Alder Hey Children’s NHS Foundation Trust

Evidence appendix

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This evidence appendix provides the supporting evidence that enabled us to come to our judgements of the quality of service provided by this trust. It is based on a combination of information provided to us by the trust, nationally available data, what we found when we inspected, and information given to us from patients, the public and other organisations. For a summary of our inspection findings, see the inspection report for this trust.

Facts and data about this 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 direct referrals from primary care as well as inpatient and community child and adolescent mental health services to support young people between the ages of 5 and 14 years. The trust is 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 hospital is the only national centre of excellence for childhood lupus and the only experimental arthritis treatment centre for children.

The hospital contains 270 inpatient beds, 48 of which are in intensive care, high dependency and the burns unit. In addition, there are 16 operating theatres, including 12 for inpatient use and four for day surgery. The theatre suite has integrated operating theatres. Seventy-five percent of the beds are single occupancy with en-suite facilities, climate control and strip lighting for the child or young person to control. Each room contains a sofa bed so that parents are able to stay with their child.

Inpatient rooms offer natural light and many have views of the park. There are separate, dedicated areas, including outdoor space for children and young people on each ward. This allows children and young people to socialise, play and relax. In addition, there is a kitchen situated on every ward.
with a ward based chef to ensure that each child is given a freshly prepared, healthy meal of their choice.

There is a research and education centre built alongside the hospital which is being extended. The work of this centre will involve partnership working with a local university and will allow researchers to develop safer, better medicines for use with children, infection, inflammation and oncology.

**Hospital sites at the trust**

A list of the sites at the trust is below:

<table>
<thead>
<tr>
<th>Name of hospital site</th>
<th>Address</th>
<th>Details of any specialist services provided at the site</th>
<th>Geographic area served</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Hospital Alder Hey Children's NHS Foundation Trust</td>
<td>Eaton Road Liverpool L12 2AP</td>
<td>Outpatients, Emergency Department, Surgery, Diagnostics, Medical care (including older people's care), End of life care, Children, Young People and Families</td>
<td>Liverpool</td>
</tr>
<tr>
<td>3TC House</td>
<td>16 Crosby Rd N, Waterloo, Liverpool L22 0NY</td>
<td>Community mental health services for children and young people.</td>
<td>Merseyside</td>
</tr>
<tr>
<td>Alder Park (Dewi Jones Unit)</td>
<td>Park Road Waterloo Liverpool L22 3XE.</td>
<td>Child and adolescent mental health wards</td>
<td>Liverpool</td>
</tr>
<tr>
<td>Community Ophthalmology, Breeze Hill Neighbourhood Health Centre</td>
<td>1 Rice Ln, Liverpool L9 1AD</td>
<td>Children, Young People and Families</td>
<td>L9 area of Liverpool</td>
</tr>
<tr>
<td>Everton Clinic</td>
<td>Sefton Community Paediatric Continence, 45 Everton Road, Everton, Liverpool, Merseyside, L6 2EH</td>
<td>CHS - Children, Young People and Families</td>
<td>Merseyside</td>
</tr>
<tr>
<td>Formby Clinic</td>
<td>Philips Lane, Formby, Liverpool L37 4AY</td>
<td>CHS - Children, Young People and Families</td>
<td>Merseyside L37</td>
</tr>
<tr>
<td>South Sefton Community Physiotherapy</td>
<td>Westway, Maghull, Liverpool L31 0DJ</td>
<td>CHS - Children, Young People and Families</td>
<td>Maghull Town</td>
</tr>
<tr>
<td>May Logan Centre</td>
<td>Community Ophthalmology, 294 Knowsley Rd, Bootle L20 5DQ</td>
<td>CHS - Children, Young People and Families</td>
<td>Sefton</td>
</tr>
<tr>
<td>-----------------------</td>
<td>-------------------------------------------------------------</td>
<td>-------------------------------------------</td>
<td>--------</td>
</tr>
<tr>
<td>The Sterrix Centre</td>
<td>South Sefton Community Physiotherapy, Sterrix Lane Litherland Liverpool L21 0DA</td>
<td>CHS - Children, Young People and Families</td>
<td>South Sefton Community</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Sites)
Is this organisation well-led?

Leadership
The trust had a stable executive leadership team. This included a chairman and a chief executive officer who were supported by a team of nine executive and six non-executive directors. There was a leadership strategy in place which was being refreshed in 2018 with a focus on values based leadership at all levels.

There was a genuine commitment to be a clinically led organisation. The trust had added the divisional clinical directors for medicine, surgery and community services to the executive team. All clinical directors attended board meetings on a regular basis. This was part of the devolved governance strategy which had been in place for the last 18 months. Devolved governance meant that clinical directors were empowered to set their own divisions up in a way that they thought would work best.

Board Members
Of the executive board members at the trust, there were no British Minority Ethnic and 50.0% were female.

Of the non-executive board members 14.0% were British Minority Ethnic and 57.0% were female.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>BME %</th>
<th>Female %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive directors</td>
<td>0.0%</td>
<td>50.0%</td>
</tr>
<tr>
<td>Non-executive directors</td>
<td>14.0%</td>
<td>57.0%</td>
</tr>
<tr>
<td>All board members</td>
<td>6.0%</td>
<td>53.0%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Board Diversity)

The executive team, particularly the CEO, Chairman and medical director were highly regarded within the trust. Without exception, all the executive and non-executive leaders we spoke with reported relationships were very positive and they functioned well as a team.

All directors had a portfolio of executive responsibilities which they were accountable for. For example, the medical director was accountable for the trust’s clinical strategy while the director of strategy was accountable for strategic service development. We reviewed minutes for a variety of meetings that were held across the trust and found that directors had regularly attended meetings where their areas of accountability had been discussed.

Board meetings were held in public every month. Private Sessions of the board were only held to discuss matters of a commercially sensitive nature. We observed one trust board meeting during the inspection. There was a clear agenda for this and we observed a limited amount of discussion and challenge to the presentations given.
While all directors had clear areas of accountability, a small number of directors had large portfolios. This meant that there was a potential risk that oversight of all areas would not be maintained. To mitigate this risk, the trust had appointed a number of associate directors to provide assurance in key areas such as safeguarding, risk management and infection control. A number of executive responsibilities had been delegated to members of the divisional management teams. This included complaints management and patient experience. Members of the management team informed us that they sometimes felt under pressure to maintain oversight of these areas due to this being a combined role with their divisional management responsibilities and as a result they felt that they were not always fully effective.

The trust had an operational structure which comprised of 3 divisions; medicine, surgery and community services. Each division was led by a triumvirate leadership team, comprising of a clinical director, a senior doctor and a senior nurse. The divisional leaders told us they felt very well supported by the executive team. The divisional structure was designed to give accountability to clinical leaders and worked on a principle of earned autonomy. We met with the divisional directors during the inspection and they told us there was excellent collaboration between the divisions.

The executive team were aware of the importance of the visibility of senior and middle management teams. Executive and non-executive directors had a programme of visits to clinical areas. We saw evidence of dates when visits had taken place together with future dates for visits. The non-executive directors were able to give us examples of when they had highlighted issues during their ward visits and then followed these through to ensure action had been taken.

Managers and leaders, we spoke with told us they tried to maintain visibility in clinical areas. Some staff in clinical areas confirmed they had seen the board members on walk arounds and we also observed executives in clinical areas during the inspection.

The chief pharmacist led pharmacy services. The medication safety officer role was shared equally between a nurse and a pharmacist. This provided a positive relationship with staff at ward and department level. There was a direct accountability from the chief pharmacist to the medical director.

The trust was meeting the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014). This regulation ensures that directors of NHS providers are fit and proper to carry out this important role.

The trust had a fit and proper person’s procedure for all non-executive and executive directors. This was contained in the recruitment and selection policy and had been reviewed since the last inspection and was approved in June 2017. We reviewed the personnel files for all executive and non-executive directors and found these all to be compliant with the regulation. This was an improvement from our last inspection.

We saw evidence of members of the executive team receiving an annual appraisal. We reviewed a sample of these, finding that they had all been completed within the last 12 months. Individual appraisals included key areas of success and development needs, as well as actions to make improvements to skills and knowledge when needed.
Members of the executive team had access to a small number of leadership courses. Some members of the team confirmed that they had taken part in these. The trust had developed an internal leadership development programme. This was still in draft format at the time of inspection. The trust recognised clinical leadership development was an area which needed further development.

Succession planning was a strategic priority for the trust board. There was a succession plan in place which identified the current position relating to board and executive team members and development plans where required.

The trust had recently commissioned an external review of leadership and governance within the organisation, which was in draft format at the time of the inspection. This had met the recommendation from NHS Improvement (developmental reviews of leadership and governance using the well-led framework) for all trusts to have an external review of their leadership and governance every three to five years. We were informed by members of the executive team that the review had identified areas of good practice as well as areas that could be improved in the future.

**Vision and strategy**

The trust had a vision which was to develop a healthier future for children and young people. The values were respect, excellence, innovation, openness together. The vision was underpinned by four strategies as well as operational and business plans.

The inspiring quality strategy for 2016-2021 was discussed by the board in February 2018. The improvement plan had 3 aims; children and families first every time, no preventable harms or deaths and outstanding clinical outcomes for children.

The operational plan for 2018-2019 which underpinned the strategy consisted of improved experience for children and families in outpatient services as well as improving the experience for staff, increase in day case activity and improving length of stay in critical care and the high dependency unit.

On reviewing minutes from executive led meetings as well as board of directors’ meetings there was limited evidence of how performance against the overall quality strategy was measured and reviewed as a whole throughout the year. However, we noted that there were elements of each aim in the strategy that were reported through executive led committees as individual items. For example, an infection prevention control report was submitted quarterly for review. This linked to the aim of patients not coming to harm while in the care of the trust. An annual report of key achievements against these aims was also documented in the trust’s annual quality accounts report.

We were informed by members of the executive team that the strategies were currently being refreshed and there was a plan to measure outcomes against these through a programme management approach. A programme management approach is a process of managing projects or areas of work with the intention of improving an organisations performance.

The trust had recently held a strategy day to allow other team members to be involved in developing the quality strategy which was attended by senior managers only this far. We were told there was a plan to open this up to include all staffing groups to allow leaders to consult with staff.
Each division had their own vision and strategy underpinned by operational plans. These were aligned with the overall trust vision and strategy. Not all of the specialities in the divisions had been fully engaged with this process and there were some strategies still to be developed. For example, diagnostic services did not have an internal vision or strategy or operational plan.

There were a number of other improvement strategies for different areas across the trust in place, for example for learning disabilities, pharmacy services, finance and estates.

The trust was actively involved in the sustainability and transformation plan (STP) and as part of the health and care partnership for Cheshire and Merseyside. The Chief Executive Officer (CEO) had been the chair of the STP although this role had now passed to another CEO.

**Culture**

Without exception, all staff who we spoke with during the inspection were proud and passionate about their work. There was a strong commitment to delivering the best care for children and young people throughout the organisation. Members of the executive team were extremely focused on providing the best outcomes for children and young people and were also passionate about giving children and young people a voice within the wider health and social care system.

During the inspection of the core services we saw examples of staff providing excellent care to children, young people and their families/carers. Children and their families received care that was compassionate. During the inspection we heard examples of care which was outstanding and rated the critical care and end of life core services as outstanding in the caring domain.

The trust had a staff recognition scheme known as Alder Hey Stars Values Award which recognised staff who had made a difference to the lives our patients and families. Nominations were accepted from the public, patients, families and staff. An award ceremony was organised every year for all shortlisted candidates.

The trust had an up to date policy for the duty of candour. The duty of candour is a legal duty on hospital trusts to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. The duty of candour aims to help patients receive accurate truthful information from health providers.

The trust policy detailed the requirements of the duty of candour which we found to be in line with the requirements of the Health and Social Care Act 2008. It highlighted the responsibilities of staff as well as the circumstances and time periods in which the duty of candour must be applied. The policy stated that when a notifiable incident had occurred, the patient or family must be informed within 10 days of it happening and a formal letter must be sent at the earliest possible opportunity.

Members of the senior management team who we spoke with had an understanding of the duty of candour requirement and demonstrated an open and honest approach in the application of this. During our core service inspections, we found staff understood the requirements of the duty of candour and of the importance of being open with patients and their families/carers.

The trust had reported a total of 29 incidents when the duty of candour had been required between January 2017 and January 2018. Records indicated that a letter had been sent to the patient or family on 24 of these occasions.

We reviewed a random sample of nine incidents when the duty of candour had been required. We found that on seven of the nine occasions there was no documented evidence the patient or the family had been notified within 10 days of it happening.
In addition, we found that in two of the nine incidents, the trust had withheld the application of the duty of candour. We were informed by members of the executive team that this had been done on compassionate grounds as they did not feel it was appropriate to notify families of the incidents due to sensitive circumstances. Whilst we could see the decisions had been made in the best interests of the families involved, the monthly serious incident report to the board did not contain information on the numbers of incidents where families had not been informed in line with the requirements of the duty of candour. This meant there were no opportunities for the board to discuss, challenge or monitor this.

In addition, we had concerns that the senior management and executive team did not always have oversight of all notifiable incidents which required the duty of candour to be applied. This was because reports demonstrating compliance with the trust policy and the Health and Social Care Act 2008 in relation to duty of candour were limited to when serious incidents had occurred. This meant that there was no evidence of oversight for all other incidents which had required the application of Duty of Candour.

The trust had an up to date whistleblowing policy and had appointed a freedom to speak up guardian in 2015. The role of the freedom to speak up guardian was created following the Sir Robert Francis Enquiry into the failings at Mid Staffordshire and was implemented with the aim of creating a more open and honest culture in NHS organisations. All trusts were required to have a guardian in place from October 2016. The trust had complied with this requirement and the role of the freedom to speak up guardian was undertaken by a non-executive director. In addition, the freedom to speak up guardian was supported by six freedom to speak up champions across the trust. We were informed that four of the champions had been involved in external training to undertake the role effectively.

On speaking with staff throughout the trust we noted not all staff we spoke with were aware of the trusts freedom to speak up guardian. In addition to the freedom to speak up guardian, there were other ways for staff to speak up about any concerns they had. We did not find any evidence during out inspection that staff didn’t feel able to speak up.

Records indicated that there had been a total of six concerns raised with freedom to speak up guardians in 2017. On reviewing the records of these we found that it was unclear what actions had been taken by the freedom to speak up guardian apart from that a number of these concerns had been raised directly with the executive team. In addition, it was also unclear if there had been any learning arising from these.

We were told during the inspection that there were no current plans to measure the effectiveness of the freedom to speak up guardian role and that there were no formal plans to make improvements to how the role was undertaken. However, a document was provided following the inspection which highlighted actions to improve the service.

There was an equality, diversity and human rights policy in place. This met the requirements that had been in place since 2010.

As part of this inspection, we reviewed the trust’s implementation of the workforce race equality standard and its approach to equality and diversity. The workforce race equality standard is a mandatory requirement for NHS organisations to identify and publish progress against nine indicators of workforce equality to review whether employees from black and minority ethnic backgrounds have equal access to career opportunities, receive fair treatment in the workplace and to improve black and minority ethnic board representation.

**Workforce race equality standard**
The scores presented below are the un-weighted question level score for question Q17b and un-weighted scores for Key Findings 25, 26, and 21, split between white, black and minority ethnic staff, as required for the workforce race equality standard.

Note that for question 17b, the percentage featured is that of “yes” responses to the question. Key finding and question numbers have changed since 2014.

In order to preserve the anonymity of individual staff, a score is replaced with a dash if the staff group in question contributed fewer than 11 responses to that score.

Of the four questions above, two questions showed a statistically significant difference in score between White and BME staff:

KF21. Percentage of staff believing that the trust provides equal opportunities for career progression or promotion

Q17b. In the last 12 months have you personally experienced discrimination at work from a manager / team leader or other colleagues?

(Source: NHS Staff Survey 2016)

The trust had a published document for workforce race equality standard for August 2017. We saw evidence of a draft action plan that had been developed as a result of this. We reviewed the action plan, noting that it had highlighted the person responsible actions and the timeframes for completion. The trust acknowledged that there was a need to increase the ethnic diversity of the executive board.

The board had agreed that the need to improve the diversity of the workforce overall was a strategic risk and this appeared on the board assurance framework for 2017/2018. This risk had remained static since 2016/2017. There was no specific action to improve the ethnic diversity of the executive board on the board assurance framework or in the workforce race equality standards action plan.
**Staff Diversity**

The trust provided the following breakdowns of medical and dental and nursing and midwifery staff by Ethnic group:

<table>
<thead>
<tr>
<th>Ethnic group</th>
<th>Medical and dental staff (%)</th>
<th>Nursing and midwifery staff (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>57.1%</td>
<td>92.5%</td>
</tr>
<tr>
<td>Mixed</td>
<td>1.8%</td>
<td>0.9%</td>
</tr>
<tr>
<td>Asian</td>
<td>25.6%</td>
<td>2.2%</td>
</tr>
<tr>
<td>Black</td>
<td>1.2%</td>
<td>0.6%</td>
</tr>
<tr>
<td>Chinese</td>
<td>0.6%</td>
<td>0.1%</td>
</tr>
<tr>
<td>Other</td>
<td>4.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Unknown / Not Stated</td>
<td>9.3%</td>
<td>3.7%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Diversity)

The trust operated a black and ethnic minority network as well as a disability network. We found that the terms of reference for both groups had been recently approved. The networks gave staff the opportunity to provide advice on key priorities for the development and delivery of training programmes, share best practice, and provided opportunities for the trust to engage with black and ethnic minority groups in the community.
**NHS Staff Survey 2016 – results better than average of acute trusts**

The trust has one key finding that exceeded the average for similar trusts in the 2016 NHS Staff Survey:

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of staff reporting errors, near misses or incidents witnessed in the last month</td>
<td>96%</td>
<td>92%</td>
</tr>
</tbody>
</table>

**NHS Staff Survey 2016 – results worse than average of acute trusts**

The trust had 21 key findings worse than the average for similar trusts in the 2016 NHS Staff Survey:

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality of appraisals</td>
<td>2.77</td>
<td>3.18</td>
</tr>
<tr>
<td>Quality of non-mandatory training, learning or development</td>
<td>3.97</td>
<td>4.07</td>
</tr>
<tr>
<td>Recognition and value of staff by managers and the organisation</td>
<td>3.27</td>
<td>3.54</td>
</tr>
<tr>
<td>Staff satisfaction with level of responsibility and involvement</td>
<td>3.79</td>
<td>3.94</td>
</tr>
<tr>
<td>Response Rate %</td>
<td>39%</td>
<td>48%</td>
</tr>
<tr>
<td>Effective team working</td>
<td>3.66</td>
<td>3.82</td>
</tr>
<tr>
<td>Support from immediate managers</td>
<td>3.58</td>
<td>3.79</td>
</tr>
<tr>
<td>Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month</td>
<td>36%</td>
<td>28%</td>
</tr>
<tr>
<td>Fairness and effectiveness of procedures for reporting errors, near misses and incidents</td>
<td>3.60</td>
<td>3.84</td>
</tr>
<tr>
<td>Effective use of patient / service user feedback</td>
<td>3.46</td>
<td>3.83</td>
</tr>
<tr>
<td>Percentage of staff/colleagues reporting most recent experience of harassment, bullying or abuse</td>
<td>41%</td>
<td>45%</td>
</tr>
<tr>
<td>Percentage of staff/colleagues reporting most recent experience of violence</td>
<td>53%</td>
<td>68%</td>
</tr>
<tr>
<td>Staff confidence and security in reporting unsafe clinical practice</td>
<td>3.50</td>
<td>3.76</td>
</tr>
<tr>
<td>Staff confidence and security in reporting unsafe clinical practice</td>
<td>61%</td>
<td>56%</td>
</tr>
<tr>
<td>Percentage of staff reporting good communication between senior management and staff</td>
<td>24%</td>
<td>37%</td>
</tr>
<tr>
<td>Percentage of staff able to contribute towards improvements at work</td>
<td>64%</td>
<td>74%</td>
</tr>
<tr>
<td>Staff motivation at work</td>
<td>3.76</td>
<td>3.95</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td>------</td>
<td>------</td>
</tr>
<tr>
<td>Percentage believing that trust provides equal opportunities for career progression or promotion</td>
<td>81%</td>
<td>86%</td>
</tr>
<tr>
<td>Overall Engagement Score</td>
<td>3.70</td>
<td>3.94</td>
</tr>
<tr>
<td>Staff satisfaction with resourcing and support</td>
<td>3.22</td>
<td>3.45</td>
</tr>
<tr>
<td>Organisation and management interest in and action on health and wellbeing</td>
<td>3.39</td>
<td>3.7</td>
</tr>
</tbody>
</table>

(Source: NHS Staff Survey 2016)

The trust had responded to the results of the 2016 staff survey and had an action plan in place. Although the data outlined above is for the 2016 Staff Survey, at the time of our inspection, the 2017 results were made available to the trust. The results were reported to the trust board in January 2018 and showed a marked improvement, providing evidence that action the trust had taken to respond to the 2016 survey had been effective.

Results indicated that the response rate had increased significantly, from 39% in 2016 to 54% in 2017, this was an 11% increase in the response rate. We also noted that the responses across a number of key areas had significantly improved. For example, I would recommend my organisation as a place to work’ had increased from 53% to 64% - an 11% increase from 2016. There were just two scores which had seen a deterioration; the % of staff reporting errors, near misses or incidents witnessed in the last month was down from 95% to 91%, and staff personally experiencing physical violence at work from patients/service users increased from 7% to 9%.

**Friends and Family test**

The Friends and Family Test was launched in April 2013. It asks people who use services whether they would recommend the services they have used, giving the opportunity to feedback on their experiences of care and treatment.

The trust scored about the same as the England average for recommending the trust as a place to receive care from December 2016 to November 2017.
(Source: Friends and Family Test)
Sickness absence rates

The trust’s sickness absence levels from September 2016 to August 2017 were higher than the England average.

(Source: NHS Digital)

The overall cumulative Trust sickness absence rate for the year to date has been relatively stable at around 4.6%-4.7%, just above the Trust target of 4.5%.

Sickness absence was discussed at every Board meeting as part of the People Update, and members were fully sighted on trends and hotspots. Absence was also discussed at every Workforce and OD Committee (WOD). The trust was in the process of undertaking a detailed review of the trusts sickness absence policy, process and supporting mechanisms, in partnership with managers and Trade Unions. The aim of this was to bring sickness absence rates down to at least the national benchmarked levels of 4%.

The top three recorded reasons for sickness absence were Anxiety/stress/depression/other psychiatric illnesses, Cold, cough, flu and Influenza and, Musculoskeletal problems. The underlying issues of these were the key priority of the trust. A number of supporting interventions for managing staff stress and resilience and enhancing wellbeing were in place, for example, a Health Trainor had been appointed who delivered mindfulness and stress awareness training. The trust had also appointed a clinical/organisational phycologist who was helping the trust develop their approach to wellbeing.

General Medical Council – National Training Scheme Survey

In the 2016 General Medical Council Survey the trust did not provide enough data for their performance to be assessed.

(Source: General Medical Council National Training Scheme Survey)
Governance

The trust had implemented a model of devolved governance. There was a governance structure in place to assure the board of directors about the standard of care that was provided. There were a number of steering groups in place, which the divisional leads reported in to on a monthly basis. However, on reviewing the terms of reference for these, it was sometimes unclear as to how performance from all three divisions was being reviewed.

For example, the heads of quality from all three divisions fed into the clinical quality steering group. When we reviewed four sets of monthly meetings for this, we were unable to find any evidence of divisional reports or quality performance dashboards being discussed and challenged. We were therefore unclear if all areas of concern were being escalated to the clinical quality assurance committee and subsequently, to the board of directors when needed. This issue had been identified in our last inspection and had not been improved.

We noted that updated terms of reference, dated February 2018, had been produced which detailed the importance of the steering group in seeking assurance from all three divisions on a monthly basis through a number of different metrics including reports and dashboards.

It was unclear as to how some groups reported in to the executive led committees. For example, there was a weekly meeting of harm where incidents across all divisions were discussed. However, we did not see any evidence of outcomes and actions from these meetings feeding into any of the executive led committees so that learning could be shared and monitored.

The trust had work plans for all executive led meetings, including the board of directors meeting. These plans detailed the agenda items that each meeting was to receive on a month by month basis. Agendas included topics which were included every month, as well as others which were included more infrequently.

All executive led meetings were chaired by a non-executive director and a number of executives also had membership in each meeting. We reviewed minutes for all executive led meetings, finding that the required members had attended on a regular basis.

The drug and therapeutics committee was partly formed by both the medicine management and optimisation committee along with the medicines safety committee which was chaired by the pharmacy clinical safety manager. The trust was also part to the pan Mersey area prescribing committee. The trust had seen benefit from the split medicine safety officer role which is equally shared between a nurse and a pharmacist. We were told that the number of incident reports had increased from 700 to 1200 with a decreased Level in harm from 18% to 3%. However, we could find no recorded evidence of this. Part of the medical safety officer role is to improve reporting and learning of medication error incidents in the organisation.

The trust was very committed to research, in fact, one of its aims was to provide “Game changing research and innovation.” The board had established a research, education and innovation committee as a full board assurance committee in recognition of the strategic importance of these areas of activity for the trust. All research was governed by the EU clinical trial directive, UK ethics committees and the trusts clinical research business unit who carried out safety and quality checks to provide organisational permission. This mechanism ensured oversight of every research study.
in the organisation. International research, education and innovation were one of the Trust’s four strategic pillars of excellence and as such had full support of the board of directors.

The trust was a member of Liverpool Health Partners which was a consortium of seven hospitals, the University of Liverpool and the Liverpool School of Tropical Medicine who worked together to provide an environment for research and health education across a regional footprint.

There were over 350 members of clinical staff who participated in research approved by the research ethics committee at Alder Hey during the financial year 2016/17. These included consultants, nurse specialists, pharmacists, scientists, clinical support staff and research nurses from across all clinical business units. Several of the trust consultants had been commended on their contribution to research and the trust was acknowledged by the National Institute for Health Research Clinical Research Network as one of the top performing trusts.

Management of risk, issues and performance

The trust had a risk management strategy in place to manage risk across the trust. This outlined roles and responsibilities of the specific committees, groups and individuals working to ensure patients were safe from avoidable harm.

The trust had an executive lead for risk management. They were supported by an associate director of nursing and governance as well as a risk management team. We were informed by the senior management team that although progress had been made in managing risk throughout the trust, there were still areas for improvement.

All senior managers, executives and non-executives were able to articulate what the main organisational risks were. We saw evidence that these had been identified on the appropriate risk registers.

Risk was managed through the board assurance framework as well as corporate and divisional risk registers. The risk management strategy highlighted at what level risks should be managed. However, we were unclear whether risks were being managed in line with the risk management strategy. This was because the system used for scoring risk in the integrated governance committee was different to what was stated in the risk management strategy.

Board assurance Framework

The trust provided their Board Assurance Framework, which details four strategic objectives within each and accompanying risks. A summary of these is below:

- Delivery of outstanding care
- Sustainability through external partnerships
- Strong foundations and the best people doing their best work
- Game-changing research and Innovation

(Source: Trust Board Assurance Framework)

We reviewed the board assurance framework and noted it outlined the risk description, existing controls, and evidence of assurances, gaps in controls and assurances as well as actions to
reduce the risk. It also showed the progress on actions and the current risk score together with the target risk score; however, it did not identify the cause or consequence of the risk.

All risks were aligned to the strategic objectives and there was a clear balance of risks between quality, performance and finance. There were executive leads identified for each of the risks. There was evidence from committee meeting papers that risks on the board assurance framework were discussed and reviewed; however, further work was needed to ensure the BAF was fully integrated into the work of the committees.

The board assurance framework had been reviewed by the trust's internal auditors in March 2017. This was to assess the approach of how the board assurance framework was used. The audit showed that the structure met all of the NHS requirements and reflected the risks that were discussed at the board of directors' meetings.

The trust provided a document detailing their 11 highest profile risks. Each of these have a current risk score of 3-1 or higher.

<table>
<thead>
<tr>
<th>ID</th>
<th>Date risk opened</th>
<th>Risk Title</th>
<th>Description</th>
<th>Risk score (current)</th>
<th>Risk level (target)</th>
<th>Last review date</th>
</tr>
</thead>
<tbody>
<tr>
<td>BAF 1.1</td>
<td></td>
<td>Maintain care quality in a cost constrained environment</td>
<td>Failure to maintain appropriate levels of care quality in a cost constrained environment</td>
<td>4-2</td>
<td>4-2</td>
<td></td>
</tr>
<tr>
<td>BAF 1.2</td>
<td></td>
<td>Mandatory &amp; compliance standard</td>
<td>Failure to deliver on all mandatory and compliance standards due to lack of engagement with internal throughput plans and targets</td>
<td>5-1</td>
<td>3-1</td>
<td></td>
</tr>
<tr>
<td>BAF 2.2</td>
<td></td>
<td>Failure to fully realise the Trust's Vision for the Park</td>
<td>Failure to fully realise the Trust's vision for the Park and campus, in partnership with the local community and other key stakeholders as a legacy for future generations</td>
<td>4-3</td>
<td>4-2</td>
<td></td>
</tr>
<tr>
<td>BAF 2.3</td>
<td></td>
<td>IT Strategic Development</td>
<td>Failure to deliver an IM&amp;T Strategy which will place Alder Hey at the forefront of technological advancement in paediatric healthcare</td>
<td>3-4</td>
<td>3-3</td>
<td></td>
</tr>
<tr>
<td>BAF 2.4</td>
<td>Financial Environment</td>
<td>Failure to deliver Trust control total and Risk rating</td>
<td>5-4</td>
<td>4-4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BAF 3.2</td>
<td>Business Development and Growth</td>
<td>Risk to business development/growth due to NHS financial environment and constraints on internal infrastructure to deliver business as usual as well as maximise growth opportunities</td>
<td>4-3</td>
<td>4-2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BAF 3.3</td>
<td>Developing the Paediatric Service Offer</td>
<td>Failure to maximise opportunities with regard to service reconfiguration and potential loss of accreditation of key specialist services</td>
<td>4-3</td>
<td>4-2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BAF 4.1</td>
<td>Workforce Sustainability &amp; Capability</td>
<td>Failure to always have the right people, with the right skills and knowledge, in the right place, at the right time</td>
<td>4-3</td>
<td>4-2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BAF 4.2</td>
<td>Staff Engagement</td>
<td>Failure to improve workforce engagement which impacts upon operational performance and achievement of strategic aims</td>
<td>3-3</td>
<td>3-2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BAF 4.3</td>
<td>Workforce Diversity &amp; Inclusion</td>
<td>Failure to proactively develop a future workforce that reflects the diversity of the local population</td>
<td>3-3</td>
<td>3-1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BAF 5.1</td>
<td>Research, Education &amp; Innovation</td>
<td>Failure to develop a cohesive approach to research, innovation &amp; education.</td>
<td>4-2</td>
<td>4-1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Source: Board assurance framework)

All of the divisions had a risk register. In addition, the trust had an integrated governance and a corporate risk register. The executive team told us risk management was an area which needed
more development. We looked at the Integrated Governance and Corporate risk register report dated November 2017 which showed 23% or risks did not have actions to mitigate the risk and 18% did not record the controls. We also reviewed minutes from the February 2018 integrated governance committee meeting, finding that that there were a high number of risks with no actions or overdue actions across each division. There was no specific recommendation or action identified in the report to ensure all risks had actions.

We noted that the trust had made improvements with the management of sepsis across the trust, which we highlighted as a concern during our last inspection. This had been managed on the risk register and a steering group had been implemented to make required improvements. The steering group for sepsis had been given new responsibilities as the sepsis pathway had been implemented across the trust.

We reviewed minutes of meetings across all services, including steering groups and executive led committees. We found that on most occasions an action log had been produced to make improvements and address issues where needed. We saw that actions from previous meetings were reviewed at the next.

On reviewing board and committee papers, not all actions identified in the minutes included a timeframe for completion. For example, when reviewing minutes from the clinical development evaluation group, an action identified in 2016 was still not completed in the minutes from the October 2017 meeting. This was the same on the action log for the hospital mortality review group where the majority of actions were marked as soon as possible and an action from 2016 was only completed in July 2017.

Service specific and divisional dashboards were presented to an executive led group on a monthly basis. This included compliance with quality, operational and financial targets. On review of these, we noted that there had been continual non-compliance in some areas across a number of months. For example, on reviewing performance dashboards for February 2018 for the division of surgery, we found that there had been some areas of poor compliance with infection control. When we reviewed the associated minutes, there was no documented evidence of poor performance being challenged or actions taken to make improvements.

We also reviewed other minutes from divisional meetings, operation board meetings as well as board of directors’ meetings and were unable to find documented evidence of discussion, challenge or more importantly actions to make improvements in a timely manner. However, staff informed us that poor performance was challenged during all of these meetings.

The trust had struggled to recruit a substantive director of infection prevention control and the medical director was currently covering this role as well as undertaking normal duties. An annual report for infection prevention control had been completed for 2016 / 2017. This stated that 53% of the objectives had been fully completed, 34% had been actioned but not completed and 13% had not been achieved.

There were up to date policies for adult and children safeguarding. We saw that the safeguarding team regularly reviewed compliance with safeguarding policies and procedures so that further improvements could be made when required. We found that action plans had been implemented to make further improvements. The safeguarding team produced an annual report which had been presented at the clinical quality assurance committee as well as the board of directors meeting.

The safeguarding team had implemented an action plan following review of the Lampard Recommendations in 2017. This identified areas that were not fully compliant and timeframes had been set to implement improvements.
The trust had an audit plan for 2016 / 2017 to monitor and improve services across the organisation. This included submissions to national audits which enabled services to compare their performance against similar services throughout the country. Examples of audits completed included the paediatric intensive care network audit as well as the management of asthma in the emergency department. We requested an updated plan for 2018/19, however, this was not provided for us to review.

Care and treatment was evidence-based and the policies and procedures, assessment tools and pathways followed recognisable and approved guidelines such as the National Institute for Health and Care Excellence. The trust reported that they were not compliant with three relevant National Institute for Health and Care Excellence guidelines and where they were partially complaint there were action plans in place to make improvements.

Finances Overview

The trust's financial performance has been consistently strong. The surplus was a control total and therefore excluded grants. The scale of grants was demonstrated in the budget information submission, and largely related to charitable grants for equipment or external grants for buildings.

There was a solid track record of financial delivery, delivering surplus and generating cash reserves to invest in high quality clinical services. The trust over delivered the control total in the financial year 2016/17 (£3.6m surplus) and was on track to deliver the control total in the financial year 2017/18. The Trust had demonstrable evidence of delivery, the Alder Hey in the Park business case was delivered on time and on budget.

Financial metrics

<table>
<thead>
<tr>
<th>Financial metrics</th>
<th>Historical Data</th>
<th>Projections</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Previous financial year (2 years ago)</td>
<td>Last financial year</td>
</tr>
<tr>
<td>Income</td>
<td>£201,685</td>
<td>£219,888</td>
</tr>
<tr>
<td>Surplus (deficit)</td>
<td>-£4,477</td>
<td>£3,530</td>
</tr>
<tr>
<td>Full costs</td>
<td>£206,162</td>
<td>£216,358</td>
</tr>
<tr>
<td>Budget</td>
<td>-£2,700</td>
<td>-£240</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Finances Overview tab)

From October 2016 the trust was monitored on NHS Improvement’s new ‘Use of Resources’ measure, replacing the financial metrics used by Monitor under the Risk Assessment Framework. NHS Improvement uses the metrics to assess financial performance by scoring each metric from 1 (best) to 4 (worst). In the financial year ending 31 March 2017, the trust had achieved an overall rating of two which was better than the planned rating of three.

The trust complied with the cost allocated and charging requirements set out in HM Treasury and Office of Public Sector Information guidance and followed the NHS costing manual and best
practice guidance published by NHS Improvement. The finance department worked with all departments to appropriately allocate expenditure to services and patients.

The trust had an audit committee which met regularly during the year. This committee reviewed and discussed finance performance and resources, information management, freedom of information requests and the annual report and account. The trust also had in place a Treasury Management Policy which was last approved by the audit committee in May 2017.

The trust also had a resources and business development committee which also discussed and reviewed financial performance. We reviewed the minutes of these meetings and saw evidence of a financial performance report being discussed.

Financial risks for services were on the risk registers with actions identified to mitigate the risks. Risks to the trust financial sustainability were reflected on the board assurance framework. Failure to maintain appropriate levels of care quality in a cost constrained environment had been identified as a risk.

Leaders were very engaged with financial management. They recognised they had been through financial instability and sustainability and intended to focus on this over the next two to three years. Senior managers meet every Monday as a finance stability group.

**Information management**

The trust produced large amounts of information about quality and sustainability. This information was gathered through a number of different sources including monthly dashboards and annual reports. The trust was aware of its performance through the use of key performance indicators as well as other metrics. These fed into the board assurance framework and the corporate risk register.

All information was fed through a number of divisional meetings, steering groups and executive led committees before providing oversight of performance at board of directors’ meetings. We saw evidence of an annual work plan for all executive led meetings, finding that a variety of information was due to be presented and scrutinised at different times of the year.

However, when we reviewed minutes from all executive led meetings, including from the board of directors’ meetings, we found that there was a lack of documentation which evidenced how this information was used to drive improvement.

The trust used a number of electronic systems across all services. This included an electronic patient records system. We were informed that there had been a number of problems with the design of this and that it had not always been matched to the need of the services that used it. For example, the system had not always supported audits being completed. As a result, information from the electronic system had to be gathered manually. The information technology team were working collaboratively with clinicians across the trust to make further improvements to this system.

We found that there were services provided by the trust where electronic systems had not yet been integrated with the rest of the hospital. For example, in community services a separate electronic system was used and information was unable to be shared between the two systems. In addition, there were a small number of locations in community services were access to electronic systems was unavailable the majority of the time and staff were reliant on paper records. This meant that there was an increased risk that not all patient information would be shared in a timely manner.
We raised concerns in our last inspection about the trust not keeping an accurate record of compliance with mandatory and role specific training. We found that the trust had put actions in place and had made improvements with being able to provide more accurate data.

There was an intranet site available to all staff allowing important information such as policies and procedures to be easily accessible.

The trust had identified a senior information risk owner (the person who is accountable for all information assets), a caldicott guardian (the person who is responsible for patient confidentiality and information sharing issues) as well as an information governance manager. We were informed that there had been no breaches of information governance in the last 12 months.

An external audit of information governance had recently been completed. The trust was waiting for the results of this at the time of inspection.

We were informed that there was a lead for cyber security and that a number of routine measures had been taken on a regular basis to protect information security. This included regular downtime and changing passwords used to access electronic systems on a regular basis.

The trust was taking part in a global digital exemplar programme. This is a programme that has been developed by NHS England to encourage several trusts nationally to become exemplars in the use of digital systems and to help spread best practice and innovation to other providers.

There was an ongoing three-year project to digitise over 40 care pathways. We were informed that nine of these would be operational by March 2018.

The trust had an automated Omnicell medication storage system which was available in all ward areas. This provided an audit trail for stock held at ward level. There was involvement by the pharmacy team with global digital excellence programme. However, we noted that the paediatric intensive care unit database was out of date. This had been identified on the risk register and actions were in place to make improvements.

Engagement

Communication systems such as the intranet, newsletters and bulletins were in place to ensure staff, patients and carers had access to up to date information about the work of the trust and the services they used.

The trust had a children and young people’s forum which meet every two months and was well supported by staff from the hospital. The forum was established in 2009 and met in three groups: children (7-11yrs); young people (11-18yrs); and a parents/carers group. We found that the number of members who had taken part in this group had continually increased. The forum participated in hospital projects and represented patients’ views, concerns ideas and experience. They had been involved in formal consultations on projects.

The forum also linked into external group participation in promoting opportunities for young people for personal self-development. This was demonstrated in research project work with the Royal College of Paediatrics and Child Health patient groups.

The young people’s group has participated in focus groups for several senior staff recruitment, including the appointment to a non-executive director.

Several parents and members of the young people’s group supported the PLACE inspection of food, wards and departments. The PLACE assessment is designed to focus on the areas which patients say matter by encouraging and facilitating the involvement of patients, the public and other bodies with an interest in healthcare. They assess how trusts are performing in relation to patient experience of care, cleanliness, as well as the condition, appearance and maintenance of
healthcare premises, the extent to which the environment supports the delivery of care with privacy and dignity, and the quality and availability of food and drink.

This link between patient experience and clinical effectiveness had been recognised as a key area of focus for the financial year 2017/18 as ‘increase engagement of children, young people and families in improving quality and developing services’.

Since 2016 the trust had put in place ‘listening into action’ events. These focussed around staff empowerment and positive change. These were used to identify issues and bring together people in the same room and work together on a solution. Examples included developing a child and adolescent mental health self-referral service and a cardiac surgical pathway.

Improving staff engagement and staff satisfaction remained a priority for the board. In addition to the staff survey, the trust undertook a monthly questionnaire called the ‘temperature check’ to measure staff engagement which included the ‘staff friends and family’ questions. As discussed earlier in this report, the staff engagement score in the 2017 staff survey had significantly improved.

Pharmacy services had not yet achieved patient or carer representation at the pharmacy committee meetings, however, there was positive junior doctor engagement. The medicine safety officers produced several directorate medicines safety newsletters, an example being the junior doctors prescribing newsletters which had improved engagement with doctors.

The trust held annual staff awards called ‘the star awards’. These awards were given to staff that went the extra mile. These included living our values, volunteer of the year and delivery of outstanding care.

The trust had over 400 volunteers who had all the appropriate checks carried out. The activities they were involved in included guiding people to their appointment, to arts and crafts activities within different departments such as the emergency department and helping children to pass the time and put them at ease. We saw a number of these during the inspection and were well received by patient, the public and staff.

As a foundation trust the board engaged with its members. The trust ensured that the council of governors and membership reflected the social and cultural mix of the population it served. Throughout the membership activities the trust provided opportunity to become an engaged member. A number of mechanisms were used including regular newsletters, email bulletins and social media for feedback. They also held an annual general meeting.

We met with members of the board of governors during the inspection and they told us they felt very engaged with the trust and were kept informed and sighted on key risks for the organisation. Staff governors were very positive about the role and felt the executive leaders listened to them. The chair of the council of governors told us they were able to comply with their statutory roles.

Governors were invited to attend the trust board and executive committees but we noted that invitation was not taken up which did limit opportunities to hold the trust board to account.

**Learning, continuous improvement and innovation**

The trust was amongst the best performers for patient safety incident reporting and there was a positive culture of reporting clinical and non-clinical incidents. Records indicated that they were within the top 25% of highest reporters when compared against 19 other specialist trusts nationally.
There was evidence of learning from incidents in services. For example, following a number of incidents the trust had commissioned human factors training. Human factors training in healthcare enhances clinical performance through an understanding of the effects of teamwork, tasks, equipment, workspace, culture and organisation on human behaviour in clinical settings.

The trust had established a weekly meeting of harm to ensure trends and lessons learnt were being identified to improve patient safety. This had continued since the last inspection. This was attended by senior managers from wards and other service areas such as pharmacy. After the weekly meeting a poster summarising the key lessons learnt following full investigation was shared across the wards and departments. We also saw evidence of action logs which highlighted actions to be taken to reduce the risk of similar incidents reoccurring.

Between January 2017 and January 2018, the trust had reported a total of 12 serious incidents and one ‘never event’. Never events are serious incidents that are entirely preventable as guidance or safety recommendations providing strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Each never event has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of specific incident occurrence for that incident to be categorised as a never event.

We noted that in August 2017 there had been an incident that had occurred but here was no evidence that this had been reported in line with the NHS Serious Incident Framework. This meant that a full investigation in line with national guidance had not been undertaken. However, when we spoke with senior managers, we were informed that there had been some learning from this incident.

There was evidence of learning across the trust from serious incidents. However, we had concerns that this had not always been done in a timely manner. This was because we reviewed all serious incidents that had happened during this period, we found that only five out of 12 incidents had been reported in line with trust policy and national guidance. These ranged between four and 14 days and one was not reported until three and half months later. The trust incident policy outlined that all incidents should be reported within 24 hours and the NHS England Serious Incident Framework (2015) states that all serious incidents should be reported within 48 hours of the incident happening.

The NHS England Serious Incident Framework (2015) also states that following a serious incident, an initial investigation should be completed within 72 hours of the event happening. We found that this had been completed on only five out of 12 occasions due to the delay in recognising serious incidents in a timely manner. The completion of 72-hour reviews were important as an initial investigation would potentially reduce the risk of a similar incident happening again while a full investigation was being undertaken.

However, we did note that the trust had made improvements following our last inspection by implementing a formal 72-hour review process which all staff were required to complete following a serious incident occurring. The trust’s incident management policy had been updated to reflect this. We also found that 72-hour reviews had been completed within 72 hours of each incident being identified which indicated improvements had been made.

We saw evidence that a full root cause analysis had been completed for all serious incidents that had been reported. There was evidence in all cases that thorough investigations had been undertaken and clear actions for improvement to reduce the risk of similar incidents happening again had been clearly documented, along with a person responsible and a date for completion.
However, we noted that in all 12 cases, the investigations had taken longer than 60 days which is the recommended time period for an investigation to be completed. The trust had identified this as an area for improvement.

The executive team had oversight of all serious incidents. We saw evidence that an overview of all serious incidents had been presented at board meetings on a monthly basis.

The trust had a hospital mortality review policy which had been put in place since the last inspection. This was previously a guideline. The policy outlined how the trust would meet the national guidance on learning from deaths which was launched in March 2017 by NHS England.

Mortality reviews were undertaken to look at any learning that could be implemented to help minimise the risks of any future unavoidable deaths. Senior staff told us that each department had its own mortality and morbidity review meetings. Learning from these meetings was cascaded to services.

Between January 2017 and December 2017, 71% of deaths had been reviewed within two months by services. This had been a slight decline since the last inspection where 88% had been reviewed within two months. The hospital mortality review group had reviewed 67% of deaths within four months and 86% within six months. This was a marked improvement from the last inspection were only 2% were being reviewed within four months. The trust target was 100% reviewed within four months.

The trust had benchmarked itself with other children’s hospitals for the hospital mortality standardised mortality ratio. Between August 2016 and July 2017, they were the same as the majority of the peer group. The hospital standardised mortality ratio is an indicator of healthcare quality that measures whether the number of deaths in hospital is higher or lower than expected.

The trust had an up to date complaints policy which was available to all staff on the intranet. This provided clear information about the complaints process and outlined how to raise informal concerns as well as formal complaints.

The executive team had oversight of complaints through quarterly reports that were discussed at both clinical quality assurance meetings and trust board meetings. We reviewed a sample of minutes from these meetings finding that the quarterly report had been noted as planned. There was no evidence discussion or challenge.

Patients and relatives were actively encouraged to raise concerns. The trust had made sure that the patient advice and liaison service was located in an area of the hospital that was visible and easily accessible.

**Number of formal complaints made to the trust**

The trust received 77 formal complaints from November 2016 to October 2017. The Medical Care core service received the most complaints with 35.

<table>
<thead>
<tr>
<th>Core Service</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical care (including older people’s care)</td>
<td>35</td>
<td>45%</td>
</tr>
<tr>
<td>Surgery</td>
<td>27</td>
<td>35%</td>
</tr>
<tr>
<td>Urgent and emergency services</td>
<td>2</td>
<td>3%</td>
</tr>
<tr>
<td>Children, Young People and Families</td>
<td>6</td>
<td>8%</td>
</tr>
<tr>
<td>Specialist community mental health services for children and young people.</td>
<td>5</td>
<td>6%</td>
</tr>
</tbody>
</table>
Complaints process overview

The trust was asked to comment on their targets for responding to complaints and current performance against these targets for the last 12 months.

<table>
<thead>
<tr>
<th>Question</th>
<th>In days</th>
<th>Current performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is your internal target for responding to complaints?</td>
<td>3</td>
<td>28 – Same day 15 – 1 day 1 – 2 days 5 – 3 days 1 – 5 days 2 – 9 days</td>
</tr>
<tr>
<td>What is your target for completing a complaint</td>
<td>25 (negotiable with complainant)</td>
<td>10 out of agreed timeframe</td>
</tr>
<tr>
<td>Number of complaints resolved without formal process in the last 12 months?</td>
<td>1,293</td>
<td>30/11/2016 - 30/11/2017</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Complaints Process Overview)

When complaints had been received, they were given to the appropriate division for further investigation.

We reviewed a sample of ten formal complaints that had been received in the last 12 months, finding that the trust had acknowledged all ten complaints within three days and that all completed investigations had been quality checked by a member of the executive team prior to a formal response being sent.

However, there had been five occasions when there was no documented evidence of the trust informing the complainant that the time taken to investigate the complaint was to exceed the 25-working day target. This was not in line with trust policy. We also noted that compliance with this was not monitored in the complaints report. This meant that there was a potential risk that members of the senior management team did not always have oversight of this.

We were informed that the main reason for poor compliance in finalising complaint investigations in the agreed time period was due to a combination of capacity issues at divisional level and that some cases were of a complex nature. This had been acknowledged by the trust as an area for improvement and there were plans to address this.

Details of the Parliamentary Health Service Ombudsman were given as part of the final response sent. The Parliamentary Health Service Ombudsman is an independent adjudicator who makes final decisions on complaints which have not been resolved as part of the formal complaints process. This was an improvement from the last inspection.

Two complaints had been handled by the Parliamentary Health Service Ombudsman in the last 12 months. We were informed that action plans had been developed for learning against these and had been allocated to the appropriate divisions for completion. However, when we requested
evidence of these having been completed, no further information was provided by the trust. This meant that we were unsure whether actions from these had been implemented and whether any improvements had been made.

The chief pharmacist was proud of the joint medication safety officer role and the collaborative working was having a positive impact on service delivery. The pharmacy team had received awards during 2017. This included the neonatal and paediatric pharmacist group for the best student oral presentation and also the North-West post graduate clinical pharmacy award for best diploma project. The trust used and was involved with the development of Medicines for Children Patient information leaflets specifically developed for children. This was a partnership programme by the royal College of Paediatrics and Child Health and the Neonatal and Paediatric Pharmacists.

A ward accreditation programme had been piloted in October 2017. This had been designed to promote learning and improvement by rewarding different levels of accreditation based on the level of achievement. We saw evidence of all areas of the hospital being included in this. If improvements were needed, an action plan was requested to demonstrate how improvements would be made.

The trust had a very active research function and was proud that it recruited more children into research trials than any other hospital in the UK. Approximately 5000 children every year were included into trials which aimed to give them the best possible clinical outcomes. The trust had a paediatric clinical research facility which included treatment rooms, residential facilities for families as well as inpatient areas with 2:1 nursing care. The trust has won national awards for participating in research, including the National Institute for Health Research @10Clinical Research Outstanding Impact 2017 award. During 2017 the secured over £7million from the National Institute for Health Research to take forward research in the next 3-5 years.

The trust was involved in a number of innovative programmes. These included producing 3D models of parts of the anatomy following scans of children. This allowed medical staff to have a clearer outline of the children's condition before any procedures were undertaken and meant that children who had to undergo surgery were potentially in theatre for shorter periods of time. The trust had also developed a virtual reality programme of a heart. This enabled medical staff to examine a child’s heart and explain the condition and any procedures pictorially to the child and parent.

An interactive application was launched in November 2017 which featured gaming and augmented reality. This was designed to provide entertainment but also distraction for the patient whilst undergoing procedures in the hospital. Young patients were able to select their own avatar to explore the hospital before they arrived.

There was a plan for a further application to be made available which would enable parents to ask questions about the hospital and their child’s condition and receive answers in real time.

The trust had an innovation laboratory known as the “Innovation Hub,” which is a large facility within the hospital. A team brings together different partners and sponsors in industry together with clinicians, researchers and academics to create products and devices and therapies for the future. The hub had a plethora of equipment and technology to give the space for industry, academia and clinicians to develop technology collaboratively.

Staff, patients and relatives/carers were encouraged to put forward ideas to help improve patient care. These were then taken forward by the trust.

‘Hackerthons’ were regularly held at the trust. These were events attended by internal and external stakeholders. Issues or concerns about care were discussed and ideas put forward to
improve patient care. An example of this was nurses identifying that cannulas fitted in children’s arms for a long time could result in pressure sores under the plaster. As a result of this problem being identified, a device was being developed to help reduce the risk of this happening.

The trust’s innovation programme was supported by a team of innovation scouts. Innovation Scouts are senior clinicians, academics and managers who actively promote and support innovation among their colleagues, from ward to board level. They learn from other organisations, through events, visits and study trips.

**Accreditations**

NHS trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

The table below shows which of the trust’s services have been awarded an accreditation.

<table>
<thead>
<tr>
<th>Accreditation scheme name</th>
<th>Service accredited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint Advisory Group on Endoscopy (JAG)</td>
<td>The new standards for JAG accreditation for pediatrics have been released this year and the Trust has started the self-assessment process</td>
</tr>
<tr>
<td>Gold Standards Framework Accreditation process, leading to the GSF Hallmark Award in End of Life Care</td>
<td>Gold standards framework accreditation is not available to children’s services</td>
</tr>
<tr>
<td>Imaging Services Accreditation Scheme (ISAS)</td>
<td>The Trust does not currently don’t partake in this scheme due to high cost and number of hours required to complete</td>
</tr>
<tr>
<td>Clinical Pathology Accreditation and its successor Medical Laboratories ISO 15189</td>
<td>Fully CPA accredited. Undergoing UKAS inspection Dec 2017 for ISO 15189</td>
</tr>
<tr>
<td>Quality Network for Inpatient CAMHS (QNIC)</td>
<td>Dewi Jones Unit, 27th April 2017</td>
</tr>
</tbody>
</table>

*(Source: Routine Provider Information Request (RPIR) – Accreditations)*
Acute services

Critical care

Facts and data about this service

The trust has 38 critical care beds. A breakdown of these beds by type is below.

Breakdown of critical care beds by type, Alder Hey Children's NHS Foundation Trust and England.

This trust

<table>
<thead>
<tr>
<th>Type</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paediatric</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

Alder Hey Children’s NHS Foundation Trust has two critical care wards; Paediatric Intensive Care (PICU) and the High Dependency Care unit.

(Source: Trust Routine Provider Request)

The critical care services (the service) is commissioned for 24 level one paediatric intensive care beds and 17 level two high dependency beds.

Level three and level two refers to the acuity of a patient. A level three patient will likely be ventilated and need intensive, 24-hour one-to-one care. A level two patient is considered to be high dependency and requires significant nurse input and is usually cared for on nurse to patient ratio of two to one.

There are 38 beds, 21 paediatric intensive care beds and 17 high dependency unit beds. However, staff told us due to the long-term care of four patients the service plans its care on 34 beds.

Occupancy levels for the paediatric intensive care unit ranged from 43% to 105% and for the high dependency unit 27% to 120%.
Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

Mandatory training completion rates

Nursing & Health visiting staff

The trust has an internal target of 90% for mandatory training completion. A breakdown of nursing & health visiting staff compliance for mandatory courses as of 30 November 2017 is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Sum of Completion rate (%)</th>
<th>Average of Trust Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality and Diversity</td>
<td>219</td>
<td>257</td>
<td>85%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>214</td>
<td>257</td>
<td>83%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Moving and Handling</td>
<td>206</td>
<td>257</td>
<td>80%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>187</td>
<td>234</td>
<td>80%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>203</td>
<td>257</td>
<td>79%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>187</td>
<td>256</td>
<td>73%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>154</td>
<td>257</td>
<td>60%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>147</td>
<td>255</td>
<td>58%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Other (Please specify in next column)</td>
<td>74</td>
<td>257</td>
<td>29%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust did not meet the 90% target for all nine mandatory training modules within critical care. Equality & diversity had the highest completion rate with 85%; the lowest scoring module was ‘other’ which achieved a 29% completion rate.

Medical & dental staff

The trust has an internal target of 90% for mandatory training completion. A breakdown of medical & dental staff compliance for mandatory courses as of 30 November 2017 is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Sum of Completion rate (%)</th>
<th>Average of Trust Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fire Safety 2 years</td>
<td>10</td>
<td>21</td>
<td>48%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Moving and Handling</td>
<td>10</td>
<td>21</td>
<td>48%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>10</td>
<td>21</td>
<td>48%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>10</td>
<td>21</td>
<td>48%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>10</td>
<td>21</td>
<td>48%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>10</td>
<td>21</td>
<td>29%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Other (Please specify in next column)</td>
<td>3</td>
<td>21</td>
<td>14%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

Medical and dental staff failed to meet the trust target of 90% for all mandatory training. Five out of the seven modules had a completion rate of 48%; the lowest scoring module was ‘Other’ which achieved 14%.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

The trust had an induction programme for permanent and temporary staff and a mandatory training plan. There was a combination of e-learning and face to face learning.
The service was not meeting the trust target for mandatory training across all modules, especially for medical staff. However, there were plans in place to improve the rates such as the provision of E learning.

Safeguarding

Safeguarding training completion rates

Nursing & midwifery staff

The trust has an internal target of 90% for safeguarding training completion. A breakdown of compliance for safeguarding courses as of 30 November 2017 is shown below;

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Sum of Completion rate (%)</th>
<th>Average of Trust Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>250</td>
<td>257</td>
<td>97</td>
<td>90</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>217</td>
<td>252</td>
<td>86</td>
<td>90</td>
<td>No</td>
</tr>
</tbody>
</table>

Safeguarding Children level 1 exceeded the trust target of 90% by achieving a 97% completion rate, Safeguarding Children level 3 failed to meet the target with 86%

Medical & Dental staff

The trust has an internal target of 90% for safeguarding training completion. A breakdown of compliance for safeguarding courses as of 30 November 2017 is shown below;

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Sum of Completion rate (%)</th>
<th>Average of Trust Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>15</td>
<td>21</td>
<td>71</td>
<td>90</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>14</td>
<td>21</td>
<td>67</td>
<td>90</td>
<td>No</td>
</tr>
</tbody>
</table>

Medical and dental staff failed to meet the 90% training completion target for both Safeguarding Children level 1 and level 3.  

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

The trust had a safeguarding policy. Safeguarding was part of mandatory training for all staff and this was monitored by managers.

There had been five safeguarding issues raised over the previous three months. Staff we spoke with knew how to report safeguarding issues.

Not all staff in the service had up to date safeguarding children training in line with national guidance.

Cleanliness, infection control and hygiene

We saw staff complied with hand hygiene practice. Adequate supplies of personal protective equipment including gloves and aprons were available and we saw staff using these appropriately.

There were dispensers with hand sanitising gel situated around the service including the main entrance to the units and inside rooms. Hand washbasins were equipped with soap, disposable towels and sanitizer.
There was awareness amongst staff about infection control and we observed staff washing their hands, complying with the ‘bare below the elbows’ policy and using hand gel. We observed all staff using alcohol hand gel when entering and exiting the unit.

Hand hygiene audits for the service were carried out monthly. There were five areas of hand hygiene audited; before patient contact, before a sterile procedure was initiated, after contact with bodily fluids, after contact with the patient and after contact with the patient environment. Results of the audits were presented at monthly meetings which showed compliance by specific grades or levels of staff. For example, band seven nurses reached 100% compliance for the five areas whilst one paediatric intensive care unit consultant achieved 96% compliance. The overall compliance for December 2017 for the paediatric intensive care unit was 95% and 96% for the high dependency unit.

We saw curtains were used around the cubicles across the service. These were clean and stain free with a date of first use indicated on them but were not disposable. Staff told us the curtains were heavy and often would come away from their runners. Disposable curtains were being purchased.

Linen storage areas were tidy and there was sufficient clean linen available.

The service had no MRSA (Methicillin-resistance Staphylococcus aureus) bacteraemia and no C. difficile cases in the last year.

The Director of Infection and Prevention Control Annual Report for 2016/17 highlighted the central line associated bloodstream infections was high (5-1000) along with the total parental nutrition line rate (3–1000).

Central line associated bloodstream infections rates were monitored monthly. For 2017 the incidence ranged between nil (July 2017) and 12 in December 2017 with an average of 4-1000 line days (3.2 until November 2017) but in December 2017 there was a sudden increase took the average to four.

Medical staff told us decreasing central line associated bloodstream infections was one of their audit projects for 2018.

The infection prevention and control team had established central line associated bloodstream infections validation meetings within the service in order to reduce the levels to 2-1000 for central line associated bloodstream infections and 1-1000 for total parental nutrition lines.

There were cubicles available for isolation of patients due to infection if needed.

**Environment and equipment**

We saw evidence that the service complied with the national standards for intensive care Health Building Note 04-02.

The service was bright and well-spaced out, individual rooms were spacious and had natural light. Privacy and dignity was maintained when carrying out personalised care by the use of blinds within each cubicle.

Staff told us the paediatric intensive care unit and high dependency units’ layout made resourcing a problem. There were six separate ‘pods’ which meant not all patients could be seen at one time.

The medical engineering department do not perform portable application testing but do perform the relevant electrical testing for medical devices and perform tests to International Electro
The trust had an equipment maintenance programme. The service kept a log of all equipment used, where the equipment was located and could demonstrate all maintenance histories. Maintenance and servicing was planned and carried out in accordance with manufacturer guidance. Staff told us they had no problems in accessing equipment in a timely manner.

Resuscitation equipment, for use in an emergency was checked daily by one of the supernumerary nurses. Equipment was documented as complete and ready for use. We reviewed documentation which showed that trolleys were checked and logged on a daily basis.

All of the equipment we examined such as vital sign monitors, mobile computers and infusion pumps were visibly clean. Staff would clean their own equipment as part of their daily safety checks.

We also saw ‘I am clean’ labels in use to indicate when equipment in storage was cleaned. We saw staff had been trained in the use of different types of equipment and training days were used to ensure staff had access to training on equipment.

Fire evacuation procedures flagged up that oxygen cylinders were stored in the fire zone which would not be easily accessed in the event of a fire. This was risk assessed and placed on the risk register for action. This resulted in oxygen cylinders to be placed in each bed space. The service was waiting for the brackets to be placed in each bed space in order for the cylinders to be attached.

**Assessing and responding to patient risk**

There were three main handovers carried out across the services at the beginning of the day. There was a 7.00am nursing handover, an 8.00am multidisciplinary team handover specifically with the cardiac team and at 8.30am there was an overall multi-disciplinary handover.

The 7.00am nursing handover took place on the paediatric intensive care unit and high dependency unit and included an update on all patients, any significant changes in their condition, any specific procedures or treatments and the staffing levels to cover both units. The 8.00am handover with the cardiac team included staff from the paediatric intensive care unit along with the cardiologists and cardiac surgical team. This was to discuss the patients who were undergoing surgical procedures that day and reviewing existing patients on the paediatric intensive care unit with a view to their clinical progress and where appropriate their transfer to step down to the high dependency unit.

The 8.30 am multi-disciplinary team handover was led by the consultant intensivist in charge for the day and included senior nursing staff, medical staff, occupational health staff, physiotherapists, dieticians and nurse specialists. The purpose for this was to update staff on the condition of individual patients over the night time period and to discuss their on-going medical and nursing care.

Staff safety huddles took place twice a day on the high dependency unit attended by the consultant in charge of the unit, ward manager, co-ordinator, team leaders, infection and prevention control nurses and pharmacists. The huddles were based on the patient safety FIRST model (find out, incidents, risks, incidents and team).

Staff on the high dependency unit used the paediatric early warning scores system to identify sick patients who were deteriorating. There was an integrated electronic system used whereby a barrier or alert was raised once the paediatric early warning score went above three. The nurse had to acknowledge the barrier /alert and respond before any further intervention could continue.
This particular system was also set to raise an alert if the patient’s oxygen levels dropped which would then be actioned immediately.

Staff on the paediatric intensive care unit did not use the paediatric early warning score but used continuous assessment by medical and nursing staff. Staff told us if they felt a patient was deteriorating they would call the team leader.

We saw there was a policy for the Management of Sepsis Six and staff told us about this policy and knew how to recognise when a patient needed to follow the pathway. We saw Sepsis Six details were collated in the daily patients’ electronic care plan.

The Sepsis Six is the name given to a bundle of medical therapies designed to reduce the mortality of patients with sepsis. Sepsis training on the paediatric intensive care unit was delivered as part of routine, yearly mandatory clinical training for clinical staff. Senior staff told us training differed from that delivered on the main inpatient wards as the presentation of sepsis was likely to differ substantially. Staff on the unit delivered an advanced clinical care of sepsis patients in a very different environment with anaesthetised and ventilated patients and 1:1 or 1:2 nurse to patient ratios and continuous monitoring of vital signs.

We were told national institute for health care and excellence sepsis screening criteria was much less applicable in this group of patients and were likely to be misleading (for example identifying changes in work of breathing, conscious level and complaints of leg pain). Paediatric intensive care patient’s sepsis training did not rely on the national institute for health care and excellence sepsis pathway used elsewhere in the hospital.

The trusts quality and safety assessment programme in 2017 showed staff could describe the presentation of a patient with sepsis and the steps they would take to escalate this. Eighty staff out of 93 staff (86% of staff) on the high dependency unit had received sepsis six training.

We were told there had been significant investment in the resuscitation service and new resuscitation trolley had been purchased since the last inspection. All resuscitation trolleys had been standardised so staff could go to any resuscitation trolley and it would have the same medication and layout as other trolleys. These were available for staff should a patient deteriorate.

**Nurse staffing**

There was a designated coordinator in charge for every shift in line with the Standards for Intensive Care Services published by the Joint Standards Committee of the Faculty of Intensive Care Medicine and the Intensive Care Society (2013).

The trust reported their staffing numbers below for the period December 2017;

<table>
<thead>
<tr>
<th>Total number of nursing staff in unit (qualified)</th>
<th>Number with a post registration award in critical care nursing</th>
</tr>
</thead>
<tbody>
<tr>
<td>PICU 204</td>
<td>110</td>
</tr>
<tr>
<td>HDU 92</td>
<td>38</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total number of nursing staff in unit (qualified)</th>
<th>Number with a post registration award in critical care nursing</th>
</tr>
</thead>
<tbody>
<tr>
<td>PICU 212</td>
<td>115</td>
</tr>
<tr>
<td>HDU 98</td>
<td>64</td>
</tr>
</tbody>
</table>
Vacancy rates

Between December 2016 and November 2017, the critical care core service was overstaffed by 7% which meant the trust has more staff in place than what was established by the trust to provide quality care.

*The information provided for vacancy rates is across all staffing groups within critical care.

Even though the trust reported that there was an over establishment of staff in the service, there was still a requirement to use bank staff due to high sickness levels and a number of staff on maternity leave.

The service’s sickness at the time of the inspection was 10% this was due to long term sickness and maternity leave. In January 2018, 15 qualified staff had been recruited to the service however 21 staff were either off sick or on maternity leave or had left the service.

Bank and agency staff usage

Between November 2016 and October 2017, the trust reported 680 shifts filled by bank staff in the critical care ward. Below is the monthly breakdown;

<table>
<thead>
<tr>
<th>Ward</th>
<th>Nov</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care Ward</td>
<td>72</td>
<td>77</td>
<td>52</td>
<td>83</td>
<td>52</td>
<td>64</td>
<td>55</td>
<td>40</td>
<td>32</td>
<td>51</td>
<td>51</td>
<td>51</td>
</tr>
<tr>
<td>Total</td>
<td>680</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

There were 180 staff on the paediatric intensive care unit and 104 on the high dependency unit.

The high dependency unit staffing numbers were two band sevens, 17 band six (16.36 WTE), 82 band five (52.39 WTE), three band four (Health care assistants (HCAs) 2.6WTE. However, there were four posts vacant and four due to start later in the year.

The paediatric intensive care unit staffing numbers were eight band sevens, 35 band six, 104 band four, two band four health care assistants.

We reviewed the staffing fill rates between August 2017 to January 2018 and found that the average percentage of shifts filled as planned for the paediatric intensive care unit was 93% in the day and 91% at night. For the same time period on the high dependency unit the average percentage of shifts filled as planned was 86% in the day and 86% at night. This showed that there were adequate numbers of staff on duty.

The service used bank staff from their own nursing staff establishment when staff absence, sickness or increased capacity required additional staff. There was no requirement to use agency staff.
Medical staffing

There were 13 consultant intensivists of which nine were full time. These worked on a nine-week rota and covered 24 hours a day, seven days a week. One full time intensivist would cover the paediatric intensive care unit with a second intensivist working as a support and would support reviewing patient scans and carrying out any specialist procedures.

The service was looking to appoint a tenth consultant intensivist to support the increase in patients having extra corporeal membrane oxygenation care. Consultant intensivists were on site whilst on call out of hours. Extra corporeal membrane oxygenation care is an extracorporeal technique of providing prolonged cardiac and respiratory support.

The high dependency unit had a consultant intensivist between 9.00am and 5.30pm. Out of hours the high dependency unit would be covered by the on-call doctors for each specialty. However, staff told us if there was an immediate problem they could access the intensivist working on the paediatric intensive care unit.

There were 15 middle grade doctors and research fellows. There were three on duty during the day and a further three out of hours.

There were also advanced nurse practitioners on duty on the high dependency unit between 9.00am and 5pm during the week.

Records

Patient records were created and stored using a paperless electronic system that was compliant with General Medical Council Confidentiality (2009) guidance. We looked at 12 sets of patient’s records. These were comprehensive and well documented and included diagnosis and management plans and consent forms.

From the notes we saw evidence of twice daily multi-disciplinary input, clinical observations, risk assessments, evidence of discussion with the patient and families, specialist nurse inputs, types of devices being used and checked, types of invasive techniques and operations.

We saw a set of notes which showed a complete and safe world health organisation (WHO) handovers following the patient from the operating theatre, to the recovery area and from recovery to the high dependency unit. The world health organisation check list is a tool for the relevant clinical teams to improve the safety of surgery for reducing deaths.

There were computers throughout the service to access patient information including test results, diagnostics and records systems. Staff were able to demonstrate how they accessed information on the trust’s electronic system.

Medicines

Medicines were stored in treatment rooms using cabinets that required an electronic access system to open them and allowed only authorised staff to access them. Storage was limited and some medication was stored outside of the cabinets, although still behind locked doors.

Potassium fluids were segregated from main intravenous fluids in line with the National Patient Safety Agency guidance. The use of potassium through a vein can be highly dangerous and storage needs to comply with the National Patient Safety Agency.

Some prescription medicines were controlled under the Misuse of Drugs legislation 2001 and called controlled drugs. We examined the controlled drugs cupboards and found that storage was...
appropriate with no other items in the cupboards. Balance checks were carried out twice daily.

The emergency equipment was identifiable; however, there were boxes that required replacement due to passing the expiry dates. The emergency boxes were updated during the inspection. The service used a grab pack of syringes and needles to support the emergency equipment boxes.

We saw nurses administering medication, checking doses and names. Both nurses wore red aprons to indicate they were carrying out medication rounds and did not need disturbing.

Critical Care have a dedicated pharmacist who visited the ward daily, checking drug charts and providing advice. The pharmacist cross referenced to the British National Formulary for children to ensure medication prescribing was up to date. We saw pharmacist providing advice to clinicians about dosages and supply while we were on the units.

Staff had access to the paediatric intensive care unit therapeutic intravenous guidelines on line at the bedside and also on the trust smartphone when prescribing and administering medication. We saw staff using this system at the time of the inspection. However, paper charts were used on the paediatric intensive care unit and an electronic system was used for the high dependency unit.

We looked at 10 medication records which were completed comprehensively, dated, signed and had no missing doses.

The trusts quality and safety assessment 2017 showed nurses on the paediatric intensive care unit knew about the five rights of medication administration. One of the recommendations to reduce medication errors and harm is to use the “five rights”: the right patient, the right drug, the right dose, the right route, and the right time.

The monitoring of medicines requiring refrigeration was not regularly checked and the wrong paperwork was also being used to record these temperatures. This was brought to the attention of senior staff at the time of the inspection. The temperature monitoring charts were not in line with March 2005 Royal Pharmaceutical Society; The Safe and Secure Handling of Medicines: A Team Approach. The minutes of the band seven nurses dated February 2018 noted the paperwork was going to be updated and made visible so staff would complete daily.

**Incidents**

**Never Events**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From December 2016 to November 2017, the trust reported no incidents classified as never events for critical care.

*(Source: Strategic Executive Information System (STEIS))*

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported six serious incidents (SIs) in critical care which met the reporting criteria set by NHS England from December 2016 to November 2017. Of these, the most common types of incident reported were
• Pressure ulcer meeting SI criteria with three (50% of total incidents).
• Treatment delay meeting SI criteria with two (33% of total incidents).
• Pending review (a category must be selected before incident is closed) with one (17% of total incidents).

(Source: Strategic Executive Information System (STEIS))

We found reliable systems and processes to keep people safe and safeguarded from abuse. Staff used an electronic reporting system to record incidents. Staff were aware of how to report incidents and staff told us that they received feedback in a timely manner.

There was a good reporting culture within the service. Staff we spoke with fully understood their responsibilities to report incidents and near misses.

There had been three incidents reported over the last two months relating to pressure ulcers which were being reviewed using the root cause analysis process. We saw documentation which showed learning had already changed practice relating to the positioning of endotracheal tubes and discussion was taking place about how these tubes were attached to the patient.

An endotracheal tube is a catheter that is inserted into the trachea for the primary purpose of establishing and maintaining a patent airway.

Between April 2017 and January 2018, the service experienced 142 critical incidents. Incidents were categorised into five main areas; airways and ventilation (11), drugs and therapeutics (47), procedures, lines and equipment (9), patient mix and environment (49) and unit management (26).

The critical incidents causing minimal, moderate and severe harm were investigated using route cause analysis methodology. Unexpected deaths were reviewed via the monthly mortality meetings. Route cause analysis’s we reviewed demonstrated patients and their families were informed of the incidents and the outcome of the investigations.

Mortality meetings took place monthly where individual patients were reviewed, discussed and changes were made to ensure learning would take place from each patient death where applicable

We saw trust-wide root cause analysis bulletins which shared learning from incidents. For example, the bulletin for January 2018 reminded staff that raised lactate levels were a serious danger in sick children and parental concern was important and needed to be listened to.

We saw incidents were discussed at daily huddles and at the monthly operational meetings.

The high dependency unit had its own incident reporting team (one band five and one band six nurse) who were given one shift a month to review all incidents. An incident reporting newsletter
was then circulated by email and hard copy was posted in the staff room.

Minutes of the January 2018 high dependency unit incident meeting showed a formal approach to the discussion of incidents and covered themes such as: medication (10), treatment/protocols (11), documentation (3), skin damage (5), medical devices (4), admission and discharges (1), staffing, (0) safeguarding (1), conduct (1) and health and safety (1). Each incident included actions to be taken.

The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of ‘certain notifiable safety incidents’ and provide reasonable support to that person.

Staff we spoke with was aware and understood what to do if something went wrong and how to report errors and near misses. We were given an example of staff speaking with a parent relating to an incident of a pressure ulcer and the parent responded by saying ‘I don’t think there was any more you could do to avoid the ulcer’.

Safety thermometer

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported three new pressure ulcers, no falls with harm and no new catheter urinary tract infections from December 2016 to December 2017 in the service.

(Source: NHS Digital)

Safety Thermometer information for measuring, monitoring and analysing harm to patients and harm free care was collected monthly. We saw information for January 2018 was displayed on the entrance to each pod, such as the numbers of pressure ulcers, medication errors and the results of January’s hand hygiene audit.

The service had recently experienced three pressure ulcers. These had been reported as an incident and were being investigated using the route cause analysis approach.

Nine medication errors had occurred which were monitored by the pharmaceutical team and the hand hygiene audit showed 93% compliance with the standards.

Is the service effective?

Evidence-based care and treatment

The service contributed to relevant local and national patient outcome and performance audits, including benchmarking activities and peer review with other NHS hospital trusts. The service used a number of national and local guidelines to care for their patients such as; spinal cord injury guidance, guidance of the care of cardiac surgical children, caring for a child with a tracheostomy and standard operating procedures for the paediatric intensive care unit transfers and discharges.
**Nutrition and hydration**

There was a paediatric dietician who undertook daily ward rounds and identified any potential issues with nutrition and ensured they were addressed.

Dietitians also attended the service daily where patients were receiving parental nutrition. Parental nutrition is a method of getting nutrition into the body through the veins. Pharmacists were also involved with parenteral nutrition for patients as required.

Daily records were kept of intravenous infusions, parental nutrition and the child’s fluid balance, with 24 hour totals completed in all records reviewed. This allowed staff to monitor the child’s nutrition and hydration input and output.

For those patients being fed via a nasogastric tube, safety checks were carried out prior to feeding.

The service had a protocol for handling, storing and modifying expressed breast milk which was accessible on the trust intranet.

**Pain relief**

Pain was assessed at hourly intervals or more frequently for patients with pain control issues. A scale specifically for patients unable to communicate their pain was used for unconscious patients. We saw pain scores were documented on the electronic patient record.

Pain management forms a core part of the Royal College’s Paediatric Intensive Care Medicine curriculum for trainees. All consultants were required to have completed this prior to their appointment.

**Patient outcomes**

The service had a comprehensive audit programme of 47 topics which covered areas such as: the use of drugs on intubation, fluid balance post-surgery, post-operative hypotension and compliance with sedation.

The service had a number of examples of changing/informing practice based on audit and research which were presented at national and international conferences.

The service regularly reviewed its patients having extracorporeal membrane oxygenation looking at the reasons for this procedure and any reasons for the increase in use of this procedure.

The service participated in a number of research studies which in time would inform and improve practice. For example, one study looked at nurse’s performance against international standards when carrying out endotracheal suctioning which showed further discussion was needed on using a more comprehensive approach to this procedure.

Another study was FEVER - this was the first phase of the study and involved interviewing parents/ legal guardians whose child had been recently admitted to a hospital with a fever and a
suspected infection. The views of these parents/guardians would help to find the best way to explain the study to parents/guardians and how to seek informed consent when a child was very ill.

**PICA net participation**

The PICA net 2017 audit shows the trust performed about the same as other trusts for three metrics.

- Metric one: case ascertainment was the same as the national aggregate (England and Wales),
- Metric two: crude proportion of retrievals with mobilisation time <1 hour 73.9% was lower than the aspirational standard of 95%.

<table>
<thead>
<tr>
<th>Non-unit specific data required</th>
<th>Alder Hey Children’s NHS Foundation Trust</th>
<th>National aggregate (England and Wales)</th>
<th>Lower limit</th>
<th>Upper limit</th>
<th>Aspirational standard</th>
<th>Interpretation</th>
<th>Previous Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metric 1: Case ascertainment</td>
<td>99.90%</td>
<td>99.90%</td>
<td></td>
<td></td>
<td>none set</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metric 2: Crude proportion of retrievals with mobilisation time &lt;1 hour</td>
<td>73.93%</td>
<td>73.93%</td>
<td></td>
<td></td>
<td>95%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metric 5: Crude number of qualified nurses per bed (WTE)</td>
<td>7.45</td>
<td>5.52</td>
<td></td>
<td></td>
<td>7.01 WTE</td>
<td>About the same</td>
<td>6.40</td>
</tr>
<tr>
<td>Metric 4: Crude 48hr emergency readmission ratio</td>
<td>1.14</td>
<td>1.00</td>
<td>1.54%</td>
<td>1.77%</td>
<td>none set</td>
<td>About the same</td>
<td></td>
</tr>
<tr>
<td>Metric 5: Risk adjusted standardised mortality ratio</td>
<td>1.42</td>
<td>1.00</td>
<td></td>
<td></td>
<td>none</td>
<td>About the same</td>
<td></td>
</tr>
</tbody>
</table>

Patients weight, length, head circumference were monitored and documented using the Igrow chart.

Outcomes for patients were monitored. For example; in December 2017 there were four cardiac arrests and three unplanned /accidental extubations. Extubation is the removal of a tube from the windpipe which helps patients to breathe. The most recent audit of unplanned extubations showed no actions were required but the service would continue to collect data and continue its review.

Unplanned readmissions within 48 hours of discharge were reported as 1.9% which is higher than the national rate of 1.6%.

The most recent annual mortality report for 2016 showed there were 72 deaths in the service which equates to 7.5%. The overall mortality rate of 7.5% was higher than the previous year which was 5.5%.

Data from the Extracorporeal Life Support Organisation July 2017 showed the survival to discharge rate for paediatric patients having elective extra corporeal membrane oxygenation was (56%) which was better than the international rate of 51%.
Extra corporeal membrane oxygenation is used when a patient has a critical condition which prevents the lungs or heart from working normally.

**Competent staff**

**Appraisal rates**

Between November 2016 and December 2017 87.9% of staff within critical care at the trust had received an appraisal.

A split by staff group can be seen below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Number of staff required (YTD)</th>
<th>Number of staff who have received an appraisal (YTD)</th>
<th>Completion percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support to Doctors and Nursing Staff</td>
<td>15</td>
<td>14</td>
<td>93.3%</td>
</tr>
<tr>
<td>Qualified Nursing and Health Visiting Staff</td>
<td>231</td>
<td>217</td>
<td>93.9%</td>
</tr>
<tr>
<td>NHS Infrastructure Support Staff</td>
<td>9</td>
<td>8</td>
<td>88.9%</td>
</tr>
<tr>
<td>Medical &amp; Dental Staff - Hospital</td>
<td>17</td>
<td>0</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

Medical staff failed to complete any appraisals within the reporting period. 93.9% of nursing and health visiting staff received an appraisal.

*(Source: Routine Provider Information Request (RPIR) P43 Appraisals)*

Staff had the skills, knowledge and experience to deliver effective care and treatment to patients. The paediatric intensive care unit met the Core Standards for Intensive Care Units of a minimum of 50% nursing staff having a post graduate qualification in intensive care. However, the high dependency unit staff failed to meet this standard with only 33% for staff meeting the standards. Eighty-nine per cent of nurses in the service were children’s nurse trained with the remaining 11% being adult trained.

The service had its own educators; one band seven, two band six nurses and one band five which was being advertised at the time of the inspection. The educators worked alongside newly qualified staff and those participating in the foundation course.

The service had its own vessel health and prevention specialist nurses who check care plans and help staff on the paediatric intensive care unit and the high dependency unit with difficult intravenous cannulations. Intravenous cannulation is a technique in which a cannula is placed inside a vein to provide venous access.

The service provided its own foundation training course for intensive care nurses in collaboration with Manchester and Birmingham hospitals.

Once staff had successfully completed the foundation course they would have a period of ‘shadowing support’ until the staff member felt confident enough to manage patients alone.
New starters would undertake induction mentored by staff from the paediatric intensive care unit, the high dependency unit and the cardiac unit.

There was an appropriate number of link nurses that covered; tissue viability, infection control, pain, cardiac care, bereavement, extra corporeal membrane oxygenation service and haemofiltration. There was also a transport nurse which was a post funded by the North West, North Wales Transport Service. Link nurses acted as a point of contact for guidance and advice about specialised issues. Haemofiltration is a process of removing blood from the system, purifying it and returning it back to the body.

We saw there was an advanced paediatric life support (APLS) trained nurse on each shift across the service. All staff were Advanced Paediatric Life Support (APLS) trained. Staff had completed additional training and leadership development.

There was access to training in specialised equipment such as ventilators and nutrition pumps. There was also training for the management of difficult airways, cultural awareness, tissue viability and specific types of beds.

The resuscitation team told us they had developed a deteriorating child response course (Respond). This was a one-day simulation course and took place on the ward areas. Each ward area was to have simulation training four times a year.

Middle grade doctors told us ‘their consultant was on the unit 24/7; they were very supportive but not so interfering that we can’t develop their skills and learn’

Middle grade doctors and registrars/research fellows had access to a monthly teaching programme as part of their job plans. There was also a Tuesday training programme for doctors to attend.

**Multidisciplinary working**

Daily ward rounds were undertaken seven days a week. Medical and nursing staff were involved in these together with physiotherapists and/or occupational therapists as required.

We observed a good working relationship between ward and theatre staff, cardiologists and cardiac surgeons, doctors and physiotherapists.

Handovers involved all the multidisciplinary team with a comprehensive handover sheet that was printed off and signed and dated by the receiving staff member.

Staff told us about their joint working with the major trauma team. Staff felt there was a great response if there was a trauma patient needing paediatric intensive care unit /high dependency unit care. Staff attended joint meetings with the trauma team, surgical team where necessary.

The North-West Transport Service is a collaborative venture between 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 centres.
The transport team includes a doctor, a retrieval nurse/s with relevant paediatric intensive care unit transport experience and a dedicated ambulance with driver. A north west and north Wales transport service consultant was available 24 hours-a-day, seven days-a-week, and travels with the transport team when needed.

We were told and saw correspondence which showed excellent working relationships with the North West and north Wales transport service. Staff within the north west and north Wales transport service noted their gratitude to the service for their ‘can do’ attitude and willingness to go over and beyond to accommodate patients externally into their service.

**Seven-day services**

There was twenty-four hours a day, seven days a week consultant cover with medical staff supported by advanced nurse practitioners who covered the medical rota.

Out of hours service cover for physiotherapists, dieticians, emergency diagnostics and pharmacists were available seven days a week including on call service.

**Health promotion**

The service had monthly safety scans which included the importance of mouth care and brushing patient’s teeth in preventing ventilator associated pneumonia (VAP). Mouth care was carried out every two to four hours and patient’s teeth were brushed 12 hourly where appropriate.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

The trust had consent to examination or treatment policy dated December 2015.

All staff were aware of the trust's consent procedures, including Gillick competency among children.

A child (anyone under 16 years old) can consent to treatment as long as they have enough understanding and intelligence to fully appreciate what is involved in their treatment. This is known as being "Gillick competent". Additional consent by a person with parental responsibility is not required. Parents told us staff always explained what treatment they were planning to give to their child and gained consent.

Staff told us they knew the process for making an application for requesting a Deprivation of Liberty safeguards for patients and when these needed to be reviewed. A deprivation of liberty means taking someone's freedom away. A recent Supreme Court judgement decided that someone is deprived of their liberty if they are both 'under continuous supervision and control and not free to leave'. This may occur when a person who has been assessed not to have capacity to consent to their care and treatment, is cared for in such a way that restricts it impacts on their freedom.

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**Is the service caring?**

**Compassionate care**
Children observed during our inspection were being treated with compassion, dignity, and respect. We spoke with parents who told us they felt the needs of their children were being met and how safe they felt in the service.

We observed the delivery of personal care for patients who required multiple and complex interventions. Blinds were drawn throughout their care and the nurses spoke in a soothing and caring manner.

We saw one patient had been cared for within the service for a number of years. The patient’s birthday was being celebrated whilst we were on our inspection.

We spoke with eight parents who confirmed that nurses were caring, calm, compassionate and sensitive with positive interactions observed between staff and their children.

We saw numerous thankyou cards received from parents, all were very positive.

One parent told us the staff ‘were fabulous’ and were consulted all the time about their child’s care.

The service scored 87% with response to the question ‘how likely are you to recommend our hospital to friends and family if they needed similar care or treatment?’

**Emotional support**

One parent told us about their child’s operation being cancelled due to there being no beds on the high dependency unit. This was upsetting as their child was receiving ventilation at home and needed complex care.

One parent told us about how staff work very hard to ‘mimic’ the care they gave so it replicated the care they received at home and made their admission more routine.

**Understanding and involvement of patients and those close to them**

The 12 sets of patient records we reviewed showed discussions with parents about their child’s care.

The trust’s quality and safety assessment programme in 2017 showed that all parents spoken with knew the name of the nurse looking after their child and parents commented that the nurse who covered their breaks also introduced themselves.

The parents we spoke with about communication stated staff kept them informed and updated. Parents told us their child’s care was explained and consent was sought prior to a procedure.

The service had developed and introduced a tool called ‘My Pad’ which is placed by the bedside for all patients on the high dependency unit. It was designed to help involve parents more in the care and provided an update of their child especially where there were multiply teams involved in their care. Feedback from parents had noted this was very good and took away some of the worry and anxiety about catching doctors when the leaving ward.

However, one parent told us that weekends could mean that regular doctors were not available and resulted in planned care being altered due to clinical judgement. The care would then be changed back once the routine doctor came on duty.
The parent information booklet for this service was reviewed. It contained specific information about the service such as ward round frequency and visiting times. However, the information needed to be updated to reflect the move to the new premises.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

The service had a two-year operational plan 2017-2019 which included workforce planning for the next two years. There were seven areas of changes/improvements; rolling recruitment to support 100% occupancy, increasing the nursing team to support the increase in cardiac and respiratory extracorporeal membrane oxygenation, increasing medical staffing at weekends, developing the role of the assistant nurse practitioners, improving health and wellbeing of staff and increase support services for physiotherapy, technical support and psychological support.

The service had a service level agreement with North West and north Wales transport service which was reviewed annually and included a number of quality assurance and governance agreements.

Critical care intensivists worked with surgical and medical colleagues in the trust and with external providers to plan and treat complex patients.

**Meeting people’s individual needs**

Feedback from an annual open day for families waiting for heart surgery and those having had heart surgery included: it was good to have the time to talk with the cardiac and ICU team members, being able to talk with other families who have had similar experiences and learning more about the care of children going through heart surgery’.

Parents told us they didn’t feel there was a designated area where they could rest and relax. The parent area at the entrance to the unit was too open and noisy. Staff told us there was no private space if families were upset or distressed.

Accommodation for relatives and visitors on the unit was limited. There were two overnight rooms available on an ad hoc basis. However, there were differing types of accommodation provided near to the hospital for families to stay whilst their children were receiving treatment and care.

There was a room for mothers to breast feed and express their milk.

There was a 69-bedroomed facility, a further set of apartments for families and a single lodge which was designated for a family with long term complex needs. The facilities offered families the opportunity to cook and eat together and share their experiences. There were also lounges, kitchens and play areas for families visiting the hospital for the day.

We saw no child friendly decorations in any area of the service and no play area for siblings. However, we did see a play specialist playing a guitar whilst visiting one child. We were told by senior staff that the lack of decorations on walls and corridors was due to the building being privately financed. The finance company did not allow decorations on walls. However, staff were in discussions with the company with a view to agreeing a way forward for hanging paintings and pictures where possible.
There was a translation service which staff could access on line. Staff were aware of how to use the translation service.

**Access and flow**

Information provided by the service showed there were 1007 admissions for 2017. 63% of the admissions were within the working day with the remaining 37% out of hours.

For December 2017 there were 71 new admissions to the paediatric intensive care unit, 15 cardiac patients, 47 emergency patients and nine for patients having general surgery. There had been 24 refusals which were noted to be the highest for a number of years. There were also seven cancellations within December 2017.

Between January 2017 and November 2017 47 patients had their operation cancelled on the day of surgery due to no beds on the paediatric intensive care unit (37) and the high dependency unit (10).

There were 140 patients transferred from the paediatric intensive care unit to the high dependency unit between the hours of 4pm and 7am.

Currently the number of delayed discharges, and reasons for their delays were not captured. Both the paediatric intensive care unit and the high dependency unit teams had recently begun to capture this data manually as part of handover documentation.

All patients being stepped down from critical care were discussed at the 7:45am critical care huddle, as well as ad hoc during the day. Their service manager would escalate internal delays as required through the divisional nursing structure(s) and liaised with the North West and north Wales transport service over delayed transfers back to other hospitals.

The main reasons for delayed transfers from the paediatric intensive care unit were; the availability of the high dependency unit beds.

Availability of ward beds, due to either physical bed spaces or appropriately staffed bed spaces where the acuity of the stepdown exceeded the normal staffing establishment of the ward. For example, some patients required a healthcare assistant one to one which might be over and above the normal funded staffing level for that ward.

The paediatric intensive care unit were now collecting this information on its activity database and would be able to provide more accurate reports on delayed transfers in the future.

The service would be alerted to a paediatric trauma by the emergency department and would call down to see if they were needed. The service kept one cubicle in pod three as a trauma bay.

Patient flow was discussed daily as well as safety huddles on the paediatric intensive care unit. Additional safety huddles were held to meet the demands of the service across the seven-days a week. All admissions were discussed with the consultant in charge, the senior nursing coordinator and the transferring consultant/doctor.

We saw the service used an electronic referral form for elective admissions. The consultant would book the patient in on an on-line diary. There was a clear online process to follow for planned admissions.

At the time of the inspection there were four patients within the service who were receiving significant long-term care and were classed as delayed discharges. These patients had highly complex medical conditions and there was evidence of the service working with external agencies.
such as social care and other NHS providers to plan their transfers to other appropriate establishments.

Due to the number of patients receiving significant long-term care this was having an impact on the service’s performance to provide the full critical care 35 bedded service.

We saw delayed discharges were a static risk on the risk register. The critical care risk register 2017 showed there were a growing number of patients over the age of 14 being cared for in critical care.

The risk register also highlighted a significant growth in the use of beds for extracorporeal membrane oxygenation patients 2014/15 80 bed days, 2015/16 150 bed days and 2016/17 233 bed days. Patients receiving this care meant the dependency level was increasing with more consultant and nursing time being taken by single patients.

Discharge to step down accommodation was assessed regularly with some being assessed daily. Staff told us the service was very responsive if there was a paediatric trauma patient needing a paediatric intensive care unit bed.

Learning from complaints and concerns

Summary of complaints

Between November 2016 and December 2017 there were two complaints relating to critical care. The trust took seven days to close the most recent complaint which was raised in February 2017; however, an earlier complaint raised in November 2016 was still ongoing. Both complaints related to alleged failure in care.

(Source: Routine Provider Information Request (RPIR) P61 Complaints)

One parent told us about a complaint she had about the actions of one nurse. Once the parent had raised the issue with the senior nurse, it was dealt with. They felt staff were open and honest and dealt with their compliant appropriately.

Is the service well-led?

Leadership

The service was part of the division of surgical care and was led by a clinical director, lead nurse and service manager.

All staff we spoke with told us they thought very highly of the management team across critical care. They told us that they felt supported and were used to seeing the clinical lead and senior nurse for the service on a daily basis.

Vision and strategy

The service had a critical care department two-year operational plan date 2017-2019. This included three strategic priorities: all beds to be opened on a substantive basis, developing a quality and safety lead and programme and benchmarking non-clinical roles and develop these roles.
We saw there was a quality improvement strategy for the service and plans for improving outcomes. These included developing systems to capture infection control metrics, reviewing the extracorporeal membrane oxygenation service, reducing delayed admissions and developing support services such as psychology support.

The operational plan also included its forecast on planned activity, budgetary targets and savings.

Culture

The service had an open, caring and supportive approach. All the staff we spoke with were positive about the care that they gave patients.

Staff told us the care delivered was a team effort and there was a good multidisciplinary team approach. Staff worked closely across the service and talked enthusiastically about how they cared for each other.

The service had an open, caring and supportive culture. One member of staff told us the noise in the coffee room at times was so loud as staff enjoyed their time together when relaxing. Both nurses and doctors informed us there were effective relationships between nursing and medical staff.

All staff we spoke with told us that the leadership team were visible and very approachable. Staff told us they felt valued.

One nurse told us how she was encouraged to report incidents and how there was a no blame culture. This particular nurse was awarded recognition for good reporting in identifying an incident before any harm came to the patient (missed incident).

Governance

Governance ward meetings took place on the paediatric intensive care unit weekly; minutes from these meetings were cascaded to those staff who could not attend.

Governance meetings on the high dependency unit took place monthly. These meetings had only just started in October 2017 and needed further embedding. For example, the high dependency unit had no database to capture activity and clinical outcomes. This was being developed at the time of the inspection.

Staff from the paediatric intensive care unit and high dependency care unit attended other governance meetings such as surgery when appropriate.

Nursing staff held monthly band seven meetings and included items such as; division governance meetings, staffing, safety issues, risk register and actions needed where necessary. The minutes made it clear band seven staff must attend at least 75% of the meetings. We saw the notes from these meetings which demonstrated over 75% attendance.

Management of risk, issues and performance

Senior managers held weekly the paediatric intensive care unit multi-disciplinary team meetings with a formal agenda that included a paediatric intensive care unit dashboard. The dashboard presented information around paediatric intensive care unit performance activity, readmissions, accidental/unplanned intubations, cardiac arrests, central line infections and hand hygiene audit results.
The service reviewed its risk register monthly which included issues such as staffing levels and patients with long term conditions causing delayed discharges.

The paediatric intensive care unit multi-disciplinary team meetings also included the review of all paediatric intensive care unit patients, the progress on research and audit activity, staffing, equipment and budgets.

Nurse meetings included items from the divisional governance meetings and demonstrated learning and actions taken from root cause analysis investigation reports. For example, guidelines for the management of patent ductus arteriosus stents had been updated and circulated following an incident with stents.

Patent ductus arteriosus stents are used in congenital heart disease.

**Information management**

The service used an electronic system which captured the full care record for the paediatric intensive care unit and the high dependency unit. It monitored trends, fluids management, drug charting, nursing handover and clinical reviews.

There were computer stations with intranet and internet access available on the paediatric intensive care unit and the high dependency unit for staff to use.

There were standardised quality information boards which provided current quality data such as staffing levels and safety performance.

There were staff information boards in staff rooms which provided information on monthly safety and governance indicators, patient experience briefing, new guidelines, new staff welcome, ward messages and thankyou messages.

**Engagement**

A number of staff told us there was a staff wellbeing service which offered staff counselling to staff if needed. We were told staff had used this service after specific serious incidents.

We saw a board was used in the staff room on the high dependency unit which showed in the last six months what staff were most proud about, what had improved, what they had learned and what staff were focusing on. What staff were most proud about was team work and being engaged.

The service was participating in a research study (DEPICT) which investigates whether burnout predicts sickness absence days and sickness absence spells in human service workers.

The service participated in open days led by the cardiac team for patients undergoing heart surgery.

**Learning, continuous improvement and innovation**

We saw evidence of learning from incidents which supported a learning and continuous improvement culture.

The service participated in a number of clinical research studies which ensured nursing and medical practice was up to date and evidenced based.
End of life care

Facts and data about this service

Alder Hey Children’s NHS Foundation Trust provides paediatric palliative care services and works in partnership with Claire House Hospice as well as eight other hospices. The paediatric palliative care team also works with all the community children’s nursing teams across Merseyside and Cheshire (Merseyside and Cheshire Children's Palliative Care Network).

End of life care encompasses all care given to patients who are approaching the end of their life and following death. It may be given on any ward or within any service in a trust. It includes aspects of essential nursing care, specialist palliative care, and bereavement support and mortuary services.

The trust had 73 deaths from October 2016 to September 2017.  
(Source: Hospital Episode Statistics)

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm. *Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

The service provided mandatory training in key skills to all staff. We saw local records which indicated that all staff in the specialist palliative care team were up to date with their training, but the details shown below, which were provided by the trust prior to the inspection showed some training had not been completed. The issue of different compliance data was raised the last time this service was inspected in 2014.

Nursing & midwifery staff

The trust’s internal target for all mandatory training completion was 90%.
A breakdown of compliance for mandatory courses as of 30 November 2017 is shown below;

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Num of staff trained (YTD)</th>
<th>Num of eligible staff (YTD)</th>
<th>Sum of Completion rate (%)</th>
<th>Averag e of Trust Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moving and Handling</td>
<td>7</td>
<td>7</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>7</td>
<td>7</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>7</td>
<td>7</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>5</td>
<td>7</td>
<td>71%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>5</td>
<td>7</td>
<td>71%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Other (Please specify in next column)</td>
<td>4</td>
<td>7</td>
<td>57%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>3</td>
<td>7</td>
<td>43%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>0</td>
<td>7</td>
<td>0%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>
Moving and handling, Equality and diversity and Health and Safety all achieved a 100% completion rate for mandatory training. The remaining five modules failed to meet the trust’s 90% target, the lowest scoring module was Manual Handling – Object with 0%.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

**Medical & dental staff**

The trust’s internal target for all mandatory training completion is 90%. Medical staff compliance with mandatory training was affected by a period of long term sickness immediately before the data collection date.

A breakdown of compliance for mandatory courses as of 30 November 2017 is shown below;

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Sum of Completion rate (%)</th>
<th>Average of Trust Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality and Diversity</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and Handling</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>0</td>
<td>1</td>
<td>0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Other (Please specify in next column)</td>
<td>0</td>
<td>1</td>
<td>0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>0</td>
<td>1</td>
<td>0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>0</td>
<td>1</td>
<td>0%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

The top three modules for mandatory training all achieved 100% completion rate by medical and dental staff. The remaining four modules all failed to meet the trusts 90% target all scoring 0%.

Staff could access their mandatory training records from their smartphone, tablet, laptop or desktop via the electronic staff record portal and much of their mandatory training could be completed via e-learning from these devices. Detailed monthly reports were provided to divisions and departments to monitor and manage compliance which was a standing agenda item on the workforce and organisational development committee.

**Safeguarding**

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

**Safeguarding training completion rates**

**Nursing & midwifery staff**

The trust’s internal target for safeguarding training completion was 90%.

A breakdown of compliance for safeguarding courses as of 30 November 2017 is shown below;
Nursing and midwifery staff achieved 100% for both safeguarding children modules.

**Medical and dental staff**

The trusts internal target for safeguarding training completion is 90%.
A breakdown of compliance for safeguarding courses as of 30 November 2017 is shown below;

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Sum of Completion rate (%)</th>
<th>Average of Trust Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>7</td>
<td>7</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>6</td>
<td>6</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Both safeguarding children level 1 and 3 achieved a 100% completion rate surpassing the trusts target of 90%.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

There was a dedicated safeguarding facility on site called the Rainbow Centre which provided a 24 hour, seven days a week child protection service.

Weekly safeguarding case review meetings were held to discuss child protection cases managed within the trust. There were bi-monthly children’s sexual assault referral centre case discussion meetings and any identified procedural issues were taken to the ‘rainbow’ management meeting, which provided a forum for discussion of such issues with partner agencies.

**Environment and equipment**

The service had suitable premises and equipment and looked after them well.

There was a bereavement suite which was organised in the form of two bedrooms; this meant a family could visit their child in the immediate aftermath of their death in a relatively informal environment. This environment had been well thought out and the separate rooms allowed two families to use the service at the same time, and have privacy.

The service used two different types of syringe driver. Those used in the community by patients at home were portable, battery driven drivers delivering a continuous infusion of one or more
medicines via a needle or cannula. These were used as a means of symptom control management over a 24-hour period in palliative or end of life care.

The hospital syringe drivers delivered one or more drugs via an electric pump with a greater volume of fluid and the doses could be increased or decreased throughout the day, as and when required. They could be used to deliver an intravenous dose of antibiotics or medicines required at an acute phase of illness over a determined length of time. They delivered the medicines via an intravenous cannula, hickman line or central line. The hospital syringe drivers had a patient controlled analgesia function whereby a patient could press a button to receive pain relief.

Syringe drivers were kept on the wards. They were serviced and cleaned after each child had used them. They underwent annual portable appliance testing.

The mortuary was in good order and well maintained.

Assessing and responding to patient risk

Patients who were at the end of life had symptom management and personal resuscitation plans in place. These enabled the continuity of care and appropriate intervention as agreed by the family and specialist palliative care team.

We reviewed three personal resuscitation plans and all had been reviewed and updated. There were flags on the electronic record system to alert staff where these were in place.

The Spectrum of Children’s Palliative Care Needs is a prognostic based framework to identify children and young people who have palliative care needs. Its primary purpose is to facilitate the collection of standardised data to improve services for children and their carers. It organises children into different prognostic groups that are likely to have meaningful and distinct support needs and rates them as red, yellow, amber or green.

The different colours provided a guide as to the child’s progression or deterioration which helped with case-reviews, workload management and communication between professionals.

We saw there was a process in place for using this tool for each patient reviewed at the weekly multidisciplinary team meeting, however the rating had not been undertaken and the cases were not colour-coded. Each child who was reviewed had a section next to their name where the rating would be completed, but it was blank. This meant the team could not see at a glance, where that child was on the spectrum of care needs.

We asked the team about this and were told this had been in place, but had stopped when the consultant in paediatric palliative care was absent from work last year. It had not been reinstated.

Nurse staffing

The service had enough nursing staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.

There were three (2.6 whole time equivalent) band 8a nurses, two band 7 nurses and one band 6 nurse. However, their time was shared between end of life services and oncology outreach.
Nursing staff saw all paediatric oncology patients. Staff told us this took up at least 50% of their time.

The matron for ward 3B spent 50% of their role as a cancer lead nurse and 50% managing nurses in the specialist palliative care team.

Some palliative care was also provided by in-reach from a local hospice under an honorary contract. There was weekly input from two hospice nursing staff who came into the hospital to support families known to them.

The specialist palliative care nursing staff worked 7.5 hour days either 8.30am-4.30pm or 9am-5pm. The on-call rota was divided equally between the team so during the day one member of staff would have the bleep and would also be on call from 5pm-9am the following morning.

On Friday and over the week-end, one nurse would be on call throughout. They would have the preceding Thursday and following Tuesday off and would handover the week-end updates at the weekly Monday meeting.

**Vacancy rates**

Between December 2016 and November 2017, the end of life core service was overstaffed by 12% which meant the trust has more staff in place than what was established by the trust to provide quality care.

*The information provided for vacancy rates is across all staffing groups within end of life care.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

**Turnover rates**

Between November 2016 and October 2017 there was a 0% turnover rate for nursing & midwifery staff within end of life care.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

**Sickness rates**

From November 2016 to December 2017 the trust reported a sickness rate of 1.4% in end of life care.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

**Medical staffing**

There was one consultant in paediatric palliative care (0.8 whole time equivalent). They were based on site at the hospital and contracted for 36 hours a week. The consultant had an additional one half day (one programmed activity) dedicated to quality and transition work. There was acknowledgement within the service that the consultant was working longer than their allocated hours for the specialist palliative care service, and a job planning review was underway.

When the consultant was absent from work, for example on annual leave or sickness absence, consultant cover was provided by doctors from other specialties. These doctors had expert
knowledge in their own areas, but did not have the same level of expertise and knowledge for children coming towards the end of their lives, as the consultant for paediatric palliative care.

This does not meet the NICE (National Institute for Health and Care Excellence) guideline: *End of life care for infants, children and young people with life-limiting conditions: planning and management (2016)*. The guideline requires that for children and young people with life-limiting conditions who are approaching the end of life and are being cared for at home, services should provide (when needed) advice from a consultant in paediatric palliative care (for example by telephone) at any time (day and night).

The trust told us that they did provide 24-hour medical cover via the general paediatric team and the medical speciality teams which included a consultant. They also stated that patients under the remit of palliative care would have been managed by one or more of the specialties which provided 24-hour cover. On reviewing the risk register this was not noted as a control for this identified risk.

The trust acknowledged that they did not meet the NICE guidance for this standard in a gap analysis. They had recognised action needed to be taken and that any actions they identified would be completed by December 2018.

Two and a half days per week there was a paediatric registrar with the team who reviewed patients with the nurses which provided good learning opportunities for both disciplines.

**Turnover rates**

Between November 2016 and October 2017 there was a 0% turnover rate for medical & dental staff within end of life care.

(Source: *Routine Provider Information Request (RPIR) P18 Turnover*)

**Sickness rates**

From November 2016 to December 2017 the trust reported a sickness rate of 43% in end of life care. (This was due to long term sick leave)

(Source: *Routine Provider Information Request (RPIR) P19 Sickness*)

**Records**

Staff kept appropriate records of patients’ care and treatment. Records were clear, up-to-date and available to all staff providing care.

There were a number of records systems in place in the hospital. There was an electronic patient record where patient details were recorded. These included notes attached to the child, hospital admissions and a care account which included every clinic and episode of care.

Letters were recorded on a different system, and some paper records were scanned into another system. Paper records were still held on some wards, including oncology.

We reviewed eight electronic patient records. All had appropriate management and care plans in place, evidence of input from the multidisciplinary team where appropriate and evidence of including the family in discussions and decisions.
Information was shared between the relevant professionals by using a secure email service and discharge summaries were sent electronically to GPs using a secure digital technology system which provided a two-way exchange of real time patient records.

When a patient died a set of referrals was generated on the electronic record to inform other services. These included the specialist palliative care team, safeguarding, the bereavement and spiritual teams and other teams and professionals involved in the child’s care.

**Medicines**

The service prescribed, gave, recorded and stored medicines well. Patients received the right medication at the right dose at the right time.

Most prescription records were electronic, however intravenous fluids and medicines were recorded on paper. Paper records were used in the paediatric intensive care unit as staff had found this to be the optimal system in this environment.

We reviewed eight electronic prescription records for palliative care patients. All were completed appropriately and were up to date.

The Association of Palliative and Paediatric Medicine formulary was used in the hospital and the most recent edition had contributions from doctors and pharmacists from Alder Hey NHS Foundation Trust.

**Incidents**

Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

**Never Events**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. From December 2016 to November 2017, the trust reported no incidents classified as never events within end of life care.

*Source: NHS Improvement - STEIS (01/12/2016 - 30/11/2017)*  
*(Source: Strategic Executive Information System (STEIS))*

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents in end of life care which met the reporting criteria set by NHS England from December 2016 to November 2017.

*Source: NHS Improvement - STEIS (01/12/2016 - 30/11/2017)*  
*(Source: Strategic Executive Information System (STEIS))
There was an electronic incident reporting system in place and staff knew how to use it. There was a flag on the system to identify incidents related to palliative care. Submitted incidents were sent to the governance team and palliative care incidents were also sent to the oncology lead in the palliative care team.

There were seven reported palliative care incidents between February 2017 and February 2018. However, these were mostly related to issues with documentation and communication. No clinical incidents were reported during this time and allocated to palliative care on the electronic incident reporting system.

However, staff we spoke with on inspection gave examples of clinical incidents, such as a medication error, that had occurred in relation to palliative care. This may indicate that some incidents were being reported in the specialty in which they occurred, for example oncology, and may therefore not be followed up with the specialist palliative care team.

Palliative care incidents were on the agenda for the weekly specialist palliative care team meeting and the oncology management team meeting. Any matters of concern were escalated to the trust weekly meeting of harm. Serious incidents were identified at the weekly meeting of harm and dependent on the incident grade, would have a 72-hour review and be reported on the strategic executive information system.

Serious incidents were also discussed at the monthly risk and governance meeting for the medical division and were overseen by the head of quality.

There were systems in place to discuss action plans from serious incidents which were communicated within the risk and governance team and the clinical quality assurance committee. If the incidents related to palliative or end of life care, an invitation to attend the risk and governance meeting would be sent to the specialist palliative care team.

Staff we spoke with provided examples of clinical incidents and spoke about the lessons learned being communicated in the team.

**Is the service effective?**

**Evidence-based care and treatment**

The service provided care and treatment based on national guidance and evidence of its effectiveness.

The consultant for paediatric palliative care chaired the North-West children’s palliative care network which worked to promote access to good quality palliative care for all babies, children and young people with life threatening and life limiting conditions. Part of the network’s remit was to inform strategic development for children’s palliative care services.

There was a point prevalence study underway across Greater Manchester, Merseyside, Cheshire and areas of Lancashire, involving partnership with acute, community services and hospices. The study was led by the consultant for paediatric palliative care at Alder Hey as part of a proposed region-wide re-design of children’s palliative care services.

This was in line with the current *NHS standard contract for paediatric medicine: palliative care (2013-4)* which states that all children and young people with palliative care needs should be
identified as this will allow paediatric palliative care networks to plan appropriate services and to analyse the gaps between the existing provision.

Nursing staff in the specialist palliative care team knew what the current NICE guidance (*End of life care for infants, children and young people with life-limiting conditions: planning and management, 2016*) included and were working to ensure their documentation reflected the current standards. We saw evidence of this in current and proposed future documentation, for example the rapid discharge pathway and the care and communication record.

The trust had recently completed a baseline assessment tool against this guidance and it showed that they were 96% compliant. However, on reviewing the evidence provided it was unclear how they had benchmarked the service as no current activity or evidence had been inputted into the document in the relevant section.

During December 2016 and January 2017, the service undertook a palliative care training needs assessment across the trust to identify knowledge, understanding and confidence in providing care for children with life threatening and life limiting conditions. This was part of a large palliative care project. The recommendations included an online ward resource pack for palliative and end of life care. This was to be launched in spring 2018.

**Nutrition and hydration**

Staff gave patients enough food and drink to meet their needs and manage their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients’ religious, cultural and other preferences.

Parents were often involved with helping to feed their children where possible. We reviewed eight patient records and all included appropriate assessment of nutritional status.

**Pain relief**

Pain relief was managed well and documented appropriately.

The consultant in paediatric palliative care had oversight of the children requiring pain relief as part of their palliative or end of life care. There was also a pain team which covered all wards on the hospital. Ward staff told us they did not usually need to bleep them for patients at the end of life but they were available if needed.

The service provided a medicines box to support anticipatory prescribing for patients coming to the end of life who were being cared for at home and may deteriorate suddenly. It is good practice to have a small amount of injectable medication in the home to reduce delay in administering medication for symptom control. The anticipatory medicines were included as part of the patient’s symptom management plan.

We reviewed eight patient records and all included appropriate symptom and pain management plans.

A hospital mortality audit review identified 45 inpatient deaths between 2016 and 2017 involving withholding or withdrawing life sustaining treatment. Of these children, all but one had
documentation indicating the appropriate administration of medication for comfort care at end of life. For one child it was not possible to identify the last drug prescription from the scanned documentation on the electronic record.

We reviewed three sets of minutes from the specialist palliative care team weekly meeting and saw that pain was discussed and medication reviewed as required for children on the case load.

**Patient outcomes**

The service monitored the effectiveness of care and treatment and used the findings to improve them.

There was a database in place which had the potential to record all caseloads, advance care plans, resuscitation plans as well as a child’s diagnosis and case management. However, the database had to be populated manually by the consultant who said they did not have the capacity to manage this on their own. The consultant told us at the time of our inspection the database was not up to date.

There was no formal children's end of life care plan in place. However, there were comprehensive end of life symptom management plans, multi-professional documentation and anticipatory prescribing protocols in place. These documents were the components used to infer an end of life care plan was in place, when monitoring outcomes.

The target was for 35% of all children receiving palliative care who died (death involved planned withholding or withdrawing life sustaining treatment) to have their care at end of life supported by the end of life care plan. This target was met in one quarter (July to September) in 2017 when four of six (67%) children under the care of the specialist palliative care team had an end of life care plan as defined above, in place.

Between April and June 2017, only three of 11 (27%) children had a plan in place and between October and December 2017, only one of 11 (9%) had an end of life care plan.

Of the children with an end of life care plan in place between January and December 2017, 100% were supported by the on-call service (direct support or indirect support to the lead service). This exceeded the target of 70%.

There was a children’s advance care plan policy which set out the features of the advance care plan, how to use it and where to find it on the electronic patient records system.

An audit of communication of advance care plans and personal resuscitation plans was undertaken in 2017. This looked at records for 44 attendances by child with an advance care plan in place, who attended accident and emergency between 1 March 2016 and 31 August 2016. The critical care indicator which flagged up the existence of an advance care plan was clearly acknowledged on only four (9%) attendances.

A child’s advance care plan and/or personal resuscitation plan should be identified and referred to (With documented evidence) during 100% of attendances to the accident and emergency department.
A comprehensive audit was completed of patients under the care of Alder Hey NHS Foundation Trust between 1 April 2016 and 31 March 2017 with a 'do not attempt cardiopulmonary resuscitation (DNACPR)' instruction in place. The audit highlighted some issues with documenting and viewing individual plans of care on the electronic system, and with regular reviewing of these plans.

As part of this audit a staff survey was undertaken to identify whether staff knew how to identify whether a child had an advance care plan or personal resuscitation plan in place on the electronic patient records systems. Responses were received from 57 senior doctors and nurses, and 25 junior doctors and nurses. Less than half of all staff who responded knew how to identify whether either plan (advance care or personal resuscitation) was in place, or how to view it on the electronic patient record.

Seven children were identified as dying outside of paediatric intensive care with a personal resuscitation plan in place. Of these, five (71%) were documented on the electronic patient record.

There were 19 instances when a child remained in hospital seven or more days after a personal resuscitation plan was documented or reviewed. In only four (21%) of these instances was the personal resuscitation plan reviewed within seven days.

Within the audit period 162 children received palliative care from the specialist palliative care team. Of these 71 (44%) children had active advance care plans within the time period. Of the 71 children with advance care plans 42 (59%) were reviewed or commenced within the 12-month period. Of the four patients not known to the palliative care team with advance care plans two (50%) were commenced or reviewed within the audit period.

Most of the issues identified in these audits were related to information technology or lack of capacity in the specialist palliative care team. Some actions had been put in place following these audits. For example, training on advance care plans and where to find them was delivered to the accident and emergency department by the specialist palliative care team following these results. There was also a simulation scenario, and information was distributed via handouts and computer mouse mats. A re-audit is due in 2018.

The final report with an action plan was completed at the end of November 2017 and one of the recommendations was that the findings be presented to the quarterly clinical quality steering group for discussion.

**Competent staff**

The service made sure staff were competent for their roles. Managers appraised staff’s work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.

**Appraisal rates**

From November 2016 to October 2017 85.7% percentage of nursing staff within end of life care at the trust had received an appraisal. There was one member of medical staff who had recently returned to work after a lengthy absence and had not yet received an appraisal.
<table>
<thead>
<tr>
<th>Staff group</th>
<th>Number of staff required (YTD)</th>
<th>Number of staff who have received an appraisal (YTD)</th>
<th>Completion percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified Nursing and Health Visiting Staff</td>
<td>7</td>
<td>6</td>
<td>85.7%</td>
</tr>
<tr>
<td>Medical &amp; Dental Staff - Hospital</td>
<td>1</td>
<td>0</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

Non-medical appraisals were undertaken between April and July each year. The trust target was 90%.

All of the nurses in the specialist palliative care team were educated to degree level and three had a master’s degree in palliative care related subjects. Two of the nurses in the specialist palliative care team were qualified nurse prescribers and we were told other nurses in the team were hoping to complete the training for this when circumstances and funding allowed.

One nurse in the team was undertaking further palliative care training but this had not been funded by the hospital trust.

All nurses in the specialist palliative care team were trained in the use of syringe drivers.

There was some further training available, related to palliative and end of life care. One nurse we spoke with had completed a pain study day and was due to shadow the hospital pain team for two days as part of their syringe driver training. All qualified nurses were eligible to apply for this.

The specialist palliative care team provided training in advance care planning to the accident and emergency department. They also provided palliative care training input into a mandatory training day for critical care and for the oncology accreditation process.

The specialist palliative care team attended prescribing peer supervision sessions at two local hospices and offered support and education on the wards on a case by case basis.

They received structured supervision from the counselling team at the Alder Centre, as and when needed. This was regarded as a positive resource that the staff could access for support.

**Multidisciplinary working**

Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.

We observed a multidisciplinary team meeting attended by six specialist palliative care nurses, the consultant in palliative care and a paediatric registrar. At the meeting the specialist palliative care team summarised the status of patients they had seen recently, new referrals, and recent deaths.
There was appropriate discussion and handover of recent communications between GPs and community nursing teams. There was an agenda item for 'patients causing concern' and patients' preferred places of care were also discussed. There was an update regarding specialist training that had been provided by the team for staff caring for a patient transitioning over to an adult hospice.

Other matters on the meeting agenda included advance care plans, symptom management and medication reviews. The meeting notes were recorded contemporaneously onto a spreadsheet and appointment dates were also recorded in a paper diary.

Good links with other services and teams were evident from matters raised in the meeting; these included midwives with additional mental health training, social workers, the safeguarding team and a children’s cancer support group (CHICS). Close liaison with other consultants, including haematology and oncology, was also evident.

A representative from the specialist palliative care team regularly attended a number of other specialty multidisciplinary team meetings. These included weekly solid tumour (surgery), neuro-oncology, haematology, and teenager and young adults meetings. There was also a longer monthly chemotherapy multidisciplinary team meeting which included case reviews, mortality and morbidity reviews and learning.

Nursing staff on the wards had differing involvement with the specialist palliative team. A nurse on ward 3B said that had regular contact with the team who were very accessible and frequently involved with patients on the ward.

The specialist palliative care team held regular (two-weekly) meetings with every community nursing team across Cheshire and Merseyside. This meant that each community nursing team had four scheduled meetings per year with the specialist palliative care team but they could be contacted at any time between those meetings.

There was a weekly telephone meeting with the local hospice. Any child categorised as an ‘on call’ with the specialist palliative care team was also on call with the hospice.

There were links with the local NHS ambulance service including liaison regarding advance care plans on the electronic records system. With family permission the specialist palliative care team would contact the ambulance service so that an alert was placed on the record of an address where there was a child with an advance care plan in place. This was done via the ambulance service’s electronic referral information sharing system.

There was input on the wards from different disciplines and services including play specialists, educational psychology, and a pain team. Input from tissue viability nurses was variable. Some wards said they had access to a tissue viability nurse, whereas others said they did not. At least one ward had access to plastic surgery.

CLIC Sargent is a charity dedicated to supporting cancer and leukaemia care in childhood. There was a team of CLIC Sargent social workers based at Alder Hey with close links to the specialist palliative care team. The social workers supported oncology and haematology patients and families, including those receiving palliative care, with financial and practical issues.
Seven-day services

There was a member of the specialist palliative care nursing team on call 24 hours a day, seven days per week. A local hospice also provided 24-hour nursing cover and if the patient was best known to them, they would be the first point of call. Oncology patients were more likely to be well known to the specialist palliative care team at the hospital.

There was no out of hours specialist consultant cover for paediatric palliative or end of life care. Oncology consultants provided cover for oncology patients and for other patients it was managed on a case by case basis dependant on which consultant was overseeing that child’s care. There were a few consultants who dealt with complex patients routinely and were able to provide out of hours cover. However, these consultants were not experts in palliative care. This had been identified as a risk to the service and was listed on the risk register as described later in this report.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

The Mental Capacity Act (2005) applies to everyone involved in the care, treatment and support of people aged 16 and over living in England and Wales who are unable to make all or some decisions for themselves.

Staff had limited understanding of their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. Staff we spoke with had not undertaken mental health training and it was not part of the mandatory training programme.

We did not see evidence of mental capacity assessments being undertaken, however there were no current patients over the age of 16 with a ‘do not attempt cardiopulmonary resuscitation’ order in place in the hospital at the time of our inspection. Staff we spoke with were unsure about the process for undertaking a mental capacity assessment, and said they would speak with the consultant in paediatric palliative care about it if the need arose.

The decision to agree a ‘do not attempt cardiopulmonary resuscitation’ (DNACPR) was made between the clinical staff and the family over time. It formed part of a wider ceiling of care and personal resuscitation plan developed as part of the advanced care planning process, rather than being a standalone document. Staff we spoke with showed good understanding of the complexity and sensitivity of putting a DNACPR in place.

The DNACPR audit detailed earlier in this report found that none of the 20 patients with personal resuscitation plans were subjected to inappropriate attempts at cardiopulmonary resuscitation.

Deprivation of Liberty information was included in the safeguarding training which all specialist palliative care team staff were up to date with.

A deprivation of liberty means taking someone's freedom away. A recent Supreme Court judgement decided that someone is deprived of their liberty if they are both ‘under continuous supervision and control and not free to leave’. This may occur when a person who has been assessed not to have capacity to consent to their care and treatment, is cared for in such a way that restricts it impacts on their freedom. This may be done following a decision which confirms the care provided is in the best interests of the patient and that actions taken are the least
restrictive. This is then authorised if appropriate by the local authority.

Is the service caring?

Compassionate care

Staff cared for patients with compassion. Feedback from families confirmed that staff treated them well and with kindness.

Staff we spoke with understood and respected the personal, cultural, social and religious needs of the children and young people and how these needs would be considered on an individual basis. Personal preferences for care were noted in advance care plans and we saw evidence of this.

We spoke with a parent who described the ward staff as wonderful and supportive and said they were respectful of their child and provided privacy and dignity. One parent was very happy with the care from the consultant in paediatric palliative care and was appreciative of their honesty.

There was contact from the specialist palliative care team following bereavement. A child would be kept on the caseload for two years and cards were sent from the team for the first Christmas and first anniversary of the child’s death. This was in addition to the bereavement support detailed below.

There was no specific link role for organ donation in the specialist palliative care team, but it was discussed as part of the advance care planning process.

They were designated care parking spaces for families using the bereavement suite. This enabled them to have easy access to the facilities and ensured there was always parking available.

Emotional support

Staff provided emotional support to patients to minimise their distress.

Following the death of a child cared for by the specialist palliative care team they offered immediate support to the family in the short term, often from the oncology lead in the specialist palliative care team, or the local hospice for non-oncology patients if they were best known to the family.

After this, practical and emotional support for families could be accessed from the Alder Centre where there were two bereavement support teams.

The bereavement care team was available 24 hours a day, seven days a week for families whose child died in Alder Hey. There were seven part time staff who were on site during office hours, with on call cover out of hours. When a child died in the hospital, a member of the team was available to be with the family within an hour, if the family chose, to offer support at the time of death. They would also help with practical arrangements such as registering the child’s death and arranging time with the deceased child. Packs were provided to families, with information about the support and different services that were available.
The staff in this team were bereavement support workers, not qualified counsellors, however they came from a range of working backgrounds, often public service that equipped them with the skills to meet the demands of this role. The team leader fulfilled a dual role and was also a qualified counsellor.

The second team consisted of six qualified part time counsellors and two students on placement. This team took referrals for anybody affected by the death of a child, including through pregnancy and adult children.

Counselling was available on a one-to-one basis, as a couple or within a family or group context. The counselling service could be accessed by self-referral, or via the volunteer child death helpline which was a national free-phone service for all those affected by the death of a child of any age. Trained, supervised and supported bereaved parents answered all calls and the helpline was open every day throughout the year.

There was also a bereavement care support team at the local hospice which may be involved with the family and able to offer support.

There was a spiritual care team based in the sanctuary at the hospital. The sanctuary included the main prayer space, as well as a quiet room where families and staff members could reflect or pray, and ablution facilities for those who may require them. It was designed to be available to all users of the hospital, regardless of their religious or spiritual belief. There were opportunities to write messages for children who were very poorly or who had died.

The spiritual care team were two members of staff who offered an on-call service 24 hour a day, seven days a week. They had access to different faith groups as and when required.

**Understanding and involvement of patients and those close to them**

Staff involved patients and those close to them in decisions about their care and treatment.

Advance care plans included sections for wishes during life which included matters that were important to the child and what they knew about their condition. It included a section for family wishes, and another for others, for example friends, and school. There was a similarly detailed section where wishes around the end of life could be documented if the child and family chose.

When a child died, the bereavement team told us they asked families how they would like their child to be transferred to the mortuary, for example in a Moses basket. The transfer route was agreed with the family who could walk the route prior to transfer, without the child, to familiarise themselves if they chose to. Nursing staff made sure the route was clear.

All child deaths were reported to the Coroner and staff assisted families with guidance regarding the medical certificate of cause of death being issued. A member of staff would go with the family to register the death at the register office if they wanted support with this.

There was a nominated registrar at the hospital who was available to issue a medical certificate of cause of death during normal working hours and on Saturday mornings, however there was no availability for this out of hours and on Sundays. The service had a standardised letter for parents.
who wanted to take a child who had died home, which explained the circumstances should a
family be stopped en-route for any reason.

It was possible for a child who had died to be taken home by their parents prior to the death
certificate being issued, and where possible this was planned for in advance. The service had
access to ‘cuddle cots’ for babies which kept them cool; similarly, cooling blankets were available
for bigger children.

Funeral directors oversaw the length of time this could continue for. After this the child could be
transferred to a hospice or a funeral parlour.

Is the service responsive?

Service delivery to meet the needs of local people

The trust planned and provided services in a way that met the needs of local people.

The specialist palliative care service accepted referrals from professionals involved in the care of
children or young people with life threatening, life shortening or life limiting conditions. Involvement
with the child and family could start before the child was born and continue until the child reached
the age where they would transition into adult services.

The specialist palliative care team provided outreach care as the lead service for oncology
patients and non-oncology patients with complex symptom management needs, registered with a
GP within the main catchment area of the service and receiving end of life care at home.

The specialist palliative care team worked in a specialist advisory role for children receiving end of
life care in an inpatient setting and for children receiving end of life care at home, registered with a
GP outside the main catchment area of the service.

The service worked in partnership with other services and agencies including nine regional
hospices. The team conducted joint visits to support and empower whichever local teams and
services were needed to support children known to them, however this was challenging in areas
where there were limited community children’s nurses.

The team tried to limit their involvement to three further teams to try and keep communication
streamlined, but this was not always possible if a child lived a long distance from the hospital as
there would be more reliance on local teams’ involvement.

Meeting people’s individual needs

The service took account of patients’ individual needs.

The specialist palliative care team told us they always tried to facilitate a child’s care in their
preferred place, however this was not always achievable if the appropriate supporting community
care was not in place in the child’s local area.

There were 40 deaths for patients under the care of the specialist palliative care team between 1
January 2017 and 31 December 2017. Out of the 40 deaths, 32 had an identified preferred place
of death. Of those with a preferred place of death identified, 91% achieved this. Preferred place of death was discussed even if the child did not have a full advance care plan.

There was a comprehensive rapid discharge pathway in place. The performance dashboard only indicated the number of patients who would have been suitable for rapid discharge.

Of children receiving end of life care who died as inpatients in Alder Hey from 1 January 2017 and 31 December 2017, 23% were under the care of the specialist palliative care team. However, 75% of patients dying outside the paediatric intensive care unit were under the care of the specialist palliative care team. End of life care was defined as the inpatient admission ending in the child’s death where there was documented evidence of withholding or withdrawing life sustaining treatment.

Due to significant capacity issues the specialist palliative care team concentrated on providing support for end of life care outside the paediatric intensive care unit on the wards and in the community as this was where staff had the least experience and patients and their families would benefit the most.

The service had access to the clinical psychology service in the hospital when needed, which provided support for oncology patients and advice for the team. If a child had complex mental health needs there was access to a child and adolescent mental health team and a safeguarding team within the hospital. On occasion, the service had secured support from an agency mental health nurse when a one-to-one was needed.

The team told us they had a caseload of about 200 children; they said they did not have the capacity to complete an advance care plan with every palliative care patient or child with a life limiting condition so they focused on those children with resuscitation plans in place.

Between 1 January 2017 to 31 December 2017, 63 of 161 (39%) patients under the care of the specialist palliative care team receiving non-oncology palliative care, oncology palliative care or oncology high risk care had advance care plans in place.

Children with an advanced care plan in place had a flag (critical care indicator) against their record on the electronic patient record system. This alerted clinical staff that the plan was in place and enabled appropriate care and management of that patient; this was particularly important for staff who may not know the child, for example if they attended the accident and emergency department. Key people involved with the child had a copy of the plan, including the family and the lead consultant.

There was a school on the hospital premises; all wards had a classroom and were allocated a qualified teacher. All children admitted were seen by a teacher as appropriate on the ward and their educational requirements were discussed. All long-term patients, including those receiving palliative or end of life care where possible, had a devised plan which encompassed the education they were presently receiving in their school environment. In addition, liaison took place between the hospital school teacher and their form school teacher. Children who were in an exam year were offered the opportunity to take exams within the hospital with appropriate supervision and support.
The bereavement team had a clear pathway and ‘bereavement box’ with information for nursing and medical staff on the wards on what to do after a child had died. We found this information was available on most of the wards we visited.

Access and flow

The specialist palliative care team took referrals for children and young people up to the age of 16 but would continue with their care after the age of 16 in individual cases. If the young person was known to the service and under the care of multiple specialties care could continue into their 20s with the medical director's approval.

The service used a flow chart system to triage referrals. Where a patient required immediate input from the team, for example if they were expected to die within 24 hours, they were prioritised but advice was sometimes given over the telephone rather than in person. Patients with urgent symptoms would be seen the next working day where possible.

Less urgent referrals should be seen within four weeks but this target was not being met due to the necessary focus on acutely unwell patients who needed their immediate needs met, for example a rapid discharge.

During the period 1 January 2017 to 31 December 2017, 100% of referrals for patients requiring immediate input were assessed and advice given within 24 hours. 72% of routine (two working days) referrals were assessed and advice given within the specified period.

83% of non-urgent (four weeks) referrals were assessed within the specified period but only 23% of these patients were reviewed by the palliative care consultant within the specified time period. There had been a significant impact of consultant long term sickness on this outcome.

There was a comprehensive rapid discharge pathway but no specific target timescale in which this should be completed. A nurse on the specialist palliative care team said they try to get children home within a couple of days but the emphasis is on safety rather than speed as children can deteriorate very quickly.

The rapid discharge pathway included information about any necessary equipment, specialist beds, input for occupation therapy, physiotherapy and wound care as well as other clinical information such as a feeding assessment and ventilation withdrawal. Consideration was given to the withdrawal of intravenous fluids, whether oxygen was required, home suctioning and any consumables that would be needed. A lead was identified for syringe driver care.

When a family transported their child home as part of a rapid discharge, a member of the specialist palliative care team followed them for support. Prior to transport, there was communication between the hospital and the GP or hospice and agreement made as to who would issue the medical certificate of cause of death when the time came.

The consultant in paediatric palliative care wrote handover letters for the hospice where appropriate, and had input into the symptom management plan and prescription for anticipatory medication which was kept in a locked medicine box at the family home.
Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.

Summary of complaints

From November 2016 to October 2017 there was one complaint about end of life care.

(Source: Routine Provider Information Request (RPIR) P61 Complaints)

However, this complaint related to care provided before the scope of this report.

Is the service well-led?

Leadership

The service had managers with the right skills and abilities to run a service providing quality sustainable care. Representation at board level for palliative or end of life care was through the medical director and the mortality lead. We were told that the medical director had responsibility for palliative or end of life care within their portfolio.

The division of medicine was organised into care groups and the specialist palliative care team was in the cancer services and laboratory medicine group. There was a lead cancer nurse in the role of matron and a new service manager was due to start the week after our inspection.

The consultant in paediatric palliative care had historically taken ownership of many of the end of life and palliative care elements of the service, for example developing advance care plans and completing the Spectrum of Children's Palliative Care Needs ratings as described earlier in this report. This placed an unsustainable reliance on one member of the team.

There had been a prolonged period of time when the consultant had been absent from work. Although cover was arranged this was not by a consultant in paediatric palliative medicine.

It was also unclear what oversight the medical division had around the service. Managers in the medical division told us that they had lost sight of the service.

Vision and strategy

We were told there was a North-West children’s palliative care network strategy that the service worked to. However, at the time of the inspection, there was no clear internal strategy and vision for the service. There was a service review in progress with a remit to develop a new model for specialist palliative care but this was in the early stages at the time of our inspection.

The general manager for the medicine division was working with commissioners to develop a transformative model of care for end of life services at Alder Hey and in the wider region. The specialist palliative care nursing team and the consultant’s roles were also being reviewed.

Following the inspection, the trust provided a two year forward operational plan from April 2018 to 2020. Within this there was a clear vision and mission statement for the service. There were also key strategic priorities identified with target delivery dates. We were informed that the medical
division leadership had met with specialist commissioners in January 2018 to consider how service provision could be developed across the network.

There was a policy in place for partnership working to facilitate end of life care in setting of choice. This stated that the trust would work in partnership with relevant universal, core and specialist palliative care providers in the Merseyside and Cheshire Children’s Palliative Care Zonal Network. It identified five priorities of care and roles and responsibilities for staff to adhere to when providing care.

The team provided consultant led specialist palliative and end of life care to children with cancer and other life threatening and life limiting conditions. The philosophy of the service was primarily to support other professionals as well as working directly with the patient and their family when indicated.

The scope of the service included pain and symptom management, psychological, social and spiritual care. The wide scope of the service and the large geographical area it covered meant the team was spread thinly and some of them considered themselves to be ‘firefighting’.

**Culture**

Staff did not always feel supported and valued. There was a lack of clarity around a common purpose based on shared values.

The team felt positive about being part of a care group where most of the areas worked across the hospital setting as they did, for example haematology. However, staff said there was a lot of transformation work happening within the care group, which had led to some feelings of uncertainty and low morale.

We observed part of a service review meeting attended by 11 staff members at different levels of seniority and speciality. There was a discussion around the current demands on the specialist palliative care team, and the balance they were currently having to strike between palliative and end of life care work and oncology outreach. It was clear that members of the team felt passionately about both patient groups but that the current stretch on their resources was untenable in the long term.

Team members we spoke with were frustrated that they were not able to provide the level of input for end of life care patients in the hospital as they would have liked. For example, the team did not have the capacity for every patient coming towards the end of their life to have an advance care plan.

The last time this service was inspected in 2014 the Care Quality Commission report identified that 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, however at the time of this inspection further specialist palliative care medical cover had not been put in place and the funding used for the temporary staff grade doctor had been redirected towards increasing nursing staffing within the team.
There was a dashboard in place, but this relied on the consultant inputting the data and they had competing demands on their time. This meant that the potential for having instant access to valuable information about patient outcomes and the team’s performance was lost. The team were using their judgement as to where they needed to direct their time, but there was no clear direction.

Nursing staff we spoke were keen to develop their skills and knowledge but some had been told there was a lack of funding for this.

Staff we spoke with in the specialist palliative care team said they were open and honest with families when things went wrong.

**Governance**

The trust used a systematic approach to continually improve the quality of its services.

There was a strategic governance meeting chaired by the chief nurse or her deputy which provided a conduit for effective information sharing within the organisation, both strategically and operationally. The operational governance meeting provided a forum for the professionals working within safeguarding to review and progress the operational safeguarding work plan and obtained updates from key work streams.

The service sat within the medical care division. We reviewed the minutes of the medical governance meeting and divisional clinical quality steering group for November 2017 and December 2017 and found that although the bereavement service attended the meetings there were no representatives from the palliative care team. There was also no discussion recorded regarding end of life care patient outcomes or performance.

However, it was noted that at the clinical quality steering group in January 2018, the palliative care consultant attended to discuss low compliance in relation to the review of do not attempt cardiopulmonary resuscitation orders and advanced care plans. An action had been identified to facilitate further training.

There was a hospital mortality review group and patient deaths were also discussed within the specialty mortality and morbidity groups.

**Management of risk, issues and performance**

There was a performance dashboard which enabled the service to monitor key indicators set out in the NHS commissioning board standard contract. This included targets, and ‘red, amber green’ ratings. However, reporting was not yet available for all the performance indicators identified. For example, the use of advanced care plans on admission and the review of advanced care plans. The dashboard did monitor symptom and pain management and children dying in their preferred place of care.

The service had systems for identifying risks but plans to reduce them were unclear. There was a local risk register for end of life care which listed one risk for having only one consultant in paediatric palliative care in post. The risk was not dated but we were told that it had been ongoing for some time. The risk register provided before the inspection showed no actions identified to
mitigate the risk and again at the beginning of the inspection. However, a further copy was provided during the inspection which identified actions to mitigate the risk. This meant we were not assured that risks were being managed in a timely way. There were no controls identified to mitigate this risk.

The consequences listed on the risk register were that the service for patients requiring palliative and end of life care may be compromised. There was nurse specialist support 24 hours a day, seven days a week, but the consultant support needed to be addressed urgently.

Mortuary staff said they had arrangements with another hospital, should an environmental issue arise whereby their facilities were out of use.

**Information management**

The trust collected, analysed, managed and used information well to support its activities, using secure electronic systems with security safeguards.

Alder Hey NHS Foundation Trust was the only specialist children’s hospital selected to join a group of NHS hospitals chosen to drive new ways of using digital technology in the NHS. They had an electronic system in place which enabled them to send timely discharge summaries to GPs and there were plans in place to develop a paediatric portal which would facilitate the sharing of information between the appropriate teams.

However, two separate audits had identified an issue with staff in different clinical areas knowing how to identify and view personal resuscitation plans and advance care plans. Problems were also identified with uploading advance care plans to the electronic system which was described as a complex process with only limited staff able to complete this due to permission requirements. This meant that there was an unnecessary reliance on one or two members of the team to complete these administrative tasks when a whole team approach would be more productive.

**Engagement**

There was limited engagement with patients, staff, the public to plan and manage appropriate end of life care services.

There were no patient surveys specifically for palliative and end of life care. Children, young people and their families did not have input into improving end of life care services at Alder Hey.

There was a North-West children’s palliative care network chaired by the consultant in paediatric palliative care from Alder Hey NHS Foundation Trust which worked in partnership with a group of parents (Parent Voices Count) who had been told their child had a life threatening or life-limiting illness. They had identified a number of projects that sought to improve current palliative care for children.

There were some opportunities for staff to undertake professional development, however staff told us there was limited funding to support this.

**Learning, continuous improvement and innovation**
The trust was committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation.

We attended a monthly mortality review meeting which was well supported by staff from across the hospital. There was good discussion and learning taken from the cases that were discussed. Findings from this meeting were taken to the clinical quality steering group for further action where appropriate.

The consultant for paediatric palliative care chaired the North-West children’s palliative care network which worked to promote access to good quality palliative care for all babies, children and young people with life threatening and life limiting conditions. Part of the network’s remit was to inform strategic development for children’s palliative care services.

The network also aimed to develop and implement procedures for feedback and performance monitoring in order to oversee the delivery of the strategy for children’s palliative care across the North West. It worked to facilitate appropriate education and training for professionals working in children’s palliative care across the network and the annual conference is to be hosted by Alder Hey in 2018.
Outpatients

Facts and data about this service
The trust's outpatient department consists of a number of services based over four floors (lower ground, ground, first floor and second floor) within a new hospital building. Services include clinics such as physiotherapy; phlebotomy; dental; occupational therapy; ear, nose and throat; fracture; cardiology; respiratory; cystic fibrosis; and ophthalmology. It also includes a general paediatric clinic. The outpatient service has a number of administrative functions such as medical records, transcription services, and booking and scheduling. These services are based within the old estate next to the new hospital.

Total number of appointments compared to England

The trust had 208,740 first and follow-up outpatient appointments from October 2016 to September 2017. The graph below represents how this compares to other trusts.

Is the service safe?
By safe, we mean people are protected from abuse* and avoidable harm.
*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

The service provided mandatory training in key skills to all staff, and its mandatory training policies were up to date. Training consisted of core skills with additional mandatory training dependent on role; for example, front line staff should have received safeguarding training level three. Line managers were responsible for ensuring they released staff for training. Training modules included a mix of e-learning and face-to-face sessions, and a central administrative team updated attendance figures weekly. The trust had an up-to-date induction programme for new staff, and a student nurse told us that she felt well supported following her induction and orientation. However, the service did not ensure that relevant staff completed all mandatory training modules, including infection control and resuscitation.

Mandatory training completion rates

Nursing and health visiting staff

The trusts internal target for mandatory training completion is 90%.
A breakdown of compliance for mandatory courses as of 30 November 2017 is shown below;
Nursing and health visiting staff achieved a 100% completion rate for Equality & Diversity training. Out of the eight remaining modules, four exceeded the trust target and four failed to meet the target; the lowest scoring module was classed as ‘Other’ with 8%.

Medical & dental staff

No data for medical and dental staff within outpatients has been provided.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Safeguarding

Safeguarding training completion rates

Nursing & health visiting staff

The trusts internal target for safeguarding training completion is 90%.
A breakdown of compliance for safeguarding courses as of 30th November 2017 is shown below;

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Sum of Completion rate (%)</th>
<th>Average of Trust Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>13</td>
<td>13</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>9</td>
<td>13</td>
<td>69%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

Safeguarding children level 1 had the highest training completion rate scoring above 90% for five out of the seven units.

All front-line staff should be trained to safeguarding level three which included modules in child sexual exploitation, female genital mutilation, radicalisation, and Deprivation of Liberty Safeguards. Based on the data sent to us by the trust following the inspection in February 2018, eligible staff met the target for completing level three safeguarding training (93% against a target of 90%). However, there was no formal safeguarding supervision within outpatients that would meet nationally recognised models, and no dedicated plans to address this.

However, the service did have access to the trust’s internal safeguarding team and there were clear procedures for reporting safeguarding concerns. Staff were aware of their safeguarding responsibilities and could articulate the process they would follow; staff told us examples of incidents they had reported, including a child who had not attended a number of clinic appointments. Staff had reported one safeguarding incident in the previous 12 months.
**Medical & dental staff**

No data for medical and dental staff within outpatients has been provided.

*(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)*

**Cleanliness, infection control and hygiene**

The service did not control infection well and this could increase the risk of spreading infection.

There were hand gels dispensers throughout ground, first and second floor outpatients. Dispensers were inaccessible for smaller children, who required an adult or carer to help them. The dispensers operated via a pull handle (they were not automatic) which could be difficult for patients with certain disabilities to use. We witnessed one broken hand gel dispenser next to public toilets and one hand gel dispenser was empty (G3 waiting area). There was a lack of hand hygiene information for staff, patients and carers in toilets and breastfeeding rooms.

The trust had an up-to-date *Toys and Play Equipment Policy (reducing the risk of spreading infection)* that stated, “all toys should be cleaned on a daily basis whilst in use”. It also stated that if there was no play specialist (there were none within outpatients), it was the responsibility of the ward or clinic manager to delegate the cleaning of toys. However, staff did not follow the policy. They told us that hospital volunteers would usually clean the toys once a week. As there had not been a volunteer in the cardiology clinic for about a month, and as staff did not complete cleaning schedules, they could not tell us whether the toys had been cleaned. There were no formal cleaning schedules for the toys in waiting areas throughout outpatients, other than in the dental clinic.

We witnessed one appointment were a consultant washed his hands before examining the patient, but did not clean the equipment they used afterwards. This could potentially lead to the spread of infection.

We witnessed unattended blood samples in an open box in a corridor. Whilst there were lids on the individual blood samples, the box was open. There was a potential risk of spreading infection should a patient or member of staff knock the box over.

Staff highlighted to us an issue with urine testing in a room using for measuring the weight and height of children. They told us that although the urine samples were disposed of properly, the room would smell of urine. Staff told that they had escalated this issue but not received feedback. We did not witness this issue during the inspection. However, we did witness staff placing allergens on a patient bed during an allergy test. This could potentially affect the next patient if the couch was not cleaned thoroughly.

However, the areas we visited were visibly clean and tidy. The dental clinic outsourced its cleaning of medical equipment. We saw the cleaning schedule which was up to date. There were covers on keyboards and personal protection equipment for staff and goggles for patients.

We saw cleaning records for otoscopes (devices used to look inside the ear) used in the ear, nose and throat clinic. The records were up to date for the two month we checked and documented the asset number of the device cleaned, and the date, time and name of the person that cleaned the scope.
When children or young people attended a clinic with a suspected infectious disease, staff would move them to an isolated area of the clinic to complete the consultation. The area would then be deep cleaned.

The hand hygiene audit results from April 2017 to January 2018 showed that the vast majority of staff complied with hand hygiene requirements.

**Environment and equipment**

The service looked after its premises and equipment well, and the areas we visited were tidy. There were slam guards on all doors, and chairs had soft or had rounded edges. We noticed that the equipment used in outpatients was maintained properly.

The outpatient department had four resuscitation trolleys available over the three floors we inspected. Some areas had undertaken resuscitation training in their department in order to ensure all staff were familiar with the location of the trolley and logistics. The ground floor trolley was shared with the day case unit. Trolleys were checked daily and all equipment and medicines were appropriate and in date at the time of the inspection. Other emergency equipment, such as defibrillators were also checked daily. Additional bottled oxygen was available in each nurse station.

However, some aspects of the premises were not suitable. Some of the staff we spoke to felt that that the outpatient department had been “forgotten about” in the design of the new building. There was insufficient space in the waiting areas, especially if a large number of people used pushchairs or wheelchairs. Areas had insufficient stimulation for children and young people waiting for appointments. Some waiting areas had televisions, but there were very few toys.

There were no leaflets about hand hygiene in the breastfeeding room between G3 and G4 waiting areas, and the emergency pull cord was tied up near the ceiling. Whilst there was an emergency button at chest height, there was no clear information in the room about how to summon help.

The emergency pull cord in the toilet near clinical assessment room B (second floor outpatients) was also tied up and inaccessible.

We observed three unlocked store cupboards that contained various items including syringes and cleaning chemicals (including toilet cleaner) at a height that children could reach. The door to one storage cupboard had been propped open. We highlighted this issue to staff during the inspection. One staff member told us that the store cupboard was not generally locked.

**Assessing and responding to patient risk**

There were no staff trained in advance paediatric life support based within the outpatient department. There were nine nursing staff (out of an eligible 20) trained in paediatric life support (more extensive than basic life support and includes choking and acute problems) and shifts were planned to ensure that there was always one trained member of staff on duty and the shift rota would indicate which floor that person worked. That person had to cover the entire outpatient department but did not have a beeper. However, staff were aware of what to do in an emergency (call 2222) and knew the locations of the resuscitation equipment stored on each floor.

Whilst the trust had up-to-date guidance on *Young people at risk of self-harm and suicide*, this was largely aimed at staff within the emergency department and inpatient wards. Staff we spoke to in outpatients were unsure how to access immediate mental health support for patients.
Nurse staffing

Vacancy rates

The information provided by the trust was not split into staff group therefore the data relates to all staff within outpatients.

Between November 2016 and October 2017, the trust had a vacancy rate of 12% within outpatients which was higher than what the trust established to provide quality care. *(Source: Routine Provider Information Request (RPIR) P17 Vacancies)*

There are no national guidelines to help determine staffing requirements in a paediatric outpatient department. The service therefore used professional judgement when determining staff numbers (each clinic decided its own staffing levels). Generally, there would be at least one registered nurse for each clinic, with a number of health care assistants to provide support. The ophthalmology and cardiac clinics typically had two registered nurses. The department had budgeted for just over 67 full time equivalent staff members, but its actual staffing level was just over 61 full time equivalents. Whilst there were some vacancies and sickness absence, staff generally felt able to provide good care for patients. Staffing levels were decided four weeks in advanced with nurses giving six weeks’ notice for annual leave.

The trust had a safer staffing policy that included pre-employment checks such as Disclosure and Barring Service information. The lead nurse told us that they only use bank staff from NHS Professionals and would not use agency staff. The trust also checked pre-employment references for people working within the department not directly employed by the trust (for example, students).

The dental team (secretaries, managers, nurses and clinicians) met every Friday to discuss staffing levels for forthcoming clinics and to increase productivity. This process started in late 2017. Although the figures were not available, staff considered that they were able to see more

The operations manager transcription services told us that the vacancy rates in their service had been high. This was largely due to staff having left following an initial roll out of voice recognition transcribing. Whilst the roll out had stopped due to some technical issues, the likely re-introduction meant that any current jobs adverts were fixed term contracts only.

Turnover rates

Between November 2016 and October 2017, the trusts turnover rate for nursing & health visiting staff was 0%.

*(Source: Routine Provider Information Request (RPIR) P18 Turnover)*

Sickness rates

Between November 2016 and October 2017, the trust had an average sickness rate of 17.3% for nursing staff within outpatients. The minutes from the weekly performance meetings in January 2018 noted “significant sickness” rates in the outpatient department but that 15 bank staff had been recruited and some staff on long term leave planned to return to work.

*(Source: Routine Provider Information Request (RPIR) P19 Sickness)*
Bank and agency staff usage

Between November 2016 and December 2017, the trust reported the number of shift filled by bank and agency staff across outpatients.

*no data was available for November 2017.

Across all units within outpatients, Transcription Services had the highest number of shifts filled with 2303. April 2017 and June 2017 had the highest number of shift filled.

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

Records

At the time of inspection, the service used a paper light system in respect of medical records, but some paper records were still used. Records were securely transported to the department on a covered trolley and in sealed bags to protect patient confidentiality. Notes were readily available at clinics during the inspection. This was both on the computerised system and within paper files. When records were delivered to clinics (morning and afternoon), a member of staff took a formal handover to ensure the notes could be tracked. The records were also signed for. We observed records stored in locked cupboards when not in use in clinics. After a clinic, the records would be collected for scanning on to the system.

The trust’s Record Management Policy stated that records should be secure and that “access and disclosure are properly controlled”. However, we witnessed records left unsecured and unattended on corridors (outside of clinic rooms) on four occasions. Although swipe card access was required to these corridors, we observed doors open with patients freely able to walk unaccompanied past the records on their way to a consultation. This presented a risk to patient confidentiality. On one occasion the notes were left for at least 45 minutes. Staff told us that the consultants found it convenient to have access to the notes this way. We witnessed a nurse office door propped open and unattended with easy access to patient information including names, dates of births and addresses.

The service did not keep appropriate records of patient care as these were not always up-to-date. At the time of inspection, it took 23.75 days to transcribe dictated notes and clinic letters; the trust’s target was three days. The delay had been 24 days in April 2017 and 10 days in July 2017. Notes from the weekly performance meeting in January 2018 highlighted that the turnaround time across all specialities has increased. There was a backlog of 12,000 transcriptions and this issue was on the corporate risk register. The transcribing service has put in a number of steps to
mitigate risks created by the delays. It has recruited six agency staff and 17 bank workers, and there was a seven-day shift. Staff had been asked to consider evening work, and the service was trialling working from home. Clinicians could flag notes as urgent and these were transcribed within 24 hours. The service has projected that it would clear the backlog by March 2018, but staff told us it would likely be July 2018.

We reviewed 10 sets of medical records. The standard of records was generally acceptable, although four contained illegible handwriting and three did not record any past medical history. In one example, the contemporaneous clinic notes contained approximately 12 words, whilst the associated clinic letter was lengthy and over a page long. Where appropriate, staff documented the patient’s height and weight, as well as allergies and consent. We were satisfied that discharge letters were accurate and copied to relevant people.

Records could be flagged if there be any safeguarding or child protection issues.

We witnessed staff updating patients red books within the cystic fibrosis clinic.

GPs did not have access to the trust’s system to access records but, blood test could be sent electronically when required.

**Medicines**

Medicines were prescribed via an electronic system during pharmacy opening hours, and a dedicated outpatient’s dispensary was open between 8.45am and 5pm Monday to Friday. Paper prescriptions were issued outside these hours. All prescription pads were secure and a log of issued items was maintained. Pre-labelled medicines were available to take home, when patients had undergone minor procedures and for out of hours clinics. Records were made when medicines were administered in clinics as part of procedures. The pharmacist on duty had access to a medical information database to clarify prescriptions. The pharmacy team regularly checked the uncollected prescriptions and proactively contacted patients and carers to prompt them to collect.

Some treatment rooms contained centralised piped oxygen facilities and staff told us this was checked regularly as part of the clinic room daily set up, however this was not documented. The dental and orthodontics department had a conscious sedation facility via a centralised gases and scavenger system. The system was maintained and quality checked by the hospitals engineering department.

The service did not store medicines appropriately. During the inspection we noted that some medicines in the dermatology clinic were out of date. These included dermovate cream (August 2016); sucrose (March 2014); ipratropium (February 2013); and sodium chloride (February 2017). Staff removed these from stock when highlighted to them. Staff also failed to store and monitor medicines requiring in accordance with the trust policy (we are waiting for the trust to send us the policy). Whilst staff regularly recorded fridge temperatures, they did not know the range medicines should be stored at or what to do if the temperature fell outside of that range. This was because the temperature monitoring chart did not record the minimum and maximum temperature or the acceptable temperature range in line with March 2005 Royal Pharmaceutical Society The Safe and Secure Handling of Medicines: A Team Approach.

We observed one fridge containing ametop gel was unlocked, and found emla cream in an unlocked filing cabinet (this medication did not require refrigeration).
Antibiotic stewardship was the responsibility of the individual services rather than the clinics and was not monitored within outpatients.

**Incidents**

**Never Events**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From December 2016 to November 2017, the trust reported no incidents classified as never events for outpatients.

(\textit{Source: Strategic Executive Information System (STEIS)})

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SIs) in outpatients which met the reporting criteria set by NHS England from December 2016 to November 2017. There was one serious incident, in January 2018 that encompassed a number of departments, including outpatients, which met the reporting criteria set by NHS England. The trust completed an initial review of the case to identify learning, and discussions were held with various departments, including outpatients, to identify how to prevent recurrence. A root cause analysis investigation was commenced and the duty of candour (every healthcare professional must be open and honest with patients when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress) was followed.

(\textit{Source: Strategic Executive Information System (STEIS)})

Staff understood how to protect patients from abuse. Incidents were raised via an electronic incident reporting system. Staff were familiar with reporting incidents and found the system easy to use. In the 12 months to January 2018, staff reported 44 near misses, 175 no harm incidents and 68 minor incidents. There was one catastrophic event (see above).

Staff we spoke to were familiar with the duty of candour

Any alerts issued by Medicines and Healthcare products Regulatory Agency were shared by the trust via an organisation wide email and placed on the intranet.

**Safety thermometer**

The outpatient department did not use a safety thermometer. However, the department did monitor hand hygiene and cleanliness audits, and complaints. This information was not available on a dashboard for staff to easily access.

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**Is the service effective?**

**Evidence-based care and treatment**
A number of staff we spoke to confirmed that they acted in accordance with relevant Nursing and Midwifery Council guidelines, including *The Code*. Nurses with the ear, nose and throat clinic were also familiar with the National Institute for Health and Clinical Care Excellence’s clinical knowledge summary on ear irrigation.

Of the records we reviewed, clinic letters were sent to community and adolescent mental health services where appropriate to ensure care was provided by these services that was based on evidenced based guidance.

Staff were aware of how to access relevant policies and procedures from the intranet.

**Nutrition and hydration**

Food and drink was not provided to patients in the outpatient department. If waiting times became excessive, staff could provide food and drink vouchers. The service could refer to dietetic services if required.

**Pain relief**

Staff in ear nose and throat clinic said that they did not use pain scales as they looked at patient distress instead. Staff in the plaster clinic told us that they did not assess pain when setting a cast. They told us that pain relief would be provided by a doctor if a patient requested it.

**Patient outcomes**

*Follow-up to new rate*

From 01 October 2016 to 30 September 2017, the follow-up to new rate for Alder Hey Children's NHS Foundation Trust was worse than the England average.

*Follow-up to new rate, Alder Hey Children's NHS Foundation Trust.*

(Source: Hospital Episode Statistics)

The lead nurse told us that they were not yet using national audit data to benchmark the performance of the outpatient department. But the service had begun to visit other trusts to look at ways of improving its effectiveness. For example, the booking and scheduling team had
introduced a hybrid booking system following one such visit. In addition, there were plans to recruit to a post to help proactively develop the department’s service provision and patient outcomes.

**Competent staff**

**Appraisal rates**

From November 2016 to October 2017 an average of 93.2% of staff within outpatients at the trust had received an appraisal.

A split by staff group can be seen in the graph below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Number of staff required (YTD)</th>
<th>Number of staff who have received an appraisal (YTD)</th>
<th>Completion percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified Nursing and Health Visiting Staff</td>
<td>12</td>
<td>12</td>
<td>100.0%</td>
</tr>
<tr>
<td>NHS Infrastructure Support Staff</td>
<td>27</td>
<td>27</td>
<td>100.0%</td>
</tr>
<tr>
<td>Support to Doctors and Nursing Staff</td>
<td>35</td>
<td>30</td>
<td>85.7%</td>
</tr>
</tbody>
</table>

Nursing and health visiting staff along with NHS infrastructure support staff both achieved 100% of completion of appraisals.

*(Source: Routine Provider Information Request (RPIR) P43 Appraisals)*

As part of the outpatient improvement project, the department conducted a training needs analysis to identify core skills, knowledge and qualifications applicable to staff in all areas and speciality areas. The department was able to develop an outpatient training programme which it implemented in July 2017. The service’s staffing skills matrix highlighted the skill set staff should have dependent on their role. It also showed that not all staff, especially on the ground floor, had completed the required training (for example in resuscitation, risk assessment or use of a new computerised referral system).

The service did not routinely check that staff were competent in their roles. We reviewed seven competency files. Whilst each member of staff had their competency assessed once, they had not been refreshed. The data sent to us by the trust confirmed that a number of staff had not had their competencies signed off. We spoke to a healthcare assistant and a nurse within ophthalmology. Both were unclear about competency updates or reassessments. Individual staff kept their own competency record and there was no central database for managers to quickly check. However, managers could review individual skills by accessing an individual’s electronic staff record. The majority of staff had yearly appraisals and were up to date.

One member of staff told us that whilst they had yearly personal development reviews, they did not have regular one to one meetings with their manager and these were only arranged when they needed them.

There was no mandatory training related to autism or learning disabilities. Some staff had carried out training but one nurse explained that she had to ask multiple times before it was agreed.
Student nurses had a seven-week placement and spent time on different floors to broaden their skills. A welcome pack explained who the student’s their mentor would be, the wider team, professional expectations, and learning opportunities.

Staff in the Ear, Nose and Throat clinic confirmed that they had received additional speciality training.

**Multidisciplinary working**

Staff of different kinds worked together as a team to benefit patients; collaboration and multidisciplinary working was evident. Patients attending the cystic fibrosis clinic were given one appointment and would be seen by a number of different specialties (for example physiotherapy, dietetics, respiratory) on the same day. This helped reduce hospital visits.

The transition to adult services began at age 13 within the same clinic. This gave the patient and staff the opportunity for joint working with the adult services.

Dental clinic staff worked closely with psychology services (and had an access room with a two-way mirror) and play specialists from inpatient wards to prepare patients for complex procedures. However, staff considered it would be more beneficial for patients to have a play specialist dedicated to outpatients.

There were good examples of staff working together within individual clinics. For example, staff within the fracture clinic developed the role of the fracture coordinator. Staff told us that the clinic waiting area was previously “chaotic” but now ran much smoother with better coordination.

Of the ten records we reviewed, discharge information was appropriately copied to external organisations including GPs and child and adolescent mental health teams.

**Seven-day services**

The trust did not provide a seven-day outpatient service. Some clinics operated on a Saturday to manage waiting lists, but there are no services on a Sunday.

**Health promotion**

There was some health promotion within the outpatient department. We saw a large poster in the ear, nose and throat clinic that explained the types of sugars harmful to children’s’ health. We also saw a cardiomyopathy magazine in the cardiology clinic, and leaflets explaining the benefits of using sun cream.

A breastfeeding room on the second floor of outpatients contained a detailed leaflet about breastfeeding. Information included the location of breast feeding rooms throughout the trust, the benefits of breastfeeding, expressing and storage of milk and problems associated with breast feeding. It also contained a chart for mothers to monitor how much milk they expressed.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

Staff we spoke to, understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They also told us that they would speak to the clinicians if they had any concerns. However, staff did not receive formal training in mental capacity. Although the Trust’s recent consent policy did include various sections relating to capacity, it did not form part of mandatory training.
Staff in the ear, nose and throat clinic told us they took consent (verbal or written) for different procedures. They would ask the parent to sign the consent form and if the child had the ability they would also be asked to sign the consent form. The consent form highlighted the need for staff to liaise with other family members or to request independent mental health capacity advocate if parents also lacked capacity. The consent form contained signature boxes for both patients and parents or carers. We did not review any completed forms during the inspection.

Staff in the dental clinic showed us the parental responsibility form they used to help determine who can provide consent for a child under the age of 16 years.

**Is the service caring?**

**Compassionate care**

Staff cared for patients with compassion, and feedback from patients confirmed that they were treated well. We observed positive interactions between staff, patients and their relatives. Staff provided reassurance and comfort to those people who were anxious and worried. The NHS Friends and Family Test results showed that 92% of patients recommended the outpatient department (746 responses – NHS Choices website – 15 February 2018).

We saw thank you cards in which patients had told staff “thank you for making [the patient] feel so at ease” and “we appreciate all you have done”.

Staff within the respiratory clinic had previously made a room available for a family to pray in whilst waiting for their child’s appointment.

We observed staff respecting patients’ privacy and dignity on most occasions. However, there was a lack of privacy when patients booked in to reception as the waiting area was close to the main desk. Patient names were displayed on large television screens which could be problematic for those patients and families that wished or needed to stay anonymous. Staff in one clinic told us that patients could use pseudonyms, but this was not a common approach throughout the department. However, no medical information was discussed or displayed at reception.

We noticed a door to a weight and height room in G5 was open whilst a baby, fully undressed, was being measured. Any patients or families walking past would have also been able to see the baby.

The plaster clinic primarily operated in a room with four bays that did not have curtains, so privacy could be an issue. However, staff told us that they would assess to the situation (age range of children) and speak to families and children to ensure they were happy. We observed two children in the bays during the inspection and both the patients and their families were happy with the arrangement.

Staff also told us that they use special types of bandages for children with autism that do not need a saw to remove them.

**Emotional support**

The outpatient’s website provided useful information in a child friendly way. It explained the steps patients would follow when visiting and provided links to individual clinics. Each link included photographs of the treatment rooms, the equipment used and the staff.

Staff provided emotional support to patients to minimise their distress. The dental clinic had arranged acclimatisation clinics for patients with learning disabilities. It ensured play specialists attend, and developed picture cards to explain the treatment offered.
The dental clinic also held a wide awake club (between 7am and 7.30am) for children with autism to receive care at quieter times. The clinic included a nurse who was a learning disability champion, and staff had received training in interacting with children with individual needs. Staff within the clinic had been nominated for an award for how the deal with children with individual needs.

**Understanding and involvement of patients and those close to them**

We spoke to 16 patients and carers. The majority of them told us that staff talked to them in a way they could understand and were friendly. One family said staff were “always amazing”. We witnessed staff interacting with children. They clearly explained what they were going to do and why and did so in an appropriate way for children.

We witnessed good care in the plaster clinic. Staff addressed both the child and the parent and answered both of their questions. Families were given a leaflet that contained advice about pain management, what to do if their condition worsened, and potential problems with swelling and poor blood supply. The leaflet included information about skin care and cast care as well as useful telephone numbers.

However, although the outpatient department’s website is child friendly, this relies on an assumption that children and carers would research their care before appointments. Furthermore, with the exception of some literature (“How to apply emollient”; exercise testing in the respiratory clinic; and www.CathChat.com - an online community for young adults with urological conditions), the majority we saw were aimed at parents and carers and were not child friendly. This included the plaster clinic’s leaflet about skin and cast care.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

**Did not attend rate**

The service had an up to date *Patient Access Policy* which set out the roles and responsibilities of various services within the outpatient department.

From 01 October 2016 to 30 September 2017, the ‘did not attend’ rate for ENGLAND was higher than the England average.

The chart below shows the ‘did not attend’ rate over time.

Proportion of patients who did not attend appointment, Alder Hey Children’s NHS Foundation Trust.
The ‘did not attend rate’ for new and follow-up appointments has fluctuated between 9.6% and 13.2% in the 12 months to September 2017. There was an outpatient improvement project aimed to reduce rate to 9% by March 2018 through a process of increased activity and better clinic utilisation. Whilst the trust had, on occasions, almost met this target, it was still much higher than the England average. The most recent figures provided by the trust showed that the overall ‘did not attend rate’ was 12% as of December 2017.

The service did not always take account of patients’ individual needs. Although there are a number of patients with individual needs, there were no sensory rooms within the department, and waiting areas could become cramped and noisy. Staff told us that this was an unpleasant environment for children with autism. There was a ‘haven room’ in the ground floor waiting area, but it was sparsely decorated with little in the way of sensory material. It was also immediately next to the busy waiting area.

There were a number of breast feeding rooms for mothers and babies to use. However, staff used one room as a storage cupboard despite signposts indicating to the public that it was a breastfeeding room (the room contained cleaning liquids, mops, brushes and a cleaning trolley). Although there was no sign to redirect mothers, there was no evidence that this had had an impact. Whilst the room was locked on the first day of inspection, it was unlocked on the second.

Signposting was generally confusing throughout the department. Each floor listed the clinics available, but it was not immediately obvious which direction those clinics were; there were no directional signposts throughout the department. Whilst speaking to a receptionist, we witnessed two people asking for directions as they were lost. Staff told us that they had raised signposting as an incident, but that no substantial changes had been made. There were volunteers in the main reception of the hospital who could direct people if requested.

The outpatient clinics we visited were busy. Some patients were seen on time but others had waited about an hour.

Due to the number of patients requiring blood tests, and as part of the outpatient improvement group, the service had introduced an additional phlebotomy room and trained additional staff to help meet patient needs.
Appointment letters were sent out in English, but patients could email to request the letter be sent in a different language (instructions about how to do this were printed in 10 different languages). The appointment letters did not go into detail about procedures. The trust website did explain certain procedures, but this required the patient to proactively research.

The outpatient clinics used feedback from the Friends and Family Test, and complaints and comments to the patient advice and liaison service to help design services to meet the needs of local people. For example, following an informal complaint, the plaster clinic introduced coloured plaster casts.

The ultrasound room within the cardiology department was better designed around the needs of children. One of the treatment rooms contained different coloured lights and a large projector playing cartoons on the wall.

Meeting people’s individual needs

The service did not always take account of patients’ individual needs. The two phlebotomy rooms in ground floor outpatients were not big enough, especially for patients with complex conditions who might also be in wheelchairs. The rooms did not have couches or patient beds. Whilst they contained reclining chairs, the lack of space prevented them from reclining far enough to allow patients to lie down if required.

Staff told us that the size of the ground floor phlebotomy rooms meant it was difficult to move and handle children that fainted, or accommodate families attending with other children. We witnessed one mother with a baby and three other family members in attendance. There was nowhere to lay the baby down to take the blood sample, and the family were unhappy that they had to hold the baby during the procedure. The emergency call bells in the ground floor phlebotomy rooms were at the opposite end of the room to where bloods were taken. This meant it would be difficult to reach whilst also attending to a distressed child. Staff were unhappy about these conditions and told us they had completed incident forms.

There was a phlebotomy room in second floor outpatients which was large and had none of the issues associated with the ground floor rooms. But this room was not consistently utilised for larger family groups.

The waiting areas throughout outpatients were cramped and we witnessed a number of parents and carers having to stand. Other than in the cardiology clinic, there were also very few toys for children to play with. Most waiting areas had a television for the children to watch except G5 were staff used a small computer monitor linked to a DVD player. There was little to keep older children entertained with no dedicated older child/teenager room. There was limited and patchy WIFI signal throughout the department.

There was no dedicated play specialist for the outpatient department. This meant that unplanned support was not always available for those children and families that needed it.

We saw good examples of how staff within the cystic fibrosis clinic met the needs of long term patients with complex conditions.

The dental clinic had the ability to remove braces and fit retainers in the same day.

The department used to measure a child’s height and weight on the ground floor, and then send them to their respective clinics (which could be on different floors). Staff found that patients were more likely to get lost. However, the department responded to feedback, redesigned the service and now took measurements on the same floor of the child’s clinic.
Access and flow

Based on the data below, the trust’s referral to treatment times appeared largely positive, with most of indicators performing in line with the England average. However, minutes from the weekly performance meeting raised concern about referral to treatment times in outpatients. In October 2017 it was noted that the times were increasing in the ear, nose and throat clinics. In January 2018 it was noted that the “forecast is poor for paediatrics. Ear, Nose and Throat and spinal were also an area of concern”. Whilst the minutes did not record the reason for the increase in referral to treatment times, they recorded that “long waits … being reviewed and worked on to ensure no 52-week breaches”. Plans to manage the referral to treatment times included additional clinics in March and April 2018.

Referral to treatment (percentage within 18 weeks) – non-admitted pathways

From 01 November 2016 to 31 October 2017 the trust’s referral to treatment time (RTT) for non-admitted pathways has been similar the England overall performance. The latest figures for October 2017 showed 90.5% of this group of patients were treated within 18 weeks versus the England average of 89.1%.

Referral to treatment rates (percentage within 18 weeks) for non-admitted pathways, Alder Hey Children’s NHS Foundation Trust.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other</td>
<td>89.0%</td>
<td>91.5%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) non-admitted performance – by specialty

No specialties were above the England average for non-admitted RTT (percentage within 18 weeks).

One specialty was below the England average for non-admitted RTT (percentage within 18 weeks).

Referral to treatment (percentage within 18 weeks) – incomplete pathways

From 01 December 2016 to 30 November 2017 the trust’s referral to treatment time (RTT) for non-admitted pathways has been better than the England overall performance.

The trust performance showed that on average 92% of patients in the trust were treated within 18 week compared to an England average of 89%.

Referral to treatment rates (percentage within 18 weeks) for incomplete pathways, Alder...
Hey Children's NHS Foundation Trust.

Referral to treatment (percentage within 18 weeks) incomplete pathways – by specialty

One specialty was above the England average for incomplete pathways RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other</td>
<td>92.1%</td>
<td>91.2%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

Cancer waiting times – Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers)

The trust performed better than the 93% operational standard for people being seen within two weeks of an urgent GP referral in Q3 16/17 however there was no further data available; inspection team to investigate further on inspection.

(Source: NHS England – Cancer Waits)

Cancer waiting times – Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (All cancers)

Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (All cancers), Alder Hey Children's NHS Foundation Trust

The trust is performing better than the 96% operational standard for patients waiting less than 31 days before receiving their first treatment following a diagnosis (decision to treat). The performance over time is shown in the graph below.

(Source: NHS England – Cancer Waits)

Cancer waiting times – Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment

The trust is performing worse than the 85% operational standard for patients receiving their first
treatment within 62 days of an urgent GP referral. The performance over time is shown in the graph below

**Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment, Alder Hey Children’s NHS Foundation Trust**

(Source: NHS England – Cancer Waits)

Following the inspection, the trust sent us updated statistics which showed it was performing better than the operational standard for patients receiving their first treatment within 62 days of an urgent GP referral.

<table>
<thead>
<tr>
<th>Month</th>
<th>All Cancers: 31 day wait referral to treatment (%)</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan-17</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Feb-17</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Mar-17</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Apr-17</td>
<td>93%</td>
<td>1 patient - clinical (anaesthetic) reasons for delay in treatment</td>
</tr>
<tr>
<td>May-17</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Jun-17</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Jul-17</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Aug-17</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Sep-17</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Oct-17</td>
<td>92%</td>
<td>Patient choice to delay treatment whilst family return from overseas</td>
</tr>
<tr>
<td>Nov-17</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Dec-17</td>
<td>100%</td>
<td></td>
</tr>
</tbody>
</table>

**Percentage of outpatient clinics cancelled**

The trust told us that as clinics were scheduled over a full year (52 weeks) rather than the consultant contracted 42 weeks and there was an inbuilt and false cancellation rate of up to 20%. It also told us that in some services, for example gastroenterology, cardiology, paediatric surgery, general paediatrics operated a 'Consultant of the week' model which also falsely increased the cancellation rate in some specialties. As the trust did not provide readjusted percentage figures we do not have any assurance that the percentage of outpatient clinics cancelled is within an appropriate range. However, the cancellation of clinics was raised in an outpatient steering group meeting towards the end of 2017 with an action to speak to relevant divisions to understand why. This concern remained on the agenda and was being monitored but there was no rationale recorded for the rate of cancellations.
<table>
<thead>
<tr>
<th>Clinic Directorate</th>
<th>Clinic Specialty</th>
<th>Clinics Held</th>
<th>Clinics Canceled</th>
<th>% Cancelled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community</td>
<td>Community Medicine</td>
<td>2,344</td>
<td>563</td>
<td>19%</td>
</tr>
<tr>
<td>Medicine</td>
<td>Allergy</td>
<td>299</td>
<td>122</td>
<td>29%</td>
</tr>
<tr>
<td>Medicine</td>
<td>Dermatology</td>
<td>466</td>
<td>93</td>
<td>17%</td>
</tr>
<tr>
<td>Medicine</td>
<td>Diabetic Medicine</td>
<td>263</td>
<td>42</td>
<td>14%</td>
</tr>
<tr>
<td>Medicine</td>
<td>Endocrinology</td>
<td>731</td>
<td>180</td>
<td>20%</td>
</tr>
<tr>
<td>Medicine</td>
<td>Gastroenterology</td>
<td>378</td>
<td>297</td>
<td>44%</td>
</tr>
<tr>
<td>Medicine</td>
<td>General Paediatrics</td>
<td>638</td>
<td>214</td>
<td>25%</td>
</tr>
<tr>
<td>Medicine</td>
<td>Haematology</td>
<td>113</td>
<td>39</td>
<td>26%</td>
</tr>
<tr>
<td>Medicine</td>
<td>ID and Immunology</td>
<td>103</td>
<td>12</td>
<td>10%</td>
</tr>
<tr>
<td>Medicine</td>
<td>LTV</td>
<td>4</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Medicine</td>
<td>Nephrology</td>
<td>226</td>
<td>119</td>
<td>34%</td>
</tr>
<tr>
<td>Medicine</td>
<td>Paediatric Metabolic Disease</td>
<td>50</td>
<td>13</td>
<td>21%</td>
</tr>
<tr>
<td>Medicine</td>
<td>Paediatric Neurology</td>
<td>689</td>
<td>283</td>
<td>29%</td>
</tr>
<tr>
<td>Medicine</td>
<td>Paediatric Oncology</td>
<td>302</td>
<td>24</td>
<td>7%</td>
</tr>
<tr>
<td>Medicine</td>
<td>Respiratory Medicine</td>
<td>645</td>
<td>121</td>
<td>16%</td>
</tr>
<tr>
<td>Medicine</td>
<td>Rheumatology</td>
<td>347</td>
<td>130</td>
<td>27%</td>
</tr>
<tr>
<td>Surgery</td>
<td>Audiology (Outpatient Only)</td>
<td>674</td>
<td>103</td>
<td>13%</td>
</tr>
<tr>
<td>Surgery</td>
<td>Burns - Surgery</td>
<td>7</td>
<td>1</td>
<td>13%</td>
</tr>
<tr>
<td>Surgery</td>
<td>Cardiology</td>
<td>559</td>
<td>218</td>
<td>28%</td>
</tr>
<tr>
<td>Surgery</td>
<td>Cardiothoracic</td>
<td>46</td>
<td>4</td>
<td>8%</td>
</tr>
<tr>
<td>Surgery</td>
<td>Community Ophthalmology</td>
<td>189</td>
<td>20</td>
<td>10%</td>
</tr>
<tr>
<td>Surgery</td>
<td>Craniofacial</td>
<td>77</td>
<td>8</td>
<td>9%</td>
</tr>
<tr>
<td>Surgery</td>
<td>Ear Nose &amp; Throat</td>
<td>808</td>
<td>225</td>
<td>22%</td>
</tr>
<tr>
<td>Surgery</td>
<td>Gynaecology</td>
<td>90</td>
<td>31</td>
<td>26%</td>
</tr>
<tr>
<td>Surgery</td>
<td>Laser (Outpatient Only)</td>
<td>237</td>
<td>16</td>
<td>6%</td>
</tr>
<tr>
<td>Surgery</td>
<td>Neurosurgery</td>
<td>205</td>
<td>62</td>
<td>23%</td>
</tr>
<tr>
<td>Surgery</td>
<td>Ophthalmology</td>
<td>1,587</td>
<td>161</td>
<td>9%</td>
</tr>
<tr>
<td>Surgery</td>
<td>Oral Surgery</td>
<td>157</td>
<td>77</td>
<td>33%</td>
</tr>
<tr>
<td>Surgery</td>
<td>Orthodontics</td>
<td>219</td>
<td>77</td>
<td>26%</td>
</tr>
<tr>
<td>Surgery</td>
<td>Orthopaedic &amp; Trauma</td>
<td>717</td>
<td>244</td>
<td>25%</td>
</tr>
<tr>
<td>Surgery</td>
<td>Paediatric Dentistry</td>
<td>326</td>
<td>51</td>
<td>14%</td>
</tr>
<tr>
<td>Surgery</td>
<td>Paediatric Surgery</td>
<td>427</td>
<td>172</td>
<td>29%</td>
</tr>
<tr>
<td>Surgery</td>
<td>Plastic Surgery</td>
<td>243</td>
<td>48</td>
<td>16%</td>
</tr>
<tr>
<td>Surgery</td>
<td>Spinal Disorders</td>
<td>159</td>
<td>44</td>
<td>22%</td>
</tr>
<tr>
<td>Surgery</td>
<td>Urology</td>
<td>473</td>
<td>170</td>
<td>26%</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>14,798</strong></td>
<td><strong>3,984</strong></td>
<td><strong>26%</strong></td>
</tr>
</tbody>
</table>

**Percentage of patients waiting over 30 minutes to see a clinician**

Of the 36,681 patients attending outpatient clinics between May 2017 and January 2018, 30.9% (11,334) waited over 35 minutes to see a clinician.

**Percentage of patients seen in outpatients without the full medical record being available**

20171116 900885 Post-inspection Evidence appendix template v3
Data sent by the trust following our inspection showed that in nearly all cases, relevant medical records were available during clinic appointments.

Patients could be referred to outpatients via their GP, midwife, health visitor or other hospitals.

We spoke to a number of patients who told us that there had been delays of between a 15 and 60 minutes for their appointment. One patient told us that they “expected to wait”. However, other patients told us they had never had to wait. Delays in clinics were communicated to patients in ground floor outpatients waiting area, but this was not a consistently done across all clinics.

The trust used the InTouch system to manage the access and flow of patients. The system tracked the patient from signing in at reception, having their height and weight measured, through to seeing a consultant. Staff told us that the system worked well when used correctly. However, some staff told us that not all consultants routinely updated the system and this affected patient flow and waiting time statistics.

Children that had had a catheter or stent removed were given written safety netting information about normal post procedure symptoms and what should be done if there was an emergency. This leaflet was for parents and carers and was not written in a way that children could also easily understand.

The outpatient department had a high ‘did not attend rate’ compared to the English average; the rate fluctuated between 9.6% and 13.2%. Staff in the ear, nose and throat clinic reviewed these rates each day. Doctors reviewed the list and dictated a letter to the patient and their GP inviting them to another appointment.

The trust had recently trialled a hybrid appointment booking system (ophthalmology, cardiology, general paediatrics and dermatology). Patients previously had to call to make an appointment but this resulted in a first come first serve situation and delays to some patients being seen. The new system pre-booked the patient’s appointment based on a priority assigned by a consultant. Patients could rebook if necessary. The booking and scheduling team also told us that they used to work separately from the clinicians. However, there was now greater joint working which helped prioritisation, access and flow. We were told that some waiting lists had fallen as a consequence of this work (ophthalmology clinic has reduced its waiting list from 2,000 patients to 300) although we did not see any evidence to support this statistic.

The booking and scheduling team would be piloting a text reminder service in cardiology, ophthalmology and dermatology. However, this service would rely on patients and families understanding written English.

**Learning from complaints and concerns**

**Summary of complaints**

From November 2016 to October 2017 were zero complaints about outpatients.

(Source: Routine Provider Information Request (RPIR) P61 Complaints)

The service took complaints seriously and investigated them. There was a clear process for staff and patients to follow. The process set out the timescale for investigations, the duty of candour, and provided details about Parliamentary and Health Service Ombudsman. However, the service did not ensure there was a formal process to share learning from complaints with all staff,
including those on the front line. We were told that learning from complaints would usually be discussed in morning huddles. But there was no agenda for these huddles and minutes were not taken. This meant that it could be difficult for those staff not directly involved in a complaint or incident to learn from them.

Is the service well-led?

Leadership

Managers across the trust promoted a positive culture that supported and valued staff, creating a common purpose based on shared values. The majority of staff we spoke with told us that the leadership within the outpatient department were visible and approachable. Staff also told us that the culture of the department was more open than in previous years, and felt comfortable raising issues with senior staff. The trust’s executive team was scheduled to meet and shadow staff in outpatients in late 2018.

Staff had their personal development reviews between April and July each year. All reviews were up to date.

There was a lack of formal and consistent succession planning for front line staff within the service. For example, whilst the service had tailored skills matrix based on staff role, there was no formal process for reviewing and reassessing staff competencies, or for providing supervision. The inadequacy of access to training and development opportunities for staff in all areas was on the corporate risk register. The dental clinic was the exception where there were numerous examples of staff developing their skills and careers.

The trust had an outpatient department risk register. This was up to date and was being monitored.

Vision and strategy

Following the previous CQC inspection in July 2015, the trust had developed an outpatients steering group (part of the outpatient improvement project) that aimed to deliver an “excellent outpatient service measured by increased patient and family satisfaction, increased staff engagement and wellbeing and an increase in clinic utilisation”. The project was due to end in March 2018 and the majority of actions had been completed or were nearing completion. The service has a vision for the outpatient department to have a triumvirate leadership team - service lead, a matron, and a transformational lead to help continue to drive improvements in patient care. The lead nurse told us that the transformational lead would focus on project work and innovations with the service. They would also look at how to benchmark the service against other providers.

Further quality improvements for the department had been identified for 2018 to 2019. These included improving patient and staff experience.

Culture

Outpatients had high sickness rates of over 17%, and a vacancy rate of over 12% for the 12 months to October 2017. This is higher than the trust’s target to provide a safe service. However, the turnover of staff for the same period was zero. The trust did not break down data into specific staffing groups.

The majority of staff we spoke to were positive about the culture in outpatients, especially over the last 12 to 18 months. They felt supported by middle management. Staff told us that felt able to raise any concerns in order to “get it right for the children”. We observed staff being respectful towards each other, not only across their specialities, but also across disciplines.
The service had established a black and minority ethnic and a disability staff network with a view to ensuring non-discriminatory care and the sharing best practice.

Some of staff we spoke to were unsure who the trust’s Freedom to Speak Up Guardian was but they told us that they would be happy to raise issues directly with their line manager. Staff were aware of the duty of candour.

Whilst there were trust wide staff recognition awards, there were no outpatient specific recognition programmes.

Staff on second floor outpatients did not consider there were sufficient facilities for them. Whilst there was a room to make a drink, it was situated in such a way that staff have to walk across two waiting areas with drinks (sometimes hot). They felt this gave the wrong impression to patients and families who might have waited some time for their appointment. There was no staff room on the floor.

**Governance**

Part of the outpatient improvement project was to increase staff engagement, which included arranging a monthly meeting for each outpatient floor, and a quarterly meeting for the whole department. Both these actions were complete and staff confirmed that these meetings took place. We reviewed the minutes from a number of these meetings. Staff discussed the departmental risk register, feedback on incidents, audits and patient surveys.

There was also a monthly meeting of the medicines divisional leads, including outpatients. The outputs from this meeting were fed through to the trust board.

**Management of risk, issues and performance**

The service collected, analysed, managed and used information reasonably well to support its activities. The service identified a number of measures of performance, which included Friends and Family Test results, complaints, and sickness levels. A recent review noted that there had been a fall in complaints about waiting times in the phlebotomy clinic. Waiting times were discussed at a weekly outpatient’s steering group with appropriate actions recorded.

The service’s outpatient improvement project had an associated risk register. In early 2017 four key risks were identified that could impact the success of the project. These included staff engagement and participation, and communication. These risks had not been reviewed since they were first placed on the register. Another risk, relating to a lack of resources, had not been assigned a risk score or any had any actions to reduce the risk.

The lead nurse could tell us the highest risks on the departmental risk register. These included the decontamination of scopes in the ear, nose and throat department (now resolved); staff competencies in ophthalmology; and delays in the transcribing clinical correspondence. These risks appeared on the corporate risk register with relevant and appropriate actions assigned to them. The risk relating to the position of the call bell in one of the ground floor phlebotomy rooms had recently been added to the group floor outpatients risk assessment. An action plan involved discussing the issue with building services with a view to about relocating the call bell.

There were weekly and monthly meetings at a divisional level about performance and harm, including risks and incidents. We saw the agendas and minutes from these meetings and therefore have assurance that actions to improve performance were being managed effectively.
Important information could be shared via the intranet or email. There were daily front line staff huddles to discuss relevant issues, but there was no formal agenda and staff do not take minutes. A quality manager also sat within the outpatient department and could provide support for incident investigations and performance data.

The booking and scheduling team monitored 'did not attend' rates. Whilst reducing the rates was part of the outpatient improvement project, the rates remain higher than the England average. During an outpatient steering group meeting in January 2018, staff noted that the current high 'did not attend' cancellation rate was likely due to the introduction of the text reminder service and was to be expected. The department also had its own milestone plan to monitor performance and progress. The majority of actions on this spreadsheet were on track. Of those that had missed the milestone, most had an explanation and revised target date.

At the time of inspection, it took 23.75 working days to type routine correspondence against a target of three days. This was an increase of almost 14 days since July 2014. However, a system had been developed to ensure correspondence relating to cancer patients are transcribed within 24 hours, and those marked as urgent, transcribed within three days. Plans had also been put in place to help reduce the transcribing backlog by March 2018 and were being monitored via the corporate risk register. However, staff told us that the backlog was likely to continue until July 2018.

**Information management**

The trust collected, analysed, and used information well using secure electronic systems with security safeguards.

Patient records were primarily kept electronically, with clinical correspondence being transcribed by transcription services. All records were stored securely when not being used in clinics. As mentioned earlier in the report, there instances were patient files were left unattended and unsecured.

The outpatient department used InTouch to track patient flow, from reception through to patients being seen in clinic. However, we were told by a number of staff that consultants did not consistently use the system. The outpatient leads were aware of this issue and had discussed the matter in a steering group meeting in November 2017. Actions included engaging with the consultants to understand their concerns, but it was noted that there had been some IT issues. We do not have the most recent minutes so cannot be assured that the consultants have been spoken to about this issue.

The trust was a global digital exemplar (internationally recognised NHS provider delivering care through the use of digital technology and information). The trust was trialling automated letters to patient GPs. The outpatient department could share test results electronically with GPs.

**Engagement**

The trust did not engage well with patients, staff, the public and local organisations to plan and manage appropriate services, or collaborate with partner organisations effectively. Apart from the Friends and Family Test, and reviewing complaints, there were no patient or parent forums for relevant to outpatients.

There were no formal benchmarking activities with other providers or comparisons with national audits. There are some examples of ad hoc working with other trusts that had contributed to the development of the hybrid appointment booking system.
Learning, continuous improvement and innovation

The dental clinic explained how they could remove a child’s brace and fit a retainer in the same day. This helps prevent multiple appointments and potential distress for children and is a service not readily available at other providers.

The lung function team within the respiratory clinical aimed to provide a world class service. It already provided detailed leaflets designed for both children and parents, and had designed various games for children to interact with during exercise tests.

The outpatient department had visited various other trusts in the country to try and better understand how they provide effective services for their patients. For example, the booking and scheduling team visited another trust to understand the benefits of a hybrid booking system.

The trust was a global digital exemplar, and the manager for this programme sat within the outpatient’s service. There were a number of aims of this programme that included sharing clinical correspondence digitally with patients’ GPs, voice recognition transcribing, and a new room booking system.
Diagnostic imaging

Facts and data about this service

Alder Hey’s Radiology department is in a central location on the ground floor of the hospital. The department performs around 73,000 examinations each year including X-rays, magnetic resonance imaging (MRI) scans and ultrasounds. The team consists of specialists including; Radiographers and Sonographers, imaging department assistant, clerical staff, PACS manager, Consultant Radiologists and Radiology Registrar.

Is the service safe?

Mandatory training

The service provided mandatory training in key skills to all staff and supported staff to complete this training. Staff could access their own training record on the intranet and it was colour coordinated to instantly show whether they were up to date. Red showed if they were overdue training in that particular area.

The trust has an internal target of 90% for completing all mandatory training courses.

A breakdown of all mandatory training courses taken between November 2016 and October 2017 are shown below;

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Sum of Completion rate (%)</th>
<th>Average of Trust Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moving and Handling</td>
<td>10</td>
<td>12</td>
<td>83%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>10</td>
<td>12</td>
<td>83%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>10</td>
<td>12</td>
<td>83%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>8</td>
<td>12</td>
<td>67%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>8</td>
<td>12</td>
<td>67%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>4</td>
<td>12</td>
<td>33%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Other (Please specify in next column)</td>
<td>3</td>
<td>12</td>
<td>25%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

All seven modules failed to meet the trusts 90% completion target for mandatory training. The highest scoring module was moving & handling with 83% and the lowest scoring module was other with 25%.

Figures showed that the department was not meeting its targets for all areas of mandatory training, between November 2016 and October 2017. For example, infection and prevention control. This was still the case at the time of the inspection. We did not see any evidence that this was on the risk register or any actions for improvement.
Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and staff we spoke with knew how to apply it.

The trust has an internal target of 90% for all safeguarding training modules.

A breakdown of all safeguarding training courses taken between November 2016 and October 2017 are shown below;

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Sum of Completion rate (%)</th>
<th>Average of Trust Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>12</td>
<td>12</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>10</td>
<td>10</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Both Safeguarding Children levels 1 and 3 achieved a 100% completion rate surpassing the trusts target of 90%.

The department checked with all patient’s the three points of identification (ID); name, address and date of birth. The patients were first called by their name from the waiting area and then asked their name again, along with the two other checks in the procedure room. Once this had been carried out the staff member should confirm these checks together with the justification, on the post procedure screen of the Radiology information system. However, we checked a number of these screens and less than 50% were compliant. Staff could tell us how these two actions were being carried out, but they were not following protocol and it was not recorded that they had been completed. We raised this with the Radiographer manager and we witnessed that it was discussed in the senior staff meeting the following morning. We were informed that it would be used in future.

We saw evidence of the PAUSE check list being used in the department. In each of the scanning rooms we saw ‘Have you paused and checked?’ posters in the department to act as an aide memoire at work stations. The checks include prompts that the examination is justified, it is the correct patient and to visually monitor the patient throughout the examination.

Cleanliness, infection control and hygiene

The service controlled the risk of infection well. All areas of the department and equipment were visibly clean and tidy. They used control measures to prevent the spread of infection.

The hospitals patient-led assessment of the care environment (PLACE) score for 2017 showed the provision for cleanliness in the hospital was 96%, which was slightly lower than the England average of 98%. The PLACE is to provide a snapshot of how an organisation is performing against a range of non-clinical activities.

We observed staff using appropriate hand washing techniques whilst delivering care. Hand gel was available inside each diagnostic area, but not within the corridors, or entrance to the department. We only saw hand gel available outside the x-ray rooms. On entering the department it was some distance before a dispenser was available.

Audits were carried out within the department for hand hygiene, by the department assistant and results were sent to the infection control team. The last audit showed 100% compliance. The audit
Results were not displayed for patients or staff to see, however on speaking to a department manager this was something they intended to do in the future. The results were fed back to staff via local staff meetings.

We saw a completed cleaning schedule which consisted of a daily check list which was kept in a file in the radiographer’s office.

We visited the theatres and saw that the mobile image intensifiers were clean. We were told that they were cleaned after each case and a sticker was placed on the equipment stating who had cleaned it and the time and date. This was also recorded in a cleaning file, which was kept in a cupboard near where the equipment was stored outside the theatres.

Members of the public we spoke to in the waiting rooms stated that they had witnessed staff washing their hands on their arrival to the diagnostic room.

If the department were made aware that a patient attending an appointment had an infectious illness, they would plan the appointment for the end of the day, sectioning of the appropriate area to reduce the risk of cross infection and ensured the room was cleaned fully after the appointment.

If a patient on the ward needed to remain isolated due to infection, staff would attend the ward to carry out plain film procedures rather than bringing them down to the department.

The department had a recovery area which was visibly clean. We identified some liquid cleaning products which had been left unsecured on the side; we brought this to the attention of the staff who took appropriate action.

**Environment and equipment**

The service had suitable premises and equipment and looked after them well. The areas we visited were visibly clean and tidy.

The department carried out risk assessments of all its equipment and we saw completed up to date risk assessments for the X-ray rooms, dual energy X-ray absorptiometry ((DEXA) a DEXA scan is a special type of X-ray that measures bone mineral density (BMD)) and Fluoroscopy.

The DEXA room was equipped with a hoist to assist children with mobility issues and the department had use of a mobile hoist. Radiation monitoring badges or dosimeters were issued to staff and we observed that these were worn at all times. These badges were used to measure how much radiation the staff receive. The badges were sent away every two months to be read and the results collated by the Radiation Protection Supervisor (RPS) for each modality. The results were then shared with staff and were available for them to view on the intranet. If the reading was abnormal the member of staff would be spoken to and all actions of the member of staff would be reviewed to ensure their safety. Role specific staff, for example cardiologists and intervention Radiologists, received additional radiation monitoring in the form of a ring and/or eye lens, which fitted onto their glasses.

The X-ray department and the CT/MRI departments were secure, with swipe access from the main waiting areas to restrict entry.

The waiting areas were comfortable and had enough seats for patients and family members. The rooms were decorated interestingly and had toys available. There was a television screen detailing the departments opening hours and directing patients to the appropriate waiting area with a prompt to check in with reception, which was located outside of the waiting area.

CCTV systems had been installed in the main waiting area, but were not yet in operational. These were to assist staff out of hours identifying when a patient was waiting and to protect the safety of the staff members working alone.
The department had a recovery area which provided two beds for patients following general anaesthetic. Each bed space had curtains for privacy and dignity. There was also emergency equipment available should it be required. There was available space for further beds but this was currently being used to store portable x-ray machines and spare trolleys.

The X-ray rooms had illuminated warning signs to indicate when in use. The doors also had warning signs and contact details for the radiation protective supervisor. Diagnostic rooms had appropriate safety areas to ensure the safety of the staff during use of the equipment. There were sufficient protective gowns available for patients and their parents and these were in good condition and decorated with animated characters. In x-ray room 1 staff showed us a portable lead lined screen which was used to ensure that the results of x-rays were not seen by patients and their families prior to reporting. This ensured that they did not receive incorrect information.

There were no staff changing areas in the department, only lockers and staff did tell us that they found this inconvenient. There were however, shared facilities in the adjoining emergency department.

There were limited changing facilities for patients within the department. Some of the rooms had curtained areas for changing. However, staff informed us that these were not regularly used and patients normally remained in their own clothes during the procedure. On occasions they needed to change into a gown they would use the toilet within the procedure room, we were informed by staff that this was because the curtain rails were not secured and had previously fell down.

Staff were aware of their responsibilities in ensuring equipment was clean and suitable to use. Staff used cleaning and testing checklists in each diagnostic room which detailed daily and weekly checks specific to the equipment they were using. We saw that these were documented and kept in files within the rooms. We checked a sample of these checklists and found gaps in the recording of some of these checks. The checks were conducted twice daily and the orthopedic imaging system (EOS) and DEXA equipment appeared to be missed the most frequently.

The medical engineering team held an equipment inventory for the department and planned all the routine maintenance. Urgent maintenance was arranged by radiology staff and the lead radiographer is informed. The service reports were then returned to the lead radiographer.

We were told the diagnostic equipment is owned by the trust who manage, the maintenance contracts and that the department are working on developing a replacement plan with the medical engineering team. However, we were told a concern which staff had was that there was no contract in place for the oxygen sensors on the MRI scanner which would affect the use of the machine.

There was one resuscitation trolley available for the radiology department, which was located in the recovery area and staff were aware of its location. Resuscitation equipment trolley was checked in line with the resuscitation equipment checklist, which outlined specific daily checks along with a monthly full trolley check. Staff told us that the checks were carried out by theatre staff and not radiology staff. We reviewed the checklist between 4 December 2017 and 6 February 2018, we identified that the daily checks were not undertaken over weekend days when the service was not operational. There were six occasions when the checklist had not been completed during weekdays. We also found that the full monthly check for January had not been completed, which we brought to the attention of the staff. We were told the electrical equipment on the trolley was checked and managed by the medical engineering department.

During our check we found an emergency medication box on the resuscitation trolley that was overdue for checking. This meant there was a risk that emergency medication may be out of date.
for use when required. We brought this to the attention of the staff who took appropriate action. We observed children’s resuscitation medication boxes available in different areas within the department such as the CT scanner, anaesthetic room and X-ray area, we found these were in date and sealed.

The department carried out risk assessments of all its equipment and we saw risk assessments for the X-ray rooms, DEXA and Fluoroscopy, these were in order and up to date.

For staff safety there were two panic buttons in the night base area, however there was only one available which was not easily assessable and was positioned in X-Ray room under the desk, behind a screen. Staff told us that they did not feel there were adequate safety systems in place to protect staff when they are working in the department on their own.

We observed waste segregation within the department; the clinical and domestic waste was in separate bins and clearly labelled. We also observed sharps bins available in the department which were secured to equipment and contained safety lids. We checked the sharps bins and found they were below the maximum fill line.

Diagnostic Reference Levels (DRL’s) were in place for staff both locally and nationally. DRLs should be set for representative examinations or procedures performed in the local area, country or region where they are applied. Diagnostic reference levels mean dose levels in medical radio-diagnostic practices. These levels are expected not to be exceeded for standard procedures when good and normal practice regarding diagnostic and technical performance is applied. Evidence of DRLs was seen in the general rooms and CT. Work was also in progress to produce local DRLs for cases in the interventional suites in theatre.

We found that a quality assurance programme was in place. This was linked in with the radiology protection advisor service. There was a rolling protocol set up details went onto the computer system which highlighted results out of tolerance. There were some that were out of tolerance but actions had been put in place. The radiology protection supervisors held an official appointment letter.

**Assessing and responding to patient risk**

The service planned for emergencies and staff understood their roles if one should happen.

The department had appointed radiation protection supervisors (RPS) in each clinical area, five in total. The Radiation protection advisor was easily accessible for providing radiation advice.

We saw evidence that staff in diagnostics had read and signed the Local Rules (IRR 99). The purpose of these local rules is to ensure that work is carried out in accordance with the Ionising Radiation Regulations 1999 (IRR99) and relevant guidance documents.

In all areas in the department we saw clear, prominent signs informing staff and patients where the areas and rooms were where radiation takes place.

The magnetic resonance imaging (MRI) unit sent out a patient safety check list whenever a child was to attend an appointment. The form was to be completed by the parent about the child, prior to attending the appointment and brought with them. Questions included; ‘Has your child had a previous MRI scan’, ‘could your child be pregnant’ (answer for females over 12 years). The form was a simple check list and explained briefly what magnetic resonance imaging was.

Warnings signs asking patients to tell staff if they may be pregnant were clearly displayed on doors into radiation controlled areas. The imaging service ensured that women who are or maybe pregnant always informed a member of staff before they were exposed to any radiation in
accordance with IR(ME)R. This was to help protect an unborn child from radiation exposure which may cause it harm. There was also a trust procedure in place.

Children aged 12 years and over attending the department, who were to be exposed to radiation, were also asked safety questions, which included whether they had started their menstruation cycle and whether they could be pregnant. If staff felt it necessary they would ask the child away from the parent, to allow the child to disclose if they were or there was likelihood they were pregnant. This was not recorded anywhere.

Since the last inspection we found improvements in the procedure. We saw a new letter which informed patients that they would be pregnancy tested. The Trusts radiation protection policy dated September 2017 stated that a pregnancy test should be completed prior to undertaking any radiological procedure with a typical fetal dose exceeding 1.0 mGy in females aged 12 and over. This form was sent out to all patients whose appointment was for specific radiological procedures, which included; CT of abdomen and a renal scan. The letter informed the patient of the risks of the procedure and why they are to be tested and what happens to the results. Patients were informed to bring a sample of urine with them to their appointment.

The department did not routinely check glomerular filtration rates (GFR) prior to contrast injection. Glomerular filtration rate is a measure of kidney function and is performed through a blood test. The Royal College of Radiologists guidance states that that the blood test for renal function levels should be checked and made available. However, this guidance was aimed at adults. The lead radiologist was aware of this and whether a change of current systems were appropriate, was under discussion. However, the patient referral required the referrer to answer the question; “Is there any renal impairment?” This was also part of the magnetic resonance imaging checklist. The trust current system did not follow the guidance, but had adapted it for children and did take precautions. Staff would always check renal function when appropriate. The lead radiographer stated that a blood test can be an extra trauma for a child, therefore if there was no renal impairment known, or suspected, then a test was not carried out.

There were clear processes in place to escalate unexpected or significant findings both at the examination and reporting stage.

The department did not have an escalation policy for unexpected findings as a result of an x-ray; however, the radiologists followed good practice by backing up the results on the electronic system with a phone call to the referrer. This was not written as a policy, but there has been an agreement on the protocol.

Out of hours a ‘Red dot ‘system was used to identify fractures etc. on the images to alert the emergency department. If any abnormalities were missed out of hours, the radiologist would attend at the emergency department to ensure the patient is followed up.

In the orthopedic imaging system (EOS) room (EOS Imaging Scan is an innovative ultra-low dose X-ray imaging system that scans a patient whilst they are standing upright), we saw additional prompts for the safety of patient’s including; shoes to be removed and to use micro doses in all circumstances apart from during the patient’s first attendance.

In the EOS there was a visible emergency call bell for patients to use in the case of an emergency.

The department had a business continuity plan for emergencies and staff had action cards available to define their roles in such circumstances. However, the action cards were stored electronically therefore would not be accessible if there was a power cut.
We saw a ‘recovery quick reference guide’ in the anaesthetic recovery area which had a pain management document for staff to refer to and the neonatal morphine protocol.

**Staffing**

The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.

At the time of our inspection the overall whole time equivalent figures for the department were 61.95 and in post were 52.50. The department was established for 12 radiologists but had three vacancies. As a result of being unable to recruit to these posts, the department had appointed a fellow (A clinical fellow is a senior specialist trainee, usually in their final year of radiology training who has selected paediatric radiology as their subspeciality interest).

It was reported on the risk register in December 2017 that the current levels of radiographic staffing within main x-ray were not sufficient to safely man all areas effectively. We were told that this was mainly down to management organisation and that radiology staff were not invited to the theatre planning.

Local inductions took place for all grades of staff new to the department. The induction period was between six to eight weeks dependant on the role. All new staff spent two weeks familiarising themselves in each department. We were informed that all new staff had a mentor. At the time of our visit we spoke to a new staff member who had recently been through induction. They had conducted a full day assessment in the x-ray department, but stated they had only had a mentor for one day.

All staff new to the department received a welcome pack which included; local rules and standard operating procedures (SOP’s).

We were not aware of a lone working assessment within the department; however, an issue concerning the waiting room had been raised and was being addressed. The configuration of the department meant that the staff were unable to see the patients in the waiting room until they physically attend in the waiting room to collect them. Staff who worked in the evening at weekends were unhappy with this.

**Vacancy rates**

Between December 2016 and November 2017, the diagnostic imaging core service was overstaffed by 10% which meant the trust has more staff in place than what was established by the trust to provide quality care.

*The information provided for vacancy rates is across all staffing groups within diagnostic imaging.*

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

**Bank and agency usage**

Between November 2016 and December 2017, the Radiology department had a total of 42 shifts filled by bank and/or agency staff.

The department did not routinely use agency staff and bank staff were always their own staff who were familiar with working on the department.
Medical staffing (radiologists)

12 WTE Radiologists, nine in post. Appointed a fellow. 38 radiographers and sonographers short staffed in radiologists. 2 vacancies, national shortage. 61.95, 52.50 in post.

Turnover rates

Between December 2016 and November 2017, the trusts average turnover rate for medical and dental staff was 1%.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Sickness rates

Between December 2016 and November 2017, the trusts average monthly sickness rate for medical (radiologists) staff was 1%.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Records

Staff kept appropriate records of patients’ care and treatment. Records were clear, up-to-date and available to all staff providing care.

The department carried our electronic reporting; the system allowed grading of reports as they were entered.

The current IT system used in the department could not check whether the referred reports had been read. However, the next update of the IT system will allow this to happen although as yet it isn’t auditable. The Trust clinical information officer was a radiologist and totally committed to improving electronic access, electronic patient records and other systems.

GP reports were faxed from the administration office within the department to individual GP practices. Fax numbers were manually inputted which could lead to human error. CT scans could be seen instantly by the consultant via the electronic system.

Medicines

The Trust had an up to date medicines management policy which was available to all staff on the intranet.

The department had an anaesthetic room to administer general anaesthetic which was visibly clean. The room contained a safety checklist which was completed and recorded by theatre staff. Controlled drugs (CD’s) were stored correctly in a secure cabinet within the anaesthetic room. Drugs which required being stored at low temperatures were kept in fridges. The fridge temperature was monitored and recorded, however there was no temperature range displayed, therefore staff did not know whether the temperature was within the correct range.

We observed medications were stored correctly in locked cabinets and staff told us that the keys for the medication cupboards were held by the recovery nurse.
We checked a sample of medicines from the secure cabinet, the fridge and other drugs cabinets, within the anaesthetics room and found them all to be in date and stored correctly.

Radiographers were able to administer a small number of medicines themselves by following a patient group direction (PGD). PGD’s allow staff to administer medicines without the need for a prescription. In the department radiographers were authorised to inject contrast for CT and MR and prescribe Hyoscine-N-butylbromide, an antimuscarinic agent (used in radiology as an antispasmodic agent. It is employed to freeze bowel motion as part of fluoroscopic, CT and MRI).

We found that the PGD’s relevant to the department were comprehensive and covered relevant drugs and the correct doses; however, none were signed by the authorising individual. The most recent and in date final signed version of the PGD should always be used. We saw evidence of communication dating back to 24 June 2017 with regards to the progress of the signing of the PGD’s but the actual signing had not been completed at the time of the inspection. We raised this issue and arrangements were made for the PDG’s to be signed which we saw evidence of.

Diagnostic techniques in nuclear medicine use radioactive tracers which emit gamma rays from within the body. Nuclear medicine uses radiation to provide diagnostic information about the functioning of a person's specific organs, or to treat them. Diagnostic procedures using radioisotopes were now routine. In the department Isotopes were delivered in pre-loaded syringes for each patient ordered from the weight of each child. Prior to the examination the child’s actually weight was checked, if the patient’s weight was less than expected, the quantity was adjusted and any unrequired isotope was disposed of in a designated sink in the preparation room. If a patient failed to attend for an appointment, then short life Isotopes were place in a lead-lined box and left to decay, until they were no longer active.

Radiology did not have its own pharmacist or technician; we were told that this was because they held limited control drugs in the department. The pharmacist attended the department once every six months to view the records. The department held a defined stock list and stock book and regular stock was delivered to the department. Once a month staff in the department checked the drugs stored for any dates nearing their end of life and against the stock list.

The Gamma camera had a separate drugs stock book.

The pharmacists were available for the department 9.30am to 4pm week days and were on call evenings, weekends and bank holidays.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

There were 89 incidents reported in Radiology between 1 January 2016 and 31 January 2017.

When things went wrong, staff apologised and gave patients honest information and suitable support. Staff gave us an example of ‘Duty of candour’ (meaning they should act in an open and transparent way in relation to care and treatment provided) regarding a patients’ mother who had accompanied their child for a Fluoroscopy, (Fluoroscopy is a type of medical imaging that shows a continuous x-ray image on a monitor, much like an x-ray movie). The mother had not worn the correct protective clothing, a lead apron. When it was realised by staff, the parent was contacted immediately and the error was explained to her and radiation risk discussed.

Clinical incidents were shared between all relevant staff via a number of meetings, which included; fortnightly management team meetings, fortnightly department leads meeting and weekly meeting of harm. Also, a daily morning safety huddle in main x-ray department attended by radiographers
included learning from incidents.

A representative from the department attended regular Radiology Events and Discrepancies (READ) meetings which is a confidential system for sharing incidents, events and discrepancies in radiology, accessible to all members and Fellows of the Royal College of Radiologists.

There was a risk register in place which was used accordingly. One manager told us of concerns with a particular brand of syringe drivers. When they were used the system would alarm as it was too sensitive. The issue was placed on the risk register and the company attended and the software was updated. To eradicate staff error, all staff also underwent re-training with the equipment.

If an incident occurred in theatres, staff knew to report it to the theatre co-ordinator, who would then input it on the computer system. Staff we spoke to stated that they would be given feedback during the morning huddle. However, we spoke to one radiographer who reported an incident that happened in theatres regarding staffing and they did not receive any feedback. We looked at the incident reporting system and saw that the incident had not yet been actioned.

A trust weekly meeting of harm was attended by staff in the department where issues were discussed and recently scheduling in theatres was highlighted by the radiographers as an issue, but this had not yet been responded to.

We saw evidence of lessons learned and themes identified. We saw actions taken after an investigation took place in March 2017 regarding an increased number of incidents in the department. An example of one of the incidents was an x-ray being carried out on a one year old instead of an ultrasound. The report identified that in the last 6 months of 2016 the department had three incidents involving not checking patient or clinical details correctly and four using the wrong detector. This was compared with three incidents of not checking details correctly and two using the wrong detector from 25 January 2017 to 17 February 2017. As a result, a new Standard operating procedure was written and disseminated to all staff in May 2016. This highlighted the importance of the PAUSE checklist in preventing errors such as imaging the wrong patient, imaging the wrong body part, using the wrong modality and not checking the correct detector is selected. The PAUSE checklist was then given to all radiographers throughout March 2017. The incidents were continually monitored. On reviewing the audit results between September 2017 and December 2017 the average compliance rate for completing the PAUSE checklist was 93%

In the anaesthetic recovery area, we saw a ‘recovery quick reference guide’ available for staff, which included; emergency preparedness resilience and response guide and a clinical concern flow chart, which staff could follow in order to raise a concern.

**Never Events**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From December 2016 to November 2017, the trust reported no incidents classified as never events for diagnostic imaging.

Four radiation incidents were reported to IR(ME)R since April 2017, and none of which fitted the criteria to report to CQC.

(Source: Strategic Executive Information System (STEIS))
Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SIs) in diagnostic imaging which met the reporting criteria set by NHS England from December 2016 to November 2017.

(Source: Strategic Executive Information System (STEIS))

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.

The department followed up to date evidence-based guidance from organisations such as the National Institute for Health and Care Excellence (NICE) and Royal College of Radiologist Guidance. Staff were aware of new relevant guidance which was passed down from governance meetings to local team meetings.

Any change in The National Institute for Health and Care Excellence (NICE) guidance was disseminated from the radiologists to the radiographers via email.

The radiology department actively carried out a number of audits in order for them to make improvements where required. We saw a radiation protection audit schedule which was based on a three-year rolling programme. Every few months a new audit would be brought in, which included radiation risk assessments and lead aprons.

Audits were not carried out on staff completing the post procedure screen on the radiology information system. There was poor use of staff checking on screen that they had confirmed the patients ID and had justified the necessity of the procedure.

Any new policies that were applicable to the staff in the department were displayed in their rest rooms/office and once the individual staff had read them they signed and dated the policy to acknowledge this.

The department had an audit lead and we saw evidence of regular audit meetings held every two months. The meetings were open to all staff; however, recently there had been no representation by radiographers. We were told by Radiologists managers that there were plans in place to re-introduce the multidisciplinary meetings.

Patient outcomes

The service monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.

The department participated in national NHS benchmarking and were currently involved in a benchmarking exercise run by an external agency. This bench marked paediatric hospitals and provided a formula for comparison and discussion. This was not an NHS bench marking project but was more appropriate for the Trust.

When comparing with other NHS Trust for percentage of outpatient MRI scans done within 72 hours the results were 90% which was rated as green. For inpatient MRI scans done within 24 hours the results were 77% which was rated as amber.
The department held regular discrepancy meetings and there was a discrepancy lead. The department followed the Royal College of Radiologists guidance for their system.

The department did not participate in the Imaging Services Accreditation Scheme (ISAS), but management were aware of the scheme.

**Competent staff**

The service made sure staff were competent for their roles. Managers appraised staff’s work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.

Staff had continuous professional development (CPD) opportunities which were managed by department leads and the department manager.

All staff who administered radiation were appropriately trained. Records of training of all staff who acted as operators were managed by the theatre lead radiographer.

There were no assistant practitioners in the department. Assistant practitioners in radiology performed limited treatment procedures, having assistant practitioners in the department would alleviate the radiographer from certain minor roles. They also work alongside the radiographer helping with aspects of an episode of care under the direct supervision of the radiographer.

Supervision of trainees was supervised by consultants and in accordance with IR (ME)R. The radiographers were trained and authorised to inject Isotopes, this formed part of their post graduate training and was not a delegation duty. Post graduate nuclear medicine imaging courses have modules that are competency based clinical practice which the staff had completed.

There were checks conducted in the department on Health and Care Professions Council (HCPC) registration by the Radiology manager. At the time of our visit we saw that the checks were in progress as registration was due at the end of February 2018.

Staff did not have any additional training to manage issues arising from patients with mental health conditions or learning disabilities. However, we saw staff dealing with patients with additional needs well, showing skill and dedication. Staff we spoke to stated that they felt additional training would be beneficial.

Staff we spoke to were familiar with the term ‘Duty of candour’ and told us they would always inform their line manager and patient if incidents occurred.

All radiologists in the department undertook their own reports. All images were reported by radiology except the Cone Beam CT. Cone beam computed tomography (CBCT) is a medical imaging technique consisting of X-ray computed tomography where the X-rays are divergent, forming a cone.

The radiology report is primarily a written communication between the radiologist interpreting the imaging study and the physician who requested the examination. This meant there were no external checks of competencies.

Radiographers did not write reports as we were informed by the lead radiologist that there were no recognised training programmes for them in paediatric hospitals. The department had approached the society of Radiographers to develop a course to be recognised but this has not yet progressed.

We saw that all staff had read the local rules and signed accordingly.
Additional radiation protection training had been developed by the lead radiographer in theatres for non-radiology staff. The presentation was delivered on a one to one basis and the training had been well received.

The Royal College of Radiologists and the College of Radiographers have developed the Imaging Services Accreditation Scheme (ISAS) to support diagnostic imaging services to manage the quality of their services and make continuous improvements. We spoke to the lead radiologist who told us the department was aware of this scheme, however they had no time to participate and no resources.

Currently the department did not report on the cone beam CT scanner, as no members of staff are trained to do this, we were told by the radiologist lead that this is something the department plan to address.

**Appraisal rates**

Between November 2016 and December 2017, 78.6% of staff within diagnostic imaging at the trust had received an appraisal.

A split by staff group can be seen below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Number of staff required (YTD)</th>
<th>Number of staff who have received an appraisal (YTD)</th>
<th>Completion percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified Healthcare Scientists</td>
<td>34</td>
<td>33</td>
<td>97.1%</td>
</tr>
<tr>
<td>Qualified Allied Health Professionals</td>
<td>42</td>
<td>36</td>
<td>85.7%</td>
</tr>
<tr>
<td>NHS Infrastructure Support Staff</td>
<td>11</td>
<td>9</td>
<td>81.8%</td>
</tr>
<tr>
<td>Support to Doctors and Nursing Staff</td>
<td>4</td>
<td>3</td>
<td>75.0%</td>
</tr>
<tr>
<td>Medical &amp; Dental Staff - Hospital</td>
<td>12</td>
<td>0</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

*(Source: Routine Provider Information Request (RPIR) P43 Appraisals)*

**Multidisciplinary working**

Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.

The department had very effective multidisciplinary team working and the appropriate sub speciality radiologist attended daily multidisciplinary team meetings.

We saw excellent multidisciplinary team working within the interventional suite in theatres.

Where appropriate any previous images taken within the department, or from outside referrals, were used to prevent unnecessary exposure to radiation. The region had a shared computer system so any regional examinations are always available. Outside the region other centres images are sent via the image exchange portal.

We saw good team working in theatres as staff worked together in using the Bi-plane hybrid equipment. It required teams to work together during the procedure and communication and organisation pre-procedure was key.

The Radiographers worked well together and there was good team communication. The radiographers we spoke to knew how to contact radiologist out of hours for advice and all the
contact numbers were readily accessible, however we were told that it was usually the Emergency Department (ED) who would contact them.

**Seven-day services**

Radiologists were on call evenings, weekends and bank holidays. The radiologists were not based in the hospital whilst on call, but were contactable by phone and attended when required. All staff were aware of the out of hours list and how to contact a radiologist out of hours.

Radiographers were available 24 hours a day, 8am to midnight, with an on-call service after midnight, seven days a week.

The department did not offer open access for CT and MRI scans from GP’s seven days a week. However, there was a walk-in service available for plain film imaging.

**Health promotion**

During our visit we spoke to a patient who was at the age for transition from the children’s radiology department. They said they had been receiving care at Alder Hey for many years and had always been part of the decision-making process. They had made decision regarding their own operations and when attending the radiology department, were always spoken to rather than staff speaking to the parent attending with them. This meant that the service was maximising patient independence.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

Consent is given from the parent /guardian for the majority of children seen in the department. Children under the age of 16 can consent to their own treatment if they’re believed to have enough intelligence, competence and understanding to fully appreciate what's involved in their treatment. Staff understood the relevant consent and decision making requirements of legislation and guidance for the Mental Capacity Act (MCA).

**Is the service caring?**

**Compassionate care**

The radiology reception is within the main atrium of the hospital therefore, service users can be overheard when speaking to the receptionist.

A chaperone service was not in place for patients attending for an ultra sound. No invasive ultra sound was carried out in the department however, some intimate examinations were. There were no assistants in the department and radiologists and sonographers worked alone, dependant on the parent or guardian to act as a chaperone. There was a risk that the lack of chaperones may leave the radiologist/sonographer vulnerable to allegations. There were no incidents reported at the hospital, but we spoke to one radiologist who felt that it was a risk and something would only be done about it when an allegation was made.

All staff we saw on our visit were encouraging towards the children, sensitive and had a supportive attitude. We spoke to service users in the waiting room who all stated that the staff were kind and caring.

Staff in the x-ray department told us that they did not always change patients into gowns prior to the x-ray and they remained in their own clothes. Staff believed that asking the children to change added to the fear of the examination.
A number of children were referred to the department having been unable to have had a scan carried out elsewhere due to their learning disability, or nervous state. The referral was for the child to have a general anaesthetic for the procedure to go ahead, however due to the sensitive and caring nature and skills of the staff, distraction techniques were used to encourage children onto the scanners and to remain still for the required period of time. In the majority cases children were successfully scanned without the use of a general anaesthetic.

We were told of one occasion when the patient had a learning disability and was particularly uncomfortable with the equipment and was showing signs of distress, the radiographer showed empathy and skill and after an hour was able to proceed with the scan.

**Emotional support**

No information leaflets were sent out to patients with appointment letters. We were told by staff in the Magnetic Resonance Imaging Unit (MRI) that a child friendly leaflet explaining the procedure in simple terms used to be sent out, however as it was only sent out printed in the English language they were told by staff at the hospital to stop sending it out. Currently children and parents know little, or nothing about what to expect at the examination to support them.

We spoke to the trust clinical information officer during our visit and saw a demonstration of a new website/system for the trust which included patients and carers being able to access information about the department and their procedure. One example we were shown was a video of a child having an x-ray taken. The rolling out of this system was imminent.

Those patients who were attending the unit for an MRI or CT scan were directed together with their parents or carers, to another paediatric hospital in the area to watch an information video about the procedure.

**Understanding and involvement of patients and those close to them**

Patients and their carers were always made aware of what happened after their appointment and it was explained to them how they would get the results. The carers were informed to contact the clinicians after the appointment if they were worried about their treatment or condition.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

The trust planned and provided services in a way that met the needs of local people.

The environment was appropriate and patient centred. We saw sufficient seating in all the waiting areas and toilets were easily assessable.

In the department was a soft play area for children to reduce stress. We also saw playhouses and toys in the waiting rooms and in the ultra sound rooms.

In the ultra sound department lights with sounds were displayed onto the ceiling to distract younger patients whilst staff undertook the procedure.

The Alder Hey website had a very easy to use and child friendly department finder. Under radiology users can view a visual representation of the journey they may have. The presentation was written in plain text with photographs depicting a child going through the process of having an x-ray.

The department was positioned off the outpatient area, but not well sign posted from the hospitals main entrance. However, there were numerous ‘Happy to help’ volunteers offering assistance and directions to children and their families and easy to spot in bright pink T-Shirts.
The waiting rooms were well appointed but there were no pagers available to allow people using the service to wait elsewhere or attend the cafes for refreshments. However, no parents or carers we spoke to found this an issue.

We reviewed the turnaround times for 2016 and 2017 and the department had demonstrated improvements during 2017. Turnaround times are the time from examination to the report being available. Throughout 2016 and 2017 the turnaround times for Outpatients remained within the threshold or above at 85% within 14 days.

**Meeting people’s individual needs**

The hospital’s patient-led assessment of the care environment (PLACE) score for 2017 showed the provision of a disability friendly environment was 66%, which was lower than the England average of 83%. The PLACE is to provide a snapshot of how an organisation is performing against a range of non-clinical activities.

We spoke with managers in the department who told us that all the equipment in the department was suitable for bariatric patients as it had been designed for adults.

For patients whose first language was not English, a telephone interpreting system was available and on-site Interpreters were easily accessible to the department. Staff in radiology told us they regularly used these aides.

If an interpreter was required it would flag up on the system and the administration staff would organise this for the date of the appointment.

Play specialist were available to assist the department with patients, however we were told that they had to be pre-booked in advance and due to the staff not knowing the child’s needs prior to the appointment, this was not possible. This was because it was not recorded on the referral. Staff said that it would be more helpful if they knew the child’s need on referral or if they could call on play specialists ad hoc, but due to the demand of them, this was not possible.

We saw a big emphasis on allowing children to feel comfortable in the environment prior to their appointment. We saw a mini scanner available for children to play with in the waiting room. The scanner doubled up for patients attending x-ray, MRI and CT and gave them an insight into what would be expected of them.

To help ensure children were relaxed and did not panic whilst on the MRI scanner, they were able to choose a DVD from a selection that the department had, or bring their own to watch during the scan. The children were able to do this by wearing a special telescope glasses and head phones. This distraction enabled the child to be scanned without a general anesthetic.

The corridor walls had been decorated with transfers, some of which were age neutral and others aimed at very young children. The radiology main waiting room had a large mural painted on the wall. We did receive feedback from one older patient who said there were no facilities in the waiting rooms to accommodate older children. We did not see any activities to occupy older children.

There were very few information leaflets available for patients and families. The main waiting area of the department had a couple of leaflets; information on free legal advice service and one regarding Alder Hey children’s charity.

Records did not ordinarily contain details of patient’s mental health needs, or learning disability alongside their physical health needs. If a patient has been referred from a consultant at the hospital, they would more often than not call the department and inform them of any additional
patient’s needs, in preparation for their appointments, however junior doctors and outside GP referrals did not share this information.

Access and flow

The department was meeting the six-week diagnostic test national standards for both diagnostic monthly and non-diagnostic monthly reportable examinations; however, we were told it could be challenging for MRI scans due to fluctuating demand and additional clinics. The national standards are mainly for general anaesthetic lists and plans were in hand to provide an additional weekly general anaesthetic list to support it. Diagnostic monthly reportable are specific exam types which are CT, MRI, ultra sound, nuclear medicine examinations and DEXA where the waiting time is reportable monthly to the clinical commissioning group or contracting service on behalf of the Department of Health. If targets are not met (there is a 1% tolerance) it may affect income, depending on the contractual agreement between the trust and the clinical commissioning group. Non-diagnostic monthly reportable examinations are any other diagnostic exams where a waiting list is generated and is variable from site to site. In children it may include plain imaging or other contrast examinations. As implied these are not reportable to the clinical commissioning group or the Department of Health but can affect patient care so it is good practice to monitor these.

The department had a rolling rota of reporting allocated to consultant radiologists on each day. Reports were prioritised based on clinical information and urgency. Radiologist complete emergency department patient’s reports first, followed by outpatients and then GP referrals.

The department did not audit did not attend figures therefore, staff were not aware of any problems and put in place ways to ensure patients had access to services when required. We spoke to staff in magnetic resonance imaging unit who stated they believed they had not attend on a daily basis and the day we spoke to them they had had three patients who did not attend for their appointments. This meant that other patients may have been able to have an appointment earlier.

We spoke to the lead radiography and quality lead who planned to produce a performance dashboard which would include did not attend data and waiting times. The lead stated that the department could then be more responsive to patient and department needs. This had been discussed at the department governance meetings.

People could access the service when they needed it. Waiting times to admit treat and discharge patients were in line with good practice.

We spoke to a number of patients’ parents and carers none of which had to wait long once they arrived in the department for the appointment.

Learning from complaints and concerns

The Radiology department had no reported complaints between 1 February 2017 and 31 January 2018.

Overall, they had very few complaints. Complaints received through The Patient Advice and Liaison Service were responded directly to the complainant. The radiographer lead and radiologist lead would investigate any complaints together. Each complaint was looked an individually and changes made when appropriate. As there had been so few complaints received management were not aware of any trends.

Any learning from complaints was shared in the senior staff meeting. A recent complaint received was regarding an alleged injury caused to a child during a scan, a considerable time ago. Their complaint system proved to be robust as they managed to trace the documentation that was
recorded at the time and were able to clarify which staff members were involved and the details of the incident. This complaint was then investigated and responded to.

**Is the service well-led?**

**Leadership**

The service had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care.

The managers we spoke to in the department during our visit appeared knowledgeable and enthusiastic about the department, and their roles.

All staff we spoke to said that they could speak to the managers about issues and felt supported.

The radiology manager had weekly open-door sessions for any staff to approach them with issues, or for discussions. There was no deputy manager in radiology and this left an ever-expanding role for the manager. The team were committed and effective but due to them all having clinical duties they told us they could not support managerial issues.

**Vision and strategy**

There was no vision statement on the trust website or in the radiology department for the service.

Students undertook placement in the department for paediatric experience. We also saw students from various other hospitals during our visit. Radiology trainees wishing to get specialist paediatric experience were rostered to Alder Hey from the Deanery (medical post graduate training). This was part of the plans for the service.

There was a strategy in place for the replacement of the equipment and was planned with medical engineering for future replacement, via a managed service contract.

**Culture**

Huddles were a choice of communication method for the staff to share information and incidents, a quality huddle took place daily. In addition to this, a monthly meeting was held for all staff members to attend, we saw minutes to this meeting. A senior huddle took place every Tuesday.

Staff we spoke to seemed happy in the organisation and worked well as a team.

The senior staff we spoke to were committed and happy and had worked for the Trust for a long period of time. There had been moral issues in the past and most staff put this down to the move to the new hospital. It was evident that efforts had been made to turn this around.

We did not see evidence of duty of candour being used as there were only few incidents in the department and they did not meet the threshold for duty of candour. However, all staff we spoke to were aware of what duty of candour was and how to meet it. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of ‘certain notifiable safety incidents’ and provide reasonable support to that person.

The radiology lead had regular open-door opportunities for staff to attend and discuss any issues or problems they had.
There was a strong emphasis on the safety and well-being of staff with regards to radiation protection. The radiology lead in theatres was continually monitoring safety of the staff both radiology and non-radiology trained.

Staff had raised issues about safety concerns and were informed that there were cost implications. Staff often worked alone in the evenings due to the other member of staff being on the wards, or in theatres. Staff raised concerns and put forward an idea to make them feel more secure in their environment, which was refused. They felt that the trust did not see their concerns as priority.

**Governance**

There was a clear governance structure in place and information was shared throughout the staff structure via; the department monthly meeting, daily multidisciplinary team (MDT) meetings, and monthly clinical effectiveness, where the risk register and any relevant incidents were discussed.

The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

Service level agreements were in place with an outside agency for radiation protection and radiation protection adviser service, we saw evidence of this.

The Trust also has a service level agreement with two other local trusts allowing them to use the orthopedic imaging system (EOS).

We saw minutes to the radiation protection committee meetings which are held twice yearly, attended by all radiation protection supervisors, radiology manager and senior consultants.

The service had tested back up emergency generators in case of failure of essential services and during the first morning of our visit, a practice took place within the hospital to test this. Under the supervision of the electricity provider, the electricity to the mains was cut off to the hospital. The radiology department tested that all imaging equipment could be used on the back-up generators alone. The event was successful, with minimal disruption.

A senior staff meeting was held monthly, bringing together consultants, radiographers and office managers. They discussed issues and provided information to changes, events and presented any new guidance. We spoke to senior staff members who said that everyone was given a chance to contribute and it felt like a true team meeting. The minutes of the meeting were made available to staff on the shared drive. We attended a morning staff meeting during our visit and saw that it was well attended.

Quality and sustainability were discussed in relevant meetings and the department ensured that there were adequate meetings to include all levels of staffing; a management team meeting was held twice weekly, department leads meeting held monthly, Imaging optimisation meeting, held every six months, which was attended by the radiology protection supervisor and a monthly Radiation Governance and Quality meeting.

**Management of risk, issues and performance**

We saw evidence of a radiology audit and update meeting every two months. We had sight of the agenda for a number of meetings, one of which showed a meeting to discuss an audit of cone beam CT dosage.

We reviewed minutes of the monthly radiology governance and quality meeting and saw that it was comprehensive and well attended. It discussed risk and performance, including; Patient advice and liaison service complaints, quality audits, standard operating procedures, health and safety, incident reports, risk reports and investigation reports called root cause analysis.
The department held management team meetings twice a week, which were well attended and we saw minutes to evidence this.

There were arrangements for identifying, recording and managing risks, issues and mitigating actions. The department held a risk register and it clearly described the condition, cause and consequence of the risks. However, one example on the risk register was the current levels of radiographic staffing within main x-ray were not sufficient to safely man all areas effectively. This was placed on the register in February 2016. The cause was recorded as; new patient flows and work practices without any increase in staff numbers, for example Theatre 8am to 6pm new rota and the consequence; reduced service and increased demand on current staff leading to closure of the department. The action was for a business case to be developed. The risk was last reviewed on 30 January 2018 and had still not been actioned. We spoke to the radiologist lead who told us that a business case was being put forward for more staff to meet the needs of the theatres and to develop staff fellowship roles.

The statistics for the department’s key performance indicators were generated outside radiology and sent to them on a monthly basis to discuss in staff meetings.

**Information management**

The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

The department used the Clinical Record Interactive Search (CRIS) system. This enabled staff to safely and securely review real life scenarios using information from the trust's clinical records. This meant it was easier to see patterns and trends, such as which treatments worked for some and didn’t work for others. CRIS is not used outside the radiology department.

The use of CRIS is combined with the Picture Archiving and Communication System (PACS). This stores all imaging digitally and can be accessed for immediate review from any computer in the trust. Together this allows the department to receive electronic referrals, book all referrals, book appointments and produce radiology reports.

Staff actively updated all patients’ notes including actions taken on the electronic system. We were told that an upgrade to the system within the department was imminent, which would take the system to the next level.

**Engagement**

The department participated in the NHS Friends and Family Test which asked patients to rate how likely they would be to recommend the service to their friends and family if they needed similar care or treatment. The results on 10 January 2018 were 86% said they were extremely likely to recommend the service, which was an increase on the results from 4 November 2017 which was 80%. However, both the November and January results were a decline from the results on 6 Sept 2017 which was 95%.

**Learning, continuous improvement and innovation**

The service was committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation.

Staff were encouraged and supported in striving for continuous improvement and innovation via the appraisal system and personal development plans.
Staff in the gamma camera department of radiology had produced a new patient leaflet for young children and children with learning difficulties. The gamma camera is an imaging technique used to carry out functional scans of the brain, thyroid, lungs, liver, gallbladder, kidneys and skeleton. Gamma cameras image the radiation from a tracer introduced into the patient's body by injection. The leaflet was pictorial with one simple line of text describing what will happen when the child attends the department. The leaflet had been developed but at the time of our visit had not been authorised to use. The leaflet was to be teamed with a journey video which would go on social media. The vision was then to adapt this leaflet and video for all radiology appointments.

We spoke to the chief clinical information officer and consultant radiologist who told us of a planned IT development which was a significant innovation and would improve information and service across the trust. The new system was to go live the following week after our visit, which allowed integrating records and actions.

The hospital had invested in an orthopedic imaging system (EOS) which is an innovative ultra-low dose x-ray imaging system that scans a patient whilst they were standing upright. Alder Hey Hospital was the first pediatric hospital in the UK to have this scanner. The orthopedic imaging system (EOS) uses an ultra-low dose of radiation to provide extremely detailed, high-quality images. It uses a significantly lower radiation dose than a general radiography x-ray, two to three times less than a general computed radiography x-ray and 20 times less than basic computed tomography scans. This really benefited children who needed to be imaged frequently. With the orthopedic imaging system (EOS) the consultants can make more informed diagnoses and create individualised treatment plans for children with musculoskeletal disorders.

We spoke to a newly appointed manager who had plans to implement changes to the staff uniforms. They stated that the department was child friendly and as the uniforms were stark white they were very medical and were not child friendly. They believed that the uniforms were intimidating to the children and planned to introduce colourful uniforms, possibly with characters on them. We were told that the staff survey for 2017 agreed with this.

We saw the Bi-plane hybrid equipment in theatres; this allowed CT as well as fluoroscopy and allows the patient to be scanned during an operation. Prior to this equipment being available, patients would have to be transferred to the radiology department after an operation; this could happen a number of times for the same patient. This relative new equipment prevented this from happening and saved time and distress for the patient. This was also a cost-effective treatment.
Community health services

Community health services for children, young people and families

Facts and data about this service

Alder Hey Children’s NHS Foundation Trust (the trust) delivers a range of community based services to children and young people across Liverpool and Sefton in a variety of community settings including home visits, at schools and health centres. Services are delivered in localities across the trust’s geographical footprint. These are North, Central and South Liverpool, and North and South Sefton.

The community division is clinically led by a divisional director, supported by an associate chief operating officer, an associate chief nurse and a team of clinical leads and service managers. The division provides care and treatment within four specialism areas; neurodevelopmental paediatrics, community therapies, community nursing, and children and adolescent mental health services.

The neurodevelopmental paediatric directorate provides services including neurodevelopment paediatrics, autistic spectrum/attention deficit hyperactivity disorder (ASD/ADSD) assessment, neuro-disability, and specialist genetic clinics. This directorate also provide statutory services for looked after children and adoption, designated doctors, and had a lead role in safeguarding in the trust’s Rainbow Centre.

The community therapies directorate provides services including physiotherapy, occupational therapy, dietetics, speech and language therapy, continence, ASD/ADHD nursing, and also included the hearing impairment network.

The community nursing directorate provided community matron and community nursing services for children with complex care needs and acute care needs.

The children and adolescent mental health services (CAMHS) directorate, which was not included in our inspection, provides mental health services including psychiatric assessment, single point of access and crisis care, eating disorder service and two community CAMHS services, Liverpool and Sefton, which offer a range of therapies and interventions to help children or young people who are struggling with how they are feeling, thinking, or the way they are doing things.

The community children, young people and families services have not previously been inspected at this trust.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity. We visited the trust’s community children, young people and families services as part of our unannounced inspection between 5 and 9 February 2018. We inspected the whole core service and looked at all five key questions. We spoke with 14 children and carers and 68 staff from different disciplines, including support staff, healthcare assistants, allied health professionals, nurses, doctors, managers and senior managers. We observed daily practice and viewed 42 sets of records across all the services we visited. Before and after our inspection, we reviewed performance information about the trust and reviewed information provided to us by the trust.

Homecare services were provided predominately by healthcare assistants.
Is the service safe?

Mandatory training

The service provided mandatory training in key skills to all staff. Training was a mixture of on-line and classroom learning. Staff told us they were given time and encouraged to complete all required training.

Across the services there were varying rates of compliance with mandatory training. There were a number of modules where compliance rates for medical staff were below the trust target of 90%, for example moving and handling and infection control level two. However, staff were aware there was a mandatory training programme and told us they were up to date with the majority of their training. Managers reported that mandatory training rates were in the region of 90% and that this was a priority for staff transferring from a previous provider in order that their training could be determined and supported appropriately.

The service manager told us some individual staff member’s training for moving and handling objects had expired. However, the manager was not aware of which staff members were out of date with this training. At the time of the inspection, the manager was unable to demonstrate clear plans or dates for when eligible staff would receive the training, or actions to mitigate the associated risks in the interim.

After the inspection, the trust clarified this situation had arisen because this staff group had transferred from another provider and moving and handling training records were in the process of being migrated to the trust’s training record system. Compliance with moving and handling training for this group of staff was subsequently reported by the trust at 70% in April 2018.

Sepsis training was included in the service’s mandatory training programme from March 2017. At the time of the inspection 49% of eligible staff had completed the training. The service told us a plan was in place to ensure the remaining staff received this training by May 2018.

Community nursing staff

All community staff

By the end of November 2017, 89% of all staff in the community services division had completed their core framework mandatory skills training. This was just short of the trust’s target of 90%. At the same time, 85% of the division’s staff had completed their role-specific mandatory training.

The trust has an internal target of 90% for completing all mandatory training courses.

A breakdown of all mandatory training courses taken between November 2016 and October 2017 are shown below;
Four modules exceeded the trusts 90% completion target for mandatory training with the highest scoring module achieving 94%. Four modules also failed to meet the trusts target with the lowest scoring module; manual handling – objects scoring 17%.

Medical staff

The trust has an internal target of 90% for completing all mandatory training courses.

A breakdown of all mandatory training courses taken between November 2016 and October 2017 are shown below;

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Sum of Completion rate (%)</th>
<th>Average of Trust Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>34</td>
<td>36</td>
<td>94%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and Handling</td>
<td>33</td>
<td>36</td>
<td>92%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>33</td>
<td>36</td>
<td>92%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>33</td>
<td>36</td>
<td>92%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>28</td>
<td>34</td>
<td>82%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>28</td>
<td>36</td>
<td>78%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Other (Please specify in next column)</td>
<td>15</td>
<td>36</td>
<td>42%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>4</td>
<td>23</td>
<td>17%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

Infection prevention level one exceeded the trusts 90% target with 91%. The remaining seven mandatory training modules failed to meet the target; Infection prevention level two was the lowest scoring module with 46%.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Safeguarding

Staff understood their role in recognising and preventing potential abuse. There were systems in place to ensure that children were appropriately protected.

The service clinical director was the safeguarding lead for the division.

All staff we asked were able to recognise and describe the types of concerns that would be reported as potential safeguarding referrals. Staff were aware of how to obtain safeguarding
advice from the trust’s Rainbow Centre or from the local authority’s safeguarding Care Line. One member of staff, who was completing their safeguarding training at the time, showed us evidence of the process for reporting an incident and the escalation process should it warrant a safeguarding assessment. They were able to explain their understanding between a general concern and a reportable incident.

The Rainbow Centre was a contact point for all safeguarding concerns related to children across the region and for all children, young people or young adults who were patients of the trust either in hospital or in the community. The Rainbow Centre was a sexual assault referral centre. It included specially designed interview rooms for interviewing children thought to have been subjected to sexual abuse or assault.

The Rainbow Centre was staffed with on-call community paediatric doctors on a one-in-five-week rota basis, including staff trained in safeguarding children levels four and five.

All staff in the service had completed safeguarding children level three training. This included training on female genital mutilation, child sexual exploitation, and the Respect Young People’s Programme (aggression within the family environment). Staff told us the training was useful. However, although there was some consideration by staff within the Rainbow Centre for vulnerable adult safeguarding for younger adults (over the age of 16) and for adults over the age of 18, some staff in the wider community services were not aware of having received any safeguarding vulnerable adults training.

Community nursing staff actively attended looked after children, and child in need meetings, including the local safeguarding children’s board meetings when required.

During our inspection we observed a senior member of staff in the community nursing team managing a safeguarding alert relating to a patient on their caseload. The staff member demonstrated a good understanding and knowledge of the procedure for reporting safeguarding concerns. We also observed the staff member providing a thorough handover of information about the alert and providing support to other members of the team. It was evident that staff were concerned for the wellbeing of the patient and had found the situation very distressing. The team spent time discussing the event, offering support to each other.

**Nursing and allied health professional staff**

The trust has an internal target of 90% for all safeguarding training modules.

A breakdown of all safeguarding training courses taken between November 2016 and October 2017 are shown below;

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Sum of Completion rate (%)</th>
<th>Average of Trust Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>36</td>
<td>36</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>26</td>
<td>26</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Both Safeguarding Children levels one and three achieved a 100% completion rate surpassing the trusts target of 90%.
Medical staff

The trust has an internal target of 90% for all safeguarding training modules.

A breakdown of all safeguarding training courses taken between November 2016 and October 2017 are shown below;

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Sum of Completion rate (%)</th>
<th>Average of Trust Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>28</td>
<td>29</td>
<td>97%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>25</td>
<td>29</td>
<td>86%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

Safeguarding Children level three achieved a 100% completion rate surpassing the trusts target of 90%. Safeguarding Children level one failed to meet the trusts target with 86%.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff kept equipment and the premises clean. They used control measures to prevent the spread of infection.

We observed staff adhering to cleanliness, infection control and hygiene practices. We observed staff adhering to the ‘arms bare below the elbow’ protocol and washing their hands before and after contact with patients in clinics and within patients’ homes. Staff wore personal protective equipment, including disposable aprons and gloves, when providing clinical care to patients.

There were sufficient antibacterial gel dispensers and hand washing facilities in the premises we visited.

Premises used in the provision of care and treatment were visibly clean and tidy. Community services staff were responsible for cleaning any equipment used; for example, toys used by the community physiotherapy and speech and language therapy staff were wiped clean after use with appropriate antibacterial wipes.

We saw evidence of hand hygiene checks for individual staff, which indicated good compliance with hand hygiene standards. At the time of the inspection, the service had agreed a plan to ensure each team will have an infection control/tissue viability link nurse. It was envisaged that, once implemented, the link nurse staff would support hygiene awareness and would carry out audits across all the community children, young people and families’ services.

We saw evidence that location and environmental risk assessments were carried out for premises across the trust’s community services geographical footprint. These included reviews of the cleanliness of clinic rooms and equipment.

Environment and equipment

The service had suitable premises and equipment which was well maintained.

All equipment we viewed appeared to be in good working order and, where appropriate, had been electrically tested. Staff were aware of how and when to report any issues with equipment.

Records showed that all equipment used for patients either in clinics or in their own homes had been risk assessed for the patient’s individual usage. Equipment risk assessments were updated yearly or as equipment changed.
The physiotherapy team in Liverpool developed a rolling programme of risk assessments to monitor the environment and equipment used by patients on their caseload. The cycle started each September and ran throughout the year. Any equipment used by patients, such as hoists and walking aides, was checked for safety by a qualified practitioner.

We observed individual patients’ risk assessment records held by the team. These clearly identified which school patients attended and a list of the equipment being used. The list of practitioners responsible for ensuring the equipment maintenance was kept up to date. We spoke to a senior member of the team who was responsible for ensuring the staff managed this effectively.

We were told that when a particular item of equipment was required, representatives from equipment supply companies were invited to discuss the product. This enabled the team to make a decision on the most suitable equipment for the patient’s needs. This process was available for both routine and urgent items. The representatives also provided the training to staff across the community and worked alongside the physiotherapy team with the patient and families.

The community nursing team held stocks of clinical supplies for use in the community. We reviewed a random sample of the equipment held. All supplies we viewed were within the manufacturer's recommended expiry dates. The stock cupboards were tidy and uncluttered, and an effective stock rotation system was in place which ensured that the oldest equipment was used first.

However, staff in the community nursing team did not carry equipment, including items such as sharps boxes, in concealed containers when transporting them to and from patients’ homes. This increased the potential risk to staff safety. Similarly, contrary to the trust’s policy on transporting samples, staff did not use an appropriate container for transporting blood samples from patients’ homes to the hospital’s pathology department. We raised both these issues with the team manager who agreed to take action to obtain appropriate transport containers.

The clinic in North Sefton was a shared facility with sexual health services. Staff raised concerns about this as they have overheard and observed conversations from patients attending sexual health services that were inappropriate for children to overhear. The service manager told us they had shared their concerns with the trust and requested that screens and better signage were ordered and installed to make the waiting room more appropriate for children. Children’s toys were available in this clinic for a range of ages.

**Assessing and responding to patient risk**

Staff we spoke with described how they would identify or respond to a child with deteriorating health. This ranged from arranging an appointment with or visit from their GP to dialling 999. All staff across the service were trained in basic life support. The service’s specialist respiratory therapists had received additional training on clinical examination and were able to escalate care if needed.

At the time of the inspection, the trust’s sepsis policy did not include a specific community pathway; however, the sepsis steering group had been asked to develop additional guidance to support staff working in the community in varied roles and settings. Sepsis was included in clinical mandatory training and staff induction training form March 2017. Of those community staff that were eligible, 49% had received sepsis training as part of mandatory training, and a plan was in place for ensuring the remaining staff had received this training by May 2018. A tailored paediatric
sepsis e-learning package was also being developed for use in mandatory training of all clinical staff. This was expected to launch in April/May 2018.

Community nursing staff told us they had the skills to recognise a patient showing symptoms of potential sepsis but they had not received any specific training. Staff told us the team did not use any form of paediatric early warning score system because the majority of patients they cared in the community were stable. Any patients discharged to community from the acute hospital had had illnesses treated and were stable before discharge. Daily team handover meetings ensured any relevant patient information was shared with staff.

There was no information in Homecare patient records regarding what to do if a child’s health appeared to be deteriorating. The Homecare healthcare assistant staff were trained to undertake a number of patient vital observations and equipment checks. However, they did not use a paediatric early warning score system to help support them in managing a deteriorating patient. This would help in recognising changes in the child’s condition and in contacting relevant parties for advice or intervention if required.

We observed four examples of patient risk assessments for patients being cared for by the physiotherapy team. All of these outlined safe manual handling procedures of patients with varying needs. The assessments included the patient’s preferences of moving and handling techniques and the practitioner’s assessment of safe moving and handling. Where equipment was used as an aid to manual handling, a risk assessment of its use and maintenance was also included. A copy of these risk assessments was filed in the patient notes and a copy given to the patient and their school or nursery.

**Nurse, healthcare assistant, allied health professional and medical staffing**

Staffing levels and skill mix were planned, implemented and reviewed to keep people safe. Managers monitored staffing caseloads.

At the time of the inspection, there was 230.5 whole time equivalent staff members employed. Of these, 17.9 whole time equivalent staff were doctors, while the remainder were nurses, healthcare assistants and allied health professionals. This was just marginally lower than the planned establishment of 232.3 whole time equivalent staff for the division.

In the physiotherapy service a caseload waiting tool, developed by the national paediatric physiotherapy managers group, was used. This took into account children’s individual complexities and aimed to ensure average caseload weighting of 50% of hours worked for each therapist. Caseloads were discussed at team meetings and through managerial supervision.

The speech and language team held an optimum caseload of 35 children requiring active care input per full time therapist. Where therapists held a larger caseload, this was because the interventions needed by children were less complex. Clinical caseload capacity and supervision sessions were in place.

Therapies staff we spoke with told us they were comfortable with current staffing levels and caseloads and did not have any concerns about how the staff were put into place and deployed. Managers told us that they have an ongoing dialogue with staff and follow safer staffing guidelines and allocated staff to meet the needs of patients.

The Homecare service had 44 healthcare assistant staff, allocated to specific teams for each of the 12 patients in the service. This ensured consistency for the patients and families. The service was overseen by a band seven manager with six band six team leaders. All staff we asked felt there were sufficient staff within the service to ensure that care and treatment was co-ordinated and delivered to meet the needs of patients.
The Liverpool physiotherapy team was well staffed with permanent staff. There were 36 members of staff and covered a range of posts, for example a manager, clinical specialists, physiotherapists and physiotherapy assistants.

**Quality of records**

Staff kept appropriate, clear and up-to-date records of patients’ care and treatment. There were varying arrangements in place to provide the correct information that staff needed to deliver consistently safe care and treatment to patients.

Patient records were managed across the service in different ways. There were three electronic systems in use within the community services; the trust’s main electronic patient record system; a shared access community based electronic system; and an electronic system used for managing correspondence.

We observed high levels of quality in the 42 sets of records we reviewed. Entries were legible, dated with the name of the professionals who had recorded care clearly.

Paper records used by the therapy teams were securely stored within the North Sefton and Liverpool offices and were well organised. The records were of good quality, were easy to navigate, were regularly reviewed which meant that staff could easily view information about the care and support planned and delivered by the team.

Homecare records, held in the patient’s own home, were returned to the main office on a monthly basis. We reviewed a number of these records, which showed they contained limited details about the care and support given by staff. These records were reviewed by an administrator using a checklist. Although this included checks such as whether or not the notes were all recorded in black ink, staff told us there was no clinical review by a registered professional of the record to determine if safe care and treatment had been consistently provided.

The trust subsequently clarified that clinical review by a senior nurse was undertaken if a trigger was reached in the administrative check. Following the inspection records are now reviewed weekly by the administrator and supervising Homecare nurse.

We also noted there was a risk of delays in updating records in patients’ homes as care plans changed. This was because the new records had to be printed and taken to patients’ homes. Staff were sent a memorandum when changes were made to make them aware. Leaders told us there were future plans to introduce electronic tablet working; however, there were no dates set as to when this would be implemented.

The trust’s electronic systems included warning flags. These could be used to highlight any high-level issues such as looked after children, or safeguarding concerns. Although the flagging system was well-used, leaders told us of their concerns that potential over-use of the flagging system could dilute its effectiveness, particularly in relation to safeguarding children. This concern had been raised at high level and was on the services risk register.

**Medicines**

None of the community services we visited held stocks of medicines. Medicines used in the community had been prescribed either by patients’ GPs or doctors within the hospital. Two respiratory physiotherapists had just qualified as non-medical prescribers; however, the service
was still in the process of developing processes for this so the staff members had not yet started prescribing.

Community nurses supported patients in the community who were discharged from hospital but required outpatient parenteral antibiotic therapy in the community. Nurses were able to seek advice on the management of the antibiotics from the trust’s outpatient parenteral antibiotic therapy team. The team also held anaphylaxis epi-pens for adults and children. It was each individual nurses’ responsibility to check the manufacturers’ recommended expiry date and to order replacements from the pharmacy.

In Homecare, patients’ relatives had a high level of input in the care and treatment of their children. As a result, there were close working relationships between families and the healthcare assistant staff who provided the care and treatment. This meant there was shared responsibility in a variety of care areas including the administration of medicines. However, patient care plans and records we viewed in the Homecare service did not contain information detailing the responsibilities of staff in supporting their patients to take medicines when they were on duty.

The dose of medicines being given by Homecare staff was not recorded on patients’ individual medicines administration records. As a result, managers could not monitor the amount of medicine administered by their staff in line with the prescription or check that staff had correctly adjusted any dose changes as needed.

There were no clear instructions to support staff in administrating as required medicines other than the labels. For example, if a patient needed an as required medicine due to agitation, there was no specific individual instructions in any of the records that described what the individual patient’s agitation looked like, if the patient could ask for the medicine, or in what circumstances the medicine was to be given.

We reviewed the trust’s medicines management policy. This appeared to focus on the management of medicines within care provided in a hospital environment. It did not appear to take into account the differences in care provided within a patient’s home by the Homecare services. A separate standard operating procedure for the community Homecare service for the administration of prescribed medicines had been developed. However, the standard operating procedure did not include information on the management of as required medicines or the administration, at parental request, of over the counter medicines by healthcare assistants in patient’s own homes. We identified one incident that had been reported in relation to the administration of an over-the-counter medicine by a staff member.

There were no arrangements to audit the practice of staff in the administration of medicines. There was a check that medicines administration records had been completed but not that the correct medicines had been given in the correct dose at the correct time.

Since the inspection, we have been told the standard operating procedure will be reviewed and the medicines administration record will be redesigned to improve the recording of medicines administration in line with best practice.

We reviewed incident reports across all the trust’s community services. These included 58 medicines incidents between the dates of 15 February 2017 and 30 January 2018. Of these, 33 incidents were for prescriptions that had not been received by families. Service leaders told us they were aware of this issue but, because these medicines could be off-licence, GPs in the area were not issuing the prescriptions as needed and these were therefore being prescribed by the hospital. There were no clear plans as to how this high proportion of medicines incidents would be addressed or the risks reduced. One family told us they came to the hospital to pick up their medicines as prescriptions could not be relied on to arrive at the correct time.
Staff also told us there was a delay of up to 28 days in letters from consultants leaving the hospital. We noted there were six consultant’s letters to GPs changing medicines doses that were delayed in being sent out. This meant medicines changes were not being managed effectively. Leaders we spoke with in the service were aware of these concerns but were unable to tell us of any specific details or plans to resolve the issue. However, transcription delays were on the trust’s corporate risk register and actions were identified to reduce the delay.

We noted one incident within the Homecare service, logged by a staff member who had administered over-the-counter pain relief medicine to a child at the parent’s request. The staff member logged the incident as staff had been informed the service could not support the administration of over-the-counter medicines. This was because there was no over-the-counter medicines administration policy in place.

Safety performance
The Homecare service monitored the development of pressure ulcers, but reported that none of their patients had ever developed a reportable pressure ulcer.

However, safety performance measures were not routinely collated or monitored across the wider community service.

Incident reporting, learning and improvement
Staff understood their role in reporting safety incidents. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff we spoke with knew how to raise an incident. Staff told us that, in recent months, they had started to receive information about incidents. We saw evidence of shared discussion and learning from incidents in team meetings; however, this was not consistent. For example, despite an automated notification process on the incident reporting system, staff we spoke with in the Homecare team told us they inconsistently received emails about incidents, and they did not always get information about incidents.

Staff in North Sefton did not have access to the trust’s main electronic system and, as such, verbally reported incidents to be logged by a member of staff with access to the correct system.

Homecare staff did not have access to computers or laptops in the community, and either had to either verbally reported incidents to the nurse coordinators (who logged incidents on their behalf), or return to the office. However, staff told us there were occasions when they did not return to the office for extended periods of time. Cover, by the on-call team, was available 24 hours a day to support Homecare staff to do this; however, Homecare staff voiced concerns that the on-call team were not always aware of the nature of their service.

Staff we asked were aware of the statutory duty of candour principles. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person.

Never Events
Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
From December 2016 to November 2017, the trust reported no incidents classified as never events for community children, young people and families.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS
In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SIs) in community children, young people and families which met the reporting criteria set by NHS England from December 2016 to November 2017.

(Source: Strategic Executive Information System (STEIS))

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and comprehensive assessment of patients’ needs.

Staff within the community children, young people and families service provided care in line with national guidance from the National Institute for Health and Care Excellence, and in line with the requirements and guidance from their professional bodies. The service’s policies and clinical guidelines were available on the trust’s intranet, and staff knew how to locate them.

Although the service did not include school nurses or health visitors, staff worked in liaison with them. Staff asked were aware of best practice health promotion such as the Healthy Child Programme. Community nursing teams followed national guidance, and in line with internal guidance from the outpatient parenteral antibiotic therapy team.

We reviewed four care plans of the 12 children with long-term conditions and complex needs supported by the Homecare service. These did not have clear personalised goals and did not always refer to best practice.

Nutrition and hydration (only include if specific evidence)

Staff monitored and children’s nutritional and hydration needs were met.

The majority of patients in the Homecare service received diet and fluids via enteral feeding. This meant patients received nutritionally complete food, containing protein, carbohydrate, fat, water, minerals and vitamins, directly into the stomach, duodenum or jejunum. Healthcare assistants delivered this service and had received training to meet these needs.

Fluid balance records were used to monitor patients’ hydration levels. These were checked on a monthly basis when records were returned to the hospital base. Each daily record included a number of checks by staff to ensure the use of the correct delivery system for enteral feeding. Care records also included some checks on the patients’ skin around the enteral system site in order to make sure that any issues with the feeding system could be identified rapidly.

Dieticians ran weight management clinics working closely with families to provide support and guidance to manage the weight of the children seen. There were links between the speech and language therapy dysphagia team, the dietician and paediatricians.

Drinks were available for patients receiving occupational therapy or physiotherapy in clinic.
Pain relief (only include if specific evidence)

Although staff provided pain relief if needed and adjusted care and treatment plans accordingly, there was inconsistent use of formal pain assessment across the services or guidance for the administration of pain relief.

We saw no evidence of care plans in the Homecare service that included an appropriate pain assessment and management plan, or guidance on provision of pain relief on an as per required need basis.

The occupational therapy and physiotherapy services used the paediatric pain profile tool. This supported staff in awareness of both verbal and non-verbal expressions of pain in children, which included checking with parents on what was normal for their individual children.

Staff adjusted care and treatment plans accordingly if a child was expressing pain. Records we reviewed in the occupational therapy and physiotherapy services indicated that pain relief was provided when needed.

Patient outcomes

The speech and language service had developed a patient outcomes framework. Therapists used a clinical reasoning tool when developing patient care plans. This enabled therapists to produce an individualised care plan based on each patient’s specific characteristics and conditions. The tool was also used to compare the patient’s level of need at the start of treatment with their level at the time of discharge.

Therapists compiled a comprehensive report on discharge for each patient which was sent to the patient’s GP. This outlined the treatment provided and included guidance and an ongoing plan for the patient so that their family and school could continue supporting the child in their daily life.

The respiratory physiotherapy team carried out a paediatric care measure (PCM) 10Q audit with parents of children in receiving care and treatment. The audit was designed to measure patients’ experiences of how therapists talked to them and help the service to set outcomes. We were shown a comparison of the service’s 2014 and 2016 audit results, which showed positive improvement.

The Liverpool physiotherapy service monitored the number of treatment episode goals achieved against the care aims approach. This showed that 82% of patient goals were achieved against the service’s target of 80%.

There were no agreed service specifications in place for the occupational therapy and Homecare services. As such there were no formal patient outcome measures in place to determine the quality of the services provided.

None of the five Homecare treatment plans we reviewed contained patient aims, objectives, outcomes or goals. This meant that staff had no measurable care and treatment standards in place to determine if the care was correct in meeting their patients’ needs. Informal measures specific to individual patients were discussed in team meetings. These conversations also included patient outcomes such as whether any patient had developed pressure ulcers (of which there were none). Community services were in the early stages of collecting and monitoring patient outcomes. The Homecare service review was due to be completed in March 2018 which would include monitoring patient outcomes.
Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.

Staff learning needs were identified and assessed during their annual appraisal. All staff we asked told us they had received their yearly appraisal and found these useful. Management said they were achieving appraisals for all staff currently in work. Staff told us the appraisal process was valuable and provided opportunity for them to discuss their personal aims as well as mandatory training.

Medical and nursing staff were supported through the revalidation process. Revalidation is the process that all nurses and midwives have followed since April 2016 to maintain their registration with the General Medical Council or the Nursing and Midwifery Council (NMC) and to enable them to continue providing care and treatment.

Healthcare assistant staff in the Homecare service had undertaken competency assessments, which included areas such as managing tracheostomy sites (an opening created at the front of the neck to insert a tube into the windpipe to help breathing), safe usage of ventilators and basic life support for adults and children.

We reviewed a competency assessment for healthcare assistant staff relating to the management of medicines. This did not evaluate if staff knew how to report concerns, how to manage over the counter medicines, or how to complete relevant records. There were no clear arrangements in place to monitor ongoing practice and support of healthcare assistant staff whilst they worked unsupervised in the community.

There was a joint training approach for relatives and carers supporting patients in their own homes. This was done to ensure that the families and staff were all fully aware of the patients’ needs and were able to provide safe consistent care. We saw evidence within the community nursing team of training competencies for both staff and parents on tracheostomy and gastrostomy care. The community nursing team was supported by a practice educator.

An induction programme was in place for new staff within the division. Two new speech and language therapists told us their induction was a positive experience; they were offered weekly supervision within the first three months and then monthly supervision thereafter. New staff undertook competency assessments in line with the requirements of registration with their professional body. We viewed one staff competency file which was fully completed and had been appropriately signed-off by a team-leader.

Staff learning needs were identified and assessed during their annual appraisal. All staff we asked told us they had received their yearly appraisal and found these useful. Management said they were achieving appraisals for all staff currently in work. Staff told us the appraisal process was valuable and provided opportunity for them to discuss their personal aims as well as mandatory training. Data provided by the trust showed that not all staff had received their annual appraisal; however, overall appraisal completion rates were above the trust target.

Appraisal rates

Between November 2016 and December 2017 86.9% of staff within community children, young people and families at the trust had received an appraisal. This was below the trust’s target of 90%. A split by staff group can be seen below:
<table>
<thead>
<tr>
<th>Staff group</th>
<th>Number of staff required (YTD)</th>
<th>Number of staff who have received an appraisal (YTD)</th>
<th>Completion percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support to Doctors and Nursing Staff</td>
<td>99</td>
<td>96</td>
<td>97.0%</td>
</tr>
<tr>
<td>Other Qualified Scientific, Therapeutic, Technician Staff</td>
<td>60</td>
<td>56</td>
<td>93.3%</td>
</tr>
<tr>
<td>Qualified Allied Health Professionals</td>
<td>119</td>
<td>110</td>
<td>92.4%</td>
</tr>
<tr>
<td>NHS Infrastructure Support Staff</td>
<td>79</td>
<td>73</td>
<td>92.4%</td>
</tr>
<tr>
<td>Qualified Nursing and Health Visiting Staff</td>
<td>35</td>
<td>30</td>
<td>85.7%</td>
</tr>
<tr>
<td>Medical &amp; Dental Staff - Hospital</td>
<td>28</td>
<td>0</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

Nursing and health visiting staff had an appraisal rate of 85.7% and Medical and dental staff failed to complete any appraisals during the reporting period

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

It should be noted that the data above included community mental health staff. When this data is extracted this shows the appraisal rate for the community children, young people and families services we inspected was 91%. This was above the trust’s appraisal completion rate target. The trust clarified that appraisals for medical staff are typically undertaken in quarter four of the year, which is not reflected in the data which was provided at an earlier point.

**Multidisciplinary working and coordinated care pathways**

Staff of different kinds worked together as a team to benefit patients and to meet the range and complexity of patients’ needs. Doctors, nurses and allied healthcare professionals supported each other to provide good care.

Allied health professional, nursing and medical staff had built good working relationships in order to provide effective care and treatment to patients. Multi-disciplinary team meetings were held to review patients’ treatment. These included input from dieticians, physiotherapists, nurses and doctors and were clearly documented in patient records and an advanced plan put into place for each patient.

We saw evidence of joint working across all the community specialisms with other healthcare provider services such as school nursing teams, special educational needs co-ordinators, health visitors and social services including multiagency safeguarding hub teams.

Care reviews were held at least yearly to plan and deliver appropriate care and treatment. The reviews included input from all relevant internal and external stake holders and discussed individual patients’ care aims and progress which helped to co-ordinate care, and maintain continuity, for patients. Discharge summaries or letters were sent to referrers following discharge from the services.

Staff described effective multidisciplinary working between the respiratory physiotherapies and the neurodevelopment paediatric teams.

Community nursing staff described good working links with the speech and language therapy teams, and with the tracheostomy nurse specialist.
Health promotion

Staff were focussed on the Making Every Contact Count programme. This programme is based on ensuring that staff use every opportunity to promote health and wellbeing for patients.

Where staff recognised the need for additional support for patients or families, they made appropriate referrals to other specialisms or organisations, including the local authority and voluntary sector providers.

Staff involved parents, carers, respite carers and school staff in relevant training to support the children in their care. This included undertaking training within the classroom, where appropriate, to ensure that children did not miss out on lessons.

The physiotherapy teams worked closely with Firefit, the Liverpool youth zone centre to improve physical activity levels in children. This included setting up fitness and exercise groups in a gym (operated by a national chain) to encourage children living with disabilities to become more active.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Prior to the on-site inspection, the trust told us its consent policy provided guidance to support clinicians in determining if a patient is competent to provide consent. However, the trust recognised that while the policy encouraged patients who were Gillick competent to consent to procedures themselves, audits showed that it was mostly parents who provided consent for procedures on behalf of their child with the patient confirming their consent on the parental consent form. Gillick competence is where a child under the age of 16 is able to consent to their own medical treatment without the need for parental permission or knowledge.

Four of the twelve Homecare records we viewed did not demonstrate any consent to care and treatment or collaborative working with parents. Although parents we spoke with told us staff had discussed the care and treatment plans for their children with them, we found no written evidence to confirm they had been involved in the development of, or agreed to, their children's care plans.

None of the records we viewed in the North Sefton occupational therapy and physiotherapy services demonstrated evidence that the patients' capacity to consent had been considered or assessed. Staff told us they would defer to the parents.

During the inspection we noted that, of the 12 patients within the Homecare service, two were over the age of 16. We found no provision within both patients' records for consulting with the patients or obtaining their consent for care and treatment.

A community nurse told us the team had not received Mental Capacity Act training and that the majority of consent decisions were made with patients within the acute inpatient setting. The nurse told us that Gillick competency was discussed in safeguarding meetings, and that advocacy arrangements for young people transitioning into adult service would be raised in the transition steering group.

Although a consent form was available for occupational therapy and physiotherapy, it did not describe the treatment to be provided in the patient's own home. The form's design only made provision for the patient’s parent to sign their consent, and did not include provision for the patient to sign consent if they were competent to do so. This did not appear to be the version of the form included in the trust’s consent policy, which included provision for the patient to consent, if competent to do so.

Further, the consent form did not describe the risks and benefits of the care and treatment being consented to. Although staff did note in patient records that they had discussed the risk and
benefits with the parent, they did not specify exactly what was discussed or the parents understanding of the discussion. There was no evidence in the records that they included the patient in these discussions, unless the patient attended the treatment clinic on their own.

There were no training opportunities in the information provided that demonstrated the awareness of the mental capacity act and the two-stage assessment for informed consent.

All staff we spoke with in the Homecare service, North Sefton occupational therapy and physiotherapy including service managers, had no understanding or awareness of the mental capacity act and where unaware this applied patients from the age of 16. This included a lack of awareness that under do not attempt cardiopulmonary resuscitation guidelines and legislation, a competent child’s view on whether or not to resuscitate them should still be taken, where possible, although the child’s parents still carry parental responsibility.

We found no evidence that, where appropriate, do not attempt cardiopulmonary resuscitation orders were in use for patients over the age of 16 receiving care from the Homecare service. Resuscitation arrangements were in place as part of care planning documentation for patients under the age of 16; however, staff were not aware of any need to review these or to take appropriate legal advice if necessary once a patient reached the age of 16. During our inspection, we identified two patients where this should have applied.

Is the service caring?

Compassionate care

Staff responded compassionately when patients or their relatives needed help. Support was given by caring staff as and when required by patients to meet their individual needs.

There was a strong, visible person-centred culture. We observed interactions between staff and patients who used services. Staff from all staff groups were kind and caring towards patients and those close to them. Staff took the time to interact with patients in a respectful and considerate manner.

All staff we spoke with were focused on giving patients a high standard of care. Feedback received from patients and families who used the services was consistently positive. Patients or their relatives said staff always provided treatment in a caring was and were supportive of them as individuals.

We were told that, in the past, where some staff in the Homecare service had been identified as not supportive, or where the relationships between staff and the parents of the child did not function appropriately, staff were replaced. This meant that a proactive supportive relationship with the patient and their families which was nurtured and maintained.

We reviewed a number of cards and letters from patients and their families that were held by the speech and language team. Comments expressed thanks to the team as well as to individual staff members; such as, “I will always be grateful to (therapist) for what she has done” and “things at home are so much easier with your input”. One patient had written a poem especially in their own words to express their gratitude to a member of the team. Thank you cards from patients and families sent to the community nursing team included comments such as “I think you are a fabulous nurse” and “you have a great attitude and a really caring nature”.

The service carried out patient satisfaction surveys. The surveys supported patients to provide comments and to report on issues and themes. The results of these were consistently positive.
Emotional support

Staff recognised the impact of a person’s care, treatment or condition had on their wellbeing both emotionally and socially. Patients and their relatives who used services were given appropriate and timely support to cope emotionally with their care, treatment or condition. Patients’ privacy and dignity was maintained at all times.

We saw examples where patients were provided with emotional support to assist them.

The Homecare service supported patients to be cared for in a familial environment. This provided additional support to patient’s sense of well-being by maintaining a social and family life.

Staff had a good knowledge of additional services, including voluntary services, where patients in need of emotional support or advice could be referred. The speech and language team had made use of the Rainbow Centre where rooms, specifically designed to provide a supportive atmosphere, could be used for counselling.

Understanding and involvement of patients and those close to them

Patients’ personal, cultural, social and religious needs were determined, although they were not consistently recorded in order to meet individual needs.

All staff we spoke with talked to patients in a manner that was supportive to their individual needs. When patients enquired or were referred to the service, staff discussed with patients and their relatives the service that could potentially be offered. All patients and their relatives we spoke with said they understood the treatment they were having and were involved in making the decisions about their treatment.

All aspects of the care to be provided to patients in Homecare and North Sefton was discussed with them at the point of delivery in order to maintain a structured and supportive involvement. In Liverpool, physiotherapy staff shared their care plans with the patient, parents and with the child’s school where appropriate.

However, care records contained limited information regarding individual social, cultural or personal preferences. This was particularly noted in Homecare where social activities, such as time out with parents or attendance to school, was supported by healthcare assistants but did not form a clear part of the planning.

We observed staff taking time to clearly and carefully explain care and treatment to patients across all the services we visited. Staff were aware of patients’ non-verbal cues. Parents and relatives, we spoke with told us that staff provided information to their children in a way they could understand, that their confidentiality was respected, and that staff included their children in the decision-making process.

Is the service responsive?

Planning and delivering services which meet people’s needs

The service planned and provided services in a way that met the needs of local people.

A number of specialisms, including the therapy services, had transferred from another local healthcare provider in April 2017. The service specifications for these transferred with the teams, with at least one service (physiotherapy) working to an approximately eight-year-old ‘rolled-over’ specification.
Senior leaders were working with the local clinical commissioning groups to understand the contracts and existing service specifications and to assist the groups in understanding what the trust’s community services could provide. As such the majority of the community division services remained under review with the aim of making best use of the community resources and to further expand service provision in the future.

Services were provided across the Liverpool and Sefton areas, which included areas of significant multiple deprivations, including income deprivation. As a result, occupational therapy and physiotherapy staff told us that home visits were of particular benefit to patients and their families.

The speech and language team accepted referrals from a variety of sources such as health visitors, school nurses and special educational needs coordinators. A triage system was in place to individually triage and allocate referrals in accordance with each individual patient’s needs.

The speech and language team administrators used a spreadsheet to allocate patients to an appropriately experienced therapist once they had been triaged. The spreadsheet tracked staff caseload capacity and was helpful when allocating and managing caseloads. This enabled fair allocation across the team and assisted the team leader in monitoring the team's capacity and management of their caseload.

The speech and language service offered training to school nurses, health visitors and special educational needs coordinators on the criteria and process for referrals. This had improved the quality and appropriateness of referrals received by the team and enabled faster care delivery.

The physiotherapy team accepted referrals from general practitioners, health and social care teams, school nursing teams, patients and their families. The team had a triage lead practitioner who assessed all referrals and allocated to a member of the team. The staff we spoke to agreed that their caseloads were manageable and the allocations fair. The team scheduled follow-up contact with young people following transition into adult services. Staff told us this had been effective and beneficial for patients and their families as therapists may have been providing treatment to the patient for many years.

The physiotherapy team set up developmental variance clinics at local GP surgeries to support GPs who were seeing an increase in the number of patients with specific physical development issues that would usually need to be referred to a specialist team. The physiotherapy led clinics assessed specific physical development issues such as gait and posture. This allowed more time for therapy staff to carry out a specialised comprehensive assessment.

As a result, the service observed a significant decrease in waiting times for patients to be seen by a practitioner as a result of holding these clinics; although there was no formal data to support this at the time of inspection. Staff told us that many of the referrals received by the clinic referrals were from worried parents who had seen gradual changes in their child’s mobility; time spent working with these children in clinic had helped reassure parents that their child’s growth was normal and had seen a reduction in unnecessary onward referrals.

The Homecare service was developed to reduce the amount of time that patients with complex and long-term conditions spent within a hospital environment. The service provided care to 12 patients who would otherwise have been admitted to long-term healthcare.

The service provided care to patients in their own homes on weekdays between 8am and 6pm. An on-call service was provided in the evenings between 6pm and 10.30pm by band six and seven nursing staff. After 10.30pm, the hospital night matron and general management provided the on-call advice and support and advice. The on-call service operated between 8am and 10.30pm on weekends and bank holidays.
Managers and staff we spoke with told us the on-call service was often not useful as the on-call staff were not always aware of the needs of the community patients, could not access patients care plans, and could not obtain advice from staff who regularly provided care to the patients.

**Meeting the needs of people in vulnerable circumstances**

The service took account of patients’ individual needs.

The trust’s computer systems included an alert to highlight any significant vulnerability issues with children, including those who were living with learning disabilities, and those for whom safeguarding concerns were known. Staff were able to access advice and assessment from the trust’s learning disability liaison nursing team, and were supported by the trust’s learning disability strategy.

Physiotherapy staff providing care to children within the Royal School for the Blind in Liverpool had received additional training in sensory impairment and learning disabilities.

Within the speech and language service, we saw evidence of patient and family involvement in their care. We observed two examples where the team had offered alternative clinic times and locations to families with attendance problems. This helped to meet the different needs of the families so that they could attend together. There was clear evidence of individualised care aims throughout all of the documentation we observed in speech and language therapy services. The team assessed each patient on an individual basis and made decisions on the best location for their care; for example, school, and clinic or at home. We also saw clear evidence of family involvement in the patient’s electronic records. Paper copies of the care plan were given to the family and the school or nursery, to support those in providing continuity of care.

However, within the Homecare service, patients and their relatives were given information verbally. There was an emphasis on communicating and involving the parents and did not consistently or appropriately include the patient themselves. Written information was not available in differing formats including patient’s records that would allow the patient to be easily involved in understanding their care and treatment. Care records we reviewed for patients using this service contained no information on any communication barriers for the individual patients or the arrangements in place to overcome them. For example, where patients were unable to express views verbally but were supported to communicate by assistive technology these arrangements were not clearly detailed in the care records.

Staff were able to access translation services for children and parents whose first language was not English. This included telephone and face to face translation. Similarly, staff could access British sign language translation services if needed.

However, staff in one clinic in North Sefton, where the local community included a significant proportion of Polish speakers, told us they did not access the available translation services as patients or their families often provided informal translation. This was not in line with best practice and risked the mistranslation of important clinical information or advice.

Information leaflets were available in a number of the community services, and on the trust’s website. These were in English, although staff told us they could access leaflets in other languages if needed. However, leaflets we viewed were predominantly written for an adult audience of parents and carers, which risked excluding children from receiving information about their care in a format they could easily understand. We were unable to find evidence of any leaflets or information in alternative formats such as large print or pictorial format.
Access to the right care at the right time

People could access the service when they needed it. Waiting times from treatment and arrangements to accept, treat and discharge patients were, for the majority of community services, within agreed targets. However, there were significant and lengthy waiting times for the autistic spectrum disorder and attention deficit hyperactivity disorder pathways.

The community services division worked with colleagues in the trust’s acute hospital teams on a 30 day plus length of stay project led by the divisional director. The project identified suitable children, who had been admitted as inpatients for longer than 30 days, and brought together a range of acute and community teams, including social care, to provide a wraparound service which enabled children to be discharged out of hospital to home. At the time of the inspection, the service had enabled approximately 46 children, who may otherwise have remained as inpatients, to be discharged.

The service’s dietetics, speech and language therapy, physiotherapy and occupational therapy teams worked to an average eighteen-week referral to initial assessment or treatment target. All but two of the teams achieved this target between April 2017 and January 2018.

The physiotherapy team for children aged up to five years old set up open access clinics within local children’s centres. This provided access to advice for parents who may be worried about their child’s development, and enabled staff to assess whether or not the child needed specialist referral. This had resulted in a 19% reduction in caseloads for the zero to five years old team.

The physiotherapy services were meeting their eight-week referral to assessment target. At the time of the inspection, as a result of earlier triage, patients were being seen within 6.5 weeks.

For speech and language therapy, patients in Liverpool were seen within 13 weeks against an 18-week referral to treatment target. However, there were known delays in the Sefton area with children waiting an average of 19.6 weeks. Managers were working with the Sefton teams on a weekly basis, monitoring throughput and waiting times. Managers were also working with the local commissioners with referrals related to the autistic spectrum disorder referrals, which was expected to positively impact on the waiting times in the area. Staff told us that in some areas this had been reduced by six months.

The community nursing team accepted referrals seven days a week between 7.30am and 5pm from the acute hospital wards and in the community from GPs, parents and other health and social care professionals, with response offered in as little as a two-hour time period. An out-of-hours service operated between 5pm and 10pm.

No new care packages had been implemented in the Homecare service since May 2016. This is because the service was under review.

Within the neurodevelopment paediatrics services there were significantly long waiting times for referral, triage, assessment and diagnosis for children on the autistic spectrum disorder and attention deficit and hyperactivity disorder pathways. Staff told us that, as a related consequence, children were being referred earlier (and younger, pre-school) to services because of the waiting time, which added additional pressure to the waiting list.

Senior managers and service leaders acknowledged this significant risk, which had resulted from a combination of a long waiting list inherited from a previous provider and an increase in the number of new referrals received. The service had originally planned for 600 referrals per year; however, it was currently receiving up to 1500 referrals per year.
The lengthy waiting time for the pathways was recorded on the service’s risk register as well as the trust’s corporate risk register. Control measures, including recruitment to all vacant posts, had been identified to address the service’s capacity issues and to address the backlog. Weekly service reviews of the waiting list were undertaken by the service managers, and regular oversight reviews were conducted with the Liverpool clinical commissioning group to identify actions for improvement.

Referrals to the pathway were managed in date order. At the end of January 2018, 1159 children, for whom referrals had been received, were still waiting to be triaged. The service was awaiting additional information on another 214 children. The lengthy wait for triage meant the service was not meeting the NICE guidance CG128 Autism spectrum disorder in under 19s: recognition, referral and diagnosis recommendation that autism diagnostic assessment should be started within three months of the referral to the autism team.

In agreement with the clinical commissioning group, the service implemented multidisciplinary triage of referrals by senior clinician and therapist staff. This, combined with GP and primary care workshops to improve staff knowledge and understanding of the pathways, enabled the service to identify which referrals were appropriate to the team. With additional funding from the clinical commissioning group, the service undertook an extra 61 assessment sessions between June and December 2017. As a result, the waiting list for diagnosis reduced from approximately two years to 18 months.

Children remained under the care of their referring clinician while awaiting triage, assessment and diagnosis. This meant the management of any risks to the child’s physical health remained with their referring clinician. However, we saw no evidence of effective communication maintained with families, carers, or referrers during the lengthy waiting periods for triage. This was reflected in the number of contacts by families with the trust’s patient advice and liaison service which recorded 60 contacts relating to waiting times and 50 contacts relating to communication failure for the community paediatrics services.

Children were accepted onto the pathway for assessment and diagnosis following triage by a multidisciplinary team. At the end of January 2018, a total of 85 children had been accepted onto the pathway and were awaiting a joint assessment appointment. The service was awaiting additional information on a further 64 children pending assessment.

The service had a process to bring a child back to the multidisciplinary triage process where additional information was received from partner agencies or where concerns were raised about the child’s changing health needs. We saw evidence patients were assessed and re-triaged regularly in the records we reviewed. However, of the seven files we reviewed, two indicated the initial referral had been lost and a re-referral had been made.

We saw little evidence of good oversight of the whole process. NICE guidance CG128 Autism spectrum disorder in under 19s: recognition, referral and diagnosis recommends there should be a case coordinator identified in the autism team for every child or young person who is to have an autism diagnostic assessment. Cases we viewed were not allocated to a case co-ordinator to oversee, although we were told this was being looked at with a view to the neurodevelopmental clinicians overseeing cases.

The service was not commissioned to provide follow up appointments after diagnosis, which would be good practice (NICE guidance CG128 Autism spectrum disorder in under 19s: recognition, referral and diagnosis). However, other support was provided as part of a partnership within Liverpool, through schools, voluntary sector partners or another health service provider. The service also provided weekly drop-in sessions for advice to children and families.
Services across the community specialisms were challenged by the lack of provision of specialist adult services in the trust’s footprints for young people that had reached the age for transition into adult services. This meant the service continued to provide care and treatment for some young adults. This included adults up to the age of 25 within the neuro-disability, autistic spectrum disorder and attention deficit hyperactivity disorder pathways. This meant the waiting times remained a particular risk for young people referred to the autistic spectrum disorder pathway who were reaching the age for transition to adult services. Between January 2017 and December 2017, the service received 78 referrals for patients over 16 years of age, against the background of an approximate 18 month waiting list.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.

Staff members were aware of how to support patients to make a complaint or raise a concern. Formal complaints could be raised through the trust’s patient advice and liaison service. Information on how to contact the service was displayed throughout the clinics and premises we visited. Further information and the trust complaints handling policy was available to the public via the trust website.

We reviewed seven complaint files during the inspection. All seven complaints were acknowledged within three working days as per the trust’s policy. However, three of the seven complaints were responded to outside of the 25-day target. The complaints were investigated appropriately and the response letters provided explanations and apologies where relevant. Areas for learning, and relevant changes to the services provided, were identified and we saw evidence of these being cascaded to staff.

Patients and relatives told us they felt confident to raise any concerns and their opinions would be listened to. One parent told us that staff apologised if they made a mistake.

Staff told us they were aware of how to support patients to make a formal complaint. However, informal complaints were not always recognised and logged. A senior manager told us the trust’s incident and complaints system included an element that could be used to record informal complaints; however, as this was not currently being utilised, managers were reliant on staff recording informal complaints within the patient’s records. This increased the risk that managers would not be aware of, recognise, or be able to address low-level complaint themes, patterns or trends.

Learning from complaints, incidents and risks were reviewed and shared in a monthly quality report compiled by the community division’s head of quality.

Complaints

Between November 2016 and December 2017, the trust received six complaints relating to community children, young people and families. Three of which are currently ongoing, the trust took an average of 36 days to close those complaints. This was not in line with the trust’s policy that states complaints should be closed within 25 working days. The main themes for complaints related to staff attitude, admissions and discharges.

There were a total of 258 concerns raised about community children, young people and families’ services with the trust’s patient advice and liaison service between February 2017 and January 2018. The main themes related to access, admission, transfer or discharge from services (123);
consent, communication or confidentiality (88); delayed receipt of medicines (27); delay in
diagnosis/treatment (18); and, documentation (2).

Is the service well-led?

Leadership

The service had managers at all levels with the right skills and abilities to run a service providing
high-quality sustainable care.

Community children, young people and families’ services were clinically led and provided within
the trust’s community division. Staff were able to describe the leadership and reporting structure
for their teams and directorates, and told us they felt supported by their managers.

Senior managers were visible and accessible to staff, and the divisional director created a monthly
video log to aid communication with the community teams. However, although executive shadow
visits had been implemented across the trust, there was variability in staff views on the visibility of
executives in the community services.

The departmental, directorate and divisional leaders we spoke with understood the challenges
facing their services. The leaders were able to clearly describe the actions that had already been
taken, or were planned to be taken, to meet these challenges.

Vision and strategy

The service had a vision for what it wanted to achieve and workable plans to turn it into action
developed with involvement from staff, patients, and key groups representing the local community.

The trust had a vision of “building a healthier future for children and young people, as one of the
recognised world leaders in research and healthcare”. The vision and plans to achieve it were set
out in a ‘plan on page’ with actions focused on the ‘delivery of outstanding care’, ‘the best people’,
‘sustainability through external partnerships’, and ‘game changing research and innovation’.

The vision was supported by the trust values of excellence, openness, respect, together, and
innovation. The trust had developed a range of five key priorities for embedding a safety culture
throughout the organisation. This included further reducing the number of reportable incidents
resulting in patient harm, increasing engagement with children, young people and families to
further improve quality, increase the number of defined clinical pathways across the service,
provide support to staff to make them feel valued and respected, and to continue to improve the
environment for patients and staff.

The service had a ‘whole system’ approach for development. This was aligning with the Healthy
Liverpool community model and strategy. The model aimed to ensure that children were placed at
the centre of services including health, education, and social care.

Culture

Managers across the service promoted a positive culture that supported and valued staff, creating
a sense of common purpose based on shared values.

Staff we spoke with throughout the service were positive about the culture within their teams, and
in their cross-team interactions with other health professionals. Staff described the culture as
being open and honest and the level of support from their managers was, on the whole, good.
Staff told us they felt able and confident to discuss issues of concerns with their leaders. Staff we asked were aware of the statutory duty of candour principles.

The community children, young people and families’ services had two freedom to speak up champions, who supported the trust’s freedom to speak up guardian. At the time of the inspection, the trust’s intranet was in the process of being updated to provide the contact details.

However, staff based in the wider community locations in Sefton, including Southport, expressed views of an ongoing sense of geographic isolation from the rest of the trust’s community services. Similarly, some staff in the community nursing team expressed a view that staff morale had declined as a result of ongoing organisational changes and, as based in the older estate buildings, that there was a sense of isolation from the main hospital services.

Some staff in the Homecare service and the community nursing teams also told us that, although their teams were ‘in good spirits’, supportive and worked well together, they felt staff in the acute hospital settings did not have a good understanding of the services provided in the community.

The physiotherapy team had a buddy system for safer lone working. Staff were able to monitor other staff locations via their outlook calendars and a paper diary with staff location was also kept on site. Staff carried a lone worker checklist, which had step by step instructions on what to do in the event of a member of staff not reporting in. Staff had key phrases that could be used for emergency situations to enable them to discreetly ask for help over the telephone. Lone working radio devices, that enabled two-way communication with security staff, were available for some but not all staff in the community services. However, all of the staff we asked told us they felt safe when attending visits alone.

The team also used an online phone application tool as a lone worker communication device. Staff logged in to report their whereabouts and at the end of the shift when they return home. We were assured that no patient identifiable information was entered in the messages and was solely used to inform the team that staff were safe. We were assured that when staff were allocated a patient, a full safety assessment was carried out. Where there were any concerns, two staff members attended the visit for safety; this included initial visits to patient homes.

**Governance**

The service used a systematic approach to continually improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.

There was a clear reporting and governance structure within the division. Staff were aware of and able to describe the structure, understood their roles and what they were accountable for. Team leaders and managers reviewed incidents for their respective teams, which fed into the ‘weekly meeting of harm’.

Quality, performance, risks, resources and issues fed into the community managers meetings and subsequently into the monthly divisional risk and governance meeting, which was attended by the divisional clinical director, and the monthly divisional board meeting. The divisional governance meetings were held in different bases within the trust’s community services footprint; this enabled senior staff to have sight of issues in local areas. A monthly clinical business meeting provided oversight of all clinical aspects of the community paediatrics and neurodisability services.

**Management of risk, issues and performance**

The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.
Incidents were logged on the trust’s risk management system and were reviewed by senior managers. The ‘weekly meeting of harm’, chaired by the chief nurse, reviewed any incidents or risks rated as moderate or above. The meeting also shared the overall number, type and themes of incidents, including any learning or action for improvement which was cascaded back to individual teams through a post-meeting newsletter. The meeting was open to all staff groups, including community teams. Incidents were reported on quarterly to the trust’s clinical quality steering group and, by exception, to the trust’s clinical quality assurance committee (a board sub-committee).

Community service specialisms produced a key issues standardised report that fed into the trust’s clinical quality safety group. This enabled the key issues to be tied into the community division’s yearly work plan.

Leaders of the community services were aware of, and able to describe, the risks, issues and performance challenges that faced each of their teams. The specialisms and division maintained a risk register for community services. These risks fed into the trust’s overall risk register.

We reviewed the trust’s risk register which included 30 ongoing risks relating to community services. These included risks that we expected to see, such as the delays in the autistic spectrum disorder and attention deficit and hyperactivity disorder pathways, and difficulties in measuring patient outcomes due to complexity of individual patients. The register included mitigation actions, owners, details of progress towards risk mitigation, and action implementation dates.

Due to an ongoing review of the service, we were told there were currently no key performance indicators for the community nursing team. However, plans were in place to address this with the clinical commissioning group in April 2018.

The therapies services monitored key performance indicators in line with the service’s contractual requirements from the local clinical commissioning groups. Measures included size of caseloads, number of new referrals, time from referral to first contact, and waiting times. Performance varied by specialism, location and clinical commissioning group area. Although the data indicated there was room for additional capacity in some services, the data also indicated that some services such as paediatric continence had received a higher than expected number of referrals or had more than the expected number of contacts with patients. However, the performance data suggested that the therapy services were, in most cases, managing the caseloads appropriately.

Information management

The service collected, managed and used information to support all its activities, using secure electronic systems with security safeguards. However, as not all services within the community division had access to all of the systems, there was a risk that staff did not always have access to all information about their patient.

Electronic and paper records were used throughout the service. The community nursing, community matron and neurodevelopment paediatrics primarily used the trust’s main electronic patient records system. The speech and language therapy service used a separate community-based electronic information system to record patient information; and, the physiotherapy teams used a mainly paper-based records system, and did not have access to the trust’s main patient record system.

All records, in whichever format, were stored securely. However, as not all the systems were linked there was a risk that vital information would not always be shared.

For example, although the community-based system included shared access with GPs in primary care, it did not link to the hospital’s main records system. Therefore, not all of the information was
available to the speech and language therapy team if patients were seen in other areas of the trust. In such cases, staff had to contact secretary’s or outpatient clinics or rely on patient and family feedback for some information. Staff we spoke to felt this did not impact on patient care and they were able to provide appropriate care and treatment with the information they held.

This presented a risk to effective communication. It also meant that some staff did not have access to up to date information about whether or not a do not attempt cardiopulmonary resuscitation order was in place for their patient. In such situations staff relied on parents to provide accurate information on whether or not such an order was in place.

**Engagement**

The service engaged with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

The Friends and Family Test gives patients the opportunity to submit feedback to providers of NHS funded care or treatment, using a simple question which asks how likely, on a scale ranging from extremely unlikely to extremely likely, they are to recommend the service to their friends and family if they needed similar care or treatment.

The trust participated in the NHS Friends and Family Test for the community health services. However, the response rate for the community services was extremely low at only 2% for November and December 2017. Of those that responded, 100% said they would recommend the service provided.

Parent support groups were in place across the services and enable parents to have a voice in any changes to the services offered.

The service worked closely with external partner organisations, including the local authority, the Liverpool children’s transformation board, and Liverpool public health.

A significant number of allied health professional staff transferred to the trust from another healthcare provider in April 2017. Staff in this group universally expressed positive views about the work carried out by the service leaders prior to, during and after staff were transferred. This helped to make staff feel welcomed and to integrate more easily into the trust’s existing structure.

The Liverpool physiotherapy team held a quarterly lunchtime journal club. Staff selected a piece of research from a journal which was sent out to everyone to read and discuss at the journal club. Staff told us this helped to keep the team up-to-date with relevant literature, to encourage debate and discussion, and to aid learning.

The trust carried out a staff survey in 2016, which had a 40% response rate from community services. The results, and an action plan, were published in early 2017. Community services teams were fully included in the roll-out of the action plan, which focussed on improving communication, engagement and recognition of staff and improvement in learning from incidents. The 2017 staff survey had an increased response rate of 61%; however, we did not have access to the results of the latest survey for community services.

Staff from the service were either nominated for, or were the winners, for over 50% of the categories at the staff 2017 awards.
Learning, continuous improvement and innovation

The service was committed to improving services through promoting training, research and innovation.

The specialist respiratory physiotherapy team had taken part in a research project with Liverpool University on respiratory symptoms in children with severe neuro-disability.

A physiotherapist within the Liverpool team achieved funding for research into the rehabilitative muscular strengthening in patients for cerebral palsy.

A physiotherapist in the Liverpool team was in the process of developing an interactive tool to encourage engagement by children and their parents in their treatment.