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 trust. 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 trust	Requires improvement
Are services at this trust safe?	Requires improvement
Are services at this trust effective?	Good
Are services at this trust caring?	Good
Are services at this trust responsive?	Requires improvement
Are services at this trust well-led?	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

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 the 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). Alder Hey Hospital has been inspected three times since its registration with CQC. The most recent inspection took place in December 2013. This was a responsive inspection focusing on the operating theatres as we had been made aware of concerns in this area. The inspection found that trust was not meeting the following essential standards:

- Care and welfare of people who use services
- Staffing
- Supporting workers
- Assessing and monitoring the quality of service provision.

The inspection took place between 20 and 22 May 2014, and an unannounced visit took place between 6am and 11am on Sunday 1 June 2014.

We followed up the outstanding compliance issues as part of this inspection.

Overall, this trust required improvement, although we rated it 'good' in terms of having effective and caring services.

Our key findings were as follows:
Nurse staffing

Nursing staff were caring and compassionate and treated children and young people with dignity and respect.

Staff were highly committed to giving children and young people a high standard of care and treatment. Nurse staffing levels on most wards within the medical division were calculated using a recognised dependency tool. However, some services had nursing vacancies. While the trust was actively recruiting to these vacancies, some areas did not provide the minimum staffing levels required, mainly at night. The trust had a system for escalating staffing shortages; however, requests for additional bank (overtime) or agency staff were not always filled, or were filled with staff that did not have the necessary expertise in a particular specialist area. When possible beds were closed to maintain safe staff to patient ratios, however, this was not always achievable in cases of unplanned absence and meant that there were times when wards were short staffed. This was a particular concern in the medical and surgical wards. The trust had already addressed the shortfall in the accident and emergency (A&E) department by providing an additional nurse for the night shift seven days per week.

Medical staffing

The hospital was staffed by highly skilled, competent and well-supervised doctors. Medical staff were universally committed to the care and treatment of children and young people. Consultants were present or accessible 24 hours a day and carried out daily ward rounds. Middle grade and junior doctors were on site 24 hours a day. However, the model of care in the high dependency unit (HDU) meant that there were clinical risks associated with a lack of overall medical leadership, clinical accountability and timely clinical decision making. 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 to the new hospital. However, we were not assured that the arrangements were always promoting the safety of children and young people on the unit and we requested that immediate remedial action be taken by the trust to mitigate the risks.

Summary of findings

On the unannounced visit, it was clear that immediate steps had been taken to improve the level of medical support on the HDU and an intensive care consultant had been allocated to the unit for 50% of their working time.

Patient mortality

The trust had a well-established mortality review process. The aims were for departments and services to undertake a mortality review within two months of the patient's death with a further review by the Hospital Mortality Review Group within four months to check the findings. The review did not always occur within the four-month timescale, largely due to clinical workloads. There were minimal variances in the findings. Both reviews identify any elements of the patient journey where harm and/or death was avoidable. Root cause analysis investigations are completed where this can add additional learning and action plans are generated and implemented.

Infection control

The hospital was clean throughout and there was good practice in the control and prevention of infection.

There had been positive changes made in the neonatal surgical unit (NSU) following an infection outbreak in 2013.

Staff applied good practice guidance, supported by training and dedicated staff for control of infection.

Some infection risks were related to the age and fabric relating to the 100-year-old hospital building. However, the trust was responding well to the challenge and managing the physical environment well until the planned move to a new hospital in 2015.

The hospital infection rates for Clostridium difficile (C.difficile) and MRSA infections were within an acceptable range for a hospital of this size.

Nutrition and hydration

There was a range of specialist support to ensure that children and young people's nutritional needs were met. Dietary and nutritional requirements were considered as part of the care planning process. Specialist support was available for a range of conditions, including children who had diabetes and coeliac disease.

The oncology unit had a designated chef onsite to support young people's nutritional needs.

On the NSU a dietician visited and reviewed all babies on a daily basis.

A new initiative on the NSU was 'Promoting transition to breastfeeding', a pathway for promoting breastfeeding and the health benefits for babies.

Fluid charts were completed, and recorded inputs and outputs. If babies were having total parenteral nutrition (nutrition administered intravenously) their daily weight was monitored to ensure that their nutritional and hydration needs were met.

Children and young people were complimentary overall about the food provided.

Improvements were required to ensure that food and drink was more readily available in the A&E department. There was a vending machine available for drinks and snacks, with a wider choice of food available in the canteen, however, children and young people (and their parents and carers) were reluctant to leave the department in case they missed their 'turn'. 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.

Nevertheless, there was no formal system to ensure that nutritional and hydration needs were met for children and their families waiting for long periods in the A&E department.

Medicines management

The trust had medicines governance and incident reporting structures. The policies and procedures for medicines handling were robust and the relevant guidelines were followed.

The pharmacy department provided a good service to most of the wards in the hospital but, due to staff shortages, could only provide a partial service to some wards. The staff shortages impacted on the ability of pharmacists to complete medicines reconciliation for each patient within the first 24 hours of their admission (recommended to reduce preventable medication errors).

Nurses and parents said there were no delays in children being discharged home as there was an effective system for ensuring that discharge medication was available in a

Summary of findings

timely manner. However, we observed that there were often delays with people being attended to by pharmacy staff when they had an outpatient's prescription to be dispensed.

Pharmacy staff undertook training and competency assessments prior to visiting wards to ensure their practice was safe.

A review of the drug charts on the wards showed that nurses were not following the trust's policy regarding the safe administration of medicines, which stated that two nurses must prepare and administer medicines to each child.

We found on two wards that nurses were not completing the records about the administration of medicines in line with NMC guidelines because they did not make an immediate record of the medicines administered. We saw that, on one of the wards, all medicines were signed for before any medication was given, and nurses told us this was usual practice.

Medicines were stored on the wards in lockable cupboards and fridges in dedicated clinical rooms. Entry to the rooms was by means of keypads. On a number of wards, we found that the fridges were unlocked. Nurses told us the key codes were not changed regularly, and we observed on one ward that people who were not authorised to have access to the room had access to the key code. This could allow unauthorised access which may lead to drug tampering.

Some medicines were not administered in accordance with safe medicine practice and there were no robust systems to ensure best practice. Interventions by pharmacists to improve patient safety were not reported as incidents and, unless they were deemed to be significant, no notes were made to support learning. We saw examples where had the Pharmacist not intervened then it would have resulted in an error. We saw that the pharmacist did not record the errors in patients' notes or in any communications with the ward staff or managers or doctors. Nurses told us that no discussions took place about errors that Pharmacists found on the patient's drug charts and that doctors were not formally informed of the changes made.

There was an incident reporting system in the trust and staff said they understood how and when to make reports. However, information received from the trust, together with our findings showed that incidents were under-reported, limiting the opportunity for learning and reducing the risk of harm.

We spoke with patients and their parents who all told us they were happy with the levels of information they had about their medicines and felt they understood what medicines were prescribed for and how to take them. However, only one parent told us that the side effects of the medication had been explained.

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 with a child protection plan.

Training records indicated that only 61% of staff across all divisions in the trust 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. This work should continue as a matter of priority so that all staff have received current training in identifying issues of abuse and neglect and are able to escalate their concerns appropriately.

Meeting the needs of young people

Managers and frontline staff were not aware of the Department of Health's 2011 standard 'You're Welcome' quality criteria for young people friendly health services. We were advised that the You're Welcome accreditation will be through the Healthy Liverpool Integrated Care Delivery (Children) programme.

New hospital plans identified a 75% single-room occupancy per ward with pull-out beds for families. The plans showed designated lounge areas for young people within ward settings.

Young people's groups had been actively involved in decision making on the future of the trust. Examples of these were the Children and Young People's Forum, medicines group and new hospital build group.

Summary of findings

As part of the new tender process, young people were invited to influence the decision of the final choice of hospital design.

We found excellent examples of evidence that young people were involved in the new build, which included choice of fabric and furnishings and challenging the choice of IT services.

The trust had a wide range of activities aimed at young people – for example, music, performing arts, and photography.

We identified that there was no trust lead to support young people with learning disabilities. We spoke with staff that were unclear on who coordinated services for young people with learning disabilities.

Young patient experience data was collected at the trust and reported to the board. This information demonstrated that children and young were happy with how they were treated by staff and included in decision making about their care. They also reported that they were less happy with information they received when they were discharged from hospital

Mandatory training

The trust has set itself a target of 90% compliance with all mandatory training. This has not been met in any identified mandatory training area. The highest rate of completion was fraud, complaints, infection control (non-clinical), health & safety and manual handling – all of which were 80% or above. Compliance below 80% was: fire – 70%; equality & diversity – 62%; information governance – 58%; infection control (non-clinical, clinical areas) – 69%; infection control (clinical) – 79%; resuscitation – 41%; practical manual handling – 30%; major incidents – 66%; conflict resolution – 41%; medicines management – 43%; transfusion e-learning – 69%.

Work to increase the levels of mandatory training should be a priority for the trust so that it can be assured that staff maintain their competency in these key areas.

We also found

- 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.
- The trust had a well-established mortality review process.
- In the surgical service, the recovery rates for children and young people were favourable when compared to similar hospitals.
- In the medical wards, care was planned and delivered in a way that took children and young people's wishes into account.
- Access to advice and information was good for children and young people, their families and carers, both during the hospital stay and after discharge.
- Some children and young people were concerned that they had to wait for long periods of time in the A&E department and did not always realise that they had been admitted to the observation unit.
- In the paediatric intensive care unit there was evidence of strong medical and nursing leadership.
- Strong professional nurse leadership on the HDU.
- The specialist palliative care team provided a safe, effective and responsive service to children and young people with life-limiting illness. 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 transitional services, we found examples of excellent pathways for young people transitioning to adult services with specific long-term health needs. However, we found that there was no overall responsibility or leadership for transitional services within the trust.
- In the outpatients department, there were concerns regarding long waiting times and the availability of case notes and records.

Summary of findings

We saw several areas of good practice, including:

- The medical division participated in research at local, national and international levels. The trust is the first Investing in Children accredited hospital in the UK.
- Alder Hey Children's Hospital has a gait laboratory to assess walking for 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 children and young people.
- The surgical department received a significant research grant to coordinate a national trial aimed at reducing the rate of infection following shunt operations for children with hydrocephalus (build-up of fluid on the brain). The results of this project will be used to produce good practice guidance to improve the care and treatment for children nationally and internationally.
- When babies were admitted to the NSU, parents were taught correct hand-washing techniques. The unit was developing infection control safety cards for parents.

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.
- 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.

Summary of findings

- 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

Background to Alder Hey Children's NHS Foundation Trust

Alder Hey Children's NHS Foundation 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. The hospital is a recognised Major Trauma Centre and is one of four national Children's Epilepsy Surgery Service centres.

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. A new Alder Hey Children's Hospital is currently being built adjacent to the existing site and is set to open in 2015. The new hospital will allow the trust to make a significant upgrade to the patient and family experience. Improvements will include:

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

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 in June 2013. The trust is a teaching hospital and supports 958 trainee doctors each year and 556 student nurses and allied health professionals. In addition 7,500 children and young people are involved in clinical trials each year.

The trust has an annual turnover of £194 million pounds.

The inspection team looked at 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, Care Quality Commission (CQC)

The inspection team had 41 members and 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.

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?

Summary of findings

- Is it well-led?

Before visiting the hospital, 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 NMC, the royal colleges and the local Healthwatch.

We held two focus groups in May 2014, supported by voluntary and community personnel 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 and Young People's Forum on Saturday 10 May 2014. This forum had been set up by the trust and 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 Alder Hey Children's 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 and carers, and reviewed their records of personal care and treatment.

We carried out an unannounced inspection between 6am and 11am on Sunday 1 June 2014. We looked at how the hospital was run out of hours, the numbers and skills 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.

What people who use the trust's services say

- Before the inspection we received large quantities of information via our website, by phone as well as emails from local people and staff. People told us they were concerned about inadequate staffing levels, particularly in the surgical department, A&E department and the HDU. People also raised infection control issues and concerns about the general care of children and young people, such as ensuring effective risk assessments were in place.
- We held two community focus groups that were run by Regional Voices for better health and Speak Out. There were 10 participants in total, representing the individual views of children and young people.
- We also attended the Children and Young People's Forum on Saturday 10 May 2014.

Summary of findings

The groups identified the following concerns and positive feedback:

- The quality of the food provided and access to drinks on the A&E department.
- Some staff use language that children and young people do not understand.
- Some staff only spoke to parents and did not involve children and young people.
- Some young people who have been treated for drug and alcohol misuse problems were not referred to the appropriate services for support in the community.
- Some staff could be moody and not considerate. Some staff were also sarcastic and underestimated the knowledge of young people to understand what was being said which made them feel like they were being lied to. Comment was made that domestic staff could be unkind, even when spoken to politely.
- Some children and young people who used a wheelchair felt they were pushed out of the way in corridors for other wheeled equipment.
- Some young people who had mental health requirements felt that staff did not always understand their needs.
- Positive experiences were shared about how kind and caring the staff were, and that the hospital was clean and hygienic. Some young people told us that doctors were very clear in explaining their care to them.

Other feedback about the trust

- The trust had 23 reviews on the NHS Choices website from children and young people and their parents and carers between February 2013 and April 2014. It scored 3 out of 5 stars overall. The highest ratings were for: compassionate, dedicated care from nursing staff and A&E staff; excellent communication between staff; and an attentive pain relief team. Treatment and procedures were discussed and explained to all parties involved. The lowest ratings were for: poor administration of intravenous medication; staff attitude; confidentiality breaches; poor hygiene standards; waiting times for x-rays and blood tests; inadequate medical care from doctors and nurses; cancellation of appointments and procedures; and lack of facilities and staff.
- Patient-led assessments of the care environment (known as PLACE) is a self-assessment undertaken by teams of NHS and independent healthcare staff and also the public and patients. In 2013, the trust scored between 79.02% and 96.54%.
- There were 32 comments on the trust's section of the Patient Opinion website; there is some overlap with the comments on the NHS Choices website. Comments included concerns regarding the booking system in the outpatient department. A number of positive comments were made about the high-quality care received.

Facts and data about this trust

Alder Hey Children's Hospital offers 20 specialist services, including a designated national centre for head and face surgery and a centre of excellence for children with cancer, heart, spinal and brain disease. 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 investigation into children's medicines, infections, inflammation and oncology. At any time there are over 100 clinical research studies taking place, ranging from observational studies to complex, interventional clinical trials. Around 7,500 children and young people are involved in clinical trials each year.

Alder Hey serves a catchment area of 7.5 million, with around 60,000 children seen in A&E each year. In addition to the hospital site at West Derby, Alder Hey has a presence at more than 40 community outreach sites and programmes and its consultants hold 800 clinic sessions each year from Cumbria to Shropshire, Wales and the Isle of Man to help and support care and treatment closer to home.

The trust provides 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.

Summary of findings

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

There are significantly high rates of children living in poverty, teenage pregnancy, smoking during pregnancy, alcohol stays for under 18s, drug misuse, alcohol-related harm and childhood obesity, and 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 addition to the team, joining the trust in June 2013. The trust is a teaching hospital and supports 958 trainee doctors each year and 556 student nurses and allied health professionals.

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe? Wards were not always adequately staffed to meet the needs of children and young people. This was a particular issue in both the medical and surgical wards. When possible beds were closed to maintain safe staff to patient ratios, however, this was not always achievable in cases of unplanned absence and meant that there were times when wards were short staffed. The medical cover in the HDU required improvement to ensure that all clinical risks were safely managed. The hospital was clean and there were good systems for the prevention and control of infection. The hospital infection rates were within an acceptable range for a trust of this size. In most clinical areas equipment was regularly checked and safe and ready for use. There was a system for reporting safeguarding concerns. This was supported by staff training, although the training required improvement. Staff did not always adhere to the trust's policy for the safe administration of medicines. Staff were supported to report clinical incidents, but there was not always robust evidence of learning and improvement from incidents to improve patient safety. However, incident reporting, feedback and learning had improved significantly in the theatre department.	**Requires improvement** 
Are services at this trust effective? National guidelines were used to treat children and young people. Appropriate care pathways were followed to support children and young people to speed up their recovery. Standards were monitored and outcomes were good when compared with other children's hospitals. Medical staff were highly motivated and innovative plans of care and treatment were in use in a range of specialities. Relevant guidance was used in planning and monitoring the effectiveness of care. Clinicians worked hard to evaluate and benchmark patient outcomes to ensure effective treatment for children and young people. Multidisciplinary teams worked well together and professionals respected and valued the contributions made by their colleagues. The effectiveness of the services provided by the trust compared well with other specialist children's hospitals.	**Good** 

Summary of findings

Are services at this trust caring?

Good

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.

All of the staff we spoke with were committed to providing children and young people with a service that met all their medical, nursing, emotional, psychological and spiritual needs. There were numerous examples of staff going the 'extra mile' to care for and treat children and young people in a highly personalised and sensitive way.

Parents and carers were also treated sensitively and compassionately. Information sharing was good and parents and carers were well-supported emotionally and psychologically to cope with difficult and highly stressful situations.

Parents, carers and children and young people were very complimentary about all staff and were positive about the support they received at the hospital and after discharge home.

Are services at this trust responsive?

Requires improvement

Overall, patients' needs were met in a timely way. The trust was meeting the national target for waiting times in A&E and referral to treatment times.

Medical staff provided clinics in Cumbria, Shropshire, Wales and the Isle of Man to support children and young people receiving care and treatment closer to home.

There were good systems to meet children and young people's individual care needs. There was good access to interpreter services for children and young people whose first language was not English.

The trust was experiencing some difficulties in outpatients in relation to booking and rearranging appointments. Parents and carers expressed dissatisfaction with the current booking system.

There were also concerns regarding the availability and provision of case records within the outpatients department that required targeted improvement work by the trust.

The current hospital building did not provide adequate provision of designated clinical and recreational space for young people. The trust moves to a new building in 2015 and plans suggest the environment will be more supportive to young people's needs.

Staff and parents told us that telephone access via the trust switchboard was poor. People we spoke with reported waits of up to 10 minutes for an answer and found this very frustrating.

Summary of findings

Are services at this trust well-led?

Requires improvement 

Staff were well-led and supported by their line managers.

Staff felt that the executive team remained remote, with the exception of the director of nursing who staff felt was visible, accessible and responsive, and the chief executive who had become more visible in recent months.

Many staff felt that the senior team did not listen, were unresponsive and that the focus was very much on the plans for the new hospital and not on addressing some long-term staffing issues and departmental pressures.

Although there were a number of initiatives to engage and encourage staff to influence service provision and help design the new hospital, a significant number of staff remained disengaged and uninformed. There was still work needed to engage and include staff in planning for the future. Although, morale had improved in theatres following targeted work by the senior team as a result of staff concerns.

Staff were proud of the work they did and there was a strong commitment to children and young people. However, there was limited evidence of an integrated organisation with staff working well as teams within the silo of their own service.

A great deal of work had been done with the clinical business units to determine how they will support the delivery of the quality aims and develop measures at trust and business unit level. Dashboards have been introduced for clinical business units and a regular quality report is presented to the Trust Board by the director of nursing.

However, governance and risk management systems still require improvement as do the completion of incident analysis. There was limited evidence of timely and systematic learning from incidents to support practice improvement and organisational learning.

Vision and strategy for this service

- There was evidence of the trust's vision and values displayed at ward and department level. The trust's ambitions to provide world-class services was understood and articulated by the senior team.
- Staff at the frontline were less engaged in the wider vision but were keen to develop and improve their own services.

Summary of findings

Governance, risk management and quality measurement

- The trust had a Clinical Quality Assurance Committee that reported to the Trust Board. The Clinical Quality Steering Group reported to this committee and received reports from the clinical business unit's governance and risk committees, in addition to the Clinical Development Evaluation Group, Children's Protection Group, Hospital Mortality Review Group, Infection Prevention and Control Group, weekly meeting of harm, Organ Donation Group, Transfusion Committee, Research Steering Group and the Resuscitation Committee. The clinical business units present their risk registers and any key risks to quality to the Clinical Quality Steering Group.
- We reviewed the corporate risk register. The risk register template and process was a standard workable format. However, the content of the register and actual management of the risks was poor.
- A number of examples were discussed with the Director of Corporate Affairs including a risk still on the register from 2008 with the only action recorded as having a target date in 2011.
- The trust had recognised the work needed to review the risk register and ensure the consistency of risk rating and the appropriate completion of all fields. It has sought professional help from a governance and risk consultant. We interviewed the consultant who articulated the plans to ensure that the trust improves its risk management in line with the timescales agreed for the Regulation 10 (assessing and monitoring the quality of service provision) compliance actions issued in December 2013.
- As this work was new, we were unable to assess the impact on the risk management systems at the time of our inspection.
- The trust had also commissioned an assessment against Monitor's Quality Governance Framework. The trust felt this was a useful piece of external work to inform its future governance arrangements. At the time of our inspection, the trust was waiting for the outcome of the assessment and anticipated a score of 5 following discussions with the auditors (a score 4 or below is required for aspirant foundation trusts). The director of corporate governance felt that this was a fair reflection of the work that the trust still has to do in terms of Quality Governance.
- Following the completion of fieldwork for the Quality Governance Framework review by KPMG, a final score of 4.5 was given to the Trust.

Summary of findings

- The Board Assurance Framework was changed in January 2014 following an internal audit in late 2013. The process and framework allow for the principal risks to achieving the trust's strategic objectives to be described and scored alongside control measures, assurance, gaps in controls and assurances and actions required. There is also a section for an update on progress for each risk.
- The majority of risks for 2013/14 did not meet the target risk score and have been carried forward into 2014/15; this is largely due to the framework refresh in January 2014.
- A useful summary of Board Assurance Framework risks was also introduced that provided a one-page overview of all risks, current and target risk ratings and the monthly trend. The Trust Board receives the Board Assurance Framework at every meeting with a 'deep-dive' report on a quarterly basis.
- The Trust Board did not appear to be fully informed of some of the areas we reviewed. For example, in relation to serious incidents, the 'Serious incident requiring investigation' report asks the Trust Board to 'note the progress made to achieve compliance with the 45-working-days investigation completion target' and to 'note the action taken and the new completion dates for completion of a root cause analysis where the 45-day target has not been achieved'.
- The report appendices have a column for 45-working-day compliance and root cause analysis that have not yet gone over the 45 days are recorded as having met this timescale, when the timescale is not actually due.
- We requested completed root cause analysis investigations for two serious incidents that should have had completed reports, as the Trust Board had been informed that they were compliant with the 45 working days. We were informed that the investigations were not yet completed.
- In February 2014, the trust reported a retained swab during a swab count following the closure of a patient following surgery. The account of this never event escalated to the Trust Board did not capture that a never event is largely preventable and should not happen. The minutes of the private section of the Trust Board on 4 March 2014 stated "Swab incident (not uncommon that swab count takes place after patient is closed); may need change in practice". This is not effective reporting of a never event.
- The quality aims for the trust have progressed since our last inspection in December 2013. In December, measures were in place for 'safety' but 'effectiveness' and 'experience' measures had not been agreed.

Summary of findings

- A great deal of work has been done with the Clinical Business Units to determine how they will support the delivery of the quality aims and develop measures at trust and business unit level. Performance dashboards have been introduced at clinical business unit level and a quality report is presented to the Trust Board by the director of nursing.

Leadership of service

- All the staff we spoke with were committed and proud to work at Alder Hey.
- Staff felt that, with the exception of the director of nursing and latterly the chief executive, the board remained remote from frontline staff.
- Other members of the board were less well-known and staff felt they would appreciate increased visibility of other senior colleagues, especially as the move to the new hospital came closer.
- Leadership at service level was very apparent. There were some strong and positive role models for staff in all of the services we inspected.
- Clinicians were active in developing and supporting improvements in their specialist fields.

Culture within the service

- The trust was working hard to embed a culture of openness and transparency
- There were opportunities to raise concerns via the 'raise it change it' campaign and the whistleblowing policy.
- Staff reported positive cultures within their own fields, with the exception of the porter staff group who felt that the proposed changes to the service had been managed badly, insensitively and in an oppressive way. We raised this with the trust at the time of our inspection.
- There was a sense of staff not feeling heard or listened to; this was supported by the comments received by the trust in its February 2014 'temperature check' with staff. The temperature check paper was sent to 210 staff, with a 37% response rate. The following comments are taken from the report:
- "I do not feel that staff are supported from a higher level"; "The trust is not listening to the real issues or tackling the big problems"; "Morale is very low"' "It's not the place, it's the management"; "The trust does not care for its staff or their opinions. [It's a] (paper exercise every time)".

Summary of findings

- The trust asked staff what the trust could do to make staff feel more valued. The most common response was “to listen to staff”. The paper presents the results and asks the Trust Board for ‘support for the process of managing and improving the results.’
- There is some information about what actions will be taken in response to the temperature check, such as to publish the results, break the results down further, and continue to undertake the temperature checks monthly. A communications plan was being developed and the clinical business units will be asked to produce local engagement plans once they have received their breakdowns. No timescales were reported for when these engagement plans or the communications plan will be in place.

Public and staff engagement

- There were focus groups and team meetings to increase the staff’s understanding of the trust’s ambitions for the services provided and regarding the service configuration in the new hospital.
- There were some excellent examples of public and patient engagement regarding service provision and the development of the new hospital site.
- The Alder Hey Children’s Charity had been launched and the Land of Remarkable People campaign was evident all over the hospital.
- Some staff remained disengaged and uninformed regarding the new hospital and were anxious about what the move meant for them and their roles.

Innovation, improvement and sustainability

- The trust provided many examples of innovation and research that were ongoing at the hospital. There were over 100 clinical research studies taking place, ranging from observational studies to complex, interventional clinical trials.
- The trust had identified medicines management and pressure ulcers as areas for improvement. The trust held two rapid improvement events in May 2014 to support education and learning in these two areas.
- The impact of this work was not yet evident at the time of our inspection.
- Staff in theatres were clear that the retained swab reported in February 2014 was a Never Event and able to talk about the immediate actions taken to prevent a recurrence. However, from a corporate perspective, the root cause analysis investigation was not yet completed (despite a completion date

of 23 April 2014 being reported to the Trust Board) and it was reported that the trust was in discussion with NHS England to determine whether the incident meets the classification of a Never Event.

- There were significant delays in completing root cause analysis investigations and these rarely met the 45 or 60 working day deadlines. For example, an incident categorised by the trust as a Near Miss Never Event was reported in December 2012 and had a third extension date of 31 March 2014. There were four incidents with investigations incomplete that had commenced over a year ago and a further six incidents between six and 12 months old. This has the potential to prevent root causes being identified and increases the risk of recurrence of the same or similar type of incident. We requested the root cause analysis report of the Never Event and a grade 4 pressure ulcer, which was reported in January 2014. Neither investigation had been completed.
- This level of performance and completion does not support timely improvement and systematic organisational learning.

Overview of ratings

Our ratings for Alder Hey Children's Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
A&E	Good	Not rated	Good	Good	Good	Good
Medical care	Requires improvement	Good	Good	Good	Good	Good
Surgery	Requires improvement	Good	Good	Good	Good	Good
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

Our ratings for Alder Hey Children's Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
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.

Outstanding practice and areas for improvement

Outstanding practice

We saw several areas of good practice, including:

- The medical division participated in research at local, national and international levels. The trust is the first Investing in Children accredited hospital in the UK.
- Alder Hey Children's Hospital has a gait laboratory to assess walking for 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.
- The surgical department has received a significant research grant to coordinate a national trial aimed at reducing the rate of infection following shunt operations for children with hydrocephalus. The results of this project will be used to produce good practice guidance to improve the care and treatment for children nationally and internationally.
- When babies were admitted to the NSU, parents were taught correct hand-washing techniques. The unit was developing infection control safety cards for parents.

Areas for improvement

Action the trust MUST take to improve

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.
- 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.

Outstanding practice and areas for improvement

- 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.

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
Assessment or medical treatment for persons detained under the Mental Health Act 1983 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
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines The registered person must protect service users against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines used for the purposes of the regulated activity. How the regulation was not being met: The provider had not ensured appropriate arrangements for the safe administration of medicines.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 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:

This section is primarily information for the provider

Compliance actions

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

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Surgical procedures

Treatment of disease, disorder or injury

Regulation

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.