

Sheffield Children's NHS Foundation Trust

Sheffield Children's Hospital

Quality Report

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

Ratings

Overall rating for this hospital	Good	
Accident and emergency	Good	
Medical care	Requires improvement	
Surgery	Good	
Critical care	Good	
Neonatal services	Good	
Transitional services	Requires improvement	
End of life care	Outstanding	
Outpatients	Good	

Summary of findings

Letter from the Chief Inspector of Hospitals

Sheffield Children's NHS Foundation Trust is one of four dedicated children's hospital trusts in the UK. It provides integrated healthcare for children and young people from the local population in Sheffield and South Yorkshire, as well as specialised services to children and young people nationally.

Sheffield Children's Hospital has been a foundation trust since 1 August 2006. They employ around 3,000 staff. They treat around 30,000 children and young people admitted to hospital as inpatients or day cases and more than 164,000 attending outpatient clinics or being treated in emergency department.

The trust has three locations registered with the Care Quality Commission. These include Sheffield Children's Hospital, Becton Centre for Children and Young People, and Ryegate Children's Centre. The trust also runs the Embrace retrieval service for the region.

The trust was in the process of a new hospital build due to be complete in 2016, which aims to improve privacy and dignity of patient with increased number of single rooms and larger bed space areas. It also aims to increase the recreational and support facilities for children and young people and their families.

We carried out this comprehensive inspection as part of the pilot phase for the methodology adapted for dedicated children's hospitals. Sheffield Children's Hospital NHS Foundation Trust was rated as medium risk in the CQC's intelligent monitoring system. The inspection took place between 7 and 9 May 2014 and an unannounced inspection took place on 22 May 2014. We did not inspect the Children's and Adolescent Mental Health Services (CAMHS) provided by Sheffield Children's Hospital.

Overall, this hospital was rated as good. We rated it good for being caring, effective, being responsive to patients' needs and being well-led, but improvement was required in providing safe care.

We rated palliative care and end of life services as outstanding and A&E, surgery, critical care, neonatal services and outpatients as good. However we rated medical care and transitional services as requiring improvement.

Our key findings were as follows:

- All staff working at the hospital were extremely proud to work for the hospital and dedicated to their work.
- The culture was found to be open and transparent with an evident commitment to continually improve the quality of care provided.
- The executive team were well known throughout the hospital and some members of the team did regular walkabout, and the medical director still worked clinically in the A&E department.
- The care provided throughout the Hospital was consistently found to be compassionate and demonstrated dignity and respect with good examples of providing emotional support to children, young people and their families or carers.
- Staffing out of hours (OOH), particularly within the A&E department was not always sufficient. The trust was in the process of presenting a paper on OOH cover to increase the number of consultants available and strengthen the OOH cover at the hospital.
- The nurse staffing tool used by the hospital was developed specifically by the Chief Nurse to take into account national standards and other factors specific to the needs of each ward and agreed levels for each shift were agreed with the ward manager as a basis for recruitment and ongoing staffing.
- The end of life care service demonstrated a clear commitment to always meet the preferences of patients on an end of life care pathway.
- The accuracy of statutory and mandatory training data was not consistent between the central database and those records held locally at the wards. Staff reported this was due to them reluctance to rely on the central database as it was often inaccurate.

Summary of findings

- The hospital was clean and infection prevention and control measures were found to be good in the majority of areas, although a few staff were found to not comply with being bare below the elbows.
- The flow throughout the hospital was in the majority good and they had a high rate of day case activity to prevent children and young people having to stay in hospital. They were also starting to work with other providers to develop pathways to keep care closer to home.

We saw several areas of outstanding practice including:

- Outstanding practice was found to be evident in end of life care, in particular their leadership and responsiveness to patients wishes and preferences on an end of life care pathway.
- The commitment and dedication of all staff and the transparent and open culture.
- The tool used for nurse staffing was developed by the chief nurse and agreed staffing levels were decided in a collaborative manner with ward managers to ensure all aspects of specialism and acuity were taken into account.
- The care and commitment provided in the A&E department was found to be excellent and the trust had consistently met the A&E 4 hour target for the previous twelve months.
- There was a drive to deliver care closer to home and reduce unnecessary admissions.

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

Importantly, the trust must:

- Ensure the hospital cover out of hours is sufficiently staffed by competent staff with the right skill mix, particularly in A&E.
- Ensure consultant cover in critical care is sufficient and that existing consultant staff are supported while there are vacancies in the department.
- Review the process for ongoing patient review for general paediatric patients following their initial consultant review to ensure there are robust processes for ongoing consultant input into their care.

In addition the trust should:

- Review and standardise risk management and governance processes to ensure the local processes are consistent to ensure there are robust processes from board to ward.
- Review the current training matrix for statutory and mandatory training and improve the recording system so that there is a comprehensive record of compliance which is consistent with local and trust wide records.
- Review the processes for transition services in all specialties and ensure that a robust system is in place for all specialties as relevant
- Ensure all medical discharge summaries are sent to GP practices in a timely manner to ensure ongoing care is maintained
- Ensure there is provision of consultant ward rounds at weekends across all areas.
- Monitor and review the impact of not having an outreach team to ensure the current provision meets the needs of all patients.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Accident and emergency

Rating

Good



Why have we given this rating?

Overall the A &E department and AAU provided good services in a bright, child friendly environment. The staff were well led within ED and worked well together as a team to deliver care. Nursing staff were up to date with training, apart from conflict management and appraisals.

The trust was achieving the national performance targets for A&E and was responsive to children's needs. Almost all children and relatives we spoke with told us they had received good care and that the staff were caring and friendly. There was a clear incident reporting culture with examples of changes being made as a consequence of investigations.

A&E services required improvement in specific areas of safety. Evidence from staff, documents and the Trust's risk register indicated safety concerns about staffing overnight: the low nurse staffing levels; the low middle grade junior doctor cover between midnight and 08.00; incomplete level of senior medical cover at weekends within A&E; and low levels of resident consultant presence in AAU during peak periods in the week and weekends. The treatment areas were not consistently a secure environment: the general public were able to access the area without being challenged.

Medical care

Requires improvement



Overall, the medical care services 'requires improvement.' The paediatric medical department was found to be cramped. We found discharge summaries were not being sent out in a timely manner. The process for review of general paediatric patients by consultants throughout their stay was not clearly formalised or consistent.

The medical division used a combination of National Institute for Health and Care Excellence (NICE), and Royal Colleges' guidelines to determine the treatment they provided. It had specific care pathways for conditions that affect children such as respiratory syncytial virus. The division had also introduced educational practitioners at ward level

Summary of findings

that enabled staff to develop their competency more effectively. There was a general paediatrician ward rounds on weekends but specialist consultants did not routinely undertake ward rounds on weekends. We saw staff treat patients and their parents with dignity and respect. Parents from ethnic minority communities commented the care and support given to them throughout their stay was sensitive to their cultural needs. Parents told us that the emotional support given to them during the stay of their child was invaluable.

Most parents told us that the needs of their children were met. However, with regard to accommodation, there was no formal separation of children and young adults. We found there was no bath or showers on ward M3 that children with wheel chair could access.

Surgery

Good



Services within surgery were found to be caring and effective. The children and young people we talked with and their parents were generally very positive about the care and treatment provided and very few negative comments were received. There were some examples of innovative practice such as the provision of pagers to parents while their children were in theatre to alert them when their child had reached recovery.

We found services were responsive to the needs of patients and their families and performance data suggested the balance between elective and emergency surgery when demand fluctuated was managed well.

Considerable work had been undertaken to improve the safety of care but there were some areas which required improvement. In particular the use of the paediatric early warning score which detects the early signs of patient deterioration, the dissemination of learning from incidents and the completion of mandatory training.

We found services to be well led at ward and theatre level but there was a lack of clarity in the management structure and the wealth of performance information was not utilised to its maximum effect.

Critical care

Good



The PCCU had systems and process in place to protect children from harm, these included reporting and learning from incidents. Nurse staffing

Summary of findings

levels were in line with national guidance and staff had access to a range of training both internal and at local universities. The needs of the majority of children were met by skilled and experienced staff; however children with complex needs did not always experience continuity of care.

Policies were based on NICE and other relevant national guidelines. PICU submitted data to PICANET national database, which shows Sheffield Children's Hospital has maintained its standardised mortality within national secular trends. There was a formal escalation process for managing deteriorating children and young people but no training had been provided for staff in its use and often a more informal approach was taken by staff. The flow of children through the unit and capacity is managed by working with other providers and Embrace.

Senior medical leadership was stretched by clinical commitments and consequently unable to drive innovation and the vision and the strategy of the unit. Nursing staff felt supported by the senior nursing team and able to raise concerns. There was limited staff and parent engagement for example in the development of the plans for the new unit. Many staff we spoke with were unaware who the members of trust board were and there was limited 'board to ward' walk rounds to identify quality issues and meet front line staff.

Neonatal services

Good



There were systems in place to ensure that babies and their families were treated in a safe, well-equipped environment by suitable numbers of qualified staff. Care was led by a consultant surgeon and there was a locum consultant neonatologist present on the unit Monday to Friday, who was responsible for managing the medical needs of babies. Care based on nationally recommended guidelines was provided by appropriately trained staff, who delivered this care in a compassionate and respectful manner. Parents felt informed involved and able to ask questions when they were unsure.

Summary of findings

We did not see a specific vision or strategy for the development of neonatal services. Nursing staff spoke highly of their immediate manager. There was a governance structure to ensure that risks and complaints were reported.

Transitional services

Requires improvement



We found there were specialities which had established transitional arrangements in place. Some specialities had arrangements in place such as a databases and specially designed documents to ensure adolescents safely transferred over to adult services. Existing transition services had developed independently within their own specialities which meant none followed standards which could be measured for effectiveness. There was some evidence of one speciality completing a nationally recognised toolkit to measure the effectiveness of its transition service. Some specialities had developed established joint transition clinics with the adult service speciality.

Sheffield Clinical Commissioning Group (CCG) had funded an initiative known as TATI which facilitated transition for adolescents with complex neurological health needs. We did not review specific evidence which demonstrated coordinated Trust wide specific planning and delivery of adolescent transition services.

There was a 'Young Person's Working Group'. However, the group did not have the authority, time or resources to develop and promote a coordinated approach to transitional care across the trust. We found evidence of good working relationships between the Trust and the adult providers to support cross transitional arrangements.

End of life care

Outstanding



Children and their families were given the choice as to whether they received end of life care in hospital, at the hospice or at home and all of the patients in the previous twelve months had their preference achieved by the commitment of the staff and multidisciplinary working.

Cleanliness, infection control and hygiene procedures were followed. There were facilities in the bereavement suite and emergency department

Summary of findings

for people who had recently lost loved ones. There were effective systems for prescribing and administering medicines to patients on the end of life care pathway.

We found that patient records were completed appropriately and the views of the child and the family were fully taken into account when it came to the issue of consent to limitation of treatment agreements.

There were advanced treatment plans which took into account a patient's individual prognosis and systems for reacting to critical clinical events.

We found that care and treatment was evidenced based and followed accepted standards and professional guidance. There was good multidisciplinary team working in palliative and end of life care services. When it came to responding to the needs of a diverse multicultural population this was done to a high standard.

With regard to whether the service was well-led we found that palliative and end of life care services, and the service offered by the bereavement suite, were outstanding. Staff we spoke with exhibited an understanding of the vision and strategy of their services. The views of patients, families and staff were taken into consideration. There was also a climate of innovation and improvement.

Outpatients

Good



The outpatients departments were kept clean and were regularly monitored for standards of cleanliness. There were sufficient numbers of suitably qualified staff to meet children and young people's needs. The outpatient department made improvements to care and treatment where these had been identified via programmes of assessment or in response to surveys.

Children, young people and parents told us they felt they received compassionate care with good emotional support. They felt they were fully informed and involved in decisions relating to their treatment and care. People had their needs met although they were not always told why a clinic was delayed. Car parking availability at the main hospital site is currently poor. We found that outpatient

Summary of findings

services were well led. The service had a clear strategy and vision over the next few years as it increased appointment capacity and space to meet demand.

Good 

Sheffield Children's Hospital

Detailed findings

Services we looked at

Accident and emergency; Medical care; Surgery; Critical care; Neonatal services; Palliative and end of life care; and Outpatients

Contents

Detailed findings from this inspection	Page
Background to Sheffield Children's Hospital	11
Our inspection team	11
How we carried out this inspection	11
Facts and data about Sheffield Children's Hospital	12
Our ratings for this hospital	13
Findings by main service	14
Outstanding practice	90
Areas for improvement	90
Action we have told the provider to take	91

Detailed findings

Background to Sheffield Children's Hospital

Sheffield Children's NHS Foundation Trust is one of four dedicated children's hospital trusts in the UK. They provides integrated healthcare for children and young people for the local population in Sheffield and South Yorkshire as well as specialised services to children and young people nationally. In the majority of cases the trust provides care for children and young people up to the age of 16 years but in some cases this is 18 years or more.

Sheffield Children's Hospital has been a foundation trust since 1 August 2006. They employ around 3,000 staff. They have seen an a consistent increase in activity and in 2012/13 had around 30,000 children and young people admitted to hospital as inpatients or day cases and more than 164,000 attending outpatient clinics or being treated in emergency department.

The trust were in the process of a new hospital build due to be complete in 2016, which aims to improve privacy and dignity of patient with increased number of single rooms and larger bed space areas. It also aims to increase the recreational and support facilities for children and young people and their families.

The trust has three locations registered with the Care Quality Commission. These include Sheffield Children's Hospital, Becton Centre for Children and Young People and Ryegate Children's Centre. The trust also runs the Embrace retrieval service for the region.

Sheffield Children's Hospital NHS Foundation Trust has a governance rating of 'green' with Monitor and has never had any regulatory action taken by them since they became a Foundation Trust. There have been no CQC inspections in the last two years.

The most recent appointment to the board was the Chief Finance Officer in May 2014. board had not had any recent appointments in the last two years. All other executive board members had been in post for between three and twelve years. The non-executive board members had been in post between two and six years.

Our inspection team

Our inspection team was led by:

Chair: Professor Edward Baker, Care Quality Commission

Head of Hospital Inspections: Heidi Smoult, Care Quality Commission

The team of 30 included CQC inspectors, specialist children's nurses, matrons, general paediatric consultants, paediatric surgeon, junior doctor, paediatric pharmacist, a paediatric intensivist, play specialist, parent representatives, NHS manager, NHS executives, CQC analysts and two recorders.

How we carried out this inspection

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

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

Prior to the announced inspection, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. These included the clinical commissioning group (CCG), Monitor, NHS England, Local Area Team (LAT), Health Education England (HEE), the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), Royal Colleges and the local Healthwatch.

Detailed findings

We held one listening event on 7 May 2014 in the evening in the local community and one focussed listening event with patients and their families and carers on the hospital site on 8 May 2014 in the daytime, which had been arranged by the hospital Patient Advice and Liaison representative. These both aimed to listen to the views of children and young people and their families and carers about services they received. Some people who were unable to attend the listening events shared their experiences via email or telephone.

We carried out an announced inspection visit on 7 to 9 May 2014. We held focus groups and drop-in sessions with a range of staff in the hospital, including junior and senior nurses, junior doctors, consultants, student nurses,

administrative and clerical staff, physiotherapists, occupational therapists, pharmacists, domestic staff and porters. We also spoke with staff individually as requested.

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

We carried out unannounced inspection on 22 May 2014. We followed up in areas we required further evidence, reviewed the levels and type of staff available, and how they cared for children and young people.

Facts and data about Sheffield Children's Hospital

Context

- Foundation Trust since 1 August 2006
- Designated Paediatric Major Trauma Centre
- Serves a population of around 350,000
- Employs around 3,000 members of staff

Activity

- Inpatient admissions around 30,000 per annum including day case activity
- Outpatient attendances around 164,000 per annum
- Around 53,000 A&E attendances per annum

Safety

- Never Events: 0 in twelve months prior to the inspection
- STEIS: 11 Serious Untoward Incidents (between Dec 2014 and March 2014)
- NRLS Deaths: 0 (excluding CAHMS); Severe: 1 (excluding CAHMS); Abuse: 0 (excluding CAHMS); Moderate: 6 (excluding CAHMS)
- Infections
 - C-difficile: 6 Not preventable following review

- MSSA: 4 Not preventable following review
- MRSA: 0

Effective

- No indicators flagged as risk or elevated risk

Caring

- NHS Choices: 4 out of 5 stars

Responsive

- A+E 4 hour target: achieved the 95% during the previous 12 months

Well-led

- Sickness levels: 3.9% (below national average)
- Staff survey 2013:
 - Ten areas tending towards better than expected
 - Nine area within expectations
 - Nine areas tending towards worse than expected

Inspection history

- No CQC inspections in the previous 12 months

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

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

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Accident and emergency, Outpatients and Neonatal services.
2. As Transitional services were inspected as a pilot in this inspection, the overall service has been rated but not the individual key questions.
3. Well-led has been given 'good' overall for this hospital, which is outside of our published ratings principles. We believe an overall rating of "good" is appropriate as the required improvement within the two services rated as "requires improvement" was limited to specific areas (one of which was dealt with during the unannounced period), and we have rated one core service as "outstanding" for leadership.

Accident and emergency

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

Information about the service

The Accident and Emergency (A&E) department at Sheffield Children's Hospital provides a 24 hour seven day a week service to the children and young people in the local area with a total population (Children and adults) of approximately 552,700. In 2012-2013 the A&E saw approximately 53,000 children and young people. Approximately 23% of attendances resulted in an admission to the hospital.

Children and their parents/carers present to the department either by walking into the reception area or arriving by ambulance. The majority of patients arrive in the department on foot and they are booked in at reception and then seen by a triage nurse. If the patient arrives by ambulance they are briefly assessed at handover and then transferred to the most appropriate area within A&E.

The ED consists of four main areas, a triage and waiting area, a minor injuries and ailments area which has four treatment areas and five consulting rooms, a room for majors which has five trolleys and a cot, and a resuscitation area with two trolleys. There was also a procedures room which could be used as a third resuscitation area if required. There was also a playroom, a relative's room and a separate cubicle near the clinician's desk which was used when a child required high dependency care.

The A&E department is a member of a regional trauma network and is a designated trauma unit for children and young people. There was also an acute assessment unit

(AAU), staffed by ED nurses which had 14 beds and was adjacent to ED. The unit had approximately 30 admissions each day and admitted children of all ages. It was a short-stay unit that accepted children from a number of sources: GP referrals, re-attendances from other parts of the trust, complex patients for urgent review by speciality consultants and A&E. There were two areas each with six bays separated by glass partitions and two single cubicles.

The A&E department was part of the "MEDicine" directorate. It employed 6.8 whole time equivalent (WTE) A&E consultants, junior doctors and approximately 52 qualified nurses, who were supported by two support workers and a play specialist. There was also support from administrative and reception staff.

During our inspection we spoke with over 35 children and relatives and approximately 40 staff, including nurses, junior and middle grade doctors, consultants, senior managers, ambulance crews and support staff over the course of the inspection. We observed care and treatment and looked at approximately 20 care records.

Accident and emergency

Summary of findings

Overall the A & E department and AAU provided good services in a bright, child friendly environment. The staff were well led within ED and worked well together as a team to deliver care. Nursing staff were up to date with training, apart from conflict management and appraisals.

The trust was achieving the national performance targets for A&E and was responsive to children's needs. Almost all children and relatives we spoke with told us they had received good care and that the staff were caring and friendly. There was a clear incident reporting culture with examples of changes being made as a consequence of investigations.

A&E services required improvement in specific areas of safety. Evidence from staff, documents and the Trust's risk register indicated safety concerns about staffing overnight: the low nurse staffing levels; the low middle grade junior doctor cover between midnight and 08.00; incomplete level of senior medical cover at weekends within A&E; and low levels of resident consultant presence in AAU during peak periods in the week and weekends. The treatment areas were not consistently a secure environment: the general public were able to access the area without being challenged.

Are accident and emergency services safe?

Requires improvement 

The department was visibly clean and tidy throughout our inspection. There was ownership of risk management and learning from incidents within the department. The environment was orientated to suit the needs of CYP, especially the waiting areas.

Nursing and medical staffing levels overnight had been highlighted on the "MEDicine" directorate's risk register and by staff we spoke with as a significant concern. There were two nurses on duty from midnight: the senior nurse also had duties covering the whole hospital. There was low middle grade junior doctor cover between midnight and 08.00; incomplete level of senior medical cover at weekends within A&E; and low levels of resident consultant presence in AAU during peak periods in the week and weekends. The trust had put some plans in place to increase A&E consultant cover up to midnight but not overnight.

Security within A&E could be improved: there was open access to the treatment areas within the A&E department. We observed a number of adults who may or may not have been with children within the treatment areas. Staff did not question any of these adults. There was a good incident reporting culture among staff and changes to practice were made following learning from incidents.

Incidents

- The trust reported three serious incidents (SI) between December 2012 and March 2014 in the ED, these related to unexpected deaths. All three incidents had been investigated and had action plans developed to prevent a similar incident re-occurring and share learning as a consequence.
- Although changes has been made following the SI's and changes had been implemented, most of the nursing staff we spoke with were not aware of the three SI's that had been reported and could not be specific about action plans and learning that came specifically from these three incidents.

Accident and emergency

- The trust provided us with the department's incident listing reports for March 2014, which recorded ten incidents that had occurred. We noted that two of these incidents related to staffing levels, both medical and surgical.
- All staff we spoke with in both the A&E and AAU stated that they were aware of the process for reporting incidents.
- Doctors told us about analysis and learning from mortality & morbidity and medical audit meetings and we saw notes from these meetings which confirmed this.
- Senior staff stated that, "The learning from incidents was only accessible to clinicians within their own directorate." and "this did not help trust-wide learning from incidents." Learning from incidents was not routinely shared across departments. However staff told us that a multidisciplinary audit meeting was planned.
- There were 'Clean' stickers on equipment in the trolley bay and resuscitation room to indicate that they had been cleaned and were ready for use.
- Material curtains separating the cubicles were clean. However, there was no evidence of a schedule of when the curtains would be changed. We were told that if there was a spillage the cleaners would be contacted to change them.
- Cleaning of the toys was the responsibility of the part time play specialist. We saw from evidence provided that toys were cleaned weekly. We observed that not all toys were cleaned after each use.
- There were policies and procedures within the department's medical guidelines on managing children with infections including diarrhoea and vomiting to prevent cross infection.

Cleanliness, infection control and hygiene

- The department was visibly clean and tidy throughout our inspection.
- Parents/carers were positive about the cleanliness of the department. Comments included that the department "Was spotless" and "It seems clean to me."
- We saw staff regularly wash their hands and use hand gel between patients. The 'bare below the elbow' policy was adhered to.
- There was a daily patient environment standards check that was completed by the nursing staff which included checking the linen room, toilets, bays and corridors, sluice, for cleanliness. It noted any action required. We saw copies of recent checks which were collated monthly and sent to the infection control lead then the modern matron.
- The hand gel dispensers were full and paper towels were available at all sinks and in toilet areas.
- There were posters on effective ways of washing hands.
- There were cleaning staff available 24 hours a day. Cleaning staff were present in both the A&E and AAU every morning until 14.00. If cleaning was required at other times of the day the cleaning team could be contacted via the on call system 24 hours a day.
- There were visible cleaning schedules on public display in both A&E and AAU, recording what required cleaning daily and weekly.

Environment and equipment

- Routine equipment such as intravenous therapy units was checked and cleaned regularly by nursing staff to ensure it was fit for use.
- Resuscitation equipment for varying age groups, such as ventilator and suction, was available and stored appropriately.
- Daily checks of the resuscitation equipment were not always completed. The team found evidence that checks had only been recorded 48 times over a 90 day period.
- Staff told us there was never a shortage of equipment in either AAU or A&E.
- The waiting area was tidy, bright and colourful. There were age-appropriate wall montages and information for CYP.
- There were a range of activities and toys available including a separate soft play area for younger children. iPads with electronic games on them were fitted to a wall for older children.

Medicines

- All the medicines we looked at were in date were well stocked.
- The policy was to check controlled drugs (CD) daily. However there were some occasions where daily checks had not been carried out.
- Emergency drugs were stored appropriately.
- Medicines were stored correctly, including locked in cupboards or fridges where necessary. Fridge temperatures were checked and recorded.

Accident and emergency

- Medicines that were prescribed to take home were stored correctly in a newly computerised robot dispensing cabinet. This required fingerprint access by staff and we observed staff being trained to use the system.
- We observed that medication given in the department was administered safely.

Records

- The department stored patient information, including summaries of previous attendances electronically using an IT system.
- X-rays, blood tests and prescriptions could be ordered through this IT system.
- There was also printed documentation for nursing and medical staff that was inputted jointly on one record. We looked at approximately 12 sets of A&E documentation during our inspection and found that they had been completed appropriately.
- Letters to GPs informing them of a patient's attendance at A&E were generated by the IT system, printed and posted out three times/week. Copies were also sent to health visitors and/or school nurses.

Consent

- There were appropriate policies and procedures in place for consent, for example, unaccompanied children and consent, legal status of children
- We observed that verbal consent was gained appropriately, procedures were explained and all questions answered.

Safeguarding

- Child safeguarding training was part of the staff induction and mandatory training for all A&E and AAU staff. From records we saw 96% of nursing staff had up-to-date training for level 3 training. Reception staff were trained up to level 2.
- Level 3 child safeguarding training was mandatory for all A&E doctors. The trust told us there were ten A&E doctors who had not completed level 3 child protection training. This lack of training was also not meeting the standards set by the College of Emergency medicine that required all senior A&E doctors to have completed this training.
- There was a system in place to alert any staff of a child who presented at A&E where there had been previous safeguarding concerns recognised.

- Staff we spoke with were aware of how to make a safeguarding referral if they had any safeguarding concerns and gave us examples of when they had raised a safeguarding alert.
- Staff told us that safeguarding was everyone's responsibility.
- Safeguarding protocols and contact details were accessible within the A&E. However, we noted the policy for safeguarding disabled children and young people should have been reviewed in 2012, this had not occurred.
- The paediatric liaison nurse for the hospital stated that all children attending the department were routinely assessing for any potential safeguarding issues. Letters were sent to every child's GP, school nurse, midwife or health visitor following an attendance at A&E.
- There was no formal protocol in A&E to ask about and record if a patient had a social worker (College of Emergency Medicine standards). When we asked staff they told us this was part of the history taking by the doctor.
- There was a monthly multi-disciplinary peer review session in A&E which reviewed any safeguarding cases from the previous month. We saw copies of notes from two meetings which included analysis of actions taken and any learning for staff.

Mandatory training

- The majority of mandatory training was delivered though specific training days for the department. Dates had been planned for October and November 2014 and staff were booked on this training
- The nursing staff's mandatory training records we looked at showed that there were set targets for each specialty and staff group to achieve compliance with training. At the time of our inspection 88% of staff had received the required training within the department.
- We noted that only 66% of staff had completed conflict resolution training, which was below the target set for the department. We were told that this was a trust-wide issue and that very recently dates had been confirmed for two training days.

Initial assessment and management of patients

- Patients who arrived by ambulance as a priority (blue light) call were transferred immediately through to the

Accident and emergency

trolley or resuscitation area. Such calls were usually phoned through in advance so that an appropriate team could be alerted and prepared for their arrival. There was a separate ambulance entrance.

- Patients who walked into the service were streamed by a receptionist on arrival. The receptionist entered a very brief history on the computer. Patients then waited to be triaged by a nurse, this was usually done within 15 minutes of the child arriving in the department.
- Receptionists told us that if they were concerned about a child they would ring through to the nurse's station or take the child straight into the department.
- We were told that if the department was busy, a second triage nurse would be deployed to ensure every patient had an initial assessment with 15 minutes.
- The triage system was based on the adult Manchester triage guidance, which had been adapted by the trust. The triage staff used 16 algorithms to aid their assessment of a patient. The triage included taking a brief history, observations and categorising the patient dependent on medical need. Pain relief, x-rays and blood tests were organised if required.
- We looked at approximately 12 sets of assessment notes, they all demonstrated that assessments were completed appropriately and pain relief was given promptly.
- Patients admitted to AAU were triaged by A&E staff first including all GP referrals and re-attendances. This was to ensure the patients were assessed promptly and then seen by the most appropriate speciality.

Management of deteriorating patients

- The paediatric early warning tool (PEW) was used throughout the hospital including in the AAU. The PEW included guidance that stated it should be reviewed every time the patient observations were recorded and there was a clear escalation protocol.
- None of the seven PEW charts we looked at had a recording of blood pressure and the PEW scores had not been routinely recorded.
- Patients who attended A&E had their observations undertaken during their initial assessment. We saw that, where required, these observations were repeated and recorded while the patient was in the department.
- PEW was not used in A&E, which could increase the risk of not recognising the deteriorating patient.

Nursing and medical handover

- Nursing and medical handovers were undertaken separately.
- Nursing handovers were held a number of times each day due to the staggering of the rotas. The handovers we observed were brief and covered the basic information required about the sicker patients. They were held in a room which maintained patient confidentiality.
- There was a more detailed verbal handover for the nurse in charge (band 7) in the evening as they were the identified nurse in charge of the hospital overnight and were responsible for managing the bed availability and any other incidents or concerns that were raised, for example, sick leave.
- Medical handovers were held a number of times each day due to the staggering of the rotas. We were told the key times were at 08.00 when the SHO and registrar took over from night staff; at 09.00 when the consultant came on duty and in the evening with the doctors on duty overnight. We observed a verbal handover from a consultant to the paediatric registrar using an SBAR system (Situation, background, assessment, recommendation).

Nursing staffing

- Information provided by the trust stated that the nursing establishment for the department was approximately 32 whole time equivalent posts. There were 52 nurses in post as some staff worked part-time.
- The department had four vacancies, a recruitment process had been started to fill two of these posts.
- All nursing posts were required to be a qualified children's nurse.
- Senior nurses (Band 7 and 8) were all qualified as emergency nurse practitioners, and had specific shifts to enhance the skill mix of the department overall.
- The department also employed two support workers and a part-time play specialist.
- The department planned to have five nursing staff during the day and six in the evening until midnight. Starting times were staggered to meet the demands of the department. Start times during the day were 07.00, 08.00, 10.00, 14.00 and 16.00.

Accident and emergency

- The staffing rotas in A&E planned for two nurses overnight one of which was a band 7 and the other usually a band 5. The band 7 was also the site/bed manager overnight and carried the “524” bleep for the hospital.
- The AAU planned to have four nurses on duty at all times with a band 6 nurse on duty overnight.
- The planned and actual staffing numbers were displayed in the A&E department and AAU for each shift.
- On the day of our inspection we saw there were only two nurses on duty in the AAU due to sickness. We were told that to maintain a safe level of care the number of beds available in AAU was limited to eight.
- To help manage the rotas more effectively staff moved between A&E and AAU.
- Nursing cover overnight was recorded as a patient safety risk for A&E on the risk register due to sickness and absence. To mitigate this risk the department used staff from the agency NHS Professionals, most of whom were the department’s own part-time staff working additional hours to fill the shifts with flexible use of staff from AAU as well.
- The rotas for A&E for four weeks in April 2014 showed that for at least 20 shifts where there were ‘temporary’ staff on duty.
- The lack of suitably trained /skilled nursing staff was also recorded as an incident in March 2014 which resulted in the AAU being closed for most of the night.
- The majority of staff we spoke with raised safety concerns regarding the nursing cover in A&E overnight. They told us that the department was still busy after midnight and because the senior nurse was also the site manager for the hospital overnight this sometimes resulted in delays in responding to calls from the wards or the bleep holder having to leave A&E. We were told staff from AAU supported A&E when this occurred.
- The trust was aware of the shortfall overnight and was scheduled to present a paper to the Trust Executive Group (TEG) on 15 May 2014 to address the nursing shortfall as part of their Hospital Out of Hours (HOOH) proposals.
- Overall, the trust’s spending on agency staff was lower than that of other trusts in the same region (Yorkshire and Humber) and in England.
- Monday to Friday there was consultant cover 8.00 until midnight, sometimes longer if the department was busy. On a weekend consultant cover varied due to a lack of consultant posts.
- Consultant cover for A&E was on the risk register with a score of 12 as there is not full 16 hour cover seven days a week. The trust’s plan was to have cover from 08.00 to midnight every day.
- Some additional funding for a WTE consultant has been agreed but this will not provide the full cover as stipulated on the risk register. Recruitment had started for this post. There was a plan to increase the cover to 8.8 WTE consultants in 2014/15.
- The proposal for HOOH being presented to TEG on 15 May 2014 also covered proposals to increase consultant cover to seven days per week.
- Overnight an A&E consultant was on call. This included any calls for major trauma.
- There was an A&E registrar on duty until 00.00hrs. From 00.00- 08.00 there was a senior house officer (up to CT3 grade) on duty in A&E. Overnight there was a low level of supervision from the onsite paediatric registrar who was covering all in-patients for general paediatrics, the paediatric medical specialities, AAU and A&E.
- The trust had done a review of medical staffing levels overnight using data up to August 2012 which found that 84% of patients were exclusively managed by the ED SHO without input from other teams or senior advice.
- Data indicated that the attendances within the department peaked between the hours of 17.00 to 21.00 and the most attendances were on a Sunday followed by a Saturday
- We were informed that there were two additional CT3 grade doctor posts that were being agreed: one had been appointed, but not yet started and interviews for the second were in May 2014. The trust told us this would allow ED to operate overnight with emergency medicine CT3 and ST4-6 Doctors from August 2015.
- Locum doctors were frequently used for the middle grade doctors’ rota within A&E. Most of the locums were long-term and so knew the department and procedures well. There were two locums on duty each day during our inspection.

Medical staffing

- The department currently has 6.8 whole time equivalent (WTE) A&E consultants.

Accident and emergency

- The consultant cover on AAU was in breach of the Royal Colleges of Paediatrics and Child Health Facing the Future Standards. (Standard Six states that a paediatric consultant (or equivalent) is present in the hospital during times of peak activity)
- Staff told us that the level of medical cover during periods of peak activity and after midnight was “Barely tolerable”.
- Junior doctors told us that consultants were contactable by phone if they needed any support. Doctors told us they felt well supported by the consultants and received professional supervision.

Major incident awareness and training

- The hospital was a designated major trauma centre for South Yorkshire.
- There was a major incident plan which had been issued in 2012 and was for review in August 2015. Staff we spoke with were aware of the plan.
- If a major trauma was called staff from other parts of the hospital were deployed, for example nurses from the intensive care unit to assist in the A&E.
- Major incident training was held annually for all staff as part of the department’s routine training days. Staff told us this included both theory and practical application, for example, the decontamination tent was erected as part of the training.
- A Children’s acute trauma course (CAT) had been developed by the department and 50% of staff had completed this training.

Security

- We observed that the A&E entrance was used by parents and visitors as the main reception to the hospital. During the day it was noted to be very busy with people asking for directions to other parts of the hospital.
- At night the external doors were locked from 23.00 onwards. Staff on switchboard, which was situated next to the A&E entrance, gave people access.
- There were no security guards; if staff required assistance they bleeped portering staff.
- A camera and alarm for reception staff had been recently installed but staff had not received training in how to use it.
- There was no key fob protected doors to separate the reception and waiting area from the rest of A&E. There was open access to the treatment areas within the A&E

department. We observed a number of adults who may or may not have been with children within the treatment areas. Staff did not question any of these adults.

- AAU was a secured area requiring a key code/buzzer to enter. Parents/carers had to be present with all children who were admitted to the unit.

Are accident and emergency services effective?

(for example, treatment is effective)

Not sufficient evidence to rate

The A&E department used nationally recognised best practice guidelines and quality standards to monitor performance, including the CEM best practice guidelines. There were standard emergency department guidelines in place, including a “Guidelines for medical staff book”. There was good multidisciplinary working with trauma specialists available 24 hours a day.

Pain management was good. Patients made positive comments about pain management, for example, a relative told us, “My child was asked directly about pain relief”.

Evidence-based care and treatment

- The A&E department used a combination of National Institute for Health and Care Excellence (NICE) and College of Emergency Medicine (CEM) best practice guidelines to determine the treatment they provided.
- There was a detailed “Guidelines for medical staff combined book” that was up to date and available in both paper copy and on the computers. NICE guidance was incorporated into the book, for example, febrile child and urinary tract infections. It stated that all Emergency Department guidelines are up-dated regularly, with a maximum of 2 years between reviews.
- We observed the guidelines book being used by clinical staff.
- The department participated in the national CEM audits, for example, a consultant sign off audit which indicated that this was largely better than average results. It

Accident and emergency

showed a higher proportion of “high risk” patients being seen first time by a consultant than elsewhere. Actions were identified where improvements were required from the audits.

- The department provided us with a list of 20 internal audits completed during the past year and the dates. For example, a review of management of viral induced wheeze in preschool children presenting to ED, the use of Dioralyte in fluid challenges in children presenting to ED with diarrhoea and vomiting, and an audit of children less than 1 year attending ED with long bone fracture to check appropriate safeguarding standards met. At the time of the inspection staff in A&E were unable to provide us with the results of these or evidence that they had used the results to assess the effectiveness of their department.
- Clinical audit meetings were held periodically during doctors’ teaching sessions. Projects were chosen from the A&E Audit Programme. Doctors told us about the meetings however there were no notes available from the meetings.
- Nursing audits were regularly performed. Each of the sisters had specific areas they led on. All audits were registered with Audit department. Nursing staff were able to tell us examples of learning from audits.
- The department was involved in a monthly mortality meeting which reviewed any deaths in A&E or after an admission through A&E.

Pain relief

- At triage the nurse made an assessment of and scored the child’s pain using the Children’s Hospital Pain tool.
- Patients and relatives we spoke with had been asked if they were in pain and offered pain relief accordingly, for example, a relative told us, “My child was asked directly about pain relief”.
- We saw the CEM national audit for pain relief in children which assessed expedience of pain relief. The results were much better than the England average performance.

Seven-day services

- A consultant was present in the department from 09.00 to midnight during the week. Consultant cover varied over the weekend. Plans were in place, as identified on the risk register to increase consultant which would improve weekend cover.

- There were trauma specialists available/on call 24 hours a day, so that people could be operated on immediately.
- There were some concerns raised by a number of staff about the ability to refer children for a CAMHS (Child and Adolescent Mental health service) assessment at the weekend. We were told children had to be admitted before a referral would be made the following morning and that if a child attended A&E on a Friday they may be hospitalised until the following Monday waiting for an assessment.
- The pharmacy was open during the day on both Saturday and Sunday. For services out of hours there was an on-call pharmacist.
- X-ray and CT scan services were available 24hours every day. There was a radiographer on site 24hours/day with a second one on call. A radiologist was on call overnight.
- Pathology and haematology were available seven days/week.
- Ward rounds occurred daily in AAU by both surgery and paediatric medicine. These were usually between 08.00-09.00hrs every day and again in the afternoon if required which meant patients clinical needs were assessed in a timely manner.
- There was a part-time (22.5hours/week) play specialist employed to cover both A&E and AAU. Their role included supporting patients during treatment, training other staff in distraction therapy, ensuring age appropriate resources were available and cleaning toys.

Are accident and emergency services caring?

Good



Almost all feedback from patients and relatives was positive about the treatment and care they had received in the A&E department and AAU. Patients and relatives felt involved in their care.

Comments from the Friends and Family test since June 2013 included: Always found staff very helpful and understanding” and “This is probably our fifth visit with one of our children and we’ve been really impressed each time - thank you! Could do better: more seating areas”.

Accident and emergency

We observed that patients and relatives were treated with dignity and respect and kept informed by staff about what was happening during the course of their stay in the department.

Compassionate care

- A&E Friends and Family test (FFT) results indicated that the majority of respondents (71%) were extremely likely to use the service again. Comments included: "Always found staff very helpful and understanding"; "This is probably our fifth visit with one of our children and we've been really impressed each time - thank you! Could do better: more seating areas"; and "Any contact my children or grandchildren have had has always been as pleasant as possible".
- The Trust had analysed the FFT comments and we noted the top three issues raised were: not enough play equipment, parking and waiting times. There were actions in place to help address these issues.
- The trust had participated in the Young Emergency department survey in 2013 which compared the trust with eight other hospitals. The trust performed as well as or better than the other trusts in all the responses. For example, the helpfulness of reception staff and staff listening to patients was better than other trusts.
- We witnessed multiple episodes of patient/relative and staff interaction, during which staff demonstrated excellent caring attitudes towards patients. We saw patients being treated with compassion, dignity and respect. Relatives told us: "All the staff were good and kind. Staff talked direct to my child"; "I'm really happy with our overall experience, my daughter is too"; and "I have no issues with care the only thing is waiting in A&E."
- We looked at patient records and found that they were completed sensitively and discussions had been held with patients and relatives.

Patient understanding and involvement

- Patients and relatives told us that they had been consulted about their treatment and felt involved in their care. A parent said "I felt I've been kept informed and know what's happening"
- We heard staff explaining and seeking verbal consent from patients, including children and their relatives, for tests and treatments.

- In the waiting area there were A3 posters which illustrated the patient journey in A&E. Most patients/relatives were able to tell us where they were on their 'journey' and what would be happening next.
- Patients and their relatives were aware of who was in charge of their care. There were signs up in the waiting area indicating who were the nurse and doctor in charge that shift, the name of the nurse running the triage and how long the wait was to see the doctor.

Emotional support

- We witnessed staff supporting patients and relatives throughout their stay in the department. Patients commented: "Staff are very kind"; "The staff here are very patient and understanding. They're very helpful. I'm satisfied with the staff"; and "I can't rate the staff highly enough. My child is happy here; he likes it here"
- We observed the use of specific boxes of "Distraction toys" available to distract children while undergoing procedures, for example, the removal of a plaster cast or a blood test.
- Relatives of patients in the resuscitation area were appropriately supported and cared for by staff. Staff told us there would usually be a member of staff allocated to support the parents/carers while the child was in resuscitation room.
- There was a relative's room opposite the resuscitation area where people could wait away from the rest of the department.

Are accident and emergency services responsive to people's needs?
(for example, to feedback?)

Good



The trust had been performing consistently better than the A&E national targets except for two low points in February and April 2013, with 95% of patients waiting less than four hours to be admitted, transferred or discharged.

Generally patient flow was maintained through the department and was better than the English average. At times when the department was very busy there was a clear escalation policy in place. Staff commented that the main bottleneck for flow through the department was waiting for beds on the wards and AAU.

Accident and emergency

There were a number of systems and services in place to ensure that A&E responded to patients' needs appropriately and in a timely manner. There was information about PALS and complaints which was easily accessible and in different languages. People were asked for feedback through the friends and family test.

Younger children had access to play materials and newly installed iPads to entertain them while waiting for treatment. During our inspection three children, over the age of eight, commented that they were "bored". We observed that children were not always fully supported / distracted during treatment. Staff told us this was because of the limited hours of the play specialist.

Access and flow

- The trust had been performing consistently better than the national target, except for two low points in February and April 2013, with 95% of patients waiting less than four hours to be admitted, transferred or discharged.
- There were fewer ambulance patients that had to wait more than 30 minutes to be handed over to A&E staff compared to the national average.
- The trust was, over last winter, better than average in timeliness of actual admission after the decision to admit to a ward was made.
- The total length of time spent in the A&E was better (shorter) than the England average.
- The number of patients waiting in the A&E department at any time was lower than the average.
- The percentage of patients that left A&E in 2013 before being seen for treatment (recognised by the Department of Health as potentially being an indicator that patients are dissatisfied with the length of time they have to wait) was lower than the national average.
- We were told that patients their initial observations and triage were carried out within the national standard of 15 minutes and we saw this occur during the inspection.
- Generally patient flow was maintained through the department and was better than the English average. At times when the department was very busy there was a clear escalation policy in place.
- Staff told us the main bottleneck for flow through the A&E department was waiting for beds on the wards and that AAU is, at times, used as a "Holding bay" and to avoid A&E breaches.
- Attendance figures showed there were a high number of patients in the evening between 17.00-21.00. Staff

commented that a significant number of these cases were more suitable for primary care if services were open. Staff we spoke with were unaware of any initiatives or plans to work with primary care services to divert attendances from A&E.

Meeting people's individual needs

- The department had a bright, welcoming, child-focussed environment, especially within the waiting area.
- Younger children had access to play materials and newly installed iPads to entertain them while waiting for treatment. During our inspection three children, over the age of eight, commented that they were "bored".
- We observed that children were not always fully supported/distracted during treatment. Staff told us this was because of the limited hours of the play specialist.
- There were adequate disabled toilet facilities within the department. A toilet had a baby changing facility.
- Within the department, there was information for staff on how to request a translator. Staff were aware of the translation service "language line" and we saw within records that the line had been used during some consultations.
- There were health promotion leaflets available that were age appropriate and in different languages.
- There were information leaflets freely available for children and parents/carers to take away which covered over 30 conditions, such as asthma or a broken wrist.
- In AAU we were told that the ability to manage single sex accommodation was at times challenging due to the physical layout of the bed spaces. There were two rooms of six bays each and two single cubicles. In the six bedded rooms the bed spaces were separated by glass partitions and curtains. Each space had a bed and a recliner chair for parents/carers.
- The unit admitted children of all ages which meant that sometimes teenagers of opposite sex were in the same six bedded area which may have compromised their privacy and dignity.
- There was no visual feedback to children, their parents and carers about changes made as a result of patient feedback (e.g. you said, we did).
- Friends and family test results and any actions taken by the trust were not displayed for patients and relatives to see.

Accident and emergency

Learning from complaints

- There were visible posters and leaflets about how to complain throughout the department and AAU. There was also information about an NHS Complaints advocacy service and the hospital's PALS (Patient advice and liaison service). The leaflets were written in English and other languages.
- Complaints were handled in line with the trust policy. If a patient or relative wanted to make an informal complaint, they would speak to the shift coordinator. If the shift coordinator was not able to deal with their concern satisfactorily, they would be provided with information about PALS or complaints. This process was outlined in the complaints leaflets.
- As part of the process a face-to-face meeting was offered.
- Formal complaints were managed through the risk management department. There was an initial response turnaround time of three days. We were told that all responses to complaints were reviewed by the ward manager and a consultant. A learning form for each complaint was completed which were held centrally once the learning had been actioned.
- We noted from the Trust's complaints register that there had been four complaints about A&E and one about AAU since October 2013 to March 2014. All concerned clinical care and only one was closed.
- Feed back to staff was through the Clinical Quality group for the medicine directorate, the A&E team meetings and the nursing team meetings.

Are accident and emergency services well-led?

Good



Staff told us there was usually a visible presence of senior leaders, for example the nurse manager, and they were "Hands on". At departmental level, there were effective procedures in place to ensure that the service was well led, for example the co-ordination of training with specific leads in the department. Staff were supportive of each other and worked together well.

There were regular audits of quality, using national best practice, for example CEM audits and the Trust's own internal audits. Learning and action plans were developed as a result of the audits.

Vision and strategy for this service

- The staff we spoke with were aware of the vision of the Trust in terms of the new building but most were unclear about the trust's overall strategy and vision.
- Staff were aware of mechanisms to feed back about concerns, suggestions and comments.

Governance, risk management and quality measurement

- We were told that there was a monthly medicine clinical quality group meeting which always discussed the risk register, incident reports, complaints, any root cause analysis of concerns and any new risk assessments. We saw the agenda from the most recent one held in May 2014. The meeting was attended by ward managers and business managers.
- Information from the clinical quality group was cascaded to the department nursing meeting and the ED team meeting which included mid-grade doctors, consultants and administration staff. A set of minutes indicated that this happened. There were eight staff recorded as attending on the minutes we saw. Staff told us the minutes were emailed to all staff and displayed on the staff notice board.
- Actions from incidents were recorded on specific forms by staff and the ward manager. These were held centrally once complete.
- We saw evidence of clinical audits being undertaken and learning documented and shared: for example, an abdominal pain audit which found that not all children with abdominal pain had a comprehensive abdominal examination record.
- There were trust-wide nursing audits, which included the A&E. Audits covered positive identification of patients, medication errors, hand hygiene, records and cleaning.
- Doctors told us they had regular clinical governance meetings. However these did not appear to be formally minuted. We were told that learning was shared via email.

Leadership of service

- A&E and AAU nursing staff were led by a ward manager. There was a lead consultant for A&E.

Accident and emergency

- A&E and AAU sat within the “MEDicine” directorate. Staff were aware of the directorate’s leadership team and of the executive team, especially the medical director who worked in A&E.
- Staff told us that the ward manager and senior staff were ‘hands-on’ and supportive.
- The doctors we spoke with felt supported by the consultants.
- All the doctors and nurses we spoke with said they would bring their family to the department.
- We saw from records that 91% of nursing staff were up to date with their appraisals and personal development reviews. Staff spoke positively about the process.
- Staff within the directorate spoke positively about the service they provided for patients. Quality and patient experience were seen as priorities and everyone’s responsibility.
- Staff worked well together and there was obvious respect not only between the specialties but across disciplines.
- The A&E service was well engaged with the rest of the hospital and did not operate in isolation.

Innovation, improvement and sustainability

- Innovation was encouraged by the senior staff within the department.
- An example was the pilot for a clinical out of hours nurse co-ordinator (COHNC) to work from 18.00 to 02.00hours from November 2013 to April 2014. The evaluation indicated that there had been a reduction of 37% in the number of incidents reported relating to out of hours care during the pilot scheme compared to the same period in the previous winter. A business case for a supernumerary ‘Night Sister’ role between the hours of 20:00 and 07:30, supported by a permanent HCA between the hours of 16:30 and 20:00 had been developed.
- Nursing staff were given lead roles to encourage innovation and development. Examples included co-ordination of training for specific topic areas and secondment to the bed manger role. We spoke to two of the training leads who commented on the learning opportunities.

Medical care

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

Information about the service

The medical services department at Sheffield's Children Hospital NHS Foundation Trust provided general paediatric care, as well as some specialist services including allergy, gastroenterology, endocrinology, cystic fibrosis unit, metabolic disorders, cardiology and respiratory disease, immunology, infectious disease, child assessment unit including paediatric forensic suite, neurology, endocrinology, Neurodisability, oncology and haematology and rheumatology. They had 64 medical ward beds, 3 beds for sleep studies and research and medical treatment lounge with 3 beds and 6 couches.

We visited four wards in the hospital. We spoke with 12 patients, eight parents and 28 members of staff. These included nursing staff, junior and senior doctors, and managers. We observed care and treatment and looked at 20 healthcare records. We received comments from people at the focused listening events, and from people who contacted us to tell us about their experiences.

Summary of findings

Overall, the medical care services 'requires improvement.' The paediatric medical department was found to be cramped. We found discharge summaries were not being sent out in a timely manner. The process for review of general paediatric patients by consultants throughout their stay was not clearly formalised or consistent.

The medical division used a combination of National Institute for Health and Care Excellence (NICE), and Royal Colleges' guidelines to determine the treatment they provided. It had specific care pathways for conditions that affect children such as respiratory syncytial virus. The division had also introduced educational practitioners at ward level that enabled staff to develop their competency more effectively. There was a general paediatrician ward rounds on weekends but specialist consultants did not routinely undertake ward rounds on weekends.

We saw staff treat patients and their parents with dignity and respect. Parents from ethnic minority communities commented the care and support given to them throughout their stay was sensitive to their cultural needs. Parents told us that the emotional support given to them during the stay of their child was invaluable.

Medical care

Most parents told us that the needs of their children were met. However, with regard to accommodation, there was no formal separation of children and young adults. We found there was no bath or showers on ward M3 that children with wheel chair could access.

Are medical care services safe?

Requires improvement 

Medical care services required improvement in the provision of services. Overall, the paediatric medical department was found to be too small. We found discharge summaries were not being sent out in a timely manner. The department does not meet the required consultant presence (Royal College of Paediatrics and Child Health standard 6 for acute paediatric services) as there is no general consultant cover from 5pm onwards on either the Acute Admissions Unit (AAU) or the acute wards.

Incidents

- Staff told us they reported any incidents on a paper form. The majority of staff said they received feedback but some said they rarely received any feedback.
- Incidents were discussed at ward meetings and minutes were produced and shared with all staff. We were shown an example of a recent incident that was also highlighted in the staff meeting minutes.
- Staff told us that there was an open culture and environment of reporting of incidents.

Cleanliness, infection control and hygiene

- The environment was clean. We saw the cleaning schedule displayed on the wards and staff knew actions to take if there was a spillage.
- During our inspection we observed staff wearing jewellery, such as rings and earrings that were not in line with the trust policy.
- We spoke to the cleaners who told us that the area was regularly cleaned and inspected by the ward manager.
- We observed staff wearing gloves and washing their hands between patients.
- Infection rates for *Clostridium difficile* were within an acceptable range and there had been no cases of methicillin-resistant staphylococcus aureus (MRSA).
- Each ward had an infection control champion whose responsibility was to ensure the ward was kept up-to-date on infection control.
- Hand hygiene audits undertaken at ward level. We found the results of these were not visible on the wards. However, staff told us they were discussed at staff meetings.

Medical care

- We found there was a weekly and daily rota for the cleaning of toys on the wards.

Environment

- Overall, the paediatric medical department was found to be cramped. In one room there were six beds and at night each parent would have a bed for themselves in the space between beds, which was limited in space and impacted on nursing staff ability to check on children safely at night without the risk of tripping over parents sleeping on their beds.
- The trust had undertaken a risk assessment of this area and they were plans to dispense with the z beds and replace them with “lie back chairs” for parents.
- There was a dedicated school between M1 and M3. When a child could not leave their bed, the school teacher worked with children by their bedside.
- There was a sensory room on M2 for adolescent with complex needs. This helped children and young people receive appropriate therapy.

Equipment

- According to the trust policy, the resuscitation trolleys are supposed to be checked weekly and there was evidence this was being carried out. The seal on the resuscitation drugs were required to be checked daily, however there were a few occasions where this was not being carried out daily with a documented check daily.
- Equipment was clean and functional. Items were labelled with the last service date and large green stickers identified when equipment was cleaned. Equipment was found to be in date.
- Staff told us there was sufficient equipment available at all times. They would borrow from other wards when necessary.
- Staff were aware of whom to contact or alert if they identified broken equipment or environmental issues that needed attention.

Medicines

- We found fridges in the department locked. Most ward fridge temperatures were checked regularly and adjusted if found to be outside the accepted range. However, some were not regularly checked and this did not ensure the efficacy of the medicines they contained.

- We observed checks made when administering drugs to patients. Two nurses would check an intravenous drug. One nurse would make the medicine and the other would check to ensure it was done accurately. Medicines were made in an allocated room.

Records

- All records were in paper format and all health care professionals documented in the same place. We checked six set of notes and found that some notes were well maintained. However, we found inaccurate completion of an intravenous chart and there was inadequate documentation regarding the monitoring of IV cannulas.
- We found discharge summaries were not being sent out in a timely manner. On the second day of our inspection, we found around 180 notes in the doctor’s room where the patient had been discharged but the discharge summaries had not yet been written. We randomly reviewed 20 sets of these notes to confirm that no discharge summaries had been sent. Staff also confirmed these healthcare records were waiting for discharge summaries to be completed. This was highlighted to the trust executive team during the announced inspection.
- When we returned on the unannounced inspection the majority of these notes now had a discharge summary completed.

Consent

- We observed verbal consent being obtained during the inspection when treatment was being provided.
- Staff were aware of consent procedures and children and young people and their families confirmed that things were explained to them clearly and consent was obtained.

Safeguarding

- The medical division has two matrons and one of the matrons is the safeguarding lead for medicine.
- Each ward had a safeguarding champion. All staff had to complete level 2/3 child protection training. The ward managers are responsible to ensure all staff on their ward are trained. We looked at the records and found 90% of staff had received training.
- Child protection team visited the wards on a daily basis and check on any safeguarding concerns from ward staff and we observed this during the inspection.

Medical care

Mandatory training

- There was a significant disparity between the mandatory training figures provided centrally by the trust and those provided by the senior nursing staff in the medical department. Local records inspected on the wards highlighted that most staff had completed all their mandatory training but trust wide data had conflicting levels of compliance.
- All training was undertaken in a week when the ward was closed allowing for ward staff to do the mandatory training and for the cleaning staff to undertake deep clean of the ward.
- The department had also introduced conflict resolution training for all clinical staff and the compliance rates for this were low but the trust was taking action to improve these.

Management of deteriorating patients

- The trust had recently introduced the paediatric national early warning score tool to escalate care for acutely ill patients. There were clear directions for escalation printed on observation charts.
- Staff we spoke with were aware of the appropriate action to be taken if patients scored higher than expected, and patients who required close monitoring and action were identified and cared for appropriately.
- We looked at a sample of completed charts on the medical wards and saw that staff had escalated correctly, and that repeat observations were taken within the necessary time frames.
- However, we found no audits undertaken on the compliance with the scoring or the medical response within one hour.
- As there is no central monitoring system on the wards for staff to monitor observations of patients, there were some instances where patients could not be seen by the nurses (the visibility of the patient blocked by 2 sets of doors) and staff told us that they had to rely, at times, on parents to come and tell them that the monitor was beeping and the patient requires assistance. This could put patients at risk.

Safety Thermometer

- The trust was developing a safety thermometer specifically for children.
- We found there were ward quality indicators that had recently started. These results were not yet shared with the ward or visible on the wards we visited. Staff we

spoke with on the ward were not aware of these. However, ward managers we spoke with told us these were discussed during one-to-one discussions between them and the matrons.

Nursing staffing

- Nurse staffing levels we calculated using a specific tool compiled by the Chief Nurse that took into account national acuity ratios and professional judgement specific to each ward's requirements. The process for confirming the staffing levels of each ward was done by the chief nurse in conjunction with the ward manager and each shift staffing levels were agreed before implemented.
- The trust was in the process of recruiting more paediatric nurses, with matrons and ward managers undertaking interviews for nurses around the time of the inspection.
- Where there is a shortfall in staff requirements, this was covered by agency nurses that worked for NHS Professionals (all qualified nurses employed through this agency also worked for the trust). The hospital does not use any other agency nurses.
- We found nurse staffing was recognised as a priority for the trust as a whole.
- To ensure proactive management of reduced staffing levels, staff told us they recruited permanent staff to cover any maternity leave.
- To cover for sickness, trained nurses are moved to cover based on their experience and competency.
- All bank nurses receive a local induction prior to starting their shift if they are unfamiliar with the ward. Evidence of this was seen at the time of our inspection.
- Nursing handover is undertaken using a tape-recorder. Nurses record conditions of patients that staff can then hear during handover time. This enables passing of quality information to nurses.

Medical staffing

- The department does not meet the required consultant presence (Royal College of Paediatrics and Child Health standard 6 for acute paediatric services) as there is no general consultant cover from 5pm onwards on either the Acute Admissions Unit (AAU) or the acute wards.
- We observed three handovers. There was a consultant at one handover.

Medical care

- At the handover, we observed patients who had not been seen by a consultant were discussed first to ensure they were reviewed by a consultant within 24 hours of admission. They are seen by the acute team after full discussion on a case by case basis.
- The remaining patients on the list are either specialty patients or general paediatric patients (who have been seen previously by a consultant within 24 hours of admission).
- Specialty patients were reviewed by the specialty team and we observed a well structured process for these patients at handover.
- However, general paediatric patients would only routinely be seen by junior doctors (registrar or SHO's). While there would be access to a consultant by phone for any advice, their care on a day to day basis is only given by a registrar with no formalised process for input from a consultant. However, notes we reviewed demonstrated these group of patients did get reviewed by consultants at times.

Security

- There was a good security system in place before entering the wards. If parents or relatives were not allowed onto the ward for any safeguarding reasons, staff on each shift were made aware of this through the handover and a note was attached to the door entry monitor at the nurse's station.
- However, we observed people gaining access by following other people in and once on the ward these people were on the ward, there were not challenged.

Are medical care services effective?

Good



The medical department used a combination of National Institute for Health and Care Excellence (NICE), and Royal Colleges' guidelines to determine the treatment they provided. It had specific care pathways for conditions that affect children such as respiratory syncytial virus. The department had also introduced educational practitioners at ward level that enabled staff to develop their competency more effectively. The trust had no mortality

outliers and overall mortality rates were within expected range. There was a general paediatrician ward rounds on weekends but specialist consultants did not undertake ward rounds on weekends or bank holidays.

Evidence-based care and treatment

- The medical department used a combination of National Institute for Health and Care Excellence (NICE), and Royal Colleges' guidelines to determine the treatment they provided. The policies and guidelines were based on national guidance where appropriate.
- The department had an annual clinical audit programme which we reviewed and they had taken part in all audits that they were eligible.
- Staff told us that changes were made as a consequence of audits where actions were identified.
- There were specific care pathways for certain conditions in order to standardise and improve the care for patients based on national guidance. For example, care pathways were used for the treatment of children with respiratory syncytial virus, a virus that infects most children, usually before the age of 2.

Pain relief

- Nurses we spoke to told us that management of pain relief was one of their priorities. Parents told us that the nurses were very responsive in providing pain relief to their children.
- Some parents had access to their children's medicine and were supported in the administration of these medicines to their children.

Nutrition and hydration

- We observed children and young people being provided with food and hydration during our inspection.
- Most children and young adults we spoke with told us that there was limited variety in the choice of food available to them but they did have access to sufficient food and hydrations.
- The ward had housekeepers in place 7 days a week who helped serve food to children and provided special diets. They also monitored the food intake of patients at mealtimes.
- We reviewed notes and fluid balance charts were completed as required.

Patient outcomes

- At the time of the inspection the trust had no mortality outliers and overall mortality rates were within expected range.

Medical care

- Emergency readmissions, which could be an indicator of the quality of care and discharge, were higher compared to other trusts. However, the trust had investigated this and recognised this was due to a coding issue of patients returning when they had open access for specific conditions or following an acute admission. The trust were taking action to address this error in recording.

Competent staff

- Clinical staff we spoke with told us that appraisals were undertaken regularly. Staff also spoke positively about the process. 72% of nurses in medical care had received an appraisal.
- Nursing staff received clinical supervision. This was introduced for assessing competency, reflective learning and supportive practice. We spoke with nursing and student nursing staff who shared their positive experience of supervision.
- The department had also introduced educational practitioners at ward level. Staff we spoke with told us this was received positively and helped staff to develop their competency.
- We attended a training session the content of which was identified as a learning need by the nurses themselves.
- Nurses were also trained to provide intravenous training to parents and children. This ensured that children are transferred home earlier
- Training on the administration of IV medicines was offered to all staff once they had been in post for six months. The training day was organised by the ward manager.

Multidisciplinary working

- Parents shared with us examples of input their children received from physiotherapy, occupational therapy, dietetics and speech and language therapy.
- The medical wards had access to allied health professionals and specialist staff as required and we observed care being provided by members of the multidisciplinary team during our inspection.
- Medical notes we reviewed had documentation from members of the multidisciplinary team involved in their care.
- Nursing and medical handovers were undertaken separately.
- Where appropriate, staff contacted the palliative care team or end of life team for support in the needs of patients and parents.

- Staff told us there were also good links with community support teams.
- Play therapists were available on the wards and provided valuable support to the well-being of the child. Parents and other clinical staff valued their contribution and spoke highly of them.
- Play therapists told us they were not part of any multi-disciplinary meetings.
- There was one play specialist per shift on a 26 bedded ward. This meant staff were unable to give daily input for every patient. At times, some patients did not get any input from a play specialist on the ward.

Seven-day services

- There was a daily ward round on the acute admissions unit (AAU) including at weekends. A consultant was available on the phone for any new admissions on the daily post-take round.
- A general paediatrician carried out ward rounds on weekends but specialist consultants did not routinely undertake ward rounds on weekends.
- Radiology services were led by a consultant and were available out-of-hours and at weekends.
- Wards also had access to physiotherapy on weekends.
- Some wards, for example M1 and M3 provided 7 day cover for play services.
- The pharmacy was open on Saturday and Sunday mornings until 2 pm. Outside those hours, there was an on-call pharmacist to dispense urgent medications.

Are medical care services caring?

Good



We saw staff treat patients and their parents and carers with dignity and respect. Parents from minority ethnic communities commented the care and support given to them throughout their stay considered their cultural factors. Parents and carers told us that the emotional support given to them during the time their child was an inpatient was invaluable.

Compassionate care

- Throughout our inspections on all wards, we saw staff treat patients and their parents with dignity and respect. We saw instances where calls bells were answered promptly but there were also a few instances where there were delays in the response to the call bells.

Medical care

- Parents from the black and ethnic minority communities commented the care and support given to them throughout their stay was culturally sensitive.
- Patients appeared to be well cared for. For example, they looked comfortable and were washed.
- We saw that doctors and nurses introduced themselves appropriately and that curtains were drawn to maintain patient privacy.
- Play specialists were highly regarded and provided support and care in a compassionate way considering individual needs.

Patient understanding and involvement

- Patients and parents we spoke with said they felt involved in their care. They had been given the opportunity to speak with the consultant looking after them.
- Children and young people told us that they felt involved in their care and that doctors and nurses explained things in a way they could understand.
- We observed procedures and diagnosis being explained to patients and families by clinical staff.

Emotional support

- Patients and parents told us staff were supportive. The ward did appear to be busy at times but we found staff gave appropriate attention to parents and the patients. For example, a parent told us how a student nurse took care of her daughter while the mother went for a shower and staff took the time to ensure emotional support was provided.
- Parents told us that the emotional support given to them during the stay of their child was invaluable.
- One parent described how staff had taken the time to help them cope with managing their child's condition with encouragement and support dealing with the emotional aspects as well as the clinical condition.

Are medical care services responsive?

Requires improvement



Most parents told us that the needs of their children were met. However, with regard to accommodation, there was no formal separation of children and young adults. Both groups of patients were sometimes in the same bay and young adults did not have the companionship of other

young adults. We found there were no bath or showers on ward M3 that children with wheel chair could access. The bath did not have a hoist and children with wheelchairs would need to access another ward to be bathed.

The plans for the new build were designed to address these shortfalls to respond to patient needs.

Service planning and delivery to meet the needs of local people

- Medical services had been part of the plans in the new build to meet the needs of children and young people and their families as activity was increasing.
- The trust were also reviewing which services they could provide closer to home with other providers to ensure care was provided in the most appropriate place.
- There was evidence of some specialities completing the "You're welcome" toolkit. This toolkit allows the assessment of a service to see if it is adolescent friendly. The gastroenterology speciality assessed their service regarding the IBD (Inflammatory bowel disease) service within a paediatric tertiary centre.

Access and flow

- Between October 2013 and December 2013, the trust's bed occupancy was 71.6%. It is generally accepted that, when the occupancy rates is below 85%, it does not exceed the threshold at which it could affect the quality of care provided to patients.
- Any child that needs to be monitored by a cardiac monitor is admitted to the Paediatric High Dependency Unit (PDHU) because the wards did not have the necessary equipment or competency for monitoring such patients.
- There were a total of 56 beds on the medical wards but demand often exceeded capacity and this was managed by using surgical beds to accommodate these patients. The medical outliers were cared for by the nurses on the wards on which they were placed. Consultants and their teams provided care to these medical 'outliers' including out of hours and at weekends.

Meeting people's individual needs

- We spoke with parents from the black and ethnic minority communities who told us that they had access to interpretation services.
- The wards operated flexible visiting times to allow for families to support the parents whose children were on the wards.

Medical care

- Most parents told us that the needs of their children were met. For example, one parent told us how they were being trained on the administration of medicine. They had completed their competency training and felt confident that they could administer medicines safely. If they had any concerns, they were given a contact number to call on the ward and seek assistance.
- With regard to accommodation, there was no formal separation of children and young adults. This meant both groups of patients were sometimes in the same bay. This meant young adults did not have the companionship of other young adults.
- We found there were no bath or showers on ward M3 that children with wheel chair could access. The bath did not have a hoist. This meant children with wheelchair would need to access another ward to be bathed. However, there are extensive plans to rebuild the paediatric department which is due to be completed in 2016. This would allow children to be treated in an appropriate environment.
- We found that play specialists lacked equipment such as communication aids for children with additional needs.
- The trust has outreach nurses in place that help and support children and parents at home. Parents we spoke with valued this service.
- There was evidence of some specialities completing the “You’re welcome” toolkit for teenagers. This toolkit allows the assessment of a service to see if it is adolescent friendly. The gastroenterology speciality assessed their service regarding the IBD (Inflammatory bowel disease) service within a paediatric tertiary centre.
- There were limited inpatient facilities available for adolescents staying in hospital. The hospital did not have a dedicated adolescent unit. Adolescents were usually admitted to the inpatient wards and placed, if possible, together in bed bay areas or in cubicles. Most wards did not have a specific adolescent area where they could relax although there was an adolescent room located adjacent to Ward M2.

Learning from complaints and concerns

- Complaints were handled in line with trust policy. Members of staff told us they would deal with any complaints on the wards. If it was not resolved or dealt with directly, they would direct patients to the Patient

Advice and Liaison Service (PALS). Staff told us they would always advise patients to make formal complaints if they remained concerns about the care provided.

- We found complaints leaflets were available throughout the hospital and on the wards.
- Parents we spoke with told us they were confident to raise their concerns with ward managers. We spoke with one parent who told us they had raised concerns about their child’s care and the situation was satisfactorily resolved.
- The medical care division, however, only closed 40% of complaints within the trust’s 25-day target. This was below the trust target of 90%

Are medical care services well-led?

Requires improvement 

The leadership at ward level was in the majority of cases good. However there was some disconnect between ward level staff and divisional managers communication, which required improvement. There were clear governance processes in place. However there were examples of this not being robust; for example the discharge letters being significantly delayed.

Vision and strategy for this service

- The future vision involving a rebuild of the unit was well known by staff. There was a disconnect between senior managers’ and on the ground staff’s knowledge about the trust values. However, we found these visibly displayed throughout the organisation.

Governance, risk management and quality measurement

- There were quality meetings held once a month. There was a set agenda for each of these meetings with certain standing items such as incidents, complaints, new initiatives and risk assessments.
- The new safety thermometer on the measurement of quality on the wards is being piloted presently and this will be part of the monthly quality meetings. These are attended by the matrons, ward managers and the clinical director and the associate general manager of the service.
- The division had no dashboard for each area that measured performance against quality and

Medical care

performance targets. This meant wards were not aware of how they performed against the targets set. For example, basic ward information on what percentage of staff had been appraised and what percentage of staff had completed their mandatory training did not correlate with trust wide information. The ward had different figures compared to the corporate figures.

- Staff told us that feedback from the divisional management team was not always consistent in sharing learning or changes to practice.

Leadership and culture within the service

- The department was led by a medical lead and supported by a manager. There were two matrons who were responsible for the overall nursing leadership in the department. Each ward had a ward manager who was a supernumerary nurse.
- We found the ward managers providing strong leadership on the wards. They were enthusiastic for the change and had introduced new practices on the wards.

- There were staff award meetings that were well known and well attended.

Public and staff engagement

- There was public consultation regarding the planned new build for paediatrics.
- There was no evidence displayed in the department of changes made as a result of patient feedback.
- There were no formal mechanism for collecting parents' feedback on their child's stay nor any process to collect children and young adults' views about the service.

Innovation, improvement and sustainability

- While the department had a culture of improvement and innovation being advocated, they felt constrained by the cramped environment until the new build was complete.
- The plans for the new build provided scope for a sustainable service to address to demand and needs of patients with medical conditions.

Surgery

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

Information about the service

Sheffield Children's Hospital provides 55 beds for elective and emergency surgery located within three wards, and the Burns Unit. There is also a Theatre Assessment Unit providing pre-operative care and day surgery. Surgical admissions include general paediatric surgery, ENT, neurosurgery, trauma and orthopaedics, spinal surgery, plastic surgery and burns.

Between April 2013 and April 2014 there were 9,550 elective spells and 4,011 non-elective spells.

We visited three wards, the operating theatres, recovery and the theatre assessment unit. We talked with 17 children and their parents. We also held focus groups and individual discussions with junior doctors, consultants, ward staff and managers and reviewed patient records.

Summary of findings

Services within surgery were found to be caring and effective. The children and young people we talked with and their parents were generally very positive about the care and treatment provided and very few negative comments were received. There were some examples of innovative practice such as the provision of pagers to parents while their children were in theatre to alert them when their child had reached recovery.

We found services were responsive to the needs of patients and their families and performance data suggested the balance between elective and emergency surgery when demand fluctuated was managed well.

Considerable work had been undertaken to improve the safety of care but there were some areas which required improvement. In particular the use of the paediatric early warning score which detects the early signs of patient deterioration, the dissemination of learning from incidents and the completion of mandatory training.

We found services to be well led at ward and theatre level but there was a lack of clarity in the management structure and the wealth of performance information was not utilised to its maximum effect.

Surgery

Are surgery services safe?

Requires improvement 

While there were many examples of good practice in surgery, evidence gained during the inspection and the information provided prior to the visit, did not provide sufficient assurance of the provision of consistently safe standards.

Considerable work had been undertaken to improve adherence to best practice in relation to consent and the implementation of the WHO checklist in the operating theatres and this was found to be good. We saw good adherence to infection prevention and control procedures and audits were routinely carried out to monitor performance.

There was an open culture of reporting incidents but there were issues with the timely dissemination of information on incidents and feedback to staff on the action taken to prevent recurrence was very variable. We found examples where action taken as a result of incidents had not been fully implemented in practice. As a result, there was a risk of similar incidents occurring in the future. A paediatric early warning score had been introduced to identify the early signs of deterioration in children and young people being cared for by the service. However, this was not being consistently used and we found there were misunderstandings among staff as to when it should be used. In over 50% of the care records we examined there were omissions in recording the score. Early signs of a deteriorating patient could therefore be missed.

It was not possible to gain assurance on levels of attendance at mandatory training due to issues with the accuracy of the training database. While some mandatory training topics indicated that over 80% of staff had completed the training others showed less than 50% of staff were up to date.

Incidents

- There were no never events in surgical services between April 2013 and April 2014.
- Discussions with a range of staff about incident reporting suggested there is an open culture within surgery and incident reports are completed readily.

- We were told Incident reports were discussed at Divisional risk management meetings and they were risk assessed. However, feedback on incidents was found to be inconsistent with some departments and groups of staff reporting they received good feedback on adverse events and action to be taken to prevent recurrence and others felt there was little or no feedback.
- There was evidence that some changes identified as a result of medication errors had been implemented but others were not embedded in practice e.g. paracetamol prescription labels.
- Mortality and Morbidity meetings were held monthly and an additional meeting was held twice yearly in conjunction with the Anaesthetists to review all deaths.

Safety thermometer

- Safety thermometer data for surgery was collected centrally but the results were not, as yet, reported back to the wards as this was a new initiative and too early to assess.
- Safety thermometer data was reported to the commissioners as part of Commissioning for Quality, Improvement and Innovation (CQUIN) and the results indicated a very low level of patient harm in the areas examined and 100% achievement in many areas. In view of this, the trust were reviewing the threshold as part of a group nationally.

Cleanliness, infection control and hygiene

- Five cases of *Clostridium difficile* were reported across the Trust in 2013/14. All have been classified as unavoidable.
- There were no cases of MRSA bacteraemia in the same period.
- We were told central lines were audited but did not see evidence of any other Infection Control High Impact Intervention audits being used. These audits monitor compliance with best practice for procedures which have a high impact on infection rates.
- Hand hygiene compliance audits were carried out monthly and compliance was consistently good. There was hand gel available near most beds. We observed staff cleaning their hands before and after providing care and patients told us staff always washed their hands before providing care.
- We looked at the mandatory training records on two wards and found over 80% of ward staff had completed mandatory training in infection control.

Surgery

Environment and equipment

- The wards had a restricted entry system and visitors had to press the bell for entry, to facilitate the safety of the children and young people. This was effective during the inspection.
- Equipment was available on each of the wards to meet the needs of the people who used the service. However, there was limited storage and this gave the impression of a cluttered environment particularly in the ward corridors. We were advised this was being addressed through the new hospital build.
- The neurosurgical ward was particularly short of space but it was clean and tidy. Space between the hospital beds was such that when parents stayed with the children on the ward, parent's reclining chairs placed between the hospital beds resulted in a very cramped environment.
- There were resuscitation trolleys on each ward but adherence to checking of these was variable.
- There was no defibrillator on the surgical wards and if a cardiac arrest occurred, a central hospital defibrillator was brought to the ward. This was in accordance with the Trust resuscitation policy.

Medicines

- There was a named ward pharmacist for each ward bringing a good level of specialist overview to medicines management and medicines management technicians carried out medicines reconciliation.
- Medicines were stored securely in locked cupboard within a locked room.
- Safe procedures for the administration of medicines were found to be in place. Staff were observed checking the identity bands for patients prior to administering medicines. The patients we talked with also told us staff always checked their identity band before giving them their medicines. Drug administration charts were properly completed and signed.
- We checked the record keeping for controlled drugs and found this to be completed appropriately. We were told changes had been introduced to the organisation of the controlled drug record following a drug error, to avoid confusion when new supplies of a drug were obtained. This indicated that some learning had occurred as a result of an error.
- Medicines to take home were obtained from pharmacy. We were told they were obtained in a timely manner

and did not cause delays to discharge. We observed one person's medicines arriving on the ward on the day of discharge prior to them being ready to leave the hospital.

Records

- We looked at several care records on each ward we visited and saw the medical records contained a plan for the care of the child/young person which was updated regularly to take account of changes that had occurred and progress made.
- Nursing records contained an assessment of each patient's needs and a daily record of care which was comprehensive. Individualised care planning was done using numbered core care plans stored on the computer. References were made within most of the records to which core care plans patients were following, however it was difficult to identify this without lengthy reading of the daily record of care. The staff we talked with confirmed this but told us the handover gave them the information they needed to provide safe and appropriate care.
- A pre-operative checklist was used to ensure the necessary checks were completed when the child/young person was transferred to theatre. These were fully completed in the records we examined.

Consent

- Consent forms were found in the records of children and young people who had had surgery. Consent forms for teenagers were signed by both the young person themselves and their parent.
- Children and young people told us the procedure had been explained fully to them and this was supported by the parents we talked with. As a result, informed consent could be obtained.
- Eight sets of parents and young people told us the Consultant always talked to the young person in a way they could understand and they felt able to ask any questions. However one set of parents said the Consultant did not talk at the child's level and was very "matter of fact"; they were seen as a procedure rather than a person.
- The Trust had carried out their own audit of consent which indicated good compliance with consent procedures and actions were identified to improve the scores in the aspects of consent which indicated lower compliance.

Surgery

Safeguarding

- There was a Trust safeguarding policy in place to identify the responsibilities for safeguarding and the procedures to be followed if concerns were identified.
- The wards received support from a Health Visitor Liaison post and there were three safeguarding specialist nurses.
- The registered nurses we talked with showed understanding of safeguarding issues and processes but there were some health care assistants who lacked awareness.
- Safeguarding training was included in the Trust mandatory training programme and the training records for the three wards we visited indicated over 85% of staff had attended safeguarding training.
- A Consultant we talked with said there was some confusion among medical staff as to the safeguarding training that was necessary to fulfil the requirements as there were a variety of training courses at different levels. This impacted on medical staff compliance with mandatory training.

Mandatory training

- Managers did not have confidence the central mandatory training record gave an accurate record of the training of their staff and they felt compliance was higher than indicated on the database. This was due to reports of training completed not being added to the database centrally. It was therefore not possible to obtain definitive information on the percentage of staff having completed mandatory training.
- The reports we looked at in conjunction with the matron and a ward manager showed higher compliance with training which was delivered face to face than with the e-learning topics. With the exception of conflict resolution training, face to face training topics were up to date for over 80% of ward staff. We were told each ward was paired with another and closed for deep cleaning once a year. Mandatory training was provided for their staff when their ward or their paired ward was closed. However, staff were expected to take some responsibility for their own e-learning and fit in the e-learning topics during their normal working time. Compliance with e-learning topics was generally under 70%.

- Medical staff were also able to undertake most of their mandatory training during the ward closures but some needed to be done separately. Medical staff suggested that further refinement of the training database was needed as some of the topics were not relevant to them.
- Conflict resolution training showed the lowest level of compliance and we were told this was because there were few training sessions and those held had been provided with short notice making allocation of ward staff difficult.

Management of deteriorating children and young people

- Observation charts were generally well completed but there was no indication of the frequency of the observations required to ensure there was a consistent approach to recording vital signs.
- The Trust had implemented the use of a paediatric early warning score (PEWS) to identify when children and young people were deteriorating.
- The SCAN audit results produced by the Trust indicated 100% compliance with the documentation of the PEWS scores in all the surgical wards. However, during the visit we saw PEWS had not been completed with every set of observations in most of the records we examined. For example, approximately 40% of PEWS scores were missing on one chart and on another, a PEWS score had not been completed for over six hours after a rise in score was documented.
- The neurosurgical ward charts also included the Glasgow Coma Scale in addition to the early warning score and the feedback from staff in this area was that the latest version of the charts had improved but needed further development to accurately reflect their patient's condition in their specialty.
- The understanding of different staff as to the frequency of completion of the early warning score was variable, with some staff telling us they should only be completed if the observations gave cause for concern. If this approach is taken deterioration can be missed.
- There was a clear escalation procedure and the trust had introduced a tool to provide clarity of communication of the key issues when escalating to medical staff. This had been found to be very useful and staff told us this ensured a timely response to escalation.
- Children and young people who required cardiac monitoring were transferred to the high Dependency

Surgery

Unit (HDU) as a decision had been taken that cardiac monitoring could not occur on the surgical wards due to competency of staff being able to interpret the reading. Staff told us, this created problems when the HDU was full or when the child or young person did not meet the criteria for admission to HDU. We were told of an example when drug treatment was delayed due to the inability to monitor the person.

Nursing staffing

- The Trust had not implemented the 2013 Royal College of Nursing recommendations for nurse staffing levels in paediatrics. A review of nurse staffing levels had been undertaken using a tool that took into account the specific requirements of each ward including professional judgement. This approach was undertaken during 2013 by the Chief Nurse in conjunction with the ward and the staffing levels increased on at least one of the surgical wards.
- The trauma and orthopaedic ward had experienced some staff shortages at the end of 2013 but this had been addressed and the establishment had been increased.
- There was a 70:30 skill mix ratio on the surgical ward and trauma and orthopaedic ward, and this was higher on the neurosurgical ward, meeting recommendations for paediatrics.
- During the two days of the visit the surgical wards appeared busy but adequately staffed. The children and young people we talked with told us staff responded quickly when they pressed the call bell and they were always available when needed.
- There was no acuity tool in place to assess variations in staffing requirements on a daily basis, but the trust advised they were implementing a tool shortly.

Medical staffing

- Consultants provided 24 hour on call cover for 7 days on a rota basis and staff reported the consultants visited the wards at weekends when they were on call to do ward rounds. All the staff we talked with reported good access to consultants for advice and good availability.
- Middle grade doctors were non-resident at night and this is considered acceptable practice. As with the consultants, staff reported no issues in relation to availability when required.
- Locums were not required to cover middle grade rotas but were regularly used at junior doctor level.

- We observed a junior doctor handover and found it was well formulated and structured. The registrar handover was more informal.

Major incident awareness and training

- The trust had a major incident plan dated 2012 that staff were aware of and this was due for review in 2015.

Pre-operative safety checks

- There was documentary evidence of the WHO checklist being used and this was observed in practice in theatres.
- We saw the results of a WHO checklist audit completed during May 2014. These indicated some of the checks were not complete on the ward but were completed as required at the point of sign in of the patient in the operating theatre.

Are surgery services effective?

Good



Surgery services were found to be effective. The department adhered to the RCPCH standards for acute paediatric services and to relevant NICE guidance. Local audits had been completed in each sub specialty including some which focused on clinical outcomes for specific patient groups.

Multidisciplinary working, both between subspecialties and allied health professionals was good. Pain relief was provided in a timely manner and alternatives to medication for relieving pain, such as positioning were also used.

There were some aspects of the service in which effectiveness could be developed such as improving theatre utilisation, staff appraisal rates and benchmarking.

Evidence-based care and treatment

- Clinical guidelines for surgical services were readily available in the wards and departments. These were referenced and within their review date, which indicated they were up to date and based on available evidence.
- Staff were aware of the clinical guidelines and referred to them as necessary.
- There were no National Clinical Audits/Confidential Enquiries relevant to surgery except NCEPOD.
- The checks we carried out during the visit indicated the service was able to adhere to the RCPCH standards for

Surgery

acute paediatric services. An independent audit indicated the Trust was in line with national findings re timeliness to being seen by either a Middle Grade or Consultant.

- A range of local audits had been completed in each of the sub specialties including ones which examined compliance with NICE guidance.

Pain relief

- Children and young people told us staff asked them if they had any pain and always responded quickly when they reported pain. One person told us they did not just offer pain relieving medications but also looked at other methods of pain relief such as positioning and the use of pillows and this helped considerably.
- Patient Controlled Analgesia (PCA) was frequently used post operatively and the pain team visited regularly in the post-operative period. When changes to PCAs were required the anaesthetist was involved.
- We saw child friendly pain charts were used with faces to illustrate the level of pain the child was experiencing.

Nutrition and hydration

- Staff reported good access to advice from the dietician.
- We did not see any evidence in the documentation of routine nutritional risk assessments being completed, but we saw evidence of the involvement of the dietician in care records we examined.
- There was out of hours access to a night fridge for special feeds when these were required.
- Fluid balance charts indicated fluid targets had been set for each person with a fluid chart and the charts were generally well completed, although there was an absence of running totals.
- Children and young people were happy with the food provided. One parent told us when their child had no appetite staff would try and get any food they wanted. A young person told us they were provided with supplements due to their condition and staff always encouraged them to eat and drink as much as possible.

Patient outcomes

- We were told individual consultants kept data on their outcomes but they did not benchmark themselves consistently as a surgical division. The trust used some third party benchmarking data but they were not formally reported within the trust.
- The local audits carried out in 2013/14 included audits of the outcomes of surgical procedures or treatments.

- Re-admission rates were high in relation to other providers and this was recognised by managers. However, they told us their investigations suggested this was due to miscoding and pre-arranged re-visits following admission. Although managers had been aware of this issue for some time they had not been able to look at it in more detail to gain a more accurate picture.
- The average length of stay for 2013/14 was 3.3 days for elective admissions and 4.5 days for non-elective admissions, which was in line with national average.

Competent staff

- The training database provided appraisal data and this was reported as 57% in surgery. However, as reported above there was a lack of confidence in the accuracy of the database and there was the perception that rates were higher than indicated. However, it should be noted the results of the NHS staff survey also indicated the percentage of staff appraised in the last 12 months was tending towards worse than expected.
- We were told all consultants in surgery were participating in re-validation and the process was established.

Multidisciplinary working

- Internally there was evidence of multi-disciplinary working within the care records we examined, both between the sub specialties and with allied health professionals.
- On the orthopaedic ward we observed close working relationships between the physiotherapists, nurses and medical staff.
- On the neurosurgical ward we observed an early morning multi-professional ward round involving surgeons, paediatricians, nurses and physiotherapists
- Neurosurgery reported good working relationships between the ward and the intensive care unit with good handovers and documentation to ensure smooth transfers of care for children and young people.
- There was good feedback from other providers and partner organisations in relation to multi-disciplinary working and the availability of specialist advice.

Seven-day services

- Consultants provided 24 hour on call cover for 7 days on a rota basis and staff reported the consultants visited the wards at weekends when they were on call to do ward rounds.

Surgery

- There was access to out of hour imaging seven days per week.
- The pharmacy was open on Saturday and Sunday mornings. Outside those hours, there was an on-call pharmacist to dispense urgent medications.

Theatre Utilisation

- Fluctuations in requirements for emergency theatre sessions were managed well and a good balance between elective and emergency surgery was achieved through daily meetings to prioritise lists and anticipate changes required.
- The Theatre assessment unit had extended their opening hours to accommodate later discharge times for day surgery patients.
- Theatre escorts had been introduced to ensure the timely and efficient transfer of children and young people to theatres.
- Delays occurred in the oncology list taking place in the theatre procedure room due to delays in obtaining the required medication. Pharmacy opening times were later than the start of the list.
- Trust data indicated there were delays in starting scheduled theatre sessions and 85% of general surgical lists commenced more than 10 minutes late. This data was felt to be flawed by managers. However, there was an acceptance that a high proportion of lists start late and there is a downward trend in this regard. In addition, 50% of lists finish early. This suggests that theatre time could be used more effectively.

Are surgery services caring?

Good



Overall, the people we talked with told us staff were kind and caring and we observed caring and supportive interactions between staff and the people using the service. Staff responded promptly to requests for help and took steps to ensure pain and discomfort were relieved in a timely and appropriate way. People's choices and preferences were listened to and where possible were acted on.

Verbal and written information was given to enable people to understand their care and support decision making.

Compassionate care

- Every child, young person and parent we talked with told us staff were kind and caring. One parent said, "Nursing staff are brilliant and you can tell they really care". Another said, "Nurses are very caring and always available". We were also told doctors were approachable and always explained what they were going to do.
- We observed interactions between staff and patients and these were very positive. Staff treated the children and young people with sensitivity and adapted their approach to the needs of the individual.
- Parents told us staff talked to the child or young person directly and treated them with dignity and respect.
- There was one negative experience relayed to us in response to a request for feedback from the public, from a parent who felt the attitude and response of staff to their child's needs was poor and they lacked support from staff in the period following surgery.
- The score for privacy, dignity and well-being in the Patient Led Assessments of the Care Environment (PLACE) was 74.3% in 2013.
- When children and young people went to theatre, a parent could accompany them and the parent was given a pager to alert them when the child or young person had been moved to recovery. This enabled parents to occupy themselves while the child was in theatre but know that they would be called as soon as it was appropriate.

Patient understanding and involvement

- The children and young people we talked with told us that they were involved in decisions about their care. They were able to clearly describe the plan for their care and their estimated discharge date.
- On the neurosurgical ward a parent said they couldn't praise the staff enough. They went on to say, "They are an extension of our family".
- Verbal explanations were supplemented with written information leaflets. Parents told us they were provided with a range of literature to take away to support the explanations provided. Orthopaedic patients attended an assessment day prior to surgery and the children and young people were shown the frames that would be in place for some time following surgery and they were able to handle them. The people we spoke to valued this. They told us it meant they knew exactly what to expect and felt very well prepared.

Surgery

- However, on the neurosurgical ward one parent said the seriousness of the operation had not been fully explained and therefore they had not fully appreciated the risks and a parent of a person who had orthopaedic surgery described a lack of information
- One parent and their child told us the doctors always spoke to them directly to explain and the nurses followed up to ensure they had understood and provide more information or explanation if needed.

Emotional support

- Parents told us they had received emotional support from staff and this was very much appreciated.
- All children we spoke to told us they felt supported by the staff looking after them.
- Clinical nurse specialists were available to discuss the implications of surgery and provided support to parents
- One parent told us that following an accident, they were admitted to a different hospital to their child. Staff had made sure they kept the family informed and in touch during this time, ringing the other hospital with updates and explaining everything.
- We spoke to some young people with a long term condition, learning disability or physical disability who told us staff understood their needs and they were well cared for; with some having repeated admissions over time and they had developed positive relationships and support from staff.

Are surgery services responsive?

Good 

The service was responsive to the needs of the people using it. The flow throughout surgery was well managed with the proportion of people treated as day cases was above the national average and co-ordinated response to fluctuation in emergency demand in conjunction with elective surgery.

We saw that the service catered well for the individual needs of the children and young people in their care, including those with learning disabilities and minority ethnic groups. Parents were able to stay in parent accommodation, as available, or by the bed-side (although this was cramped) and parents were given meal vouchers if their child stayed for longer than three days.

Service planning and delivery to meet the needs of local people

- Surgery services have links with surrounding District General Hospitals and undertake outpatient clinics in these locations. Negotiations are taking place to undertake operating lists at three of the surrounding hospitals to bring services closer to the patient.

Access and flow

- The Trust's bed occupancy rate for October to December 2013 was 71.6% and is below the threshold which is considered to affect the quality of care.
- The department carried out a high proportion of their surgery as day cases (72% for 2013/14) to reduce the amount of time patients needed to stay in hospital, where appropriate in line with national standards.
- The time taken from referral to the Trust to treatment target is 18 weeks. Surgery met this target for 91.7% of referrals in 2013/14 against a national target of 90%.
- Most children and young people who undergo elective surgery are admitted to the Theatre Assessment Unit on the day of operation and are transferred to theatre from there. Following surgery those requiring an overnight stay are transferred to a surgical ward. This helps patient flow but does mean children and young people are not familiar with the ward and staff when they wake up following surgery. However, the children and young people we talked with about this did not consider it to be a problem.
- The number of cancelled operations is similar to the expected range, as is the number of patients not treated within 28 days of last minute cancellation due to a non-clinical reason (as measured by the Department of Health).
- All of the families we talked with about discharge were aware of the plan for their discharge. One parent told us staff had arranged training for them in life support to ensure they could respond in an emergency situation with their child following discharge.

Meeting people's individual needs

- During the visit we observed children and young people were cared for in bays of children of the same sex and of a similar age group, or in single rooms. The children and young people we talked with said they liked this as they were able to make friends with the other people in their

Surgery

bay and do things together. Most told us there were suitable activities for their age group although one six year old said there should be more toys for older children.

- The Trust had not declared any breaches of same sex accommodation during 2013/14. Same sex accommodation breaches have to be declared in people aged 16 years and over. On one ward we talked with staff about the difficulties in placing children appropriately according to age and sex and we were told that it sometimes causes challenges and mixing of sexes did sometimes occur but where mixing had to occur it was for short a period and never overnight.
- We saw a range of toys on each ward suitable for the ages of the children being cared for.
- There was a range of equipment available for those with special needs and we talked with some young people with a long term condition, learning disability or physical disability who told us staff understood their needs and they were well cared for. Some had repeated admissions over time and they had developed positive relationships with the staff.
- They were confident in the care they would receive. One parent said, "We are always happier to come to Sheffield Hospital rather than others".
- There was access to interpretation services for those for whom English was not their first language and for the deaf and hard of hearing. The ward staff we talked with were aware of the procedure to follow to obtain an interpreter.
- There were 5 WTE play lead posts in surgery, but at the time of the inspection one post holder was absent on maternity leave and this person had not been replaced. The play leaders were managed by the ward manager and were well supported as part of the ward team.
- Although children and young people could visit the ward at pre-assessment, the ward play leader was not involved in preparing the child and there was no hand over from the outpatient play leader to the ward play leader. As a result children and young people with special needs were not identified in advance of their admission and preparations made.
- The play leader used a theatre preparation book containing photos to help prepare children for surgery on the day.
- Limited accommodation was available for parents away from the ward but parents were able to stay on the ward in either a bed or reclining chair by their child's bed.

There was access to a shower and toilet for parents off the ward but some felt uncomfortable in walking across the corridor in their night clothes to access it. Parents who stayed with their children for a longer period would have appreciated access to cooking and laundry facilities.

- We were told food vouchers were available for parents who were there for more than three days, to buy food at discounted rates in the hospital staff facilities but many had not been told about them. On the neurosurgical ward a parent who had stayed on a number of occasions said they never been offered the vouchers but another parent had told them about them and when they asked they were given some.
- A display board on the neurosurgical ward provided information to parents on a variety of issues including a colour coded who is who.

Learning from complaints and concerns

- Approximately half of the parents we talked with said they had seen information about how to make a complaint.
- We were told complaints and incidents were discussed at the monthly divisional meetings.
- Comments and Suggestions cards were available on the surgical wards for people to complete. However, these were often located in locations that were not easily seen by parents.
- The Orthopaedic ward was the only ward that had had significant numbers of these submitted. This was due to a proactive approach being taken to encourage people to complete them. 25 of the 36 comments in relation to this ward were thanks.

Are surgery services well-led?

Good



There was strong leadership at ward and theatre level and staff felt well supported. However, ward level quality indicators were in their infancy and there was limited scrutiny or performance management in place on a monthly basis.

There was a lack of clarity in the management structure but this has been recognised and was being addressed. The

Surgery

service had developed a comprehensive range of performance indicators but the robustness of the data was still being tested and there had been little progress in addressing the apparent performance issues they raised.

Vision and strategy for this service

- The trust is undergoing a re-development project which will improve the environment of care and create additional theatre and ward facilities, including increasing the space around beds.
- Models of care are being explored to enable operating lists to be carried out in the surrounding non-specialist trusts to keep care closer to home where appropriate.

Governance, risk management and quality measurement

- Governance meetings took place and there was discussion regarding incidents and complaints.
- The staff could not articulate the quality priorities the trust is focusing on this year.
- A set of “quality” indicators had recently been developed to assess ward performance. However, there were limited clinical quality indicators and they did not include a performance management system.
- Board to ward to Board communication of issues and action was limited and there was no clinical quality information displayed on the ward for patients or staff to see.

Leadership of service

- Surgical services were operationally managed in four divisions and the management structure had recently been reviewed. At the time of the inspection, we were told the structure was evolving and still required further development. We found there was a lack of clarity in respect of some responsibilities within the new structure and cross division working was limited.
- A new Business Manager post had been created to address some of the issues identified but it was too early to assess the impact of this.
- A project had been undertaken with an external agency to produce monthly performance data. As a result a comprehensive set of metrics had been developed and there was a wealth of data available. However, the performance management mechanisms did not appear able to address the issues identified. In several cases

when we identified performance concerns from the data, we were told the data was inaccurate and scrutiny of the issues and problem solving appeared to have stopped at this point. Re-admissions were an example of this.

- Leadership at ward level and theatre level was strong. Ward managers had recently been given the time to become supernumerary enabling them to carry out the full leadership role. Staff felt well supported by their ward manager and matron.

Culture within the service

- The staff we talked with were proud to work at the Trust and felt it was a centre of excellence.
- There was a culture of openness and staff felt able to report concerns.
- Staff told us that information flows and communication from the board did not always occur and could be improved.

Public and staff engagement

- There was limited evidence of the involvement of patients and the public in service development. We were told they were working with parents to look at the theatre environment in the new theatre build project and there had been some audits and surveys carried out to explore people’s experience of day care.
- Real time patient surveys were not completed in a planned or structured manner.

Innovation, improvement and sustainability

- The new build will allow surgical service to provide a sustainable service to meet the needs of children, young people and their families/carers. This had been approved and work was underway.
- Day case surgery was proactively developed to ensure length of stay in hospital was reduced to ensure children and young people could return home with their families.
- Work to provide services in satellite sites with other providers was being reviewed to ensure care was being provided in the most appropriate place and closer to home where possible.
- Re-design of the patient pathway in the Theatre Assessment Unit using lean methodology had improved patient flow and staff felt they had been involved and influenced the outcome.

Critical care

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

Information about the service

The Paediatric Critical Care Unit (PCCU) at the Sheffield Children’s Hospital has 17 beds; it consists of two geographically separate areas the PICU with nine intensive care beds; a separate high dependency unit (HDU) with eight high dependency care beds. Children admitted to an intensive care bed; receive one-to-one nursing care, while those children too ill to be cared for on a general ward and admitted to a high dependency bed receive two patients to one nurse care. The unit has around 1,000 admissions per year.

The paediatric and neonatal transport service, Embrace, is hosted by the trust with the service located off site. In the last 12 months the service has transferred 600 children, 66% of these were ventilated. In addition 1686 neonates and 442 in-utero transfers were also arranged.

We spoke with one young person, six relatives, 15 staff including, nurses, doctors, consultants, senior managers and support staff. During the inspection we looked at care and treatment, we also reviewed care records. Before and during our inspection we reviewed performance information from, and about, the trust.

Summary of findings

The PCCU had systems and process in place to protect children from harm, these included reporting and learning from incidents. Nurse staffing levels were in line with national guidance and staff had access to a range of training both internal and at local universities. The needs of the majority of children were met by skilled and experienced staff; however children with complex needs did not always experience continuity of care.

Policies were based on NICE and other relevant national guidelines. PICU submitted data to PICANET national database, which shows Sheffield Children’s Hospital has maintained its standardised mortality within national secular trends. There was a formal escalation process for managing deteriorating children and young people but no training had been provided for staff in its use and often a more informal approach was taken by staff. The flow of children through the unit and capacity is managed by working with other providers and Embrace.

Senior medical leadership was stretched by clinical commitments and consequently unable to drive innovation and the vision and the strategy of the unit. Nursing staff felt supported by the senior nursing team and able to raise concerns. There was limited staff and parent engagement for example in the development of the plans for the new unit. Many staff we spoke with were unaware who the members of trust board were and there was limited ‘board to ward’ walk rounds to identify quality issues and meet front line staff.

Critical care

Are critical care services safe?

Good



The PCCU had systems and process in place to protect children from harm, these included reporting and learning from incidents. Staff understood their roles and responsibilities in relation to safeguarding children and how they worked with other agencies to promote the child's best interest. Nurse staffing levels were in line with national guidance and staff had access to a range of training both internal and at local universities.

There was a formal escalation process for managing deteriorating children and young people but often a more informal approach was taken by staff. The trust had implemented the paediatric early warning score (PEWS) and provided staff with written guidance on how to use this tool but no training. There was some quality monitoring but limited audit to identify areas for improvement.

Incidents

- Staff we spoke with stated that incident reporting was high as there was a culture on the unit of reporting all risks including those considered to be low risk. These incidents were discussed at the unit's fortnightly governance meeting, reviewed at the division's monthly governance group and incident reports went to the division lead and trust board on a quarterly basis.
- Staff received feedback on safety issues through the unit's monthly newsletters and at quarterly unit meetings.
- The monthly critical incident newsletter covered specific learning from incidents.
- Monthly PCCU mortality meetings were held at which all deaths that occurred on the unit were reviewed. All doctors and nurses were invited to participate in these meetings but the majority of attendees were doctors. It was unclear if any action was being taken to encourage nurses to participate in these meetings.
- There had been no Never Events (never events are very serious, largely preventable patient safety incidents that should not occur if the relevant preventative measures have been put in place) in the year preceding our inspection.

Quality monitoring

- The PCCU uses a specialised service quality dashboard that reports on areas such as accidental extubation, readmissions within 48 hours of discharge from the PICU. These results showed that the unit was performing similar to other units.
- Performance information including mandatory training figures were displayed on a noticeboard in the staff room of the PCCU, these highlighted areas of good performance and those that needed to be improved.
- The PICU used a skin integrity tool to record any pressure sores. If a pressure sore was noted staff documented the area, any intervention and completed an incident form. This information was also included in the child's nursing documentation.
- In the period April 2013 to March 2014, the trust reported two new pressure ulcers in July 2013 and March 2014. A rate compatible with children's hospital.
- At the time of our inspection we were told that the unit did not routinely audit line infections but all cases were individually reviewed by the microbiologist. Staff stated that this lack of auditing was due to the unit have very low rates of infection and audit was only undertaken if an issue occurred.
- Ventilation and endotracheal tube (ET) were not audited to identify any possible improvements that could be made. However, accidental extubations were continuously audited and the unit had daily patient safety checks on the ward round.
- We were told that the unit did not know what their ventilator-associated pneumonia (VAP) rates were, which could have been used by the trust as a quality measure.

Cleanliness, infection control and hygiene

- The unit was visibly clean with dedicated cleaning staff who felt part of the unit's team.
- Ward staff are expected to complete daily cleaning checklist of the patient environment. The PCCU did not return any checklists for the last three quarters. However, evidence provided by the trust showed that these had been completed but not submitted. The PCCU results were January 2014 70%, February 75% and March 2014 96.7%.
- The trust wide infection control policy included guidance on which children and young people should

Critical care

be isolated in a cubicle. The PICU had four cubicles, one of which was a double cubicle, to isolate children and to prevent cross infection. In addition the HDU had a double cubicle.

- The Director of Infection Prevention and Control (DIPC) and infection control nurse attended a daily ward round on the PCCU to review microbiology result and children in cubicles to identify if anyone could be moved out into main PCCU area. They were also available for advice on if a child or young person should be isolated.
- The trust had no cases of methicillin resistant staphylococcus aureus (MRSA), four cases of Methicillin sensitive staphylococcus aureus (MSSA), and five cases of Clostridium Difficile (C. Difficile) had been reported between March 2013 and February 2014. All these cases had been reviewed by the microbiologist and reported to have been unavoidable.
- Quarterly meetings of all infection control link nurses across the trust took place and the link nurses attended an annual study day.
- Most staff we saw during our inspection adhered to the bare below the elbows policy, as well as utilising appropriate protective equipment such as gloves and aprons to carry out procedures and personal care activities. However, we did observe two doctors on the PICU wearing watches and one doctor not bare below the elbow.
- To educate children on infection control issues we noted that there were a range of posters highlighting specific bugs throughout the trust. We were told by the DIPC these were changed regularly with a bug of the month focused on.

Environment and equipment

- The unit was locked preventing unauthorised access. Parents and visitors gained access via a buzzer and we noted security cameras in the main corridors, images from these were displayed on screens at the nurse's station.
- The environment was calm and welcoming with a ward clerk based outside side the unit's entrance to welcome families and visitors
- There was a visitor's waiting area with notice boards and refreshments, providing families and relatives with an area to take a break away from the bedside.
- There was no quiet room on the unit to break bad news to parents. However, offices and staff resource room were used for this purpose

- Resuscitation equipment was checked daily and we noted that a signature was recorded after each check.
- The medical equipment management group (MEMG) is responsible for the management of all medical equipment within the trust. This group meets regularly and discusses a range of topics including the replacement of medical equipment.
- On the PCCU there was 1.5 whole time equivalent of designated technician time. The technicians managed the equipment at unit level and ensured it was sent to medical physics for repair as appropriate.
- Medical physics also provided all staff with equipment training and were responsible for the testing of equipment. All equipment we checked was found to be in date for PAT testing or external company servicing.
- There were unannounced 'spot checks' undertaken by the senior nurse, infection control nurse and domestic supervisor to audit cleaning on the PCCU. Any identified issues are resolved at the time and the audits were used to inform the cleaning report that was sent to the DIPC and trust board.

Medicines

- The critical care pharmacist attended the unit daily to review patients and their medications to ensure that they were suitable and within prescribing guidelines.
- Advanced Nurse Practitioners (ANPs) prescribed a range of medicines on the PCCU; an audit of their prescribing in January 2013 found that the trust prescription writing standard were not always met. An action plan has been developed and was being implemented at the time of our inspection to improve these standards.
- We were told that there was a high rate of medication errors on the PCCU, the high numbers of drugs administered and effective reporting arrangements were stated to be contributing factors to this high figure. All medications errors were investigated and reviewed at the unit's fortnightly governance meeting and action taken to prevent re-occurrence of a similar error.
- Staff were able to provide examples of learning and changes to practice as a result of these medication errors, including the development of medication guidelines and changes to the strength of medication supplied.
- All medicines cupboards were noted to be locked and secure. Controlled drugs checks were completed daily and record kept of these checks.

Critical care

- The drug fridges were locked; and daily temperature checks were completed and recorded.

Records

- We looked at nine set of notes during our inspection of children currently on the PCCU and HDU. All notes were complete, entries were legible, dated and signed with the designation of the staff member reviewing the child. They provided a record of the child's plan of care and any investigation results.
- The nursing records we looked at provided a record of individual care plans, a summary of care delivered and a record of the child's observations.
- Risk assessments were completed for HDU children including risks associated with the child being discharged home with equipment such as ventilators. These assessments influenced the decision to discharge a child as if the parent is not able to use the equipment safety the child cannot be discharged.

Consent

- We saw that consent had been sought from the child's parent prior to any surgical intervention; this had been signed and dated.
- There was a 'Limitation of Treatment Agreements' (LOTA) policy that replaced the previous DNAR policy, which was available on the trust's intranet. This policy was developed as it is acknowledged that resuscitation is not appropriate for all children and young people due to the nature of their illness. At the time of our inspection no children on the PCCU were on a LOTA.

Safeguarding

- The trust had a safeguarding policy and there were systems in place to identify and protect vulnerable children. These included the recording of all telephone conversations in the child's notes.
- All doctors and nurse working in the PCCU were required to complete level 3 child protection training. Training records held at unit level showed that the majority of staff had completed safeguarding training. These were in line with the data provided by the central learning and development department which also recorded training staff had attended.
- The trust has a safeguarding team based in the hospital who could be contacted Monday to Friday 090-17.00 for support and advice. One of the two nurses from the

safeguarding team frequently visited the unit to identify if there were any safeguarding concerns. There is an acute consultant paediatrician on call 24 hrs, 7 days per week to respond to out of hours safeguarding issues.

- Staff we spoke with were able to describe the process for reporting any concerns to social services. These included contacting the trust's safeguarding team in working hours or social services out of hours. They worked with the police and social services to ensure the child's best interests were protected.
- All long term children in the HDU had a Common Assessment Framework (CAF) form completed. The CAF form is a standardized tool used to conduct an assessment of a child or young person's additional needs and helps practitioners to decide how those needs should be met.
- The trust's new electronic admission system had the ability to alert staff if the child was subject to a child protection plan. This system had recently been implemented and at the time of our inspection not all staff had been trained in how to use it.

Mandatory training

- Staff had access to a range of regular training provided by the unit's supernumerary ward educator and one of the ANPs. The unit had a topic of the week for which training was provided. This topic was repeated every six to eight weeks to ensure as many staff as possible had the opportunity to attend the training.
- We were told topics focused on staff need and included stimulation exercises. These not only increased staff's skills and experience but also identify potential issues such as location of equipment that may increase response time. Any identified issues were addressed to improve practice.
- On the day of our inspection a stimulation exercise of the insertion of a chest drain was taking place on unit, all levels of staff were involved in the exercise and staff were positive about the benefits of the exercise.
- Mentorship training, to prepare staff to act as a mentor and offer students and new staff support and guidance was provided and all band 5 staff nurses were required to undertake a mentorship course.
- We saw evidence that staff completed a range of mandatory training. The unit maintained a record of all mandatory training completed by staff including the date the training completed. This information was also available from the learning and development

Critical care

department; however the records of e-learning and other training did not always match those held at local level as often the central records did not reflect all training completed.

- At the junior doctor's focus group, doctors were very positive about the two day induction programme and safeguarding training that the trust had provided for them. A similar finding was reported in the General Medical Council (GMC), national training survey in 2013 which stated that induction and local teaching was better than expected when compared to other trusts.

Management of deteriorating children and young people

- The PCCU did not have an outreach team to support wards when children deteriorated. We were told that for a period of time a pilot of an outreach team had been run. While this had been beneficial in supporting the wards it had removed too many experienced PCCU nurse from the unit. Staff told us that a decision had been made by the trust executives not to continue with the outreach team following the pilot period and they were not aware of any plans to re-introduce the outreach team.
- There was an escalation algorithm in place for children requiring critical care. We were told that this was not always used and staff took an informal approach to referring children to the PICU team or seeking support.
- The formal escalation process included the PICU being contacted on a red telephone, a registrar taking the call and a record of the referral being documented and reviewed to assess its suitability for admission.
- We were told that the consultant was made aware of most referrals and of all admissions to ensure they were available to support and provide care as necessary.
- The trust had implemented the national paediatric early warning score (PEWS) for any patient deemed at risk of deterioration; the system standardises the assessment of acute illness severity, and indicates when senior staff should be contacted.
- While guidance had been produced on how to use the PEWS document, training had not been provided on the use of PEWS. We found that the document was not always fully completed therefore the escalation to critical care of children requiring additional support was not effective.
- Some of the doctors expressed a lack of confidence in the ward staff's ability to provide safe and effective care

to children who required short term enhanced levels of care. Examples include a child who was having a seizure being admitted to PCCU as it was assumed the staff could not administer the required medication. It was reported that the delay in administering the medication, had resulted in the child having a number of seizures before being given the medication at ward level.

- Staff stated that the ward areas did not have cardiac monitors due to competence of interpretation on the wards and therefore could not deliver high dependency care or administer some drugs. This resulted in some children being transferred to PCCU.

Nursing staffing

- Staffing levels were based on the paediatric intensive care (PIC) standard, for example those children requiring level 3 care, were nurse on a 1:1 basis.
- The unit's nursing establishment was currently 90 WTE, there were six vacant posts, these were being recruited to with two new staff starting soon and four posts being recruited to in September 2014 from newly qualified nurses.
- We were told that the PCCU staff worked flexibly with staff working in both HDU/PICU depending on need. Staff were allocated by the nurse in charge at the beginning of their shift to either the HDU or PICU
- Staff sickness and vacancies were covered by bank or agency staff, which were usually the unit's own staff who wished to work additional hours.
- There was also a 'flexible hours' system in place, when PCCU activity and patient dependency allowed staff to flex off duty. The owed flexi hours were paid back when the workload and dependency of the unit increased.
- There was a standardised handover procedure for nursing staff, which consisted of once staff had been allocated to a specific patient they received handover at the bedside from the nurse who had been caring for the child on the previous shift. The shift leader, senior staff and others then received handover for all children from the nurses who had been on duty on the previous shift.
- The handover information was recorded by the nurse in charge on an iPad; this included daily treatment plans, progress and any concerns that needed to be raised at the multidisciplinary ward round.

Critical care

- All band 7 staff and 50% of band 8 (there are only 2) had completed advance paediatric life support (APLS). We noted the majority of band 5 and 6 nursing staff had completed either the basic life support or APLS course.

Medical staffing

- There were seven consultants cover the PICU and one who only covered the HDU. There is also a visiting consultant who contributed to the consultant rota.
- One of the seven consultants covered the PICU for a 24 hours period daily. The children on HDU were managed by a separate consultant Monday to Friday 09.00-17.00. Outside this time their care was managed by the PCCU consultant for the day.
- The consultant to patient ratio on the PCCU is 1:7, which is in line with national guidance for the number of consultants for this size of unit.
- There was one consultant vacancy and some long term sickness. The trust was experiencing difficulties recruiting consultants due to a national shortage. This had resulted in a high use of locum doctors on the PICU.
- To cover the gaps on the junior doctor's rotas the trust is developing the ANP programme which will increase the numbers of ANPs on the PICU who can undertake specific medical duties.
- There was a standardised handover procedure for shift changes between medical staff, including a written handover junior to junior doctor on a standard template and a walk round with the consultant of the day. The GMC national training survey in 2013 reported that the unit was performing better than expected for handover, with junior doctors providing positive feedback.
- A consultant led the multidisciplinary clinical ward round on the PICU.
- There was a 24 hour consultant led service, approximately ten hours per day consultants are on site. Outside this consultants were on call from home for advice over the telephone and available to be on site if necessary.
- The junior doctors we spoke with told us they felt able to call consultants for advice and that they would come in if needed.
- All middle grade doctors and consultants had completed the APLS course and if necessary had attended APLS update training.

Major incident awareness and training

- Staff we spoke with were aware of the trust's major incident plan including the folder of flow charts which identified the action that should be taken and by whom.
- There had been a mock run of the major incident plan and all band 7 nurses had attended major incident training as they were expected to play a key role.

Are critical care services effective?

Good



Policies were based on NICE and other relevant guidelines. They were regularly reviewed and updated to ensure they reflected any changes in practice. However, there was limited audit activity taking place. The development of care bundles was in the early stages of development and there was limited patient outcome data. PICU submitted data to PICANET national database, which shows Sheffield Children's Hospital has maintained its standardised mortality within national secular trends.

There was a structured nurse induction and development programme. Staff had the skills and experience to deliver effective care to children. Care was delivered by a cohesive multidisciplinary team who utilised their individual skills and knowledge.

Cover was provided over seven days to meet the needs of the patients and allied health professionals were available seven days per week as requested.

Evidence-based care and treatment

- Policies were based on NICE and Royal College of Surgeons' guidelines.
- Policies were regularly reviewed to ensure they were based on NICE guidelines or best practice. We noted in the PCCU clinical governance minutes that it had been identified that the trust's policy on the use of aprons may not be in line with NICE guidance (139). An individual was identified to check the policy and explore if this guidance should be adopted.
- Staff told us they were unable to carrying out audits and research in a proactive manner on the PCCU due to a lack of medical staff capacity.

Critical care

- We were told that there had been no audits of high impact interventions in 2013-14. The reason for this lack of audits was stated to be due to the low incidence of ventilator acquired pneumonia; catheter related urinary infections and line based septicaemia.
- We were told that the trust takes part in the National Cardiac Arrest Audit (NCAA), a clinical audit of in hospital arrests. However, we were not provided with the results of this audit.
- In January 2013 the trust undertook an audit of omitted and delayed medications in response to an NPSA Alert. This audit found while the majority of medication, 83%, was administered on time. However, there was a lack of documentation in relation to the reason for the delay or omission. In response to these findings the trust implemented an action plan to improve recording of the reasons for delays or omissions.
- The four-monthly infection prevention and control performance report for the period October 2013 to January 2014 showed that the PCCU was 100% compliant for the screening of all admission within 48 hours for MRSA.
- The PCCU had an identified infection prevention and control link nurse, who had completed eight hand hygiene audits per quarter. The results of the infection control audits were displayed for the public in the corridors and also in the PCCU staff room. Action had been taken on findings of hand hygiene audits, such as re-education of staff and parents and re-enforcing hand hygiene.
- PICU submitted data to PICANET national database, which shows Sheffield Children's Hospital, performs well on measures reported and has maintained its standardised mortality within national secular trends. As a multidisciplinary team, PICU had carried out an audit of the latest PICANET data and presented the findings to Clinical Audit and Effectiveness Committee in October 2013.

Pain relief

- The trust wide pain team visit the unit daily and review all patients to assess if their pain relief is appropriate and effective.

Nutrition and hydration

- The PCCU observations charts recorded intravenous infusions, parenteral nutrition and the patients' fluid balance, enabling staff to monitor the child's nutrition and hydration status.

- Nurses referred children to the dietician as necessary. The dietician visited the unit daily Monday to Friday and was available to discuss any specific issues.

Patient outcomes

- Care bundles, a group of three to five evidence based interventions, which when preformed together have better outcomes for the patient, were being developed by one of the ANPs. We were told that this work was in the early stages and the ANP was currently auditing practice to identify specific risks which could be reduced by the introduction of care bundles.
- The Trust has been involved in national benchmarking from a third party company, which compared the performance of the trust with other specialist hospitals.

Competent staff

- The PCCU had a structured induction programme for all new staff. This included a staff development pathway with 90 days with a preceptor, during this time they completed specific critical care competencies which the individual had six months to complete and were signed off by their preceptor.
- Following the preceptor period the member of staff was handover over to an identified appraiser who was responsible for continuing to support them
- All staff employed in the unit for over 12 months could apply and were supported to completed mentorship and critical care courses. The trust funded six places annually on the critical care course
- The staff we spoke with all had an identified appraiser who appraised them annually. Appraisal records were kept at local level and staff reported their appraiser showed a genuine interest in their development and had assisted in identifying their training needs for the following year.
- Appraisals were completed within mentor groups, led by a band 6 nurse responsible for the staff in the group.
- The current completion rate for appraisals for nurses up to February 2014 in the PCCU was 63%. However, new staff had been appointed and therefore had not completed the appraisal process.
- Medical staff that we spoke with confirmed that they were up to date with their appraisals.
- Staff were supported and encouraged to reflect on their practice and incidents. There were monthly reflective

Critical care

practice sessions plus debriefing sessions as necessary for example following a cardiac arrest or major incident. These are led by consultants, psychologist or nurse depending on the specific incident.

- A band 7 nurse leads the organ donation special interest group and is the link nurse with the organ donation team.
- Some staff raised concerns about how the Embrace team could maintain their paediatric critical care skills, especially those who were not paediatric trained, when a high number of transfers they undertook were of babies and children who were not critically ill. However, the trust confirmed that the staff skill set is specific to the transport environment and is competency based through training.
- The Embrace team did not rota through the unit to update their critical care skills but rather their critical care transport skills were maintained through their workload and specifically designed education strategy including the use of simulation based training.

Multidisciplinary working

- We found that multidisciplinary teams (MDT) were working effectively in the PCCU. We observed that the consultant, nurses, pharmacist and microbiologist supported the children to ensure they received appropriate care in a timely manner.
- MDT ward rounds were held daily, at which the staff discussed the children's progress and treatment plans.
- The HDU unit held two weekly MDT meetings at which all teams including the community team were encouraged to attend and the child's discharge was discussed.
- The unit's psychologist was available for parents and critical care staff on a one to one basis. This service could be accessed either via a referral by a member of staff or staff could self-refer themselves.
- The pharmacist attended the unit daily to check medication charts and we observed her advising and supporting nursing staff.
- The unit's staff provided network support for the local district general hospitals, including education (through the regional Operational Delivery Network) and clinical advice.

- The Trust hosts Embrace, the Yorkshire and Humber Infant and Children's Transport Service, for the region. The team works across the region to ensure that infants, children and young people are transferred to the appropriate facilities to receive the care they require
- The Embrace team facilitated advice to local district general hospitals on the management of sick children.

Seven-day services

- There was always a consultant presence on the unit Monday to Friday and out of hours they could be contacted via their bleep. At weekends the consultant on call would remain present on the unit as required depending on the needs of the ward and provide on call cover when off site.
- The junior doctors and staff we spoke with told us that they would contact the consultant for support and that they always responded in a timely manner.
- Physiotherapy, pharmacy, imaging and microbiology services were provided seven days per week.

Are critical care services caring?

Good



Children and their families were treated with compassion, dignity and respect. Parents we spoke with were positive about the care their child had received. They felt informed, involved and able to ask questions when they were unsure.

Families and children were provided with emotional support to enable them to cope with their treatment and any long term care needs.

Compassionate care

- Throughout our inspection we observed children and their families being treated with compassion, dignity and respect.
- We saw doctors introduced themselves to families and curtains were drawn to maintain patient dignity.
- On the HDU the consultant was readily available on the unit Monday to Friday 09.00 to 17.00 and we observed that families approached him to clarify issues.
- The comments received via NHS Choices were varied and praised staff for being helpful and reassuring. The comments also highlighted doctor's attitude as being

Critical care

rude, this was not what we observed during our inspection. Doctors were observed to be polite with both children and their families taking time to explain information.

- The PCCU sought feedback from families in a variety of ways including comment cards which were available in the parent's room and an annual parent's satisfaction survey. There was no evidence displayed in the unit or examples provided of changes that had been made as a result of this feedback.
- All 12 parents and relatives we spoke with were positive about the caring, friendly staff. They said the care their child and themselves received was kind, compassionate and supportive.
- At our focus groups with nurses, play specialists and healthcare support workers staff were very proud of the care they delivered and how they supported children and their families.

Patient understanding and involvement

- Prior to admission to the HDU we were told that if appropriate the HDU consultant would visit babies and parents at the Jessop unit, a neighbouring trust's NICU before the baby was transferred. This meeting assisted in the management of parent's expectations, prepared them for the move and provided an opportunity for the consultant to have conversations with staff and parents in environment they were familiar with.
- All parents and those children who could communicate with us were aware of the name of the nurse who was responsible for their care. They knew who their consultant was and the name of the doctor on duty.
- Those parent's whose child would be discharged from hospital with on-going care needs were provided with specific training to enable them to provide this care safely at home. Staff signed off the parent as competent to deliver this care once they had demonstrated they were confident in delivering it. This care included training in gastric feeding and ventilation.
- All parents whose children had long term or complex needs were aware of their child's long term plan and the consultants who was the lead for their child's care.
- Parents we spoke with told us that they had been kept informed of their child's plan of care and the progress their child was making. They felt able to raise any concerns with either the doctor or nurse.

Emotional support

- We saw children and families being reassured by the nursing staff and heard explanations of their care being given.
- There was a psychologist available for all staff and parents this was a relatively new post and was created following the review of an incident that highlighted the need for psychological support for both staff and parents.
- There was a patient advocate liaison (PAL) officer who was proactive and responsive to parents' needs. We observed her on the PCCU discussing with staff how best to support a family.

Are critical care services responsive?

Good



The flow of children through the unit is managed to avoid delays in discharges and by working with other providers, such as Embrace, the unit is able to effectively manage capacity. Discharges out of the unit did not occur out of hours unless escalated to the executive on call.

The trust did not provide an outreach service to the wards. The needs of the majority of children are met on PCCU; however children with complex needs do not always experience continuity of care due to the medical leadership changing every 24 hours. The unit had play specialists to support those in PCCU and had access to parent accommodation that had recently been refurbished specifically for PCCU. There was a technician that assisted with training parents in relation to ongoing care needs prior to discharge. The department had very few complaints.

Service planning and delivery to meet the needs of local people

- The PCCU utilised agency staff from their own nursing establishment to cover during busy periods to allow them to flex the service. The unit were recruiting up to establishment, although not all nurses were yet in post.
- By working with the local critical care network, the unit was able to deal with capacity issues in the region. This included Embrace transferring children back to their local hospital to create a PCCU bed.

Critical care

Access and flow

- There was a bed manager that visited the PCCU daily to identify if any children were ready for discharge and would if necessary make this child a priority to be transferred to the ward to ensure that there was a bed available for the emergency admission.
- The PCCU's bed occupancy was above 90% between November 2013 and January 2014. Staff reported that this high level of bed occupancy was due to a higher than normal requirement for intensive care beds in the region.
- In the 12 months prior to the inspection there had been 11 refused admissions to PCCU, the majority of these were due to the referral requiring specialist care such as cardiac care or staff sickness.
- All admissions both internal and external referrals, were discussed with the consultant in charge and the referring doctor to ensure the unit was the most appropriate place for the child to be care for in.
- The unit had a policy of not transferring children to another hospital after 17.00 or internally to a ward after 20.00. If it is necessary to transfer a child out of the unit after 22.00 the consultant in charge contacted the executive on call to explain the reason for the transfer.
- The HDU had a continuing care nurse who worked with families from when a child was identified as requiring continuing care. We were told discharges were frequently delayed due suitable housing or carers not being available and therefore there was a need to start the discharge process earlier to reduce delays. At the time of our inspection this early planning was not taking place.
- The PCCU did not have an outreach team to support wards when children deteriorated.
- We were told that children and young people would only be transferred out of the PICU to another PICU or hospital if they required a specialist service, such as cardiac services, that the trust did not provide.

Meeting people's individual needs

- The unit's team included two play specialists who worked with children to distract them during treatment or interventions and also engaged them in developmental play.

- There was no parent's accommodation on the unit. However parent and family rooms were available a short walk from the unit linked via an indoor corridor, which had recently been refurbished and built providing specific accommodation for PCCU.
- As many of the HDU children went home on long term ventilation, the unit had undertaken a "Parent Questionnaire of Long Term Ventilated Patients" audit to identify areas for improvement. We were informed that the audit report had not been finalised at the time of our inspection.
- A translation telephone service was available so that families for who English was not their first language were able to communicate with the staff.
- Information boards were sited around the hospital and in the relative's room, providing a range of information.
- The PCCU team, including the designated technicians, assisted in training parents of children who would require equipment once they were discharged. This involved providing around five days training to the parents and completing their workbook to confirm they have been assessed as competent to use the equipment.
- Some children with complex needs or multiple system problems experienced long waits to be seen by specialist teams from services not provided by the trust. These include reviews by the cardiac, liver and renal teams from other trusts.
- As the medical leadership of the PICU changed on a daily basis, continuity of care for longer term children or those with complex problems was reported to be an issue as there was a lack of ownership for these children and active decision making was not evident.
- The Embrace team provided a transfer service of both emergency and elective cases to the trust and other local hospitals. The service was well resourced and could meet the needs of children and their families.

Learning from complaints and concerns

- The unit had a low level of complaints, as staff tried to resolve issues as they arose to avoid a formal complaint being submitted ,
- The complaint's team co-ordinate the response to any complaint with the input from the unit.
- Staff we spoke with stated that learning from complaints takes place at a local level but as trust wide complaints themes are not identified there is no trust wide learning.

Critical care

Are critical care services well-led?

Requires improvement 

The unit had an open, caring and supportive approach. However, medical leadership was not effective in driving the vision and the strategy of the unit due to vacancies and workload pressures. Nursing staff felt supported by the senior nursing team and able to raise concerns. There was limited staff and parent engagement for example in the development of the plans for the new unit, although we were advised their views would be captured once detailed planning commenced.

Many staff we spoke with were unaware who the members of trust board were and there were limited executive walk rounds to identify quality issues and meet front line staff.

Vision and strategy for this service

- The senior medical cover was inadequate to drive the vision and strategy for unit. While the current arrangements allowed the PCCU to function at a basic level there was reported to be no prospect of developing the unit until the medical cover issues were addressed.
- Nursing staff we spoke with stated that there were plans to increase bed numbers by six to eight beds. PCCU beds will be used flexibly for both HDU and PITU.
- While the staff were aware of the PCCU's priorities, not all staff were aware of the trust's priorities or objectives.

Governance, risk management and quality measurement

- There were fortnightly departmental clinical governance meetings at which incidents and risks were discussed. In addition, there were monthly clinical governance meetings. We were told that it was unclear who was expected to attend these clinical governance meetings. The minutes seen showed that actions were identified for individuals and feedback was provided on the progress of these actions.
- The Surgical and Critical Care risk register, included risks from all areas in the division. There was a record of the actions to be taken, if an action plan had been developed and also a review date.

- Staff we spoke with stated that risks were placed on the risk register when an incident had been reported; they were unaware of any other route that risks may be identified by.
- The risk register highlighted that risks were identified via a number of routes including incident reporting and service continuity.

Leadership of service

- There was effective nursing leadership at unit level with senior nursing staff being visible and approachable, supporting staff, ensuring training was completed and any issues addressed in a timely manner.
- There was evidence that effective medical leadership was constrained by consultant vacancies and long-term sickness. This lack of medical resources had impacted on the ability to manage and develop the medical workforce, which was impacting on job satisfaction and morale among the senior doctors.
- The consultants lacked cohesion and rarely met together formally. There was limited engagement in the unit and we were told that there was a high level of "burn out" among the consultants.
- Some staff told us that members of the trust board did not make themselves available on a regular basis to see the quality of services for themselves. Some staff were not aware of who board members were.
- It was reported that there was no clinical leadership forum in the trust; staff felt this resulted in the progress and resolving issues taking significant lengths of time.

Culture within the service

- The service had an open, caring and supportive approach. Care was delivered as team effort and there was effective team working.
- Staff were positive about the quality and care that they gave to their patients and took pride in the hospital.
- We observed that staff worked well together and showed respect for each other on the unit but were not integrated with the rest of the hospital.
- Many staff described the hospital as friendly and due to its size there were informal ways of working often bypassing formal structures to get things done quickly.
- The Embrace team were happy and engaged in the delivery of the service, they stated that they had time and opportunities to develop their skills.

Critical care

Public and staff engagement

- There was limited staff and parent engagement for example in the development of the plans for the new unit. However, we were advised that the business case for the new unit was being written and detailed planning had not begun with plans to involve staff and patients.
- Embrace collected parent's views in a variety of ways including via text, website and leaflets to identify areas for improvement. All feedback seen was positive and there were no areas for improvements identified.
- Staff reported that often email was used as a form of communication, while this was a quick way to contact

staff; some staff felt that it was used too often, especially by the executive team. They also reported that as they frequently did not have access to emails during their shift they missed information or received it too late.

- Staff were unclear if the trust used 'team brief' to communicate corporate information.

Innovation, improvement

- Senior leadership in the PCCU was significantly stretched by clinical commitments and therefore did not provide capacity for innovation to be at the forefront of the department's agenda. This was exacerbated by long term sickness and vacancies in the medical consultant group.

Neonatal services

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

Information about the service

The Neonatal Surgical Unit (NSU) at the Sheffield Children's Hospital has 11 cots. It consists of three separate areas which are designated for babies requiring different levels of care from high dependency care to those babies ready for discharge home or to their local hospital. Babies who require intensive care are transferred to the hospital's Paediatric Critical Care Unit (PCCU) as the NSU does not currently ventilate babies on the unit, because the unit focused on surgery for neonates working in conjunction with another tertiary provider that has the provision for neonatal intensive care.

We spoke with, six parents, ten members staff including, nurses, doctors, consultants, and support staff. During the inspection we looked at care and treatment, we also reviewed care records. Before and during our inspection we reviewed performance information from, and about, the trust.

Summary of findings

There were systems in place to ensure that babies and their families were treated in a safe, well-equipped environment by suitable numbers of qualified staff. Care was led by a consultant surgeon and there was a locum consultant neonatologist present on the unit Monday to Friday, who was responsible for managing the medical needs of babies. Care based on nationally recommended guidelines was provided by appropriately trained staff, who delivered this care in a compassionate and respectful manner. Parents felt informed involved and able to ask questions when they were unsure.

We did not see a specific vision or strategy for the development of neonatal services. Nursing staff spoke highly of their immediate manager. There was a governance structure to ensure that risks and complaints were reported.

Neonatal services

Are neonatal services safe?

Good 

There were systems in place to ensure that babies were treated in a safe, well-equipped environment by suitable numbers of qualified staff. Care was led by a consultant surgeon and a locum consultant neonatologist present on the unit Monday to Friday. Out of hour cover was provided by the surgical registrar, medical registrar, medical consultant and PCCU consultant input when required based on individual patient needs.

There was a process for reporting incidents and any areas for learning were shared with staff. The department was clean and Infection control practices were good. The majority of staff were up to date with mandatory training. Staff demonstrated good awareness of safeguarding and record keeping was found to be good. Medicines were securely stored. Staff were aware of, and some staff had attended mock major incident planning exercises.

Incidents

- There had been no Never Events in the year preceding our inspection.
- Staff we spoke with stated that they were encouraged by the senior staff to report all risks including those considered to be low risk. These incident forms were completed in either paper form or electronic and posted to the risk management team for review.
- All incidents were reviewed at the risk management board and may be re-graded if necessary, if the category of risk reported by the member of staff was considered to be incorrect.
- Incident feedback was provided at the monthly risk management meeting and action plans were developed and implemented, Updates on the action plans were reported monthly to the senior nurse and if timescales for actions had not been met, the reason for this delay was investigated.
- There was an identified nurse who was taking the lead on identifying themes from the unit's incident reports. It was reported that common themes identified included staffing and equipment issues and sharp's injuries.

Action had been taken to address these themes to reduce the risk of re-occurrence. This action included education of staff regarding prevention of sharp's injuries.

- There were monthly mortality meetings held at which all the unit's deaths were reviewed. All doctors and nurses were invited to participate in these meetings but the majority of attendees were doctors.

Quality monitoring

- The unit was meeting the majority of the 'toolkit for high quality neonatal surgery guidance'. This included having access to support services for advice and information such as to paediatric neurosurgery. There were systems in place for the assessment and management of procedural and post-operative pain in babies.

Cleanliness, infection control and hygiene

- The unit was visibly clean, clutter free with dedicated cleaning staff who felt part of the unit's team. Ward staff complete a daily cleaning checklists of the patient environment and return these to the matron who is responsible for analysing these. The NSU results were for January 2014 – 99%, February 94% and March 2014-97%.
- The trust wide infection control policy included guidance on which babies should be isolated in a cubicle. The NSU had one cubicle, to isolate babies and to prevent cross inspection. Staff told us that this usually met their needs and if more than one baby required isolation they would be nursed together in a specific bay on the unit.
- The trust had no cases of methicillin resistant staphylococcus aureus (MRSA), four cases of Methicillin sensitive staphylococcus aureus (MSSA), and five cases of Clostridium Difficile (C. Difficile) had been reported between March 2013 and February 2014. All these cases had been reviewed by the microbiologist and reported to have been unavoidable.
- The four-monthly infection prevention and control performance report for the period October 2013 to January 2014 showed that the NSU was 100% compliant for the MRSA screening.
- We observed that staff washed their hands before they delivered care.

Neonatal services

- All staff, except one, we saw during our inspection adhered to the bare below the elbows policy, as well as utilising appropriate protective equipment such as gloves and aprons to carry out procedures and personal care activities.

Environment and equipment

- The unit was locked preventing unauthorised access. Parents and visitors gained access via a buzzer.
- The visitor's waiting area was shared with the PCCU and had notice boards and refreshments, providing families and relatives with an area to take a break away from the bedside.
- Resuscitation equipment was checked daily and signed to evidence that all equipment was available.
- The medical equipment management group (MEMG) was responsible for the management of all medical equipment within the trust. This group meets regularly and discusses a range of topics including the replacement of medical equipment.
- We noted that all the equipment we checked was in date for PAT testing or external company servicing. Staff reported that they did not experience any issues obtaining equipment and were confident in using all equipment.

Medicines

- All medicines cupboards were noted to be locked and secure. Controlled drugs checks were completed daily and record kept of these checks.
- The drug fridges were locked; and daily temperature checks were completed and recorded.
- Both the unit's pharmacist and the TPN pharmacist visit the unit daily to review charts and provide staff with advice.

Records

- We looked at four set of notes during our inspection of babies currently on the NSU. All notes were complete, entries were legible, dated and signed with the designation of the staff member reviewing the baby.
- There was a record of the baby's plan of care, a summary of any discussions with the family and any investigation results recorded in the notes.
- The nursing records we looked at provided a summary of care delivered.
- Each baby had an individual care plan, that included information on the basic care the baby required and

information that related to their condition or illness. We were told by the senior staff that work was due to begin on improving these care plans and replace some with care pathways.

- An audit of the current nursing documentation found that it did not meet the unit's needs as there was a need for a more in-depth neonatal history section and the summary of events was not always completed. In response to this audit new documentation is being developed.
- The unit uses the trust wide 'Limiting Care' (which included DNA CPR) policy. Any discussions regarding limiting treatment were held with the surgeon, parents and nursing staff. We were told that a record of the discussion would be recorded in the baby's notes. At the time of our inspection no baby on the NSU had this in place.

Consent

- We saw that consent had been sought from the baby's parent prior to any surgery. The form had been signed, dated and filed in their notes.
- The unit participated in the trust's consent audit in 2013 which found several areas were compliant but there were some areas for improvement including consent form being filed securely in the correct section of notes.

Safeguarding

- The trust had a safeguarding policy and there were systems in place to identify and protect vulnerable babies. These included the recording of all telephone conversations in the baby's notes. Staff we spoke with were aware of the trust's safeguarding policy and procedure.
- The trust had a safeguarding team that could be contacted Monday to Friday 09.00-17.00 for support and advice.
- All nurses working in the NSU were expected to complete Level 3 Child protection training. Training records held at unit level showed that the majority of staff had completed safeguarding training. These were in line with the data provided by the central learning and development department who also maintained a record of training completed by staff across the trust.
- Staff were made aware of any baby on a child protection plan admitted to the unit by the referring trust. Staff gave examples of this information being shared by midwives and staff from other providers that referred a number of babies.

Neonatal services

- The unit had close links with the midwife who leads on the care of babies born to drug dependent mothers at a neighbouring trust to ensure information was shared prior to admission to the NSU.
- We were told that the trust's child protection nurse was responsive and would support staff to make safeguarding referrals when necessary. Out of hours staff stated that they would contact the on call social worker if they had any concerns.

Mandatory training

- The unit had a structured induction programme that all staff completed when they commenced employment.
- Staff were able to access a range of mandatory training and had individual personal development plans.
- The unit's supernumerary ward educator organised training for staff and also maintained staff training records. We noted that a record of staff training including any outstanding training was displaced in area only accessible by staff. This information showed that the majority of staff were up to date with mandatory training or were booked on training in the near future.
- Data held by the ward demonstrated that the majority of staff were up to date with their mandatory training. However, figures for some training provided by the learning and development department differed from those held by the NSU
- During quiet periods on the unit staff had the opportunity to complete their e-learning training as the unit had a computer cart to allow staff to do this at bedside.

Management of deteriorating neonates

- The trust had implemented the national paediatric early warning score (PEWS) for any baby deemed at risk of deterioration; the system standardises the assessment of acute illness severity, and indicates when senior staff should be contacted.
- Guidance had been produced on how to use the PEWS documentation, but specific training had not been provided.
- We found that there were two PEWS documents in use, one that included neurology prompts and another without these. Staff told us that they would decide which document to use based on the baby's needs.
- There was an escalation procedure that staff followed in the event of a baby deteriorating. Staff we spoke with

were all aware of these procedures and stated they would discuss the baby with the senior nurse on duty who would contact the PCCU or the baby's surgeon for support.

Nursing staffing

- Staffing levels were based on the paediatric intensive care (PIC) standard, for example those babies requiring level 2 care, they were nurse on a 1:2 basis.
- All nurses employed on the unit were children's nurses and that the unit had very few vacancies. However, there were a number of staff approaching retirement and others going on maternity leave. Staff seemed unclear about succession planning for these posts.
- Staff sickness and vacancies were covered by bank or agency staff, which were usually the unit's own staff who wished to work additional hours.
- If the unit was quiet and there are more nurses on duty than required, staff were moved to other wards to cover sickness or vacancies not filled by the agency. A record of all staff movements was monitored by the bed manager; it was unclear from the evidence provided how this information was used or who this was reported to.
- There was a standardised handover procedure for nursing staff; this was the nurse handing over to the nurse in charge of the shift. This brief handover was followed by the allocation of staff. Following this there was a nurse to nurse handover at the bedside.
- All staff have completed basic life support training with 70% of staff completing advance paediatric life support (APLS).

Medical staffing

- At the time of our inspection the NSU did not have a permanent consultant neonatologist. This post was being covered by a locum consultant, Monday to Friday. At weekends the unit was covered by PCCU.
- The NSU staff had identified this lack of permanent senior medical cover as a risk but it was not recorded on the unit's risk register.
- There were plans to recruit to the post of consultant neonatologist and the vacancy was currently being advertised.
- There was a weekly Friday ward round attended by the surgeons, paediatrician, nursing staff, discharge co-ordinator and neonatologist at which all babies were reviewed and their plan of care updated.

Neonatal services

- The baby's care was led by the surgical team, who review all babies daily. During our inspection we observed junior doctors present on the NSU and reviewing babies, updating records and speaking to parents.
- The junior doctors told us that they were rotated to the NSU from the surgical wards for a two week period. They told us they felt able to call the registrar or consultants for advice and that they would come in if needed out of hours.

Major incident awareness and training

- There was a trust's major incident plan which identified the action that should be taken and by who. Staff who spoke with were aware of the policy and the roles they were expected to undertake in the event of a major incident.
- We were told that the trust had run a mock major incident exercise and all band 7 nurses had attended major incident training.

Are neonatal services effective?

Not sufficient evidence to rate

Care based on nationally recommended guidelines was provided. Babies received care from staff who were appropriately trained and apprised. There was a structured induction programme in place for all new staff that included a total patient assessment before staff were considered competent to deliver care. There was sufficient equipment to provide effective care and staff were competent in its use.

Evidence-based care and treatment

- There were a range of guidelines on the unit that were based on national guidance.
- We noted that the assessment of specialist neonatal care- baseline was in progress but only partially applicable due to the type of babies cared for on the unit.
- In August 2012 the trust reviewed the NICE guidance for the prescribing of antibiotics for early-onset neonatal infection. This review reported that this guidance was not applicable to the trust and therefore no action was taken to update policies to reflect the content of the guidance.

- The unit's audit activity was limited but included audits of pathways to access support services.
- At the time of our inspection the trust had not completed the base line assessment of the NICE guidance for Feverish illness in children. Therefore it was not possible to assess if the unit's policy relating to the management of feverish illness needed to be updated.

Pain relief

- The trust wide pain team visited the unit daily and review all babies to assess if their pain relief was appropriate and effective.
- Parents told us that listened to them when they raised concerns about their baby's post-operative pain and took action as appropriate.

Nutrition and hydration

- All baby's nutritional needs were reviewed by the dietician who visited the unit daily Monday to Friday and was available to discuss any specific issues.
- The total nutrition (TN) team visited the unit twice a week to review all babies receiving total nutrition feeds to assess their progress and update their plan of care for nutrition if necessary.
- The staff maintained a record of intravenous infusions and parenteral nutrition enabling staff to monitor the baby's nutrition and hydration status.

Patient outcomes

- The unit used a database known as Badger, to monitor refused admissions, discharges, ward attenders and occupancy rates. This information had also been used to demonstrate that an increase in nurse staffing levels were required and the need for additional cots to meet capacity.
- We were told that the TN team had recently completed an audit of central lines used to administer TN through to assess risks and identify areas for improvement. We were not provided with results of this audit at the time of our inspection.

Competent staff

- The unit had recruited newly qualified nurse who were supported to develop their skills with the support of experienced nurses and a preceptorship programme
- There was a structured induction programme for all new staff. This included a staff development pathway with 90

Neonatal services

days with a preceptor, during this time the individual was expected to complete specific competencies and a total patient assessment which was signed off by their preceptor.

- Following the preceptorship period the member of staff was expected to be competent in a range of skills including the administration of oral medications. In the following six months they were expected to develop other skills such as IV medication administration and catheterisation.
- All staff we spoke with had an annual appraisal at which their training needs had been identified for the following year. Progress against staff's development plans had been assessed after six months and updated as appropriate.
- The current completion rate for appraisals for nurses up to February 2014 in the NSU was 53%. However, new staff had been appointed and therefore had not completed the appraisal process.
- Following any unexpected incidents debriefing sessions were held to support staff. For example there have been two unexpected deaths recently, following both these debriefing sessions were held.

Multidisciplinary working

- Babies were transferred in and out of the NSU by Embrace, the transfer service of both emergency and elective cases.
- The pharmacist attended the NSU daily to check medication charts and we observed her advising and supporting nursing staff.
- The total nutrition (TN) team visited the unit twice a week to review all babies receiving total nutrition feeds to assess their progress and update their plan of care for nutrition if necessary.

Seven-day services

- Physiotherapy, pharmacy, imaging and microbiology services were provided seven days per week.
- It was reported that access to the surgical consultant out of hours could easily be obtained. However, if support was required from other specialist teams for example the neurosurgical team; this could be difficult as they also covered the adult service.

Are neonatal services caring?

Good



Babies and their families were treated with compassion and respect. Parents we spoke with felt informed involved and able to ask questions when they were unsure. There was emotional support provided for families when needed.

Compassionate care

- Staff treated babies and their families in a kind and reassuring manner.
- We saw that doctors and nurses introduced themselves to parents. Parents felt staff kept them informed and were positive about the care and treatment their baby received.
- We spoke with six parents who were positive about the way they had been treated.
- The unit had open visiting and the only time parents were asked to leave their baby's bedside was during the doctor's rounds. Staff stated that this was to ensure the confidentiality of the other babies in the bay. If no other babies were in the bay parents could stay during ward rounds.

Patient understanding and involvement

- The unit had introduced a form to document all telephone conversations they had with parents post discharge. This included any advice given, a record of the parent's concern and the time and date they called. This provided a record that could be used if the parent re-contacted the unit.
- All parents we spoke with were aware of the name of the nurse who was responsible for their baby's care.
- Parents reported that the doctors provided them with opportunities to ask questions and provided information that they understood.

Emotional support

- We saw parents being reassured by the nursing staff and heard explanations of their baby's care being given.
- One father told us that when they arrived on the NSU it felt like someone had 'put their arms around them'. They felt reassured by the staff and confident in their ability to care for their baby.

Are neonatal services responsive?

Neonatal services

Good



The unit responsive to the needs of babies and families who used the service. The unit took a proactive approach to managing admission and discharges. The unit engaged with family to address any complaints or concerns.

Service planning and delivery to meet the needs of local people

- There was a bed manager who identified beds in the hospital for babies to be transferred to enable emergency admissions to be admitted to the unit. At the weekend this role was covered by the ward sisters including the NSU staff.
- We were told that admission priority was given to surgical babies and the unit would often increase its cots to 12 if there are enough staff and the unit is aware that a baby will be discharged in the next 24-48 hours.

Access and flow

- The NSU bed occupancy was 91% between November 2013 and January 2014.
- Babies were referred to the unit from a range of other trusts for surgery or from neonatal intensive care units outside the trust for ongoing care until they were ready for discharge home. There were admission processes, including an admission flowchart to assist staff in their decision making, around if the referral was appropriate for the unit with the final decision being made by the consultant surgeon.
- There was an admission's log that recorded all referrals in a folder with details of the baby, referring trust, history and the decision to admit or not. This information was used to track babies waiting to come into the unit and to prioritise admissions.
- A monthly report was produced from this referral information to track all pending patients. We noted that in the last two months, one baby had been refused due to capacity.
- There was a discharge co-ordinator on the unit who assisted in the facilitation of discharges working with stakeholders in the community to reduce delays and ensure families had appropriate support once they left the unit.

Meeting people's individual needs

- Babies who required intensive care were transferred to the hospital's PCCU as the NSU does not currently ventilate babies on the unit.
- We were told that if possible a nurse from the NSU would accompany the baby and provide their nursing care. However, this was not always possible due to the shortage of nursing staff.
- A translation telephone service was available so that patients for who English was not their first language were able to communicate with the staff.
- We were told that translators could be booked to attend meetings between parents and doctors when the baby's long term care plan or prognosis was being explained. However, we noted that the arranging of these meeting sometimes were not done in a timely manner due to the need to co-ordinate several consultants' availability.
- Parent's accommodation was provided in one of the trust's two parent's facilities. Most parents were provided with accommodation in Magnolia House which had parent and family rooms and was linked to the unit via an indoor corridor.
- There was no quiet room on the unit to break bad news to parents. However, offices were used for this purpose.

Learning from complaints and concerns

- The unit stated that they received very few complaints and staff tried to resolve issues as they arose to avoid a formal complaint being submitted ,
- The complaint's team co-ordinate the response to any complaint with the input from the unit.
- Staff we spoke with stated that the patient advocate liaison officer (PALO) was available to assist families if they wish to make a formal complaint. We observed her offering support to both parents and staff on the unit during our inspection.

Are neonatal services well-led?

Good



The neonatal surgical unit was part of the surgical and critical care division. We did not see a specific vision or strategy for the development of neonatal services. All the

Neonatal services

nursing staff spoke highly of their immediate manager; however there was a lack of permanent medical leadership at unit from a neonatologist. The overall leadership was provided by a consultant surgeon.

There was a strong positive and caring ethos in the unit. Some staff felt confident in reporting anything that could affect the safety and welfare of babies and their families. There was a governance structure to ensure that risks and complaints were reported.

Vision and strategy for this service

- The nursing staff had a clear vision and strategy for the unit including the need to recruit a neonatologist to lead the team.
- Staff demonstrated an understanding of the demographic profile of the families accessing the service. They were aware of vulnerable groups and gave examples of how they met their needs.

Governance, risk management and quality measurement

- There were monthly risk management meetings at which incidents were discussed.
- The Surgical and Critical Care risk register, included risks from a range of areas in the division. There were no risks recorded for the NSU on this register.

Leadership of service

- There was effective nursing leadership and staff were positive about the nursing management structure and the support they received.
- Some staff told us that they felt confident in raising concerns or escalating issues to the chief executive as they felt he would listen.
- There was a consultant surgeon who led the NSU and working in conjunction with a locum neonatologist. The neonatologist was present on the unit all day, Monday to Friday providing supervision and support to the junior doctors and managed the medical needs of the baby. The neonatologist was a locum, however the trust was in the process of advertising for a permanent neonatologist.
- There were regular team meetings in addition to daily handovers.

Culture within the service

- The service had an open and friendly approach with team working being reported as strong and effective.
- There were several experienced neonatal surgical nurses on the unit who were keen to develop the skills of more junior staff.

Public and staff engagement

- There was limited staff engagement however; staff were able to give examples of how they had influenced the re-design of the unit previously.

Transitional services

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	Requires improvement 

Information about the service

Note: Pilot for this inspection

Transitional services were provided as part of the overall services for children and were not managed as a distinct clinical area (such as medicine or surgery). Transitional services for adolescents were developed and managed by individual specialities within the hospital. Some specialities had established cross transitional arrangements with adult specialities within Sheffield Teaching Hospitals NHS Foundation Trust.

During our inspection of transitional services we spoke with 22 adolescents and their parents in the outpatient departments and two adolescents and their parents on ward M2. We spoke with members of staff of all grades from a sample of specialities that provided transitional care, including diabetes, haematology, cystic fibrosis, neurology, long term ventilation, gastroenterology and oncology.

Summary of findings

We found there were specialities which had established transitional arrangements in place. Some specialities had arrangements in place such as a databases and specially designed documents to ensure adolescents safely transferred over to adult services. Existing transition services had developed independently within their own specialities which meant none followed standards which could be measured for effectiveness. There was some evidence of one speciality completing a nationally recognised toolkit to measure the effectiveness of its transition service. Some specialities had developed established joint transition clinics with the adult service speciality.

Sheffield Clinical Commissioning Group (CCG) had funded an initiative known as TATI which facilitated transition for adolescents with complex neurological health needs. We did not review specific evidence which demonstrated coordinated Trust wide specific planning and delivery of adolescent transition services.

There was a 'Young Person's Working Group'. However, the group did not have the authority, time or resources to develop and promote a coordinated approach to transitional care across the trust.

We found evidence of good working relationships between the Trust and the adult providers to support cross transitional arrangements.

Transitional services

Are transitional services safe?

The Trust had a clinical policy in place for the transition of adolescent's to adult services. There was limited evidence that the policy had been followed by specialities providing transition services. However, we found specialities which had established transitional arrangements in place. Some specialities had arrangements in place such as a databases and specially designed documents to ensure adolescents safely transferred over to adult services.

Measures to facilitate safe transition to adult services

- The Trust has a clinical policy “The transition of care of young people with long term health conditions from a paediatric to an adult setting” available as guidance for members of staff who care for adolescents.
- The policy sets out broad statements concerning the Trusts intent regarding the transition of adolescents. The policy does not provide focused timelines or specific core standards that all specialities should follow as a basis for a consistent and robust transition process.
- Our review of the transition services available demonstrated that some policy statements have not been followed. For example, the policy states “all clinical teams should ensure that they routinely undertake audit or service evaluations of different aspects of their transition pathway.” We were only given evidence that the gastroenterology speciality had undertaken any sort of transition audit.
- Some speciality teams we interviewed were not aware of the policy.
- We found some specialities, such as diabetes and gastroenterology, had robust and established transition arrangements in place which helped ensure an adolescent safely transferred over to adult services.
- The diabetes team provided an example of how a young person was supported who could have become ‘lost’ and dropped out of the healthcare system as they transitioned to adult services. This would have placed them at risk. The young person of 16 years had become disengaged and was individually supported through the transition process via home visits so that they now access services.
- We talked with two adolescents who were inpatients on ward M2 who had complex health needs aged 15 and 16 years. We found neither had a structured transition

process in place. Neither of these adolescents had a nominated “key worker” regarding transitional care. One parent had self-nominated a clinical nurse specialist to oversee all the complexities of the adolescents care.

Records relating to transitional care

- There was not trust wide specific adolescent documentation for adolescent inpatient care or transition services. The transition policy did include two records within its appendices, including an ‘annual adolescent transition plan’ and an ‘audit tool for transition of care of young people.’ We did not see evidence that these two documents were actually used with the specialities providing transitional care.
- Specialities such as diabetes, gastroenterology, rheumatology and cystic fibrosis had developed their own transition documentation such as letters, information and forms to aid transition. For example, in gastroenterology, three forms had been developed for early stage transition (12-14 years), middle stage (14-15 years) and late stage (15-16 years). These documents captured information such as advocacy, psychosocial and educational discussion as part of the preparation for transition.
- Some specialities such as gastroenterology and cystic fibrosis held transition databases or similar to assist in ensuring the young person safely transitioned to adult services.

Training on transitional care

- Mandatory training provision for members of staff who care for adolescents was the responsibility of the individual division and department where members of staff were employed.
- The Trust explained that it did not currently provide specific transitional training for all staff groups.

Are transitional services effective?

Existing transition services had developed independently within their own specialities which meant none followed any core standards which could be measured for effectiveness. There was evidence of two specialities completing a nationally recognised toolkit to measure the effectiveness of its transition service. Some specialities had

Transitional services

developed established joint transition clinics with the adult service speciality. We found there was evidence of positive multi-disciplinary working across specialities both within the Trust and with adult services for adolescents.

Evidence-based care and treatment

- There was no formal consistent approach to the adolescent transition services we reviewed. Existing transition services had developed independently within their respective specialities which meant none followed any core standards which could be measured for effectiveness.
- There was some evidence of two specialities completing the “You’re welcome” toolkit. This toolkit allows the assessment of a service to see if it is adolescent friendly. The gastroenterology speciality assessed their service regarding the IBD (Inflammatory bowel disease) service within a paediatric tertiary centre. The Rheumatology had assessed its services in both the child and adult settings.
- The Gastroenterology speciality had completed other audit. Changes made to the transition pathway for adolescents with IBD led to the service being further evaluated in 2013. The audit found adolescents thought transitional arrangements had improved since the “You’re welcome” audit assessment.
- Some specialities such as gastroenterology, rheumatology, diabetes and cystic fibrosis had developed joint transition clinics across the both the Trust and Sheffield Teaching Hospitals (adult) sites. Other specialities such as metabolic bone disease had similar processes.
- For example, the cystic fibrosis adolescent clinic operated three times per year at the Children’s hospital and three times per year at the Adult Cystic Fibrosis Unit. Appointments at these clinics involved both teams and were in addition to usual clinic appointments. Joint transition clinics allowed effective transitional arrangements.
- We were told by the chairperson of the Young Person’s Working Group and meeting minutes from this group confirmed that there was a scoping exercise underway to identify the transition pathway that all clinical teams should follow.

- There was evidence which showed the rheumatology speciality adult hospital adolescent consultant had been involved in developing a draft ‘cross trust transition pathway’ developed for all specialities at the Trust and Sheffield Teaching Hospitals (adult services).

Multidisciplinary working and joint clinics with adult services

- Within the speciality transition teams there was positive evidence of multi-disciplinary working within the Trust, for example, long term neurological conditions team. There was also evidence of positive multi-disciplinary working between the Trust and Adult services, for example, the adult community learning disabilities physiotherapy team and the Trust’s paediatric physiotherapy team.

Are transitional services caring?

We found transitional services overall were caring. We found specialities with teams which provided compassionate care with good emotional support through transition. There were specialities which had information available on transitional arrangements to adult services. We observed, and parents and adolescents told us, that members of staff talked with them at an appropriate level of understanding through transition. However some teenagers felt they could have been better supported in relation to their transitional care.

Compassionate care

- We observed staff that provided compassionate and sensitive care which met the needs of the young person and their parents.
- We observed members of staff who had a positive and friendly approach towards the young person and parent. For example, staff explained what they were doing, for example, taking them to the next stage of their appointment.
- The parent of one young person explained how she observed one young person getting upset in the accident and emergency department and saw that older members of staff gave care which calmed them down. The parent noticed that younger staff seemed “less responsive to young people’s needs.”

Patient understanding and involvement

- We observed members of staff and doctors who talked with adolescents at an appropriate level of

Transitional services

understanding. We spoke with one adolescent in the main outpatient department who said the consultant was on my “wavelength.” The accompanying mum observed that the consultant was dressed casually “which helped young people feel more comfortable.”

- Teenagers we talked with told us they felt fully involved in the planning of their care and treatment.
- Teenagers and their parents explained that consultants and other staff spoke directly to the young person about their transitional care.
- One young adult who now sits on the Foundation Trust board of governors described their transition experience with the child and adult metabolic bone services. They told us they had found the prospect “daunting” because they had attended the hospital many years. The young adult felt the transition process used had fully involved them in decisions about transition between the two services and was tailored to meet their own needs.
- We talked with one teenager and parent on ward M2 who had complex health needs. We were told they had received excellent communication, information and had positive relationship with the consultant staff. However, this young person aged 16 had no structured transition in place and felt the “future was uncertain.”
- There was some speciality specific evidence of good information leaflets in relation to transitional care. For example, information leaflet regarding “Transition to adult services for children with complex neurological health needs.”
- There was a generic Trust wide information leaflet on transition available for adolescents and their families entitled “Transition – getting ready to move on to adult services.” This leaflet made clear that transition would be managed by the speciality team.

Emotional support

- Most teenagers we talked with told us they felt well supported by the nursing staff, doctors and other healthcare professionals in planning their transitional care.
- Some adolescents we talked with expressed worries about transitional care to adult services. For example, one adolescent we talked with in outpatients said “[I’m] worried about going to adults and would prefer not to transition to adult services.”
- We spoke with one adolescent who was aged 17 in the outpatient department who had received a negative experience in relation to transition. They had been seen

by a consultant in the adult hospital and informed that another provider would be taking over their care. The adolescent had not received confirmation of the transfer. They felt they had “no hope” and told us no psychological support had been offered.

Are transitional services responsive?

Sheffield Clinical Commissioning Group (CCG) had funded an initiative known as TATI which facilitated transition for adolescents with complex neurological health needs. There was evidence of some specialities using a nationally recognised toolkit to audit and develop their transitional services. We did not review specific evidence which demonstrated coordinated Trust wide specific planning and delivery of adolescent transition services.

Some adolescent’s with complex needs did not have any transition plans in place for their coordinated transfer to adult services.

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

- We did not receive specific evidence which demonstrated Trust wide specific planning and delivery of transition services.
- The Rheumatology speciality had also completed this toolkit and compared findings with adolescents accessing the children’s hospital site and the adult hospital site.
- The hepatology speciality had completed an audit process during November 2012 to March 2013. The audit found transition processes could be improved across child and adult services. The audit included an action plan for improvement though we did review evidence which showed these improvements had been implemented.
- There was evidence which showed the rheumatology speciality adult hospital adolescent consultant had been involved in sharing transitional work developed in Sheffield nationally. The work completed, included a draft ‘cross trust transition pathway’ developed for all specialities at the Trust and local teaching hospitals (adult services).

Transitional services

Are transitional services well-led?

We found that transitional services required improvement. There was a Young Person's Working Group and a Nurse Consultant who was informally nominated as the Trust's lead for transitional care. However, the group did not have the authority, time or resources to develop and promote a coordinated approach to transitional care across the trust. We did not review evidence that there was a formally nominated executive lead to promote the views of adolescents at board level although we saw some evidence that executive director involvement. Documents such as the new build business case showed that the needs of adolescents had been considered.

We found evidence of good working relationships between the Trust and the adult Trust to support cross transitional arrangements. Transitional services had been developed within individual specialities and there was no evidence that showed how the trust coordinated, supported and monitored these arrangements. The NHS Foundation Trust board of governors acknowledged that their membership should include more adolescents or young adults with experience of the services provided at the Trust.

Vision and strategy for this service

- Development of transitional services were integral to the plans for the new build. However we were not able to see detailed plans outlining a standardised framework and care planning approach for transitional care, both locally and nationally.

Governance, risk management and quality measurement

- The Trust has facilitated a Young Person's Working Group (YPWG) over a number of years. This group has previously met three to four times per year and attendance has included members of staff who have a specific interest in adolescent and transitional care. Some recent meeting minutes we reviewed noted that the group had previously facilitated the writing of the transition policy, supported a youth worker when in post, and contributed to various study days and other events.
- We were informed that the group did not carry any authority or ability to drive through change. The group met with the Director of Nursing 11th February 2014 to

discuss the future role and remit of the group along with other developments. The minutes contained action points including the convening of a "strategic meeting" though we were not told if this meeting had occurred.

- The Trust along with Sheffield Teaching Hospitals NHS Foundation Trust (adult services) have facilitated a twice yearly "Cross Trust Transition Meeting" held in the adjacent Royal Hallamshire Hospital. These meetings included a combination of discussion about service developments along with educational sessions.
- As part of our inspection we met with six representatives of the board of governors, one of whom was a young adult and a former patient of the hospital. We asked them about transition. One governor recalled the Trust previously giving them a presentation about adolescent and transitional care.

Leadership of service

- There was limited evidence which demonstrated Trust wide coordination of adolescent transition services. This meant transition services had an inconsistent approach across the hospital.
- The YPWG was chaired by the Haematology nurse consultant who is informally identified as the Trust's transition lead along with a Gastroenterology consultant. We were told these lead roles are not formalised via any addition to their respective job descriptions and do not carry any funding or protected time.
- Currently the development and responsibility for adolescent transition services lies with the individual speciality team and we saw limited evidence that demonstrated this was monitored by the Trust's senior management or governance teams.
- A sample of meeting minutes from the young person's working group showed that there had been some involvement by the executive director of nursing regarding decisions relating to the development of adolescent care.
- The director of nursing and clinical operations shared an email which demonstrated they and the medical director were involved in the development of a standard approach to transitional services.

Culture within the service

- Within the speciality teams who provided transition services we found they had members of staff who demonstrated a passion for the robust and successful transition of their adolescent to adult services. For

Transitional services

example the Neurology team based at the Ryegate Centre demonstrated a real commitment and passion to their service for adolescents and their transition to adult services.

- Outside of these services we could not establish how the Trust and staff culture felt regarding the care of adolescents and their transition to adult services. Some staff with spoke with showed limited awareness of how adolescents transitioned to adult services.

Public and staff engagement

- We were not provided with clear evidence of previous involvement of the public in decisions relating to transitional care.
- There was some evidence available which showed there had been staff engagement relating to transitional care. The Young person's working group meeting minutes from May 2013 noted the group had facilitated a "transition grand round" (educational session) in March 2013 which had been "well attended and evaluated."
- The same meeting minutes stated that a transition survey had been recently undertaken and sent to "all team leaders." The same minutes noted that some teams had nominated their own transition leads and there were plans for these leads to attend the group. Subsequent meeting minutes seen showed that attendance of the group had been low.
- The Trust provided examples of how it had utilised social media sites to engage with adolescents. For example, one consultant had participated in an "ask my anything" session on a website popular with adolescents.

- The Trust along with Sheffield Teaching Hospitals NHS Foundation Trust (adult services) had facilitated a twice yearly "Cross Trust Transition Meeting" which had included educational sessions.

Innovation, improvement and sustainability

- There was a Sheffield Clinical Commissioning Group (CCG) funded initiative in progress known as TATI (Transition across Trusts initiative). This initiative was to facilitate transition for adolescents aged 15-25 with complex neurological health needs who were receiving continuing health care funding.
- Gastroenterology had an established transition process in place which had been reviewed by utilising nationally developed audit processes such as the 'You're Welcome' toolkit. Use of the toolkit had led to service improvements following the baseline and follow up audits.
- The Rheumatology speciality had also audited its service using the 'You're Welcome' toolkit.
- There was evidence which showed the rheumatology speciality adult hospital adolescent consultant had been involved in sharing transitional work developed in Sheffield nationally. The work completed, included a draft 'cross trust transition pathway' developed for all specialities at the Trust and Sheffield Teaching Hospitals (adult service speciality).

End of life care

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

Information about the service

The palliative and end of life service at Sheffield Children's Hospital NHS Foundation Trust is a multidisciplinary service provided by medical consultants and specialist nursing teams. There is a lead consultant for palliative and end of life care who also works as an intensivist within the critical care unit, and is clinical director of the Bluebell Wood Children's Hospice. The hospice is run independently of the trust but works in close collaboration with the service. There are neurology and oncology medical teams led by consultants who work with the service. Both these medical teams work with two specialist nursing outreach teams. These are the Helena Specialist Nursing Team (Helena), for neurology patients, and the Paediatric Oncology Outreach Nursing Service (POONS). These teams care for patients in their own homes, at the hospice and on wards in the hospital. We were told that the majority of patients died at home.

As of 2 May 2014 there were 24 children under the care of the end of life care team. Of this number nine were receiving care from the Helena team, while seven were receiving care from the POONS team.

We spoke with members of the various teams and a charity which worked closely with the service.

We also looked at the bereavement and chaplaincy service, including the work they do in the case of children who have died suddenly, as well as patients on the end of life pathway who have died. We visited the bereavement suite

and the chaplaincy, and spoke with staff in the centre and with the multi-faith chaplain. We also spoke with staff from the emergency department, critical care unit and wards within the hospital.

Because of the nature of the service we did not speak with children on end of life pathway or their families.

End of life care

Summary of findings

Children and their families were given the choice as to whether they received end of life care in hospital, at the hospice or at home and all of the patients in the previous twelve months had their preference achieved by the commitment of the staff and multidisciplinary working.

Cleanliness, infection control and hygiene procedures were followed. There were facilities in the bereavement suite and emergency department for people who had recently lost loved ones. There were effective systems for prescribing and administering medicines to patients on the end of life care pathway.

We found that patient records were completed appropriately and the views of the child and the family were fully taken into account when it came to the issue of consent to limitation of treatment agreements.

There were advanced treatment plans which took into account a patient's individual prognosis and systems for reacting to critical clinical events.

We found that care and treatment was evidenced based and followed accepted standards and professional guidance. There was good multidisciplinary team working in palliative and end of life care services. When it came to responding to the needs of a diverse multicultural population this was done to a high standard.

With regard to whether the service was well-led we found that palliative and end of life care services, and the service offered by the bereavement suite, were outstanding. Staff we spoke with exhibited an understanding of the vision and strategy of their services. The views of patients, families and staff were taken into consideration. There was also a climate of innovation and improvement.

Are end of life care services safe?

Good



With regard to safety we found that overall palliative and end of life care services were safe.

Although there had been no recent incidents staff were aware of the system for reporting them. Cleanliness, infection control and hygiene procedures were followed.. There were effective systems for prescribing and administering medicines to patients on the end of life care pathway. These included the use of autonomous nurse prescribers and having a drugs' box in patients' homes which could be easily accessed by staff.

We found that patient records were completed appropriately and the views of the child and the family were fully taken into account when it came to the issue of consent to limitation of treatment agreements. With regard to safeguarding procedures we found that the majority of staff had been trained in safeguarding children procedures and those we spoke with were able to fully explain their role.

We found there were procedures in place to manage patients' deteriorating medical conditions. There were advanced treatment plans which took into account a patient's individual prognosis and systems for reacting to critical clinical events. All these procedures were proactive while allowing staff to react quickly in emergency situations.

Incidents

- The members of the medical and nursing teams we spoke with told us there had been no 'never events' or other incidents.
- The staff were aware there were systems in place for the reporting and investigation of incidents.
- Trust records showed there had been no reported medication incidents leading to harm between April 2013 and April 2014.
- Trust records also showed there had been no reported incidents leading to serious harm as a result of a failure to monitor, or through poor care practice, between April 2013 and April 2014.

End of life care

Cleanliness, infection control and hygiene

- We found that 79% of Helena and POONS nursing staff had recently undertaken infection control training.
- We found that 81% of staff in the bereavement suite and mortuary had recently undertaken infection control training.
- On our visit to the bereavement suite we found there were hand cleaning gel dispensers which we observed staff using.
- There were also notices advising people to use the hand gel dispensers.

Medicines

- Two of the specialist nurses on the Helena and POONS teams were autonomous prescribers. This meant they could give medication to patients without medical involvement.
- A drugs' box was kept in patients' homes which could be accessed by the nursing and medical teams. The drugs were prescribed by the lead consultant and were used when there were changes or deterioration in the patient's condition.
- The box included buccal medications which could be given by parents and carers. These are medications which are placed between the gums and the cheek.

Records

- We reviewed patients' health records which we found to contained appropriate information regarding clinical care and treatments.
- They were clear and concise, with the contents dated and signed.
- They evidenced flexible care arrangements with both nurses and medical staff visiting children at home.
- They also showed there was telephone advice and support after death.
- They contained records of pain relief, and of nutrition and hydration.
- We saw that the child's wishes were noted, such as when a child did not wish to know when they were dying.
- There were multidisciplinary team end of life pathway forms which were signed by both nursing and medical staff.

Consent

- When a child received end of life care a limitation of treatment agreement (LOTA) form was completed.

- We found that these forms were completed by the consultant with the family, and where appropriate the child.
- The LOTA policy stated that patients under the age of 16 who had sufficient understanding and intelligence to understand what was involved should be involved in the decision making process.
- The agreement limited treatment options including cardio-pulmonary resuscitation.
- We found there were sufficient systems in place to allow for full translation services for people whose first language was not English.
- We spoke with the lead consultant for palliative and end of life care who described how they discussed all issues fully with the family and took time to resolve any disagreements about the approach to take.
- We also found that the LOTA policy was followed by the Yorkshire ambulance service.

Safeguarding

- The end of life and palliative care teams were trained to levels two and three of safeguarding children depending on their seniority and responsibilities. This was the same for the team in the bereavement centre.
- Trust records showed that 88% of the Helena and POONS team had received recent safeguarding children training. For the bereavement suite and mortuary team this was at 87%.
- We spoke with the lead nurse for the emergency department (ED) who told us about their safeguarding procedures in the event of a sudden death. They told us they would check for non-accidental injuries in appropriate case and liaise with the police.
- This was corroborated by the ED guidelines booklet.
- We also spoke with the consultant paediatrician and designated doctor for sudden unexplained death in infants who explained the procedures involved after such an occurrence. These involved a rapid response to any unexpected child death, and the formation of a local panel to take an overview of all child deaths within a defined area.
- They both showed an expert knowledge of safeguarding children procedures.

Mandatory training

- Trust records showed that 67% of Helena, POONS, bereavement suite and mortuary staff had undertaken mandatory training in the last year however local records were significantly higher.

End of life care

- Conflict resolution training was low at 44% for the Helena and POONS teams. However this had recently been implemented by the trust and therefore sufficient training sessions had not been available for higher compliance.

Management of deteriorating children and young people

- As part of the care of the patient on an end of life pathway dedicated advanced care plans were reviewed. We reviewed two of these plans which had been provided in an anonymised version by the trust.
- They were specific to each patient but included instructions for the management of expected events such as seizures, chest infections and gastric symptoms.
- They both included sections detailing the actions to be taken in the event of sudden critical events.
- The plans were drawn up and agreed by the palliative and of life care consultant ('the lead consultant'), the specialty consultant and the specialist palliative care nurse.

Nursing staffing

- The Helena team consisted of a lead nurse, two team leaders, 7.6 whole time equivalent (WTE) nurses and 22 wte support workers.
- The POONS team consists of 3.4 wte nurses.
- The team leaders and members of the teams told us there were no issues with staffing numbers. They told us that when required cover was provided by other experienced members of staff.

Medical staffing

- There was a lead consultant for the service. While being responsible for palliative and end of life care they were also a critical care intensivist, and the clinical lead for the hospice.
- There was also a consultant neurologist and a consultant paediatric oncologist responsible for end of life care in their particular specialties.
- During a discussion of the service the consultant paediatric oncologist told us that the medical staffing numbers met the needs of the service.
- Support was also provided by doctors training in the specialties which make up the medical team.
- We spoke with a consultant histopathologist who told us there were four consultants, three of whom were on-call.

Major incident awareness and training

- We found there was a trust major incident plan. There were also specific plans for mass casualties and 'chemical biological radiation nuclear' (CBRN) incidents.
- Within the major incident plan the mortuary technician from the bereavement suite was contacted as part of the emergency call-out cascade.

Are end of life care services effective?

Good



With regard to effectiveness we found that overall palliative and end of life care services were good. We found that staff were competent and had received specialist training. The nursing staff also told us they could access clinical supervision and support when they required it.

We found that care and treatment was evidenced based and followed accepted standards and professional guidance. However, an audit of the limitation of treatment agreement policy had found that staff did not always follow the policy although there was an ongoing action plan in place.

We found there were systems in place that ensured patients had adequate pain relief at the right time. There were also no concerns identified with the provision of nutrition and hydration for patients.

With regard to patient outcomes we reviewed a report produced by the designated doctor for sudden unexplained death in infants. This showed that a full research evaluation had been undertaken into unexplained infant death in the Sheffield area which was used to help improve patient outcomes. We also reviewed a palliative care service summary which included information as to where children and their families chose to receive treatment when on the end of life pathway.

We found there was good multidisciplinary team working in both palliative and end of life care services, and the bereavement suite.

End of life care

Evidence-based care and treatment

- The palliative care and oncology consultants told us their care and treatment was benchmarked against similar centres in the UK and the USA. They told us they used international benchmarking because of the very specialised nature of the service they provided.
- We found that the limitation of treatment agreement (LOTA) policy referenced guidance from the Royal College of Paediatrics and Child Health (RCPCH); including “Withholding or withdrawing life sustaining treatment – a framework for practice 2nd edition” (2004), and “Advocating for children” (2008).
- We reviewed a clinical audit and service evaluation report which was carried out in June 2013 into the LOTA policy. The audit reported that clinical staff did not always follow the policy. An action plan was initiated with completion dates up to July 2014. Although we have not seen the completed actions, interviews with nursing staff showed a good understanding of the LOTA.
- We reviewed the policy on “Sudden unexpected death in infancy and childhood”. We found it incorporated the report of the working group on sudden death in infants convened by the Royal College of Pathologists and the RCPCH, from 2004.

Pain relief

- We reviewed two dedicated advanced care plans which included a management plan for when the patients suffered pain and should be given, and when to increase the dosage or use a different drug.
- They also indicated if the patient was sensitive or allergic to the medication.

Nutrition and hydration

- The health care records we reviewed provided written evidence of nutrition and hydration being provided to patients on the end of life and palliative care pathways.

Patient outcomes

- A report into sudden unexpected infant deaths in Sheffield was carried out covering the period September 2006 to September 2009: Alison, L, Byrne, R. (2013); “Sudden Unexpected Infant Deaths in Sheffield & Infant deaths from SIDS.”
- It was undertaken by the designated doctor for sudden unexplained death in infants, with other contributors.
- The report identified social, lifestyle, safeguarding and medical factors in the deaths examined.

- Following the report a number of initiatives were implemented including a campaign to encourage safe sleeping positions. Unsafe sleeping arrangements had been seen to contribute to early death.
- We were also provided with a leaflet produced by the trust which gave advice on safe sleep positions to mothers.
- We reviewed a palliative care service summary for 2013/14 which included information as to where children and their families chose to receive treatment when on the end of life pathway.

Competent staff

- Trust records and local records for appraisal rates were conflicting and therefore we were unable to take assurance from the data supplied.
- We spoke with a Helena and a POONS nurse who both told us they had received an appraisal within the last year.
- They also told us they received regular clinical supervision, which was always available when they requested it.
- We found that the lead consultant last received an appraisal in January 2014.
- We spoke with a member of the Helena nursing team who told us they had received specialist training in the end of life pathway and the limitation of treatment policy.
- The lead consultant told us that the team took part in paediatric palliative simulation training using scenarios at a specialist training centre.
- This course was run four times a year and was attended by all members of the multidisciplinary palliative and end of life care team.

Multidisciplinary working

- We found that a monthly multidisciplinary palliative care meeting was held for all professionals providing collaborative care in South Yorkshire. Attendees included a clinical psychologist.
- There was a close working relationship with the Bluebell Wood Children’s Hospice. The lead consultant for end of life care at the trust was also the clinical lead for the hospice.
- We spoke with a representative of ‘Clic Sargent’, a charity which provided practical help to families with children on the end of life pathway who have cancer. They told us they liaised on an ongoing basis with the POONS team and the oncology team.

End of life care

- We also found that the bereavement suite used a bereavement pack which contained advice and information to assist the wards and departments when a sudden death had occurred.
- In order to test this we visited the M3 medical ward where staff told us how they would obtain the pack, which they told us was available out-of-hours from the critical care unit.
- Staff on the critical care unit were aware of the pack and told us that other wards in the hospital came to them for pack.
- This showed multidisciplinary working with regards to the care of patients who died suddenly.
- We also found there that the bereavement suite team offered training to police family liaison officers. These are officers who look after family members when there has been a homicide.

Seven-day services

- The Helena and POONS nursing service were available out-of-hours.
- There was also out-of-hours medical support provided by the palliative care consultant. This is on an emergency basis for patients requiring palliative or end of life care.
- We also found there was an out-of-hours chaplaincy service to provide emotional support to patients and their families.

Are end of life care services caring?

Good



With regard to offering a caring service we found that palliative and end of life care services, and the service offered by the bereavement suite, were good.

We did not speak with patients and their families as we did not wish to cause unnecessary distress at such a difficult time. We used comments taken from an internal review carried out by a consultant for palliative and end of life care. We also spoke with staff and reviewed the services offered.

Families who responded to the review, said they were offered compassionate care, that their needs were understood and they were involved in the processes of care for their child.

We also found there was emotional support for families at all stages of the palliative and end of life care process, with one family saying that the lead consultant had “demonstrated warmth and sympathy at our loss”.

We also found there was a multi-faith chaplaincy service which offered emotional and spiritual support for people who had suffered bereavement.

Compassionate care

- The following comments were taken from a review carried out by a lead consultant’s in palliative care.
- “He was of great support and showed genuine compassion and care for our (child) and for us parents. We felt all advice and care was in the best interests of our daughter.”
- “He was very supportive after our (child’s) death and has offered further support should we need it.”
- The lead consultant told us how he had allowed a parent to ventilate their own child using a breathing circuit. This had allowed the parent to feel they were personally caring for their child.
- We found that after a child had died in the hospital they were transferred on a trolley to the bereavement suite. An oxygen mask was placed on the child to protect their privacy and dignity while they were on the trolley.
- We spoke with a porter who told us how they ensured the privacy and dignity of the child was maintained after death when they were transferring them.

Emotional support

- We found that emotional support was provided by clinical psychologists within the end of life care multidisciplinary team.
- The Helena and POONS nurses also supported families by providing respite care for families caring for a child at home.
- The team also used the services of the ‘Clic Sargent’ charity that provided practical support to families so they could concentrate on looking after their child. They provided support to families for a year after their child had passed away.
- We also found there was access to a multi-faith chaplaincy service available for children on the end of life care pathway and their families. A service which was also available to the families and friends of a child who had died suddenly.
- We visited the chaplaincy and spoke with the multi-faith chaplain.

End of life care

- They explained they provided a service for patients, their families and friends whether they had a religious belief or not.

Are end of life care services responsive?

Outstanding



With regard to responsiveness we found that palliative and end of life care services, and the service offered by the bereavement suite, were outstanding.

Children and their families were given the choice as to whether they received end of life care in hospital, at the hospice or at home and all of the patients in the previous twelve months had their preference achieved by the commitment of the staff and multidisciplinary working.

We found the service was planned to meet the needs of local people not only in Sheffield but in the South Yorkshire area. There was an appreciation of the particular demographics of the region and the cultural and religious needs of the different ethnic and faith groups.

When it came to responding to the needs of a diverse multicultural population this was done to a high standard. People of different cultures and beliefs were cared for by staff that understood their cultures and beliefs and treated them with respect. There was information provided to staff which explained the different cultural responses and rules around death and bereavement. In particular the clinical team in the mortuary had made every effort to respect the profound opposition in many cultures to invasive post mortems being performed. This had taken the form of researching minimally invasive and non-invasive post mortem procedures.

There were also translation services for people who could not speak English and services within the trust to obtain interpretation services for British Sign Language (BSL) users.

We also found there was support through the chaplaincy service for people of all faiths, and those who did not have a religious belief. This support was available on a 24 hour basis when required and took into account people as individuals who grieved in different ways.

We also found evidence of learning from complaints where they had been received.

Service planning and delivery to meet the needs of local people

- The palliative and end of life care service is designed to meet the needs of children and their families in South Yorkshire.
- The bereavement suite provided services for children and their families in South Yorkshire
- Both services had arrangements to ensure there was a consistent service, including at busy times.

Access and flow

- The palliative and end of life care service was accessed by children and their families in South Yorkshire.
- For the year ending April 2014 we found that 24 children received end of life care.
- Of this number nine died at home, ten died at the Bluebell Wood hospice, and five died in Sheffield Children's Hospital. These were all based on the preference of the patient and their families.
- The workload for the palliative care team as of 2 May 2014 was that 20 children had limitation of treatment, and advanced care plans in place. There were no children on the end of life care pathway as of that date.

Meeting people's individual needs

- The staff in the mortuary (viewing room) provided individual handmade blankets for all patients who had reached the end of life. Each blanket was individually made so that families would not see a similar blanket used elsewhere and would be specific to their family member.
- We were told by the consultant paediatric oncologist that they were in the process of completing an MSc dissertation on the parental perception of hospice care. This found that although families were generally opposed to using a hospice at the beginning of a child's illness, they were very supportive of hospice care at the end of the process. This helped in the design of the service in assisting families get the best out of hospice care.
- We found the palliative and end of life care service provided a holistic service that took account of children and their families physical, emotional and spiritual needs.
- After a full discussion children and the families were given the choice as to whether they received end of life care in hospital, at the hospice or at home.

End of life care

- They were also involved in full discussions about the application of limitation of treatment agreements, and in the drawing up of dedicated advanced care plans.
- We found that translation services were provided for those people for whom English was not their first language. This was the case in both the palliative and end of life care service, and the bereavement suite. Translation services were also available in the chaplaincy.
- Out-of-hours and in emergencies telephone translation services were used. This was especially the case in the emergency department when a child had died suddenly.
- We found that leaflets were available in the most common local non-English languages in the service areas we visited.
- We found that the bereavement suite had translated a leaflet, which described safe sleeping positions for babies, into Slovak. The translation into Slovak was undertaken because a number of people from Slovakia had recently come to Sheffield. This showed the service took special account of changing demographics among the local population.
- The leaflet was also produced in a pictographic format in the translated and English language versions. This met the needs of people who could not understand written language, including people with a learning disability.
- We spoke with both the palliative and end of life care teams, and the bereavement suite about the use of British sign language (BSL) interpretation services. Although staff told us they had not recently used BSL interpreters they knew where to obtain them. They told us this would be through the patient advice and liaison service (PALS).
- The consultant paediatric oncologist told us about their experience of communication with a family who were blind, whose child was on the end of life pathway.
- In order to prevent delay when a child died in the community members of the specialist nursing team could verify death at home. This prevented the distress caused to families when they had to wait for a doctor to come to their home to verify death.
- We visited the paediatric association for children with tumours (PACT) that provided accommodation and support for families. This was located on ward M3 and was part funded by a charity and part funded by the trust. They told us how they organised monthly bereavement support coffee mornings. We found these were also advertised in the bereavement suite. The manager of the service told us they had attendances of between six and 15 people.
- We also visited 'Magnolia House' which offered accommodation and support to families whose children were receiving intensive or critical care. This was also part funded by a charity and part funded by the trust. The manager told us that when a child had died the family could stay until they felt able to leave.
- We visited the chaplaincy and found it contained a chapel which was designed to meet the needs of all Christian denominations.
- There was also a Muslim prayer room which was situated next to a room where people could wash themselves before prayer. In the prayer room there were prayer mats and the direction of prayer was indicated. There was also a screen to separate men and women while they were at prayer.
- We spoke with the multi-faith chaplain who told us that the chaplaincy offered a service for people who had a religious belief as well as those who did not have spiritual beliefs.
- We found there was access to a Muslim Imam, as well as to a Roman Catholic priest and representatives of the different Protestant faiths.
- It was clear that every effort had been made to meet people's religious and humanist beliefs.
- There was also an on-call out-of-hours service.
- We also found there was an 'ethnic bereavement pack' which was prepared to advise staff about families different religious and cultural needs.
- We also spoke with the manager of the bereavement suite who told us that within different religious and cultural belief systems families had different views about what care they wanted for their child. They therefore told us that they would always ask the family what they wanted. This showed that the service treated people as individuals.
- This approach was also recommended in the pack.
- There were also systems in place which allowed families to take their child home after death.
- We spoke with a consultant histopathologist who explained the post mortem process and how they made every effort to meet the cultural and religious beliefs of the deceased child and their families.
- As they were involved in the Sheffield minimally invasive post mortem research project they could offer a

End of life care

minimally invasive post mortem. This was designed to go some way towards meeting the cultural and religious needs of people who did not want their child to have a post mortem.

- As part of this project a business case had been submitted for a magnetic resonance imaging (MRI) scanner. This would allow them to conduct a non-invasive post mortem fully meeting people's religious and cultural needs in respect of post mortems.
- In the bereavement suite there was a viewing room where families could view children who had recently died.
- There was also a lounge area used by the families. The atmosphere was homely with a couch and other comfortable seating. The room was child friendly and contained books and toys.
- There were also tea and coffee making facilities for the use of families.
- We found that in the emergency department there was a dedicated room where people whose child had died in the department could go. If the child was small enough to carry they could take them into the room to grieve before they were transferred to the bereavement suite. If the child who had died was older the family could stay with them in the resuscitation room until they were taken to the bereavement suite.

Learning from complaints and concerns

- Members of the palliative and end of life care team told us they had not had any recent complaints. However, they were aware of the trust's complaints' procedures and of the patient advice and liaison service (PALS).
- The manager of the bereavement suite told us that a parent had complained that when they were viewing their deceased infant in the viewing room they could hear a baby crying outside. As such a situation was an obvious cause of distress the service ensured that the viewing room was sound proofed to prevent such an incident occurring again.

Are end of life care services well-led?

Outstanding



With regard to whether the service was well-led we found that palliative and end of life care services, and the service offered by the bereavement suite, were outstanding.

Staff we spoke with exhibited an understanding of the vision and strategy of their services. There were systems in place for governance, risk and quality management. There was a structure of leadership and the lead consultant for palliative and end of life care told us they felt listened to.

Both services had a culture of caring for both patients, families and staff in a compassionate way. The dominant culture very strongly came across as one of compassion.

The views of patients, families and staff were taken into consideration. There was also a climate of innovation and improvement. This was shown in the use of innovative simulation based training in palliative and end of life care, and in the development of new approaches to post mortem services. We felt this, along with their understanding of the local population, made for a sustainable service model.

Vision and strategy for this service

- The "Palliative Care service summary" for 2013/14 was provided to us by the service. It described the service and how it worked in partnership with the Bluebell Wood hospice.
- We reviewed a mission statement for the Helena specialist nursing team. This described how they offered holistic, family centred care to children with complex health needs and life limiting conditions. The purpose was to provide care in patients' own homes to prevent hospital admission whenever possible.
- The medical and nursing leaders of the service described to us their vision and strategy in a knowledgeable and enthusiastic manner.
- We found that the service took part in audit and research in order to develop their vision and strategy.
- We found that staff in the bereavement suite described to us their vision and strategy in a knowledgeable and enthusiastic manner.
- They also took part in audit and research in order to develop their vision and strategy.

Governance, risk management and quality measurement

- We found that both services were involved in the management of quality through audit and research.
- In the palliative and end of life care service this included audits of the limitation of treatment agreement.
- The consultant responsible for sudden infant death had also conducted research into the causes of sudden death in infants in the Sheffield area.

End of life care

- The palliative and end of life care service, and the bereavement suite reported through their respective divisions into the clinical governance committee, and the risk and audit committee.
- These two committees reported directly to the board of governors.

Leadership of service

- The palliative and end of life care service is part of the medicine division, which is led by a clinical director and an associate director.
- The division reported into the trust executive group, which reported to the trust board.
- The executive lead for the palliative and end of life care service was the director of nursing.
- The lead consultant told us they felt the trust executive listened to them and took their concerns into consideration.
- The bereavement suite and mortuary service was part of the pharmacy, diagnostics and genetics division, which was led by a clinical director and an associate director.
- The division reported into the trust executive group, which reported to the trust board.

Culture within the service

- We found the culture of both the palliative and end of life care service, and the bereavement suite to be open and empathetic.
- There was ready access to a confidential counselling service provided by trained counsellors and psychologists.

- We spoke with members of the Helena and POONS nursing teams who told us that it was easy to access these services, and that they were totally confidential.

Public and staff engagement

- As described above the lead consultant had sought the views of families as part of his appraisal.
- The paediatric oncology consultant had also sought the views of families in their MSc dissertation assessing people's attitude to hospice care.
- We found that regular meetings occurred within the multidisciplinary teams, in both end of life care and the bereavement suite, in order for there to be a full engagement with staff.
- We found that as part of their appraisal the lead consultant undertook a 360 degree appraisal process which involved obtaining the views of patients and their carer's in a special report.

Innovation, improvement and sustainability

- The palliative and end of life care team told us how they used palliative simulation scenarios as a teaching aid.
- We found evidence that they had produced audit presentations into the benefits of this as a method of teaching.
- We spoke with a consultant histopathologist who described how they were involved in the Sheffield minimally invasive post mortem research project. This included research into the use of minimally invasive post mortem techniques, and investigations into the benefits of using an MRI scanner.

Outpatients

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

Information about the service

Outpatient services are provided in various settings throughout the main hospital site including main outpatients, Haematology/Oncology outpatients, Ophthalmology outpatients, and the Cystic Fibrosis Unit. Outpatient services are also provided at the Ryegate Centre, and at the Northern General Hospital campus.

During the period 1st April 2013 to 31st March 2014 the outpatient departments saw 33,599 new attendances and 81,478 follow up attendances.

We visited all of the outpatient department areas except the Northern General Hospital Campus and talked with 30 children, young people and parents / carers along with 18 members of staff.

Summary of findings

The outpatients departments were kept clean and were regularly monitored for standards of cleanliness. There were sufficient numbers of suitably qualified staff to meet children and young people's needs. The outpatient department made improvements to care and treatment where these had been identified via programmes of assessment or in response to surveys.

Children, young people and parents told us they felt they received compassionate care with good emotional support. They felt they were fully informed and involved in decisions relating to their treatment and care. People had their needs met although they were not always told why a clinic was delayed. Car parking availability at the main hospital site is currently poor. We found that outpatient services were well led. The service had a clear strategy and vision over the next few years as it increased appointment capacity and space to meet demand.

Outpatients

Are outpatients services safe?

Good



Staff in the outpatients department demonstrated awareness of how they should report incidents though they did not routinely receive feedback on incidents they had reported. We found all outpatient departments were kept clean and were regularly monitored for standards of cleanliness. Parents told us the environment was kept calm. The environment was busy and cluttered at times which may pose a potential health and safety risk at times.

Medicines were stored and administered correctly. Medical records were handled safely and protected. Staff demonstrated awareness of the laws surrounding children and young people's consent. Staff had received mandatory training and there were sufficient numbers of suitably qualified staff to meet children and young people's needs. Equipment and processes were in place to manage children and young people who became poorly.

Incidents

- There were no serious incidents reported within the outpatient department between the period 1st September 2013 and 31st March 2014. A total of 13 incident reports were submitted by members of staff within the same period. These included incidents such as slips, trips or falls and none had required an individual detailed investigation. We reviewed a sample of completed incident forms by members of staff which confirmed the types and nature of incidents reported.
- We were told by the matron and deputy sister that staff were encouraged to report incidents. Members of staff showed awareness of how and when an incident should be reported. Staff had not always received feedback on how an incident had been reviewed and managed via the trust's incident reporting processes. A review of staff team meetings in the department showed incidents were not currently discussed by members of staff.
- During our inspection a live incident occurred. We found that staff were well organised and managed the incident as a team. The incident was quickly resolved and the junior sister promptly recorded and reported the incident.

Cleanliness, infection control and hygiene

- We found the haematology, ophthalmology, main outpatient departments along with the cystic fibrosis unit and the Ryegate Centre outpatient areas were kept clean, tidy and had infection prevention measures in place such as wall mounted hand gels and hand wash sinks.
- A review of documentation showed that a recorded "daily patient environment standards check" had been maintained of the outpatient environment. These had been collated into a monthly report submitted to the responsible matron. Other evidence showed the matron and infection control team conducted quarterly hygiene inspections of the outpatient departments.
- The department had good processes in place to ensure toys were regularly cleaned.
- We observed staff members in all departments adhering to uniform policies and ensuring hand hygiene procedures were maintained.
- We were told the cystic fibrosis unit outpatient area did not always have sufficient consultation rooms available to meet children's and young people's needs. This led to them being moved and assessed in a room within the main outpatient department or other area of the hospital. This may pose an infection control risk for a child with cystic fibrosis vulnerable to infection.

Environment and equipment

- The main outpatient department was split into colour coded zones which assisted parents and children to identify which reception desk they reported on arrival. We saw that the volume of clinic attendances during each session meant that the circulating space available for people in the waiting areas was very limited and cluttered. One parent told us it was "very busy... more space is needed as difficult to navigate with pushchairs and wheelchairs." This may pose a risk in relation to tripping and also evacuation during an emergency.
- The current physical environment of the outpatient department along with the numbers of people waiting also meant the environment became warm and stuffy. Despite the environment we observed staff maintaining a calm atmosphere for parents and children. This view was shared by people we talked with. For example, one young person attending the department stated "the environment is nice and calm."
- The Trust was aware of the current limitations of the environment. There was a detailed strategy in progress

Outpatients

to increase capacity at a second outpatient department site located within a building on the Northern General Hospital campus, which will relieve pressure on the main site. The main hospital outpatient department will be re-located when the new hospital extension is built and completed.

- The junior sister and other members of staff told us they had the equipment they needed within outpatient departments. We found equipment was serviced and checked via a contract with a department of the Sheffield Teaching Hospitals NHS Foundation Trust.
- The resuscitation trolley for the main outpatient department was located within one of the treatment rooms. We saw that the sealed trolley had been checked weekly by members of staff.

Medicines

- We were told the main medications administered within the department included pain relief medications and local anaesthetic for minor procedures. We found medicines had been appropriately stored, checked and administered within the various outpatient departments.

Records

- The medical records department ensured records were prepared and delivered to each outpatient department prior to each clinic session. Staff we spoke with told us there were no concerns about the availability of records for appointments.
- We found records were securely held within each consultation room and we did not observe any records that were left unattended. When parents and children were required to visit other parts of the hospital medical records were placed in plastic seal tagged packages to maintain security and confidentiality.

Consent

- The junior sister explained that most consent for planned surgery was taken via pre-assessment clinics for specialities such as general surgery and orthopaedics. Some consent was obtained prior to surgery within the outpatient department.
- We checked a sample of five medical records for consent obtained within the ENT clinic and an orthopaedic pre-assessment clinic being held within the department. The completed consent forms were signed and dated and showed that the surgeons had appropriately recorded the benefits and risks of surgery.

- Staff we talked with showed that they understood the Fraser guidelines and explained that the consent process actively encouraged the involvement of young people in decisions relating to their proposed treatment.

Safeguarding

- Managers and members of staff demonstrated a clear awareness of the referral processes they must follow should a safeguarding concern arise within the outpatient departments.
- The matron talked through a recent safeguarding referral made by a consultant within the main outpatient department which showed how concerns were identified and acted on.
- Training records held locally for the outpatient department showed 100% of staff working in the department had received a mandatory safeguarding awareness session over the last 12 months.

Mandatory training

- We reviewed mandatory training records held locally for the outpatient departments which showed 100% of staff had undertaken mandatory training over the last 12 months. Staff we spoke with confirmed they had undertaken mandatory training.
- We saw the mandatory training plan for the current period (1st April 2014 – 31st March 2015). This showed that staff were split into three group sessions and received training over a three day period. Training included mandatory type training such as fire along with more specific training such as medical equipment and outpatient department based learning. This showed that the department had a well organised and planned approach to training its staff.

Management of deteriorating children and young people

- The main outpatient department had a fully equipped sealed resuscitation trolley which had been checked weekly. Members of staff had received mandatory training in basic life support.
- The matron explained how the trust wide emergency response team would be called should a child become poorly and stabilised prior to their transfer to the accident and emergency department.

Nursing staffing

- We reviewed the last six month's duty rotas for the outpatient department which showed there had been

Outpatients

sufficient numbers of staff on duty based on the existing staffing establishment. The matron, junior sister and other members of staff we spoke with confirmed there had been sufficient members of staff on duty.

- The band 7 department manager had very recently retired. This was the only current vacancy though recruitment had already been completed and arrangements made for the successful candidate commencing in the role.
- Staff sickness levels within the department were low, for example, January 2014 – 3.34%, February 2014 – 2.28% and March 2014 – 0.60%.
- Examples were given of how staffing the department had been developed over the last 12 months which had improved service provision. For example, health care assistants were being trained in phlebotomy and other staff were training to become fully accredited plaster technicians.

Major incident awareness and training

- During a major incident the main outpatient department was closed and utilised as a location for 'walking casualties' so that the accident and emergency department may focus on more serious emergencies.
- The matron explained the trust's major incident processes were tested twice yearly via exercises. It was also explained that members of staff had received training on the major incident plans via table top learning experiences. We did not review documentation which corroborated these learning experiences.

Are outpatients services effective?

Not sufficient evidence to rate

The outpatient department made improvements to care and treatment where these had been identified via programmes of assessment or in response to surveys. Children were provided with pain relief when they needed it. Staff had received an annual appraisal. There was good evidence of multi-disciplinary working across various disciplines and specialities.

Evidence-based care and treatment

- There have been no national evidence based guidelines which required implementation directly within the outpatient departments over the last 12 months.

- The matron gave other examples of how changes had been made to practice to ensure the improved effectiveness of services within the department. For example, we reviewed a range of documentation relating to the NHS Institute for Innovation and Improvement's 15 step challenge quality programme which has been assessed and implemented within the main outpatient department, ophthalmology and Ryegate departments.
- This programme has led to a number of quality focused improvements for each respective area. For example, in the main outpatient department improvements have been made to signage and a large display board has been created which walks a child through the journey they may take while in the department.

Pain relief

- Children and young people had access to a range of oral medications, Entonox (breathable pain relief) and local anaesthetic to ensure pain control was effective during procedures.
- The department used an evidence based pain scoring tool to assess the impact of pain when this was needed.
- The department would be able to access the hospital's pain management team for a child who required a detailed assessment and management of an acute pain episode.
- It was explained there was sometimes an un-necessary delay to the application of topical anaesthetic cream prior to the taking of a blood sample. The delay was caused by the current process of prescribing by a doctor and application of the cream by a registered nurse. The current process could cause lengthy waiting for parents and children.

Patient outcomes

- Results from the Picker Institute 'Young outpatients survey 2012' published in January 2013 showed 78% of young outpatients aged 8+ years felt they were looked after very well during their hospital visit and 19% said fairly well. 98% of parents/carers felt their child's overall care was excellent, very good or good with 2% rating it fair or poor.
- The trust action plan for this survey highlighted various improvements had been implemented following the survey to improve the patient experience relating to information provided prior to the appointment, arrival

Outpatients

in the department through to investigations performed such as x-rays. We saw that the action plan had been implemented during our observation of the department.

Competent staff

- There were formal processes in place to ensure staff had received training and an annual appraisal.
- Records showed that 100% of outpatient department staff had received an annual appraisal last year. We checked individual staff records which showed staff had received a documented appraisal and this was confirmed by members of staff we talked with.
- Members of staff gave positive feedback about the individual support they received regarding their personal development.

Multidisciplinary working

- The outpatient departments facilitated and supported multiple nurse led specialty clinics along with surgical and orthopaedic pre-assessment clinics.
- Specialities such as metabolic bone disease ran joint multi-disciplinary clinics which included the consultant, nurse specialist, physiotherapist and occupational therapist reviewing patients together. Evidence of joint working also occurred in outpatient clinics held in the haematology, ophthalmology, cystic fibrosis departments along with neurology outpatients held at the Ryegate Centre.
- The outpatient department was able to demonstrate how it worked closely with various multi-disciplinary teams and specialities throughout the trust. The matron provided one example regarding the dermatology service. The dermatology clinical nurse specialist and dermatology support worker now applied topical creams rather than outpatient staff who focused on the smooth running of the clinic. This meant the child's intervention such as cream application was provided by specialist members of staff which improved the level of service provided.

Seven-day services

- Currently outpatient services are held all day on Saturday for various surgical and medical specialities.

Are outpatients services caring?

Good



Children, young people and parents told us they felt they received compassionate care with good emotional support. They felt they were fully informed and involved in decisions relating to their treatment and care.

Compassionate care

- Throughout our inspection we observed staff which provided compassionate and sensitive care that met the needs of the child, young person and parent/carers.
- We observed members of staff who had a positive and friendly approach towards the child and parent. Staff explained what they were doing, for example, taking them to the next stage of their appointment.
- We observed staff that interacted positively with the child, for example, helping children use a colouring/drawing board. We saw one nurse who took the time to make sure the colouring pencils were sharp.
- The main outpatient department generally allowed for consultations to be completed in privacy within individual consultation rooms. However, on some occasions we saw consultation rooms with doors not fully closed which meant you could visually see the consultation taking place. The plaster room, which has bed areas surrounded by curtains, may not always have sufficient privacy to meet a young person's needs. One parent and young person told us they had felt "embarrassed" while in the plaster room.
- We spoke with several children and parents who provided examples of how they have been provided with supportive care beyond what they had expected. For example, in the ophthalmology clinic, one parent told us how the consultant called the family at home to help allay worries and concerns. Another parent in the main department said about their consultant was "Excellent, listens, gets things done, always able to get appointments. Very positive experience."

Patient understanding and involvement

- We observed members of staff and doctors who talked with children and young people at an appropriate age related level of understanding. We spoke with one

Outpatients

young person who said the consultant was on “my wavelength.” The accompanying mum observed that the consultant was dressed casually “which helped young people feel more comfortable.”

- We spoke with over 30 children, young people and parents/carers during our visit to the outpatient departments. We were told by a number of people that they had felt fully involved in the planning and decisions relating to their care. One parent explained how they had “really good relations with staff” and felt “fully involved in planning.” Another parent stated “[Staff] trust parent’s judgement, very positive experience.”
- These families also explained how they had been given sufficient information to make an informed choice.
- We found the outpatients department had informative web pages within the trust’s internet website, including a video tour of the experience. There were a large range of information leaflets available about various treatments and other services available within the department and the hospital.
- Parents and children we spoke with talked positively about the information they had received. For example, one parent stated “Brilliant, always helpful and they give lots of information.”
- We found the department respected people’s religious and cultural needs. There were a range of core information leaflets available in other languages such as Urdu.
- The hospital’s “Medway” patient administration system was able to flag up where a family would need an interpreter for an appointment. Parents and children we talked with told us they felt their cultural and language needs had been met. One parent explained how an interpreter had been arranged for previous appointments.

Emotional support

- Parents and children told us they had been well supported during their visits to the outpatient departments.
- We observed that the play specialist team and other staff were responsive and supportive to a child’s emotional needs. Outpatient staff asked the play specialist for input where a child was anxious during their stay in the department.

- We were told play specialists were not used much in the phlebotomy area. Distraction techniques, during the taking of a blood sample, were provided by a support worker but there were limited distraction tools evident such as toys.
- Parent we spoke with gave examples of how staff supported their children. One parent explained that staff were “excellent with complex needs such as Autism.”

Are outpatients services responsive?

Good



The outpatient service planned and delivered services to meet the needs of local people. Access and flow to the outpatient service was monitored and improvements were being made to develop the responsiveness of the service. The volume of formal complaints is very low and verbal complaints are not recorded to allow effective learning. People had their needs met although they were not always told why a clinic was delayed. Car parking availability at the main hospital site is currently poor.

Service planning and delivery to meet the needs of local people

- The outpatient department monitored service planning and delivery. Increases in service demand for outpatient services across specialities had led to a range of ongoing initiatives to improve systems relating to the way patients were booked, seen in clinic and how cancelled appointments were managed.
- We reviewed a sample of meeting minutes from the “Outpatients Transformation Management Group” which demonstrated how service planning and delivery was being managed. For example, a section on ‘session length optimisation’ reviewed how to optimise the consultants clinic session time.
- The Trust has plans in progress to extend the number of outpatient sessions by increasing capacity at the Northern General Hospital clinic site. We were told this should benefit the needs of local people who access services in the north of the city and surrounding areas toward Barnsley.

Outpatients

Access and flow

- The number of clinic attendances for the last quarter of 2013/14 was 29,185 attendances, of which 3,675 did not attend (DNA's) which gave a percentage DNA rate of 11.18%.
- As part of the Trust's outpatient transformation project, clinic slot utilisation has been closely monitored. For all specialities documentation showed DNA rates by month have percentage rates which had improved from a high of 13% in August 2013 to 9% in March 2014. The matron explained the Trust's target percentage for DNA is currently set at 8%. This meant DNA trends were improving toward the Trust's target.
- Changes introduced during the course of 2013, such as text message reminders of appointment slots had assisted in improving attendance rates for the outpatient departments.
- The Trust shared data relating to 'referral to 1st attendance – wait in weeks' for all specialities between September 2013 and February 2014. The figures for the medical speciality were complex because they were broken down into a range of sub-specialities.
- Using February 2014 as an example, the 'general paediatric' percentage wait for first attendance in less than six weeks was 82% (3 week average wait). Some medical specialities fell well below this figure, for example, in endocrinology where the percentage was 36% (7.8 week average wait).
- The surgical specialities generally had reasonable six week wait times for February 2014. For example, paediatric surgery was 86% (3.4 week average wait), trauma and orthopaedics 71% (4.5 week average wait) and ENT 89% (3.2 week average wait).
- The Trust provided information but not statistics relating to cancelled clinics. The information showed that clinics were cancelled for reasons such as consultant and registrar annual leave.

Meeting people's individual needs

- The Trust had recently introduced a new "Medway" patient administration system. Administrative staff who worked on the outpatient reception desks told us the new system had allowed a more prompt and responsive approach to the booking of new appointments.
- We observed how the new system had facilitated the prompt re-arrangement of an appointment the same morning. A patient arrived at 12-midday but their

appointment should have been at 11am. The staff promptly responded by ensuring the patient could still be seen in the clinic. We were informed this would have been more difficult to arrange with the old system.

- Parents and children we talked with did not raise particular issues with outpatient appointment wait times although clinics did sometimes run with delays. One person we talked with felt more support could be given regarding delays where it involved children with learning disabilities.
- We received four CQC comments cards prior to the inspection. Two cards included positive comments about waiting times and two included negative comments with one person stating there had been a "40 minute delay, no explanation why."
- We observed members of staff informing people where the clinic was delayed during the inspection.
- The majority of parents we talked with complained about the lack of car parking currently available at the main hospital site. The Trust was aware of the issues regarding parking, which in part were due to enabling works for the new hospital extension.
- The main outpatient department had a small adolescent open area known as 'the zone'. This room had games consoles (Xbox) and other facilities more suited to adolescents. However, we observed that the room was mostly used by parents with young children who required a more peaceful space than the busy department. We only saw the room occasionally used by adolescents.
- The matron explained the trust was examining the possibility of developing weekday evening clinics.

Learning from complaints and concerns

- The outpatient departments had not received any formal written complaints for the period 1st September 2013 to 31st March 2014. The matron explained formal complaints regarding the outpatient department were rare.
- The junior sister explained that parents and young people may complain but this is usually informally and resolved straight away. Verbal complaints were not currently recorded so that learning could take place from these concerns.
- Members of staff we talked with demonstrated awareness of how to manage and handle a complaint.
- The matron provided an example of how service improvement occurred as a result of a previous

Outpatients

complaint. The phlebotomy service provision has been changed over the last 12 months. The service used to be provided within the laboratory but has now been placed directly under the management of the outpatient department. This had led to improvements in the service, including the training of additional members of staff to take blood samples.

Are outpatients services well-led?

Good



We found that outpatient services were well led. The service had a clear strategy and vision over the next few years as it increased appointment capacity and space to meet demand. There was an established leadership structure in place within the medical division which managed all most outpatient areas. The ophthalmology outpatient department was currently isolated from the rest of the other departments in the surgical division.

There were governance processes in place and risks were actively monitored. Team meetings did not routinely discuss incidents or complaints. Children's, young peoples and parent's views were sought via surveys, comments cards and interactive colourful boards. There was a culture of openness and flexibility which placed the child and family at the centre of decision making processes.

Vision and strategy for this service

- The outpatient service had a strategy and vision. The existing main outpatient department was no longer adequate to meet the ongoing increase in demand for appointments. Therefore the Trust had completed an "Outpatients Services – Activity and Capacity Review" (January 2014). This document outlined plans to relocate some clinics to an enlarged outpatient department at the Northern General Hospital campus. These plans were currently in progress.
- This work was also captured via the 'outpatients transformation management group' which contributed toward developing various ways of developing the future direction and vision for outpatient services. We reviewed a sample of meeting minutes from this group which showed the department was developing various ways of improving the effectiveness and responsiveness of the Trusts outpatient services.

- The matron, junior sister and other members of staff we talked with had a clear understanding of the ongoing developments within the department.

Governance, risk management and quality measurement

- The main outpatients, haematology, cystic fibrosis, Ryegate Centre and the Northern General Hospital clinic were managed within the medical division governance arrangements. We reviewed January – March 2014 meeting minutes for the divisions 'clinical quality group meeting'. These minutes included a section for the outpatient ward manager to feedback matters such as training, appraisal, and sickness along with other areas such as progress relating to service development. Risk management, including incidents were also discussed at the meeting.
- The outpatient departments had completed and updated risk assessments covering environmental and other associated risks. The main outpatient department risk assessments had been recently reviewed in April 2014.
- There was a division of medicine "OPD (outpatient department)" risk register. This currently had four stated risks with action and control measures in place to minimise and remove those risks.
- The main outpatient department and other areas had ward/department meetings. We reviewed a sample of meeting minutes for the main outpatient department, which captured outline information of the matters discussed. The junior sister confirmed that currently, this meeting did not routinely discuss incidents or complaints so that learning from them could be shared effectively.
- The ophthalmology outpatient department had not recently had any staff meetings where the nursing team and optometrists met formally together. We were informed that the matron for surgery had held informal meetings with the nursing staff. We were told that the optometrists met weekly but the nursing team did not attend these meetings although they spoke regularly within the department.

Leadership of service

- There was a leadership structure for the departments and staff understood the structure, who their line manager was and who they reported to on the structure.

Outpatients

- The ward manager had recently retired. Recruitment for a new manager was completed and the new manager recruited from within the hospital was to work some days in outpatients while they worked their notice period.
- The ophthalmology outpatients department was managed via the surgical division and was isolated from the rest of the outpatient service. This department was currently being managed by the matron for surgery because the ward manager was not available. We were informed by two matrons that there were plans in place move the management of this department with the rest of outpatients.

Culture within the service

- We found there was a culture of openness and flexibility. Staff within the outpatient departments spoke positively about the service they provided for children, young people and parents. Placing the child and the family at the centre of their care was seen as a priority and everyone's responsibility.
- Staff worked well together and there were positive working relationships between the multi-disciplinary teams and specialities.

Public and staff engagement

- Results from the Picker Institute 'Young outpatients survey 2012' published in January 2013 showed 98% of parents/carers felt their child's overall care was excellent, very good or good with 2% rating it fair or poor. The trust action plan for this survey highlighted various improvements had been implemented following the survey to improve the patient experience.
- The Trust had also participated in the 2014 Picker survey. We did not have the survey results to review its findings. The ward manager had produced an action plan during April 2014, which highlighted 2 areas for improvement. These included "parent not told there

was a wait" and "parent did not fully know before appointment what was going to happen." Actions to improve these two areas were recorded as being implemented.

- The department also captured people's views about the service via comments cards. We reviewed a sample of these cards which were regularly reviewed, collated and fed back to the ward manager.
- We found there were interactive wall board audits to seek the views of children on specific subject areas. One wall board involved children and young people, by age group and identifying how they had fractured their bone. The audit results would be collated so that a learning resource could be developed to help improve the areas of fracture risk identified.
- A further wall board had recently been introduced which would have a 'question of the month' where children and young people could place a comment. We were told these comments would be reviewed each month and action would be taken to address the comments via a 'you said, we did' section.

Innovation, improvement and sustainability

- The matron gave an example of how changes had been made to practice to ensure the improved effectiveness of services within the department. For example, we reviewed a range of documentation relating to the 'NHS Institution for Innovation and Improvement's' 15 step challenge quality programme which has been assessed and implemented within the main outpatient department, ophthalmology and Ryegate Centre departments.
- This programme has resulted in various improvements to the department including improved signage and a new display which walked a child through the journey they may take in the outpatient department.

Outstanding practice and areas for improvement

Outstanding practice

We saw several areas of good and outstanding practice including:

- Outstanding practice was found to be evident in end of life care, in particular their leadership and responsiveness to patients wishes and preferences on an end of life care pathway.
- The commitment and dedication of all staff and the transparent and open culture.
- The tool used for nurse staffing was developed by the chief nurse and agreed staffing levels were decided in a collaborative manner with ward managers to ensure all aspects of specialism and acuity were taken into account.
- The care and commitment provided in the A&E department was found to be excellent and the trust had consistently met the A&E 4 hour target for the previous twelve months.
- There was a drive to deliver care closer to home and reduce unnecessary admissions.

Areas for improvement

Action the hospital MUST take to improve

- Ensure the hospital cover out of hours is sufficiently staffed by competent staff with the right skill mix, particularly in A&E.
- Ensure consultant cover in critical care is sufficient and that existing consultant staff are supported while there are vacancies in the department.
- Review the process for ongoing patient review for general paediatric patients following their initial consultant review to ensure there are robust processes for ongoing consultant input into their care.

Action the hospital SHOULD take to improve

- Review and standardise risk management and governance processes to ensure the local processes are consistent to ensure there are robust processes from board to ward.

- Review the current training matrix for statutory and mandatory training and improve the recording system so that there is a comprehensive record of compliance which is consistent with local and trust wide records.
- Review the processes for transition services in all specialties and ensure that a robust system is in place for all specialties as relevant
- Ensure all medical discharge summaries are sent to GP practices in a timely manner to ensure ongoing care is maintained
- Ensure there is provision of consultant ward rounds at weekends across all areas.
- Monitor and review the impact of not having an outreach team to ensure the current provision meets the needs of all patients.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity

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

Diagnostic and screening procedures

Nursing care

Surgical procedures

Transport services, triage and medical advice provided remotely

Treatment of disease, disorder or injury

Regulation

Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services

Service users were not protected against the risks of receiving care or treatment that was inappropriate or unsafe. This was because general paediatric patients were not reviewed on an ongoing basis by consultant grade staff.

Regulation 9 (1), (a), (b) (i, ii, iii); Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

Care and welfare of people who use services

Regulated activity

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

Diagnostic and screening procedures

Nursing care

Transport services, triage and medical advice provided remotely

Treatment of disease, disorder or injury

Regulation

Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing

Service users were not protected against the risks associated with not having sufficient numbers of suitably qualified, skilled and experienced staff employed for the purposes of carrying out the regulated activity.

Regulation 22: Health and Social Care Act 2008 (Regulated Activities) Regulations 2010