds of patients and their families who have come together to enjoy a live arts programme.

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Future Plans

- Continue to develop and implement existing projects outlined in the report
- Pilot a new programme with the Everyman Theatre and Playhouse, looking at ways to improve young people's confidence and self-esteem through participatory drama workshops.
- Start another Youth Music funded programme, Music as Medicine, which will train early career musicians to work in paediatric healthcare as well as giving CPD in using music for healthcare staff – this project will build on the achievements of the 2017 – 18 programme.
- Offer creative writing programmes for healthcare staff, in partnership with the University of Liverpool

R. Improving the transition from Children and Young People Services to Adult Services

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

Why is a Transition pathway needed?

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

Achievements in 2018/19

- Planned and delivered a national transition conference at Alder Hey on 29th June 2018 attended by over 110 delegates. Excellent evaluation
- 2nd Transition publication 'The 10 Steps Transition Pathway: Improving Transition for Children in Hospital Settings. International Journal of Nursing December 2018, Vol. 5, No. 2, pp. 1-11. Link http://ijnnet.com/current-ijn
- Delivered multiple local, regional and international presentations
- Newsletter continued to share transition information Trust wide
- Contributed to Transition research i.e. - Kings Fund Jan 2019
- Locally worked with two large Liverpool GP practices to re-engage GP's in the transition of their patients
- Maintenance of the transition exception register which informs North West Ambulance Service of names and details of all young people over 18 years, but remain under the care of paediatric services therefore the young person should come to Alder Hey A&E
- Non clinical appointments offered to all young people over the age of 17 years with complex neuro disabilities to discuss transition to adult services.
- Continued work to develop a pathway for Young People with complex neuro-disabilities from paediatric specialist respiratory physiotherapy to adult respiratory physiotherapy
- Continue to engage with schools in Education Health and Care Plan (EHCP) planning for young people with complex neuro-disabilities
- Continued delivery of multi-agency transition training
- Developed patient and parent information leaflet relating to the 'mental capacity act' (MCA), 'Deprivation of liberty and Safeguards' (DOL's) and 'best interest' in partnership with Edge Hill University (currently out to consultation)

Key priorities for 2019/20

- Further develop work on transition of patients with complex conditions as per CQUIN for 2018/19
- Implement the transition folder for children with a long term condition, to hold all their transition specific information in and their personal transition plan

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- Planning a third National Transition Conference, to be delivered in partnership with Lancashire, Manchester, NW Coast SCN, MHT, Claire House and Alder Hey, as a North West approach to Transition to be held in June 2018
- Development of a ‘capacity, decision making and best interest’ information leaflet in partnership with Edge Hill University
- Continue to implement Transition specialty by specialty Trust wide

Appendix 1. Reporting against core indicators

The report provides historical data and benchmarked data where available, and includes the prescribed indicators based on the NHS Improvement Single Oversight Framework

			2017-18				2018-19			
Target or Indicator	**Threshold**	**National Performance 2018-19**	**Qtr1**	**Qtr2**	**Qtr3**	**Qtr4**	**Qtr1**	**Qtr2**	**Qtr3**	**Qtr4**
Summary Hospital level Mortality Indicator (SHMI)[1]	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
C. Difficile Numbers – due to lapses in care	0		0	0	0	1	0	0	0	1*
C. Difficile - Rates per 100,000 Bed days	0		0	0	0	5.37	0	0	0	7.2*
18 Week RTT Target Open Pathways (Patients still waiting for Treatment	92%	87.00%[2]	92%	92%	92%	92%	92%	92%	92%	92%
All cancers: two week GP referrals	93%	93.40%[3]	100%	100%	97%	100%	100%	100%	97%	97%
All cancers: one month diagnosis (decision to treat) to treatment	85%	76.1%[3]	96%	100%	96%	100%	100%	100%	100%	97%
All cancers: 31 days until subsequent treatments	94%	96.97%	100%	100%	100%	100%	100%	100%	100%	100%
A&E - Total time in A&E (95th Percentile) <4 hours	95%	79.47%[4]	95.97%	95.29%	93.77%	94.61%	95.28%	96.09%	93.32%	92.91%
			2017-18				**2018-19**			

Target or Indicator	Threshold	National Performance	Qtr1	Qtr2	Qtr3	Qtr4	Qtr1	Qtr2	Qtr3	Qtr4
Readmission rate within 28 days of Discharge [5]	National data collection methodology currently under review	0-15 Yrs 16 Yrs and above	9% 10%	11% 18%	10% 17%	11% 18%	10% 10%	9% 13%	11% 13%	8% 11%
Financial and Service Performance (Use of Resource) Ratings			3	3	3	1	3	2	1	1
% of Staff who would recommend the trust as a provider of care to their family or friends [6]		89.7%	83.6%				89.3%			
Staff Survey results: % of staff experiencing harassment, bullying or abuse from staff in last 12 months [7]		21.5%	21%				23.5%			
Staff Survey results: % believing that trust provides equal opportunities for career progression or promotion for the Workforce Race Equality Standard [8]		86.1%	81%				85.9%			
Rate of Patient Safety Incidents per 1000 bed days		50 [9]	75	75	68	76	77	88	77	95
Total Patient Safety Incidents and the Percentage that result in Severe Harm or Death		0.48% [9]	1302 (0.15%)	1290 (0.08%)	1215 (0.16%)	1424 (0.14%)	1350 (0.00%)	1335 (0.00%)	1286 (0.00%)	1306 (0.23%)
Diagnostics: % waiting under 6 weeks	99%	97.7% [10]	100%	100%	100%	99.9%	99.6%	99.4%	99.7%	99.6%

* The case of *C. difficile* is under review and is awaiting a decision regarding whether this was due to lapse of care
NOTE: Unless otherwise indicated, the data in the table above has been obtained from local Patient Administration Service, to enable the Trust to provide the most recent available data. Most of this data is accessible through the NHS England website

[1] Specialist Trusts are excluded from SHMI reporting
[2] RTT National Performance based on most recent published data for Feb 2019, NHSE website.
[3] Cancer Waiting Times National Performance is based on most recent published data for Feb 2019, NHSE website
[4] A&E National Performance based on most recent published data for March 2019 for Type 1 A&E Depts, NHSE website.
[5] Data source: Trust Patient Administration System – not published nationally.
[6] Data source: 2018 National Staff Survey report - question 21d (*If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation*)

[7] Data source: 2018 National Staff Survey report - question 13a (*In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from patients / service users, their relatives or other members of the public)*

[8] Data Source: 2018 National Staff Survey report - question 14 (*Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?)*

[9] Data source: Trust Incident Reporting System – national data is from most recent published NRLS data which covers March 18 to September 18
[10] Diagnostics national performance based on most recently published data (February 2019)

Alder Hey Children's NHS Foundation Trust considers that this data is as described for the following reasons:

- The indicators are subject to a regular schedule of audit comprising completeness and accuracy checks which are reported monthly via the Data Quality Steering Group.

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

- Continuing to review and refresh the Infection Control Work Plan.
- Further improving our Winter Planning to predict and mitigate peak activity weeks, so as to improve patient flow throughout the hospital and deliver improvement in the A&E targets.
- Placing a strong focus on Health and Wellbeing of our staff, including driving our Freedom to Speak Up campaign
- Maintaining safety as a high priority and continually encouraging staff to report incidents

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

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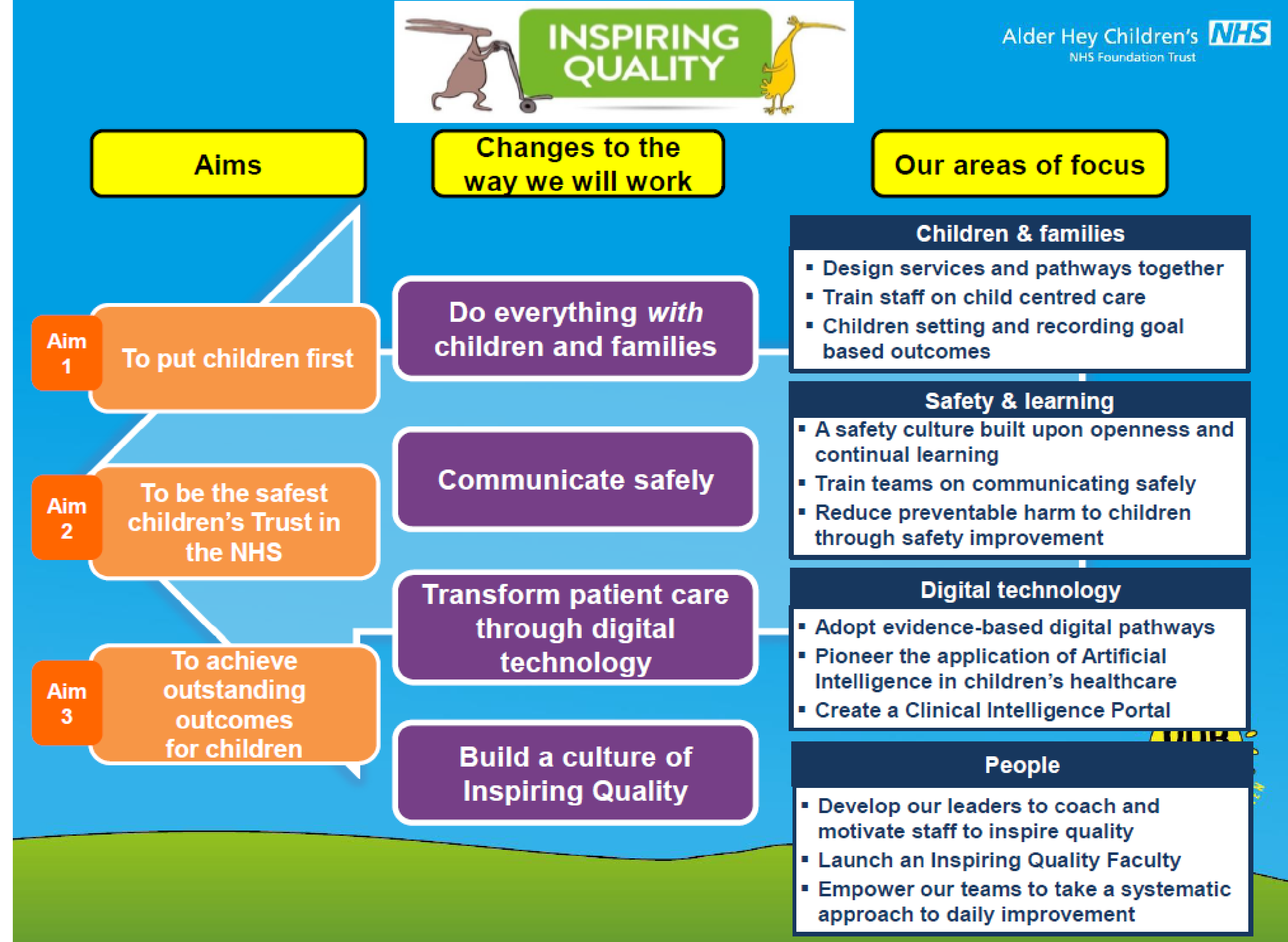
Appendix 2. Inspiring Quality



Annex 1 – Statement on the Quality Report by partner organisations

Commentary from Governors

The report is thorough and details the broad range and depth of work being carried out in the Trust to improve the quality of the services we provide. It is heartening to see how much we are involving young people, their families and carers in this work.

Our continued involvement in a range of clinical audit, both locally and nationally is also a very positive contribution to this area of clinical understanding and development.
Kate Jackson, Public Governor - Wider North West and Lead Governor
9th May 2019

I have read in detail quality account 2018-2019 and strongly agree with its components. I am proud to be affiliated with Alder Hey Children's NHS Foundation Trust and delighted to see the improvements that have been made especially in phlebotomy services.

I cannot praise enough ALL our staff members who work tirelessly to maintain this excellent standard of our services.

Well done team
Rafia Aftab, Public Governor - Rest of England
9th May 2019

As a governor I am happy to endorse this report as it is testimony to the hard work and dedication of all the staff at Alder Hey.
This is a thorough report that demonstrates excellence in many fields and it is reassuring to know the hospital is fully settled in to the new building; the moral and performance of staff is high and everyone is focused on delivering the best quality care possible to children, young people and their families.
Councillor Barbara Murray, Appointed Governor – Local Authorities
Liverpool City Council
10th May 2019

I am pleased to hear that the Phlebotomy ticketed appointment is proving effective.
I am also pleased that the Music as Medicine project was beneficial, and I hope a similar project continues to the benefit of recovering patients.
I look forward to the follow-up audits during monthly CQAC (Clinical Quality Audit Committee) meetings and reports.
Simon Hooker, Public Governor - North Wales
13th May 2019

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Commentary from Healthwatch organisations

Healthwatch Liverpool welcomes this opportunity to comment on the Quality Account of 2018-19.
We base these comments on the contents of a draft Quality Account which was provided to us prior to publication, as well as our ongoing engagement with the Trust and feedback received from patients and families.

It is clear from the Quality Account that the year has seen a large number of successes for the Trust.

From a clinical perspective, it is reassuring to see that the Trust has seen no preventable deaths and that the number of pressure ulcers has reduced. Good progress has also been made in work to identify and treat sepsis, particularly rolling out the sepsis pathway and providing sepsis awareness training to staff.

As with all Trusts in Liverpool, we hold an annual Listening Event where a team of staff and volunteers from Healthwatch Liverpool visits the hospital to speak to patients and visitors about their experiences. These events are intended to provide a snapshot of what patients and visitors think about the service. The Trust can then use this feedback in conjunction with other patient experience measures to provide valuable insight. This year we visited Alder Hey on 24th May 2018 and spoke to a total of 77 people.

A large number of people we spoke to felt the staff were kind and listened to them. Positive feedback was also received about the environment and the food. We did hear some negative comments about a variety of topics including availability of parking and the sofa beds on the wards. We submitted a report to the Trust with our findings and we were pleased to receive a response which gave details of how the negative feedback is being addressed. A summary of our findings and the Trust's response is included in this Quality Account.

Despite the successes detailed in this Quality Account there are also areas where further improvements are needed.

It is reassuring to see that progress has been made in relation to Seven Day Hospital Services, however standard 2 (time to initial consultant review) was missed by a large margin. We are aware that other Trusts are struggling to meet this target too.

Staff recruitment and retention is a national issue for the NHS and the statement on junior doctor rota gaps details the difficulties the Trust is having in this area. It is reassuring to see that the Trust has taken robust action to address this issue.

In relation to patient feedback, it is disappointing to see that improvements in Friends and Family Test (FFT) scores were not sustained throughout the year. There has also been an increase in the number of formal complaints compared to the previous three years. We encourage the Trust to carry out further engagement with patients and families to understand the reasons behind decreased satisfaction and put in place actions to address the underlying reasons.

As in previous years, it is positive to see the large number of schemes related to play and creativity to enhance patient experience such as Music as Medicine, Young Makers and DadaFest.

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The work done this year around outpatient appointments, particularly the Brilliant Booking Services scheme, changes to phlebotomy appointments and increased access to play and distraction have shown improvements in patient satisfaction in those areas.

In summary, we are pleased to see the innovative work being done at Alder Hey to improve patient experience and we are reassured, where patient satisfaction is not as good as it could be, that this is recognised and actively addressed.

We look forward to continuing to work closely with the Trust over the forthcoming year.

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Healthwatch Sefton would like to thank the Trust for the opportunity to comment on the draft Quality Account 2018-19. We attended the Quality Account session on the 3rd May 2019 at which the Trust presented and this was very useful.

In reviewing the readability of the account, initially the document was found to be lengthy, (over 100 pages). However in reading the document, it has been laid out in a easy to read format with there being very useful background information being included to support the reader in understanding the various sections.

In reviewing last years account, we shared that we would be keen to see a reduction in preventable pressure ulcers over the next 12 months. It was reassuring to see that there has only been one grade 3 hospital acquired pressure ulcer during this period compared with 6 in the previous year and the Trust should be proud that once again there has been zero tolerance in grade 4 pressure ulcers, both targets within this priority being met. There were more grade 2 pressure ulcers during this period but we note improved reporting, this being linked to improvements in the education of staff and the earlier intervention to prevent grade 3 and 4 ulcers. In reviewing other areas of 'no preventable harms or deaths' it is encouraging to see the sepsis screening process in place and the establishment of a sepsis team.

In reading the section, 'statements from the Care Quality Commission (CQC)', we have noted the area of 'safe' as requires improvement. However, it is clear from reading the account and from our work with the trust that there has been a lot of work undertaken to ensure that the trust has a strong safety culture and this can be supported by the Trusts reporting of having zero preventable deaths during this period and also in being the 2nd highest incident reporter for acute specialists, which indicates a transparent way of working. We also note from reading the account, learning which has taken place from deaths and the case reviews undertaken. It was comforting to read that none of the 55 inpatients who had died during this period were found to be due to lapses in care. We welcome the plans to strengthen links with Liverpool Women's Hospital to improve neonatal care across the city.

In reviewing the trusts work to ensure children's and families' experiences are the best they can be, the account provides a good overview of the work undertaken by the Trust. We note the relaunch of the children and young people's forum. In looking at the future plans for the forum it is great to see that there are plans to integrate with out local Chameleons group in Sefton CAMHS and we look forward to hearing more about this.

In looking at the 'friends and family' test, it is great to see that 97% of those responding responded positively. However in reviewing the graph within this section, it is unclear about what this means in practice and some explanation about this would have helped in understanding this data.

In examining the outcomes from the Trusts PLACE assessment, it was really encouraging to see that the area of disability has shown a big improvement particularly with reference to wheelchair access. However, we have noted the drop in the area of dignity and respect and the issue of overcrowding in outpatient waiting areas. To support this, we read about the work to engage with families in voting for which waiting area seating they would prefer to see and look forward to seeing this at one of our future visits to the Trust. We have also noted within the account, the improved dignity and respect from the review of interpretation services provided and the future plans to strengthen this area further.

Improving the transition from Children and Young People services to Adult services is a key area of interest for us and we welcome the work being undertaken on the '10 steps to adult services'. We have noted the local work being undertaken with two large GP practices in Liverpool and would be keen to understand how this work will move across to Sefton. It was really good to see that the Clinical Commissioning Group CQUIN was achieved for transitions out of children's and young people's mental health services.

We have met with colleagues from the trust on a number of occasions and we have been involved in the Trusts equality, diversity and inclusion work. The trust has invested a significant resource into ensuring that they are supporting their workforce and this can be seen in the development of a range of policies, introduction of staff networks, cultural sensitivity training and the development of guidance for reasonable adjustments. It is encouraging to see the emphasis placed on this work by the Trust.

In reviewing progress in improving access to services through brilliant booking systems, we note the work of the trust to send out letters which include an appointment date (rather than a letter which asks the family to phone the trust to make an appointment) and the introduction of a six week follow up being booked in clinic. We also note the use of a bi-directional texting service which provides the ability to easily confirm or cancel appointments. We have been working closely with one of our steering group members, Sefton Parent Carer Forum over the past 12 months who have shared with us a number of issues that parents and carers across Sefton have been facing. Issues have included access to medication and the process for this, appointments with the community paediatric service and appointments within the Audiology service. We are currently planning a meeting with Lisa Cooper, the Director of community and mental health services to discuss further the concerns which have been raised. We have received positive responses from the Trust during this period about the issues raised and following our feedback the trust reviewed their current process for ordering repeat prescriptions

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and from January 2019 introduced an electronic form which can be completed and emailed to the trust for those who don't want to reply on the answer machine service. We have welcomed this open approach from the Trust and look forward to our continued work to improve services for children and their families.

A further area we have been keen to see is the Trusts work to improve the experience of children with a Learning Disability and/ or Autistic Spectrum Condition. In reviewing the improvements, it was good to see the continued long term secondment of the consultant Learning Disability nurse, ongoing training and the partnerships with local voluntary and community sector organisations including Sefton Carers. We would welcome the involvement further with Sefton based organisations.

It is good to have sight of the priority areas for 2018/2019 and we look forward to our work with the trust over the next 12 months.

17th May 2019

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Commentary from Clinical Commissioning Groups

NHS South Sefton Clinical Commissioning Group

NHS Liverpool Clinical Commissioning Group

NHS Southport and Formby Clinical Commissioning Group

NHS Knowsley Clinical Commissioning Group

Liverpool, South Sefton, Southport and Formby and Knowsley CCGs welcome the opportunity to jointly comment on the Alder Hey Children's Hospital NHS Foundation Trust Draft Quality Account for 2018/19. It is acknowledged that the submission to Commissioners was draft and that some parts of the document require updating. Commissioners look forward to receiving the Trust's final version of the Quality Account.

We have worked closely with the Trust throughout 2018/19 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.

The Trust's presentation of its Quality Account was an honest, open and positive demonstration of the improvements made to date and an acknowledgement of areas that need to be developed further.

This Account details 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 2018/19 which are:

Priority 1: Patient Experience: to put children first: doing everything with children and families
Priority 2: Patient Safety: to be the safest children's trust in the NHS: communicating safely
Priority 3: Clinical Effectiveness: to achieve outstanding outcomes for children: transforming patient care through digital technology
Priority 4: To build a culture of inspiring quality

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

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 Trusts use of digital technology to improve safety is commended.

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The Trust places significant emphasis on its safety agenda, with an open and transparent culture, and this is reflected with the work the Trust has undertaken to further embed a safety culture in the organisation.

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

- Significantly reducing the number of category 3 pressure ulcers reported
- The Trust is the second highest reporter of incidents, maintaining its position in the top quartile with a further increase in reported incidents in 2018/19
- Achieving a 60% return in the annual staff survey (the highest return ever for the Trust).
- Reductions in hospital acquired infections with zero MRSA bacteraemia, a 25% reduction in MSSA and a 10% reduction in CLABSI
- Improvements in the outcomes in diabetes management
- The developments in the Trust in relation to arts, performance and play
- The work undertaken in relation to staff health and wellbeing in particular the focus on BAME, disability and LGBTIQ+ staff networks

Commissioners are aspiring through strategic objectives to develop a local 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 reflective of the current issues across the health economy. The priorities being:
Priority 1: Putting children first
Priority 2: Being the safest children's trust in the NHS Priority 3: Achieving outstanding outcomes for children Priority 4: Building a culture of inspiring quality

We therefore commend the Trust in taking account of opportunities to further improve the delivery of excellent, compassionate and safe care for every patient, every time.

Liverpool CCG	**South Sefton CCG** **Southport and Formby CCG**	**Knowsley CCG**
Jan Ledward Chief Officer Date 20 May 2019	Fiona Taylor Chief Officer Date 17 May 2019	Dianne Johnson Chief Executive Date 17 May 2019

Commentary from Overview and Scrutiny Committee

The Overview and Scrutiny Committee were invited to comment on the Quality Account, a response was received from the Chair of the Social Care and Health Select Committee which feeds into the above Committee.

As Chair of the Select Committee I have reviewed the Quality Accounts for Alder Hey 2018-19 and submit the following comments:
Overall, the Quality Accounts show the Trust continue to deliver a high standard of care to patients, which is commendable.
In particular, I have highlighted the following as areas of success –

- The Trust's commitment and plans for patient safety and for the patient experience, including the robust plans for monitoring and reporting;
- The commitment to involving children in the design of care;
- The Trust's priority for measuring patient outcomes;
- Clinical Audit's showing effective responses to meet the patient needs through robust action plans;
- The participation in clinical research is to be commended;
- The staff recruitment and retention plans are to be commended, as is the volunteering programme;
- The clearer signage in the hospital shows how a small adjustment can enhance the patient experience

I have highlighted the following as areas for attention –

- Whilst it is encouraging to see the compliance with the Freedom to Speak Up scheme for staff, I would have liked to have seen participation information;
- The Ward Accreditation Scheme is good overall, but I would hope to see improvements in the ICU and Emergency Departments;
- The PLACE assessment showing a drop in privacy and dignity is very concerning, and I hope to see this addressed without delay

Overall my message is keep up the good work and I look forward to seeing your improvement plans enacted without undue delay.

Councillor Richard McLinden, Chair of the Social Care and Health Select Committee for Liverpool
10th May 2019

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Statement of Directors' responsibilities in respect of the Quality Report

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

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

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

- the content of the Quality Report meets the requirements set out in the NHS foundation trust Annual Reporting Manual 2018/19 and supporting guidance
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period April 2018 to May 2019
  - papers relating to quality reported to the board over the period April 2018 to May 2019
  - feedback from commissioners – not received at time of publication
  - feedback from governors dated 9th, 10th and 13th May 2019
  - feedback from local Healthwatch organisations dated 9th and 11th May 2019
  - feedback from Overview and Scrutiny Committee dated 10th May 2019
  - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 22/05/18, 04/09/18, 04/12/18 and 05/03/19 (four quarterly reports)
  - the 2018 national patient survey
  - the 2018 national staff survey
  - the Head of Internal Audit's annual opinion of the trust's control environment dated 23 May 2019
  - CQC inspection report dated 21st June 2018
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

28th May 2019 ______________________________ Chair

28th May 2019 ______________________________ Chief Executive

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

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 NHS Foundation Trust ("the 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 2019 (the 'Quality Report') and certain performance indicators contained therein.

This report is made solely to the Trust's Council of Governors, as a body, in accordance with our engagement letter dated 03/05/2019. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2019 to enable the Council of Governors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators.

To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's Council of Governors as a body, for our examination, for this report, or for the conclusions we have formed.

Our work has been undertaken so that we might report to the Council of Governors those matters that we have agreed to state to them in this report and for no other purpose. Our report must not be recited or referred to in whole or in part in any other document nor made available, copied or recited to any other party, in any circumstances, without our express prior written permission. This engagement is separate to, and distinct from, our appointment as the auditors to the Trust.

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Scope and subject matter

The indicators for the year ended 31 March 2019 subject to limited assurance consist of the national priority indicators as mandated by NHS Improvement:

- ► **Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge.**
- ► **All cancers: 31 days until subsequent treatments.**

We refer to these national priority indicators collectively as the 'indicators'.

Respective responsibilities of the directors and Ernst & Young LLP

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 2018/19' issued by NHS Improvement.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the quality report is not prepared in all material respects in line with the criteria set out in the 'NHS Foundation Trust Annual Reporting Manual 2018/19', which is supported by NHS Improvement's Detailed Requirements for quality reports 2018/19;
- the quality report is not consistent in all material respects with the sources specified in detailed in Section 2.1 of the 'Detailed guidance for external assurance on quality reports 2018/19' 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 2018/19' and supporting guidance and the six dimensions of data quality set out in the 'Detailed Guidance for External Assurance on Quality Reports 2018/19'.

We read the Quality Report and consider whether it addresses the content requirements of the 'NHS Foundation Trust Annual Reporting Manual 2018/19' 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 the other information sources detailed in Section 2.1 of the 'Detailed guidance for external assurance on quality reports 2018/19'. These are:

- Board minutes for the period April 2018 to May 2019
- Papers relating to quality reported to the Board over the period April 2018 to May 2019
- feedback from commissioners, dated 20/05/2019

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- feedback from governors, dated 09/05/2019
- feedback from local Healthwatch organisations, dated 09/05/2019
- feedback from Overview and Scrutiny Committee dated 10/05/2019
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated quarterly throughout the year, final quarter dated 05/03/2019
- the latest national patient survey, dated 2018
- the latest national staff survey, dated 2019
- Care Quality Commission inspection, dated 21/06/2018
- the Head of Internal Audit's annual opinion over the trust's control environment, dated 23 May 2019.

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 NHS Foundation Trust NHS Foundation Trust as a body, to assist the Council of Governors in reporting Alder Hey Children's 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 2019, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. 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.

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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, but were not limited to:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators
- making enquiries of management
- 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 2018/19' to the categories reported in the Quality Report.
- reading the documents.

The objective of a limited assurance engagement is to perform such procedures as to obtain information and explanations in order to provide us with sufficient appropriate evidence to express a negative conclusion on the Quality Report**.** The procedures performed in a limited assurance engagement vary in nature and timing from, and are less in extent than for, a reasonable assurance engagement. Consequently the level of assurance obtained in a limited assurance engagement is substantially lower than the assurance that would have been obtained had a reasonable assurance engagement been performed.

Inherent limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the 'NHS foundation trust annual reporting manual 2018/19' and supporting guidance. The scope of our assurance work has not included governance over quality or non- mandated indicators, which have been determined locally by Alder Hey Children's NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019:

- 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 2018/19 and the Detailed requirements for quality reports 2018/19, published in December 2018, issued by NHS Improvement
- the Quality Report is not consistent in all material respects with the sources specified, and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with NHS Foundation Trust Annual Reporting Manual

2018/19 and the Detailed requirements for quality reports 2018/19 published in December 2018, issued by NHS Improvement .

Hassan Rohimun Ernst &
Young Manchester
22 May 2019

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Notes:

1. The maintenance and integrity of the Alder Hey Children's NHS Foundation Trust's web site is the responsibility of the directors; the work carried out by Ernst & Young LLP does not involve consideration of these matters and, accordingly, Ernst & Young LLP accept no responsibility for any changes that may have occurred to the Quality Report since it was initially presented on the web site.

2. Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions

Provider accounts template - single entity accounts

Inputs

MARSID	ALDERHEY
Name of trust	Alder Hey Children's NHS Foundation Trust
Provider status	FT
Date of year end (dd/mm/yyyy)	31/03/2019
Start of current year (dd/mm/yyyy)	01/04/2018
Comparative year end (dd/mm/yyyy)	31/03/2018
Start of comparative year (dd/mm/yyyy)	01/04/2017
Year for financial reporting (20XX/YY)	2018/19
Year for comparative year (20XX/YY)	2017/18
Year for year end (20XX)	2019
Year for comparative year (20XX)	2018
Opening Year (20XX)	2017
Next financial year (20XX/YY)	2019/20
Date of approval of financial statements (dd/mm/yyyy)	

Updating links:
This file contains links to a dummy PFR file. To update the links to your locally completed PFR select 'Data' on the ribbon and within the 'Connections' section select 'Edit Links'. In the dialogue box, select the existing source (linked to a dummy file) and choose 'Change source'. Then navigate to where your local TAC file is saved and select. This will redirect all links in this workbook to your trust's TAC file.

Links should be broken before submitting this file (as draft or audited) to NHS Improvement via your portal.

Alder Hey Children's NHS Foundation Trust

Annual accounts for the year ended 31 March 2019

Foreword to the accounts

Alder Hey Children's NHS Foundation Trust

These accounts, for the year ended 31 March 2019, have been prepared by Alder Hey Children's NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed	…………………………………………….
Name	**Louise Shepherd**
Job title	**Chief Executive**
Date	

Statement of Comprehensive Income

	Note	2018/19 £000	2017/18 £000
Operating income from patient care activities	3	232,052	213,491
Other operating income	4	61,962	51,068
Operating expenses	6, 8	(247,790)	(248,073)
Operating surplus/(deficit) from continuing operations		**46,224**	**16,486**
Finance income	11	143	30
Finance expenses	12	(9,652)	(9,693)
PDC dividends payable		(1,009)	(913)
Net finance costs		**(10,518)**	**(10,576)**
Other gains / (losses)	13	4,466	98
Share of profit / (losses) of associates / joint arrangements		-	-
Surplus / (deficit) for the year		**40,172**	**6,008**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	(30)	(4,728)
Revaluations	17	-	1,218
Share of comprehensive income from associates and joint ventures		-	-
Total comprehensive income / (expense) for the period		**40,142**	**2,498**

Statement of Financial Position

	Note	31 March 2019 £000	31 March 2018 £000
Non-current assets			
Intangible assets	14	13,737	12,931
Property, plant and equipment	15	193,171	193,527
Investments in associates and joint ventures	18	450	450
Receivables	21	89	81
Total non-current assets		**207,447**	**206,989**
Current assets			
Inventories	20	3,288	2,693
Receivables	21	62,381	35,300
Non-current assets held for sale / assets in disposal groups	22	-	-
Cash and cash equivalents	23	33,699	12,244
Total current assets		**99,368**	**50,237**
Current liabilities			
Trade and other payables	24	(30,467)	(23,034)
Borrowings	26	(12,711)	(4,463)
Provisions	28	(332)	(445)
Other liabilities	25	(749)	(1,070)
Total current liabilities		**(44,259)**	**(29,012)**
Total assets less current liabilities		**262,556**	**228,214**
Non-current liabilities			
Trade and other payables	24	-	-
Borrowings	26	(140,604)	(150,934)
Provisions	28	(731)	(756)
Other liabilities	25	(3,495)	(3,632)
Total non-current liabilities		**(144,830)**	**(155,322)**
Total assets employed		**117,726**	**72,892**
Financed by			
Public dividend capital		55,775	51,083
Revaluation reserve		2,037	2,091
Income and expenditure reserve		59,914	19,718
Total taxpayers' equity		**117,726**	**72,892**

The notes on pages X to X form part of these accounts.

Signed:
Name Louise Shepherd
Position Chief Executive
Date

Statement of Changes in Equity for the year ended 31 March 2019

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2018 - brought forward	**51,083**	**2,091**	**19,718**	**72,892**
Impact of implementing IFRS 15 on 1 April 2018	-	-	-	**-**
Impact of implementing IFRS 9 on 1 April 2018	-	-	-	**-**
Surplus/(deficit) for the year	-	-	40,172	**40,172**
Other transfers between reserves	-	(24)	24	**-**
Impairments	-	(30)	-	**(30)**
Public dividend capital received	4,692	-	-	**4,692**
Taxpayers' equity at 31 March 2019	**55,775**	**2,037**	**59,914**	**117,726**

Statement of Changes in Equity for the year ended 31 March 2018

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2017 - brought forward	**45,745**	**5,670**	**13,641**	**65,056**
Prior period adjustment	-	-	-	**-**
Taxpayers' equity at 1 April 2017 - restated	**45,745**	**5,670**	**13,641**	**65,056**
Surplus/(deficit) for the year	-	-	6,008	**6,008**
Other transfers between reserves	-	(69)	69	**-**
Impairments	-	(4,728)	-	**(4,728)**
Revaluations	-	1,218	-	**1,218**
Public dividend capital received	5,338	-	-	**5,338**
Taxpayers' equity at 31 March 2018	**51,083**	**2,091**	**19,718**	**72,892**

Information on reserves

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.   Revaluation reserve is adjusted each year for excess depreciation.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the trust.

Statement of Cash Flows

	Note	2018/19 £000	2017/18 £000
Cash flows from operating activities			
Operating surplus / (deficit)		46,224	16,486
Non-cash income and expense:			
Depreciation and amortisation	6.1	8,035	8,084
Net impairments	7	5,987	18,631
Income recognised in respect of capital donations	4	1,649	(4,681)
Amortisation of PFI deferred credit		(137)	(137)
(Increase) / decrease in receivables and other assets		(25,420)	(18,429)
(Increase) / decrease in inventories		(595)	(182)
Increase / (decrease) in payables and other liabilties		5,764	2,315
Increase / (decrease) in provisions		(139)	57
Net cash generated from / (used in) operating activities		**41,368**	**22,144**
Cash flows from investing activities			
Interest received		143	30
Purchase and sale of financial assets / investments		-	(450)
Purchase of intangible assets		(2,905)	(2,308)
Sales of intangible assets		-	-
Purchase of property, plant, equipment and investment property		(13,904)	(11,374)
Sales of property, plant, equipment and investment property		4,467	111
Receipt of cash donations to purchase capital assets		771	4,426
Net cash generated from / (used in) investing activities		**(11,428)**	**(9,565)**
Cash flows from financing activities			
Public dividend capital received		4,692	5,338
Movement on loans from the Department of Health and Social Care		(359)	769
Capital element of finance lease rental payments		(168)	(88)
Capital element of PFI, LIFT and other service concession payments		(2,220)	(2,070)
Interest on loans		(1,040)	(1,031)
Interest paid on finance lease liabilities		(12)	(7)
Interest paid on PFI, LIFT and other service concession obligations		(8,593)	(8,648)
PDC dividend (paid) / refunded		(785)	(1,110)
Net cash generated from / (used in) financing activities		**(8,485)**	**(6,847)**
Increase / (decrease) in cash and cash equivalents		**21,455**	**5,732**
Cash and cash equivalents at 1 April - brought forward		**12,244**	**6,516**
Cash and cash equivalents transferred under absorption accounting		-	(4)
Cash and cash equivalents at 31 March	23	**33,699**	**12,244**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2018/19 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts

Note 1.1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.2 Going concern

These accounts have been prepared on a going concern basis. Non-trading entities in the public sector are assumed to be going concern where the continued provision of a service in the future is anticipated, as evidenced by inclusion of financial position for that service in public documents. The Trust is planning to be financially sustainable over the next five year NHS planning horizon. The Trust is planning a trading surplus of £1.6m in 2019/20.

Note 1.3 Interests in other entities

Joint Arrangements

Arrangements over which the Trust has joint control with one or more other entities are classified as joint arrangements. Joint control is the contractually agreed sharing of control of an arrangement. A joint arrangement is either a joint operation or a joint venture.

A joint venture is a joint arrangements whereby the parties that have joint control of the arrangement have rights to the net assets of the arrangement. Joint ventures are recognised as an investment and accounted for using the equity method.

The Trust has entered into a joint venture with Alder Hey Children's Charity for development of patient experience.

Subsidiaries

Entities over which the Trust has the power to exercise control are classifid as subsidiaries and are consolidated.

The Trust has registered a wholly owned subsidiary company, Alder Hey Ventures Ltd. However, during 2018/19 there has been no financial activity through the company and therefore consolidation is not required.

Equity Investments

The Trust has an interest in a number of unconsolidated subsidiaries, details of which are disclosed in note 19.

Note 1.4 Critical accounting judgements and key sources of estimation uncertainty

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions. These are regularly reviewed.

The following are the critical judgements that management have made in the process of applying the Trust's accounting policies, together with the key assumptions concerning the future and other key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying value of assets and liabilities within the next financial year.

Asset valuation and lives

The value and remaining useful lives of land and buildings have been estimated by Cushman & Wakefield. The valuations have been carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) Valuation Standards. The full valuations for land and buildings were carried out during 2017/18 and were applied to the 31 March 2018 land and building values. Asset values have been adjusted to reflect latest BCIS "All in" Tender Price Indices for 2018/19 increase. Valuations are carried out using the Modern Equivalent Asset basis to determine the Depreciated Replacement Cost for specialised operational property and Existing Use Value for non-specialised operational property. The value of retained estate land and buildings at 31 March 2019 reflect the valuation indicated by Cushman & Wakefield given that most of the original hospital buildings are in the process of being demolished.

The lives of equipment assets are estimated using historical experience of similar equipment lives with reference to national guidance and consideration of the pace of technological change. Operational equipment is carried at current value. Where assets are of low value and/or have short useful economic lives, these are carried at depreciated historical cost as this is not considered to be materially different from fair value.

Software licenses are depreciated over the shorter of the term of the licence and the useful economic life.

Provisions

Pension provisions relating to former employees, including Directors, have been estimated using the life expectancy from the Government's actuarial tables.

Other legal claims provisions relate to employer and public liability claims and expected costs are advised by NHS Resolution.

Allowance for impaired receivables

An allowance for expected credit losses has been made for amounts which are uncertain to be received from organisations at 31 March 2019. The allowance is £1,196,000 (31 March 2018: £1,238,000) and includes a provision of £395,000 (31 March 2018: £318,000) against the Injury Costs Recovery debt. The recoverability of Injury Costs Recovery debt has been assessed and as the level of debt has increased, the Trust has fully provided for Injury Costs Recovery incidents that are over 10 years old. The balance of the Injury Costs Recovery debt has been provided for at 10% (31 March 2018: 10%) to reflect recoverability of more recent incidents.

Holiday pay accrual

The accrual for outstanding leave has been calculated on an actual basis.

The amount of outstanding annual leave as at 31 March has been requested from all managers from across the Trust. The accrual is calculated based on the returns from those managers. The Trust's annual leave policy clearly states that annual leave is expected to be taken in the year it relates to and only carried forward on an exceptional basis and with agreement from managers.

Note 1.5 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS). As directed by the GAM, the transition to IFRS 15 in 2018/19 has been completed in accordance with paragraph C3 (b) of the Standard: applying the Standard retrospectively but recognising the cumulative effects at the date of initial application (1 April 2018).

In the adoption of IFRS15 a number of practical expedients offered in the Standard have been employed.

These are as follows:

As per paragraph 121 of the Standard, the Trust will not disclose information regarding the performance obligations part of a contract that has an original expected duration of one year or less.

The Trust is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of performance completed to date.

The FReM has mandated the exercise of practical expedient offered in C7 (a) of the Standard that requires the Trust to reflect the aggregate effect of all contracts modified before the date of initial application.

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

The Trust receives payments each month based on agreed contract value. Invoices/credits are raised during the year to reflect the actual activity performance.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

Revenue is recognised to the extent that collection of consideration is probable. Where contract challenges from commissioners are expected to be upheld, the Trust reflects this in the transaction price and derecognises the relevant portion of income.

Where the Trust is aware of a penalty based on contractual performance, the Trust reflects this in the transaction price for its recognition of revenue. Revenue is reduced by the value of the penalty.

The Trust receives income from commissioners under Commissioning for Quality and Innovation (CQUIN) schemes. The Trust agrees schemes with its commissioner but they affect how care is provided to patients. That is, the CQUIN payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the contract.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract.

NHS injury cost recovery scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Note 1.5.1 Revenue grants and other contributions to expenditure

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

The value of the benefit received when accessing funds from the the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.5.2 Other income

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

Note 1.6 Expenditure on employee benefits

Short-term employee benefits
Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs
NHS Pension Scheme
Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

Note 1.7 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.8 Property, plant and equipment

Note 1.8.1 Recognition

Property, plant and equipment is capitalised where:

• it is held for use in delivering services or for administrative purposes
• it is probable that future economic benefits will flow to, or service potential be provided to, the Trust
• it is expected to be used for more than one financial year
• the cost of the item can be measured reliably
• the item has cost of at least £5,000, or
• collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, eg, plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

Note 1.8.2 Measurement

Valuation
All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

All assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (i.e. operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements of the services being provided.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

Subsequent expenditure
Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation
Items of property, plant and equipment are depreciated on a straight line basis over their remaining useful lives which is in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'held for sale' cease to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.
Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

At each financial year end, the Trust checks whether there is any indication that its property, plant and equipment or intangible assets have suffered an impairment loss. If there is indication of such an impairment, the recoverable amount of the asset is estimated to determine whether there has been a loss and if so, its amount. Intangible assets not yet available for use are tested for impairment annually at the financial year end.

Note 1.8.3 De-recognition

Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:

• the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
• the sale must be highly probable i.e.:

- management are committed to a plan to sell the asset
- an active programme has begun to find a buyer and complete the sale
- the asset is being actively marketed at a reasonable price
- the sale is expected to be completed within 12 months of the date of classification as 'held for sale' and
- the actions needed to complete the plan indicate it is unlikely that the plan will be abandoned or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Note 1.8.4 Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Note 1.8.5 Private Finance Initiative (PFI) and Local Improvement Finance Trust (LIFT) transactions

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's *FReM*, are accounted for as 'on-Statement of Financial Position' by the Trust. In accordance with IAS 17, the underlying assets are recognised as property, plant and equipment, together with an equivalent finance lease liability. Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate.

The annual contract payments are apportioned between the repayment of the liability, a finance cost, the charges for services and lifecycle replacement of components of the asset. The element of the annual unitary payment increase due to cumulative indexation is treated as contingent rent and is expensed as incurred.

The service charge is recognised in operating expenses and the finance cost is charged to finance costs in the Statement of Comprehensive Income.

Components of the asset replaced by the contractor during the contract (lifecycle replacement) are capitalised where they meet the trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at cost.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term accrual or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a "free" asset and a deferred income balance is recognised.

The deferred income is released to operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

Assets contributed by the Trust for use in the scheme continue to be recognised as items of property, plant and equipment in the Trust's Statement of Financial Position.

On initial recognition of the asset, the difference between the fair value of the asset and the initial value of the liability is recognised as deferred income, representing the future service potential to be received by the Trust through the asset being made available to third party users.

The balance is subsequently released to operating income over the life of the concession on a straight line basis.

Note 1.8.6 Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset as at the last valuation and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life	**Max life**
	Years	**Years**
Land	-	-
Buildings, excluding dwellings	2	91
Dwellings	40	40
Plant & machinery	1	20
Information technology	2	11
Furniture & fittings	2	11

Finance-leased assets (including land) are depreciated over the shorter of the useful life or the lease term, unless the Trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Note 1.9 Intangible assets

Note 1.9.1 Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust; where they are capable of being used in a trust's activities for more than one year; the cost of the asset can be measured reliably and they have a cost of at least £5,000.

Expenditure on research is not capitalised.

Software which is integral to the operation of hardware, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset.

Note 1.9.2 Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

Intangible assets held for sale are measured at the lower of their carrying amount or fair value less costs to sell.

Amortisation

Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits.

Note 1.9.3 Useful economic life of intangible assets

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life	**Max life**
	Years	**Years**
Software licences	-	10

Note 1.10 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first-in first-out cost method.

Note 1.11 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.12 Carbon Reduction Commitment scheme (CRC)

The CRC scheme is a mandatory cap and trade scheme for non-transport CO2 emissions. The Trust is registered with the CRC scheme, and is therefore required to surrender to the Government an allowance for every tonne of CO2 it emits during the financial year. A liability and related expense is recognised in respect of this obligation as CO2 emissions are made.

The carrying amount of the liability at the financial year end will therefore reflect the CO2 emissions that have been made during that financial year, less the allowances (if any) surrendered voluntarily during the financial year in respect of that financial year.

The liability will be measured at the amount expected to be incurred in settling the obligation. This will be the cost of the number of allowances required to settle the obligation.

Note 1.13 Financial assets and financial liabilities

Note 1.13.1 Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by Office of National Statistics.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

Note 1.13.2 Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below.

Financial assets are classified as subsequently measured at amortised cost.

Financial liabilities classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Financial assets and financial liabilities at fair value through income and expenditure

Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or at fair value through other comprehensive income. This category also includes financial assets and liabilities acquired principally for the purpose of selling in the short term (held for trading) and derivatives. Derivatives which are embedded in other contracts, but which are separable from the host contract are measured within this category. Movements in the fair value of financial assets and liabilities in this category are recognised as gains or losses in the Statement of Comprehensive income.

The Trust has entered into a joint venture with Alder Hey Children's Charity for development of patient experience.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

Expected credit losses are determined using historical losses as a guide. Specific impairment provisions are made for non contract receivables where required. Credit losses with other NHS bodies are not normally recognised unless there is evidence of impairment.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Note 1.13.3 Derecognition

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Note 1.14 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Note 1.14.1 The Trust as lessee

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property plant and equipment.

The annual rental charge is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

Operating leases
Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Leases of land and buildings
Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

Note 1.14.2 The Trust as lessor

Finance leases
Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Note 1.15 Provisions
The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

Clinical negligence costs
NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the trust is disclosed at note 28.2 but is not recognised in the Trust’s accounts.

Non-clinical risk pooling
The trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any “excesses” payable in respect of particular claims are charged to operating expenses when the liability arises.

The Trust has also taken commercial insurance to cover property damage and business interruption.

Note 1.16 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 29 where an inflow of economic benefits is probable.
Contingent liabilities are not recognised, but are disclosed in note 29, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.17 Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for
(i) donated assets (including lottery funded assets),
(ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and
(iii) any PDC dividend balance receivable or payable.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.18 Value added tax
Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.19 Corporation tax
TheTrust has determined that it has no corporation tax liability as it does not carry out significant commercial activities that are not part of healthcare delivery.

Note 1.20 Foreign exchange
The functional and presentational currency of the Trust is sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

• monetary items are translated at the spot exchange rate on 31 March
• non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction and
• non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

Note 1.21 Third party assets
Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. TheTrust has no third party assets at 31 March 2019.

Note 1.22 Losses and special payments
Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However the losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.23 Charity
Alder Hey Children's Charity is governed by independent Trustees and has independent processes. The Trust does not have power to govern the financial and operating policies of the charitable fund and therefore the charity is not consolidated.

Note 1.24 Early adoption of standards, amendments and interpretations
No new accounting standards or revisions to existing standards have been early adopted in 2018/19.

Note 1.25 Standards, amendments and interpretations in issue but not yet effective or adopted

The following standards have been issued but are not yet effective:

IFRS 16 Leases	Application required for accounting periods beginning on or after 1 January 2019; but not yet adopted by the FReM: early adoption is not therefore permitted.
IFRS 17 Insurance Contracts	Application required for accounting periods beginning on or after 1 January 2021; but not yet adopted by the FReM: early adoption is not therefore permitted.
IFRIC 23 Uncertainty over Income Tax Treatments	Application required for accounting periods beginning on or after 1 January 2019.

Note 2 Operating Segments

The Trust has considered segmental reporting and the Chief Executive and the Board receive sufficient and appropriate high level information to enable the business to be managed effectively and to monitor and manage the strategic aims of the Trust. Sufficiently detailed information is used by middle and lower management to ensure effective management at an operational level. Neither of these are sufficiently discrete to profile operating segments, as defined by IFRS8, that would enable a user of these financial statements to evaluate the nature and financial effects of the business activities that the Trust undertakes. Therefore the Trust has decided that it has one operating segment for healthcare.

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.5

Note 3.1 Income from patient care activities (by nature)	**2018/19**	**2017/18**
	£000	**£000**
Acute services		
Elective income	50,197	46,527
Non elective income	41,236	37,489
First outpatient income	9,452	9,105
Follow up outpatient income	20,255	16,820
A & E income	6,594	6,057
High cost drugs income from commissioners (excluding pass-through costs)	17,262	16,531
Other NHS clinical income	57,746	54,213
Mental health services		
Cost and volume contract income	102	92
Block contract income	10,073	9,832
Community services		
Community services income from CCGs and NHS England	15,554	14,702
Income from other sources (e.g. local authorities)	771	1,261
All services		
Private patient income	236	434
Agenda for Change pay award central funding	2,027	-
Other clinical income	547	428
Total income from activities	**232,052**	**213,491**

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	**2018/19**	**2017/18**
	£000	**£000**
NHS England	144,603	129,553
Clinical commissioning groups	65,689	64,329
Department of Health and Social Care	2,027	-
Other NHS providers	260	298
NHS other	-	-
Local authorities	524	974
Non-NHS: private patients	236	434
Non-NHS: overseas patients (chargeable to patient)	-	-
Injury cost recovery scheme	533	428
Non NHS: Welsh Health Commissioners	15,858	14,584
Non NHS: other	2,322	2,891
Total income from activities	**232,052**	**213,491**
Of which:		
Related to continuing operations	232,052	213,491
Related to discontinued operations	-	-

Injury cost recovery scheme income is subject to an allowance for credit losses to reflect expected rates of collection. This amounts to £395,000 (£318,000 at 31 March 2018)

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

	2018/19	2017/18
	£000	£000
Income recognised this year	-	-
Cash payments received in-year	-	-
Amounts added to provision for impairment of receivables	-	-
Amounts written off in-year	-	-

Note 4 Other operating income

	2018/19	2017/18
	£000	£000
Other operating income from contracts with customers:		
Research and development (contract)	5,370	4,548
Education and training (excluding notional apprenticeship levy income)	8,243	7,765
Non-patient care services to other bodies	6,314	8,234
Provider sustainability / sustainability and transformation fund income (PSF / STF)	35,852	17,087
Income in respect of employee benefits accounted on a gross basis	570	533
Other contract income	4,933	4,419
Other non-contract operating income		
Receipt of capital grants and donations	(1,649)	4,681
Charitable and other contributions to expenditure	2,192	3,664
Amortisation of PFI deferred income / credits	137	137
Total other operating income	**61,962**	**51,068**
Of which:		
Related to continuing operations	61,962	51,068
Related to discontinued operations	-	-

The education and training income arises from the provision of mandatory education and training set out in the Trust's terms of authorisation.

Capital grants includes an adjustment for a prior year grant which has now become repayable.

Note 4.1 Analysis of Other operating income other

	2018/19	2017/18
	£000	£000
Car parking	1,212	1,010
Clinical excellence awards	792	723
Catering	894	842
Property rental	431	391
Creche services	401	240
Other	1,203	1,213
	4,933	**4,419**

Note 5.1 Additional information on revenue from contracts with customers recognised in the period

	2018/19
	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	619
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	-

Note 5.2 Transaction price allocated to remaining performance obligations

There is no transaction price allocated to remaining performance obligations.

The trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from (i) contracts with an expected duration of one year or less and (ii) contracts where the trust recognises revenue directly corresponding to work done to date is not disclosed.

Note 5.3 Income from activities arising from commissioner requested services

Under the terms of its provider licence, the trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider license and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2018/19	2017/18
	£000	£000
Income from services designated as commissioner requested services	221,855	200,622
Income from services not designated as commissioner requested services	10,197	12,869
Total	**232,052**	**213,491**

Note 5.4 Profits and losses on disposal of property, plant and equipment

	2018/19	2017/18
	£000	£000
Equipment disposals	**113**	98
Land and building disposals	**4,353**	-
	4,466	**98**

The Trust has disposed of surplus land in 2018/19. The land was not used to provide commissioner requested services.

Note 6.1 Operating expenses

	2018/19	2017/18
	£000	£000
Purchase of healthcare from non-NHS and non-DHSC bodies	1,045	676
Staff and executive directors costs	149,959	138,548
Remuneration of non-executive directors	135	136
Supplies and services - clinical (excluding drugs costs)	23,302	22,665
Supplies and services - general	3,319	3,178
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	19,919	19,136
Inventories written down	-	-
Consultancy costs	518	903
Establishment	2,631	2,208
Premises	11,952	10,152
Transport (including patient travel)	740	637
Depreciation on property, plant and equipment	6,344	6,385
Amortisation on intangible assets	1,691	1,699
Net impairments	5,987	18,631
Movement in credit loss allowance: contract receivables / contract assets	43	-
Movement in credit loss allowance: all other receivables and investments	(77)	558
Increase/(decrease) in other provisions	-	-
Change in provisions discount rate(s)	(11)	9
Audit fees payable to the external auditor		
audit services- statutory audit	65	59
audit services - quality audit	11	11
Internal audit costs	-	1
Clinical negligence	3,049	4,356
Legal fees	134	656
Insurance	275	231
Research and development	5,286	3,808
Education and training	7,716	8,080
Rentals under operating leases	54	5
Early retirements	88	149
Redundancy	208	261
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI)	1,593	1,376
Car parking & security	898	534
Hospitality	14	27
Losses, ex gratia & special payments	148	157
Other services, eg external payroll	197	247
Other	557	2,594
Total	**247,790**	**248,073**
Of which:		
Related to continuing operations	247,790	248,073
Related to discontinued operations	-	-

Research and development expenditure reflects payments to other organisations in respect of research contracts.

Employee expenses - staff, include £2,905,000 (2017/18 £2,406,000) relating to research and development activities.

The Trust was host for the Sustainability and Transformation Plan for part of 2017/18 and incurred £2,300,000 of expenditure that year, including £441,000 of consultancy costs.

Note 6.2 Other auditor remuneration

There were no other non-audit services paid to the external auditor.

Note 6.3 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £2m (2017/18: £2m).

Note 7 Impairment of assets

	2018/19	2017/18
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Other	5,987	18,631
Total net impairments charged to operating surplus / deficit	**5,987**	**18,631**
Impairments charged to the revaluation reserve	30	4,728
Total net impairments	**6,017**	**23,359**

	2018/19	2017/18
Impairment of expenditure on retained estate	**1,200**	5,536
Impairment of PFI building on revaluation	**-**	17,751
Impairment of Institute in the Park building Phase 1 on revaluation	**-**	72
Impairment of Institute in the Park building Phase 2 on bringing into use	**3,103**	-
Physical obsolescence on PFI and retained estate in year	**1,714**	-
	6,017	**23,359**

Note 8 Employee benefits

	2018/19	2017/18
	Total	Total
	£000	£000
Salaries and wages	132,275	122,802
Social security costs	11,239	10,433
Apprenticeship levy	569	531
Employer's contributions to NHS pensions	14,376	13,482
Temporary staff (including agency)	6,144	5,312
Total gross staff costs	**164,603**	**152,560**
Recoveries in respect of seconded staff	**(1,507)**	(1,366)
Total staff costs	**163,096**	**151,194**
Of which		
Costs capitalised as part of assets	2,994	2,380

Note 8.1 Retirements due to ill-health

During 2018/19 there were 2 early retirements from the trust agreed on the grounds of ill-health (1 in the year ended 31 March 2018). The estimated additional pension liabilities of these ill-health retirements is £128k (£74k in 2017/18).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 9 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”. An outline of these follows:

a) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgement from the Court of Appeal in 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

The Trust offers an additional defined contribution workplace pension scheme, the National Employment Savings Scheme (NEST), to employees. The amount included in expenses for employer contributions to the scheme are £13,091 (2017/18 £6,001).

Note 10 Operating leases

Note 10.1 Alder Hey Children's NHS Foundation Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Alder Hey Children's NHS Foundation Trust is the lessee.

	2018/19	2017/18
	£000	£000
Operating lease expense		
Minimum lease payments	54	5
Contingent rents	-	-
Less sublease payments received	-	-
Total	**54**	**5**

	31 March 2019	31 March 2018
	£000	£000
Future minimum lease payments due:		
- not later than one year;	68	-
- later than one year and not later than five years;	247	-
- later than five years.	-	-
Total	**315**	**-**
Future minimum sublease payments to be received	-	-

Note 11 Finance income

Finance income represents interest received on assets and investments in the period.

	2018/19	2017/18
	£000	£000
Interest on bank accounts	143	30
Total finance income	**143**	**30**

Note 12 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money.

	2018/19	2017/18
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	1,046	1,036
Finance leases	12	7
Interest on late payment of commercial debt	-	-
Main finance costs on PFI and LIFT schemes obligations	7,944	8,098
Contingent finance costs on PFI and LIFT scheme obligations	649	550
Total interest expense	**9,651**	**9,691**
Unwinding of discount on provisions	1	2
Other finance costs	-	-
Total finance costs	**9,652**	**9,693**

Note 13 Other gains / (losses)

	2018/19	2017/18
	£000	£000
Gains on disposal of assets	4,466	98
Losses on disposal of assets	-	-
Total gains / (losses) on disposal of assets	**4,466**	**98**

The Trust has disposed of surplus land during 2018/19.

Note 14.1 Intangible assets - 2018/19

	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2018 - brought forward	**13,995**	**3,320**	**17,315**
Additions	595	1,902	**2,497**
Reclassifications	1,201	(1,201)	**-**
Disposals / derecognition	(70)	-	**(70)**
Valuation / gross cost at 31 March 2019	**15,721**	**4,021**	**19,742**
Amortisation at 1 April 2018 - brought forward	**4,384**	**-**	**4,384**
Provided during the year	1,691	-	**1,691**
Disposals / derecognition	(70)	-	**(70)**
Amortisation at 31 March 2019	**6,005**	**-**	**6,005**
Net book value at 31 March 2019	**9,716**	**4,021**	**13,737**
Net book value at 1 April 2018	**9,611**	**3,320**	**12,931**

Note 14.2 Intangible assets - 2017/18

	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2017 - as previously stated	**13,910**	**425**	**14,335**
Additions	85	2,895	**2,980**
Valuation / gross cost at 31 March 2018	**13,995**	**3,320**	**17,315**
Amortisation at 1 April 2017 - as previously stated	**2,685**	**-**	**2,685**
Provided during the year	1,699	-	**1,699**
Amortisation at 31 March 2018	**4,384**	**-**	**4,384**
Net book value at 31 March 2018	**9,611**	**3,320**	**12,931**
Net book value at 1 April 2017	**11,225**	**425**	**11,650**

Note 15.1 Property, plant and equipment - 2018/19

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2018 - brought forward	**4,029**	**154,878**	**104**	**12,333**	**29,698**	**9,017**	**3,869**	**213,928**
Additions	-	4,837	-	3,948	3,845	876	393	**13,899**
Impairments	-	(3,883)	(1)	(448)	-	-	-	**(4,332)**
Reclassifications	-	10,654	-	(10,764)	25	85	-	**-**
Disposals / derecognition	(1)	(1,938)	-	-	(969)	(147)	-	**(3,055)**
Valuation/gross cost at 31 March 2019	**4,028**	**164,548**	**103**	**5,069**	**32,599**	**9,831**	**4,262**	**220,440**
Accumulated depreciation at 1 April 2018 - brought forward	**-**	**2,813**	**-**	**-**	**13,911**	**2,866**	**811**	**20,401**
Provided during the year	-	1,994	3	-	2,871	1,105	371	**6,344**
Impairments	-	1,685	-	-	-	-	-	**1,685**
Disposals / derecognition	-	(45)	-	-	(969)	(147)	-	**(1,161)**
Accumulated depreciation at 31 March 2019	**-**	**6,447**	**3**	**-**	**15,813**	**3,824**	**1,182**	**27,269**
Net book value at 31 March 2019	**4,028**	**158,101**	**100**	**5,069**	**16,786**	**6,007**	**3,080**	**193,171**
Net book value at 1 April 2018	**4,029**	**152,065**	**104**	**12,333**	**15,787**	**6,151**	**3,058**	**193,527**

Note 15.2 Property, plant and equipment - 2017/18

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2017 - brought forward	**4,131**	**180,522**	**148**	**1,930**	**29,075**	**9,746**	**3,869**	**229,421**
Additions	-	1,222	-	10,543	1,880	176	-	**13,821**
Impairments	(847)	(22,479)	-	(140)	-	-	-	**(23,466)**
Reversals of impairments	67	40	-	-	-	-	-	**107**
Revaluations	633	(1,469)	1	-	-	-	-	**(835)**
Reclassifications	45	-	(45)	-	-	-	-	**-**
Transfers to / from assets held for sale	-	-	-	-	(319)	-	-	**(319)**
Disposals / derecognition	-	(2,958)	-	-	(938)	(905)	-	**(4,801)**
Valuation/gross cost at 31 March 2018	**4,029**	**154,878**	**104**	**12,333**	**29,698**	**9,017**	**3,869**	**213,928**
Accumulated depreciation at 1 April 2017 - brought forward	**-**	**5,623**	**-**	**-**	**12,426**	**2,690**	**450**	**21,189**
Provided during the year	-	2,197	4	-	2,742	1,081	361	**6,385**
Revaluations	-	(2,049)	(4)	-	-	-	-	**(2,053)**
Transfers to / from assets held for sale	-	-	-	-	(319)	-	-	**(319)**
Disposals / derecognition	-	(2,958)	-	-	(938)	(905)	-	**(4,801)**
Accumulated depreciation at 31 March 2018	**-**	**2,813**	**-**	**-**	**13,911**	**2,866**	**811**	**20,401**
Net book value at 31 March 2018	**4,029**	**152,065**	**104**	**12,333**	**15,787**	**6,151**	**3,058**	**193,527**
Net book value at 1 April 2017	**4,131**	**174,899**	**148**	**1,930**	**16,649**	**7,056**	**3,419**	**208,232**

Note 15.3 Property, plant and equipment financing - 2018/19

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2019								
Owned - purchased	4,028	10,920	100	4,886	4,863	5,670	3,080	**33,547**
Finance leased	-	-	-	-	925	-	-	**925**
On-SoFP PFI contracts and other service concession arrangements	-	141,294	-	-	-	-	-	**141,294**
Owned - donated	-	5,887	-	183	10,998	337	-	**17,405**
NBV total at 31 March 2019	**4,028**	**158,101**	**100**	**5,069**	**16,786**	**6,007**	**3,080**	**193,171**

Note 15.4 Property, plant and equipment financing - 2017/18

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2018								
Owned - purchased	4,029	3,168	104	7,976	3,203	5,828	3,058	**27,366**
Finance leased	-	-	-	-	406	-	-	**406**
On-SoFP PFI contracts and other service concession arrangements	-	144,773	-	-	-	-	-	**144,773**
Owned - donated	-	4,124	-	4,357	12,178	323	-	**20,982**
NBV total at 31 March 2018	**4,029**	**152,065**	**104**	**12,333**	**15,787**	**6,151**	**3,058**	**193,527**

Note 16 Donations of property, plant and equipment

The Trust has purchased medical equipment and incurred cost on the Institute in the Park, funded by charity donations.

Note 17 Revaluations of property, plant and equipment

All land and buildings were revalued as at 31 March 2018.

The valuation was carried out by an independent valuer, Cushman & Wakefield.

The basis of the valuation was to use the Depreciated Replacement Cost (DRC) approach. The DRC approach assumes that the asset would be replaced with a modern equivalent, not a building of identical design, with the same service potential as the existing asset. The modern equivalent may be smaller than the existing asset for example, due to technological advances in plant and machinery.

The ultimate objective of the valuation is to place a value upon the asset, and in this the value of the land in providing a modern equivalent facility must be considered. The modern equivalent asset may be located on a new site out of town, or be on a smaller site due to changes in the way services are provided. The site is valued based on the size of the modern equivalent, and not the actual site area occupied currently.

Asset values have been adjusted to reflect the latest BCIS "All in" Tender Price Indices to reflect change in valuation to 31 March 2019.

Note 18 Investments in associates and joint ventures

	2018/19	2017/18
	£000	£000
Carrying value at 1 April - brought forward	**450**	**-**
Acquisitions in year	-	450
Carrying value at 31 March	**450**	**450**

Note 19 Disclosure of interests in other entities

The Trust has a wholly owned subsidiary which is not yet trading and therefore not consolidated.

Name / Purpose	% Shareholding
Alder Hey Ventures Limited - commercialisation and exploitation of IP	100

The Trust has a number of interests in other entities for the commercialisation and exploitation of IP. These interests are not accounted for on the grounds of immateriality.

Name	% Shareholding
Asthma Buddy Limited	30
Doctors Hours Limited	30
Bloom Revalidation Limited	30
Digital Audiology Technologies Limited	30
Fresh Wellness Limited	30
Conquer Kids Phobia Limited	30
Blood Sense Limited	30
Physio Pal Digital Limited	30
Remedy Medpass Limited	30
Sample Tracker Limited	30
Reel Medical Technology Limited	30
Acorn Partners Limited	27.5
Kids COPD Monitoring Limited	40.1
Pik Kit Limited	40.1
Kids Medicine Compliance Limited	40.1
Hand Hygiene Solutions Limited	30
Cofoundary Enterprise 36 Limited	30

Note 20 Inventories

	31 March 2019	31 March 2018
	£000	£000
Drugs	1,046	930
Consumables	2,180	1,703
Energy	62	60
Other	-	-
Total inventories	**3,288**	**2,693**
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £31,485k (2017/18: £31,286k). Write-down of inventories recognised as expenses for the year were £0k (2017/18: £0k).

Note 21.1 Trade receivables and other receivables

	31 March 2019 £000	31 March 2018 £000
Current		
Contract receivables*	56,111	
Trade receivables*		10,177
Accrued income*		21,993
Allowance for impaired contract receivables / assets*	(1,070)	
Allowance for other impaired receivables	(126)	(1,238)
Prepayments (non-PFI)	1,675	1,856
Finance lease receivables	1,893	-
PDC dividend receivable	79	303
VAT receivable	-	360
Other receivables	3,819	1,849
Total current trade and other receivables	**62,381**	**35,300**
Non-current		
Prepayments (non-PFI)	89	81
Total non-current trade and other receivables	**89**	**81**
Of which receivables from NHS and DHSC group bodies:		
Current	45,501	26,072
Non-current	-	-

*Following the application of IFRS 15 from 1 April 2018, the trust's entitlements to consideration for work performed under contracts with customers are shown separately as contract receivables and contract assets. This replaces the previous analysis into trade receivables and accrued income. IFRS 15 is applied without restatement therefore the comparative analysis of receivables has not been restated under IFRS 15.

Contract receivables includes accrued income for Provider Sustainability Fund income due to be paid to the Trust, together with incompleted spells as at 31 March 2019.

The great majority of trade is with Clinical Commissioning Groups and NHS England, as commissioners for NHS patient care services. As these bodies are funded by government to buy NHS patient care services, no credit score of them is considered necessary.

Other receivables include a credit for PFI service failures and non-contract receivables.

Note 21.2 Allowances for credit losses - 2018/19

	Contract receivables and contract assets	All other receivables
	£000	£000
Allowances as at 1 Apr 2018 - brought forward	**-**	**1,238**
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018	1,034	(1,034)
New allowances arising	770	19
Changes in existing allowances	-	-
Reversals of allowances	(727)	(96)
Utilisation of allowances (write offs)	(7)	(1)
Allowances as at 31 Mar 2019	**1,070**	**126**

Note 21.3 Allowances for credit losses - 2017/18

IFRS 9 and IFRS 15 are adopted without restatement therefore this analysis is prepared in line with the requirements of IFRS 7 prior to IFRS 9 adoption. As a result it differs in format to the current period disclosure.

	All receivables
	£000
Allowances as at 1 Apr 2017 - as previously stated	**996**
Prior period adjustments	-
Allowances as at 1 Apr 2017 - restated	**996**
Increase in provision	993
Amounts utilised	(316)
Unused amounts reversed	(435)
Allowances as at 31 Mar 2018	**1,238**

Note 22 Non-current assets held for sale and assets in disposal groups

	2018/19	2017/18
	£000	£000
NBV of non-current assets for sale and assets in disposal groups at 1 April	**-**	**13**
Assets sold in year	-	(13)
NBV of non-current assets for sale and assets in disposal groups at 31 March	**-**	**-**

Note 23 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2018/19	2017/18
	£000	£000
At 1 April	**12,244**	**6,516**
Prior period adjustments	-	-
At 1 April (restated)	**12,244**	**6,516**
Transfers by absorption	-	(4)
Net change in year	21,455	5,732
At 31 March	**33,699**	**12,244**
Broken down into:		
Cash at commercial banks and in hand	57	56
Cash with the Government Banking Service	33,642	12,188
Deposits with the National Loan Fund	-	-
Total cash and cash equivalents as in SoFP	**33,699**	**12,244**
Bank overdrafts (GBS and commercial banks)	-	-
Total cash and cash equivalents as in SoCF	**33,699**	**12,244**

Note 24 Trade and other payables

	31 March 2019 £000	31 March 2018 £000
Current		
Trade payables	5,846	5,166
Capital payables	3,239	4,831
Accruals	14,851	7,426
VAT payables	94	-
Other taxes payable	3,259	3,036
Accrued interest on loans*		60
Other payables	3,178	2,515
Total current trade and other payables	**30,467**	**23,034**
Of which payables from NHS and DHSC group bodies:		
Current	3,189	1,573
Non-current	-	-

*Following adoption of IFRS 9 on 1 April 2018, loans are measured at amortised cost. Any accrued interest is now included in the carrying value of the loan within note . IFRS 9 is applied without restatement therefore comparatives have not been restated.

Trade payables and accruals are expected to be paid within 30 days of receipt of a valid invoice.

Other payables includes £2,040,000 (£1,919,000 at 31 March 2018) outstanding pension contributions at 31 March 2019.

Other payables includes the accrual for untaken annual leave at 31 March 2019. It is expected that this will be used before 31 March 2020.

Note 25 Other liabilities

	31 March 2019 £000	31 March 2018 £000
Current		
Deferred income: contract liabilities	612	933
PFI deferred income / credits	137	137
Total other current liabilities	**749**	**1,070**
Non-current		
PFI deferred income / credits	3,495	3,632
Total other non-current liabilities	**3,495**	**3,632**

Note 26 Borrowings

	31 March 2019 £000	31 March 2018 £000
Current		
Loans from the Department of Health and Scoial Care	10,382	2,157
Obligations under finance leases	105	86
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	2,224	2,220
Total current borrowings	**12,711**	**4,463**
Non-current		
Loans from the Department of Health and Scoial Care	37,526	46,044
Obligations under finance leases	685	273
Obligations under PFI, LIFT or other service concession contracts	102,393	104,617
Total non-current borrowings	**140,604**	**150,934**

Note 26.1 Reconciliation of liabilities arising from financing activities

	Loans from DHSC	Finance leases	PFI and LIFT schemes	Total
	£000	£000	£000	£000
Carrying value at 1 April 2018	**48,201**	**359**	**106,837**	**155,397**
Cash movements:				
Financing cash flows - payments and receipts of principal	(359)	(168)	(2,220)	**(2,747)**
Financing cash flows - payments of interest	(1,040)	(12)	(7,944)	**(8,996)**
Non-cash movements:				
Impact of implementing IFRS 9 on 1 April 2018	60	-	-	**60**
Transfers by absorption	-	-	-	**-**
Additions	-	599	-	**599**
Application of effective interest rate	1,046	12	7,944	**9,002**
Change in effective interest rate	-	-	-	**-**
Changes in fair value	-	-	-	**-**
Other changes	-	-	-	**-**
Carrying value at 31 March 2019	**47,908**	**790**	**104,617**	**153,315**

Note 27 Finance leases

Note 27.1 Alder Hey Children's NHS Foundation Trust as a lessor

Future lease receipts due under finance lease agreements where Alder Hey Children's NHS Foundation Trust is the lessor:

	31 March 2019 £000	31 March 2018 £000
Gross lease receivables	**1,893**	**-**
of which those receivable:		
- not later than one year;	1,893	-
- later than one year and not later than five years;	-	-
- later than five years.	-	-
Unearned interest income	-	-
Allowance for uncollectable lease payments	-	-
Net lease receivables	**1,893**	**-**
of which those receivable:		
- not later than one year;	1,893	-
- later than one year and not later than five years;	-	-
- later than five years.	-	-
The unguaranteed residual value accruing to the lessor	-	-
Contingent rents recognised as income in the period	-	-

The Trust has a leasing arrangement with a university in respect of part of the Institute in the Park building

Note 27.2 Alder Hey Children's NHS Foundation Trust as a lessee

Obligations under finance leases where Alder Hey Children's NHS Foundation Trust is the lessee.

	31 March 2019 £000	31 March 2018 £000
Gross lease liabilities	**856**	**383**
of which liabilities are due:		
- not later than one year;	127	86
- later than one year and not later than five years;	705	226
- later than five years.	24	71
Finance charges allocated to future periods	(66)	(24)
Net lease liabilities	**790**	**359**
of which payable:		
- not later than one year;	105	86
- later than one year and not later than five years;	662	205
- later than five years.	23	68
Total of future minimum sublease payments to be received at the reporting date	-	-
Contingent rent recognised as an expense in the period	-	-

Note 28.1 Provisions for liabilities and charges analysis

	Pensions: early departure costs	Pensions: injury benefits*	Legal claims	Other	Total
	£000	£000	£000	£000	£000
At 1 April 2018	**160**	**691**	**230**	**120**	**1,201**
Change in the discount rate	(1)	(10)	-	-	**(11)**
Arising during the year	88	-	141	-	**229**
Utilised during the year	(51)	(47)	(122)	(114)	**(334)**
Reclassified to liabilities held in disposal groups	-	-	-	-	**-**
Reversed unused	-	-	(17)	(6)	**(23)**
Unwinding of discount	-	1	-	-	**1**
At 31 March 2019	**196**	**635**	**232**	**-**	**1,063**
Expected timing of cash flows:					
- not later than one year;	53	47	232	-	**332**
- later than one year and not later than five years;	104	181	-	-	**285**
- later than five years.	39	407	-	-	**446**
Total	**196**	**635**	**232**	**-**	**1,063**

Early departure costs and injury benefits for former employees have been estimated using life expectancy from the Government's actuarial tables.

Legal claims relate to third party and employer liability claims and have been estimated by NHS Resolution. It is expected that these claims will be settled in the next year.

* In 2018/19 the analysis of provisions has been revised to separately identify provisions for injury benefit liabilities. In previous periods, these provisions were included within early departure costs.

Note 28.2 Clinical negligence liabilities

At 31 March 2019, £156,587k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Alder Hey Children's NHS Foundation Trust (31 March 2018: £138,230k).

Note 29 Contingent assets and liabilities

The sale of land during 2018/19 contract has a buy-back clause which can be triggered following uncertain future events. This will be capital expenditure of £3,960k for the trust if it comes to fruition.

Note 30 Contractual capital commitments

	31 March 2019	31 March 2018
	£000	£000
Property, plant and equipment	1,039	4,030
Intangible assets	435	256
Total	**1,474**	**4,286**

Contractual capital commitments relate to capital items/work which has been ordered but not received at 31 March 2019.

Note 31 Other financial commitments

The trust is committed to making payments under non-cancellable contracts (which are not leases, PFI contracts or other service concession arrangement), analysed by the period during which the payment is made:

	31 March 2019	31 March 2018
	£000	£000
not later than 1 year	-	764
after 1 year and not later than 5 years	824	1,473
after 5 years	-	-
Total	**824**	**2,237**

Note 32 On-SoFP PFI, LIFT or other service concession arrangements

The PFI scheme relates to the main hospital building on East Prescot Road.

The Trust has the right to use the buildings, however Alder Hey (Special Purpose Vehicle) Limited (Acorn Consortium) have responsibility for maintaining the buildings to an agreed standard. All lifecycle replacement is also the responsibility of Alder Hey (Special Purpose Vehicle) Limited.

A key feature of the PFI scheme is that the operator is responsible for ensuring that the property is maintained to an agreed standard for the entire life of the contract. These are known as lifecycle costs. The costs which the operator expects to incur in doing this is reflected in the unitary payment.

The contract with Alder Hey (Special Purpose Vehicle) Limited expires on 21 June 2045, after which time the trust will become responsible for the maintenance and lifecycle costs of those buidlings.

Note 32.1 Imputed finance lease obligations

Alder Hey Children's NHS Foundation Trust has the following obligations in respect of the finance lease element of on-Statement of Financial Position PFI and LIFT schemes:

	31 March 2019	31 March 2018
	£000	£000
Gross PFI, LIFT or other service concession liabilities	**274,288**	**285,100**
Of which liabilities are due		
- not later than one year;	10,719	10,813
- later than one year and not later than five years;	42,664	42,871
- later than five years.	220,905	231,416
Finance charges allocated to future periods	(169,671)	(178,263)
Net PFI, LIFT or other service concession arrangement obligation	**104,617**	**106,837**
- not later than one year;	2,224	2,220
- later than one year and not later than five years;	9,687	9,447
- later than five years.	92,706	95,170

Note 32.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

Total future obligations under these on-SoFP schemes are as follows:

	31 March 2019	31 March 2018
	£000	£000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**455,980**	**470,081**
Of which liabilities are due:		
- not later than one year;	14,287	14,102
- later than one year and not later than five years;	59,105	58,304
- later than five years.	382,588	397,675

Note 32.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the unitary payments made to the service concession operator:

	2018/19	2017/18
	£000	£000
Unitary payment payable to service concession operator	**12,406**	**12,094**
Consisting of:		
- Interest charge	7,944	8,098
- Repayment of finance lease liability	2,220	2,070
- Service element and other charges to operating expenditure	1,337	1,174
- Revenue lifecycle maintenance	256	202
- Contingent rent	649	550
Total amount paid to service concession operator	**12,406**	**12,094**

Note 33 Financial instruments

Note 33.1 Financial risk management

Financial reporting standard IFRS7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the trust has with clinical commissioning groups (CCGs) and the way those CCGs are financed, the trust is not exposed to the degree of financial risk faced by business activities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply.

The trust's treasury management operations are carried out by the finance department, within parameters defined formally within the trust's standing financial instructions and policies agreed by the Board of Directors. Trust treasury activity is subject to review by the trust's internal auditors.

Liquidity Risk

Alder Hey Children's NHS Foundation Trust net operating costs are incurred under legally binding contracts with local CCGs. The trust receives regular monthly payments from CCGs based on an agreed contract value with adjustments made for actual services provided.

The trust finances its capital expenditure from internally generated funds or Public Dividend Capital made available by the Department of Health and Social Care. The trust is therefore not exposed to significant liquidity risks.

Interest Rate Risk

All of the trust's financial assets carry nil or fixed rates of interest. The trust is not exposed to significant interest rate risk.

Foreign Currency Risk

The trust is principally a domestic organisation with the majority of transactions, assets and liabilities being in the UK and sterling based. The trust has limited business with overseas clients. The trust therefore has low exposure to currency rate fluctuations.

Price Risk

The contracts from NHS commissioners in respect of healthcare services have a pre-determined price structure which negates the risk of price fluctuation.

Credit Risk

The contracts from NHS commissioners in respect of healthcare services are agreed annually and take into account the commissioners' ability to pay and hence credit risk is minimal.

Note 33.2 Carrying values of financial assets

IFRS 9 Financial Instruments is applied restrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

Carrying values of financial assets as at 31 March 2019 under IFRS 9	Held at amortised cost £000	Held at fair value through I&E £000	Total book value £000
Trade and other receivables excluding non financial assets	56,083	-	**56,083**
Other investments / financial assets	-	-	**-**
Cash and cash equivalents at bank and in hand	33,699	-	**33,699**
Total at 31 March 2019	**89,782**	**-**	**89,782**

Carrying values of financial assets as at 31 March 2018 under IAS 39	Loans and receivables £000	Assets at fair value through the I&E £000	Total book value £000
Trade and other receivables excluding non financial assets	31,556	-	**31,556**
Other investments / financial assets	-	450	**450**
Cash and cash equivalents at bank and in hand	12,244	-	**12,244**
Total at 31 March 2018	**43,800**	**450**	**44,250**

Note 33.3 Carrying value of financial liabilities

IFRS 9 Financial Instruments is applied restrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

	Held at amortised cost	Total book value
	£000	£000
Carrying values of financial liabilities as at 31 March 2019 under IFRS 9		
Loans from the Department of Health and Social Care	47,908	**47,908**
Obligations under finance leases	790	**790**
Obligations under PFI, LIFT and other service concession contracts	104,617	**104,617**
Trade and other payables excluding non financial liabilities	27,114	**27,114**
Total at 31 March 2019	**180,429**	**180,429**

	Other financial liabilities	Total book value
	£000	£000
Carrying values of financial liabilities as at 31 March 2018 under IAS 39		
Loans from the Department of Health and Social Care	48,201	**48,201**
Obligations under finance leases	359	**359**
Obligations under PFI, LIFT and other service concession contracts	106,837	**106,837**
Trade and other payables excluding non financial liabilities	19,998	**19,998**
Total at 31 March 2018	**175,395**	**175,395**

Note 33.4 Fair values of financial assets and liabilities

Note 33.5 Maturity of financial liabilities

	31 March 2019	31 March 2018
	£000	£000
In one year or less	39,825	24,461
In more than one year but not more than two years	4,844	12,513
In more than two years but not more than five years	14,769	13,844
In more than five years	120,991	124,577
Total	**180,429**	**175,395**

Note 34 Losses and special payments

	2018/19		2017/18	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	2	1	11	30
Bad debts and claims abandoned	15	7	22	6
Stores losses and damage to property	1	20	1	40
Total losses	**18**	**28**	**34**	**76**
Special payments				
Ex-gratia payments	42	141	36	142
Total special payments	**42**	**141**	**36**	**142**
Total losses and special payments	**60**	**169**	**70**	**218**
Compensation payments received		-		-

Note 35.1 Initial application of IFRS 9

IFRS 9 Financial Instruments as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to reserves on 1 April 2018.

IFRS 9 replaces IAS 39 and introduces a revised approach to classification and measurement of financial assets and financial liabilities, a new forward-looking 'expected loss' impairment model and a revised approach to hedge accounting.

Under IFRS 9, borrowings from the Department of Health and Social Care, which were previously held at historic cost, are measured on an amortised cost basis. Consequently, on 1 April 2018 borrowings increased by £60k, and trade payables correspondingly reduced.
Reassessment of allowances for credit losses under the expected loss model resulted in no change in carrying value of receivables.

The GAM expands the definition of a contract in the context of financial instruments to include legislation and regulations, except where this gives rise to a tax. Implementation of this adaptation on 1 April 2018 has led to the classifiction of receivables relating to Injury Cost Recovery as a financial asset measured at amortised cost. The carrying value of these receivables at 1 April 2018 was £0k.

Note 35.2 Initial application of IFRS 15

IFRS 15 Revenue from Contracts with Customers as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to the income and expenditure reserve on 1 April 2018.

IFRS 15 introduces a new model for the recognition of revenue from contracts with customers replacing the previous standards IAS 11, IAS 18 and related Interpretations. The core principle of IFRS 15 is that an entity recognises revenue when it satisfies performance obligations through the transfer of promised goods or services to customers at an amount that reflects the consideration to which the entity expects to be entitled to in exchange for those goods or services.

As directed by the GAM, the Trust has applied the practical expedient offered in C7A of the standard removing the need to retrospectively restate any contract modifications that occurred before the date of implementation (1 April 2018).
Implementation of IFRS 15 has had no material impact on the financial statements of the Trust.

Note 36 Related parties

Alder Hey Children's NHS Foundation Trust is a public interest body authorised by NHS Improvement.

During the period, none of the Trust board members of members of the key management staff, or parties related to any of them, has undertaken any transactions with Alder Hey Children's NHS Foundation Trust.

The Department of Health and Social Care is regarded as a related party. During the period the Trust has had a significant number of transactions with the Department, and with other entities for which the Department is regarded as the parent Department. The transactions relate mainly to the provision of healthcare services and purchase of services in the ordinary course of business.

	Revenue	Expenditure	Receivables	Payables
	£000	£000	£000	£000
Liverpool Womens Hospital NHS Foundation Trust	613	645	548	325
Manchester University NHS Foundation Trust	1469	927	622	282
Mersey Care NHS Foundation Trust	78	490	89	237
Royal Liverpool & Broadgreen University Hospitals NHS Trust	1246	643	101	464
Warrington and Halton Hospitals NHS Foundation Trust	218	315	41	45
Wirral University Teaching Hospital NHS Foundation Trust	262	306	263	202
NHS Halton CCG	1249	0	181	0
NHS Knowsley CCG	6226	0	56	0
NHS Morecambe Bay CCG	317	0	51	0
NHS Liverpool CCG	34169	0	577	0
NHS South Cheshire CCG	568	0	33	0
NHS South Sefton CCG	10286	0	298	0
NHS Southport And Formby CCG	4163	0	310	0
NHS St Helens CCG	1709	0	0	47
NHS Vale Royal CCG	368	0	7	0
NHS Warrington CCG	1331	0	144	0
NHS West Cheshire CCG	876	0	11	0
NHS West Lancashire CCG	897	0	0	13
NHS Wigan Borough CCG	539	0	32	0
NHS Wirral CCG	2074	0	56	0
Health Education England	7705	3	45	0
Department of Health & Social Care	4718	0	180	0
NHS England - Core	36546	0	32516	0
NHS England Cheshire & Merseyside Local Office	1871	4	125	0
NHS England Lancashire & South Cumbria Local Office	348	0	0	0
NHS England North West Specialist Commissioning Hub	143039	0	7753	0
NHS Resolution	0	3260	0	33
All Other NHS Bodies	4161	3380	1383	1375

In addition, the Trust has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with:

	Revenue	Expenditure	Receivables	Payables
	£000	£000	£000	£000
Liverpool City Council	1048	26	161	0
Welsh Health Bodies - Cwm Taf Local Health Board	15858	0	0	0
HM Revenue & Customs - Other taxes and duties	0	11807	0	3259
NHS Pension Scheme	0	14376	0	2040
NHS Professionals	0	4824	0	503
NHS Blood and Transplant	7	1159	0	11
Northern Health & Social Care Trust - Northern Ireland	761	0	330	0
Other WGA Bodies	251	153	86	98

Expenditure with Liverpool Health Partners Ltd was £205,000 (£81,000 2017/18).

Transactions with related parties are on an arm's length basis.

Note 37 Accounting Standards in issue but not yet adopted

IFRS 16 Lease Accounting will be implemented from 1st April 2020. The trust has a number of operating leases which involve the right to use assets. These assets will be recognised on the Statement of Financial Position from 1st April 2020 as right to use assets, and will be depreciated in the same way as other items of property, plant and equipment. The effect of implementing IFRS 16 is not material to the Trust's financial statements.

INDEPENDENT AUDITOR'S STATEMENT TO THE DIRECTORS OF ALDER HEY CHILDREN'S NHS FOUNDATION TRUST ON THE NHS FOUNDATION TRUST CONSOLIDATION SCHEDULES

We have examined the consolidation schedules designated TAC02 to TAC29 for tables outlined in red, excluding TAC05A, TAC23, and TAC28A of Alder Hey Children's NHS Foundation Trust, version 1.18.12.1C for the year ended 31 March 2019, which have been prepared by the Director of Finance and acknowledged by the Chief Executive.

This statement is made solely to the Board of Directors of Alder Hey Children's NHS Foundation Trust in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006 (the Act) and paragraph 4.2 of the Code of Audit Practice and for no other purpose.

For the purpose of this statement, reviewing the consistency of figures between the audited financial statements and the consolidation schedules extends only to those figures within the consolidation schedules which are also included in the audited financial statements.

Auditors are required to report on any differences over £300,000 between the audited financial statements and the consolidation schedules.

Unqualified audit opinion on the audited financial statements; one difference identified:

The figures reported in the consolidation schedules are consistent with the audited financial statements, on which we have issued an unqualified opinion, except for the following:

The 31 March 2018 comparator of £450,000 within the Financial Instruments note 33.2 on Financial Assets has been removed in the consolidation schedules following a request from NHS Improvement to remove investment in joint venture following adoption of IFRS9. The audited financial statements include the comparator as IFRS9 was not adopted at 31 March 2018 and this does not constitute a prior period adjustment.

Hassan Rohimun
For and on behalf of Ernst & Young LLP

2 St Peters' Square
Manchester
M2 3EY

28/05/2019

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

Opinion

We have audited the financial statements of Alder Hey Children's NHS Foundation Trust for the year ended 31/03/2019 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, Statement of Cash Flows, the Statement of Changes in Equity and the related notes1 to 37, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union and HM Treasury's Financial Reporting Manual (FReM) to the extent that they are meaningful and appropriate to NHS foundation trusts.

In our opinion, the financial statements:

- give a true and fair view of the state of Alder Hey Children's NHS Foundation Trust's affairs as at 31 March 2019 and of its income and expenditure and cash flows for the year then ended; and
- have been prepared in accordance with the Department of Health and Social Care's Group Accounting Manual 2018/19 and the directions under paragraphs 24 and 25 of Schedule 7 of the National Health Service Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report below. We are independent of the Foundation Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard and the Comptroller and Auditor General's (C&AG) AGN01, and we have fulfilled our other ethical responsibilities in accordance with these requirements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

We have nothing to report in respect of the following matters in relation to which the ISAs (UK) require us to report to you where:

- the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or
- the Accountable Officer has not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the company's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

Overview of our audit approach

Key audit matters	• Fraud in revenue and expenditire recognition • Misstatements due to fraud or error
Materiality	• Overall materiality of £4.96 million which represents 2% of operating expenditure.

Key audit matters

Key audit matters are those matters that, in our professional judgment, were of most significance in our audit of the financial statements of the current period and include the most significant assessed risks of material misstatement (whether or not due to fraud) that we identified. These matters included those which had the greatest effect on: the overall audit strategy, the allocation of resources in the audit; and directing the efforts of the engagement team. These matters were addressed in the context of our audit of the financial statements as a whole, and in our opinion thereon, and we do not provide a separate opinion on these matters.

Risk	Our response to the risk	Key observations communicated to the Audit Committee
Risk of fraud in revenue and expenditure recognition Under ISA 240 there is a presumed risk that revenue may be misstated due to improper revenue recognition. In the public sector, this requirement is modified by Practice Note 10 issued by the Financial Reporting Council, which states that auditors should also consider the risk that material misstatements may occur by the manipulation of expenditure recognition.	We reviewed and tested revenue and expenditure recognition policies We reviewed accounting estimates for evidence of management bias, including testing of expenditure accruals and provisions We reviewed the financial statements for evidence of significant or unusual transactions. We also tested a sample of income and expenditure transactions from material revenue streams including year-end debtor and creditor balances, and tested variances between amounts recognised and amounts externally confirmed through the Agreement of Balances exercise. We tested cut-off of income and expenditure at the year-end and conducted testing to identify any unrecorded liabilities at the year-end. We tested capital expenditure to assess whether the items were capital or revenue in nature, to identify expenditure	Our testing has not identified any material misstatements from revenue and expenditure recognition. Overall we identified two significant unusual transactions. Our audit work on these items did not identify any material issues or indicate any improper misreporting of the Trust's financial position.

	excluded from the Statement of Comprehensive Income. Our testing also reviews the transactions that have occurred post year end to identify any omissions in expenditure.	
Misstatements due to fraud or error There is a risk that the financial statements as a whole are not free of material misstatements whether caused by fraud or error. As identified in ISA (UK and Ireland) 240, management is in a unique position to perpetrate fraud because of its ability to manipulate accounting records directly or indirectly and prepare fraudulent financial statements by overriding controls that otherwise appear to be operating effectively.	We carried out procedures for identifying fraud risks during the planning stages, and inquired with management about risks of fraud and the controls put in place to address those risks. We gained an understanding the oversight given by those charged with governance of management's processes over fraud. We considered the effectiveness of management's controls designed to address the risk of fraud. We carried out specific audit procedures to test journal entries in the accounts, particularly testing journal entries and other adjustments in the preparation of the financial statements.	We have not identified any material weaknesses in controls or evidence of management override. We have not identified any instances of inappropriate judgements being applied which would indicate manipulation in accounting records or fraudulent financial reporting. We identified two significant unusual transactions in our work on revenue. Our audit work on these items did not identify any material issues or indicate any improper misreporting of the Trust's financial position. We did not identify any other transactions during our audit which appeared unusual or outside the Trusts normal course of business.

In the prior year, our auditor's report included a key audit matter in relation to the valuation of land and buildings. In the current year, this matter has not been included as the full valuation in the prior year has been updated by a desktop exercise in the current year.

In the prior year, our auditor's report included a key audit matter in relation to accounting for the Private Finance Initiative Scheme, due to that year being our first audit of the matter. In the current year, this matter has not been included as there is no significant change to the matter.

An overview of the scope of our audit

Tailoring the scope

Our assessment of audit risk, our evaluation of materiality and our allocation of performance materiality determine our audit scope for the Foundation Trust. This enables us to form an opinion on the financial statements. We take into account size, risk profile, the organisation of the Foundation Trust and effectiveness of controls, including controls and changes in the business environment when assessing the level of work to be performed. All audit work was performed directly by the audit engagement team.

Materiality
The magnitude of an omission or misstatement that, individually or in the aggregate, could reasonably be expected to influence the economic decisions of the users of the financial statements. Materiality provides a basis for determining the nature and extent of our audit procedures.

We determined materiality for the Trust to be £4.96 million, which is 2% of operating expenditure (2017/18 £2.48 million, 1% of operating expenditure). We believe that operating expenditure provides us with a reasonable basis for determining materiality as it is the key driver of the Trust's financial position.

During the course of our audit, we reassessed initial materiality and concluded that it remained appropriate in relation to the reported actual financial position at year end.

Performance materiality
The application of materiality at the individual account or balance level. It is set at an amount to reduce to an appropriately low level the probability that the aggregate of uncorrected and undetected misstatements exceeds materiality.

On the basis of our risk assessments, together with our assessment of the Trust's overall control environment, our judgement was that performance materiality was 75% of our planning materiality, namely £3.72 million (2017/18 50% of our materiality, £1.24 million). We have set performance materiality at this percentage due to our experience of our prior year audit finding no significant issues and our understanding of the control environment at the Trust.

Reporting threshold
An amount below which identified misstatements are considered as being clearly trivial.

We agreed with the Audit Committee that we would report to them all uncorrected audit differences in excess of £0.25 million (2017/18 £0.12 million), which is set at 5% of materiality, as well as differences below that threshold that, in our view, warranted reporting on qualitative grounds.

We evaluate any uncorrected misstatements against both the quantitative measures of materiality discussed above and in light of other relevant qualitative considerations in forming our opinion.

Other information

The other information comprises the information included in the annual report on pages 4 to 239, other than the financial statements and our auditor's report thereon. The directors are responsible for the other information.

Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in this report, we do not express any form of assurance conclusion thereon.

We read all the financial and non-financial information in the Annual Report and Accounts to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

We have nothing to report in this regard.

Opinion on other matters prescribe by the Code of Audit Practice issued by the NAO

In our opinion:

- the information given in the performance report and accountability report for the financial year for which the financial statements are prepared is consistent with the financial statements; and

- the parts of the Remuneration and Staff report identified as subject to audit has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2018/19.

Matters on which we report by exception

The Code of Audit Practice requires us to report to you if

- We issue a report in the public interest under schedule 10(3) of the National Health Service Act 2006;
- We refer the matter to the regulator under schedule 10(6) of the National Health Service Act 2006 because we have reason to believe that the Trust, or a director or officer of the Trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency;
- We are not satisfied that the Trust has put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources as required by schedule 10(1)(d) of the National Health Service Act 2006;
- we have been unable to satisfy ourselves that the Annual Governance Statement, and other information published with the financial statements meets the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2018/19 and is not misleading or inconsistent with other information forthcoming from the audit; or
- we have been unable to satisfy ourselves that proper practices have been observed in the compilation of the financial statements.

We have nothing to report in respect of these matters.

The NHS Foundation Trust Annual Reporting Manual 2018/19 requires us to report to you if in our opinion, information in the Annual Report is:

- materially inconsistent with the information in the audited financial statements; or
- apparently materially incorrect based on, or materially inconsistent with, our knowledge of the NHS Foundation Trust acquired in the course of performing our audit.
- otherwise misleading.

We have nothing to report in respect of these matters.

Responsibilities of Accounting Officer

As explained more fully in the Accountable Officer's responsibilities statement set out on page 104, the Accountable Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the Accountable Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accountable Officer is responsible for assessing the company's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Council of Governors intend to cease operations, or have no realistic alternative but to do so.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Auditor's responsibilities with respect to value for money arrangements

We are required to consider whether the Foundation Trust has put in place 'proper arrangements' to secure economy, efficiency and effectiveness on its use of resources. This is based on the overall criterion that "in all significant respects, the audited body had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people".

Proper arrangements are defined by statutory guidance issued by the National Audit Office and comprise the arrangements to:

- Take informed decisions;
- Deploy resources in a sustainable manner; and
- Work with partners and other third parties.

In considering your proper arrangements, we draw on the requirements of the guidance issued by NHS Improvement to ensure that our assessment is made against a framework that you are already required to have in place and to report on through documents such as your annual governance statement.

We are only required to determine whether there are any risks that we consider significant, which the Code of Audit Practice defines as:

"A matter is significant if, in the auditor's professional view, it is reasonable to conclude that the matter would be of interest to the audited body or the wider public. Significance has both qualitative and quantitative aspects".

Our risk assessment supports the planning of sufficient work to enable us to deliver a safe conclusion on arrangements to secure value for money and enables us to determine the nature and extent of further work that may be required. If we do not identify any significant risk there is no requirement to carry out further work. Our risk assessment considers both the potential financial impact of the issues we have identified, and also the likelihood that the issue will be of interest to local taxpayers, the Government and other stakeholders.

Use of our report

This report is made solely to the Council of Governors of Alder Hey Children's NHS Foundation Trust in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006 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, for our audit work, for this report, or for the opinions we have formed.

Certificate

We certify that we have completed the audit of the financial statements of Alder Hey Children's NHS Foundation Trust in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice issued by the National Audit Office on behalf of the Comptroller and Auditor General (C&AG).

Hassan Rohimun
for and on behalf of Ernst & Young LLP
Manchester
28 May 2019

The maintenance and integrity of the Alder Hey Children's NHS Foundation Trust web site is the responsibility of the directors; the work carried out by the auditors does not involve consideration of these matters and, accordingly, the auditors accept no responsibility for any changes that may have occurred to the financial statements since they were initially presented on the web site.

Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

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 NHS Foundation Trust ("the 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 2019 (the 'Quality Report') and certain performance indicators contained therein.

This report is made solely to the Trust's Council of Governors, as a body, in accordance with our engagement letter dated 03/05/2019. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2019 to enable the Council of Governors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators.

To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's Council of Governors as a body, for our examination, for this report, or for the conclusions we have formed.

Our work has been undertaken so that we might report to the Council of Governors those matters that we have agreed to state to them in this report and for no other purpose. Our report must not be recited or referred to in whole or in part in any other document nor made available, copied or recited to any other party, in any circumstances, without our express prior written permission. This engagement is separate to, and distinct from, our appointment as the auditors to the Trust.

Scope and subject matter

The indicators for the year ended 31 March 2019 subject to limited assurance consist of the national priority indicators as mandated by NHS Improvement:

- ► **Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge.**
- ► **All cancers: 31 days until subsequent treatments.**

We refer to these national priority indicators collectively as the 'indicators'.

Respective responsibilities of the directors and Ernst & Young LLP

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 2018/19' issued by NHS Improvement.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the quality report is not prepared in all material respects in line with the criteria set out in the 'NHS Foundation Trust Annual Reporting Manual 2018/19', which is supported by NHS Improvement's Detailed Requirements for quality reports 2018/19;
- the quality report is not consistent in all material respects with the sources specified in Section 2.1 of the 'Detailed guidance for external assurance on quality reports 2018/19' 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 2018/19' and supporting guidance and the six dimensions of data quality set out in the 'Detailed Guidance for External Assurance on Quality Reports 2018/19'.

We read the Quality Report and consider whether it addresses the content requirements of the 'NHS Foundation Trust Annual Reporting Manual 2018/19' 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 the other information sources detailed in Section 2.1 of the 'Detailed guidance for external assurance on quality reports 2018/19'. These are:

- Board minutes for the period April 2018 to May 2019
- Papers relating to quality reported to the Board over the period April 2018 to May 2019
- feedback from commissioners, dated 20/05/2019
- feedback from governors, dated 09/05/2019
- feedback from local Healthwatch organisations, dated 09/05/2019
- feedback from Overview and Scrutiny Committee dated 10/05/2019
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated quarterly throughout the year, final quarter dated 05/03/2019
- the latest national patient survey, dated 2018
- the latest national staff survey, dated 2018
- Care Quality Commission inspection, dated 21/06/2018
- the Head of Internal Audit's annual opinion over the trust's control environment, dated 23 May 2019.

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 NHS Foundation Trust NHS Foundation Trust as a body, to assist the Council of Governors in reporting Alder Hey Children's 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 2019, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. 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, but were not limited to:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators
- making enquiries of management
- 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 2018/19' to the categories reported in the Quality Report.
- reading the documents.

The objective of a limited assurance engagement is to perform such procedures as to obtain information and explanations in order to provide us with sufficient appropriate evidence to express a negative conclusion on the Quality Report**.** The procedures performed in a limited assurance engagement vary in nature and timing from, and are less in extent than for, a reasonable assurance engagement. Consequently the level of assurance obtained in a limited assurance engagement is substantially lower than the assurance that would have been obtained had a reasonable assurance engagement been performed.

Inherent limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the 'NHS foundation trust annual reporting manual 2018/19' and supporting guidance. The scope of our assurance work has not included governance over quality or non-mandated indicators, which have been determined locally by Alder Hey Children's NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019:

- 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 2018/19 (published on 6 November 2018) and the Detailed requirements for quality reports 2018/19 (published on 17 December 2018), , issued by NHS Improvement
- the Quality Report is not consistent in all material respects with the sources specified, and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with NHS Foundation Trust Annual Reporting Manual

2018/19 (published on 6 November 2018) and the Detailed requirements for quality reports 2018/19 (published on 17 December 2018), issued by NHS Improvement .

Ernst & Young
Manchester
28 May 2019

Notes:

1. The maintenance and integrity of the Alder Hey Children's NHS Foundation Trust's web site is the responsibility of the directors; the work carried out by Ernst & Young LLP does not involve consideration of these matters and, accordingly, Ernst & Young LLP accept no responsibility for any changes that may have occurred to the Quality Report since it was initially presented on the web site.

2. Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

BOARD OF DIRECTORS

Tuesday 28 May 2019

Report of:	Director of Corporate Affairs
Paper Prepared by:	Director of Corporate Affairs/ Governance Manager
Subject/Title:	Board Self Certification 2019 - Compliance with NHS provider licence conditions
Background Papers:	NHS foundation trusts are required to self-certify whether or not they have complied with the conditions of the NHS provider licence, have the required resources available if providing commissioner requested services, and have complied with governance requirements.
Purpose of Paper:	The purpose of this paper is to provide assurances to support the Board in making the required self-declarations.
Action/Decision Required:	The Board is asked to consider the evidence in the annual self-assessment and to approve the Self-Certification of Compliance with the Trust's Provider Licence.
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	➢ Delivery of outstanding care ➢ The best people doing their best work ➢ Sustainability through external partnerships ➢ Game-changing research & innovation
Resource Impact:	

This template may be used by Foundation trusts and NHS trusts to record the self-certifications that must be made under their NHS Provider Licence.
You do not need to return your completed template to NHS Improvement unless it is requested for audit purposes.

Self-Certification Template - Condition FT4

Alder Hey Children's NHS Foundation Trust *Insert name of organisation*

Foundation Trusts and NHS trusts are required to make the following self-certifications to NHS Improvement:

Corporate Governance Statement - in accordance with Foundation Trust condition 4 (Foundations Trusts and NHS trusts)
Certification on training of Governors - in accordance with s151(5) of the Health and Social Care Act (Foundation Trusts only)

These self-certifications are set out in this template.

How to use this template

1) Save this file to your Local Network or Computer.
2) Enter responses and information into the yellow data-entry cells as appropriate.
3) Once the data has been entered, add signatures to the document.

Worksheet "FT4 declaration" Financial Year to which self-certification relates | | Please Respond

Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

	Corporate Governance Statement	Response	Risks and Mitigating actions	
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	[including where the Board is able to respond 'Confirmed']	#REF!
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	[including where the Board is able to respond 'Confirmed']	#REF!
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	[including where the Board is able to respond 'Confirmed']	#REF!
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed	[including where the Board is able to respond 'Confirmed']	#REF!
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	[including where the Board is able to respond 'Confirmed']	#REF!
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	[including where the Board is able to respond 'Confirmed']	#REF!

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature J. Williams **Signature** L.C. Shepherd

Name Dame Jo Williams **Name** Louise Shepherd

Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4.

A | | Please Respond

Worksheet "Training of governors"

Financial Year to which self-certification relates 2018/19 Please Respond

Certification on training of governors (FTs only)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements. Explanatory information should be provided where required.

Training of Governors

1 The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role. — Confirmed — OK

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Dame Jo Williams	**Name**	Louise Shepherd
Capacity	Chair	**Capacity**	Chief Executive
Date	28 May 2019	**Date**	28 May 2019

Further explanatory information should be provided below where the Board has been unable to confirm declarations under s151(5) of the Health and Social Care Act

A

This template may be used by Foundation trusts and NHS trusts to record the self-certifications that must be made under their NHS Provider Licence.
You do not need to return your completed template to NHS Improvement unless it is requested for audit purposes.

Self-Certification Template - Conditions G6 and CoS7

Alder Hey Children's NHS Foundation Trust *Insert name of organisation*

Foundation Trusts and NHS trusts are required to make the following self-certifications to NHS Improvement:

Systems or compliance with licence conditions - in accordance with General condition 6 of the NHS provider licence
Availability of resources and accompanying statement - in accordance with Continuity of Services condition 7 of the NHS provider licence (Foundation Trusts designated CRS providers only)

These self-certifications are set out in this template.

How to use this template
1) Save this file to your Local Network or Computer.
2) Enter responses and information into the yellow data-entry cells as appropriate.
3) Once the data has been entered, add signatures to the document.

Worksheet "G6 & CoS7"

Financial Year to which self-certification relates: 2018/19

Please complete the explanatory information in cell

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with licence conditions (FTs and NHS trusts)

1 Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution. — **Confirmed** — OK

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

3a After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. — **Confirmed** — Please fill details in cell E22

OR

3b After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.

OR

3c In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

The Trust Board has signed off an annual plan for the year that sees it delivering a £1.8m surplus and sees itself clearly as a going concern. The plan highlights a series of risks of delivery particularly with regard to delivery of our efficiency plan and the impact of changes to the children's tariff. Despite these risks the Board have mitigations in place.

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature	[signature]	**Signature**	[signature]
Name	Dame Jo Williams	**Name**	Louise Shepherd
Capacity	Chair	**Capacity**	Chief Executive
Date	28 May 2019	**Date**	28 May 2019

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

NHS Improvement Provider Licence Self-Assessment - Update as at April 2019

Licence Condition	Current position	Assurance	Gap	Action
Section 1 – General Conditions				
G1 - Provision of information	All monitoring submissions provided by deadline via the portal. Additional documents provided on request, e.g. following quarterly review meeting.	• Quarterly reports scrutinised in-year and approved by RBD and submitted to Audit Committee to oversee assurance process • Operational DoF checks financial returns before submission and reports to RBD • Annual Report and Accounts audited and scrutinised by Audit Committee then BoD	None identified at present	None – the Trust remains compliant with this condition.
G2 – Publication of information	Trust reports placed in the public domain in accordance with NHSI requirements, e.g. Annual Report and Accounts	• Hard copies of reports available at AMM and within Trust premises; summary sent to members • Trust website • Trust Publication Scheme	None identified at present	NHSI bulletins and guidance for any new requirements
G3 – Payment of fees to Monitor	This condition reflects the power given to NHSI/Monitor under the Act to require licensees to pay fees in relation to its regulatory functions. Fees are not currently in place, not has any decision	N/A	N/A	None required at present. Provision has never been implemented

Licence Condition	Current position	Assurance	Gap	Action
	yet been taken as to whether NHSI will begin to charge fees.			
G4 - Fit and proper persons	Trust arrangements have been updated to reflect CQC regulation 19 (applies to directors only). This includes a separate declaration, amendments to Directors' contracts/letters of appointment, additional checks around insolvency and disqualification and revised Recruitment Policy	• Annual declaration process • Directors undergo enhanced DBS checks and other robust pre-employment checks • Existing directors undergoing DBS refresh • Annual checks for insolvency and disqualification	None at present	None outstanding – CQC satisfied with current arrangements following last inspection
G5 – Monitor guidance	Guidance consistently and stringently followed	• Reports to Board Committees e.g. Annual Plan, Annual Report and Accounts, Corporate Report (Single Oversight Framework) • Well Led review completed. • FTSU self-review tool received by Trust Board • Quality Governance Framework received by CQAC.	None identified at present	Continue to track new guidance through appropriate committee on publication
G6 – Systems for compliance with licence conditions and related obligations (i.e. NHS	Systems and processes are currently set up to ensure compliance with provisions of the Licence and other mandatory requirements; risk set out in	• Corporate Report links to Single Oversight Framework • Quarterly Reports to NHSI reviewed by RBD in-year	None identified at present	Compliance with Licence conditions formally reviewed by the Board as part of its annual work plan.

Licence Condition	Current position	Assurance	Gap	Action
Acts and Constitution)	BAF. Constitution amended to reflect 2012 Act.	• Certification produced in accordance with paras 10 and 11 of this Condition in May 2016 covering financial year. • Monthly Board and assurance committee oversight of BAF		
G7 – Registration with the Care Quality Commission	Currently registered without conditions for all relevant services. June 2016 inspection – Good.	All inspection and registration issues reported monthly through appropriate assurance committee/s and Board	None identified at present	Continue with regular engagement meetings with CQC; ensure NHSI informed of all key issues.
G8 – Patient eligibility and selection criteria	This condition requires licensees to set and publish transparent patient eligibility criteria and to apply these in a transparent manner. Explicit eligibility criteria are not currently published for individual AH services, however they are covered in a range of activities: • Declarations of compliance with specialist service specifications; • Information on individual services provided on trust website; • Clinical discussions at MDT level including where any ambiguity exists for example with regard to age limits (16 – 18) and where adult	• At MDT level • Compliance with service specifications issued by Spec Comm. • Quality contract monitoring by CCG	Individual eligibility and selection criteria not currently published together in one place due to nature of services – all children under 16 eligible depending on clinical need.	Statement to form part of Annual Report

Licence Condition	Current position	Assurance	Gap	Action
	transition services are not established			
G9 – Application of S.5 (Continuity of Services)	All previous Mandatory Services migrated to Commissioner Requested Services as of 1st April 2013. Three services derogated as part of Spec Comm assessment of trusts against service specifications in	NHSE (Spec Comm) contract monitoring meetings	Derogation in place for Oncology, Major Trauma and Implantable Hearing Aids.	SDIP to be put in place for each service with plan to achieve compliance
Section 2 – Pricing				
P1 – Recording of Information	Under this condition NHSI may require licensees to record information on their costs in line with guidance. They may also require licensees to record other information, e.g. quality and outcome data to support NHSI in carrying out its pricing functions. PLICS has been developed and rolled out to Divisions; and finance team have developed a suite of reports in support of service line reporting.	• Reports to RBD and Audit Committee • Trust submits reference costs data to DH in line with timetable and guidance • Trust takes part in voluntary exercise to share Patient Level Costing data with NHSI. NHS Improvement once again rated Alder Hey's costing information, methodologies and governance number one in England in 2018 • Suite of quarterly reports to Divisions/CBUs regarding service line, consultant, procedure and patient level cost and income performance.	None identified at present	Continue to develop and refine reporting / costing at service line level / patient level costing.

Licence Condition	Current position	Assurance	Gap	Action
P2 – Provision of information	As G1 above. NHSI places particular emphasis on the availability of consistently recorded and accurate information on costs to enable them to set prices for NHS services at an appropriate level.	Reports to RBD and Audit Committee. Trust has self-assessed its data quality and costing processes against NHSI's assessment framework and has scored gold which is the highest in the country.	None identified at present	As above P1
P3 – Assurance report on submissions to Monitor	Links to P2 above – NHSI will require assurance on the accuracy of the costing information provided.	Reports to RBD and Audit Committee as required	N/A	N/A
P4 – Compliance with the National Tariff	This condition imposes an obligation on providers as well as commissioners to charge for NHS services in line with National Tariff.	Reports to RBD and Audit Committee as required. Contracts signed with commissioners based on national standard contracts. Impact of national tariffs reflected in 2019/20 financial plans agreed by the Board.	None currently identified	None in terms of compliance with the Licence condition, however the impact of the 2019/20 tariff on the Trust will need to be closely monitored and discussed with NHSI as part of the quarterly reporting cycle.
P5 – Constructive engagement concerning local tariff modifications	The Act gives NHSI responsibility for setting the process and rules around local pricing modifications. This condition requires licensees to engage constructively with commissioners to try to reach local agreement before applying	Reports to RBD	None currently identified	Trust will follow guidance as and when applicable and where local pricing modifications are agreed with Commissioners which meet NHSI's criteria for notification.

Licence Condition	Current position	Assurance	Gap	Action
	to NHSI for a local modification. Head of Contracting works closely with local commissioners to address specific service issues.			
Section 3 – Choice and Competition				
C1 – The right of patients to make choices	This condition requires licensees to notify their patients when they have a choice of provider either under the NHS Constitution or conferred locally by commissioners. It requires providers to tell patients where they can find information about the choices they have in a way that is not misleading. Any information provided to AH patients would be on the basis of clinical need. No inducements are offered to referring clinicians by the Trust under any circumstances. Patients are informed of their NHS Constitution right to choosing alternative providers for those waiting longer than 18 weeks from RTT.	Reports to RBD re contract performance.	None currently identified	Patient information leaflets to be updated as required to include aspects on choice where appropriate
C2 – Competition oversight	This condition prohibits the licensee from entering into or maintaining agreements that have the object or effect of preventing, restricting or	This will be considered on a case by case basis when the Trust bids for or establishes contractual arrangements for the provision of services.	None currently identified	None currently identified

Licence Condition	Current position	Assurance	Gap	Action
	distorting competition to the extent that it is against the interests of health care users.	Trust follows EU guidance where applicable. Major contract changes reviewed and approved by the Board and or R&BD.		
Section 4 – Integrated care				
IC1 – Provision of integrated care	Trust actively pursuing plans to deliver better integration of children's services in the city with Liverpool CCG and other partners. Significant partnership work has continued in-year, detailed in the Trust's Annual Report.	Reports to BoD	None currently identified	None from a compliance perspective
Section 5 – Continuity of Services				
CoS1 – Continuing provision of Commissioner Requested Services	All services currently delivered as per contract/agreed specification issued by commissioners	Quality meetings with commissioners. Reports by exception to Board Contract performance review meetings with Commissioners	See G9 above	See G9 above
CoS2 – Restriction on the disposal of assets	Trust has an up to date asset register	Register maintained by the Finance team	None currently identified	None currently identified
CoS3 – Standards of corporate governance and financial management	Trust has robust corporate and financial governance arrangements that are compliant with all relevant guidance including that issued by NHSI	Internal and external audit reports provided to Audit Committee, Board and Governors. Annual Governance Statement, HoIAO, CQC well-led	None currently identified	Track any updates and changes to guidance

Licence Condition	Current position	Assurance	Gap	Action
		inspection and monthly monitoring of financial and performance risks. The Board commissioned an independent review against the Well Led Framework against NHSIs Guidance which states that 'The *overall conclusion from our review is that the Trust is well-led. It is an organisation with lived values, a talented Board, a determined strategic intent and a momentum to developing a clinical leadership model.*'		
CoS4 – Undertaking from the ultimate controller	NHSI/Monitor defines the 'ultimate controller' as being anybody that could instruct the licensee to carry out particular actions, i.e. the parent company of a subsidiary that has been licensed by Monitor. If there is no single body that could instruct the licensee in this way, the licensee does not have an ultimate controller and there is no need for an undertaking under this condition. Monitor has clarified that governors and directors of FTs are not regarded as ultimate controllers and will not need to provide undertakings.	N/A	N/A	N/A

Licence Condition	Current position	Assurance	Gap	Action
CoS5 – Risk pool levy	In the event of a provider entering special administration, the costs of administration will be met by a central fund known as the risk pool. This condition requires the licensee to contribute to the funding of the pool if NHSI/Monitor requests it.	N/A	N/A	N/A
CoS6 – Co-operation in the event of financial distress	This condition applies when a licensee fails to meet the test of sound financial management (as per CoS3) under the RAF, in which case the licensee is required to provide information to 3rd parties as directed by NHSI and allow access to premises. We are currently rated as 2 under the SOF.	Corporate Report scrutinised by RBD and BoD Ops Board and Exec Performance Reviews oversee operational delivery.	None identified	Trust financial position and risks to delivery continues to be subject to regular review and update
CoS7 – Availability of resources	This condition sets out the Board certification requirement which aims to provide NHSI with reassurance that the Board has given consideration to the resources to be dedicated to the provision of CRS over the coming 12 month period.	All previous updates to certification requirements have been fulfilled either by the entire Board or by RBD as part of its delegated authority.	None identified	Certificate to be drafted for consideration by the Board to the required timescale and to be available for NHSI audit purposes.
Section 6 – NHS Foundation Trust Conditions				
FT1 – Information to update the register of NHS foundation trusts	Trust constitution, annual report, annual accounts and auditor's report have been consistently provided to NHSI/Monitor within	Reports to the Board. Publication of Trust information on NHSI's website	None identified	Ensure any changes to guidance are tracked e.g. New requirements in the ARM

Licence Condition	Current position	Assurance	Gap	Action
	the specified timescales.			
FT2 – Payment to Monitor in respect of registration and related costs	This condition creates the provision for Monitor to charge fees specifically to FTs for the cost of regulation e.g. maintaining registers etc. No decision has yet been taken by NHSI/Monitor as to whether this will be put into practice however a separate consultation is planned. NB Monitor has had the power to levy fees from FTs since 2004 but has chosen not to do so.	N/A	N/A	Keep watching brief
FT3 – Provision of information to advisory panel	Monitor has set up its 'Panel for Advising Governors' as described by the 2012 Act. The panel has been created as a source of independent advice to governors in order to help them fulfil their role; the focus is on governors using the panel when their trust has failed in its obligations either under the constitution or the Act. Licensees are required to provide information to the panel when requested. NB. The Act requires a majority of governors to support the submission of a query following consideration at a full meeting of	Governors are provided with all Board papers and full information about the Trust via Basecamp and at regular meetings. Key issues presented to Governors at every meeting Governors are regularly reminded that Board meetings are open to the public	None currently identified	Ensure any new Governors are aware of the process for submitting a query to the Panel as part of induction

Licence Condition	Current position	Assurance	Gap	Action
	the Council of Governors.			
FT4 – NHS foundation trust governance arrangements	This condition builds upon the existing requirements set out in the Code of Governance and other guidance documents including the ARM. The Trust has consistently complied with the requirements to demonstrate the effectiveness of its governance arrangements.	External and internal audit reports to Audit Committee. There is a well-developed committee structure which is the subject of an annual effectiveness review.	None identified at present	Continue to ensure requirements are adhered to.

Erica Saunders
May 2019

Register of Company Shareholdings
As at 30th April 2019

Changes made since last reporting period:

Changes highlighted in blue

1. New Companies formed with Alder Hey as Shareholder

As noted in the March update, the Trust formally entered into 2 shareholder agreements for companies established by the ACORN partnership. A copy of the company documents signed and a briefing note on the agreements is included in Appendix A.

2. Filing of Company Accounts

The filing of accounts for all companies operating under the ACORN partnership are managed through the partner `We are Nova`. During April, five company accounts was filed on companies house.

Name	Date of Incorporation	AH Director	Shareholdings	Company No	Address	Nature	Purpose & Product Description	Filing	Status
Physiopal Digital Ltd	27/06/2018	No	30.00% - person with significant control	10838856	Boundary Street, Liverpool	Commercial	App development and commercialisation	Managed through 3rd party Accounts filed 17.04.19 for y/e 28th Dec 18	Active
Kids COPD Monitoring Ltd	14/12/2017	No	40.1%	11112790	Boundary Street, Liverpool	Commercial	App development and commercialisation	Managed through 3rd party Accounts filed 30.04.19 for y/e 31st Dec 18	Active

Name	Date of Incorporation	AH Director	Shareholdings	Company No	Address	Nature	Purpose & Product Description	Filing	Status
Pik Kit Ltd	15/12/2017	No	40.1%	11112815	Boundary Street, Liverpool	Commercial	App development and commercialisation	Managed through 3rd party Accounts filed 30.04.19 for y/e 31st Dec 18	Active
Kids Medicine Compliance Ltd	15/12/2017	No	40.1%	11112938	Boundary Street, Liverpool	Commercial	App development and commercialisation	Managed through 3rd party Accounts filed 30.04.19 for y/e 31st Dec 18	Active
Hand Hygenie Solutions Ltd	09/11/2017	No	30%	11055776	Boundary Street, Liverpool	Commercial	Hand compliance sensor system	Managed through 3rd party Accounts filed 30.04.19 for y/e 30TH Nov 18	Active

Full Master Company Register as at 30th April 2019:

Name	Date of Incorporation	AH Director	Shareholdings	Company No	Address	Nature	Purpose & Product Description	Filing	Status
Alder Hey Ventures LTD	27.06.17	David Powell	100% wholly owned subsidiary	10837212	AH	Commercial No employees	Commercial, innovation, product development and exploit IP	Confirmation statement: 12.07. YE: 30.06.18 Accounts due: 27.03.19	'Active' Not used Not consolidated
Alder Hey Living Hospital LTD	24.04.17	John Grinnell Sir David Henshaw David Powell	50% JV with Alder Hey Children's Charity AH significant control	10835638	AH Charity	Commercial No employees	App development and commercialisation	Confirmation statement: 23.04.18 YE: 31.03.18 Accounts filed: 31.12.18	'Active' used Equity investment materiality
Asthma Buddy Ltd	18/05/2017	No	30.10%	10188710	Boundary Street, Liverpool	Commercial	Peer to Peer support for information on Asthma App development and commercialisation	Managed through 3rd party	Active
Doctors Hours Ltd	18/05/2017	No	30.10%	10188794	Boundary Street, Liverpool	Commercial	Junior doctors hours monitoring App development and commercialisation	Managed through 3rd party	Active
Bloom Revalidation	18/05/2017	No	30.10%	10189548	Boundary Street,	Commercial	Nurse revalidation	Managed through 3rd party	Active

Name	Date of Incorporation	AH Director	Shareholdings	Company No	Address	Nature	Purpose & Product Description	Filing	Status
Ltd					Liverpool		App development and commercialisation		
Digital Audiology Technologies Ltd	18/05/2017	No	30.10%	10189060	Boundary Street, Liverpool	Commercial	Digitised gaming hearing test App development and commercialisation	Managed through 3rd party	Active
Fresh Wellness Ltd	30/06/2017	No	30.10%	10259396	Boundary Street, Liverpool	Commercial	Mental health support app App development and commercialisation	Managed through 3rd party	Active
Conquer Kids Phobia Ltd	27/04/2017	No	30.00%	10746202	Boundary Street, Liverpool	Commercial	App development and commercialisation	Managed through 3rd party	Active
Blood Sense Ltd	27/04/2017	No	30.00%	10746341	Boundary Street, Liverpool	Commercial	App development and commercialisation	Managed through 3rd party	Active
Physiopal Digital Ltd	27/06/2018	No	30.00% - person with significant control	10838856	Boundary Street, Liverpool	Commercial	App development and commercialisation	Managed through 3rd party	Active
Remedy Medpass Ltd	27/04/2018	No	30.00%	10746292	Boundary Street, Liverpool	Commercial	App development and commercialisation	Managed through 3rd party	Active

Name	Date of Incorporation	AH Director	Shareholdings	Company No	Address	Nature	Purpose & Product Description	Filing	Status
Sample Tracker Ltd	27/04/2018	No	30.00%	10746420	Boundary Street, Liverpool	Commercial	App development and commercialisation	Managed through 3rd party	Active
Reel Medical Technology Ltd	27/04/2018	No	30.00%	10746455	Boundary Street, Liverpool	Commercial	App development and commercialisation	Managed through 3rd party	Active
Acorn Partners Ltd	18/05/2018	No	27.5%	10188842	Boundary Street, Liverpool	Commercial	Managing company for partnership	Managed through 3rd party	Active
Kids COPD Monitoring Ltd	14/12/2017	No	40.1%	11112790	Boundary Street, Liverpool	Commercial	App development and commercialisation	Managed through 3rd party	Active
Pik Kit Ltd	15/12/2017	No	40.1%	11112815	Boundary Street, Liverpool	Commercial	App development and commercialisation	Managed through 3rd party	Active
Kids Medicine Compliance Ltd	15/12/2017	No	40.1%	11112938	Boundary Street, Liverpool	Commercial	App development and commercialisation	Managed through 3rd party	Active
Hand Hygenie Solutions Ltd	09/11/2017	No	30%	11055776	Boundary Street, Liverpool	Commercial	Hand compliance sensor system	Managed through 3rd party	Active
Cofoundary Enterprise 36	15/12/2017	No	0%	11112857	Boundary Street, Liverpool	Commercial	Sensor based alternative to spirometry	Managed through 3rd party	Active

Resources and Business Development Committee
Draft Minutes of the meeting held on: Monday 29th April 2019 at 1:00pm in Large Meeting Room, Institute in the Park

Present	Ian Quinlan (Chair)	Non-Executive Director	(IQ)
	Adam Bateman	Chief Operating Officer	(AB)
	Claire Dove	Non-Executive Director	(CD)
	John Grinnell	Director of Finance	(JG)
	Claire Liddy	Director of Operational Finance	(CL)
In attendance	Mark Flannagan	Director of Communications	(MF)
	Erica Saunders	Director of Corporate Affairs	(ES)
	Karen McKeown	Committee Administrator (*minutes*)	(KMc)
	Kate Warriner	Chief Information Officer	(KW)
Apologies	Sue Brown	Associate Director for Development	(SB)
	Natalie Deakin		(ND)
	Dani Jones	Director of Strategy	(DJ)
	Phil O'Connor	Deputy Director of Nursing.	(POC)
	Melissa Swindell	Director of HR & OD	(MS)
	Julie Tsao	Committee Administrator (*minutes*)	(JT)
	Graeme Dixon	Head of Building Services	(GD)
Agenda Item: 22/25	Sara Naylor	Associate Director Financial Planning	(SN)
22/24	Graeme Dixon	Head of Building Services	(GD)
22	Hilda Gwilliams	Chief Nurse	(HG)
33	Helen Cibinda	Service Manager, Medicine	(HC)
33	Jason Dean	Costing Accountant	(JD)

19/20/19 Apologies

The Chair noted the apologies received from Sue Brown, Natalie Deakin, Dani Jones, Melissa Swindell and Julie Tsao.

19/20/20 Minutes from the meeting held on 1st April 2019
Resolved:

The minutes from the meeting held on the 1st April were approved.

19/20/21 Matters Arising and Action log

19/20/22 Top 5 Risks/Key Priority Areas for 2019/20.

RABD received the latest slides on the three areas below:

CIPs

The final 2018/19 position for CIP delivery is £6.8m with a shortfall of £0.1m on the full year delivery against a target of £6.9m. The CIP year to date identified is £3m as schemes fully developed/plan in progress. Attention was drawn to the £3m that is yet to be identified which is a risk to the delivery of the CIP target for 2019/20.

It was reported that work is taking place with the Divisions to identify CIPs going forward and support is being offered to managers by the Finance and Costing team.

Claire Liddy highlighted a forthcoming issues that will affect CIP i.e Change *to the procurement landscape* – Products are being transferred to the centre and high level procurement is to be addressed nationally, thus reducing income.

Claire Liddy advised that discussions will take place to look at transformation schemes along with the challenges for CIP going forward. A CIP Strategy communication will also be circulated to staff members to encourage employees to become involved in spending wisely. It was agreed to provide an update on the CIP Strategy communication at the next meeting.

19/20/10 **Action: CL**

PFI

Graeme Dixon provided the Committee with an overview of the situation to date in respect to the issues relating to building risks across the hospital. The following points were highlighted and discussed:

- *Corroded pipework* – It was reported that this area of work is behind time and a letter has been issued to SPV requesting a response regarding this matter. Regular monthly meetings are taking place between Alder Hey and SPV and a request has been made to Project Co for the submission of an action plan in order to clarify timelines/work that is going to take place to address the issues. John Grinnell highlighted the importance of having a strategy to support the action plan.
- *ICU Ventilation* – It was confirmed that the CPG has approved funding of £45k for a feasibility study. Work is taking place with Val Weston re the design of air flow and sealing of rooms.
- *Theatre Temperatures* – This area of work has been resolved and will be signed off once assurance has been provided.
- *Falling Ceiling Tiles* - There has been one recent report of a falling ceiling tile. It was confirmed that weekly walk rounds are still in force.
- *Air Changes* - It was confirmed that there have been no recent reporting of failures.
- *Hot and Cold Water Temperatures* - It was confirmed that this area of work is on track. Out of a total of 53 areas there are only six that were unable to be addressed.

Elective Programme

Adam Bateman provided the Committee with an update on elective activity for month 12. The following points were highlighted:

- It was confirmed that during March 2019 elective activity fell behind target as a result of emergency cases coming into the Trust.
- Combined elective and day case run rate is at 96.6 for March which is an additional 3.5 compared to March 2018.
- Surgical day case was 42.0 per working day in March 2019, this is the highest in a two year period.
- Combined IP electives reached 20.1 in March, the highest seen since June 2017.

Catering Update

Hilda Gwilliams provided an update on the Catering review and reorganisation process which commenced in the summer of 2018.

It was confirmed that four of the six initiatives that were agreed to help address overspend have been fully implemented; price increase, pop-up stalls, portion control and new tills.

As at the end of month 12 it was reported that the Trust is starting to see a financial impact of these improvements bedding in. Overall catering income fell at the end of December 2018 and beginning of January 2019 but increased during February and March 2019 whilst expenditure was also contained further. It was reported that the full year effect of savings in 2018/19 was £22k.

The Committee was advised of the drill down that is going to take place in respect to hospitality and footfall in R&E2 to identify the cause of overspend.

A discussion took place around the cost benefits of portion control and it was queried as to whether they are at their full extent. It was confirmed that data will be available once the EPOS and Indicator system has been installed on the tills which in due course will provide in-depth information in addition to daily takings.

Claire Liddy felt that once the new data collection system was up and running it may be beneficial to have a KPI to help understand whether actions e.g. portion control is producing an increase in profit.

19/20/23 Top Risks/Key Priorities for 2019/20

Following discussion the Committee agreed that the following risks should be addressed on a monthly basis:

- Estates.
- Sustainable surplus; efficiency programme to include meds, corporate and workforce.
- Facilities.
- Digital Strategy.
- Financial benefits of green sustainability; to include governance element for this compliance.

19/20/24 PFI Monitoring Contract

Interserve has reported that 98% of PPMs were completed on time. The Chair queried as to whether there had been an impact to services following Interserve going into planned administration on the 15.3.19. It was reported that there has been no impact on services but there has been a delay in suppliers furnishing goods to Interserve. This has not affected the Trust in any way.

Resolved:
The Committee noted the Building Services report for month 12.

19/20/25 Finance Report

The Committee was provided with an overview of the draft year end results. The following points were highlighted:

- The Trust is reporting a control total surplus for the year of £49.9m which is ahead of plan by £17.7m. £15.5m of the surplus relates to one off technical opportunities and £35.8m relates to PSF income. These will provide investment into the Trust's 5 year capital programme. The Trust's trading position has a deficit of £1.4m. The Use of Resources risk rating is 1 in line with the plan and cash in the bank of £33.7.
- It was reported that the additional £20m incentive funds are not in the bank to date.
- As a result of hosting the STP IT projects the Trust will hold cash of £6m by the year end.
- The Committee was provided with an overview of the income received as a result of the following areas performing better than expected; PSF, bonus money, PFI, land sale and A&E delivery. The Trust received a large amount of bonus money due to the Divisions achieving their forecasts. The Medicine Division hit their control total and had the best performance figures. It was confirmed that as of the 3.5.19 the PFI deal documents will be signed.
- Claire Liddy highlighted the Trust's positive performance across an array of areas; cash balance, the low agency spend and the growth on elective activity. Attention was also drawn to the A&E performance that helped the organisation achieve 100% of its PSF funding. The Chair queried as to whether there were any areas of funding that the Trust was unsuccessful in achieving. John Grinnell reported on the unexpected backdated pay claims that arose and the issues being experienced to reduce the temporary staff run rate to below £1m.
- John Grinnell highlighted the Trust's underlying £1.4m deficit position and the importance of ensuring that the organisation achieves a recurrent position without PSF funding. Attention was drawn to the importance of managing internal communications to ensure that staff are aware of how the surplus received for 2018/19 fits with the Investment Strategy for the next 5 years.
- Claire Liddy advised the Committee that work needs to take place around postage, catering, domestics and porters in order to bring these services back into budget.

Resolved
The Committee noted the contents of the Finance report for month 12.

19/20/26 Estates

The Committee received a draft report on the development of the campus at Alder Hey. The report provides an early preview of the Estates agenda and highlights the schemes involved; Neuro-assessment Hub, Dewi Jones Unit, Alder Centre, Neonates expansion scheme, new District heating scheme and associated sites/community developments. There will be a new robust governance structure wrapped around the exercise and work is taking place to address the brand and language.

Resolved:
The Committee noted the draft report on the development of the campus at Alder Hey.

19/20/27 **Programme Assurance**

The Committee was apprised of the assurance status of the change programme and the actions that have been requested by the Executive sponsors.

- The Trust is refocussing on its 2019/20 programme with some projects being closed off and new ones being initiated. The final report will be submitted to the Programme Board in June 2019 for approval.
- It was reported that the Aseptic business investment case was approved on the 25.4.19. This will enable the project to progress and the rag rating turn green.
- The Committee was advised that a review is required of the Park Community Estates and the Alder Centre as both projects are behind plan. The Chair requested that the Committee have a clear overview of the projects, from a narrative perspective, so that an in-depth discussion can take place at the next meeting in order to offer assurance to the Trust Board.

19/20/11 **Action: JG**

- The Committee discussed the work that has taken place around voice recognition (VR). The aspiration for this project was that VR could be used in all areas across the Trust but it was reported that it has been hard to judge as to whether it has been a success. Kate Warriner felt that VR should be reviewed as part of the Digital Strategy/Operational Strategy in order to evaluate the project from a benefits and financial perspective. It was agreed to conduct a piece of work, with the support of the clinicians, to determine whether the project should continue or cease.

19/20/12 **Action: KW**

Resolved
RABD received the latest assurance report.

19/20/28 **Marketing and Communications**

Mark Flannagan provided the Committee with an update on progress against the Marketing and Communications Operational Plan and highlighted some of the key areas of work that is being progressed; brand, website and external communications in relation to the planning application for Springfield Park

It was reported that work is taking place on the website/extranet and an update will be provided during May's meeting. A query was raised around the timings for completion of the website and whether the Trust has sought external advice. It was reported that the Trust had acquired external advice and it was of the consensus that an internal Super User group should be established to assist with progressing the website. An update will be available on timings etc. in due course.

The Chair queried the cost of the work that is taking place to progress the Trust's brand and website. Mark Flannagan advised that the work taking place at the present time is being conducted internally but in the event additional funding is required it was confirmed that a proposal will be submitted for approval.

Resolved:
RABD received an update on progress against the Marketing and Communications Operational Plan.

19/20/29 **Board Assurance Framework (BAF)**

The BAF was submitted to the Committee for information and assurance purposes. The Committee was informed of the key items:

- Financial risk going forward,
- Partnership risk to be rearticulated
- Digital risk to be examined from a strategic perspective.

Resolved:
RABD received and noted the BAF cover report for month 12.

19/20/30 **NHSI Q4 Report**

Resolved:
The Committee received and noted the NHS Improvement Monitoring report for Q4.

19/20/31 **RABD Committee Annual Report**

Resolved:
The Committee received and approved the annual report

19/20/32 **Corporate Report**

The Committee received and noted the Corporate Report for month 12. The following points were highlighted:

- A&E 4 hour target has been achieved for March 2019
- All access targets have been achieved for 2018/19.
- 'Was Not Brought' rate has reduced to below 10%. It was felt that this was as a result of bi-directional texting.
- Clinic utilisation has been above 85% for a second consecutive month. This has been as a result of working with Divisional teams. It was confirmed that the figure to date is 88.7%.
- Performance in relation to last minute cancellations for non-clinical reason has improved, with a 69% on reduction in cancellations observed in Q4.
- Sickness rates have improved but this comes with a temporary staffing cost implication.

Resolved:
The Committee received and noted the Corporate Report for month 12.

19/20/33 **Service Line Reporting**

The Committee received a presentation on the plan to support clinical services to improve sustainability by working productively, spending wisely and reducing waste. The presentation provided an overview on the approach of the plan, the information sources included in the value pack, the reporting process along with the strategy and the outcome of the Gastroenterology pilot.

Resolved:

The Committee noted the presentation that was submitted by Jason Dean and Helen Cibinda.

19/20/34 Global Digital Excellence Programme

The Committee was provided with an update on the Digital and Information Technology current position and planned next steps.

It was reported that the Trust has performed excellently with regards to the Global Digital Exemplar Programme. The programme has had both an internal and external focus. All milestones, as agreed with NHS England and NHS Digital, have been achieved to date. 2019/20 sees the final year of the GDE programme for Alder Hey, as the programme is set to close in March 2020.

Internally, focus has largely been on removing paper from care processes, and streamlining pathways through the implementation of 'specialty packages'. Speciality packages have been implemented with services and should be considered a core tenant of the Trust's Inspiring Quality priorities with regards to improving care through digital technologies. Internally, much of this work has been around embedding core processes and developing the Trust's EPR system. Externally, focus has been with regards to the leadership and early stages of delivery of the regional shared care record through the Share2Care programme. It was reported that the organisation has demonstrated real leadership in respect to the STP.

The Committee was advised of the range of IT services delivered to staff with a blended approach of in house, the technical delivery programmes that are in development and the 2000 to 2500 IT operational issues that are managed on a monthly basis. It was pointed out that there are a number of national 'must dos' which include the upgrading of hardware estate to Windows 10 and achieving Cyber Essential accreditation.

Attention was drawn to the operational pressures requiring quick attention including a review of the requirements and service model for Community services, some departmental hot spots, and improvements made to the operation of Multi-Disciplinary Team meetings with external partners. It was reported that work is taking place to address KPIs which will report into the Resources and Business Development Committee.

The Committee was informed of the next phase of developments for Alder Hey; development of the revised Alder Hey Digital Strategy, review of Information Technology Operating Model and delivery of current priorities. It was confirmed that engagement has commenced with clinical colleagues in respect to the revised Digital Strategy and independent support has been sought to progress the operating model. In terms of current priorities the Trust has to deliver the final year of the GDE programme and achieve level 6 and 7 HYMS accreditation.

A draft version of the Digital Strategy is to be submitted to the Trust Board in July for approval. Following discussion, it was agreed to submit the draft report to RABD in June for information purposes.

19/20/13 Action: KW

Resolved:
The Committee noted the update.

19/20/35 **RABD ToR**

The Committee reviewed the Terms of Reference and agreed that the terminology and reporting arrangements were appropriate. Following discussion it was agreed that Kate Warriner should be included in the ToR as a member of the Committee.

19/20/14 **Action: ES**

Resolved:
The Committee approved the updated Terms of Reference, pending the amendment.

19/20/22 **Any Other Business**

There was none to discuss.

Date and Time of Next Meeting: Wednesday 22nd May 2019, 9:30am – 12:30pm, Large Meeting Room, Institute in the park.

Audit Committee

Draft Minutes of the meeting held on **Thursday 18th April 2019**

Tony Bell Board Room, Institute in the park

Present:	Mrs K Byrne (Chair)	Non-Executive Director	(KB)
	Mrs. A. Marsland	Non-Executive Director	(AM)
In Attendance:	Mr G Baines	Assistant Director, MIAA	(GB)
	Mr J Grinnell	Director of Finance	(JG)
	Mrs C Liddy	Operational Director of Finance	(CL)
	Mrs V Martin	Counter Fraud Specialist, MIAA	(VM)
	Ms M McMahon	Senior Audit Manager, MIAA	(MMc)
	Miss J Preece	Governance Manager	(JP)
	Mr H Rohimun	Executive Director, Ernst and Young	(HR)
	Mrs L Shepherd	Chief Executive (Item 11)	(LS)
	Ms E Saunders	Director of Corporate Affairs	(ES)
	Mrs J Tsao	Committee Administrator *(minutes)*	(SS)
Apologies:	Mrs L Cobain	Assistant Director, MIAA	(LC)
	Mrs. J. France-Hayhurst	Non-Executive Director	(JFH)
	Mr Richard Tyler	E&Y Accounts Manager	(RT)
Agenda item: 3	Cathy Fox	Programme Director for Digital	
3	Rachel Greer	Associate Chief Information Officer – Community	
3	Elaine Morgan	Head of Information and Clinical Coding	

19/20/01 Minutes of the previous meeting held on 24th January 2019

Subject to the last word under section 73, Accounting Policies being changed to "consider", Audit Committee approved the minutes from the last meeting held on 24th January 2019.

Resolved:

Audit Committee APPROVED the minutes.

19/20/02 Matters Arising and Action List

18/19/73.1 Accounting Policies

The action to review the current paper based annual leave process to see if this could be converted to electronic would be monitored under the HR work-plan and removed from the Audit Committee Action log.

All other actions had either been closed or had been included on the agenda.

19/20/03 Progress Report, MIAA

The Chair noted the number of draft internal audit reports included in MIAA's Progress Report and asked that, going forward the report only includes final reports. It is understood that draft reports have been included in this Report given the need to provide the Draft Head of Internal Audit Opinion. To ensure that all internal audit reports are finalised in good time for the year-end the Chair requested that all field work be completed by January. Exceptions may be provided upon individual request for approval by either Erica Saunders or John Grinnell.

Whilst included as draft reports in this Progress Report the Chair requested that the results from the audits named below be presented and discussed at the next Audit Committee on 23rd May 2019:

- Sepsis
- Serious Incidents
- Did Not Attend

Update on the Meditech (Critical Application) audit

Cathy Fox went through the progress made against the outstanding recommendations:

A review of the confidentiality audits is in place and will be completed by the end of quarter 1. This was a joint piece of work with Information Governance. The Chair queried if there was capacity for this to be completed. Erica Saunders responded noting discussions were being held between IT and the Governance teams to prioritise.

Audit Committee agreed that the recommendation around ensuring that the IT department is informed when staff move jobs within the Trust to ensure their access levels are reviewed was an action for the HR work plan rather than for IT to implement. John Grinnell provided background noting a checklist process was to be introduced for when staff move jobs which will include a review of IT systems access. Audit Committee requested an update on progress in introducing a checklist at its meeting on 26th September 2019.
Action: Melissa Swindell

In relation to password controls aligning with Trust policy and National Cyber Security Centre guidance this would be ongoing as the action moves forward.

The IT business continuity plan is being processed.

Audit Report - Data Security and Protection

The audit report noted the robust structure in place, with no recommendations.

Audit Report - Safe Together & Always Right (STAR)

Audit Committee noted the positive areas included in the outcomes noting it was good to see this as positive areas are not always included.

Audit Report - Assurance Framework Opinion

No recommendations were raised.

As discussed previously it was agreed that MIAA would circulate final Audit Reports to Julie Tsao for saving centrally on Virtual Boardroom.
Action: MIAA/JT

Resolved:
Audit Committee received the Internal Audit Progress Report.

Follow-Up Audit Report
Audit Committee received the above report. It was suggested that the report does not reflect some of the actions taken recently to implement the actions. Maria McMahon and Erica Saunders agreed to go through the Follow Up Report and identify actions recently implemented for reporting to the next Audit Committee.

Action: MMc/ES

Resolved:
Audit Committee received the Follow up Report.

19/20/04 Draft Head of Internal Audit Opinion and Annual Report 2018-19

Gary Baines presented the Draft Director of Internal Audit Opinion and Annual Report for 2018/19 to the Committee. It was confirmed that a *Substantial Assurance* opinion can be given, subject to the issue of final reports relating to Sepsis, Serious Incidents and Was Not Brought confirming that there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently.

Areas for consideration to be part of the Annual Governance Statement had been included.

Resolved:
Audit Committee received the Draft Director of Audit Opinion and Annual Report for 2018/19 and noted the Substantial Assurance Opinion.

19/20/05 Draft Internal Audit Plan 2019/20

Audit Committee received the Draft Internal Audit Plan for 2019/20 and discussed the contents. An audit of Programme Assurance would be part of the 2020/21 plan.

Resolved:
Audit Committee APPROVED the draft Internal Audit Plan.

19/20/06 Internal Audit Charter

Audit Committee received the above report. The KPIs included in the report were discussed and it was commented that they are largely time based and do not reflect quality. MIAA were asked to consider introducing quality aspects into the KPIs, perhaps using a questionnaire for auditees to complete and to provide an update to the September meeting..
Action: MIAA

Resolved:
Audit Committee APPROVED the Internal Audit Charter.

19/20/07 Draft Counter Fraud Annual Report 2019/20

Virginia Martin presented the report summarising the anti-fraud work undertaken during the year. Virginia Martin drew the Committee's attention to three standards rated as amber in the self-assessment against the NHSCFA "Standards for Providers":

1.4 Going forward fraud and bribery risks are to be recorded on the Trust's risk register. It was commented that there will already by a number of such risks included on the various risk registers throughout the Trust, but they may not be specifically flagged as such. Virginia Martin agreed to meet with Cathy Umbers to review whether fraud and bribery risks are adequately recorded on risk registers and to ensure that they are formally flagged as such and provide an update on progress of this at the September meeting.
Action: VM

2.2 For this standard to be rated green the Trust would be required to demonstrate significant levels of awareness of the Counter Fraud Policy. The Learning & Development Manager is looking at ways to demonstrate awareness of the Counter Fraud Policy through inductions, ESR and e-learning.

2.4 To achieve green the Trust needs to demonstrate effective implementation of MES Declare. A review of Conflicts of Interest has been included in both the Internal Audit and Counter Fraud 19/20 work plans and a joint review is proposed.

Resolved:
Audit Committee received the draft Counter Fraud Annual report 2019/20.

19/20/08 Anti-Fraud Work-plan 2019-20
Resolved:
Audit Committee received and APPROVED the Counter-Fraud work-plan 2019/20.

19/20/09 Ernst and Young Update
Handover Meeting for new Audit Manager
Hassan Rohimun advised Richard Tyler had commenced his post of E&Y Accounts Manager and had been meeting with the Finance team.

19/20/10 Audit Committee 2018/19 Annual Report
The Audit Committee Annual Report for 2017/18 was submitted to the Committee for approval. The need to ensure appropriate skills are included on the Committee as part of the recruitment of Non-Executive Directors was recognised. Subject to highlighted areas being confirmed the committee approved the report.

A discussion was held on commencing a self-review of the effectiveness of the Audit Committee which could feed into the Annual Report. Gary Baines agreed to share processes and questionnaires used by other Trust's to review the effectiveness of their Audit Committees.
Action: GB

Resolved:
Audit Committee APPROVED the Audit Committee Annual Report for 2018/19.

19/20/11 Draft Annual Governance Statement 2018/19
Louise Shepherd joined the meeting for this item noting examples throughout the Statement on improvement of services across the Trust.

The Trust received a draft rating of 'substantial assurance' relating to internal control as confirmed by the Director of Internal Audit Opinion for 2018/19.

Resolved:
Audit Committee APPROVED the Annual Governance Statement for 2018/19.

19/20/12 KPMG Acorn review
KPMG are working on the final recommendations for the report on the Acorn Ltd governance structure prior to holding a workshop.

Resolved:
Audit Committee received an update on progress to date of the KPMG Acorn review.

19/20/13 Reference Costs
Claire Liddy presented the current position of the actions required from the 2016/17 Costing Transformation Plan Audit.

Audit Committee was asked to note the status of the three areas identified for development:

- Audit Trail of Reference Cost Reconciliation Exclusions – Implemented in 2018.
- Classification of Activity Feeds – No longer required.
- Pharmacy Ward Stock Drugs – Patient level data feed tested in February and will go-live in April / May.

Resolved:
Audit Committee received progress against 2016/17 Reference Cost Audit findings.

19/20/14 Review Gifts & Hospitality Register

Audit Committee reviewed the 2018/19 Gifts and Hospitality Register noting a number of submissions had not included the approver. It was agreed this would be updated and circulated.
Action: JT

Resolved:
Audit Committee noted the Gifts and Hospitality Register for 2018/19.

19/20/15 Board Assurance Framework (BAF)

Audit Committee received the BAF noting the end of year position report was in progress.

Resolved:
Audit Committee received and noted the contents of the BAF for including the ongoing scrutiny of all strategic risks by the relevant assurance committee.

19/20/16 Any Other Business

There was none to discuss.

19/20/17 Meeting Review

No items required forwarding to any of the other committees.

Date and Time of next meeting: Thursday 23rd May 2019, at 14:00, Tony Bell Board Room, Institute in the park.

NHS
Alder Hey Children's
NHS Foundation Trust
Corporate Report April 2019
BRILLIANT BASICS
GROW THE FUTURE

How Did We Do?

Executive Summary **Month: April** **Year: 2019**

Delivery of Outstanding Care

Safe

- Strong start to 2019-20 in the safe domain with an overall continued high rate of reporting, no pressure ulcers category 3 and above and no never events.

Highlight

- No incidents occurred resulting in moderate or severe harm to a patient.

Challenges

- Slight increase in medication errors resulting in harm; these are low harm incidents and are being investigated.

The Best People Doing their Best Work

Caring

- Meridian system implemented across the Trust to increase the opportunity for families to share feedback with the Trust. Real time feedback can be shared with departments to aid local resolution and improvement.
- Decrease in formal complaints following a spike in March 2019.

Highlight

- Over 97% F&F would recommend the Trust.

Challenges

- Response to F&F in ED less than 80%. Targeted work underway in ED and shared with Council of Governors.

Delivery of Outstanding Care

Effective

- The Emergency Department waiting time is 93.57%, below the national standard. In order to sustain high performance a task & finish groups established for designing the optimal assessment unit models, and appointment based consultations for non-urgent patients.
- We continue to work on the improved use of clinic time which at 86.8% in April represents an increase relative to Q1 2018-19 but a fall from the peak in March 2019. Recent improvements in performance have not been sustained in the Community & Mental Health Division and the weekly Operational Delivery Group will oversee support to sustaining an improvement in the use of clinics.

Highlight

- Significant reduction in the number of long stay patients over 21 days
- Full-delivery of national standards relating to referral to treatment for planned care, diagnostics and cancer care

Challenges

- ED waiting time standard below national standard
- Clinic utilisation less than 90%

Delivery of Outstanding Care

Responsive

- Our performance in relation to access standards for planned care remains strong, as indicated by RTT performance and waiting list size.
- The number of patients waiting over 21 days has significantly reduced below the target of 33 down to 21. There has been a planned focus from the complex care project team and the MDT to take earlier intervention to undertake preparations for discharge sooner.

Highlight

- Delivery of all open pathway waiting time and cancer standards
- Number of Super Stranded Patients has decreased significantly.

Challenges

The Best People Doing their Best Work

Well Led

- The Trust made a deficit of £1.6m in month 1 which was £0.4m behind plan. Whilst April is always a challenging month the key drivers for the underperformance were activity levels, CIP delivery and cost pressures in the Estates and Facilities Teams.
- Temporary staffing remains at an average of £1m per month.
- CIP underperformed by £0.16m in month which in part is driven by us having a full year target gap of £2.7m. A recovery plan has been developed focussing particularly on the Medical Division, Corporate Teams and Facilities. This is overseen by a weekly Executive led Group and tracked through RABD.
- Cash levels were £34m which is higher than plan relating to low creditor payment runs in month. This has been exacerbated by problems with the new ledger system. Action shave been taken to resolve. We are also starting to see capital slippage relating to the campus programme.
- Elective and Day Case performance was below plan and needs to recover to improve the run rate to required levels
- Sickness levels remain high at 5.3% which are higher than at the same point last year. A programme of health and wellbeing support is underway and this is a key objective for the year. This is one of the drivers for the high temporary spend levels.
- Safer Staffing levels continue to be met and Mandatory Training is again meeting our target levels

Highlight

- Staffing levels
- Mandatory Training
- Staff Turnover

Challenges

- Control Total delivery
- CIP gap
- Activity run rate
- Sickness Levels
- Temporary spend

Alder Hey Children's
NHS Foundation Trust

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Delivery of Outstanding Care

SAFE

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	Last 12 Months	RAG			Comments Available
Clinical Incidents resulting in Near Miss	71	98	78	69	66	76	74	81	60	58	84	76	64		>=75	>=71	<71	✔
Clinical Incidents resulting in No Harm	258	272	321	279	301	285	310	283	216	281	248	277	291		>=272	>=259	<259	✔
Clinical Incidents resulting in minor, non permanent harm	83	75	88	83	79	89	94	95	69	82	86	107	97		<=86	N/A	>86	✔
Clinical Incidents resulting in moderate, semi permanent harm	0	1	2	1	1	2	0	1	1	2	1	0	0		0	N/A	>0	✔
Clinical Incidents resulting in severe, permanent harm	0	0	0	0	0	0	0	0	0	0	0	0	0		0	N/A	>0	✔
Clinical Incidents resulting in catastrophic, death	0	0	0	0	0	0	0	0	0	1	2	0	0		0	N/A	>0	✔
Medication errors resulting in harm	4	3	4	3	4	4	2	6	2	2	4	2	6		<=3	N/A	>3	✔
Pressure Ulcers (Category 3)	0	1	0	0	0	0	0	0	0	0	0	0	0		0	N/A	>0	✔
Pressure Ulcers (Category 4)	0	0	0	0	0	0	0	0	0	0	0	0	0		0	N/A	>0	✔
Never Events	0	0	0	0	2	0	0	0	0	1	0	0	0		0	N/A	>0	✔

The Best People doing their best Work

CARING

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	Last 12 Months	RAG	Comments Available
Friends & Family A&E - % Recommend the Trust	85.4%	82.6%	83.9%	86.3%	88.2%	85.5%	80.0%	80.6%	90.1%	90.5%	80.3%	89.5%	78.8%		>=95 % >=90 % <90 %	✔
Friends & Family Community - % Recommend the Trust	100.0%	96.8%	96.4%	92.2%	100.0%	100.0%	93.2%	100.0%	100.0%	98.5%	100.0%	98.6%	97.9%		>=95 % >=90 % <90 %	✔
Friends & Family Inpatients - % Recommend the Trust	93.7%	95.5%	94.9%	97.0%	97.0%	98.3%	98.2%	97.9%	98.2%	97.0%	96.2%	97.8%	97.3%		>=95 % >=90 % <90 %	✔
Friends & Family Mental Health - % Recommend the Trust	87.5%	82.6%	88.9%	100.0%	89.9%	89.4%	84.7%	97.5%	100.0%	88.9%	76.9%	82.9%	100.0%		>=95 % >=90 % <90 %	✔
Friends & Family Outpatients - % Recommend the Trust	90.3%	88.6%	86.9%	85.5%	89.7%	90.0%	90.3%	91.4%	91.7%	87.4%	89.1%	91.1%	92.7%		>=95 % >=90 % <90 %	✔
Complaints	8	11	11	14	14	12	13	5	7	6	8	16	7		No Threshold	✔
PALS	151	127	99	100	100	125	132	115	71	137	98	95	108		<=136 <=151 >151	✔

Delivery of Outstanding Care

EFFECTIVE

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	Last 12 Months	RAG			Comments Available
Sepsis: Patients treated for Sepsis - A&E	66.7%	55.6%	57.1%	65.5%	68.2%	54.5%	65.4%	57.6%	51.9%	77.4%	71.1%	79.4%	58.8%		>=90 %	N/A	<90 %	✔
Sepsis: Patients treated for Sepsis within 60 mins - Inpatients	76.0%	72.7%	78.9%	71.4%	72.5%	78.2%	70.2%	76.2%	73.3%	70.2%	82.1%	73.3%	81.8%		>=90 %	N/A	<90 %	✔
No of children that have suffered avoidable death - Internal	0	0	0	0	0	0	0	0	0	0	0	0	0		0	N/A	>0	✔
% Readmissions to PICU within 48 hrs	3.6%	2.5%	2.7%	6.5%	0.0%	2.7%	1.0%	1.1%	2.4%	1.4%	1.8%	2.5%	1.3%		<=3 %	N/A	>3 %	✔
Hospital Acquired Organisms - MRSA (BSI)	0	0	0	0	0	0	0	0	0	0	0	0	0		0	N/A	>0	✔
Hospital Acquired Organisms - C.difficile	0	0	0	0	0	0	0	0	0	0	0	1	0		0	N/A	>0	✔
Hospital Acquired Organisms - RSV	0	0	0	0	0	0	5	10	13	2	3	1	0		0	N/A	>0	✔
Hospital Acquired Organisms - MSSA	0	1	0	0	0	1	2	0	1	1	0	4	1		<=1	N/A	>1	✔
Hospital Acquired Organisms - CLABSI - ICU Only	2	2	2	0	1	0	2	1	3	0	1	3	1		<=1	N/A	>1	✔
Hospital Acquired Organisms - Gram Negative BSI	2	0	1	0	1	2	2	2	2	1	3	0	0		<=1	N/A	>1	✔
Bed Occupancy (Accessible Funded Beds)	90.3%	84.9%	88.5%	83.9%	76.2%	79.9%	85.8%	85.3%	73.7%	72.9%	80.8%	79.1%	77.7%		<=89 %	<=93 %	>93 %	✔
ED: 95% Treated within 4 Hours	95.3%	95.0%	95.6%	96.5%	98.4%	93.7%	90.9%	93.8%	95.3%	92.1%	90.6%	95.6%	93.6%		>=95 %	N/A	<95 %	✔
Average LoS - Elective (Days)	2.79	2.87	2.89	3.13	2.80	2.79	3.05	2.90	3.58	2.35	3.04	3.14	3.05		<=2.8	N/A	>2.8	✔
Average LoS - Non-Elective (Days)	1.96	2.01	2.01	1.85	2.03	1.73	2.05	1.98	1.92	1.81	1.90	1.70	1.85		<=2.0	N/A	>2.0	✔
Theatre Utilisation - % of Session Utilised	88.2%	88.6%	87.9%	89.3%	87.0%	86.6%	86.5%	87.2%	85.8%	88.7%	88.7%	89.2%	88.6%		>=90 %	>=80 %	<80 %	✔
On the day Elective Cancelled Operations for Non Clinical Reasons	26	30	43	35	18	12	28	38	21	11	10	11	9		<=20	N/A	>20	✔
28 Day Breaches	7	5	6	6	7	1	0	6	6	4	1	1	0		0	N/A	>0	✔
Clinic Session Utilisation	83.7%	84.0%	84.9%	82.4%	83.0%	84.2%	83.1%	84.6%	82.2%	83.0%	86.3%	88.9%	87.0%		>=90 %	>=85 %	<85 %	✔
Was Not Brought Rate	10.7%	11.5%	12.2%	12.4%	13.6%	11.4%	11.8%	11.5%	13.3%	12.7%	11.3%	9.6%	11.1%		<=12 %	<=14 %	>14 %	✔
Average Scanning Turnaround - Inpatient											44.00	49.00	49.00		<=7	N/A	>7	✔
Average Scanning Turnaround - Outpatient											26.00	23.00	24.00		<=5	N/A	>5	✔

Delivery of Outstanding Care

RESPONSIVE

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	Last 12 Months	RAG			Comments Available
IP Survey: % Received information enabling choices about their care	94.8%	91.6%	96.2%	94.7%	94.7%	96.3%	96.4%	95.1%	96.7%	96.0%	94.9%	95.7%	98.3%		>=95 %	>=90 %	<90 %	✔
IP Survey: % Treated with respect	97.7%	98.8%	99.7%	99.7%	99.6%	99.5%	99.6%	100.0%	99.6%	100.0%	99.3%	99.5%	99.3%		100 %	>=95 %	<95 %	✔
IP Survey: % Know their planned date of discharge	60.5%	76.1%	63.7%	65.7%	60.6%	55.3%	60.2%	69.0%	59.4%	76.5%	82.8%	80.6%	88.8%		>=90 %	>=85 %	<85 %	✔
IP Survey: % Know who is in charge of their care	91.3%	90.9%	92.7%	94.7%	91.6%	94.9%	92.2%	92.2%	92.5%	96.3%	94.3%	93.4%	99.3%		>=95 %	>=90 %	<90 %	✔
IP Survey: % Patients involved in play and learning	74.9%	77.8%	74.4%	73.1%	74.8%	73.7%	74.3%	72.5%	68.2%	78.5%	78.8%	77.9%	87.3%		>=90 %	>=85 %	<85 %	✔
RTT: Open Pathway: % Waiting within 18 Weeks	92.1%	92.0%	92.1%	92.0%	92.0%	92.1%	92.1%	92.1%	92.0%	92.0%	92.0%	92.0%	92.0%		>=92 %	>=90 %	<90 %	✔
Waiting List Size	13,235	13,238	12,879	12,962	12,925	12,884	12,961	12,934	12,859	12,872	12,888	12,746	12,871		<=12905	N/A	>12905	✔
Waiting Greater than 52 weeks	0	0	0	0	0	0	0	0	0	0	0	0	0		0	N/A	>0	✔
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.7%	100.0%	100.0%	100.0%	95.5%	100.0%	100.0%		100 %	N/A	<100 %	✔
All Cancers: 31 day diagnosis to treament	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	87.5%	100.0%	100.0%		100 %	N/A	<100 %	✔
All Cancers: 31 day wait until subsequent treatments	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100 %	N/A	<100 %	✔
31 days from urgent referral for suspected cancer to first treatment (Children's Cancers)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	87.5%	100.0%			100 %	N/A	<100 %	✔
Diagnostics: % Completed Within 6 Weeks	99.8%	99.8%	99.2%	99.3%	99.0%	99.8%	99.8%	99.3%	100.0%	99.7%	99.6%	99.5%	100.0%		>=99 %	N/A	<99 %	✔
Number of Super Stranded Patients (21+ Days)	34	27	32	29	32	29	32	28	24	35	39	33	21		<=33	N/A	>33	✔
PFI: PPM%	98.6%	99.0%	99.0%	96.0%	98.0%	100.0%	98.0%	99.0%	100.0%	100.0%	100.0%	98.0%	98.0%		>=98 %	N/A	<98 %	✔

The Best People doing their best Work

WELL LED

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	Last 12 Months	RAG	Comments Available
CIP In Month Variance (£'000s)	-248	104	153	-238	-137	175	-174	-285	151	-199	-74	-75	-163		>=-5% / >=-20% / <-20%	✔
Control Total In Month Variance (£'000s)	-426	154	285	29	-396	359	-463	-48	564	-21	-433		-394		>=-5% / >=-20% / <-20%	✔
Capital Expenditure In Month Variance (£'000s)	1,090	-333	1,701	-462	-129	2,907	-751	1,041	1,032	1,032	259	1,610	1,030		>=-5% / >=-10% / <-10%	✔
Cash in Bank (£'000s)	12,406	10,455	9,455	23,910	21,519	20,023	20,315	17,580	23,136	19,983	22,068	33,699	34,361		>=-5% / >=-20% / <-20%	✔
Income In Month Variance (£'000s)	218	591	425	998	741	263	624	684	142	456	355	19,495	-612		>=-5% / >=-20% / <-20%	✔
Pay In Month Variance (£'000s)	-17	-7	-38	-111	-311	51	-372	-74	-267	-510	-850	-495	183		>=-5% / >=-20% / <-20%	✔
Non Pay In Month Variance (£'000s)	-627	-431	-102	-858	-825	45	-715	-659	689	34	63	-942	34		>=-5% / >=-20% / <-20%	✔
NHSI Use of Resources	3	3	3	3	3	2	2	1	1	1	1	1	1		<=3 / N/A / >3	✔
AvP: IP - Non-Elective	1,342	1,338	1,248	1,318	1,134	1,344	1,439	1,508	1,432	1,309	1,215	1,385	52		>=0 / N/A / <0	✔
AvP: IP Elective vs Forecast	379	435	398	424	399	390	442	419	328	412	401	457	-45		>=0 / N/A / <0	✔
AvP: Daycase Activity vs Forecast	1,809	1,905	1,917	1,894	1,873	1,722	2,007	1,954	1,623	2,011	1,764	1,850	-55		>=0 / N/A / <0	✔
AvP: Outpatient Activity vs Forecast	18,374	19,468	18,763	19,622	17,742	17,988	21,320	21,395	16,138	20,863	18,943	20,844	411		>=0 / N/A / <0	✔
PDR	1.3%	11.3%	31.1%	64.7%	82.3%	88.8%	90.1%	90.1%	90.1%	90.1%	92.2%	92.2%	4.8%		No Threshold	
Medical Appraisal	69.0%	69.0%	2.0%	4.0%	6.3%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		>=95 % / >=90 % / <90 %	✔
Mandatory Training	92.1%	92.0%	92.1%	91.6%	88.6%	88.1%	89.7%	89.7%	89.0%	89.4%	88.8%	89.6%	90.0%		>=90 % / >=80 % / <80 %	✔
Sickness	4.4%	4.6%	4.9%	5.3%	5.2%	5.5%	5.6%	5.6%	6.0%	5.7%	5.7%	5.4%	5.2%		<=4 % / <=4.5 % / >4.5 %	✔
Short Term Sickness	1.3%	1.2%	1.4%	1.5%	1.3%	1.4%	1.6%	1.6%	1.6%	1.8%	1.7%	1.7%	1.5%		<=1 % / N/A / >1 %	✔
Long Term Sickness	3.1%	3.4%	3.5%	3.8%	4.0%	4.0%	4.0%	3.9%	4.4%	3.9%	4.0%	3.7%	3.8%		<=3 % / N/A / >3 %	✔
Temporary Spend ('000s)	977	973	947	901	1,082	820	998	971	883	937	1,057	1,357	1,114		<=800 / <=960 / >960	✔
Staff Turnover	10.6%	10.9%	10.6%	11.5%	10.4%	10.9%	11.2%	10.6%	9.5%	9.8%	9.6%	10.4%	9.9%		<=10 % / <=11 % / >11 %	✔
% of Correct Pay Achieved	99.8%	99.4%	99.5%	99.5%	99.5%	99.4%	99.4%	99.5%	99.5%	99.5%	99.5%	99.5%	99.6%		>=99.5 % / >=99 % / <99 %	✔
Safer Staffing (Shift Fill Rate)	96.4%	96.5%	94.8%	95.0%	93.9%	93.1%	93.2%	95.3%	94.2%	94.5%	92.8%	95.4%	95.3%		>=90 % / N/A / <90 %	✔
Domestic Cleaning Audit Compliance	90.0%	85.0%	65.5%	97.5%	85.0%	93.8%	60.0%	90.0%	90.0%	92.0%	95.0%	86.0%	81.5%		>=85 % / N/A / <85 %	✔
Performance Against Single Oversight Framework Themes	0	0	0	0	0	0	0	0	0	0	0	0	0		0 / <=1 / >1	✔

Game Changing Research & Innovation

R&D

Alder Hey Children's NHS
NHS Foundation Trust

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	Last 12 Months	RAG			Comments Available
Number of Open Studies - Academic	148	153	159	159	156	115	143	136	123	121	121	153	154		>=130	>=111	<111	✔
Number of Open Studies - Commercial	34	33	34	34	37	27	31	28	27	29	26	60	59		>=30	>=21	<21	✔
Number of New Studies Opened - Academic	5	2	5	7	2	3	6	8	2	6	5	3	1		>=3	>=2	<2	✔
Number of New Studies Opened - Commercial	3	0	0	1	2	3	2	0	0	1	1	4	2		>=1	N/A	<1	✔
Number of patients recruited	272	308	245	288	249	238	195	296	158	238	211	314	234		>=200	>=171	<171	✔

Delivery of Outstanding Care

7.1 - QUALITY - SAFE

	Description	Performance	Threshold	Trend	Management Action (SMART)
Incidents: Reducing Harm	**Clinical Incidents resulting in minor, non permanent harm** Total number of Minor Harm Incidents reported. The threshold is based on a reduction for the period Apr 18 - Mar 19 (1036). 19/20 aim is to see volume reported less than last year for the same month. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	97	R >86 A N/A G <=86	Chart: Actual, Average, UCL, LCL, UWL, LWL, Green; Apr-18 to Apr-19	Divisional Governance monthly assurance reports including lessons learned presented to Divisional Governance Integrated Governance Committee and Clinical Quality Steering group and escalated to Clinical Quality Assurance Committee by exception.
Incidents: Increasing Reporting	**Clinical Incidents resulting in No Harm** Total number of No Harm Incidents reported. The threshold is based on increasing on last year for the period Apr 18 - Mar 19 (3328). 19/20 aim is to see more than 5% reported than last year for the same month. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	291	R <259 A >=259 G >=272	Chart: Actual, Average, UCL, LCL, UWL, LWL, Green; Apr-18 to Apr-19	No Action Required
Incidents: Increasing Reporting	**Clinical Incidents resulting in Near Miss** Total number of Near Miss Incidents reported. The threshold is based on increasing on last year for the period Apr 18 - Mar 19 (897). 19/20 aim is to see more than 5% reported than last year for the same month to demonstrate a learning culture. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	64	R <71 A >=71 G >=75	Chart: Actual, Average, UCL, LCL, UWL, LWL, Green; Apr-18 to Apr-19	Divisional Governance monthly assurance reports including lessons learned presented to Divisional Governance Integrated Governance Committee and Clinical Quality Steering group and escalated to Clinical Quality Assurance Committee by exception.

Delivery of Outstanding Care

7.2 - QUALITY - SAFE

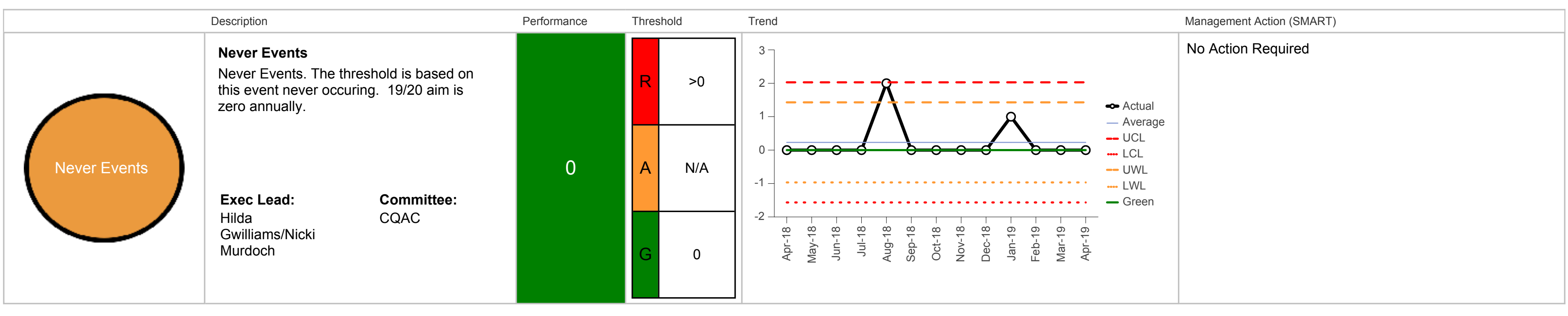
	Description	Performance	Threshold		Trend	Management Action (SMART)
Incidents: Reducing Harm	**Clinical Incidents resulting in severe, permanent harm** Incidents reported resulting in severe harm. The threshold is based on this event never occuring. 19/20 aim is zero annually. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	0	R A G	>0 N/A 0		No Action Required
Incidents: Reducing Harm	**Clinical Incidents resulting in moderate, semi permanent harm** Incidents reported resulting in moderate harm. The threshold is based on achieving a 10% reduction on the period Apr 18 - Mar 19 (12). 19/20 aim is 11 or less, annually. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	0	R A G	>0 N/A 0		No Action Required
Incidents: Reducing Harm	**Clinical Incidents resulting in catastrophic, death** Incidents reported resulting in severe harm. The threshold is based on this event never occuring. 19/20 aim is zero annually. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	0	R A G	>0 N/A 0		No Action Required

Delivery of Outstanding Care

7.3 - QUALITY - SAFE

	Description	Performance	Threshold		Trend	Management Action (SMART)
Reducing Pressure Ulcers	**Pressure Ulcers (Category 3)** Pressure Ulcers of Category 3. The threshold is based on this event never occuring. 19/20 Aim is zero annually. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	0	R A G	>0 N/A 0	Chart: Apr-18 to Apr-19 (Actual, Average, UCL, LCL, UWL, LWL, Green)	No Action Required
Reducing Pressure Ulcers	**Pressure Ulcers (Category 4)** Pressure Ulcers of Category 4. The threshold is based on this event never occuring. 19/20 Aim is zero annually. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	0	R A G	>0 N/A 0	Chart: Apr-18 to Apr-19 (Actual, Average, UCL, LCL, UWL, LWL, Green)	No Action Required
Reducing Medication Errors	**Medication errors resulting in harm** Medication errors reported resulting in minor, moderate, major or catastrpohic (death) harm. The threshold is based on achieving a 20% reduction on the period Apr 18 - Mar 19 (42), on trajectory with WHO global initiative to reduce severe, avoidable medication-associated harm in all countries by 50% by 2022. 19/20 aim is less than 34 annually **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	6	R A G	>3 N/A <=3	Chart: Apr-18 to Apr-19 (Actual, Average, UCL, LCL, UWL, LWL, Green)	There have been increases in the number of incidents that have reached the patient and caused non-permanent harm. Two of these relate to the self-administration policy where doses were not increased in line with the treatment plan. The authors have been asked to review the guideline in light of these to prevent re-occurrence. One incident related to application of a cream to which the patient was allergic which has been highlighted in the monthly newsletter. The Trust has held Insulin Safety Week which is one of the focused workstreams of the Medication Safety Committee. AMR (MSO)

7.4 - QUALITY - SAFE



	Description	Performance	Threshold		Trend	Management Action (SMART)
Never Events	**Never Events** Never Events. The threshold is based on this event never occuring. 19/20 aim is zero annually. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	0	R	>0		No Action Required
			A	N/A		
			G	0		

8.1 - QUALITY - CARING

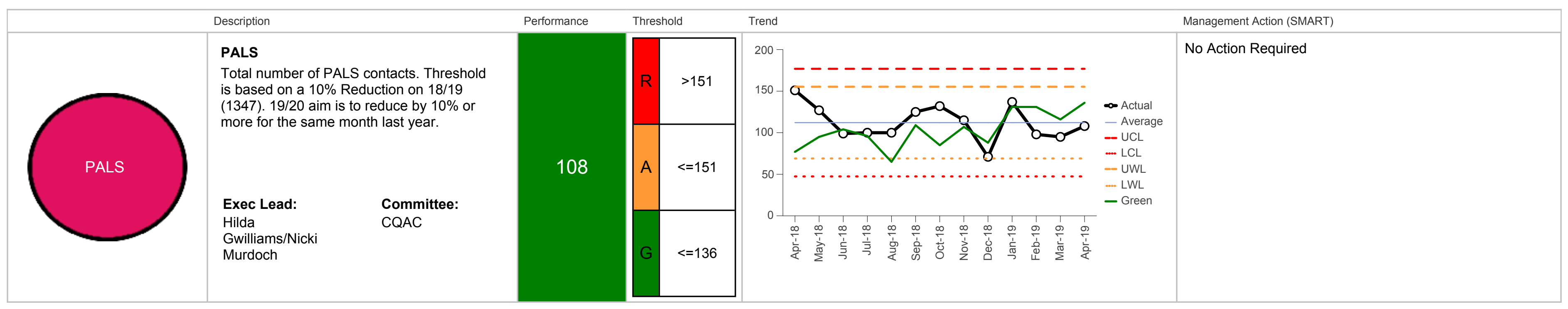
	Description	Performance	Threshold	Trend	Management Action (SMART)
Friends & Family	**Friends & Family Community - % Recommend the Trust** Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	97.86 %	R <90 % A >=90 % G >=95 %		No Action Required
Friends & Family	**Friends & Family Inpatients - % Recommend the Trust** Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	97.34 %	R <90 % A >=90 % G >=95 %		No Action Required
Friends & Family	**Friends & Family A&E - % Recommend the Trust** Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	78.81 %	R <90 % A >=90 % G >=95 %		

8.2 - QUALITY - CARING

	Description	Performance	Threshold	Trend	Management Action (SMART)
Friends & Family	**Friends & Family Outpatients - % Recommend the Trust** Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	92.68 %	R <90 % A >=90 % G >=95 %	Chart: Apr-18 to Apr-19 (Actual, Average, UCL, LCL, UWL, LWL, Green)	A ticketed system has been introduced in Phlebotomy to help manage the flow and prioritisation of patients'. The system provides more control for the Phlebotomists and gives families the option to go away and come back at their allotted time without fear of missing their slot. A time and motion study was carried out to measure the improvement and we are happy to report that the waiting times have reduced along with the PALS for Phlebotomy. Just at a glance it is clear to see that the G2 waiting area is not overflowing as it was a few months ago and the atmosphere down there is much calmer.
Friends & Family	**Friends & Family Mental Health - % Recommend the Trust** Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	100 %	R <90 % A >=90 % G >=95 %	Chart: Apr-18 to Apr-19 (Actual, Average, UCL, LCL, UWL, LWL, Green)	No Action Required
Complaints	**Complaints** Total complaints received. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	7	No Threshold	Chart: Apr-18 to Apr-19 (Actual, Average, UCL, LCL, UWL, LWL, Green)	This number of complaints is more in line with the monthly figure usually received.

The Best People doing their best Work

8.3 - QUALITY - CARING



	Description	Performance	Threshold		Trend	Management Action (SMART)
PALS	**PALS** Total number of PALS contacts. Threshold is based on a 10% Reduction on 18/19 (1347). 19/20 aim is to reduce by 10% or more for the same month last year. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	108	R	>151		No Action Required
			A	<=151		
			G	<=136		

Delivery of Outstanding Care

9.1 - QUALITY - EFFECTIVE

	Description	Performance	Threshold		Trend	Management Action (SMART)
Mortality	**No of children that have suffered avoidable death - Internal** Total number of children that have suffered avoidable death with issues relating to care provided in Alderhey. Figures provided by HMRG group. The threshold for 19/20 is zero. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	0	R A G	>0 N/A 0		No Action Required
Sepsis	**Sepsis: Patients treated for Sepsis - A&E** Percentage of Sepis Patients receiving antibiotic within 60 mins for ED. 19/20 aim is 90%. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	58.82 %	R A G	<90 % N/A >=90 %		After discussion with ED sepsis nurse and review of cases, less patients requiring 'resus' at initial point of presentation. Although approx same number of patients identifeid, clinical acuity has been less which may represent an increase in treatment time and a decrease in overall percentage. However this data is still collected from prescription so still includes patients who will have been given IVAB for sepsis but potentially were not 'septic' as has been discussed before. To refine this data the plan will be to have a sepsis status as well for ED built in to the ED electronic doc
Sepsis	**Sepsis: Patients treated for Sepsis within 60 mins - Inpatients** Percentage of Sepis Patients receiving antibiotic within 60 mins for Inpatients. 19/20 aim is 90%. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	81.82 %	R A G	<90 % N/A >=90 %		Sepsis status being used across inpatient areas. Reporting now looking at the patients with a 'Treat as Sepsis' status. Still work to be done with BI in relation to sepsis dashboard and also continued feedback to team in relation to the importance of documentation and use of the sepsis status. Need to modify training packages to encorporate the sepsis status for both nurses and clinicians. Number of identified patients has decreased which was the aim to try and be more specific at identifying septic patients rather than patients with infection.

Delivery of Outstanding Care

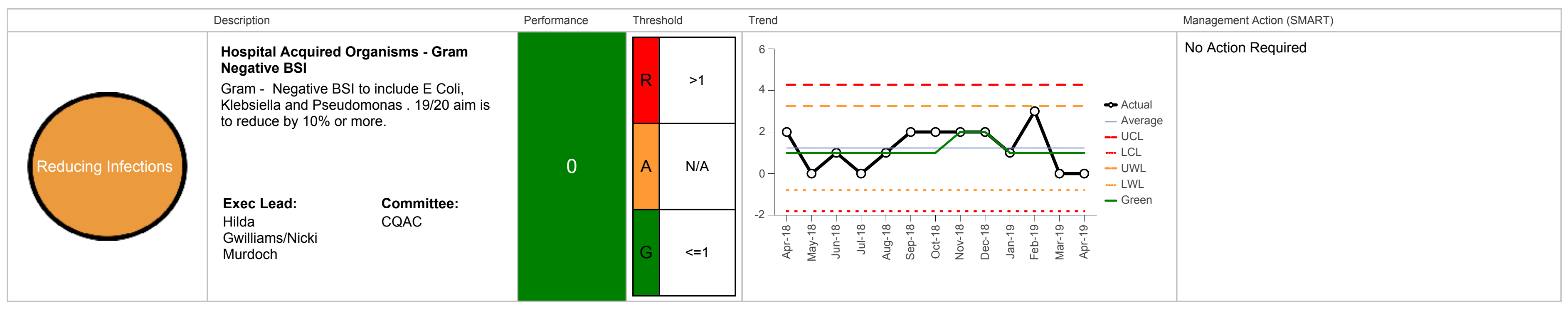
9.2 - QUALITY - EFFECTIVE

	Description	Performance	Threshold		Trend	Management Action (SMART)
PICU Re-admissions	**% Readmissions to PICU within 48 hrs** % of discharges readmitted to PICU within 48hrs sourced from PICANet [Paediatric Intensive Care Audit Network]. Threshold agreed with PICU is based on the reported range nationally from all UK PICUs, most recent published range (16/17) was 0-3% averaged over a calendar year. Data is presented as monthly incidence for the purpose of this report. Annual average for this site was 2.4% **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	1.33 %	R A G	>3 % N/A <=3 %	Chart: Apr-18 to Apr-19; legend: Actual, Average, UCL, LCL, UWL, LWL, Green	No Action Required
Reducing Infections	**Hospital Acquired Organisms - MRSA (BSI)** The threshold is based on this event never occuring. 19/20 Aim is zero annually. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	0	R A G	>0 N/A 0	Chart: Apr-18 to Apr-19; legend: Actual, Average, UCL, LCL, UWL, LWL, Green	No Action Required
Reducing Infections	**Hospital Acquired Organisms - C.difficile** The threshold is based on this event never occuring. 19/20 Aim is zero annually. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	0	R A G	>0 N/A 0	Chart: Apr-18 to Apr-19; legend: Actual, Average, UCL, LCL, UWL, LWL, Green	No Action Required

9.3 - QUALITY - EFFECTIVE

	Description	Performance	Threshold		Trend	Management Action (SMART)
Reducing Infections	**Hospital Acquired Organisms - RSV** Hospital Acquired Organisms - RSV. 19/20 aim is to reduce by 25% or more. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	0	R	>0		No Action Required
			A	N/A		
			G	0		
Reducing Infections	**Hospital Acquired Organisms - MSSA** Hospital Acquired Organisms - MSSA . 19/20 aim is to reduce by 10% or more. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	1	R	>1		No Action Required
			A	N/A		
			G	<=1		
Reducing Infections	**Hospital Acquired Organisms - CLABSI - ICU Only** Hospital Acquired Organisms - CLABSI on ICU Ward Only. 19/20 aim is to reduce by 10% or more. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	1	R	>1		No Action Required
			A	N/A		
			G	<=1		

9.4 - QUALITY - EFFECTIVE



	Description	Performance	Threshold		Trend	Management Action (SMART)
Reducing Infections	**Hospital Acquired Organisms - Gram Negative BSI** Gram - Negative BSI to include E Coli, Klebsiella and Pseudomonas . 19/20 aim is to reduce by 10% or more. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	0	R	>1		No Action Required
			A	N/A		
			G	<=1		

10.1 - QUALITY - RESPONSIVE

	Description	Performance	Threshold	Trend	Management Action (SMART)
Inpatient Survey: Date of Discharge	**IP Survey: % Know their planned date of discharge** Percentage of children / families that report knowing their planned date of discharge. Thresholds are based on previously defined local targets. The 19/20 aim is 90% or above. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	88.77 %	R <85 % A >=85 % G >=90 %		This is a great improvement and shows the current discharge project and the new wording when asking families the question has made a difference.
Inpatient Survey: Choices	**IP Survey: % Received information enabling choices about their care** Percentage of patients / families that report receiving information to enable them to make choices. Thresholds are based on previously defined local targets. The 19/20 aim is 95% or above. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	98.29 %	R <90 % A >=90 % G >=95 %		No Action Required
Inpatient Survey: Respect	**IP Survey: % Treated with respect** Percentage of children / families that report being treated with respect. Thresholds are based on previously defined local targets. The 19/20 is 100%. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	99.32 %	R <95 % A >=95 % G 100 %		This continues to be stable at 99.32% work is continuing within the teams to ensure all our families are treated with respect.

10.2 - QUALITY - RESPONSIVE

	Description	Performance	Threshold	Trend	Management Action (SMART)
Inpatient Survey: Play and Learning	**IP Survey: % Patients involved in play and learning** % of children / families that report engaging in play / learning. Thresholds are based on previously defined local targets. The 19/20 aim is 90% or above. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	87.29 %	R <85 % A >=85 % G >=90 %		This is the most positive improvement and it is lovely to see all the changes and hard work has paid off.
Inpatient Survey: In Charge of Care	**IP Survey: % Know who is in charge of their care** % of children / families that report knowing who is in charge of their care. Thresholds are based on previously defined local targets. The 19/20 aim is 95% or above. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	99.32 %	R <90 % A >=90 % G >=95 %		No Action Required

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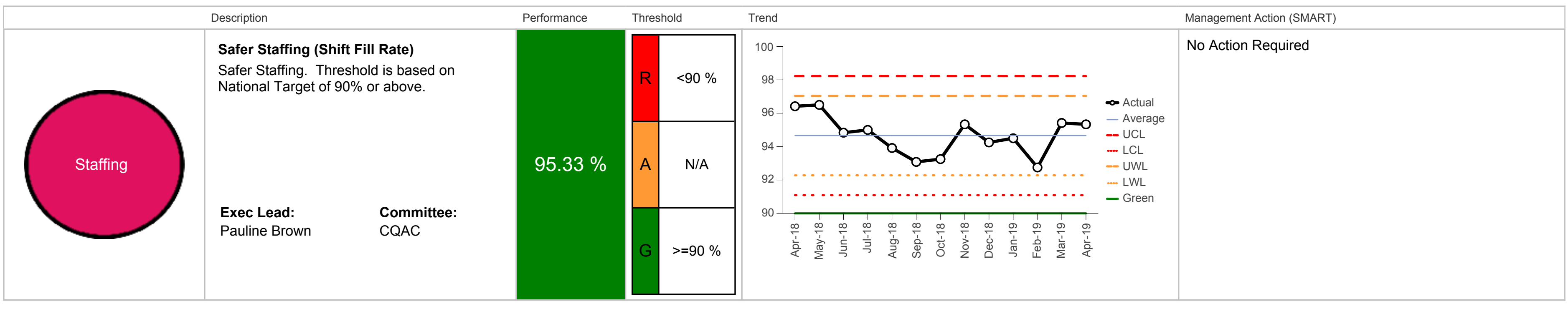
11.1 - QUALITY - WELL LED



	Description	Performance	Threshold		Trend	Management Action (SMART)
Staffing	**Safer Staffing (Shift Fill Rate)** Safer Staffing. Threshold is based on National Target of 90% or above. **Exec Lead:** Pauline Brown **Committee:** CQAC	95.33 %	R	<90 %		No Action Required
			A	N/A		
			G	>=90 %		

Delivery of Outstanding Care

12.1 - PERFORMANCE - EFFECTIVE

Alder Hey Children's NHS
NHS Foundation Trust

	Description	Performance	Threshold		Trend	Management Action (SMART)
ED 4 Hour Standard	**ED: 95% Treated within 4 Hours** Threshold is based on National Guidance set by NHS England at 95%. **Exec Lead:** Adam Bateman **Committee:** RABD	93.57 %	R A G	<95 % N/A >=95 %	Chart: Apr-18 to Apr-19 (Actual, Average, UCL, LCL, UWL, LWL, Green); y-axis 85–105	Attendances in April increased by 7% compared to the same period last year, this represents an additional 348 actual attendances. This increase in attendances was concentrated into 2 weeks and these weeks particularly proved challenging in the achievement of the 4 hour standard. However, in April 2019 we completed care for 262 more patients within 4 hours than April 2018. This represents an improvement in the number of patients treated within 4 hours of 5.7%.
Bed Occupancy	**Bed Occupancy (Accessible Funded Beds)** Percentage of funded beds that are occupied in accessible wards 3A, 4A, 3C and 4C, this is based on 3 occupancy readings measured throughout the day. Threshold is based on National NHS Guidance on safe staffing and occupancy levels. **Exec Lead:** Adam Bateman **Committee:** RABD	77.75 %	R A G	>93 % <=93 % <=89 %	Chart: Apr-18 to Apr-19 (Actual, Average, UCL, LCL, UWL, LWL, Green); y-axis 60–100	No Action Required
LoS: Elective	**Average LoS - Elective (Days)** Average Elective Length of Stay (days). 19/20 aim is to not increase Length of Stay for the same month last year. **Exec Lead:** Adam Bateman **Committee:** RABD	3.05	R A G	>2.8 N/A <=2.8	Chart: Apr-18 to Apr-19 (Actual, Average, UCL, LCL, UWL, LWL, Green); y-axis 2–4	Improvement noted with elective LOS for April which is in line with seasonal variation. Improvement programmes continue to pull forward discharges and CUR data continues to support identifying non-qualified patients in our beds to support early discharge. 1 long stay patient discharged which has contributed to the LOS and masked further underlying improvements. This also reflects the confidence within the 18/19 winter plan to maintain the elective programme reflective of the LOS.

Delivery of Outstanding Care

12.2 - PERFORMANCE - EFFECTIVE

	Description	Performance	Threshold		Trend	Management Action (SMART)
Cancelled Operations	**On the day Elective Cancelled Operations for Non Clinical Reasons** Performance is measured for on the day cancelled elective operations for non clinical reasons. This based on National Guidance. Threshold aims to reduce cancellations by 16% based on 18/19 overall performance (284). This is inline with trajectory from Oct 18 - Mar 19 **Exec Lead:** Adam Bateman **Committee:** RABD	9	R	>20	Chart: Apr-18 to Apr-19; Actual, Average, UCL, LCL, UWL, LWL, Green	No Action Required
			A	N/A		
			G	<=20		
Theatre Utilisation	**Theatre Utilisation - % of Session Utilised** Threshold is based on the productive theatre improvement measures at greater than or equal to 90% utilisation of theatres. **Exec Lead:** Adam Bateman **Committee:** RABD	88.59 %	R	<80 %	Chart: Apr-18 to Apr-19; Actual, Average, UCL, LCL, UWL, LWL, Green	Weekly daycase utilisation review ongoing, empty lists at 3 week stage are reallocated to another specialty. Utilisation is t be monitored further at Best in Operative Care monthly meetings as part of new KPI dashboard.
			A	>=80 %		
			G	>=90 %		
LoS: Non-Elective	**Average LoS - Non-Elective (Days)** Average Non Elective Length of Stay (days). 19/20 aim is to not increase Length of Stay for the same month last year. **Exec Lead:** Adam Bateman **Committee:** RABD	1.85	R	>2.0	Chart: Apr-18 to Apr-19; Actual, Average, UCL, LCL, UWL, LWL, Green	No Action Required
			A	N/A		
			G	<=2.0		

Delivery of Outstanding Care

12.3 - PERFORMANCE - EFFECTIVE

	Description	Performance	Threshold		Trend	Management Action (SMART)
Was Not Brought	**Was Not Brought Rate** The target of 12% is a local target aligned to outpatient improvement workstreams (Hybrid Booking, Patient Demogrpahic Checking and bidirectional automate text reminders). **Exec Lead:** Adam Bateman **Committee:** RABD	11.14 %	R A G	>14 % <=14 % <=12 %	Chart (Apr-18 to Apr-19; Actual, Average, UCL, LCL, UWL, LWL, Green)	No Action Required
Clinic Utilisation	**Clinic Session Utilisation** Threshold is based on a resonable expectation utilising clinics at 90% or greater to take into account short notice cancellations and Was Not Brought patients. **Exec Lead:** Adam Bateman **Committee:** RABD	87.03 %	R A G	<85 % >=85 % >=90 %	Chart (Apr-18 to Apr-19; Actual, Average, UCL, LCL, UWL, LWL, Green)	Slight reduction noted for M1 performance however the underlying trend remains positive. Review of the specialties identifies a small number where attendances have been lower than expected which is disappointing. The Brilliant Booking & OP programme will now amalgamate with one of the key metrics remaining increased utilisation of clinics
Operation Breaches	**28 Day Breaches** Standard is when a patients operation is cancelled by the hospital last minute for non-clinical reasons, the hospital will have to offer another binding date with 28 days. This is based on national guidance. **Exec Lead:** Adam Bateman **Committee:** RABD	0	R A G	>0 N/A 0	Chart (Apr-18 to Apr-19; Actual, Average, UCL, LCL, UWL, LWL, Green)	No Action Required

Delivery of Outstanding Care

12.4 - PERFORMANCE - EFFECTIVE

	Description	Performance	Threshold	Trend	Management Action (SMART)
Stranded Patients	**Number of Super Stranded Patients (21+ Days)** National measure as part of the 18/19 NHSI plan. The target is to reduce the number of stranded patients 21 or more days from March 2018. This excludes patients on ICU/HDU/NEO and Cardiac HDU. **Exec Lead:** Adam Bateman **Committee:** RABD	21	R >33; A N/A; G <=33		No Action Required
Scanning	**Average Scanning Turnaround - Inpatient** Days from being clinically coded following inpatient discharge to episode notes being scanned and uploaded on to the viewing system (Image Now). Average based on working days. **Exec Lead:** Adam Bateman **Committee:** RABD	49	R >7; A N/A; G <=7		The KPI for Inpatients is 7 working days and until the 'Grey Paper' had maintained at 5 working days. Several actions have been taken to address the issue including standard inpatient documentation, update sessions with clinical staff on how they can help eg no gel pens, results insertion etc. Additional hours are currently being worked to help address the backlog and a Task & Finish group has been established which has identified several key actions that are currently being worked up – these actions cover Processes, IMT options as well as more strategic actions.
Scanning	**Average Scanning Turnaround - Outpatient** Days from Clinic attendance to episode notes being scanned and uploaded on to the viewing system (Image Now). Average based on working days. **Exec Lead:** Adam Bateman **Committee:** RABD	24	R >5; A N/A; G <=5		The KPI for Outpatients is 5 working days and until the 'Grey Paper' had maintained at 3 working days. Several actions have been taken to address the issue including stopping scanning blanks/not written in paper light folders, update sessions with clinical staff on how they can help eg no gel pens, results insertion etc. Additional hours are currently being worked to help address the backlog and a Task & Finish group has been established which has identified several key actions that are currently being worked up – these actions cover Processes, IMT options as well as more strategic actions.

Delivery of Outstanding Care

13.1 - PERFORMANCE - RESPONSIVE

	Description	Performance	Threshold		Trend	Management Action (SMART)
RTT	**RTT: Open Pathway: % Waiting within 18 Weeks** Percentage of patients waiting within 18 weeks. Threshold is based on previous national target of 92%, this is applied in order to maintain monitoring of measure. **Exec Lead:** Adam Bateman **Committee:** RABD	92.04 %	R A G	<90 % >=90 % >=92 %	Actual, Average, UCL, LCL, UWL, LWL, Green; Apr-18 to Apr-19; 91.9–92.3	No Action Required
Waiting Times	**Waiting List Size** National threshold as part of the 18/19 NHSI plan. The target is to maintain reduction of the total waitlist size from March 2018. **Exec Lead:** Adam Bateman **Committee:** RABD	12871	R A G	>12905 N/A <=12905	Actual, Average, UCL, LCL, UWL, LWL, Green; Apr-18 to Apr-19; 12,400–13,400	No Action Required
Waiting Times	**Waiting Greater than 52 weeks** Total number of more than 52 weeks for first treatment. The threshold is based on this event never occuring. 19/20 aim is zero annually. There is a financial and contractual penalties in the failure to achieve this. **Exec Lead:** Adam Bateman **Committee:** RABD	0	R A G	>0 N/A 0	Actual, Average, UCL, LCL, UWL, LWL, Green; Apr-18 to Apr-19; -1–1	No Action Required

Delivery of Outstanding Care

13.2 - PERFORMANCE - RESPONSIVE

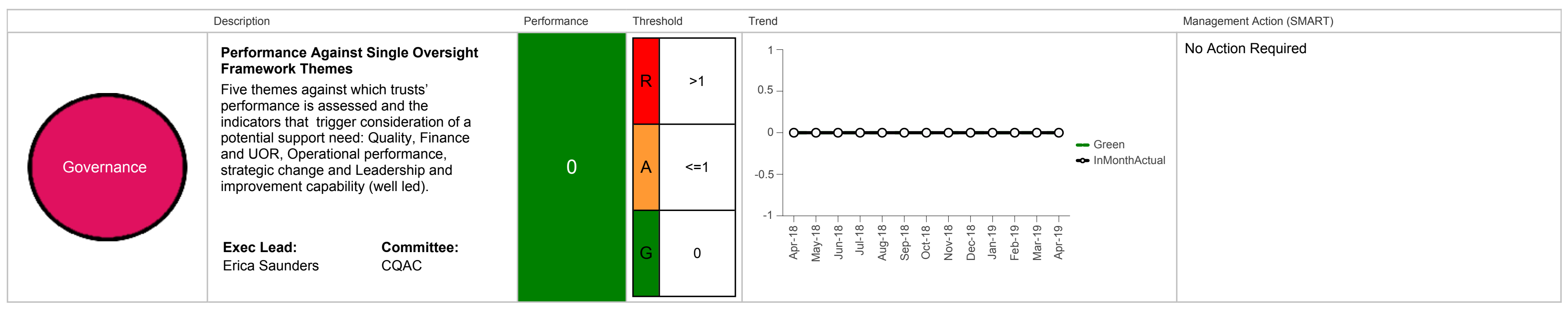
	Description	Performance	Threshold		Trend	Management Action (SMART)
Cancer RTT	**All Cancers: 31 day wait until subsequent treatments** Threshold is set at 100% which a stretch target set higher than national performance. **Exec Lead:** Adam Bateman **Committee:** RABD	100 %	R A G	<100 % N/A 100 %	Chart: Apr-18 to Apr-19 (Actual, Average, UCL, LCL, UWL, LWL, Green)	No Action Required
Cancer RTT	**All Cancers: 31 day diagnosis to treament** Threshold is set at 100% which a stretch target set higher than national performance. **Exec Lead:** Adam Bateman **Committee:** RABD	100 %	R A G	<100 % N/A 100 %	Chart: Apr-18 to Apr-19 (Actual, Average, UCL, LCL, UWL, LWL, Green)	No Action Required
Cancer RTT	**Cancer: 2 week wait from referral to date 1st seen - all urgent referrals** Threshold is set at 100% which a stretch target set higher than national performance. **Exec Lead:** Adam Bateman **Committee:** RABD	100 %	R A G	<100 % N/A 100 %	Chart: Apr-18 to Apr-19 (Actual, Average, UCL, LCL, UWL, LWL, Green)	No Action Required

Delivery of Outstanding Care

13.3 - PERFORMANCE - RESPONSIVE

	Description	Performance	Threshold		Trend	Management Action (SMART)
Cancer RTT	**31 days from urgent referral for suspected cancer to first treatment (Children's Cancers)** Threshold is set at 100% which a stretch target set higher than national performance. **Exec Lead:** Adam Bateman **Committee:** RABD		R	<100 %		No Action Required
			A	N/A		
			G	100 %		
Diagnostics	**Diagnostics: % Completed Within 6 Weeks** Threshold is based on National Guidance set by NHS England at 99%. **Exec Lead:** Adam Bateman **Committee:** RABD	100 %	R	<99 %		No Action Required
			A	N/A		
			G	>=99 %		

14.1 - PERFORMANCE - WELL LED



	Description	Performance	Threshold	Trend	Management Action (SMART)
Governance	**Performance Against Single Oversight Framework Themes** Five themes against which trusts' performance is assessed and the indicators that trigger consideration of a potential support need: Quality, Finance and UOR, Operational performance, strategic change and Leadership and improvement capability (well led). **Exec Lead:** Erica Saunders **Committee:** CQAC	0	R >1 A <=1 G 0		No Action Required

The Best People doing their best Work

15.1 - FINANCE - WELL LED

	Description	Performance	Threshold		Trend	Management Action (SMART)
Finance	**CIP In Month Variance (£'000s)** Variance from Sustainability plan (CIP). Variation between months is usual and the threshold of -5% to - 20% is viewed as reasonable to be rectified the following month. **Exec Lead:** John Grinnell **Committee:** RABD	-163	R A G	<-20% >=-20% >=-5%	Chart: Apr-18 to Apr-19 (Actual, Average, UCL, LCL, UWL, LWL, Green)	The April CIP performance across the Trust showed an under achievement of £0.163m. The full year CIP target is £6m. The forecast outturn for CIP delivery is £3.2m, a forecast CIP under performance of £2.7m representing a risk to CIP delivery for the full year.
Finance	**Control Total In Month Variance (£'000s)** Variance from Control Total plan. Variation between months is usual and the threshold of -5% to - 20% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	-394	R A G	<-20% >=-20% >=-5%	Chart: Apr-18 to Apr-19 (Actual, Average, UCL, LCL, UWL, LWL, Green)	The Trust is reporting a control total deficit for April of £1.6m which is behind plan by £0.4m. Income is behind plan by £0.6m and is offset by underspends of £0.2m
Finance	**Capital Expenditure In Month Variance (£'000s)** Variance from capital plan. Variation between months is usual and the threshold of + or - 5% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	1,030	R A G	<-10% >=-10% >=-5%	Chart: Apr-18 to Apr-19 (Actual, Average, UCL, LCL, UWL, LWL, Green)	No Action Required

15.2 - FINANCE - WELL LED

	Description	Performance	Threshold	Trend	Management Action (SMART)
Finance	**Income In Month Variance (£'000s)** Variance from income plan. Variation between months is usual and the threshold of -5% to - 20% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	-612	R <-20% A >=-20% G >=-5%		No Action Required
Finance	**Cash in Bank (£'000s)** Variance from Cash plan. Variation between months is usual and the threshold of -5% to - 20% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	34,361	R <-20% A >=-20% G >=-5%		At the end of April, cash balance was £34m which is £11m higher than plan. I&E performance was slightly worse than plan and capital spend slipped.
Finance	**Pay In Month Variance (£'000s)** Variance from pay plan. Variation between months is usual and the threshold of -5% to - 20% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	183	R <-20% A >=-20% G >=-5%		No Action Required

15.3 - FINANCE - WELL LED

	Description	Performance	Threshold		Trend	Management Action (SMART)
Finance	**Non Pay In Month Variance (£'000s)** Variance from non pay plan. Variation between months is usual and the threshold of -5% to - 20% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	34	R	<-20%		No Action Required
			A	>=-20%		
			G	>=-5%		
Finance	**NHSI Use of Resources** NHSI Use of Resources Metric indicates financial sustainability of the Trust. This varies from 1 to 4 with 1 being the highest score possible and 4 being the lowest **Exec Lead:** John Grinnell **Committee:** RABD	1	R	>3		No Action Required
			A	N/A		
			G	<=3		
Finance	**AvP: IP - Non-Elective** Actvity vs Forecast for Inpatient Non-Elective Activity. The threshold is based on achieving plan or higher. **Exec Lead:** John Grinnell **Committee:** RABD	52.12	R	<0		No Action Required
			A	N/A		
			G	>=0		

15.4 - FINANCE - WELL LED

	Description	Performance	Threshold	Trend	Management Action (SMART)
Finance	**AvP: IP Elective vs Forecast** Actvity vs Forecast for Inpatient Elective activity. The threshold is based on achieving plan or higher. **Exec Lead:** John Grinnell **Committee:** RABD	-44.80	R <0 A N/A G >=0	Chart: Apr-18 to Apr-19; Actual, Average, UCL, LCL, UWL, LWL, Green	The most significant adverse variances were in LTV/sleep studies (27 spells) and ENT (23 spells)
Finance	**AvP: Outpatient Activity vs Forecast** Actvity vs Forecast for Outpatient activity. The threshold is based on achieving plan or higher. **Exec Lead:** John Grinnell **Committee:** RABD	410.85	R <0 A N/A G >=0	Chart: Apr-18 to Apr-19; Actual, Average, UCL, LCL, UWL, LWL, Green	No Action Required
Finance	**AvP: Daycase Activity vs Forecast** Actvity vs Forecast for Daycase activity. The threshold is based on achieving plan or higher. **Exec Lead:** John Grinnell **Committee:** RABD	-54.54	R <0 A N/A G >=0	Chart: Apr-18 to Apr-19; Actual, Average, UCL, LCL, UWL, LWL, Green	The most significant adverse variances were in ENT (33 spells) and gastro (27 spells)

The Best People doing their best Work

16.1 - HR - WELL LED

	Description	Performance	Threshold	Trend	Management Action (SMART)
Personal Development	**PDR** Trust target, measuring compliance of staff Personal Development Reviews (Non medical). The Trust compliance period is set to be achieved in the first 4 months of each year (April -July). **Exec Lead:** Melissa Swindell **Committee:** WOD	4.81 %	No Threshold		
Training	**Mandatory Training** This is a Trust target that measures all required training including Resuscitation. **Exec Lead:** Melissa Swindell **Committee:** WOD	90.03 %	R <80 % A >=80 % G >=90 %		No Action Required
Appraisal	**Medical Appraisal** Trust Target for compliance for medical staff, which is on a rolling 12mth period. **Exec Lead:** Melissa Swindell **Committee:** WOD	100 %	R <90 % A >=90 % G >=95 %		No Action Required

The Best People doing their best Work

16.2 - HR - WELL LED

	Description	Performance	Threshold		Trend	Management Action (SMART)
Sickness	**Sickness** % of staff who have been absent from work due to sickness, this is broken down into LTS & STS in further metrics **Exec Lead:** Melissa Swindell **Committee:** WOD	5.25 %	R	>4.5 %		The absence rate has fallen for the 3rd month in a row but still remains above the Trust target, which has been revised from 1st April 2019 to 4% overall (Short Term - 1% and Long Term stays at 3%) Absences relating to Anxiety, Stress & Depression have come down slightly to 30% of all absences in April, this is followed by Other Musculoskeletal Problems (10%) and Gatrointestinal problems (9.9%) Action plans are in place for areas with significant absence. In addition a full review of all absences is being undertaken with individual action plans in place.
			A	<=4.5 %		
			G	<=4 %		
Sickness	**Short Term Sickness** % of Trust staff who have been absent from work due to sickness lasting less than 28 days **Exec Lead:** Melissa Swindell **Committee:** WOD	1.46 %	R	>1 %		As above
			A	N/A		
			G	<=1 %		
Sickness	**Long Term Sickness** % of Trust staff who have been absent from work due to sickness lasting 28 days or more **Exec Lead:** Melissa Swindell **Committee:** WOD	3.79 %	R	>3 %		As above
			A	N/A		
			G	<=3 %		

The Best People doing their best Work

16.3 - HR - WELL LED

	Description	Performance	Threshold		Trend	Management Action (SMART)
Staff Turnover	**Staff Turnover** Trust Target which is based on a rolling 12mth period **Exec Lead:** Melissa Swindell **Committee:** WOD	9.87 %	R A G	>11 % <=11 % <=10 %		No Action Required
Temporary Spend	**Temporary Spend ('000s)** Indicates the expenditure on premium temporary pay spend and monitors the reduction. **Exec Lead:** Melissa Swindell **Committee:** WOD	1114.30	R A G	>960 <=960 <=800		Business Partners together with Finance Accountants and Ass COOs regularly review status in Divisions and advise on actions as appropriate. Monthly temporary staffing reviews also take place with the Director & Deputy Directors of HR & Finance.
Payroll	**% of Correct Pay Achieved** An agreed service Level target with the Trust payroll provider. **Exec Lead:** Melissa Swindell **Committee:** WOD	99.55 %	R A G	<99 % >=99 % >=99.5 %		No Action Required

Game Changing Research & Innovation

17.1 - RESEARCH & DEVELOPMENT - WELL LED

	Description	Performance	Threshold		Trend	Management Action (SMART)
Clinical Research	**Number of Open Studies - Commercial** Number of commercial studies currently open. **Exec Lead:** Matthew Peak **Committee:** REIC	59	R A G	<21 >=21 >=30	Chart (Apr-18 to Apr-19): Actual, Average, UCL, LCL, UWL, LWL, Green	No Action Required
Clinical Research	**Number of Open Studies - Academic** Number of academic studies currently open. **Exec Lead:** Matthew Peak **Committee:** REIC	154	R A G	<111 >=111 >=130	Chart (Apr-18 to Apr-19): Actual, Average, UCL, LCL, UWL, LWL, Green	No Action Required
Clinical Research	**Number of New Studies Opened - Academic** Number of new academic studies opened in month. **Exec Lead:** Matthew Peak **Committee:** REIC	1	R A G	<2 >=2 >=3	Chart (Apr-18 to Apr-19): Actual, Average, UCL, LCL, UWL, LWL, Green	Clinical Research do not have much control over the number of studies which are brought forward, there seems to be a trend which dips before the number picks up again before repeating. If this decrease was to carry on for longer (3-6 months) it may be an indicator that there are underlying problems, such as lack of capacity in research or in the trust.

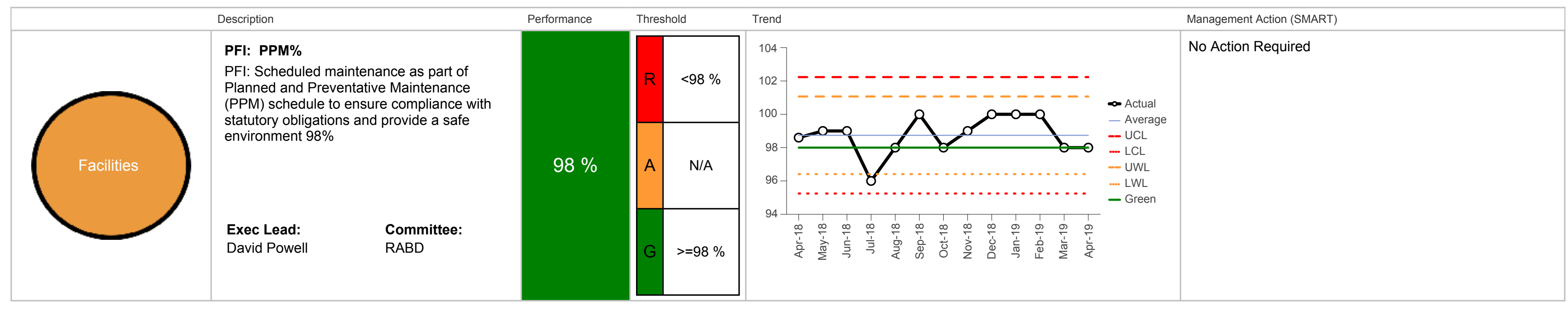
Game Changing Research & Innovation

17.2 - RESEARCH & DEVELOPMENT - WELL LED

	Description	Performance	Threshold		Trend	Management Action (SMART)
Clinical Research	**Number of patients recruited** Number of patients recruited to NIHR portfolio studies in month. **Exec Lead:** Matthew Peak **Committee:** REIC	234	R	<171		No Action Required
			A	>=171		
			G	>=200		
Clinical Research	**Number of New Studies Opened - Commercial** Number of new commercial studies opened in month. **Exec Lead:** Matthew Peak **Committee:** REIC	2	R	<1		No Action Required
			A	N/A		
			G	>=1		

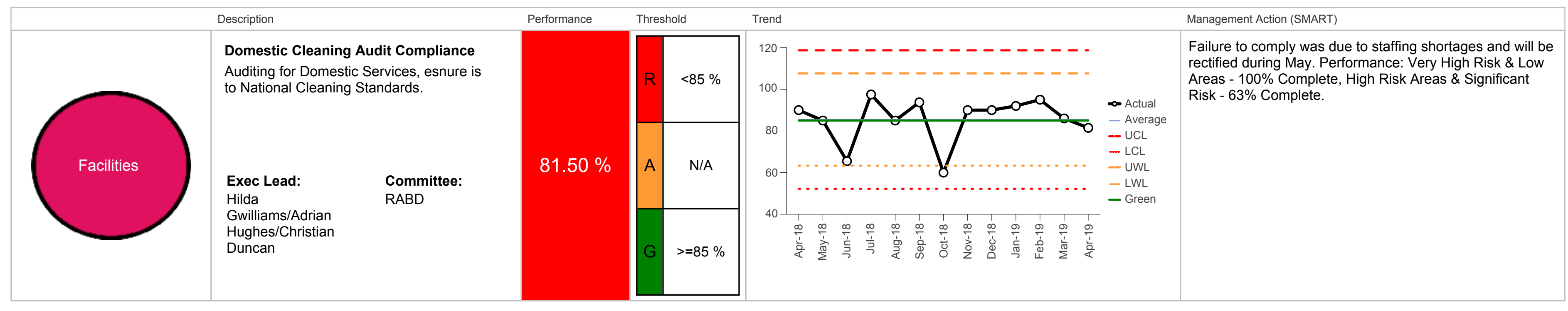
Delivery of Outstanding Care

18.1 - FACILITIES - RESPONSIVE

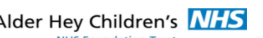


	Description	Performance	Threshold	Trend	Management Action (SMART)
Facilities	**PFI: PPM%** PFI: Scheduled maintenance as part of Planned and Preventative Maintenance (PPM) schedule to ensure compliance with statutory obligations and provide a safe environment 98% **Exec Lead:** David Powell **Committee:** RABD	98 %	R: <98 % A: N/A G: >=98 %		No Action Required

19.1 - FACILITIES - WELL LED



	Description	Performance	Threshold		Trend	Management Action (SMART)
Facilities	**Domestic Cleaning Audit Compliance** Auditing for Domestic Services, esnure is to National Cleaning Standards. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** RABD	81.50 %	R	<85 %		Failure to comply was due to staffing shortages and will be rectified during May. Performance: Very High Risk & Low Areas - 100% Complete, High Risk Areas & Significant Risk - 63% Complete.
			A	N/A		
			G	>=85 %		



All Divisions

SAFE

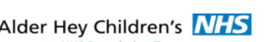
	COMMUNITY	MEDICINE	SURGERY	RAG		
Total no of incidents reported Near Miss & Above	32	146	221	No Threshold		
Clinical Incidents resulting in minor harm & above	1	33	49	No Threshold		
Clinical Incidents resulting in Near Miss	4	20	34	No Threshold		
Clinical Incidents resulting in No Harm	27	93	138	No Threshold		
Clinical Incidents resulting in minor, non permanent harm	1	33	49	No Threshold		
Clinical Incidents resulting in moderate, semi permanent harm	0	0	0	0	N/A	>0
Clinical Incidents resulting in severe, permanent harm	0	0	0	0	N/A	>0
Clinical Incidents resulting in catastrophic, death	0	0	0	0	N/A	>0
Medication errors resulting in harm	0	4	2	No Threshold		
Pressure Ulcers (Category 3)	0	0	0	0	N/A	>0
Pressure Ulcers (Category 4)	0	0	0	0	N/A	>0
Acute readmissions of patients with long term conditions within 28 days	0	2	0	No Threshold		
Medication errors resulting in moderate, sever harm or death	0	0	0	0	N/A	>0
Never Events	0	0	0	0	N/A	>0

CARING

	COMMUNITY	MEDICINE	SURGERY	RAG
Complaints	4	2	0	No Threshold
PALS	30	24	22	No Threshold

EFFECTIVE

	COMMUNITY	MEDICINE	SURGERY	RAG		
Sepsis: Patients treated for Sepsis within 60 mins - Inpatients		100.0%	75.0%	>=90 %	>=85 %	<90 %
Readmissions to PICU within 48 hrs	0	0	0	No Threshold		
% of acute readmissions within 48 hrs of discharge (exc Oncology)	0.0%	1.3%	0.9%	No Threshold		
Readmissions within 48 hrs	0	27	14	No Threshold		



All Divisions

	COMMUNITY	MEDICINE	SURGERY	RAG		
Outbreak Acquired Organisms - Other	0	0	0	No Threshold		
Hospital Acquired Organisms - MRSA (BSI)	0	0	0	0	N/A	>0
Hospital Acquired Organisms - C.difficile	0	0	0	0	N/A	>0
Hospital Acquired Organisms - RSV	0	0	0	0	N/A	>0
Hospital Acquired Organisms - MSSA	0	0	1	No Threshold		
Hospital Acquired Organisms - CLABSI - ICU Only			1	No Threshold		
Outbreak Infections	0	0	0	No Threshold		
Referrals Received (Total)	874	1,972	3,656	No Threshold		
ED: 95% Treated within 4 Hours		93.6%		>=95 %	N/A	<95 %
Average LoS - Elective (Days)		3.15	2.92	No Threshold		
Average LoS - Non-Elective (Days)		1.29	2.65	No Threshold		
Theatre Utilisation - % of Session Utilised		79.7%	90.0%	>=90 %	>=85 %	<80 %
Cancelled Operations - Non Clinical - On Same Day (%)	0.0%	0.1%	0.7%	<=0.8 %	N/A	>0.8 %
On the day Elective Cancelled Operations for Non Clinical Reasons	0	1	8	No Threshold		
28 Day Breaches	0	0	0	0	N/A	>0
Clinic Session Utilisation	82.9%	85.6%	88.7%	>=90 %	>=85 %	<85 %
OP Appointments Cancelled by Hospital %	20.7%	17.5%	13.9%	<=5 %	<=10 %	>10 %
Was Not Brought Rate	12.7%	11.1%	10.7%	<=12 %	<=14 %	>14 %
Incomplete Pathway Forms in Outpatients	785	4,898	8,676	No Threshold		
Referral Turnaround (days to log)	4.44	3.27	3.83	No Threshold		
Referral Turnaround (Consultant to Action)	8.61	7.32	4.94	No Threshold		
Coding average comorbidities	6.50	4.17	3.94	No Threshold		
CAMHS: Was Not Brought Rate - New	11.8%			<=6 %	<=8 %	>8 %
CAMHS: Was Not Brought Rate - Follow Up	14.2%			<=10 %	<=16 %	>16 %

All Divisions

RESPONSIVE

	COMMUNITY	MEDICINE	SURGERY	RAG		
IP Survey: % Received information enabling choices about their care	100.0%	98.6%	98.0%	>=95 %	>=90 %	<90 %
IP Survey: % Treated with respect	100.0%	99.3%	99.3%	100 %	>=95 %	<95 %
IP Survey: % Know their planned date of discharge	100.0%	85.0%	92.4%	>=90 %	>=85 %	<85 %
IP Survey: % Know who is in charge of their care	100.0%	98.6%	100.0%	>=95 %	>=90 %	<90 %
IP Survey: % Patients involved in play and learning	100.0%	84.1%	90.2%	>=90 %	>=85 %	<85 %
RTT: Open Pathway: % Waiting within 18 Weeks	75.2%	94.6%	93.6%	>=92 %	>=90 %	<90 %
Waiting List Size	1,272	3,434	8,165	No Threshold		
Waiting Greater than 52 weeks	0	0	0	0	N/A	>0
Diagnostics: % Completed Within 6 Weeks		100.0%	100.0%	>=99 %	N/A	<99 %
Number of Stranded Patients (7+ Days)		23	20	No Threshold		
Number of Super Stranded Patients (21+ Days)		10	11	No Threshold		
CAMHS: 2 Appointments within 6 weeks	0			No Threshold		
Urgent EDYS Pathway Average Wait in Weeks	0	0	0	No Threshold		
Routine EDYS Pathway Average Wait in Weeks	0	0	0	No Threshold		
Routine Eating Disorders (EDYS) Pathway Average Wait in Days	36.00			No Threshold		
Urgent Eating Disorders (EDYS) Pathway Average Wait in Days	5.00			No Threshold		
CAMHS: Avg Wait from referral to Partnership Appt (Weeks)- Liverpool Specialist	16.00	0.00	0.00	No Threshold		
CAMHS: Avg Wait from referral to Partnership Appt (Weeks)- Sefton Specialist	17.00	0.00	0.00	No Threshold		

WELL LED

	COMMUNITY	MEDICINE	SURGERY	RAG
Control Total In Month Variance (£'000s)	-20	-187	-405	No Threshold
Income In Month Variance (£'000s)	-111	-225	-372	No Threshold
Pay In Month Variance (£'000s)	189	-59	23	No Threshold
Non Pay In Month Variance (£'000s)	-98	97	-57	No Threshold

All Divisions

	COMMUNITY	MEDICINE	SURGERY	RAG		
AvP: IP - Non-Elective		17	35	>=0	N/A	<0
AvP: IP Elective vs Forecast	0	-30	-15	>=0	N/A	<0
AvP: OP New	-2.48	60.61	-210.29	>=0	N/A	<0
AvP: OP FollowUp	-30.87	-240.82	231.69	>=0	N/A	<0
AvP: Daycase Activity vs Forecast		-6	-48	>=0	N/A	<0
AvP: Outpatient Activity vs Forecast	-33	-180	21	>=0	N/A	<0
PDR	1.4%	2.8%	11.6%	No Threshold		
Mandatory Training	92.2%	90.7%	88.8%	>=90 %	>=80 %	<80 %
Actual vs Planned Establishment (%)	93.7%	94.5%	96.4%	No Threshold		
Sickness	4.9%	5.2%	5.4%	<=4 %	<=4.5 %	>4.5 %
Attendance (HR)	95.1%	94.8%	94.6%	>=95.5 %	>=90 %	<90 %
Short Term Sickness	1.2%	1.5%	1.5%	<=1 %	N/A	>1 %
Long Term Sickness	3.7%	3.7%	3.9%	<=3 %	N/A	>3 %
Temporary Spend ('000s)	181	287	515	No Threshold		
Staff Turnover	12.3%	8.8%	10.4%	<=10 %	<=11 %	>11 %
Safer Staffing (Shift Fill Rate)	100.0%	100.2%	91.9%	>=90 %	>=80 %	<90 %

Medicine

SAFE

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	Last 12 Months	RAG
Acute readmissions of patients with long term conditions within 28 days	1	1	4	0	3	2	4	6	3	3	3	2	2	No Data Available	No Threshold

CARING

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	Last 12 Months	RAG
Complaints	1	7	4	4	3	6	6	1	4	3	1	3	2		No Threshold
PALS	51	31	27	28	23	21	34	19	21	41	33	20	24		No Threshold

EFFECTIVE

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	Last 12 Months	RAG
Hospital Acquired Organisms - MRSA (BSI)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 / N/A / >0
Hospital Acquired Organisms - C.difficile	0	0	0	0	0	0	0	0	0	0	0	0	0		0 / N/A / >0
Referrals Received (Total)	1,843	1,949	2,011	1,904	1,569	1,678	2,082	1,984	1,747	2,024	1,920	2,161	1,972	No Data Available	No Threshold
ED: 95% Treated within 4 Hours	95.3%	95.0%	95.6%	96.5%	98.4%	93.7%	90.9%	93.8%	95.3%	92.1%	90.6%	95.6%	93.6%		>=95 % / N/A / <95 %
Average LoS - Elective (Days)	3.23	2.66	4.01	3.84	2.85	3.18	2.89	3.08	3.54	2.88	3.10	2.87	3.15		No Threshold
Average LoS - Non-Elective (Days)	1.52	1.55	1.59	1.28	1.45	1.35	1.54	1.64	1.45	1.39	1.53	1.21	1.29		No Threshold
Theatre Utilisation - % of Session Utilised	75.4%	75.6%	78.6%	83.0%	77.8%	84.8%	80.4%	80.9%	86.7%	84.5%	83.8%	82.4%	79.7%		>=90 % / >=80 % / <80 %
Clinic Session Utilisation	85.2%	83.7%	84.9%	82.2%	82.0%	85.0%	83.9%	85.9%	82.2%	82.2%	88.1%	88.2%	85.6%		>=90 % / >=80 % / <85 %
OP Appointments Cancelled by Hospital %	13.6%	14.2%	12.9%	16.4%	15.7%	14.0%	14.5%	14.2%	15.6%	15.3%	15.3%	13.7%	17.5%	No Data Available	<=5 % / <=10 % / >10 %
Was Not Brought Rate	10.1%	11.0%	12.6%	12.3%	13.6%	12.3%	12.4%	11.0%	13.3%	11.8%	11.8%	9.6%	11.1%		<=12 % / <=14 % / >14 %
Coding average comorbidities	3.41	3.31	3.24	3.32	3.49	3.48	3.56	3.50	3.75	3.74	3.99	3.92	4.17	No Data Available	No Threshold

RESPONSIVE

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	Last 12 Months	RAG
RTT: Open Pathway: % Waiting within 18 Weeks	90.0%	90.2%	89.5%	89.7%	90.2%	91.1%	89.9%	91.5%	92.7%	92.9%	92.5%	93.9%	94.6%		>=92 % / >=90 % / <90 %
Diagnostics: % Completed Within 6 Weeks	99.8%	99.8%	99.1%	99.3%	99.0%	99.8%	99.8%	99.3%	100.0%	99.7%	100.0%	99.6%	100.0%		>=99 % / N/A / <99 %

WELL LED

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	Last 12 Months	RAG
Control Total In Month Variance (£'000s)	127	122	408	223	75	178	-115	15	69	-444	-254		-187		No Threshold
AvP: IP - Non-Elective	911	858	772	823	672	931	1,017	1,103	1,026	925	849	918	17		>=0 / N/A / <0
AvP: IP Elective vs Forecast	106	122	102	120	105	86	112	100	82	107	93	121	-30		>=0 / N/A / <0
AvP: OP New	2,505.00	2,620.00	2,675.00	2,654.00	2,244.00	2,330.00	2,646.00	2,616.00	2,241.00	2,636.00	2,496.00	2,910.00	60.61	No Data Available	>=0 / N/A / <0
AvP: OP FollowUp	3,069.00	3,282.00	3,260.00	3,096.00	3,022.00	3,147.00	3,679.00	3,662.00	2,780.00	3,707.00	3,232.00	3,530.00	-240.82	No Data Available	>=0 / N/A / <0
AvP: Daycase Activity vs Forecast	1,040	1,088	1,055	1,068	1,091	984	1,113	1,043	942	1,145	1,007	964	-6		>=0 / N/A / <0
AvP: Outpatient Activity vs Forecast	5,574	5,902	5,935	5,750	5,266	5,477	6,325	6,278	5,021	6,343	5,728	6,440	-180		>=0 / N/A / <0
PDR	2.2%	13.4%	35.5%	67.2%	85.5%	88.6%	89.2%	89.2%	89.2%	89.2%	89.2%	89.2%	2.8%		No Threshold
Mandatory Training	92.7%	92.8%	92.4%	91.3%	87.9%	87.6%	89.4%	90.4%	90.0%	91.0%	90.1%	90.7%	90.7%		>=90 % / >=80 % / <80 %
Sickness	3.8%	4.0%	4.4%	5.8%	5.1%	5.3%	5.2%	5.3%	6.1%	5.8%	5.6%	5.9%	5.2%		<=4 % / <=4.5 % / >4.5 %
Temporary Spend ('000s)	246	276	196	227	261	212	217	261	197	247	324	354	287		No Threshold

Alder Hey Children's NHS
NHS Foundation Trust

Surgery

SAFE

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	Last 12 Months	RAG
Acute readmissions of patients with long term conditions within 28 days	0	0	0	0	0	0	0	0	0	0	0	0	0	No Data Available	No Threshold

CARING

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	Last 12 Months	RAG
Complaints	1	2	1	5	3	1	1	1	0	1	1	3	0		No Threshold
PALS	25	36	28	20	22	27	27	27	16	27	18	16	22		No Threshold

EFFECTIVE

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	Last 12 Months	RAG
Hospital Acquired Organisms - MRSA (BSI)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 / N/A / >0
Hospital Acquired Organisms - C.difficile	0	0	0	0	0	0	0	0	0	0	0	1	0		0 / N/A / >0
Referrals Received (Total)	3,769	4,091	3,834	4,250	3,379	3,238	3,674	3,778	2,822	3,636	3,751	3,981	3,656	No Data Available	No Threshold
Average LoS - Elective (Days)	2.40	2.94	2.55	2.68	2.72	2.66	2.97	2.72	3.38	2.10	2.85	3.16	2.92		No Threshold
Average LoS - Non-Elective (Days)	2.63	2.78	2.63	2.61	2.72	2.49	3.15	2.69	2.91	2.65	2.45	2.59	2.65		No Threshold
Theatre Utilisation - % of Session Utilised	90.5%	90.6%	89.5%	90.4%	88.7%	86.9%	87.4%	88.2%	85.6%	89.4%	89.5%	90.1%	90.0%		>=90 % / >=80 % / <80 %
Clinic Session Utilisation	84.2%	85.0%	85.8%	82.8%	83.8%	84.3%	82.8%	84.5%	82.9%	84.2%	86.2%	89.7%	88.7%		>=90 % / >=80 % / <85 %
OP Appointments Cancelled by Hospital %	11.2%	12.3%	12.3%	12.4%	12.6%	14.3%	13.6%	12.8%	13.4%	14.1%	14.5%	14.1%	13.9%	No Data Available	<=5 % / <=10 % / >10 %
Was Not Brought Rate	9.6%	10.6%	11.2%	12.0%	12.9%	10.6%	11.7%	11.2%	13.2%	12.8%	10.9%	9.3%	10.7%		<=12 % / <=14 % / >14 %
Coding average comorbidities	3.35	3.46	3.64	3.60	3.70	3.75	3.70	3.56	3.99	3.95	4.10	3.91	3.94	No Data Available	No Threshold

RESPONSIVE

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	Last 12 Months	RAG
RTT: Open Pathway: % Waiting within 18 Weeks	92.3%	92.5%	93.1%	92.9%	92.7%	93.1%	93.6%	94.1%	93.7%	93.1%	94.0%	94.0%	93.6%		>=92 % / >=90 % / <90 %
Diagnostics: % Completed Within 6 Weeks	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	89.5%	92.3%	100.0%		>=99 % / N/A / <99 %

WELL LED

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	Last 12 Months	RAG
Control Total In Month Variance (£'000s)	-169	33	-24	89	-45	-320	-25	-209	-253	-240	-470		-405		No Threshold
AvP: IP - Non-Elective	431	479	475	495	462	413	422	405	406	384	366	467	35		>=0 / N/A / <0
AvP: IP Elective vs Forecast	273	311	294	302	293	304	328	319	245	305	308	335	-15		>=0 / N/A / <0
AvP: OP New	4,135.00	4,625.00	4,418.00	4,495.00	3,972.00	3,834.00	4,452.00	4,382.00	3,347.00	4,253.00	3,820.00	4,377.00	-210.29	No Data Available	>=0 / N/A / <0
AvP: OP FollowUp	5,827.00	5,844.00	5,396.00	6,060.00	5,809.00	5,713.00	6,959.00	7,147.00	5,314.00	6,804.00	6,167.00	6,432.00	231.69	No Data Available	>=0 / N/A / <0
AvP: Daycase Activity vs Forecast	767	815	858	825	782	736	894	909	680	861	756	884	-48		>=0 / N/A / <0
AvP: Outpatient Activity vs Forecast	9,962	10,469	9,814	10,555	9,781	9,547	11,411	11,529	8,661	11,057	9,987	10,809	21		>=0 / N/A / <0
PDR	1.1%	10.0%	33.5%	64.4%	83.6%	90.7%	90.0%	90.0%	90.0%	90.0%	96.6%	96.6%	11.6%		No Threshold
Mandatory Training	90.2%	89.9%	90.9%	90.3%	87.2%	87.8%	88.6%	87.8%	88.0%	90.0%	88.4%	89.4%	88.8%		>=90 % / >=80 % / <80 %
Sickness	4.3%	4.7%	5.5%	5.4%	5.6%	6.0%	6.5%	6.0%	6.4%	6.3%	6.5%	5.3%	5.4%		<=4 % / <=4.5 % / >4.5 %
Temporary Spend ('000s)	468	419	480	445	509	374	529	485	484	474	564	591	515		No Threshold

Community

SAFE

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	Last 12 Months	RAG
Acute readmissions of patients with long term conditions within 28 days	0	0	0	0	0	0	0	0	0	0	0	0	0	No Data Available	No Threshold

CARING

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	Last 12 Months	RAG
Complaints	2	2	3	5	5	3	2	2	1	1	4	5	4		No Threshold
PALS	32	28	20	21	26	43	36	40	11	35	27	31	30		No Threshold

EFFECTIVE

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	Last 12 Months	RAG
Hospital Acquired Organisms - MRSA (BSI)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Hospital Acquired Organisms - C.difficile	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Referrals Received (Total)	862	1,093	850	1,079	663	692	976	1,058	765	902	968	1,067	874	No Data Available	No Threshold
Average LoS - Elective (Days)								1.00	3.00						No Threshold
Clinic Session Utilisation	75.3%	79.2%	78.7%	79.9%	80.7%	80.5%	82.7%	81.6%	77.7%	79.1%	81.0%	87.1%	82.9%		>=90 % >=85 % <85 %
OP Appointments Cancelled by Hospital %	16.1%	10.8%	16.8%	16.2%	23.3%	22.3%	17.7%	22.1%	23.6%	18.3%	21.7%	22.8%	20.7%	No Data Available	<=5 % <=10 % >10 %
Was Not Brought Rate	14.6%	14.6%	14.3%	13.8%	15.7%	12.5%	11.1%	13.0%	13.5%	13.9%	11.5%	10.5%	12.7%		<=12 % <=14 % >14 %
Coding average comorbidities	5.00	2.33		2.00	8.00	4.00	2.00	2.67		2.00	1.50	6.00	6.50	No Data Available	No Threshold

RESPONSIVE

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	Last 12 Months	RAG
RTT: Open Pathway: % Waiting within 18 Weeks	97.1%	96.1%	95.3%	92.2%	92.7%	87.3%	87.1%	78.8%	78.3%	82.7%	78.3%	74.2%	75.2%		>=92 % >=90 % <90 %

WELL LED

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	Last 12 Months	RAG
Control Total In Month Variance (£'000s)	-108	-70	30	62	-144	87	54	-61	118	-23	26		-20		No Threshold
AvP: IP Elective vs Forecast													0		>=0 N/A <0
AvP: OP New	406.00	446.00	421.00	408.00	311.00	356.00	532.00	531.00	337.00	407.00	390.00	413.00	-2.48	No Data Available	>=0 N/A <0
AvP: OP FollowUp	2,379.00	2,614.00	2,496.00	2,502.00	1,938.00	2,141.00	2,631.00	2,630.00	1,812.00	2,606.00	2,424.00	2,703.00	-30.87	No Data Available	>=0 N/A <0
AvP: Outpatient Activity vs Forecast	2,785	3,060	2,917	2,910	2,249	2,497	3,163	3,161	2,149	3,013	2,814	3,116	-33		>=0 N/A <0
PDR	0.4%	9.3%	31.9%	58.8%	78.7%	87.9%	93.0%	93.0%	93.0%	93.7%	93.7%	93.7%	1.4%		No Threshold
Mandatory Training	95.4%	95.0%	94.1%	94.2%	92.7%	91.2%	92.5%	91.4%	90.9%	88.3%	89.2%	90.3%	92.2%		>=90 % >=80 % <80 %
Sickness	4.8%	5.2%	3.9%	3.5%	3.4%	4.1%	4.0%	5.2%	5.3%	5.3%	5.3%	5.0%	4.9%		<=4 % <=4.5 % >4.5 %
Temporary Spend ('000s)	166	180	142	131	154	125	131	150	121	151	91	339	181		No Threshold

Board of Directors
28th May 2019

Report of	Director of Corporate Affairs
Paper prepared by	Executive Team Governance Manager
Subject/Title	Board Assurance Framework Review (May 2019)
Background papers	Monthly BAF Reports
Purpose of Paper	To provide the Board with the BAF update Report
Action/Decision required	The Board is asked to discuss and note the Board Assurance Framework – May position
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	➢ Delivery of outstanding care ➢ The best people doing their best work ➢ Sustainability through external partnerships ➢ Game-changing research & innovation
Resource Impact	Non achievement of the Trust's objectives could have a negative impact on the services provided by the Trust.

Board Assurance Framework 2019/20

1. Purpose

This report is a summary of the current Board Assurance Framework (BAF) for review and discussion.

2. Review of the BAF

A thorough review of the BAF is currently ongoing looking at its layout on the Ulysses system and how this could be improved for a better read-across. Board members will be aware of the strategy session planned to take place in June – outputs from which will be used to inform and finalise the assurance framework for 2019/20 ensuring risks to delivery of the Trust's Strategic Plan are fully articulated.

The diagram below gives a high level view of the current version, followed by a summary and a brief on the changes since the last Board meeting. The full document is included as Appendix A.

BAF Risk Register - Overview at 22 May 2019

BAF Risk Register - Overview at 22 May 2019
3.4: Financial Environment (S)   1.3: New Hospital Environment (S)
2.3: Workforce Equality, Diversity & Inclusion (S)   3.2: Service sustainability and Growth. (S)
2.1: Workforce Sustainability (S)   2.2: Staff Engagement (S)   4.2: IT Strategic Development. (S)
1.4: Sustaining operational delivery in the event of a 'No Deal' exit from the European Union (S)
1.1: Achievement of Outstanding Quality for Children and Young People as defined by the Care Quality Commission (CQC) regula (S)
3.1: Failure to fully realise the Trust's Vision for the Park (S)   4.1: Research, Education & Innovation (S)
1.2: Achievement of national and local mandatory & compliance standards (S)

Trend of risk rating indicated by: NEW, B- Better, S - Static, W – Worse

3. Summary of BAF - at 22 May 2019

The diagram below shows that all risks remained static in-month.

Ref, Owner	Risk Title	Risk Rating: I x L		Monthly Trend	
		Current	Target	Last	Now
STRATEGIC PILLAR: Delivery of Outstanding Care					
1.1 HG	**Achievement of outstanding quality for children and young people**	3-3	2-2	STATIC	STATIC
1.2 ES	**Achievement of national and local mandatory standards**	3-2	3-2	BETTER	STATIC
1.3 DP	**New Hospital Environment**	4-4	4-2	STATIC	STATIC
1.4 JG	**Sustainable operational delivery in the event of a 'No Deal' exit from EU**	3-3	3-3	BETTER	STATIC
STRATEGIC PILLAR: The Best People Doing Their Best Work					
2.1 MS	**Workforce Sustainability**	3-3	3-2	STATIC	STATIC
2.2 MS	**Staff Engagement**	3-3	3-1	STATIC	STATIC
2.3 MS	**Workforce Equality, Diversity & Inclusion**	3-4	3-1	STATIC	STATIC
STRATEGIC PILLAR: Sustainability Through External Partnerships					
3.1 DP	**Failure to fully realise the Trust's Vision for the Park**	3-3	3-2	STATIC	STATIC
3.2 DJ	**Service Sustainability & Growth**	4-3	4-2	STATIC	STATIC
3.4 JG	**Financial Environment**	4-4	4-3	STATIC	STATIC
STRATEGIC PILLAR: Game-Changing Research And Innovation					
4.1 DP	**Research, Education & Innovation**	3-3	3-2	STATIC	STATIC
4.2 KW	**IT Strategic Development**	3-3	3-2	STATIC	STATIC

8. Changes since 7 May 2019 Board meeting

External risks

- ***Service Sustainability and Growth (DJ)***
  Single Neonatal Service: progressing to appoint joint leadership and nursing roles and ensuring SLA's are in place to allow staff to work across both sites. Manchester: continued work to develop shared plans for cardio, neuro and burns; joint agenda agreed for next partnership board 4th June 19. International: Healthcare UK workshops during May/June, culminating in strategy document July 19.

- ***Achievement of National and Local Mandatory & Compliance Standards (ES)***
  Strong start to the year maintained with on the day elective cancelled operations for non-clinical reasons in-line with trajectory; referral to treatment times met in-month; zero 28 breaches for cancelled ops and 100% of diagnostics completed within 6 weeks.

  ED performance was challenged in-month due to a spike in attendances and fell slightly below NHSE Guidance target at 94%.

- ***Sustaining operational delivery in the event of a 'No Deal' exit from the European Union (JG)***
  EU Exit deadline extended to 31/10/19. Brexit Assurance Group meetings moved from meeting weekly to monthly.

Internal risks:

- ***Achievement of Outstanding Quality for Children and Young People as defined by the Care Quality Commission (CQC) regulations (HG)***
  Nurse staffing paper presented at WOD on 3rd May providing significant assurance related to safe and appropriate front line nurse staffing levels. Positive feedback received from WOD. Paper to be presented to CCG at CQPG on 24th May and Trust Board on 2nd July. Significant assurance given by MIAA following audit of ward Accreditation process. Programme of annual nursing audit and Matron audits devised and commenced to monitor key elements of the quality of care delivered

- ***Financial Environment (JG)***
  Month 1 19/20 delivered a £0.3m adverse variance. Total run rate including CIP risk is £8m which is being mitigated through robust forward look and CIP planning. Longer term risks include HRGv4+ Children's Tariff risk which transitions to £7m downside per annum. Capital 5 year planning exercise underway and will conclude in Q2, latest forecast present a cash affordability concern that is being validated.

- ***Failure to fully realise the Trust's Vision for the Park (DP)***
  Park planning application in consultation

- ***IT Strategic Development (KW)***
  Strategy on track for July Trust Board. Options appraisal with regards to resilience of key systems to be undertaken as integral part of technology roadmap.

- ***Workforce Sustainability (MS)***
  All actions on track.

- ***Staff Engagement (MS)***
  All actions on track. Staff Survey Big conversations underway.

- ***Workforce Equality, Diversity & Inclusion (MS)***
  All actions on track.

- ***New Hospital Environment (DP)***
  Written to Project Co. to get an updated plan for pipework, response due by end of May 2019

- ***Research, Education & Innovation (DP)***
  Considering structure and relationship between innovation and research

Erica Saunders
Director of Corporate Affairs
28 May 2019

Board Assurance Framework 2019-20

BAF 1.1	**Strategic Objective:** Delivery Of Outstanding Care	Risk Title: Achievement of Outstanding Quality for Children and Young People as defined by the Care Quality Commission (CQC) regulations.	
Related CQC Themes: Safe, Caring, Effective, Responsive, Well Led			
Exec Lead: Hilda Gwilliams	**Type:** Internal, Known	Current IxL: 3-3	Target IxL: 2-2
		Trend: STATIC	

Risk Description

Not having sufficiently robust, clear governance systems and processes and people in place supported by the expected culture and values that underpin learning for improvement

Existing Control Measures

• 1. Quality impact assessment completed for all planned changes (NHSe). Change programme assurance reports monthly	• 2. Risk registers including corporate register inform Board assurance.
• 3. Quality section of Corporate Report including incidents, complaints, infection control including sepsis, friends and family test, best in acute care, best in surgical care, performance managed at Clinical Quality Assurance Committee and Trust Board.	• 4. Division and Corporate Quality & Safety Dashboards in place and monitored consistently via performance framework. This includes safety thermometer i.e. infections, falls, pressure ulcers, medication, workforce 'Hard Truths', sickness, appraisals, etc.
• 5. Patient Safety Meeting monitors incidents, including lessons learned, immediate actions for improvement and sharing Trust wide.	• 6. Programme of quality assurance rounds, developed and implemented across all services, aligned to Care Quality Commission, Key lines of enquiry (KLOE).
• 7. Annual clinical workforce assurance report presented to Board, aligned to Relevant Professional Standards.	•
• 8. Quality Strategy 2016/2021, Quality Improvement Change Programme established - associated workstreams subject to sub-committee assurance reporting.	• 9. Governance including risk processes from Ward to Board, linked to NHSI Single Oversight Framework
•	• 10. Acute Provider Infection Prevention and Control framework and associated dashboards and action plans for improvement.
• 11. Internal Nursing pool established and funded	• 12. Nursing leadership in alignment with Royal College of Nursing and Midwifery Standards.
• 13. Annual Patient Survey reports and associated action plans	• 14. Trust policies underpinning expected standards
• 15. CQC regulation compliance	

Assurance Evidence	Gaps in Controls/Assurance
1. Annual QIA assurance report and change programme assurance report 2. Risk assessments etc and associated risks monitored via the Integrated Governance Committee. Trust Board informed via Integrated Governance Committee minutes. Divisional Integrated Governance Committee minutes. 3. Clinical Quality Assurance Committee, Trust Board and Divisional Governance minutes 4. Corporate report/quality section, Trust Board and Divisional Quality Board minutes. 5. Minutes from Trust Board, Clinical Quality Assurance Committee, Executive Committee, Weekly patient safety group, Clinical Quality Steering Group, Divisional Integrated Governance Committees. Also MIAA audit report. 6. Reports and minutes from Clinical Quality Assurance Committee and Divisional Integrated Governance Committees. 7. Annual Medical Appraisal Report and Nurse staffing report to Trust Board biannually and associated minutes. 8. Board and sub-board committees minutes and associated reports. 9. Minutes from NHSI Quarterly engagement meetings, CQC engagement meetings, Trust Board, Clinical Quality Assurance Committee, Executive Committee, Weekly patient safety group, Clinical Quality Steering Group, Divisional Integrated Governance Committees. Patient survey reports and associated action plans, 10. IPC action plan and Trust Board, Clinical Quality Assurance Committee, Integrated Governance Committee, Divisional Quality Board minutes. 11. Nursing Workforce report and associated Board minutes. 12. Nursing Workforce report and associated Board minutes. 13. Patient survey reports and associated action plans, Trust Board, Clinical Quality Steering Group, Workforce and Organisational Development Committee, Divisional Quality Board minutes. 14. Audit committee reports and minutes. 15. CQC action plan monitoring via Board and sub board committees	15. CQC regulation ratings.

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Robust action plan to be developed, implemented and monitored via the Trust Board, Board subcommittees and individual services.	Continued monthly monitoring via CQAC; commitment to remove completed actions to focus on the outstanding elements in closer detail at the next meeting.

Executive Lead's Assessment
MAR 2019: Preparations underway in relation to the Trust's CIP plans and Quality Impact Assessment mandated processes to be presented by the Chief Nurse and Medical Director at the CCG first week in April. APR 2019: CCG event in relation to CIP QIAs complete, positive outcome. Annual workforce report complete and due to be presented at WOD in May followed by Trust Board in June. MAY 2019: Nurse staffing paper presented at WOD on 3rd May providing significant assurance related to safe and appropriate front line nurse staffing levels. Positive feedback received from WOD. Paper to be presented to CCG at CQPG on 24th May and Trust Board on 2nd July. Significant assurance given by MIAA following audit of ward Accreditation process. Programme of annual nursing audit and Matron audits devised and commenced to monitor key elements of the quality of care delivered

Board Assurance Framework 2019-20

BAF 1.2	**Strategic Objective:** Delivery Of Outstanding Care		Risk Title: Achievement of national and local mandatory & compliance standards		
Related CQC Themes: Safe, Caring, Responsive, Well Led, Effective					
Exec Lead: Erica Saunders		**Type:** Internal, Known	Current IxL: 3-2	Target IxL: 3-2	Trend: STATIC

Risk Description

Failure to meet targets and internal performance metrics due to poor flow and lack of capacity to fulfil activity plans and respond to increasing demand

Existing Control Measures

• Operational Delivery Board taking action to resolve performance issues as they emerge	• Emergency Planning & Resilience meetings in place
• Divisional Executive Review Meetings taking place monthly with 'three at the top'	• Regulatory status with: NHSI, CQC,NHSLA, ICO, HSE, CPA, HTA,MHRA etc.
• Compliance tracked through the corporate report and Divisional Dashboards.	• Risks to delivery addressed through Operational Board, RBD, CQAC, WOD, IGC & CQSG and then through to Board
• Early Warning indicators now in place	• Weekly performance meetings in place to track progress
• 6 weekly meetings with commissioners (CQPG)	• Divisional leadership structure to implement and embed clinically led services
• Weekly Exec Comm Cell overseeing key operational issues and blockages.	• Refresh of Corporate Report undertaken for 2018/19

Assurance Evidence	Gaps in Controls/Assurance
Regular reporting of delivery against compliance targets through assurance committees & Board. Monthly reporting to the Board via the Corporate Report. NHSI quality concern rating Operational effectiveness measures (key risks with early warning measures) to RABD Compliance assessment against NHSI Provider Licence to Board Divisional/Executive performance reviews Exceptions discussed / resolved at Ops Board Quarterly review meeting and report to NHSI	Critical Care bed capacity Some areas remain fragile e.g. ED 4 hour target. Assurance required to underpin Divisional reporting on CQC standards Work with CCG to manage demand & develop / fully utilise existing capacity across PC Proactive management of patient flow making better use of trend analysis data

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Monitor flow, length of stay and utilisation rates to ensure full activity plan delivered as per profile by Division; review activity profile through winter months.	Significant improvements in management of flow achieved in 2018/19 via bed meetings chaired by Hospital Manager of the Week, weekly performance meetings and specific task and finish work eg clinic utilisation
Plans to ensure performance sustained across the year need to be embedded and maintained	New Models of Care review findings presented and agree at Ops Board September; action plan agreed.

Executive Lead's Assessment

MARCH 2019: ED 4 hour target on track to be met for the month of March; all other access targets achieved; cancelled operation performance sustaining at lowest ever levels; clinic utilisation on improvement trajectory.
APRIL 2019: All access targets met for March including ED 4 hour wait placing Alder Hey as one of only ten trusts nationally to achieve against this standard. Target number of CCAD cases exceeded (410 for the year - highest level of performance for Trust).
MAY 2019: Strong start to the year maintained with on the day elective cancelled operations for non-clinical reasons in-line with trajectory; referral to treatment times met in-month; zero 28 breaches (cancelled Ops) and 100% of diagnostics completed within 6 weeks.
ED performance was challenged in-month due to a spike in attendances and fell slightly below NHSE Guidance target at 94%.

Board Assurance Framework 2019-20

BAF 1.3	Strategic Objective: Delivery Of Outstanding Care		Risk Title: New Hospital Environment		
Related CQC Themes: Safe					
Exec Lead: David Powell		Type: Internal, New	Current IxL: 4-4	Target IxL: 4-2	Trend: STATIC

Risk Description
Sale of PFI Project co. whilst a number of commissioning risks are still present could lead to lack of focus and problems in maintaining safe environment

Existing Control Measures	
• Monthly issue meetings	• Monthly liaison meetings
• Regular reports to IGC	• Liaison minutes reported to Trust Board monthly
• Building Management Services Risk Register	

Assurance Evidence	Gaps in Controls/Assurance
Maintenance of Issues List Issues Review Meeting Escalation to Liaison meeting Red Button escalation mechanism Help Desk monitoring reports	Some repeat/overlap reporting Some lack of clarity over risk ownership/H&S role

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Replacement programme for pipe work to be agreed with builder	Paper top be presented 7 May 2019 Board
Prepare recommendation to Board on proposed pipework replacement strategy	Project Co have been asked to meet with Board representatives to establish plan
Senior team meeting with Project Co to discuss pipework plans	

Executive Lead's Assessment
February 2019: Liaison meeting with Project Co. to review outstanding risk items APR 2019: Pipework discussed at Liaison Committee - planned series of meetings with Project Co MAY 2019: Written to Project Co. to get an updated plan for pipework, response due by end of May 2019

Board Assurance Framework 2019-20

BAF 1.4	Strategic Objective: Delivery Of Outstanding Care	Risk Title: Sustaining operational delivery in the event of a 'No Deal' exit from the European Union		
Related CQC Themes: Safe, Effective, Responsive				
Exec Lead: John Grinnell	**Type:** External,	Current IxL: 3-3	Target IxL: 3-3	Trend: STATIC

Risk Description

Failure of measures put in place nationally and locally in the event of a 'no deal' exit from the EU to safeguard the organisation's ability to deliver services safely and maintain business continuity.

Existing Control Measures

• National NHS EU coordination centre established to oversee planning and provide support to local teams to resolve escalating issues. Internal team in place to implement operational guidance.	• Internal command team structure focusing on eight key areas each week to assess level of risk and update plans based on national information. Group responds to national guidance as it is published.

Assurance Evidence	Gaps in Controls/Assurance
Information provided by the centre with regard to provision being made for vital clinical supplies to continue to flow to the UK post 29th March. National coordination centre overseeing three functions: central control, logistics and EPRR. Trust command team planning for operational readiness: SRO identified, risks kept under review, EPRR plans tested, communications plan implemented, Brexit mailbox in place, walkabouts commenced, divisional leads in place, NHSE assessment of hospital is green.	There may be supply issues in the event of a No deal Brexit. Our assurance is that we are in a position to respond to this and have alternatives in place for the identified high ridsk areas which we do.

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Continuing to refine oversight arrangements and associated resources ahead of 31st October 2019 deadline	
Continue to engage and lobby NHSE colleagues to ensure centrally managed mitigations are understood and adequate	

Executive Lead's Assessment

MAR 2019: Progress made since last Board in strengthening business continuity plans including further assessment of high risk areas, staff brieifings, on call arrangements, command room in place. Operational Divisional Leads identified to supplement subject matter experts. Next stage to test on the ground business continuity risks e.g. supply failure. Patient information on the subject to reviewed.
APR 2019: All actions previously identified continue.
MAY 2019: EU Exit deadline extended to 31/10/19. Brexit Assurance Group have moved from meeting weekly to monthly.

Board Assurance Framework 2019-20

BAF 2.1	Strategic Objective: The Best People Doing Their Best Work		Risk Title: Workforce Sustainability		
Related CQC Themes: Safe, Effective, Responsive, Well Led, Well Led, Well					
Exec Lead: Melissa Swindell		Type: Internal, Known	Current IxL: 3-3	Target IxL: 3-2	Trend: STATIC

Risk Description
Failure to deliver consistent, high quality patient centred services due to not having the right people, with the right skills and knowledge, in the right place, at the right time.

Existing Control Measures	
• Workforce KPIs tracked through the corporate report and divisional dashboards	• Bi-monthly Divisional Performance Meetings.
• Mandatory training fully reviewed in 2017, with a new system of reporting linked to competencies on ESR; enabling better quality reporting.	• Mandatory training mapped to Core Skills Framework. Online portal enables all staff to see their compliance on their chosen IT device.
• Permanent nurse staffing pool	• HR Workforce Policies
• Attendance management process to reduce short & long term absence	• Wellbeing Steering Group established
• Large-scale nurse recruitment event 4 times per year	• Training Needs Analysis linked to CPD requirements
• Apprenticeship Strategy implemented	• Engaged in pre-employment programmes with local job centres to support supply routes
• Engagement with HEENW in support of new role development	• People Strategy

Assurance Evidence	Gaps in Controls/Assurance
Regular reporting of delivery against compliance targets via corporate & divisional reports Monthly reporting to the Board via the Corporate Report Reporting at ward level which supports Ward to Board Reporting to HEE People Strategy report monthly to Board Programme Board reporting	Not meeting compliance target in relation to mandatory training in some areas Sickness Absence levels higher than target. Lack of standard methodology to workforce planning across the organisation

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Continue with regular reporting of data target hotspot areas and staff groups review methodology of accessing training	
Action plan developed in conjunction with NHSI to support the reduction of sickness absence across the organisation. Target is 4% absence rates across the organisation.	
Development of a methodology to roll-out across the organisation. Plan for a workforce summit in June/July 2019	

Executive Lead's Assessment
MAY 2019: all actions on track.

Board Assurance Framework 2019-20

BAF 2.2	**Strategic Objective:** The Best People Doing Their Best Work	Risk Title: Staff Engagement	
Related CQC Themes: Safe, Effective, Responsive, Well Led			
Exec Lead: Melissa Swindell	**Type:** Internal, Known	Current IxL: 3-3	Target IxL: 3-1	Trend: STATIC

Risk Description
Failure to improve workforce engagement which impacts upon operational performance and achievement of strategic aims.

Existing Control Measures	
• People Strategy	• Wellbeing Strategy implementation
• Action Plans for Staff Survey	• Values and Behaviours Framework
• Staff Temperature Check Reports to Board (quarterly)	• Values based PDR process
• People Strategy Reports to Board (monthly)	• Listening into Action Guidance and Programme of work
• Staff surveys analysed and followed up (shows improvement)	• Reward and recognition schemes in place: Annual Awards, Star of the Month and quarterly Long Service Recognition Event, Annual Fab Staff Change Week.
•	• BME and Disability Staff Networks
• LGBTQI+ Network launched December 2019	

Assurance Evidence	Gaps in Controls/Assurance
Monthly People Strategy Report to Board Outcomes from Annual Staff Survey reported to the Board. Staff Survey local departmental conversations PDR completion rates Values and Behaviours Framework Quarterly Engagement Temperature Check reported to the Board. Quarterly Engagement Temperature Check local data sent to Divisions on a quarterly basis to enable them to analyse data locally. Ongoing consultation and information sharing with staff side and LNC Progress reports from LiA to Board Wellbeing Strategy progress reported to WOD Board/sub-Board Committee minutes Minutes of Staff Networks Engagement through Editorial Board leadership for Alder Hey Life	Internal Communications Strategy and Plan Refreshed Leadership Strategy

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Brand paper taken to March Ops Board and detailed implementation now under way	
High level leadership strategy has been approved; the plan will be rolled out during 19/20	

Executive Lead's Assessment
MAY 2019: All actions on track. Staff Survey Big conversations underway.

Board Assurance Framework 2019-20

BAF 2.3	**Strategic Objective:** The Best People Doing Their Best Work	Risk Title: Workforce Equality, Diversity & Inclusion	
Related CQC Themes: Well Led, Effective			
Exec Lead: Melissa Swindell	**Type:** Internal, Known	Current IxL: 3-4 / Target IxL: 3-1	Trend: STATIC

Risk Description
Failure to proactively develop a future workforce that reflects the diversity of the local population, and provide equal opportunities for career development and growth for existing staff.

Existing Control Measures	
• Wellbeing Strategy	• WOD Committee ToR includes duties around diversity and inclusion, and requirements for regular reporting.
• Wellbeing Steering Group	• Staff Survey results analysed by protected characteristics and actions taken by E&D Lead.
• HR Workforce Policies	• Equality Analysis Policy
• Equality, Diversity & Human Rights Policy	• BME Network established, sponsored by Director of HR & OD
• Disability Network established, sponsored by Director of HR & OD	• Actions taken in response to the WRES
• Action plan specifically in response to increasing the diversity of the workforce, and improving the experience of BME staff who work at Alder Hey	• LGBTQ+ Network established
•	•

Assurance Evidence	Gaps in Controls/Assurance
Monthly recruitment reports provided by HR to divisions Diversity and Inclusion Action Plan reported to Board Bi-monthly reporting to Board via WOD on diversity and inclusion issues Monthly Corporate Report (including workforce KPIs) to the Board Taking forward actions for LiA - enabling achievement of a more inclusive culture Equality Impact Assessments undertaken for every policy & project Workforce Race Equality Standards EDS Publication Equality Objectives	Workforce not representative of the local community BME and disabled staff reporting lower levels of satisfaction in the Staff Survey than non-BME other staff

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Work with the BME and Disability Networks to develop specific action plans to improve experience.	
Work with Community Engagement expert to develop actions to work with local community	

Executive Lead's Assessment
MAY 2019: all actions on track

Board Assurance Framework 2019-20

BAF 3.1	Strategic Objective: Sustainability Through External Partnerships		Risk Title: Failure to fully realise the Trust's Vision for the Park		
Related CQC Themes: Responsive, Well Led					
Exec Lead: David Powell		Type: Internal, Known	Current IxL: 3-3	Target IxL: 3-2	Trend: STATIC

Risk Description

Failure to fully realise the Trust's vision for the Park and campus, in partnership with the local community and other key stakeholders as a legacy for future generations

Existing Control Measures

• Business Cases developed for various elements of the Park & Campus	• Monitoring reports on progress
• Heads of Terms agreed with LCC for joint venture approved	• Redevelopment Steering Group
• Monthly reports to Board & RABD	

Assurance Evidence	Gaps in Controls/Assurance
Approved Business Cases for various elements of the Park & Campus approved Every Project has a dedicated Project Manager assigned to it End user consultation events held Highlight reports to relevant assurance committees and through to Board Stakeholder events held/reported back to Trust Board Representation at Friends of Springfield Park Group Monthly Board report	Fully reconciled budget with Plan. Risk quantification around the development projects.

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Secure approval for plans to increase Park footprint	Planning for Park extension submitted 31/07/2018
Approval of Business Case at LCC / Discuss park Heads of Terms with LCC	On hold-Dependent upon residential scheme (revised target date no April 2018)
Prepare and submit planning application	Complete
Procure works for stage 1 park reinstatement	
Complete cost plan for final park works	

Executive Lead's Assessment

March 2019- interaction events with the public continue and engagement with local residents. More positive feedback on revised plans shared with them
APR 2019: Planning application is with Council and consultations being held with the public.
MAY 2019: Park planning application in consultation

Board Assurance Framework 2019-20

BAF 3.2	**Strategic Objective:** Sustainability Through External Partnerships	Risk Title: Service sustainability and Growth.	
Related CQC Themes: Caring, Effective, Responsive, Safe, Well Led			
Exec Lead: Dani Jones	**Type:** External, Known	Current IxL: 4-3 / Target IxL: 4-2	Trend: STATIC

Risk Description

Risk to service sustainability development/growth; due to NHS financial environment and constraints on internal infrastructure to deliver business as usual as well as maximise growth opportunities. External opportunities for partnership, and/or to reduce variation in Children & Young People's services (across the city and beyond) may not be fully optimised.

Existing Control Measures

• Divisional Performance Management Framework.	• Clear trajectories for challenged specialities to deliver.
• Accreditations confirmed through national review processes	• Change Programme Projects (Strategic Partnerships & International Clinical Business and non NHS Patient Services)
• Five year plan agreed by Board and Governors in 2014	• Compliance with All Age ACHD Standard
• Service development strategy including Private / International patient proposal approved by Council of Governors as part of strategic plan sign off (March 18, September 18)	• Capacity Plan identifies beds and theatres required to deliver BD plan
• Weekly meeting with divisions established to review forward look re elective and day case patient bookings to ensure activity scheduled meets contract requirements	• Growth and sustainability through external partnerships is a key theme in the Change Programme.
• Internal review of service specifications as part of Specialist Commissioning review	• Gap / risk analysis against all draft national service specification undertaken and action plans developed
• Compliance with Neonatal Standards	• Post Implementation review of Trauma Business Case
• Alder Hey leading the partnership development of the future model of Paediatric Urgent Care in Liverpool	• Change Programme - 7 Day Working Project

Assurance Evidence	Gaps in Controls/Assurance
Business Development Plan reviewed monthly by RBDC via Contract Monitoring Report. Daily activity tracker and forecast monitoring performance for all activity. CIPs in new Change Programme subject to assurance and sub-committee performance management. Clinical Network Partnership development with Manchester Children's Hospital. Key developments monitored through Divisions Monitored at refreshed 'Sustainability Through External Partnerships Steering Group' (proposal to develop this during Q2 2019 into Strategy & Ops Delivery Board - to maximise alignment to the strategy and delivery agendas). Monthly to Board via RABD and Board. Compliance with final national specifications. Single Neonatal Services Business Case approved by NHS England. Growth through Partnerships included in Strategic Business planning - both annual operational plan and developing long term plan. ACHD Level 1 service now up and running; developing wider all-age network to support - agreement reached to host at Alder Hey.	Ability to respond swiftly to potential problems. Workforce constraints in specialised services. Early warning indicators for leading indicators. Inability to recruit to highly specialist roles due to skill shortages nationally. Trust has sought derogation in a number of service areas where it does not meet certain standards and is progressing actions to ensure compliance by due date. Potential elective underperformance due to cancelled sessions.

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Strengthening the paediatric workforce	6 monthly audit of 7-day standards is subject to external scrutiny. Global Digital Excellence has improved measurement capability. Adrian Hughes is now leading as one of the top 5 Operational Priorities known as 'New Models of Care'. In addition, junior doctor numbers were bolstered during the winter which improved cover and consultant arrangements.

Executive Lead's Assessment

APR 2019: Agreement reached for Alder Hey to host the expanded all-age ACHD network; plans underway with Level 1 partners to shape.
Alder Hey maintain senior presence at every stage of Liverpool's System Capability Programme; final session scheduled for 15th May, expectation that agreed 'One Liverpool' programme of work retains existing links with Children's Transformation Plan.

MAY 19: Single Neonatal Service: progressing to appoint joint leadership and nursing roles and ensuring SLA's are in place to allow staff to work across both sites. Manchester: continued work to develop shared plans for cardio, neuro and burns; joint agenda agreed for next partnership board 4th June 19. International: Healthcare UK workshops during May/June, culminating in strategy document July 19.

Board Assurance Framework 2019-20

BAF 3.4	Strategic Objective: Sustainability Through External Partnerships	Risk Title: Financial Environment		
Related CQC Themes: Safe, Effective, Responsive, Well Led				
Exec Lead: John Grinnell	Type: Internal, Known	Current IxL: 4-4	Target IxL: 4-4	Trend: STATIC

Risk Description

Failure to deliver Trust control total and affordability of Trust Capital requirements.

Existing Control Measures

• Organisation-wide financial plan.	• NHSi financial regime and Use of Resources risk rating.
• Financial systems, budgetary control and financial reporting processes.	• Capital Planning Review Group
• Monthly performance review meetings with Divisional Clinical/Management Team and the Executive	• Financial Position (subject to regular monitoring).
• Weekly meeting with divisions to review forward look bookings for elective and day case procedures to ensure activity booked meets contract and recovery plans. Also review of status of outpatient slot utilisation	• Weekly Sustainability Delivery Group overseeing efficiency programme
• CIP subject to programme assessment and sub-committee performance management	• RABD deep dive into key financial risk areas at every meeting

Assurance Evidence	Gaps in Controls/Assurance
Monthly Corporate Performance Report presented to both Board and the RABD. Specific Reports (i.e. NHSI Plan Review by RABD) Monthly Performance Management Reporting with General Managers. Internal and External Audit reporting through Audit Committee. Daily activity tracker to support divisional performance management of activity delivery Pay cost control 10 point plan introduced aimed at forecasting and tracking actions to reduce pay cost overspend run rate - updates to Execs, R&BD. Full electronic access to budgets & specialty performance results Weekly Financial Sustainability delivery meeting papers Board 2 Board with Spec comm High Impact changes amalgamated into Programme Delivery Board 5 Year capital plan to be ratified by Trust Board	Divisions improved financial control and effective recovery required in identified where slippage against agreed recovery trajectories occurring Ongoing cost of temporary staff Divisional recovery plans to hit yearend financial control targets to ensure delivery of overall Trust financial plan. 'Grip' on CIP CIP Position improved however Divisional forecasts still showing a potential £1.6m gap

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Tracking actions from Sustainability Delivery Group	on target
Develop fully worked up CIP programme - £2.7m gap	Reviewed at financial sustainability group 2.7.18 Further work to take place as part of Q1 review and in July. Review again at expected completion date
5 Year capital plan	

Executive Lead's Assessment

APRIL 19 - year end surplus target achieved which included strong end of year performance from divisions, end of year contract agreements and two material transactions relating to the agreed land sale and PFO contractual reset. Alongside PSF incentive and bonus culminated in 49.9m surplus (pre audited accounts). Focus now on underlying position for 19/20 that without PSF see us remain in underlying deficit. Work to be done to bridge CIP gap (currently £2+m.)
MAY 2019: Month 1 19/20 delivered a £0.4m adverse variance. Total run rate risk including CIP risk is £8m which is being mitigated through robust forward look and CiP planning exercise. Longer term risks include HRGv4+ Children's Tariff risk which transitions to £7m downside per annum. Capital 5 year planning exercise underway and will conclude in Q2, latest forecast present a cash affordability concern that is being validated.

Board Assurance Framework 2019-20

BAF 4.1	**Strategic Objective:** Game-Changing Research And Innovation	Risk Title: Research, Education & Innovation	
Related CQC Themes: Responsive, Well Led			
Exec Lead: David Powell	**Type:** Internal, Known	Current IxL: 3-3	Target IxL: 3-2
		Trend: STATIC	

Risk Description	
Failure to exploit new opportunities in research, innovation & education due to incomplete management systems.	
Existing Control Measures	
• Establishment of RIE Board Sub-committee	• Steering Board reporting through to Trust Board
• RABD review of contractual arrangements	• Programme assurance via regular Programme Board scrutiny
• Digital Exemplar budget completed and reconciled	• Innovation Co budget in place
Assurance Evidence	**Gaps in Controls/Assurance**
Research Strategy Committee set up as a new Board Assurance Committee Research, Education and Innovation Committee established Secured ERDF funding for Innovation Team Innovation Board established	Sporadic meetings of RIE committee Governance structure for Innovation Board to be agreed Re-energise Research governance processes Reporting frameworks and standards for all services to be agreed/harmonised
Actions Required to Reduce Risk to Target Rating	**Latest Progress on Actions**
Develop a robust Academy Business Model	Framework refresh
Agree incentivisation framework for staff and teams	
	Draft contract shared with University

Executive Lead's Assessment
Feb 2019: Funding strategy review APR 2019: Occupation of building almost complete MAY 2019: Considering structure and relationship between innovation and research

Board Assurance Framework 2019-20

BAF 4.2	**Strategic Objective:** Game-Changing Research And Innovation	Risk Title: IT Strategic Development.	
Related CQC Themes: Safe, Caring, Effective, Responsive, Well Led			
Exec Lead: Kate Warriner	**Type:** Internal, Known	Current IxL: 3-3	Target IxL: 3-2	Trend: STATIC

Risk Description

Failure to deliver a Digital Strategy which will place Alder Hey at the forefront of technological advancement in paediatric healthcare

Existing Control Measures

• Key projects and progress tracked through the GDE Programme Board and RABD Committee	• Clinical Systems Informatics Project Group leading on stakeholder engagement - ad hoc groups on specific key topics as needed
• Forward Communications plan agreed and tracked at steering group.	• Board approval "Asset Owner" process in place to ensure organisational ownership of systems and system development
• Improvement scheduled training provision including refresher training and workshops to address data quality issues	• Formal change control processes now in place
• Executive level CIO in place	• Monthly update to Trust Board on digital developments
• GDE Programme Board in place & fully resourced - Chaired by Medical Director	• Clinical and Divisional Engagement in Digital Strategy
• NHSE & NHS Digital external oversight of GDE programme	• Resilience of underlying infrastructure
• A plan is now in place to develop new strategy and roadmap to present to Board in Summer 2019	• Integration with divisions needs strengthening

Assurance Evidence	Gaps in Controls/Assurance
Regular progress reports presented to RABD & Trust Board MIAA providing assurance role Board agreed change process Participate in Digital Alder Hey programme Internal Audit Reviews NHSD tracking of GDE Programme GDE Programme Board tracking delivery - Chaired by MD Implementation of fortnightly huddle with divisions	IM&T Strategy out of date - update work in progress to produce digital strategy for Summer 2019 Resilience of underlying infrastructure - options appraisal for disaster recovery to be undertaken IT operating model assessment underway

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Replacement equipment procured - equipment is now installed however delay in ensuring appropriate electrical back up in place which is being rectified. Awaiting final solution on electrical supply.	Equipment installed. Further risks in terms of disaster recovery identified. Options appraisal to be undertaken.
Digital Strategy & operating model work to be concluded	Good progress on digital strategy, on track to take to board in July. Operating Model baseline assessment undertaken.

Executive Lead's Assessment

MAR 19: Progress is being maintained. Clinical leads interviews have taken place and offers being formalised
APR 19: New CIO in post, Digital Strategy & operating model in development. Strategy due for July Trust Board.
MAY 2019: Strategy on track for July Trust Board. Options appraisal with regards to resilience of key systems to be undertaken as integral part of technology roadmap.

Board of Directors

28th May 2019

Report of:	Director of Human Resources & Organisational Development
Paper Prepared by:	Director of Human Resources & Organisational Development
Subject/Title:	People Strategy Update for April 2019
Background Papers:	
Purpose of Paper:	To present to the Board monthly update of activity for noting and/or discussion.
Action/Decision Required:	none
Link to: **Trust's Strategic Direction Strategic Objectives**	The Best People Doing their Best Work
Resource Impact:	None

1. Staff Engagement

Reward & Recognition

The current focus of the Reward and Recognition group is on arranging a large scale/high profile summer event, bringing together staff and the local community on the Alder Hey and Springfield Park site. It is anticipated that this will be a music event following the similar theme as the Fab week, collecting Pledges based on “Inspiring quality” events incorporating stalls with discounts for staff and various staff assistance pods around the trust offering various services.

Staff Survey

All divisional and departmental breakdowns of the staff survey results have been distributed to the relevant heads to support them with facilitating ‘Big Conversations’ with their staff, with support provided by HR & OD if required.

A Trust wide action plan has also been developed and was discussed at Board in April 2019.

Improving Staff Wellbeing

The importance of staff health and wellbeing is widely recognised and as an employer we aim to champion physical, mental, emotional and financial wellbeing of everyone working in the organisation. The HR Team and Trust wellbeing group are developing the provision of tools, resources and support to ensure that staff health and wellbeing is a priority. In doing so we will see continued improvements in performance, patient experience and quality of patient care through improved staff engagement. Numerous initiatives have been adopted, to support the promotion and championing of health and wellbeing across the organisation. This includes committing to the Time to Change pledge and changing how we think and talk about mental health and empowering staff to challenge stigma and share their story. The Trust has developed a time to change action plan which has was approved by the Time to Change team in May 2019. In addition we are also working in conjunction with NHS Improvement and have developed a Health and Wellbeing action plan which details the strategies, initiatives and milestones required to help improve health and wellbeing.

Brexit- EU Settlement Scheme

In April we held a breakfast session held to support staff with information and guidance in applying for the EU settlement scheme, this was supported by the HR department and executive support. The HR department continue to be contact with

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

2. Workforce Sustainability and Capability

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

Implementation of the transitioning of band 1 staff to band 2 is progressing. HR continues to work in partnership with staff side colleagues to ensure a smooth transition for those staff affected.

To date 114 staff has transitioned from Band 1 to Band 2. Band 1 staff will also receive a one of non-consolidated lump sum payment of £194 (pro-rata) in April's pay, in accordance with the National Terms and Conditions of Service.

Education, Learning and Development

Apprenticeships-

Two new Tutors have joined the HR & OD Team, to deliver internal provision in the following apprenticeships; Healthcare Support Services Level 2, Team Leader Level 2 and Customer Service Level 2. Internal Delivery will commence in June 2019.

Ofsed Inspectors are due to visit the Trust for an unannounced monitoring visit.

Meetings have taken place with the Head of Nurse Education to discuss clear pathways for HCAs and are supporting a process to identify staff that need upskilling with English and maths and an Apprenticeship in Healthcare.

Mandatory Training- Mandatory training figures have increased slightly to 90% for Core Mandatory Training, reaching our Trust Target. Overall Mandatory training has increased to 88%. From May onwards it has been agreed to cease reporting of Core Mandatory Training and instead focus on Overall Mandatory Training figure to reduce any confusion surrounding our current compliance rates.

The key outlier in terms of low compliance continues to be Information Governance, although it has increased substantially over the last month, now at 75%. The Learning and Development team are continuing to work with the IG lead to identify ways to improve compliance for this topic over the coming months.

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

3. Employee Relations

Employee Consultations

Organisational Change

Portering

Following a meeting with trade unions, arrangements were made to meet with key affected individuals during early March 2019 with a view to progressing along the basis of the alternative proposals. Further discussions have now taken place with the portering team in May 2019 and management are clarifying a number of points to respond to the portering team and their representatives with a view of concluding negotiations during June 2019.

Emergency Department Reception team

An organisational change consultation to review the shift rotas within the reception team, has now concluded, following good engagement from the reception team with a number of suggestions for alternative arrangements having been considered by management, some of which was included within the final rota. New shift patterns have now been created from June 2019 with some individual discussions taking place.

Day Case Theatres

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

In order to support these changes the SDC and SAL services will need to review the current shift patterns across both teams. The current arrangements are not currently

conducive to supporting a batched admission process and a dynamic nursing model is required that enables the service to provide safe, effective quality care and enhance patient experience.

Catering Department

A number of staff briefing sessions were conducted on 14th March 2019 to launch the proposed organisational change within the dept. The proposed changes affect the rotas of the Catering Assistants, Chefs and Supervisors. This is following recommendations made from an external catering review.

The 30 day formal consultation process has now passed, but an extension has been agreed with staffside in order to complete all the 1:1's with staff. 3 Group consultation meetings have now taken place and all but 6 of the 1:1's have also taken place. Chefs have submitted a counter proposal regarding the rota and feedback has been given. The Dept is currently working towards an implementation date of 1st July 2019.

Employee Relations Activity

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

Row Labels	Number of Cases
Corporate	**4**
Disciplinary	1
Harassment	3
Surgery	**10**
Disciplinary	4
Grievance	4
Harassment	2
Community	**3**
Capability No UHR	1
Disciplinary	2
Medicine	**2**
Disciplinary	2
Grand Total	19

Employment Tribunal Cases

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

The Trust has also received a notification of 2 ET cases.

4. Corporate Report

The HR KPIs in the April Corporate Report are:

- Sickness rates have a further decrease for the third month consecutively from 5.47 to **5.31%**
- The Rolling 12 month sickness figure has increased slightly to 5.43% to **5.69%**
- Core Mandatory training compliance is at Trust target of **90.03%**
- First month of the PDR window shows compliance for end April at **5%**

ANNEX A

WORKFORCE & OD COMMITTEE
MINUTES FROM MEETING
1ST MARCH 2019

Present:	Ms C Dove	Non-Executive Director (Chair)	(CD)
	Mrs M Swindell	Director of HR & OD	(MKS)
	Mr M Flannagan	Director of Communications & Marketing	(MF)
	Mrs J France-Hayhurst	Non-Executive Director	(JFH)
In Attendance:	Mrs P Brown	Director of Nursing	(PB)
	Ms A Chew	Associate FD – Operational Finance (Part)	(AC)
	Ms N Deakin	Change Programme Manager	(ND)
	Mr N Davies	HR Business Partner (Part attendance)	(ND)
	Mrs S Owen	Deputy Director of HR&OD	(SO)
	Mrs K Turner	Trust LiA Lead	(KT)
	Mr A McColl	Associate COO	(AMc)
	Ms E White	Care Pathways, Policies & Guidance Manager	(EW)
	Mr D Shaw	Learning & Development Manager	(DS)
	Mrs V Shannon	Patient Experience & Quality Lead (Part Attendance)	(VS)
	Ms A Doyle	Volunteer & Patient Experience Admin.(Part Attendance)	(AD)
	Ms L Cooper	Director of Children & Young People	(LC)
	Mrs N Murdock	Medical Director	(NM)
Apologies:	Mrs D Brannigan	Patient Governor (Parent & Carer)	(DB)
	Mr J Gibson	Programme Assurance Manager	(JG)
	Mr T Johnson	Staff Side Chair	(TJ)
	Mr A Bateman	Chief Operating Officer	(AB)
	Mrs H Gwilliams	Chief Nurse	(HG)
	Mr A Hughes	Joint Interim Medical Director	(AJ)
	Mr P OConnor	Deputy Director of Nursing	(POC)
	Mrs A Kinsella	Health & Safety Manager	(AK)
	Mr I Quinlan	Non-Executive Director	(IQ)
	Mrs H Ainsworth	Equality & Diversity Manager	(HA)

Agenda Item	Key Discussion Points	Action	Owner	Timescale
19/14 **Minutes of the Previous Meeting & Meeting Protocol**	The Committee considered the minutes of the meeting held on 23rd January 2019 and they were approved as an accurate record. Introductions were made to the Committee.			
19/15	**Corporate Induction** The Learning & Development Manager gave a brief verbal update on the latest development to support Corporate Induction processes at the Trust. The focus over			

Agenda Item	Key Discussion Points	Action	Owner	Timescale
	the last 12 months has been to evaluate processes (i.e. presentations given to staff) for corporate induction supported by local induction to improve the quality of methods in place (inclusion of Trust Values and Inspiring Quality). DS acknowledged that it was all about welcoming new staff to the Trust in the first few weeks of joining the Trust and welcomed feedback from the Committee around processes and the practice of encouraging new recruits to attend corporate and local inductions on the first day where possible. LC made an observation that a video about children and young people could be incorporated as this would set the tone/feel for the organisation and agreed it would be beneficial for inductions to commence on the first day. NM acknowledged the challenge faced by clinicians to commence employment on a particular date of the month (i.e. 1st day of the month). The Committee recognised the benefits, but acknowledged the flip side being that following the recruitment process/notice periods – the possibility of a further delay being incurred due to waiting for the next corporate induction to commence before joining the Trust. Other observations raised by the Committee were that the 'game' was very good, but may be better placed taking place following lunch break. NM suggested Corporate and local inductions take place twice a month. DS advised that changes have been put in place to accommodate further dates for nursing inductions and work continues to develop processes. The Committee **noted** the progress made.			
19/16	**Review Terms of Reference** The Committee received the updated terms of reference, it was agreed to include LGBTIQ Network as group reporting to WOD Committee. The Committee approved the terms of reference.			
19/17	**Review of Reporting Timetable for 2019-2020** The Committee received an updated Reporting Timetable for consideration. MKS advised that the reporting timetable is normally accompanied by the Committee's annual report for sign-off. This report will be issued virtually to the Committee for approval. MKS suggested the Committee would benefit from receiving the regular update for Marketing & Communication that is presented at RABD. MF agreed to present to the Committee an Activity Report for Marketing & Communications.	Virtually issue the Annual Report to the Committee for approval Present a regular Marketing & Communications Activity Report to the Committee	MKS MF	Virtually April 2019

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Agenda Item	Key Discussion Points	Action	Owner	Timescale
	The Committee **approved** the content of the Reporting Timetable for 2019-20 subject to inclusion update discussed by the Committee.			
19/18 **Matters Arising, Actions**	The Committee considered the following under matters arising: **18/49 – NHSI Health & Wellbeing Improvement Programme Update** Sickness data availability for CommCell – SO confirmed this item will be delivered to the Committee on 24th April 2019. CD confirmed that sickness costs are monetised at RABD Committee.			
19/19 **Programme Assurance 'The Best People Doing Their Best Work'**	**Programme Assurance Framework – February 2019** The Committee received a regular summary prepared by the Executive Sponsors of the Assurance Framework, External Programme Assessor and Assurance Team. The purpose of this assurance framework is to ensure the monitoring of robust processes for progression. All papers supporting Programme Assurance for the work stream 'The Best People Doing Their Best Work' is recorded as read prior to the meeting. ND gave a brief summary of the current dashboard. The Apprenticeship Project continues to be managed to a high standard of project management with consistently strong evidence available on the SharePoint site. The Catering Project that recently moved under The Best People doing their Best Work programme displays overall a good standard of assurance evidence. Improving Portering Services Project now requires a thorough review which should include charting the course of the project through this year and to its eventual closure. MKS advised that the Portering Review has been a complex/interesting journey, with multiple Trade Union involvement. Jo Potier – Psychologist Consultant has supported the team and we are reaching a point where we can see a close to this project. CD asked MKS to review diversity in relation to the apprenticeship scheme. The Committee **noted** the comments made.			
19/20 Progress against the People Strategy	**Staff Survey Update** The Committee received the Staff Survey Benchmark Report and the Directorate Report for Alder Hey; the reports are noted as read. MKS advised that the results have been published here and nationally and communications to the Trust are to be progressed. MKS added that the headlines are looking good for the Trust; the format of the Benchmark report has changed and focusses on 10 different areas. The report sees Alder Hey showing significant improvement in 4 of the different areas and sees improvement with the rest. DS is currently focussing on drilling			

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Agenda Item	Key Discussion Points	Action	Owner	Timescale
	down into the information provided (5 key themes) in relation to weighted comparators. MKS acknowledged that finally the Trust is going in the right direction for the Staff Survey. CD added that now we are on the right trajectory we need to keep in mind the Trust staff appraisals system to support improvements for the next Staff Survey The Committee **noted** the progress made.			
19/21	**'Temperature Checks' Review** The Committee received a report prepared by the Learning and Development Manager. The purpose of the report is to update the Committee on the planned implementation of new processes to support the new questionnaires issued to staff. The report is noted as read. DS outlined the background, challenge and proposed solution, with the planned re-alignment of Temperature Check questions to the Staff Survey questions to support meaningful data/metrics. This will enable the Trust to identify trends as well as predict our expected direction of travel for the Staff Survey. Also being explored is a second metric around 'Psychological Safety which has been proven to link heavily into Mental Health at work by the World Mental Health Organisation. Identified in the report are the fifteen questions around engagement and Psychological Safety Culture. Based on these questions it is proposed to run the temperature checks quarterly and demographically issued to staff for completion. Working closely with the Clinical Audit Team it is planned to ensure the new questionnaire and process is embedded for the 1st April 2019 to ensure the Trust is able to utilise the new process for the coming year in full and have the first set of data available for July 2019. Each member of staff will receive 1 set of questions each year. The Committee discussed the content of the questions and a number suggestions/observations were made highlights are: • AMc referred to the 'Psychological Safety Culture' questions – the 4th question 'It is completely safe to take a risk on this team', suggested that there a number of ways you could read that question dependant on various roles and departments. • PB referred to the 'Engagement' questions and observed that care of patients do not feature in the questionnaire until the 7th question. • AMc referred to the 'Engagement' and suggested that questions could be asked by management face to face at team meetings rather than by formal questionnaire. AMc also recognised that the possibility of using volunteers to ask questions face to face – as they neutral/independent of the Trust may be more productive. • KT referred to 'Pulse Checks' concept (progressed via LiA – face to face			

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Agenda Item	Key Discussion Points	Action	Owner	Timescale
	questions) and advised that she had been working with DS and Psychologist to progress. The Committee acknowledged that overall the questions were good and in plain English and were happy to support the planned implementation of the 'Temperature Check Questionnaire' with a caveat of inclusion of the above suggestions. The Committee **approved** the Temperature Check Review.			
19/22	**Mandatory Training Update – February 2019** The Committee received a report prepared by the Learning & Development Manager. The purpose of the report is to outline areas of focus to achieve the Trust target for compliance with all mandatory training subjects of 90%. The report was noted as read. DS advised that as of 20th February 2019 Core Mandatory Training is currently at 89%, with overall Mandatory Training compliance which includes core training and role specific mandatory requirements currently at 87%. DS went on to outline the work to improve compliance across a range of topics that dropped in August 2018 due to the expiry of the 'Big Move Workbook' as outlined in the report. All these areas with the exception of Information Governance have improved considerably within this period and now comfortably above the target of 90%. Information Governance compliance is currently the main area of concern within Mandatory Training, impacted by a change in the Toolkit and the removal of training via workbook due to the requirement for training to be assessed as the workbook would not meet the requirements. The Committee recognised that Junior Doctors where not employed by the Trust and that induction statistics for this group has not been included in this report. The Committee **noted** the progress made.			
19/23	**Volunteering Update** The Committee received a presentation delivered by the Patient Experience/Quality Lead and the Volunteer & Patient Experience Co-ordinator. VS & AD thanked the Committee for inviting them to join the meeting. The purpose of the presentation is to give the Committee an overview of the developments/initiatives that have taken place and the long term plans for our volunteering staff. Particular attention was brought to the volunteer metrics and the Committee noted there were currently 500 active volunteers, with an extremely robust volunteer programme in place at the Trust. Following the Prime Ministers visit in January and the launch of the NHS Long Term Plan, a Help force programme to support volunteers across the country has been set up by NHS England with at least £2.3 million funding put in place. The aim at the Trust is to see the numbers of volunteers increase from 500-1000 by 2021. As outlined in the presentation AD went on to summarise the following –			

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Agenda Item	Key Discussion Points	Action	Owner	Timescale
	volunteering achievements; vision for the future; areas at the Trust currently supported by our volunteers; volunteering impact and future plans. A number of questions were raised by the Committee and responses received. The Committee recognised that volunteers can apply for jobs at the Trust if they have volunteered at the Trust for 6 months (i.e. at least 100 hours). The volunteers currently work between the hours of 8am-8pm and weekends, support by concierge is in place out of office hours. Currently volunteers have their own welcome event, DS and VS have had conversations around linking the volunteers into the Corporate Induction. VS advised that they are also reviewing ways of how to keep staff informed as to what is available i.e. a slot on corporate induction; inclusion of volunteers in 'Alder Hey Life'. The Committee also discussed the possibility of Trust staff volunteering in the community and it was acknowledged you would need to find the right project to support a strong volunteer culture. The Committee pointed out that volunteering has really been transformed. CD recognised the hard work the volunteers did at the Trust and congratulated the team on receiving the staff award for volunteer of the year at the recent Alder Hey Stars event. The Committee **noted** the progress made.			
19/24	**Workforce EDI Objectives 2018-2021** The Committee received the EDI Objectives prepared by the Equality & Diversity Manager. In the absence of the E&D Manager, MKS advised of the content for approval, prior to publishing on our websites. Particular attention was brought to the following objectives: Objective number 4, 'Resource an involve staff networks to provide a collective voice for staff with protected characteristics' with an additional Network established (LGBTIQ + Network) and the actions and measures in place to support that objective. An additional objective number 6 has been added, 'Minimise the Gender Pay Gap' – this will look to see year on year increases in the number of medics applying for CEA's and receiving CEA's to reduce the gender pay gap. CD encouraged more positive actions to support workforce balance. The Committee **approved** the objectives.			
19/25	**Gender Pay Gap Report 2018** The Committee received the Gender Pay Gap report prepared by the Equality & Diversity Manager. This is the 2nd Trust Gender Pay Gap report produced to meet the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 which came into force on 31st March 2017.			

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Agenda Item	Key Discussion Points	Action	Owner	Timescale
	The purpose of the report is to outline the findings and recommendations and seek the Committee's approval, prior to presenting to Trust Board. This is in readiness for publication on the Trust and government website by the deadline of 30th March 2019. In the absence of the E&D Manager, MKS outlined the legislation requirements around timescale for publication. The legislation requires the Trust to publish figures using mandatory calculations (six calculations) using a specific reference date. The Committee noted the importance of recognising that the gender pay gap differs to equal pay. Equal pay is in relation to pay differences between men and woman who carry out the same job for different pay, which is unlawful. The gender pay gap shows the difference in average pay of all men and the average pay of all women employed by the Trust. It is therefore possible to have genuine pay equality but still have a gender pay gap. As outlined in the report steps to reduce gender pay gap will be incorporated into the Trust Workforce Equality Objectives and monitored by this Committee on a quarterly basis. The specific objective for 2019 will be to 'support all females, including part-time female medical and dental staff, to apply for Clinical Excellence Awards'. CD raised a question about the Trust position in relation to modern slavery. MKS to pick this up. The Committee **noted** the content of the report.			
19/26	**Review of Exit Process** The Committee received a report prepared by Deputy Director of HR&OD. The purpose of the report is to advise of the progress made to support the introduction of a revised exit process to help identify trends of why employees leave the Trust. Any issues identified can then be addressed and improvements can be made to reduce turnover and increase retention. SO outlined the action taken, with a review of how we currently capture exit information. All employees and managers currently access ESR to record and manage HR and employment data; therefore it seemed like an appropriate solution to explore this functionality, as ESR also offers a suite of standard reports which also includes a standard exit questionnaire dashboard. To signpost employees to the exit questionnaire within ESR Self Service, a leaver's acknowledgement notification has been produced which will be emailed to the employee leaving at the point the leavers notice is being processed by Employment Services Team. The employee's line manager will also receive a copy of the acknowledgement email sent to ensure they are aware of the exit process. Support by HRBP's and managers/advisors are also advising managers of the new process. As outlined in the report it is important that the data provided from the exit			

Agenda Item	Key Discussion Points	Action	Owner	Timescale
	questionnaires is reviewed regularly. As part of the new process a monthly report will be extracted by the ESR team which will be sent to the HR team for their information. The HR team will then review the report and ensure any issues are identified. This report will be produced as part of the workforce reporting cycle from March 2019 and may be reviewed following a 3 month period to ensure the reports being received produce tangible information. KT advised in terms of the acknowledgement notification – inclusion of a reference that staff have the option to speak to the freedom to speak up champion to support exit interview processes should be included (paragraph 2). SO and KT to pick up outside of meeting. The Committee **noted** the progress made.			
19/27 **Key Workforce Risks – Review of top Workforce Risks action planning against most significant risks**	**Board Assurance Framework – January 2019** The Committee received a regular (BAF) report under the Strategic Objective 'The Best People Doing Their Best Work' for January 2018. The report is noted as read, with no questions raised. CD suggested that a review take place into how long the risks have been included in the BAF report. The Committee **noted** the content of the Board Assurance Framework.			
19/28	**Key Workforce Risks KPIs – January 2019** The Committee received a regular report prepared by the Deputy Director of HR concerning the key risks relating to workforce monitoring for January 2019. The purpose of the report is to update on key targets/measures and advise of actions to support improvement. The report is noted as read. Key headlines are: SO advised that overall, sickness has reduced from December but there has been a slight increase in short term sicknesses. This can be attributed to the Winter season and is reflected in the increase in cough, cold and flu absences. Action plans are in place for significant absence. In addition a full review of all absences has been undertaken with individual action plans in place. Monthly temporary spend reviews are in place to advise on actions as appropriate to tighten up processes. KT made an observation about the sickness policy from a union viewpoint. KT had concerns about how perception of the policy is viewed by different managers. SO advised that new and revised training process is currently being reviewed to support this. The Committee **noted** the content of the report.			

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Agenda Item	Key Discussion Points	Action	Owner	Timescale
19/29 **Legislation, terms & conditions, employment policies/EIA's – review & ratification/approval**	The Committee considered the following Policies and Equality Impact Assessments for formal ratification and approval. **Work Experience** SO advised that this policy had been to the Policy Review Group with no contentions found, some clarity around process and timetable/structure had been included. The Committee **ratified** the policy and **approved** the EIA. **Learning Activity Support (Study Leave)** SO advised that this policy had also been to the Policy Review Group for consultation. Update of terminology and clear guidance added. The Committee ratified the policy and approved the EIA.			
19/30 Sub Committee Minutes	The Committee received the minutes for the following for information. • JCNC – 27.11.2018 • Health & Safety Committee 11.12.2018 The Committee **noted** the content.			
Date of Next Meeting	**Friday 3rd May 2019, 11am, Room 5, Mezzanine (Originally 24th April 2019)**			

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Action List

Minute Reference	Action	Who	When	Status
Meeting Protocol				
	Review of Reporting Timetable for 2019-2020 & Annual Report			
19/17	• Issue the Annual Report virtually to the Committee for sign off • Present a regular Marketing & Communications Activity Report to the Committee	MKS MF	March April/Ongoing	
Programme Assurance 'Developing Our Workforce'				
	Programme Assurance/progress update			
17/21	• Feedback on outcomes of Change Programme Framework • Update on identified resource for Projects AHP, Temporary Staffing and E-Rostering. Noted on 23/10/2018 – Rob Griffiths has been identified as resource for AHP. Temp staffing has seen a recent spike and it was advised that MKS will lead a group to get under the E-rostering issues.	JG MKS		Ongoing Ongoing
People Strategy Overview & Progress Against Strategic Aims				
	Engagement			
15/08 16/02	• Develop Values in Procurement, values based recruitment – develop opportunities to incorporate into the Procurement processes/standards for contractors. Liaise with Deputy Director of Finance to progress to review employment opportunities.	MKS/CL	Ongoing	Ongoing
	Equality & Diversity			
17/13	• Equality Objectives Plan for 2018-2021 – Quarterly Update required & Objectives to be reviewed every 6 months • Equality Metrics Report to be brought back to next Committee	HA HA/SM	1/4ly Update 6 monthly Review	Ongoing Ongoing
18/05	• **Corporate Induction** – review current practice of holding on a set day as opposed to the 1st day of commencement in post. The Committee noted on 21st May that the new Learning & Development Manager will be reviewing in conjunction with Communications. Noted on 23/10/2018 - MKS advised that this item will be presented at February 2019 meeting.	MKS/DS/	March 2019	Complete
	Education Governance Update			
18/38	• To be a regular item on the Committee Agenda.	HB	May 2019	Ongoing
19/04	Postgraduate Education Monitoring Visit Action Plan – share actions to divisional leads, divisional boards and HRBPs to inform response to HEE	RG/AMc	ASAP	
	Wellbeing			

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18/49	NHSI Health & Wellbeing Improvement Programme Update • Pick up with Sarah Smith sickness data availability for CommCell	MKS	ASAP	
Key Workforce Risks				
	Board Assurance Framework			
18/58	Review the exit interview process and make more visible the proforma. Noted on 23/10/2018 that an update will be brought to December's meeting.	MKS	March 2019	Complete
Legislation, Terms & Conditions, Employment policies/EIA's				
	Volunteering			
19/11	PB to request a the Volunteering team to present an update to the Committee	PB	March 2019	Complete

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BOARD OF DIRECTORS

Tuesday 28th May 2019

Report of:	Adam, Bateman Chief Operating Officer
Paper Prepared by:	Mary Passant, Programme Manager Sian Calderwood, Service Manager Alder Hey Jen Deeney, Head of Neonatal Nursing & Operations Liverpool Women's
Subject/Title:	Update on single neonatal service
Background Papers:	
Purpose of Paper:	To inform the Board of the latest position on this development
Action/Decision Required:	Consider support of the high-level milestone plan
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Sustainability through external partnerships Delivering outstanding care
Resource Impact:	

Single Neonatal Service

Keeping the baby at the centre of what we do

1. Introduction

This paper provides an update for the Trust Boards of Alder Hey Children's and Liverpool Women's Hospital regarding the development of a single neonatal service between.

There are three key reasons why a new model of care for neonatal babies in Liverpool is critical:

1. **The quality care of babies will be improved by strengthening the joint working between both organisations and ensuring babies will receive the right care in the right place**
2. **Reducing the number of unnecessary transfers between hospitals sites by 50% will improve the clinical outcomes for babies as well as making the experience for families less stressful and upsetting. Impacting on mortality and morbidity**
3. **To ensure babies at both site receive high quality as in line with national standards**.

2. Update on progress made

Both Trusts have continued to work together in partnership to improve the service prevision for babies and families within The Network. Over the past 6 months the following has been delivered:

2.1 Contractual & commissioning

- Specialist Commissioner approved business case (February 2019)
- First phase of funding stream allocation provide by the commissioners in March 2019
- On behalf of both organisations Alder Hey finance team continue to negotiate the finalised finding agreement with Specialist Commissioners

2.2 Designing the new NICU

- Workshop held with parents, staff and relevant stakeholders to discuss the requirements of the new build estate at Alder Hey (January 2019)
- International visit to the newest Neonatal Unit in the World, Sidar, Doha, Qatar April 2019- paper produced on findings
- Options appraisal for location of new NICU tabled to Alder Hey Executive Team

2.3 Single way of working

- Workshop held on the 10th of April 2019 to bring staff together from both organisations to gain insight into the way forward for the project

- Mary Passant appointed Joint Programme Manger appointed to The Single Neonatal Service February 2019
- Monthly neonatal partnership delivery meeting with joint representation
- Successful implementation of 7 Day Consultant Neonatologist working at Alder Hey Neonatal Unit
- Daily ANNP presence at AHCH Neonatal Unit embedded
- Establishing a single leadership team with designated project support as follows:

Roles	WTE
Senior Programme Manager	0.4
Services Manager	1
Clinical Director Single Neonatal Service	0.3
Deputy Clinical Director Single Neonatal Service	0.2
Head of Neonatal Nursing	1
Project Manager	0.8
Project administration	0.8
Total Proposal	3.6

3. Risks

Risk	Mitigation
Financial risk surrounding the cost of the build at Alder Hey	▪ Trust capital plan review ▪ Fundraising strategy
Ensuring teams from both organisation are supported and encouraged to work collaboratively for the best interests of the babies and families	▪ Inter-team development plan ▪ Single leadership team
Robust recruitment strategy required to ensure safe staffing model is achieved	▪ Resource a recruitment strategy ▪ Nursing establishment review
Specialist Commissioners do not agree to fund to BAMP standards across the service	▪ Escalate concern regarding funding calculation
Robust governance arrangements in place that deal with multi-site service provision	▪ Establish bi-annual Neonatal Partnership Board meeting ▪ Clinical Governance Policy

4. Next Steps

Please note a detailed project plan is available and will be tracked through the Neonatal Partnership Delivery Group.

The high-level milestones for the next 6 months are as follows:

- To appoint to leadership roles for the Single Neonatal Service – June 2019
- Ensure SLA's are in place to allow staff to work flexibly and fluidly across both sites and both organisations – June 2019
- Secure appropriate funding agreement with Speciality Commissioners – July 2019
- Develop required brief for the estates build at Alder Hey – July 2019
- Continue to explore other successful neonatal units who have embedded family integrated care – July 2019
- Initiate nursing recruitment drive – August 2019