

Alder Hey Children's NHS Foundation Trust

Alder Hey Children's Hospital

Quality Report

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This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this hospital

Good



Medical care

Good



Surgery

Good



Critical care

Good



Transitional services

Good



Outpatients and diagnostic imaging

Requires improvement



Summary of findings

Letter from the Chief Inspector of Hospitals

Alder Hey Children's Hospital is one of two registered locations that forms part of Alder Hey Children's NHS Foundation Trust. The trust's other location is the Dewi Jones Unit - an inpatient mental health facility to support young people between the ages of 5 and 14 years.

Alder Hey Children's Hospital is a specialist acute hospital for children and young people that provides urgent and emergency care, medical care, surgery, critical care, outpatients and diagnostic services, neonatal services, end of life care and transitional services.

Alder Hey Children's Hospital has 246 beds and provides a wide range of inpatient medical, surgical and specialist services as well as a 24-hour A&E. The hospital is also a designated national centre for head and face surgery, a centre of excellence for heart, cancer, spinal and brain disease and a Major Trauma Centre. It is one of four national Children's Epilepsy Surgery Service centres. A new Alder Hey Hospital is currently being built adjacent to the existing site and is set to open in 2015.

We previously inspected this hospital in May 2014 and rated it as "Requires Improvement" overall. We judged the hospital to be "Requires Improvement" for safe, responsive, well-led and "Good" for effective and caring. Our main concerns centred on the critical care and outpatients services, but we also had concerns about how the hospital managed the care of young people with complex needs who were due to transition into adult services.

This was a follow up inspection to the comprehensive inspection of May 2014. The inspection was focused and specifically considered the areas that required improvement. The inspection took place on the 15th and 16th June 2015.

We inspected the following core services in full:

- Critical Care
- Outpatients and diagnostic imaging services*
- Transition services

*The last inspection in May 2014 was part of a wave of inspections to test our methodology and at that time, diagnostic imaging was not explicitly included in the outpatients' methodology. This inspection included diagnostic imaging services, which is part of our updated methodology.

We also looked at the "Safe" domain in the following core services to check whether improvements had been made:

- Medical care
- Surgery

It was evident that the trust had made a very positive response to the findings of our last inspection and improvements had been made in all of the areas we identified. The trust had also improved in a number of areas where we indicated it should make improvements with particular reference to the services for young people transitioning in to adult services and in the engagement and inclusion of staff in the change agenda. However, outpatients and diagnostics still required improvement overall.

Despite only inspecting the areas outlined above, we have used the ratings from the last inspection to re-aggregate the overall rating for this hospital. In the lead up to the inspection, we discussed the performance of the trust with commissioners, other regulatory colleagues and stakeholder groups, such as Healthwatch. We did not receive any intelligence to suggest that the areas we rated last time had regressed and this is the basis for re-aggregating the overall rating for Alder Hey Hospital to "Good".

Our key findings were as follows:

Summary of findings

- The trust had significantly improved the levels of nurse staffing. Over 80 additional nurses had been recruited and all of the wards and departments we inspected were adequately staffed to meet the needs of patients.
- Medical support for the High Dependency Unit (HDU) had significantly improved since our last inspection and it was evident that the trust had taken action to address the lack of medical leadership within the unit.
- The outpatients department had made considerable progress since our last inspection with regard to the management and availability of medical records. The trust had undertaken a lot of work to achieve their target of ensuring that 95% of records were available for the clinics. Effective systems had been put in place to ensure the availability of records within the department.
- There has been a significant amount of progress in transitional services since we last inspected and we have been impressed by the trust's response in this area. A clear overarching vision, framework and strategy for transitional care had been developed. The trust had put in place a designated medical and nursing lead for transition who had recently led a review of the arrangements for transitional services and there was evidence of a co-ordinated trust wide approach to transitional services that was monitored at executive level.
- There was still a shortage of isolation cubicles for children with an infectious disease but the hospital had put plans in place to flex cohort areas and minimise the risk of cross infection. The trust recognises that the issue would not be fully resolved until services moved to the new hospital.
- The trust had reviewed resuscitation equipment to ensure they met the minimum equipment and drugs required for paediatric cardio-pulmonary resuscitation as outlined in the Resuscitation Council (UK) 2013 guidance. Daily checklists for the equipment were in place; however, the checklist records that we looked at in some areas had not always been completed daily. In radiology we saw that the checklists had not been updated for several months and in some cases a number of years.
- Patients received care and treatment in a visibly clean environment. Wards and departments were cleaned regularly and cleaning schedules maintained. Staff, in the main, followed good practice guidance in relation to the control and prevention of infection, although hand hygiene practice and the completion of cleaning schedules required improvement in the outpatients and diagnostic departments.
- The areas we visited were visibly tidy but there were some limitations of the ageing hospital environment which we were told would be addressed as part of the planned move to the new hospital in October 2015.
- There was good access to interpreter services for children and young people whose first language was not English; however, there was no evidence that the trust provided information leaflets in any other language than in English.
- Appointment letters and supporting information were only sent out in English and were not available in any other language.
- Staff within outpatients and diagnostics told us that lessons learnt from the investigation of reported incidents were not always shared to prevent recurrence.
- Staff in all disciplines remained proud and passionate about their work and there was a strong commitment to delivering and securing the best for children and young people evident throughout the organisation.

We saw that the compassionate care being delivered by staff on the critical care unit was outstanding.

However, there were also areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

- Ensure that departmental risk registers are kept up to date and reviewed appropriately.
- Improve its risk management processes in the outpatient and diagnostic imaging departments and provide appropriate training for those delegated to manage risk.
- Ensure there is an appropriate process in place for checking and recording pregnancy status in adolescent female patients.
- Ensure that learning from incidents and complaints is shared with staff to prevent recurrent issues.
- Ensure that processes are robust and effective in relation to patient emergencies in the radiology department and that first aid and resuscitation equipment is suitably available and checks completed and documented regularly.

Summary of findings

- Ensure that correct hand hygiene measures are in place and that people are aware of and using the correct techniques.

In addition the trust should:

- Improve staff compliance with mandatory training.
- Improve staff compliance with safeguarding training.
- Provide adult safeguarding training for staff across all services.
- Continue to recruit nursing and medical staff to address shortfalls across the surgical and critical care services.
- Improve patient access and flow across critical care services.
- Ensure that people's medicines are given in the necessary quantities at all times and that the records reflect what has been administered to prevent the risks associated with medicines that are not administered as prescribed.
- Ensure that outstanding actions on the risk register are reviewed and updated across all departments.
- Ensure that adequate signage is displayed in relation to entering areas in the radiology department.
- Seek to fill vacancies on medical wards and reduce the need for locum cover.
- Continue to recruit nursing and medical staff to address shortfalls across the surgical services.
- Maintain staffing levels in the Neonatal Unit according to nationally recognised guidance.
- Implement policies and procedures relating to transition, to ensure there are trust-wide policies and procedures for staff to refer to when dealing with young people that are; or, should be considered for transitional pathways.
- Ensure that work undertaken in the learning disabilities steering group and the transition steering group are linked so that information is shared and used to benefit both of these vulnerable groups of children and young people.
- Continue to develop relationships with adult health and social care providers to ensure the safe and effective transition of care for young people.
- Ensure that appropriate systems are in place for patients or those close to them to raise an alarm if they require assistance whilst in outpatient changing areas.
- Undertake a review of staffing within each area of the outpatients department to ensure that there is an appropriate system in place to determine staffing requirements.
- Improve communication with people for whom English is not their first language.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Medical care

Rating

Good



Why have we given this rating?

At our previous visit in May 2014 we found some areas of medical care that required improvement. In June 2015, we returned to inspect and report on those issues. We inspected the safe domain and found that there had been improvements since our last inspection. There were good practices in place to promote the safety of patients and staff and prevent harm. There were clear processes for reporting and investigating incidents. Learning from incidents was shared and there were examples of changes in practice in response to incidents. Staff assessed and responded to patient risks in a timely manner. There was still a shortage of isolation cubicles but the hospital had put plans in place to flex cohort areas and minimise the risk of cross infection. Wards and equipment were visibly clean, although some ward areas, which were for patient use, were being used to store equipment. Essential checklists were not always completed on a daily basis. Entries in medical records were of a good standard but entries on the medication charts were at times below the standard required. Staff were aware of the policies and procedures to protect and safeguard children and adults and training statistics showed that the majority of staff had completed level 1 safeguarding training but just over half had completed level 3 which is a trust requirement for clinical staff. Staff attended other mandatory training courses and were positive about the training provided; however compliance was below the trust target. There were clear plans in place, at ward level, to increase the number of staff completing their mandatory training. Staffing levels were sufficient to meet the needs of patients; however there were medical staffing vacancies. Managers had identified ways to ensure appropriate cover until vacancies were filled.

Surgery

Good



At our previous visit in May 2014 we found some areas of surgical care that required improvement. In June 2015, we returned to inspect and report on those issues. We inspected the safe domain and found that there had been improvements since our

Summary of findings

last inspection. There were good systems in place to prevent avoidable patient harm. The staffing levels and skill mix was sufficient to meet patients' needs and staff assessed and responded to patient risks in a timely manner. The theatre teams were undertaking the 'five steps to safer surgery' procedures, including the use of the World Health Organisation (WHO) checklist and staff adherence to WHO guidelines was monitored through routine audits. Patient records were completed appropriately. The majority of staff had completed their mandatory training but there was low compliance in information governance, safeguarding level 3 training and fire safety training. Incidents were reported and learning was shared across the departments. The environment was visibly clean, well maintained and in a good state of repair. Staff were aware of infection prevention and control guidelines. Equipment was appropriately serviced and available. Medicines were stored and administered appropriately.

Critical care

Good



At our previous visit in May 2014 we found some areas of critical care that required improvement. In June 2015, we returned to inspect the whole service and saw that improvements had been made. The staffing levels and skill mix was sufficient to meet patients' needs and staff assessed and responded to patient's risks in a timely manner. Incidents were reported and learning was shared across the departments. The environment was visibly clean, well maintained and in a good state of repair. Staff were aware of infection prevention and control guidelines. Equipment was appropriately serviced and available. Medicines were stored and administered appropriately and patient records were completed appropriately. The majority of staff had completed their mandatory training but there was low compliance in information governance, safeguarding level 3 training and equality and diversity training. Staff worked to policies, procedures and clinical care pathways in line with local and national guidance. Patients were assessed for pain relief and supported in an appropriate manner. Staff had the appropriate skills and knowledge to seek consent from patients and explained how they sought verbal and implied

Summary of findings

informed consent. Outcomes for children were comparable to similar children's trusts in terms of mortality, length of stay and unplanned re-admissions. Parents, carers and children were consistently positive about the care and treatment provided. They felt supported, involved and received information in a manner they understood. Staff were compassionate, kind and respectful whilst delivering care. Children were admitted to critical care services in a timely manner; however, there were frequent delays in transfer of care and patients were routinely discharged out of hours. There were plans to address the patient access and flow issues as part of the reconfiguration of services following the planned move to the new hospital site in October 2015. Critical care services were overseen by a clinical director, a lead nurse and a general manager. There was also a designated clinical lead for HDU. Staff felt proud to work at the hospital and morale was high. There were routine clinical business unit risk and governance board meetings and departmental staff meetings where key risks were identified and reviewed. Staff told us they received good management support.

Transitional services

Good



At our previous visit in May 2014 we found that transitional services required improvement. In June 2015, we returned to inspect the whole service. We saw that there had been significant improvements since our last inspection. We found that the trust had a co-ordinated trust wide strategy for planning and delivering transition services which supported young people. There were excellent examples of transition pathways for young people with specific long-term needs. There was a commitment from the trust to further develop existing partnerships with health and social care providers of adult services. Since our last inspection, the trust had appointed a designated transition nurse and named medical consultant. As a result, progress had been made in developing over-arching policies and procedures relating to transition arrangements for young people with complex needs. These were due to be formally rolled out across the trust shortly after our inspection. There was clear leadership, vision and a desire to use research and audit programmes to share good practice and identify gaps in transition

Summary of findings

and use this to improve outcomes for young people. There was evidence of patient, public and staff involvement in shaping policies and procedures related to transition.

Outpatients and diagnostic imaging

Requires improvement



At our previous visit in May 2014 we found some areas of outpatients that required improvement. In June 2015, we returned to inspect outpatients and diagnostic imaging services and saw that considerable progress had been made with regard to the management and availability of medical records but that the service "requires improvement" overall. Within outpatients and diagnostic imaging services there were areas of governance that required improvement, particularly in relation to the identification and management of risks. There were no regular departmental team meetings taking place at the time of the inspection; however, some departments, such as audiology and the ears, nose and throat department (ENT) held their own multidisciplinary meetings. Lessons learned were not consistently shared with staff. Departmental risk registers were not kept up to date and there was no evidence that they were reviewed on a regular basis. Robust procedures for identifying if young female patients were pregnant prior to undergoing scans within the diagnostic imaging department were described in the trust's radiation protection policy but they were not always followed. Emergency resuscitation equipment was available in all areas that we inspected. In outpatients, records indicated that the equipment was checked twice daily; however, within radiology, despite staff telling us that checks were completed regularly, we saw that the checklists had not been updated for several months and in some cases a number of years. Mandatory training and safeguarding (level 3) training completion rates for staff within outpatients and diagnostics were low and well below the trust's target for the majority of the training modules. Completion rates have not improved markedly from the last inspection. Care and treatment was delivered in line with evidence based practice. Policies and procedures followed recognisable and nationally approved guidelines. Patients and those close to them were treated with dignity and respect by caring and compassionate staff. Outpatient

Summary of findings

clinics were very busy and we observed some carers complaining to members of staff about waiting times. Patient information leaflets, appointment letters and supporting information were not available in any other language except English. There was no process in place for sharing lessons learned from complaints made about the department.

Alder Hey Children's Hospital

Detailed findings

Services we looked at

Medical care; Surgery; Critical care; Transitional services; Outpatients and diagnostic imaging

Detailed findings

Contents

Detailed findings from this inspection	Page
Background to Alder Hey Children's Hospital	11
Our inspection team	11
How we carried out this inspection	11
Facts and data about Alder Hey Children's Hospital	12
Our ratings for this hospital	12
Action we have told the provider to take	63

Background to Alder Hey Children's Hospital

Alder Hey Children's Hospital is one of two locations that forms part of Alder Hey Children's NHS Foundation Trust. The trust became a foundation trust in August 2008 and provides care for more than 270,000 children, young people and their families.

Alder Hey Children's Hospital has 279 beds and provides a wide range of inpatient medical, surgical and specialist services as well as 24-hour A&E and outpatient services. A new Alder Hey Children's Hospital is currently being built

adjacent to the existing site and is set to open in 2015. The new hospital will allow the trust to make a significant upgrade to the patient and family experience. Improvements will include:

- Improved clinic areas, education and research facilities, new operating theatres and a new A&E department;
- 75% of beds will be offered as single, en suite rooms with pull-out beds for parents;
- Access to play areas, natural light and views of the park, wherever possible;
- Children, young people and teenagers will have dedicated areas to play and relax.

Our inspection team

Our inspection team was led by:

Head of Hospital Inspections: Ann Ford, Care Quality Commission

The team included a CQC inspection manager, nine CQC inspectors, a modern paediatric matron for complex and tertiary medicine, a chief nurse, a paediatric surgeon, a radiographer, a governance specialist, an inspection planner and a recorder.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Detailed findings

However as this was a follow up inspection to the comprehensive inspection we undertook in May 2014, we only reviewed the areas where Alder Hey Hospital had been rated as "requires improvement".

We inspected the following core services in full:

- Critical Care
- Outpatients and diagnostic imaging services*
- Transitional services

*The last inspection in May 2014 was part of a wave of inspections to test our methodology and at that time, diagnostic imaging was not explicitly included in the outpatients' methodology. This inspection included diagnostic imaging services, which is part of our updated methodology.

We also looked at the "Safe" domain in the following core services to check whether improvements had been made:

- Medical care
- Surgery

The inspection took place between 15 and 16 June 2015. Before carrying out this inspection, we reviewed a range of information we held, and asked other organisations to share what they knew about the hospital. These included clinical commissioning groups (CCGs); Monitor and the local Healthwatch.

Facts and data about Alder Hey Children's Hospital

Alder Hey Children's NHS Foundation trust offers 20 specialist services, including a designated national centre for head and face surgery and a centre of excellence for children with cancer, heart, spinal and brain disease. Alder Hey Hospital is a teaching hospital and trains 958 medical and 556 nursing students each year. The hospital is also a designated Major Trauma Centre, and is one of four national Children's Epilepsy Surgery Service centres.

Alder Hey Children's Hospital is a paediatric research centre, leading investigation into children's medicines, infections, inflammation and oncology. At any time there are over 100 clinical research studies taking place, ranging from observational studies to complex, interventional clinical trials. Around 7,500 children and young people are involved in clinical trials each year.

Alder Hey serves a catchment area of 7.5 million, with around 60,000 children seen in A&E each year. In addition to the hospital site at West Derby, Alder Hey has a

presence at more than 40 community outreach sites and programmes and its consultants hold 800 clinic sessions each year from Cumbria to Shropshire, Wales and the Isle of Man to help and support care and treatment closer to home.



The trust provides over 270,000 episodes of care each year. In 2013/14 41,100 patients were admitted to hospital as inpatients or day cases, more than 177,200 attended outpatient clinics and 56,100 were treated in the A&E department.

Alder Hey Children's Hospital is in West Derby in the north of Liverpool, a city within the metropolitan borough of Merseyside. Liverpool is the most deprived of 326 local authorities in England. It has a population of around 467,000 (2011). However, 60% of the hospital's income is from specialised services across the North West, North Wales – a population of around eight million.

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Good	N/A	N/A	N/A	N/A	Good
Surgery	Good	N/A	N/A	N/A	N/A	Good
Critical care	Good	Good	 Outstanding	Good	Good	Good
Transitional services	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Good	Good	 Outstanding	Good	Good	Good

Notes

Notes for overall ratings for this hospital

1. The overall ratings for this hospital have been aggregated using an amalgamation of the ratings from our inspection in May 2014 and our updated ratings from the focused inspection of medical care, surgical care, critical care, outpatients and diagnostics and transitional services.

Notes for Outpatients and diagnostics ratings

1. The last inspection in May 2014 was part of a wave of inspections to test our methodology and at that time, diagnostic imaging was not explicitly included in the outpatients' methodology. This inspection included diagnostic imaging services, which is part of our updated methodology.
2. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for outpatients and diagnostic imaging.

Medical care

Safe

Good



Overall

Good



Information about the service

We visited Alder Hey Hospital as part of our announced inspection during 15-16 June 2015.

The acute medical care services at Alder Hey provided care and treatment for a wide range of medical conditions, including general paediatric medicine, cardiology, respiratory, rheumatology and gastroenterology.

We visited wards D2, E3, K2, C2, C3, neuromedical, oncology unit and the medical assessment unit over the course of the two day inspection. We considered the environment, staffing levels and looked at seven care records and 30 prescription charts. We spoke with family members, patients and 21 staff of different grades including nurses, doctors, ward managers, a housekeeper and the clinical director

We received comments from people who contacted us to tell us about their experiences, and we reviewed performance information about the trust.

We previously inspected this hospital in May 2014 and rated the “Safe” domain for medical care as ‘requires improvement’. As part of that inspection, we identified that incidents relating to medicines were under-reported, the numbers of staff who had received safeguarding training was low at 61%, there were insufficient cubicles available to isolate children and young people who may present a risk of infection to others, there were shortages of nursing staff on some wards and middle grade medical staff were stretched out of normal working hours. We carried out this inspection to check whether improvements had been made.

Summary of findings

Improvements had been made since our last inspection in May 2014. Staff were aware of how to report incidents and could clearly show how and when incidents had been reported. This included incidents relating to medicines. Lessons were learned from incidents and staff felt confident about reporting them.

There were good systems in place to prevent avoidable patient harm. The staffing levels and skill mix was sufficient to meet patients’ needs and staff assessed and responded to patient’s risks in a timely manner.

There were appropriate protocols for safeguarding vulnerable children and adults, and staff were clearly aware of their role and responsibilities in relation to safeguarding. The numbers of staff who had received safeguarding level 1 training had increased; however, level 3 safeguarding compliance rates were poor.

Staff attended other mandatory training courses and were positive about the training provided; however compliance was below the trust target. There were clear plans in place, at ward level, to increase the number of staff completing their mandatory training.

Medical care

Are medical care services safe?

Good



There were good practices in place to promote the safety of patients and staff and prevent avoidable harm. There were clear processes for reporting and investigating incidents. Learning from incidents was shared and there were examples of changes in practice in response to incidents. Staff assessed and responded to patient risks in a timely manner.

Wards and equipment were visibly clean, although some ward areas, which were for patient use, were being used to store equipment. Essential checklists were not always completed on a daily basis.

Entries in medical records were of a good standard but entries on the medication charts were at times below the standard required.

Staff were aware of the policies and procedures to protect and safeguard children and adults and training statistics showed that the majority of staff had completed level 1 safeguarding training but just over half had completed level 3 which is a trust requirement for clinical staff. Compliance with safeguarding training had not markedly improved since our last inspection.

Staff attended other mandatory training courses and were positive about the training provided; however compliance was below the trust target. There were clear plans in place, at ward level, to increase the number of staff completing their mandatory training.

Staffing levels were sufficient to meet the needs of patients; however there were medical staffing vacancies. Managers had identified ways to ensure appropriate cover until vacancies were filled.

Incidents

- There had been no Never Events (wholly preventable patient safety incidents that should not occur if the relevant preventative measures had been put in place) reported in the division of medicine between December 2013 and the date of our inspection; however, there were two serious incidents. We saw evidence that the trust undertook an investigation using a root cause analysis process to identify any contributing factors. It

was clear from the investigation reports that learning points had been identified and included on the risk register. The risk register showed actions that were being implemented to prevent recurrence.

- Staff were familiar with and encouraged to use the trust's procedures for reporting incidents. There was evidence that staff understood their responsibilities to raise concerns and record safety incidents. Between June 2014 and May 2015 the Clinical Business Unit (CBU) responsible for medical care reported 992 incidents.
- Following incidents, ward staff told us that they received feedback from ward managers, though not always through formal meetings. Safety alerts were displayed on the wards and staff notice boards. We saw that these contained learning points from previous incidents in the trust.
- Minutes of the CBU board meeting showed that incidents were discussed and actions identified.
- Weekly meetings for ward managers across the medical division were held to discuss any incidents that had occurred. The minutes of these meetings outlined learning from incidents but some ward managers had not regularly received a copy which meant that they may not be aware of learning points from incidents if they weren't in attendance.
- Examples were given of how staff had been involved in reviewing incidents and the support they received.
- A ward manager provided evidence of how incidents were documented and discussed at the monthly mortality and morbidity meetings.
- Since the duty of candour regulations were introduced in November 2014, the trust policy of informing parents/carers about incidents had been utilised. We saw evidence that parents had been informed of an incident and the actions taken to prevent recurrence.

Safety thermometer

- As a children's trust, Alder Hey is not required to submit data as part of the NHS Safety Thermometer (a tool designed to be used by frontline healthcare professionals to measure a snapshot of specific harms once a month).
- The trust performed a similar assessment called the Paediatric Safety Scan, which was based on the National Safety Thermometer. The measurements included pain, skin integrity, medication, nutrition and the completion of the paediatric early warning system (PEWS). PEWS is a

Medical care

system used to monitor whether a child's condition is deteriorating. Between May 2014 and April 2015, each ward had completed a monthly audit of compliance with the patient safety scan assessment.

- The results of the patient safety scan were displayed on a notice board in the corridors on some wards.

Cleanliness, infection control and hygiene

- The ward areas we visited were visibly clean. Staff followed good practice guidance in relation to the control and prevention of infection. This included the use of 'I am clean' stickers to inform colleagues at a glance that equipment or furniture had been cleaned.
- There were adequate hand gel dispensers in each ward which ensured staff and people visiting the ward were able to clean their hands
- There was still a shortage of isolation cubicles but the hospital had put plans in place to flex cohort areas and minimise the risk of cross infection. Between January 2015 to June 2015 there had been four occasions when the trust had been unable to isolate a child with an infectious disease in an isolation cubicle. The trust recognise that the issue would not be fully resolved until services moved to the new hospital.

Environment and equipment

- Most of the wards we visited were cramped and storage facilities for mobility aids on some wards was limited. We saw plans for the ward layout within the new building to resolve current issues with the environment.
- Parents reported that they were able to stay overnight with their child and fold away beds were available.
- We saw a clinic room being used to store additional medical equipment and a shower room on one ward was being used to store wheelchairs.
- There was an alternative bathroom for patients to use which had a hand held shower attachment over the bath; however, this would not have been suitable for people with restricted mobility. There was no evidence of a risk assessment completed for this.
- Resuscitation equipment was available on all of the wards we visited. The resuscitation equipment and emergency drugs were kept together which meant that staff could locate them in an emergency. This equipment should be checked daily; however, records indicated that there were occasions when this had not been completed by staff on wards C3, D2 and E3.

- Staff explained the system for ordering stock and said that cover was always available when the person responsible for ordering stock was not on duty.
- Equipment was readily available and staff knew who to contact if they had any faulty equipment that needed attention. This could usually be replaced from the hospital's equipment store.

Medicines

- Medicines, including controlled drugs, were stored securely and access was limited to qualified staff employed by the trust. Medicines requiring storage at temperatures below eight degrees centigrade were appropriately stored in fridges; however, the daily temperature checklists were not consistently completed on some of the wards we visited.
- We found one episode of missed medication which had not been reported as an incident or investigated. There were other entries on the medication charts relating to possible missed doses for some patients. It was unclear from the records we looked at if this was due to incomplete recording of medications given or missed doses. This was reported to the ward manager and lead nurse.
- Medication audits were undertaken on each ward but staff said they did not always know the outcome of the audit which may mean that opportunities to learn are missed.
- The minutes of the last CBU board meeting showed that there had been an increase in the number of medication errors being reported since the last inspection. The number of medication errors that resulted in harm was low. This is an improvement from our last inspection when we found that medication errors were under-reported.
- Staff said that information of lessons learnt from medication errors were included in the trust newsletter which we saw on the staff notice board on one of the wards.
- Staff were aware of the on-call system for accessing medication out of hours.

Records

- Records were a mixture of electronic and paper records. We reviewed seven paper records. In six of the records we looked at documentation was accurate, legible, signed and dated; however, in one of the records some of the nursing entries were not signed.

Medical care

- Some of the records we reviewed were in a poor state of repair and one had loose leaf pages which meant there was a risk that patient information could get lost or misfiled.
- We reviewed 30 medication charts and 24 did not have all information correctly recorded on each page, such as allergies or patient names. This was a risk that important information was not clearly visible when administering medicines. The trust was moving to an electronic system for recording medication details which would help to mitigate this risk.
- On the medication charts, medication that was no longer needed by the patient had been crossed out but not signed or dated in the appropriate place.
- The trust undertook comprehensive medical records audits but information from the trust showed that the last one had been postponed.
- A trust quality review report for one ward highlighted the risk of test results not being filed appropriately as an issue and actions had been taken to mitigate this risk.

Safeguarding

- There were safeguarding policies and procedures in place which were understood by staff. Staff knew how to refer a safeguarding issue to the safeguarding team at any time of the day. Specialist advice and support was available from the trust's safeguarding team, who were on site at the Rainbow Centre 24 hours a day.
- On call medical staff were available for staff to contact if they needed advice on safeguarding should they have a concern
- There had been 459 referrals from medical wards to the trust safeguarding team between June 2014 and May 2015.
- Training statistics provided by the trust showed that on the medical wards 71% of admin staff, 62% of medical staff and 88% of nursing staff had received level 1 safeguarding training. Only 54% of nursing staff and 51% of medical staff had received level 3 safeguarding training. This was much lower than the trust target of 90% and there hadn't been a marked improvement on the figures since our last inspection in May 2014.
- On two separate wards, we saw a child allowing visitors to the ward through a controlled access door. This was in place to prevent children and young people leaving unnoticed and to protect against people entering unobserved. This was raised with staff members at the time who took remedial action.

Mandatory training

- Staff received mandatory training on a rolling annual programme. They were able to access on line courses, booklets and face to face sessions.
- The mandatory training was in areas such as manual handling, fire safety, equality and diversity and safeguarding.
- At the time of our inspection, 67% of staff on medical wards had completed their required mandatory training, which was below the trust's target of 90%
- Mandatory training was identified as a risk on the risk register with actions identified to increase compliance. There were individual ward plans in place to increase the percentage of staff completing their mandatory training.

Assessing and Responding to Risk

- Staff were aware of how to escalate key risks that could affect patient safety, such as staffing and bed capacity issues, and there was daily involvement by ward managers and the clinical business unit lead nurse to address these risks.
- Upon admission to medical wards and before treatment, staff carried out risk assessments to identify patients at risk of harm. Patients at high risk were placed on care pathways and care plans were put in place to ensure they received the right level of care.
- The medical wards used the paediatric early warning score (PEWS) for recording the vital signs of patients on the ward so that early signs of deterioration could be identified and action taken.
- We saw appropriately completed PEWS observation sheets.

Nursing staffing

- The Royal College of Nursing (RCN) guidelines for staffing levels for children and young people's services had been used when planning nurse staffing levels. The guidelines stated that on general wards there should be a nurse to patient ratio for children under 2 of 1:3 day and night and over 2 years of 1:4 day and night.
- Medical wards we visited displayed nurse staffing information on a notice board on the wards. This showed the planned and actual number of qualified nurses and nursing assistants on duty for the day.

Medical care

- The wards we visited had a sufficient number of trained nurse and support staff on shift based on the RCN guidelines at the time of our inspection.
- We found on one ward that the rota showed that one shift at night had yet to be covered. The ward manager informed us that this shift would be covered by temporary staffing (nurse bank staff).
- Examples were given of how the medical service was increasing the skill level of staff. This included training in managing complex patients and nurse prescribing. Ward training plans showed the numbers of staff booked onto a nurse prescribing course to prescribe simple pain relief medication.
- Information provided by the trust showed that in January 2015, 90% of nurse shifts had been covered and in February 2015, 95% of shifts had been covered. Since our last inspection in May 2014 there had been an increase in the recruitment of staff and there were currently no nursing vacancies for the medical wards.
- Medical services had three consultant vacancies that were being advertised. Measures such as utilising locum medical staff had been put in place until the vacancies had been filled. The risk register showed that there were a reduced number of registrars across the medical service. Actions had been identified to increase the number of medical staff, 4 had been completed but 2 actions remained outstanding. These were to temporary increase nurse capacity and develop a business case for additional medical staff.
- Senior medical staff said that recently there had been times when it had been difficult to get locum doctors due to demand. To mitigate this risk, the trust had set up a register of doctors already employed at the trust who would work extra shifts to cover any gaps.
- From January 2015 to 21 July 2015 out of 1,638 shifts 74 required locum cover. 54 of these shifts were covered.
- Families reported that they did not always see a doctor at the weekends although there was sufficient on call cover outside of normal working hours and at weekends.

Medical staffing

- Rotas were completed for all medical staff which included out of hours cover for all medical admissions and all medical inpatients across all wards. All medical trainees contributed to this rota. The information we reviewed showed that medical staffing was appropriate
- Nursing staff on wards reported occasional delays in accessing a doctor to attend the ward when required. The staff we spoke to told us that there was always access by phone to a doctor out of hours for advice.
- There had been a serious incident on one ward when there had been a delay in getting a doctor to attend the ward when needed during the day. Nursing staff managed the incident at the time and told us that no harm came to the patient. We saw the completed incident forms which identified medical staffing issues; however, this was still being investigated further.

Major incident awareness and training

- There was a documented major incident plan within the medical areas and this listed key risks that could affect the provision of care and treatment. There were clear instructions for staff to follow in the event of a fire or other major incident.
- Staff were aware of what they would need to do in a major incident and demonstrated how they would find the trust policy and access key documents and guidance.
- Records showed that 100% of nursing staff and admin staff had completed major incident training and 96% of medical staff had completed it.

Surgery

Safe

Good



Overall

Good



Information about the service

We visited Alder Hey Hospital as part of our announced inspection during 15-16 June 2015.

Alder Hey Children's NHS Foundation Trust Department of Paediatric Surgery and Urology provides all general and urological surgery at secondary and tertiary level to the children of Merseyside and Cheshire and, working with Manchester Children's Hospital, tertiary services to the North West of England and North Wales including the Isle of Man. This includes neonatal surgery, surgical oncology, paediatric gynaecology and reconstructive urology; providing one of the few transitional urology services in the country. Additional surgical specialities include: orthopaedics, neurosurgery, plastics, craniofacial surgery and ENT.

We inspected the Direct Admissions Unit, Ward M3 (Surgical Gastro/Bowel), the Neurosurgical Ward (NS) and the Neonatal Unit (NEO) as well as the surgical theatres. We spoke with the families and relatives of nine patients. We observed care and treatment and looked at the care records of five patients. We also spoke with a range of staff at different grades including nurses, doctors, consultants, ward managers and the clinical director for surgery, which includes theatres. We received comments from people who contacted us to tell us about their experiences, and we reviewed performance information about the trust.

We previously inspected this hospital in May 2014 and rated the "Safe" domain for surgery as 'requires improvement'. As part of that inspection, we identified shortfalls in nurse staffing, a high reliance on agency staff in ward areas, staff mandatory training levels were low and reported incidents were not always accurately assessed and learning implemented. We carried out this inspection to check whether improvements had been made.

Summary of findings

Improvements had been made since our previous inspection in May 2014.

There were good systems in place to prevent avoidable patient harm. The staffing levels and skills mix was sufficient to meet patients' needs and staff assessed and responded to patient's risks in a timely manner. The theatre teams were undertaking the 'five steps to safer surgery' procedures, including the use of the World Health Organisation (WHO) checklist and staff adherence to WHO guidelines was monitored through routine audits. Patient records were completed appropriately.

The majority of staff had completed their mandatory training but there was low compliance in information governance, safeguarding level 3 training and fire safety training. Incidents were reported and learning was shared across the departments. The environment was visibly clean, well maintained and in a good state of repair. Staff were aware of infection prevention and control guidelines. Equipment was appropriately serviced and available. Medicines were stored and administered appropriately.

Surgery

Are surgery services safe?

Good



Improvements had been made since our previous inspection in May 2014.

There were good systems in place to prevent avoidable patient harm. The staffing levels and skill mix was sufficient to meet patients' needs and staff assessed and responded to patient's risks in a timely manner. The theatre teams were undertaking the 'five steps to safer surgery' procedures, including the use of the World Health Organisation (WHO) checklist and staff adherence to WHO guidelines was monitored through routine audits. Patient records were completed appropriately.

The majority of staff had completed their mandatory training but there was low compliance in information governance, safeguarding level 3 training and fire safety training. Incidents were reported and learning was shared across the departments. The environment was visibly clean, well maintained and in a good state of repair. Staff were aware of infection prevention and control guidelines. Equipment was appropriately serviced and available. Medicines were stored and administered appropriately.

Incidents

- Incidents were reported using an electronic reporting system. Staff knew the types of incident they needed to report and could demonstrate how these would be recorded and escalated.
- When incidents occurred, an investigation was conducted using a root cause analysis process to identify any contributing factors.
- Learning from incidents had been shared at safety huddles and team meetings and changes in practice had been made where required.
- Staff told us they would also inform parents or carers when incidents occurred and of the outcomes. Evidence was seen in one patient's notes where the parents had been informed of an incident and the actions taken as a consequence.
- There were 13 serious incidents recorded by the trust relating to surgical services between April 2014 and March 2015.

- Mortality and morbidity reviews were held in accordance with trust policies and were underpinned by the Hospital Mortality Review Group procedures. All deaths were reviewed thoroughly and appropriate changes made to help to ensure the safety of children and young people.

Safety thermometer

- As a children's trust, Alder Hey is not required to submit data as part of the NHS Safety Thermometer (a tool designed to be used by frontline healthcare professionals to measure a snapshot of specific harms once a month).
- The trust had performed a similar assessment called the Paediatric Safety Scan, which was based on the National Safety Thermometer. Each ward undertook an audit on all patients on the first Thursday of each month to determine whether any patient was harmed in six areas of care.
- The Paediatric Safety Scan conducted between May 2014 and April 2015 showed 100% completion of Paediatric Early Warning Score (PEWS) which is a system used to monitor whether a child's condition is deteriorating. The safety scan also reported on pain management, pressure sore assessment, medication procedures, nutrition and extravasation (evidence of extravasation at the cannula site is recorded as harm). The results for these assessments also demonstrated a high level of compliance with policy and process.

Cleanliness, infection control and hygiene

- Children and young people were being cared for in a safe environment in the wards and theatres we inspected.
- Cleaning schedules were in place with clearly defined roles and responsibilities for cleaning the environment and decontaminating equipment. The patient and public areas were generally visibly clean, hygienic and fit for purpose; however, in some areas, we found the cleaning regime wasn't always followed and there was dust on high level surfaces. We found the bathroom and sluice areas had not been effectively cleaned. Overall, these findings were deemed to be of low risk and we notified trust management of our findings during the inspection. Action was taken to provide additional cleaning in the areas we had noted.
- Staff were aware of and adhered to current infection prevention and control guidelines such as the 'bare

Surgery

below the elbow' policy. We observed staff using appropriate hand-washing techniques and protective personal equipment, such as gloves and aprons, whilst delivering care.

- There were arrangements in place for the handling, storage and disposal of clinical waste, including sharps.
- Patients identified with an infection were isolated in side rooms with appropriate signage to protect staff and visitors.
- There had been three cases of Methicillin-Resistant Staphylococcus Aureus (MRSA) bacteraemia infections and no cases of Clostridium difficile (C. diff) infections between April 2014 and March 2015. The trust policy was to screen all patients for MRSA upon admission.

Environment and equipment

- The wards and theatre areas we visited were well maintained, with controlled access and provided a suitable environment for treating patients.
- Emergency resuscitation equipment was available in all the areas we inspected and records indicated that they were checked on a daily basis by staff. Monthly audits of the daily checklist were undertaken to ensure compliance with the policy. The trust had reviewed the resuscitation equipment on each surgical ward to ensure they met the minimum equipment and drugs required for paediatric cardio-pulmonary resuscitation as outlined in the Resuscitation Council (UK) 2013 guidance.
- Equipment was appropriately checked, decontaminated and cleaned by the ward staff and serviced by the trust's maintenance team. Equipment such as baby weigh scales were calibrated to ensure they were providing the correct weight.
- Equipment needed for surgery was readily available and any faulty equipment could be replaced from the hospital's equipment store.
- Single-use, sterile instruments were stored appropriately and were within their expiry dates and theatre staff told us they did not have any concerns relating to the sterilisation or availability of surgical instruments used for surgery.
- The trust had reviewed risk assessments for the fire escapes in the surgical wards to ensure they were secure enough to prevent children and young people leaving unnoticed and protected against people entering unobserved. The trust concluded the controls in place meant the overall risk was low.

Medicines

- Medicines, including controlled drugs, were stored securely and access was limited to qualified staff employed by the trust. Medicines requiring storage at temperatures below 8°C were appropriately stored in fridges with daily temperature checks.
- Staff carried out daily checks on controlled drugs and medication stocks to ensure medicines were reconciled correctly. We checked the balance of controlled drugs in the cupboards and found the stock balances correlated with the registers and two members of staff had signed each entry upon dispensation.
- Medication charts for three patients were reviewed and found to be complete, up to date and reviewed on a regular basis.
- Staff from the pharmacy department carried out daily reviews on each ward area to maintain minimum stock levels and to ensure medication was within its expiry dates. Medicines were ordered, stored and discarded safely and appropriately.

Records

- We looked at the records for seven patients. Nursing and medical assessment information was computerised and minimal paper records were available. The records showed that nursing and clinical assessments were carried out before, during and after surgery and these were documented correctly.
- The paper records we reviewed were structured, legible and up to date. However, we found some minor errors. For example, a nurse had hand-written a nursing evaluation but had not recorded the date. Another patient record did not clearly state the mental health issues or details of the surgical procedure to be undertaken for the patient.
- Patient records included standardised paediatric care bundles and risk assessments, such as for moving and handling, pressure care or nutrition and these were completed correctly. A 'skin bundle' care plan was also in place.
- Standardised nursing documentation was kept at the end of patients' beds. Observations were well recorded and the observation times were dependent on the level of care needed by the patient.

Safeguarding

Surgery

- During our last inspection of this trust in May 2014, safeguarding training rates were low, with only 61% of all staff in the surgical directorate having received level one child safeguarding training and 57 % receiving level three training. The current figures show that improvements are still needed in this area. At the time of our inspection, 89% of nursing staff had completed level one child safeguarding training; however, only 62% had completed level three. Only 68% of medical staff had completed level one child safeguarding training and 44% had completed the level three safeguarding training.
- Policies outlined the processes for safeguarding vulnerable adults and children and a safeguarding referral file was available in the department.
- Staff confirmed they could contact the designated safeguarding lead, safeguarding link nurses, social workers or a health visitor if a patient was suspected of being at increased risk of neglect or abuse.
- It was mandatory for staff to complete a safeguarding trigger in the clinical assessment record. The patient record alerted staff to any previous safeguarding issues. Records reviewed contained the appropriate triggers.
- Staff were aware of how to escalate key risks that could affect patient safety, such as staffing and bed capacity issues, and there was daily involvement by ward managers and the clinical business unit lead nurse to address these risks.
- Upon admission to the surgical wards and before surgery, staff carried out risk assessments to identify children at risk of harm. Children at high risk were placed on care pathways and care plans were put in place to ensure they received the right level of care.
- The surgical wards used the paediatric early warning score (PEWS) for recording the vital signs of children on the wards so that early signs of deterioration could be identified and remedial action taken. We saw that age-appropriate PEWS were used to match the age of the child.
- Staff told us that doctors and senior nurses responded quickly when PEWS scores identified the deterioration in a child's condition.
- We observed two theatre teams undertaking the 'five steps to safer surgery' procedures, including the use of the World Health Organization (WHO) checklist. The theatre staff completed safety checks before, during and after surgery and demonstrated a good understanding of the 'five steps to safer surgery' procedures.
- The completion of the WHO surgical safety checklist was recorded on the hospital's electronic patient record system. This data was reviewed on a monthly basis by the theatre clinical leads.
- Records between March 2015 and May 2015 showed there had been a total of 4475 surgical procedures where the WHO checklist was completed correctly and three occasions where the WHO checklist was not completed during this period.
- The clinical leads for day surgery and inpatient theatres also monitored staff compliance with the WHO checklist by observing at least two surgical teams per week. Any compliance issues were escalated to the theatre manager.

Mandatory training

- Staff received training in fire safety, health and safety, equality and diversity, manual handling, information governance, infection control, major incidents, resuscitation and child safeguarding level one and level three training.
- Nursing and medical staff had completed the majority of their mandatory training; however, the figures were low in some areas.
- Records showed the training completion rate among nursing staff across the surgical services ranged between 56.9% and 92%. The topics with the lowest completion rates for nursing staff were information governance (56.9%) and safeguarding level 3 training (62%), which were significantly lower than the trust's target of 90%.
- Records showed the training completion rate among medical staff across the surgical services ranged between 38.1% and 72%. The topics with the lowest completion rates for medical staff were fire safety training (50.9%), safeguarding level 3 training (44%) and information governance (38.1%).

Assessing and responding to patient risk

Nursing staffing

- Nursing staff handovers occurred twice a day and included discussions around patient needs and any staffing or capacity issues. The expected and actual staffing levels were displayed on a notice board in the unit and these were updated on a daily basis.
- Ward managers carried out daily staff monitoring and escalated staffing shortfalls due to unplanned sickness

Surgery

or leave. The ward managers told us staffing levels were based on the dependency of patients and this was reviewed daily using the Scottish Children's Acuity Measurement in Paediatric Settings (SCAMPS) acuity tool.

- During our inspection, the surgical wards and theatres had a sufficient number of trained nursing and support staff with an appropriate skills mix on shift to ensure that patients received the right level of care.
- Since our last inspection in May 2014, there had been ongoing recruitment and the majority of surgical wards were staffed to establishment. Records showed 33 whole time equivalent posts had been filled across the surgery, cardiac, anaesthesia and critical care business unit between November 2014 and April 2015.
- Royal College of Nursing (RCN) guidelines recommend a nursing ratio of one qualified nurse to four paediatric children and young people. This rises to one to three for children under two years of age, both day and night.
- We found the surgical wards were meeting the recommended nursing ratios. However, staff rotas on ward N3 (the neonatal ward) for June 2015 showed that staffing ratios did not meet the recommended guidelines in four (night shifts) out of 21 shifts. Ward staff told us this did not have any impact on their ability to provide safe care for patients.
- The theatres had 6.6 whole time equivalent vacancies for anaesthetic nurses and 1.88 whole time equivalent vacancies for recovery nurses. The theatre manager told us recruitment for these posts was on-going. The theatres had also recruited nine nurses that were scheduled to work in the department for five months on a supernumerary basis as part of their induction.
- Cover for staff leave or sickness on the surgical wards and theatres was provided by agency staff as well as the use of the existing nursing team through bank or staff working additional hours. The theatre manager told us the agency staff working in the theatres were regular agency staff that had undergone induction training and were familiar with the theatre department's policies and procedures.

Surgical staffing

- The wards and theatres we inspected had a sufficient number of medical staff with an appropriate skills mix to ensure that patients received the right level of care.
- There was sufficient on-call consultant cover over a 24-hour period and there was sufficient medical cover outside of normal working hours and at weekends. The on-call consultants were free from other clinical duties to ensure they were available when needed.
- The junior doctors and middle grade doctors we spoke with told us they received good support and could easily access the on-call consultant if needed.
- Locum doctors were used to cover for existing vacancies and for staff during leave. Where locum doctors were used, they underwent recruitment checks and induction training to ensure they understood the hospital's policies and procedures.
- Daily medical handovers took place during shift changes and these included discussions about specific patient needs.

Major incident awareness and training

- There was a documented major incident plan within the surgical services and this listed key risks that could affect the provision of care and treatment. There were clear instructions for staff to follow in the event of a fire or other major incident.
- Records showed that 88% of nursing staff had completed major incidents training; however, only 62% of administrative staff and 63% of medical staff had completed it.
- There was a dedicated 24-hour theatre available for emergency general surgery and trauma patients. Staff followed protocols so elective procedures could be cancelled if emergency lists exceeded 15 hours in a day to allow patients requiring emergency surgery to be treated promptly.

Critical care

Safe	Good	●
Effective	Good	●
Caring	Outstanding	☆
Responsive	Good	●
Well-led	Good	●
Overall	Good	●

Information about the service

We visited Alder Hey Hospital as part of our announced inspection on 15 - 16 June 2015.

The critical care services provided at Alder Hey Children's Hospital sit in the surgery, cardiac, anaesthesia and critical care clinical business unit (CBU). The paediatric intensive care unit (PICU) is commissioned for 22 intensive care beds and the high dependency unit (HDU) is commissioned for 14 high dependency beds. Both units have one additional physical bed to be used during emergencies. The PICU accepts over 1,100 admissions a year, with around 600 admissions to HDU.

We inspected the PICU and HDU facilities at the hospital. We spoke with the families and relatives of seven children. We observed care and treatment and looked at the care records for two children. We also spoke with a range of staff at different grades including nurses, doctors, consultants, ward managers, the clinical director, the lead nurse and the consultant lead for PICU. We received comments from people who contacted us to tell us about their experiences, and we reviewed performance information about the trust.

We previously inspected critical care services at this hospital in May 2014 and rated the service as 'requires improvement' overall. As part of that inspection, we identified that the HDU lacked medical and clinical leadership and there were shortfalls in nursing staffing. We also found that bed capacity constraints impacted on patient access and flow. We carried out this inspection to check whether improvements had been made.

Summary of findings

At our previous visit in May 2014 we found some areas of critical care services that required improvement. In June 2015, we returned to inspect the whole service and saw that the trust had made improvements in the quality of care being delivered. We have now rated the service as being "Good" overall, but the caring domain has been rated as "Outstanding".

The staffing levels and skill mix was sufficient to meet patients' needs and staff assessed and responded to patient's risks in a timely manner. Incidents were reported and learning was shared across the departments. The environment was visibly clean, well maintained and in a good state of repair. Staff were aware of infection prevention and control guidelines. Equipment was appropriately serviced and available. Medicines were stored and administered appropriately and patient records were completed appropriately.

The majority of staff had completed their mandatory training but there was low compliance in information governance, safeguarding level 3 training and equality and diversity training.

Staff worked to policies, procedures and clinical care pathways in line with local and national guidance. Patients were assessed for pain relief and supported in an appropriate manner. Staff had the appropriate skills and knowledge to seek consent from patients and

Critical care

explained how they sought verbal and implied informed consent. Outcomes for children were comparable to similar children's trusts in terms of mortality, length of stay and unplanned re-admissions.

Feedback from parents, carers and children about the care and treatment provided in critical care was consistently positive. Children and those close to them felt supported, involved and received information in a manner they understood. Staff were compassionate, kind and respectful whilst delivering care. We observed positive interactions between staff, patients and their relatives when seeking verbal consent. Staff supported patients and their relatives with their emotional and spiritual needs.

During our inspection, we made observations about the care people received using a Short Observational Framework for Inspection (a way of observing care to help us understand the experience of people who could not talk with us). Throughout our observations, we saw very positive interactions between staff, children, infants and their parents.

We saw staff attending to an infant who was receiving life support, throughout the time staff were with the infant, we saw them speaking to and comforting the child. During our observation we noted that as each intervention was completed, the nurse interacted with the infant verbally in a sensitive manner. We also observed staff using "touch" as a method of communication, stroking the infants arm whilst carrying out necessary observations and interventions.

Children, their parents and staff could be referred to the hospital's psychology services if necessary, where specialist support was available. We observed staff emotionally supporting parents during the inspection.

Children were admitted to critical care services in a timely manner; however, there were frequent delays in transfer of care and patients were routinely discharged out of hours. There were plans to address the patient access and flow issues as part of the reconfiguration of services following the planned move to the new hospital site in October 2015.

Critical care services were overseen by a clinical director, a lead nurse and a general manager. There was also a designated clinical lead for HDU. Staff felt proud to work

at the hospital and morale was high. There were routine clinical business unit risk and governance board meetings and departmental staff meetings where key risks were identified and reviewed.

Critical care

Are critical care services safe?

Good



At the previous inspection, we reported the nursing and medical staffing levels on the paediatric intensive care unit (PICU) were safe but we found the staffing levels (nursing and medical) on the high dependency unit (HDU) meant that at times children did not get the level of care they required.

At this inspection, we found that the staffing levels and skill mix was sufficient to meet patients' needs and staff assessed and responded to patient's risks in a timely manner. Incidents were reported and learning was shared across the departments. The environment was visibly clean, well maintained and in a good state of repair. Staff were aware of infection prevention and control guidelines. Equipment was appropriately serviced and available. Medicines were stored and administered appropriately and patient records were completed appropriately.

The majority of staff had completed their mandatory training but there was low compliance in information governance, safeguarding level 3 training and equality and diversity training. There were plans to improve training compliance by arranging for staff to attend monthly training days.

Incidents

- Incidents were reported using an electronic reporting system. Staff knew the types of incident they needed to report and could demonstrate how these would be recorded and escalated.
- When incidents occurred, an investigation was conducted using a root cause analysis process to identify any contributing factors.
- Learning from incidents had been shared at meetings and changes in practice had been made where required. Staff told us they would also inform parents or carers when incidents occurred and of the outcomes.
- There had been no Never Events (very serious, wholly preventable patient safety incidents that should not occur if the relevant preventative measures had been put in place) or serious incidents recorded by the trust relating to critical care services between April 2014 and March 2015.

- Mortality and morbidity reviews were held in accordance with trust policies and were underpinned by the Hospital Mortality Review Group procedures. Deaths were reviewed thoroughly and appropriate changes made to help to ensure the safety of children and young people.

Safety thermometer

- As a children's trust, Alder Hey is not required to submit data as part of the NHS Safety Thermometer (a tool designed to be used by frontline healthcare professionals to measure a snapshot of specific harms once a month).
- The trust had produced a Paediatric Safety Scan based on the National Safety Thermometer whereby each ward undertook an audit on all patients on the first Thursday of each month to determine whether any patient was harmed in six areas of care.
- The Paediatric Safety Scan conducted between May 2014 and April 2015 showed 100% completion of Paediatric Early Warning Scores (PEWS). The safety scan also reported on pain management, pressure sore assessment, medication procedures and nutrition. The results for these assessments also demonstrated compliance with policy and process.

Cleanliness, infection control and hygiene

- Children and young people were being cared for in a clean, hygienic and safe environment in the wards we inspected.
- Staff were aware of and adhered to current infection prevention and control guidelines such as the 'bare below the elbow' policy. We observed staff using appropriate hand-washing techniques and protective personal equipment, such as gloves and aprons, whilst delivering care.
- Cleaning schedules were in place with clearly defined roles and responsibilities for cleaning the environment and decontaminating equipment.
- There were arrangements in place for the handling, storage and disposal of clinical waste, including sharps.
- Patients identified with an infection were isolated in side rooms with appropriate signage to protect staff and visitors.
- The Infection Prevention & Control Team had conducted an audit in the high dependency unit (HDU) during April 2015. The overall compliance was 71% (classed as a fail)

Critical care

with shortfalls in areas such as the environment, waste management and poor hand hygiene. The team were due to revisit in July 2015 but many of the failings identified had been rectified.

- Results from monitoring hand hygiene between interactions from January to March 2015 in the critical care wards including the high dependency unit (HDU) and the paediatric intensive care unit (PICU) showed the average compliance was 80% with the PICU only achieving 58% in March 2015 due to medical staff not following appropriate hand hygiene guidance. Action had been taken which included making portable hand gel available at the entrances to the HDU and PICU for staff and visitors.
- There had been no MRSA bacteraemia infections and no *Clostridium difficile* (C. diff) infections between April 2014 and March 2015.

Environment and equipment

- The environment in the areas we visited was safe with controlled access into the ward areas.
- Patient areas were well maintained, free from clutter and provided a suitable environment for treating patients.
- Equipment was appropriately checked, decontaminated and cleaned by the ward staff and serviced by the trust's maintenance team.
- Single-use, sterile instruments were stored appropriately and were within their expiry dates.
- Emergency resuscitation equipment was available in all the areas we inspected and records indicated that it was checked on a daily basis by staff.

Medicines

- Medicines, including controlled drugs, were stored securely and access was limited to qualified staff employed by the trust. Medicines that required storage at temperatures below 8°C were appropriately stored in fridges with daily temperature checks.
- Records indicated that staff carried out daily checks on controlled drugs and medication stocks to ensure medicines were reconciled correctly. We checked the balance of controlled drugs in the cupboards and found the stock balances correlated with the registers and two members of staff had signed each entry upon dispensation.

- Staff from the pharmacy department carried out daily reviews on each ward area to maintain minimum stock levels and to ensure medication was within its expiry dates.

Records

- We looked at the records for two patients. Medical assessments and care plans were recorded electronically and information such as patient observations were recorded on paper records.
- The medical and nursing notes were structured, legible, complete and up to date and showed that timely assessments by nurses and daily medical reviews took place.
- Patient records included standardised paediatric care bundles and risk assessments, such as for pressure care or nutrition and these were completed correctly in the records that we reviewed.
- Standardised nursing documentation was kept at the end of patients' beds. Observations were well recorded and the observation times were dependent on the level of care needed by the patient.

Safeguarding

- Policies outlined processes for safeguarding vulnerable adults and children and a safeguarding referral file was available in the department.
- Staff confirmed they could contact the safeguarding link nurse, social services or a health visitor if a patient was suspected of being at increased risk of neglect or abuse.
- It was mandatory for staff to complete a safeguarding trigger in the clinical assessment record. The patient record alerted staff to any previous safeguarding issues. Records reviewed contained the appropriate triggers.
- Data showed 76% of medical staff had completed level 1 safeguarding training and 47% had also completed the level 3 safeguarding training. Only 69% of nursing staff were currently up to date with level 1 of the safeguarding training and 86% had completed level 3.

Mandatory training

- Staff received training in fire safety, health and safety, equality and diversity, manual handling, information governance, infection control, major incidents, resuscitation and safeguarding level one and level three training.

Critical care

- The majority of nursing and medical staff had completed their mandatory training; however, the figures were low in some areas.
- Records showed the training completion rate among nursing staff across the critical care service ranged between 56.9% and 92%. The topics with the lowest completion rates for nursing staff were information governance (56.9%) and safeguarding level 1 training (68.9%).
- Records showed the training completion rate among medical staff across the critical care service ranged between 47% and 78%. The topics with the lowest completion rates for medical staff were equality and diversity training (57.4%), information governance (50%) and safeguarding level 3 training (47%).
- Staff were given the opportunity to complete any outstanding mandatory training during monthly training days.

Assessing and responding to patient risk

- The critical care staff used the paediatric early warning score (PEWS) for recording the vital signs of children on the wards so that early signs of deterioration could be identified and remedial action taken. We saw that age-appropriate PEWS were used to match the age of the child.
- If a patient's health deteriorated, ward staff were supported by the critical care nurses and doctors as there was no formal outreach service. A decision was then made collaboratively whether to admit to the paediatric intensive care unit (PICU) or high dependency unit (HDU).
- The hospital carried out an audit of paediatric safety and harms. Records showed that between June 2014 and May 2015 there had been 22 incidents which resulted in harm relating to the incorrect use of the PEWS process across the hospital and all these incidents were reported within the PICU.

Nursing staffing

- The paediatric intensive care unit (PICU) and high dependency unit (HDU) had a sufficient number of trained nursing and support staff with an appropriate skill mix on shift to ensure that patients received the right level of care.
- Nursing staff handovers occurred twice a day and included discussions about the child's needs and any staffing or capacity issues.

- The expected and actual staffing levels were displayed on a notice board in the unit and these were updated on a daily basis.
- All level 3 (intensive care) patients were nursed 1:1 and all level two (high dependency) patients were nursed 1:2 in accordance with best practice guidelines.
- There was a lead nurse on each shift within the HDU and PICU that was supernumerary and did not form part of the staffing establishment.
- The HDU and PICU ward managers carried out daily staff monitoring and escalated staffing shortfalls due to unplanned sickness or leave. The ward managers told us staffing levels were based on the dependency of patients and this was reviewed daily.
- The PICU ward manager told us there were eight nurses on maternity leave and additional nurses had been recruited as part of the establishment to cover for the staff on long term leave.
- Since our last inspection in May 2014, a total of a total of 18.62 whole time equivalent vacant nursing posts within the HDU had been recruited to. At the time of this inspection, there were five whole time equivalent band 5 nurse vacancies in the HDU. Recruitment for additional nursing staff was on-going and interviews for these posts were scheduled in the coming weeks.
- The ward managers for PICU and the HDU told us they did not routinely use external agency staff. The majority of cover for staff leave or sickness was provided by the existing nursing team through bank or staff working additional hours.

Medical staffing

- Critical care services had a sufficient number of medical staff with an appropriate skill mix to ensure that patients received the right level of care. The majority of staff cover was arranged from the existing team working additional hours; however, the service used agency or locum medical staff if that was not possible.
- Medical staff handovers occurred twice a day and included discussions around patient needs.
- There was a designated lead consultant for intensive care within the PICU. Care in the PICU was supported by twice-daily consultant-led ward rounds. All admissions to the PICU were agreed by a consultant.
- Two consultants were present on the PICU from 8.30am to 5.30pm weekdays, with two consultants being on call out of hours. There was at least one consultant available on-call during weekends.

Critical care

- The trust had appointed a lead intensive care consultant within the HDU, to provide medical leadership and clinical accountability on the unit.
- Consultants in both units were supported by a team of registrars. Three intensivists and a nurse consultant oversaw the HDU and they were supported by an advanced paediatric nurse practitioner (APNP) that worked four days a week between 8am and 6pm.
- The PICU lead consultant and the clinical lead for the surgery, cardiac, anaesthesia and critical care business unit told us there were no vacant registrar posts. There were plans to recruit to three substantive consultant posts by August 2015 and individuals had been identified for interview.

Major incident awareness and training

- There was a documented major incident plan in the critical care services, and this listed key risks that could affect the provision of care and treatment, such as fire, loss of utilities or disruptions to services. There were clear instructions in place for staff to follow in the event of a major incident.
- Records showed that 66% of administrative staff, 78% of medical staff and 88% of nursing staff across the critical care services had completed major incidents training.

Are critical care services effective?

Good



Staff worked to policies, procedures and clinical care pathways in line with local and national guidance. Patients were assessed for pain relief and supported in an appropriate manner. Staff had the appropriate skills and knowledge to seek consent from patients and explained how they sought verbal and implied informed consent.

The critical care services contributed to the Paediatric Intensive Care Audit Network (PICANet) database. The PICANet 2014 report demonstrated that the outcomes at this hospital were comparable to similar children's trusts in terms of mortality, length of stay and unplanned re-admissions. Patients received care and treatment by trained, competent staff that worked well as part of a multidisciplinary team.

Evidence-based care and treatment

- Care and treatment was delivered in line with evidence-based practice. Policies and procedures, assessment tools and pathways followed recognisable and approved guidelines such as the National Institute for Health and Care Excellence (NICE), Royal Colleges' and the Paediatric Intensive Care Society guidance.
- Clinical pathways and bundles used to ensure appropriate and timely care for children and young people with specific needs, such as ventilation, were developed in line with nationally recognised standards.
- Updated guidance and identified changes to practice were available to staff electronically and regularly discussed at local meetings and safety huddles and displayed on the team information board.
- The critical care department had a clinical audit programme to monitor how guidance was adhered to and staff undertook local audits to assess compliance. All of these audits resulted in staff education and changes in practice to improve patient care.

Pain relief

- The hospital had a dedicated pain service which helped to support and advise children and young people and their families.
- Pain assessment tools were in place where appropriate and pain relief was administered as required for children such as those with long-term conditions or children with complex needs and those who required ventilation.
- Nursing staff told us pain relief was also supported with the use of appropriate positioning e.g. use of special beds, mattresses and specialist seating for children and young people who were not mobile.

Nutrition and hydration

- Staff in the PICU and HDU worked with the trust's nutrition, dietetics and special feeds teams as required in the management of children and young people.
- Nurses provided training to parents and carers for children with complex needs around nutrition and the use of feeding equipment where appropriate.
- Hydration and fluid balance was monitored appropriately for children and young people in the PICU and HDU.
- Breast milk was stored for mothers with young children in appropriate fridges and freezers at the appropriate temperatures with systems and checks in place to ensure full traceability was maintained.

Critical care

Patient outcomes

- The PICU contributed to the Paediatric Intensive Care Audit Network (PICANet) database. (PICANet is an international audit of paediatric intensive care which collects data on all children admitted to paediatric intensive care units in the UK and Ireland).
- The PICANet 2014 report demonstrated that the PICU at Alder Hey achieved comparable outcomes to similar children's trusts in terms of mortality, length of stay and unplanned re-admissions.
- The patients and relatives we spoke with were positive about the care and treatment they received.

Competent staff

- Newly appointed staff were inducted to the area and their competency was assessed over a three month period before working unsupervised. Agency staff also had a competency based induction before starting work.
- The critical care service had practice educators that oversaw training processes and carried out competency assessments. The nursing and medical staff were positive about on-the-job learning and development opportunities and told us they were supported well by their line management.
- Records showed that 97.8% of medical staff had completed their appraisal. Records up to April 2015 showed that 86% of administrative staff and 53% of nursing staff had completed their annual personal development reviews (PDR's). The remaining staff were scheduled to complete their PDR appraisals by the end of July 2015.
- The ward manager for PICU told us at least 50% of staff had completed the post registration award in critical care nursing, which was in line with good practice standards.
- Records showed that nine of the 11 eligible consultants in the critical care services had been revalidated with the General Medical Council (GMC). The remaining two were not due for revalidation until later in the year.

Multidisciplinary working

- There was effective daily communication between multidisciplinary teams within the critical care services.

Staff handover meetings took place during shift changes and multidisciplinary 'safety huddles' were carried out on a daily basis to ensure all staff had up-to-date information about risks and concerns.

- Patient care in the PICU was led by paediatric consultant intensivists. There was a daily multidisciplinary ward round which had input from nursing, microbiology, pharmacy and physiotherapy.
- The care of a child or young person in HDU was managed by a combination of consultants, depending on the patient's clinical need, with a lead consultant who oversaw the care. Patients requiring long term ventilation were seen by consultant intensivists. For other admissions, the care was led by the relevant specialist team (such as cardiology, gastroenterology).
- There was effective working with the North West and North Wales Transport Service (NWTs) and some of the trust's intensive care nurses and anaesthetic doctors were allocated time to work with the transfer and retrieval teams.
- The nursing staff told us they had a good relationship with consultants and ward-based doctors.
- There was a formal weekly multidisciplinary team meeting that involved staff from different disciplines. Patient records showed that there was routine input from nursing and medical staff and allied health professionals.
- Staff told us they received good support from pharmacists, dieticians and physiotherapists as well as diagnostic support for things such as x-rays and scans. Speech and language therapists and occupational therapists were available by referral when needed.

Seven-day services

- Staff rotas showed that nursing staff levels were appropriately maintained outside normal working hours and at weekends to meet patients' needs.
- Patients admitted to the PICU or HDU were seen daily by a consultant intensivist.
- Microbiology, imaging (e.g. x-rays), physiotherapy and pharmacy support was available on-call outside of normal working hours and at weekends.
- We found that sufficient out-of-hours medical cover was provided to patients in the critical care services. Ward staff told us they received good support outside normal working hours and at weekends.

Access to information

Critical care

- The hospital used both paper based and electronic patient records. Medical assessments and care plans were recorded electronically and information such as patient observations were recorded on paper records.
- The patient records we looked at were complete, up to date and easy to follow. The records we looked at contained detailed patient information from admission through to transfer or discharge. This meant that staff could access all the information needed about the patient at any time during the patient journey.
- We saw that information such as staffing levels, performance information and internal correspondence was displayed in all the areas we inspected.
- Staff told us the information about patients was easily accessible. Staff could access information such as policies and procedures from the hospital's intranet.

Consent and Mental Capacity Act

- Staff had the skills and knowledge to ask children and their representatives for consent and explained how they sought verbal and implied informed consent.
- Staff used the Gillick competency and Fraser guidelines (used to decide whether a child is mature enough to make decisions), where appropriate, to balance children's rights and wishes with the responsibility to keep children safe from harm.
- Patient records showed verbal or written consent was obtained appropriately from children or their representatives.

Are critical care services caring?

Outstanding



Feedback from parents, carers and children about the care and treatment provided in critical care was consistently positive. Children and those close to them felt supported, involved and received information in a manner they understood. Staff were compassionate, kind and respectful whilst delivering care. We observed positive interactions between staff, patients and their relatives when seeking verbal consent. Staff supported patients and their relatives with their emotional and spiritual needs.

During our inspection, we made observations about the care people received using a Short Observational Framework for Inspection (a way of observing care to help

us understand the experience of people who could not talk with us). Throughout our observations, we saw very positive interactions between staff, children, infants and their parents.

We saw staff attending to an infant who was receiving life support, throughout the time staff were with the infant, we saw them speaking to and comforting the child. During our observation we noted that as each intervention was completed, the nurse interacted with the infant verbally in a sensitive manner. We also observed staff using "touch" as a method of communication, stroking the infants arm whilst carrying out necessary observations and interventions.

Children, their parents and staff could be referred to the hospital's psychology services if necessary, where specialist support was available. We observed staff emotionally supporting parents during the inspection.

Compassionate care

- Children, young people, their families, relatives and representatives were positive about the care and treatment provided.
- We observed many examples of compassionate care given to children, young people and their families based on individual needs. Staff provided reassurance and comfort to parents who were anxious or worried.
- Cubicle curtains and doors were closed during consultations to maintain privacy.
- Children, young people and their families and carers were being treated with compassion, dignity and respect by staff of all grades.
- The NHS Friends and Family Test (a survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care) only became applicable to critical care from April 2015 and results were not available.
- At this inspection, we made observations about the care people received using a Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.
- Using SOFI, we followed the care of infants and children using the service within the high dependency unit (HDU) to help us understand their experiences of the care and treatment they received. Throughout our observations, we saw very positive interactions between staff,

Critical care

children, infants and their parents. We noted that staff were kind, compassionate and caring. We saw staff attending to an infant who was receiving life support, throughout the time staff were with the infant, we saw them speaking to and comforting the child. During our observation we noted that as each intervention was completed, the nurse interacted with the infant verbally in a sensitive manner. We also observed staff using “touch” as a method of communication, stroking the infants arm whilst carrying out necessary observations and interventions. This showed that staff were skilled in communicating with children and infants.

Understanding and involvement of patients and those close to them

- Parents and young people received information about their care and treatment in a manner they understood.
- Parents and young people were involved in the planning of their care and contributed to developing the child’s care plan. Patient records included assessments that took into account individual preferences.
- Upon admission, children were allocated a designated member of staff to oversee the provision of care they received to ensure continuity.
- We observed positive interactions between staff, patients and their parents or representatives when seeking verbal consent.
- Parents, young people and those close to them were involved in the planning for discharge or transfer from the department.
- As part of the SOFI, we observed discussions between staff and parents on the HDU. Staff were caring and compassionate in their manner and acted on the wishes of parents whilst ensuring the impact of those wishes was communicated clearly. We observed one nurse discussing a patient’s imminent discharge with a parent. The parent expressed some anxieties about leaving the unit and coping once home and the nurse took time to encourage the parent and assure them support would be put in place to ensure the process went smoothly.

Emotional support

- Children, their parents and staff could be referred to the hospital’s psychology services if necessary, where specialist support was available.

- Staff could seek support from the hospital’s palliative care team if a child required end of life care. Staff were also able to provide overnight accommodation for relatives.
- Staff made people aware of the support groups that they could access. For example, the Alder Centre which provides services for bereaved families, including counselling and access to a telephone helpline.
- We observed staff emotionally supporting parents. For example, we saw a nurse accompanying a parent back onto the unit after their infant had gone into theatre. They were able to reassure and comfort the parent whilst their infant was off the unit.

Are critical care services responsive?

Good



At the previous inspection bed availability in the HDU was affected by the number of children or young people who required long-term ventilation or respiratory support. This sometimes impacted on the PICU’s ability to step down children or young people to HDU in a timely manner. There were cases when patients had their surgery cancelled on the day of operation due to the lack of HDU beds. The HDU did not have appropriate facilities for visiting parents and carers.

At this inspection the bed occupancy levels between November 2014 and April 2015 ranged between 90% and 97% in the HDU and between 84% and 94% in the PICU. There had been 36 last minute elective admission cancellations between May 2014 and April 2015 due to lack of available beds in the PICU. Patients were admitted to the critical care services in a timely manner. However, there were frequent delays in transfer of care and patients were routinely discharged during out of hours. The critical care services planned to address the patient access and flow issues, including the bed occupancy and facilities for parents, as part of the reconfiguration of services following the planned move to the new hospital site in October 2015.

Staff had access to a telephone interpreter service. There had been no formal complaints relating to critical care services between October 2014 and March 2015.

Service planning and delivery to meet the needs of local people

Critical care

- The environment for patients was comfortable with plenty of seating available for families whilst visiting. The PICU had facilities for parents which included a fridge, microwave and hot drink-making facilities.
- The paediatric intensive care unit (PICU) was commissioned for 22 intensive care beds and the high dependency unit (HDU) was commissioned for 14 high dependency beds. The PICU accepted over 1,100 admissions a year, with around 600 admissions to the HDU.
- The hospital took referrals from across the North West of England and the Isle of Man and as such had children and families travelling long distances to be treated. Purpose built free accommodation for the families of seriously ill children was available in the “Ronald McDonald House”.
- There were eight high dependency beds on the cardiac ward and six high dependency beds on the neurosurgical ward. These beds were allocated to high dependency patients that did not require ventilator support so they could be cared for by trained staff within the cardiac and neurosurgical specialties.
- During the inspection, we saw that the majority of available beds were occupied by patients. Records showed bed occupancy levels between November 2014 and April 2015 ranged between 90% and 97% in the HDU and between 84% and 94% in the PICU.
- Records showed there had been 36 last minute elective admission cancellations between May 2014 and April 2015 due to lack of available beds in the PICU.
- The North West & North Wales Paediatric Transport Service (NWTs) was a collaborative venture between the Royal Manchester Children’s Hospital and Alder Hey Children’s Hospital and had been commissioned by the specialist commissioning team in the North West to transfer critically ill children from district general hospitals to one of the two PICUs in the North West and North Wales region. Part of the role of the transport service was to provide a formal educational outreach service for district general hospital staff in the region involved in the care of critically ill or injured children.

Meeting people’s individual needs

- Staff had access to a telephone interpreter service for young people, parents and carers whose first language was not English. Information gathered when patients were admitted to the ward identified who would need this service and translators were booked when staff needed to explain any treatment or procedures.
- Staff told us they wouldn’t use family members to translate for consent which is in line with best practice guidance.
- Information was available for patients throughout the hospital via information leaflets and displayed on noticeboards. Patient information leaflets were available but were mostly in English.

Access and flow

- Staff carried out daily meetings to maintain patient flow and to identify and resolve any issues relating to the admission or discharge of patients.
- The PICU had 21 beds including two double cubicles so could take a maximum of 23 patients if required. The HDU was commissioned to provide 14 beds but this could be increased to 15 beds if required. Patients with complex needs that required ventilation or respiratory support were admitted directly to the PICU or HDU. Hospital records showed during the 2014/2015 financial year and up to May 2015, there had been no patients outside of the critical care services receiving invasive ventilation.
- Patients in the wards or emergency department that required admission to critical care were assessed and treated by the PICU doctors, who stabilised the patient prior to transfer to the PICU.
- Patients transferred out of hours fell into two categories: early evening transfers (4pm onwards), where a bed in the hospital only became available after the discharge of a day-case surgery patient and later discharges (10pm onwards), where the patient was moved to permit the admission of a child who was more in need.
- Records between November 2014 and April 2015 showed that 182 patients were discharged from 4pm to 7:59am on weekdays, 39 patients were discharged from 10pm to 6:59am on weekdays and 109 patients were discharged during weekends. The lead consultant for PICU told us patients were only discharged out of hours if it was clinically safe to do so.

Critical care

- The PICU planned to carry out an audit to identify which patients were transferred out of the PICU out of hours and capturing key information from the nurse in charge of the ward about the circumstances which surround the transfer.
- There had been no non-clinical patient transfers between November 2014 and April 2015.
- Records for delayed transfers of care showed there had been a total of 728 delayed transfer days on the PICU between November 2013 and October 2014. The average length of delayed transfers was two days during this period.
- The largest cause of delayed transfer days was access to ward K2 with 290 days (39%) of all delayed transfer days. The second largest cause of delayed transfer days was access to HDU with 103 days (14% of all delayed transfer days).
- The clinical business unit 2014-16 business plan included an objective to 'Increase capacity in critical care and cardiac services to improve patient flow, access and experience, and deliver income growth.'
- The critical care services planned to address the patient access and flow issues as part of the reconfiguration of services following the planned move to the new hospital site in October 2015.
- The proposed reconfiguration was to provide critical care services from a combined HDU / PICU unit with capacity for 43 beds (including 21 PICU and 20 HDU beds).

Learning from complaints and concerns

- Information on how to raise complaints was displayed within the critical care services and included contact details for the Patient Advice and Liaison Service (PALS).
- The hospital's aim was to respond to complaints within 25 working days or a timescale negotiated with the complainant. The PICU and HDU ward managers were responsible for reviewing and investigating complaints. Staff told us information about complaints would be discussed during routine team meetings to raise staff awareness and aid future learning; however, records showed there had been no formal complaints made relating to critical care services between October 2014 and March 2015.

Are critical care services well-led?

Good



At the previous inspection we reported there was strong leadership on both units. The paediatric intensive care unit (PICU) had a designated clinical director and ward manager but the high dependency unit (HDU) did not have a designated clinical lead. At the time, we were not convinced the arrangements in place were always promoting the safety of children and young people on the HDU. We requested that immediate remedial action be taken by the trust to mitigate the risks.

At this inspection it was clear steps had been taken to improve the level of medical support in the units. The critical care services were incorporated into the surgery, cardiac, anaesthesia and critical care business unit, which was overseen by a clinical director, a lead nurse and a general manager. There was also a designated clinical lead for the HDU. The vision for critical care and the trust was embedded in the department and staff embraced the values in the work they undertook. Staff focused on providing the right treatment at the correct time and nursing the children most in need of care in the most appropriate area. Staff felt proud to work at the hospital and morale was high.

There were routine clinical business unit risk and governance board meetings and departmental staff meetings where key risks were identified and reviewed. There was effective teamwork and clearly visible leadership within the PICU and HDU. There was a designated lead consultant and a ward manager for each area. Staff told us they received good management support.

Vision and strategy for this service

- The vision for critical care services, developed in conjunction with Situation Awareness for Everyone (SAFE) guidance, was "to provide safer care across the trust generally, through improved situational awareness, and a defined structured periodic team review, and establish clear leadership to this process."
- The strategy for critical care was to work towards creating a clear pathway through critical care and the general wards to enable a seamless transition into adult services and towards the development and education of ward staff to enable safe care and management of patients on non-invasive respiratory support.

Critical care

- The future strategy was to develop an integrated PICU/ HDU service with 43 beds in the new Alder Hey hospital due to open in October 2015.
- Staff had a clear understanding of the vision and strategy and could articulate what the vision and values meant for their practice.

Governance, risk management and quality measurement

- There was a monthly clinical business unit risk and governance board meeting that included the review of incidents, key risks and monitoring of performance. Identified performance shortfalls were addressed by action planning and regular review.
- Within the PICU and HDU, there were routine multidisciplinary staff meetings to discuss day-to-day issues and to share information on complaints, incidents and audit results.
- Risks were documented and escalated by the service appropriately. The risk register for the surgery, cardiac, anaesthesia and critical care business unit listed risks relating to the critical care services and this showed that key risks had been identified and assessed.
- We saw that routine audit and monitoring of key processes took place to monitor performance against objectives. Information relating to performance against key quality, safety and performance objectives was monitored and cascaded to staff through performance dashboards.

Leadership of service

- The critical care services were incorporated into the surgery, cardiac, anaesthesia and critical care business unit, which was overseen by a clinical director, a lead nurse and a general manager.
- There were clearly defined and visible leadership roles within the PICU and HDU. There was a designated lead consultant and a ward manager in each area. The nursing staff were managed by a supernumerary lead nurse on each shift, who reported to the ward manager within their unit.
- The staff we spoke with told us they understood the reporting structures clearly and that they received good management support.

Culture within the service

- Staff told us they focused on providing the right treatment at the correct time. The team ethos was to nurse the children most in need in the most appropriate area.
- There was a positive attitude and culture within where staff valued each other and felt encouraged to speak freely to raise concerns that would be acted upon. Staff were dedicated, compassionate and felt proud to work at the hospital.
- Staff from all specialities worked well together and had mutual respect for each other's contribution to the holistic care of their patients.
- Staff told us the morale within the department was good and had improved recently due to increased staffing levels.

Public engagement

- Information on how public could provide feedback was displayed in the departmental areas and feedback mechanisms for the public to engage with the trust were also on the internet site.
- Staff told us they routinely engaged with children and their relatives to gain feedback from them.
- The department included 'you said we did' information on notice boards which listed improvements made as a result of public engagement such as responses to complaints.

Staff engagement

- Staff received regular communications from the trust and the department. Communication was disseminated from their line managers, from team meetings and during huddles.
- The trust also engaged with staff via emails, newsletters and through information displayed on notice boards in staff areas.
- Staff accessed information electronically such as policies and procedures. Computer screens had daily alerts and messages such as updates to practices or safety alerts displayed.
- The trust had reviewed the findings from the 2014 survey of NHS staff in the HDU and PICU. Areas for improvement included staff feeling there were little opportunities for them to develop their career in this organisation and staff felt the person they reported to didn't always create opportunities for their professional







Critical care

growth. Staff felt very positive about their colleagues and strongly agreed with the statement “I would consider some of my work colleagues to be good friends”.

Innovation, improvement and sustainability

- The critical care services were scheduled to relocate to a new ‘purpose-built’ hospital with a combined unit with 21 ICU and 20 HDU beds during October 2015. The services planned to improve patient access and flow as part of the reconfiguration plan.
- An upgrade to the electronic patient record system was being rolled out across the hospital during June 2015. Training in the new system had been rolled out to staff across the critical care services.
- There had been a number of improvements made since our last inspection, such as improvements in nursing staffing and consultant cover and medical leadership on HDU.
- The business unit clinical director and lead nurse were confident about the future sustainability of services. The lead nurse told us the key risks going forward were to maintain appropriate staffing levels and deliver timely patient access and flow.

Transitional services

Safe	Good	
Effective	Good	
Caring	Good	
Responsive	Good	
Well-led	Good	
Overall	Good	

Information about the service

We visited Alder Hey Hospital as part of our announced inspection on 15 - 16 June 2015.

Transition services are provided as part of the overall services at the trust for children and young people and are not managed as a distinct clinical area (such as medicine or surgery). Transition services for young people are managed by individual specialities within the hospital.

The trust provides both inpatient and outpatient services for young people over the age of 12 and in some instances past the age of 18. Between November 2014 and April 2015 a total of 21 young people over the age of 19 were admitted to the trust. The trust provided transition services from paediatric care to adult services for those children and young people with long term health needs. At the time of our visit, there were 39 young people over the age of 12 who were inpatients. Alder Hey Children's hospital did not have a designated adolescence ward, with the exception of the oncology teenage unit. The trust offers transition clinics for young people with long term conditions and complex needs.

We visited six inpatient areas, spoke with five young people, three parents and 17 staff. We observed care and treatment and reviewed three pathways of clinical care. We looked at transition arrangements for young people moving into adult services. Before the inspection, we reviewed performance information from, and about, the hospital.

We previously inspected this hospital in May 2014 and rated transition services as 'requires improvement' overall. As

part of that inspection, we identified that there was no overall responsibility or leadership for transitional services in the trust, there was no co-ordinated trust wide planning for the delivery of transition services, there was no overarching transition strategy, vision or agreed core standards set by the trust, there was no identified lead for this work and staff were unaware of who had responsibility for developing transitional services outside of their own field of work. We carried out this inspection to check whether improvements had been made.

Transitional services

Summary of findings

Since our last inspection, there have been significant improvements and we have been impressed by the amount of progress in transitional services since we last inspected. We found that the trust had a co-ordinated trust wide strategy for planning and delivering transition services which supported young people. We found excellent examples of transition pathways for young people with specific long-term needs. We found that there was a commitment from the trust to further develop existing partnerships with health and social care providers of adult services.

Since our last inspection, the trust had appointed a designated transition nurse and named medical consultant. As a result, progress had been made in developing over-arching policies and procedures relating to transition arrangements for young people with complex needs. We were unable to assess the full impact of these at the time as policies and procedures had not been formally rolled out.

There was clear leadership, vision and desire at Alder Hey to use research and audit programmes to share good practice and identify gaps in transition and use this to improve outcomes for young people. There was evidence of patient, public and staff involvement in shaping policies and procedures related to transition.

Are transitional services safe?

Good



There were arrangements in place to report and monitor incidents that related to young people who were due to transition into adult services. We found equipment to be fit for purpose and undertook observations of infection prevention practice which we found to be satisfactory.

We found that in the areas we visited, the environment was clean and tidy; however the environment was not always supportive to young people due to the restriction of the building. Staff told us that the move into the new hospital scheduled for October 2015 would improve the environment for young people.

Over-arching policies and procedures had been developed in order to support the safe transfer of young people to adult services. The introduction of a transition register and review process for young people aged 14 and over supported safeguarding young people.

Incidents

- Incidents were reported using an electronic reporting system. Staff knew the types of incident they should report and could demonstrate how these would be recorded and escalated.
- We reviewed information that the trust provided and found that there were no never events or serious incidents involving young people in transition.
- We reviewed incident information data available for the past six months, which showed that there were no incidents reported that were related to transition.
- The category of 'young people in transition' had been added to the trust incident reporting system. We were advised that these would be reported to the transition steering group on a quarterly basis going forward for action and shared learning.
- We found evidence of shared information from other providers and reporting from other providers within serious incident requiring investigation (SIRI) information
- There were no incidents recorded for patients in transition; however, the trust had a process in place to manage incidents which would fit the criteria for duty of candour.

Transitional services

Cleanliness, infection control and hygiene

- The teenage cancer unit was the only area specifically designated for young people who would be considered as part of transitional services and we found the area to be visibly clean and well maintained.
- We observed staff following hand hygiene practice in line with local and national policy.
- We observed staff using personal protective clothing appropriately.
- All areas that we visited had appropriate and accessible hand hygiene facilities.
- The trust as a whole reported low incidences of MRSA bacteraemia and no cases of Clostridium difficile between April 2014 to March 2015.

Environment and equipment

- Age appropriate resuscitation equipment and emergency equipment was available for staff across children's and young people's areas.
- The transition team had identified young people with complex needs that were supported by specific equipment and technological aids as part of the work undertaken to support young people with complex needs.
- At the time of our inspection, with the exception of the teenage oncology unit, young people were cared for in the same environment as younger children. We observed three young people who were all nursed in a single room.

Medicines

- Daily checklists were in place to monitor fridge temperatures to ensure safe storage of medicines.
- We found good examples of young people being supported to manage medications for long term conditions such as nephrology, cardiology, diabetes and cystic fibrosis.
- Within cardiology we found that as part of transition planning, key check points for young people to understand their medications were built in as part of the review process.
- We found that information was easily available for young people regarding medications.

Records

- Since our last visit the trust had completed a trust wide review on documentation used to support young people ready for transition. This was used to develop transition documentation which supports those young people with complex needs and multiple specialities.
- For some young people transitioning into adult services, hand held records were available which had key information, prompts and advice. We saw three good examples of this for young people with cardiac, renal conditions and diabetes.
- The trust has just implemented health passports for young people with complex health issues which were designed to meet the young person's individual needs.
- We found examples of established shared documentation relating to transition for a number of long-term conditions such as cardiology and diabetes.
- The trust had established links with a large number of tertiary hospital's and adult services. The trust supported a number of transition clinics for young people with specific conditions.

Safeguarding

- Monitoring arrangements were in place to review all young people aged 18 or over that were admitted to the trust through the safeguarding committee. Between January – March 2014, the trust reported that 21 young people were admitted aged 18 or over.
- The trust currently does not provide adult safeguarding training for staff; however, it is understood that there has been consultation with senior staff and commissioners to assess the trust needs.

Mandatory training

- The trust did not provide specific mandatory training related to transition within its core mandatory training, however since our last visit the trust had completed a training needs analysis and competency framework related to transition. As part of the trust strategy related to transition we were advised that transition training would be mandatory for relevant staff.

Assessing and responding to patient risk

- The trust had introduced a transition register for young people from the age of 14 where it is identified that transition to adult services may be difficult based on clear criteria. This includes some young people with complex needs.

Transitional services

- The trust has also introduced a register and monitoring arrangements of all young people over the age of 18 who continue to receive care at Alder Hey. All patients who are on the register are reviewed every six months by the medical director and the lead clinician must provide information every six months related to the young person's individual needs.
- The introduction of the role of the transition nurse and lead consultant has enabled families and carers of young people with complex needs to have a direct point of access at the trust if they have any worries or concerns.

Nursing staffing

- There has been a recent appointment of lead nurse for transition. Evidence we reviewed showed us that this role was supportive of young people with complex needs in transitioning to adult services and acting as an advocate to safeguard young people and their families.

Medical staffing

- Since our last visit the trust has identified two designated medical leads who provided educational sessions and specialist information for staff supporting young people in transition and young people with a learning disability. At the time of our visit, these were part of existing arrangements and specified time was not included in individual job plans.

Major incident awareness and training

- There were business continuity plans and major incident plans in place for children and young people's services.

Are transitional services effective?

Good



There were positive examples of transition pathways in a number of condition specific services which were evidence based. The trust had completed a review of transition services and reviewed the needs of young people and their families and collated a research and audit programme based on measurable outcomes.

Young people were provided with adequate nutrition and hydration; however, two young people told us that they would like more choice. Young people involved in transition had access to services to support nutritional needs.

Over-arching policies and procedures and training competencies had recently been developed following extensive consultation and there were plans to roll them out imminently at the time of the inspection.

Evidence-based care and treatment

- Young people were treated according to national guidance, including those from the National Institute for Health and care Excellence (NICE) and Royal college of Paediatrics and Child Health. Policies and procedures were based on national guidelines.
- Since our last visit, the trust had completed a review of transition services based on evidence based national guidance and had mapped policies and procedures to this guidance. These were due to be published imminently after our visit.
- The trust had developed a trust-wide audit of the transition programme following completion of a baseline audit. Within this there were clear measurable outcomes within the "ten steps to transition" pathway. This was based on national guidance and modelled against local best practice.
- There was an established research programme in place looking at transition. Examples of these were a research based study looking at transition outcomes and interventions for young people across North West England and models of transitional care across Merseyside which involved multi-disciplinary input and feedback from young people.
- We found a number of examples of condition specific research including nephrology, epilepsy, long-term ventilation and cardiology. A young person and their family told us that their experience of being involved in a research programme at Alder Hey had been really positive.
- Staff from Cardiology services told us that the impact of research for those young people eligible to switch to a medication regime which required no monitoring had had a significant positive impact as young people were not on medication that required regular monitoring.

Transitional services

- For condition specific pathways, young people had a named consultant in regional adult services which was facilitated through dual led transition clinics.
- Alder Hey demonstrated good links with local adult providers, notably Aintree University Hospital NHS Foundation Trust.
- Since our last visit we found that those young people under the care of more than one consultant were being supported in transition by a named consultant and lead nurse.
- Alder Hey “Ten steps to Transition” programme supported the transition planning. This included considering what support a young person required from a range of health, education and social service providers.

Pain relief

- There was a pain team available to support young people and pain assessments were reviewed as part of transition planning.
- Young people were supported in Alder Hey with pain interventions by the play specialist team.

Nutrition and hydration

- Transition planning included a review of an individual's nutrition and hydration needs. This included involvement from dietitians and experts in parental nutrition where appropriate.
- We saw evidence of involvement from catering staff to support a young person with specific nutritional requirements.
- A young person that we spoke to told us that “the food is not always nice”.
- One young person told us they would like more choice, particularly vegetarian options and that the dietician was devising a menu to support this.
- There was catering representation on both the young people's forum and parent's forum where menu options were discussed and reviewed.
- Young people, parents and staff told us that having a chef available to cater for individual needs on the Teenage Cancer unit had a positive impact on young people's health and well-being.

Patient outcomes

- The trust completed a Self-Assessment against the “You're Welcome” quality criteria set by the Department of Health for young people friendly health services. The completed self-assessment document sign-posted to the trust overall transition policies and procedures.
- The trust had completed a baseline audit of transition arrangements and developed a local audit programme of key measures based on the trust policy. To monitor this going forward, the trust had built in clear reporting and monitoring arrangements for audits through the transition steering group.
- The draft trust transition policy included an evaluation process following completion of transition. We were advised that the information will be used to measure outcomes for young people and transition to adult services. We were not able to assess this at the time of our visit as the policy had not been formally ratified and rolled out.

Competent staff

- The transition team showed us draft competencies for staff at three levels for transition and supporting people with complex long-term conditions of all ages. These levels were set as part of the trust training needs assessment for staff roles. The competencies were based on what staff told the team as part of a web based evaluation of which 210 staff members took part.
- Competencies were aligned to the “ten steps to transition” pathways; however, we were not able to assess the impact of this programme as it had not commenced at the time of our visit.
- As part of work related to supporting young people with learning disabilities, 18 staff had been identified in the trust as learning disabilities champions. They were provided with information, training and resources to carry out this role.

Multidisciplinary working

- Alder Hey evidenced strong partnership working across the “Healthy Liverpool” project which is focussed on improving pathways and integration through the commissioning of services for young people.
- Alder Hey were able to demonstrate commissioned links with Aintree University Hospital NHS Foundation Trust and transition policies and procedures were written in conjunction with them.
- The ten steps to transition model identified strong links with general practitioners and other health care

Transitional services

providers in order to facilitate transition. For some young people with complex needs, multi-disciplinary meetings were convened in order to facilitate transition to adult services.

- As part of transition policies and procedures, circle of support documentation was used to clearly identify multidisciplinary leads and responsibilities for young people with complex needs.
- The ten steps to transition pathway identified wider support networks, for example advocacy, school nursing, dentistry and dietetics.
- The transition nurse evidenced how the (new) role they were undertaking had facilitated liaison with multiple services in order to support young people in preparation for transition.
- There was strong evidence of multi-disciplinary working between children's and adult services for young people with long-term conditions. For example in nephrology, oncology and diabetes.
- We found examples of good practice between cardiology services and psychology and dentistry in the pre-operative setting. Staff told us that these links had strengthened recently and that they found it very supportive.
- The trust transition steering group had internal and external agency representation involved in transition from children's to adult services.

Access to information

- Following our last visit, the trust has benchmarked transition services both internally and externally. We viewed a range of policies, procedures and documentation which have been designed to support young people with complex needs, families and multi-disciplinary professionals.
- At the time of our visit we could not evaluate how effective some of the information was as it was due to be implemented after our visit; however, we were satisfied that the trust had robust arrangements to monitor this through the trust steering group.
- The trust transition registers used criteria and risk assessments to clearly identify information sharing requirements with multi-disciplinary professionals.
- We found established information links between children's and adult services relating to transition for specific condition pathways. Example we saw were in cardiology, nephrology, oncology and diabetes.

Consent

- Consent was gained from young people and their families if it was considered that a young person would benefit from being on the transition register. Consent forms had been designed in conjunction with information leaflets relating to transition arrangements.
- We spoke to five young people who told us that they were involved in decision making about their care.

Are transitional services caring?

Good



Young people, their families and carers told us that they felt safe and supported by staff. Young people were included in decision-making and through our observations and speaking with young people it was evident that they were involved in decision making.

We observed positive interactions with young people, families and staff. Staff were committed to continually improving services to support young people in transition.

Results collated from the friends and family test supported what people told us and what we observed.

Compassionate care

- Young people and their parents told us they felt safe at Alder Hey and that staff were caring and supportive.
- Young people and parents felt that the commitment from staff to support young people was above what you would expect from them.
- During interviews with staff, we were told of occasions where staff went above and beyond working commitments in order to support children and young people, and on occasions travelling to other trusts to provide expert knowledge.
- Throughout our inspection, we saw staff acting with compassion and delivering care in a dignified and respectful way.
- NHS Friends and family test results from young people between November 2014 - April 2015 showed that 233 young people (out of 247) were very likely or likely to recommend Alder Hey to friends and family. Seven young people were neither likely nor unlikely, three were unlikely and four didn't know.

Transitional services

- The trust undertook specific inpatient surveys for young people. In May 2015, they received 30 responses and the results were positive. For example, all of the respondents stated that they had received enough information about their care. The results of the surveys were displayed on hospital corridors.

Understanding and involvement of patients and those close to them

- Some young people of transition age, were routinely given the opportunity to see a health professional independently of their parents/guardian. We saw good examples of this in cardiology, nephrology and oncology. A recent consultation exercise within the trust identified that this needed to be embedded in other services.
- Young people told us they felt involved in their care and that they were able to see a health professional if they needed to.
- Information relating to transition for specific condition pathways were individualised and reflected a young person needs.
- We spoke with three parents who told us that they had been involved in decision making with young people and staff at the trust.

Emotional support

- Psychology services were actively involved in supporting young people in transition to adult services. We saw good examples of the use of psychology in cardiology and nephrology. Young people told us that they found these services supportive.
- Emotional support was provided routinely. We were given an example of cardiology nurse specialists who had visited schools to provide emotional support and information to young people and school staff on individual specific health matters.
- The transition nurse and designated lead consultant for young people with complex needs and their families had provided a point of contact for advice and emotional support.
- Health play therapists provided emotional support through condition specific pathways into adult services. At the time of our visit, some health play therapists were not aware of the transition nurse role or how to access specialist advice.

- As the structure of health play specialists were led through clinical business units, it was unclear how they shared knowledge with each other in order to support young people.

Are transitional services responsive?

Good



Arrangements were in place to support young people with complex needs. The trust had undertaken a review of transition services and introduced a transition register to take account of a young person's individual needs.

There were established transition planning processes in place which were focussed on a young people's individual needs as part of condition specific pathways.

Transition planning for those young people under the care of three or more consultants was co-ordinated by the transition lead consultant and transition nurse.

Young people and their families had access to multi-disciplinary professionals in order to support transition.

Service planning and delivery to meet the needs of local people

- There was strong leadership from consultants in co-ordinating transition to adult services for those young people with specific long-term conditions.
- The trust had worked extensively since our last inspection, engaging with young people and their families in order to clearly define transition process and safeguards for young people with complex needs.
- The trust had introduced an application process to admit young people onto a transition register which was reported to the trust board. The application clearly identified the reasons for young people staying under the care of Alder Hey into adulthood. This included best interest decision making for the young person and the lack of adult service provision. The register clearly identified young people who were under the care of Alder Hey after their 18th birthday and this was monitored by the board. The trust planned to use information collated through the transition audit programme to influence transition arrangements and commissioning going forward.

Transitional services

- Due to the limitations of the hospital buildings, facilities were not available specifically for young people; however, we were told this would be addressed as part of the planned move to the new hospital in October 2015.

Access and flow

- Between November 2014 - April 2015, 116 young people between the ages of 12 to 25 had been admitted. Of those 116, there had been 14 admissions for young people between the ages of 19 -25.
- Some clinics had routine processes for young people to be seen separately, for example in cystic fibrosis and nephrology clinics. We saw evidence that other clinics offered this on a case by case basis. This was reflected in the trusts “you’re welcome” self-assessment.
- Between November 2014 – April 2015, Alder Hey ran 38 transition satellite clinics in neurology, diabetes, anaesthetics and rheumatology which were designed to meet the needs of individuals.
- The trust had commenced consultant led transition clinics for young people on the transition register. The transition nurse reviewed attendance and non-attendance figures and had on occasion facilitated home appointments in order meet the individual needs of young people.
- Collaborative planning meetings were due to commence in the trust in September 2015, aimed at young people with complex neuro-disability transferring to adult services.
- We saw excellent examples of the use of technology in order to support patient telephone consultation to discuss titration of medications in cardiology. Staff told us that young people liked this as it led to less frequent appointments.

Meeting people’s individual needs

- There were established transition planning processes in place which focussed on young people’s individual needs for condition specific pathways. Examples included cardiology, cleft services, diabetes and cardiology.
- There was a wide range of information leaflets which were condition specific and identified the services available to support young people’s emotional needs.
- A young person told us they were able to receive dialysis whilst at home instead of going to the hospital and they were positive about this change.

- Young people’s individual needs were included in transition planning and we saw examples of photograph journeys being used to support a young person and show them the location of adult services.
- Transition planning for young people under the care of three or more consultants was co-ordinated by the transition lead consultant and transition nurse.
- Health passports were established for some young people with long-term conditions such as cardiology. At the time of our visit, modified health passports were not in place for young people with complex needs and learning disabilities.
- Translation services were available for young people to access and staff were aware of what services were available and how to access them.
- Ward staff and health play therapists liaised with educational services for young people who were not able to attend school. We spoke with two young people regarding support that had been provided in order to access education whilst in hospital.
- At the time of our inspection, with the exception of the teenage oncology unit, young people were cared for in the same environment as younger children. We observed three young people who were all nursed in a single room. There were currently shared bathroom arrangements; however staff told us that single en-suite provision will be available in the move to the new hospital which was planned for October 2015.
- Accommodation was available on-site for families at the hospital. Parents were also able to stay with their child whilst in hospital. We found facilities in the teenage cancer unit excellent for young people and families. Young people’s individual needs were not always met in the rest of the hospital; however facilities should improve when the trust move into the new hospital.

Learning from complaints and concerns

- Information about how to complain was available in both inpatient and outpatient areas.
- From information we received from the trust, we identified that there were no complaints raised for young people in transition at the time of our visit.
- The nursing and medical leads for transition told us there would be specific monitoring arrangements in place through the trust’s governance processes for any transition specific complaints or concerns going forward.

Transitional services

Are transitional services well-led?

Good



Since our last inspection, there have been significant improvements and we have been impressed by the amount of progress in transitional services since we last inspected.

There were clear transition reporting arrangements in place at board level, with a designated executive lead. There was evidence of strong leadership across services at both a local and trust wide level through the new transition roles at the trust.

There was a clear vision and development of an over-arching strategy for transition services which supported the existing condition specific arrangements for transition and supported young people with complex needs.

There was evidence of consultation with staff, young people, families and wider services in the development of policies and procedures.

Vision and strategy for this service

- There was a clear overarching vision, framework and strategy for transitional care following a review of transition services both internally and externally.
- A transition strategy was in place for young people with complex needs and there were arrangements in place to identify gaps in provision and escalate externally.
- The long-term vision was to engage all services who were able to influence and support young people requiring transition to adult service, looking at best practice in collaboration with other services across the health economy. Notably, commissioned links were in place with an adult provider.
- There were established strategies in place for condition specific pathways of care led by clinicians.
- Some ward based nursing staff we spoke to were not aware of the work ongoing related to transition; however at the time of our visit there were a number of policies and procedures that had not been formally implemented and rolled out.

- A second piece of work was being undertaken in the trust at the time of our inspection which related to children and young people with learning disabilities. We were not able to establish if; or, how the two pieces of work were linked to support young people in transition.

Governance, risk management and quality measurement

- There was a transition steering group in place which had clear governance arrangements related to risk and quality measures.
- There was a named executive lead for transition who chaired the transition steering group.
- There were arrangements in place for escalation of concerns to the board through the executive lead.
- There were clear terms of reference for transition meetings with multidisciplinary representation.
- Commissioning arrangements for quality and innovation (CQUIN) quality indicators were in place for transition. In the year 2014/15 quality indicators relating to transition had been met by the trust.
- At the time of this inspection we were not able to establish how work undertaken in the learning disabilities steering group was reported/linked to the transition steering group. Since our last visit, the trust had appointed a designated transition nurse and identified a lead consultant to support and prepare young people with complex needs into adult services. As part of this work the team has worked with young people and families in order to develop a register which identifies key information related to young people with complex needs in order to minimise risks.
- Overarching trust wide policies and procedures for the transition of young people into adult services had just been drafted at the time of our visit. Policies were written in conjunction with a local provider of adult services; however, they hadn't been formally rolled out.
- As part of this work, the transition team reviewed records nationally and locally to produce the "Ten steps to Transition" documentation to support young people and health care professionals.

Leadership of service

- The trust had a designated medical and nurse lead for transition who had recently led a review of transition services for young people into adult services, focusing on those young people with complex needs.

Transitional services

- The team were able to clearly identify challenges in transition into adult services and had formulated clear aims and objectives in order to improve transition arrangements for young people.
- The team were represented at a number of regional and national groups, influencing and reviewing the complexities of transition planning for young people.
- The staff we met were committed and passionate about improving transitional arrangements across health services, which was demonstrated in the significant progress made since our last inspection.
- Clinical leadership was well established; supporting transition pathways through clinical pathways.

Culture within the service

- Staff at all levels were committed to supporting young people transition into adult services.
- Staff were passionate in wanting to influence both clinical pathways and decisions related to transition in the wider health economy in order to improve the experience of young people.
- The trust had committed to a research and audit programme related to transition. We were told the results would be disseminated and used to influence practice both inside and outside of the trust.

Public and staff engagement







- The views of young people, family and carers had recently been collated following roadshows and surveys in order to establish and map transitional services.
- The transition team sought experience from multi-disciplinary professionals involved in transition such as people in education and the private sector in order to map the service provision for young people with complex needs. This information had been used to identify a baseline position for transition arrangements and identify gaps.
- Some parents had completed diaries in order to identify what services would need to be in place in adult services in order for successful transition for young people with complex needs. This information has been used by the trust when developing policies and procedures.

- Patient stories were collated from working with parents who had children with complex needs and then presented at transition roadshows.
- The trust had young people and parent forums in place which were well established. The work undertaken by the trust relating to transition had recently been discussed in these forums.
- Transition surveys specific to cardiology and cleft services were used to evaluate what was important to young people.
- The teenage cancer unit had focus groups in place and these were used for staff and young people to discuss ideas on what was working well and how things could be improved.
- 17 clinical teams in three business units were involved in recent transition roadshows. 60 Staff, parents and young people attended a workshop on transition. Themes were collated and used to develop policies and procedures.
- 41 members of staff took part in an event focused on identifying the difficulties in “tackling tricky transitions”. Themes identified by staff were used to influence transition staff competencies.
- 24 staff had been identified as transition champions and were given support in fulfilling this role through trust study days.
- 212 staff had recently completed a web based survey to assess transition arrangements. Themes were collated and used to develop policies and procedures.
- We spoke to some nursing staff on the wards who were not aware of the work being undertaken related to transition.

Innovation, improvement and sustainability

- Staff were focussed on driving improvements in transition arrangements and working collaboratively with adult service providers.
- The use of research and audit programmes had been designed to measure outcomes in transition services in order to improve care provision.
- We were not able to establish if the current allocated provision of sessional time for the lead medical representative would influence the pace of progress over the longer term.

Outpatients and diagnostic imaging

Safe	Requires improvement	
Effective	Not sufficient evidence to rate	
Caring	Good	
Responsive	Requires improvement	
Well-led	Requires improvement	
Overall	Requires improvement	

Information about the service

A range of outpatient and diagnostic services are provided at Alder Hey Children's Hospital. In 2014/15 there were 182,494 outpatient appointments at this hospital.

The outpatient department offers a wide variety of specialist clinics including ear, nose and throat (ENT), ophthalmology, paediatric medicine and surgery, audiology, physiotherapy, oncology/haematology, trauma and orthopaedic, respiratory medicine and dermatology.

The diagnostic imaging department provides a comprehensive range of diagnostic services to the patients of Alder Hey including x-ray, ultrasound, gamma camera, DEXA scanner, fluoroscopy unit, CT scanner, MRI scanner and 3T MRI. Portable x-ray and image intensifying machines are also available.

We previously inspected outpatient services at this hospital in May 2014 and rated the service overall as "Requires Improvement". As part of that inspection, we identified issues regarding the records management system and availability of patient's records, low levels of safeguarding training, the lack of risk assessments, clinic waiting times and leadership concerns. We carried out this inspection to check whether improvements had been made.

The last inspection in May 2014 was part of a wave of inspections to test our methodology and at that time, diagnostic imaging was not explicitly included in the outpatients' methodology. This inspection included diagnostic imaging services, which is part of our updated methodology.

Summary of findings

Since our last inspection, the trust has made considerable progress with records management and availability. This was evident within the outpatients department; however, within both outpatients and diagnostic imaging services, there were areas of governance that required improvement, particularly in relation to the identification and management of risks.

There were no regular departmental team meetings taking place at the time of the inspection; however, some departments, such as audiology and the ears, nose and throat department (ENT) were holding their own multidisciplinary meetings. Lessons learned were not consistently shared with staff. Departmental risk registers were not kept up to date and there was no evidence that they were reviewed on a regular basis.

Robust procedures for identifying if young female patients were pregnant prior to undergoing scans within the diagnostic imaging department were described in the trust's radiation protection policy but they were not always followed.

Mandatory training and safeguarding (level 3) training completion rates for staff within outpatients and diagnostics were low and significantly below the trust's target for the majority of the training modules. In addition, the completion rates have not improved markedly since our last inspection.

Emergency resuscitation equipment was available in all areas that we inspected. In outpatients, records

Outpatients and diagnostic imaging

indicated that the equipment was checked twice daily; however, within radiology, checklists had not been updated for several months and in some cases a number of years.

Appointment letters and supporting information were only sent out in English and were not available in any other language.

Care and treatment was delivered in line with evidence based practice. Policies and procedures followed recognisable and nationally approved guidelines. Patients and those close to them were treated with dignity and respect by caring and compassionate staff.

Are outpatient and diagnostic imaging services safe?

Requires improvement



The outpatients department has made considerable progress since our last inspection with regard to the management and availability of medical records. The majority of records were available for clinics and effective systems were in place to ensure the availability of records. The trust was due to go live with a new electronic medical records system on the week of the inspection which was anticipated to further improve the management and availability of patient records within the trust. Staff had received training in the use of the new system and staff felt confident in using it.

Managers with responsibility for determining the correct staffing levels used their own judgement to allocate staff in outpatients. However, there was no clear system or guidance for determining minimum nurse staffing levels on a daily basis that took into account the complexity of the clinic or potential acuity of the children and the associated skill mix that may be required.

Robust procedures for identifying if young female patients were pregnant prior to undergoing scans within the diagnostic imaging department were described in the trust's radiation protection policy but they were not always followed.

The target of 90% attendance for mandatory training was not being consistently met within the service, with resuscitation training being at 60% for nursing staff and 50% for diagnostic staff, infection prevention training was at 42% for clerical staff and 81% for nurses and fire safety was at 59.7% for clerical staff.

Emergency resuscitation equipment was available in all areas that we inspected. In outpatients, records indicated that the equipment was checked twice daily; however, within radiology, despite staff telling us that checks were completed regularly, we saw that the checklists had not been updated for several months and in some cases a number of years.

Outpatients and diagnostic imaging

The safeguarding level 3 training was low at 25% for nurses in outpatients and 50% for diagnostics staff. This was much lower than the trust target of 90% completion and there has been no marked improvement in the completion rates since our last inspection.

Although training figures were below the planned target, staff were aware of their safeguarding responsibilities and who to contact if they had concerns. For example, staff gave examples of where they had suspected a non-accidental injury on a child and had followed the correct procedure. There was also an internal safeguarding team based on site in the Rainbow Centre at Alder Hey who offered advice to staff when required.

Feedback from incidents was not given consistently and lessons learnt from incidents were not shared in a systematic way across the outpatients and diagnostics service.

Incidents

- There were no never events (very serious, wholly preventable patient safety incident that should not occur if the relevant preventative measures have been put into place) or serious incidents requiring investigation reported in outpatients and diagnostics between March 2014 and February 2015.
- Incidents were raised via the electronic incident reporting system and a policy was in place to support staff in this regard. Staff were familiar with reporting procedures and duty of candour legislation and could provide examples of incidents they had reported.
- When incidents occurred, an investigation was carried out. For more significant or serious incidents, a root cause analysis process was used to identify contributing factors; however, despite staff being automatically notified when incidents had been reviewed by the investigating manager, lessons learnt were not always shared to prevent further avoidable incidents. Many of the staff within the diagnostics department told us that they had received no feedback at all in relation to outcomes, actions or lessons learnt.
- Staff in outpatients reported that patients were informed of any incidents that involved them. This was usually done whilst the patient was still in the unit to ensure the correct information was captured.
- The outpatients department had completed a trend analysis of incidents in November 2014. This identified that the highest area of concern in relation to incidents

was the management and availability of records. The department had subsequently prioritised this area and had completed a project to address this, that had resulted in a fall in the number of incidents being reported relating to patient records.

Cleanliness, infection control and hygiene

- All the areas that were visited were visibly clean and tidy, with the exception of one mobile x-ray unit which was seen to be very dusty.
- Cleaning schedules were seen in x-ray rooms and were reasonably up to date; however, this was not the case for the mobile x-ray unit where the cleaning schedule had not been updated since December 2013 and the equipment was visibly dusty. Senior staff advised they were aware of the issue and planned to improve the schedules and processes.
- Hand hygiene audits were completed internally through observation but staff indicated that they had no knowledge of the results or where these were kept. Staff reported they were not given any feedback of how well they were performing with hand hygiene practice or any areas for improvement.
- We observed some members of staff, including doctors, nurses and health care assistants within B1 and D1 who did not wash their hands or use hand gel between patients which could potentially lead to the spread of infection.
- Hand gel dispensers were available in clinic areas but some were found to be inaccessible or not in prominent areas, such as above seats in the waiting areas and some were too high on the wall to be used by children. In some cases, the dispensers were not immediately visible to visitors of the department.
- We did not see staff encouraging people to use hand gel and witnessed a number of people entering clinics without using gel dispensers.
- The two hand gel dispensers that were prominent on the wall on entry to the outpatients department in B1 were empty on the first day of the inspection, so could not be used. The inspection team informed the nurse in charge at the time. When inspectors returned to B1 on the second day of the inspection, the hand gel dispensers remained empty.
- When children and young people were seen with any suspected communicable disease, the area was deep cleaned after the consultation was completed. The area was not used until this process had been completed.

Outpatients and diagnostic imaging

- Lead vests (used by staff working in the radiology department) were checked and found to be visibly clean and in good condition.
- Infection control and prevention policy and procedures were in place and accessible to all staff on the intranet.
- Training figures for infection prevention training showed that nursing staff in the outpatients department were 81% compliant, which was lower than the Trust's target of 90%; however, diagnostic imaging staff were achieving the trust's 90% compliance target. Completion rates for administration staff were much lower than the trust target at 42%.

Environment and equipment

- The areas we visited were visibly tidy but there were some limitations of the ageing hospital environment which we were told would be addressed as part of the planned move to the new hospital in October 2015. One example of this was the waiting areas within D1 and B1 where the environment was found to be very hot and they were frequently very busy. We received patient feedback reflecting concern in this area. A further example was the height and weight room within B1 which was very small and cluttered. There was very limited provision for privacy within this room due to the room layout.
- The trust held an equipment register for radiology which logged the age, model and serial numbers as required by legislation. Maintenance contracts were in place and managed by the trust's biomedical team.
- We observed three sets of weighing scales that had no date of calibration on them. However, the departmental medical devices register for outpatients and diagnostic imaging contained this information and was used to plan servicing and calibration.
- Emergency resuscitation equipment was available in all areas that we inspected. In outpatients, records indicated that the equipment was checked twice daily; however, within radiology, despite staff telling us that checks were completed regularly, we saw that the checklists had not been updated for several months and in some cases a number of years.
- First aid boxes were present in the radiology department and contained bandages which were out of date by several years. Staff told us they had checked the box but could not get bandages easily to replace what was out of date. We also found that checklists for the contents had not been completed for several months.
- Within the radiology department we found that although lighting was used to warn people about radiation, entry restriction signs were missing, including entry to the gamma x-ray room, fluoroscopy and the door to the nuclear medicine department.
- We also saw an open door accessible to the public, leading to 'Room 2' which was an area where radiation was being used.
- The last audit for radiation exposure and dosage was undertaken in April 2012. The next audit, planned for 2015, was postponed and re-scheduled to take place after the move to the new hospital. Staff in the radiology department were seen to be wearing personal radiation dose monitors and these were monitored in accordance with legislation
- We witnessed two occasions when IT systems were extremely slow and staff confirmed this happened routinely. One occasion involved accessing trust computer files relating to risk management. We were told that the slow IT systems had an impact on the delivery of patient care due to the increased waiting times.
- Sharps bins in D1 and B1 were dated and signed when opened. They were securely attached to the walls within the clinics. However, in the sluice room on the neurosciences unit, there were three full sharps bins that had been sealed. These did not have any date when they were opened or closed and no staff name or area identified. This would ensure there was an audit trail of the sharps bins and also compliance with the trust's waste management policy which identifies that there needs to be traceability for waste products.
- There was a fire door observed to be wedged open using a foot stool on the physiotherapy department with a further fire door observed to be held open with a strap in the records office.
- All consultation rooms that were inspected in each of the departments within outpatients were found to be clean and organised, with a stock of toys.
- Standard Operating Procedures (SOPs) such as for height and weight measurement, were in place within the outpatients department. However, staff were unsure how to access them.

Medicines

- Some medications were stored within the outpatient department, for example topical treatments for skin conditions, paracetamol for pain relief and local

Outpatients and diagnostic imaging

anaesthetic. Allergy testing equipment was also stored in fridges. The outpatients department used FP10 prescription pads which were seen to be stored appropriately in a locked cupboard. FP10 prescriptions can be taken to any pharmacy when prescribed by a Doctor.

- All medication within D1 and B1 outpatient department was locked away securely. The medication was noted to be in date and the stock was rotated regularly to prevent any medications being out of date. However some medication, such as topical skin treatments, found in the neurosciences unit was not locked away, making it accessible to the general public. We also found medication within this area to have an expiry date of July 2014.
- In the radiology department the door leading to a medicine and equipment storage room was unlocked and ajar, making it easily accessible to the public. Inside this room we found an unlocked open cabinet containing keys to a drugs cupboard. Contrast medium requiring secure storage below 25 degrees Celsius, and out of date urine test strips were also present. Staff using this storage area were unable to confirm what drugs were stored securely, or identify any processes relating to the control and monitoring of drugs in the department.
- We looked at fridges where medicines and testing agents were stored in the outpatients department. We found that although records indicated fridge temperatures were checked on a daily basis, the fridge temperature ranges were not being recorded or monitored. This meant that staff were not always aware when temperatures went above or fell below the recommended range for storage. When these materials are not stored at the correct temperature they can become unfit for use. The nurses in charge did not know that this information was not being recorded.

Records

- At the time of the inspection, the trust was in the process of moving to a 'paper light' system in respect of medical records. A 'paper light' system is one in which there is very limited use of any paper records. This meant that there were both paper records and electronic patient records database. Ten sets of records were reviewed on the electronic system within the outpatients department. All the records had personal identifiable data recorded correctly. The medical

consultation was scanned onto the system after the clinic; however, these consultations were mostly illegible with no time or printed name evident on the page. The trust were due to implement a new electronic system on the week of the inspection; however, we were told that consultants could choose to continue to hand write their consultation up and continue to have it scanned onto the system.

- We reviewed 15 sets of electronic medical records in the radiology department which were comprehensive.
- We saw examples of staff confirming patients' identities; however we saw no evidence that this was documented in accordance with trust guidance.
- It was noted that letters from the clinics were typed up within a few days of the clinic taking place, which ensured effective communication between health professionals. Copies of these letters were also sent out to the parents.
- Notes were readily available at clinics during the inspection. This was both on the computerised system and within the lilac paper files.
- The physiotherapy department had their own separate records for children and young people. These were stored within the department behind the reception area. The records were kept in lockable storage units but these were open and unlocked during the inspection, making them accessible to the public.
- Within the physiotherapy department, there were several large boxes behind the reception area that contained patient identifiable data. Two of these boxes were labelled as 'for scanning.' This raised a concern that the medical records were not contemporaneous due to the backlog of records that required scanning. The 'for scanning' boxes contained many loose leaf pieces of paper.
- In the physiotherapy department, a room which was labelled 'the splinter room' had a key in the door which was easily accessible by the general public. Upon entering the room, we noted that there was patient identifiable data left out on a table unattended.
- There was a confidential waste tray visible on the reception desk in outpatients which contained personal information.

Safeguarding

- An electronic referral process was used to record and manage safeguarding concerns. A paper based system was used if the system was not working. Specialist

Outpatients and diagnostic imaging

advice and support was available from the trust's internal safeguarding team who were based on site 24 hours per day in the Rainbow Centre, which was a specialist facility within the trust that catered for children who may have suffered abuse.

- Staff were aware of their safeguarding responsibilities and could clearly articulate the process they would follow if they had safeguarding concerns with a child.
- Safeguarding training statistics had not improved markedly from the previous inspection with only 25% of nursing staff and 50 % of diagnostic staff completing level 3 safeguarding training which was significantly lower than the trust wide completion rates of 63% and the trust's target of 90%. The training statistics also showed that 62% of clerical staff had completed their safeguarding level one training which was below the trust's overall completion rate of 84%.

Mandatory training

- Staff received mandatory training in areas such as safeguarding children, fire, equality and diversity and moving and handling. The training figures supplied by the trust showed the training completion rates among nursing staff ranged between 42% and 68% which was lower than the trust target of 90%. For diagnostic imaging staff, the training completion rate ranged from 50% to 91%.
- Resuscitation training figures were 60% for nursing staff and 50% for diagnostic staff. This was much lower than the trust target of 90%.
- Training was delivered centrally through the trust's Education Centre either face to face or via e-learning. Staff were expected to keep themselves up to date with training.
- Staff felt that they had time to complete mandatory training and were able to access it as required.
- Staff told us that completed training was not recorded unless a request was made to the education centre. Staff also told us that it was possible for staff to claim modules had been completed when this was not the case.

Assessing and responding to patient risk

- There was an effective process in place for any children that attended the outpatients department who required hospital admission.
- Clerical staff were not aware of the process for the care of a deteriorating patient and were unfamiliar with the

2222 process, which is the process to summon emergency help within the hospital. Instead staff told us they would go and locate a radiographer which could cause delays.

- Resuscitation equipment was held in the radiology department in case of emergency. However the equipment was stored in different locations which could take longer to source if required.
- In the radiology department, staff told us that the responsibility for establishing whether adolescent female patients were pregnant lay with referring clinicians rather than those in radiology. However, there were no procedures in place to ensure that this had been checked. A senior clinician told us that they would check this if the status had not been documented, however other clinical staff told us this was not the case. Staff advised us of their concerns about the consistency of checks to confirm pregnancy in patients. We reviewed 18 sets of adolescent female patient records to establish whether checks to confirm last menstrual period (LMP) had been completed. No LMP checks had been documented on the notes we reviewed.
- A changing cubicle in the radiology department had no emergency alarm in place for people to use if assistance was required.

Nursing staffing

- Managers with responsibility for determining the correct staffing levels used their own judgement to allocate staff in outpatients. However, there was no clear system or guidance for determining minimum nurse staffing levels on a daily basis that took into account the complexity of the clinic or potential acuity of the children and the associated skill mix that may be required.
- Agency staff were used in the outpatients department to provide cover for long term sick leave. The agency staff that were used were staff that were familiar with the department and had worked there on a regular basis.
- The off duty rota for the four weeks prior to inspection which showed that B1 had experienced staffing shortages due to 3 members of staff being on sick leave at the same time. There was no record of what staffing had been put in place to cover for this sickness and the nurses in charge of the shifts were unable to recall what cover arrangements had been put in place.
- There were no nurses employed in the radiology department.

Outpatients and diagnostic imaging

Medical staffing

- Outpatient clinics were arranged by consultants to meet the needs of their specialities. Consultants were supported by junior doctors in some clinics, where this was appropriate.
- Staff reported that there had been a period of significant staffing shortages within the diagnostics department but this had been rectified with the appointment of new members of staff within the department.

Major incident awareness and training

- Staff were aware of the procedures to follow should a major incident be declared.
- Supplies for use during a major incident such as door signage and contact lists were stored appropriately in a plastic sealed box in the radiology department. Although these had been checked periodically, the person who was responsible for checking this had left the department and no subsequent checks had been completed. Once this was identified, staff took action to rectify this and to ensure checks were subsequently completed.
- Training statistics identified that staff were compliant in major incident awareness training with 100% of nursing staff and 90% of diagnostic imaging service staff having undertaken the training. However training figures for fire safety was 70% for nursing staff, 70% for diagnostic imaging staff and 60% for administration staff, which were all lower than the trust target of 90%.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

Care and treatment was delivered in line with evidence-based practice. Policies and procedures followed recognisable and approved guidelines. There was evidence that the trust had looked at national audit data and were using this to benchmark their own service.

Trust records showed, as of May 2015, only 7% of clerical staff within outpatients had received their appraisal with 80% planned to be undertaken before 31s July 2015, which was much lower than the trust completion rate of 48% and

the trust's target of 90%. The appraisal rate was higher for nursing staff, with 71% having had an appraisal at the time of the inspection and 65% of diagnostics staff had been appraised.

Collaboration and communication amongst all members of the multidisciplinary team was evident and this supported the planning and delivery of care.

There were no plans, at the time of the inspection, for the services to move to a seven-day service; however, the radiology department operated an out of hours, on-call service at evenings and weekends.

Information about what patients should expect when they visit the radiology department for diagnostic tests was not included with appointment letters.

Evidence-based care and treatment

- Care and treatment within the outpatient and diagnostic imaging department was delivered in line with evidence-based practice. Policies and procedures, assessment tools and pathways followed recognisable and approved guidelines such as the National Institute for Health and Care Excellence (NICE). Examples of this included guidance that had been adopted for head injuries, multi-trauma and urinary tract infection.
- A senior member of radiology staff told us that new guidance was discussed at meetings and was escalated to senior management meetings if guidance needed to be implemented. Staff received updates when new guidance was reviewed. We were told that the outpatients department kept a paper database for staff to sign when they had read the new guidance; however, this database had been misplaced at the time of the inspection so could not be reviewed.
- Staff were aware of how to access relevant policies and procedures from the intranet.
- The radiology department had internal targets for producing reports following examination which was 48 hours for ward and emergency department patients and 2 weeks for the outpatients. Statistics showed that compliance for outpatients ranged from 93% and 100% between December 2014 and May 2015 but adherence to the 48 hour target was much lower for the emergency department which ranged from 52% to 80% between December 2014 and May 2015.

Outpatients and diagnostic imaging

- There were specific patient pathways, such as epilepsy and spinal care. These pathways were implemented by the named paediatrician.

Pain relief

- Paracetamol was kept in a locked storage cabinet to enable clinicians to administer pain relief in the clinic, if required.
- Pain specialists were available to offer advice if required and staff told us that requests were well received and promptly actioned.

Patient outcomes

- The outpatients' management team had started looking at national audit data and using this to benchmark their own service. They were also sharing information with other hospital trusts.
- Radiology staff showed us a list of audits which had been completed in relation to patient outcomes, for example: gonad shielding and dose audits. We saw evidence that action was taken following audits such as the decision not to administer a certain type of contrast media in some cases.
- The trust was not affiliated with the Imaging Services Accreditation Scheme (ISAS) but plans were in place for the trust to commit to this in the future. No implementation date had been identified at the time of the inspection.
- Radiology consultants held monthly discrepancy meetings. The purpose of the meetings was to facilitate collective learning from radiology discrepancies and errors and thereby improve patient outcomes and safety. The meetings were minuted and lessons learnt were regularly shared at this forum.

Competent staff

- Clinical supervision was not in place within the outpatient or diagnostic imaging departments. Some staff had completed clinical supervision training but had not had the opportunity to conduct any supervision sessions. This was mainly due to staff being able to choose whether or not they wanted to have supervision.
- The appraisal rate was at 7% completion for clerical staff within the outpatients department at the time of inspection with a further 80% planned to be undertaken before 31st July 2015. This was much lower than the

trust completion rate of 48% completion. For nursing staff the completion rate was 71% and diagnostics imaging staff was 65% which were higher than the trust completion rate.

- Some of the staff who had received their appraisal told us they felt that it was not meaningful and did not relate to their personal development. We were also told by a senior member of staff that the task of delivering appraisals and attending senior meetings had been delegated without training. Another member of staff felt that the process had been used as an opportunity for their manager to delegate tasks rather than discussing personal development, training or progression.
- We found that there were specific training modules available for certain clinical staff, for example nurse prescribers, who have authority to refer people for radiation based procedures such as x-ray. However once completed, there was no clinical competency assessment in place to ensure that the clinician was able to make sound judgments when referring patients for these procedures.
- All new staff completed corporate induction training. Within outpatients new staff also completed a six week mentorship programme and competency assessments. This also included role specific training incorporating areas such as height and weight measurements for children and young people and administration of eye drops.
- The manager told us that all areas of radiology had appointed and trained Radiation Protection Supervisors (RPS). Supervisors are a requirement of IR(ME)R regulations and ensure that equipment safety, quality checks and ionising radiation procedures are followed in accordance with national guidance and local procedures. All of the RPS had received appropriate training to undertake this role.

Multidisciplinary working

- Collaboration and multidisciplinary working was evident. Within smaller departments, such as Electroencephalography (EEG) and audiology, regular multidisciplinary meetings were held and good working relationships were evident.
- Specialist nurses worked within certain areas of outpatients, including a specialist nurse for epilepsy, a specialist nurse for burns and plastic surgery and a specialist pain team.

Outpatients and diagnostic imaging

- Patient pathways were in place and followed within the outpatients department to ensure all professionals were working collaboratively.
- Radiologist teams were supported by colleagues of other disciplines when caring for patients. For example, radiographers were able to request assistance from play specialists or psychologists if required. Staff told us the requests were well received and promptly met; however, radiologist staff also told us that multi-disciplinary meetings had been difficult to facilitate because of low staffing.
- Multi-disciplinary working was available at a regional level. Due to shared imaging systems for radiology, different NHS trusts were able to view records which worked well when specialist advice was required. We were not provided with any shared protocols or procedures relating to this practice.

Seven-day services

- There were no routine clinics established at weekends and no plans in place to move to a seven day service; however, the radiology department operated an out of hours, on-call service at evenings and weekends.
- There were some clinics in operation on Saturdays within the outpatients department that had been set up to reduce waiting times where a need was identified.

Access to information

- Staff told us the information about patients was easily accessible. Staff could access information such as policies and procedures from the hospital's intranet.
- The radiology department used a system called the Picture Archiving and Communications System (PACS). This is a nationally recognised system used to report and store patient images. The system was used across the trust and within a North West consortium of 10 trusts who shared the system, allowing local and regional access to images.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff in the radiology and outpatients department worked on the principle of implied consent. We observed staff explaining procedures to patients who were old enough to understand. Staff told us that, if necessary, they used personal judgement to assess whether children were able to consent to or refuse treatment.

- Best interest decisions were made when children refused treatment. Colleagues from the psychology or pain team, and play specialists and other appropriate professionals were available to assist and support best interest decisions if required. If treatments or procedures were not completed, this was documented.

Are outpatient and diagnostic imaging services caring?

Good



Staff were compassionate, kind and respectful towards the children, young people and their families whilst delivering care. Positive interactions were observed between staff, patients and their relatives. Staff provided reassurance and comfort to people who were anxious or worried.

Children, young people and their relatives felt supported and involved in the planning of their care. The NHS Friends and Family Test results showed that the majority of patients would recommend the departments to their family and friends.

Compassionate care

- Children, young people and relatives at clinics were all very positive about the care provided by staff. Patients and those close to them were happy and relaxed in the department and staff interacted well with them.
- We observed that the privacy and dignity of some patients was compromised in respect of personal information being discussed with parents at the reception areas within clinics. This was particularly significant in D1 where there was two queues of people waiting to be seen by the clerical staff.
- We observed many examples of compassionate care given to children, young people and their families based on individual needs. Staff spoke to children and young people respectfully and were open, caring and friendly in their approach.

Understanding and involvement of patients and those close to them

- Children, young people and their carers told us staff were good at communicating with them and they felt involved in the planning of their care.

Outpatients and diagnostic imaging

- We witnessed staff explaining processes to a child in an age appropriate and caring way.
- One mother described how staff explained everything that was going on with her child when she visited the department with her baby.

Emotional support

- We observed many positive interactions of staff providing reassurances and comfort to people who were anxious and worried.
- During clinics we observed a caring and supportive environment to allow parents to speak openly. Staff were seen giving young people and parents' time to talk and reflect.
- One mother explained how staff had provided emotional support when she became upset during a procedure involving her baby.

Are outpatient and diagnostic imaging services responsive?

Requires improvement



Outpatient clinics were very busy and we observed some carers complaining to members of staff about how long they had waited to be seen.

Patient information leaflets were not available in any other language except English. Therefore there was no supportive information offered to families whose first language was not in English. Appointment letters and supporting information were only sent out in English and were not available in any other language. Additionally the letters also did not include any information about procedures.

The clinic waiting areas had no water facilities and the waiting areas were very hot. There was limited seating available and at busy times, parents were expected to stand for long periods of time.

Whilst efforts were being made to capture the views of those visiting the departments, there was no process in place for sharing lessons learned from complaints.

Service planning and delivery met the needs of the local community. Transport was arranged as required. Specialist clinics were available at Alder Hey for areas such as dermatology, audiology and epilepsy.

Service planning and delivery to meet the needs of local people

- There were specialist clinics running within outpatients that included dermatology, audiology, and epilepsy clinics.
- Commissioners were involved in planning services where appropriate.
- There were no water facilities within the clinic waiting areas. Some areas did have a vending machine but the one within the neurosciences department was not stocked. The environment was noted to be very hot at times during the day and the waiting areas became very busy with some parents having to stand up for periods of time. This issue will potentially be resolved when the trust moves into the new hospital, which was planned for October 2015.
- Transport was arranged for children, young people and their families where necessary.
- Staff told us that a process was in place for patients to be seen in the x-ray department on the same day, if referred to the trust by their GP.
- Service level agreements (agreements held between NHS Trusts and Commissioning teams) were in place in the radiology department.
- Instead of leaflets, some limited information, such as a requirement for nil by mouth, was included in the appointment letter. Staff told us it would be useful if patients were given more information so that they know what to expect given that radiology equipment can be daunting for children.
- Appointment letters for radiology did not include any information about the procedures patients were due to undergo. Staff told us that whilst information leaflets used to be sent to patients, the practice was stopped because leaflets would have needed to be generated in a range of languages.

Access and flow

- Staff and patients raised concerns about the partial booking system that was in operation. This booking system meant that if a child's follow up appointment was within six weeks an appointment would be made whilst they were at the hospital, however if it was after six weeks, they would be written to and asked to phone to arrange a suitable time and date. Within audiology, it was reported that there appeared to be no consistency

Outpatients and diagnostic imaging

in waiting times for patients attending for their initial appointments. The audiology team reported that they often saw patients who had waited for a few weeks to a few months within the same clinic.

- We witnessed two families who verbally complained that they had waited 50 minutes and one hour respectively past their appointment time to be seen in clinic. Clinics frequently ran behind and families waiting for their appointment were not advised of any waiting times. We observed waiting times in the diagnostic imaging department of between 10 and 40 minutes.
- We were told that clinics were only cancelled with six weeks' notice and could only be cancelled by the Clinical Business Unit. This was to ensure that patients were not cancelled at short notice and to ensure the effective running of the clinics.
- The percentage of patients that did not attend (DNA) rate showed improvement between July 2013 and June 2014, though it was still worse than the England average.
- All cancer patients from April 2013 to December 2014 waited less than 31 days from diagnosis to first definitive treatment which was better than the England average.
- The trust met referral to treatment targets between April 2013 to September 2014 but there was a dip in performance in October and November 2014.
- The NHS target for radiology diagnostics was for patients to be seen within 6 weeks, and at the time of inspection this was being met. The wait time had increased to 10 weeks in November 2014 but the department had taken action to reduce it by facilitating extra clinics.
- For patients requiring more than one appointment in the radiology department, the booking team facilitated these on the same day where possible.
- For patients undergoing ultrasound procedures, results were entered onto the Radiology Information System (RIS) immediately and were available for clinicians in outpatients' clinics to view if required.
- The dermatology department had seen a decrease in the number of patients being admitted to hospital with skin conditions after a dedicated area was opened. Staff felt that this was because patients could be managed as a day case and subsequently prevented hospital admission.
- The outpatients department had an ambulatory service which provided appointments for children who needed an urgent medical review by a paediatrician and

referrals could be taken via a general practitioner, midwife or health visitor. There was no referral criteria for the ambulatory service and all referrals were accepted when appointments were available. This service did not have a waiting list, so if there were no appointments available then the referral was declined. In total 366 children had been declined between January 2015 and the time of the inspection, meaning that these children had to attend the emergency department or wait on a waiting list for the appropriate consultant.

- Appointments for radiology patients were sent out by letter which meant that people were not able to choose an appropriate time to come to hospital for appointments.

Meeting people's individual needs

- There was a new initiative in place for children and young people who had a needle phobia. This initiative involved any children with a needle phobia being referred to a play leader who subsequently undertook a piece of supportive work with the child. The play leader would also support the child or young person at their phlebotomy appointment. This initiative had received very good feedback. Play specialists and psychologists were also available to see radiology patients with complex needs if required.
- When it was identified that a family would require an interpreter, this was requested at the time of booking. On review of the records we saw one family had been seen without an interpreter present even though it had been identified that one was required.
- Radiographers told us they used telephone translation services for appointments if a translator could not be arranged but there were no examples of this to observe at the time of inspection.

Learning from complaints and concerns

- The analysis of formal complaints including themes and trends was produced corporately on a quarterly basis and the report was discussed at the clinical governance committee for the clinical business unit that outpatients and diagnostics were part of. However, verbal complaints were not documented and were dealt with locally and not fed into any database. Subsequently, no trend analysis could be completed for them.
- A senior member of staff told us that there was no process in place for sharing learning from complaints.

Outpatients and diagnostic imaging

We were also advised that complaint response letters were not seen by the relevant manager before issue to the family and therefore feedback was not provided for staff involved in complaints.

- We reviewed minutes from the diagnostic imaging departmental meetings and whilst numbers of complaints were highlighted, there was no detail relating to possible trends or efforts to address the issues arising. When this was highlighted to staff they agreed that there was 'no actual substance' to the information.
- Staff identified that they directed parents and carers to the Patient Advisory Liaison Service (PALS) to make a complaint.
- Patients were given FP10 prescriptions on the outpatients department which was as a result of complaints received from parents. These complaints related to parents frequently waiting long periods of time at the hospital pharmacy. The FP10 prescriptions allowed patients to access any pharmacy in the community to collect their medication rather than only being able to collect from the hospital pharmacy.

Are outpatient and diagnostic imaging services well-led?

Requires improvement



Whilst steps had been taken to improve the leadership and risk management processes in outpatients since our last inspection, we found that there were still a number of areas that required improvement. In addition, we also found that the leadership, governance and risk management processes in radiology were poor.

Radiation regulations state that instructions must be visible to keep patients and staff safe in radiology departments. These are known as 'local rules'. Whilst these were present in the required areas, they were out of date by 3 years.

We saw that teams worked well locally but were not formally aware of key issues such as risks, complaints, incident outcomes or audits. Staff were being asked to take on extra duties that they were not trained to do, such as appraisals and risk management work.

There was a lack of understanding amongst staff across the outpatient and diagnostic departments in relation to risk management with team leaders not being aware of the risk assessments for the clinic areas or what risks were held on the departmental risk register. The team leaders also had no awareness of where the risk assessments or risk register could be found. Team leaders that we spoke to in outpatients were not trained to complete risk assessments.

Departmental risk registers were not kept up to date, with no evidence that they were reviewed on a regular basis. Not all identified risks had an action plan, assurances or control measures. There was no evidence that risks were reviewed on or near the identified target date, some of which dated back to 2012.

No team meetings were held within the main outpatients area. Staff felt that they were not involved or informed of changes within practice. Meetings were held within the diagnostic imaging department.

There had been two visioning events held for outpatients where a range of staff, including reception, nursing and medical staff were invited. This subsequently led to an improvement plan being put in place and had identified nine work streams but at the time of the inspection, work on the improvement plan had mainly focussed on the first work stream, which centred on medical records.

Vision and strategy for this service

- There had been two visioning events held for outpatients where a range of staff, including reception, nursing and medical staff were invited. This subsequently led to an improvement plan being put in place and had identified nine work streams to be established. At the time of the inspection, work on the improvement plan was mainly focusing on the first work stream which centred on medical records. This was to ensure an efficient system was in place prior to the hospital's move into new premises. There had been no formal impact analysis within the outpatient department for any of the new work streams being looked at.
- Staff told us that they felt they were not aware of changes that took place within the hospital and their department. Several examples were given where change

Outpatients and diagnostic imaging

had happened and staff had found out after the change had been implemented or where staff had found out by hearsay, examples included changes to computerised systems and records.

- Staff were aware of the vision and values of the trust and lanyards worn by staff displayed the trust values.

Governance, risk management and quality measurement

- There were no team meetings held for nursing staff within areas of the outpatients department. No minutes of meetings were provided on request and both managers and staff members confirmed that regular meetings did not happen. The reason that was given for team meetings not taking place was due to the logistics of getting the team together because of the time schedules of the clinics. The senior management team held fortnightly governance meetings but staff were not aware of these meetings or the areas being addressed within them.
- Team meetings had recently commenced for the clerical staff within the outpatients department with two meetings being held in the 8-10 weeks before the inspection.
- There were regular multidisciplinary team meetings held in isolated smaller clinics within outpatients, such as dermatology and audiology.
- When speaking to staff who were involved in managing risk, we found a lack of understanding in relation to risks and the systems used to record and manage them both within outpatients department and diagnostic imaging services. Team leaders also had no awareness of what risk assessments had been completed for their areas or where to find them. They also had not completed training in relation to how to complete risk assessments.
- Staff could not tell us how risks were escalated or shared and presumed that senior staff would be aware of risks by checking the register themselves.
- Although departmental risk registers were in place, these were noted to be out of date and not robustly managed. Staff, including team leaders, were not aware of what risks were held on the risk register or where to find this information. Several of the risks had been on the register for three or more years and there was no evidence on it to identify a plan of action, review date, actions taken or controls to mitigate risk. An example of this was an identified risk of a 'shortage of stock', which referred to the flu vaccines. The assurance identified was 'experience during the pandemic flu season 2009/10'. The action plan target date was 19th July 2012.
- 'Meditech 6' is an electronic patient records system or medical technology information system. This system was due to be implemented by the trust the week after our inspection. The implementation of this system was put on the departmental risk register but there were no control measures or assurances identified. Risk assessments were requested from the trust for the implementation of the new 'Meditech 6' system, however these were not provided. Staff and team leaders were unaware of any risk assessments being completed.
- There was a greater awareness of governance within the medical records department where focussed pieces of work had taken place and staff had been involved. Improvements in this area were observed and this had had a positive impact on the staff and patients in the clinics.
- Staff in the radiology department were given certain clinical governance and supervisory responsibilities. However, not all of them had been given the necessary training to support them in managing this element of their role.
- Regulations state that instructions must be visible to keep patients and staff safe in radiology departments. These are known as 'local rules'. Whilst these were present in the required areas, they were out of date by 3 years.
- We saw a policy for screening lead coats used in the radiology department. Screening identifies cracks in the lead making them unfit for purpose. The policy stated that coats should be screened annually; however, staff in all areas except the Computed Tomography (CT) department told us that this had not been done for a 'number of years' and staff were unable to source records relating to this process.
- Radiology departments should keep a record of anyone (for example a relative) who assists by supporting the patient during x-ray procedures. Although the department held a file for this, there had been no entry since 2013. Staff were unable to explain why no further entries had been made. This was not the case in the CT department where holders were identified next to patient names on clinic lists.

Outpatients and diagnostic imaging

- A medical records audit for the completion of medical records that was due to be undertaken by the trust had been postponed. Audits of case note availability was requested from the trust and several copies of recent spot check sheets were supplied. There was no evidence of any findings or action plans written as a result of the spot checks.
- Radiology departments should have a Radiation Safety Committee which meets at least twice annually. The principal function of this committee is to ensure that clinical radiation procedures and supporting activities in the trust are undertaken in compliance with ionising and non-ionising radiation legislation. The committee had met twice per year and received reports from the appointed Radiation Protection Advisers, ensuring that relevant recommendations were met. A manager in the radiology department told us that minutes from these meetings were not actively shared at executive level. This presented a risk in that senior staff within the organisation potentially may not be aware of issues associated with Ionizing Radiation (Medical Exposure) Regulations 2000 IR(ME)R.

Leadership of service

- Leadership within the radiology department was poor and we found a number of issues around poor practice which should have been identified through the management structure and addressed. Staff reported that communication from managers was limited and that they had been asked to take on additional responsibilities without training to support them in carrying out those additional duties.
- Team leaders within the outpatients department reported that they had a weekly one to one meeting with their line manager.
- The management team had identified that there was a lack of staff engagement and were looking at engaging with staff every six weeks. The plan was for this to be either a newsletter sent to all staff in the department or a staff meeting.
- Relevant information from management meetings, within the outpatients department, was not consistently shared with staff. There was subsequently a general lack of awareness of managerial decisions and any pertinent changes to practice.

- There were plans for managers to be more visible in the outpatients department with the implementation of management 'walkabouts'. There had been one completed prior to the inspection.
- During the inspection, we saw that teams worked well locally but were not formally aware of key issues such as risks, complaints, incident outcomes or audits. Staff were being asked to take on extra duties that they were not trained to do, such as appraisals and risk management work.

Culture within the service

- The staff sickness rate was 8% for booking and scheduling staff and 8% for B1 outpatients staff which was much higher than the trust target of 4%.
- Staff that we spoke to were positive about the service they provided for the children and young people and expressed that they wanted to do their best for them. Staff also reported positive working relationships and we observed that staff were respectful towards each other, not only in their specialities, but also across disciplines.
- We found that staff within both the outpatients and the diagnostic imaging department were feeling despondent with the lack of communication from management and did not feel their opinions were valued within the organisation. Staff also told us that there was inadequate communication from the trust when services were expanded which increased their workload.
- We heard examples of staff raising concerns about staffing levels and increasing workload on multiple occasions. One staff member told us she was 'tired of raising concerns about staffing'.

Public engagement

- Within an initial workshop for the outpatients improvement plan, staff were asked to seek the opinion of parents in the department at that time, however parents were not invited to attend any meetings.
- The trust used the NHS friends and family test to gain the views of people using services. Trust data showed that of 29 respondents, 28 were likely or extremely likely to recommend the outpatients services to their friends or family. The NHS friends and family test was introduced in 2013 and asks patients whether they would recommend NHS services to their friends and family if they needed similar care or treatment.

Outpatients and diagnostic imaging

Staff engagement

- Staff did not feel that managers engaged with them in relation to new ways of working and in service planning and delivery. Staff gave examples of where they had raised concerns in relation to service delivery to their managers and no actions had been taken as a result of this. Examples included the partial booking system.
- Some staff members had been invited to the initial 'visioning' session which was held to identify the priority improvement areas within the outpatient department.
- Communication and staff engagement had been identified as an area for improvement within the outpatient improvement plan as a separate work stream. Work on this area had not commenced at the time of the inspection.
- Staff told us that posters had recently been displayed highlighting promises made by the trust to people attending the outpatients department. They reported that the posters had been taken down due to staff feeling frustrated about the promises being made.

Innovation, improvement and sustainability

- Alder Hey is a specialist trust for the bone anchored hearing aid (BAHA) service that was provided by the audiology department. The audiology department also ran a new 'balance rehabilitation' service and was one of only three centres nationally that provided this service.
- There was a new service run by a nurse specialist that was for babies with polydactyl (babies born with extra fingers or toes). This service meant that the extra digits could be removed when the baby was under 14 weeks using local anaesthetic. Previously this procedure could only be undertaken when the baby reached six months of age using a general anaesthetic.

Outstanding practice and areas for improvement

Outstanding practice

We saw that the compassionate care being delivered by staff on the critical care unit was outstanding.

Areas for improvement

Action the hospital **MUST** take to improve

- Ensure that departmental risk registers are kept up to date and reviewed appropriately.
- Improve its risk management processes in the outpatient and diagnostic imaging departments and provide appropriate training for those delegated to manage risk.
- Ensure there is an appropriate process in place for checking and recording pregnancy status in adolescent female patients.
- Ensure that learning from incidents and complaints is shared with staff to prevent recurrent issues.
- Ensure that processes are robust and effective in relation to patient emergencies in the radiology department and that first aid and resuscitation equipment is suitably available and checks completed and documented regularly.
- Ensure that correct hand hygiene measures are in place and that people are aware of and using the correct techniques.

Action the hospital **SHOULD** take to improve

- Improve staff compliance with mandatory training.
- Improve staff compliance with safeguarding training.
- Provide adult safeguarding training for staff across all services.
- Continue to recruit nursing and medical staff to address shortfalls across the surgical and critical care services.
- Improve patient access and flow across critical care services.
- Ensure that people's medicines are given in the necessary quantities at all times and that the records reflect what has been administered to prevent the risks associated with medicines that are not administered as prescribed.

- Ensure that outstanding actions on the risk register are reviewed and updated across all departments.
- Ensure that adequate signage is displayed in relation to entering areas in the radiology department.
- Seek to fill vacancies on medical wards and reduce the need for locum cover.
- Continue to recruit nursing and medical staff to address shortfalls across the surgical services.
- Maintain staffing levels in the Neonatal Unit according to nationally recognised guidance.
- Implement policies and procedures relating to transition, to ensure there are trust-wide policies and procedures for staff to refer to when dealing with young people that are; or, should be considered for transitional pathways.
- Ensure that work undertaken in the learning disabilities steering group and the transition steering group are linked so that information is shared and used to benefit both of these vulnerable groups of children and young people.
- Continue to develop relationships with adult health and social care providers to ensure the safe and effective transition of care for young people.
- Ensure that appropriate systems are in place for patients or those close to them to raise an alarm if they require assistance whilst in outpatient changing areas.
- Undertake a review of staffing within each area of the outpatients department to ensure that there is an appropriate system in place to determine staffing requirements.
- Improve communication with people for whom English is not their first language.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the fundamental standards that were not being met. The provider must send CQC a report that says what action they are going to take to meet these fundamental standards.

Regulated activity

Diagnostic and screening procedures
Surgical procedures
Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

How the regulation was not being met: Departmental risk registers in outpatients and diagnostics were not kept up to date or reviewed appropriately. Processes for the assessment and management of risk were not adequate and staff were not appropriately trained to manage risk. We found no evidence that lessons learned from incidents or complaints were shared appropriately with staff. Regulation 17(2) (b)

Regulated activity

Diagnostic and screening procedures
Surgical procedures
Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

How the regulation was not being met:

We found that checks for resuscitation equipment in radiology were not documented appropriately and that equipment was not stored together, increasing the time taken to source it if required. Regulation 12 (2)(b).

Robust procedures were not followed to check pregnancy in adolescent females. Regulation 12 (2)(b).

Hand hygiene practice was not correctly adopted or encouraged in certain areas. Regulation 12 (2)(h).