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.

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.

We inspected the trust between 14 and 17 June 2016. We undertook an unannounced inspection at the emergency department on 30 June. We previously inspected the Sheffield Children's Hospital in May 2014 and rated it as good overall.

At this inspection we followed-up areas identified as requiring improvement or not rated at the previous inspection. We have rated the individual areas we inspected. We did not review the overall rating for the hospital as the inspection was focused on specific areas only.

We inspected the following core services:

- Urgent and Emergency Services
- Medical Care
- Surgery
- Critical Care
- Neonatal Services
- Transitional Care

We did not inspect outpatients and diagnostic services or end of life care at this inspection.

In the inspection in May 2014, we identified that the trust must ensure the hospital cover out of hours was sufficiently staffed by competent staff with the right skill mix, particularly in the Emergency department. We also identified the trust must ensure consultant cover in critical care was sufficient and that existing consultant staff were supported while there were vacancies in the department and that the process for ongoing patient review for general paediatric patients, following their initial consultant review, must be reviewed to ensure there were robust processes for ongoing consultant input into their care. We found that at this inspection, all these areas had been addressed.

At this inspection, our key findings were as follows:

- The trust had taken action to address most areas identified at the inspection in May 2014. However, the trust had made insufficient progress in developing transition services since our last inspection. The trust directors recognised there was further work to do.
- There was an open culture within the organisation. Challenge was encouraged by executives and non-executive directors. However, the trust was not meeting all the requirements under the duty of candour.
- There were some staff shortages, however additional posts had been approved in principle by the Board and recruitment was underway.
- Incidents were reported and investigated and lessons learned. The trust was planning to introduce an electronic incident reporting system which would improve capability to analyse themes.
- Infection prevention and control policies were effective. There had been no cases of MRSA reported since 2008. All reported cases of Clostridium difficile between April 2015 and March 2016 were unavoidable.
- Feedback from people who used the service and those who are close to them was mostly positive about the way staff treated people.
- There was evidence of public engagement, however it was recognised by the trust, that there needed to be a more systematic approach; there was no patient and public involvement strategy in place.
- Services were planned and delivered to meet the needs of people.
- There were no mortality outliers at the trust.

Summary of findings

- Staff did not always take a proactive approach to safeguarding, particularly in the emergency department.
- The trust was in the process of building work to provide new accommodation for some of the wards, accident and emergency and outpatients. The aim was to provide an environment to better meet the needs of children, young people and their families.

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

Importantly, the trust must:

- Ensure there are effective governance systems in place to capture, respond, and learn from transition related complaints and incidents
- Ensure that sufficient numbers of staff have appropriate training in the Mental Capacity Act.
- Ensure there is an effective clinical audit system in place to monitor transitional care provision.
- Ensure all children are appropriately assessed for safeguarding risks.
- Ensure that staff undertake and document appropriate risk assessments to promote safe care.

In addition the trust should:

- The trust should implement sepsis tool documentation to enable early intervention for febrile patients.
- The trust should implement the use of the paediatric early warning system for all children who attend the department to enable early intervention for deteriorating patients.
- The trust must ensure that staff undertake and document appropriate risk assessments to promote safe care.
- The trust should ensure that there is a consistent and robust approach to the assessment and planning of transitional care.
- The trust should ensure that a consistent approach is adopted to the completion and storage of transition medical records.
- The trust should ensure that steps are taken to create and maintain a transition database to allow patients in transition to be identified.
- The trust should ensure that staff dealing with transitional patients have appropriate knowledge and training around transition care.
- The trust should ensure that its transition pathway is considered in conjunction with community and mental health services.
- The trust should ensure that an appropriate gap analysis is conducted to identify any gaps in its transition service provision against the applicable guidance from the national institute of health and care excellence.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Sheffield Children's Hospital

Detailed findings

Services we looked at

Urgent and emergency services; Medical care; Surgery; Critical care; Neonatal Care; Transitional Care

Detailed findings

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Background to Sheffield Children's Hospital

Sheffield Children's NHS Foundation Trust provides acute and community services for children and young people in Sheffield and South Yorkshire, as well as specialised services for patients further afield.

The trust operates from one main acute hospital site, Sheffield Children's Hospital, as well as inpatient Child and Adolescent Services at the Becton Centre and respite care provided at Ryegate House. In addition, care is provided to children and young people in their own homes and at clinics across the city.

The trust has 284 beds which includes 18 critical care beds.

We previously inspected the Sheffield Children's Hospital in May 2014. The mental health services and community services were not inspected at that time. This inspection was to inspect the mental health and community services. We also followed-up areas not rated or identified as requiring improvement at that inspection.

At this inspection, we rated services that had not previously been rated and also the specific areas we inspected. However, we did not review the overall rating for the trust as the inspection was focused on specific areas only.

Our inspection team

Our inspection team was led by:

Chair: Jenny Leggott

Head of Hospital Inspections: Julie Walton, Head of Inspection

The team included CQC inspectors and a variety of specialists: including consultants, specialist children's nurses, health visitor, school nurse, allied health professionals and an expert by experience.

How we carried out this inspection

To get to the heart of patients' 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?

Detailed findings

The inspection team inspected the following core services at Sheffield Children's Hospital that were rated at the inspection in May 2014 as requires improvement or not rated (due to the methodology at that time):

- Urgent and emergency care – safe and effective
- Medical care – safe, responsive and well-led
- Surgery - safe
- Critical care – well-led
- Neonatal services - effective
- Transition – safe, effective, caring, responsive and well-led.

Before the announced inspection, we reviewed a range of information that we held and asked other organisations to share what they knew about the trust. These included the clinical commissioning

group (CCG), Monitor, NHS England, Health Education England (HEE), the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), royal colleges and the local Healthwatch.

We held a stall in the trust on 7 June 2016 and spoke with young people and their families and received written comments in our comments boxes. We used this information to help us decide what aspects of care and treatment to look at as part of the inspection. During the inspection we attended a Young Healthwatch meeting to gain the views of young people who had experience of the services provided. The team would like to thank all who shared their experiences.

Drop-in sessions were held at Sheffield Children's Hospital and we also spoke with staff individually as requested. We talked with children, young people and their families in the hospital. We observed how children and young people were being cared for, talked with carers and/or family members, and reviewed personal care and treatment records.

We carried out an announced inspection on 14 to 17 June 2016 and an unannounced inspection on 30 June 2016.

Facts and data about Sheffield Children's Hospital

Sheffield Children's Hospital NHS Foundation Trust had the following activity for the period 1 April 2015 to 29 March 2016:

- 32,685 inpatient admissions
- 132,812 outpatient (total attendances)
- 56,029 Accident & Emergency (attendances)

The trust provides services for children and young people in Sheffield and South Yorkshire, as well as specialised services for patients further afield. Three of the four districts within South Yorkshire (Barnsley, Doncaster and Rotherham) have a lower than average proportion of Black, Asian and Minority ethnic (BAME) residents. Sheffield has a similar ethnic make up to the England average. However, there is a higher percentage of residents from 'other ethnic groups' (2.2% compared to an England average of 1%).

The four districts making up South Yorkshire (Barnsley, Doncaster, Rotherham and Sheffield) all lie within the first quintile in the index of deprivation meaning they are four of the most deprived districts in England.

Urgent and emergency services

Safe	Requires improvement
Effective	Good

Information about the service

A comprehensive inspection was undertaken in May 2014. We rated caring, responsive and well-led as good. We rated safe as requires improvement. We did not rate effective nationally at that time. Therefore, at this inspection we re-inspected safe and inspected effective.

The urgent and emergency care department at Sheffield Children's Hospital provides a 24 hour, seven day a week service. The trust provides care to the population of Sheffield and South Yorkshire. There were a total of 53,659 attendances during 2014 and 2015, of which 13% resulted in admission to hospital. Between January and March 2016 there was an average attendance rate of 1150 children per week. The service is managed within the MEDicine division.

The department is part of the regional trauma network and a designated major trauma centre for children and young people.

The department has a two bedded resuscitation room, four cubicles, a six bedded bay, one high dependency room, five consulting rooms, a procedure room, a playroom and a room for parents. The department also has x-ray facilities and an ambulance receiving area.

There is also a fourteen bedded acute assessment unit attached to the emergency department. The unit admits children from the emergency department who require a period of observation, above four hours, by the emergency department team. Children also attend directly, through GP referral, re-attendances to the emergency department and attendance for a medical review. Children can stay on the unit for up to 24 hours.

During our inspection, we spoke with 22 members of staff of all disciplines and examined 20 records.

Summary of findings

- The trust had addressed the safety concern about adequate medical staffing cover following its comprehensive inspection in May 2014. There had been an increase in consultant staff to provide appropriate medical cover across the department.
- However, safeguarding recommendations from a CQC review of children's services in Sheffield, in December 2015, had not fully been implemented. Evidence from meeting minutes demonstrated that children were not always receiving an adequate risk assessment and there was not always appropriate referral and communication with other practitioners and agencies.
- Nurse staffing was below national standard guidelines; night time staffing was a recognised risk on the risk register.

We also found:

- There was evidence of learning from incidents. However, incident reporting was paper based which restricted the scope for robustly analysing incidents to learn from them.
- Clinical guidelines were accessible to all staff. Guidelines were in line with current recommendations and were up dated yearly. There were up to date pathways of care available for all staff, for example, asthma and sepsis management. However, the department did not have sepsis screening documentation in place for staff to use.
- All staff in the department were involved in auditing as part of the appraisal process. We saw evidence of actions in response to audit outcomes.
- We observed staff interacting with patients and saw staff explaining care and receiving consent. Staff worked in a child centred way.

Urgent and emergency services

Are urgent and emergency services safe?

Requires improvement

We rated safe as requires improvement because:

- Safeguarding recommendations from a CQC review of children's services in Sheffield had not been fully implemented.
- The trust applied a process for monitoring sepsis to meet their CQUIN target. However, there was no sepsis screening documentation in place for staff to use Risk assessments were not routinely used. A paediatric early warning system was not systematically used to monitor deterioration in all patients.
- Nurse staffing at night on the emergency department was low. This had been on the risk register at the previous inspection.
- Medical staff levels were not at national recommended levels.
- Access to the emergency department was not secure.

However:

- There had been some improvements since our previous inspection in 2014, particularly with overnight staffing provision.
- There was evidence of lessons being learnt from incidents.

- Mandatory training levels met the trust target.

Incidents

- Within the last 12 months there had been no never events reported. Never events are serious, largely preventable patient safety incidents that should not occur if available preventative measures are implemented. Although each never event type has the potential to cause serious potential harm or death, harm is not required to have occurred for an incident to be categorised as a never event.
- Within the last 12 months the service had reported one serious incident. The incident was a delay in treatment. We were provided with the root cause analysis report and subsequent action plan. Staff were aware of the incident and provided details of changes in practice, for example providing written information on discharge.
- Incidents were reported on a paper based system. This was highlighted as a risk at the previous inspection. There was work towards introducing an electronic reporting system, but staff could not tell us when this would happen. Senior staff acknowledged that the current system for reporting had limitations in the ability to analyse incidents and identify themes and trends robustly.
- Between May 2015 and April 2016 there were 48 incidents reported. No harm was reported in 96% of incidents and low harm in 4% of reported incidents. Medication incidents were the most commonly reported at 40% overall. 17% of incidents were categorised as admission, discharge and transfer of patients and 15% categorised as infrastructure (staffing, facilities and environment).
- The department held monthly morbidity and mortality meetings, to discuss cases and share learning points.
- Staff had knowledge of duty of candour and spoke about the need to be open and honest with patients and their carers. The duty of candour is a regulatory duty that relates to openness and transparency. It requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.

Cleanliness, infection control and hygiene

- Trust-wide there were no cases of Multi-resistant Staphylococcus Aureus screening (MRSA) between August 2014 and August 2015. There were nine cases of Clostridium difficile in the same period.
- Wall mounted alcohol gel was available at all entrances and exits to the departments; personal protection equipment and alcohol gel was available at all sink areas. We observed staff to be compliant with the bare below the elbow policy.
- The department undertook environmental reviews to monitor cleanliness and infection control. In March 2016, an environmental review of the acute assessment unit scored 82% against a target of 85%. The environmental review of the emergency department of January 2016 scored 88%.

- Hand hygiene audits were undertaken across the medical division during the period of 2015/2016. From the data, we could identify an average score across the year for the department of 98%.

Environment and equipment

- The department had open access to the public during the day. Due to the building work at the main entrance and the position of a public bus stop outside the department door, the public used the department as a thoroughfare to the rest of the hospital.
- The doors into the ward of the emergency department were not locked meaning any one from the general public could access the ward area. We raised this with the trust at the time of inspection. The door to the acute assessment unit was secured and required staff to swipe ID cards.
- All resuscitation equipment in the department was checked daily and recorded.
- All equipment had stickers showing they had received up to date testing to ensure its safety. Staff knew how to report faulty equipment and access replacements.

Medicines

- Medicines were securely stored. Controlled drugs were checked daily and stored securely.
- Fridge temperatures were recorded daily, however staff did not record maximum and minimum temperatures. This was raised to staff at the time of inspection.
- Staff had electronic access to patient group directives. These allowed staff to give certain authorised medicines without a prescription, for example, to provide pain relief in triage. This was documented on the triage card.
- Patients in the department were not routinely provided with a wrist band, even if they had medicines prescribed and administered.

Records

- Records in the emergency department were paper based and recorded both medical and nursing notes and observations. There were no prompts on the record cards to undertake risk assessments. Clinical observations and pain scores were documented.
- Medical and nursing records were kept separate on AAU. Nursing care plans were recorded on an electronic system and observational charts were at patient bedsides.
- We examined 20 records and found them to be legible and signed. Patient details, including allergies and weight were recorded.

Safeguarding

- The department had received recommendations from a CQC review of children's services in Sheffield, in October 2015, to improve safeguarding procedures. These recommendations had not been fully implemented, although some progress had been made. However, there were still outstanding actions. The recommendations were about improving risk assessments and documentation to prompt assessment of safeguarding needs and sharing of information with other agencies and practitioners.
- The department used an electronic patient administration system. This system provided a flag alert if a child was known to have safeguarding concerns. However, there were no prompts on records to encourage staff to make safeguarding risk assessments, until the discharge summary completion by medical staff.
- We observed a patient attend triage who had a safeguarding flag recorded. There was no assessment of current risk by the practitioner.
- We spoke with nursing and medical staff across the unit about responsibilities for risk assessing safeguarding concerns. Nursing staff told us it was a medical responsibility. Medical staff told us nursing staff would raise concerns to them.
- Monthly peer review meetings were held with the safeguarding team to raise concerns and to learn from issues. An example of issues raised in May 2016 were concerned with lack of risk assessment, failure to document discussions when children with flag alerts leave the department without medical care and failure to refer to other agencies.
- There were some actions to address this documented, for example discussions with staff involved, but no actions relating to systems and process.
- The trust had a safeguarding children policy that had regard to the statutory guidance Working Together to Safeguard Children (2013). However, this statutory guidance was updated in 2015; the trust told us that staff had reviewed the updated guidance in 2015, but did not feel that this involved a significant change in practice. However, following our inspection the trust confirmed that it would now be updating it's policy.

- Nursing, medical and allied health professionals working in the medical division undertook level 3 safeguarding training in alignment with requirements from the intercollegiate document for safeguarding.
- Staff had received some training on child sexual exploitation and female genital mutilation as part of the level three training.
- Data provided for the division showed that as of June 2016 training compliance was 85% for nursing staff and 70% for medical staff. The trust compliance target for safeguarding training was 85%.

Mandatory training

- The trust compliance target for mandatory training was 85%. Mandatory training was a programme of 27 modules. These included fire safety, infection prevention and control, resuscitation, risk management and safeguarding children.
- The department had an overall compliance rate of 86%. However, there were some modules which staff groups were not achieving 85% compliance. For example, 79% medical staff were compliant with paediatric life support and 75% compliant with level 3 medicines management. Nursing staff were compliant with all modules with an exception of conflict resolution level 2 training.
- Training levels were similar to what we found at the previous inspection.

Assessing and responding to patient risk

- The department used a paediatric early warning system, a recording tool for clinical observations. If a child's clinical condition is deteriorating the 'score' for the observations will (usually) increase and so a higher or increasing score gives an early indication that intervention may be required. However, the department only used the tool once a decision had been made to admit the patient to a ward or for observation in the acute assessment unit, rather than consistently with all patients.
- The trust monitored sepsis as part of a CQUIN target. However, there was no sepsis pathway documentation in place for staff to use.Patients who presented at reception were all triaged by a registered nurse who had completed triage competencies. The competency tool was based on the recognised Manchester Triage model.
- The department had escalation procedures which guided staff to respond if the department became busy or an incident occurred.
- There was no rapid access clinic at the department.
- The median time to initial assessment was below (better than) the England average and time to treatment was consistently below (better than) the England average and below the standard of 60 minutes.
- There were no ambulance hand-overs delayed over 30 minutes and no black breaches reported by the trust.

Nursing staffing

- The emergency department and acute assessment unit were staffed as one department. Each area had a band 7 co-ordinator and at least one registered nurse trained in advanced paediatric life support.
- The Royal College of Nursing (2003) recommended the following levels of staff for day and night shifts: For children's wards the staff to patient ratio should be: patients under two years of age, 1 registered nurse to 3 patients and for patients over two years of age, 1 registered nurse to 4 patients.
- Nursing rotas provided for the period January 2016 to April 2016 showed that there were consistent establishment staffing levels of nine qualified staff. Five registered nurses and one support worker for the emergency department. Four registered nurses for the 14 bed acute assessment unit. These staffing levels were the same as at the previous inspection.
- Between midnight and 7 am there were two qualified nurses on duty in the emergency department. The department highlighted this as an area of concern and was on the divisional risk register. This was on the risk register at the previous inspection.
- On the acute assessment unit, beds reduced to 12 at night, if there were nursing shortages, providing a 1:4 ratio of nurse to patient.
- There was not an acuity tool to measure the required number of staff for each shift. The trust had undertaken some recruitment since the previous inspection and had increased staff. However, there were other factors such as maternity leave which impacted on staffing levels. The department used its own staff to cover staffing gaps whenever possible. As of January 2016 agency use was 2.1%

Urgent and emergency services

- The senior nurse covering the night shift was no longer responsible for bed management as was highlighted as a risk in the previous inspection.
- There were staff trained as emergency nurse practitioners. However, we were told it was rare that they could undertake this role as they were required to contribute to the registered nurse staffing levels.
- As of April 2016, vacancies in the department were for 3 whole time equivalent at band 5 and two whole time equivalent band 6.

Medical staffing

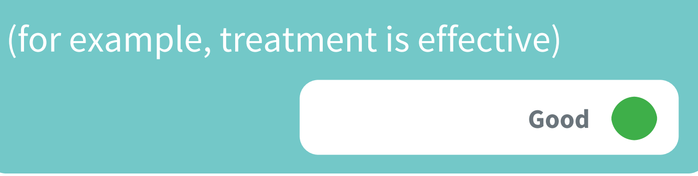
- The college of emergency medicine (CEM) recommends 10 whole time equivalent consultants as a minimum in every emergency department. The department had 7.6 whole time equivalent emergency department consultants. This was an increase in 0.8 whole time equivalent consultants since the previous inspection, where medical staffing was highlighted as a risk.
- Consultants provided medical cover between 8am and midnight, seven days a week which addressed the lack of medical cover seen at the previous inspection.
- Consultants provided on call medical cover (including calls for major trauma) for the remaining hours.
- There were no vacancies for consultants.
- A registrar was on duty 8am-midnight Monday-Friday and 9am-9pm Saturday & Sunday. Senior medical staff (up to CT3) provided cover between midnight and 7am seven days per week, with support from the onsite paediatric registrar.
- Gaps in the medical rota were covered by locums. Induction to the area, the IT systems and departmental guidelines was provided. Locums did not cover night shifts unless supervised.
- Medical handovers were twice daily at 8am and 4pm.

Major incident awareness and training

- There was an up to date major incident policy. Alongside this were several plans to respond to incidents, for example, mass casualty, chemical biological nuclear radiological emergency response and heatwave plan, which were all up to date.
- Major incident training was undertaken on a yearly basis.

Are urgent and emergency services effective?

(for example, treatment is effective)



We rated effective as good because:

- Evidence based clinical guidelines were in use.
- The department contributed to national audits for patient outcomes, there was some evidence of actions from audits implemented in the department to drive improvement in patient outcomes.
- There was a culture of local audit and acting on outcomes.
- Staff worked in a child centred way.
- Staff were meeting the trust target for appraisals.

Evidence-based care and treatment

- Clinical guidelines were accessible to all staff. Guidelines were in line with current recommendations and were up dated yearly.
- There were up to date pathways of care available for all staff, for example, asthma and fever management. However, the department did not have a sepsis screening tool in place.
- The department was part of the South Yorkshire trauma audit and research network and contributed clinical data for reporting.

Pain relief

- Patient group directives were in place to enable staff to administer pain relief in a timely way.
- Patients' pain was monitored within the paediatric early warning score and by clinical assessment from the nursing staff.

Nutrition and hydration

- Staff could provide patients with drinks and snacks 24 hours a day.
- Staff in the acute assessment unit could access catering for special dietary requirements.
- We saw fluid balance charts in use, completed appropriately and timely.

Patient outcomes

Urgent and emergency services

- The department took part in fourteen local and national audits. The purpose of these audits was to benchmark care against college standards and against other emergency departments nationally to identify areas for improvement.
- Results of the January 2016 audit of vital signs in children showed there needed to be improvement in the recording and repeating of vital signs.
- From the August 2015 audit of the fitting child, the department met three of the five Royal College of Emergency standards. The department identified that it was required to improve the discharge information for parents. We saw leaflets available for parents in the department.
- The febrile child audit was reported on in June 2015. The department was meeting two out of five standards and provided and action plan to improve education of nursing and medical staff in undertaking and recording of observations and good management of the febrile child. Staff were not able to tell us of any education up-dates received or when it was likely to be implemented.
- In the 2013/14 asthma in children audit the trust performed better than the England average in four out of ten indicators and the same as the England average in the remaining six indicators.
- Medical and nursing staff undertook yearly audits as part of their appraisal. Examples of these were wrist band audit, audit of observations following diamorphine medication.
- The unplanned re-attendance rate between April 2015 and February 2016 was an average of 8%. This was higher than the trust target of 5%. The rates showed seasonal deterioration in the winter months.
- The department undertook an audit of unplanned re-attendances and concluded when benchmarked against other paediatric emergency departments there were similar re-attendance rates of 8-10%.
- In the 2013 consultant sign off audit the trust performed in the upper England quartile for the percentage of patients seen by a consultant. However, they performed in the lower England quartile for the percentage of patients discussed with a consultant.

Competent staff

- Appraisal rates for nursing and administrative staff in the emergency department was 94% and 90% respectively. The trust target for appraisals was 85%.
- Staff undertook triage competency training after 18 months experience in the department.
- Staff were encouraged to attend further training, for example, children’s advanced training (CAT).
- A clinical educator had been recruited to the department.
- There were staff members who had received advanced paediatric training and were paediatric emergency nurse practitioners. However, the staff were functioning at a registered nurse level to fill the gaps in staffing, at this level.

Multidisciplinary working

- There was a paediatric liaison team to support the department in sharing information with external practitioners and agencies.
- The play specialist team were able to offer support in the department if therapeutic play was required so a patient could receive treatment.
- There was access to the CAMHS service for patients requiring mental health support and assessment.

Seven-day services

- The department was available 24 hours a day, seven days a week.
- The department provided a fracture clinic at weekends and bank holidays.
- There were x-ray and CT scan facilities available 24 hours a day.

Access to information

- There was an electronic discharge system in place which provided communication to GP’s when a child had attended the department.
- Staff could make referrals to the paediatric liaison nurse, for example, if a child had made frequent visits to the department or had a head injury. The paediatric liaison nurse shared this information with community staff, such as health visitors and school nurses.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke with told us they were aware of how to apply Gillick competency and Fraser guidelines to assess the decision making competency of children and young people.
- We observed staff interacting with patients and saw staff explaining care and receiving consent. Staff worked in a child centred way.
- Staff told us they had received training about the mental capacity act.

Medical care

Safe	Good
Responsive	Good
Well-led	Good

Information about the service

A comprehensive inspection was undertaken in May 2014. We rated caring and effective as good. We rated safe, responsive and well-led as requires improvement. Therefore, at this inspection we re-inspected safe, responsive and well-led.

The medical services at Sheffield Children's Hospital are based in three wards and one day case unit. Services provided include general paediatric medical care, haematology, oncology and a range of specialist services. Specialist services include neurology, gastroenterology, cardiology and respiratory disease, immunology and rheumatology. The service is managed within the MEDicine division.

Ward M1 provides medical care to 0-7 year old children and has 20 cots/beds. M2 provides medical care to children aged 7-16 years old and has 24 beds. There are 12 beds on M3, which provide care for children receiving haematology and oncology treatment. M3 has the capacity to flex up to 18 beds to accommodate treatment on a day care basis.

The medical day case unit, provides drug therapy and testing Monday to Friday, 8am until 6pm. The unit has eight treatment rooms, three with beds. There is also a lounge with eight reclining chairs for patients to receive treatment and a waiting area.

During our inspection, we spoke with 28 members of staff of all disciplines and examined 17 records from across the service.

Summary of findings

- The trust had addressed the issues raised from the comprehensive inspection in May 2014. There had been recruitment of paediatric consultants to provide out of hours medical cover and there were plans for further recruitment.
- The backlog of discharge summaries had been addressed and there was a system in place to ensure any discharge summaries delayed by 48 hours were escalated to the executive team.
- There was evidence of reporting and learning from incidents, however, incident reporting was paper based which restricted the scope for robustly analysing incidents to learn from them.
- There were governance structures in place to review and share learning from incidents and complaints.
- There were developments in the service to promote sustainability and to provide care closer to home.
- Care and decision making was child centred.
- A nurse staffing review had been undertaken which had identified the need for increased nurse staffing levels. Plans were in place to increase the nurse staffing establishment.

However:

- There were limited documented clinical risk assessments.

Medical care

We rated safe as good because:

- We saw evidence of incident reporting and learning from incidents.
- Concerns from the previous inspection about the backlog of discharge summaries had been addressed.
- There had been an increase in medical staff with a plan for further increases.
- A nurse staffing review had been undertaken which had identified the need for increased nurse staffing levels. Plans were in place to increase the nurse staffing establishment.

However:

- There was a lack of documented clinical risk assessments of patients.

Incidents

- Within the 12 months prior to inspection there had been one never event reported, a wrong site surgery. Never events are serious, largely preventable patient safety incidents that should not occur if available preventative measures are implemented. Although each never event type has the potential to cause serious potential harm or death, harm is not required to have occurred for an incident to be categorized as a never event.
- Within the 12 months prior to inspection, the service had reported two serious incidents. One incident was a delay in treatment, due to a delay in test reporting. The other was a wrong site injection. This incident occurred in theatre but had implications for medical day care.
- Investigation using root cause analysis was undertaken in both incidents and there were action plans. Staff were able to provide examples of how practice had changed following the incidents and the processes in place to prevent similar incidents occurring. For example, a nurse specialist was now assisting with rheumatology injections in medical day care.
- Incidents were reported on a paper based system. This was highlighted at the previous inspection. There was work towards introducing an electronic reporting system, but staff could not tell us when this would happen. Senior staff acknowledgedthat the current system for reporting had limitations in the ability to analyse incidents and identify themes and trends robustly.
- Between May 2015 and April 2016 there were 716 incidents reported to the NHS national reporting and learning system. No harm was reported in 95% of incidents and low harm in 5% of reported incidents. Common categories for incidents were medication (22%), documentation (15%), consent and communication (13%), clinical assessment (12%).
- The division held monthly morbidity and mortality meetings, to discuss cases and any subsequent learning or actions.
- Staff had knowledge of duty of candour and spoke about the need to be open and honest with patients and their carers. The duty of candour is a regulatory duty that relates to openness and transparency. It requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person.

Safety thermometer

- The trust contributed data to the NHS safety thermometer, a tool developed to measure specific harms in a snapshot of time. According to published data, at the time of inspection, ward M1 reported 100% harm free care between July 2014 and July 2015. M2 reported harm free care in ten out of the 12 months reported for the same time period and M3, 11 out of those 12 months.
- During inspection, we observed up to date safety thermometer information displayed on the wards.

Cleanliness, infection control and hygiene

Medical care

- Trust wide there were no cases of Multi-resistant Staphylococcus Aureus screening (MRSA) between August 2014 and August 2015. There were nine cases of Clostridium difficile in the same period.
- Wall mounted alcohol gel was available at all entrances and exits to the departments; personal protection equipment and alcohol gel was available at all sink areas. We observed staff to be compliant with the bare below the elbow policy.
- The play specialist team were responsible for maintaining the cleanliness of the playrooms and toys.
- The wards undertook environmental reviews to monitor cleanliness and infection control. During March 2016, M1 scored 82%, M2 86%, M3 94% and medical day-care 82% against a target of 85%.
- Hand hygiene audits were undertaken across the medical division during the period of 2015/2016. From the data we could identify average scores across the year for medical wards. M1 scored 95% and M2 scored 85%. M3 were only assessed in three quarter periods and scored 99%. Medical day care were assessed in two quarter periods and scored 94%.
- In the 2014 CQC Children and Young People's Survey, the trust scored 8.8 out of 10 (about the same as the England average) in the question of whether the hospital room or ward the child was seen in was considered to be clean.

Environment and equipment

- The wards were locked to prevent unauthorised access. There was a buzzer system for access outside each ward.
- All resuscitation equipment across the wards were checked daily and recorded, with the exception of M3. Medical day care did not have a resuscitation trolley, only an anaphylaxis drug box, which was stored securely and in date.
- All equipment had stickers showing they had received up to date testing to ensure its safety. Staff knew how to report faulty equipment and access replacements.
- Data provided up to October 2015 showed that over 90% of staff across the medical wards had received training in the use of equipment.

Medicines

- Medicines were securely stored. Controlled drugs were checked daily and stored securely.
- Fridge temperatures were recorded daily, however staff did not record maximum and minimum temperatures. This was raised to staff at the time of inspection.
- Staff undertook medicines management training, however only 78% of staff had received training as of June 2016, against the trust target of 85%.
- We observed medication being administered and saw correct checking and calculation procedures taking place.
- Staff supported young people with long term medication, for example patients with diabetes, to continue their self-administration whilst in hospital. Staff ensured these medicines were stored appropriately.

Records

- At the previous inspection there were concerns about a large backlog of discharge summaries, which are used to inform GP's of the care a patient has received in hospital and any care needs on discharge.
- A system had been introduced to support medical staff to complete the discharge summaries within 24 hours; administration staff had oversight of the system and would escalate to the medical directorate management team if there were delays of 48 hours. We saw that there were few records waiting for summaries at the time of inspection.
- We examined 8 sets of medical records and seven nursing records, which were in paper format. All the records included patient identification throughout, there was recording and updating of patients' weight.
- The nursing records all contained a paediatric early warning score sheet which completed. Patients with intravenous fluids had a visual infusion phlebitis score chart to monitor the infusion site.
- However, these were the only risk assessments undertaken across the wards. Staff told us they would

undertake other risk assessments, for example, moving and handling or pressure sore risk, but did not routinely document that this had been done unless there was a problem identified.

- Medical day care accessed paper and electronic records. They reported weekly issues with tracking notes to ensure records were available when a patient attended for day care. The team leader was working towards addressing this.

Safeguarding

- The trust had a safeguarding children policy that had regard to the statutory guidance Working Together to Safeguard Children (2013). However, this statutory guidance was updated in 2015; the trust told us that staff had reviewed the updated guidance in 2015, but did not feel that this involved a significant change in practice. However, following our inspection the Trust confirmed that it would now be updating its policy.
- Nursing, medical and allied health professionals working in the medical division undertook level 3 safeguarding training in alignment with requirements from the intercollegiate document for safeguarding.
- The trust compliance target for safeguarding training was 85%.
- Data provided for the MEDicine division showed that as of June 2016 training compliance was 87% for nursing staff and 78% for medical staff and 79% for allied health professionals.
- Staff received information about safeguarding alerts and looked after children from the admission handover.
- Staff told us they had received guidance on female genital mutilation and child sexual exploitation as part of their safeguarding level 3 training.
- Safeguarding records were kept securely with medical records.
- A member of the safeguarding team visited the wards daily to support staff, and were also available by bleep.
- Staff felt well supported by the team and were aware of the safeguarding processes. There were opportunities for regular supervision and debriefing following safeguarding incidents.

Mandatory training

- The trust compliance target for mandatory training was 85%. Mandatory training was a programme of 27 modules. These included fire safety, infection prevention and control, resuscitation, risk management and safeguarding children.
- The division had an overall compliance rate of 86%.

Assessing and responding to patient risk

- The medical wards used the Paediatric Early Warning System (PEWS) to monitor and assess patient condition. If a child's clinical condition is deteriorating the 'score' for the observations will (usually) increase and so a higher or increasing score gives an early indication that intervention may be required.
- Monthly audits were undertaken on the compliance in completing the PEWS charts accurately. February 2016 audit data showed 92-96% compliance across the wards.
- Staff told us they were well supported by medical staff when dealing with deteriorating patients.
- Medical day care did not have a resuscitation trolley. If a patient deteriorated an emergency call would be put out and a resuscitation trolley from the ward across the trolley obtained. The ward had recognised the need to have a trolley on the unit.
- M1 was part of the RCPCH 'SAFE' (situational awareness for everyone) pilot project. The project aimed to promote a safety-based culture to improve outcomes for patients. As part of the project staff took part in safety 'huddles' after ward rounds to identify patients at risk.

Nursing staffing

- The division had the use of an evaluative version of PANDA, an acuity tool to measure nurse staffing requirements, but did not have access to all

functionality. Instead, the wards were staffed to establishment each day without assessment of acuity, due to overall staff numbers. There were plans in place to use a fully functioning acuity tool by autumn 2016.

- M1 had a set establishment of four registered nurses and one health care assistant on a day shift, which reduced to three registered nurses and one healthcare assistant at night. M2 had an establishment of six registered nurses and two health care assistants, reducing to four and one at night. This did not meet the recommendation for staff levels.
- M2 struggled to maintain the establishment of qualified nurses. For example, staffing levels for February 2016 showed that there were six qualified nurses on only ten days of the month. The rest of the month, the ward was staffed with either four or five registered nurses.
- A nurse staffing review had been undertaken which had identified the need for increased nurse staffing levels. The division had presented a business plan to the executive team to recruit to the wards to increase and maintain the establishment to six registered nurses and two healthcare assistants during day shifts. Additional funding had been agreed.
- M3 provided staffing levels in line with national cancer care guidelines to provide care on the basis of:

  HDU – one nurse to two patients

  Cancer regimes – one to one care

  General patients – one nurse to three patients
- However, during the night shift this level of care decreased to one nurse to almost five patients.
- Situation reports about nurse staffing were provided to the director of nursing twice a day.
- Nursing handovers were based on SBAR (situation, background, assessment, recommendation) and were recorded on a dictaphone. This facilitated staff to remain on the ward during handovers to continue care and also if there were staff movements across wards staff could easily be provided with a handover.
- Regular substantive staff covered gaps in staffing where possible to avoid agency use.
- There were two band 6 vacancies and four band 5 vacancies at the time of inspection.

Medical staffing

- At the previous inspection medical cover was highlighted as a safety issue. The trust provided a business plan in which they outlined their recruitment strategy over the next three years to improve medical cover across the division. Five consultants had been recruited at the time of inspection and a further five were expected to be in post by the end of the plan.
- Medical cover during the day was provided by general paediatricians and doctors in specialism. For example, gastroenterology, neurology and endocrinology.
- The wards had consultant cover 9am until 5pm Monday to Friday. At weekends two consultants covered the morning and one remained on call the rest of the day.
- Day shifts were covered by four registrars and three junior doctors, which reduced to two registrars overnight.
- The medical staff felt there were enough doctors to provide safe care at all times.
- Medical handovers occurred three times a day and were led by a consultant. We observed a medical handover. Patients who had not been seen by a consultant were reviewed first to ensure they were reviewed by a consultant within 24 hours of admission. However, this was below the recommendation of consultant review by 14 hours, in the Royal College of Child and Paediatric Health document 'Facing the Future' (2015).
- We spoke with locums who worked on a regular basis to cover gaps in the medical rota. They had received induction and support.

Major incident awareness and training

- There was an up to date major incident policy and business continuity plans for the wards.

Are medical care services responsive?

Good

We rated responsive as good because:

- Access to equipment had improved since our last inspection. The wards had access to moving and handling equipment, such as hoists and an electric bath. There was also sensory equipment available to facilitate the care of patients with complex physical needs.
- The trust had made changes to bed capacity, since our last inspection, to make best use of the current accommodation.
- A new team had been established to provide therapeutic care closer to home.
- Play and music therapists provided individualised support for patients.

However:

- Complaints took longer to address than the trust target of 25 days.

Service planning and delivery to meet the needs of local people

- All the wards had challenges with storage space and this made the wards appear cramped. Concerns were raised at the previous inspection about space between beds and cots and the lack of dignity and privacy this provided.
- M2 had reduced bed capacity by two which enabled there to be more space in a particularly small bay. M1 had provided cots rather than beds in one bay to provide more space and privacy.
- The trust was in the process of building work to provide new accommodation for some of the medical wards. The aim was to provide an environment to better meet the needs of children, young people and their families.
- The division had established a team to provide intra-venous therapy in the community. The Outpatient Parental Antibiotic Therapy (OPAT) team enabled patients to have early discharge, by providing intra-venous antibiotics either at home or in an outpatient setting. This work reflected a change in service delivery in line with the Royal College of Paediatric and Child Health guidance, right care, right time, right place (2015), supporting care closer to home.
- The trust was working with clinical commissioners to ensure patients had access to respite care in a place which best met their needs.

Access and flow

- Patients were admitted to the medical wards via the emergency department or the acute assessment unit.
- There was an escalation and de-escalation plan in place to manage bed capacity and the flow of patients. There was a senior member of staff appointed as bed manager each day to identify bed capacity and facilitate staff movement across the wards to promote access and flow.
- Medical day care had capacity to care for 30 patients a day.
- M2 were piloting a discharge planning pathway to facilitate co-ordination of timely discharges.
- There had been issues with patients having long waiting times for telemetry service. Appointments had been cancelled at short notice due to the lack of bed capacity on the medical wards. We were told by management that two beds were now allocated for the use of telemetry only, which would avoid cancellations and reduce the waiting times for the service.
- Medical staff were allocated to review medical outliers. Beds on an adjacent ward to M2 were used for medical outliers to provide some consistency in care and management.
- 2.6% of patients moved wards two or more times during their hospital stay. There was a policy not to move patients at night, which was adhered to.

Meeting people's individual needs

- The wards had access to moving and handling equipment, such as hoists and an electric bath. There was also sensory equipment available to facilitate the care of patients with complex physical needs.
- The play specialists provided play plans for patients with complex needs to enable learning and interaction during their hospital stay.
- M3, which delivered cancer care, had a music therapist to provide therapeutic sessions. The purpose of this was to reduce stress and anxiety and improve patients' well-being.

Medical care

- We were told that patients with long term conditions who were likely to have frequent attendances to hospital had sick day plans. However, we did not see any examples of these.
- Patients with long term conditions were encouraged to continue to be independent in their care where possible. For example, patients with diabetes would continue to self-administer medication. Nursing staff would support the safe storage of medicines.
- Staff had access to a telephone translation service to meet the needs of families from different cultural and ethnic backgrounds, whose first language was not English.
- There was a lack of facilities to meet the needs of adolescents. A youth room was available within the hospital for older patients to enjoy television, games and entertainment that was age appropriate. We were told the new building would better meet the needs of adolescents.

Learning from complaints and concerns

- Between April 2015 and March 2016 the MEDicine division received 15 complaints. During this period the average time to deal with complaints was 29 days. The trust target to respond to complaints was 25 days.
- Themes of complaints were communication issues and the lack of functioning televisions in the wards.
- We saw examples of responding to feedback. 'You said - we did' responses were displayed on the wards.
- We saw patient information leaflets about making a complaint on display in the wards.

Are medical care services well-led?

Good

We rated well led as good because:

- The trust strategy encouraged the involvement of young people in development of the service.
- Risks were mitigated with action plans review dates in place. Actions and initiatives were in place to promote safe care.
- Leadership of the service was visible and approachable to staff.
- There was a culture of child centre care and decision making.

Vision and strategy for this service

- The service was included in the trust wide strategy rather than a local strategy for the directorate. The division developed strategies which reflected demand, capacity and areas requiring intervention. Recent strategies had included the care closer to home development, redesign of the neurodisability service and the business plan to increase general paediatric cover.
- The vision of the trust was 'keeping children, young people and families at the heart of what we do'.
- Staff we spoke to were aware of the trust vision and values of child-centred care.

Governance, risk management and quality measurement

- There were eleven risks on the divisional risk register as of April 2016. The risks were consistentwith those identified at inspection. Three of those risks were specific to the medical wards and medical day care: safer sharps, bed capacity on M1 and lack of telemetry beds. Actions and review dates were in place to mitigate the risks.
- Nursing and medical staffing were identified as a corporate risk for the service. On-going recruitment was reportedly taking place to overcome nursing shortages.
- Governance issues were discussed at monthly divisional quality groups. There was an agenda, which contained standing items such as risks, complaints and incidents.
- Ward M1 were part of the Royal College of Paediatrics and Child Health SAFE (situation awareness for everyone) project. They had introduced safety huddles which were regular meetings on the ward during shifts to identify an risks or issues to escalate to senior staff. Also a programme of regular safety audits, for example PEWS and ID wrist bands, had been implemented.
- A SAFE newsletter was issued to staff monthly. This shared audit outcomes, meetings and lessons learnt to all staff across the division.

- The wards had bi-monthly team meetings where they shared learning from incidents. Wards had staff communication books to share information, for example, for staff to catch up with issues and changes following periods of leave.

Leadership of service

- Staff in the division felt well supported by their ward sisters and matron; they were visible and approachable. Staff felt the executive teams were also visible.
- Medical staff felt supported by the medical leadership in the division. They told us they were provided with good opportunities for learning and professional development.
- Each ward had a band 7 nurse to provide day to day management and leadership. We were told that this role was part supernumerary, however due to staffing pressures this was not always achieved.
- Staff on medical day care had received a trust award for team work.

Culture within the service

- We observed child centred care and decision making. Staff we spoke with were focussed on providing care to ensure children had good outcomes.
- Staff told us they felt supported by their colleagues and management and felt valued in the organisation. They said they were happy to raise concerns and report incidents.
- Allied health professionals told us they were proud of the multi-disciplinary team working across the division.

Staff and public engagement

- Staff told us they had opportunities to contribute to the planning of the new building. Staff were positive about the move and had adopted a change in working by functioning across the medical wards. Staff did this to develop confidence in working with older or younger children to facilitate new working practices in the new building.
- We saw evidence that the service was active in seeking feedback from patients and relatives in a format appropriate to the service. We saw evidence of positive feedback which was displayed for staff and patients to see.
- Feedback was from patients was gathered in a child friendly format, for example, tops and pants. This was an activity for children to complete, they chose a paper cut out of either pants or a top to provide comments, or just to colour them in. Pants signified negative feedback and tops were for positive feedback.
- Young people were encouraged to engage with the trust. There was a youth forum, and there were opportunities for young people to be involved in recruitment of management and executive staff in the division.

Innovation, improvement and sustainability

- The scope of the new building was to provide a sustainable service and there were initiatives to support the drive for 'care closer to home'.

Surgery

Safe | Good

Information about the service

A comprehensive inspection was undertaken in May 2014. We rated effective, caring, responsive and well-led as good. We rated safe as requires improvement. Therefore, at this inspection we re-inspected safe.

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, orthopaedics, spinal surgery, plastic surgery and burns.

During our inspection we visited wards S1,S2,S3,Burns unit, the theatre assessment unit and an operating theatre.

Ward S1 is a surgical ward with 23 beds, made up of three bays with six beds and five side rooms. The side rooms were mostly used for children with infection, small babies or children needing extra protection. There is a play room for children with toys and a play specialist to keep them entertained.

Ward S2, is a dedicated neurosciences ward where children with conditions affecting the brain and nervous system were nursed. The ward includes two side rooms and six beds on the main ward.

Ward S3 accommodated emergency trauma, orthopaedic and plastic surgery. There are 20 beds comprising of four bays and three side rooms. The burns unit had four side rooms.

We spoke with eleven children and eight sets of parents. We observed care children received and attended handover sessions. We had group and individual discussions with nurses, doctors, allied professionals and managers. We looked at six patient records and read minutes of meetings.

At our last inspection in May 2014, we found the system for dissemination of information to staff on the actions following incidents was not robust therefore not all staff were informed of the required improvements. We also found, a paediatric early warning score, introduced to help detect deterioration in children and young people, was not being consistently used and there was a lack of understanding among staff as to when it should be used. We also found that previously, it was not possible to gain assurance on the levels of staff attendance at mandatory training due to the training database not being accurate.

Surgery

Summary of findings

- Staff reported incidents and took action as a result to improve safety of the children and the young people.
- The paediatric early warning system score (PEWS) is a severity of illness score to predict urgent medical need in hospitalised children on the wards. We observed staff using PEWS on the wards. Monthly audits were carried out on the PEWS records. The last audit showed that there was 69% to 88.8%, compliance with completing the information which demonstrated good progress.
- Ward staff understood and were able to verbalise the process for protecting vulnerable children and told us that they had received training in safeguarding.
- Staff adhered to infection control policy by using personal protective equipment (PPE) when delivering personal care.
- Assessments of risks were carried out and risk management plans were developed to manage and minimise the risks.
- Action had been taken to ensure sufficient numbers of medical and allied professionals were deployed to meet the needs of the children and young people.
- We saw audits and improvement plans in use to ensure safety of the children.

However:

- Staff did not fully understand the regulatory responsibility involved with Duty of Candour.
- The trust safeguarding team members visited the wards when referrals were made. They maintained their own records when they spoke with parents and /or the child and staff members but the notes were not made available to ward staff. The records made by the safeguarding team members on the medical notes did not give a clear audit trail of the actions to be taken or that had been taken.
- The surgical wards were busy and the ward areas looked cluttered with equipment due to the lack of storage space on the wards.

Are surgery services safe?

We rated safe as good because:

- Staff reported incidents and took action as a result to improve safety of the children and the young people. At the beginning of each shift, as part of handover, all staff were informed of the outcome of incidents reported and the actions to be taken thereby all staff on duty were made aware of the actions. Patients were found to receive 93% to 100% harm free care within the surgical wards.
- The paediatric early warning system score (PEWS) is a severity of illness score to predict urgent medical need in hospitalised children on the wards. Results of PEWS plays an integral part in detecting deteriorating children and helps to seek attention promptly. We observed staff using PEWS on the wards.
- Monthly audits were carried out on the PEWS records. The last audit showed that there was 69% to 88.8%, compliance with completing the information which demonstrated good progress.
- Ward staff understood and were able to verbalise the process for protecting vulnerable children and told us that they had received training in safeguarding. To ensure safety of the children and young people the wards had restricted access so visitors needed to get permission to enter each ward.
- Staff adhered to infection control policy by using personal protective equipment (PPE) when delivering personal care.
- Assessments of risks were carried out and risk management plans were developed to manage and minimise the risks.
- Action had been taken to ensure sufficient numbers of medical and allied professionals were deployed to meet the needs of the children and young people.
- We saw audits and improvement plans in use to ensure safety of the children.

However:

- Staff did not fully understand the regulatory responsibility involved with Duty of Candour. They said it was about acknowledging when mistakes were made, being transparent and learning from mistakes. Senior staff were unable to describe the process including offering written notification to the parents.
- The trust safeguarding team members visited the wards when referrals were made. They maintained their own records when they spoke with parents and /or the child and staff members but the notes were not made available to ward staff. The records made by the safeguarding team members on the medical notes did not give a clear audit trail of the actions to be taken or that had been taken.
- The surgical wards were busy and the ward areas looked cluttered with equipment due to the lack of storage space on the wards.
- The surgical division compliance with maintenance of equipment was 88.8% therefore not fully compliant.

Incidents

- Dissemination of learning from incidents was through staff meetings, daily safety huddles and newsletters. We spoke with the ward managers, matron and ward staff who informed us that they followed the trust policy when reporting incidents. Ward staff said incident reporting was through Band 7 nurses on duty. They said that the system for reporting incidents was paper based and they also needed to email their managers with the information to keep them up to date as the present system was not reliable. The trust planned to introduce an electronic incident reporting system.
- We looked at the time line for reporting incidents between May 2015 and April 2016. The trust records showed that 644 incidents were reported under the core service surgery, none of which resulted in severe harm or death. However 46 incidents (7.1%) resulted in low harm.
- The record revealed an average of 54 incidents was reported each month within the time span. We noted a higher number of 75 incidents were reported in May 2015 and a lower number of 39 were reported in March 2016. It was reported that the lower number reported in March 2016 could reflect a delay in reporting incidents and this figure may increase over time. This was due to the present system used for reporting incidents. The managers assured us that they were aware of all the incidents on their wards and gave us examples where they had taken prompt action to maintain safety.
- We identified instances of learning from incidents, for example evidence of changes to the restraints policy and review of the standard operating policy was being carried out within the core service division.
- The most commonly reported incident category was medication incidents (139 or 22%). The second most commonly reported category was documentation (95 or15%).
- The present incident reporting system showed that 64% of all incidents were reported within 30 days of the date of incident. 3% were reported over 60 days after the incident. Staff told us these delays were due to the paper based system in use.
- Serious Incidents analysis between 1st April 2015 and 31st March 2016 highlighted that there were seven incidents reported which were related to surgery. Two of those were never events and the descriptions of the incidents were both wrong site surgery. The analysis showed that there was no clear theme to the types of incidents reported. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- Following these incidents the surgical team had reviewed their standard operating procedures and had introduced a trust wide Local Safety Standards for Invasive Procedures (LocSSIPs) to ensure standardised checks were used in theatres and other areas where surgical procedures take place.
- The World Health Organization (WHO) published the WHO Surgical Safety Checklist and Implementation Manual in 2008 in order to increase the safety of patients undergoing surgery. As part of the actions following the incidents of wrong site surgery, the WHO checklist time out box used by the trust was amended to include specific instructions for checks to be undertaken by two appropriate members of staff as outlined in the guidance.

- We observed staff following these amendments to their standard procedures during our theatre and ward visits. Staff were fully aware of the learning from the incidents and they ensured everyone was following the procedures correctly.
- Staff did not fully understand the regulatory responsibility involved with Duty of Candour. They said it was about acknowledging when mistakes were made, being transparent and learning from mistakes. Senior staff were unable to describe the process including offering
- Our findings confirmed when serious incidents occurred; parents were made aware of the incidents by staff. The error was explained to them following detection along with a verbal apology and confirmation if any harm to the patient had occurred as a result of the error. Staff had documented that the parents were happy with the explanation and the apology; and had declined to be involved any further. There was no evidence of any written notification to the parents including information that was provided in person and an apology.
- We found the process used by staff when investigating serious events did not fully comply with regulation 20(4) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. It states that written notification must be given to the relevant person following the notification that was given in person, even though enquiries may not yet be complete. The written notification must contain all the information that was provided in person, including an apology, as well as the results of any enquiries that have been made since the notification in person. The outcomes or results of any further enquiries and investigations must also be provided in writing to the relevant person through further written notifications, if they wish to receive them. We raised this with the senior staff who assured us that they were working to be fully compliant with the regulation by training of staff and monitoring.
- We noted from the minutes of the meetings that annual mortality and morbidity (M&M) data was discussed at the directorate governance meetings. Monthly mortality and morbidity case review meetings were held and learning points were discussed. We saw minutes of the case reviews and documented learning points for all staff involved.
- We found that the specialty leads, were tasked with presenting and discussing cases at staff meetings and ensuring staff were clear of the actions to be taken.

Safety thermometer

- The NHS Safety Thermometer has been designed to be used by frontline healthcare professionals to measure a snapshot of harm once a month from pressure ulcers, falls, urinary infection in patients with catheters and treatment for venous thromboembolism (VTE) this is the formation of blood clots in the vein. It is called the NHS safety thermometer because it takes only a minimum set of data to help signal where individuals, teams and organisations might need to focus more detailed measurement, training and improvement.
- Safety thermometer information was displayed on the wards. This meant staff, patients and visitors could see the incidence of harm free care.
- The trust had surveyed patients for the safety thermometer in four services – burns, neurosurgery, surgery and trauma and orthopaedics. This equated to 645 patients over the thirteen month period (an average of 50 patients per month).
- The percentage of patients receiving harm free care ranged from 93% to 100% in the time span. One month they achieved 100% of patients receiving harm free care.

Mandatory training

- Staff on the wards were confident that they were up to date with the essential mandatory training. They told us that there has been a drive for them to achieve 100% compliance with training by the divisional manager.
- Managers on the wards had access to the training records and they showed us that they did not have any red flags on any training topics alerting them of staff non-compliance.
- Minutes of the Surgery & Critical Care Operational Delivery Board Meeting has mandatory training as a standing item and at each meeting they had reported on progress. At the February 2016, they reported that the overall achievement for the division was 87%. The trust expectation was 85%.

Safeguarding

- There were arrangements in place to safeguard children from abuse in line with relevant legislation and local requirements.

- Managers told us that staff understood their responsibilities and adhere to local safeguarding policies and procedures. They told us that safeguarding training was mandatory and that they had all received appropriate levels of training.
- The information supplied by the trust showed that surgery and critical care staff compliance with safeguarding level 3 training was 86%. The two areas were under the same division.
- There was a named nurse and doctor in accordance with requirements. Safeguarding team members visited ward areas, supported staff, gave advice on the referrals and ensured staff were following the trust policy correctly.
- We spoke with ward staff and also with the safeguarding team members. We found some unclear practices. For example, when a member of the safeguarding team visited the ward and spoke with parents and /or the child, they maintained their own records and this was not always made available to other multidisciplinary staff who were caring for the child. The records made by the safeguarding team members on the medical notes did not give a clear audit trail of the actions to be taken or that had been taken.

Cleanliness, infection control and hygiene

- Regular infection prevention and control (IPC) audits were carried out; in February 2016 the following results were published on the wards. The trust's expected compliance target was 85%;

- Ward S1 was 90% compliant on 14/03/2016
- Ward S2 on 23/02/2016 was found to be only 70% compliant. This was due to a lack of maintenance and repairs being carried out making cleaning difficult.
- Ward S3 scored 90% on 18/02/2016
- Burns Unit scored 86% compliant on 02/03/2016
- The gaps were areas found to be dusty and insufficient storage making areas cluttered and therefore difficult to keep clean.
- All C.difficile cases were reported to the CCG between April 2015 and March 2016 and agreed as unavoidable.
- We found the ward areas occupied by children and the clinical areas within the wards were clean and free of offensive odour. Other areas such as the store rooms, the sluice, staff station and relatives waiting areas were also found to be clean.
- Sharps bins we saw were less than one-third full and all bins in use were dated and signed by a member of staff in line with the local policy.
- We were informed by the ward managers that they had sufficient domestic staff support to carry out cleaning schedules and these were audited by their supervisors as well as at the infection control audits. We saw cleaning logs had been used by staff to ensure all areas were cleaned regularly.

- We observed staff adhering to infection control policy and using personal protective equipment (PPE) when delivering personal care. Staff told us they had sufficient supplies of PPE and other disposable consumables for use.
- Antiseptic wash was made available to all visitors and staff. We observed people entering and exiting the wards, decontaminating their hands by using the wash.
- There were side rooms to use as isolation rooms on the wards.

Environment and equipment

- To ensure safety of the children and young adults the wards had restricted access so visitors needed to get permission to enter each ward.
- The surgical wards were busy and the ward areas looked cluttered with equipment. This was due to the lack of storage on the wards.
- Medical equipment was managed within the surgery and critical care division and the board members had acknowledged the need for obtaining new equipment and replacing equipment at the right time. They reported to the capital investment team each month. They had identified that, at present, the demand for equipment severely outweighed the budget and they were in discussion with the capital investment team and the executive directors for a solution.
- We looked at the equipment which was in use on the wards including resuscitation equipment. There were service stickers on the equipment with dates stating that they had been checked and in good order. The trust had carried out a medical equipment service check and the compliance was 88.8%.
- The resuscitation equipment had been checked by staff regularly and records kept confirm this.

- The trust informed us that a health and safety audit was carried out on individual environments including each ward and units each year together with Patient-led assessments of the care environment (PLACE).
- We were informed by staff that equipment used for bariatric patients was supplied by contractors as and when needed. We observed staff making arrangement for a patient's admission and ensuring the bed was going to be delivered on time.

Medicines

- We observed a medicine round on one of the surgical wards, where staff followed the policies on safe administration and management of medicine.
- Our pharmacy inspector visited the wards, spoke with and observed staff handling medication. They reported that the administration, storage and disposal of medicine was in line with the nursing and midwifery council standards for medicine management and also complied with NICE medicines practice guidelines.
- There had been a number of audits carried out to address medication errors and take proactive measures to ensure improvements in the practices within the surgical wards. This included an audit in 2016, on the compliance with the NICE guideline [NG29] Intravenous fluid therapy in children and young people in hospital. The results highlighted that the prescribers needed education and training and that further reviews should be undertaken to address the gaps in practice. An audit of the accuracy of information reaching GPs when patients were discharged identified, that in surgical wards, the number of drugs on discharge to take out (TTO) prescriptions, were six times more than the medication patients were on as in-patients.
- An audit of the use of pre-printed stickers for IV paracetamol prescriptions demonstrated that 20% of in-patients' prescriptions for IV paracetamol were not prescribed using the appropriate pre-printed stickers. The audit suggested a need for awareness amongst ward staff of the existence of the trust IV paracetamol guidelines, dosage tables and pre-printed stickers, and where these can be located. We saw evidence that action had been taken by the trust address the areas identified.

Records

- Patients' medical and nursing notes were securely stored on the wards to maintain patient confidentiality.
- Records were held in electronic and in paper format.
- Nursing staff told us that they have all attended training on information governance.
- Patients' records contained multi-professional documentation which included notes with decision, treatment options, individual care plan, risk assessments, daily progress, reviews and consent to treatment.
- The records were legible, filed in chronological order with dates and signatures.
- The records demonstrated a personalised care and treatment approach. It was noted that there was a designated consultant review of patients and treatment plans for patients were written following ward rounds by medical staff.
- There was written evidence in the records of regular communication with relatives and patient's representatives by professionals.

Assessing and responding to patient risk

- Assessments of risks were carried out and risk management plans were developed in line with national guidance. We spoke with parents and staff on the wards and looked at care records to confirm that ongoing risks together with the new risks were identified and plans were put in place to manage and minimise the risks.
- The records showed that regular reviews had a multidisciplinary approach to risks and they were managed in a positive way.
- The multidisciplinary team identified and responded to the changing health of children, medical emergencies and children who exhibited behaviour that was challenging. Staff shared with us some examples where they had managed the situations safely.
- Staff on the wards were aware of the hospital wide standardised approach to the detection of the deteriorating patient and the escalation response process.
- The paediatric early warning system score (PEWS) is a severity of illness score to predict urgent medical need in hospitalised children on the wards. Results of PEWS plays an integral part in detecting deteriorating children and helps to seek attention promptly. We observed PEWS being used on the wards. Staff told us if in doubt they contacted critical care staff to ask for help.
- The WHO check lists were in use. A revised pre-operative WHO checklist was used by staff to ensure necessary checks were carried out prior to the child/young person

being transferred to theatre. We observed the completed check lists on the patients' notes as well as seeing this in practice when we followed a child from admissions to theatre

- A situation awareness audit was carried out in March 2016 on nine areas using PEWS. It measured the number of episodes where patients had deteriorated on the wards. The measurement within the surgical wards showed, there had been 42 episodes where PEWS score had been used to identify and support deteriorating patients. The analysis of the episodes highlighted that on 15 occurrences where PEWS was five or above, once it was nine or above and on 26 episodes the situation was categorised as 'Worrying Child'.
- Monthly audits were carried out on the PEWS records and reported on each ward. The audit showed that ward S1 was 77%, ward S2 was 88.8%, ward S3 was 69.2% and the Burns unit was 80% compliance with completing the information. The main shortfall identified was staff not recording patients' observations as frequently as stated on the monitoring charts. Staff on the wards were aware of the results and told us that they were checking the records when they came on duty.
- Staff ensured they complied with the five steps to safer surgery and World Health Organisation (WHO) surgical checklist when children went through surgical procedures. With the permission of the parents and a child, we tracked the child having surgery from admission until they went into theatre. We observed staff checking pre-operative assessment which had been completed, following the five steps to safer surgery and World Health Organisation (WHO) surgical checklist to ensure safety.

Nursing staffing

- Staffing levels and skill mix were planned and reviewed to ensure patients receive safe care and treatment at all times. The trust had used an evaluative copy of the Paediatric Acute Nursing Dependency Assessment Tool (PANDA) developed at Great Ormond Street since October 2014. A full version was due to be implemented in Autumn 2016.
- We viewed staffing levels for four months considering actual staffing and planned staffing. The actual staffing levels between November 2015 and February 2016 within the surgical wards were 88% – 96% compare to the planned staffing levels.
- We were informed by the managers this was achieved by staff working flexibly and using bank and agency staff. Staff informed us that they worked as a team and worked over or worked an extra shift to make sure sufficient staff were on duty to deliver care.
- We observed two handover sessions. Staff were given the daily safety briefing by the manager and a comprehensive handover was given to staff who were to take over the shift. We noted the manager/person in charge for the shift made sure when allocating staff considered continuity for patients.

Surgical Medical staffing

- The trust provided the details regarding medical cover for surgical services at the Sheffield Children's' Hospital. The information includes all specialities and the 24hour cover provision for the services. These were some examples:
- A resident anaesthetist was available between Mondays to Friday 8:00 to 18:00 hrs and a consultant anaesthetist provided on-call cover between 18:00 and 8:00 hrs and the weekends.
- There was registrar cover over 24 hours providing cover for theatres, resuscitation and pain control.
- ENT, Plastic Surgery, Burns and Paediatric Dentistry had 24 hours cover shared with a neighbouring trust.
- Paediatric Surgery consultant cover was in place for at all times. This was provided by Sheffield Children's Hospital consultants on a split week basis. A first and second on call senior house officer (SHO) shift was in operation during the day and one SHO shift at night from 20:30hrs until 08:00hrs. One Specialist Registrar was on call during the day and a night Specialist Registrar was resident from 17:00 until 08:00hrs.
- Ophthalmology - On call cover was provided by the General Ophthalmic Consultant on call at Sheffield Teaching Hospitals. They were on call for one week at a time and there were 13 staff who share this.
- Medical staffing levels compared to England average was seen as favourable. The data from the trust showed that there were 94 WTE medical staff in post within the surgical division and of which 48% consultants, 1% Middle Career SHO or a higher grade within their chosen specialty, 50% Specialist Registrars and 2% Junior doctors Foundation Year (1-2); this is compared to the

England average of 41% consultants, 11% Middle Career SHO or a higher grade within their chosen specialty, 37% Specialist Registrars and 12% Junior doctors Foundation Year (1-2).

- There was an informal method of handover between consultants, usually email or telephone call. This was due to specialist consultants being based at different sites within Sheffield Children's and Sheffield teaching Hospitals.
- We were informed that the trainee doctors had a written handover of all inpatients under the service's care, which was updated once or twice per day. The trainee doctors said they also used the electronic system to update information. Trainees worked a one in thirteen 24-hour on call shift, which covered the trust and some services at a neighbouring trust under the supervision of the Consultants on call.
- We were informed that all patients were seen by a medical team each day; this was sometimes carried out by Specialist registrars rather than the consultants.

Major incident awareness and training

- During induction staff were informed about the policies and procedures on how to respond to emergencies and major incidents. They said when changes were made to any aspects of the policy they were informed in their daily handover so that they were up to date.

Critical care

Well-led

Good

Information about the service

A comprehensive inspection was undertaken in May 2014. We rated safe, effective, caring and responsive and as good. We rated well-led as requires improvement. Therefore, at this inspection we re-inspected well-led.

Paediatric Critical Care Unit (PCCU) which comprises Intensive Care Unit (ICU), High Dependency Unit (HDU) and Neonatal Surgical Unit (NSU). Patients range from 0-18 years and on occasions from a few hours depending on their needs.

The Sheffield Children's PCCU is a regional lead center and receives patients from across South Yorkshire and nationally.

On the PCCU there are nine ICU, eight HDU beds and 11 cots in the NSU.

Between May 2015 and March 2016 admissions to PCCU under each units were; Intensive Care Unit 497, High Dependency Unit 435 and Neonatal Surgical Unit 225.

During our inspection in 2014, we found out that the medical leadership was not effective in driving the vision and the strategy of the unit due to vacancies and workload pressures. At that time, many staff we spoke with was unaware who the members of trust board were and there were limited executive walk rounds to identify quality issues and meet front line staff.

During this inspection, we spoke with eleven staff, three managers, three children and five family members. We looked at three medical and nursing records, read minutes of meetings, attended three meetings and two handovers.

Summary of findings

- There had been improvements and the areas identified at the previous inspection had been addressed.
- There was appropriate leadership in place. A designated lead clinician and lead for critical care in accordance with national guidance.
- The division had produced a vision statement and set of objectives which focused on quality and safety.
- There was an effective governance framework in place.
- Staff felt respected and valued. There was a strong sense of team work and patient focus.

Critical care

We rated the service as good for well-led because:

- There had been improvements and the areas identified at the previous inspection had been addressed.
- There was appropriate leadership in place. A designated lead clinician and lead for critical care in accordance with national guidance.
- The division had produced a vision statement and set of objectives which focused on quality and safety.
- There was an effective governance framework in place.
- Staff felt respected and valued. There was a strong sense of team work and patient focus.

Vision and strategy for this service

- Since our last inspection, the division had produced a vision statement and set of objectives which focused on quality and safety. Work was in progress to produce a divisional strategy which would align with the trust objectives.
- Key stakeholders in the division were involved in the development of the divisional vision and strategy. Two workshops had been held with staff.
- Staff were aware of the development of the strategy and managers within each team were actively involved in developing action plans to address the objectives.

Governance, risk management and quality measurement

- There was an effective governance framework in place. This was confirmed by the review of minutes of meetings and what staff told us. However, the timely reporting of incidents continued to be an issue; the trust planned to introduce electronic incident reporting system.
- Staff we spoke with were clear about their roles, responsibilities and what they were accountable for.
- There was a divisional risk register in place which included identified risks. There was clear ownership of the identified risks, mitigation in place and review dates.
- Senior staff worked with partners to audit and manage the risks. They met with the clinical commissioning group and were part of the critical care network.
- An assurance system and service performance measures were in place. These included some patient experience and safety indicators. These were reported and monitored at divisional board meetings.
- The service self-assessed against in the Guidelines for the Provision of Intensive Care Services (GPICS) (2015) to monitor compliance. Arrangements were mostly in line with the GPICS 2015 recommendations.
- Monthly mortality and morbidity case reviews took place where cases were discussed and any learning points were recorded. Minutes of the reviews were cascaded to staff who were not present at the meetings.

Leadership of service

- There was a designated lead clinician and lead for critical care in accordance with national guidance. The lead clinician was a consultant paediatrician and an intensivist. The post holder had changed since our previous inspection.
- At our previous inspection, there were concerns about medical leadership on the unit. At this inspection, staff informed us that the trust leaders and the senior divisional staff were more visible and took more interest in what was happening on the 'shop floor.' They were also accessible to staff if they wanted to discuss any issues. The unit manager and the lead consultant had an 'open door' policy.
- The unit leaders had the skills, knowledge and experience needed. They demonstrated they understood the challenges of delivering high quality care.

Culture within the service

- Staff felt respected and valued. We attended a weekly meeting where a senior manager consulted with unit staff about the immediate priorities, ongoing issues, staffing and training needs. We observed open and honest discussions amongst all members.
- Staff reported a strong sense of team work and patient focus. Members of the multidisciplinary team told us that they worked collaboratively, resolved any conflict constructively and shared responsibility to deliver good quality care to the children.

- Staff were flexible in their activities/tasks. We observed staff organising their daily activities centred on the needs and preferences of the children and young people.
- Senior staff worked with staff and offered support to address any behaviour or performance issues before taking formal actions. This was confirmed by staff who spoke with us.
- The culture encouraged openness. Staff understood the need for being open and honest and admitting when errors happened to the children and families. However, there was a lack of written communication with the relevant person/ family members when errors had happened in accordance with the duty of candour. We shared this with the senior members during the inspection.

Public engagement

- The trust completed the national PICCA Net parental survey twice yearly in February and July.
- Parent comment cards were available on the units to capture parents' views. Consultants and senior staff had identified the present methods of capturing feedback were not always effective and planned to capture the feedback from patients/parents by using different methods.
- Children and their parents/representatives were actively engaged and involved in the decisions. We observed multidisciplinary staff engagement with families during ward rounds.
- Family members felt listened to by the management. Relatives and carers made positive comments about the culture on the unit. They said management listened to their comments and acted on them.

Staff engagement

- Staff felt actively engaged in discussions about the day to day activities in the unit. They were positive about changes to the local management structure.
- Staff reported improved collaborative working between medical and allied professionals and regular meetings were held when multidisciplinary views were reflected upon to shape the future delivery of the service.
- The lead consultant intensivist and the lead nurse were proactive in involving the multi-disciplinary staff groups and allowing them to take ownership, prioritise issues and lead projects.
- Both leaders and staff understood the value of staff raising concerns which were constructive and took appropriate action to improve the service.

Innovation, improvement and sustainability

- Band specific away day's had been introduced on the unit to improve team development, encourage working together and learning from each other.
- A newly formed staff clinic was run by band 7 nurses for other nursing and health care assistants to discuss things they wanted to and were worried about.
- A six month pilot of a 'family care nurse' role was in place and the validity of the role was being audited.
- An electronic application for drug prescription was being developed to minimise human errors and promote patient safety.

Neonatal services

Effective | Requires improvement

Information about the service

A comprehensive inspection was undertaken in May 2014. We rated safe, caring, responsive and well-led as good. We were not rating effective in neonatal services at that time. Therefore, at this inspection we inspected effective.

Neonatal Surgical Unit (NSU) has eleven beds for babies that require major surgery shortly after or within a few weeks of birth.

NSU is situated on C Floor of the Green Wing next to the Intensive Care Unit (ICU) and the High Dependency Unit (HDU). The unit is divided into three bays of three to four electrically heated cots and one isolation cubicle.

Parents are allowed to bring one or two small soft toys to put in the cot with the baby. There is provision for parents to stay within the hospital.

Between April 2015 to January 2016, thirteen 24 to 28 weeks, one hundred and nine 28 to 32 weeks and thirteen full term babies were admitted to NSU.

We spoke with eight staff, one manager, three family members and observed all nine babies who were on the unit when staff or parents were in attendance. We looked at three medical and nursing records, read minutes of meetings, observed a ward round and a handover.

Summary of findings

- To monitor and improve patient outcome Badger net was in use. However, work was in progress to analyse and present the information in a user friendly way so that staff were able to use the results and make improvements, if required.
- The NSU did not have designated regular MDT meetings as these were conducted on a patient by patient basis by the individual consultants. However, monthly neonatal surgical team meetings took place to discuss the unit and the delivery of service.
- Community team worked with the unit to provide outreach work. However there was no outreach team provided by the trust.

However, we also found:

- Current evidence-based guidance and standards were used by staff.
- Practice developmental care days were held to familiarise staff with current best practices.
- Babies nutritional and hydration needs and pain were assessed.
- Local quality improvement projects to promote better outcomes were in place; for example a parent comments board.
- Staff understood the relevant consent and decision making requirements of legislation and guidance, including the Mental Capacity Act 2005 and the Children Acts 1989 and 2004.

Neonatal services

Are neonatal services effective?

Requires improvement

We rated the service as requires improvement for effective because:

- To monitor and improve patient outcome Badger net was in use. However, work was in progress to analyse and present the information in a user friendly way so that staff were able to use the results and make improvements, if required.
- The NSU did not have designated regular MDT meetings as these were conducted on a patient by patient basis by the individual consultants. However, monthly neonatal surgical team meetings took place to discuss the unit and the delivery of service.
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- Staff understood the relevant consent and decision making requirements of legislation and guidance, including the Mental Capacity Act 2005 and the Children Acts 1989 and 2004.

Evidence-based care and treatment

- Staff used current evidence-based guidance, standards and best practice policies in line with necessary legislation. These included NICE guidelines such as Specialist neonatal care quality standard (QS4), Antibiotics for neonatal infection (QS75), Neonatal jaundice (QS57) and Antibiotics for early-onset neonatal infection (CG149).
- The senior nurse informed us that to ensure compliance with the above they had ongoing audits and improvement plans. They shared some of the improvements they were working on; such as renewal of baby cots, determining ideal temperature, light and noise in the unit.
- Practice developmental care days had been held by multidisciplinary staff to familiarise themselves with current best practices. Staff told us that these were valuable and gave them educational value and support.
- Part of evidence-based practice, community support nurses were involved in supporting parents, carers and young parents with the care of babies with Down's syndrome, congenital abnormalities and complex needs. When babies were admitted to the unit, they kept in touch to provide a seamless service on discharge.
- British Association of Perinatal Medicine standards and policies were reviewed and were in the process of implementation. A checklist was used by nurses when reviews were carried out.

Nutrition and hydration

- Babies nutrition and hydration needs were assessed and plans were in place to meet their needs.
- On admission, surgical reviews included the nutritionist who helped plan the feeding regime and ensured the milk kitchen had the necessary guidance. This was discussed at every ward round which also included baby weight.
- Mothers who wish to breast feed their babies were provided with appropriate facilities. There was provision for mothers to express milk, so that babies were able to have milk when mothers were away.
- Sheffield Children's Neonatal unit is part of the Yorkshire and Humber Neonatal Operational

Delivery Networks. At their last meeting they had agreed on a Neonatal Parenteral Nutrition toolkit to ensure consistent approach to Parenteral feeding within the area. This work was in progress.

- Staff told us that they had the support of the nutritionist and they met regularly when reviewing babies, they gave their input and provided on call cover.
- We observed staff helping babies with feeding and taking their time and monitoring their input and weight gain by maintaining records.

Pain relief

- Appropriate tools were in use to detect pain and administer pain relief to ensure babies were comfortable.
- Staff told us that babies cried to show their dissatisfaction, discomfort or hunger. Therefore to help them find out if a baby was in pain they used a behavioural pain assessment tool referred as the FLACC pain scale.
- FLACC is an acronym for: FACE LEGS ACTIVITY CRY CONSOLABILITY. FLACC includes the categories of crying, facial expression, position of trunk, leg position, motoric restlessness, and consolability to be associated with pain. Each category is scored on a 0 - 2 scale and a total score of 0 - 10. We saw staff using FLACC scores on the charts of babies.
- There was a trust wide pain assessment team that visited the unit and supported the staff.
- Parents were happy with the way babies were kept comfortable on the unit.

Patient outcomes

- To monitor and improve patient outcome Badger net was in use. Information about the outcomes of children's care and treatment was routinely collected and monitored by the use of Badger Net. This is a national neonatal audit programme. Data entry guideline for Badger net with audit questions and national neonatal dataset was used by the unit to collect information on the care delivered on the unit. However, work was in progress to analyse and present the information in a user friendly way so that staff were able to appreciate the results and make improvements if required.
- Local quality improvement projects to promote better outcomes had taken place; for example a parent satisfaction board has been developed. This is called 'Burps and Giggles' and parents were encouraged to write their comments and share with everyone; if good it was indicated as a 'giggle' and if bad or needing improvement as a 'burp'. We saw some useful comments which were helpful to other parents and staff.
- Staff attended Yorkshire and Humber Neonatal Operational Delivery Network and took part in service delivery monitoring and peer review and support.

Competent staff

- Appropriately qualified and knowledgeable staff were employed to work on the unit.
- All new staff attended a trust wide induction programme before commencing work.
- The trust informed us that there were no specific neonatal training modules for neonatal nurses at SCH. They informed us that all requirements were covered through mandatory training and the QIS course which matched knowledge and skills through clinical competency for qualified nurses in speciality (QIS) such as Neonatal care.
- To maintain staff competence, staff learning needs were identified and training had been offered. We looked into staff attendance of training. 27 out of 32 staff had attended training which was 84.4% and the trust target was 85%.
- We also looked at some specific training uptake by staff to assess if staff were competent to perform their duties; for example out of 32 staff,

- 31 staff had attended Level 3 - Safeguarding training and Level 3 - Resuscitation training.
- All staff had attended Level 2 - Risk Management training
- However only six (19%) staff had attended Moving and Handling - Level 4 training.

- Staff told us that they were encouraged and given opportunities to develop. We saw staff spending part of their working week collecting data for audits. They said it gave them the insight into why accurate data was necessary and therefore they were able to influence other staff.

Neonatal services

- **Senior staff told us that there were arrangements for supporting and managing staff, but due to vacancies they were not always able to have regular clinical supervision and one to one conversations with their staff. However, staff said the manager was approachable, although the demands on their working day did not give them time to take up opportunities and develop their roles. They were optimistic about the current drive to recruit staff and being offered internal rotation to other units would help the situation.**
- **The unit manager told us that they had recently taken on this role and was getting to know staff and supporting them. They said senior staff were attending training on performance development reviews (PDR) and therefore once training was complete staff would be allocated to senior staff and they hoped to achieve 100% PDR. The present rate supplied by the trust showed 73%.**
- **Staff on the unit had access to specialist lead professionals to help them deliver appropriate care. The lead professionals had undertaken appropriate training for their roles and were able to support other staff. These roles included breastfeeding, developmental needs and care of the baby, emotional and psychological support to families, safeguarding children, palliative care bereavement support and education and training.**

Multidisciplinary working

- **Staff had access to a paediatric / neonatal pharmacy adviser at all times. They had access to a physiotherapist and a nutritionist. The microbiologist was available for advice.**
- **Babies on the unit were under different specialists; therefore daily ward rounds to see a specific baby took place where surgeons, nurses and allies professionals attended. We observed when each specialist team visited the unit to see an individual baby, staff on the unit were aware who had overall responsibility for each baby's care and discussed issues.**
- **We were informed by the trust that the NSU did not have a designated regular MDT; these were conducted on a patient by patient basis.**
- **However, monthly neonatal surgical team meetings took place and we saw the minutes of the meeting from February 2016.**
- **Staff told us they had standard operating polies for transfers and discharges of babies and they were in use.**
- **Community team worked with the unit to provide outreach work. However, there was no neonatal outreach team provided by the trust as these babies were referred to local neonatal outreach or the paediatric outreach services at the trust.**

Seven-day services

- **There was out of hours access to support and diagnostic services, such as occupational therapy, physiotherapy and diagnostic imaging.**
- **A transfer service for babies to and from other units was provided by Embrace. Embrace is a round-the-clock transport service for critically ill infants and children in Yorkshire and the Humber who require care in another hospital in the region or further afield.**
- **Monday to Friday at 1pm a team huddle of neonatal staff discuss babies with poor PEWS 'worrying child'. On Fridays there was a formal handover between the surgical and medical team ready for the weekend.**
- **A consultant neonatologist had been appointed. However, at the weekend unless requested, babies were seen by registrars and senior doctors.**

Access to information

- **We saw that information was accessible to staff in a timely manner, so that they were able to deliver effective care and treatment. Multidisciplinary staff had access to care plans, risk assessments, case notes and test results on the unit to help them make decisions.**
- **Records were available in paper and electronic format.**
- **Staff told us that as babies moved between teams and services as their needs/conditions changed, all the necessary information on babies were transferred appropriately to the correct departments/units, in a timely way and in line with relevant protocols including compliance with data protection.**

- **We were informed most babies go to other wards before being discharged home and therefore they did not get involved in the discharge process. However, staff said GPs did contact the unit if they wanted an update or wanted clarification about information they had received on the discharge letter.**
- **GPs had direct access to a consultant and specialist registrars for advice on the phone.**
- **NSU used Personal Child Records (Red Book) to record surgical episode but the books were held by the parents. NSU got the Red Books from Child Health and distributed to those patients came with books from the local maternity/neonatal units.**

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- **Staff understood the relevant consent and decision making requirements of legislation and guidance, including the Mental Capacity Act 2005 and the Children Acts 1989 and 2004.**
- **They were able to tell us the difference between lawful and unlawful restraint practices.**
- **Arrangements were in place if parents were thought not be capable of providing consent and understand procedures. Staff gave us examples where a social worker was involved to help the family member and another instance when they had contacted the family GP for assistance. They told us that they followed the trust policy and consulted the lead nurse if they needed help.**

Transitional services

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

Information about the service

'Transition' describes the process of planning, preparing and moving a young person from children's services to adult services. The majority of young people move to adult services between the ages of 16-18 years; however, this does vary depending on the young person's specific health and developmental needs.

Transition services were provided as part of the overall services at the trust for children and young people. They were not managed as a distinct clinical area (such as medicine or surgery). Transition services for young people were managed by individual specialities within the hospital. The trust did have a designated transition team in place to provide general support and guidance for specialties in dealing with transitional care. This focused on patients who attended the acute trust and did not incorporate oversight or leadership for community based patients or patients with mental health needs.

During our last inspection in 2014, transition services received an overall rating of requires improvement. However, individual core services were not rated. We found that some specialities had established transitional arrangements in place, but that there was no coordinated trust wide approach to transition care.

During this inspection, we visited ward and clinic areas where patients in transition attended and spoke with staff involved in transitional care, alongside patients, and carers of patients going through the transition process. In total, we spoke with 18 staff, reviewed 18 sets of acute records, observed a transition clinic and spoke with 7 young people.

Summary of findings

We rated transition care as requires improvement, because:

- Although some work had taken place since the last inspection to establish transition practices, there had been limited progress and many of the issues identified in our 2014 inspection remained. The Trust acknowledged this and recognised there was further work required to develop and embed transitional care across the trust.
- There was no overarching vision or strategy for transition services within the trust and governance structures were not yet fully in place. There was no formal audit system in place to monitor and assess the effectiveness of transitional care within the trust. The focus on transition had been limited to the acute trust and did not incorporate the wider community or mental health services.
- There was no centralised record of the number or type of young people transitioning into adult services in the trust's care. The trust did not have a robust process in place to monitor, consider and learn from complaints and incidents that related to transition.
- We found inconsistent practice in how transition was recorded in medical records. Many records we reviewed did not contain transition plans or clear indications of how transition was to be managed. There was limited evidence to show that young

Transitional services

people transitioning into adult services were supported in administering their own medications whilst in hospital. Few staff had any training or understanding around the Mental Capacity Act.

- There was an inconsistent approach to multidisciplinary team (MDT) working and the availability of support from youth workers and psychologists. There was no provision for multi-specialty clinics, meaning patients had to attend hospital on multiple occasions to see different specialties. There was no formalised training in place for staff acting as leads for transitional care within services.
- There were limited examples of staff and public engagement in driving the transition agenda within the trust. There was no single clear, structured education programme or guidance for patients or carers around the transition planning process. There was inconsistent practice around how the trust explained and recorded patient and carer understanding about the transition process.

However:

- There was a designated Transition team, and lead clinical and nursing staff for young people transitioning into adult services in the acute trust. We saw that the new long term conditions transition policy incorporated National Institute of Health and Care (NICE) guidance and the 'Ready, Steady, Go' documentation had begun to be rolled out to services to help in transition planning. Specialist transition clinics were available in most clinical specialties.
- The trust had begun to engage with young people via youth forums and the internet to help ensure that they could be involved in transitional care. Individual services held transition registers, which helped them to identify and adapt to the needs of patients within these services.
- We observed staff providing compassionate and person centred care. Patients and their carers told us that staff were caring and met their needs. Patients had access to nurse specialists, and in some cases psychology support, to help them with their emotional needs around transition.

Are transitional services safe?

Requires improvement

We rated this service as requires improvement for safe, because:

- The trust did not have a robust process in place to identify, monitor and share learning from transition related incidents.
- We found inconsistent practice in how transition was recorded in medical records. Many records we reviewed did not contain transition plans or clear indications of how transition was to be managed.
- There was limited evidence to show that patients undergoing transition were supported in administering their own medications whilst in hospital.

However:

- There was a designated transition team, with lead clinical and nursing staff, for young people transitioning into adult services.
- The trust had begun to roll out use of the 'Ready, Steady. Go' programme to ensure that a more consistent approach to record keeping could be made. This is a programme, and supporting documentation, to help patients in transition gain the knowledge and skills to manage their condition.

Incidents

- The trust explained that it did not have an electronic system for recording incidents and therefore the mechanism for identifying and coordinating specific transition related incidents was limited. The trust was in the process of procuring an electronic risk system that would allow specific transition incidents to be recorded. However, no mitigating action was in place until this system was implemented.(TS-23)
- We were told that any transition incidents would need to be identified by directorate managers when they were carrying our monthly considerations of reported incidents. The transition team were not fully assured that all transition incidents would be identified, but said that they would expect managers to flag these incidents with them. Leaders within the transition service were confident that any serious incidents regarding transition would be picked up at the above meetings.

- The trust told us that any incidents that were flagged as 'transition related' were discussed at the trust wide Transition and Young Persons Working Group and at the Cross Trust Transition meeting. At the time of our inspection, the Cross Trust Transition meeting was not minuted for us to confirm this, and no incidents were outlined in the agenda we received from the May 2016 meeting.
- At the time of our inspection, the trust reported no serious incidents or never events where transition care was the main concern. Never events are serious, largely preventable patient safety incidents that should not occur if available preventative measures are implemented. Although each never event type has the potential to cause serious potential harm or death, harm is not required to have occurred for an incident to be categorized as a never event.
- Staff told us that many transition related incidents may not be reported to the trust, but to the local trust where patients transitioned to. At the time of our inspection, there was no arrangement in place to allow such incidents to be identified and shared with the trust.
- Staff had knowledge of duty of candour and spoke about the need to be open and honest with young people transitioning into adult care and their carers. The duty of candour is a regulatory duty that relates to openness and transparency. It requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.

Cleanliness, infection control and hygiene

- Young people in transition clinics or attending wards were seen within clinical areas that fell under the specialty they were attending.
- Wall mounted alcohol gel was available at all entrances and exits to the departments and clinics we visited. We observed staff to be compliant with the bare below the elbow policy and maintaining hand hygiene when interacting with these patients.

Environment and equipment

- There was no specific environment in which transition care was provided. This was provided in general clinic and ward areas.
- We saw that appropriate medical equipment was available in ward areas for young people transitioning into adult care. This included adult resuscitation and medication bags. These had been appropriately checked by staff.

Medicines

- We were told that the process for considering whether young people transitioning into adult care could manage their medications differed between services. For example, in the allergy service patients were provided with training on how to self-administer their epinephrine medication. In rheumatology, we were told that this would form part of the clinic notes in considering whether patients were ready to transition.
- There was no standardised process or documentation to record whether patients were confident to self-administer medication. Reference to confidence with medication was included in the 'Ready, Steady, Go' documentation, but that had not yet been fully rolled out to staff and was not consistently used at the time of our inspection.
- At the time of our inspection, no trust wide audit had taken place into medication use in young people transitioning into adult care to see whether these patients were receiving appropriate support and guidance to enable them to self-medicate.

Records

- The acute trust was mainly using paper-based records. An electronic patient record system had begun to be rolled out, but this was not expected to be completed until the end of Autumn 2016.
- The trust had begun an audit of transition documentation within medical notes in October 2015. This focused on six long-term conditions that formed part of the Trust's CQUIN target. This considered if there was a database on which young people transitioning into adult care were tracked within specialties and whether the transition documentation was filed in the medical notes.
- The results were available in December 2015. This identified that the services held separate databases to track young people transitioning into adult care and there were inconsistencies in how transition documentation was stored. For example, the epilepsy and oncology service were storing transition documentation in the medical records in line with the

trust's expectation. However, in rheumatology and diabetes, transition documentation was stored separately. The audit identified that there was no specified area in the notes where transition documentation should be stored. This had the potential to cause confusion to staff.
- An action plan was put in place to address these needs. At the time of our inspection the trust told us that it had completed this action plan.
- Of the 18 patient records we reviewed for young people transitioning into adult care at the hospital, only five records contained Ready, Steady, Go documentation or a transition plan. Of these, no set of records contained the full Ready, Steady, Go pathway documentation. Some records contained no transition planning documentation, with one record showing the first mention of transition planning in a clinic letter only two weeks prior to a young person being transferred to adult services.
- The trust told us that the 'Ready, Steady, Go' documentation included a 'Hello' element of the documentation. This was a specific document that allowed information to be passed on to the adult service. The trust policy on transition also included guidance on the 'transfer' documentation required when transition was complete.
- The neurodisability and therapy services had adopted the use of patient passports for young people transitioning into adult care with complex needs. This allowed more detailed information on care needs and preferences to be taken with young people when moving between children and adult services to ensure that their needs were fully understood.

Safeguarding

- Safeguarding children and adults training formed part of the trust's mandatory training modules. No specific data was collected for transition staff, with their training being reflected in the figures for the service they worked within.
- The trust told us that any safeguarding concerns raised as part of the transition process were reported to the trust safeguarding team, in line with the safeguarding policy.
- Staff we spoke with were confident in how to raise safeguarding concerns in line with the policy.
- The trust had a safeguarding children policy that had regard to the statutory guidance Working Together to Safeguard Children (2013). However, this statutory guidance was updated in 2015 The trust told us that staff had reviewed the updated guidance in 2015, but did not feel that this involved a significant change in practice. However, following our inspection the Trust confirmed that it would now be updating its policy.

Mandatory training

- The trust explained that staff dealing with transition did not have data recorded against them specifically. Instead, this was recorded against their care group or department where they were based.
- Transition leads told us that they were hoping to develop a mandatory training module for staff on transition. The next available meeting at which this could be discussed was in September 2016, and any progress would depend on the outcome of that meeting.

Assessing and responding to patient risk

- For inpatients, the hospital used the Paediatric Early Warning System (PEWS) to monitor and assess the condition of young people. This allowed staff to use a scoring system to identify increased patient risk and take appropriate action to escalate concerns.

Nursing staffing

- At the time of our inspection, the transition team had resource for a one day per week post as transition lead nurse. Funding had previously been available for two days per week, with two staff sharing this role. However, this had been reduced.
- The staff member no longer in post remained a transition link for their relevant service and had dedicated their own time to continuing to assist with the transition team agenda. This did not form part of their current job role.
- Within services, designated named nurses were highlighted as being responsible for transition care. Staff we spoke to told us that this routinely meant that they were involved in the running of transition clinics and could act as the named contact for young people transitioning into adult care within their service.

Medical staffing

- A clinical lead had been appointed to the transition team. They were resourced to provide 0.25 days per week. This was alongside their substantive post.

Transitional services

- There was no further specific clinical appointments to deal with transition.
- Medical staff were identified as leads within the separate services. Staff we spoke to told us that this routinely meant that they were involved in the running of transition clinics and could act as the named contact for young people transitioning into adult care within their service.

Major incident awareness and training

- The trust had an up to date major incident policy in place to identify the actions that staff should take when a major incident was declared.
- Staff were not expected to respond to major incidents as a transition team. Instead, responsibility and any activities involved in responding to a major incident fell to the clinical specialties.

Are transitional services effective?

Requires improvement

We rated this service as requires improvement for effective, because:

- There was no coordinated audit system in place to monitor and assess the effectiveness of transitional care within the trust.
- There was no formalised training in place for staff acting as leads for transitional care within services.
- There was an inconsistent approach to MDT working and the availability of support from youth workers and psychologists.
- Very few staff had any training or understanding around the Mental Capacity Act.

However:

- We saw that the new long-term conditions transition policy incorporated NICE guidance.
- The 'Ready, Steady, Go' documentation had begun to be rolled out to services to help in transition planning.

Evidence-based care and treatment

- The trust had begun an audit of transition documentation within medical notes in October 2015. This focused on six long-term conditions that formed part of the Trust's CQUIN target. This considered if transition planning followed a recognised framework. This identified that no service was using a recognised framework for transition planning at the time of the audit.
- The trust had incorporated the National Institute of Health and Care Excellence guidelines (NG43-Transition from children to adult services for young people using health or social care services) into its transition policy. We requested that the trust provide us with a gap analysis to show the difference in practice and NICE guidance. The trust had carried out a GAP analysis to show where its practice did not confirm to the guidance. This had identified that the trust was compliant with 21 of 51 relevent recommendations (41%). The GAP analysis did not contain information to identify the actions the trust would take, the nominated lead, or timescales in which it expected to be compliant.
- In response to the audit, the trust had also incorporated the NHS 'Ready, Steady, Go' guidance into its policy and transition planning.
- The trust explained that some services (for example, gastroenterology) had not begun using the 'Ready, Steady, Go' guidance. Some services had yet to put it in to practice, whilst other services provided a more tailored transition planning approach for young people with more complex needs.

Nutrition and hydration

- For inpatients, there was no specific nutritional or hydration tool used for young people transitioning into adult care. Standard tools were in use at the trust to monitor fluid and nutritional intake.
- For outpatients, the Ready, Steady, Go documentation provided a prompt to ask about the young person's ability to make 'snacks/meals'. The parent/carer documentation also provided a prompt to parents around understanding the importance of a healthy diet for the young person. Further support could then be requested if young people or carers did not feel comfortable with these issues.
- Staff told us that inpatients had good access to support from dieticians. However, dietician support was not routinely available in all transition clinics.

Pain relief

- For inpatients, there was no pain tool used for young people transitioning into adult care. Standard tools were in use at the trust to monitor and respond to pain.

- Specific assessment of the pain relief needs of patients transitioning into adult care fell to the care provided within the clinical specialty they were attending.
- For outpatients, the Ready, Steady, Go documentation provided a prompt to ask young people and carers about the young person's ability to take medication, and confidence in this occurring. Further support could then be requested if they did not feel comfortable with this.

Patient outcomes

- The trust had no coordinated audit plan in place concerning transitional care. Audits took place within specialties on an ad-hoc basis. The transition team told us that they did hope to introduce a more formalised audit plan of young people transitioning into adult care going forward. However, this was reliant on the trust's electronic patient record system being rolled out in full and enabling young people transitioning into adult care to be flagged. Without this, staff explained that it would be very difficult to identify all relevant young people undergoing transition for audit purposes.
- The trust had two CQUIN targets in place with regard to transition care. The trust had achieved a target to implement a trust wide transition policy (May 2016). Results from quarter four of 2015/2016 also showed that the trust was meeting its CQUIN target of 80% of patients aged 15 years or older, and with one of six identified long term conditions, having a transition plan in place. All six identified areas had achieved above 80%, with an average score of 93.8%.
- In spring 2016, the trust sent out questionnaires to young people transitioning into adult care and carers in the six medical specialties identified within the CQUIN about their experience of the transition process. The trust received 14 young person's responses and 18 responses from parents. This showed that an average of 93% of young people and 88% of carers were either satisfied, or very satisfied, with the trust's transition arrangements.
- The trust provided details of a post-transition questionnaire pack that had been used in immunology services. The pack contained a questionnaire for young people transitioning into adult care and one for their family/carers. It included questions around the transition care they received and asked them to identify information they received.
- Assessment of 'young people friendliness' of services is set out in the Department of Health (DoH) 'Quality criteria for young people friendly health services' (or 'You're Welcome') guidance (2011). This identified 10 areas of quality criteria for services to consider. We did not see that the trust had a standardised plan in place to monitor the You're Welcome quality criteria within its services.

Competent staff

- The trust told us that all staff had access to the trust wide transition study day, cross trust transition meetings (which have an educational component) and that there was free e-learning available on transition.
- The last study day was held in 2015, with the next planned for January 2017. No study events were planned between this period and planning was still underway as to the proposed content of the 2017 session.
- We were provided with an agenda for the last Cross Trust Transition meeting. This had no specific slot allocated for training and the meeting was not minuted. Staff told us that this involved informal learning and discussions around the transition process and pathways.
- Staff explained that the e-learning module available was provided via an external resource and linked to the Royal College of Physician materials on adolescents. This was not mandatory and there was no record to show how many staff had accessed this resource.
- Staff within the transition team told us that they had plans to disseminate learning via a quarterly transition newsletter and e-mail updates to a transition group e-mail. At the time of our inspection, the first newsletter had been published in April/May 2016.
- Two specialist nurses for transition had attended training at the University of York. This was a degree and post-graduate module in transition care, which was supported by a local specialist children's NHS trust.

Multidisciplinary working

- Some services, such as oncology and cystic fibrosis, already provided MDT clinics. The oncology team had developed a multi-disciplinary teenage and young adult follow up and transition clinic for young people diagnosed with non-cancerous tumours. Young people over 13 years old were invited to attend for ongoing tumour follow up and were given the chance to meet

with a youth support worker, clinical psychologist and late effects nurse specialist. As well as undertaking tumour surveillance, young people were holistically assessed, received health promotion and began transition planning.

- Other services explained that MDT working was developed on a more ad hoc basis, as per the demands of individual young people attending the service. For example, provision had been made for young people with lung cancer to be seen at the trust by adult specialists. However, no formalised MDT arrangements or meetings were in place to discuss the specific needs of young people transitioning into adult care; particularly those with complex needs who may be seen in more than one specialty.
- Staff within the neurodisability and therapy services attended yearly MDT reviews with special schools for young people attending these services.
- Each service provided its own transition clinic. The transition team told us that there were plans to consider MDT clinics and the support this would require (for example, from psychologist or youth workers). However, this was in the early stages of development and no formal plan or proposal had been developed.
- Transition clinics within specialties relied on relationships with the equivalent specialty in the local NHS trust. Staff told us that most specialties had a named transition contact, who was responsible for transition care and would participate in joint clinic sessions. Where this was not the case, or where the young person was to transfer to another trust, staff told us that they often knew which particular consultant to refer the young person to based on previous experience.
- Planning for transition was not uniform across the trust, with different services accessing varying levels of support. The majority of services focused on the medical needs of patients and had no access to social work, psychology or youth worker support. This meant that there was no holistic assessment of transition needs available to many patients as suggested in the NICE guidance.

Seven-day services

- Clinics for young people transitioning into adult care ran at differing times and intervals depending on the needs of the service.
- Clinics were provided within working hours Monday to Friday.
- Young people transitioning into adult care could access the trust for emergency treatment via Accident and Emergency outside of working hours.

Access to information

- Where joint clinics took place with the local adult NHS trust, the trust explained that information was shared in clinic and was beginning to be shared via the Ready, Steady, Go documentation.
- Where joint clinics did not take place, or where young people were transferring to other NHS hospitals, staff explained that information would routinely be shared via a transfer letter.
- At the time of our inspection, there was no provision for medical records to be shared electronically with the local NHS trust.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke with told us that they had limited understanding or training on the Mental Capacity Act, or how it could apply to transitional care. They identified that they would request support from the transition team if they had any concerns.
- At the time of our inspection, the trust had only recently begun providing training to staff. No specific data was collected for staff dealing with transition, but 3.4% of trust staff had completed this training. This meant that there was a risk that staff did not understand capacity needs of young people, or parents, within the transition process.
- The results of a questionnaire the trust issued to young people in Spring 2016 showed that of 14 young people and 18 carers, 50% of young people and 55% of carers either did not know, or did not understand, issues around the Mental Capacity Act and consent in regard to transition care arrangements.
- The trust transition website provided a link to an easy read leaflet with information about the Mental Capacity Act and Deprivation of Liberty safeguards.
- Staff we spoke with told us that they were aware of Gillick competency and provided examples of where they had reached decisions on the competency on young people in delivering their care.
- However, from the records we received, we saw that some clinic letters continued to be directed to the

parents of young people transitioning into adult care and contained confidential patient information. We saw no documentation to confirm that this was what had been requested by the patients in question.

We rated this service as good for caring, because:

- Young people transitioning into adult care and their carers told us that staff were caring and met their needs.
- We observed staff providing compassionate and person centred care.
- Young people transitioning into adult care had access to nurse specialists, and in some cases psychology support, to help them with their emotional needs around transition.

However:

- There was inconsistent practice around how the trust explained and recorded patient and carer understanding about the transition process.

Compassionate care

- Young people transitioning into adult care told us that they felt that staff were caring and met their needs.
- We saw that professionals addressed young people directly in a manner in which they could understand and interpret.
- We observed staff providing care to young people transitioning into adult care. We saw that they met the needs of the young people we observed and considered the circumstances in which the they were being seen. For example, in the cystic fibrosis clinic we saw that provision had been made to provide refreshments for young people and multidisciplinary staff rotated around the young person, rather than asking the young person to move around clinic rooms.
- Staff we spoke with were caring and passionate about ensuring an effective transition into adult care for their patients.
- Carers we spoke to told us that staff were caring and spoke positively about the care their loved ones had received.

Understanding and involvement of patients and those close to them

- Staff told us that young people were always offered the opportunity to discuss their care without a parent or carer being present. We saw that this was a routine part of some specialist pathways, and was referenced in clinic documentation from other areas.
- However, there was no consistent practice on how this information was offered or recorded in the medical records. Two young people we spoke with told us that they had not been told that they had the opportunity to discuss their care without their carer being present.
- Two older teenagers we spoke with told us that they had not yet begun transition planning and did not understand what process this was to follow.
- The Ready, Steady, Go documentation included a list of questions that allowed young people transitioning into adult care to identify if they were confident around a range of areas involved in the transition process. Some transition pathways developed by the trust also included a transition plan, which had some scope to record the patient’s understanding and prompt staff to respond to concerns.
- The Ready, Steady, Go documentation included a specific form for carers to complete to identify if they also felt confident in the transition process.
- We saw limited evidence of young person and carer understanding being recorded in the medical records we reviewed. Of the 18 records we saw, only five records contained Ready, Steady, Go documentation or a transition plan showing that the process had been discussed with young people. Only one record had a completed parent/carer form to record their understanding of the transition process.
- The results of a questionnaire the trust issued to patients in Spring 2016 showed that of 14 young people and 18 carers, 53% of young people and 48% of carers, either did not know or could not identify that a specific transition care plan was in place.
- The results also showed that 93% of young people and 94% of carers identified that they had received enough information on their medical condition.

Emotional support

Transitional services

- The results of the trust questionnaire showed that of 14 young people and 18 carers, 93% of young people and 83% of carers could identify a named staff member that was able to provide support.
- Clinical nurse specialists were available across a range of transition services and often acted as the named transition nurse. This allowed young people transitioning into adult care to access emotional support and advice from nurses within transition clinics.
- Some services, such as oncology and the neurodisability service provided psychological support within transition clinics. However, this provision was not available within every service.

Are transitional services responsive?

Requires improvement

We rated this service as requires improvement for responsive, because:

- There was no centralised record of the number or type of young people transitioning into adult care.
- There was no provision for multi-specialty clinics, meaning some young people had to attend hospital on multiple occasions to see different specialties.
- There was no single clear, structured education programme or guidance for young people or carers around the transition planning process.
- The trust did not have a robust process in place to monitor and consider complaints that may relate to transitional care.

However:

- Specialist transition clinics were available in most clinical specialties.
- Individual services held transition registers, which helped them to identify and adapt to the needs of young people within these services.

Service planning and delivery to meet the needs of local people

- The trust held no centralised record of young people transitioning into adult care, and these young people could not be flagged within the trust's record system at the time of our inspection. This meant that it was not possible to accurately determine why some young people continued to receive care beyond the age of 18, as no specific trust wide records were kept.
- Some services told us that young people would routinely stay with them after they reached 18 years old, due to the different transitional needs within these services. For example, neurodisability patients transitioned at 19 years old. We observed a 21 year old patient being provided with care on a side room in the ward. Staff told us that this was due to their history with the trust and an understanding of their complex physical needs.
- Some services, such as oncology, told us that young people would stay with them after 18 years old where they were still undergoing active treatment, and to transition would mean doing so during a course of treatment.
- Specialist transitional clinics were available in the majority of services. These were age appropriate and allowed young people transitioning into adult care to be seen alongside other adolescents, or first on clinic lists so that their needs could be specifically addressed.

Access and flow

- At the time of our inspection, the trust was unable to provide any data to identify the number of young people transitioning into adult care. It explained that a new electronic patient administration and document management system was expected to be in place from Autumn 2016. From this point, it hoped to be able to more accurately identify the number of young people transitioning into adult care.
- Services operated separate transition clinics. There was no co-ordinated approach to clinic planning and booking to ensure that the number of visits to hospital could be minimised. The transition team told us that this was something they were considering going forward, but that no specific plan or strategy was yet in place to this effect. This meant that young people transitioning into adult care, who required input from multiple clinical specialties, had to attend the trust on multiple occasions to discuss their care.

Meeting people's individual needs

- We noted that there were a number of transition planning processes in place at the time of our inspection. The trust was in the process of rolling out

Ready, Steady, Go, it also had its own draft transition plan when this was not suitable due to more complex patient needs. Some specialties continued to use their own transition planning documentation, whilst physiotherapy and neurodisability used a transition passport system. This meant that there was a risk that transition planning and delivery could be confused, particularly where patients were attending multiple-specialties.

- However, the trust had developed a specific transition pathway for critical care. This allowed a specific tool to be used to allow young people to be passed onto adult services, and contained all the necessary clinical handover information to allow the individual needs of the patient to be met in adult services.
- There was no structured education programme available for young people transitioning into adult care. Services within the trust provided varying levels of support and information to patients and we saw evidence of this in the medical records that we reviewed. This meant that there was a risk that patients and carers were not getting appropriate support or education to help them understand and plan transitional care.
- The Ready, Steady, Go documentation offered prompts on a number of questions where young people or carers could then request further support from staff if they felt that they did not understand or feel fully comfortable.
- The neurodisability and therapy team had developed a transition passport. This included key information about their care and personal preferences that could be taken with young people to transition clinics and adult services to help access the care they required.
- The transition policy set out that general transition planning should be discussed from the age of 13. Once a child was 14-15, individual transition plans were to be completed each year to identify their individual transition needs. This was to include consideration around joint clinics and visits to adult services. From the records we reviewed, we noted that this was not yet happening within services. However, staff were confident that this would occur once the policy had an opportunity to be embedded.
- At the time of our inspection, some services held a separate transition register to identify the patients within its service that were entering the transition phase of care. Staff told us that this helped individual specialties to identify and meet the needs of these specific young people.
- We observed staff interacting with a young person with complex needs. They spoke to the young person directly, as well as interacting with their carers. The young person was able to use sign language, and staff relied on the carer to communicate via sign language with the patient.
- Some services had access to youth workers as part of the transition clinic process, for example in cystic fibrosis clinic. However, this provision was not universal in all clinics.
- Staff had access to a telephone translation service to meet the needs of families from different cultural and ethnic backgrounds.

Meeting the needs of adolescents

- There was no specific adolescent ward available for older patients. Instead, these young people were seen on wards that met their clinical presentation.
- Staff told us that they would routinely try to ensure that older patients seen on wards were nursed in a side room to provide them with some privacy. However, this was not always possible and patients as old as 21 years were placed in general same-sex bays on wards. We asked staff if they would routinely be placed in bays with older children. Staff told us that this would happen where possible, but that they could be in bays with younger children if there was limited capacity.
- A youth room was available within the hospital. This allowed older patients to enjoy television, games and entertainment that was suitable for their age. For example, we noted that 15 rated films were available to older transitioning patients.
- The clinic and ward environments were generally decorated for younger children. This was commented on by young people who attended the Youth Forum. They asked for more grown up decoration. The trust told us that a dedicated transition clinic area was being considered as part of the new outpatients opening in late 2016.

Learning from complaints and concerns

- The trust explained that due to the lack of an electronic system, there was no specific way in which complaints

could be flagged as being specifically in relation to transition. The trust could not provide details of the number of complaints where transition was identified as a concern.

- The transition team told us that they could not recall any specific transition complaints being raised with them.
- Service leads told us that they would identify complaints about transition when complaints were passed to them for investigation.
- The transition team told us that they were relatively confident that any complaints regarding transition would be identified by service management and flagged to them. However, there was no formalised way in which this occurred or was recorded.
- The neurodisability service was able to provide an example of learning from a specific complaint around transition. This identified that the young person had been transitioned too late in their care, and that this had caused problems accessing adult services. As a result, and as part of a service review, staff were now looking at what age young people should begin to transition in more detail.

Are transitional services well-led?

Requires improvement

We rated this service as requires improvement for well led, because:

- The trust had made insufficient progress in developing transition services since our last inspection.
- There was no overarching vision or strategy for transition services within the trust and governance structures were not yet fully in place.
- There were limited examples of staff and public engagement in driving the transition agenda within the trust.

However:

- A transition policy for long term conditions had recently been introduced and was beginning to be used by staff.
- A transition team had been established to help drive the transition agenda for long term conditions.
- The trust had begun to engage with patients via youth forums and the internet to help to ensure patients could be involved in transitional care.

Vision and strategy for this service

- The trust's corporate objectives for 2016/2017 included working with partners to improve transition care for patients with mental health needs. However, transitional care for non-mental health patients was not identified within the objectives.
- There was no stated overarching vision or strategy in regard to the delivery of transitional care.
- The trust's focus for transition was on patients with long term medical conditions. The medicine directorate explained that it did not have a local strategy plan in place, rather it developed strategies based on those areas requiring greatest intervention/change as a result of capacity/demand issues. In regard to transition, it identified that it was committed to the continued development of transition services. It noted that the directorate now had nursing, clinical and managerial time dedicated for transition and would 'look to take forward the pathways, policies and audit associated with these services'.

Governance, risk management and quality measurement

- The trust did not prepare an annual report on transition services. However, a presentation around this had been planned to be given to the trust executive. The trust told us that quarterly reports would be provided to the trust's quality committee to monitor transitional care. At the time of our inspection, the first report had not yet been made available to the quality committee. This was due to be discussed at the next quarterly meeting.
- The transition team had delivered a presentation to the board in May 2016. Senior staff told us that this was the first time since our previous inspection in 2014 that transition arrangements had been specifically discussed at trust board.
- The trust explained that it held no central risk register for transition services. Instead, any relevant risk would be noted on the appropriate directorate risk register.
- The transition team had prepared a risk assessment, which incorporated the key risks around transition within the trust. The greatest risks were around incident

reporting, audit, transition databases and multi-specialty transition. The risk assessment identified some actions to improve processes, but did not fully address some concerns.

- For example, in regard to identifying young people transitioning into adult care on databases, the risk assessment identified that there was a risk that young people transitioning into adult care could be overlooked. They planned to produce a database when the trust's electronic document management system was active. However, there was no plan as to how to ensure these patients were not overlooked in the intervening period, until the system was active.
- The trust had a transition and young people's working group in place to identify and discuss transition issues within the trust. The group had first met in November 2015, and most recently in March 2016. The group was made up of consultant leads, team leads, and associate directors from the trust.
- The trust held ‘cross trust’ transition meetings with a local NHS Trust. We were provided with an agenda for the latest meeting in May 2016. This included discussions around care pathways and work on the Ready, Steady, Go programme. We were told that the meetings were not minuted which meant that we could not confirm what was discussed in detail.
- The trust was represented on the transition steering group at the local NHS trust. We saw that this allowed trust staff to input into key decisions on inter-trust transition discussions. This group met once per year.
- The trust told us that some specialities, such as diabetes, had developed their own transition databases and used these to identify young people that needed transitional care.
- A performance dashboard had been developed by the Yorkshire and Humber clinical network transition task and finish group. The trust was part of this network and was due to begin using the dashboard to monitor performance following its release in late June 2016.
- The current governance structures were limited to discussions around the transition of young people within the hospital setting and in therapy services. They did not incorporate wider community or mental health services. Transition within these services was discussed and managed within the governance and risk management structure of those services.

Leadership of service

- The Director of Nursing was the executive lead for transition on the trust board. They had taken this role on following their appointment in November 2015. Prior to this, there was no nominated executive lead for transition.
- At the time of our inspection, the trust did not have a non-executive lead for transition appointed to the trust board. The trust explained that it was in the process of recruiting new non-executive directors, and that one of the new appointees would fulfil this role.
- The transition team had been allocated funding in November 2015 and a business case had been developed to allow funding for staff to dedicate allotted time to transition. At the time of our inspection, the trust had a clinical lead for transition, a transition lead nurse, and a management lead for transition. They performed these roles alongside their other substantive posts and were the main points of contact for clinical, nursing, and managerial support around transitional care planning.
- Within services, there were nominated consultants, nurses, and AHPs that took on the lead role for transitional planning and clinics.

Culture within the service

- The transition team told us that they felt positive and well supported to deliver the transition agenda.
- Transition leads told us that they had been well supported and felt confident in approaching the transition team with any questions or queries around the transition process.
- Staff providing transition services worked within their designated specialties and directorates. Given this, there was no shared leadership or culture at a clinical level. Each specialty and service had its own culture, as reflected in our wider inspection reports.

Public engagement

- The trust had established a young person's forum. The forum consisted of young people or siblings of patients who had been looked after by the trust, who were aged 11 to18 years old, and who were interested in providing feedback to hospital staff and decision makers who wanted feedback on new developments within the trust. This was established on 1 June 2016 and had met once at the time of our visit.

Transitional services

- The trust had intended to consult with the Youth Forum in the development of its transition policy. However, this had not been possible due to a delay in the Youth Forum being convened.
- The transition team told us that they hoped to appoint the chair and vice chair of the Youth Forum onto the Transition and Young Persons Working Group. At the time of our inspection, this had not yet taken place and no young people had yet been present at group meetings.
- The trust had developed a leaflet, 'Transition – getting ready to move on to adult services' to provide general information to young people and their carers around the transition process.
- The forum and leaflet were dedicated to providing information around long term conditions and did not include specific representation or information in regard to community or mental health services.

Staff engagement

- The trust had previously held a transition study day in conjunction with the local acute hospital in March 2015. It planned to hold a further transition study day in January 2017 for staff at the trust, and in conjunction with a local adult trust. This was with the aim of increasing awareness of transition practices.
- The trust told us that they had a transition newsletter in place. We saw that the first newsletter was circulated in April 2016. The June 2016 newsletter was displayed on wards within the children's hospital and included information about the transition team and recent developments with the transition policy and ready steady go documentation.

Innovation, improvement and sustainability

- The transition team had produced a video, which was accessible via the internet, to provide young people and their families with some general information about the transition process.
- The trust had a dedicated website for transition. This provided information about the process, including links to the Ready, Steady, Go documentation, the trust's annual transition plan and details of services offering transition clinics.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- The trust MUST ensure all children are appropriately assessed for safeguarding risks.
- The trust MUST monitor and utilise outcome data on the neonatal unit.
- The trust MUST ensure that there are effective governance systems in place to capture, respond, and learn from transition related complaints and incidents.
- The trust MUST ensure that sufficient numbers of staff have appropriate training in the Mental Capacity Act.
- The trust MUST ensure that there is an effective clinical audit system in place to monitor transitional care provision.

Action the hospital SHOULD take to improve

- The trust should implement sepsis tool documentation to enable early intervention for febrile patients.
- The trust should implement the use of the paediatric early warning system for all children who attend the department to enable early intervention for deteriorating patients.
- The trust must ensure that staff undertake and document appropriate risk assessments to promote safe care.
- The trust should ensure that there is a consistent and robust approach to the assessment and planning of transitional care
- The trust should ensure that a consistent approach is adopted to the completion and storage of transition medical records.
- The trust should ensure that steps are taken to create and maintain a transition database to allow patients in transition to be identified.
- The trust should ensure that staff dealing with transitional patients have appropriate knowledge and training around transition care.
- The trust should ensure that its transition pathway is considered in conjunction with community and mental health services.
- The trust should ensure that an appropriate gap analysis is conducted to identify any gaps in its transition service provision against the applicable guidance from the National Institute of Health and Care Excellence.
- The trust should review systems in place for medical equipment service checks so all equipment is appropriately checked.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: There was no consistency across the trust with regards to records. There was a risk that practitioners did not have access to information in a timely manner.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment How the regulation was not being met: Within the emergency department there were missed opportunities to undertake risk assessments and documentation to prompt assessment of safeguarding needs and sharing of information with other agencies.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent How the regulation was not being met: Staff we spoke with told us that they had limited understanding or training on the Mental Capacity Act, or how it could apply to transitional care.

This section is primarily information for the provider

Requirement notices

There were clinic letters that continued to be directed to the parents of young people transitioning into adult care and contained confidential patient information. We saw no documentation to confirm that this was what had been requested by the patients in question.