Care Quality Commission

Alder Hey Children's NHS Foundation Trust

Alder Hey Children's NHS Foundation Trust

Quality Report

Alder Hey Hospital
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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	Requires improvement
Accident and emergency	Good
Medical care	Good
Surgery	Good
Critical care	Requires improvement
Neonatal services	Good
Transitional services	Requires improvement
Palliative and end of life care	Outstanding
Outpatients	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

Alder Hey Children's Hospital is one of two locations that formed part of Alder Hey Children's NHS Foundation Trust. The trust's other location was the Dewi Jones Unit, which was an inpatient mental health facility to support young people between the ages of 5 and 14 years. Until recently, the trust had two other locations based at Broadgreen Hospital and Liverpool Women's Hospital; these locations have now been de-registered. Alder Hey Children's Hospital was an acute hospital and provided accident and emergency (A&E), medical care, surgery, critical care, neonatal services, adolescent and transitional services, palliative and end of life care and outpatients services.

Alder Hey Children's Hospital had 246 beds and provided a wide range of inpatient medical, surgical and specialist services as well as 24-hour A&E and outpatient services. The hospital was 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.

The Care Quality Commission (CQC) carried out this comprehensive inspection because the Alder Hey Children's NHS Foundation Trust had been flagged as a potential risk on CQC's intelligent monitoring system (which looks at a wide range of data, including patient and staff surveys, hospital performance information, and the views of the public and local partner organisations). The inspection took place between 21 and 22 May 2014 and an unannounced visit took place between 6am and 11am on Sunday 1 June 2014.

Overall, this hospital requires improvement. We rated it 'good' for caring for children and young people and providing effective care, but improvements are needed in providing safe and responsive care and being well-led.

Our key findings were as follows:

- Staff were caring and compassionate and treated children and young people with dignity and respect.
- The hospital was clean and well-maintained. Infection control rates in the hospital were managed effectively. However, there were insufficient cubicles available within the hospital wards with which to isolate children and young people who may represent an infection risk to others...
- The trust had a well-established mortality review process that was comprehensive and robust.
- There were systems and processes for reporting and escalating incidents and concerns; these were well understood by staff. However, staff did not always use the system to report all incidents.
- Further work was needed to improve the quality of food and ensure children and young people had access to food and drink, particularly in the A&E department.
- There were concerns about nurse staffing levels across the A&E department, medical wards and surgical wards. Medical cover needed to improve in critical care services.
- Some children and young people were concerned that they had to wait for a long time in the department and did not always realise that they had been placed on the observation unit.
- In the medical department, care was planned and delivered in a way that took children and young people's wishes into account. National guidelines were used to treat children and young people. Care pathways were reflected national guidelines. Standards were monitored and outcomes were good when compared with other children's hospitals. Access to advice and information was good for children and young people, their families and carers, both during the hospital stay and after discharge.
- In the surgical department, staff provided safe services to children and young people because they followed best practice guidance in care and treatment. Care was person-centred. Surgical staff were well-trained and the recovery rate for children and young people was favourable when compared with similar hospitals.
- A consultant surgeon was available either in the hospital or on call for 24 hours each day and middle grade surgeons were on site 24 hours a day, seven days a week.

Summary of findings

- In the paediatric intensive care unit (PICU) there was evidence of strong medical and nursing leadership.
- The neonatal surgical unit (NSU) had recently introduced a breastfeeding care pathway, 'Promoting transition to breastfeeding', which was becoming embedded in practice. Mothers spoke positively about the support they received. There was strong local leadership on the unit, with a clear ethos about staff working together.
- In adolescent and transitional services, we found examples of excellent pathways for young people with specific long-term health needs who were transitioning to adult services. We found that there was no overall responsibility or leadership for transitional services in the trust.
- The specialist palliative care team provided a safe, effective and responsive service. Staff throughout the hospital knew how to make referrals to the team. Children and young people were appropriately referred and assessed by the specialist palliative care team. A bereavement service supported families' emotional needs at the end of life and afterwards. Counselling support was available through the Alder Centre.
- In the outpatient's service, children, young people and staff told us that one of the biggest challenges was late running clinics and missing case records. Although there had been recent improvements, many staff, particularly in the general outpatient area, said they had not been listened to by management on key service changes and that outpatient services had not been a priority for the trust.
- Some staff told us they had been actively engaged and communicated with about the move to the new hospital site, while other staff told us they had not.

We saw several areas of outstanding practice including:

- Alder Hey Children's Hospital has a gait laboratory to assess children with neuromuscular disorders, such as cerebral palsy, which is not available elsewhere in North West England. The service therefore receives referrals from all over the North West.
- Trust physiotherapists have linked with community physiotherapists to provide appropriate postoperative care and a trust audit demonstrated that this has translated into improved outcomes for the children and young people.
- When babies were admitted to the NSU, parents were taught correct hand-washing techniques. The unit was developing infection control safety cards for parents.
- The paediatric oncology unit has a ward-based chef and kitchen providing freshly prepared food for children and young people between 11am and 7pm.

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

Importantly, the trust must:

- Continue to address staffing shortfalls. Nurse staffing levels must also be appropriate in all areas, without substantive staff feeling obligated to work excessive hours or additional shifts.
- Provide a longer-term solution for the medical leadership on the HDU.
- Ensure that children and young people who require one-to-one support in the isolation pods on the HDU receive it.
- Take action to ensure there are sufficient levels of nursing staff across the HDU.
- Continue to take action to ensure that clinical records are available in the outpatients department.
- Take action to ensure that nurses are following the trust's policy regarding the safe administration of medicines.
- Review the resuscitation equipment on each surgical ward to ensure that this meets the minimum equipment and drugs required for paediatric cardio-pulmonary resuscitation as outlined in the Resuscitation Council (UK) 2013 guidance.
- Address the shortfalls in governance and risk management systems.
- Improve the timely completion of investigation of incidents and Never Events (serious harm that is largely preventable) so that learning can be systematically applied to avoid recurrence.

In addition the trust should:

- Review its pharmacy arrangements to improve support to wards out of hours and at weekends.

Summary of findings

- Ensure that the A&E department clarifies its use of the observation ward as a CDU and make it clear to children and young people and their parents when they have been transferred to the CDU rather than being in A&E.
- Ensure that the A&E department reviews its arrangements for providing food and drinks in the waiting areas, and make it clear that hot and cold drinks and food are available on request.
- Ensure that children, young people and their parents using A&E services are aware of the trust's complaints procedure and are supported in using it where necessary.
- Review the provision of isolation cubicles within the hospital to isolate children and young people who may represent an infection risk to others.
- Consider changing open storage units to closed ones in the surgical wards to reduce the risk of cross-infection, especially in areas where clinical procedures take place, such as the treatment rooms.
- Consider removing the bin in the children's play area on Ward K3.
- Consider reviewing the risk assessment for the fire escapes in the surgical wards to make sure they are secure enough to prevent children and young people leaving unnoticed and protect against people entering unobserved.
- Consider the provision of a dedicated health play specialist and psychology resource to the critical care areas.
- Ensure that the arrangements stated in the board papers received by the inspection chair on 22 May 2014 concerning the medical cover in HDU are monitored.
- Ensure that staff report incidents on the NSU.
- Ensure that staff effectively check and sign resuscitation equipment on the NSU.
- Ensure that drug charts are appropriately completed on the NSU.
- Review the learning disability service provision to ascertain roles and responsibilities of both nurses and doctors for adolescents and young people in transition.
- Consider the Trust's overall strategy, board reporting mechanisms and leadership responsibilities related to transitional care.
- Take action to implement risk assessments in the outpatients department. The risk assessments would ensure the safety of children, young people, relatives and staff within the department.
- Ensure staff in the outpatients department have the opportunity to receive clinical supervision via a Trust wide model.
- Improve systems to ensure children and young people and their relatives and carers can make appointments in the outpatients department.
- Ensure letters sent to children and young people and their parents and carers are in the appropriate community language for those people who do not speak English as a first language.
- Ensure that staff in the outpatients department are effectively engaged in the development of the service.
- Improve staff engagement across all services and improve the visibility of the board and senior team.
- Improve the communication with staff to demonstrate a listening and responsive senior team.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Accident and emergency	Good	The service was safe and responsive to children and young people's needs, however, there were issues regarding nurse staffing levels, especially at night. The trust took immediate action to resolve this concern by providing an additional trained nurse for the full night shift. Some children and young people were concerned that they had to wait for long periods of time on the department and did not always realise that they had been admitted to the observation unit. Staff were caring and approachable, and engaged well with children and young people. The department's management team were exploring ways to reduce demand on A&E services and encouraged children and young people to seek alternative avenues of care and treatment to avoid unnecessary admissions to hospital. Some staff told us that they did not feel appropriately supported by their managers.
Medical care	Good	Medical services were delivered by a hard-working, caring and compassionate staff. Children and young people were treated with dignity and respect and care was planned and delivered in a way that took their wishes into account. National guidelines were used to treat children and young people and care pathways reflected national guidelines. Standards were monitored and outcomes were good when compared with other children's hospitals. Access to advice and information was good for children and young people, their families and carers, both during the hospital stay and after discharge. There were robust systems for the reporting of incidents and the management of risk. Ward areas were clean, but there were insufficient cubicles available within the hospital with which to isolate children and young people who may represent an infection risk to others. There were shortages of nursing staff on some wards and middle grade medical staff were very stretched out of normal working hours. Multidisciplinary teams and medical

Summary of findings

specialties worked well together. Medical outliers were well-managed and we found examples of good leadership by individual members of staff throughout the medical division.

Surgery

Good

Alder Hey paediatric surgical department provided safe services to children and young people because they followed best practice guidance in care and treatment. Care was person centred. Surgical staff were well-trained and the recovery rate for children and young people was favourable when compared to similar hospitals.
A consultant surgeon was available either in the hospital or on call for 24 hours each day and middle grade surgeons were on site 24 hours a day, seven days a week. We found that there was a lack of nursing staff and high reliance on agency staff. Staff had received safeguarding training so that they could recognise and take action to protect children and young people who may be at risk of harm. We observed considerate and compassionate care in all the areas we visited. Children and young people were provided with information about their procedures and everything was explained appropriately to them by staff.

Critical care

Requires improvement

In the PICU there was evidence of strong medical and nursing leadership that led to positive outcomes for children and young people. Care and treatment in the PICU was of a good standard and as a stand-alone service would have been rated accordingly across all domains. However, the HDU lacked medical and clinical leadership, although there was strong nurse leadership that provided great support for the team in challenging circumstances. The trust was aware of the risks associated with the HDU and had developed some solutions for the short and medium term prior to the planned move in 2015 to the new hospital. However, we were not assured that 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. On the unannounced visit, it was clear that immediate steps had been taken to improve the level of medical support on the HDU. The parents we spoke with on both the PICU and HDU gave us examples of good care and support

Summary of findings

			they and their children had received. Though we also heard of some frustrations from several parents about communications and the limitations of the ageing hospital environment.
Neonatal services	**Good**		Parents we spoke with gave us examples of the good level of care that their babies had received on the NSU. We were told about how supportive staff were, and that parents were informed about the care and treatment their babies received, and were involved in the process. The NSU had recently introduced a breastfeeding care pathway, Promoting transition to breastfeeding, which was becoming embedded in practice. Mothers spoke positively about the support they received. There was strong local leadership on the unit, with a clear ethos about staff working together.
Transitional services	**Requires improvement**		Young people were treated with dignity, respect and compassion. Clinical teams supporting care were committed to supporting young people requiring transitional services. We found examples of excellent care pathways for young people with specific long-term health needs transitioning to adult services. However, we found that there was no overall responsibility or leadership for transitional services in the trust.
Palliative and end of life care	**Outstanding**		The specialist palliative care team provided a safe, effective and responsive service. Staff throughout the hospital knew how to make referrals to the team. Children and young people were appropriately referred and assessed by the specialist palliative care team. The service had developed advanced life care plans in partnership with other service providers in the region for use in hospital and the community. Specialist children's palliative care nurses supported children and young people in hospital and in the community working in partnership with local community nursing teams. Children, young people and families had access to specialist advice and support 24 hours a day from a nurse-led, on-call team for end of life. Palliative care advice was also available for professionals. A bereavement service

Summary of findings

supported families' emotional needs during end of life and afterwards. Counselling support was available through the Alder Centre. Mortuary staff were trained in bereavement counselling.

Outpatients	**Requires improvement**		Children and young people received compassionate care and were treated with dignity and respect. Children and young people told us that staff were kind and supportive, and they felt fully involved in making decisions about their care. The outpatient areas we visited were clean and equipment was well-maintained. Children and young people and staff told us that one of the biggest challenges was clinics running late and missing case records. Although there had been recent improvements, many staff, particularly in the general outpatient area, said they had not been listened to by management on key service changes and that outpatient services had not been a priority for the trust.

Alder Hey Children's NHS Foundation Trust

Detailed findings

Services we looked at
Accident and emergency; Medical care; Surgery; Critical care; Neonatal services; Adolescent and transitional services; Palliative and end of life care; and Outpatients

Contents

Detailed findings

Background to Alder Hey Children's NHS Foundation Trust

Alder Hey Children's Hospital was one of two locations that formed part of Alder Hey Children's NHS Foundation Trust. The trust became a foundation trust in August 2008. The trust provides care for more than 270,000 children young people and their families. The trust also leads research into children's medicines, infection, inflammation and oncology. The trust has a broad range of hospital and community services, including many for direct referral from primary care. The trust is also a designated national centre for head and face surgery as well as a centre of excellence for heart, cancer, spinal and brain disease. It is a Major Trauma Centre and one of four national Children's Epilepsy Surgery Service centres.

Alder Hey Children's Hospital had 216 beds and provided a wide range of inpatient medical, surgical and specialist services as well as 24-hour A&E and outpatient services. A new Alder Hey Hospital is currently being built adjacent to the existing site and is set to open in 2015. The new Alder Hey site 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, ensuite rooms with pull-out beds for parents.
- Access to play areas, natural light and views of the park will be available wherever possible.
- Children, young people and teenagers will have dedicated areas to play and relax.

Alder Hey Children's Hospital was inspected three times since its registration with CQC. The most recent inspection took place in December 2013, and the trust was found to be not meeting essential standards for care and welfare of people who use services, staffing, supporting workers and assessing and monitoring the quality of service provision. This was a responsive inspection, focused on the surgical department following concerns reported to the CQC.

We inspected this trust as part of our in-depth hospital inspection programme. We chose this trust because it represented a variation in hospital care according to our new intelligent monitoring model. This looks at a wide range of data, including patient and staff surveys, hospital performance information and the views of the public and local partner organisations. Using this model, the trust was considered to be a high-risk service.

The inspection team inspected the following eight core services at Alder Hey Children's Hospital :

- Accident and emergency (A&E)
- Medical care
- Surgery
- Critical care
- Neonatal services
- Adolescent and transitional services
- Palliative and end of life care
- Outpatients.

Our inspection team

Our inspection team was led by:

Chair: Dr Sheila Shribman, consultant paediatrician

Head of Hospital Inspections: Ann Ford, CQC

The team of 41 included CQC inspectors, a pharmacist inspector and analysts, director of nursing, two paediatricians, two paediatric surgeons, a paediatric intensivist, a junior doctor, specialist children's nurses, a children's theatre nurse, an A&E specialist, a modern matron a paediatric pharmacist, a hospital play specialist, a paediatric general hospital manager, a governance specialist, inspection planner and two recorders.

Detailed findings

How we carried out this inspection

To get to the heart of children and young people's 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?

Before visiting, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. These included the clinical commissioning groups, Monitor, NHS England, Health Education England, the General Medical Council, the Nursing and Midwifery Council, the royal colleges and the local Healthwatch.

We held two focus groups in May 2014 supported by voluntary personnel and the community through the Regional Voices programme. These focus groups aimed to listen to the views of children and young people and their parents and carers about services they received. We also attended the Children's and Young People's Forum on Saturday 10 May 2014. This forum met every six weeks for workshops, and discussions about hospital issues. It provided children and young people with an opportunity to represent the many thousands of young people who use Alder Hey and be included in the hospital's decision-making process, as well as supporting the hospital to develop its services.

We held two listening events, in Liverpool and Chester, on 20 May 2014, where people shared their views and experiences of the hospital. Some people who were unable to attend the listening events shared their experiences via email or telephone.

We carried out announced inspection visits on 21 and 22 May 2014. We held focus groups and drop-in sessions with a range of staff in the hospital, including nurses, junior doctors, consultants, student nurses, administrative and clerical staff, physiotherapists, occupational therapists, pharmacists, domestic staff and porters. We also spoke with staff individually as requested.

We talked with children and young people and staff from all the ward areas and outpatient services. We observed how children and young people were being cared for, talked with their parents carers, and reviewed their records of personal care and treatment.

We carried out an unannounced inspection between 6am and 11am on Sunday 01 June 2014. We looked at how the hospital was run out of hours, the levels and type of staff available, and how they cared for children and young people.

We would like to thank all staff, children and young people, their parents and carers and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment at Alder Hey Children's Hospital.

Facts and data about Alder Hey Children's NHS Foundation Trust

Alder Hey Children's Hospital offers 20 specialist services including being the designated national centre for head and face surgery and a centre of excellence for children with cancer, heart, spinal and brain disease. It is a teaching hospital and trains 550 medical and 400 nursing students each year. Alder Hey is 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 research into children's medicines, infection, 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 at 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, helping deliver care closer to home.

Detailed findings

The trust provides 270,000 episodes of care each year. In 2012/13 almost 33,300 patients were admitted to hospital as inpatients or day cases, more than 175,000 attended outpatient clinics and 57,500 were treated in the A&E department.

Alder Hey Children's Hospital is in West Derby in the north of Liverpool, a city and metropolitan borough of Merseyside. Liverpool is the most deprived of 326 local authorities in England. It has a population of around 467,000 (2011). Although, 60% of its income is from specialised services across the North West, North Wales – a population of around eight million. There are significantly high rates of children living in poverty, teen pregnancy, smoking during pregnancy, alcohol stays for under 18s, drug misuse, alcohol-related harm and childhood obesity. There are low rates of breastfeeding, healthy eating and GCSE attainment. Early death rates from cancer and from heart disease and stroke have fallen but remain worse than the England average. Life expectancy rates for men and women are lower than the England average: 11.0 years lower for men and 8.1 years lower for women in the most-deprived areas of Liverpool than in the least-deprived areas.

The trust has a stable executive team, with the director of nursing having been in post almost two years. The director of finance is the most recent recruit, joining in June 2013. The trust is a teaching hospital and supports 958 trainee doctors each year and 556 student nurses and allied health professionals.

The trust has an annual turnover of £194 million.

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Accident and emergency	Good	Not rated	Good	Good	Good	Good
Medical care	Requires improvement	Good	Good	Good	Good	Good
	N/A	N/A	N/A	N/A	N/A	N/A
Surgery	Requires improvement	Good	Good	Good	Good	Good
	N/A	N/A	N/A	N/A	N/A	N/A
Critical care	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Neonatal services	Good	Not rated	Good	Good	Good	Good
Transitional services: PILOT	Not rated	Not rated	Not rated	Not rated	Not rated	Requires improvement
Palliative and end of life care	Good	Good	☆ Outstanding	Good	☆ Outstanding	☆ Outstanding
Outpatients	Requires improvement	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for both Accident and Emergency and Outpatients.
2. As transitional services were inspected as a Pilot in this inspection, we have rated the overall service, but not the individual questions.

Accident and emergency

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

Information about the service

The accident and Emergency (A&E) service at Alder Hey Children's Hospital was the 'front door' for children and young people referred by GPs, 999 calls and local walk-in services, as well as self-referring patients. Between April 2013 and March 2014, 56,500 children and young people attended the service and there had been no rise in the number of admissions over the last three years. The department had a good record on achieving the national target to have patients discharged or admitted within four hours of arrival at A&E.

The department is staffed by 42 full-time equivalent nursing staff and 10 consultants who, between them, provide support every day of the year. The department can cater for a wide range of medical conditions which range from minor injuries to major trauma. It also has an isolation unit for patients with infectious diseases. Although the department does not have a purpose-built clinical decision unit (CDU) it had been agreed with the service's commissioners that the observation ward could be used for this purpose. During our visit we talked to children and young people and their parents, nursing and medical staff, and reception staff. We observed the interactions between children and young people and clinicians, and also looked at equipment and medical records.

Summary of findings

The service was safe and responsive to children and young people's needs, however, there were issues regarding nurse staffing levels, especially at night. The trust took immediate action to resolve this concern by providing an additional trained nurse for the full night shift. Some children and young people were concerned that they had to wait for long periods of time on the department and did not always realise that they had been admitted to the observation unit.

Staff were caring and approachable, and engaged well with children and young people.

The department's management team were exploring ways to reduce demand on A&E services and encouraged children and young people to seek alternative avenues of care and treatment to avoid unnecessary admissions to hospital.

Some staff told us that they did not feel appropriately supported by their managers.

Accident and emergency

Are accident and emergency services safe?

Good

Children and young people were being properly assessed by triage on arrival at the department, and there were safe and effective systems to manage serious trauma and other serious medical conditions. Staff understood their responsibilities to protect children who may be subject to harm or abuse. We found concerns about staffing levels, particularly between midnight and 7am, where there appeared to be minimal nurse staffing cover. At the end of our inspection, senior managers confirmed to us that additional nurse staff cover would be provided during the night with immediate effect.

Incidents

- The department had no recent Never Events (very serious, largely preventable patient safety incidents that should not occur if the relevant preventative measures have been put in place) between January 2013 and December 2013.
- Between March 2013 and February 2014 there was one incident reported to the National Reporting and Learning System (NRLS) related to a moderate safeguarding incident recorded in the department.
- Learning and changes to practice were communicated through regular staff team meetings, and staff meeting minutes confirmed this. As an example of team learning we were shown a report that examined the treatment of a baby, the lessons learned and the subsequent changes to practice.

Safety thermometer

- The NHS Safety Thermometer is a tool designed to be used by frontline healthcare professionals to measure a snapshot of specific harms once a month. As a children's trust, Alder Hey is not required to submit data as part of the NHS Safety Thermometer. However, the trust had introduced its own safety thermometer chart in the A&E department that provided information about cleanliness, hand hygiene, medicines management and complaints. This chart had only just been introduced and staff had not yet completed it. However, there were plans to collate this information on a monthly basis.

Cleanliness, infection control and hygiene

- The general areas of the A&E department and observation unit were clean and staff used hand hygiene gels and personal protective equipment, such as gloves and aprons.
- We noticed that there was damage to the vinyl floor in a number of places in the isolation unit that could present an infection control risk. A senior staff member said they had requested that this problem be addressed, but were still awaiting a response from the estates department. We noted from the infection prevention and control (IPC) audit action plan that this issue had been raised in February 2014. When we identified the concerns, immediate remedial action was taken.
- All the equipment we looked at was clean and appropriate systems were in place to ensure equipment was kept clean.

Environment and equipment

- The major trauma area was clean and uncluttered. We found that, across the unit, equipment was stored in an orderly manner.
- There was a trauma trolley with a burns kit readily available.
- Resuscitation equipment had been checked in line with trust policy.
- Areas of the department were locked to visitors. Reception staff ensured no unauthorised visitors were allowed entry. A security team was on duty 24 hours each day. However, we found that we could get through a security door between the waiting areas to the observation ward without a swipe card, meaning that unauthorised persons could enter the unit undetected. This concern was brought to the attention of staff on the unit.

Medicines

- Medicines were stored correctly in a locked cupboard and fridge. Appropriate arrangements were in place to ensure that medicines were in date and replenished when necessary, including at weekends and out of hours.
- Doctors were able to dispense medicines to children and young people after 5.30pm when pharmacy services had closed for the day.
- Medicine fridge temperatures were correct and monitored daily in line with trust policy.

Accident and emergency

Records

- All children and young people who suffered a trauma were appropriately logged. We checked three records which were complete and included information on ambulance handover.
- We also checked one child's record relating to epilepsy and found this to be properly completed.
- Documentation completed by doctors followed a consistent approach and used the medical model of assessment that included: presenting complaint; history of presenting complaint; past medical history; medication and allergy history; social history; examination and initial diagnoses; and plan of care. Reviews were evident after investigations were completed and action plans clearly identified.
- A number of assessment tools were used to assess children and young people with a range of presenting issues such as mental health needs, alcohol misuse, self-harm and challenging behaviour.

Consent

- Staff understood their responsibilities to use the Gillick competencies and Fraser guidelines to decide whether a young person was able to consent and understand the care and treatment that was offered to them.
- We observed staff speaking with children and young people in a respectful manner and they explained issues to them in a way they understood.
- Staff ensured that all issues about consent to care and treatment were recorded in line with trust policy.
- One young person who had recently arrived at the department told us that nurses had explained what would happen regarding their assessment and treatment in a way they could understand.

Safeguarding

- Staff were able to clearly report what they would do in the event of a safeguarding concern. They were aware of the need to inform the relevant local authority who had a responsibility for coordinating safeguard investigations.
- There was a system in place to highlight local children who were subject to a child protection plan.

The trust's safeguarding concerns 'trigger tool' included concerns relating to young people such as multiple attendances, protection plans and attendance relating to violence (such as assault gun/knife crime and deliberate self-harm and risk-taking behaviour).

- Staff were clearly aware of their responsibilities in line with both the trust and multi-agency safeguarding procedures.
- There was a room in the department that was used for children and young people who were detained under the Mental Health Act 1983. We were informed that, at no time were children or young people locked in this room on their own. There was clear policy which specified in detail the circumstances in which children and young people could be placed in the room and what safeguards had to be in place.
- We noted from the safeguarding training records that three out of 49 nursing staff were overdue on their renewal of their level 2 safeguarding training, and eight on their renewal for their level 3 training.
- Regular safeguarding meetings took place across the trust and a representative from the department attended.
- Contact information for a local support agency that dealt with concerns related to domestic violence was on display in case children and young people needed it.

Mandatory training

- Nurses undertake Advanced Paediatric Life Support (APLS) resuscitation training within 12 to 18 months of starting, and revalidate every four years. This was confirmed on the department's APLS training spreadsheet.
- Trauma scenarios were carried out on a weekly basis, to ensure that doctors and nurses were equipped with the necessary skills to deal with trauma events.
- There was a comprehensive induction pack for new staff recruited to the department. The induction focused on the required staff competencies to work in the department and training included the management of trauma, blood sampling and safe administration of medicines.
- There was a good system in place to check that all staff who worked on the department received their mandatory training.
- Staff told us that the quality of training they received was good. However, only 55% of staff had received their mandatory training in the last 12 months. This was significantly below the trusts target.

Initial assessment of children and young people

- New patients were triaged (assessed) on arrival and classified into one of four categories:
  - Red: seen straightaway

  - Orange: observed close to the nursing station
  - Yellow: monitored by a nurse
  - Green: non-urgent – could wait up to four hours.
- An experienced nurse would conduct the initial triage and we were able to observe this process in action.
- We were given a copy of the department's rapid tranquilisation protocol, and were told that this had only been used on a couple of occasions. Any child or young person subjected to rapid tranquilisation would be admitted to the medical assessment unit (MAU) immediately afterwards.
- We observed trolleys set up for full resuscitation with fluid and blanket warmers.
- The lead consultant told us they could get children and young people into theatre very quickly for major trauma and serious conditions. They also confirmed that, if necessary, they were able to access neurosurgical support.
- Radiology services were accessible very quickly and there was also an out-of-hours radiologist on call.

Management of deteriorating patients

- Staff used the Paediatric Early Warning Score (PEWS) for recording the vital signs of children on the department so that early signs of deterioration could be identified and remedial action taken.
- Nurses we talked with said that it was a very useful tool which they used diligently because it worked.
- Nurses described the escalation process depending on the PEWS score.
- We were told that doctors and senior nurses responded quickly when they were informed of high PEW scores.
- There were clear instructions about how to use the PEWS scoring system and this was in keeping with the information provided by staff.
- We discussed the management and transfer of the deteriorating child with staff. Nursing staff were clear about the process and the responsibility of staff and the need to refer children in a timely manner to the high dependency unit or intensive care unit.

Nursing staffing

- Staffing records showed us that 42 full-time nursing staff plus one play specialist were employed in the department at the end of April 2014. Of these, 11 were band 7, 8 or emergency nurse practitioner (ENP) grade.
- One of the senior nursing staff told us that nursing levels in the department were as follows:
  - Five between 7am and 11am
  - Seven between 11am and 1.30pm
  - Nine between 1.30pm and midnight
  - Three between midnight and 7pm.
- After midnight there was an on-call consultant.
- We were given copies of the nursing staff rotas covering the period between February and the end of April 2014, and noted that these confirmed the shift patterns conveyed to us by the senior nursing staff member.
- A number of staff said they would ideally like to have at least four nurses on night duty.
- Some staff were very concerned about staffing levels, especially at night. They said that assistant practitioners were being used to support the rota. Also, clinical staff were being expected to work five to 10 extra hours a week.
- Senior managers confirmed that a review of nurse staffing on the unit had taken place and, with immediate effect, an additional qualified nurse post would be made available during the night. This meant that each night, four qualified nurses would be on duty during each night shift.
- We were told that due to qualified nurses having to support children in the resuscitation bay, there can be times, when a registered nurse may not be available in the minor injury department. In these cases an assistant practitioner (AP) or PLS trained HCA is always available. Patients with serious injury or who have been given morphine are continuously monitored and medical help is readily available in the Minors area.
- However, we observed that children who had significant fractures or required intranasal diamorphine were left without qualified nursing supervision.

Medical staffing

- The department employed 10 A&E consultants.
- The consultants were on duty between 8am and midnight. Often a consultant would be in the department until 2am.
- We were given the medical staffing rotas covering the period January to March 2014 and noted that there was always one junior doctor on duty between midnight and 8am. During busy times, for example, late afternoon and early evening, we noted that there could be up to eight medical staff on duty with another senior consultant on call.

Accident and emergency

Major incident awareness and training

- The major incident cupboard was stocked for 50 patients and included fluids, gowns and casualty cards. Initial triage for major incidents was conducted in the ambulance entrance by a nurse or consultant.
- We noted that the major incident triage chart was incorrect. It indicated that a person should be pronounced dead if they were not breathing, rather than instructing the clinician to open the patient's airway. This chart should be amended or removed.

Are accident and emergency services effective?

(for example, treatment is effective)

Not sufficient evidence to rate

National guidelines were used to treat children and young people and care pathways were followed to support and speed recovery. Standards were monitored and outcomes were good when compared with other children's hospitals.

Staff worked well across disciplines to secure good outcomes for children and young people.

Evidence-based care and treatment

- The department adhered to all the appropriate National Institute for Health and Care Excellence (NICE) and College of Emergency Medicine (CEM) guidelines regarding treatment.
- There were specific care pathways for certain conditions in order to standardise and improve the care for children and young people. For example, care pathways were displayed for the management of seizures, choking and cardiac arrests.
- The trust participated in all the national clinical audits they were eligible for.
- Not all A&E policies were based on current best practice and were revised and updated regularly. Some of the policies were out of date, such as the policy for asthma care. The policy was written in 2006 and was due to be reviewed in 2013. However, this had not taken place.

Pain relief

- The department was following recognised pain management protocols, including the use of Ketamine for short interventions and the use of intranasal diamorphine.
- Patient experience feedback showed that the majority of children and young people felt their pain was being managed effectively.
- Pain levels were monitored regularly and analgesia was administered according to needs.

Nutrition and hydration

- Some children and young people told us that they struggled to access food and drinks in the department, particularly during the night. One young person told us that they were in the department recently at the weekend from 10pm to 2am. They said the vending machine was broken, so they could not buy a drink, and they could not see a water station. They told us that staff did not offer them a drink.
- There was information on display to advise children and young people that only cold food and drink was permitted on the unit and that food and drink should not be consumed until children and young people had seen the doctor. This was appropriate and in line with good practice.
- Staff told us that children and young people could access food and drink from the hospital canteen 24 hours each day. Information was displayed advising children and young people that food and drink was available at the canteen.
- Staff reported that improvements were required to ensure that food and drink was more readily available on the unit to children, young people and their parents and carers. We observed that the vending machine to buy drinks was broken when our inspection started. This was repaired by the time we completed the inspection. We observed staff support one young person with a disability to drink and eat. Staff told us that they would provide a drink and toast to children and young people who had been waiting in the department for a long time if asked.

Patient outcomes

- Emergency readmission rates were better than the national average. We found that 1.3% of children and young people were admitted against a national average of 2.1%.

Accident and emergency

Competent staff

- Medical and nursing staff had appropriate qualifications and skills to work with acutely ill children.
- Most nursing staff felt supported to develop and achieve their training requirements.
- Staff told us they received effective supervision and appraisals from their managers.
- The unit had a clear process for students and new members of staff that explained how the department was run and the objectives they needed to meet to become a competent member of the A&E team.
- The unit had a practice development nurse who was central to the management of the organisation of staff training.

Multidisciplinary working

- Five thousand children and young people were seen at two other local A&E departments every year, and these patients were safely transferred to Alder Hey.
- Arrangements were in place to transfer children and young people to specialist services within the trust, for example, to the Child and Adolescent Mental Health Service (CAMHS).
- Medical and nursing staff worked well with other specialities and therapy services to provide effective care to children and young people.
- Staff valued the contribution of other professional disciplines.
- Some young people who told us that they had been admitted to the department for drug and alcohol-related problems told us that they had not always been referred to the local external agency for continued support. However, the trust informed us that all patients with drug or alcohol related attendances are referred to an internal brief intervention clinic. If appropriate at this stage, they will be referred to external agencies for further support.

Seven-day services

- One consultant was on duty between 8am and midnight on both Saturday and Sunday, and was supported by five junior and middle grade doctors over a 24-hour period. 3 junior doctors until 2am, 2 until 4am and 1 from 4am to 8am. Plus 1 registrar to 2am.

Are accident and emergency services caring?

Good

We found that, overall, children and young people and their parents, were happy with the level of care and treatment they were being offered. In fact, many preferred to use A&E instead of going to their GP. We observed clinicians interacting with children and young people and noted that staff spoke directly to the patient and carefully explained the nature of their problem and how it was to be treated. We also found that there were effective arrangements to support parents and staff following the death of a child or young person.

Compassionate care

- We spoke to 12 children and young people, with their parents. They all expressed satisfaction with the service. One of the children we spoke with said the nurses and doctors were always nice and caring towards them.
- Senior staff in the department told us that, if children and their parents had to wait a long time, a clinician would apologise to them and explain the reason for the delay. A recent inpatient survey of the level of care and support provided revealed that children and young people were highly satisfied with the care and support provided by staff. The survey reported that staff were friendly, and the experience of doctors and nurses was outstanding. All children and young people we spoke with said that the department could do better with waiting times and ensuring that young people were engaged in age-appropriate conversations. This survey was conducted by the play specialist and was on display in the reception area.

Patient understanding and involvement

- The children and young people and their parents we spoke with said the clinicians would always explain to them the nature of their problem and how it was going to be treated.
- We observed a consultation by a nurse with a young person and their parent. The nurse introduced themselves to the young person and spoke directly to them about their problem. The nurse explained the probable diagnosis and how it was to be treated, and did this using clear, understandable language.

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Emotional support

- Parents and staff were properly supported in the event of the death of a child or young person. Staff explained that a nurse would sit with the child or young person and their parents during the final hours and would explain to them what was happening.
- The bereavement team based at the Alder Centre were on call 24 hours a day and would be available to support the parents and the family. Debriefing sessions were also conducted with relevant staff members.
- Staff offered children and young people appropriate levels of reassurance and comfort during their time on the department.

Are accident and emergency services responsive to people's needs?

(for example, to feedback?)

Good

We found that the main challenge to the department was to manage its patient flow. The department performed well in terms of achieving the four-hour wait target, although the use of the observation ward as a 'virtual' clinical decision unit meant that some children and young people remained in the A&E for up to 17 hours. Overall, the department was able to meet the individual needs of children and young people. Children and young people were supported following discharge. We found that children and young people, and their parents, were not aware of the complaints procedure in the department and we found no evidence in minutes from the emergency department senior staff meeting, departmental meeting and monthly business meeting that the department was using complaints as an opportunity for learning.

Service planning and delivery to meet the needs of local people

- The department's management explained that they were trying to find ways to encourage children and young people to use community-based services instead of A&E, but acknowledged that there was a deeply engrained culture in the community regarding the use of A&E. There was in a plan to bring in two GPs into the unit from September 2014, as it was hoped this would reduce pressure on the department.
- Three parents told us that they didn't trust their GP so always came to A&E if there was any kind of health problem with their children.
- We found that, during busy times, staff could access additional medical and nursing staff to ensure that children and young people's care and support were not compromised.

Access and flow

- The hospital had the busiest children's A&E department in the country and peak times were in the evening, between 5pm and 11pm. We were told that the department was the first port of call for many children and young people in the area.
- Between 2 December 2013 and 11 May 2014, 26,724 children and young people accessed A&E at Alder Hey. Of these, 719 (2.7%) were recorded as waiting longer than four hours to be treated. The trust's target of 95% patients being seen within four hours was breached on 18 days during this period.
- However, feedback from staff and parents of children and young people indicated that waits of up to 17 hours were quite common. The management of the department explained that this was due to the observation ward being used as a 'virtual' CDU. This meant that, although children and young people who were placed in the 'virtual' CDU were technically no longer deemed to be in A&E, from their perspective, this was still the case. The senior manager team reported that this arrangement had been agreed with commissioners. However, we were concerned that children and young people were confused and did not appear to be aware that they had left the A&E department.
- The percentage of children and young people who left A&E before being seen shows the trust had a higher than the England average in February and March 2013 then again in December 2013. The trusts performance on children and young people who had to wait longer than 30 minutes for a transfer from the ambulance service was better than the national average.
- The department was in the process of developing a plan to manage all aspects of patient flow.
- The senior staff explained that it would only take one serious trauma patient or staff sickness to skew the waiting time figures. The waiting time data supported this view as there were no discernable patterns to breaches of the four-hour target.

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- Most of the children and young people and their parents said that sometimes they had to wait a long time. One parent said the longest wait had been five-and-a-half hours. They said a nurse would always apologise to them for the long waits. When we visited out of hours, two children and their parents told us that they had been seen very quickly and efficiently.

Meeting people's individual needs

- We observed that there were limited activities for children, for example, games, colouring books or jigsaws, or television to keep them occupied while they were waiting to be seen. We were told by a member of staff that colouring books were available on request. When we visited out of hours, one parent told us that a play specialist was available and the support they provided to their child was excellent.
- The department currently had one qualified full-time play specialist who worked 10am to 6pm, Tuesday to Saturday. Staff reported that, ideally, an additional play specialist would ensure that children could receive this sort of support every day of the week.
- The department had a sensory room which was used to calm anxious children and young people. We were told that the room was used four to six times a day.
- The Language Line translation service was available for children and young people or their parents whose first language was not English.
- Staff told us that, if a child or young person presented themselves to the A&E department on their own, staff would conduct a brief assessment and then contact the parent or guardian as soon as possible.

Learning from complaints and concerns

- Trust data showed that, between September 2013 and March 2014, there were nine recorded complaints in the A&E department. Five of these concerned clinical care, three staff attitude, and one discharge arrangements. We found that six of these complaints had not been responded to with the trust's target of 28 days.
- None of the children and young people and their parents we spoke with were aware of the trust's complaints procedure. There were no visible signs, for example, posters or leaflets, in the waiting areas, signposting children and young people to the Patient Advice and Liaison Service or explaining the complaints process.
- We found that children and young people, and their parents, were not aware of the department's complaints procedure, and we found no minutes from senior staff meetings, departmental meetings and monthly business meetings to show that the department was using complaints as an opportunity for learning.

Support following discharge

- As an example of how children and young people were supported following discharge from A&E, we were given copies of three discharge information sheets covering mild head injuries, wrist buckle fractures, and fevers. These gave basic information on how the child or young person should be looked after at home, and when to seek medical advice or return to the hospital.

Are accident and emergency services well-led?

Good

The department's management team was focusing on finding new and innovative ways to reduce the pressure on A&E and had conducted research into this area. Although managers said they felt supported by the Trust Board, more junior staff talked of a gap between the department and the board. We saw evidence that the management team was regularly monitoring and discussing a wide range of clinical and operational issues within the department and conducting patient experience surveys as another form of quality assurance. The culture within the department was described as "team orientated"; however, some nurses told us that they did not feel appropriately supported by their immediate line managers.

Vision and strategy for this service

- The general manager of integrated community services, which included A&E, told us that their main focus was to encourage children and young people and their parents to look at receiving care and support from community-based services – for example, their GP or walk-in centres – as their first port of call, rather than A&E. At the same time, they wanted to build on the good practice developed over the years in the current department and transfer this over to the new hospital next year.
- The manager said they had carried out a lot of research into inappropriate use of A&E services and alternatives to A&E, and we were given some examples of this work.

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Governance, risk management and quality measurement

- We were given copies of minutes from the department's monthly business meeting, a recent departmental meeting, and the last senior staff meeting. These demonstrated that the department was monitoring all aspects of care delivery and treatment, and addressing any issues as they arose.
- Matters such as clinical incidents, infection control, staffing levels and patient experience were discussed at these meetings.
- Risks within the department division were discussed regularly at both ward and divisional level and escalated to senior managers when necessary.
- There was a range of different quality and governance meetings that took place in the department. These included senior nurse leadership, clinical governance and training and development meetings. The scheduling dates and notes of these meetings were available in the nurses' office.

Leadership of service

- valued by senior management. They said that the chief executive and chief operating officer had visited the department at 11pm last December, and were there when they were needed.
- Feedback from some more junior staff suggested that the senior management of the trust were not very visible and that there was a disconnect between 'the frontline' and the board.
- Most staff members told us that their immediate line managers were accessible and approachable, and provided them with good support.

Culture within the service

- The management culture within the A&E department was described by managers as "team oriented" and collaborative, with a focus on doing the right thing for the child and their family.
- However, members of nursing staff told us that they were not supported appropriately by their managers and there was not an open culture for them to freely discuss any concerns they had.
- Staff told us that more needed to be done to learn about the positive feedback and complaints they received from children and young people and their parents and carers.

Public and staff engagement

- We were shown copies of the monthly patient satisfaction questionnaire and noted that this was addressed to the parent. It covered areas such as the number of times the parent had to repeat their story, how well they were kept informed, and whether their child was offered toys or books to entertain them.
- Although the results of the questionnaire showed a generally high level of satisfaction, waiting times featured strongly as a negative experience.
- We received a mixed response from staff regarding their involvement about the move to the new hospital. Some told us that they had been involved in the design of the new department, while others reported that they had not been as engaged as they would have liked.

Innovation, improvement and sustainability

- One of the senior staff told us the department was always learning from visits to other A&E departments, for example, Birmingham Children's Hospital.

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

Information about the service

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 K2, C2, C3, E3, D2, neuromedical, transitional care unit (neurology), oncology unit, medical assessment unit and Winter Ward over the course of a three-day inspection, one outside of normal working hours. We observed care, considered the environment and looked at care records for seven children. We spoke with 17 children and young people, 23 family members and carers and 41 staff across all disciplines. Before our inspection, we reviewed performance information from, and about, the hospital.

Summary of findings

Medical services were delivered by a hard-working, caring and compassionate staff. Children and young people were treated with dignity and respect and care was planned and delivered in a way that took their wishes into account. National guidelines were used to treat children and young people and care pathways reflected national guidelines. Standards were monitored and outcomes were good when compared with other children's hospitals. Access to advice and information was good for children and young people, their families and carers, both during the hospital stay and after discharge.

There were robust systems for the reporting incidents and managing risk. However, information received from the trust, together with our findings showed that incidents relating to medicines were under-reported, limiting the opportunity for learning and reducing the risk of harm.

Ward areas were clean, but 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 very stretched out of normal working hours. Multidisciplinary teams and medical specialties worked well together. Medical outliers were well-managed and we found examples of

Medical care

good leadership by individual members of staff throughout the medical division. In addition, the numbers of staff who had received safeguarding training was low at 61%.

Are medical care services safe?

Requires improvement

There were robust systems for reporting incidents and managing risk within the medical division. However, information received from the trust, together with our findings showed that incidents relating to medicines were under-reported, limiting the opportunity for learning and reducing the risk of harm.

Ward areas were clean, but there were occasions when there were insufficient cubicles to isolate children and young people who may present a risk of infection to others. The trust had taken actions to address this issue and There were shortages of nursing staff on some wards and middle grade medical staff were very stretched outside of normal working hours. In addition, the numbers of staff who had received safeguarding training was low at 61%.

Incidents

- There had been no Never Events (serious, largely preventable patient safety incidents that should not occur if the relevant preventative measures have been put in place) reported in the division of medicine between January 2013 and December 2013.
- The number of incidents reported by the trust between December 2012 and January 2014 was low when compared with other similar trusts, which could indicate that the system for reporting incidents was not robust. However, we found there were effective systems for reporting incidents and 'near misses' across the medical division.
- Staff were confident in reporting incidents and 'near misses' and were supported by managers to do so. Feedback was given and there were examples of learning from incidents being applied and evaluated.
- Mortality and morbidity meetings were held regularly and were attended by ward managers. These meetings discussed any deaths which had occurred and any learning as a result. Ward managers then took the learning points back to their individual teams.

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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).
- Within the medical division, wards submitted a monthly snapshot of "care indicators" to the trust which had recently been reviewed, amended and re-named "patient safety scans". They included measurements of tissue viability, care plan documentation and infection control.
- Progress against the safety data was discussed regularly by staff at ward level and was used to improve practice.
- This information was not always displayed on the ward noticeboards, or was not clearly displayed in a format that was easy to understand.
- Many wards within the medical division also measured additional specific data relevant to their area of expertise.

Cleanliness, infection control and hygiene

- The ward areas we inspected were clean.
- Staff were aware of current trust policy with regard to the prevention and control of infection. There was a sufficient number of hand wash sinks and hand gels. Hand towel and soap dispensers were adequately stocked. We observed staff following hand hygiene practice and 'bare below the elbow' guidance.
- There was a shortage of cubicles within the hospital to isolate children and young people who may present a risk of infection to others, particularly during times of peak demand. The trust had responded to this issue by adding temporary "ice-pod" cubicles in several areas. Improving rapid diagnosis through implementation of film array technology to reduce the burden of isolation.
- However, there were occasions when children who presented an infection risk were not always isolated appropriately and resulted in the least-infectious children and young people being nursed on the main wards using portable isolation screens that did not completely isolate them, and therefore were a potential risk to others.
- The design and layout of the new hospital should address this risk, however in the meantime , the trust should review the actions taken to manage the isolation of children with infectious conditions.
- Infection rates for methicillin-resistant staphylococcus aureus (MRSA) and Clostridium difficile (C. difficile) for the trust were within an acceptable range.

Environment and equipment

- The layout and flow through most of the wards we inspected were not ideal due to the age of the hospital. Storage facilities were also limited. However, all wards we inspected had plans for the layout of their specialities within the new hospital building to resolve any current issues.
- Staff told us there was sufficient equipment available but it was not unusual to run out of small single-use items. This was because the ordering system did not identify when an item was out of stock at the point of ordering. Therefore, staff would only become aware when the item did not arrive on the ward, at a point where stocks were already low. It was frequently necessary to borrow small, single-use items of equipment from wards, or lend them to other wards.
- Staff knew who to contact or alert if they identified broken equipment or environmental issues that needed attention.
- We checked the resuscitation equipment on all of the wards we visited and found they had been checked regularly by a designated nurse.
- Resuscitation equipment and emergency drugs were kept in separate places within the ward areas. Although ward staff were aware of how to locate these drugs and equipment, there was a risk that bank (overtime) and agency staff would have difficulty locating them quickly in the event of an emergency.
- All of the wards we visited had an informal system for ensuring that bank and agency staff were aware of the location of emergency drugs and equipment. None of the wards used a formal system, such as a checklist. On one ward, staff informed us that, when they were very busy, bank and agency staff would not be given any form of orientation to the ward, including the location of emergency drugs and equipment.

Medicines

- Administration of oral medication on most wards was delayed due to the large numbers of children requiring intravenous medicines, which were prioritised over oral medication.

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- There were delays in access to discharge medicines, reported by staff and parents at weekends. This was reported as an issue with the doctors completing the relevant paperwork rather than delays involving the pharmacy team.
- During the inspection we found one medication error had occurred where medicines were not reviewed by a pharmacist until four days after admission. The chief pharmacist told us of a similar type of medication error that occurred where the child's medicines had not been reviewed for three days. Both these errors occurred during the weekend.

Records

- Records relating to children and young people were kept in both electronic and paper formats.
- During our inspection we reviewed seven sets of records on five wards. In all the records we looked at, documentation was accurate, legible, signed and dated, easy to follow and gave a clear plan and record of the children and young people's care and treatment. Risk assessments were well-documented and regularly reviewed. Care plans contained clear accounts of actions in place to reduce and manage risks to patient safety.
- Some of the paper records we reviewed were in a poor state of repair, with loose pages, representing a risk that patient information would get lost or misfiled.

Consent

- Records we reviewed showed that patient consent had been obtained and recorded appropriately.

Safeguarding

- Staff had a good knowledge and understanding of safeguarding procedures and knew how to contact the hospital safeguarding team, should this be necessary.
- The electronic system within the hospital identified children and young people who had a child protection plan.
- Training records indicated that only 61% of staff within the trust, across all divisions, had received level 1 (the lowest level) safeguarding training or a safeguarding update within the last year. There were initiatives in place to increase the level 1 safeguarding training, including increased use of e-learning and workbooks.

Mandatory training

- Information supplied by the trust recorded mandatory training levels at 73% in February 2014 against a trust target of 90%.
- Trust-wide electronic training records did not correspond with records held at ward level. This made it difficult to accurately ascertain levels of mandatory training throughout the medical division.
- Staff reported frequently being removed from pre-booked training due to reduced staffing levels on wards.
- Some mandatory training could only be accessed on the same day each week. This meant that staff with clinical duties on this day, such as a clinic session, were unable to attend.
- Access to the e-learning system was frequently reported by staff at all levels as frustrating due to difficulties with passwords.
- Physical access to a computer terminal in order to undertake e-learning was reported as difficult by many staff.

Management of deteriorating children and young people

- The trust used a modified Paediatric Early Warning Score (PEWS) which was designed to identify children and young people whose condition was deteriorating. Staff were prompted when to call for appropriate support. The chart incorporated a clear escalation policy and gave guidance about ensuring timely intervention by appropriately trained personnel.
- Steps had been taken to ensure that staff understood how to use the PEWS system.
- For some children and young people with specific conditions, using the PEWS tool prompted staff to call for further support too often. Staff would use their clinical judgement to downgrade the alert.

Nursing staffing

- Nurse staffing levels on most wards within the medical division were calculated using a recognised dependency tool.
- Staffing levels on some wards within the medical division did not reach the minimum staffing levels required, particularly at night. When possible beds were closed to maintain safe staff to patient ratios; however, this was not always achievable in the case of unplanned absence and there were times when wards were short staffed.

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- We saw that the trust had a system for escalating staffing shortages; however, requests for additional bank or agency staff were not always filled, or were filled with staff that did not have the necessary expertise in a specialist area.
- Staff were redeployed across the medical division to reduce the risk of unsafe staffing levels when temporary staff were unavailable. In some cases, beds were closed to admissions on specific wards, such as the medical admissions unit, until staffing levels improved.
- Shortages of intensive care and high dependency beds led to increasing pressure on ward nursing staff to manage more acutely ill children and young people at ward level, without the corresponding increases in staff to reflect the higher dependency levels of these patients.
- Communication between members of nursing staff was effective, with staff handover meetings taking place during daily shift changes.

Medical staffing

- There were two middle grade doctors and two junior doctors providing general paediatric medical cover for the hospital out of hours. Middle grade doctors told us they felt very stretched out of hours due to the volume and complexity of the workload, particularly during the winter months.
- Nursing staff on wards reported occasional delays in accessing a doctor with the appropriate specialist knowledge out of hours, as the first and second on-call doctors did not always have the appropriate specialist knowledge.
- Medical handovers for the first on call were effective, but specialist handovers did not always take place each afternoon.
- There was no written system for identifying children and young people who may be at particular risk overnight within the medical division. Consultants we spoke with told us consideration was being given to the use of a similar model to the one used within the surgical division.
- There were consultant vacancies in some specialities, where recruitment of consultants with the appropriate expertise (for example, allergies) was difficult. Appropriate interim arrangements had been put in place and recruitment was taking place internationally.

Major incident awareness and training

- Planning for periods of maximum activity within the trust, such as arrangements for coping during the season when bronchiolitis is prevalent, took place throughout the year. This planning took a multidisciplinary approach and included all the divisions within the trust, including the medical division.

Are medical care services effective?

Good

National guidelines were used to treat children and young people and care pathways were followed to support and speed recovery. Standards were monitored and outcomes were good when compared with other children's hospitals.

Multidisciplinary teams and medical specialties worked well together. Availability of the Child and Adolescent Mental Health Service (CAMHS), health play specialists and portering services for equipment need to improve at the weekend.

Evidence-based care and treatment

- The medical division used a combination of National Institute for Health and Care Excellence (NICE), and Royal Colleges' guidelines and quality standards to determine the treatment they provided.
- Care was provided in line with current best practice as described in the Royal College of Paediatrics and Child Health standards.
- There were specific care pathways for certain conditions in order to standardise and improve the care for patients. For example, care pathways were used for the management of difficult asthma and pneumonia.
- The trust participated in all the national clinical audits they were eligible for.
- Operational policies and procedures were based on current best practice guidance within the medical division and were revised and updated regularly.

Pain relief

- Children and young people and their families and carers reported timely and effective pain control.
- The trust-wide pain team worked throughout the medical wards. We saw examples of children and young people with complex conditions whose pain was being

effectively managed by this team on medical wards. This meant that these children and young people could be cared for at ward level rather than on a high dependency unit.

Nutrition and hydration

- Most of the children and young people we spoke with were complimentary about the meals served at the trust. People were provided with a choice of suitable and nutritious food and drink, and we observed hot and cold drinks available throughout the day. Staff were able to tell us how they addressed peoples' religious and cultural needs regarding food. However, some children and young people told us that they did not like the food that was offered. One young person told us that they only ever ate a baked potato because they did not like any of the other food on offer.
- There was a voucher system available so that children and young people could eat at the hospital restaurant with their families.
- The 2013 Patient-led assessments of the care environment (known as PLACE) programme scored food at 79%. These self-assessments are undertaken by teams which include at least 50% members of the public.
- Dieticians were available throughout the medical division and staff told us that access to the service provided by the dieticians was good.

Patient outcomes

- Emergency readmissions for diabetes and epilepsy were lower than other specialist children's trusts.
- Emergency readmissions for asthma were 23.5%. This was higher than other specialist children's trusts, which averaged 15.2%; however, there were local demographic factors which had a significant influence on readmission rates at this hospital.
- Action plans were in place for specialities where full compliance with national standards had not been achieved, which were monitored regularly. Across the medical division the non-compliance was predominantly related to shortages of specialist medical and nursing staff. Several medical specialties had submitted business cases to the trust for the appointment of additional specialist staff.
- The hospital participated in national audits for long-term health conditions, for example, the National Paediatric Diabetes Audit and Epilepsy 12 National Audit. Data from these audits indicated that Alder Hey's performance was higher than the national average.
- There were no outliers for mortality associated with medical conditions.

Competent staff

- Appraisals of both medical and nursing staff were being undertaken and most staff we spoke with had received an appraisal during the last year and spoke positively about the process.
- Appraisals were occasionally undertaken by managers who staff felt did not fully understand their role. For example, appraisals for health play specialists were undertaken by the ward managers.
- Information from Health Education England requested prior to the inspection confirmed that all medical staff had been through the required revalidation process, including those on the speciality register.

Multidisciplinary working

- Multidisciplinary teams worked well together to ensure coordinated care for children and young people. From our observations and discussions with members of the multidisciplinary team, we saw that staff across all disciplines genuinely respected and valued the work of other members of the team.
- We saw that teams met at various times throughout the day, both formally and informally, to review care for children and young people and plan for discharge. Multidisciplinary team decisions were recorded and care and treatment plans amended to include changes.
- There were good links between the community nursing team and the hospital diabetes team. This partnership working enabled newly diagnosed diabetics to be discharged home in a shorter time than would otherwise have been possible.
- Medical specialities within the hospital worked well together.
- Access to CAMHS was good during working hours but there was no service provided out of hours. This meant that discharges for children and young people referred to the CAMHS team on Saturday morning were delayed until after the weekend.
- Specialist teams within Alder Hey worked closely with primary care providers and the local authority. An example of this was a quarterly meeting led by the

asthma team, involving the clinical commissioning group and the council's environmental health department to take forward ways children and young people with asthma could be better managed within a community setting.

Seven-day services

- Consultants were present in the medical division for a minimum of 11 hours on weekdays and seven hours at weekends. Consultants undertook ward rounds daily.
- All the specialist teams, with the exception of rheumatology, had a 24-hour consultant on-call rota.
- There was limited access to some diagnostic tests at weekends, such as electrocardiogram (ECG) and radiography. This had an impact on discharges, which were sometimes delayed at weekends while awaiting test results.
- Health play specialists were not usually available out of hours.
- A portering service for equipment was only available during working hours. This meant nursing staff had to leave wards to collect equipment from the equipment store out of hours.

Are medical care services caring?

Good

Medical services were delivered by a hard-working, caring and compassionate staff. We observed that staff treated children and young people with dignity and respect and planned and delivered care in a way that took their wishes into account. Emotional support was available for both children and young people and their families and carers.

Compassionate care

- We found that medical services were delivered by a hard-working, caring and compassionate staff.
- We observed that staff treated children and young people with dignity and respect.
- We spoke with 17 children and young people and 23 relatives and almost everyone spoke very positively about the care that they or their child had received. Comments included: "This is the best hospital in the world", "I love it here" and "Everyone looks after him really well, I haven't got a bad thing to say about the place".
- We also saw examples of ways children and young people were encouraged to share their impression of the hospital and how improvements could be made.This included input from the children and young people and their families regarding the design and layout of the new hospital.
- Inpatient surveys were undertaken using a tablet featuring an animated character called Fabio the Frog, who guides children and young people through a series of questions about their hospital stay. Feedback from these surveys was predominantly positive, although the number of surveys undertaken in the medical division was small.
- A snapshot of views from children and young people, their families and carers was included each month as part of the trust's ongoing audit procedures.

Patient understanding and involvement

- Care was planned and delivered in a way that took into account the wishes of the children and young people. We saw staff obtaining verbal consent when helping young patients with personal care.
- Children and young people we spoke with told us they felt involved in their care and treatment. Families and carers also felt involved.
- Staff explained the benefits and risks about care and treatment in a way that was easy to understand. One young person told us, "They speak to me like a proper person, not a little child".
- A named nurse system was in place throughout the medical division and most children and young people, or their families, were aware who their named nurse was.
- Most children and young people we spoke with, or their families, had not been given an expected date of discharge. Inpatient survey data confirmed this, with over 70% of children, young people and their families and carers reporting not receiving an expected date of discharge.

Emotional support

- Specialties within the division of medicine had access to psychological support, including those with complex or long-term conditions such as cystic fibrosis and diabetes.
- Ongoing support was provided by the clinical nurse specialists, advanced nurse practitioners and nurse consultants throughout the medical division.

Medical care

- Counselling services for staff were available from the Alder Centre. Staff were aware of the service and one staff member we spoke with had used the service and found it helpful.

Are medical care services responsive?

Good

Services were planned in order to meet local need. Cubicles adapted for use by children and young people with specific conditions were sometimes unavailable as they were being used for isolation purposes. Medical outliers were well-managed.

Access to advice and information was good for children and young people, their families and carers, both during the hospital stay and after discharge. This included people for whom English was not their first language. Insufficient health play specialists and lack of wheelchairs reduced the quality of the inpatient experience for some children and young people. Complaints were well-managed at ward level.

Service planning and delivery to meet the needs of local people

- A telephone home maintenance clinic for children and young people with leukaemia had been initiated in response to audit findings that some patients were travelling considerable distances. This had successfully reduced the number of clinic visits.
- The Winter Ward, opened in response to winter pressures, would usually have been closed by the time of our inspection. However, it had been kept open indefinitely in response to the demand on hospital beds.

Access and flow

- Discharges at weekends were delayed due to lack of availability of doctors to prescribe medicines to take home.
- Medical outliers (patients cared for in non-medical wards due to the lack of medical beds) requiring isolation were cared for and treated on wards throughout the hospital due to a shortage of isolation facilities. This meant that doctors were travelling throughout the hospital to see these children and young people. However, the process for the management of outliers was effective and communication between medical and nursing staff was good.
- Children and young people were cared for throughout the hospital when beds were closed on the medical assessment unit and winter ward due to shortages in nurse staffing.
- Telemetry (intensive monitoring tool) for children and young people was occasionally postponed as the room used was required as an isolation room.
- Access to a cubicle adapted for children and young people with suicidal intent was limited due to the lack of cubicles for isolation. During our inspection we observed one young person being cared for on the main ward as the adapted cubicle was being used by a baby with an infectious condition.

Meeting people's individual needs

- Telephone advice was provided by most specialties, some of which, such as diabetes, provided a 24-hour emergency advice service.
- Facilities for parents and family members on wards within the medical division were good and accommodation was available on site. Feedback from parents, families and carers regarding the accommodation was very good.
- Health play specialists were used throughout the hospital and were highly valued by staff, children and young people, families and carers. Health play specialists used distraction techniques to enable difficult procedures to be undertaken with the least level of distress to young patients.
- It was not always possible to include the health play specialists in the delivery of care as often as staff wanted to as staff believed their numbers had been reduced and they were often shared between wards. Everyone we spoke with felt that the reduction in numbers of health play specialists had been detrimental to the quality of the inpatient experience for some children and young people.
- There was an effective planning process to enable children and young people with complex needs who had been in Alder Hey for many months to return home, although it was a challenging and time-consuming process for a small number of children, due to the extent of the care necessary to maintain their health outside of a hospital setting.

Medical care

- Interpretation services were available, including British Sign Language) interpreters for people with hearing impairments. We spoke with two families for whom English was not their first language who told us that the interpretation service provided had been good.
- There was a shortage of wheelchairs throughout the hospital. This meant that children who were well enough to access other parts of the hospital were confined to their ward areas.

Learning from complaints and concerns

- Complaints were handled in line with trust policy. Staff would direct people wishing to make a complaint to the Patient Advice and Liaison Service if they were unable to deal with concerns directly. They would be advised to make a formal complaint if their concerns remained.
- Complaints leaflets were comprehensive and available at the entrance to each ward.
- Children, young people and families were confident to raise their concerns with ward managers without fear of reprisals.

Are medical care services well-led?

Good

The trust had a vision and values for the organisation which had been cascaded across the medical division. We found examples of good leadership by individual members of medical and nursing staff throughout the service. Staff engagement regarding the new hospital was better at senior level than with junior staff. The hospital participated extensively in local, national and international research.

Vision and strategy for this service

- There was a clear vision for the trust of "Building a healthier future for children and young people, as one of the recognised world leaders in research and care" which staff were aware of.
- Some individual specialties within the medical division had an additional vision for their team. An example of this was the diabetes team's vision to "provide a high quality, holistic, child and family centred service based on current evidence to deliver the best care to children and young people with diabetes delivered by a skilled, enthusiastic team of clinical and support staff".

Governance, risk management and quality measurement

- The trust was assessed and achieved level 3 of the NHS Litigation Authority risk management standards in February 2010.
- Risks within the medical division were discussed regularly at both ward and divisional levels and escalated, mitigated and recorded.

Leadership of service

- We saw several examples of good leadership by individual members of medical and nursing staff throughout the medical division that were positive role models for staff.
- Staff told us that their immediate line managers were accessible and approachable.
- Team meetings were difficult to organise since the rota system for nurses had changed and there was no longer any overlap of staff. Staff and ward managers told us that the frequency of team meetings had decreased.
- The results of the NHS Staff Survey 2013 indicated that the trust was worse than expected for the percentage of staff reporting good communication between senior management and staff.
- 19% of staff reported that communication was good, compared with the national average of 29%.

Culture within the service

- Many staff spoke enthusiastically about their work. They described how they loved their work, and how proud they were to work at the trust. There was a culture of "good will" within the medical division, where many members of staff, from all disciplines, worked beyond their contracted hours to support colleagues and to provide good patient care.
- Openness and honesty was the expectation within the medical directorate and was encouraged at all levels.

Public and staff engagement

- There had been extensive public engagement with local people as well and children, young people, families and carers regarding the building of the new hospital.
- Staff we spoke with from all disciplines were excited about the new hospital currently under construction and most were looking forward to the move to the new building, although sad to be leaving the hospital they were fond of.

Medical care

- Senior staff had been very engaged with the planning of the new hospital, but more junior staff told us they felt they had not been as involved.

Innovation, improvement and sustainability

- Several wards within the medical division had received Investing in Children accreditation.
- Alder Hey participated in an extensive programme of local, national and internationally recognised research.

Detailed findings

Information about the service

Description text...

Summary of findings

description text...

Are accident and emergency services safe?

Patient safety

description text...

Surgery

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

Information about the service

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.

In 2012/13, 6,868 children were seen in the general surgery/urology outpatients department, 3,235 children underwent elective surgical procedures and 2,012 children had non-elective (emergency surgery).

In December 2013, the CQC conducted a responsive inspection in reaction to information of concern received about the theatre department. At that time we found that improvements were needed because staff in the theatre department were not following national published guidance, essential equipment was not in place, appropriate checks were not carried out and theatres were short-staffed. We asked the trust to take action to improve these areas. The trust provided us with an action plan which included dates by which improvements would be achieved. These dates extended into June 2015 which is when the hospital will transfer into the new building, 'Alder Hey in the Park'.

At this May 2014 inspection we reviewed the action taken and the progress the trust had made against their improvement plan and found substantial improvements in some key areas of concern. We found that, in some areas, the plans had not yet been fully implemented; however, we did not find that patient safety had been compromised within the surgical department. We visited six wards and the theatres. Care and treatment was observed and information on the wards and department reviewed. We talked with about 27 children and young people or their parents, and around 50 members of staff, including band 7, 6 and 5 qualified nurses, play workers, healthcare assistants and theatre operating staff, doctors and surgeons, including consultant surgeons, middle grade and trainee doctors.

Surgery

Summary of findings

Alder Hey paediatric surgical department provided good services to children and young people as the care and treatment was provided in accordance with research-based practice and national guidelines. Care was person-centred. Surgical staff were well-trained and the recovery rate for children and young people was favourable when compared to other children's hospitals.

A consultant surgeon was available either in the hospital or on call for 24 hours each day and middle grade surgeons were on site 24 hours a day, seven days a week. We found that there was a lack of nursing staff and high reliance on agency staff in some ward areas. Staff had received safeguarding training so that they could recognise and take action to protect children and young people who may be at risk of harm. We observed considerate and compassionate care in all the areas we visited. Children and young people were provided with information about their procedures and everything was explained appropriately to them by staff.

Are surgery services safe?

Requires improvement

We found that the majority of staff knew how to report incidents and these were reviewed and local action taken to prevent recurrence. Children and young people were protected from avoidable harm. There was a surgical consultant or middle grade doctor available 24 hours each day. Systems were in place to keep the environment clean and there was good compliance with infection control policies and the 'five steps to safer surgery' procedures (from the Patient Safety First campaign).

There had been significant improvements in theatres in respect of compliance with national guidelines, and in line with the Association of Anaesthetists of Great Britain and Ireland (AAGBI).

We found that there were nurse staffing shortfalls and high reliance on agency staff in ward areas that meant wards were not always appropriately staffed.

There was evidence that reported incidents were not always accurately assessed and learning implemented. In addition, not all staff had completed the required mandatory training.

Incidents

- One Never Event (very serious, largely preventable patient safety incidents that should not occur if the relevant preventative measures have been put in place) was reported for the period of April 2013 to March 2014.
- We found, however, that an event which should have been reported as a Never Event had been recorded as a Serious Incident Requiring Investigation (SIRI). Records showed that this had been fully investigated in April 2014. The trust had demonstrated their duty of candour by making the family aware of the incident, and conducting a full root cause analysis investigation. Lessons were learned from the incident and a plan put in place to prevent a recurrence.
- The tendency to report incidents differed on the wards we visited. For example, on K3, M3, L2 and M2, nursing staff were confident that all incidents would be reported. On the neurosurgical ward, however, the nurse in charge said that staff needed to work harder at ensuring all incidents were reported on the system.

Surgery

- We reviewed the reports for two medication errors on one ward and discussed these with a band 5 nurse. Staff described the actions taken at a local level to prevent recurrence, such as ensuring that medication administration sheets were held in individual patient files.
- We found that those staff who reported incidents were very open about the events and felt supported by their managers to report.
- Nursing staff on the wards described the difference between near misses, serious incidents and Never Events. They said there was a 'no blame' culture with regards to incident reporting. But, they were not always aware of how incidents were used to improve safety throughout the surgical department or the hospital as whole.
- Surgical doctors, however, told us that 'clusters' or patterns in incidents were identified and an in-depth look at the events was completed when required.
- At the April 2014 risk panel review meeting, the trust reported an improvement in incident reporting because the weekly incident reporting average had increased from 22 in January 2014 to 58 in April 2014.
- During this inspection, we reviewed the risk and incident reporting systems used in the theatres because these were a concern at our last visit.
- We observed that the electronic management system was still in place and staff confirmed to us they were confident to use the system. Staff reported that, after our last inspection, training was provided on the importance of incident reporting. We discussed the process with staff that were able to show an improved understanding of what an incident was and what action they would take.
- We found that incident reporting within the theatre department had increased and staff reported to us that feedback following such events had improved.
- Feedback was discussed with staff on a one-to-one basis, at staff meetings and the incidents and actions taken were laminated in a poster and displayed on the wall for all staff to view.
- We reviewed the audit activity within the theatre department and found that local audits, such as infection control, patient pain relief and cannulation (intravenous medication or fluids medicines and fluids that are administered through a vein) had taken place and action plans were completed and implemented.
- We found, overall, that management of risk had improved.

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). However, we were told that, once a month, all the wards in the hospital were asked for information about: their audits for infection control and hand hygiene; feedback about pain management; pressure area and cannula care; and completion and response to the paediatric early warning score.
- We were told that the trust had recently decided on the best way to display the results of the checks. It had started to put the results of safety checks on display, and we saw these on six of the wards we visited.
- The findings on display showed that all children and young people who needed them had pressure and cannula risk assessments and none had experienced pressure sores at the site of their cannula during March 2014.
- The information included how parents and their children could help to maintain a safe environment, preventing falls and infection control.

Cleanliness, infection control and hygiene

- There had not been any infections from MRSA or Clostridium difficile (C. difficile) on the surgical wards.
- Most wards we visited had at least two single rooms that could be used for isolation. The orthopaedic surgical ward had one single room which meant that surgical orthopaedic children and young people who required single accommodation because of a risk of infection were often placed on other wards.
- Although the wards we visited were generally clean, we saw that dirty linen was left on the floor when beds were being changed on Ward K3. This is not good practice because dirty items should be bagged to prevent infection spreading.
- Wards L2 and K3 were cluttered because storage was limited. On Ward K3 we also saw that toys and books were left at the end of the ward on the floor in the same area as a bin. This meant that toys could become contaminated by footwear and also from items being disposed of in the bins.

- Staff in all the clinical areas we visited adhered to the 'bare below the elbow' rule and washed their hands or used hand-cleansing fluid appropriately.
- Each ward had a lead nurse for infection control and audits were completed. We reviewed the results of sample of audits. We noted that, on one ward, staff had only achieved 75% compliance with infection control. We were told that this was because some equipment, such as dressings, were stored in the treatment room on an open storage unit.
- No plans were in place to revise the storage of these items and we noted that the same open storage units were in use on four of the wards we visited.
- There was limited information about the rate of surgical site infection; however, this did not show up as an area of concern in the audits we reviewed.
- We saw reports from different steering groups, such as the February 2014 Clinical Quality Steering Group (CQSG) that confirmed infections after surgery were investigated and a root cause analysis completed.

Environment and equipment

- The resuscitation equipment on the wards was in a metal case that contained all the required devises to deal with a respiratory or cardiac arrest. Emergency medication was in a separate box kept in close proximity to the resuscitation case.
- The nurse in charge informed us that masks, oxygen and oxygen tubing was available at each bedside. The management of this equipment varied. On some wards, there was an inventory of the contents and a chart confirming that the boxes were checked daily to ensure they had not been opened; on others, there was no evidence that this check had been completed.
- We questioned the suitability of this equipment and we were informed that this was the 'custom and practice' resuscitation kit for each ward. Staff were not aware of whether this kit had been risk-assessed as appropriate.
- At the previous inspection in December 2013, we found that improvements were needed in the theatre department because staff were not following national published guidance, essential equipment was not in place and appropriate checks had not been carried out.
- At this inspection we found improvements. We found compliance with national guidelines. In line with the AAGBI we found that all anaesthetic machines had a log book and regular checks had been made of the machines. These machines were checked daily and records were kept for audit purposes. All breathing circuits were now being protected from foreign objects. There were monitors in place to safely monitor patient carbon dioxide levels.
- There was laminated information for staff for algorithms (recommended stages and processes for treatment) for advanced life support, anaphylaxis and difficult airway management.
- We reviewed the theatres 'difficult airway' trolley and found the Difficult Airway Society's intubation guidelines. These are required by AABGI guidance. Daily checks were made and records were observed to verify this.
- In both sets of theatres we observed TV monitors showing a range of safety notices, including effective hand-washing techniques, information about the World Health Organization (WHO) surgical safety checklist and other safety information.
- At our last inspection, we were concerned that the use of capnography, which was required for monitoring carbon dioxide levels, was not in place. During this visit we observed the use of this for each patient.
- We found that patient defibrillators were present in the recovery areas of both sets of theatres with evidence of daily checks being made. All resuscitation drugs and equipment were within expiry dates. We checked that medical air and oxygen cylinders were in date.
- Since our last inspection, work had been completed for the emergency call alarm system and this had been repaired so was fit for use.
- Staff also said that the rapid response team always attended an emergency call within one minute of a call out. We found that entry to all the wards was via an intercom system with closed-circuit television. We noted that this was used diligently.
- One area of concern was drawn to our attention – this was the lack of security in relation to the fire escape at the end of some wards, but notable on Ward M3. The fire escape door was easy to open and not alarmed. This opened onto a fire escape that led straight down into a car park. The only barrier was a makeshift wooden frame, which would prevent small children from entering the fire escape, but would not deter children large enough to climb over the barrier, or an adult, from entering the ward.

Surgery

Medicines

- Medications, including intravenous fluids on the surgical wards, were stored securely and in keeping with the Royal Pharmaceutical Society guidance.
- Medicines were well-managed on the surgical wards. Each ward had an allocated pharmacist who visited each weekday to review stock. Pharmacists also received orders for take home medication for children and young people due for discharge the following day, which meant that children and young people were able to leave the hospital as soon as possible after been seen by the consultant.
- Medication administration record sheets were completed in full and provided evidence that medication had been given as prescribed.
- The medication administration record sheets also provided the opportunity for a pain score to be recorded with each administration of analgesia so that the effectiveness of the medication was reviewed and adjusted accordingly.
- Records seen in patients' notes indicated that staff in the theatres ensured that cannula (small plastic tube inserted into a vein to deliver medication or fluids) were flushed clean to make sure there was no residual amounts of anaesthesia. This was good practice and in keeping with the NHS Patient Safety Alert published on 14 April 2014.

Records

- We reviewed a sample of the nursing and medical records on the wards we visited and in theatres. On most wards, assessment information was computerised and minimal paper records were available. Paper records we reviewed were neat and easy to read. Instructions and information were easy to find.
- We observed doctors and nurses inputting information on to the electronic reporting system. Information included personal details such as the legal status of the adult accompanying a child, the mood of the child and known involvement with social services.
- Standardised paediatric care bundles and risk assessments had also been completed, for example, epidural care plan and pain risk assessments. A 'skin bundle' care plan had just been introduced.
- Staff said that records were reviewed for completeness; however, there were no reports available to confirm the areas checked, the outcomes and recommendations.
- Confidential information such as the name of children and bed spaces were on display in the main ward areas. This was not in keeping with the Code of Practice on Protecting the Confidentiality of Service User Information.
- At the previous inspection at Alder Hey Hospital, December 2013, we found that the local implementation of quality monitoring systems in the theatre department was not effective and there was an increased risk of inappropriate and unsafe care and treatment as a consequence.
- At this inspection, we found improvements. In theatre we reviewed patient records, consent forms, prescription charts and documentation relating to the correct site surgery and WHO surgical safety checklist all of which were being appropriately used.
- The details on the operating lists were sufficient, with minimum abbreviations to avoid misunderstandings and mistakes.

Consent

- Best practice in assessing a child (aged under 16) and their ability to give consent is covered by the Fraser guidelines. Staff we talked with told us that only doctors gained written consent from parents. Nursing staff ensured that they gained verbal consent and cooperation from the parent, child or young person.
- Nursing staff stated that training was in place but this had been delayed because of staffing difficulties. The trust's mandatory training record for February 2014 showed that only just over 20. % of eligible staff had completed this training.
- Young people on the wards told us that the doctors and nurses always explained procedures to them in a way that was easy to understand. We observed positive interaction between children and young people, nurses, medical and other staff. We saw that patients were always treated with respect and they were asked for their opinion and preferences, for example, how to get to theatre or whether they wanted to join in with activities.
- Care plan bundles included consent forms that invited young patients as well as their parents to sign their agreement to their operations if they wished.
- During our visit we observed a patient attending theatre and we accompanied a consultant anaesthetist while

patient consent was obtained. We saw this was carried out safely, and the surgery and risks and benefits involved were explained clearly to the patient and their family.

Safeguarding

- Staff were aware that increasing safeguarding training was a trust priority.
- Ward staff knew how to recognise signs of abuse in children.
- Staff knew how to raise a safeguarding alert and also how to access the safeguarding team for guidance.
- The training record provided to CQC was an analysis of safeguarding training that had taken place up until February 2014. This showed that almost 61% of all staff in the surgical directorate, including administration staff had completed level 1 safeguarding training.
- Good practice would dictate that 100% of staff should complete this training.
- The training record also showed that almost 57% of staff had completed level 3 training.
- The trust has a dedicated team of safeguarding nurses and social workers which included a designated safeguarding lead.

Mandatory training

- The mandatory training record provided by the trust in April 2014 showed that staff compliance with completing mandatory training needed to improve.
- On one ward we were shown personal folders provided by the trust for collecting certificates. This had been a recent innovation and, at the time of our inspection, no certificates were available to view.
- We discussed training and development and many staff members reported they had more opportunities than previously. We noted in particular that night staff were not accessing all of the required mandatory training. We discussed this with the theatre managers who were aware of the issue and had plans to improve access to training.

Management of deteriorating children and young people

- The surgical wards use the Paediatric Early Warning Score (PEWS) for recording the vital signs of children on the ward so that early signs of deterioration can be identified and remedial action taken.
- We saw that age-appropriate PEWS were used to match the age of the child because base level vital signs change as children become older.
- We found that the trust had reviewed the use of this observation tool and adjusted the response to 'triggers' to match the specialism and condition of the child.
- Nurses said that it was a very useful tool which they used diligently because it worked. Nurses described the escalation process depending on the PEWS score.
- We were told that doctors and senior nurses responded quickly when they were informed of high PEW scores.
- Following surgery, we observed adequate and systematic handovers to the recovery practitioners. Oxygen and monitoring equipment was used to monitor vital signs. Temperature, consciousness, pain and nausea were monitored and recorded. We observed that one-to-one care was given until the patient regained consciousness and airway control.
- We reviewed the trust's guidance to staff called Escalation policy C23 March 2014. There were clear instructions about how to use the PEWS scoring system and this was in keeping with the information provided by staff. The policy stated that all nursing staff should have intermediate resuscitation training and all medical staff should have completed advanced paediatric life support training.
- The trust completed a resuscitation audit for 2012 and 2013.
- The April 2013 report confirmed that 100% of doctors in training and 67.7% of critical care staff had completed the relevant resuscitation training because they had protected and designated teaching times.
- The report showed that only about 53% of other permanent staff had completed the appropriate training at that time. Figures for 2014 were not yet available.
- We discussed the management and transfer of the deteriorating child with ward staff. The surgical nursing staff were clear about the process and the responsibility of the medical team during resuscitation and transfer to the critical care unit.
- Staff said that an attending middle or senior grade anaesthetist was always on call and the transfer would be facilitated by the resuscitation team handling the case.

Surgery

Nursing staffing

- All the nurses we talked with stated that they were short of staff and there was a high use of agency and bank (overtime) staff.
- The shift hours were 7am until 7.30pm for days and 7pm until 7.30am for nights.
- Good practice guidelines, for example the Defining staffing levels for children and young people's services: RCN standards for clinical professionals and service managers (Second edition, August 2013) recommends 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.
- None of the wards we visited met these recommendations in full.
- We reviewed the duty roster for one ward at random. Ward M3 is a 14-bed ward and the planned staffing ratio was three trained nurses and one healthcare assistant (HCA) during the day and two trained staff at night. The night ratio was well below good practice guidance.
- The duty roster for the ward confirmed that, for the weeks commencing 5 May 2014 and 12 May 2014, three trained nurses and one HCA were on duty for 11 out of the 14 days, and four trained staff and one HCA on the remaining shifts.
- On one occasion, the roster showed that only one nurse was on duty during a night shift.
- The ward manager and other nursing staff we interviewed told us that the trust always tried to respond to staff shortages and so additional staff were always provided when requests were made to the bed manager.
- We saw from the rosters that, in the majority of times, staffing on the wards met the trust's planned or established numbers, but staff raised concerns about the frequent use of agency staff because they could not carry out certain procedures which resulted in an added burden on permanent staff.
- The duty roster for Ward M3 showed that at least one member of staff on duty each shift was either bank or agency.
- One ward manager we talked with on another surgical ward said that the trust had been piloting the use of a staff planning or acuity tool called the Scottish Children's Acuity Measurement in Paediatric Settings. We also noted that the escalation policy was being reviewed and the draft document included the use of Scottish acuity tool to determine the correct number of staff needed for each shift.
- We asked about recruitment of permanent staff. We were told that there had been a recruitment drive and, although a number of nurses had been employed, an equal number had either retired or gone on maternity leave.
- The escalation policy also established the need for the ward manager or senior nurse staff to review the needs of the children and young people on the ward twice each day to ensure that the staffing met their needs.
- The staff rosters confirmed that there was a 30-minute handover period at shift changeover.
- The trust employed clinical nurse specialists in sufficient numbers to meet the needs of the surgical decision unit that had four beds for children who attended for observation.

Medical staffing

- We were informed that there was a consultant surgeon of the week –. The consultant surgeon of the week is freed from elective surgical and outpatient commitments and is on duty from 0800-1700 Mon-Fri and 24 hour cover Fri-Mon at 0800
- Surgical handovers: are at 0800 and 1700 each day; videoconferencing is available for consultants who are off site or who had been operating during the night.
- There were also nine middle grade doctors who completed ward rounds twice a day.
- In addition, there were specialist surgical teams that included consultants and middle grade doctors on duty to run clinics and conduct specialist surgical procedures. The specialists included neurosurgeons; orthopaedic surgeons and plastic surgeons.
- Nursing and surgical staff stated there were sufficient doctors on duty to meet their needs.
- We talked with a group of surgical doctors and all said they felt well-supported to carry out their roles. They felt the trust listened to concerns raised about staffing and acted accordingly.
- The emergency list runs 24/7; there is a clear escalation plan if there is more than 15hours emergency operating that includes cancellation of elective lists. There is no separate emergency orthopaedic list at present.
- The trust's corporate risk register report for April 2014 identified that a significant number of patients were

waiting in excess of 18 weeks for surgical procedures once they had been referred for treatment. One reason for this was a reduction of consultants through retirement.
- There was also an increase in demand for theatre space. The risk register report confirmed that additional consultants and middle grade surgeons had been recruited to help reduce this risk. The duty roster for the surgery department was requested, but this was not provided.

Major incident awareness and training

- The trust did not report any major incidents for the year 2013/14.
- The trust's mandatory training report dated February 2014 showed that 62% of staff in the surgical department had completed major incident training.
- The trust's escalation plan, that was introduced July 2014, includes protocols for deferring elective or planned operations to prioritise unscheduled emergency procedures.
- It was found, however, that this process was well-established as one of the concerns raised by staff was the need for additional theatres because routine or non-urgent operations were often cancelled in order to deal with emergencies.

Are surgery services effective?

Good

The surgery department's systems meant that the service was effective at meeting the needs of children and young people.

Innovative plans of care and treatment in use and the surgical business unit ensured all relevant guidance was used in planning and monitoring the effectiveness of care. Pain control was well-managed. Surgeons working for the trust were highly skilled and well-supervised to carry out their duties. Systems were in place for effective multidisciplinary working.

Evidence-based care and treatment

- The trust-wide policies we reviewed provided details about the best practice and evidence-based documents they used to develop their guidelines. This information confirmed that the appropriate best practice guidelines and legislation were used, such as National Institute for Health and Care Excellence (NICE), the Mental Health Act 1983 and NHS executive guidance.
- The policies also detailed how adherence to the guidelines would be monitored.
- The results of the audits were published in different formats, such as the safety thermometers and audit reports.
- The Clinical Quality Assurance Committee reported that NICE and National Confidential Enquiries assurance reports confirmed that the standard to which the surgical directorate adhered to the relevant guidance was monitored and action plans put in place if the result fell below what was required.
- The trust published an annual report about the activities of the department of paediatric surgery and urology in 2012/13. This document provided detailed information about the trust's participation in national and local audits for paediatric general and specialist surgery.
- The annual report illustrated a number of areas of good practice, including low readmission rates for children and young people following circumcision and appendectomy.
- The CQC specialist advisers considered Alder Hey to be unique among paediatric surgical departments in England in comparing their performance with national data and presenting this information.
- The report identified areas of excellence, lessons learnt and improvements made as a result of these performance audits.
- We looked for areas of outstanding practice in respect of providing a safe and effective service.
- The specialist advisers on the inspection team identified areas of clinical excellence. They considered that two of the findings demonstrated 'outstanding' service provision.
- Neuromuscular service in orthopaedics: Alder Hey has a gait laboratory to assess walking for children with neuromuscular disorders, such as cerebral palsy. This investigation is not available elsewhere in North West England. The service therefore receives many referrals. The trust physiotherapists have linked with the community physiotherapists to provide appropriate postoperative care. An audit demonstrated that this has translated into improved outcomes for the children and young people.

Surgery

- Neurosurgery: the department has received a significant research grant to coordinate a national prospective trial to reduce the rate of infection following shunt operations for children with hydrocephalus. This illustrates how well-respected and rated the department is against other UK neurosurgical departments.
- The results of these projects and studies have been used to produce good practice guidance for national and international application.
- Since our last inspection, the theatre team had fully implemented the WHO surgical safety checklist to reduce the risk of wrong site surgery and minimise complications. We observed the use of the WHO checklist and were assured that the process was conducted in an effective manner. The time-outs were led by theatre staff. All of the team were present, ready and engaged with the process. The stages and use of the WHO checklist was documented on the checklist itself and stored in patients' records.

Pain relief

- We reviewed a sample of care plans and files on the wards we visited. We saw that each care plan and assessment included information about pain and pain control.
- The trust monitored patients' satisfaction with pain control. The result of the audit showed that they were under-performing in this area.
- The PEWS score included an assessment of pain.
- The trust has a dedicated pain team. The team have produced a booklet, Pain Busters in a comic book format. The aim of the booklet was to provide information about the different ways pain was managed at the hospital.
- The comic book also helped children and young people to describe the extent and type of pain. We saw that a copy of this booklet was available for each child.

Nutrition and hydration

- We asked about nutritional assessments and the responses we received from staff were vague.
- Staff described the use of fluid balance charts and we saw that these had been completed for children and young people who had returned from theatre.
- We were shown menus which provided a choice of cooked meals made from fresh ingredients as well as snacks and sandwiches.
- Menus also included choices for special diets and cultural preferences such as halal, kosher or vegetarian diets.
- Children and young people sometimes experienced a delay or cancellation to their operations, and, as required, they had not eaten anything. The young people who told us they had been informed about the delay within a reasonable time before they were due to go to the operating theatre. And they said that they were immediately provided with a light snack and a drink.
- The wards we visited had a baby milk fridge. These were kept locked and milk was provided for babies on request.

Patient outcomes

- There were no outliers in relation to the surgical department. 'Outliers' are when the number of certain events such as the number of deaths are more than would be expected for the type of hospital.
- The trust reviewed the department's performance for readmissions against children's hospitals of a similar kind and measured their performance in relation to two of the most common operations: appendectomy and circumcisions.
- The trust sourced its information from Dr Foster Intelligence. The most recent information available from the trust was for October to December 2012. This showed that the surgery department performed favourably when compared to similar hospitals.
- At Alder Hey, the readmission rate for appendectomies within 28 days of discharge was around 6%, and the next best performing hospital had a readmission rate of around 12% at that time. Readmission rates within 28 days of discharge for circumcisions was about 2%, and the next best performing hospital's readmission rate was about 2.5%.
- Information provided by the trust showed that the average length of stay for children who had planned operations remained stable at around 2.5 days between 2011/12 and 2012/13. Over the same period, the average length of stay for emergency admissions fell from more than 3 days to less than 2.5 days.

Competent staff

- The supervision plans for surgeons were clearly defined and measurable. For example, there were instructions that, the first time a surgeon performed particular operations at the hospital, they had to be supervised by a longstanding consultant.

Surgery

- All surgeons had to have achieved procedure based assessment level 4 before they were permitted to carry out operations unsupervised.
- The Board Assurance Framework 2014/15 included plans for finalisation of an education strategy, which included establishment of an education project team and appointment of a director of medical education.
- We reviewed the staffing and skills mix across the department and found there remained a high number of vacancies and staff absence due to sickness which the trust was actively recruiting to cover. Agency staff were used to maintain staffing levels and this was managed on a weekly basis by the theatre managers.
- We observed that a new performance development rating process had been implemented. The management team had received training and plans were in place to undertake a performance development review (PDR) with all staff. Those who had had a review reported a positive experience.

Revalidation

- All working consultants underwent appraisals in 2012 and four were scheduled to revalidate in 2013.
- Information provided to the CQC in May 2014 from Health Education England confirmed that 48 specialist doctors at Alder Hey had completed or were working through the revalidation process.

Multidisciplinary working

- We saw that the surgical teams worked with community services, district general hospitals and other statutory services to protect the wellbeing of children and young people.
- Staff informed us that part of the discharge plan following surgery was sending a letter to the general practitioner, health visitor and school nurse when appropriate.
- Records and reports showed that multidisciplinary working included allied healthcare professionals, such as physiotherapists; dieticians and diagnostic staff.
- The 'escalation' policy and procedures confirmed that the trust had developed standard operating procedures with partner agencies and hospitals in relation to relevant surgical procedures such as the requirement to treat burns.
- Information from district general hospitals was mostly positive about partnership working, although it was commented that an ongoing problem was follow-up letters from Alder Hey surgeons to surgeons in the local district general hospital.
- We found that there were insufficient health play specialists. Two of the wards we visited did not have any input from health play specialists which meant that children being prepared for surgery, or who were frightened, did not benefit from the support of a specialist play leader.

Seven-day services

- The theatre team conducts operations 24 hours a day, seven days a week.
- During the week and the weekend, out-of-hours consultant surgeons were on call and the wards were staffed by a team of four middle grade doctors.

Are surgery services caring?

Good

Care provided at Alder Hey was caring and compassionate. We saw that staff spent time with children and young people to make sure they understood the care they were to receive, and processes were in place to ensure they received written information about their conditions.

Surveys completed by young patients and their families stated that that staff were kind, thoughtful and compassionate, and those we talked with during the inspection echoed this.

Compassionate care

- Alder Hey hosts patient experience forums for children and young people and their parents/carers. Parents and their children have also completed patient experience questionnaires.
- We reviewed the results from March 2014 for theatres and individual surgical wards. The theatre results showed that all 15 children and young people who responded felt that the staff in theatre recovery were friendly.

Surgery

- The results for surgical wards showed that all 18 children and young people felt that staff treated them "nicely". Out of the 18 who responded, 12 said they would recommend the hospital to friends and family who needed an operation.
- We talked with 27 children and young people and relatives between the surgical wards we visited. Everyone we talked with said they were either happy or extremely happy with the quality of the care and support they had received from doctors and nurses.
- Staff were mostly described as "kind", "caring" and "willing to help". Two of the 27 commented that they preferred one ward over another, for example, one person said the environment and nursing levels was markedly better on Ward K3 than on Ward M3.
- Although parents were content with the quality of care and treatment on each ward, they commented that wards seemed short-staffed. Parents who were accustomed to visiting the hospital commented that staffing seemed "worse than this time last year".
- We observed positive interactions between children and young people and medical and nursing staff. Staff listened to children and young people and their parents.
- We observed two separate occasions of children and young people returning to wards post-discharge to give gifts as a token of gratitude for the care and treatment provided.

Patient understanding and involvement

- Records we reviewed identified that children and young people had a named nurse. Young patients we spoke to could name their nurse.
- All 27 children and young people or parents confirmed that care and treatment had been discussed with them in full. Those who had planned operations said that, in addition to receiving leaflets, a nurse from the hospital had called them before the operation to discuss the procedure.
- Patients with unplanned operations said everything had been explained in full and in language they could understand. We saw that specialist nurses were available to spend one-to-one time with parents teaching them about managing the care of their child and dealing with equipment such as tracheostomies.
- We saw leaflets and information sheets on the wards we visited. Staff also informed us that leaflets were available from the hospital intranet.
- We viewed the intranet and noted a full list of patient information leaflets which could be downloaded as required.
- We observed written information being provided to children and young people when they were due for discharge.
- We observed a paper outlining feedback from parents of inpatients during May 2014. Views were sought on patient information, access, theatre staff uniforms, and communications with staff. Mostly positive answers were given for these questions.

Emotional support

- We saw that initial assessments included observations for anxiety and depression.
- The trust employed specialist band 6 nurses who provide specialist advice to patients and parents, including emotional support.
- Parents told us they had received good emotional support from the craniofacial nurses.

Are surgery services responsive?

Good

The service was meeting referral to treatments times for 97% of children and young people requiring admission. Patients were admitted within the recommended 18 weeks. This is above the national target referral to treatment time of 90%. However, there were still concerns regarding the number of cancelled operations as a result of theatre staffing shortfalls. The trust was working hard to address this matter and was actively recruiting staff.

Plans of care were patient-centred and developed to meet the individual needs of the child. In theatres there was additional support available for children and young people with learning disabilities to allay their fears about going to theatre. The Wide Awake Club enabled children with a learning disability to go to theatre at 7am so they did not have to wait long periods throughout the day.

Staff embraced caring for children and young people from different cultures and worked hard to meet their needs. There was good access to the Language Line translation service and cultural dietary requirements were also catered for.

Surgery

Parents were able to stay with their children. However, facilities on the wards were basic and did not always promote privacy.

Service planning and delivery to meet the needs of local people

- The escalation policy described in full the processes for monitoring and responding to patient flow and busy times throughout the hospital.

Access and flow

- NHS England assessed that an average bed occupancy of above 85% reduces the effectiveness of care.
- Bed occupancy for the hospital as a whole was reported to be around 81.3% from October 2013 to December 2013. However, we saw that for Ward E2 (the orthopaedic surgical ward) the bed occupancy for April 2014 was 97%. This figure did not include orthopaedic surgery patients being nursed on other wards.
- In the department of paediatric surgery and urology annual report for 2012/13, the trust stated that 97% of children and young people requiring admission were admitted within the recommended 18 weeks. This is above the national target referral to treatment time of 90%.
- Although admission to the surgical decision unit for observation was well-managed, there was a risk of delay for treatment that was not considered immediately life-threatening.
- This meant, however, that treatment for children and young people in discomfort could be delayed. This also meant that planned surgery was also delayed, especially if intensive care was required after surgery. Information provided by the trust showed that 111 planned surgical procedures had been cancelled between September 2013 and February 2014.
- Most cancellations during that period had been caused by a lack of theatre staff. The trust risk register highlighted this problem and the trust had initiated a recruitment drive as one means to partially resolve this issue.
- Discharge arrangements on the wards we visited were generally well-organised and, once a child or young person was assessed as ready for discharge, the process was completed quickly. Patients and their parents were all aware of when they would be discharged.
- During the week, pharmacists worked on the wards to ensure take home medication was prepared the day before discharge. We saw that the MEDITECH computerised patient record system was used by surgical doctors to update information and prepare letters for GPs.
- We talked with two young people who were waiting for operations. Their parents told us that they had been seen by the surgeon and information had been provided about the timescales for their surgery. One had experienced a cancellation to their procedure with a delay of one day. The delay had been relayed to them quickly so that they were not left without food and drink for longer than necessary.
- Nurses we talked with, however, felt that children and young people who were not on the correct ward did not benefit from specialist nursing care.

Meeting people's individual needs

- We discussed meeting the needs of young patients with special needs. Staff said that plans of care would be patient-centred and developed to meet the individual needs of the child. In theatres we were told about additional support available to patients with learning disabilities to help allay their fears of going to theatre. A Wide Awake Club was run by staff, allowing such patients to go to theatre at 7am so they did not have to wait long periods throughout the day.
- All the wards we visited were mixed age and gender, and curtains were used to provide privacy.
- Staff were keen to state that the hospital embraced caring for children and young people from all cultures. Staff said there was good access to the Language Line translation service. This could be either by phone or face-to-face.
- Parents were able to stay with their children. Facilities on the wards were basic and did not promote privacy. One reason was that the shower rooms were mixed-sex and opened straight onto a lounge area.
- The hospital restaurant closed at 8pm and we were told that, on occasion, the drinks vending machines did not work.
- Parents of patients having planned admissions could apply to use the Ronald McDonald House, a serviced block of flats adjacent to the hospital. Staff would support parents in arranging accommodation in exceptional circumstances.

- Parents who needed to leave their child did not have an identified person who was responsible for making sure the child was provided with enough activities and company to make sure they were not bored or lonely.

Learning from complaints and concerns

- We saw information about making complaints on display on noticeboards on the wards we visited. Staff we talked with told us that generally complaints and concerns were dealt with at the time, however, if the situation could not be resolved, parents were asked to go to the Patient Advice and Liaison Service (PALS).
- Staff were not sure of how to deal with a concern at ward level without sending the parent to PALS.
- We reviewed a record of the most recent complaints board meeting, dated March 2013.
- We saw that plans for improving the reporting and responding to complaints had been put in place. These need to be further embedded to provide a robust complaints process

Are surgery services well-led?

Good

Although we found an open culture in the department of surgery locally, there was evidence that nursing staff at ward level were not listened to. This meant that opportunities for improvement in the quality of the service might have been missed.

Ward-level nursing staff felt that the directors and board had little understanding or appreciation of the amount of 'good will' shown in respect of working extra hours.

Vision and strategy for this service

- Within the surgical department, there was a vision to become world leaders in specific surgical fields.
- We saw that, in relation to surgical staff and specialist nurses, there was a strategy in place to provide highly skilled and professional clinicians.
- However, this strategy was not filtered down to ward level in relation to providing sufficient support, training and day-to-day leadership to nurses on the ward.

Governance, risk management and quality measurement

- The department of paediatric surgery and urology annual report 2012/13 demonstrated that there was highly effective governance and quality measurement in relation to surgical procedures and aftercare.
- However, more action is required to fully promote the safety and wellbeing of children and young people because findings concerning the over-occupancy of beds and the level of delayed operations need to be addressed.

Leadership of service

- The surgical clinicians are well-led because we found responsive, effective and dynamic leadership.
- The best example of this was the publication of the department of paediatric surgery and urology audit 2012/13.
- This document demonstrated that the department was led in a way to promote and to provide excellent, effective and world-class quality care, monitor and assess the outcomes for children and young people, and take appropriate action to deal with instances when things went wrong.
- This document also confirmed that the surgical team had excellent relationships with key stakeholders in the arena of paediatric surgery.

Culture within the service

- The culture within the service was open and transparent.
- Staff we talked with were prepared to be honest and open about their concerns. This was predominantly about the lack of nursing staff, training, working 12-hour shifts and then having to continue working because agency or bank staff were slow in arriving or needed additional support.
- Staff told us that they were able to comment and make suggestions about the new development at Alder Hey in the Park but they were not listened to.
- We talked with around 40 members of staff, including nurse managers, operating theatre operative, qualified and student nurses, healthcare play workers, consultant surgeons, middle grade and trainee doctors. All were aware of the whistleblowing policy but also felt able to raise any concerns with the board or hospital directors.
- Surgical staff felt particularly well-supported and able to influence how the department was run and push forward improvements.

Surgery

- Nursing staff said that, although they were able to say what they wanted without redress, managers were not taking note of what was said.
- Staff felt able to admit to mistakes because they said they would be treated fairly.
- We asked staff about equality and diversity issues. Staff we talked with privately and in groups said they did not feel discriminated against and were appropriately supported by their colleagues and managers regarding any individual needs.
- Staff told us that they observed that neither their colleagues nor children and young people were discriminated against or treated less favourably on the grounds of equality and diversity issues such as ethnicity, gender, sexuality, class or cultural background.
- We spoke with theatre staff about how confident they were to raise concerns without fear of recrimination. All bar one said that they knew about and could access the whistleblowing policy and they were not afraid to use this. They told us that senior managers were now listening to staff concerns and were taking action when needed.

Public and staff engagement

- Alder Hey Children's Hospital holds a six-weekly Children and Young People's Forum. This is advertised on the trust website. We reviewed the minutes taken form the forum held in January 2014 which was the most recent available. We saw that children and young people made suggestions about improving uniforms and facilities in the theatre.
- Information from the trust did not include trust response to these suggestions and the minutes did not include feedback from suggestions that had been made previously.
- After our last inspection, the trust developed a theatre quality improvement group. All staff were invited to join a work stream, with topics of patient experience, safety, workforce, leadership and development.
- Staff we spoke with were positive about their involvement. An example shown to us of the effectiveness of these groups was an organised patient forum visit, whereby young children were invited to come to theatre to give comments on the environment and the patient experience. Children were very positive about the visit.

Innovation, improvement and sustainability

- Alder Hey is in the process of building a new state-of-the-art hospital.
- We reviewed the plans and staff were thoughtful about how new innovative ideas, such as all single rooms and merging different surgical departments, would work.
- We found, however, that not all staff had the same understanding about how the new build would be configured.
- The trust should update staff more frequently when there are plans and developments regarding the new hospital.

Detailed findings

Information about the service

Description text...

Summary of findings

description text...

Are accident and emergency services safe?

Patient safety

description text...

Critical care

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

Information about the service

For the purpose of their management and governance, the critical care services provided at Alder Hey Children's Hospital sit in the surgery, cardiac, anaesthetic and critical care clinical business unit (CBU). The service was commissioned for 22 PICU beds but has 23 physical beds and is commissioned for 14 HDU beds with 15 physical beds. The PICU accepts over 1,100 admissions a year, with around 600 admissions to HDU.

We visited the PICU and HDU facilities on both an announced and unannounced basis and talked with 10 parents and 15 staff. These included nursing staff, junior and senior doctors and managers. We observed care and treatment and looked at three care records in detail. Before and during the inspection we reviewed performance information from, and about, the hospital.

Summary of findings

In the PICU there was evidence of strong medical and nursing leadership that led to positive outcomes for children and young people. Care and treatment in the PICU was of a good standard and as a stand-alone service would have been rated accordingly across all domains. However, the HDU lacked medical and clinical leadership, although there was strong nurse leadership that provided great support for the team in challenging circumstances. The trust was aware of the risks associated with the HDU and had developed some solutions for the short and medium term, prior to the planned move in 2015 to the new hospital. However, we were not assured that the arrangements 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. On the unannounced visit, it was clear that immediate steps had been taken to improve the level of medical support on the HDU.

The parents we spoke with on both PICU and HDU gave us examples good care and support they and their children had received. Though we also heard of some frustrations from several parents in respect of communications and the limitations of the ageing hospital environment.

Critical care

Are critical care services safe?

Requires improvement

Overall, critical care services required improvement. While the nursing and medical staffing levels on the PICU were safe, we found that the staffing levels (nursing and medical) on the HDU meant that at times children did not get the level of care they required. The trust was aware of this shortfall, having carried out a quality review in March 2014. An evidence-based business case had also recently been submitted by the unit for an increase in nursing staff. We understood from our enquiries that recruitment for the additional nursing posts in HDU had begun.

All the staff we spoke to said they were encouraged to report incidents and they received direct feedback via one-to-one and team meetings. We saw that the environment was clean and hygienic. Nursing staff worked 12-hour shifts and conducted twice-daily handovers. We saw a comprehensive printed handover sheet being used which helped to ensure staff were appropriately updated and that children and young people received continuity of care.

Incidents

- There had been no Never Events (very serious, largely preventable patient safety incidents that should not occur if the relevant preventative measures have been put in place) reported on either PICU or HDU since January 2013.
- Between April 2013 and March 2014 there had been just one serious incident from critical care reported to the National Reporting and Learning System (NRLS).
- We noted that in 2013, 231 critical incidents had been reported from critical care, classified across the following domains: airway/ventilation; drugs and therapeutics; procedures/lines/equipment; patient management/environment; and unit management. To date, 46 critical incidents had been reported for 2014. Most reported incidents related to patient management and environmental factors.
- All the staff we spoke with knew how to report incidents and regularly did so. We saw that incidents were reviewed and analysed at weekly critical incident meetings. Trends were mapped and lessons learned and actions were fed back to staff both verbally and via written critical incident briefings and risk alerts.
- Two serious clinical incidents in HDU had been specifically attributed to the use of recently installed isolation pods. These incidents had been reported appropriately via the trust's reporting systems.
- A total of 47 incidents had been reported in HDU between October 2013 and March 2014. The main themes were medication errors, staffing and pressure ulcers.
- There was a thorough approach to mortality and morbidity with trust policies to underpin Hospital Mortality Review Group procedures. These assured that deaths were reviewed and appropriate changes made to help to ensure the safety of children and young people. Reports showed that there had been 63 deaths across the trust in 2013. As in other children's trusts 85–90% of those deaths occurred in PICU. The 2013 annual report from the Paediatric Intensive Care Audit Network (PICANet) indicated that mortality was monitored and managed within the trust.

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).
- Paediatric safety scans were recorded monthly. These included an assessment of whether Paediatric Early Warning Scores (PEWS) were completed and acted on. For both April and May 2014, the results showed 100% completion of PEWS scoring and 100% of cases escalated appropriately. The safety scans also reported on whether the child or young person had a peripheral cannula (small plastic tube) and that any related appropriate documentation was in place. These scans also showed 100% compliance with policy. 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 cared for in a clean and hygienic environment.

Critical care

- Staff followed the trust policy on infection control. The 'bare below the elbow' policy was adhered to and hygienic hand-washing facilities and protective personal equipment, such as gloves and aprons, were readily available and used appropriately by staff.
- The HDU nursing team formally met with the infection prevention and control team on a weekly basis to review and discuss the infection control status for all children and young people. Because of the shortfalls in nurse staffing and the known risks related to the use of the isolation pods, it has not always been possible to nurse children and young people requiring isolation on a one-to-one basis. On such occasions, the risks have been appropriately escalated within the trust to give further weight to the case for more nursing staff on HDU.
- October 2013 to March 2014, infection control audit reported PICU 80% compliance and HDU 85%. The main areas for action were equipment cleaning in circulating areas.
- There were appropriate arrangements for the safe disposal of sharps and contaminated items, though the trust had reported a high incidence of needle stick injuries, usually related to re-sheathing of needles.

Environment and equipment

- All the equipment we looked at was checked and cleaned regularly. For example, this included the eight different types of ventilator being used on HDU. This also included the resuscitation, bed space and transfer equipment used throughout the critical care units.
- The environment on both PICU and HDU was safe.

Medicines

- Medicines were being stored correctly in locked cupboards and fridges when necessary. Fridge temperatures were being checked and recorded.
- Controlled drugs were checked and administered at the bedside by two nurses. This reflected standard practice and helped to promote safety.

Records

- A twice-daily updated printed handover sheet was used to help ensure that important information relating to the management, care and treatment of children and young people on the units was communicated to all staff.
- We looked at three sets of medical notes which all included daily entries from medical staff, clear summaries of investigations undertaken, evidence of consultations, including external input and typed summaries from senior staff.
- Nursing documentation including shift reports and risk assessments. Care plans were recorded on an electronic patient record system.
- Detailed paper observation and PEWS charts were kept by the bedside in both units and completed appropriately.

Consent

- Staff were able to describe the need to balance young patients' rights and wishes with the responsibility to keep them safe from harm.
- Parents were closely involved in the care and treatment decision making of their children.
- Consent was appropriately sought and obtained in accordance with good practice

Safeguarding

- Staff were able to describe their responsibilities in relation to the safeguarding of children and young people.
- The majority of staff had received safeguarding training at level 3 and demonstrated an understanding of how to recognise abuse and how to share information safely.

Mandatory training

- Detailed training records were kept and they showed that not all mandatory training for everyone was up to date. There were shortfalls, especially in those numbers requiring manual-handling training.
- Three mandatory training sessions had been cancelled in the 2013 winter period due to work pressures.
- Both the PICU and HDU had nurses in educational lead roles and they allocated one day per week each to support that function.
- Additional mandatory training was undertaken in HDU to assist staff competency in managing the eight different types of ventilator in use with their long-term ventilated patients.

Management of deteriorating children and young people

- Age-specific observation and PEWS recording sheets were being used on the HDU. The PEWS charts included an embedded colour coding and scoring matrix which

helped to clarify the required escalation or action related to the observation being recorded. For example, an overall score of +10 stated in red that an urgent medical review should be obtained.
- An impact evaluation on the use of the PEWS showed that there had been an increase in the number of calls to escalate but a reduction in the number of cardiac arrest calls.

Nursing staffing

- The PICU was able to provide staffing levels that met the needs of children and young people. All children were nursed one-to-one.
- The PICU had four band 6 nurse vacancies and the trust was actively recruiting to the posts. In the interim, the vacancies were being covered by permanent staff working additional hours and bank (overtime) and agency staff.
- The HDU was funded for 10 nursing staff per shift. This meant that a maximum of 14 children or young people could be looked after, depending on their clinical need.
- A recent case had been presented for an increase in HDU nurse staffing by 13.5 full-time staff. We understood this had been agreed in principle, though no new appointments had yet been made. However, the trust was working to address this issue at the time of our inspection and was in the process of recruiting staff.
- There continue to be occasions where one nurse in HDU has to look after two children in isolation cubicles which results in the need to leave the cubicle door slightly open to hear both the child and the equipment alarms.
- There was a supernumerary coordinator or team leader on duty each shift on both PICU and HDU.
- There were high levels of maternity leave on both PICU (10.5 full-time equivalent) and HDU (10.8 full-time equivalent). The subsequent shortfalls in the staffing numbers were usually met from the existing establishment working extra shifts.

Medical staffing

- The PICU and the HDU had a designated clinical director and 10 PICU consultant intensivists.
- Care in the PICU was supported by twice-daily consultant-led ward rounds.
- A consultant was present on the unit from 8am through to 10pm during the week, with two consultants being on call out of hours.
- Consultants were supported by a team of other doctors that included a specialist registrar, and junior doctors.
- All admissions to the PICU were agreed by a consultant.
- The model of care in the HDU meant that there were clinical risks associated with a lack of overall medical leadership, clinical accountability and timely clinical decision making.
- There was no dedicated medical cover for HDU out of hours.
- As an interim measure, one PICU consultant was working 50% of their time covering the HDU.
- A paper proposing short- and medium-term solutions to the PICU and HDU medical issues had been submitted to the Trust Board in May 2014 and no final decision had been made at the time of our inspection.

Major incident awareness and training

- The units had a number of policies relating to the management of major incidents, internal disaster and business continuity. The staff received training on major incidents every three years as part of their mandatory training programme.

Are critical care services effective?

Good

Overall, critical care services were effective. Examination of the PICANet data reports from 2010–2012 indicated that, when comparing Alder Hey with other specialised children's trusts of a similar size and case mix (exclusively children with cardiac and general conditions, nursed on the same intensive care unit), risk-adjusted mortality and intensity profile (levels of support) are entirely comparable, as is length of stay. The proportion of readmissions within 48 hours of discharge from intensive care is also within expectations.

There was good multidisciplinary team working and a commitment to clinical audit and evaluation.

Evidence-based care and treatment

- A range of local policies and procedures were in place. These had been developed using National Institute for Health and Care Excellence (NICE) and Paediatric Intensive Care Society guidance.
- There were care pathways and bundles used to ensure appropriate and timely care for children and young people with specific needs, such as ventilation.

Critical care

- The unit had a clinical audit programme to monitor how guidance was adhered to.
- The PICU also contributed to international research programmes, for example, the Therapeutic Hypothermia after Paediatric Cardiac Arrest trials.
- There were examples of recent audit activity which identified shortfalls in the use of suction on high-risk cardiac patients, and the use of incubator humidity for premature babies.

Pain relief

- The hospital had a dedicated pain service which helped to support and advise children and young people and their families.
- Several age-specific pain assessment tools were used, including a self-assessment tool for children over three years of age.
- Pain relief was considered part of care planning and monitored for efficiency.

Nutrition and hydration

- Both 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.
- The monitoring of hydration and fluid balance was a key component in the care of the paediatric intensive care patient and was well-managed in both units.

Patient outcomes

- The PICU at Alder Hey 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). This demonstrated that the PICU at Alder Hey performed similarly to comparator children's trusts in terms of mortality and unplanned re-admissions.
- The introduction of a nurse led vascular access initiative had significantly impacted upon the numbers and incidence of catheter associated infection rates. The introduction of high impact interventions (e.g. early line removal) and staff training programmes have seen line infections reduce by 75%.

Competent staff

- For all nurses new to PICU there was a three-month compulsory orientation programme. All new staff were assigned a band 7 mentor and a dedicated mentor to monitor their progress and determine competency.
- 65% of the nursing staff had a specific paediatric intensive care qualification.
- There were dedicated band 6 education nurse leads that had the equivalent of one day per week to devote to that educational role. They were responsible for implementing and monitoring the mandatory training programme.
- At the time of the inspection, all but one PICU consultant had been through revalidation and appraisal.
- A new system of appraisal and performance development review (PDR) was being introduced for nursing staff. This was not yet embedded and staff were awaiting the required training to deliver it. This training had been scheduled to take place over the coming months.

Multidisciplinary working

- There was a daily multidisciplinary ward round that had input from nursing, physiotherapy and others as appropriate (for example, microbiology, speech and language therapy). Patient care in the PICU was led by paediatric consultant intensivists.
- There was a dedicated PICU pharmacy service.
- The care of the child or young person in HDU was managed by a combination of consultants, depending on the person's clinical need. For those requiring long -ventilation this was usually a PICU intensivist. 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 with some of the trust's anaesthetic doctor's also spending time working with the transfer and retrieval teams.
- There was no formal outreach service from either PICU or HDU.
- Representatives from both PICU and HDU attended the twice-daily bed management and patient flow meetings. These consider individual ward and unit staffing, bed availability and acuity.

Seven-day services

- A consultant intensivist provided 24-hour care on the PICU at the weekend, supported by a senior registrar and junior doctors. A second consultant was available on call.

Critical care

- On the HDU the medical cover at weekend was provided by the specialist teams second and first on call. This did sometimes result in delays in attendance on HDU when the medical staff were busy elsewhere (such as in theatres).
- Out-of-hours physiotherapy and imaging services were available during the daytime at weekends and then on call.

Are critical care services caring?

Good

Overall, critical care services were caring. We saw children and young people and their parents being treated with understanding, compassion, dignity and respect. During the course of the inspection, we spoke with 10 parents, many of whom spoke positively about the caring attitude and practice of the staff on both PICU and HDU. We were told of examples where parents reported the staff took the time to try and build a supportive relationship with them. In many cases, this grew over time as children and young people had often had a number of previous admissions. Privacy and dignity arrangements for children and young people were acceptable.

Compassionate care

- Throughout our inspection, we saw children, young people and their families and carers being treated with compassion, dignity and respect.
- On the 23-bed PICU, the unit was divided broadly into two areas (cardiac and general) with cubicles available for isolation. In HDU there was cubicle facilities for seven children or young people with the installation of an eighth planned. Both units provided mixed-sex facilities.
- While many of the parents we spoke with praised the nursing and medical staff on both units, there were those who were less happy. We were told of individual issues and examples of poor communication between staff and parents.
- During the course of the inspection we observed the admission of an acutely ill child who was transferred by PICU staff from one of the inpatient wards at Alder Hey. This was managed in a professional and compassionate manner with support given to both the child and the parent.
- No positive or negative comments were gathered about the units from the Patient Opinion website.
- Share Your Experience is a service organised by CQC whereby patients are asked to provide feedback on the standard of care. There were no comments recorded for this trust.

Patient understanding and involvement

- Because of the nature of the care provided in a critical care environment, children could not always be directly involved in their care. However, whenever possible, the views and preferences of children and young people were taken into account.
- Again, because of the nature of the care provided, and the often very young age of the children, they were not always in a position to give their consent to care and treatment. So their families and carers played a vital role in advocating for their children and making sure that they were involved in best interest decision making. We saw an example of where this advocacy had been facilitated with the parent successfully challenging the decisions being made by the medical team. This was conducted with a degree of sensitivity and compassion that left the parent's confidence in the medical and nursing teams intact.
- In the PICU, parents were able to visit the unit prior to their child having planned cardiac surgery and, wherever possible, got to meet the nurse who would then be looking after their child.

Emotional support

- There was evidence that staff built up trusting relationships with children and young people and their families and carers. These relationships often developed overtime as many of the children we saw had previous admissions to both PICU and HDU.
- We saw that referrals could be made to psychology services but the critical care units did not have their own dedicated psychology resource.
- 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.
- Several of the parents told us that they had also been supported by the hospital's Patient Advice and Liaison Service.

Are critical care services responsive?

Critical care

Requires improvement

At times, 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 had an impact 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 absence of clear medical leadership in the HDU had affected admissions to the unit. For example, it was reported that pressure had been applied on the nursing staff to make decisions about whether an ill child could be admitted, even when the unit was already stretched.

We spoke with staff and parents who felt that the physical and mental health needs of some children and young people could be more appropriately met if they had more accessible psychological support.

The HDU did not have appropriate facilities for visiting parents and carers. Some parents stated that "there is nowhere to go and cry". Some of the issues identified by parents may well be addressed when the new hospital opens in 2015.

Service planning and delivery to meet the needs of local people

- Being a specialist children's trust and taking referrals from across the North West of England and the Isle of Man, the units need to cater for the needs of more than just local people.
- The trust has developed a number of services to help meet the needs of the population it serves. Some examples are:
  - The Alder Centre offering support and services to bereaved families.
  - Patient Advice and Liaison Service
  - Ronald McDonald House, that provides free accommodation for the families of seriously ill children.
- Staff demonstrated a good understanding of people's social and cultural needs and how these could be met in the PICU/HDU environment.

Access and flow

- At times, 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 had an impact on the PICU's ability to step down children or young people to HDU in a timely manner.
- Some patients had their surgery cancelled on the day of operation due to the lack of HDU beds.
- The absence of clear medical leadership in the HDU had affected admissions to the unit. For example, it was reported that pressure had been applied on the nursing staff to make decisions about whether an ill child could be admitted, even when the unit was already stretched.
- Analysis of discharge data, and from talking to staff, showed evidence to support the claim that the PICU did not transfer children or young people out for non-clinical indications.
- The North West & North Wales Paediatric Transport Service is a collaborative venture between the Royal Manchester Children's Hospital and Alder Hey Children's Hospital and has 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 within the North West and North Wales area. It is part of the role of the transport service 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.
- Representatives from both PICU and HDU attended the twice-daily bed management and patient flow meetings. These considered individual ward and unit staffing, bed availability and acuity.

Meeting people's individual needs

- The PICU had an adjoining parents' room where there was a fridge, microwave and hot drink-making facilities.
- The HDU did not have a parents' room or toilet that parents could use on the unit itself. Several parents stated that the lack of facilities on the HDU made things difficult – for example, one parent said, "there is nowhere to go and cry".
- While a referral could be made for psychological support, neither PICU nor HDU had their own psychology resource.
- Not all children and young people who had been risk-assessed as requiring one-to-one care and treatment on the HDU were able to receive it.

Critical care

- Interpreter services were available both by phone and in person.

Learning from complaints and concerns

- Complaints were handled in accordance with trust policy. If a young person, family member or carer wanted to make an informal complaint, this would initially be dealt with by the team leader. People were advised to make a formal compliant if their concerns remained.
- Not all parents, families and carers were aware of the function of the Patient Advice and Liaison Service, or how to access their help.
- One example of learning related to a complaint made that hot drinks could not be taken to the bedside for patients' family or carers. This was resolved by the introduction of lids for hot drinks.

Are critical care services well-led?

Requires improvement

Overall, there was strong leadership on both units. The PICU had a designated clinical director and ward manager. The HDU was led by an excellent ward manager but there was no consultant clinical lead currently in post for this element of the service. The trust was aware of the risks associated with the medical staffing in HDU and had developed some solutions for the short and medium term. We were not convinced that the arrangements in place at the time of the inspection 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. On the unannounced visit it was clear that some immediate steps had been instigated to improve the level of medical support in the short-term to the HDU.

Vision and strategy for this service

- There was a clear vision for developing an integrated PICU/HDU service in the new Alder Hey in the Park hospital due to open in 2015. This would see an increase to 43 beds in total.
- There had been a detailed review of the critical care workforce in advance of the move. This included recruitment to additional consultant and nursing posts.
- Senior staff reported that they had been involved and engaged with the development of the new unit, though not all staff at other levels felt that they had been involved, and were unsure how the unit would function as an integrated PICU/HDU.
- There was an aspiration to improve the care for the deteriorating child or young person by developing a 24-hour-a-day, seven-days-a-week medical emergency/ rapid response team.
- The critical care model for the future hoped to address some of the existing flow, efficiency and safety issues. For example, reduced refusal rates to both PICU and HDU, reduced length of stay and the development of an outreach service.

Governance, risk management and quality measurement

- The CBU, including critical care, held monthly risk and governance meetings that reported on and discussed audit, patient outcomes, incidents, complaints and quality improvements.
- A critical incident summary document was shared with unit staff, where trends were identified and learning disseminated. This was backed up by face-to-face briefings with staff and the publication of monthly risk alerts.
- The risks inherent with the delivery of safe care were understood by the trust and identified on the trust's risk register. While plans were being developed for future solutions, it was clear on the inspection that immediate steps were required to improve the medical leadership and decision making on the HDU.

Leadership of service

- Senior medical and nurse leaders were committed to providing a good service for children and young people. They were positive role models for their staff.
- The PICU was led by a designated consultant clinical lead, a manager and a lead nurse. The HDU was led by a ward manager. That leaders were positive role models was especially evident on the HDU where the nurse manager provided a very strong and positive leadership style.
- The local leadership of the units was also very strong.
- Each shift was led by senior nursing staff with paediatric intensive care experience and qualifications that had supervisory responsibility for the staff working with them.

Critical care

Culture within the service

- Staff spoke positively about the level of team working and the service they provided for children and young people on both units.
- Staff worked well together and there was obvious respect between professional groups.
- Staff were encouraged to report incidents and raise concerns openly.

Public and staff engagement

- In 2013 Alder Hey was shortlisted for its engagement work with children and young people taking part in clinical research in the annual Health Service Journal awards.

Innovation, improvement and sustainability

- The PICU is currently working to develop and improve the quality of a number of different aspects of care and treatment. For example, nurse-led weaning and extubation (removal of endotracheal tube) and the development of a team of nurses to deliver extra corporeal membrane oxygenation (use of an artificial lung outside the body to oxygenate the blood).
- All staff were involved in quality improvement and audit.

Neonatal services

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

Information about the service

The neonatal surgical unit (NSU) in Alder Hey Children's NHS Foundation Trust has nine beds. Consultant surgeons are trained in a full range of neonatal surgery.

We visited the NSU and the inpatient areas in the hospital. We spoke with 14 parents, both mothers and fathers and 24 staff. These included nursing staff, junior and senior doctors, a dietician, domestic staff and managers. We observed care and treatment and looked at four sets of records. Before the inspection we reviewed performance information from, and about, the hospital.

Summary of findings

Parents that we spoke with gave us examples of the good level of care that their babies had received on the NSU. We were told about how supportive staff were, and that parents were informed about the care and treatment their babies received, and were involved in the process.

Early in 2014 the NSU introduced a breastfeeding pathway, Promoting transition to breastfeeding which was becoming embedded in practice. Mothers spoke positively about the support they received. There was strong local leadership on the unit, with a clear ethos about staff working together. Policy guidance was not always adhered to; we found that daily equipment checks had not been signed for on two separate occasions; and we noted that, on three separate dates, drug charts had not been double signed as per the trust's medicines management policy.

Neonatal services

Are neonatal services safe?

Good

The environment was clean and hygienic with clear information about infection control measures for staff and visitors. Staff records and notes had been completed appropriately.

Incidents

- Neonatal services had no recent Never Events (very serious, largely preventable patient safety incidents that should not occur if the relevant preventative measures have been put in place) reported between January 2013 and December 2013.
- There had been one incident in July 2013 on the NSU that had been reported to the Strategic Executive Information System following an E. coli outbreak on the unit. This led to a full root cause analysis being completed.
- Learning from the incident resulted in reducing the number of neonatal beds on the unit from 12 to nine, a review of the nursing staff establishment, and a changed ratio of nurse to babies from 1:3 to 1:2, in line with Royal College of Nursing (RCN) guidelines.
- We reviewed three incidents that had been reported, (one as moderate harm), and a root cause analysis was being undertaken. Another reported incident related to alarms on the unit not being heard by staff if they were in cubicles. All appropriate actions to rectify the risk had been taken; however, the incident had not been linked with or recorded on the NSU risk register.
- All staff we spoke with knew about incident reporting, some cited non-compliance with recording incidents due to the amount of time to complete and record the incident. Staff who recorded incidents did not always receive direct feedback about the outcomes.
- Weekly meetings were attended by senior staff to review incidents for the week.
- There were monthly mortality and morbidity reviews held at department level, as well as six-monthly meetings with the urology service. There was also a Hospital Mortality Review Group which held monthly meetings hospital-wide to review all patient deaths.

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). However, the NSU participated in a Paediatric Safety Thermometer, and its results were displayed on a board in the unit. This included information about the Paediatric Early Warning system (PEWS), cannulation (inserting a small plastic tube into a patient's vein for infusions), pain management, skin integrity, medication and nutrition. This was a new initiative that the NSU had recently introduced.
- There was also 'How are we doing?' boards which displayed information about patient/parent satisfaction data gathered from the Fabio the Frog patient feedback tool, information on pressure ulcers , cleanliness, hand washing, medication and complaints.

Cleanliness, infection control and hygiene

- Babies and their families were cared for in a clean and hygienic environment, and cleaning schedules were displayed.
- There was good practice demonstrated within the unit, such as high visibility information about infection control charts on cubicle doors.
- Trust policy on infection control was implemented and staff adhered to best practice guidance. There was access to hygienic hand-washing facilities and protective personal equipment, such as gloves and aprons, and staff were observed to be using them in accordance with the infection control policy.
- Staff challenged others visiting the unit who did not adhere to the infection control policy.
- When babies were admitted to the NSU, parents were taught correct hand-washing techniques.
- The unit was developing infection control safety cards for parents.

Environment and equipment

- The resuscitation equipment was checked and was accessible.
- The hospital resuscitation policy stipulated that equipment must be checked daily and signed off against the resuscitation equipment checklist. We looked at the seven days prior to our inspection and the checklist had not been signed for two of the days. One staff member said this happened because the unit was very busy and there was a lack of staff.

- During a review of the unit environment, we saw that a fire door with a 'keep locked' sign was open.

Medicines

- The drugs fridge was not locked but was in a room with a keypad on the door. Fridge temperatures had not been recorded on 3 and 10 May 2014. Nurses did not change the code for the keypad entry on the door (increasing the risk of unauthorised entry)
- Drug charts were not always double signed, as per medicines management policy. This occurred on 13, 17 and 19 May 2014.
- We observed intravenous medication being prepared and administered as per the trust's medicines management policy, with nurses following good practice for infection control while giving the medication. We checked the child's identification wristband which was correct.

Records

- Nursing documentation combined electronic and paper formats to record care planning.
- Two sets of nursing records we reviewed showed clear documentation of the babies' care and observations. The nursing documentation corresponded with the observation chart, escalation and action for triggering the PEWS system, and medical notes.
- There was a named nurse allocated to each baby admitted to the NSU; this information was given to parents and was recorded in the notes.
- Staff on the NSU used a proforma to conduct daily reviews and maintain accurate and thorough assessment of babies. The weekend review proforma provided a summary; nurses recorded their care summaries onto a dictaphone, as well as using a printed handover sheet.
- We reviewed two sets of medical notes which showed clear recording of the care babies received and evidence of multidisciplinary team involvement in management.

Consent

- Staff were confident and competent in seeking consent appropriately and sensitively. Parents we spoke with told us that any procedures or investigations had been explained clearly to them. Medical records we reviewed indicated that consent forms had been appropriately signed by both the parent and doctor. The trust's consent policy was available on the intranet for reference and guidance.

Safeguarding

- The safeguarding policy was available on the intranet, and staff were aware of it and could articulate the process for making a safeguarding referral and liaising with the safeguarding lead nurse.
- Safeguarding children and vulnerable adults training compliance for the clinical business unit (CBU), which the NSU was part of, was recorded as being 55%. The trust aims to achieve a compliance rate of greater than 90%.

Mandatory training

- We reviewed evidence for mandatory training for staff but were unable to clarify the NSU compliance rate due to incomplete information on the training plan. Mandatory training figures were emailed monthly to the ward manager, and any queries about discrepancies would be followed up if staff had attended updates but the training plan did not reflect this.
- Staff told us that current working patterns of 12-hour shifts had impacted negatively on the time available for workplace training as previously training had taken place during shift overlaps when more staff were working.

Management of deteriorating neonates

- The trust used the PEWS system to standardise the assessment of acute illness severity and the RCN standards for assessing, measuring and monitoring vital signs in infants, children and young people.
- The NSU used observation charts integrated with PEWS. Staff were able to demonstrate the escalation process and actions associated with appropriate management of a deteriorating baby.

Nursing staffing

- Staffing levels on the NSU had been increased after the reconfiguration of the unit; babies were looked after in cubicles, and the increase in the nursing establishment ensured a ratio of one nurse to two babies in line with the RCN guidelines.
- A neonatal surgery dependency scoring system was used on the NSU to assess the dependency of each baby, a score of six or above denotes a level of high dependency. On the day of the inspection, no baby had a score below six.
- The handover procedure for the unit required each nurse to use a dictaphone to record a summary of care; they also used a printed handover sheet.

Neonatal services

- A senior nurse led each shift; they were required to coordinate the NSU as well as allocating neonatal babies to look after.
- When required, the NSU used agency or bank (overtime) nurses if they were unable to cover a shift using permanent staff. We spoke with one bank nurse who told us that shifts had been arranged as a block booking to the NSU to provide continuity. The staff member had accessed mandatory training provided by the trust.
- Nursing staff can be moved from the unit to cover other areas. There were examples of agency staff being left on the unit on night shift while permanent trust staff were moved to cover other areas.
- The trust was planning to have a resource of 'pool staff', band 5 nurses who could work within any area as required. This would add flexibility for staff to be allocated to areas within the hospital where cover was needed and staff would have knowledge of hospital policies and procedures.

Medical staffing

- There was a junior doctor on duty on the NSU between 8am and 5pm.
- Seven surgical consultants provided out-of-hours cover on an on-call basis. Out-of-hours cover was provided by a specialist registrar and a junior doctor.
- There was a daily morning handover meeting at 8am for consultants, registrars and junior staff.
- A new initiative in the Surgical Cardiac Anaesthetic and Critical Care (SCACC) CBU was the introduction of a consultant of the week. The aim of this initiative was to allow the receiving consultant to see acute admissions and other babies in a timely manner. Referrals would always be seen within 24 hours or sooner if urgent.
- We were told that the general paediatric consultant presence at the weekend was variable, but they would always come in if requested by a junior doctor.
- The daily review performance and neonatal surgery weekend summary were used by the junior doctor, providing continuity for follow-up and the planning of care.

Major incident awareness and training

- The Major Incident Plan was available for staff on the unit, and they were aware of the policy and associated actions.

Are neonatal services effective?

The NSU used a combination of National Institute for Health and Care Excellence (NICE), British Association of Perinatal Medicine (BAPM) and Royal College guidelines to determine the treatment they provided.

There was effective working within the multidisciplinary teams and with medical specialities.

The trust carried out regular case note audits.

Evidence-based care and treatment

- The NSU used a combination of NICE, BAPM and Royal College guidelines to determine the treatment they provided.
- Care provided on the unit used NICE guidance including, QS4: Specialist neonatal care, CG149: Antibiotics for early-onset neonatal infection.
- The NSU had a clinical audit programme to monitor how guidance and policies were applied within the service.

Pain relief

- There was a pain nurse specialist who provided cover and support for the hospital, including the NSU. Nurses were trained to use nurse controlled analgesia post-operatively; the pain nurse specialist provided support to the unit on request.
- Staff used pain assessment tools in accordance with the RCN guidelines to gauge the pain relief needs of neonatal patients.
- The unit used a modified intravenous paracetamol protocol for neonatal care that differs from the British National Formulary for Children; it had been passed by the hospital medicines management committee.
- For invasive procedures, babies were given sucrose for short-term analgesic effect.
- One parent told us their baby had been given appropriate pain relief; the nurse used a pain scoring assessment tool.
- All policies and guidelines in relation to safe and appropriate pain relief were accessible to staff on the intranet.

Neonatal services

Nutrition and hydration

- A dietician visited and reviewed all babies on a daily basis. We were told by the dietician that the trust would be introducing an electronic nutritional screening tool in the near future.
- A new initiative on the NSU was 'promoting transition to breastfeeding, a care pathway for promoting the health benefits of breastfeeding.
- Fluid charts were completed, recording both input and output, and if babies were having total parenteral (or drip-fed) nutrition, their daily weight was monitored.

Patient outcomes

- Outcomes on the NSU compared favourably to similar units in other hospitals.

Competent staff

- We were told that both medical and nursing appraisals had been undertaken on the NSU. Twenty-two nurses had completed their appraisals, which represented a compliance rate of 85%.
- 50% of nursing staff held a post-registration qualification specifically in neonatal care. A further two nurses will complete post-registration training in July 2014, and a further two will be undertaking the training in September 2014.
- The NSU sponsors two nurses to undertake a neonatal post-registration course each year.

Multidisciplinary working

- Staff on the NSU worked well in partnership with other professional disciplines. There was an 8am morning handover from the night surgical cover, and a consultant led the daily surgical ward round, with input from nursing staff. A dietician attended the ward round two days per week. There was a weekly ward round by the microbiologist. We observed good working relationships between the different medical specialities.
- There was a pharmacist who attended the NSU daily.
- Transfers between sites (from or to other hospitals) follow perinatal network guidelines (Cheshire and Merseyside Neonatal Network) and care pathways.
- There were links with midwives from the Liverpool Women's Hospital three afternoons per week to support mothers. Midwives from the Liverpool Women's Hospital visited mothers with babies being cared for on the NSU.

Seven-day services

- Out-of-hours cover was provided by a surgical specialist registrar and junior doctor, with consultants available on call.
- Referrals were always seen within 24 hours or sooner if urgent.
- Out of hours there was an on-call pharmacist available. The pharmacy hours at the weekend were 9.30am to 4pm.

Are neonatal services caring?

Good

Babies admitted to the NSU and their parents and carers were treated with dignity and respect. Staff were kind and showed a caring and compassionate attitude to their patients, building positive relationships with the babies and their parents.

Staff communicated well with parents and carers and provided good support to allay fears and anxieties about their baby's care and progress.

Compassionate care

- Throughout our inspection, we observed babies and their parents being treated with sensitivity, understanding and respect. We observed both the nursing and medical staff engaging with parents in a positive manner, ensuring as far as possible their participation and engagement.
- Parents praised the care and devotion shown to the babies being looked after on the unit. One parent told us that the staff "will let you know any changes straight away". Another parent told us "I felt able to leave baby to go home because of the staff. They will phone you at home and give you progress reports". The staff reiterated the importance of the parents being involved.
- Parents were happy with the 'open visiting' policy. They were able to come and stay with their baby and remain at their bedside, and they appreciated that the nurses worked around them and included and consulted with them about their baby's care.
- We saw one family returning to the unit with a gift for the staff. They told us staff had been "faultless – could not praise them enough".

Neonatal services

Patient understanding and involvement

- When a baby was admitted to the NSU, they were allocated a named nurse, whose name was recorded on a board by the nursing station. For continuity of care, they would normally be allocated to care for that baby when on duty.

Emotional support

- Parents told us they received emotional support from the nursing staff. Staff listened and responded to parents' anxieties in a sensitive manner.
- Parents were able to access counselling and support from the Alder Centre. However, staff told us they were not clear about the referral process and how long it would take to access this support.
- Following admission to the unit, the parents we spoke with had been seen by a consultant. They were able to ask questions and be kept informed about changes and progress in their child's condition.

Are neonatal services responsive?

Good

Services on the NSU were planned in a way to meet local need. For parents who did not speak English as their first language, the unit had access to the Language Line interpreting service. There was accommodation for parents to stay overnight on the unit. Parents we spoke with told us that discharge planning was discussed with them and included follow-up care arrangements.

There were very few complaints received on the unit. Parents understood the complaints process and information about the complaints procedure was displayed for parents to see.

Service planning and delivery to meet the needs of local people

- There was a dedicated junior doctor based on the NSU Monday through to Friday.
- We found good working relationships between different medical specialities.
- Parents and carers are given the option to complete a written questionnaire about the quality of care provided to their babies, at a time convenient to them.

Access and flow

- A triage process was used to assess the baby's needs. Depending on management options, if surgery was required, then the baby would be transferred to Alder Hey Children's Hospital. If the baby did not require surgery, they would continue to be assessed and monitored at the Liverpool Women's Hospital.
- From April 2013 to March 2014, the bed occupancy rate on the NSU for eight months of this period was below the English national average of 85.9%.
- On the day of the inspection, we witnessed a telephone request to admit a baby to the NSU; the admission was refused due to not having enough staff available to cover the shift. The Trust keeps records of refused admissions via the Patient Flow team.

Meeting people's individual needs

- The unit was baby friendly, with a supply of toys and mobiles that gave a nursery feel to the cubicles and ward area. There was a relatives' room with tea and coffee-making facilities. A parents' room could accommodate one family, and parents had priority for the Ronald McDonald House accommodation. There were also two designated breastfeeding rooms which gave mothers assured privacy and the appropriate equipment for expressing their breast milk.
- For parents who did not speak English as their first language, the unit has access to Language Line interpreting services.

Learning from complaints and concerns

- Information about how to make a complaint was appropriately displayed. We were told by the ward manager that very few complaints were received and attempts are made to resolve any complaints or concerns immediately.
- Some parents had been told about the complaints process, while others had not.
- We spoke with one family who had raised a concern; it was dealt with by the shift leader and resolved satisfactorily.

Discharge planning

- Discharge planning was discussed with parents. A discharge proforma was completed and appropriate follow-up information was also given to them.

Are neonatal services well-led?

Neonatal services

Good

The NSU had a strong leadership structure. The vision and focus of the unit was on the care and treatment babies and their families experienced. There was a positive and engaging culture between parents and staff members. Team working was very strong and described by staff as excellent. We observed that support from consultant surgeons was good and staff worked well together as a team.

Vision and strategy for this service

- The vision for this service was reflected in the trust's vision and purpose. The focus was on the care babies and their families experienced while on the NSU. We were told by a senior member of staff that the ethos on the unit was for staff to work together and "always go the extra mile".

Governance, risk management and quality measurement

- The NSU is part of the Surgical Cardiac Anaesthetic and Critical Care (SCACC) CBU. There was a weekly harm meeting held to review incidents that had been reported on the trust's monitoring programme. Senior staff attended to review trends and incidents and identify action plans. An SCACC risk and governance meeting was held monthly to review complaints, audits and quality improvement initiatives.
- Staff told us that team meetings were not held – due to the 12-hour shift patterns staff worked, it was not conducive to allowing staff to attend meetings. We were told an alternative method to provide feedback and share learning from other areas was through a newsletter, Risky business. This meant that staff did not have the opportunity to meet and discuss any issues of concern or developments required.

Leadership of service

- The leadership structure consisted of a designated clinical lead consultant surgeon. There was evidence of strong unit leadership, and close working relationships between medical and nursing managers. The nursing leadership consisted of an identified ward manager; there was also a lead nurse who was a link and resource for the NSU.
- The nursing team was cohesive and supportive of each other; staff had worked together for a length of time and had built up strong working relationships that meant the unit functioned well.

Culture within the service

- We were told by staff members that team working was excellent; support from consultant surgeons was good. They were very approachable, and easy to contact, even when not on call. Other staff told us that there was good support from the nursing staff.
- We observed a positive and engaging culture with parents and staff members, evident by the feedback we received from parents during the inspection. Observations of interactions between the nursing staff and parents when caring for their babies showed mutual respect.

Public and staff engagement

- In December 2013, the trust held an NSU –parent focus group. It was the first meeting held, attended by parents and their children, nursing staff from the NSU, a consultant surgeon and registrar.
- Parents' feedback highlighted important information about what worked well, what they wished worked better, and what the NSU were going to do to make improvements. Two initiatives identified were an IT solution to offer a 'virtual visit' for a family to see their baby. One staff member was working on producing a journey board for all babies admitted to the NSU, to show a record of the baby's journey while a patient on the NSU.
- The transition to the new hospital was viewed with anxiety by some staff; we were told that they did not always feel well-informed and updated by their managers about developments in this area.

Innovation, improvement and sustainability

- At the beginning of 2014, a new breastfeeding care pathway was introduced on to the NSU, every new mother who wished to breastfeed was fully supported by staff; there were also facilities for expressing and storing breast milk.
- Senior staff told us that there had been collaborative working with the Liverpool Woman's Hospital to look at the appointment of a consultant paediatric intensivist to

provide surgical postoperative care to work jointly across both hospitals. The collaboration also included a nurse consultant specialist in neonatal nursing to work across both areas.

- Transition of services to the new hospital will include facilities for parents to be able to stay with their babies in a purpose-built unit, including ensuite facilities.

Transitional services

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

Information about the service

Transitional services were provided as part of the overall services for children and were not managed as a distinct clinical area (such as medicine or surgery). Transitional services for adolescents were developed and managed by individual specialities within the hospital. Some specialities had established excellent transitional arrangements with adult specialities in other hospitals.

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. In 2013/14, a total of 424 young people aged 18 or over were admitted to the trust. The trust provided transition services from paediatric care to adult services for young people with long-term health needs. At the time of our visit, there were 56 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.

We visited eight inpatient areas and one outpatient area. We spoke with seven young people, two parents and 20 staff. We observed care and treatment and reviewed four care records. We reviewed eight pathways of clinical care, looking at transition procedures for young people moving into adult services. Before the inspection, we reviewed performance information from, and about, the hospital.

Summary of findings

We found there were specialities that had established transitional arrangements in place. Clinical teams providing care were committed to supporting young people in transition to adult services. We found examples of excellent transition pathways for young people with specific long-term health needs

However, we found that there was no overall responsibility or leadership for transitional services in the trust.

We did not find evidence of coordinated trust wide planning for the delivery of t transition services.

Transitional services

Are transitional services safe?

Not sufficient evidence to rate

The trust had comprehensive local transition policies and procedures for all the clinical pathways that we reviewed. Transition policies were related to young people with specific long-term health needs.

Policies and procedures for the transition of young people with complex needs, or young people under multiple specialities, were not available. In this instance, clinicians planned transition on a case-by-case basis.

We found good examples of medicine support within care pathways for specific conditions, such as cystic fibrosis, hydrocephalus and diabetes, when transition planning. These plans provided opportunity for young people to be assessed and supported to manage medicines safely.

Measures to facilitate safe transition to adult services.

- The trust had comprehensive local transition policies and procedures for all the clinical pathways. Transition policies were related to young people with specific long-term health needs.
- Policies and procedures for the transition of young people with complex needs, or young people under multiple specialities, were not available. In these instances, clinicians planned transition on a case-by-case basis.
- Rheumatology services ran transition clinics in conjunction with Aintree University Hospital NHS Trust and The Royal Liverpool and Broadgreen university Hospitals NHS Trust.
- For patients with Cystic Fibrosis there were arrangements with a number of district general hospitals: including Countess of Chester, Eastern Cheshire, Mid Cheshire, Wrightington, Wigan and Leigh; and in Wales, Wrexham, Bangor Community and Glan Clywd.
- Staff we spoke with acknowledged that transition for young people with learning disabilities and complex needs was sometimes difficult due to complexities and lack of coordination across boundaries.
- As part of the transitional planning process we found good examples of medicine support within care pathways for specific conditions, such as cystic fibrosis, hydrocephalus and diabetes. These plans provided opportunity for young people to be assessed and supported to manage their medicines safely.

Records relating to transitional care

- We found that care plans were individualised and the information provided to young people and their families was bespoke and reflected their individual needs.
- For some young people transitioning to adults services, a record was available that they could keep at home and bring to hospital appointments. This included important information on their plan of care and included tips, prompts and reminders. We found good examples of this for young people with diabetes and young people with encephalitis

Consent

- Confidentiality and consent was a fundamental component of all condition-specific transition plans that we reviewed.
- Young people we spoke to told us that they had been involved in decision making regarding their treatment and this was evident in their care records.
- Services in cystic fibrosis, rheumatology, oncology and cardiology showed good evidence of outpatient clinic management which provided young people with opportunities to discuss treatment options on a one-to-one basis.

Mandatory training

- Mandatory training for staff that cared for young people in transition was the responsibility of the individual division or department where staff were employed.
- We were not provided with evidence that the Trust provided specific transitional training for all staff groups.

Are transitional services effective?

Not sufficient evidence to rate

Existing transition services had developed independently within their own specialities that meant there were no stated and agreed core standards for transition set by the trust.

There were some very positive examples in some specialities of effective pathways and robust transition arrangements that were securing positive outcomes for

Transitional services

young people. There was good evidence of multidisciplinary working however, Teams acknowledged that multidisciplinary working was currently focused on young people's medical needs.

Evidence-based care and care planning

- Young people were treated according to national guidance, included 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 current national guidelines.
- Transition services for rheumatology and cystic fibrosis were highlighted as examples of excellence. Trust-led research for evaluating a baseline for all transition pathways was being led by the research department to identify excellent practice.
- An audit of transitional care for inflammatory bowel disease analysis had been completed that showed the positive impact transition planning had in patient outcomes and experience

Multidisciplinary working

- The trust runs 833 satellite clinics across 31 sites per year.
- The trust has consultant representation on the Healthy Liverpool Integrated Care Delivery (Children) programme, focusing on multi-agency working to improve pathways and integration through the commissioning of services.
- There was positive evidence of multi-disciplinary working across a number of specialties. Similarly there was positive multidisciplinary working between the trust and adult services to support good outcomes for young people in transition.

Are transitional services caring?

Not sufficient evidence to rate

We found transitional services overall were caring. We found specialist teams provided compassionate care with good emotional support through transition. Parents and young people felt that members of staff talked with them at an appropriate level of understanding and explained things clearly.

Young people felt consulted and included in their care and treatment. Young people and those close to them were treated with dignity, compassion and respect.

Compassionate care

- Parents and young people told us that they felt safe and supported at the trust. Throughout our inspection we saw young people being treated with dignity and respect, and observed staff providing compassionate care.
- Young people and those close to them felt that went above and beyond their expectations in terms of supporting their needs.

Understanding and involvement

- Transitional plans clearly considered young people's choices around transition timescales. This was reflected in a young person's journey where the team had coordinated services to the hospital of choice and had deferred the start of transition for six months.
- Young people and those close to them felt consulted and included in care planning for transition
- We reviewed the records held by the play therapists and found comprehensive, individualised programmes for young people which included setting milestones for goals and achievements through the transition period
- The information provided to young people about transition was bespoke to reflect their needs.
- Both staff and young people told us that play therapists were an essential part of care and were instrumental in young people being supported to have clinical procedures.

Emotional support

- Psychologist services were actively involved in supporting young people with long-term health needs and though transition to adult services.
- Specialist nurse-led clinics focused on providing young people with support relating to health and emotional needs.
- Health play therapists were a valuable support for young people, providing emotional support during the transition period.

Transitional services

Are transitional services responsive?

Not sufficient evidence to rate

We found excellent examples of service planning for transitional services focusing on the young person's health needs that was diagnosis driven. We were not assured of the coordination of transition arrangements to support young people with learning disabilities and other complex needs as this was unclear at the time of our inspection.

Service planning and delivery to meet the needs of patients requiring transitional planning.

- There was strong leadership from consultants responsible for young people's care with long-term health needs that were in transition to adult services.
- Transition pathways were driven by the young person's primary health need and we found areas of excellent practice when reviewing transition planning for specific medical health needs. From speaking to young people, families and staff and reviewing care pathways, it was clear that strong relationships with other adult providers was key to the success of transition into adult services.
- The process and responsibilities of coordination of services for young people with complex needs, and how they were identified as requiring transition planning to adult services in the future, was unclear.
- Young people, in some instances, were supported after the age of 18, with decision making based on best interests, within clinical pathways and patient choice – for example, in oncology. However, we were concerned that some young people were still supported by the trust after the age of 18 because there was a lack of coordination and planning with adult services. Doctors and nurses told us that they were concerned about the availability of services for young people with complex needs when they reached adulthood.
- Young people with learning disabilities were supported either as part of pathways or though clinical and health play therapy teams.

Are transitional services well-led?

Not sufficient evidence to rate

There were some excellent examples of good practice identified across pathways of care. Reporting structures were well-established throughout the trust, however, transitional services were not included in monitoring arrangements. Therefore, reporting arrangements to the board were unclear for these services. There was good evidence of local policies and local leadership relating to transition services; however, we found no overarching strategy or vision relating to transitional services within the trust. There was no identified lead for transitional services and staff were unaware of who had responsibility for developing transitional services outside of their own field of work.

There was research ongoing into excellence in transitional services, however, the outcomes of this work were not yet formalised in to a strategy for future service provision.

Vision and strategy for this service

- Vision and strategy related to adolescent care and transition services was driven effectively by clinicians though clinical business units (CBUs) based on pathways of care.
- There was no overarching vision or strategy available for transitional care.
- Staff were not clear of overall responsibility for transitional services.

Governance, risk management and quality measurement

- Monitoring arrangements for risks and quality of care provision relating to transitional services were focused on pathways of care, so trends were not clearly identifiable.
- Future commissioning arrangements include Commissioning for Quality and Innovation (CQUIN) quality indicators for transition.
- Governance arrangements were in place in 2013 for children and young people with learning disabilities as part of the learning disability monitor compliance meeting. It was unclear what reporting arrangements existed for this group. The last minutes available for the meeting were from September 2013 and there were

outstanding actions relating to a business case to support children and young people with learning disabilities. This group had not met since September 2013.

Leadership of service

- Clinical leadership was well-established; supporting transition services though clinical pathways.
- There was no overall senior responsibility at board level for adolescent and transitional services.
- We identified that there was no trust lead for young people with learning disabilities. We were told by a senior manager that different consultants looked after individual patients and there was no one consultant leading on the development of transitional services for this group of patients.

Culture within the service

- Trust staff were key members of partnership boards and clinical pathway planning looking at future requirements to support young people transitioning to adult services.
- Staff members were committed in driving improvements in transitional care across the catchment area and were looking forward to and planning for what young people may need in the future. Staff had a clear clinical vision of what was needed.

Public and staff engagement

- Young people in transition were active in the children and young people's forum that enabled them to contribute to the development of services.
- There was a range of opportunities for young people to feedback their experiences, however we were not made aware of any for that were specifically related to young people in transition to adult services.

Innovation, improvement and sustainability

- The trust has undertaken transitional care research to identify areas of excellent practice and how to support young people going forward.

Palliative and end of life care

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

Information about the service

The specialist palliative care team supports children and young people affected by life-threatening conditions and their families and carers. The team provides support to young patients with cancer and receives referrals from professionals working in other hospitals and in the community for other life-threatening or life-limiting conditions from across the North West region. The team is based within the oncology unit at Alder Hey Children's Hospital. We visited six wards and spoke with four people who used the service and six relatives. We spoke with members of the palliative care team and other staff within the hospital who referred children and young people to the palliative care service. We spoke to a counsellor based at the Alder Centre who also managed the bereavement service. The Alder Centre is adjacent to the hospital and provides counselling services. We also visited the mortuary.

Summary of findings

The specialist palliative care team provided a safe, effective and responsive service for children with life-limiting illness. Staff throughout the hospital knew how to make referrals to the team. Children and young people were appropriately referred and assessed by the specialist palliative care team so that their individual needs were met.

The service had developed advanced life care plans in partnership with other service providers in the region for use in hospital and the community. Specialist children's palliative care nurses supported children and young people in hospital and in the community, working in partnership with local community nursing teams. Children, young people and families had access to specialist advice and support 24 hours a day from a nurse-led, on-call team for end of life care. Palliative care advice was also available for professionals. A bereavement service supported the families' emotional needs when children were at the end of life, and continued to provide support afterwards. Counselling support was available through the Alder Centre. Mortuary staff were trained in bereavement counselling.

Palliative and end of life care

Are palliative and end of life care services safe?

Good

There were clear referral processes in place and effective arrangements to assess and coordinate children and young people's care. Weekly reviews of care plans meant the safety and quality of care could be effectively planned and coordinated.

The palliative care team analysed and learned from incidents and had processes for planning and monitoring the safety of the care provided.

Incidents

- There had been no Never Events (serious, largely preventable patient safety incidents that should not occur if the relevant preventative measures have been put in place) reported between January 2013 and December 2013.
- Staff were confident in reporting incidents and 'near misses'.
- Feedback was given and there were examples of learning from incidents being applied and evaluated, which included the introduction of an information leaflet about the use of electronic intravenous pumps. The leaflet had been developed following an incident and was based on national guidance received about the safety of this equipment.

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).
- Wards visited by the palliative care team participated in trust-wide safety audits but the palliative care team did not directly participate in these audits.

Infection control

- The ward areas we inspected were clean.
- There was a sufficient number of hand-wash sinks and hand gels. Hand towel and soap dispensers were adequately stocked. We observed staff following hand hygiene practice and 'bare below the elbow' guidance.
- We spoke with six relatives who told us they felt the wards were clean and they saw staff wash their hands before they came into contact with children and young people. Two relatives told us the waste bins were emptied frequently during the course of the day.

Environment and equipment

- There was sufficient equipment available to meet the needs of children and young people at all times.
- The needs of children and young people who required end of life care were prioritised within the hospital. This meant that the palliative care team were able to access a suitable environment to deliver care for these children and young people.

Medicines

- Medicines were managed safely and securely.
- The operational policy and guidance developed for staff on the use of cytotoxic drugs (used in cancer treatment), which was comprehensive and up to date.
- The policy provided staff with guidance, both in the hospital and for children and young people being cared for by the community team in their home.

Records

- Records relating to children and young people were kept in both electronic and paper formats.
- During our inspection, we reviewed five sets of records. In all the records we looked at documentation was accurate, legible, signed and dated, easy to follow and gave a clear plan and record of the children and young people's care and treatment.
- We saw risk assessments in patients' records. However, we found instances where not all ward-based staff were familiar with the content of the risk assessments and the care provided, for example, one-to-one nursing was not always in place.
- We reviewed advanced life care plans. These were multi-agency plans developed in partnership with the ambulance service and other trusts. The plans were designed to be used at home, in school and in A&E. The documents were designed to describe and share the wishes of the child or young person about their goals during life, diagnosis and health needs and management around the end of life. We saw an example of a completed plan where the section on do not attempt cardio-pulmonary resuscitation (DNA CPR) had been completed appropriately confirming the patient's wishes.

Palliative and end of life care

- Arrangements were in place to check which children and young people required personal resuscitation plans. This information was updated weekly and made available for medical and nursing staff responsible for providing the care.
- The pathway coordinator also ensured this information was highlighted on the electronic patient information system so that it was immediately apparent to all staff as soon as the children and young people accessed the hospital.

Consent

- Records we reviewed showed that consent had been obtained and recorded appropriately and in accordance with national best practice guidance.

Safeguarding

- We spoke with three members of staff about protecting children and young people from the risk of abuse. They knew how to contact the safeguarding team via the Rainbow Centre. They also knew they could contact the local safeguarding team in and out of hours. They had received training within the last two years and told us they were confident their concerns would be investigated. One new member of staff told us they had received safeguarding training as part of their induction process. They also told us they were aware of the weekly harm meeting where all issues and incidents were reviewed.

Mandatory training

- Information supplied by the trust recorded mandatory training levels at 73% in February 2014 against a trust target of 90%.
- The electronic system sent reminders to staff when training was due. Staff could see if the overdue training was mandatory.
- Training places could be booked online.
- Trust-wide electronic training records did not correspond with records held by individual members of the palliative care team. We saw one member of staff's training record which they accessed online. They told us that the system sometimes showed training was incomplete when it had been done, and there was a trust lapse between completing the training and the system being updated.

Management of deteriorating children and young people

- The palliative care team facilitated rapid discharge from hospital to home or another hospital in the last days of life. Relatives told us that children and young people and their families and carers were able to access a 24-hour, seven-days-a-week, on-call service for advice and support.
- The palliative care team prescribed a palliative care drug box which was transferred to a safe place in the child or young person's home. We saw the guidelines staff used to make a decision about the appropriateness of rapid discharge. This provided a governance and risk management framework that aided decision making. We spoke with three members of staff about these arrangements. They all told us they only put these arrangements in place if they had completed the risk assessment and it was safe to do so. We saw the assessment documentation which referred to medication needs, equipment and primary care involvement.
- We spoke with two relatives who told us the palliative care team provided advice and support for pain and symptom management and empowered families to manage pain and symptoms effectively. One relative told us they contacted staff by phone if they needed advice and support and that they received a positive response.

Nursing staffing

- The palliative care team establishment was for 5.6 full-time equivalent nursing posts. Posts were 5.4 full. One associate nurse specialist post was funded temporarily until September 2015. An established nurse consultant's post had been vacant since June 2012. The funds were used to cover the costs of a staff grade doctor until August 2014.
- Staff in the palliative care team told us they provided cover for each other and did not use bank (overtime) or agency staff.

Medical staffing

- Medical cover was provided by a 0.8 full-time equivalent consultant in paediatric palliative medicine and a full-time temporary staff grade doctor until August 2014. A business case had been submitted to the trust for further funding after August 2014

Palliative and end of life care

- Pressures on the consultants' time meant they were not able to have a presence on the paediatric intensive care unit and high dependency unit to provide advice and support for children and young people, their families and staff as they would have wanted.

Are palliative and end of life care services effective?

Good

There was evidence of well-developed systems in place, based on the standards expected for children and young people receiving end of life and palliative care services.

Evidence-based care and treatment

- The palliative care team used a combination of National Institute for Health and Care Excellence (NICE), and Royal Colleges' guidelines and quality standards to determine the care provided.
- There were specific care pathways for specific conditions in order to standardise and improve the care for patients. For example, care pathways were used for the management of neutropenic sepsis (a risk for people receiving anti-cancer treatment).
- A pathway coordinator supported the team to organise children and young people's care.
- The trust participated in all the national clinical audits they were eligible for. There were no children's palliative care audits.
- Operational policies were based on current best practice guidance within the palliative and end of life service and were revised and updated regularly. The policies and procedures we reviewed during our inspection were up to date and reflected current best practice guidelines. For example, we saw the service used a Together For Short Lives clinical pathway developed by the International Children's Palliative Care Network which used a holistic approach for all babies, children and young people with life-limiting disease. This was based on guidance contained in The Guide to the Development of Children's Palliative Care Services (ACT 2009).The service was designed around the six core standards set out in the ACT guidance (breaking news, planning for going home, multi-agency assessment of the family's needs, multi-agency care plan, end of life care plan, and continuing bereavement support). The palliative care team benchmarked the service against those standards.
- The North West Children's Palliative Care Network had developed a set of comparators and quality markers which the service was implementing. These were based on guidance contained within the National Framework for Children and Young People's Continuing Care (DoH 2010). Few of these data items were being routinely collected and there was very little comparative data available for other services.

Pain relief

- Staff told us, and we saw from care records, that there were arrangements to provide advice and direct support for pain relief and symptom management.
- Children and young people and their families and carers reported timely and effective pain control.
- Advanced life care plans described plans for pain control and, when a child or young person was receiving end of life care, individualised plans were developed which contained advice on appropriate medication, doses and routes of administration.

Nutrition and hydration

- We saw the advance care plans and rapid discharge plans contained information about children and young people's nutritional and fluid needs.
- Families appreciated that the paediatric oncology department had their own kitchen based on the ward and a chef who prepare meals for children and young people between 11am and 7pm.
- This service was highly valued by the children and young people on the ward.

Patient outcomes

- We saw the referral pathway used by the service for patients who required palliative care but did not have a diagnosis of cancer. This showed how referrals should be made and recorded by the palliative care team, the arrangements for discussing all new referrals and allocating the case which was coordinated by one of the specialist nurses. This meant there were mechanisms in place for coordinating referrals from a wide range of specialties. This also enabled children and young people's care to be monitored weekly.
- There are no national audits for children's palliative care.

Palliative and end of life care

Competent staff

- Appraisals of both medical and nursing staff had been undertaken. Most staff we spoke with had received an appraisal during the last year and spoke positively about the process.
- Staff within the palliative care team received clinical supervision from staff based in the Alder Centre.
- Information from Health Education England requested prior to the inspection confirmed that all medical staff had been through the required revalidation process, including those on the speciality register.

Multidisciplinary working

- There was a high level of awareness among all ward staff we spoke with about access to the palliative care team. Staff were confident and competent in making referrals.
- Medical specialities within the hospital worked well with the palliative care team.
- There were good links between the community nursing team and the hospital palliative care team. This partnership working enabled children to be discharged home in a timely manner and supported appropriately within a community setting.
- We reviewed details of 20 multidisciplinary teams supported by the palliative care team, both within the trust and across the palliative care network. A member of the palliative care team attends the multidisciplinary team meeting when a child with palliative care needs is discussed.
- Within the hospital, members of the palliative care team attend meetings for leukaemia, neuro-oncology solid tumour clinical oncology, and multidisciplinary team meetings for teenagers and young adults, one-off patients, psycho social, involving psychologists, social workers, ward staff and palliative care teams.

Seven-day services

- There was access to a nursing on-call team, available out of hours. Children and young people, their families and carers were provided with mobile phone contact details.
- The palliative care consultant also provided mobile phone contact details and provided advice out of hours.
- The bereavement service provided an on-call service out of hours.

Are palliative and end of life care services caring?

Outstanding ☆

Palliative and end of life care services were delivered by a hard-working, caring and compassionate staff. We observed that care was planned and delivered in a way that took the wishes of children and young people into account. Emotional support was available for children and young people, their families and carers.

Compassionate care

- Parents, children and young people we spoke with all said members of the palliative care team were caring and compassionate.
- A bereavement service was available to provide support for families and carers, including an on-call service out of hours.
- The bereavement service was also available to support staff.
- Mortuary staff were trained in bereavement counselling and provided flexible out-of-hours viewing.

Patient understanding and involvement

- Care was planned and delivered in a way that took into account the wishes of the children and young people.
- Children and young people we spoke with told us they felt involved in their care and treatment. Families and carers also felt involved.
- We spoke with a young person (16 years old) who told us they "felt involved and informed and able to make decisions". They said "Staff talk to me first". Their parent confirmed: "Staff always speak to [my child] first. I wait and fill in or ask later".
- A parent voices group had been set up which was a partnership between the Rainbow Trust charity and the North West Children's Palliative Care Network. The children and young people's palliative care consultant was the chair of the network and Alder Hey Children's Hospital had been central to the formation of this regional group. The parent voices group were a group of parents who had been told their child has a life-threatening illness and have used the palliative care service. The group have contributed to the development of the network's strategy for 2011–2014. The group have identified a list of projects to improve palliative care for

children. This included providing suitable equipment more quickly, improving waiting times for medicines at pharmacies and developing whole family support meetings. Parents contributed to the work of the group by attending monthly meetings, providing feedback or becoming involved in the work of the North West strategy group.

Emotional support

- Alder Hey's bereavement service had five counsellors who provided support for children, young people, families and carers before and after death. They were available 24 hours a day, with an on-call service out of hours.
- The bereavement service also supported staff who had been involved in the care of children and young people at the end of their life.
- Because of the high quality of the service provided, the coroner referred people to this team, even those who had not had any contact with the hospital.
- Bereavement care pathway training was offered once a month to staff working elsewhere in the hospital.
- Further counselling support was available at the Alder Centre. One relative told us the "Alder Centre is the hidden service of the hospital".
- The palliative care team told us the lack of dedicated psychology input limited the development of psychological support for children, young people, families and carers. We found there was dedicated psychological support available for children and young people cared for by the palliative care team on the wards we visited.
- We spoke with the chairman of the Children's Cancer Support Group who told us about the emotional, financial and practical support they provided for children, young people and families affected by cancer. They said they had been involved in a Merseyside and Cheshire children's cancer network group as a result of their involvement with the hospital. Nurses and social workers who were part of the palliative care team put parents in touch with the group.

Are palliative and end of life care services responsive?

Good

Children, young people and families referred to the palliative care team received a prompt response and were able to access advice and support out of hours.

Service planning and delivery to meet the needs of local people

- The palliative care team accepted referrals for children and young people up to the age of 18 who live within Cheshire and Merseyside. Children and young people under the care of Alder Hey Children's Hospital but not resident in Cheshire and Merseyside could also be referred to the palliative care team. Referrals were assessed and support provided if there was no other more appropriate service available. The palliative care team supported children and young people with new diagnoses of cancer up to the age of 20 years. These young people then had the option of staying with the oncology centre until they were 24 years old. The palliative care team supported all young people from Merseyside and Cheshire who remain under the care of the paediatric oncology unit at Alder Hey. The referral system is based on the guidance set out in Improving Outcomes in Children and Young People's Cancer (NICE, 2005).
- The consultant in palliative care medicine leads the North West Children's Palliative Care Network which is a managed clinical network which brings together children and young people's zonal groups from Cheshire and Merseyside with two other zonal groups to plan palliative care services.
- The service has improved the content of drug boxes provided for patients to use at home, based on an evaluation and audit.
- The palliative care team are developing the role of a key worker to include clear definition of the role and accredited training.
- In the absence of national standards, the palliative care team have set local operational standards that are audited regularly. The team aims to respond to all referrals within four weeks. The response times for referrals requesting a response within 24 hours was

100% in 2013. The response time for referrals requiring a response within four weeks was 90% in 2013. The team prioritised urgent referrals, although this was sometimes limited to telephone advice.

Access and flow

- A system of rapid discharge was in place, following the appropriate risk assessments, which enabled children and young people to return home as soon as possible.
- All oncology patients went straight to the unit and bypassed the A&E department.
- All non-oncology patients were admitted via A&E.
- A relative told us that occasionally there were delays in admitting children and young people who were ventilated to a ward, as there were insufficient staff to be able to care for them safely.

Meeting people's individual needs

- Interpreting facilities were available. We observed a member of staff arranging access to a translation service to help them plan a child's end of life care with parents who did not speak English. The member of staff told us that the child's sibling spoke English. However, it had been identified that it was not appropriate for them to translate for the family. This was good practice.
- Accommodation for parents was provided on some, but not all ward areas – for example, pull-down beds were available on the oncology unit. Folding beds were available for use by parents.
- We spoke with a parent who told us they slept in their child's bed because of concerns about them falling out of bed, and the lack of a suitable high-sided bed that met the needs of children and young people with physical and/or learning disabilities.
- 81% of patients who wished to die at home died in their preferred location (13 patients) in 2013.
- All patients who wished to die in a hospice or in hospital died in their preferred location in 2013.
- 20% of patients had a rapid discharge in 2013 (24–28 hours).

Learning from complaints and concerns

- Complaints were handled in line with trust policy. Staff would direct people wishing to make a complaint to the Patient Advice and Liaison Service if they were unable to deal with concerns directly. They would be advised to make a formal complaint if their concerns remained.

Are palliative and end of life care services well-led?

Outstanding ☆

Palliative care and end of life services were led by a consultant who leads the development of children and young people's palliative care across the North West of England. There was clear evidence of leadership of the team and a vision for future development of the service.

Vision and strategy for this service

- We saw that the palliative care team had developed a strategy and business plan which described the service's vision and mission statement. The specialist palliative care team's mission was to deliver a "High quality, evidence-based, comprehensive service for children and young people and their families with cancer and other life-threatening or limiting illnesses".
- Members of the palliative and end of life care team felt there was a clear vision and care pathway for oncology patients which they could explain and share with others. The team were in the process of developing a similar clarity of vision for non-oncology pathways.
- Staff within the palliative care team were not aware of a non-executive director with lead responsibility for palliative and end of life care services at Alder Hey.

Governance, risk management and quality measurement

- The trust was assessed and achieved level 3 of the NHS Litigation Authority risk management standards in February 2010.
- Risks within the palliative and end of life care team were discussed regularly and escalated to senior staff where necessary.
- The palliative and end of life care team had strong links with the oncology team. We saw records of joint meetings between specialist nurses within the oncology and palliative care teams and their respective line managers. Staff told us that managers worked hard to ensure effective communications were in place.

Leadership of service

- The palliative care team led a range of national and regional education and training events.

Palliative and end of life care

- The consultant in palliative medicine provided leadership for the Cheshire Children's Palliative Care Zonal Network and chairs the North West Children's Palliative Care Network.
- The palliative care consultant also provided leadership for the development of care pathways for children and young people transitioning to the care of the adult services.

Culture within the service

- The team held supervision and development days to improve team working and communication and develop a shared vision and values.
- Information from a previous team development day described communications within the team as "open and honest".
- Staff reported high levels of job satisfaction.

Public and staff engagement

- The palliative care team have organised a family day for two years. Over 70 people attended the last event in October 2013. The day included an opportunity for siblings to discuss issues which affected them. There were opportunities for families to tell their stories about their child or young person. The team asked families for suggestions on how to improve the service. The feedback received included suggestions ranging from better facilities for teenagers to a dedicated pharmacy with shorter waiting times for dispensing prescriptions.

Innovation, improvement and sustainability

- The palliative care team had developed their service far beyond the boundaries of a service established originally to support children and young people with 'other life-threatening and life-limiting conditions'. This meant the palliative care team supported 11 other specialties in addition to supporting oncology patients.
- The majority of staff we spoke with outside of oncology were aware that the team provided palliative care support to other specialties and how to refer. This meant the palliative care team have made considerable progress in achieving their strategic goal of a clear pathway for non-oncology patients.
- The palliative care team had been awarded Investing in Children accreditation for the last two years. Alder Hey is the only NHS Trust in the country to have received this status.
- While we were visiting the service, we became aware that palliative care services in other trusts were seeking advice from the Alder Hey palliative care team.

Outpatients

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

Alder Hey Children's Hospital had outpatient clinics which covered a wide range of areas – for example, cardiac, ophthalmology and ear, nose and throat (ENT). The general outpatient area catered for a variety of specialisms, including orthopaedics, rheumatology and ophthalmology. The trust had more than 174,000 outpatient appointments in 2012/13.

We visited the general outpatient area, cardiac, ENT, audiology, rheumatology and fracture clinics. We spoke with nine patients and relatives and 14 staff, including nurses, healthcare assistants, medical staff, ward sister, administrators and receptionists. We observed care and treatment, and looked at care records. During our inspection, we reviewed performance information from, and about, the hospital.

Summary of findings

Children and young people received compassionate care and were treated with dignity and respect. Children and young people told us that staff were kind and supportive, and they felt fully involved in making decisions about their care. The outpatient areas we visited were clean and equipment was well-maintained.

Children and young people and staff told us that one of the biggest challenges was clinics running late and missing case records. Although there had been recent improvements, some staff, particularly in the general outpatient area, said they had not been listened to by management on key service changes and that outpatient services had not been a priority for the trust.

Outpatients

Are outpatients services safe?

Requires improvement

Overall, children and young people received safe and appropriate care in the department. The outpatient areas were clean and well-maintained and measures were taken to control and prevent infection. The outpatient department was adequately staffed and we noted that arrangements were in place for staff to complete their mandatory training.

We found there were issues regarding the management of systems for patient's records which could impact on the child or young person having to wait a long time while records were either being found or duplicated. However, during our visit to the ENT department, audiology and cardiology, instances of missing notes were referred to the clinician who either requested a duplicate or delayed seeing the patient until the appropriate notes arrived. We observed no instances of a child or young person being seen by a clinician without their notes. This concern had already been flagged as high risk on the monthly management meetings. We also noted there were no risk assessments in place which ensured the safety of children, young people and staff within the outpatient's environment.

Incidents

- Outpatient services had no recent Never Events (very serious, largely preventable patient safety incidents that should not occur if the relevant preventative measures have been put in place) reported between January 2013 and December 2013.
- The outpatients' service manager received a monthly clinical support incident report. We reviewed the report for April 2014 and noted that the 'impact' section varied from 'no harm/minor' and 'near miss' to one of 'major and/or permanent harm'. We noted that the risk governance team had identified a major risk to permanent harm from an incident reported on 17 April 2014. The major incident has been identified as a Serious Incident Requiring Investigation (SIRI) due to lack of tests requested and "no consultant had been involved in the diagnostic workup and clinical management". Based on this information, the incident was reported to the Strategic Executive Information System.
- Staff were confident and aware of how to report incidents and 'near misses.' Staff were supported by managers to do so and they reported incidents using an online system.
- We saw that staff had access to the online reporting system via password-protected computers. The trust-wide evidence provided showed us that the trust was reporting concerns through the National Reporting and Learning System (NRLS).
- The NRLS data provided between April 2013 and March 2014 indicated 11 serious incidents had occurred at the trust, although none were attributed to outpatients.
- However, we found there was no evidence that incidents were analysed for trends or that lessons learned shared with staff to prevent future avoidable incidents. The staff we spoke with said they were unaware of the results of incidents submitted and had not received any feedback. This was confirmed by management who said that this was an area which required improvement in this service.

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). During our visit to outpatients we found no safety information available or on display.

Cleanliness, infection control and hygiene

- All the outpatient areas we visited were found to be clean and tidy.
- Infection control practices were monitored through audits, and, where required, identified action plans were in place for staff to respond and record the outcomes.
- Staff followed the trust policy on infection control. Staff observed the hospital's 'bare arms below the elbow' policy. Personal protective clothing, such as gloves and aprons, were used by staff when required to deliver personal care to children and young people.
- Infection prevention and control policies and procedures were available and accessible to staff on the staff intranet.
- We observed in some clinics, children, young people and relatives not being encouraged by staff to use the hand gel prior to entering the units.

Outpatients

Environment and equipment

- Equipment in the department was regularly serviced, tested and appropriately cleaned.
- Resuscitation trolleys were located in, or close to, each outpatient area and regularly checked and maintained.
- The environment in the general outpatient was well-maintained, although we found during our observation of other areas (for example, ENT) that the environment was very hot with limited space available. A family member we spoke with said that the area was "boring" and "not easy to manage a child after five to 10 minutes waiting".
- Most people we spoke with liked the big screen television which identified the name of the person and the area to go to when they were due to be seen. The provider might find it useful to note that the screens were not visible from all seating areas. During our stay within outpatients, we noted that reception staff did not inform patients of this system and some people we spoke with found the system confusing.

Medicines

- The outpatients department did not store any medicines; written prescriptions were dealt with by the pharmacy department. Children, young people and/or their relatives had no issues or concerns with their medicines. One relative we spoke with said that staff had kindly gone to pharmacy and collected the medicines on their behalf which they found "very useful".

Records

- Medical records were regularly reported as missing by staff which impacted on children, young people, relatives and staff. We were informed that missing notes had resulted in many duplicated records being created. We observed missing medical records were regularly identified within the incident reports.
- On the day of our inspection, we visited the audiology clinic and enquired about missing medical records. Staff informed us there were six sets of notes missing which equated to 12% of records missing for the clinic. We observed staff constantly telephoning to chase. Staff said that it was "much better when we used to do it".
- The preparation of medical records was recently transferred to the records department who were in the process of scanning paper notes onto the electronic system. We spoke with the records manager who informed us they were aware of the issues with regard to missing records and provided us with their current action plan. Areas identified included: working with the clinics by making them more accountable for the return of records; additional 'trolley runs' between 5pm and 8pm to capture and identify trends regarding the non-return of records; ensuring that incident reports were completed to make the system more visible and to highlight areas of concern. At the time of our inspection, an audit had not been undertaken to analyse the percentage of shortfalls in case notes being delivered on time or of records that were fully completed.
- We reviewed quarter three data for 2013/14 compiled by the central booking unit for the health and safety committee. We identified gaps in compliance in relation to the outpatients department, for example, we found no risk assessments had been completed for the outpatients department and the report had actioned a completion date of February 2014 for compliance.
- On the day of our visit, we noted that the outpatients department's risk assessments had not been completed, and this was confirmed by managers working in the department. Examples of outstanding risk assessments included needle stick injuries (caused from used needles as well as work equipment), and use of the visual display unit computer screen that staff used to record and update data. The report also identified an insufficient number of risk assessors available across the central booking unit with no training available to replace staff who had left. Staff had also identified the need for refresher training and support from the health and safety team.

Consent

- Patients' consent was appropriately obtained. Staff knew they required consent to treatment from the young patient or an identified representative.
- All staff we spoke with were aware of the consent form that needed to be completed and confirmed that consent was obtained by the consultants when they were treating children and young people.
- Staff were confident and competent in seeking consent from children appropriately. Where children were too young or lacked capacity to give their consent, there were appropriate arrangements to ensure best interest decisions were made.

Outpatients

Safeguarding

- Staff we spoke with confirmed they were aware of their responsibilities to safeguard children and young people and to report any concerns which, if required, included the local authority which had responsibilities to investigate safeguarding matters.
- Staff we spoke with confirmed they had completed safeguarding training at level 1 for non-clinical staff. The training records provided identified that 53% of staff had completed their level 1 training and 42%of staff had completed their level 3 training.

Mandatory training

- In all the areas we visited, staff told us they were supported to complete their mandatory training which was a mixture of both e-learning and face-to-face sessions. Examples include manual handling, health and safety and infection control.
- Mandatory training was monitored for individual staff and other training was scheduled when required.
- Staff we spoke with said that they had either recently undertaken some mandatory training or they had identified sessions to complete their training schedules.

Management of deteriorating patients

- The hospital provided an outreach service, for example, ophthalmology, and dealing with diseases of the eyes. The outreach service was currently clinician-led with no input from the outpatients department. We were informed that, in the future, healthcare assistants from the outpatients department will provide support to the clinicians in the community, and this would enable the clinicians to deal with more complex cases.

Nursing staffing

- The manager informed us that there were no issues or concerns with regard to staffing levels within the outpatients department. There were three staff vacancies, and they were actively recruiting. Staff worked flexibly to ensure cover was provided within outpatients. The manager informed us that they were able to work flexibly to ensure clinics were appropriately staffed.

Medical staffing

- We spoke with a consultant cardiologist who informed us that they had "sufficient staff but could always do with more". They had recently received funding to recruit four further consultants but informed us that this did not have an impact on the clinic as there were "more than enough" trainees to support. The other units we visited, for example, audiology and rheumatology, confirmed they were at capacity.
- Management informed us they did not utilise the out-of-hours cover service and consultants gave sufficient notice for clinics to be cancelled and rescheduled appropriately.

Major incident awareness and training

- We reviewed the monthly clinical support incident report which was reviewed and discussed by the management team. The report outlined the impact to the service, the underlying cause, as well as the risk and governance team's comments. Staff said they had not received feedback or training with regard to major incidents, which may impact on the running of the service.

Are outpatients services effective?

Not sufficient evidence to rate

The outpatient units were able to demonstrate that children and young people who used this service received effective care and treatment by competent staff. There was good continuity of nursing staff and they received the support of specialist nurses.

Staff appraisals had been conducted annually, although we noted that staff had not received any clinical supervision. Multidisciplinary teams worked well together in some clinics to ensure coordinated care for children and young people, although there appeared to be some delays in arranging appointment times.

Evidence-based care and treatment

- We noted that all policies and procedures were accessible for staff via the intranet. We were informed that all changes in policies and procedures were identified and passed on to staff via e-mail.
- We noted there was a cardiac liaison facility available within the cardiac unit, as well as a family support group to cater to children and young people's needs. Staff at the cardiac unit informed us that they were able to draw on the services of the health play specialist from the ward when required.

Outpatients

- The cardiac unit were in the process of recruiting a volunteer to support play/waiting time. Staff said they were currently interviewing for the position. The appointed volunteer would support the unit and children and young people in the department by providing diversional activities.

Pain relief

- Children, young people and parents said that they had been dealt with efficiently and had received necessary pain relief, if required, after seeing the consultant. Relatives told us they picked the medicines up via the pharmacy department.

Patient outcomes

- Children, young people and relatives told us they had no issues with waiting times. One relative told us they did not mind waiting a long time to be seen as the "consultant did not rush you" and you were given "plenty of time".

Competent staff

- Staff told us they had received annual appraisals known as personal development reviews (PDRs). Records showed that PDRs had taken place and that staff were supported with their development and educational needs. The records identified all staff as having received an annual review.
- We noted that the next PDRs were scheduled to recommence in July 2014.
- The outpatients department were in the process of supporting healthcare assistants in cross-specialism knowledge so that they would be able to work in any clinic.
- Staff confirmed that they had not received clinical supervision, which was confirmed and identified by managers as outstanding.
- Staff completed a variety of competency exercises to assess their ability and review the effectiveness of the guidance provided. Examples included administration of eye drops, and the removal of wound closure materials. We saw evidence of staff attending training sessions in areas such as venipuncture (the collection of blood from a vein) and cannulation (involves putting a small plastic tube into a patient's vein for infusions).

Multidisciplinary working

- Within the cardiac clinic, staff told us they felt integrated and part of a team as they were invited to the multidisciplinary meetings which were held twice a week. Staff said that they found it very useful to reflect on how other specialist/departments worked.
- We saw good evidence of patient pathways within the units. A patient pathway is the route a child or young person will take from their first contact with a member of staff to the completion of their treatment. We saw the spinal pathway nurse interact with a young person in outpatients allaying their fears regarding a forthcoming operation.

Seven-day services

- The service operated five days each week with extra clinics held during the week if necessary.

Are outpatients services caring?

Good

Outpatient services were delivered by a hard-working, caring and compassionate staff. We observed that staff treated the children and young people with dignity and respect, and planned and delivered care in a way that took into account the wishes of the child or young person. The trust might find it useful to note that we were aware of young patients' personal information being disclosed on accessing the reception area of the outpatients department.

We found that staff were good at involving children, young people, family and friends in all aspects of their care and treatment.

Compassionate care

- Children, young people and relatives waiting at clinics were all very positive about the care provided by staff. One relative told us they "couldn't speak highly enough of the clinical care" provided and a young person said the "hospital is good" and the "doctors are nice".
- We observed staff speaking with children and young people respectfully and were open, caring and friendly in their approach.
- Staff listened to children, young people and relatives and responded positively to questions and requests for information.

Outpatients

- All staff spoke with pride about their work including those who were working in difficult circumstances.

Patient understanding and involvement

- Children, young people and relatives we spoke with said they felt they had been involved in decisions regarding their care and treatment.
- Information was given to them in a language they understood.
- The environment in the outpatients department did not allow for confidential conversations in reception areas and we observed patients' personal details being freely discussed by staff.
- The outpatient reception area had self-check-in monitors which enabled children and young people to confirm their details confidentially. However, we observed that the receptionist staff did not refer or promote the self-check-in system to patients or families. We also found that, should there be any changes to a child or young person's details; the self-check-in system was unable to complete the amendment which had to be done at reception. This was a source of frustration to both children and young people and their relatives who ended up at the back of a queue that they had tried to avoid in the first place by 'trying' new technology.

Emotional support

- Children, young people and relatives told us they had been supported when they had arrived at the service. They had been assisted to find the correct clinic and, when asked, informed of the waiting times.
- We observed staff responding and speaking very sensitively with a young person who was tearful and in pain. The staff member offered appropriate reassurance.
- Staff had good awareness of children and young people who may require a separate room should they display anxious or challenging behaviour during their visit to outpatients.
- Staff had not received training in conflict resolution which helps them support children and young people with challenging behaviour. The training plan identified that 45% of staff had completed this training.

Are outpatients services responsive?

Requires improvement

We noted that the outpatient cancellation dashboard was showing an improvement over the last year. We were unable to assess what benchmark the trust had used to justify the figures to ensure that it complied with the national average. The hospital had introduced a partial booking system which allowed patients to contact the hospital and choose an appointment date and time convenient to them. This was seen as a positive step in offering children, young people and their relative's choice. Some people who used the services commented that they appreciated this. There were, however, some negative aspects of this approach, and many relatives told they had problems or issues with accessing the hospital's appointment booking phone line.

Clinics were busy and, although the trust had a programme to reduce waiting times, some people told us that waiting times were variable. Relatives told us the usual waiting time was 30 to 45 minutes, but there had been occasions when they had waited up to three hours.

We found that there was a good system in place for requesting the presence of an interpreter, only to find that letters were sent out in English which caused delays. All written information/leaflets were also available in English only.

Service planning and delivery to meet the needs of local people

- The trust produced a 'dashboard graph' for April 2013 to April 2014 for children or young people who did not attend their appointments. The graph showed a percentage decrease from16% in April 2013 to 15% for April 2014. Medical and administrative staff told us it was trust policy that children and young people were referred back to their GP if they did not attend an appointment twice by their consultant or senior medical staff.
- We reviewed the central booking unit summary data for April 2014 which identified that the total available slots against total booked allowed a 120% planned utilisation rate. This took into account the number of patient

non-attendances and cancellations within 24 hours, which equated to an actual utilisation rate of 100%. This meant that the outpatients department was meeting its target.

- Children, young people and relatives told us they felt that appointment flexibility had been reduced by the introduction of the partial booking system. The partial booking system came into effect if patients needed an appointment after six weeks. The hospital would write three weeks prior to the appointment date and request the patient or relative to telephone to arrange an appointment which suits them. This allowed for choice and flexibility in their appointment date, and some said they had benefitted from this approach.
- Feedback from other children, young people and/or their relatives expressed frustration with the new system as they had problems getting through on the telephone and had to wait a long time, only to find the appointment date had been taken and they were placed back on to the booking system queue. One relative told us they felt frustrated and angry about the delay in seeing a consultant. Another relative said they had encountered these problems and said the "old system was much better" as you could "plan" for your appointment date. Managers we spoke with said that the timescales were in the process of being reviewed and that children and young people would receive written requests more than three weeks prior to the appointment date which was felt would address some of the issues raised.
- The manager of the call centre received a daily summary report which outlined the number of calls received and answered throughout the day. The report included the number of lost or unanswered calls. We looked at the number of lost calls, which ranged between 3% and 7%.
- We reviewed the outpatient cancellation dashboard for April 2013 to April 2014. The figures for April 2013 identified that the cancellation numbers were just under 5,000 but, as of April 2014, the figures had decreased to 3,000. We were informed that the system had initially had "teething problems" but it was now beginning to show an improvement with regard to outpatient cancellations.

Access and flow

- The trust had introduced an efficiency programme 18 months ago whereby clinics would be four hours in duration with a goal of 10-minute waiting time maximum. There were variances in staff's knowledge of the programme and, during our visit, we observed an average waiting time of 20 to 30 minutes. Children, young people and/or relatives we spoke with confirmed that waiting times were variable from 30 minutes to three hours.
- The trust had an 18-week referral to treatment time. This means that the waiting starts on the day the hospital receives the referral letter or on the day you make the booking for your first appointment. We reviewed the minutes of a meeting held in February 2014 to discuss the 18-week target. The minutes identified that the outpatient primary targeting list had "significantly improved for those children and young people waiting more than 18 weeks". This improvement was identified as the result of the new validation process which was created to meet the needs of service users.
- Referral to treatment times not being met was a particular problem for children and young people with gastroenterology problems.

Meeting people's individual needs

- We observed that children and young people's needs had been considered with regard to access and we found ramps strategically placed to support children and young people with mobility needs and families with pushchairs.
- There was a system for alerting staff to any special needs a child or young person had, including the need for an interpreter when the person's first language was not English. Request for interpreters at short notice could be arranged via a telephone. We were informed by staff, however, that any follow-up letters were sent out in English and that occasionally resulted in appointments beings missed or misunderstood.
- We noted that written information and patient leaflets were only available in English.
- One person we spoke with said that they had been referred to the speech and language therapist team in April 2014 but were currently waiting for the appointment and had been told the earliest would be August 2014.
- We observed that the play areas were variable within different units, with some having good play facilities (for example, play station consoles) while others had poor facilities (such as a few colouring pads and crayons).

Outpatients

- During out visit we found that the vending machine was not working properly and relatives were requested to go to the canteen for drinks, only to find there was not a staff member available to deal with their request. We also observed that there were no water facilities available for children and young people should they get thirsty while waiting for their appointment.

Learning from complaints and concerns

- Complaints were handled in line with trust policy. Staff would direct children, young people and/or their relatives to the Patient Advice and Liaison Service if they were unable to deal with concerns raised. They would be advised to make a formal complaint if their concerns remained.
- In all the areas we visited information on how to make a complaint was displayed.
- People told us that, if necessary, they would not hesitate to raise a concern.
- We reviewed the central booking unit's monthly complaints registered report for April 2014 received via the Patient Advice and Liaison Service. We found that the majority of complaints related to the booking system, loss of medical records and cancelled appointments.

Are outpatients services well-led?

Requires improvement

Although there had been recent improvements, many staff, particularly in the general outpatient area, said they had not been listened to about key service changes and that outpatients had not been a priority for the trust.

The trust had a vision in place and had developed some new values for the organisation, but staff expressed their concern that there was a lack of visibility of the trust executive management team. There was a mixed response from the staff regarding the move to the new hospital; some staff were unclear of their future after transition. Quality, risk and patients' experiences were not monitored consistently. There was an agreed vision and strategy for the movement of the outpatients department into the new hospital.

Vision and strategy for this service

- Staff we spoke with said they were unaware of the trust's vision and values.
- Staff said that they were aware of a review taking place regarding the outpatient services, but they did not always feel as though their views were taken into account.
- Most staff told us they felt well-supported at a local team level, although we identified some staff concerns about the management of a reorganisation that involved changes of job roles.

Governance, risk management and quality measurement

- Managers said that they felt the trust had now developed good governance arrangements with an ongoing audit trail.
- We noted there were monthly directorate meetings which covered/monitored children and young people's non-attendance and the response to booking times.
- Staff told us they were aware of the trust's whistleblowing and safeguarding policy and that they felt able to report incidents and raise concerns through these processes. The training records identified that training for safeguarding ranged between 41% and 52%. We noted that all staff had completed major incidents and complaints training.
- There were concerns noted with regard to risk assessments not having been completed which were identified within the central booking unit review for quarter three in the health and safety report. The report also identified that the outpatients department required additional training for staff to undertake this risk-assessment role.

Leadership of service

- Weekly management meetings took place. The feedback from these meetings was shared with staff.
- We noted inconsistencies with regard to staff team meetings, with some stating that they had regular 'huddle' (or updating) meetings, while others said they had not received any staff meeting minutes for a few months.
- Staff told us that they received annual appraisals (or PDRs) but had no clinical supervision.
- Some staff told us that they felt that staff morale was quite low and that there was a lack of visibility of senior trust leaders at frontline services. Most staff told us they felt well-supported at a local team level.

Outpatients

- We identified some staff concerns about the move to the new hospital. Some staff members said they were anxious as they were unsure of their deployment and whether the new hospital would have an impact on their working role. Others stated that they were looking forward to the transition to the new hospital.

Culture within the service

- Staff told us the service manager had an open door policy and they were able to discuss any issues or concerns they had.
- We found that staff were very loyal and flexible. Many staff members had worked for the trust for a number of years and were committed to providing a good service.
- There was an overwhelming view from staff that services worked so well due to the "goodwill" of staff.
- Staff coped well with the continual challenges within the service and demonstrated a commitment to address them.

Public and staff engagement

- We observed good interaction between children, young people, their relatives and staff. Staff were able to respond to the needs of children and young people visiting outpatients.
- We found good evidence of innovation with regard to patient feedback within audiology. They used a token system for young people to rate the service by placing the token in the appropriate area – for example, 'excellent', or 'poor'. We saw that the results were on display within the unit. It was noted that none of the other units used this system to capture patient feedback.
- We reviewed the monthly outpatient survey report for March and April 2014 and found that areas of concern included waiting times and parking facilities. Positive comments included "have always been impressed by staff" and the clinician "explained everything very clearly".

Innovation, improvement and sustainability

- The partial booking project showed early signs of improvement. This demonstrates the trust's commitment to addressing the issues that accompanied most innovative ideas, and also highlights the trust's commitment to translate innovation into sustained improvement for the benefit of people who use the services.

Outstanding practice and areas for improvement

Outstanding practice

Areas of good practice seen in this inspection:

- Alder Hey Hospital has a Gait Lab to assess children with neuromuscular disorders, such as cerebral palsy which is not available elsewhere in North West England. The service therefore receives referrals from all over the North West.
- Trust physiotherapists have linked with the community physiotherapists to provide appropriate postoperative care and a trust audit demonstrated that this has translated into improved outcomes for the children and young people.
- When babies were admitted to the NSU parents were taught correct hand washing techniques. Development of infection control safety cards for parents was currently being undertaken.
- The paediatric oncology unit has a ward based chef and kitchen that provides freshly prepared food for children and young people between 11am and 7pm.

Areas for improvement

Action the hospital MUST take to improve

- Continue to address staffing shortfalls. Nurse staffing levels must also be appropriate in all areas, without substantive staff feeling obligated to work excessive hours or additional shifts.
- Provide a longer-term solution for the medical leadership on the HDU.
- Ensure that children and young people who require one-to-one support in the isolation pods on the HDU receive it.
- Take action to ensure there are sufficient levels of nursing staff across the HDU.
- Continue to take action to ensure that clinical records are available in the outpatients department.
- Take action to ensure that nurses are following the trust's policy regarding the safe administration of medicines.
- Review the resuscitation equipment on each surgical ward to ensure that this meets the minimum equipment and drugs required for paediatric cardio-pulmonary resuscitation as outlined in the Resuscitation Council (UK) 2013 guidance.
- Address the shortfalls in governance and risk management systems.
- Improve the timely completion of investigation of incidents and Never Events (serious harm that is largely preventable) so that learning can be systematically applied to avoid recurrence.

Action the hospital SHOULD take to improve

- Review its pharmacy arrangements to improve support to wards out of hours and at weekends.
- Ensure that the A&E department clarifies its use of the observation ward as a CDU and make it clear to children and young people and their parents when they have been transferred to the CDU rather than being in A&E.
- Ensure the A&E department reviews its arrangements for providing food and drinks in the waiting areas, and make it clear that hot and cold drinks and food are available on request.
- Ensure that children, young people and their parents using A&E services are aware of the trust's complaints procedure and are supported in using it where necessary.
- Ensure there are sufficient cubicles within the hospital to isolate children and young people who may represent an infection risk to others.
- Consider changing open storage units to closed ones in the surgical wards to reduce the risk of cross-infection, especially in areas where clinical procedures take place, such as the treatment rooms.
- Consider removing the bin in the children's play area on Ward K3.

Outstanding practice and areas for improvement

- Consider reviewing the risk assessment for the fire escapes in the surgical wards to make sure they are secure enough to prevent children and young people leaving unnoticed and protect against people entering unobserved.
- Consider the provision of a dedicated health play specialist and psychology resource to the critical care areas.
- Ensure that the arrangements stated in the written assurances from the board received by the inspection chair on 22 May 2014 concerning the medical cover in HDU are monitored.
- Ensure that staff report incidents on the NSU.
- Ensure that staff effectively check and sign resuscitation equipment on the NSU.
- Ensure that drug charts are appropriately completed on the NSU.
- Review learning disability service provision to ascertain roles and responsibilities of both nurses and doctors for adolescents and young people in transition.
- Consider the Trust's overall strategy, board reporting mechanisms and leadership responsibilities related to transitional care.
- Take action to implement risk assessments in the outpatients department. The risk assessments would ensure the safety of children, young people, relatives and staff within the department.
- Ensure staff in the outpatients department have the opportunity to receive clinical supervision via a Trust wide model.
- Improve systems to ensure children and young people and their relatives and carers can make appointments in the outpatients department.
- Ensure letters sent to children and young people and their parents and carers are in the appropriate community language for those people who do not speak English as a first language.
- Ensure that staff in the outpatients department are effectively engaged in the development of the service.
- Improve staff engagement across all services and improve the visibility of the board and senior team.
- Provide a wider range of opportunities to listen to staff and respond in a timely way.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **How the regulation was not being met:** **The provider has not protected people by means of an effective operation of systems to identify, assess and manage risks relating to the health, welfare and safety of service users.** **Regulation 10(1) (b) and 10(2) (c) (i).**

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control **Regulation 12 (1)(a)(b)(c);12 (2)(a) and (c)(i)(ii)**

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment **How the regulation was not being met:** **The provider has not ensured that service users are protected from the use of unsafe equipment used for the purposes of resuscitation.** **Regulation 16 (1) (a).**

Regulated activity	Regulation

This section is primarily information for the provider

Compliance actions

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records How the regulation was not being met: The provider has not ensured that service users, in the out patients department, are protected against the risks of unsafe or inappropriate care and treatment arising from a lack of appropriate information about them being located promptly when required. Regulation 20 (2) (a).

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing How the regulation was not being met: The provider has not ensured that at all times there are sufficient numbers of sufficiently qualified, skilled and experienced persons employed for the purpose of carrying on the regulated activity. Regulation 22.