

Alder Hey Children's NHS Foundation Trust

Quality Report

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2017
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This report describes our judgement of the quality of care at this trust. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this trust

Are services at this trust safe?

Are services at this trust effective?

Are services at this trust caring?

Are services at this trust responsive?

Are services at this trust well-led?

Summary of findings

Letter from the Chief Inspector of Hospitals

Alder Hey Children's NHS Foundation Hospital is one of the busiest children's hospital in Europe and provides care for more than 270,000 children, young people and their families every year. The trust provides a range of services and leads on research into children's medicine. The trust also provides child and adolescent mental health inpatient and community services.

Before visiting the trust, we reviewed a range of information we held and asked other organisations to share what they knew about the trust.

We last inspected the services in September 2015 and we rated the provider as 'good' overall. In reaching our judgement we told the trust that there were areas for improvement.

We carried out this responsive inspection on 19 and 20 April 2017 and 5 May 2017 following concerns we had about the services and to follow up on concerns from the last inspection in the community child and adolescent mental health services (CAMHS). We inspected surgical and medical care services together with community CAMHS. At the last inspection in 2015, surgery and medical care services were judged to be good overall and CAMHS was judged to be requires improvement overall. At this inspection surgery was judged to be requires improvement overall, medical services was judged to be good overall and CAMHS services was judged to be requires improvement overall.

We did not inspect urgent and emergency services, critical care, neonatal services, end of life care, outpatient and diagnostic imaging, transitional services or CAMHS inpatient services.

We did not rate Alder Hey Children's NHS Foundation Hospital overall for this inspection. We found that:

- Safeguarding practice was supported by staff training, although the number who had received training was below the trust target.
- Serious incidents were not always being reported within the timeframe identified in the trust policy and national guidance. The Trust had recently implemented a 72 hour review following serious

incidents, however these were not always being completed within the timeframe and no immediate actions had been identified to mitigate the risk of the incident happening again.

- We were not assured that children and young people were receiving treatment for sepsis in medical services that reflected national guidance. A training programme for sepsis had been set up and staff were currently undertaking this training but not all clinical staff had yet completed this training. There was no audit or review of the pilot phase of the pathway identified.
- There was resuscitation equipment available to respond to an emergency, however, this was not kept together in one place on the wards and relied on several staff to collect the equipment in an emergency. There was also a lack of clarity for staff over responsibilities.
- The hospital did not always ensure that a member of staff who was trained in advanced paediatric life support (APLS) was available on each department at all times. This did not meet the Royal College of Nursing (RCN) minimum staffing requirements. This shortfall had also been acknowledged in a recent nursing staffing review which stated the need for all band 6 co-ordinators to be trained in APLS. However, no formal plans had yet been made to implement the improvements.
- The personal alarm system in CAMHS community services was a concern at the last inspection. We observed during this inspection the use of alarms was included in the revised lone working policy for child and adolescent mental health services for the Liverpool site. At the Liverpool site, there were portable alarms but they did not work correctly so were not in use. There were no alarms in the Sefton site.
- At the time of our inspection the numbers of staff who had completed mandatory training varied

Summary of findings

across the hospital. It was noted that the compliance rate for medical staff was particularly low and the medical director acknowledged this was an area for improvement.

- The appraisal system was used to underpin on going professional development. However the compliance rate for medical and non-medical staff was below the trust target. This was significantly less than at the last inspection.
- The trust had recently implemented a model of devolved governance to services. However at the time of the inspection these were relatively new and not all systems and processes had been identified to support continuous quality improvement. Some of the risk registers had no actions identified to mitigate the risk.
- The trust recruitment policy on pre-employment checks did not comply with the fit and proper regulation (FPPR). Also, the checks to fully comply with this regulation for executives and non-executives had not been completed at the time of the inspection. There was also a lack of assurance that the internal processes to monitor the self-declaration forms for executives and non-executives were robust.

However

- Children and those close to them were treated with dignity and compassion. Children and young people were very positive about the caring and supportive attitudes of staff. They were active partners in care and felt involved in the decision-making process. Children and young people's individual preferences and needs were reflected in how care was delivered.
- The wards were adequately staffed to meet the needs of the patient and there was an escalation process in place for staff to alert managers when they needed additional staff.
- Medical staff were highly skilled and competent. Doctors were committed to the care and treatment of children and young people. Staff were highly motivated to offer support to children and young people which was kind and caring and they were willing to go the extra mile.

- Care and treatment was evidenced based and the policies and procedures and pathways followed recognisable and approved guidelines. There was good use of clinical audit to monitor and improve performance and Multi-disciplinary team work was well established and focused on ensuring the best outcomes for children and young people.
- The Trust were one of only two paediatric centres nationally who were able to provide extracorporeal membrane oxygenation (ECMO). ECMO is used to support patients whose heart or lungs are unable to provide an adequate amount of gas exchange to support life.
- At the last inspection waiting lists in CAMHS community services were found to be over the operational national standard, and the trust did not monitor them effectively. At this inspection we found that the waiting lists and the time people wait had reduced.
- Staff were responsive to the individual needs of patients and those close to them. There was good evidence of personalised care planning that focused on the needs of children and young people.
- Staff understood the process for receiving and handling complaints and were able to give examples of how they would deal with a complaint effectively. Staff knew about their responsibilities in relation to duty of candour and knew when to be open and transparent with people who used the services at the trust.
- There was a clear vision and strategy across the trust and services were planned and delivered to meet the needs of patients. The trust had an aim to be an inclusive and accessible place for all to visit and work and had implemented actions to meet this aim. There was increased clinical engagement since the last inspection.
- The trust was involved in a number of innovation and improvement areas and had been recognised nationally and internationally for the work they were doing.

We saw several areas of outstanding practice including:

Summary of findings

- Each ward had their own dedicated pharmacist and medication was accessed by fingerprint technology this ensured that medication was secured and stock levels were adequately controlled.
- There was a chef allocated to each ward and all food was prepared on the ward.
- A hybrid theatre had recently been opened and a small number of operations had been undertaken using this facility. This was the first paediatric hybrid theatre to be opened in Europe.
- The hospital innovation team had worked collaboratively with a local university to develop 'virtual surgery' and to use high definition 3D printing so that organs can be viewed in much more detail. This allowed staff to 'virtually walk around' organs.
- The child and adolescent mental health (CAMHS) community service was part of a network of statutory and voluntary services. It was piloting ways to make it easier for people to contact services, so they could be either referred to the child and adolescent mental health services, or signposted elsewhere.
- The CAMHS community service followed best practice by using the choice and partnership approach, which emphasised collaborative working with children and young people and their families. The service had recently introduced the "THRIVE" model, which aims to provide better outcomes for children and young people, and reduce waiting times.
- The hospital had an international health partnership with a hospital in Kathmandu and many specialities were engaged in quality improvement work including the emergency department for resuscitation training.

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

Importantly, the trust must:

- Ensure that all serious incidents are reported in line with the trust policy and initial investigations are carried out in a timely way so that any immediate actions to mitigate risk are identified.
- Ensure all children and young people receive treatment in relation to sepsis within appropriate timeframes and have a process to monitor adherence to policy for patient's treated for sepsis..
- Ensure that robust arrangements are in place to govern the fit and proper person's process.

At Alder Hey Hospital

- Take action to ensure all staff who are involved with assessing, planning, and evaluating care for children and young people are trained to safeguarding level three in line with the safeguarding children and young people: roles and competencies for health care staff Intercollegiate Document (2014).
- Ensure that there is a member of staff trained in advanced paediatric life support available in every department at all times as outlined in the Royal College of Nursing guidelines
- Ensure that compliance with mandatory training is improved, particularly for medical staff.
- Ensure that formal risk assessments are undertaken in all departments and all identified risks are captured on the risk register where needed.

Child and Adolescent Mental Health Services (CAMHS) – Community

- Ensure that lone working practices are implemented, to ensure the safety of staff and others.
- Ensure that the confidentiality of patient information is maintained, and that patient records are only accessible to authorised staff.

Professor Ted Baker

Chief Inspector of Hospitals

Summary of findings

Background to Alder Hey Children's NHS Foundation Trust

Alder Hey Children's NHS Foundation Trust became a foundation trust in August 2008. The trust provides care for more than 270,000 children young people and their families. The trust also leads research into children's medicines, infection, inflammation and oncology. The trust has a broad range of hospital and community services, including many for direct referral from primary care and an inpatient and community Child and Adolescent Mental Health Service (CAMHS) 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 trust also provide the paediatric arm of one of three nationally commissioned centres of excellence for Behcet's syndrome.

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 lightening for the child or young person to control. Each room contains a sofa bed to enable parents to stay with their child.

Each inpatient room offers 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 to allow them 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 new research and education centre built alongside the hospital. 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.

The inspection team looked at the following core services in full at Alder Hey Children's Hospital:

- Surgery
- Medical Care

The trust also provides community mental health services and we inspected:

- Community - Child and Adolescent Mental Health Services (CAMHS)

This was a responsive inspection in response to increasing concerns around the safety and quality of services in medical care and surgery and to follow up concerns raised in the last inspection of CAMHS in 2015. At the last inspection in 2015, surgery and medical care services were judged to be good overall and CAMHS was judged to be requires improvement.

Our inspection team

Our inspection team was led by:

Head of Hospital Inspections: Ann Ford, Care Quality Commission (CQC)

The inspection team included three CQC inspector managers, four CQC inspectors, a neonatal consultant, a lead nurse and a governance specialist.

How we carried out this inspection

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

- Is it safe?
- Is it effective?
- Is it caring?

Summary of findings

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

Before visiting the trust, we reviewed a range of information we held and asked other organisations to share what they knew about the trust.

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

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

What people who use the trust's services say

Friends and family test results from young people between June 2016 to March 2017 November showed that out of 2083 responses, 98% of young people were very likely or likely to recommend Alder Hey.

The friends and family test for community child and adolescent mental health services showed that in the year to the end of March 2017 there had been 38 respondents. Of these, 29 people were extremely likely and two people were likely to recommend the service to their friends and family, with only one person unlikely to do so.

In the CQC Children's Survey 2014, the trust performed about the same as other trusts for 16 out of 19 questions relating to understanding and involvement of patients and those close to them. The trust performed better than other trusts for keeping patients and relatives informed, and communicating with children in a way they understood.

Facts and data about this trust

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

Alder Hey Children's Hospital is a paediatric research centre, leading investigation into children's medicines, infections, inflammation and oncology. Between April 2016 and March 2017 312 clinical research studies took place, ranging from observational studies to complex, interventional clinical trials and 3372 children and young people took place.

Alder Hey serves a catchment area of 7.5 million

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

The hospital treats 275,000 patients a year and 75% of children have their own room with pull out beds, offering more dignity and privacy to visiting families. All patients have easy access to relaxation areas including a giant indoor tree-house, play desks and fish tanks.

Alder Hey Children's NHS Foundation Trust also provides a child and adolescent mental health service (CAMHS). Inpatient services, for children aged between five and

Summary of findings

fourteen, are provided at the Dewi Jones Unit. Community services are provided by four teams, which are accessed via a single point of access at Mulberry House, based at the main trust site.

The CAMHS service supports children who are experiencing emotional or psychological difficulties. It

provides treatment and support for a range of conditions including anxiety and emotional disorders, depression, eating disorders, autism, obsessive compulsive disorders and self-harm.

Summary of findings

Our judgements about each of our five key questions

	Rating
<p>Are services at this trust safe?</p> <p>We did not rate the trust overall during this inspection. The team made judgements about three services. Of those, all three were judged to be requires improvement. Therefore the trust was not consistently delivering good standards</p> <ul style="list-style-type: none">• There were good systems for reporting safeguarding concerns. Staff were able to identify and escalate appropriately issues of abuse and neglect. Practice was supported by staff training, although the number who had received training was below the trust target.• We found that the trust Board of Directors received limited information about serious incidents and there was no overview of actions taken or shared learning. Serious incidents were not always being reported within the timeframe identified in the trust policy and national guidance.• The Trust had recently implemented a 72 hours review following serious incidents, however these were not always being completed and no immediate actions had been identified to mitigate the risk of the incident happening again. The trust incident reporting policy had not been updated to reflect the introduction of the 72 hour review process.• The trust had established a weekly meeting of harm to ensure trends and lessons learnt were being identified to improve patient safety. However, we found that there was limited discussion about any immediate actions taken whilst investigations were ongoing for new incidents.• We found examples of when serious incidents were not reported within the set timeframe, which meant that an initial investigation to identify immediate learning had not taken place in a timely manner. We also found that there was limited learning from incidents recorded to mitigate the risk of the incident happening again• We were not assured that systems and processes did not fully mitigate the risk of complications of sepsis. There were two systems for alerting staff to the risk of sepsis but calculated parameters differently. There was no audit identified following the pilot to measure if the pathway was robust..	

Summary of findings

- A training programme for sepsis had been set up and staff were currently undertaking this training but not all clinical staff had yet completed this training. At the last review of the risk of lack of sepsis recognition, on the risk register, it showed that new documentation was being trialled on one of the wards.
- The hospital did not always ensure that a member of staff who was trained in advanced paediatric life support (APLS) was available on each department at all times. This did not meet the Royal College of Nursing (RCN) staffing recommendations.
- There was resuscitation equipment available to respond to an emergency, however, this was not kept together in one place on the wards and relied on several staff to collect the equipment in an emergency. There was also a lack of clarity from staff over responsibilities.
- The personal alarm system in CAMHS community services was a concern at the last inspection. We observed during this inspection the use of alarms was included in the revised lone working policy for child and adolescent mental health services for the Liverpool site. At the Liverpool site, there were portable alarms but they did not work correctly so were not in use. There were no alarms in the Sefton site.
- In CAMHS community services confidential information about children and young people was left in an unlocked office on a corridor shared with non-NHS businesses. This meant unauthorised people could potentially see patients' records.
- At the time of our inspection the numbers of staff who had completed mandatory training varied across the hospital. It was noted that the compliance rate for medical staff was particularly low and the medical director acknowledged this was an area for improvement.
- Whilst all deaths were subject to a local mortality review, the trust target of them being reviewed by the trust mortality team within four months was not being met which meant there was a backlog of reviews to be undertaken and a risk that trust wide learning was not being identified in a timely way.

However:

- The hospital was visibly clean and there were good processes for the prevention and control of infection. Infection rates were within the normal range for a trust of this size.
- Staff knew about their responsibilities in relation to duty of candour and knew when to be open and transparent with people who used the services at the trust.
- The wards were adequately staffed to meet the needs of the patient and there was an escalation process in place for staff to alert managers when they needed additional staff.

Summary of findings

- In surgery there was good use of the World Health Organization (WHO) safety checklist. There were regular audits of practice that demonstrated high levels of compliance with safe surgical practice.
- Medical staff were highly skilled and well-supervised.

Duty of Candour

- The trust was prepared for its duties and responsibilities in relation to the Duty of Candour (DoC). The aim of the duty of candour regulation is to ensure trusts are open and transparent with people who use services and inform and apologise to them when things go wrong with their care and treatment.
- Since the duty of candour regulation was introduced in November 2014, the trust policy of informing parents/carers about incidents that had occurred had been used. There was evidence that the number of incidents where this had occurred was reported through the trust governance structures.
- There was good evidence that the trust had acted appropriately when the DoC requirements had been triggered by safety incidents. There was evidence that parents had been informed of an incident as outlined in the trust Duty of Candour policy. Between April 2016 to March 2017, the trust had implemented formal duty of candour on nine out of 10 occasions. The one that was not implemented was for an incident which also involved another trust and the formal Duty of candour letter was sent by the other trust.
- Staff were aware of the process in relation to Duty of Candour and we saw examples of staff escalating and reporting concerns appropriately.

Safeguarding

- There was a system in place for reporting safeguarding concerns. Staff were able to identify and escalate suspected abuse and neglect. Practice was supported by staff training, although improved the numbers of staff who had received training was below the trusts set target of 90%. Training figures for child safeguarding level 3 were poor and had not markedly improved in some areas since our last inspection. In surgical and child and adolescent mental health (CAMHS) community services the overall compliance with level 3 training was 67%. In medical care services the compliance with level 3 training was 85%.
- Staff had access to specialist advice and support available from the trust's safeguarding team 24 hours a day.
- There was evidence that safeguarding concerns were escalated and managed appropriately.

Summary of findings

Incidents

- The trust was amongst the best performers for patient safety incident reporting and there was a positive culture around incident reporting
- National Reporting and Learning System (NRLS) incidents reported between April 2016 and September 2016 showed that the trust takes a median average of 6 days to report an incident. This compares to 26 days for all trusts between April 2016 and September 2016. The trust reported 2,404 incidents during this period, which is a rate of 105.68 incidents per 1,000 bed days. This places the trust within the 25% of highest reporters of 19 acute specialist organisations.
- Between January 2016 and January 2017 there were 17 serious incidents reported
- The trust has reported four “never events” since our previous inspection. 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 type 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 a specific incident occurrence for that incident to be categorised as a never event.
- All serious incidents were subject to a Root Cause Analysis (RCA) investigation. We requested and reviewed completed RCA investigations, including the never events. There was good evidence of root cause methodology being applied appropriately within these investigations.
- We found that the trust Board of Directors received limited information about serious incidents. The board report provided an update on whether the 45 working day compliance was on track for achievement. There was an overview of the incident, but no overview of any actions taken immediately in response to the incident, or planned actions to prevent recurrence.
- We were informed that the detail is not provided to the Board but that actions required are monitored. The most recent monitoring report was provided and showed that in May there were 11 overdue actions with the oldest actions having an original completion date of March 2017. This is a significant reduction from the previous inspection which showed 41 overdue actions.
- Staff told us that learning from incidents was discussed at the trust quality groups. We reviewed minutes of the clinical quality assurance committee (CQAC), which reported to the Board, together with the minutes of the clinical quality steering group

Summary of findings

which reported to the CQAC, for January 2017, February 2017 and March 2017. We saw that incidents were discussed but this was largely around the number and timeframe and where the lessons learnt had been discussed. There was no discussion about shared learning recorded.

- The trust had established a weekly meeting of harm to ensure trends and lessons learnt were being identified to improve patient safety. This was attended by senior managers from wards and service areas. We observed one of these meetings and found that there was limited discussion about any immediate actions taken whilst investigations were ongoing for new incidents.
- After the weekly meeting a poster summarising the key lessons learnt following full investigation was shared across the wards and departments. Staff told us they received information from the meeting. An example of learning from incidents was induction training now included subjects such as completing the paediatric early warning scores and the identification and management of sepsis.
- The trust incident policy outlined that incidents had to be reported 24 hours. In addition, the NHS England serious incident framework (2015) states that all incidents should be reported within 48 hours and an initial review of every serious incident should be undertaken within 72 hours of the event occurring.
- We looked at the five serious incidents from between January 2017 and April 2017 and found that only four were reported within this timeframe.
- The Trust had recently implemented a 72 hours review following serious incidents as outlined in the serious incident framework 2015 guidance. This had only been in place since January 2017. When reviewing the five serious incidents only four had a completed 72 hours review. The purpose of these reviews is to identify any immediate action taken to mitigate the risk of the incident happening again. On reviewing the information provided on the forms the immediate actions taken were largely around the next steps in the process of the investigation not any immediate actions recorded taken to mitigate the risk. This meant there was limited assurance that these had been identified, though staff told us that action had been taken.
- The trust incident reporting policy had not been updated to reflect the introduction of the 72 hour review process.

Nurse staffing

Summary of findings

- The trust calculated nurse staffing levels using a recognised dependency tool (SCAMPS) for wards and departments. This was used to identify any increased nursing intervention for patients. There was a central pool of nurses with an effective system of allocating nurses from this pool as the need arose. For example sickness and maternity leave.
- A recent paper went to the Trust board in March 2017 which outlined current staffing across the wards and future plans. This included the introduction of Matrons across all clinical business units and a senior children's nurse to be available at all times for advice to meet the Royal College of Nursing standard which they were not currently being met.
- Since the last inspection in June 2015 197 new nurses have commenced employment within the nurse pool which then allocates nursing staff to cover all vacancies across the organisation. There were currently no nurse vacancies across the inpatient wards
- The turnover rate for nurses was low. Between April 2016 and March 2017 the turnover rate was 0.7%.
- We reviewed staffing figures for January 2017 and all the wards were above the national benchmark of 80% during the day and night. The trust average fill rate for January was 93% in the day and 93% at night. As a result, wards and departments were adequately staffed to meet the needs of patients.
- There was an escalation process in place for staff to alert managers when patient acuity increased or to cover unplanned absence. Staffing was discussed at the bed management meetings which occurred at least three times a day.
- At night there was always a trust team of band 6 and band 7 nurses who were supernumerary, to support staff on the wards that did not have a supernumerary senior nurse on duty at night.
- CAMHS community services employed adequate numbers of staff, but there were staff shortages caused by staff absences which included long term sickness, maternity leave and training.

Medical staffing

- Medical staff were highly skilled, competent and well-supervised. Doctors were committed to the care and treatment of children and young people.
- Consultants were present or accessible 24 hours a day and carried out daily ward rounds. Middle grade and junior doctors were on site 24 hours a day.
- The turnover rate for medical staff was low. Between April 2016 and March 2017 the turnover rate was 1.39%.

Summary of findings

- There was one medical vacancy across the trust which was for a haematologist.
- There was a risk of insufficient junior doctors being available to cover duties and to staff the rotas which had been highlighted on the corporate risk register. There were actions identified to minimise the risk, for example, developing in house training programmes for alternative practitioners such as advanced nurse practitioners. At the time of the inspection progress had been made on this action.

Cleanliness and Hygiene

- Patients received care and treatment in visibly clean environments. Wards and departments were cleaned regularly and cleaning schedules maintained. Staff followed good practice guidance in relation to the control and prevention of infection,
- Hygiene systems included the use of 'I am clean' stickers to inform colleagues at a glance that equipment or furniture had been cleaned and was ready for use.
- Trust patient led assessments of the environment (PLACE) in 2016 showed a standard of 94% in the trust for cleanliness which was slightly below the England average of 98%.
- The trust had a target of no hospital acquired MRSA bacteraemia and no clostridium difficile infections due to lapses of care between April 2016 to March 2017. However, there had been two cases of MRSA bacteraemia and one clostridium difficile infection across the trust.
- An audit of hand hygiene, for March 2017 showed a compliance rate of 100% on ward 3C. However, this ward had reported six hospital acquired infections for March 2017.
- Compliance with infection, prevention and control standards were relatively good in theatre, however, on surgical wards, between April 2016 and December 2016 the compliance rate was consistently low. For example, on ward 1B it ranged from 59% to 72% and ward 3A it ranged from 54% to 72%

Monitoring safety and responding to risk

- We were not assured that children and young people were receiving treatment for sepsis in medical services that reflected national guidance. On reviewing two records for children who had a history of sepsis, this showed that there were delays of 12 and 18 hours when they were escalated for medical review and appropriate antibiotics administered in a timely way. This meant there was a risk of delay in ongoing treatment.

Summary of findings

- There were two systems in place that highlighted the potential diagnosis of sepsis but they calculated parameters slightly differently.
- This was raised with the executive team who proposed changes to the way the information on the systems presented to staff along with updating the trust sepsis policy. But no date for completion had been identified at the time of the inspection.
- A training programme for sepsis had been set up and staff were currently undertaking this training but not all clinical staff had yet completed this training. For example on ward 3C, only 44 out of 50 staff had completed the training and on ward 4C, 31 out of 66 staff had completed the training. However, the band 6 staff members that rotated onto night shifts had completed all the training.
- The lack of sepsis recognition had been on the corporate risk register since the middle of 2016 and on the last review it showed that there was a pilot of the sepsis pathway but no audit had been identified. Also new documentation was only being trialled on one of the wards. The trust was also involved in a commissioning for quality and innovation (CQUIN) national goals during 2016 -2017. The one for timely identification and treatment of sepsis in emergency departments and in acute inpatient setting had not been fully achieved.
- There was good use of the paediatric early warning tool to promptly identify children and young people whose condition was deteriorating. Medical staff were alerted and attended promptly.
- There was resuscitation equipment available to respond to an emergency, however, this was not kept together in one place on the wards and relied on several staff to collect the equipment in an emergency. There was also a lack of clarity from staff over responsibilities. This was raised with the trust and since the inspection they have provided evidence that trolleys had been ordered so that equipment could be kept together.
- Children, young people, and visitors could leave the ward unsupervised by using the exit buttons as staff were not always available to observe the ward exit. This meant there was a risk of children absconding or being abducted. This issue was highlighted as a risk in our previous inspection of the new building and environment before the hospital opened in 2015.
- The trust continued to have a quality review programme which looked at safety and risk. This process involved reviewing data about the ward areas, including incidents, meeting minutes and risk registers, observing care, reviewing care records, speaking with patients and parents and engaging with staff. Since moving into the new hospital the programme had mainly

Summary of findings

consisted of issues arising from the move. However, senior staff told us that they would be reverting to the more in-depth quality review programme shortly. The results of the quality review were reported and actions identified to improve safety.

- Staff were aware of how to escalate key risks that could affect patient safety, such as staffing and bed capacity issues, and there was daily involvement by ward managers and the clinical business unit lead nurse to escalate and manage risks.
- In surgery there was good use of the World Health Organization (WHO) safety checklist. There were regular audits of practice that demonstrated high levels of compliance with safe surgical practice.
- There was currently no medical emergency team (MET) in place to respond to the deteriorating patient. This was currently being reviewed by the trust and a proposal, 'safe at all times 24/7' had been drafted. However, there were sufficient numbers of qualified staff to care for patients that deteriorated and the trust were reviewing the provision of a medical emergency team as part of the safe at all times 24/7 proposal.
- The hospital were unable to ensure that there was always a member of staff trained in advanced paediatric life support (APLS) in every department or ward area. This did not meet the minimum requirements outlined in the Royal College of Nursing; Defining Staffing Levels for Children and Young People's Services (2013). This was the case on wards 1C and 3A. Members of the ward management teams informed us that no nurses had been trained in APLS. . Importantly, a number of patients on ward 1C had undergone cardiac surgery so were at higher risk of requiring emergency treatment. This shortfall had also been acknowledged in a recent nursing staffing review which stated the need for all band 6 co-ordinators to be trained in APLS. However, no formal plans had yet been made to implement the improvements.
- In contrast, we did note that on ward 4A, all band 6 co-ordinators had received training in APLS and additionally, there was always a member of staff who was APLS trained in theatre recovery as there was a supernumerary anaesthetist available in both recovery areas, meaning that the required standard was met.
- We were told that all senior medical staff and out of hours senior nursing team were trained in advanced paediatric life support (APLS) to ensure that wards could access a health professional with the necessary emergency skills whenever needed.
- As in the previous inspection in 2015, lone working policies were not consistently followed by staff working in child and

Summary of findings

adolescent mental health service (CAMHS) community services. Staff had a limited understanding of the policy and were not clear what action to take if a member of staff did not return from an appointment within a designated time period.

- The personal alarm system in CAMHS community services was a concern at the last inspection. We observed during this inspection the use of alarms was included in the revised lone working policy for child and adolescent mental health services for the Liverpool site. At the Liverpool site, there were portable alarms but they did not work correctly so were not in use. A fault with the alarm system had been identified and reported on 9 March 2017, but had still not been fixed at the time of our inspection on 16 April 2017. Staff told us that were unclear about who should respond to any alarms, and what action they should take. There were no alarms in the Sefton site.
- In CAMHS community services confidential information about children and young people was left in an unlocked office on a corridor shared with non-NHS businesses. This meant unauthorised people could potentially see patients' records.

Medicines Management

- The trust had set itself improvement targets for some of the themes from incidents, including medication errors. The target for medication errors was to reduce the number of medication errors that result in harm to the patient by 15% by March 2017. This was achieved.
- The trust reported 1069 medication errors that reached the patient compared with 703 the previous year, which is an increase of 52%. This showed a positive reporting culture.
- In response to the medication errors, the trust had implemented the medication error reporting programme (MERP) which provided a grading structure for harm caused by a medication error and provided an objective method of assessment.
- The trust had also developed a medication safety mandatory training workbook which had been approved by the medicines management committee.
- The trust acknowledged there was still work to do in developing more audits and developing an independent checking process.
- Every three months the trust undertook a controlled drug (CD) audit to ensure at ward level the storage and management of controlled drugs met the legislative requirements. The trust was asked to provide the last CD audit and they provided us with the results of the October 2016 audit. This showed that the wards were not compliant with the entire target. For example there were unauthorised items stored in the CD cupboard and

Summary of findings

errors in the record book were not marked in such a way that the original entry was still visible and that they were not always signed, dated and witnessed. The recommendations on the audit were to share the findings with ward managers and repeat the audit.

- Recent audits showed that all medicines were being stored securely and safely.

Mandatory training

- Staff received mandatory training on a rolling annual programme. They were able to access online courses, booklets and face to face sessions.
- The mandatory training was in areas such as manual handling, fire safety, equality and diversity and safeguarding.
- At the time of our inspection the numbers of staff who had completed mandatory training varied across the hospital.
- Mandatory training compliance levels were 76% in May 2017. It was noted that the compliance rate for medical staff in medical services was 55% which was significantly below the 90% trust target and in surgical services the compliance rates for medical staff in some of the subjects was low, for example, health and safety was 48% and information governance was 41%. The medical director acknowledged that this was an area for improvement.
- In CAMHS community services overall mandatory training compliance levels was 78%.
- Mandatory training was subject to actions identified to increase compliance. There were individual ward plans in place to increase the percentage of staff completing their mandatory training.

Patient mortality

- The trust had a well-established mortality review process. The expectation was that departments and services were to undertake mortality review within two months of the patient's death with a further review by the Hospital Mortality Review Group (HMRG) within four months to review the findings. The trust was not meeting the target of all reviews to be undertaken within four months at the HMRG. Only 2% were meeting this target with 61% being reviewed within six months. However, 88% had been reviewed by services within the two month target. This meant there was a backlog of reviews to be undertaken by the HMRG. This issue was being addressed by the medical director.

Summary of findings

- Both reviews identified any elements of the patient journey where harm and/or death were avoidable. Root cause analysis investigations were completed where this could add additional learning and action plans were generated and implemented.

Are services at this trust effective?

We did not rate the trust overall during this inspection. The team made judgements about three services. Of those, all three were judged to be good. Therefore the trust was consistently delivering effective services

- Care and treatment was evidence based and the policies and procedures and pathways followed recognisable and approved guidelines.
- The trust participates and leads in diabetes research and has the highest number of patients recruited to this study compared to the other centres nationally.
- There was good use of clinical audit to monitor and improve performance. In the absence of national data clinicians worked well together to benchmark patient outcomes.
- Multi-disciplinary team work was well established and focused on ensuring the best outcomes for children and young people.
- The Trust were one of only two paediatric centres nationally who were able to provide extracorporeal membrane oxygenation (ECMO). ECMO is used to support patients whose heart or lungs are unable to provide an adequate amount of gas exchange to support life. Results for children receiving cardiac support were better than international cardiac support results.
- At the last inspection waiting lists in CAMHS community services were found to be over the national target, and the trust did not monitor them effectively. At this inspection we found that the waiting lists and the time people wait had reduced.
- Staff had the skills and knowledge to ask children and their representatives for consent and were familiar with the correct processes to seek best interest decisions where required.

However:

- Staff were not clear about the Fraser guidelines which are specifically related to consent for contraception and sexual health.
- The appraisal system was used to underpin on going professional development. However the compliance rate for medical and non-medical staff was below the trust target. This was significantly less than at the last inspection.

Evidence based care and treatment

Summary of findings

- 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 (NICE).
- Clinical pathways and care bundles were used to ensure appropriate and timely care for children and young people with specific needs in accordance with nationally recognised standards.
- We observed the pathway for children and young people with newly diagnosed diabetes had not been updated since 2013 despite new guidelines coming out in 2015. Staff told us that this was currently in the process of being updated and was waiting for sign off and had been in progress for at least two years.
- The trust monitored compliance with NICE guidance via the Clinical Quality Assurance Committee. Baseline compliance was sent to each clinical business unit to review.
- The trust was involved in a number of national and international research programmes. For example, research into outcomes with a hospital in Toronto and being part of the trauma audit and research network looking at measuring physical, emotional, social and cognitive functioning to give an overall assessment of patient outcomes.

Patient outcomes

- The risk of readmission for non-elective medicine was higher when compared to an average of children's specialist trusts, but remained within the expected ratio for other specialities.
- We requested outcomes for national clinical audits for medical services, but this data was not available from the trust.
- Where there was an absence of national data medical staff worked well together with their colleagues in other children's hospitals to benchmark patient outcomes. The data collated indicated that outcomes were comparable to or better than other children's centres.
- The Trust were one of only two paediatric centres nationally who were able to provide extracorporeal membrane oxygenation (ECMO). ECMO is used to support patients whose heart or lungs are unable to provide an adequate amount of gas exchange to support life. The hospital had undertaken a yearly International audit which benchmarked them against other similar providers. Results indicated that in 2016, for children receiving cardiac support, survival rates were better

Summary of findings

than International survival rates (80% in comparison to 50%). For the same period, results for children receiving respiratory support were slightly worse than International survival rates (40% in comparison to 50%).

- At the last inspection waiting lists in CAMHS community services were found to be over the national target, and the trust did not monitor them effectively. At this inspection we found that the waiting lists and the time people wait had reduced. The waiting lists and times were monitored, and reviewed at a weekly meeting. Average waiting times were within the trusts target of 12 weeks from referral to treatment, and the national target of 18 weeks from referral to treatment.
- There were internal waits for therapies in CAMHS, and this included waiting to see a consultant psychiatrist. The waiting lists and times were monitored.

Pain Management

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

Multidisciplinary working

- Multidisciplinary team (MDT) work was well established and focused on the best outcomes for children and young people.
- Staff across all disciplines worked well together for the benefit of patients. There were robust mechanisms in place such as combined ward rounds and regular MDT meetings that enable all disciplines to positively contribute to the care and treatment of children.
- There were a number of specialist staff who were available to support staff caring for children and young people. For example, play specialists, dieticians, and a cystic fibrosis team.
- MDT meetings were effective in (CAMHS).

Consent, Mental Capacity Act, and Deprivation of Liberty safeguards

- The trust had a policy for seeking informed consent. The policy was implemented across the hospital.

Summary of findings

- Gillick competency (used to decide whether a child is mature enough to make decisions about their care), were applied appropriately, to balance children's rights and wishes with the responsibility to keep children safe from harm. However, staff were not clear about the Fraser guidelines which are specifically related to consent for contraception and sexual health.
- Staff had the skills and knowledge to ask children and their representatives for consent and were familiar with the correct processes to seek best interest decisions where required.

Competent staff

- Data provided by the trust indicated 59% compliance in both medical and non-medical appraisal for 2016/17. The trust target was 90%. This was significantly less than at the last inspection when the compliance rate was 97%
- The appraisal system was used to underpin on going professional development.
- The trust was involved in the apprenticeship nursing scheme. Cadet nurses were undertaking a national vocational qualification in care. This helped ensure that any future applications for nursing posts were from competent people who had the skills and experience required.
- The trust had also been successful in gaining two places on the associate nurse programme. This is a new support role for nurses to deliver hands on care. The associate nurses were given opportunities to gain skills and progress into nursing.
- Staff in bands 1 to 4 were offered opportunities to undertake appropriate vocational qualifications.
- The hospital employed practice education facilitators across most departments. They were supported by a trust-wide education team. The only exception to this in surgery was on ward 3A where training was facilitated by the ward manager.

Are services at this trust caring?

We did not rate the trust overall during this inspection. The team made judgements about three services. Of those, two were judged to be good and one was judged to be outstanding. Therefore the trust was consistently delivering caring and compassionate care.

- Staff were highly motivated to offer support to children and young people which was kind and caring and they were willing to go the extra mile.

Summary of findings

- Children and those close to them were treated with dignity and compassion. Care and treatment was delivered in a person-centred and sensitive way. Patients and those close to them were very positive about the caring and supportive attitudes of staff.
- Children and parents were active partners in care and felt involved in the decision-making process. Children and young people's individual preferences and needs were reflected in how care was delivered.
- Children and those close to them understood their treatment and the choices available to them
- Friends and family test results from young people between June 2016 to March 2017 November showed that out of 2083 responses, 98% of young people were very likely or likely to recommend Alder Hey.

Compassionate care

- Children, young people, their families, relatives and representatives were very positive about the care and treatment provided. Comments from children included 'they have worked magic on my back' and 'they made my operation fun'.
- Children, young people and their families and carers were observed being treated with compassion, dignity and respect by staff of all grades.
- Friends and family test results from young people between June 2016 to March 2017 showed that out of 2083 responses, 98% of young people would recommend Alder Hey to friends and family if they needed similar care.
- The friends and family test for community child and adolescent mental health services showed that in the year to the end of March 2017 there had been 38 respondents. Of these, 29 people were extremely likely and two people were likely to recommend the service to their friends and family, with only one person unlikely to do so.
- Staff ensured that during Easter, a child was given a toy rather than a chocolate egg as they were unable to eat chocolate and they did not want the child to be left out whilst all the other children on the ward were given a chocolate egg.

Understanding and involvement of patients and those close to them

Summary of findings

- Parents and young people received information about their care and treatment in a manner they understood and contributed to the development of a personalised care plan. Patient records included assessments that took into account individual preferences.
- Parents, young people and those close to them were involved in the planning for discharge or transfer. Parents we spoke to said they were treated as partners in care.
- Children and young people said they felt safe on the ward and had been orientated to the ward area on admission. Family members said they were kept well informed about how their relative was progressing. Both the children and family were communicated with about developments, likely outcomes and treatments in a way they could understand.

Emotional support

- Health play therapists provided emotional support through condition specific pathways and diversional and distraction techniques for younger children.
- Meeting people's emotional needs was recognised as important by all staff, and staff were skilled and sensitive in supporting patients and those close to them during difficult and stressful periods.
- Children, young people and those close to them told us that clinical staff were approachable and they were able to talk to them if they needed to.
- Chaplaincy services were available for children and their families if required.

Are services at this trust responsive?

We did not rate the trust overall during this inspection. The team made judgements about three services. Of those, all three were judged to be good. Therefore the trust was consistently delivering responsive services

- Services were planned and delivered to meet the needs of patients. The facilities and premises for surgery were planned by reference to best practice and through consultation with staff and the local community. There was access to facilities for parents who needed to stay close to the hospital. Services worked with other referring trusts and local agencies to co-ordinate care for children and young people.
- Staff were responsive to the individual needs of patients and those close to them. There was good evidence of personalised care planning that focused on the needs of children and young people.

Summary of findings

- There was access to beds at all times as the occupancy levels on the wards met the total number of admissions. Staff understood the process for receiving and handling complaints and were able to give examples of how they would deal with a complaint effectively.
- The trust had an aim to be an inclusive and accessible place for all to visit and work and had implemented actions to meet this aim.

However:

- There was limited evidence that the trust provided information leaflets in any other language than in English.
- There were a number of cancelled operations for non-clinical reasons and were not subsequently treated within 28 days which was higher than the England average and breached the standard set by NHS England.
- Stage one complaint response letters did not give information on the independent body that can make final decisions on complaints that have been investigated by the NHS and are not resolved to the complainant's satisfaction. Since the inspection the complaint response letters have been amended.

Service planning and delivery to meet the needs of local people

- There were facilities on the wards for parents to prepare food and drinks and there were rooms available if they needed somewhere quiet away from their child's bedside. There was access to fold down beds for them to sleep on if they wanted to stay with their child overnight although some parents told us these were uncomfortable.
- The facilities and premises for surgery at Alder Hey were planned by reference to best practice research and through consultation with staff, experts and members of the local community
- Services were planned and delivered to meet the patients' needs.
- The hospital had a helipad on site to enable speedy access for emergency cases.
- Services worked with other referring trusts and local agencies to co-ordinate care for children and young people.
- There was access to facilities in the 'Ronald McDonald House' near the hospital for parents to stay who needed to be close by or had a lengthy journey to the hospital.
- There was access to outside areas which were accessed by staff via a swipe card system and only used under supervision.

Meeting people's individual needs

Summary of findings

- As part of the trust aim to be an inclusive and accessible place for all to visit and work, a consultant learning disability nurse had been appointed and a pre-employment programme had been run to attract people belonging to black and minority ethnic groups.
- The trust was also appointing an additional three learning disability nurses to work with patients and has rolled out mandatory learning disability awareness training for staff. This helped support people who have a learning disability and were receiving care at the hospital. Children and young people with a learning disability were sensitively managed with a person centred approach and staff were skilled in meeting their needs appropriately.
- The hospital had an Arts for Health programme in place. This was to enhance the physical environment to improve the patient experience. The team and children and young people developed pieces of art on display in the hospital to connect the nature and the outdoors with the environment. The team had also involved patients in a wide range of art forms which include, dance, music and craft making. 76% of patient who were involved in the music project said it enabled them to forget about their illness or condition.
- In November 2016 the trust launched an app which supported patients with sickle cell disease and offered advice and information to manage pain through a series of interactive games. This was developed by a storyteller working with patients.
- Staff were responsive to the individual needs of patients and those close to them. There was good evidence of personalised care planning that focused on the needs of children and young people.
- There was good access to interpreter services for children and young people whose first language was not English; however, there was limited evidence that the trust provided information leaflets in any other language than in English.
- Appointment letters and supporting information were only produced in other languages on request

Access and flow

- There was access to beds at all times as the occupancy levels on the wards met the total number of admissions. The bed occupancy on the medical wards ranged from 68% to 95% between January 2017 and March 2017.

Summary of findings

- Between December 2015 and end of November 2016, patients had a shorter average length of stay when compared to an average of four children's specialist trusts for both elective and non-elective medicine.
- The average length of stay for patients following surgical procedures at Alder Hey from April 2016 to April 2017 was 1.7 days, which was shorter (better) than the average across other children's trusts in England which is 2.6 days.
- For the period April 2016 to March 2017 the paediatric cancer waiting time standards for two week waits, 31 day referral to treatment, and all cancers 31 day waits until subsequent treatment, were achieved in 100% of cases, with the exception of the cancer two week waits in November 2016, which was 88%.
- From January 2016 to December 2016, 304 pre-planned surgical procedures were cancelled for non-clinical reasons, of these 61 (20%) were not subsequently treated within 28 days. This was higher than the England average which was 6% of patients not treated within 28 days. NHS England considers that failing to treat patients within 28 days of a procedure which was cancelled for non-clinical reasons to be a breach of the standard.
- Between April 2016 and March 2017, on average 92% of patients received treatment with 18 weeks of the date they were referred for that treatment. This ranged from 73% for patients waiting for spinal procedures to 100% of patients waiting for orthodontic treatment. Overall this was better than some other specialist paediatric trusts but not as good as others nationally.

Learning from complaints and concerns

- Staff understood the process for receiving and handling complaints and were able to give examples of how they would deal with a complaint effectively.
- The trust recorded complaints centrally on the trust-wide system. The local ward managers and clinical business unit managers were responsible for investigating complaints in their areas. Ward managers told us how they were working to achieve 'on the spot' resolutions of concerns where possible.
- Information provided by the trust showed there had been 66 formal complaints raised across all services between April 2016 and March 2017. The number of formal complaints had decreased over the past three years.

Summary of findings

- We looked at five complaint responses and found that four had been responded within the agreed timeframe. There was a delay of 13 days with the response for one complaint but we saw that the response was in draft and final amendments being made.
- It was noted that the response letter did not give information on the parliamentary health service ombudsman (PHSO). The PSHO is an independent body that can make final decisions on complaints that have been investigated by the NHS and are not resolved to the complainant's satisfaction.

Are services at this trust well-led?

We did not rate the trust overall during this inspection. The team made judgements about three services. Of those, two were judged to be requires improvement and one was judged to be good.

Therefore the trust was not consistently delivering good standards

- There was a clear vision and strategy across the trust and the senior team were visible across all departments. Staff were positive about their line managers and found them to be supportive.
- Staff knew who to escalate concerns to and felt supported to do so. There was increased clinical engagement since the last inspection.
- The trust was involved in a number of innovation and improvement areas and had been recognised nationally and internationally for the work they were doing.
- The trust had recently implemented a model of devolved governance to services. However at the time of the inspection these were relatively new and not all systems and processes had been identified to support continuous quality improvement. This was especially evident in surgical services.
- The trust had a clear governance structure to ensure they were assured about the care patients received. However, we observed the clinical steering group key issues report presented to the clinical quality assurance committee noted that the key issue report from the clinical business units were only in the process of being pulled together.

However:

- We found that training for sepsis and the recognition for the identification and escalation of the deteriorating patient was identified on the medical clinical business unit risk

Summary of findings

register. However: it was not clear what date the risk was placed on the risk register and at the time of the inspection, the risk had not been reviewed and there was no audit or review of the pilot phase of the pathway identified.

- The surgical risk register had a number of risks without actions and there was a lack of controls recorded to mitigate the risk. The medical risk register had actions which did not appear to have been monitored or reviewed in a timely way.
- Not all risks we identified during the inspection had been included on the risk register, for example, the absconion or abduction of children from the wards, which was highlighted at the inspection of the new hospital.
- The trust recruitment policy on pre-employment checks covered criminal record, identity, right to work, employment history, professional registration and qualification checks. However, internal processes did not include a check with any relevant professional bodies (for example, financial and legal) and undertake due diligence checks for senior appointments that would comply with the fit and proper person regulation (FPPR). Also, we found that the trust had not completed financial and legal checks for the senior managers which meant there were not fully compliant with the FPPR regulation. We were not assured that the process in place to monitor the self-declaration forms for all directors and non-executive directors was being monitored robustly.

Vision and strategy

- The five year quality strategy, 'inspiring quality' was approved by the Board in 2016. This had a focus on patient safety, patient experience and clinical effectiveness. There were key aims, for example, patients will have the best possible experience, patients will receive the most effective evidenced based care and to improve workforce, health and wellbeing.

Governance, risk management and quality measurement

- The trust had recently implemented a model of devolved governance to services. There had been three newly appointed heads of quality, one for each clinical business unit to implement a system of local governance and risk. However at the time of the inspection these were relatively new and not all systems and processes had been identified to support continuous quality improvement. This was especially evident in surgical services. Staff told us that a lot of information was being gathered but still needed to be brought together to identify any further actions, lessons learnt and key performance indicators.

Summary of findings

- The trust quality improvement plan 2017-2018 identified focus areas for the coming year. These included further embedding a safety culture and increase patient and family engagement in improving quality and developing services. How they were going to deliver the aims was also identified in the plan, for example improvement interventions included reducing infections, improve capture of family feedback and improve out of hours medical cover. However, there was no measurement of success identified.
- The trust has not recently completed an independent well led review whilst moving to the new hospital, but will be commissioning one in the near future as set out in the Well-Led Framework for Governance Reviews. However, they had begun a self-assessment and identified gaps in evidence to action.
- The trust had completed an independent review into the quality governance framework in December 2016. This showed there was some weakness in the design and operation of controls which could impair the achievement of the objectives. However, the impact would be minimal or unlikely to occur. The trust had actions in place to meet the recommendations of the review. These actions were due to be completed by the end of June 2017 and staff told us they were on target and due to be reported to the May clinical quality assurance committee.
- The trust had a clear governance structure to ensure they were assured about the care patients received. However, we observed the clinical steering group key issues report presented to the clinical quality assurance committee in April 2017, noted that the key issue report from the clinical business units were only in the process of being pulled together. This meant there was a risk that the trust committee were not receiving assurances about services being delivered.
- The trust had a risk management strategy in place that ensured systems were 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.
- There had been further improvements in the proactive management of risks within services but a number of risks at department level that could potentially have an impact at service level had not always been identified as such. For example, the risk of children absconding or being abducted. It was also noted that the issues around mortality reviews was not on the corporate risk register. Staff told us further risk management training was being made available.

Summary of findings

- We found that training for sepsis and the recognition for the identification and escalation of the deteriorating patient was identified on the medical clinical business unit risk register. The control measure was that a sepsis pathway was being piloted on a medical ward however: it was not clear what date the risk was placed on the risk register and as at 20 April 2017, the risk had not been reviewed. We found at the time of our inspection that the pathway for sepsis was being rolled out to other wards but there had been no audit or review of the pilot phase.
- A deep dive into the medical clinical business unit risk register was undertaken in January 2017. This found that a number of risks had been identified as improving, however all service managers had been asked to re look at the risks and reassess the risk rating and ensure all appropriate controls were in place. The deep dive in surgical clinical business unit showed that further training was required for staff as the review highlighted gaps in knowledge on managing risks. This was the same issue highlighted in the community deep dive review.
- The surgical risk register had a number of risks without actions and there was a lack of controls recorded to mitigate the risk.
- The medical risk register had actions which did not appear to have been monitored or reviewed in a timely way. For example, actions identified to mitigate risks in January 2016 had not been confirmed as completed at the last review in October 2016.
- The corporate risk register was further improved when compared with the register at previous inspections. The risk register template included clear sections for the risk description, causes and consequences to prompt risk owners to consider all potential causes and consequences of the risk condition. There is a section for existing controls but gaps in controls had not been identified or recorded. It was also unclear if all of the actions identified to mitigate the risk had been completed. For example actions from January 2016 had not been confirmed as completed. The electronic system did not automatically move any actions completed into the controls section. We raised this with staff who told us they would manually move these in the future.
- The Board Assurance Framework (BAF) was a comprehensive document. The principal risks were set out under each strategic objective with existing controls, assurance evidence, gaps in controls and assurance, actions required and progress. However, it does not describe the cause and consequence.
- In March 2017, the trust BAF was reviewed by Mersey Internal Audit Agency. This was to assess the approach and how the trust

Summary of findings

maintains and uses the BAF. This showed that the structure met the NHS requirements, was visible by the board and reflects the risks discussed at the board meeting. The trust was meeting all the standards in the assessment.

Leadership of the trust

- The senior team were visible and accessible to staff. Staff were positive about the increased visibility of the senior team.
- Staff were positive about their line managers and felt they were supportive and knowledgeable. They told us that they could go and get advice at any time.
- Leadership at service level remained apparent. There were some strong and positive role models for staff in all of the services we inspected. Staff knew who to escalate concerns to and felt supported to do so.
- Clinicians remained active in developing and supporting improvements within their specialist fields and there was an increase in clinical involvement in the trust.

Culture within the trust

- The trust was making good progress to promote a positive inclusive culture throughout the organisation.
- The 2016 staff survey showed that 87% of staff would recommend the trust as a provider of care to their family or friends. This was better than the national average of 80%.
- 81% of staff believed the trust provided an equal opportunity for career progression or promotion for the workforce race equality standard. This was below the national average of 89%.
- In December 2016, a random sample of 200 staff were asked if they would recommend the trust as a place to work. The result was 73% of staff would recommend the trust.
- The percentage of staff in the trust experiencing harassment, bullying or abuse from other staff in the last 12 months was 24 which was the same as the national average.
- The CAMHS community service had requested one and commissioned another independent review following concerns about the service, and poor staff morale in 2015. The service was still in the process of implementing the changes of these findings, and was in a process of transition. This included a revised leadership structure. The service had put strategies in place to address low staff morale.
- Staff in all disciplines remained proud and passionate about their work and there was a strong commitment to delivering and securing the best for children and young people evident throughout the organisation.

Equalities and Diversity

Summary of findings

- Information from the trust showed that only 5% of black Asian minority ethnicity (BAME) staff made up the workforce compared to 11% locally. Actions had been identified to address this issue. This included establishing a permanent group to advise on BAME issues at the hospital and to set up a listening into action session to listen to the experience of these staff with an aim to improve working lives of BAME staff at the hospital.

Fit and Proper Persons

- The trust was aware of how to meet 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 policy on pre-employment checks covered criminal record, identity, right to work, employment history, professional registration and qualification checks. However, internal processes did not include a check with any relevant professional bodies (for example, financial and legal) and undertake due diligence checks for senior appointments. This for example, would exclude candidates who could not demonstrate they were capable. The checks were also to include non-executive directors. However, we have been told that a reviewed recruitment policy to include checks that would comply with the FPPR regulation, had been drafted after the inspection and was due for approval.
- We reviewed 18 personal records for the directors and found that the due diligence checks for senior managers had not been completed. Following the inspection the trust completed these checks. This meant at the time of the inspection the trust was not fully compliant with the FPPR regulation.
- The internal processes included self-declaration forms for all directors and non-executive directors. We reviewed 18 personal files and found that they all had these forms completed, however on three of them, one was found not to be completed fully, one had alterations on the form and one was pre-dated to July 2017. We were told that the one that had alterations on was due to the member of staff not fully understanding the questions and was advised to amend the form once this was explained to them; the other was a mistake with the date. This meant we were not assured that the process was being monitored robustly.

Public engagement

Summary of findings

- The young people's group had participated in focus groups, for a number of senior staff recruitment. They fed back to the selection panel themselves.
- Several parents and members of the young people's group undertook inspections into different areas, for example, the food, cleanliness and maintenance of wards and departments.
- The trust quality and safety leads had visited the young people's group and parents to discuss engagement opportunities which included the ongoing development of the ward accreditation programme.
- The communications team had been working with young people to develop the new trust extranet.
- The transitions lead nurse had engaged with young people as they approached adulthood to discuss the service and how to improve the service.
- The trust sought feedback from children, young people and their parents or carers. During June 2016 to March 2017, 94% said they received information enabling them to make choices and 99% said they were treated with respect. However, there was improvement needed in the area of engagement in play and learning with the score only being 61%. This was going to be a key priority for the trust during the coming year.

Staff engagement

- The chair of the clinical quality assurance committee regularly undertook visits to services to engage with staff and review quality indicators.
- The trust had a 'Listening in Action' lead that had been in post since April 2016. Listening in action enables organisations to engage with employees to contribute to the improvement of the organisation in a way to make them feel proud.
- In the 12 months prior to our inspection there had been six 'Big Conversation' events resulting in attendance of 50-80 staff across the trust.
- Staff engagement plans were having a positive impact and staff felt better informed and heard.

Innovation, improvement and sustainability

- The trust was also involved in a number of commissioning for quality and innovation (CQUIN) national goals during 2016-2017. One was for improving health and wellbeing of NHS staff, which was achieved, another was for a reduction in antibiotic consumption which was also achieved.

Summary of findings

- The trust had recently received acknowledgement from the secretary of state, congratulating them on the best improvement with regard to the four hour accident and emergency target in England between November 2016 to January 2017.
- The trust had recent held their first 'dragons den'.Services bid for quality improvement projects.For example an ophthalmology screening in schools for children with a learning disability.This was due to 40% of children with a learning disability have issues with their vision.
- In 2017 the hospital won an award at the annual north west coast research and innovation award ceremony.
- Children and young people were involved with the development of the service through the "FRESH" initiative. This involved children and young people in developing information such as posters, leaflets, and a website about the service, and mental health in general. The FRESH logo, and the written materials associated with it, were in a clear but distinctive and recognisable design. The patients' forum had been used to lead developments in the service, which included the decoration of the reception area in both services. Children and young people were involved in recruitment, and had participated in mental health awareness in schools. FRESH+ was a parents and carers group.
- The gait lab and had been recognised for the excellent work undertaken with Liverpool john moore's university on monitoring a range of clinical outcomes following surgery in cerebral palsy children.A team member had received international acclaim and recognition in being shortlisted for the David Winter young investigator award 2017.

Overview of ratings

Our ratings for Alder Hey Children's Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Requires improvement	Good	Good	Good	Good	Good
Surgery	Requires improvement	Good	Outstanding	Good	Requires improvement	Requires improvement

Our ratings for Alder Hey Children's NHS Foundation Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	N/A	N/A	N/A	N/A	N/A	N/A

Our ratings for Mental Health Services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Specialist community mental health services for children and young people	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement

Outstanding practice and areas for improvement

Outstanding practice

- Each ward had their own dedicated pharmacist and medication was accessed by fingerprint technology this ensured that medication was secured and stock levels were adequately controlled.
- There was a chef allocated to each ward and all food was prepared on the ward.
- A hybrid theatre had recently been opened and a small number of operations had been undertaken using this facility. This was the first paediatric hybrid theatre to be opened in Europe.
- The hospital innovation team had worked collaboratively with a local university to develop 'virtual surgery' and to use high definition 3D printing so that organs can be viewed in much more detail. This allowed staff to 'virtually walk around' organs.
- The child and adolescent mental health (CAMHS) community service was part of a network of statutory and voluntary services. It was piloting ways to make it easier for people to contact services, so they could be either referred to the child and adolescent mental health services, or signposted elsewhere. This included accepting self-referrals from children and young people or their parents, and trialling visiting GP practices so that GPs did not have to make a written referral to the service.
- The CAMHS community service followed best practice by using the choice and partnership approach, which emphasised collaborative working with children and young people and their families. The service had recently introduced the "THRIVE" model, which aims to provide better outcomes for children and young people, and reduce waiting times.
- The hospital had an international health partnership with a hospital in Kathmandu and many specialities were engaged in quality improvement work including the emergency department for resuscitation training.

Areas for improvement

Action the trust MUST take to improve

Action the trust MUST take to improve

- The trust must ensure that all serious incidents are reported in line with the trust policy and initial investigations are carried out in a timely way so that any immediate actions to mitigate risk are identified.
- The trust must take action to ensure all children and young people receive treatment in relation to sepsis within appropriate timeframes. Have a process to monitor adherence to policy for patient's treated for sepsis.
- The trust must ensure that robust arrangements are in place to govern the fit and proper person's process.

At Alder Hey Hospital

- The trust must take action to ensure all staff who is involved with assessing, planning, and evaluating

care for children and young people are trained to safeguarding level three in line with the safeguarding children and young people: roles and competencies for health care staff Intercollegiate Document (2014).

- The trust must ensure that there is a member of staff trained in advanced paediatric life support available in every department at all times as outlined in the Royal College of nursing guidelines.
- The trust must ensure that compliance with mandatory training is improved, particularly for training in safeguarding level three for children and for medical staff.
- The trust must ensure that formal risk assessments are undertaken in all departments and all identified risks are captured on the risk register where needed.

Child and Adolescent Mental Health Services (CAMHS) – Community

Outstanding practice and areas for improvement

- The trust must ensure that lone working practices are implemented, to ensure the safety of staff and others.
- The trust must ensure that the confidentiality of patient information is maintained, and that patient records are only accessible to authorised staff.

Please refer to the location reports for details of areas where the trust SHOULD make improvements.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity

Regulation

Regulation 5 HSCA (RA) Regulations 2014 Fit and proper persons: directors

How this regulation was not being met:

The trust's processes for managing the fit and proper person's processes were not robust. Regulation 5

Regulated activity

Regulation

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

How the regulation was not being met:

Not all clinical staff who contributed to assessing, planning, and evaluating the needs of a child or young person had completed a mandatory training update in safeguarding (level 3). Regulation 13 (2)

Regulated activity

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

How the regulation was not being met:

Systems and processes did not fully mitigate risk of complications of sepsis. Records for two children with a history of sepsis were reviewed and both highlighted delays in treatment. Both these children had alerts on the electronic system saying 'high risk of sepsis, immediate review' however there were delays of 12 and 18 hours for review which delayed ongoing treatment. Not all clinical staff had received sepsis training and there were no audit identified following the pilot to measure if the pathway was robust.

This section is primarily information for the provider

Requirement notices

We found at ward level, formal risk assessments were not being undertaken and as a result, there were examples of risks that had not been captured on the risk register.

We found examples of when serious incidents were not reported within the set timeframe, which meant that an initial investigation to identify immediate learning had not taken place in a timely manner. We also found that there was limited learning from incidents recorded to mitigate the risk of the incident happening again.

In CAMHS Community Confidential information was not stored securely at all sites, and was potentially accessible by people outside the trust.

The trust had a lone working policy, but this was not all relevant to individual services, and was not fully implemented. Regulation 17 (2) (b)

Regulated activity

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

How the regulation was not being met:

The hospital was unable to provide a member of staff who was trained in advanced paediatric life support in every department at all times. Regulation (1) (2) (a)